Crisis Standards of Care-Small and Critical Access Hospitals

A Guidance Document for the State of Nebraska

This guidance is adapted from the Northwest Healthcare Response Network Scarce Resource Management and Crisis Standards of Care Triage Team Guidelines. This guidance document is intended to provide supplemental guidance to the Health Care Crisis Protocol provided by the state (Neb. Rev. Stat. 71-2701 - 71-2705). Small and critical access hospitals may choose to use this guidance document as an addition to their required Health Care Crisis Protocol planning.

PURPOSE: To provide a transparent, fair, equitable, and consistent approach to allocation of scarce resources during a declared emergency in which Crisis Standards of Care (CSC) has been implemented.

SCOPE: Small healthcare organizations and providers within the affected region where a regional triage team is advantageous for CSC decision making.

During a sustained public health emergency, it is anticipated that limitations of resources, including staff, space, and/or material resources, may develop that would preclude the provision of the usual standard of care for patients. Crisis standards of care (CSC) describes attempts to deliver the best possible healthcare at a time when very severe resource constraints prohibit delivery of the usual standards of care. This document—Crisis Standards of Care-Guidance for Small and Critical Access Hospitals—is a framework designed to help rural health care facilities plan for shortfalls in the health care system during a pervasive or catastrophic public health event, which may cause overwhelming medical surge. This guidance assumes incident management and incident command practices are implemented and key personnel are familiar with Nebraska Healthcare Crisis Protocol's Ethical Framework and processes that underlie scarce resource decision-making.

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

Staffing & Surge:

- just in time training for staff to assist in other areas of the facility (Emergency Department, Pediatric)
- telehealth with other facilities or providers
- implementation of the regional triage team
- referencing the medical surge response strategy for supplies, staffing and space for surge recommendations

Small Healthcare Facilities and Critical Access Hospitals (CAH) are an essential part of the healthcare system, who face challenges unlike larger hospital systems. Limited staffing, equipment, and space create additional stressors and considerations for critical access hospitals along with geographic distances between them and other healthcare resources. This healthcare

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system will be stressed to its limits during a mass casualty incident, pandemic, and other multiple patient incidents, requiring all components of the system to implement contingency measures to manage the surge in medical demand.

The formation of Regional Triage Teams will help create a transparent, equitable, and consistent approach to allocation of scarce resources during a catastrophic event. This document describes the composition of the Regional Triage Team and describes the operation of the team both during contingency and crisis standards of care. Allocation of a scarce resource is a complex task, and to maintain the ethical framework outlined in the healthcare crisis protocol, it is crucial that the decision-making process be consistent, and that oversight and review mechanisms be established.

REGIONAL TRIAGE TEAM

Each Health Care Coalition should decide on how to implement the structures and processes described in this document. For example, a Coalition may decide to construct a single Regional Triage Team and Triage Oversight Committee to manage all facilities within its region. A Regional Triage Team may offer a varied support to facilities. It may serve as the triage team for a facility. It may support the region by providing consultation to a facility triage team, or a member of the regional triage team may serve on the facilities triage team. If a Coalition is unable to have a region-wide structure, then it is the responsibility of each facility in the region to develop a Triage Team and Triage Oversight Committee. Multi-facility Triage Teams and Triage Oversight Committees may also be considered for facilities without the appropriate personnel to stand up these groups on their own.

If applicable, a Regional Triage Team should manage the prioritization and placement of patients in its region. Regional Triage Teams should fairly represent the local healthcare institutions. Members can be determined by the Healthcare Coalition and/or other relevant partners to include but not limited to other Public Health experts, outside Subject Matter Experts (SME), Nebraska Medical Emergency Operation Center Surge team, etc.

TRIAGE TEAM MEMBERSHIP

Triage Teams, whether regional or facility-specific, should consist of *Triage Officers*. Triage Officers should be the most experienced providers with established expertise in the management of critically ill patients, leadership ability, and effective communication and conflict resolution skills.

Triage Officers will oversee the initial triage process, assess all patients, **assign a level of priority for each, communicate with treating physicians, and direct attention to the highest-priority patients**. The Triage Officers will have the responsibility and authority to:

- make decisions about which patients will receive the highest priority for receiving critical care

- make decisions regarding reallocation of critical care resources when there is ongoing scarcity and patients
- communicate clearly with bedside nurses, physicians, and other clinicians the triage decisions
- seek consultation with a clinician for appropriate age groups involved to determine respective priority levels

To best mitigate implicit bias, to the greatest extent possible, each facility should aim to have a group of Triage Officers and a Triage Team that adequately reflects the diversity of the patient population served by the facility in terms of demographics such as race, ethnicity, disability, preferred language, sexual orientation and gender identity. Every attempt should be made to assemble a team that reflects the diversity of the community and population served by the facility.

The Triage Team members will provide information to the Triage Officer(s) making initial triage decisions and **help facilitate and support their decision-making process.** The Triage Team will:

- conduct reassessments of patients already receiving critical care to make decisions about continuation of critical care
- review and report out to clinical leadership how triage is being conducted

For Small Healthcare Facilities and Critical Access Hospitals (CAH), it is recommended a Regional Triage Team manage prioritization and placement of patients as described in the Healthcare Crisis Protocol in need of a scarce resource in the affected geographic region who cannot be managed within a specific hospital system. A Regional Triage Team should fairly represent the local healthcare institutions. Members can be determined by the Healthcare Coalition and/or other relevant partners to include but not limited to other Public Health experts, outside Subject Matter Experts (SME), Nebraska Medical Emergency Operation Center Surge team, etc. and can consist of members from the Healthcare Coalition or the community at large representing the following:

- 2-3 senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer who oversees all Triage processes
- 1 medical ethicist, palliative care, social work, or related field
- when possible, clinicians on the Regional Triage Team will not be primary providers of the patients under consideration, nor members of the referring Triage Team
- when possible, if patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc., then one of the senior clinicians on the Regional Triage Team should be of that specialty, or attempts will be made to contact specialty clinicians remotely

DECISION-MAKING FRAMEWORK

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

The decision-making framework is composed of three steps:

1. a calculation of each patient's **priority score**
2. an assignment for each patient to a **color-coded priority group**
3. a daily determination of how many priority groups can **receive the scarce resource**

Step 1a: Priority Scoring

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

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

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

SOFA = Sequential Organ Failure Assessment

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

Specification	**Point System**			
	1	2	3	4
Prognosis for survival of the acute illness	75-100% chance of short-term survival	50-75% chance of short-term survival	25-50% chance of short-term survival	0-25% chance of short-term survival

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Presence of underlying conditions			Severe co-morbid conditions; death likely within 1 year	Conditions expected to be non-survivable during this admission

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

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

Step 2: Assign patients to color-coded priority groups

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

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

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

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

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

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

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

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

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

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

It is recommended the Regional Triage Team follow the communication guidelines below in order to maintain accurate and up to date situational awareness.

REGIONAL TRIAGE TEAM OVERSIGHT COMMITTEE

When an event occurs which requires activation of the Regional Triage Team the following documentation will be required and will be reviewed by the Regional Triage Team Oversight Committee. Committee members will be determined by the Healthcare Coalition and/or other relevant partners to include but not limited to other Public Health experts, outside SME's, Nebraska Medical Emergency Operation Center Surge team, etc. and can consist of members from the Healthcare Coalition or the clinical community at large representing the following:

- Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Chair who oversees all Oversight processes.
- When possible clinicians on the Regional Triage Team Oversight Committee will not be primary providers of the patients under consideration nor members of the Regional Triage Team.
- When possible, if patients under review fall under a specific specialty such as burn, trauma, pediatrics, etc. then one of the senior clinicians on the Oversight Committee should be of that specialty, or attempts will be made to contact specialty clinicians remotely.
- At least one medical ethicist.

All patients presented to the Regional Triage Team Oversight Committee will be recorded in a Regional Oversight Triage Team Log, which will include:

- All patient demographics.
- Date and time of the case consideration.

- All patient information presented to the Regional Triage Team at the time of consideration.
- The Regional Triage Team decision date, time and supporting documentation reviewed and produced for the decision.
- Patient outcome.

The Regional Triage Team Oversight Committee should review all cases presented to the Regional Triage Team at agreed upon intervals to ensure the following:

- All appropriate clinical information was considered.
- Accurate documentation was recorded.
- Extreme variances be reviewed and addressed.

Depending on the nature of the incident oversight review may be in real time (i.e. in a prolonged event such as a pandemic). However, in no notice, sudden or brief events, this review may be retrospective.

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REFERENCES AND RESOURCES

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

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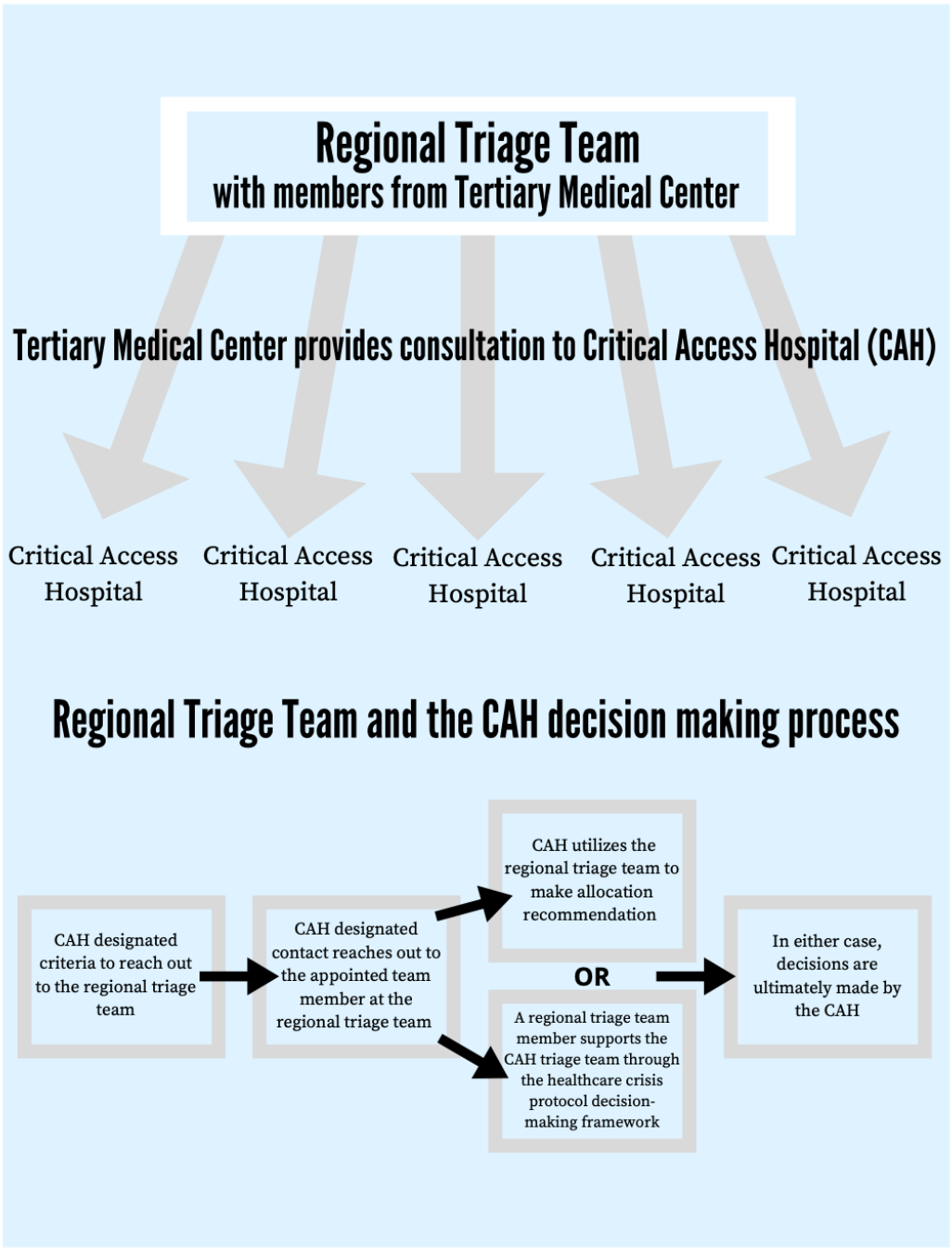
Resources for Multi-principle Strategy to Allocate Critical Care to Pediatric Patients During a Public Health Emergency:

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

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

Example Schematic of Regional Triage Team:



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