SOUTHWEST TEXAS REGIONAL ADVISORY COUNCIL'S HOSPITAL AND ICU PANDEMIC CRISIS GUIDELINES Version 1.5 - January 2021

Purpose: To support clinicians, health systems, and the community by providing a clinically and ethically sound triage protocol for allocating healthcare resources (e.g. hospital care, ICU care, ventilators) during a crisis when resources are critically scarce (such as a pandemic respiratory crisis).

Basic principles:

- Resource allocation should be considered only when necessary during a crisis after (and while) all other efforts are made to reduce scarcity of resources.
- No institution or individual can transition to Crisis Levels 2 or 3 without seeking guidance from the Regional Medical Operations Center and the State Operations Center.
- Medical and surgical care during a crisis should be based on usual clinical and ethical duties to provide effective and compassionate care, respect patient autonomy, and avoid unnecessary harm. In the setting of uncertainty and time-sensitive decisions, clinical judgment and situational awareness remain essential.
- Stewardship, equity, and accountability require that scarce resource allocation aims to save as many lives as possible while prioritizing resources for those who are in greatest need and are likely to survive the acute illness or injury. Levels of priority for hospital and ICU admission should focus on patient preferences, clinical needs, and survivability.
- Fairness and respect entail avoiding discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, disability, age, weight/ size, inability to pay, homelessness, or perceived or assessed quality of life (pre or post-treatment) or social value, as well as incarceration, veteran, insurance, or immigration status.
- Persons with disabilities are entitled to reasonable accommodations to ensure they are provided equal opportunity to benefit from care. These accommodations include: the use of clinical judgment in place of prognostic scoring systems where a patient's baseline would adversely affect a score; time and support to process medical information and decisions; visitation from support persons to accompany patients with physical, emotional, and communication-related disabilities; a pledge that disability-related home ventilators brought to the health system will not be re-allocated in a crisis.
- Patients who are not likely to survive should receive the best available supportive care.

Scope:

- Under a declared state of emergency, the Governor maintains the authority to supersede existing healthcare regulations or statutes.
- These guidelines are intended to complement the policies and procedures of participating STRAC health systems and to comply with the Texas Health & Safety Code, including Chapters 166 ("Advance Directive Act"), 311.022, and 313, as well as the Texas Administrative Code, Chapter 133.42.
- These guidelines are intended to comply with Title II of the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act, Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), and the Age Discrimination Act of 1975 ("Age Act").
- The principles of hospital and ICU triage apply equally to pediatric, adult, and pregnant populations. However, specialized clinical assessment and statutory guidance may be needed.

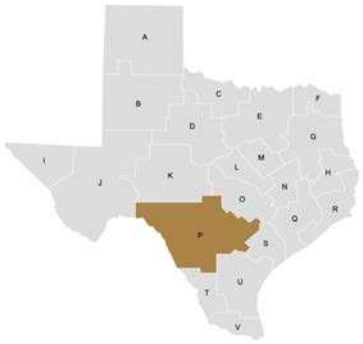
Activation: These guidelines are activated when the Governor or other appropriate official declares a pandemic respiratory crisis or other public health emergency that has the potential to overwhelm available hospital or ICU resources. Individual health systems may define terms of activation and crisis levels.

Guideline review and application:

- STRAC strongly recommends health-system-level formation of Triage Review Committees to review these guidelines and provide timely clinician support, consultation, and updated information related to resource availability and health-system bed capacity. Committee membership should be interdisciplinary, diverse, and inclusive. Members should include intensivists, nursing and organizational leadership, ethics committee members, spiritual care providers, community representatives, and legal consultants. Committee members should consider disability-specific training and offer a review and appeal process for patients, families, and providers for concerns related to fairness and possible bias.
- Guidelines may be updated by STRAC with guidance from participating health system Committees based on emerging evidence related to effective treatments and feedback from clinical staff and the community.
- Health systems should maximize supportive, administrative, and consultative services for complex treatment decisions and to coordinate care. Clinicians should have access to updated and expected resource availability. Peer support and wellness programs should be made available to staff during and after a crisis.

Contents:

STRAC
Southwest Texas Regional Advisory Council



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights

OVERVIEW OF CRISIS LEVELS: EXAMPLE

Crisis Level 1
Early in the pandemic

- Hospitals are receiving patients with active infections in significantly increased numbers.
- Emergency departments, ICUs and hospital floors are able to perform normal functions but are busy with respect to patients with active infections.
- Public health officials are reporting significant community transmission and increasing positive cases in the region.
- Note: In the event of a severe and rapidly progressing pandemic, start with Crisis Level 2.

Crisis Level 2
Worsening pandemic

- Hospitals have surged to maximum bed capacity and emergency departments are overwhelmed, and;
- There are not enough staffed beds to accommodate all patients needing hospital admission, and;
- Hospitals are considering cohorting of patients and securing assets (personnel, equipment, clinical specialists). Efforts are being made to discharge patients safely to lower levels of care; home care may involve expanded telehealth care.

Crisis Level 3
Worst-case scenario

- Criteria met for Crisis Level 2, and;
- There are not enough ventilators to accommodate all patients with respiratory failure, and;
- Hospitals have implemented altered standards of care regarding nurse/patient ratios and have expanded capacity by adding patients to occupied hospital rooms, requested additional supplies of ventilators and PPE, or converting PACUs or ORs to ICUs.

CONSIDERATIONS FOR PREHOSPITAL SETTINGS

INITIAL TRIAGE

Applies to: Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments
Implemented by: Physicians, clinic staff, pre-screening staff
Other uses: Publish in newspapers or web sites for self-use by public

ALL Crisis Levels: Provide initial triage screening as well as instructions and directions for patients who need additional care or medical screening.

EMS, PHYSICIAN OFFICES AND CLINICS

Applies to: Patients who present for care or call for guidance for where to go or how to care for ill family members
Implemented by: Primary care staff, hospital help lines, community help lines, and health department help lines

Crisis Level 1:

- Evaluate patients before sending to hospital ED or treating in an outpatient facility.

Crisis Levels 2 and 3:

- Implement alternate plans to support patients who can receive care at home or in a secondary setting.
- Begin coordination with Free Standing Emergency Centers to care for patients in this setting.

HOME CARE, LONG-TERM CARE FACILITIES, AND OTHER INSTITUTIONAL FACILITIES

Applies to: Patients in institutional facilities **Implemented by:** Institutional facility staff

ALL Crisis Levels:

- Ensure that all liquid oxygen tanks are full.
- Limit visitation to control infection. Reasonable accommodations must be made to allow for support persons of patients with disabilities as well as for clergy access in compassionate care situations, including at end of life.
- Consultation with San Antonio Metro Health Department or appropriate local health department about infection control and containment strategies.
- Ensure adequate PPE levels meet current and anticipated needs.
- Develop contingency plans for augmenting PPE levels with locally sourced materials

Crisis Levels 2 and 3:

- Use clinical judgment and, when appropriate, the tools and tips in this document (pages 4-9), to evaluate patients.
- Provide palliative and supportive care on-site when possible.
- Contact Regional Medical Operations Center for coordination and guidance.

CONSIDERATIONS FOR HOSPITAL SETTINGS

HOSPITAL ADMINISTRATIVE ROLES - GENERAL

Crisis Level 1:

1) Preserve bed capacity by:
   - Minimizing, postponing and rescheduling all elective operations in CMS Tiers 1a-2b. Proceed with operations and procedures where a delay in operation would create harm for the patient (CMS Tier 3a and 3b).
   - Note: Use standard operation and triage decisions for admission to ICU.
2) Preserve oxygen capacity by:
   - Phasing out all non-acute hyperbaric medicine treatments.
   - Ensuring that all liquid oxygen tanks are full.
3) Preserve PPE in low risk situations. Order additional PPE based on projected need.
4) Improve patient care capacity by transitioning space in ICUs to accommodate more patients with respiratory failure.
5) Control infection by limiting visitation. Visitors and support persons must adhere to infection control procedures including screening for illness and PPE. Reasonable accommodations must be made to allow for support persons of patients with disabilities as well as for clergy access in compassionate care situations, including at end of life.
6) Assessment of supply and initiate ordering of pertinent medications to include sedatives, analgesia, paralytics, MDIs, iNO tanks and disease-specific treatments as well as intubation equipment, HEPA filters, ventilator circuits, CRRT fluids & circuits.
7) Implement provider self-assessment of clinical skills related to triage, floor level care, critical care, palliative care and procedures. From this, create a database in order to create an appropriately staffed tiered back-up system using all available providers.

Crisis Level 2:

1) Preserve bed capacity by:
   - Canceling all elective surgeries unless necessary to facilitate hospital discharge.
   - Evaluating hospitalized elective surgery patients for discharge using same criteria as medical patients.
   - Reasonable accommodations must be made to ensure that persons with disabilities have the same access to elective surgical care as persons without disabilities.
2) Improve patient care capacity by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to occupied hospital rooms.
3) Institute a supportive and/or palliative care team to provided symptom management, counseling, care coordination for patients, and support for families of patients who need it and for those who do not receive higher levels of care and are unlikely to survive.
4) Implement a Triage Review Committee for the review and application of these guidelines (as described on page 1).
5) Maximize supportive, administrative, and consultative services for complex treatment decisions and palliative care.
6) Call for assistance from the Regional Medical Operations committee to request all available resources for equipment and personnel to care for current and anticipated patients, such as additional nurses/physicians/APPs, PPE, mechanical ventilators, materials to retool PACUs & ORs into ICU areas
7) Implement crisis standards for PPE if supplies are critically short.
8) Analyze provider self-assessment of clinical skills related to triage, floor level care, critical care, palliative care and procedures taking into account any providers that may be out due to illness and create multidisciplinary tiered teams that will be ready to mobilize for backup and cross-filling when needed. Provide educational resources for these providers.
9) Begin coordination with Free Standing Emergency Centers

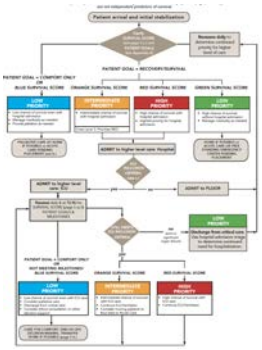
Crisis Level 3:

1) Preserve bed capacity by limiting to only necessary CMS tier 3b procedures. Implement damage control surgery protocol to limit OR time and supplies.
   - To increase ICU capacity, transition all unused OR and PACU space into ICUs.
2) Implement backup and crossfill plans to augment critical care physicians and hospitalists.
3) Declare internal disaster.
4) Coordinate all decisions regarding new EMS transports with the Emergency Operations Center and the Regional Medical Operations Center. Request diversion to all EMS traffic.
5) Request transfer of patients appropriate for transfer through the Regional Medical Operations Center.
6) Ensure palliative care teams are engaged with clinicians and their patients.
7) Transfer and transport appropriate patients to Free Standing Emergency Centers.

EMERGENCY DEPARTMENT, HOSPITAL AND ICU — CLINICAL TRIAGE

Use clinical judgment and, when appropriate, the tools and tips in this document (pages 4-9), to evaluate patients. Clinical decisions should be individualized and based on patient preferences. In Crisis Levels 2 and 3, the *lowest* priority for admission is given to patients with the lowest chance of survival from acute illness or injury *even with* available treatment and to patients with the highest chance of survival *without* treatment. Race, age, and disability are not independent predictors of survival. Because clinical decisions are time-sensitive and shrouded in uncertainty, physician judgment should be used in applying these guidelines. Continual reassessment of availability of hospital beds and ventilators should be performed. Consultation with critical care providers and the Triage Review Committee is encouraged.

ALGORITHM: **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE**



Crisis Level 2:

- Use clinical judgment and, when appropriate, the tools and tips in this document (pages 4-9) to help determine priority for ICU admission.
- Reassess need for ICU/ventilator treatment daily and/or as necessary. After 72 - 96 hours, it is recommended that all ICU patients have a reassessment of the patient's goals and whether clinical milestones have been met.

Crisis Level 3:

- Use clinical judgment and, when appropriate, the tools and tips in this document (pages 4-9), to help determine priority for ICU, intubation, and/or mechanical ventilation.
- Triage patients who do not meet ICU inclusion criteria or with green survival scores (page 5) to lower level of care.
- Triage patients with red or orange survival scores (page 5) to continued higher level of care.

Also available as part of the eCourse
2022 Health Law eConference

First appeared as part of the conference materials for the
33rd Annual Health Law Conference session
"Crisis Standards of Care"