

COVID-19 Resources

Society of Critical Care Medicine Crisis Standard of Care Recommendations for Triage Critical Resources During the COVID-19 Pandemic

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Purpose

The purpose of these recommendations is to provide a transparent, equitable, and consistent approach to allocation of scarce resources during a COVID-19-declared emergency in which crisis standards of care have been implemented. The development of hospital policies ideally reflects the values, voices, and perspectives of multiple communities, both within and outside the institution. *These guidelines will be updated as our understanding of the spread, pathophysiology, treatment, and outcomes of COVID-19 infection evolves.*

Resource Scarcity Level and Associated Recommendations¹⁻⁶

The threshold to implement these recommendations should be determined by hospital leadership and reconciled with state and local law.⁷ It is assumed that all transfer options have been exhausted by the time these recommendations are implemented. Assessment of the hospital's capacity status should be continuous and associated recommendations adjusted as appropriate, as follows:

Conventional capacity: Availability of spaces, staff, and supplies (including medications and personal protective equipment [PPE]) is consistent with the institution's daily practices; however, an event has triggered the facility emergency operations plan. Attention is on careful stewardship of resources (e.g., cancellation of elective procedures, early palliative care interventions) to prevent scarcity.

Contingency capacity: Use of spaces, staff, and supplies (including medications and PPE) is not consistent with daily practices but supports care that is functionally equivalent to usual patient care practices. This phase represents the beginning of extreme resource scarcity, which, when activated by hospital leadership, prompts a shift from first-come, first-served to a triage allocation system in which those most likely to benefit from a given resource are assigned priority based on the premise of the greatest good for the greatest number. In this phase, it is ethically permissible to withhold life-sustaining treatment. Such a system requires the following essential elements: 1) development of a priority scale or triage allocation scheme, 2) a process to implement the priority scale and a waiting list for those not given immediate access to critical care resources, 3) a triage committee (**Appendix A**), and 4) an appeals process.

Crisis capacity: Use of adaptive spaces, staff, and supplies (including medication and PPE) is not consistent with usual standards of care but support sufficiency of care in the setting of a catastrophic disaster (i.e., the best possible care given circumstances and resources). Activation constitutes a significant adjustment to standards of care. In this phase, it is ethically permissible to withhold life-sustaining treatment and also to withdraw life-sustaining treatment from a patient with a worsening condition after a reasonable period of maximum treatment and to divert those resources to a patient on the waiting list. Experience has shown that intubated patients with COVID-19 may recover

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after remaining intubated for weeks;⁷ thus the determination of the length of the reevaluation period must balance the need for resources with what is known about the disease's natural history. Healthcare surrogates must be informed of the decision and offered end-of-life care services for the patient. *This is a consideration that must be taken with the greatest respect for human life and dignity and the aim of preserving the greater public good. It requires consistency with state law.*

Special Considerations

Cardiopulmonary Resuscitation⁸

The Centers for Disease Control and Prevention considers cardiopulmonary resuscitation (CPR) with respect to COVID-19 a medium-risk exposure event. The duty to provide CPR, even when there is some personal risk, is not absolute, as when risk to healthcare professionals cannot be mitigated due to lack of PPE. Clinicians should ensure their own safety, including donning appropriate PPE when preparing to provide CPR. If enabled by governmental implementation of crisis standards of care, attempted CPR would be withheld when the healthcare professional believes that it will have no physiologic benefit.⁹

Healthcare Worker Access to Limited Resources

Prioritizing access to scarce critical care resources for patients who are healthcare workers, first responders, or hospital employees over others in the community is controversial.^{2,10} Each institution must decide what is appropriate according to its own values as well as those of the community. Consideration for healthcare worker access may be based on the principle of compensatory justice (healthcare workers should be fairly compensated for injury that occurred in the process of doing their jobs) and to support the morale of workers on the frontlines that may help prevent attrition and ensure the short-term preservation of the workforce. On the other hand, healthcare workers have an expected duty to care for patients even at some risk to themselves.

Review Process

To maintain fairness and accountability, decisions made by the triage committee should undergo review weekly or more frequently as needed to allow for adjustment of the triage system if needed.

Appeals Process

To maintain fairness and accountability, a mechanism is needed for rapid appeal of the triage committee's decision by a member of the primary healthcare team. Appeals should be based only on the claim of incorrect adherence to established triage processes (e.g., an error in prognosis or a challenge to the timing of reassessment) rather than an appeal for an exception to the process itself. The appeal should be adjudicated by a third party not currently involved in the patient's care and who represents hospital administration. This third party should be provided with the same clinical information as the triage committee. Resolution should be expected within an hour.

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Appendix A. Designation of a Triage Committee

Triage Committee Goals

- Provide consistency, transparency, and fairness in the resource allocation process
- Allow the bedside healthcare care team to advocate on behalf of their patients for access to scarce resources without a conflict of interest
- Mitigate burnout and stress for healthcare professionals on the frontlines¹¹

Triage Committee Structure

- Membership:
 - » Minimum of two senior clinicians with experience in tertiary triage who are not currently involved with patient care
 - » Clinical ethicist
 - » Patient services representative, patient advocate, or community member, if possible
- Consultation with medical specialists to be undertaken as needed

The size of the triage committee depends on an institution's available staff. Some hospitals may have access to a single triage officer. Based on available resources, a triage committee may be called on to assist other hospitals in their network. Each institution defines how many members constitute a quorum. The triage committee should decide in advance whether a triage decision requires unanimous agreement or a majority vote (in which case the committee must comprise an odd number of members).

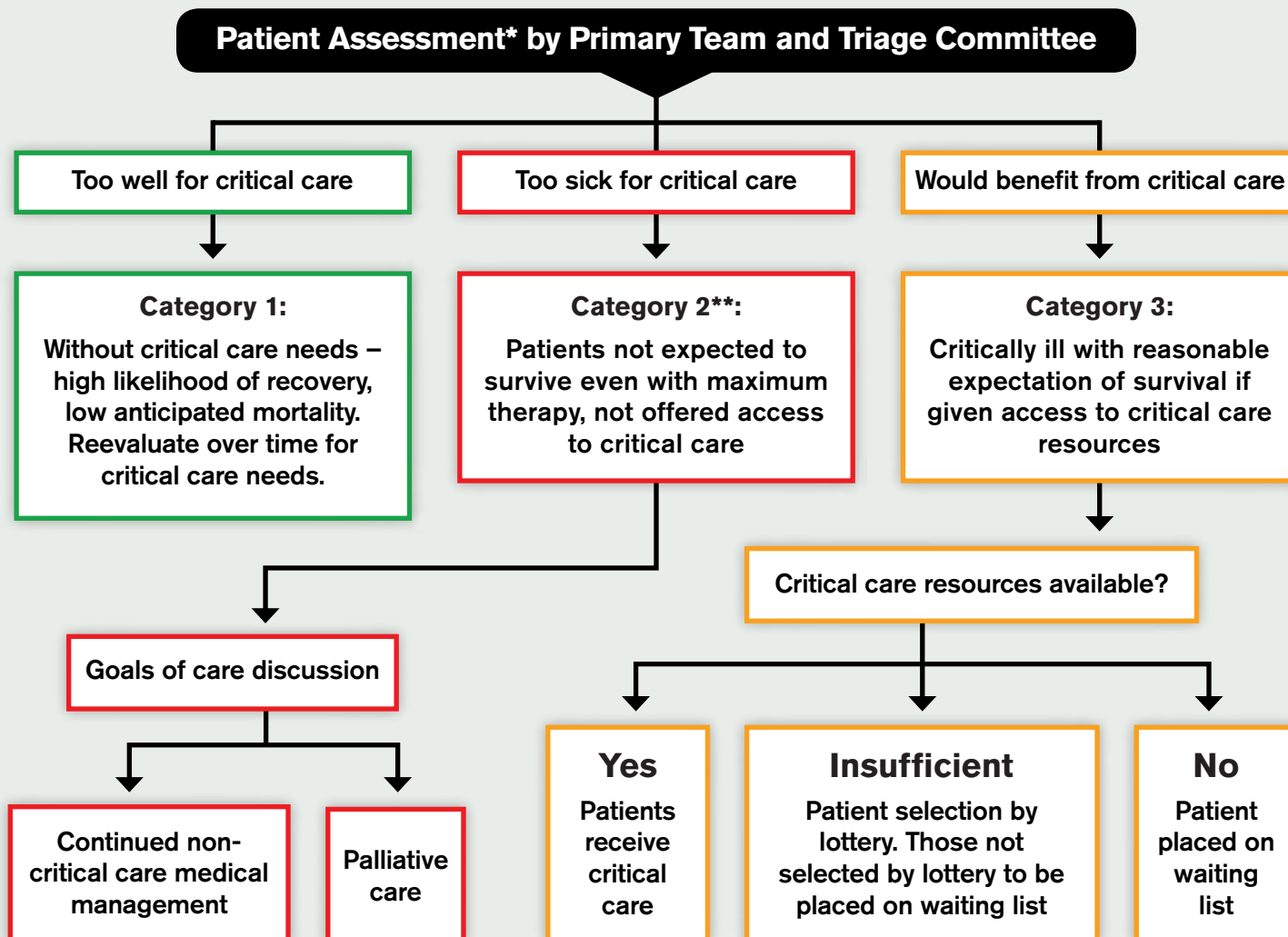
Triage Process

All patients are evaluated for access to resources in the same way, regardless of their diagnosis (**Figure 1**). Priority is assigned based on overall likelihood of receiving benefit from the interventions, based on prospectively determined criteria. These guidelines do not endorse any one predictive scoring system but require each institution to determine such criteria in advance, in accordance with its values and those of the community it serves, and apply them consistently to all patients. Regardless of which scoring system an institution uses, priority should never be assigned on the basis of race, gender, disability, sexual orientation, religious beliefs, citizenship, or socioeconomic or insurance status. The triage committee should be given the patient's age and date of birth (without any other demographics or identifiers) as well as the patient's clinical condition and other medical information relevant to prognostication. Triage committee decisions should be shared with the patient and the primary team. All triage committee activity should be documented and should include the information used and the decision made.

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Figure 1. Allocation Algorithm



*Patients should be assessed using one of any number of physiologic-based predictive scales and possibly comorbidities scales in combination with the clinical judgement of the primary team and the triage committee. While no predictive system has been clearly shown to correlate with patient outcomes of COVID-19, it is imperative that triage committees prospectively develop an algorithm to prioritize patients in a way that reflects the values of their hospital and their community and that is applied fairly and consistently to all patients who are evaluated during a designated time of crisis standard of care.

These patients and families should be informed of the decision and offered the best medical management. Withholding access to critical care resources **does not mean denial of further treatment. If a patient or family opts for continued aggressive medical management, this should be provided (short of access to critically scarce resources). Patients in category 2 should be offered access to palliative care services.

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