2022

Crisis Standards of Care Plan Guidance

Region 3 Healthcare Coalition Alliance

Approved: June 2022

1. INTRODUCTION

For purposes of developing recommendations for situations in which healthcare resources are overwhelmed, the Institute of Medicine (IOM) defined the level of health and medical care capable of being delivered during a catastrophic event as "crisis standards of care":

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

Florida is susceptible to a wide variety of hazards that would potentially overwhelm the healthcare system and necessary supplies and resources. Purpose

1.1 BACKGROUND

The ASPR Hospital Preparedness Program (HPP) has continuously evolved in Florida from a focus on hospitals to one that includes the entire health & medical system. Healthcare coalitions (HCCs) were originally utilized primarily for information sharing. However, HCC roles have expanded during the COVID-19 response, to include resource sharing, communications, and coordination of information amongst facilities. HCCs were directed to write a Crisis Standards of Care plan and integrate it into their Coalitions.

The most recent effort to address Crisis Standards of Care at a state level in Florida began during the 2014 Ebola Viral Disease (EVD) preparedness effort. During this time, it became overwhelmingly necessary to review the recommended response to new and/or re-emerging infectious disease outbreaks, to establish procedures, resources, equipment, and to provide training to maintain current standards of care with limited availability of appropriate PPE. Considering these threats to public health and our experience with both real and potential catastrophic events, it was recommended that a more formal review of current best practices be conducted, and a guidance document be developed to address the issue from an all-hazards perspective.

The State of Florida Department of Health Bureau of Preparedness and Response took the initiative during the EVD event to begin a review of current literature and evidence-based practices relating to the need to respond to a public health emergency in which patients will seek and require medical care. However, as of the writing of this document, no state-level guidance on establishing Contingency or Crisis Standards of Care in Florida has been developed. The decision to implement such standards is being left with the individual health care organizations and their leadership.

The Region 3 Healthcare Coalition Alliance (Alliance) provides situational awareness of emerging and current crisis situations to our member and partner agencies, opportunities for discussion and collaboration during incidents that impact multiple organization and jurisdictions, and relevant trainings and exercises on multiple and varied crisis situations.

1.2 PURPOSE AND SCOPE

The purpose of this Crisis Standard of Care (CSC) guidance is to provide a framework for emergency medical services, healthcare systems, facilities, and organizations to plan, prepare for and respond to emergencies which present in resource-limited environments. In addition, this document provides a guide for making informed decisions based on the premise of the CSC, which is to do the greatest good for the greatest number of persons. The overall goal is to achieve the most significant and diverse allocation of patient care during all phases of a public health or medical emergency.

This CSC document provides background and planning guidance for developing an approach to understanding the circumstances and triggers that could result in an immediate need to implement altered standards of care. This guidance should apply whether the precipitating event is the result of an act of weather, natural disasters, terrorism, public health pandemics, infectious diseases or medical emergency, a mass casualty event (MCE), or inadequate resources available to maintain the current standard of care.

Consideration of the Alliance's CSC guidance will assist coalition members and regional partners in a process of more informed decision-making during emergencies. Members of the coalition include all hospitals, healthcare partners, county health departments, emergency management, emergency medical services, public safety, and other agency types identified by CMS to be a part of healthcare coalitions.

1.3 PLAN DEVELOPMENT

The Region 3 Alliance staff works with subject matter experts and the state Healthcare Coalition Working Groups to develop the basic planning template. The Crisis Standards of Care Plan Guidance and all supplemental, supporting documents are presented to all healthcare coalition members during a scheduled Board meeting. The draft plan is then emailed to every member and posted on the Alliance website. Members are asked to provide review and input. Comments and feedback from members are analyzed and included in the final planning document presented to each Board for annual approval. This Crisis Standards of Care Plan Guidance is considered a "living document", in that it is subject to an annual review and revision based upon recommendations following any type of test of the plan or change in State or Federal guidelines.

The final plan is provided to all Board members for approval annually at the June meeting. A copy of the approved plan is posted on the Coalition Alliance website (www.FLRegion3HCC.org) for use by all Coalition members.

1.4 Legal Authority

This document is not intended as official policy but to provide healthcare providers and healthcare facilities with information to consider when planning their response to an event in which the decision to allocate scarce resources in a manner that is different from usual circumstances but appropriate to the situation.

Healthcare Coalitions have no legal or jurisdictional authority over clinical standards of care decisions. This authority lies within state/local governments, regulatory agencies (such as the Florida Department of Health, Agency for Healthcare Administration, etc.), and medical leadership at individual healthcare delivery organizations.

1.5 Guiding Principles and Ethical Considerations

Public health emergencies raise ethical challenges for healthcare professional and institutions at every level. In these situations, the primary duty is to protect the health and welfare of the community, not that of an individual. During a public health emergency with the threat of high morbidity and mortality, like COVID-19, demands exceeding capacity for care may result in a situation where the ultimate clinical goal is to do the greatest good for the greatest number of people. Services may not be available in a disaster. It is essential to identify, plan and prepare for making necessary adjustments in medical care standards to ensure that the care provided in response to mass events results in as many saved lives as possible.

Healthcare professionals have a duty to provide care. The Coalition goal is to provide information and resources to the healthcare professionals. Principles are formalized and instituted to guide decision makers through public health emergencies and plan for response.

2. Considerations for Concept of Operations

When an emergency declaration is made, it changes the legal environment and enables specific legal and regulatory powers and protections for public health and healthcare providers concerning their actions and omissions associated with allocating and utilizing scarce medical resources and implementing crisis standards of care (CSC). This guidance provides a delineated continuum of care from normal operations to eventual crisis standards. The continuum involves the scarcity of all other resource options until it is no longer feasible to provide normal care, including strategies to utilize and optimize existing resources, and augment existing resources from numerous partners and sources.

Basic medical procedures for immediate care permit some actions during crisis situations that would not be acceptable under ordinary circumstances, such as implementing resource allocation protocols that could preclude the use of certain resources on some patients when others would derive greater benefit from them (i.e. ventilators, ICU beds). Healthcare professionals are obligated always to provide the best care they reasonably can to each patient in their care, including during crises. When resource scarcity reaches catastrophic levels, healthcare entities are ethically justified and are ethically obligated to use the available resources to sustain life and well-being to the greatest extent possible.

The final determination as to the applicability of the information contained in this guidance document is very dynamic by virtue of:

- The event and its variables and circumstances, information available, resource and inventories on hand and availability of adequately trained staff, medical supplies, and equipment for major events, and
- The locations and structures in which the region's healthcare partners can provide care, i.e., alternate care sites, testing at various locations, shelters, etc.

Applicability of the guidance would include following federal guidance by meeting the following conditions:

- Identification of critically limited resources and infrastructure
- Surge capacity fully employed within healthcare facility and knowledge of alternate facilities for surge medical patients
- Maximal attempts at allocation, reuse, adaptation, and substitution performed for PPE and other associated equipment
- Patient transfer or use of evacuation equipment (Ambubus), if possible, or implications to agencies if transfers are started too late and cause impairment to first responders.
- Request for necessary resources made to local and regional health officials through county, state, or regional agency contacts (Emergency Managers, County ESF8, State ESF8, Federal DMAT teams, regional response teams)
- Declared state of emergency, federal declarations, Executive Orders, or other authoritative documentation.

1.6 Framework for Developing Crisis Standards of Care

Facilities should follow a framework recommended to address the issue of crisis standards of care from state and local public health departments, local and state government representatives, providers from the healthcare community including relevant medical disciplines, nursing, emergency medical services, palliative care, hospice, home health care agencies, and healthcare and hospital administrators. Several recommendations might include the following:

- Develop crisis standards of care protocols
- Seek community and provider engagement
- Ensure consistency in CSC implementation

Ethical features of the CSC will consist of fairness, duty to share due to governmental orders and forced orders that may be made on emerging situation or crises.

Common Indicators for CSC – example:

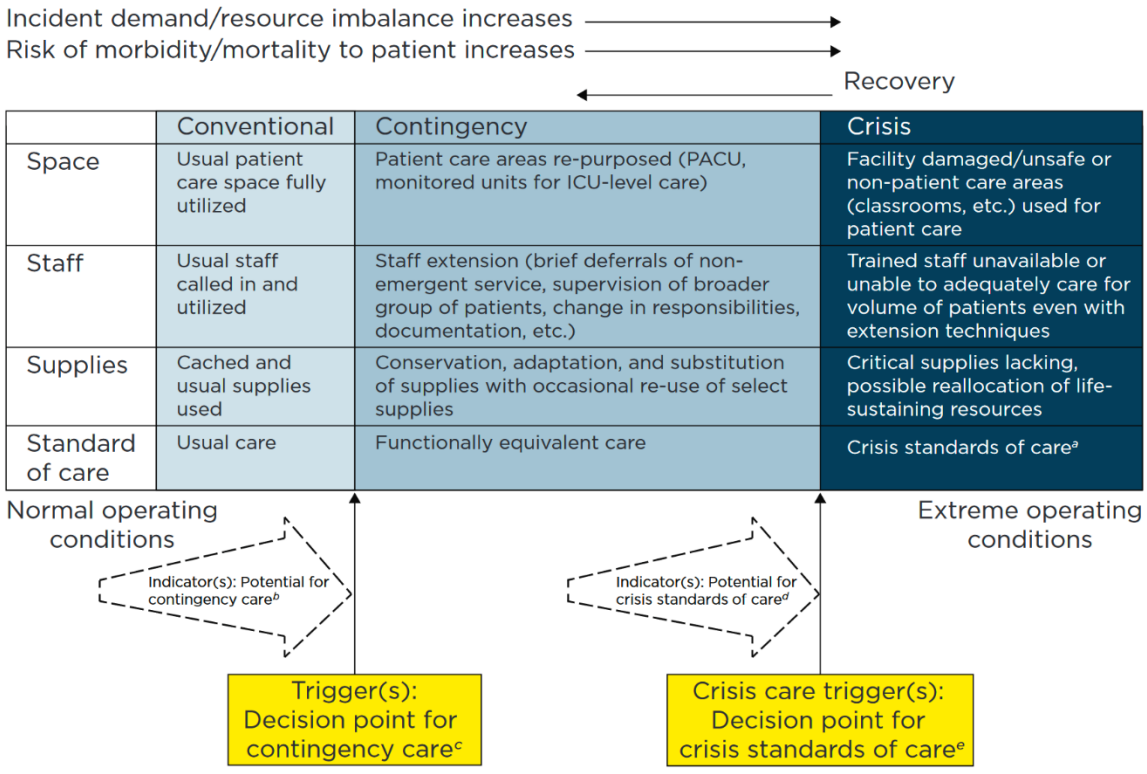
- Situation is causing individual healthcare organizations to consider initiation of surge protocols
- Healthcare facilities are maximizing surge capacity at their facility and throughout the HCC

- HCC members are working together to utilize and maximize available resources
- HCC members are working together to avoid noncritical use of scarce resources
- Healthcare facilities are using appropriate resources to facilitate the discharge of inpatients and consider or initiate postponing elective procedure surgeries
- HCC will make every effort to assist in securing additional resources to reduce impacts
- HCC members are collecting and responding to information shared

1.7 Standards of Care Under Conventional, Contingency, and Crisis Conditions

When demand for staffing, space, and supplies outstrips availability, or when demand remains high for an extended period of time, healthcare facilities and systems must determine whether they can maintain care practices typically used in conventional conditions or whether they face contingency conditions or crisis conditions. If scarcity is widespread, local or state authorities may be responsible for acknowledging contingency or crisis conditions and providing guidance for ethical response.

In a public health emergency such as the COVID-19 pandemic, care is provided on a spectrum, starting with conventional conditions, progressing to contingency conditions when increased demand for one or more resources requires alterations in usual healthcare delivery practices, and in some circumstances moving to crisis conditions, when scarcity of resources relative to demand becomes acute and it is no longer possible to provide care that is functionally equivalent to conventional care.



	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[a]

Table 1: Contrasting conventional, contingency, and crisis conditions

1.7.1 Conventional Care Conditions

Usual standards of care apply. Best practices, individual patient choice, and the patient's best interests should guide care. As usual standards of care involve providing care that is customary under normal circumstances, the healthcare system or facility has no special obligation to communicate to the community and patients that usual standards of care are in operation, other than to clarify when this norm has been resumed after adaptations to contingency or crisis conditions have been temporarily instituted. It should be noted that there is variation in the care customarily provided by healthcare institutions under conventional conditions, given diversity among institutions and their capacity. For example, tertiary care hospitals provide different types of care in conventional conditions than do critical access hospitals. Nevertheless, best practices, individual patient choice, and the patient's best interests should guide care in conventional conditions relative to the capacity of the institution.

1.7.2 Contingency Care Conditions

The core goal in contingency conditions is to adapt care practices—e.g., through conservation or substitution of resources, changes in staffing plans or use of space—to avoid crisis conditions while striving to maintain usual standards of care. The care delivered may be different but should be functionally equivalent to care that is provided in conventional conditions. Functional equivalence does not require that outcomes will be identical to those in conventional conditions. Given the limitations of contingency conditions created by resource shortages, a range of possible care practices and associated outcomes may be functionally equivalent to those in conventional circumstances. This range is characterized by two types of factors:

1. Outcomes of care should be expected to be substantially similar in contingency conditions as in conventional ones; death or serious adverse outcomes should not be expected because of altered care delivery, for patients (who may be affected by e.g. shortages of supplies or staff) or staff (who may be affected by e.g. shortages of personal protective equipment (PPE), or hazardous conditions at the facility related to a tornado or bombing). Adapting practices to provide functionally equivalent care may require identification of alternative therapeutics to replace those in short supply, alternative models for staffing or use of space, cancellation, or postponement of elective procedures, and/or load-balancing across the system or region. Care practices should remain as close as possible to those in conventional conditions, given limitations imposed by resource constraints, but a range of outcomes may be functionally equivalent to those attained in conventional conditions. Regional authorities and the state should work collaboratively with health systems to ensure that outcomes are tracked so data can anchor assessments of functional equivalence, as there may be uncertainties about which conditions or practices may significantly compromise patient outcomes.

2. In addition, the aim of care should continue to be focused primarily on the well-being and treatment preferences of each individual patient. This contrasts with crisis standards of care, in which the primary goals of care shift to advancing population health. Contingency conditions require attention to population health considerations only to the extent that resources need to be conserved, extended, and adapted to meet the needs of all patients.

If these 2 conditions are no longer met, then care is no longer functionally equivalent. At that point, care transitions from contingency conditions to crisis conditions, and crisis standards of care must be implemented.

It should be noted that triage or rationing does not always compromise patient outcomes, and in such cases these practices are permissible in conventional or contingency conditions. For example, rationing may be used across a patient population as a conservation strategy for particular resources to prevent moving into crisis conditions; examples that are not expected to compromise patient outcomes include across-the-board strategies such as decreasing to 90% the value at which oxygen saturations are maintained to conserve oxygen, rationing prophylactic antibiotics to prioritize treatment uses, or disallowing the use of IV hydration when oral intake is possible. Similarly, it is customary to triage patients in busy emergency departments even in conventional conditions and doing so need not compromise patient outcomes. **However, when triage or rationing substantially compromise patient outcomes**—e.g., when ventilators or medications are in such short supply that the needs of all patients cannot be met—**then crisis conditions apply for those resources.**

Scarcity is dynamic and may evolve rapidly, so that **conditions may shift across the surge continuum as scarcity and the ability to maintain care that is functionally equivalent to that provided in conventional conditions waxes or wanes. Deviations from conventional approaches to care should be minimized and should be applied only to resources that are becoming scarce, not extended to other resources.** Further, impending crisis conditions should trigger the facility to seek assistance with obtaining additional resources or load-balancing patients to reduce the burden and allow the facility to stay in contingency conditions. Healthcare systems have an ethical obligation to collaborate to maintain as much as possible a uniform or consistent approach to conservation and extension of resources across the region, through load-balancing or other strategies.

When a shift away from conventional approaches to care is required, decisions must be transparent, accountable, and consistent with fundamental ethical values, so that they provide effective protections for patients and appropriate support for healthcare professionals. **The mechanisms for resolving disagreements about medical decision-making under contingency conditions may be accelerated or otherwise streamlined.** However, these processes should be functionally equivalent to those used under conventional conditions in terms of protections for patients.

Bedside clinicians should not engage in ad hoc alterations to care practices -- i.e., alterations in care made at the bedside (including triage or rationing) without appropriate consultation. Changes to care practices should be made in consultation with unit, facility, or system leadership, and following explicit institutional policy if available or relevant ethics guidance such as ethics frameworks disseminated by MDH. Those consultations with leadership will facilitate:

- recognition of resource shortages and understanding of the challenges faced by providers at the bedside,
- activation of efforts to maintain care that is functionally equivalent to that provided in conventional conditions,

- standardization of the facility's/system's approach to resolving the issue, which is likely not limited to a single patient care encounter, and
- efforts to avoid CSC.

If the bedside clinician must make a very time-sensitive decision about patient care -- e.g., deciding which patient can safely remain on BIPAP and which should be intubated, or which can wait for dialysis and which needs treatment more urgently -- and consultation with leadership would not be possible in the required timeframe, the provider should consult with at least one other provider with relevant expertise, and then rapidly notify leadership about the resource shortage and the decision that was made. All consultations with leadership or other providers should be documented. **Judgments concerning functional equivalence may require input by clinician specialists (e.g., to answer questions about whether alterations in frequency of dialysis may increase risk for patients) or incident command in consultation with unit directors and/or practice managers (e.g., in the case of staffing changes). These decisions should be informed by evidence on functional equivalence to the extent possible** but shifting conditions as the incident unfolds may mean that some decisions must be made under uncertainty. **To promote functionally equivalent care, healthcare facilities/systems should provide support for healthcare workers,** including by communicating clearly about scarcity and plans for addressing it, designating leaders authorized to address questions about how to adapt care to evolving conditions, protecting workers with adequate personal protective equipment (PPE), and addressing their psychological and moral distress.

If a healthcare system or facility is facing shortages of one or more resources that create contingency conditions, the system or facility should **explicitly communicate this to providers** in order to support efforts to maintain care that is functionally equivalent to that provided in conventional conditions and to aid efforts to avoid CSC. The system or facility should also **communicate this development to regional partners** to promote coordination of efforts to avoid CSC, such as load-balancing. Finally, the healthcare system or facility also has an **obligation to communicate to patients and the community** that while care is functionally equivalent, the conditions of care are different than usual, especially when the system or facility is approaching crisis conditions with respect to any particular resource or scarcity broadly impacts care delivery. Doing so promotes transparency, and may help reinforce messages about the importance of public health measures (such as masking and social distancing to prevent pandemic surges) that may worsen conditions in healthcare facilities.

1.7.3 Crisis Care Conditions

Crisis standards of care (CSC) apply to resources

- that are unavoidably scarce and for which there is no appropriate substitute or alternative, despite the efforts to mitigate scarcity outlined above, and
- when such scarcity places some patients at substantial risk of adverse outcome.

In such crisis conditions, care may be allocated according to a different set of clinical and/or other criteria than under usual standards of care; **crisis conditions "justify temporarily adjusting practice standards and/or shifting the balance of ethical concerns to emphasize the needs of the community**

rather than the needs of individuals."[1] In pervasive or catastrophic public health events with medical surge implications, response must focus on the overall benefit to the population, to try to minimize morbidity and mortality, while also respecting rights and promoting fairness across our population.

- **Changes to care practices that may significantly compromise patient outcomes may not be implemented unless they are unavoidable.**
- **Any such changes must be due to specific shortages of specific resources.** Specific scarce resources may require triage or rationing or other alterations to care practices, but this does not mean that clinicians are free to triage or ration unrelated resources or to change practices more widely than necessary. Providers should maintain care that is functionally equivalent to usual standards, if possible.
- When shortages undermine the ability to provide care that is functionally equivalent to that provided in conventional conditions, **decisions regarding changes to care practices must be transparent, accountable, and consistent with fundamental ethical values.**
- **Bedside providers should not engage in ad hoc triage or rationing.** Ad hoc decisions fail to provide appropriate protections for patients or adequate support for healthcare professionals. The need for other changes to care practices -- e.g., implementing crisis plans for staffing or space -- should also be escalated to facility/system leadership.
- Providers should not obscure or conflate justifications for alteration, withdrawal, or withholding of treatment; **decisions to triage or ration due to resource scarcity must not be conflated with decisions that an intervention is futile, potentially inappropriate for patient-specific reasons not related to scarcity, or constitutes non-beneficial care,** as discussed below.

Depending on how widespread crisis conditions are within the state, facilities, healthcare systems, the regions to which they belong, or the state should determine and **communicate to patients and to the community that operating conditions have changed,** that specific resources are scarce in a way that may result in poorer outcomes for patients, that care may thus no longer be functionally equivalent to usual standards of care, and that triage or rationing may occur. Facilities, healthcare systems, and regions or the state should also **communicate when CSC are no longer needed** for the resource in question.

Response plans should **address access barriers and health disparities to avoid exacerbating health inequities.** Obligations to distribute the burdens and benefits of the healthcare system fairly and equitably across the community remain.

Response plans must also implement **appropriate protections for critical workers in high-risk settings** -- including relevant healthcare workers -- in addition to attending directly to the needs of the general public. This may mean giving workers priority for scarce resources or changing expectations about what

[1] Institute of Medicine. 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Vol. 1: Introduction and CSC Framework. Washington, DC: National Academies Press: 1-1.

types of treatment they are required to provide patients if certain interventions are too risky to healthcare providers.

Conditions	Ethical obligations	Clinical Practices
Conventional	Optimize individual patient care; pursue care options consistent with best practices, patient choice, and best interests.	Usual standards of care apply. Do not tolerate unusual or substandard care.
Contingency	Strive to maintain usual standards of care by providing care that is functionally equivalent to that given in conventional circumstances. Recognize that a range of care practices may be functionally equivalent to care in conventional conditions. Track outcomes to better anchor assessments of functional equivalence. Standard of care is still oriented to individual patient interests, with obligations to conserve and extend resources, in order to avoid or delay crisis standards of care.	Tolerate practices that utilize limited resources differently than usual with the expectation that such altered practices are developed and performed in accordance with usual standards of care. In contingency conditions, this standard of care is maintained by providing care within the range of options that are functionally equivalent to care in conventional conditions. Changes to care practices that are likely to adversely affect patient outcomes are not permitted.
Crisis	Obligations to community supersede individual patient interests. Minimize morbidity and mortality, while also respecting rights and promoting fairness across the population. Facilities, healthcare systems, regions, and/or the state should communicate to patients and to the community that operating conditions have changed.	Crisis standards of care apply. Care is no longer functionally equivalent to usual standards of care. Significant risk to the patient or provider may exist but should be mitigated to every extent possible.

Table 2: Comparing ethical obligations and clinical practices across the spectrum of care

1.8 Ethical Obligations Across the Continuum of Care

Ethical obligations that remain constant under conventional, contingency, and crisis conditions:

- Fundamental norms of good care apply across the continuum of care. Patients should be provided the best care possible given available resources.
- Equity considerations continue to be fundamental across the spectrum of care. Consideration should be given to measures that will be needed to promote equity as conditions worsen, to prevent bias from affecting decision-making (e.g., anti-racism training for staff, the inclusion of equity officers on decision-making teams when such teams are needed).

- Patients should be allowed to communicate with their loved ones, and authorized decision-makers should be able to participate in care decisions. While it may be necessary to restrict visitors during the pandemic, healthcare facilities should create alternative ways to meet these communication priorities. Hospitals should also provide support for people who need assistance with communication or other support from family, an aide, an authorized decision-maker, or staff.
- Patients have a right to refuse treatment at any time, and to designate individuals to make decisions on their behalf if they can no longer make decisions for themselves.
- Patients should receive supportive care and treatment to manage symptoms, including palliative care; this applies to all patients, including those who are not prioritized to receive specific resources.
- Institutions should identify a process for ethics support during an emergency. The primary functions of ethics support are to facilitate application of ethical frameworks for emergency response (especially given the need to respond to challenging ethical issues that will inevitably arise during the emergency), and to help manage moral distress of providers.
- Conflicts in decision-making should be resolved with a transparent, fair, and consistent process that applies to all patients equally. As the strain on healthcare resources deepens, the mechanisms for resolving disputes may be accelerated or otherwise altered, if it is no longer possible to maintain conventional processes.
- Healthcare institutions have no obligation to provide treatment that is futile -- meaning that an intervention simply cannot accomplish the intended physiologic goal. Withholding or withdrawing futile treatment is not a form of rationing.
- Obligations to fairly and equitably distribute the burdens and benefits of the healthcare system across the community remain.
- Healthcare institutions have an obligation to protect the interests of their workers across the continuum of care, including in contingency and crisis conditions. This obligation is grounded in three ethical considerations:
    - the instrumental value of those workers' services to the community mean that healthcare workers should be protected so that they can continue to provide services to patients;
    - duties of reciprocity, given that workers take on risk to protect others; and
    - duties of respect, which require support for healthcare workers' physical, mental, and emotional well-being, regardless of their professional role and obligations.

As scarcity increases or other risks related to the event (e.g. infrastructure damage from a bombing or storm) compromise safety, changes to care delivery or the standard of care increase the likelihood of psychological and moral distress among workers. In addition, scarcity of some resources may compromise worker safety. Thus, institutions have obligations to provide psychological support, to implement a process for ethics support to address moral distress, and to maintain safe working conditions including, but not limited to, providing adequate PPE. In addition, these considerations may ground changing expectations about what types of treatment healthcare workers are required to provide patients if certain interventions pose high risks to the workers.

1.9 Ethical Processes in Contingency Conditions or CSC

Individual hospitals or healthcare facilities have the capacity to identify scarcity that affects care, and the responsibility to mitigate shortages by reaching out to other facilities, systems, regional Health Care Coalitions, or statewide authorities; to adapt care practices to maintain functional equivalence to care in conventional conditions; and also to determine when no further mitigation strategies can stave off resource shortages that necessitate a shift to CSC within the practice setting.

If multiple facilities or healthcare systems in an area all have a common shortage that cannot be resolved, then regional Health Care Coalitions should acknowledge regional shortages. Similarly, if multiple regions have unresolvable shortages in the same resources, then state-level administrative units have an obligation to acknowledge widespread shortages that may warrant a shift to crisis standards of care for particular resources. When shortages are widespread within a region, or between regions, it will be helpful for the state to endorse common strategies to address these shortages. When shortages do not affect facilities or health systems throughout the state, state-wide shifts in care practices or standards of care will not be warranted, and these situations should be mitigated by moving resources or patients to allow facilities to move out of crisis conditions as soon as possible.

For localized shortages, individual facilities or healthcare systems also have the responsibility to identify when scarcity has abated or ended, and care practices or standards of care should return to contingency or conventional. For more widespread shortages, that responsibility should fall on the region or the state.

1.10 Ethical Procedures for Triage or Rationing Decisions Under CSC

- Facilities/systems should develop policies and procedures regarding triage or rationing that are grounded in best practices and guidance (including ethics guidance) and established in advance of the onset of crisis conditions, where possible. If emerging conditions give rise to the need to develop new guidance during the incident, facilities/systems should designate personnel who will be responsible for leading this effort.
- **Bedside providers should not make triage or rationing decisions unless they are based upon policies developed by the facility or system for managing such shortages.** When triage or rationing decisions involve significant judgment (rather than simply applying clearly stated metrics) then elevating those decisions away from bedside providers and to individuals/teams accountable to facility leaders promotes ethical allocation of resources and promotes awareness among facility leadership about the ways in which scarcity impacts patient care and the experience of bedside providers.
- Facilities/systems should designate individuals or teams who will be responsible for making triage or rationing decisions when guidance or facility/system policy recommends that bedside providers not make such decisions. These individuals/teams may be separate from (or the same as) the triage officers or teams established for triage of critical care resources. The individuals/teams designated to make triage or rationing decisions for specific resources should have relevant clinical expertise, as well as training concerning equity and fairness in decision-making.

- Triage or rationing scarce resources means that a patient's access will depend on both individualized assessment and a comparative assessment of patients who need the resource at the same time.
- Triage and rationing decision-makers should have access to ethics support to help resolve ethical issues as they arise.
- Triage or rationing decisions should NOT consider or be based upon:
  - Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, or socioeconomic status;
  - Ability to pay;
  - Age as a criterion in and of itself (this does not limit consideration of a patient's age as it relates directly to clinical prognostication of likelihood to survive this acute episode);
  - Disability status or comorbid condition(s) as a criterion in and of itself (this does not limit consideration of a patient's physical condition as it relates directly to clinical prognostication of likelihood to survive this acute episode);
  - Predictions about baseline life expectancy beyond the current episode of care (i.e., life expectancy if the patient were not facing the current crisis), unless the patient is imminently and irreversibly dying or terminally ill with life expectancy under 6 months (e.g., eligible for admission to hospice);
  - First-come, first-served;
  - Judgments that some people have greater "quality of life" than others; or
  - Judgments that some people have greater "social value" than others. In some circumstances (e.g., an acute shortage of healthcare workers and this is increasing risk to patients), certain workers providing critical services in high-risk settings should be prioritized for access to certain resources. The ethical rationale for prioritizing these workers in resource allocation relates to their specific job function in incident response, and does not involve a view that some individuals have greater social value than others.

- Processes should be established to conduct periodic retrospective review of all triage and rationing policies and decisions. This is important to ensure that the policies are current and appropriately inclusive, and that any triage and secondary review processes are working appropriately and in keeping with ethical requirements, including considerations of equity. Problems discovered should be resolved immediately.

2 APPENDIX: RECOMMENDED STRATEGIES

2.1 STRATEGIES FOR HEALTH SYSTEMS, LOCAL LEADERSHIP, AND STATEWIDE LEADERSHIP

1. Optimize local surge capacity through extended staffing models, expanding bed availability, utilization of regional and national resources (e.g., Strategic National Stockpile).
2. Continue active collaboration, load-leveling, and resource problem-solving with local, regional and state groups.
3. Provide communication with providers and the public about basics of current conditions, stressors on the care delivery system, and setting of expectations, with the healthcare leadership and other regional, and state authorities.
4. Collaboratively develop metrics and actively monitor care conditions and patient outcomes for evidence-based assessment of when care remains functionally equivalent to care in conventional conditions versus when care is no longer functionally equivalent such that crisis standards of care (CSC) should be implemented.
5. Clearly communicate to providers and the public when crisis standards of care are in effect, to what resource(s) they apply, and when crisis standards end.

2.2 STRATEGIES FOR INDIVIDUAL HOSPITALS AND FACILITIES

1. Provide clear and regular communication regarding scarcity conditions, operational status, standards of care, and support resources between administrators and frontline teams.
2. Actively monitor care conditions and patient outcomes in an effort to promote evidence-based assessment of when care remains functionally equivalent to care in conventional conditions versus when care is no longer functionally equivalent such that crisis standards of care (CSC) should be implemented. In the absence of such an evidence base, decisions about functional equivalence will be made under some degree of uncertainty and should be guided by expert judgement.
3. Clearly communicate to providers and the public when crisis standards of care are in effect, to what resource(s) they apply, and when crisis standards end.
4. Reaffirm/reference public communications by system, regional, and state authorities, and provide more detailed, organization-specific, patient- and family-centric communication. Develop and maintain multiple communication platforms and modalities to ensure effective communication with the diverse populations of the state, and target messages to local underserved communities and communities of color.
5. Identify potential stress points via simple and safe strategies (e.g., consider weekly review of difficult cases/circumstances, daily “huddles,” or designated team members to regularly query hospital teams) to ask hospital teams about worrisome circumstances (e.g., patients with poor prognosis and incompatible treatment goals, or related to current or impending resource shortages).
6. Engage equity and inclusion representatives/experts for patient and team support and use practices such as anti-racism/anti-bias education for involved team members.

7. Establish clear procedures for conflict resolution under contingency conditions and under crisis standards of care.
8. Establish clear procedures for scarcity mitigation under contingency conditions, and clear procedures for consultation and triage or rationing during contingency conditions and crisis standards of care. Engage health systems, regional and/or state authorities to mitigate scarcity through load-balancing and resource problem-solving.
9. Identify resources to mitigate staff burnout and to address staff moral distress.
10. When scarcity of a resource is resolved, promptly restore full access to those in need; do not triage or ration for longer than necessary and ensure communication of the change is disseminated to bedside providers or decision-makers.
11. When triage or rationing is needed, monitor patients who are not initially prioritized for resources to enable reassessment of their priority for allocation if their condition changes or if circumstances alter, increasing their priority.

2.3 Strategies for Bedside Clinicians

1. Avoid ad hoc triage or rationing at the bedside. Follow established policies and processes. Escalate decisions on whether to institute triage or rationing to designated leaders/teams.
2. Elicit treatment preferences from patients (or the authorized decision-makers of patients who lack decisional capacity).
3. Ensure daily patient and family communication by nursing and provider teams. Acknowledge difficulty/hardship with visitor restriction and leverage technology to maintain patient communication with loved ones and caregiver communication with families. Review prior conversations, clarify situation and perceptions, discuss current status and potential shortages if potentially relevant. Maintain transparency and collaboration to support patients and families, while also acknowledging staff health/impacts; empathetically communicate that “we are in the storm together.”
4. Specifically inform patients and families of active regional collaboration, and the shared goal of maintaining a consistent standard of care and providing what each patient needs to the greatest extent possible.
5. When stressful situations are identified, support patients, families, and teams early in the process in a way that is robust and culturally attuned. When decision-making is stressful, schedule conversations at regular intervals (at least every 2-4 days) and adjust approach based on outcome.
6. Obtain ethics consults as needed and available; consider engaging regional or other external resources; seek critical care support via alternate channels to obtain insight/support.
7. Consult institutional policy on duties to provide life-sustaining interventions during resolution of conflicts over the patient’s care plan. If the intervention about which a case review is requested is already being provided to the patient and is necessary to avoid death during the case review process, institutional policy will commonly recognize a duty to continue providing that intervention until such time as a decision to withdraw or withhold that intervention is finalized.

2.4 Strategies for Triage and Review Personnel under CDC

1. Bedside providers should not make triage or rationing decisions for individual patients under scarcity when this decision could result in adverse outcome or death, unless facility policy for allocation of that resource assigns these decisions to bedside providers. Instead, triage or rationing, and reallocation decisions of this nature should ordinarily be made by a separate triage officer or team. If local resources cannot support a separate triage officer or team for allocation and review processes, regional resources should be contacted for assistance.
2. Once review and triage teams are implemented, then they should collect information on resource scarcity from relevant stakeholders, including bedside staff and regional authorities, at frequent intervals.
3. Triage and review teams should conduct regular case reviews and reviews of aggregate data to identify trends and address concerns, including equity issues.
4. Triage and review teams should communicate with patients and surrogates affected by scarcity to gather information from them, to provide referral to supports and services, and to inform them of their rights and interests, including due process rights in addressing conflicts.
5. Triage and review teams should prospectively identify and manage potential conflicts of interest.

2.5 Note

The Region 3 Healthcare Coalition Alliance has no authority or jurisdiction over clinical standards of care. This authority lies within state/local governments, regulatory agencies (such as the Florida Department of Health, Agency for Healthcare Administration, etc.), and medical leadership at individual healthcare delivery organizations.