I. BACKGROUND:
The COVID-19 pandemic has presented the United States and the world with an unprecedented crisis, one that demands a shift in perspective, individual sacrifice and a redefined sense of community.

Citizens, health systems, businesses and the government are all being asked to change their daily routines, protect each other from a potentially deadly illness and to stay safe within their homes and neighborhoods. In short, we are all in this together and in these uncertain times, we must protect the lives and well-being of ourselves, the ones we love and our communities.

With these considerations in mind, the purpose of this document is to provide guidance for the fair allocation of critical care resources in the event that a public health crisis causes demand for critical resources to overwhelm the supply. These triage recommendations will only be enacted within the Community Memorial Health System if our critical care capacity is unable to meet our patient care needs and if a regional authority has declared a critical public health emergency.

A. Ethical Foundation for Allocating Scarce Resources during a Public Health Emergency. Since the allocation of scarce resources in this COVID-19 pandemic is an unprecedented occurrence, the responsibility to undertake these triage efforts requires an explicit ethical framework.

1. "Patient-centered practice"
   In usual clinical practice, the goal of medicine is to maximize the patient’s individual best interests. This is accomplished by doctors advocating for the highest quality care for their patients while respecting the rights of each patient to define their own goals and values in their care choices. This "traditional patient centered ethic" is how doctors and hospitals usually provide health care to our communities in normal times.

2. "Population-centered practice"
   In a true public health emergency, the goal of health care is forced to shift away from the needs of individual patients and focus more energy and resources to provide "the greatest amount of good for the greatest number of people". In practical terms, this competing "public health ethic" forces our communities and our country to "saving the most lives possible." In extreme cases caused by a public health crisis, the scarcity of critical care equipment, highly trained health care workers and hospital space may cause some patients to receive less critical care services than they might otherwise receive if there was not an overwhelming patient demand for services.
While health systems historically strive to provide all of our patients with the right care at the right time, a true public health crisis, like the one being experienced now by the COVID-19 pandemic of 2020, creates an inherent tension between maximizing the treatment needs of one patient while leaving little if anything left to treat another. Sadly, this tragic situation is currently occurring today in parts of Europe, Asia, the Middle East and even in regions of the United States. Tragically, due to a lack of critically needed resources brought about by this pandemic, coupled with a lack of a fair and consistent triage plan, bedside doctors are being forced to ration care individually at the patient’s bedside without clear and consistent guidance. To address this morally and societally untenable situation, these guidelines seek to provide a clear and ethical framework for the allocation of scarce resources caused by the unprecedented COVID-19 pandemic. By promoting these guidelines fairly and consistently throughout our health system, our goal is to maintain both the traditional doctor-patient relationship and the urgent public health imperative to save as many lives as possible.

B. The Blending of "Patient-Centered" ethics with "Population-Centered" ethics

A public health crisis requires health care institutions to expand their traditional focus on promoting the well-being of individual patients to include advancing the well-being of the entire population. Practically speaking, this means balancing the best possible outcomes for individual patients with the best possible outcomes for the greatest number of people. Finding the right balance between such competing interests compels both physicians and health systems to revisit the four foundational principles of biomedical ethics.

These are:

1. Respect for patient autonomy. Even in the face of medical scarcity, physicians should treat all patients with inherent respect and dignity. Values such as patient self-determination, informed consent, confidentiality, truthfulness, and empathic communication remain crucial to maintaining the trust of patients, their families and the public.

2. Beneficence. The entire Community Memorial Health System and its organized Medical Staff embrace our ‘duty to care’ for individual patients and our community. Even during an emergency public health crisis, we pride ourselves by remaining true to our motto: “where excellence begins with caring.” Despite the tragic and unprecedented possibility of confronting the challenge of allocating scarce medical resources, our goal remains to act in the best interests of our patients and our community while sustaining the traditional fiduciary relationship between doctor and patient. To honor this core ethical principle, NO bedside clinicians will be responsible for patient, equipment or staff allocation decisions.

3. Non-Maleficence. Respecting this principle during the COVID-19 pandemic expands our responsibility to avoid preventable harms not only for our patients but also for our community and our staff. Since the beginning of this COVID-19 crisis, (and even predating it), the Community Memorial Health System has worked hard to plan, coordinate and manage resources to avoid situations of medical scarcity. Collaborating with the Ventura County Department of Public Health and coordinating with other regional health systems, is a reflection of our commitment to be as prepared as possible in the event of a dramatic patient surge in our community. This allocation document itself, created by a task force of doctors, nurses and administrative staff in the midst of this crisis, exemplifies our commitment to face unprecedented allocation demands in a fair and equitable manner.
4. Respect for Justice. The Community Memorial Health System strongly believes in the values of fairness, non-discrimination, transparency and accountability. Allocation decisions, if required by an overwhelming demand for critical medical services, which outstrips supplies, needs to be applied consistently and equitably across people and across time. In an effort to eliminate issues of bias and prejudice, allocation decisions will be made as objectively as possible by independent triage teams with no direct patient care responsibilities and blinded to the names of the patients being triaged. An appeals process will help to ensure accuracy, consistency and fairness. Honest disclosures of difficult allocation decisions, with support from trained clinicians with expert communication skills, help to ensure a culture of fairness, procedural justice and empathic caring.

II. POLICY & PROCEDURE:
A. Triage Team:
   Goal: It is important to emphasize that the patient’s treating physicians will NOT make allocation decisions. Triage teams with training in this allocation framework and in direct coordination with administration leaders will make all allocation decisions.

   The separation of the triage role from the clinical role is intended to assist bedside clinicians and the health system ensure quality decision-making, enhance objectivity, avoid conflicts of commitments and minimize clinician moral trauma and distress.

   Composition and Function of the Triage Teams
   1. Five (5) teams of two (2) people (total of ten 10 Triage Officers)
   2. Each team will be on-call for 24 hours every five (5) days
   3. Triage team will meet regularly when there exists a systemwide shift in the health system from conventional/”usual care” to contingency/”surge care”.
   4. Triage teams will begin using ethical allocation of Scarce Resource Triage Tools when there is a systemwide shift from contingency/”surge care” to contingency/”crisis care”.
   5. Triage teams will begin making allocation decisions after being notified by the CMHS’s CEO, CMHS’s Chief of Staff and the COVID-19 Crisis Task Force Coordinator/Director.
   6. Every morning, one triage officer will meet with the ”Incident Commander” to identify scarce hospital resources (ICU beds, ventilators, PPE, critical health workers) for the next 24 hours.
   7. Administration will supply a staff member to support the work of the triage team. The staff member should have access to the ”Incident Commander” to maintain an updated database of scarce resources within the health system.
   8. The Triage Officers should be well-respected physicians with expertise in hospital medicine, outpatient medicine or both.
   9. In general, it should be the responsibility of the attending physician to notify the patient and/or family of the allocation decision. The Palliative Care Service, Chaplain, social worker or another clinician (at the request of the attending physician) maybe asked to participate in a conversation with the patient and/or family.

   It should also be appreciated that all critical care services are begun as ”time-trials”. All critical care services will be reassessed periodically to ensure that they remain therapeutically beneficial. (see procedure for reassessment).
B. Appeals Process for Allocation Decisions

1. In the event a patient, family or a healthcare professional challenges an individual allocation decision, an appeals mechanism will seek to resolve such disputes.

2. An “Appeals Committee” of at least three (3) persons will adjudicate the appeal. Members of the “Appeals Committee” may include a physician, a nurse, a risk manager, the hospital Attorney, an ethics committee representative or a chaplain. None of these individuals should be on triage committees or a member of the patient's health care team.

3. For an appeal of the initial allocation decision, it is considered appropriate that the only permissible appeal be based on a claim that an error was made in the calculation of the priority score. The process of the appeal should begin with the triage team and the appeals team verifying the accuracy of the priority score calculation.

4. An appeals process should be timely and completed within eight (8) hours.

5. DECISIONS TO WITHDRAW a scarce critical care resource from a patient who is already receiving it may cause heightened moral concern and be based on a higher degree of clinical judgment than the initial allocation decision.

6. Unless a re-allocation decision will cause significant harm to another waiting patient, a more comprehensive appeals process should include:
   a. The appeal should immediately be brought to the “Triage committee” and then forwarded to the “Appeals Committee”.
   b. The individual(s) who are appealing should explain verbally and in writing their disagreement with the decision.
   c. An appeal may not be brought over an objection to the medical allocation framework in general.
   d. The Triage Team should explain the grounds for the allocation decision that was made. The priority score should be verified by the Triage and Appeals committees.
   e. After a consensus by the “Appeals committee” is reached, the decision should be communicated to the “Triage committee” and the attending physician.
   f. The decision of the “Appeals committee” will be final.
   g. Periodically, the “Appeals committee” should retrospectively assess whether the triage process is consistent with an effective, fair and timely application of the allocation framework.

C. Exclusions from the Triage Protocol:

This allocation document and the entire Community Memorial Health System explicitly believes that all individuals should be treated with inherent dignity and worth. In keeping with this strongly held belief, even in a critical public health emergency, all individuals are considered to be worth saving. Therefore, this allocation policy recognizes NO categorical exclusion criteria. Specifically, in an effort to maximize fairness and minimize bias, all patients who are candidates for scarce medical resources will be considered eligible without regard to race, color, religion, gender, age, ancestry, national origin, disability, sexual orientation, marital status, insurance status, social worth, citizenship, primary language or immigration status. Decisions concerning whether a patient will receive limited allocated medical resources will be based on an individualized patient assessment utilizing the best available objective medical evidence.

In keeping with the current ethical and legal standards of respect for personal autonomy, patients always have the right to refuse any/all proposed medical treatments. If a patient with decision making capacity (or a surrogate for a patient without DMC) determines that he/she does not wish to begin or continue a medical intervention, then that treatment should be withheld or withdrawn. If a patient refuses to be considered for scarce medical resources, she/he may refuse to participate further in...
D. Allocation Framework:
This allocation framework will be activated at the direction of the CMHS’s CEO, CMHS Chief of Staff and the COVID-19 Crisis Task Force Coordinator/Director. As detailed below, under such severe crisis conditions, an individualized clinical assessment will be delivered to a triage team who will utilize an allocation protocol for all patients who have illnesses that requires critical care resources. This allocation framework MUST be applied to ALL patients presenting with critical illness, not simply those that arose from the public health emergency.

The allocation process involves four (4) steps:
1. The attending physician for each critical patient will calculate a ‘triage score’ based upon the SOFA screening tool. (See appendix A).
2. Each patient will be assigned to a priority group. Determining on a daily basis how many priority groups will access critical care interventions.
3. If there are fewer resources than patients within a priority group, additional considerations will be used to determine which patients will receive access to critical care resources.

In the event a patient is critically decompensating before or during a triage assessment, all medically appropriate efforts should be performed to immediately stabilize the patient. This may include cardiopulmonary resuscitation, pressor agents and ventilator support. Once stabilized, every effort should be made to complete the initial triage assessment as rapidly as possible.

This allocation framework is based primarily on two overarching goals; 1. Saving lives and 2. Saving life years. Patients who are more likely to survive with intensive care are prioritized over patients who are less likely to survive with intensive care. Patients who do not have a severely-limited life expectancy are given priority over those who have such advanced co-morbidities that they have a very limited life expectancy even if they survive the acute critical illness.

Finally, in a further effort to promote fairness, consistency and transparency, the patient's name will be known only to the attending physician and the treating team. To maintain impartiality and avoid bias, triage officers will remain ‘blinded’ to all persons being considered for scarce resource allocation.
A. Process for Generating a Triage Score

Step 1. Initial Assessment for Allocation of Critical Care Resources

a. The attending physician will first determine if intensive care treatments (ICU admission or ventilator support) is indicated. There is no difference in allocating scarce resources between patients with COVID-19 and those with other medical conditions.

b. Prior to being enrolled in a Triage Allocation Process, the attending physician should notify the patient of:
   i. What is the patient being considered for and why
   ii. The risks and benefits of the proposed treatment
   iii. Any questions from the patient and/or family and recommendations from the physician
   iv. The opportunity for the patient to opt in or opt out of the triage process (the attending physician is providing the patient informed consent regarding the process)
   v. An understanding that all treatment interventions are time trials. Reassessments will occur regularly to monitor success or failure of our intervention.

c. The attending physician will then calculate the patient's short-term likelihood of surviving the acute medical episode, utilizing the Sequential Organ Failure Assessment (SOFA) tool.

Note: The attending physician is NOT making an allocation decision but simply collecting data for analysis by the triage committee. The calculation of an individual's short-term survival is based on assessing end-organ functions utilizing the Sequential Organ Failure Assessment (SOFA) tool.

SOFA

<table>
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<tr>
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<th>SOFA Score</th>
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<tr>
<td>Respiratory</td>
<td>PaO₂/FIO₂ &gt; 400</td>
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<tr>
<td>Cardiovascular (doses in mg/kg/min)</td>
<td>MAP ≥ 70 mm Hg</td>
</tr>
<tr>
<td>Liver (bilirubin, mg/dL)</td>
<td>&lt; 1.2</td>
</tr>
<tr>
<td>Renal (creatinine, mg/dL)</td>
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</tr>
<tr>
<td>Coagulation (platelets x 10^9/mm³)</td>
<td>≥ 150</td>
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<td>Neurologic (GCS score)</td>
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Step 2: The Triage Officer/Team converts the raw SOFA Score into 1 of 4 “Priority Scores”.

Table 1

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<tr>
<th>Raw SOFA Scores</th>
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<tbody>
<tr>
<td>Total SOFA score</td>
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</tr>
<tr>
<td>&lt; 6</td>
<td>1</td>
</tr>
<tr>
<td>6 - 8</td>
<td>2</td>
</tr>
<tr>
<td>9 - 11</td>
<td>3</td>
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<td>&gt; 12</td>
<td>4</td>
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Key:
Priority Score 1 = Triage Tier 1 = Highest Priority
Priority Score 2 = Triage Tier 2 = High Priority
Priority Score 3 = Triage Tier 3 = Intermediate Priority
Priority Score 4 = Triage Tier 4 = Low Priority

a. Patients in the highest priority Triage Tier 1 have the best chance to benefit from critical care interventions and should receive priority over all the other groups in crisis situations.

b. Patients in Triage Tier 2 (high priority) have the next best chance to benefit from critical care services and should receive critical care resources if there are available resources after all patients in Tier 1 have been allocated needed resources.

c. Patients in Triage Tier 3 (intermediate priority) may receive critical care services if there are available resources after all patients in Tiers 1 and 2 have received their allocation.

d. Patients in Tier 4 (low priority) may receive scarce resources if there are available resources after all patients in Tiers 1, 2 and 3 have already been allocated their resources.

Note: It is important to note that all patients remain eligible to receive critical care services regardless of their MPS scores. The availability of critical care resources will determine how many eligible patients will receive critical care.

Patients who are not allocated critical care, ventilators or both, will receive medical care that includes intensive symptom management, palliative care and psychosocial support. They should be reassessed daily to determine if more resources become available or if their clinical status changes in regard to critical care. The role of palliative care services cannot be underestimated for these patients.

Step 3: Reassessment

a. All patients who are triaged to receive critical care services should be told by the attending physician, prior to the initiation of treatment, that these services will be periodically reassessed to determine their clinical efficacy. Reassessments will be made at 48 hours and 120 hours after initiation of critical resources to assure that critical care services remain clinically beneficial.

b. The ethical justification for such reassessment is that in a public health emergency when there are not enough critical care services for all, the goal of maximizing population outcomes would be jeopardized if patients who were determined to be unlikely to survive were allowed indefinite use of scarce critical care resources. Also, reassessment lessen the chance that arbitrary consideration (like first come, first served) unfairly affects a later patient’s fair access to treatment.

c. Periodic reassessments of patients receiving critical care resources will involve recalculating SOFA scores, assessing changes in the patient’s clinical...
trajectory and the likelihood of further success with critical intensive therapies. Patient’s showing improvement will continue to receive critical care resources until their next reassessment. If there are patients awaiting critical care services, then currently treated patients who are demonstrating substantial clinical deterioration (as evidenced by worsening SOFA scores or other clinical metrics) then the triage team will determine whether it is appropriate to reallocate the scarce resources they are receiving. Although patients should generally be given the full duration of a timed trial, if patients experience a precipitous decline (e.g. refractory shock or DIC or a highly morbid complication (e.g. massive stroke) which portends a very poor prognosis, the triage team might render a triage decision before the completion of the trial period. Patients no longer eligible for critical care should receive intensive symptom management and psychosocial support. Early involvement of palliative care teams should be strongly considered.

d. For all clinicians and staff practicing in these unprecedented times, please reference Appendix C which offers some practical advice on how to talk about difficult topics related to COVID-19.

Step 4: Resolving Ties Between Patients within the Same Priority Triage Tier

a. There are five possible tie-breakers to consider:

i. Pregnancy – If a patient is pregnant, she will be assigned 3 tie-breaker points.

ii. Essential Health Care Worker- If a patient is an essential health care worker (defined as eligible for COVID-19 vaccination in Group 1 by the VCPH), then he/she will be assigned 2 tie-breaker points.

iii. Essential Workers- If a patient is an essential worker (defined as eligible in Group 2 by the VCPH) then he/she will be assigned 1 tie-breaker point.

iv. Life-limiting Co-morbidities- If a patient has life-limiting co-morbidities where death is likely within 1 year, then the patient will be assigned -3 (minus) points.

Note: The Medicare Hospice guidelines are a widely used tool to help prognosticate death within 6 months. Extrapolating back to one year is reasonable for patients with life limiting illnesses who are approaching Medicare Hospice eligibility.

v. Finally, all triage patients will receive a 3 digit computer generated random allocation number.

vi. Summary- Tie-breaker within Tiers

- Pregnancy +3 points
- Essential Health Care Worker +2 points
- Essential Worker +1 point
- Life-limiting co-morbidities -3 points
- Random allocation number +0.001 to + .0999

vii. After calculating tie-breaker points for all participants being triaged, then patients within each priority tier will be numerically ranked by their tie-breaker score. Allocating within each tier will proceed from the highest to the lowest score within each SOFA-based priority tier.

Note: Tie-breakers are only to be considered as a way to resolve ties within each priority tier. Tie-breakers will not allow patients to jump to a higher or fall to a lower tier.
This document is no longer current once it is printed. Most current version is in Intelex

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<td>Appendix C – COVID Ready Communication Playbook</td>
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<td>Date: 01/06/2021</td>
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SCARCE RESOURCE ALLOCATION WORKSHEET
(To be filled out by attending physician)

1. Date: ________________   Time: ________________

2. Attending Physician: __________________

3. Medical Record#: __________________

4. Requested Critical Care Resource: (Check All Needed)
   ICU/CCU  Ventilator  Isolation  Other
   □ □ □ □

5. SOFA Score: ________________
   SOFA Tool

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6. Life-limiting comorbidities – Circle one:
   NONE  Prognosis < 1 year  Medicare Hospice Guidelines

7. Reciprocity Status: (Check one)
   None   Essential Health Care Worker   Essential Community Worker
   □ □ □

8. Pregnant?  □ Yes   □ No