North Texas Mass Critical Care Guidelines

Produced by the North Texas Mass Critical Care Guideline Task Force in cooperation with

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office for Civil Rights

Mass Critical Care Guideline for Adult Hospital and ICU Triage

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PURPOSE:

- To provide an ethically sound, clinically objective, practical, non-discriminatory, and transparent triage guideline for allocation of limited medical resources in the event of a mass critical care situation during which the demand for hospital and critical care services exceeds supply.

Basic Premises:

- The overall goal is to save as many lives as possible. When a patient is so ill due to any cause that survival to hospital discharge is unlikely, it is not reasonable to allocate scarce life sustaining resources to that patient. Such patients will be triaged to supportive palliative care or hospice care, allocating the scarce life sustaining treatment to patients judged more likely to survive to discharge.
- **Non-discrimination:** Each patient will receive medical treatment delivered with respect, care, and compassion and without regard to basis of race, ethnicity, color, national origin, religion, sex, disability, veteran status, age, genetic information, sexual orientation, gender identity, or any other protected characteristic under applicable law. Further, medical treatment should not be allocated under this Guideline based on the patient's ability to pay, insurance status, socioeconomic status, immigration status, incarceration status, homelessness, past or future use of resources, perceived self-worth, perceived or assessed quality of life, or weight/size.
- **Reasonable Accommodation:** Take appropriate steps to accommodate and provide individuals with disabilities meaningful access and an equal opportunity to participate in, or receive the services and benefits under this Guideline, as required by hospital policy, and in accordance with the Department of Health and Human Services Office of Civil Rights guidance[1]. Reasonable accommodation may include, but is not limited to the following:
  - Providing effective communication with individuals who are deaf, hard of hearing, blind, have low vision, or have speech disabilities through the use of qualified interpreters, picture boards, and other means;
  - Providing meaningful access to programs and information to individuals with limited English proficiency through the use of qualified interpreters and through other means;
  - Making emergency messaging available in plain language and in languages prevalent in the affected area(s) and in multiple formats, such as audio, large print, and captioning, and ensuring that websites providing emergency-related information are accessible;
  - Addressing the needs of individuals with disabilities, including individuals with mobility impairments, individuals who use assistive devices, auxiliary aids, or durable medical equipment, individuals with impaired sensory, manual, and speaking skills, and individuals with immunosuppressed conditions including HIV/AIDS in emergency planning;
  - Respecting requests for religious accommodations in treatment and access to clergy or faith practices as practicable.
- **Patient Ventilator/Equipment:** Hospitals may not re-allocate a personal ventilator (or a ventilator brought by the patient to the facility at admission to continue the patient's personal use).
- **Hospital Policies:** This Guideline should be read in concert with current hospital policies, procedures, and/or Guidelines. Implementing facilities may consider adding direct references to relevant policies.
- **Guideline prerequisites:** This Guideline should be used only in genuinely extraordinary situations in which the demand for services overwhelms supply and when activated by appropriate governmental and/or institutional authorities.
- **Guideline application:** Whether applied by individual treating clinicians, clinical triage committees, or clinical triage officers, this Guideline requires assessment of each patient's treatment preferences and likelihood of survival, giving priority to likelihood of survival to hospital discharge with treatment.

[1] For COVID-19 please refer to the Office of Civil Rights, BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVDI-19), https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf.

- **Physician judgment:** Application of this Guideline is primarily a physician responsibility and must include: 1) a physician's reasonable medical judgment based upon an individualized assessment of each patient's treatment preferences and survival likelihood based on best available, relevant, and objective evidence; and 2) as-needed modification and accommodation of this Guideline and any tools the physician might select to support reasonable medical judgment based on the individual patient's clinical circumstances including any disabilities and/or chronic conditions the individual may have.
- **Patient treatment preferences:** Patient values and preferences related to life sustaining treatment should be assessed with the patient (or surrogate decision-maker if patient is unable to communicate), if feasible. If the patient is unable to communicate and is judged to be terminally or irreversibly ill, patient treatment preferences as expressed in an advance directive [Directive to Physicians/Living Will, Medical Power of Attorney, Out of Hospital DNR (unless pregnant)] or other clear evidence indicating the patient prefers a "comfort only" treatment approach should be given strong consideration. Physicians must be careful not to exert pressure on patients or surrogate decision-makers to decline life sustaining treatments in the process of discussing advance care planning decisions or to make particular advance care planning decisions for the good of the provider or due to judgments regarding quality of life or relative worth. Providers must provide information on treatment options, including both "comfort only" and continued life sustaining treatment, as long as the treatment option is medically appropriate based upon reasonable medical judgment and current medical evidence. Physicians may not require patients to complete advance directives and may not issue blanket Do Not Attempt Resuscitation ("DNAR") orders for reasons of resource constraint, except as consistent with or allowed by Texas law.
- **Likelihood of survival:** For purposes of this Guideline, likelihood of survival primarily means the physician's reasonable medical judgment about survival to hospital discharge. This relies on clinician judgment of the patient's risk of dying even with disease modifying treatment during the current acute care hospitalization. This clinician judgment should be informed as much as medically reasonable by objective clinical parameters and should not consider perceived quality of life or age. A physician's reasonable medical judgment about likelihood of survival may be further informed by one or more clinical assessment/prognostic tools including but not limited to: SOFA or MSOFA[2], APACHE score, Simplified Acute Physiology Score (SAP), TNM cancer staging, Palliative Performance Scale (PPSv2), Karnofsky Performance Status (KPS), Eastern Cooperative Oncology Group (ECOG) score, BODE Index, NYHA Functional Class, the Seattle Heart Failure Model, various proprietary artificial intelligence based tools a clinician might have access to when approved for use in the facility where the patient is being treated, eligibility for additional treatments if indicated for other conditions following COVID-19 treatment such as bone marrow or solid organ transplants, LVAD as bridge or destination therapy, dialysis, and more. The decision to utilize any specific clinical assessment/prognostication tool is solely at the discretion of the responsible treating physician(s) and may change over time as patient characteristics and/or clinical science changes. No matter the clinical criteria utilized, clinical trajectory over time is often more important than any single point in time criteria. If one patient's likelihood of survival is declining more rapidly than the other patient needing the same limited resource, the limited resource should be assigned to the patient with the less rapid rate of decline. Additional survival beyond hospital discharge may only be considered after all clinical factors related to achieving hospital discharge have been considered, and the likelihood of survival to hospital discharge is, in reasonable medical judgment, the same for two (2) patients but treatment is available only for one. This is hopefully a rare situation, but if it occurs, consideration may only be given to the short-term post-hospitalization survivability of the patient, provided neither disability, age, nor perceived quality of life are part of that consideration. In all cases, clinical judgment about survival should be based upon an individual patient assessment including reasonable modification of any clinical assessment/prognostic tool(s) utilized as necessary to accommodate for patients with a disability, and in line with the principles of non-discrimination outlined above.
- **No categorical exclusions:** Neither this Guideline nor the tools referenced are intended to create any categorical exclusions from life sustaining treatment. However, a patient may have an advance directive (Directive to Physicians/Living Will, Medical Power of Attorney, Out of Hospital DNR) or other clear evidence indicating the patient prefers a "comfort only" treatment approach if the patient is, in reasonable medical judgment, terminally ill and unable to express her or his wishes.

[2]Many clinical prognostic assessment tools are better validated for some conditions than others. For example, SOFA or MSOFA are best validated in the setting of sepsis with multi-organ system failure and may have less utility as a supplement to physician judgment in isolated single organ lung failure from an infectious disease like COVID-19. < https://nam.edu/wp-content/uploads/2020/12/csc-issue-summary_updated.pdf >

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