

New Hampshire State Triage Committee Crisis Standards of Care Clinical Guidelines

Recommendations for healthcare facilities for crisis standards in response to the COVID-19 pandemic.

Introduction

The State of New Hampshire Crisis Standards of Care Plan (NH CSC) provides guidance on a wide range of issues faced by health care organizations during any public health crisis. During a particular crisis, the NH CSC also calls for formation of a State Disaster Medical Advisory Committee (SDMAC) and State Triage Committee (hereafter referred to as “the Committee”) to develop and lead a unified and consistent approach to resource allocation.

It is expected that all hospitals and healthcare facilities develop and regularly update Emergency Operations Plans and guidelines for Crisis Standards of Care individualized to their facilities resources. The NH CSC Plan provides frameworks to assist in this planning.

These NH CSC Clinical Guidelines addresses specific areas of clinical care that require alignment among healthcare facilities in response to the COVID-19 pandemic and makes recommendations for guidelines and policies specific to crisis standards of care.

The Clinical Guidelines in this report primarily address the allocation of scarce critical care resources such as ventilators and critical care beds. These Guidelines could also be used in other scarce resource situations, such as determining priority for surgery or dialysis, depending on the local resource availability and nature of the crisis.

The Committee recognizes that there is no perfect system for the allocation of scarce resources in a crisis. No recommendations from this Committee are made with discriminatory intent, and all efforts have been made to avoid discriminatory impact. The goal of these recommendations, using the ethical framework of the NH CSC Plan, is to save the most lives by doing so in an ethically grounded, transparent, and accountable manner.

The Committee hopes this document will foster continued dialogue among the residents of New Hampshire about how best to allocate resources in a health crisis so that these recommendations may be updated in the future. The State of New Hampshire and its healthcare community will do everything in their power to avoid needing these Guidelines, including reallocation of resources when the timing and nature of the crisis permits. However, the Committee believes these recommendations will help assure the residents of New Hampshire that they will be treated in a consistent, fair, and equitable manner regardless of where they receive care.

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Principles of Crisis Standards of Care

Core Strategies

In developing crisis standards of care plans (and emergency operations plans) at the facility level, the following strategies must be considered:

- **Prepare** - pre-event actions taken to minimize resource scarcity (e.g., stockpiling of medications).
- **Substitute** - use an essentially equivalent device, drug, or personnel for one that would usually be available (e.g., morphine for fentanyl)
- **Adapt** – use a device, drug, or personnel that is not equivalent but that will provide sufficient care (e.g., anesthesia machine for mechanical ventilation).
- **Conserve** – use less of a resource by lowering dosage or changing utilization practices (e.g., minimizing use of oxygen driven nebulizers to conserve oxygen).
- **Re-use** – re-use (after appropriate disinfection/sterilization) items that would normally be single-use items.
- **Re-allocate** – restrict or prioritize use of resources to those patients with a better prognosis or greater need.

Triage and reallocation of resources should only take place if resources are overwhelmed despite exhaustive efforts to augment, share, and extend resources. The NH Department of Health and Human Services must be consulted when implementation of resource rationing and allocation takes place and can assist in the redistribution of certain critical resources or the transfer of patients if one area of the state is overwhelmed while resources in another part of the state are available.

Ethical Considerations

In scarce resource situations, when the need to triage and reallocate resources becomes clear, the criteria used to allocate those resources must be applied equally to all patients who could benefit from a limited resource. The NH CSC Plan addresses several ethical principles that should be accounted for when developing any CSC guidelines:

- Justice (fairness and equity)
- Transparency
- Respect for Persons
- Beneficence
- Non-maleficence
- Participatory (inclusiveness)
- Proportionality
- Solidarity
- Duty to Care
- Reciprocity
- Privacy and Individual Liberty

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The goal of crisis standards of care in New Hampshire is to save the most lives possible under extreme circumstances. The process by which they are developed and applied must also adhere to the ethical principles above and be transparent and accountable.

Further information on the activation, implementation, and ethical principles of crisis standards of care in NH can be found in the NH CSC Plan.

Recommendations for the Development of Triage Criteria

The allocation of scarce resources in a crisis necessitates the creation of a priority scoring system to determine who will receive a particular resource should demand overwhelm supply. Alignment of priority score criteria among hospitals in New Hampshire is essential for maintenance of the public trust that all persons will receive fair and equitable treatment regardless of where they receive their care.

Priority scoring of patients for the allocation of a resource generally occurs in three stages: 1) inclusion criteria, 2) assignment of a priority score and application of secondary criteria, and 3) periodic reevaluation and possible reassignment of resources.

All crisis standards of care guidelines should embody the following overarching recommendations, and must be as clear, transparent, and objective as possible. Triage and allocation of resources should be based on objective, biological factors related only to the likelihood and magnitude of benefit from those resources. Factors including, but not limited to, age, sex, gender identity, sexual orientation, race, creed, color, marital status, familial status, physical or mental disability, national origin, ability to pay, socioeconomic status, perceived social worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources, are irrelevant to the allocation of resources in a crisis, and should not be considered by providers making allocation decisions.

Inclusion Criteria

The first step in allocating a resource is determining who requires it. The Committee recommends against the use of exclusion criteria at any point during the triage process. Using a framework in which all patients are eligible and worthy of care is most in keeping with the ethical framework of the NH CSC Plan.

The Committee does recommend the use of inclusion criteria to determine the need for prioritization. Inclusion criteria must be clinically relevant to the resource being allocated. The allocation framework must be applied equally to all patients in need of a resource regardless of their diagnoses and medical history.

Implementation of crisis standards of care and a triage scoring system does not preclude clinical decisions (with patient and family or healthcare agent involvement) about the appropriateness of pursuing aggressive therapy that would take place under routine circumstances.

Assignment of a Priority Score

Assignment of a priority score would occur to determine the order in which patients receive a limited resource. Resources should be allocated using a priority score that assesses the

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likelihood of a patient to benefit from the resource based on objective measures of near-term survival. A priority score should allow for meaningful access for all patients and incorporate individualized clinical assessment based on best-available, relevant, and objective evidence.

The Committee recommends the use of the Sequential Organ Failure Assessment (SOFA) or modified SOFA (mSOFA) for initial assessment of near-term survival in adults, and the Pediatric Logistic Organ Dysfunction-2 score (PELOD-2) in children. It must be acknowledged that all such scoring systems have limitations. Individuals with underlying health conditions that do not affect near-term survival pose particular scoring challenges. The Committee recommends that baseline levels of impairment prior to an acute episode not be factored into those individuals' priority scores unless they directly impact near-term survival.

Additional assessment of near-term survival may include objective clinician assessment for the presence of severe life-limiting conditions with predicted survival of less than one year. Assessment of comorbidities with the goal of predicting long-term survival beyond 12 months, carries the risk of unwarranted discrimination on the factors listed above, and is not recommended.

Care should be taken if primary priority scores are further divided into color coded priority groups. Usage of color groups may limit the ability to assess dynamic changes in priority scores and may not translate well to other institutions.

Patients with lower primary priority scores are prioritized for the allocation of resources.

Application of Secondary Criteria

If there is a tie between two or more patients in need of the same resource, secondary criteria should be considered. The Committee recommends the following secondary criteria:

- **Pregnancy:** In the event of a tie between a pregnant woman and another non-pregnant patient, a fetal evaluation of fetal heart tones and fetal viability should be performed. If normal, priority should be given to the pregnant woman.
- **Age less than 18:** Children under the age of 18 may be prioritized, especially if transfer to a pediatric service with resources reserved for this population is possible.

The Committee recommends against consideration of stage of life or age in-and-of itself as a criterion. Use of the stages of life explicitly treats age as a triage consideration separate from its prognostic significance, which conflicts with the ethical framework set out in the NH CSC Plan. Prioritization of children is the one exception to this recommendation.

While the prioritization of frontline healthcare workers and first responders is ethically justifiable, doing so in a fair, transparent, and accountable way is operationally difficult at best. The Committee recommends against giving priority to healthcare workers at this time, until a framework for such determinations can be agreed upon by appropriate stakeholders.

If there remains a tie after consideration of secondary criteria, the Committee recommends the random allocation of the resource using a validated random allocation method. A first-come, first-served method is not recommended as it may disadvantage rural and other vulnerable populations with less access to care.

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Periodic Reassessment and Possible Reassignment of Resources

Reassessment of patients who have received a scarce resource is necessary for the ethical allocation of resources in a crisis. The Committee recommends that reassessments should occur at regular intervals for as long as a resource continues to require allocation. Patients should be given a therapeutic trial of a duration specific and proportional to their individual disease process, as determined by the hospital triage committee. These determinations should be made in the context of a patient's underlying conditions or disability, with reasonable accommodations (such as extending a therapeutic trial) made for those with conditions or disabilities present prior to the acute episode that may cause variations in recovery. The duration of a therapeutic trial should be established based on existing clinical data and modified as new data becomes available.

In the event of considerable clinical deterioration, highly morbid complication, or other clear indication that a patient will not benefit from ongoing utilization of a resource, the hospital triage committee may decide to end a therapeutic trial and withdraw the resource so that it may benefit another patient. This process will necessitate the exercise of clinical judgment and should be carried out objectively. Withdrawal of resource decisions made by the hospital triage committee should be transparent to the patient, family, and/or healthcare agent prior to discontinuation. While consent is not required for the withdrawal of a resource during a crisis, patients or their healthcare agents must be given the opportunity to appeal a decision and have that appeal be decided in a timely manner prior to withdrawal of the resource. All patients who are considered for the allocation of a resource and their family or healthcare agents should be notified in advance of the possibility of resource withdrawal. Notification and disclosure should be a collaborative process between the triage committee and the bedside physician.

All patients who are unable to receive needed critical care resources or have them withdrawn shall receive comprehensive palliative care for symptom management and psychosocial support to the fullest extent possible.

Additional Recommendations

Triage Process

The Committee reaffirms that decisions regarding triage and allocation of scarce resources, when possible, should not be made by bedside clinicians. Hospital triage committees should be utilized to make proactive triage decisions and relieve bedside clinicians of the burden of decision-making when allocating resources. Each hospital should appoint a Triage Committee (or at minimum a Triage Officer), typically consisting of 3 to 4 willing providers tasked with applying the CSC guidelines and protocols in order to allocate care and resources at the hospital level. Inclusion of a critical care nurse or a non-clinician provider (e.g., a respiratory therapist) with relevant expertise is suggested.

The standards used by all triage committees in the state should be aligned in criteria and application to minimize disparities in the delivery of care, while accounting for differences in the available resources at facilities.

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All triage decisions must be documented clearly in the patient chart. Summary data on triage decisions and appeals, including the number of patients triaged, triage decisions, and the age, gender, race, and disability of patients triaged must be gathered and reported to the State Triage Committee via established data sharing pathways (e.g. Juvare).

Hospitals and facilities implementing triage of resources must have a clear, transparent, and accessible process for clinicians, patients, or healthcare agents to make concurrent and retrospective appeals of resource allocation decisions. Information on the triage criteria and process should be made available in accessible formats in a culturally competent manner, with reasonable accommodations made available for those who require it.

Additional information on triage committees and recommendations for developing a process of appealing triage decisions can be found in the NH CSC Plan.

Provider Orders for Life Sustaining Treatment

Current NH state law (RSA 137-L) recognizes Provider Orders for Life Sustaining Treatment (POLST) originating from within the state but does not specifically support reciprocity or recognition of out-of-state POLST forms.

The Committee believes that protections should be given to healthcare providers who recognize and honor POLST forms, regardless of state of origin. Providers who honor POLST orders and believe in good faith that a POLST is valid, regardless of state of origin, and that it has not been revoked, should not be subject to civil or criminal sanctions for orders specific to the condition or crisis for which Crisis Standards of Care are implemented.

However, state law currently grants immunity only based on the statewide POLST registry: “any person reporting information to the POLST registry or acting on information obtained from the POLST registry in good faith shall be immune from any civil or criminal liability that might otherwise be incurred or imposed with respect to the reporting of information to the POLST registry or acting on information obtained from the POLST registry.” (RSA 137-L:8).

Limitations on Resuscitative Care During a Crisis

The Committee believes it is unethical to deny patients cardiopulmonary resuscitation based solely on arbitrary factors (e.g., all patients with COVID-19) that are out of line with the patient’s wishes, advanced directives, or POLST. However, in resource scarce situations patients with unwitnessed cardiac arrest, recurrent cardiac arrest, or who are unresponsive to a reasonable trial of Advanced Cardiovascular Life Support (ACLS) care with defibrillation may have care withdrawn if continued resuscitation attempts would draw resources and care from other patients.

Community Engagement and Education

Early communication regarding the goals and application of Crisis Standards of Care is critical for maintenance of public trust and upholding the principles of transparency and accountability. The Committee recommends that hospitals work with NH DHHS to develop and distribute

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educational material for both healthcare providers and the public. These materials should include information on:

- What crisis standards of care are,
- When and how they would be implemented,
- What facilities and the State are doing to avoid their use, and
- What the public can do to help.

Visitor Policies

The Committee acknowledges the need for reasonable alterations to visitor policies in times of crisis and during a pandemic. Visitor policies during any crisis must be consistent with disability rights laws while being supportive of the health and safety of patients, healthcare providers, and support persons. People with disabilities must be allowed reasonable access to a designated support person to support disability related needs if possible, including assistance and support with communication and managing healthcare decisions.

