COMMUNITY MEDICAL CENTERS

Crisis Care Guidelines for COVID-19 Pandemic

Revised January 12, 2021

1) INTRODUCTION

a) The coronavirus (COVID-19) is an international health crisis and hospitals in every country are having to make difficult decisions while providing care. Hospitals around the nation are experiencing severe shortages of many essential resources, such as staffed critical care beds, necessary critical care equipment, and personal protective equipment. There are a number of protocols and strategies developed for allocating resources during a disaster with the goal to maximize benefits and save the most lives. In response to this pandemic, Community Medical Centers (CMC) has mobilized our Disaster Plan as we anticipate a surge in patient volume from a mass increase of respiratory-related illnesses requiring hospitalization.

b) Allocation of resources will be triaged based on objective criteria which is outlined in this document. Decisions will be based on the patient's current medical condition and NOT on any other reasons such as race, gender, religion, health insurance status, ability to pay, sexual orientation, employment status or immigration status. We evaluate all patients for survivability based on the same model and prioritize allocation based on their short term and long term survival scores. Triage criteria was developed by the hospital with careful thought and input from experienced critical care physicians, legal and risk departments, ethics experts, and with guidance from protocols from other healthcare organizations in the United States facing the COVID-19 pandemic.

2) PURPOSE

a) To provide guidance for the triage of critically ill patients (adult and pediatric) in the event that a public health emergency creates demand for critical care resources that outstrips the supply.

b) To prioritize those patients most likely to benefit from lifesaving resources.

c) To be feasibly deployed in chaotic and time-pressured circumstances of a pandemic or disaster.

3) SCOPE OF ACTIVITIES

a) To ensure patients receive the best care possible in a pandemic, a patient's attending physician does not determine whether his/her patient receives (or continues with) critical care resource therapy. Instead, a Triage Officer or triage committee makes this decision based on the objective criteria outlined in the document.

   i) While the attending physician interacts with and conducts the clinical evaluation of a patient, a Triage Officer or triage committee does not have any direct contact with the patient.

   ii) The Triage Officer or triage committee examines patient level data and makes the determination about a patient's level of access to a critical care resources; this role sequestration allows the critical care resource allocation protocol to operate smoothly.

b) A Triage Officer or a group of Triage Officers should be appointed. This individual will oversee the triage process, using objective data to assess and assign a level of priority for patients requiring a resource that has met scarce levels as determined by the Command Center. The determination will be communicated with treating physicians, and will direct their attention to the highest priority patients.

c) The Triage Officer(s) will work from a transparent and well-intentioned response script (Appendix E) and algorithm (Appendix C) designed to determine critical care resource allocation in a crisis situation.

d) This framework will be implemented at Clovis Community Medical Center (CCMC), Community Regional Medical Center (CRMC) and Fresno Heart and Surgical Hospital (FHSH) based on situational demand and as determined by the Command Center.

4) ETHICAL FRAMEWORK

a) This allocation framework is grounded in ethical obligations that include the duty to care, duty to steward resources to optimize population health, distributive and procedural justice, and transparency. It is consistent with existing recommendations for how to allocate scarce critical care resources during a public health emergency, and has been informed by extensive consultation with citizens, disaster medicine experts, and ethicists.

b) A major strength of the allocation framework described in the policy is that it does not exclude large groups of people from access to critical care, which many other allocation strategies do.

c) This framework delineates objective, readily recognizable medically sound criteria for identifying patients most likely to benefit from critical care resources.

d) Assessment "is performed by a Triage Officer or a triage committee composed of people who have no clinical responsibilities for the care of the patient. Anticipating the need to

allocate ventilators to the patients who are most likely to benefit, clinicians should proactively engage in discussions with patients and families regarding do-not-intubate orders for high-risk subgroups of patients before their health deteriorates." (Truog, NEJM, 2020.) In the setting of a severe pandemic, those patients with respiratory failure from illnesses not caused by the pandemic or other conditions will also be subject to the allocation framework and protocol. (U Pitt, NY State Guidelines)

5) OVERVIEW OF RESOURCE ALLOCATION FOR COVID-19 PANDEMIC

a) Triage

i) Structure of Triage Team: has no clinical responsibilities for the care of the patient.

(1) Triage Officer(s)

(a) Selection criteria

(i) A physician trained in emergency medicine or critical care is preferred. Other physicians, advanced practice practitioners, or uniquely qualified individuals based on training and/or experience may be considered.

(ii) Desirable qualities: strong leadership ability, effective communication, and conflict resolution skills.

(iii) Based on situational demand and as resources allow, the Triage Officer(s) will be available to meet the needs of the facilities for allocation of critical care resources as outlined in policy.

(iv) Triage Officers will be nominated by the chairs/directors of the clinical departments that provide care to critically ill patients.

(v) The Chief Medical Officer, acting on behalf of the Command Center and the President of the Medical Staff, acting on behalf of the Medical Executive Committee will approve these nominations.

(vi) A large roster of approved Triage Officers should be maintained to ensure that Triage Officers will be available on short notice at all times, and that they will have sufficient rest periods between shifts.

(b) Additional triage provisions include shifts that balance staff respite with the triage function; at least daily application of the allocation framework with an assessment of clinical improvement or worsening for patients already being supported by the scarce resource; and a limited appeals process in resource withdrawal cases.

(c) Duties

(i) Oversee the triage process, using objective data to assess and assign a level of priority for patients requiring a resource that has met scarce levels as determined by the Command Center. The determination will be communicated with treating physicians, and direct attention to the highest priority patients.

(ii) Make decisions according to an allocation framework, which is designed to benefit the greatest number of patients, even though these decisions may not necessarily be best for some individual patients.

(iii) Make decisions regarding reallocation of critical care resources that have previously been allocated to patients, again using the principles and processes approved by hospital administration.

(iv) Communicate information about these decisions with the clinical team.

(v) Act as a resource in collaboration with the clinical team to attain appropriate goals for patients.

(vi) Document the triage evaluation in the patient's electronic healthcare record.

(2) Triage Support Team

(a) Composition – to be designated by the Triage Officer(s) – preferred members, are not limited to, but include representation from:

(i) Command Center, adult and pediatric intensivists, respiratory therapy, nursing, social work, chaplain, data management, palliative care, and ethics.

(ii) Triage of pediatric patients (<18 years of age) will include: pediatric intensivist, pediatric ED attending (if available), and Pediatric Intensive Care Unit (PICU) or Emergency Medicine (EM) supervisor as part of the triage evaluation.

(b) Duties

(i) General support of the Triage Officer(s) including:

1. Active rounding.

2. Updating patient lists including daily Sequential Organ Failure Assessment (SOFA) scoring.

3. Generating daily reports.

(ii) Counseling resource for families.

(iii) All other duties as assigned by the Triage Officer.

(3) Triage Appeals and Review Committee

(a) Composition

(i) prefer to have five individuals on this committee, but minimum of three individuals, from the following:

1. Chief Medical Officer or designee,
2. Chief Nursing Officer or designee,
3. Chief Legal Officer or designee,
4. Ethics Committee Chair or designee, and
5. Off-duty Triage Officer.

(ii) Using a simple majority vote, three committee members are needed for a quorum to render a decision.

(b) Duties

(i) Be available 24 hours a day, 7 days a week by phone to assist the Triage Officer(s) if families or treating physicians question the process designated by this policy and procedure.

ii) Triage Process

(1) Triage Process will be enacted only if:

(a) Critical care resources are, or will shortly be, overwhelmed despite taking all appropriate steps to increase the surge capacity to care for critically ill patients; and

(b) As defined by the Command Center for CRISIS/SURGE mode; and

(c) A regional authority has declared a public health emergency.

(2) Overview:

(a) Identifying patients for triage evaluation:

(i) Review rounding list.

(ii) Attending physicians may also trigger a request to the Triage Officer for evaluation – this may occur in patients that are not intubated, but may soon need to be.

(iii) Command Center may also trigger a request to the Triage Officer for evaluation.

(b) Evaluating the likelihood of both short term and long term survival.

(i) The initial triage proceeds in two steps, to determine priority for critical care resources:

1. Step 1 -Exclusion Criteria

a. Adult Patients (Appendix A)

i. Cardiac arrest, limited to: unwitnessed arrest, recurrent arrest without hemodynamic stability, arrest unresponsive to standard interventions and measures, trauma-related arrest,

ii. Irreversible age-specific hypotension unresponsive to fluid resuscitation and vasopressor therapy,

iii. Traumatic brain injury deemed non-survivable,

iv. Severe burns: where predicted survival is ≤ 10% even with unlimited aggressive therapy, or

v. Any other conditions resulting in immediate or near-immediate mortality, even with aggressive therapy.

b. Pediatric Patients (Appendix B)

i. Cardiac arrest not responsive to PALS interventions within 20 minutes of appropriate resuscitation,

ii. Recurrent cardiac arrest, without interval hemodynamic stability,

iii. Irreversible age -specific hypotension unresponsive to fluid resuscitation and vasopressor therapy,

iv. Traumatic Brain Injury with no motor response to painful stimuli,

v. Burn > 91 % of BSA for children < 2 years of age,

vi. Congenital heart disease with poor chance of long-term survival,

vii. Cardiomyopathy with ejection fraction < 25% and pulmonary edema unresponsive to therapy,

viii. Severe chronic lung disease including pulmonary fibrosis, cystic fibrosis, obstructive or restrictive diseases requiring continuous home oxygen or mechanical ventilation use prior to onset of acute illness,

ix. Central nervous system, solid organ, or hematopoietic malignancy with poor prognosis for recovery,

x. Liver disease with ascites, history of variceal bleeding, fixed coagulopathy or encephalopathy; Acute hepatic failure with hyperammonemia,

xi. Acute and chronic and irreversible neurologic impairment, that makes patient dependent for all personal care (e.g. severe stroke, congenital syndrome, persistent vegetative state, severe dementia, etc.), or

xii. Any other conditions resulting in immediate or near-immediate mortality, even with aggressive therapy.

2. Step 2 - Assessment of Likelihood of Benefit from Resource Use:

   a. Adult Patients

      i. The following two scores (short term survival assessment + long term survival assessment) are combined to give a raw score:

         a) Short Term Survival: assessment of mortality risk using the SOFA score (Appendix A, Table 1), and

         b) Long Term Survival: assessment of prognosis using the Charlson Comorbidity Index (CCI) (Appendix A, Table 2).

         The combined score determines the priority color for resource allocation (Appendix A, Table 3 and Table 3.1)

      ii. Summary of prioritization:

         - Red: highest priority, use critical care resources as available. Reassess in 48 hours.
         - Yellow: intermediate priority, use critical care resources as available. Reassess in 48 hours.
         - Green: use alternative forms of medical intervention, defer or discharge. Reassess as needed.
         - Blue: no critical care resources provided, use alternative forms of medical intervention and/or palliative care or discharge.

   b. Pediatric Patients

i. The triage process for pediatric patients is similar in scope to adult framework.

a) Assessment of severity of illness using the Pediatric Logistic Organ Dysfunction (PELOD) score (Appendix B, Table 1).

PELOD score determines the priority color for resource allocation (Appendix B, Table 2 and Table 2.1)

ii. Summary of prioritization:

- Red: highest priority, use critical care resources as available. Reassess in 48 hours.
- Yellow: intermediate priority, use critical care resources as available. Reassess in 48 hours.
- Green: use alternative forms of medical intervention, defer or discharge. Reassess as needed.
- Blue: no critical care resources provided, use alternative forms of medical intervention and/or palliative care or discharge.

c. In the event there are more patients with the same score and color priority than available resource:

i. Additional criteria may be applied reducing the raw score. Criteria may include: Front Line Health Care Workers, as defined in Community Medical Centers' COVID-19 Preservation Standards of Care Ethical Framework and incorporated herein by reference, thereby reducing the raw score by 2, and pregnant women with viable pregnancy 24 weeks or greater, thereby reducing the raw score by 1. Criteria applied should be documented in the Triage Officer notes.

ii. If additional criteria are needed, individual raw scores will be reevaluated. The Triage Officer and/or Triage Support Team will conduct a secondary detailed review of objective clinical information available to ensure the appropriate clinical status of the patients is reflected. This secondary clinical evaluation in combination with the adjusted score will be used to make a decision on how the resource is allocated, and documented in the Triage Officer notes.

iii. Should there continue to be more patients than resources available and completed reviews of additional criteria continue to yield the same scores and same likelihood to benefit, a lottery shall be used to break the tie. The use and outcome of that lottery should be documented in the Triage Officer notes for each patient involved in the lottery.

(ii) Repeat assessments

1. Patients on reassessment are moved into the appropriate category based on the most recent scoring. Should the scoring indicate that no critical care resources are to be provided, this will be communicated to the treating physician.
2. Repeat assessments will occur at 48 hours, 120 hours, and as appropriate.
3. Periodic reassessments of priority for patients requiring a critical care resource that has met scarce levels, as determined by the Command Center, may be performed as needed.
4. For adult patients, the SOFA score is used for the reassessment process.
5. For pediatric patients, the PELOD score in conjunction with multidisciplinary evaluation are used for the reassessment process.

b) Appeals Process

i) Used in the event that patients, families, or clinicians challenge the Triage Officer's decisions.

ii) Appeals should be limited to questions around the allocation process/criteria calculations and their proper implementation.

iii) The individuals appealing the triage decision should explain to the Triage Officer the grounds for their appeal. <u>Appeals based on an objection to the overall allocation framework should not be considered.</u>

(1) Appeals should immediately be brought to the Triage Review Committee (that is independent of the Triage Officer/triage support team and of the patient's care team).

(2) The appeals process must occur quickly enough that no harm is caused for patients who are in the queue for scarce critical care resources currently being used by the patient who is the subject of the appeal.

(3) The decision of the Triage Review Committee will be final.

(4) Periodically, the Triage Review Committee should retrospectively evaluate whether the review process is consistent with effective, fair, and timely application of the allocation framework.

c) Patient and Family Education: The patient and/or their family or representative(s) should be informed that critical care resource and/or therapy represents a trial of therapy that may not improve a patient's condition sufficiently and that the critical care resource(s) will be removed if this approach does not enable the patient to meet specific criteria.

   i) See Appendix D

d) Staff Education: Staff education should include guidance on how to discuss the triage allocation protocols. Communication should be clear upon hospital admission and ICU admission, as well as upon initiation of critical care resources.

6) REFERENCES

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7) APPENDIX A – CLINICAL TRIAGE TOOLS FOR ADULTS

TABLE 1: Sequential Organ Failure Assessment (SOFA) Score

SYSTEM	SOFA	
Central Nervous System	0	GCS = 15
	1	GCS = 13-14
	2	GCS = 10-12
	3	GCS = 6-9
	4	GCS = < 6
Cardiovascular *catecholamine doses are given as mcg/kg/min*	0	MAP ≥ 70 mmHg
	1	MAP < 70 mmHg
	2	Dopamine < 5 OR Dobutamine any dose
	3	Dopamine 5.1-15 OR Epinephrine < 0.1 OR Norepinephrine < 0.1
	4	Dopamine > 15 OR epinephrine > 0.1 OR norepinephrine > 0.1
Respiration *PaO2/FIO2, mmHg*	0	≥ 400 (53.3)
	1	< 400 (53.3)
	2	< 300 (40)
	3	*< 200 (26.7) w/respiratory support*
	4	< 100 (13.3) w/respiratory support
Renal *Creatinine, mg/dL (µmol/L)urine output (UO) mL/d*	0	< 1.2 (110)
	1	1.2-1.9 (110-170)
	2	2.0-3.4 (171-299)
	3	3.5-4.9 (300-440) UO < 500
	4	≥ 5.0 (440) UO < 200
Coagulation *Platelets, x 10^3/µL*	0	≥ 150
	1	> 150
	2	< 100
	3	< 50
	4	< 20
Liver *Bilirubin, mg/dL (µmol/L)*	0	< 1.2 (20)
	1	1.2-1.9 (20-32)
	2	2.0-5.9 (33-101)
	3	6.0-11.9 (102-204)
	4	> 12 (204)

TABLE 2: Charlson Comorbidity Index

SCORE	CONDITION
1	Myocardial Infraction (history, not ECG changes only)
	Congestive heart failure
	Peripheral vascular disease (includes aortic aneurysm ≥6cm)
	Cerebrovascular disease: CVA with mild or no residua or TIA
	Dementia
	Chronic pulmonary disease
	Connective tissue disease
	Peptic ulcer disease
	Mild liver disease (without portal hypertension, includes chronic hepatitis)
	Diabetes without end-organ damage (excludes diet-controlled alone)
2	Hemiplegia
	Moderate or severe renal disease
	Diabetes with end-organ damage (retinopathy, neuropathy, nephropathy, or brittle diabetes)
	Tumor without metastases (exclude if >5years from diagnosis)
	Leukemia (acute or chronic)
	Lymphoma
3	Moderate or severe liver disease
6	Metastatic solid tumor
	AIDS (not just HIV-positive)

TABLE 3: Combined Scoring System for Adults

Principle	Specification	Point System Highest Priority → Lowest Priority			
		1	2	3	4
Prognosis for short term survival	SOFA (adults)	< 7	8-9	10-11	>11
Prognosis for long term survival	Charlson Comorbidity Index	≤ 2	3-4	5-6	≥ 6

TABLE 3.1: Priority Level Based on Combined Score for Adults

Highest Priority → Lowest Priority	Color Code / Level of Access	Assessment of Mortality Risk / Organ Failure
	RED Highest Priority Use Critical Care Resources as available	**Combined Score ≤ 2**
	YELLOW Intermediate/Priority Use Critical Care Resources as available	**Combined Score 3-5**
	GREEN Use alternate forms of medical intervention defer or discharge. Reassess as needed.	**Combined Score 6-7** Does not require lifesaving resources
	BLUE No Critical Care Resources Provided Use Alternative forms of medical intervention and/or palliative care of discharge	Exclusion criterion or **Combined Score = 8**

TIE BREAKERS (see above for more details):

1. Front Line Health Care Worker and Pregnant women
2. Secondary evaluation of objective clinical information
3. Lottery

8) APPENDIX B – CLINICAL TRIAGE TOOLS FOR PEDIATRICS

I. A patient's attending physician examines his/her patient for an exclusion criterion and will forward this clinical data to a Triage Officer/committee to make the triage decision. Patients with exclusion criteria do not have access to critical care resources and instead are provided with alternative forms of medical intervention and/or palliative care.

II. If medical information is not readily available or accessible, it may be assumed a patient is free of exclusion criteria and may proceed to the next step of the resource allocation protocol.

Exclusion Criteria for Pediatric Patient

Pediatric patients with conditions that result in immediate or near-immediate mortality even with aggressive therapy are excluded. Examples of underlying diseases that may predict poor short-term survival or long- term resource demand may include, but are not limited to:

I. Cardiac arrest not responsive to PALS interventions within 20 minutes of appropriate resuscitation

II. Recurrent cardiac arrest, without interval hemodynamic stability

III. Irreversible age -specific hypotension unresponsive to fluid resuscitation and vasopressor therapy

IV. Traumatic Brain Injury with no motor response to painful stimuli

V. Burn > 91 % of BSA for children < 2 years of age

VI. Congenital heart disease with poor chance of long-term survival.

VII. Cardiomyopathy with ejection fraction < 25% and pulmonary edema unresponsive to therapy

VIII. Severe chronic lung disease including pulmonary fibrosis, cystic fibrosis, obstructive or restrictive diseases requiring continuous home oxygen or mechanical ventilation use prior to onset of acute illness

IX. Central nervous system, solid organ, or hematopoietic malignancy with poor prognosis for recovery.

X. Liver disease with ascites, history of variceal bleeding, fixed coagulopathy or encephalopathy; Acute hepatic failure with hyperammonemia

XI. Acute and chronic and irreversible neurologic impairment, what makes patient dependent for all personal care (e.g. severe stroke, congenital syndrome, persistent vegetative state, severe dementia, etc.)

XII. Any other conditions resulting in immediate or near-immediate mortality, even with aggressive therapy.

American Burn Association (ABA)
Triage Decision Table for Burn Victims Based on Anticipated Outcomes Compared with Resource Allocation

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	Out-patient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0 - 19.9	Out-patient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low

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, length of stay < 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.

Determining Traumatic Brian Injury

No Motor Response to Painful Stimulus (i.e., Best Motor Response = 1)

Best Motor Response (1 to 6)	No Motor Response to Painful Stimulus	1
	Extension to Painful Stimulus	2
	Flexion to Painful Stimulus	3
	Withdraws from Painful Stimulus	4
	Localizes to Painful Stimulus	5
	Obeys Commands	6

TABLE 1: Pediatric Logistic Organ Dysfunction (PELOD) Score

Organ system and variable	Points assigned			
	0	1	10	20
Neurologic*				
Glasgow coma score	12–15	7–11	4–6	3
	and		*or*	
Pupillary reaction	Both reactive		Both fixed	
Cardiovascular				
Heart rate, beats/min				
< 12 years	≤ 195		> 195	
≥ 12 years	≤ 150		> 150	
	and		*or*	
Systolic blood pressure, mm Hg				
< 1 mo	> 65		35–65	< 35
≥ 1 mo–< 1 yr	> 75		35–75	< 35
≥ 1 yr–< 12 yr	> 85		45–85	< 45
≥ 12 yr	> 95		55–95	< 55
Renal				
Creatinine, μmol/L (mg/dL)				
< 7 d	< 140 (< 1.59)		≥ 140 (≥ 1.59)	
≥ 7 d–< 1 yr	< 55 (< 0.62)		≥ 55 (≥ 0.62)	
≥ 1 yr–< 12 yr	< 100 (< 1.13)		≥ 100 (≥ 1.13)	
≥ 12 yr	< 140 (< 1.59)		≥ 140 (≥ 1.59)	
Respiratory				
PaO_2:FiO_2 ratio, mm Hg	> 70		≤ 70	
	and		*or*	
$PaCO_2$, mm Hg (kPa)	≤ 90 (≤ 11.7)		> 90 (> 11.7)	
	and			
Mechanical ventilation†	No ventilation	Ventilation		
Hematologic				
Leukocyte count, × 10^9/L	≥ 4.5	1.5–4.4	< 1.5	
	and	*or*		
Platelet count, × 10^9/L	≥ 35	< 35		
Hepatic				
Glutamic oxaloacetic transaminase, IU/L	< 950	≥ 950		
	and	*or*		
Prothrombin time, % of standard (international normalized ratio)	> 60 (< 1.40)	≤ 60 (≥ 1.40)		

Note: FiO_2 = fraction of inspired oxygen, $PaCO_2$ = partial pressure of carbon dioxide in arterial blood, PaO_2 = partial pressure of oxygen in arterial blood.
*For the Glasgow coma score, use the lowest value. If the patient is sedated, record the estimated coma score before sedation. Assess the patient only with known or suspected acute central nervous system disease. For pupillary reactions, nonreactive pupils must be > 3 mm; do not assess after iatrogenic pupillary dilatation.
†The use of mask ventilation is not considered to be mechanical ventilation.

Link to Pediatric Risk of Mortality (PRISM III) Calculator:
https://www.cpccrn.org/calculators/prismiiicalculator/

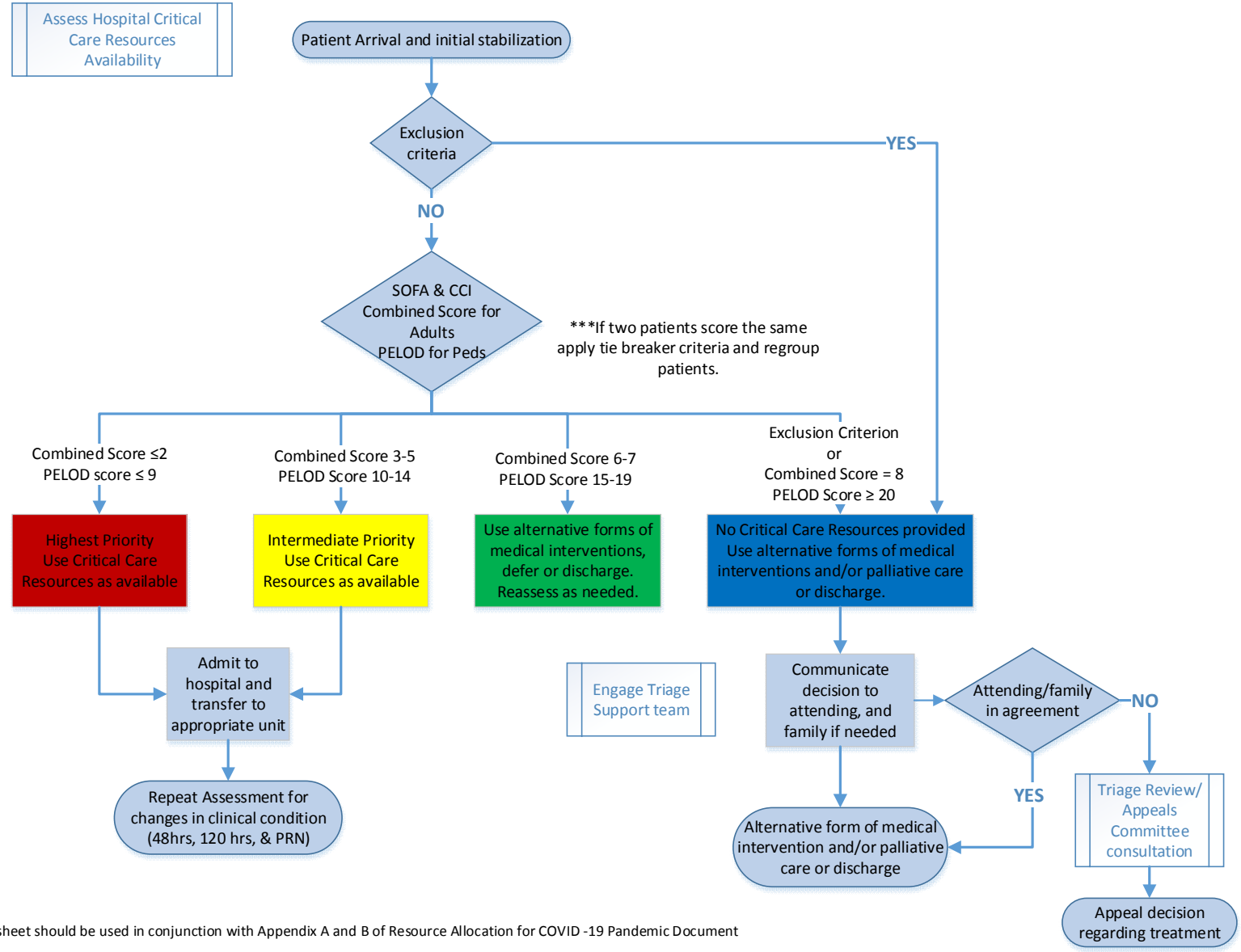
TABLE 2: Scoring System for Pediatrics

Principle	Specification	Point System Highest Priority → Lowest Priority			
		1	2	3	4
Prognosis for short term survival	PELOD-2 (pediatrics)	≤ 9	10-14	15-19	≥ 20
Secondary Consideration	Pediatric Risk of Mortality (PRISM III)				

TABLE 2.1: Priority Level Based on Score for Pediatrics

Highest Priority → Lowest Priority	Color Code / Level of Access	Assessment of Mortality Risk / Organ Failure
	RED Highest Priority Use Critical Care Resources as available	**PELOD score ≤ 9**
	YELLOW Intermediate/Priority Use Critical Care Resources as available	**PELOD score 10-14**
	GREEN Use alternate forms of medical intervention defer or discharge. Reassess as needed.	**PELOD score 15-19** Does not require lifesaving resources
	BLUE No Critical Care Resources Provided Use Alternative forms of medical intervention and/or palliative care of discharge	Exclusion criterion or **PELOD score ≥ 20**

9) APPENDIX C – TRIAGE OFFICER DECISION TREE / WORKFLOW



Flowsheet should be used in conjunction with Appendix A and B of Resource Allocation for COVID -19 Pandemic Document

10) APPENDIX D – PATIENT FAMILY GUIDELINES

To our Valued Patients and Their Families, January 7, 2021

The coronavirus (COVID-19) pandemic is an international health crisis and hospitals in every country are having to make difficult decisions while providing care. Our caregivers are highly trained and prepared for situations like this and work closely with the Centers for Disease Control (CDC), the California Department of Public Health, the Fresno County Department of Public Health and other health agencies.

In times of crisis and as this pandemic continues to exhaust our resources, our patient care resources will be used based on those who need the care the most—usually critically ill patients. When necessary, allocation of resources will be guided by our internal experts including a cross section of groups such as: critical care, palliative care, medical ethics, as well as other hospital organizations in the United States.

You may be impacted in the following ways:

- Advance Care Planning –It is important to prepare for worst-case scenarios and have the opportunity to discuss these situations before they occur. This can be done through a document called an Advance Health Care Directive. Click here and follow the steps outlined to complete one.
- Palliative Care – Our palliative care team provides support and relief to families and patients, both physically and emotionally. Additional information and resources for palliative care is available here, as well as this Frequently Asked Questions section.
- Patient transfers – Our care team will make necessary decisions about the available location in which you receive care based on our current state of resources.
- Visitor restrictions – Currently, visitor restrictions remain in place with exceptions as outlined in the Visitor Restrictions Information Handout. Our staff understands that you want to spend time with loved ones who are critically ill and will do our best to make that happen. However, if your loved one passes away, we may not be able to allow a viewing period at the hospital due to space limitations and recommend that you coordinate with the funeral home to schedule a viewing.
- Allocation of Scarce Resources – These may be limited at times. Examples include staffing, medical equipment (such as ventilators), medications, services and bed space—all in demand across our nation
    - When these resources become scarce (i.e., Intensive Care Unit or Mechanical Ventilation--breathing machine), these will be considered based on your specific condition.

- Some patients will be extremely ill and may not survive their illness even with critical treatment. Aggressive treatments with a ventilator may cause more burdens and suffering, while prolonging the dying process. This would also take away resources from those who may survive.
    - Patients who aren't considered for ICU or ventilator care will receive treatment for pain and comfort measures.

We remain committed to diversity and inclusion for the quality of care for you and your loved one. We want to be clear that any decision is based only on the patient's current medical condition and is not based on any reasons such as sex, race, color, national origin, age, disability, religion, health insurance status, ability to pay, sexual orientation or gender identity, employment status or immigration status. We evaluate all patients for survivability based on the same measures of how sick they are, taking into account any chronic medical conditions prior to them becoming acutely ill.

If you have any questions, our hospital team is here to serve you. Thank you.

Your Community Care Team

Updated: 01/07/2021
Version 3

11) APPENDIX E – COMMUNICATION RESOURCES

Communications with Patients and Family

We have created scripted topics related to COVID-19 to talk with patients and family members. These conversations may be challenging, direct and emotionally draining. As medical professionals, we are called to heal. But during this unprecedented time, you may be forced to help a patient and their family make difficult decisions that cause tremendous grief.

The format below is intended to serve as guide touse during these difficult conversations. Not every scenario is listed, but our goal is to provide a framework for honest and open bedside conversations.

Conveying compassion may be the best we can do for comfort care if we are unable to provide necessary equipment (ventilators) for a very sick and dying family member. Explaining to family members the realities of the situation undoubtedly will provide courage and sympathy as you explain why we are unable to provide life support and need to focus on comfort care. Our palliative care team will also help you with this transition of care.

We also want to be clear that this decision is based on the patient's current medical condition and the likelihood of not recovering as set forth by our hospital policy. This decision is not based on any reasons such as sex, race, color, national origin, age, disability, religion, health insurance status, ability to pay, sexual orientation, employment status or immigration status. We evaluate all patients for survivability based on the same measures of how sick they are, taking into account any chronic medical conditions prior to them becoming acutely ill.

This information below does include hospitalized patients with suspected or confirmed COVID-19 and is intended to assist with clinical decision-making and does NOT replace personalized evaluation and management decisions based on individual patient factors.

COVID-19 Scripts

To Patient/Family Member

SCREENING: When someone is worried they might be infected	
What they say	**What you say**
Can I get tested?	If you are showing symptoms or fall into a high-risk category, contact your physician to determine if a test is necessary. *Your doctor will need to make that decision if a test is needed.*
Why do the tests take so long?	The lab is doing them as fast as they can. We have improved our testing results turnaround time with an on-site lab which helps to speed up the process. *I know it's difficult to wait.*
How come the basketball players got tested?	I don't know the details, but what I can tell you is that was a different time and not in this location. *The situation is changing so fast that what may have occurred a week ago is not what we are doing today.*

TRIAGING: When you're deciding where a patient should go	
What they say	**What you say**
Why shouldn't I just go to the hospital?	Our primary concern is your safety. We have a process when people come in. *You can help us by following the process we have to keep you and everyone else safe.*
Why are you keeping me out of the hospital?	I imagine you are worried and want the best possible care. Right now, we have designated areas within our campus to keep you safe while we determine your condition. *The safest thing for you is to allow us to place you in a safe area of our facility.*

ADMITTING: When your patient needs the hospital, or the ICU	
What they say	**What you say**
Does this mean I have COVID-19?	We will need to test you with a nasal swab, and we will know the result by {insert timeline}. *It is normal to feel stressed when you*

	are waiting for results, so it's helpful to practice the things that make you feel calmer and less anxious.
How bad is this?	From the information I have now and from my exam, your situation is serious enough that you should be in the hospital. *We will know more in the next day*, and we will update you.
Is my grandfather going to make it?	I imagine you are scared. Here's what I can say: because he is 90, and is already dealing with other illnesses, *it is quite possible that he will not make it out of the hospital. Honestly, it is too soon to say for certain.*
Are you saying that no one can visit me?	I know it is hard to not have visitors. The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. *They will be in more danger if they come into the hospital.* I wish things were different.
How can you not let me in for a visit?	The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. We can help you be in contact electronically or by phone. *I wish I could let you visit, because I know it's important, but it is not possible now.*

COUNSELING: When coping needs a boost, or emotions are running high	
What they say	**What you say**
I'm scared.	This is such a tough situation. *I think anyone would be scared.* Could you share more with me?
I need some hope.	Tell me about the things you are hoping for? *I want to understand more.*
You people are incompetent!	I can see why you are not happy with things. *I am willing to do what is in my power to improve things for you.* What could I do that would help?
I want to talk to your boss.	I can see you are frustrated. *I will ask my boss to come by as soon as they can. Please realize that they are juggling many things right now.*
Do I need to say my goodbyes?	I'm hoping that's not the case. And I worry time could indeed be short. What's most pressing on your mind?

DECIDING: When things aren't going well, goals of care, code status	
What they say	**What you say**
I want everything possible. I want to live.	We are doing everything we can. This is a tough situation. Could we step back for a moment so I can learn more about you? *What do I need to know about you to do a better job taking care of you?*
I don't think my grandfather would have wanted this.	Well, let's pause and talk about what he would have wanted. Can you tell me what he considered most important in his life? *What meant the most to him, gave his life meaning?*
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. *Can you say more about what you mean?*
I am not sure what my grandfather wanted—we never spoke about it.	You know, many people find themselves in the same boat. This is a hard situation. To be honest, given his overall condition now, if we need to put him on a breathing machine or do CPR, he will not make it. The odds are just against him. *My recommendation is that we accept that he will not live much longer and allow him to pass on peacefully.* I know that is hard to hear. What do you think?

RESOURCING: When limitations force you to choose, and even ration	
What they say	**What you say, and why**
Why can't my 90-year-old grandmother go to the ICU?	*This is an extraordinary time. We are trying to use resources in a way that is fair for everyone.* Your grandmother's situation does not meet the criteria for the ICU today. I wish things were different.
Shouldn't I be in an intensive care unit?	Your situation does not meet criteria for the ICU right now. The hospital is using special rules about the ICU because we are trying to use our resources in a way that is fair for everyone. *If this were a year ago, we might be making a different decision. This is an extraordinary time.* I wish I had more resources.

My grandmother needs the ICU! Or she is going to die!	I know this is a scary situation, and I am worried for your grandmother myself. *This virus is so deadly that even if we could transfer her to the ICU, I am not sure she would make it.* So we need to be prepared that she could die. We will do everything we can for her.
Are you just discriminating against her because she is old?	I can see how it might seem like that. No, we are not discriminating. *We are using guidelines that were developed by people in this community to prepare for an event like this*. The guidelines have been developed over the years, involving health care professionals, ethics experts, and lay people to consider all the pros and cons. I can see that you really care about her.
We aren't from this country. Or, we are a same-sex couple. Are you treating us differently because of that?	No. I am sorry you feel that way. *Please understand these decisions are based on your loved one's current medical condition and not on any reasons such sex, race, color, national origin, age, disability, religion, health insurance status, ability to pay, sexual orientation, employment status or immigration status.* My focus is on the best care for your loved one and not anything else.
You're treating us differently because of the color of our skin.	*I can imagine that you may have had negative experiences in the past with health care simply because of who you are.* That is not fair, and I wish things had been different. The situation today is that our medical resources are stretched so thin that we are using guidelines that were developed by people in this community, including people of color, and all forms of diversity so that we can be fair. I do not want people to be treated differently because of the color of their skin either.
It sounds like you are rationing.	What we are doing is trying to spread out our resources in the best way possible. *This is a time where I wish we had more for every single person in this hospital.*
You are telling me you won't provide my mother a ventilator?	Your mother is very sick and will not benefit from a ventilator. We will continue to care for her. We will focus on her comfort and pay close attention to any signs of discomfort. *I wish the answer were different. We are here to support you through this.*
What do you mean by 'palliative care'?	Palliative care is a special team of people who will help determine the best treatments of pain and provide comfort for your mother. This includes her quality of life encompassing the body, mind and spirit. We are here to assist you and your mother during this difficult time.

How can you just take them off a ventilator when their life depends on it?	I'm so sorry that her condition has gotten worse, even though we are doing everything. Because we are in an extraordinary time, we are following special guidelines that apply to everyone here. We cannot continue to provide critical care to patients who are not getting better. This means that we need to accept that she will die, and that we need to take her off the ventilator. I wish things were different.
Will I be excluded from treatment access because of my disability?	*Disability is not an exclusion criterion. Every patient at Community will receive an individualized assessment of their condition and potential to benefit from treatment.*
I read that triage tries to maximize lives saved and life-years saved. Won't that put me at a disadvantage?	*Community's criteria do try to maximize how many patients we can help, but we are not prioritizing some lives at the expense of others. Our main concern is a patient's ability to receive and likely benefit from treatment for their current acute condition.*
My disability may affect my medical test results, will that mean I will get less treatment?	*Our physicians will take into account a patient's disability and other relevant conditions when they interpret what the results of any test mean for a patient's current condition and prognosis.*
What if I am concerned that my disability is the reason I did not receive treatment?	*Talk with your physician about your concerns first. If you have further questions, there is an appeal mechanism to triage decisions that may be available to you.*
ADA requires reasonable accommodations of persons with disabilities; what are you doing to make sure my additional health needs are accommodated if I need aggressive treatment?	*Please inform healthcare staff of any needs you may have. Reasonable accommodations will be made provided they do not unduly burden staff or disproportionately restrict other patients' ability to access to staff and resources.*
If it takes me a longer time or extra resources to get better, are you going to give those resources to someone else instead?	*Our physicians will ensure that all patients have a fair chance to improve before any such decisions are made. Please make sure they are fully aware of your medical condition. If, unfortunately, the decision is made to allocate scarce resources to another patient, talk with your physicians to understand why. If you have further questions, there is an appeal mechanism to triage decisions that may be available to you.*

You're playing God. You can't do that.	I am sorry. I did not mean to give you that feeling. *Across the city, every hospital is working together to try to use resources in a way that is fair for everyone. I realize that we don't have enough.* I wish we had more. Please understand that we are all working as hard as possible.
Can't you get 15 more ventilators from somewhere else?	Right now the hospital is operating over capacity. It is not possible for us to increase our capacity like that overnight. And *I realize that must be disappointing to hear.*

ANTICIPATING: When you're worries about what might happen	
What you fear	**What you can do**
That patient's son is going to be very angry.	Before you go in the room, take a moment for one deep breath. *What's the anger about?* Love, responsibility, fear?
I don't know how to tell this adorable grandmother that I can't put her in the ICU and that she is going to die.	*Remember what you can do*: you can hear what she's concerned about, you can explain what's happening, you can help her prepare, you can be present. These are gifts.
I have been working all day with infected people and I am worried I could be passing this on to the people who matter most.	Talk to them about what you are worried about. You can decide together about what is best. There are no simple answers. But *worries are easier to bear when you share them*.
I am afraid of burnout, and of losing my heart.	Can you look for moments every day where you connect with someone, share something, enjoy something? *It is possible to find little pockets of peace even in the middle of a maelstrom.*
I'm worried that I will be overwhelmed and that I won't be able to do what is really the best for my patients.	Check your own state of being, even if you only have a moment. If one extreme is wiped out, and the other is feeling strong, where am I now? *Remember that whatever your own state, that these feelings are inextricable to our human condition.* Can you accept them, not try to push them away, and then decide what you need?

GRIEVING: When you've lost someone	
What I'm thinking	**What you can do**
I should have been able to save that person.	Notice: *am I grading myself?* Could I step back and just feel? Maybe it's sadness, or frustration, or just fatigue. Those feelings are normal. And these times are distinctly abnormal.
OMG I cannot believe we don't have the right equipment / how mean that person was to me / how everything I do seems like its blowing up	Notice: *am I catastrophizing?* Is all this analyzing really about something else? Like how sad this is, how powerless I feel, how puny our efforts look? Under these conditions, such thoughts are to be expected. But we don't have to let them suck us under. Can we notice them, and feel them, maybe share them? And then ask ourselves: *can I step into a less reactive, more balanced place even as I move into the next thing?*

Updated April 21, 2020
Adapted from VitalTalk

COVID-19 Scripts

Patient Dying Despite Critical Care Support

'WARNING SHOT' (Provider Updating Family)	
Action	**'Warning Shot' and Asking Permission**
Preview	"I have some serious news to share with you. Would it be okay if we talk about it?"
Headline	"In the past few (hours/days) your loved one (has become more ill/has not improved). I am very worried about their chances of recovering. (Allow a pause for family to absorb this information). I wish things were different."
State Clearly What You Will Do	"I want you to know that we will continue to use all available medical treatments that we think will help your loved one recover from this illness. We would like to talk again in (*specify time*), unless s/he has a change in condition sooner." *If* family asks (at this time) for critical care and/or ventilator use to continue:
2nd Headline	"I can see how worried you are. I want to reassure you that today I'm just calling to give you an update on your loved one's condition and my concerns about how they are doing. I want to assure you that we are continuing to support him/her. I should mention that in some cases this illness worsens quite suddenly. We will continue to keep you updated. I would like to call you again later or tomorrow—is that ok?"

Provider Calling Back to Update Family About Plans to Remove Ventilator	
Action	**'Warning Shot' and Asking Permission**
Preview	"I'm calling to follow up on our last conversation. Would it be okay if we talk now?"

Headline, part one	"In the past few (hours/days) your loved one has gotten worse. (Allow a pause for family to absorb this information). Their condition has worsened to the point where we need to change the course of our care." (Allow a second pause.)
Headline, part two	"I'm calling to let you know that your loved one is dying now. We are recommending that we remove the ventilator and allow for a natural (or "peaceful" or "comfortable" death) Allow pause. I wish things were different." (Allow a pause; respond to emotions – see below.)
State Clearly What You <u>Will</u> Do	"I want you to know we <u>will</u> focus our care on treating symptoms to ensure your loved one's comfort and allow a peaceful death. We will pay close attention to shortness of breath, or any other signs of discomfort, and give medications and other treatments that help your loved one feel more comfortable. (Allow a pause for family to absorb this information). I wish things were different."
Headline, part three	"Is it OK if I give you more information now about what to expect next? (Pause, and wait for permission to proceed.) People with this virus who are as sick as your ____ usually die quickly, possibly even within minutes to hours." (Allow a pause; respond to emotions – see below. Explain CMC's visiting policy for dying patients.)
Offer Support	"I want you to know that we are absolutely here to support you through this. Is there anything you can think of right now that would be helpful?" (If asked, explain your CMC's resources for support of these families, e.g. social work or chaplaincy, etc.)
Saying Goodbye	Offer to talk family through the process of saying goodbye, and say that you will support them to do it by phone or iPad if they are not able to come in right away or are not allowed to visit in

	person because of hospital policy. See below for a script for helping families say goodbye to dying loved ones over the phone.

RESPONDING TO EMOTIONS	
Action	**"I Wish" and Other Empathy Statements**
Responding to family concerns	"I wish we had a treatment available that would help your family member recover. We will do our very best to make sure they are comfortable during the dying process." (Allow a pause for family to absorb this information). "I wish things were different. This is an extraordinary time we all find ourselves in." "I can't imagine how difficult this is for you and everyone else who loves (patient's name)." "You have been an incredible advocate for your loved one. I can see how deeply you care."
Responding to family anger	"It is understandable that you would be angry. I wish I had treatments available that would help him/her recover. We will stay committed to doing our very best for your loved one with the treatments focused on their comfort." "It is understandable that you would be angry. I can see that you care about her/him a great deal. This is an extraordinary time we all find ourselves in."
Responding to family grief/sadness	"I want you to know that all of us here care deeply about your experience and your loved one's experience right now." "I understand how difficult it is even under normal circumstances to have your loved one in an ICU. It must be unimaginably hard during this pandemic."

OFFERING SUPPORT FOR WHAT TO SAY TO A LOVED ONE WHO IS DYING	
Action	**The 5 Things**
Preview and Asking Permission	"Sometimes people wonder what to say when their loved one is dying. Is that something you are wondering about? Would it be helpful if I shared some things some people have found helpful?" If yes, then: "Some of these things may apply to you, and others might not. There is no order and you can use any of these 5 things that feel right to you. We think that even though your loved one is sedated and comfortable, that many patients retain their ability to hear, even when they are unconscious. So if you wish, this is the time to say good-bye. These are the 5 things to consider saying. You might want to write them down." 1) Please forgive me (for anything I may have done that caused you pain) 2) I forgive you 3) I love you 4) Thank you (for being my father…) 5) Goodbye Many patients worry about their families and whether they will be okay after they die. It helps some patients to be reassured that their family will take care of one another after the patient dies.

Updated: May 6, 2020
Source: Center to Advance Palliative Care https://www.capc.org/toolkits/covid-19-response-resources/
Created by Elizabeth Lindenberger, MD and Shoshana Helman, MD, Diane Meier, MD,3.20.20 - 3.24.20, adapted from Elke LowenKopf, MD, Caroline Hurd, MD.

12) APPENDIX F – MEDICAL PRINCIPLES/PALLIATIVE CARE REFERENCE

Given what we have seen happening around the world and especially in Italy, we must prepare for the possibility that our limited medical resources could become strained, particularly ventilators.

Our hope is that if Palliative Care (PC) gets involved early we may be able to mitigate the family issues that arise from end of life care, especially the problems that arise from miscommunication.

Those who are elderly, frail, and/or with underlying chronic or serious illness are most at risk from COVID-19. **These are palliative care's core patient population.** Utilizing the unique skills and strengths found in palliative care must be part of the response.

Available forms of palliative care are offered to patients who are not eligible for ventilator treatment as well as patients who fail to meet clinical criteria for continued use of a ventilator. Palliative care is an interdisciplinary service designed to ease the discomfort that can accompany serious or life-threatening illness. Its provision respects the dignity of a patient who does not or can no longer receive ventilator treatment. Palliative care is aimed at providing comfort, both physically and emotionally, under the circumstances.

Actively providing effective palliative care to patients who do not or no longer qualify for ventilator therapy decreases patient discomfort and fulfills the provider's duty to care, even when the clinician cannot offer ventilator treatment. Care should include pain management and nonpharmacological interventions, such as holding a hand or offering words of comfort. Efforts should include educating a patient and his/her loved ones. Information regarding a patient's condition, prognosis, and the general circumstances of the influenza pandemic situation aids a patient and loved ones in making informed decisions regarding care. Providing the physical and emotional care required to keep a patient as comfortable as possible is important to both the patient and his/her family.

In the ventilator withdrawal context, appropriate measures should be taken to prepare for and ease the process of withdrawal for patients and their loved ones. Palliative care providers are well-versed in the clinical implications of ventilator withdrawal as well as with the parameters of end-of-life decision-making, and therefore, can help loved ones prepare both practically and emotionally. Preferences regarding extubation procedures, including agreed upon levels of sedation and pain management, should be respected and followed when appropriate and available. Ideally, decisions concerning the withholding and withdrawing of treatment includes a patient's loved ones; however, their involvement may be limited by the pandemic situation. Standard protocols for extubation may offer guidance for appropriate medications and dosing, length of weaning process, and other associated procedures. Medical decisions should intend to provide comfort care and reduce the risk of shortness of breath appropriately as ventilator treatment is withdrawn. Transparency is a crucial element in adhering to ethical standards; clinicians should clearly document their rationale and decisions regarding the process of ventilator withdrawal. Finally, facilities should prepare for a significant increase in demand for palliative care supplies and expertise, and they should become familiar with State and local

palliative care resources to help meet the demand. For patients who are not eligible for ventilator therapy, health care providers should administer pain management and non-pharmacological interventions. In addition, alternative forms of medical intervention should be provided.

Triage

Regardless of the types of humanitarian crisis or the types of suffering it causes, several principles apply to the triage process (Table Below):

1) Palliative care and life-saving treatment should not be regarded as distinct. Palliative care should be integrated as much as possible with life-saving treatment for patients with acute life-threatening conditions (triaged red).
2) Palliative care must be provided for all patients deemed expectant (triaged blue) and should commence immediately.
3) Palliative care should commence immediately, as needed, for patients with non-life-threatening conditions whose injury- or disease-specific treatment may be delayed (triaged yellow).
4) Repeat triage should be practiced, especially for patients triaged blue and yellow, to make sure that important changes in the patient's condition that should result in a change in triage category are not missed.

Recommended Triage Categories in Humanitarian Emergencies and Crises

Category	Color Code	Description
1. Immediate	Red	• Survival possible with immediate treatment. • Palliative care should be integrated with life-sustaining treatment as much as possible.
2. Expectant	Blue	• Survival not possible given the care that is available. • Palliative care is required.
3. Delayed	Yellow	• Not in immediate danger of death, but treatment needed soon. • Palliative care and/or symptom relief may be needed immediately.
4. Minimal	Green	• Will need medical care at some point after patients with more critical conditions have been treated. • Symptom relief may be needed.

Source: WHO (2018).[3]

13) APPENDIX G – OTHER RESOURCES AND INFORMATION

Real-Time Data Collection and Analysis and Modification of the Guidelines

Public health officials and clinicians operating during a pandemic must engage in real-time data collection and analysis to modify the Guidelines based on new information. As data become available during a pandemic, experts learn more about the particular viral strain and should adjust response measures accordingly. For example, data analysis may discern relevant factors such as how the virus affects certain patient populations, the average duration of sickness and the time necessary for recovery, or whether particular patient groups have a greater likelihood of survival (or mortality), which permit evidence-based modification of the clinical ventilator allocation protocol. Specific components of the clinical ventilator allocation protocol that may need to be modified in the face of new information including, for example, exclusion criteria, the SOFA score values that correspond to color codes, and the time allotted for time trials once a patient begins ventilator treatment.

Data collection and analysis on the pandemic viral strain, such as symptoms, disease course, treatments, and survival are necessary so that the clinical ventilator allocation protocol may be adjusted accordingly to ensure that patients receive the best care possible. Furthermore, data collection must include real-time availability of ventilators so that resources can be allocated most effectively. Knowing the exact availability of ventilators also assists a Triage Officer/committee in providing the most appropriate treatment options for patients.

Ethical Values to Guide Rationing of Absolutely Scarce Health Care Resources in a Covid-19 Pandemic.

Ethical Values and Guiding Principles	Application to COVID-19 Pandemic
Maximize benefits	
Save the most lives	Receives the highest priority
Save the most life-years — maximize prognosis	Receives the highest priority
Treat people equally	
First-come, first-served	Should not be used
Random selection	Used for selecting among patients with similar prognosis
Promote and reward instrumental value (benefit to others)	
Retrospective — priority to those who have made relevant contributions	Gives priority to research participants and health care workers when other factors such as maximizing benefits are equal
Prospective — priority to those who are likely to make relevant contributions	Gives priority to health care workers
Give priority to the worst off	
Sickest first	Used when it aligns with maximizing benefits
Youngest first	Used when it aligns with maximizing benefits such as preventing spread of the virus

14) APPENDIX H – CODE BLUE RECOMMENDATIONS DURING CRISIS STANDARDS OF CARE

PURPOSE:

- Risk versus Benefit: CPR is a high risk procedure for the transmission of COVID-19, thus to reduce risk to staff we recommend only doing CPR if the benefit to the patient is equal or greater than the risk to staff.
- Conserve resources to save the most lives.
- Provide a guideline for staff during Crisis Standards of Care.

DEFINITIONS:

- CPR: Cardiopulmonary Resuscitation
- ROSC: Return of Spontaneous Circulation
- BLS: Basic Life Support
- ACLS: Advanced Cardiovascular Life Support
- PALS: Pediatric Advanced Life Support

DESCRIPTION OF CPR-BLS/ACLS/PALS ELEMENTS/INTERVENTIONS:

- Chest Compressions
- Artificial Ventilation (bag valve mask or ventilator)
- Intubation
- Medication (given only if performing chest compressions or patient has a pulse)
- Defibrillation

POLICY:

- All patients will have their code status addressed by the provider as soon as reasonable upon arrival to the hospital. This will be decided using the medical judgment of the treating provider(s).
- The provider will strive to set realistic expectations for the patient regarding resuscitation during this time.
    - Inform the patient regarding surge resource allocation protocols (Provide Code Status patient education)
    - Correct any misunderstanding about the success of CPR. (This may be achieved through the use of the provided communication from the hospital and palliative care.)
- Whenever feasible, use tele-conferences, phone or video conference with the family member responsible for consent.

The below exemption criteria is for patient populations that this policy does not include.

EXEMPTION CRITERIA:

- Surgical/Procedural Areas

- Intubation in progress
- Pediatric/Neonatal Patients
- Do Not Resuscitate Orders or Advance Directive

NOTE: In an effort to reduce the risk of transmission of COVID-19, when the COVID-19 status of the patient is positive, unclear or pending, ALL resuscitation scenarios will be performed by staff/medical staff only when the proper PPE is donned.

During Crisis Standards of Care and the patient does not fall into one of the exemption categories, the recommendation is to respond to cardiac and/or respiratory arrests in a reasonable manner to conserve resources and protect staff while seeking to ensure positive outcomes for our patients.

Cardiopulmonary arrest or respiratory arrest will be managed by nursing and other staff in the usual manner, until a physician assumes responsibility.

If a cardiopulmonary arrest is unwitnessed, the amount of time that has passed is unclear; therefore, when at surge capacity, we recommend that physicians forego any efforts to resuscitate a patient who experiences an unwitnessed cardiopulmonary arrest. In the case of unwitnessed respiratory arrest, however, the patient still has a perfusing rhythm and thus the respiratory arrest is of relatively recent onset. The etiology of the respiratory arrest may range from difficult to treat (e.g., Acute Catastrophe or End-Stage of Disease) to conditions that are readily treatable (e.g., Positional Asphyxia, Foreign Body Obstruction of the Airway, drug toxicity amenable to administration of antidote). It is therefore appropriate for physicians to rapidly rule out or treat correctable conditions prior to deciding if further intervention is indicated.

<u>Special Considerations:</u>
Patient arriving to the emergency department via emergency medical services with CPR in progress may have resuscitation efforts continued at the discretion of the primary treating physician or licensed independent practitioner assuming care of the patient if he/she believes the cause of the arrest could be reversible and/or the benefits to the patient outweigh the risk to the staff.

Hospitalized patients will continue to be treated proactively with rapid responses for any appropriate concern and/or sudden change in patient condition. If during the rapid response the patient experiences cardiac and/or respiratory arrest, all efforts will be made to continue resuscitation efforts until a physician determines it is NOT medically indicated.

If there is a witnessed cardiac and/or respiratory arrest while in the hospital, qualified staff may initiate resuscitation efforts and begin treating until a physician determines the continued resuscitation effort is NOT medically indicated.

If a hospitalized patient experiences ventricular fibrillation or pulseless ventricular tachycardia, and the event is unwitnessed, the qualified staff member may treat the ventricular fibrillation or

pulseless ventricular tachycardia with defibrillation and continue ACLS treatment protocols. All efforts will be made until a physician arrives and the physician determines continued resuscitation efforts are NOT medically indicated.

Rationale for Recommendations:

The resuscitative attempt may not be futile, unless the patient's condition is so dire that it makes it such. But, attempted resuscitation in the surge setting may NOT be medically indicated because of lack of ICU beds, staff shortages, and the like. Furthermore, the responding provider (if it is the patient's physician or advanced practice providers) may be aware of a patient's no CPR status or wish that has not yet been charted; qualified staff finding a pulseless patient may be aware of this status, but also they may not.