



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

October 15, 2021

Colleagues and Partners,

Washington State's updated Crisis Standards of Care (CSC) guidance reflects a key statewide commitment by health partners to work together and share resources and information so should implementation of CSC become necessary, no single hospital or region goes into it alone. To be clear, the decision to implement CSC in Washington shall occur only at the state level.

The development of Washington's CSC protocols started in 2012 and is built upon the national framework developed by the National Academy of Medicine (NAM; formerly, the Institute of Medicine), evidence-based literature reviews, regional committee meetings, and individual subject matter expert workgroups, including prior community engagement efforts to solicit input on decision-making about scarce resource allocation. Since its inception in 2015, Washington's Disaster Medical Advisory Committee (DMAC) has been tasked with providing guidance on scarce critical resource planning in the state of Washington.

Since Governor Inslee's declaration of COVID-19 as a statewide emergency in early 2020 and in coordination with the Washington State Department of Health (DOH), the DMAC has been convened on a regular basis and has worked diligently to address updates necessary to CSC based on consideration by its committee makeup of healthcare providers, ethicists, equity specialists, and other experts from across Washington. Their collective goal has been to help reshape CSC guidance to reflect state-specific healthcare needs in the midst of this pandemic and beyond.

Based on additional input from community stakeholders and subject matter experts in areas of disability rights, equity, social justice, and community engagement, revisions have been made to the critical care triage algorithms included in the current version of the CSC guidance. As a state, we continue to learn from experiences in other states and in localities within Washington, which may necessitate additional revision of guidelines as new information, science, and best practices become available. In other words, these guidelines are not intended to be a final body of work but one that will most certainly continually evolve over time as the need arises.

This latest resource, the *Triage Teams Operational Guidebook*, represents the finalized protocols for Washington's crisis standards of care, specifically on Triage Team operations and adult ICU allocation. Vetted by the DMAC and adopted by DOH, these protocols are centered on NAM's ethical framework intended to guide equitable, ethical decision-making during the most stressful of crisis situations. This has been a methodical, deliberative, and expert consensus-driven process that has been far from easy given the complexities involved. The addition of the DOH logo to this key resource is a deliberate action that reflects our agency's firm support of Washington's health care facilities, associations, and coalitions, and our commitment to this partnership even in the face of the most difficult crisis we have faced in recent history.

We would like to acknowledge the partners who have worked with DOH to develop and review Washington's crisis standards of care guidebook: members of the DMAC, the Northwest Healthcare Response Network (NWHRN), the REDi Health Care Coalition, and countless others. Together, along with the Washington State Hospital Association (WSHA), the Washington Medical Coordination Center (WMCC), Washington's long-term care associations, key state agencies, and health and medical association partners, we commit to preparing for potential implementation of crisis standards of care.

Despite the above planning and preparation efforts, we also resolutely reaffirm our continued and collective commitment to doing everything we can to avoid the need to ever have to use CSC whether now or in the foreseeable future.

Best,

Umair A. Shah, MD, MPH
Secretary of Health

Washington State Crisis Standards of Care Triage Team Operational Guidebook

OCTOBER 2021



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Section 1: Introduction

In the event of a large-scale disaster—either a no-notice event such as a natural disaster or a prolonged event such as a pandemic—there is potential for an overwhelming number of ill or injured patients requiring medical treatment and medical resources. In these situations, certain medical resources can become scarce, and healthcare providers may need to implement prioritization with the limited resources available.

Washington State aligns with the foundational principles established by the National Academy of Sciences, Engineering and Medicine (NASEM) regarding the care continuum during medical surge. This continuum is defined by three phases, identified as “conventional”, “contingency” and “crisis.”¹ The state also recognizes that healthcare may need to adapt by implementing a variety of complex and graded changes to provide care during medical surge as became evident during the COVID-19 pandemic.² Therefore, the contingency phase of the care continuum may encompass a wide variety of mitigation strategies with the utmost priority of avoiding crisis standards of care.

However, in the event of an overwhelming surge, after all mitigation strategies have been exhausted, Washington State recognizes that crisis standards of care (CSC) include first and foremost the implementation of CSC Triage Teams. This Guidebook contains the tools and information needed to implement CSC Triage Teams within a healthcare facility or system.

The content of this *Washington State Crisis Standards of Care Triage Team Operational Guidebook* is based on a thorough review of the literature, guidelines published by leading national healthcare specialty colleges and societies, recommendations of the National Academy of Sciences, Engineering and Medicine (NASEM) and detailed discussion and deliberation by the Washington State Disaster Medical Advisory Committee (DMAC), DMAC subject matter experts (SMEs), other local clinicians and ethicists, and includes input from both local and state Community Engagement Reports^{3,4}. Much of the data supporting this Guidebook is the result of a 4-phase study and statewide clinician engagement on operationalizing crisis standards of care conducted between June 2020 and June 2021.

The Washington State Crisis Standards of Care Triage Team Operational Guidebook provides guidance on four key steps:

1. Patient Data Entry
2. Triage Team Prioritization
3. Allocation of the Scarce Resource
4. Communication

Purpose

The purpose of this Guidebook is to provide clear and detailed recommendations on how to implement the four procedural steps needed to support the Triage Teams’ decision-making

process. The Triage Teams' decision-making process is based on the Washington State CSC Ethical Framework. This Ethical Framework provides the foundational principles upon which all CSC work in the state of Washington is built. This Ethical Framework encompasses the following below and serves as the driving principles behind the contents of this Guidebook. *For more information on the full Washington State Crisis Standards of Care Guidance Framework, please contact the Washington State Department of Health.*

Ethical Framework:

Washington State has adopted and will use the Ethical Framework developed by NASEM, which stresses the importance of an ethically grounded system to guide decision-making in a crisis standard of care situation. All decisions and communications will be based on the ethical principles below. The National Academy of Medicine within NASEM defines these ethical principles as:

- **Fairness** – Standards that are, to the highest degree possible, recognized as fair by those affected by them – including the members of affected communities, practitioners, and provider organizations – and are evidence-based and responsive to specific needs of individuals and the population.
- **Duty to care** – Standards are focused on the duty of healthcare professionals to care for patients in need of medical care.
- **Duty to steward resources** – Healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- **Transparency** – In development, decision-making and information sharing.
- **Consistency** – In application across populations and among individuals regardless of their human condition (e.g., race, age disability, ethnicity, ability to pay, socioeconomic status, pre-existing health conditions, relative worth, perceived obstacles to treatment, past use of resources).
- **Proportionality** – Public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.
- **Accountability** – Of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.³

It is the responsibility of everyone involved in the implementation of CSC Triage Teams to maintain current training and understanding of implicit bias. The type and frequency of implicit bias training will be the responsibility of each individual institution. DOH encourages broad consideration of equity, diversity, and inclusiveness.

1. IOM (Institute of Medicine) 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press
2. Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. 2021. *Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do? NAM Perspectives*. Discussion, National Academy of Medicine, Washington, DC.
3. Washington State Crisis Standards of Care Community Engagement Report, June 2019, WA DOH.
4. Li-Vollmer, M. *Health Care Decisions in Disasters: Engaging the Public On Medical Service Prioritization During a Severe Influenza Pandemic*. *Journal of Participatory Medicine*. Vol 2. December 14, 2010.

Scope

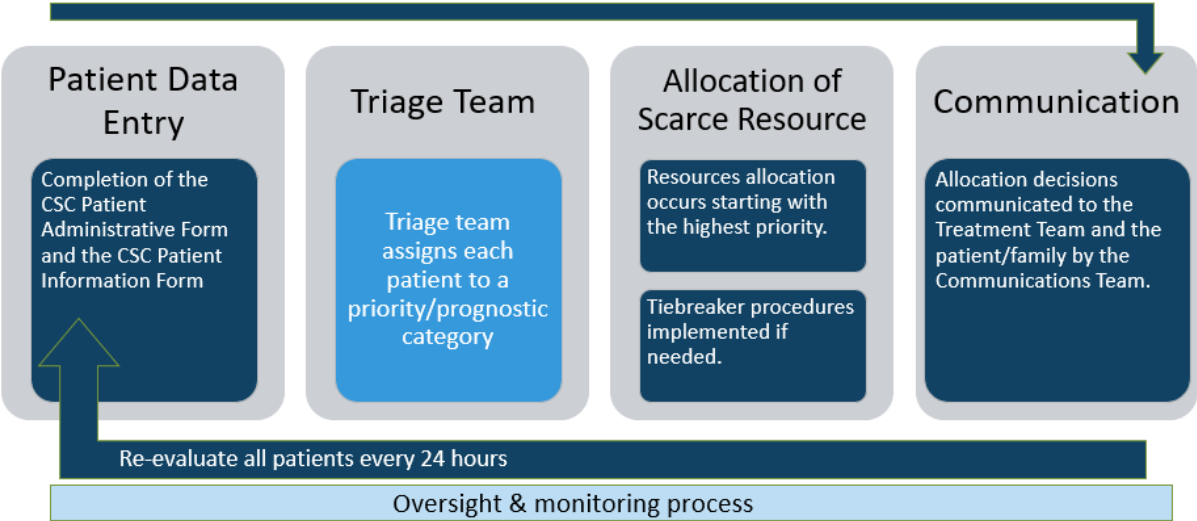
This Guidebook is intended for use by all healthcare facilities in the state of Washington when crisis standards of care have been implemented. There will be specific guidelines developed for specialty services (e.g., Pediatric, EMS). However, the CSC Triage Teams process will remain similar to what is outlined in this Guidebook.

Assumptions

- Hospital and healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver medical treatment.
- State mitigation strategies have been exhausted.
- Federal assets have been requested but are unavailable or cannot be mobilized quickly enough to address the evolving requirements of the situation.
- All facilities will adhere to this Guidebook issued by the Washington State Department of Health (DOH) to the best of their abilities given the situation at hand. It is understood that circumstances surrounding crisis standards of care can be extremely challenging and must be taken into account.
- There are many staffing requirements mentioned throughout this Guidebook. It is understood that implementation of this Guidebook could occur during extremely stressful and potentially dire circumstances. It is understood that full staffing of all recommended positions with all recommended qualifications may not be possible. However, every attempt should be made to ensure that all available individuals are objective and unbiased members who understand the full ethical framework and principles encompassed in this Guidebook. There are suggestions for alternate staffing options throughout the Guidebook.

Section 2: Overview

The overall CSC Triage Team operational concept is represented in the image below. When Triage Teams are activated, these four operational pieces need to be initiated. The remaining sections of this Guidebook contain detailed information for each step.



Section 3: Patient Data Entry

When CSC has been implemented, facilities must initiate all steps included in this Guidebook to prepare for the triage, prioritization, and allocation of a scarce resource.

The first step in the Guidebook requires gathering specific patient information. Facilities should designate an individual (preferably one with RN or similar-degree clinical training) to gather and complete the CSC Patient Administrative Form (Appendix A) and the CSC Patient Information Form (Appendix B).

The content of the Patient Administrative Form (PAF) and the Patient Information Form (PIF) **must not be changed, deleted, or altered in any way.** Items should not be added or deleted. Two of the basic principles of the ethical framework are consistency and transparency, and every decision made during CSC must be made based on accurate and identical sets of information. If an institution is transcribing the PAF or PIF to another format, these requirements must be met.

All Patient Administrative Forms and Patient Information Forms should be saved and become part of the patient’s permanent medical record.

For best practices, if a facility is operating at a high level of contingency and feels that CSC implementation is imminent, it is recommended that facilities expedite data entry and begin inputting patient data into the PAF and PIF prior to full implementation of CSC. However, once data entry has been started, either before or during CSC, it is important that the PIF and PAF be updated every 24 hours.

CSC Patient Administrative Form (PAF)

The CSC Patient Administrative Form (Appendix A) contains important patient identification and patient demographics, which will be needed during the oversight process and may also be needed in specific scenarios, such as a tiebreaker situation or during a request for patient case re-evaluation.

For more information on a tiebreaker situation, please refer to [page 29](#).

For more information on the request for patient case re-evaluation, please refer to [page 26](#).

It is important to note that all efforts should be taken to keep the Patient Administrative Form secure and separate from the Triage Team. The Triage Team members must make their decisions based only on objective blinded data captured on the Patient Information Form. Triage Team members should not have access to the Patient Administrative Form.

Data Entry

Please ensure that the individual who completes the Patient Administrative Form includes their name and contact information, should they be contacted with any questions regarding the data entry.

The Patient Administrative Form requires the following information:

- Patient’s medical record number (MRN)
- Hospital name and location
- Unique Triage Tracking ID (see below)
- Date of birth: MM-DD-YYYY
- Patient’s sex: M/F/other
- Pregnancy status: Y/N/unknown
- Patient’s current resource status (i.e., currently receiving resource or not currently receiving resource.)
- Race/ethnicity
- Home address, unhoused or unknown (see below)
- Patient’s care preferences (see below)
- Patient’s Social Vulnerability Index (SVI) score (see below)
- Patient outcome (see below)
- Triage prioritization category

Unique Triage Tracking ID

Unique Triage Tracking ID**:	Click or tap here to enter text.
Random Triage ID Number Generator	**Triage tracking ID <u>MUST</u> be entered into patient's Medical Record. Please use locally approved system to create a Triage Number. If none exist, the "Random Triage ID Number Generator" can be used

Within the Patient Administrative Form, there is a section for a “Unique Triage Tracking ID.” This tracking ID must be different and separate from the patient’s medical record number (MRN). This will provide a way to track the patient through the CSC Triage Team process and better ensure that information given to the CSC Triage Team is objective and de-identified. Please use your facility’s approved system for creating a Unique Triage Tracking ID number. If your facility does not have an approved system established, you may [click here](#) to generate a random triage ID to connect to the patient. To use the random number generator provided, please open the link provided and press “F9” to generate a new Unique Triage Tracking ID. Highlight and copy the selected ID to paste into the Patient Administrative Form.

<u>Non-Repeating RANDOM TRIAGE ID</u>
327Vt3096Q957
<ol style="list-style-type: none"> 1. Hit F9 to get a new auto-generated number 2. Highlight ID 3. Copy selected 4. Paste Special "value only" into cell needed.

Patient's Care Preferences

- This section is for the purpose of documenting the patient's preference for either withholding or modifying medical interventions.
- This information can usually be found in the patient's Electronic Medical Record (EMR) under their goals of care, POLST, advance directive (AD), living will, or other similar documents.

Patient's Care Preferences:	<input type="checkbox"/> Wants ALL medically appropriate ICU treatments <input type="checkbox"/> LIMITS to ICU, advance care planning documents (POLST, AD, etc.) states: <input type="checkbox"/> LIMITS to ICU, patient with decisional capacity <input type="checkbox"/> LIMITS to ICU, patient's substitute decision-maker
Details for any limits:	

- The two basic ICU preferences are:
 - The patient wants all medically appropriate ICU treatment, or their preferences are unknown.
 - This should be the default choice when NO patient preferences are documented, or patient preferences cannot be confirmed.
 - The patient requests limits to ICU treatments.
 - If there are limits to the ICU treatment requested by the patient, or substitute decision-maker, please document how those limits were recorded (POLST, AD, living will, direct patient conversation, surrogate decision-making conversation) and document (via free text box) the detailed and specific limitations.

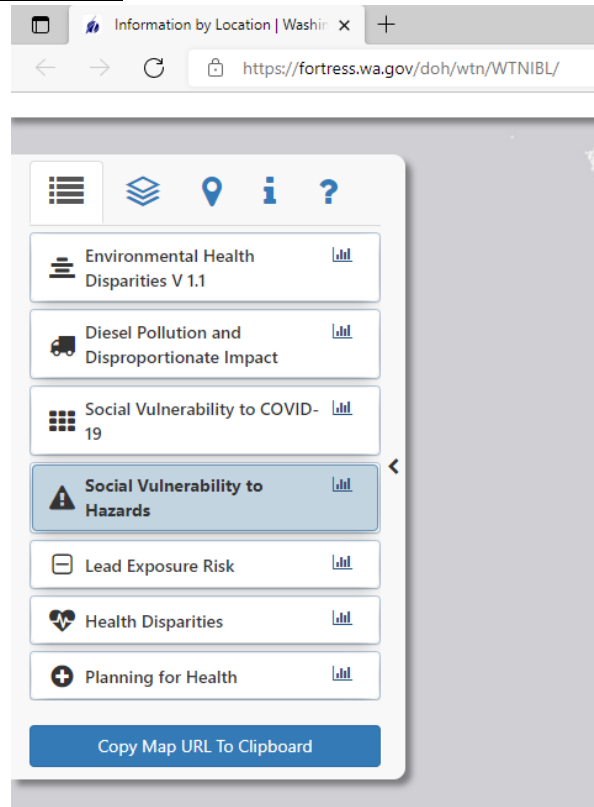
Social Vulnerability Index (SVI) Score

An SVI score will be used only for patients under consideration for a Level 3 tiebreaker situation. (Please see [page 26](#) for a full discussion of the Tiebreaker process.) The Triage Team does not see the SVI score. In order to decrease the data entry burden, the score can be entered only when needed.

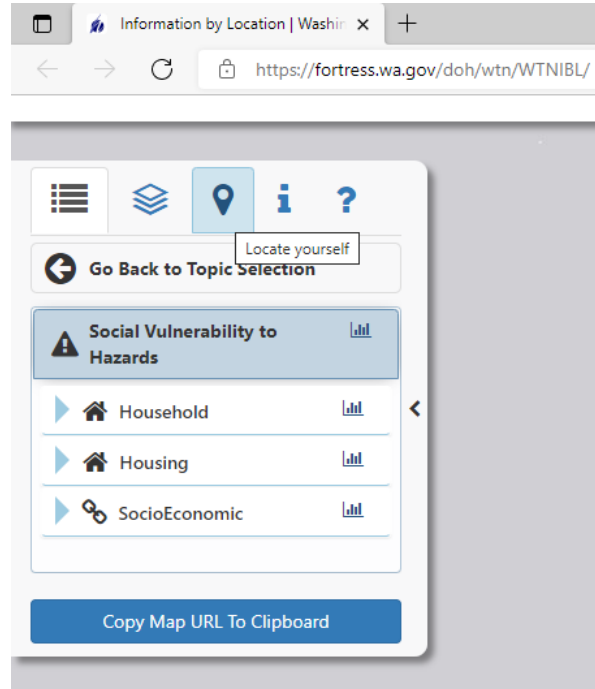
Tools such as the social vulnerability index (SVI) have been developed to better characterize the many non-medical socioeconomic factors which contribute to health risks and health inequity. These tools are used in various ways for targeting treatments, testing and mitigation strategies. In this context, the SVI score identifies patients who are likely to have experienced extreme poverty, chronic unemployment, and discrimination that impede equitable access to healthcare.

For the purposes of this Guidebook, the SVI score is determined by the patient’s home address, with an SVI score of 1 meaning the patient is considered the “least vulnerable,” and 10 meaning the patient is considered as having the “highest vulnerability.” To determine a patient’s SVI Score based on their address, please use the Washington Tracking Network Social Vulnerability to Hazards tool, [located here](#).

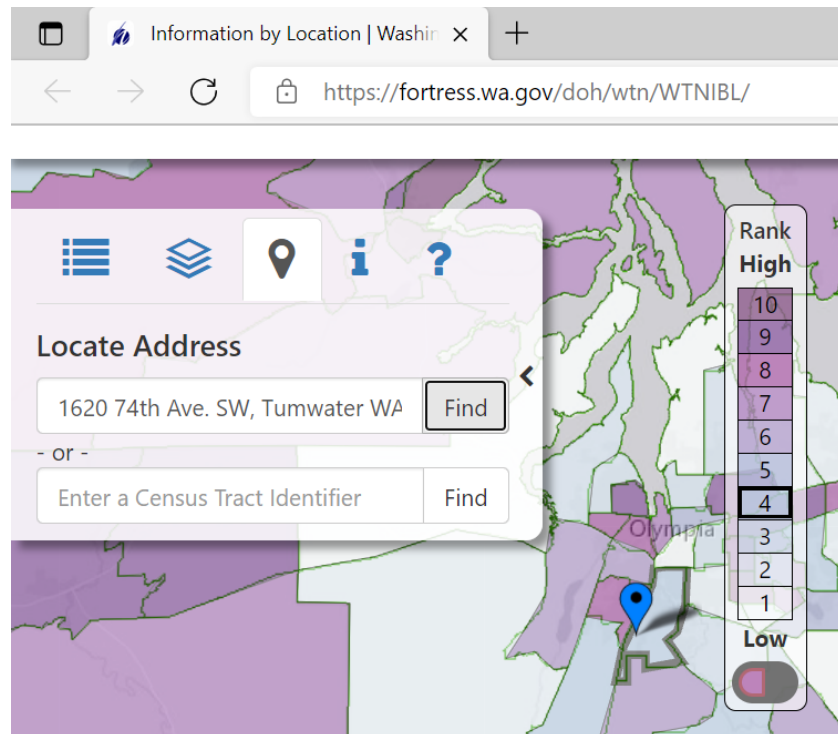
- After accessing the Washington Tracking Network mapping tool, please click “**Social Vulnerability to Hazards.**”



- Then hover over the navigator pin identifying “locate yourself.”



- Type in the address of the patient and click “find”. The SVI score will be displayed after hovering over the identified locator section. Below is an example of using a non-residential address to identify the SVI score. This example address ranks the location with an SVI score of 4. The number 4 would be then included in the patient’s PAF.



For more information on the Washington Tracking Network tools, including a demonstration on how to use the mapping tools, please [click here](#).

- ***If the patient is unhoused, please use the patient’s last known address (i.e., shelter or location where they received services).***
- ***If there is no address available for any reason, or there is no ability to calculate an SVI, then Level 3 Tiebreaker will not be used and allocation should move to randomization.***

Patient Outcome at Time of Discharge from Acute Care:

The last information to be gathered on the PAF is the patient’s final outcome at discharge from acute care. This information should be completed after the final patient disposition and includes the following choices:

- Discharged to community (e.g., home, shelter, basic long-term care facility, adult family home)
- Discharged to Skilled Nursing Facility (SNF) or Long-Term Acute Care (LTAC) facility
- Deceased
- Unknown
- Other

CSC Patient Information Form (PIF)

Once the PAF has been completed, the next step is completing the PIF (Appendix B). The PIF contains the clinical information which will be used by the CSC Triage Team to determine the patient’s priority level for receiving the scarce resource in question. Only the PIF, not the PAF, will be seen by the CSC Triage Team, and only this form will be used to determine the prioritization and allocation of the resource in question.

It is recommended that a member of the treatment team complete the PIF, as it requires specific knowledge of the patient’s past medical history, current condition, and response to treatment. A PIF must be completed on each patient under consideration for the scarce resource in question every 24 hours while CSC is implemented. It is recommended that the PIF be incorporated as a templated part of the daily progress note (e.g., a “smart phrase” within the EMR) thus decreasing the need for repetitive data input.

Most of the PIF can be completed by checking the options in the boxes provided. However, there are free text boxes that allow for individual input. All free text information entered must be objective, non-discriminatory, and unbiased. Those inputting data should be actively mindful to ensure implicit biases do not influence clinical judgment. Implicit biases include those based on stereotypes, assessments of the quality of life, and judgments about a person’s “relative worth,” Examples of wording that suggest eliciting bias would be including a pre-existing disability that does not impact likelihood to survive to discharge, substance use disorder, suspected or confirmed criminal behavior, incarceration status, homelessness, and/or behavioral or mental

health disorders. Instead, data input should focus on specific objective medical conditions. For example, conditions may be “refractory to treatment”; “sepsis secondary to deep tissue anaerobic abscesses”; “hyponatremic seizures.”

It is important that information included in the PIF be objective and contain only clinically relevant information pertaining to the patient’s likelihood for survival to discharge and must be based on the best evidence and clinical judgement at the time of completing the PIF.

The PIF requires completing the following information:

A. Unique Triage Tracking ID:

- This Unique Triage Tracking ID should match the one generated and recorded on the PAF.

B. Patient’s age:

- The patient’s age will be calculated in years as determined by the date of birth.
 - It is important to note that the patient’s age will be considered **in combination** with all additional information on the PIF and will be used **only** when age is prognostically relevant and impacts a person’s likelihood to survive to discharge.
 - For patients without a documented date of birth, an estimated age should be documented based on the treating team’s estimate.

C. Past Medical History (PMH):

- The only PMH allowed on the PIF will be medical history which reflects severe or end-stage disease of six physiologically relevant diseases affecting the likelihood of survival to discharge. Any components of the PMH that are not severe or end-stage and/or do not affect the patient’s likelihood to survive to discharge will not be included on the PIF.

Chronic Lung Disease	<input type="checkbox"/> SEVERE = Assessed and charted as severe (On home oxygen or NIPPV) <input type="checkbox"/> END-STAGE = Assessed and charted as End-stage
Chronic Heart Failure	<input type="checkbox"/> SEVERE = NYHA Stage III - OR- Ejection Fraction = 21 - 40% <input type="checkbox"/> END-STAGE = NYHA Stage IV - OR- Ejection Fraction < 20%
Coronary Artery Disease	<input type="checkbox"/> SEVERE = Assessed and charted as severe, multiple stent placements and/or CABG <input type="checkbox"/> END-STAGE = Assessed and charted as end-stage, not subject to intervention
Chronic Kidney Disease	<input type="checkbox"/> END-STAGE = Receiving maintenance Renal Replacement Therapy (RRT)
Chronic Liver Disease	<input type="checkbox"/> SEVERE = Assessed and charted as severe (If known, MELD score greater than 15) <input type="checkbox"/> END-STAGE = Assessed and charted as end-stage
Malignancy	<input type="checkbox"/> SEVERE = Metastatic or unresponsive to interventions <input type="checkbox"/> END-STAGE = Metastatic having exhausted treatment options

- The use of “Other Severe/End-Stage Ailment” allows clinicians to highlight a specific disease process when it **affects a patient’s ability to survive to discharge.** Any ailment entered must be supported by increased morbidity and mortality.
- Three specific patient conditions have been identified as having a very poor prognosis for survival to discharge even in conventional care. These include:
 - Severe acute neurologic event with low chance of survival (e.g., non-survivable head injury, cerebral herniation with no option for intervention).
 - Severe burns with low chance of survival (based on American Burn Associate burn guide).
 - Pre-existing or persistent coma or vegetative state.
 - If the patient has one of these 3 conditions, it should be indicated on the PIF under the box titled “Patient Arrived with.”

<p>Patient has been diagnosed with one of the following: <i>Mark all that apply</i></p>	<p><input type="checkbox"/> Severe acute neurologic event with low chance of survival (e.g., non-survivable head injury, cerebral herniation with no option for intervention)</p> <p><input type="checkbox"/> Severe burns with low chance of survival (*See Burn chart below)</p> <p><input type="checkbox"/> Pre-existing or persistent coma or vegetative state</p>
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D. “Prior to this hospitalization, is death within 6 months expected?”:

- This section of the PIF is intended to give the Triage Team an idea of the patient’s condition **prior** to the current hospitalization.
- If death is not expected within 6 months prior to this hospitalization, then “NO” should be checked.
- If death is expected within 6 months prior to this hospitalization, then “YES” should be checked.

<p>Prior to this hospitalization, is death within 6 months expected <i>(from either an underlying terminal/end-stage condition or irreversible cause)</i> based on the best evidence and clinician judgement?</p>	<p><input type="checkbox"/> NO. Prior to the current ailment, death in 6 months is not expected.</p> <p><input type="checkbox"/> YES. Prior to the current ailment death in less than 6 months is expected.</p>
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E. Current Assessment: This section contains information pertaining to the patient’s current clinical status.

<p>DATE OF ADMISSION: <i>If transferred, use the date FIRST admitted to a hospital. (M-D-Y)</i></p>	
<p>Date of Assessment (must be within 24 hours of submitting PIF). <i>(M-D-Y)</i></p>	
<p>Primary diagnosis/diagnoses/reason(s) for hospital and ICU admission:</p>	

- Date of Admission (MM-DD-YYYY):
 - This date determines how many days the patient has been in the hospital and therefore should be calculated from the date the patient first was admitted **to any medical facility**. This is especially important if the patient was transferred from another facility or unit or has been hospitalized at multiple facilities during this current hospitalization. This date should **not** be the transfer date, but rather the date when the patient was first hospitalized.

- Date of Assessment (MM-DD-YYYY):
 - This is to ensure that the Triage Team is making their decision based on data gathered on the day of deliberation. The Triage Team decision should be based on clinical information entered within 24 hours of deliberation.
- Primary diagnosis/diagnoses/reason(s) for hospital and ICU admission:
 - This is a free text box and allows for multiple diagnoses/reasons for hospital admission. For example, the patient could have been initially admitted for sepsis which resulted in acute kidney injury and liver injury, respiratory failure, and hypotension. All can be listed in this free text box. Care should be taken to enter only medically relevant information – avoiding potentially biasing information that does not affect prognosis.

F. ICU Admission Criteria:

- There are 3 main reasons by which a patient can meet ICU admission criteria during the use of this protocol.
 1. Respiratory Failure: The patient requires either invasive or non-invasive ventilatory support as determined by the following criteria:
 - Requires ventilatory support with clinical evidence of impending respiratory failure by showing either:
 - Refractory hypoxemia (SpO₂< 90% on FiO₂>0.85)
 - Respiratory acidosis (pH< 7.2)
 - Inability to protect or maintain airway
 2. Hypotension: Patient experiences hypotension with clinical evidence of shock refractory to volume resuscitation that cannot be managed in a non-ICU setting.
 3. “Other” as determined by intensivist (or intensivist equivalent):
 - Free text box provides an opportunity for explanation

If the patient ***has met*** ICU criteria, then the following boxes must be completed:

<p>Date ICU Criteria was 1st met on: <i>(Note: this may be different than the date of admission)</i></p>	<p>NOTE: This may be different from the date of admission</p>
<p>Current indications for admission to the ICU: <i>(choose ALL that apply)</i></p>	<p><input type="checkbox"/> Requires ventilatory support <input type="checkbox"/> Inability to protect or maintain airway <input type="checkbox"/> Hypotension with clinical evidence of shock refractory to volume resuscitation that cannot be managed in a non-ICU setting <input type="checkbox"/> Other (as determined by intensivist or equivalent):</p>
<p>COVID Test Status (for current hospitalization)</p>	<p><input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Pending-suspected positive <input type="checkbox"/> Pending-no clinical suspicion <input type="checkbox"/> Not sent. Reason:</p>
<p>Current level of respiratory support:</p>	<p><input type="checkbox"/> Ventilator <input type="checkbox"/> CPAP or bi-PAP <input type="checkbox"/> High flow oxygen (>6 LPM) <input type="checkbox"/> Low flow oxygen (<6 LPM) <input type="checkbox"/> No support <input type="checkbox"/> Other:</p>

<p>What degree of ARDS does the patient have?</p> <p>ARDS Definition:</p> <ul style="list-style-type: none"> • Impaired oxygenation AND: <ul style="list-style-type: none"> ○ Within 1 week of a clinical insult/new or worsening respiratory symptoms ○ Bilateral opacities not fully explained by effusions, lobar/lung collapse, or nodules ○ Respiratory failure not fully explained by cardiac failure or fluid overload 	<input type="checkbox"/> None/no ARDS <input type="checkbox"/> Mild (PaO ₂ /FiO ₂ =200-300 with PEEP or CPAP≥5) <input type="checkbox"/> Moderate (PaO ₂ /FiO ₂ =100-199 with PEEP or CPAP≥5) <input type="checkbox"/> Severe (PaO ₂ /FiO ₂ <100 with PEEP or CPAP≥5) <input type="checkbox"/> Unable to evaluate based on current information	
<p>To Calculate ARDS Severity:</p>	$\frac{PaO_2}{FiO_2} =$	
<p>What is the patient's response to current treatment with the scarce resource?</p> <p>(See "Scoring Systems Statement" below)</p> <p>When answering this question, the Treatment Team should not use any scoring systems in determining patient's response to treatment.</p>	<input type="checkbox"/> Improving = a patient who clinically improves <input type="checkbox"/> Unchanged / Expected Disease Course = a patient who remains clinically unchanged or the clinical course falls in line with an expected disease course with no to minor complications <input type="checkbox"/> Worsening = a patient who clinical declines more than the expected disease course and changes their overall likelihood to survive to discharge even with scarce resource <input type="checkbox"/> Unknown - Treatment just began < 24 hours ago	

G. Response to Treatment:

The response to the current treatment question on the PIF is an important evaluation question that will require input every 24 hours. This assessment can be done in a variety of different ways as determined by the Treatment Team. However, it is important to note that scoring systems of any kind (i.e., SOFA, mSOFA, APACHE, etc.) should not be used to determine response to treatment. Although these systems are frequently used to assist with diagnosis and prognosis, most of these scoring systems contain biased information leading to incorrect conclusions, especially during crisis allocation.^{1, 2} The data collected to support many scoring systems are oftentimes derived from patient populations that are not reflective nor inclusive of historically oppressed communities and can use factors that do not have supportive data (like race) to change the score.^{3, 4} Therefore, scoring systems should not be used in determining a patient's response to treatment.

1. Raschke RA, Agarwal S, Rangan P, Heise CW, Curry SC. Discriminant Accuracy of the SOFA Score for Determining the Probable Mortality of Patients With COVID-19 Pneumonia Requiring Mechanical Ventilation. JAMA. 2021;325(14):1469–1470. doi:10.1001/jama.2021.1545

2. Schmidt H, Roberts DE, Eneanya ND. Rationing, racism and justice: advancing the debate around 'colourblind' COVID-19 ventilator allocation [published online ahead of print, 2021 Jan 6]. J Med Ethics. 2021; medethics-2020-106856. doi:10.1136/medethics-2020-106856

3. Gumbsch, Thomas et al. (2021) Ethnicity-based bias in clinical severity scores The Lancet Digital Health, Volume 3, Issue 4, e209 - e210

4. National Kidney Foundation. Establishing a Task Force to Reassess the Inclusion of Race in Diagnosing Kidney Diseases. A joint statement from the National Kidney Foundation and the American Society of Nephrology. July 2, 2020

Section 4: CSC Triage Team Composition, Roles, and Responsibilities

Hospital or Hospital System Triage Teams

Each individual hospital facility or hospital system will develop a Triage Team according to the recommendations below.

Every hospital system should maintain good communications between individual hospitals in their system to assist in maintaining awareness of resources that could become scarce and impact patient care. DOH recommends that every hospital and hospital system have a mechanism by which critical resources can be obtained, maximized, and distributed throughout their facility and/or systems and ensure all appropriate channels to obtain additional resources have been exhausted.

Hospital systems may elect to maintain a single, systems-level Triage Team, rather than multiple individual facility-level Triage Teams.

CSC Hospital or Hospital System Triage Team

The CSC Hospital (or hospital system) Triage Team will report directly to the Medical Operations Branch Director (or equivalent position) within their institution's hospital incident command system (HICS).

- a. It is recommended the CSC Hospital (or hospital system) Triage Team consist of:
 - 2-3 senior clinicians, one of which being a physician (MD, DO). All team members should have experience in triage (e.g., Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer. Clinicians must be licensed and actively practicing in their field.
 - One medical ethicist. It is recommended that the ethicist filling any role in CSC operations have experience and training as a healthcare ethics consultant and can meet all the requirements under "responsibilities".
 - One administrative assistant.
 - This does not necessarily need to be a separate individual, but a team member needs to be designated as responsible for all the administrative duties outlined below.
 - Clinicians on the CSC Triage Team will not be providers involved with the medical care of the patients under consideration.
 - It is understood that under extreme conditions, staffing a full CSC Triage Team may not be possible, but every attempt should be made to ensure that Triage Teams consist of objective and unbiased members. If assistance is needed facilities are encouraged to reach out to each other to assist in building out individual or system CSC Triage Teams. CSC Triage Team members are not required to be associated with the same facility as the patients under consideration, nor are they

required to practice in the same geographic area (for example, clinicians in Eastern Washington may assist in a CSC Triage Team in Southwestern Washington.) The only specific criteria for CSC Triage Team members are: 1. If clinical, they must have a current and active license, and 2. They must be actively practicing in their field. Further consideration will be made for those who are retired or licensed in other states. As mentioned above, it is recommended that they be senior clinicians with experience in triage.

- CSC Regional Triage Team (see below) may also be used as a resource for Triage Team members.
 - When patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc., then all attempts will be made to consult that specialty either in person or remotely during consideration. These specialty consults can also be from other local or regional hospitals and do not need to be limited by any geographic or facility boundaries.
- b. All patients presented to the CSC Hospital (or hospital system) Triage Team will have a completed CSC Patient Administrative Form (Appendix A) and a CSC Patient Information Form (Appendix B).
- c. It is important that the CSC Triage Teams work from the most updated Patient Information Form and understand the current clinical situation, including current epidemiology. It is the responsibility of the Medical Operations Branch Director (or equivalent) under HICS to ensure that Triage Teams have this information available.
- d. Roles and Responsibilities:
- CSC Triage Team Members:
 - Agree to adhere to the state ethical framework of Fairness, Duty to Care, Duty to Steward Resources, Transparency, Consistency, Proportionality, and Accountability as outlined on [page 1](#).
 - Review and understand the Triage Team decision-making process ([page 21](#)) and priority system for allocation under consideration during the time of implementation.
 - Receive education and training on implicit bias.
 - CSC Triage Team Leader:
 - Directs and guides the Triage Team through each patient under consideration.
 - Checks that all clinical parameters outlined on the PIF are understood and ensures clarification of any questions on the PIF.
 - Ensures that all members have equal participation and that all opinions are heard.
 - Ensures, along with the Triage Team ethicist, an objective, unbiased review of each case.
 - Guides the team to consensus decisions in a timely fashion.
 - CSC Triage Team Ethicist:

- Ensures a leader is chosen and that members understand their roles on the team.
- Sets a tone of inclusive, open, honest discussion where different perspectives are valuable to decision-making
- Attends to fairness and openly and compassionately discusses biases as they arise.
- Ensures all voices are heard.
- Facilitates discussion of values.
- Clarifies ethical issues pertinent to the case.
- Promotes the consistent application of the priority scale.
- Elicits clinical and ethical rationale for priority assignment.
- Helps the Triage Team identify and differentiate what is known, unknown, and/or assumed.
- Helps to identify when the input for a specialist or clarification of data is needed.
- Assists the Triage Team Leader in facilitating consensus.
- CSC Triage Team Administrative Assistant:
 - Ensures all forms are completed, signed, and dated.
 - Records final Triage Team decisions.
 - Keeps and maintains all records and documents and ensures the final Triage Team decisions are delivered to the Medical Operations Branch Director (or equivalent).

CSC Regional Triage Team (RTT)

Situations may arise whereby a single facility may have difficulty staffing and administering a full Triage Team. The Regional Triage Team upon request is a resource option that may serve as a primary Triage Team to these facilities. The term “Regional” is meant to indicate the ability of team members to work beyond their hospital affiliation. It does not in and of itself hold any geographic boundaries and in fact, a CSC RTT can serve remotely for any location in the state.

Members of the RTT can come from a variety of different sources such as local Disaster Clinical Advisory Committee (DCAC) members, medical societies, local health jurisdiction or local health officer recommended clinicians, or regional healthcare coalition recommended clinicians.

- a. Recommended members of the CSC Regional Triage Team are as follows:
 - 2-3 senior clinicians, one of which being a physician (MD, DO). All team members should have experience in triage (e.g., Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer who oversees all Triage processes.
 - One medical ethicist.
 - One administrative assistant.

- This does not necessarily need to be a separate individual, but a team member needs to be designated as responsible for all the administrative duties outline below.
 - Clinicians on the CSC Regional Triage Team will not be providers involved with the medical care of the patients under consideration.
 - It is understood that under extreme conditions this may not be possible, but every attempt should be made to ensure that members of the CSC RTT consist of objective and unbiased members.
 - When patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc. then all attempts will be made to consult that specialty either in person or remotely during consideration.
- b. All patients presented to the Regional Triage Team will have a completed CSC PAF and PIF.
- The requesting facility is responsible for providing the CSC Regional Triage Team with the completed PIF for all patients under consideration. The requesting facility is also responsible for completing the PAF, but this form should not be shared with the RTT. The PAF should be maintained by the referring hospital only.
- c. It is imperative that the RTTs work from the most updated PIF and understand the current clinical situation, including current epidemiology. It is the responsibility of the Medical Operations Branch Director (or equivalent) of the requesting facility to ensure that the RTT has this information.
- d. Roles and Responsibilities: please refer to Section 1, Item D above.

Section 5: CSC Triage Team Decision-Making Process

A CSC Triage Team will convene (either in person or virtually) to discuss all patients under consideration during the implementation of CSC protocols. CSC Triage Team decisions on prioritization should not be done individually. Discussion and interaction are important factors in the decision-making process.

The individual CSC Triage Team members' roles and responsibilities are outlined on [page 18](#). Below are recommendations for how the CSC Triage Team should function, how to use the Critical Care Prioritization Scale and how to report the Triage Team's final decision.

CSC Triage Team Process

It is recommended that there be a designated Triage Team Lead as the lead is responsible for the overall function of the triage team. The Triage Team lead can switch between team members as needed.

It is recommended that each case be read out aloud by a Triage Team member to ensure that all team members understand the content of the PIF. Open discussion can then proceed, and the final prioritization is decided.

Critical Care Prioritization Scale

The single objective of the CSC Triage Team is to assign a priority level/color to each patient based solely on the information contained in the PIF. The CSC Triage Team should not be given access to the patient's full medical record or have communication with the Treatment Team about the specific case under consideration. Using the Critical Care Priority Table, the priority level decision should be made based on two considerations:

1. What is the likelihood that the patient will survive to discharge if given the resource?
2. What is the patient's response to current treatment? (This information is known only if the patient has been hospitalized for >24 hours)

The patient will be placed in the **RED** or **Priority 1** level if the patient has a greater than or equal to 90% chance of survival to discharge if provided the resource.

The patient will be placed in the **ORANGE** or **Priority 2** level if the patient has a 50-89% chance of survival discharge if provided the resource.


The patient will be placed in the **YELLOW** or **Priority 3** level if the patient has an 11-49% chance of survival to discharge if provided the resource.

The patient will be placed in the **BLUE** or **Priority 4** level if the patient has a less than or equal to 10% chance of survival to discharge if provided the resource.

The patient is placed in the **STRIPED** or **Priority 5** level if they have:

- Severe acute neurological event with low chance of survival (non-survivable head injury, cerebral herniation with no option for intervention).
- Severe burns with low chance of survival (according to the ABS Burn Chart).
- Persistent vegetative state or coma.

In general patients in the **RED** and **ORANGE** priority levels show some clinical improvement during treatment whereas patients in the **YELLOW** or **BLUE** would show either less improvement than expected or a worsening clinical course.

Considerations for Priority Level		
Priority Levels	Likelihood to Survive to Discharge with Resource	Re-evaluation of Treatment
RED Priority 1 Scarce Resource (SR) when available	≥90%	
ORANGE Priority 2 SR when available <i>after RED</i>	50-89%	
YELLOW Priority 3 SR when available <i>after RED & ORANGE</i>	11-49%	
BLUE Priority 4 SR when available <i>after RED, ORANGE, & YELLOW</i>	≤10%	
Striped Priority 5 SR when available <i>after RED, ORANGE, YELLOW, and BLUE</i>	Persons who have been diagnosed with one of the following conditions: <ol style="list-style-type: none"> Severe acute neurological event with low chance of survival* Severe burns with low chance of survival** Persistent vegetative state or coma 	

Reference Table: Anchor Cases

To help “anchor” the discussion, patient examples can at times be helpful and may be provided to assist as needed with discussion. These cases will be developed and reviewed by providers with expertise regarding the resource under consideration (for example, intensivists experts will develop these examples if ICU is the scarce resource; pediatricians would develop examples if a pediatric resource were under consideration). These cases are intended as a tool for anchoring discussion. These examples may be used to compare the patient under consideration to these example cases. This approach is intended to increase consistency across teams by anchoring everyone to a common spectrum of prognostic predictions. These cases are not meant to be prescriptive or to indicate ‘required’ characteristics for each category.

	Sample case – COVID-19	Sample case – myocardial infarction
Red >90% survival to discharge	35-year-old patient with no known severe or end-stage comorbidities admitted for COVID-19 requiring mechanical ventilation for mild ARDS. Hospital day #12 with clinical status improving.	71-year-old patient with no known severe chronic conditions admitted for an acute ST-elevation myocardial infarction (STEMI), now post re-vascularization requiring vasoactive support for shock refractory to volume resuscitation. Hospital day #1 with clinical status improving.
Orange 50-89% survival	63-year-old patient with no known severe or end-stage comorbidities admitted for COVID-19 requiring mechanical ventilation for mild ARDS and vasoactive support for shock refractory to volume resuscitation. Hospital day #3, currently with expected clinical course.	65-year-old patient with severe coronary disease and end-stage kidney disease admitted with an acute STEMI awaiting coronary artery bypass graft (CABG) and requiring vasoactive support for hypotension refractory to volume resuscitation. Hospital day #2, currently with expected clinical course.
Yellow 11-49% survival	72-year-old patient with severe chronic lung disease and severe heart failure admitted with COVID-19 requiring mechanical ventilation for moderate ARDS. Hospital day #5, currently with expected clinical course.	50-year-old patient with severe coronary artery disease and end-stage kidney disease admitted with acute STEMI status post CABG requiring ventilator support for airway protection and vasoactive support for shock refractory to volume resuscitation. Hospital day #8 with clinical status worsening.
Blue ≤10% survival	66-year-old patient with end-stage lung disease, severe heart failure, and severe coronary disease admitted with COVID-19 and requiring mechanical ventilation for severe ARDS and vasoactive support for shock refractory to volume resuscitation. Hospital day #16 with clinical status worsening.	75-year-old patient with severe chronic lung disease, severe coronary artery disease, and severe chronic liver disease admitted with STEMI status post CABG requiring mechanical ventilation for mild ARDS and airway protection and vasoactive support for shock refractory to volume resuscitation. Hospital day #10 with worsening clinical status.
Striped	45-year-old patient COVID positive, with severe burns with low chance of survival (>75% total body surface area). Hospital day #7 with clinical status worsening.	45-year-old patient with severe burns with low chance of survival (>75% total body surface area) requiring ventilatory support for airway protection and vasoactive support for shock refractory to volume resuscitation. Hospital day #0.

Reporting CSC Triage Team's Final Decision

The Triage Team's final decision of the patient's priority level is documented at the bottom of the PIF. The Triage Team decision consists of 7 options followed by a signature and date/time the decision is made.

Note: Two of the options include reasons why a priority decision cannot be made. These clarifications must occur before the Triage Team priority decision can be made. When all patients under consideration have been prioritized, allocation of the resource can then occur.

TRIAGE TEAM DECISION:

- Red
 - Orange
 - Yellow
 - Blue
 - Striped
 - Unable – need input from specialist first
 - Unable – need clarification on data entered (for example acronym clarification)
-

Oversight Committee

To maintain transparency and ensure a fair, equitable, and consistent approach to the allocation of scarce resources, it is important that all Triage Teams have an oversight process for decisions made during the implementation of CSC.

Purpose: The purpose of the Oversight Committee is to ensure that facilities are adhering to and compliant with all state processes and guidelines for operationalizing Triage Teams during CSC. When an event occurs which requires implementation of CSC Triage Teams, a Patient Administrative Form and CSC Patient Information Form will be completed and saved in the patient's permanent medical record for each case under consideration. This information should be maintained and regularly reviewed by the respective CSC Oversight Committee designated by the Medical Operations Branch Director (or equivalent) as outlined in HICS.

It is recommended the CSC Triage Team Oversight Committee consist of at least 2-3 members with experience in the following:

- Senior clinician with experience in Quality Assurance/Quality Improvement.
- Hospital Quality Improvement/Assurance leader and/or Hospital Risk Manager.
- Medical ethicist.
- When possible, clinicians on the CSC Triage Team Oversight Committee will not be providers involved with the medical care of the patients under consideration nor members of the CSC Triage Team.

It is recommended that one Oversight Committee member be designated as Lead who oversees all Oversight processes.

- All CSC Regional Triage Team are under the same oversight requirements as the CSC Hospital and Hospital System Triage Teams outlined below. All oversight processes and documentation for the RTT will be the responsibility of the requesting facility.

The CSC Oversight Committee will review and provide oversight on all CSC Operational processes to include:

- Data Entry:
 - Ensure accurate, complete, and unbiased data entry by PIF and PAF audit, with specific attention to the free text boxes to ensure any that all free text data is relevant to prognosis only and is free from non-prognostic and/or biased information.
- Triage Team and Allocation Processes:
 - Ensure Triage Teams are abiding by the Washington State CSC Framework.
 - Consider the independent observation of Triage Teams.
 - Monitor Triage Team priority decisions to ensure consistent application and decision-making. Consider comparison at a regional level to ensure consistency and flag inconsistencies for closer review.

- Re-evaluation Process:
 - Ensure that the requests to evaluate a specific case are managed transparently, ensuring all processes are clear and understandable by all parties involved.
- Ensure that the re-evaluation process monitors affected population demographics to identify and address communities that may be over- or under-represented in the re-evaluation process.
- Depending on the nature of the incident, oversight review may be in real-time (e.g., in a prolonged event). However, in no notice, sudden, or brief events, this review may be retrospective.

Re-evaluation Process During Response

Request to re-evaluate specific patient cases

- Any clinician may bring a CSC request for patient re-evaluation of a specific case to the respective Medical Care Branch Director (or equivalent), * and designated ethicist by completing a CSC patient case re-evaluation form (Appendix D).
- The Medical Operations Branch Director (or equivalent) has authority over the respective CSC Triage Team who made the initial decision under consideration (i.e., individual hospital, hospital system, or CSC Regional Triage Team). The requesting clinician will complete a CSC Patient Case Re-evaluation Form, sign, date, and submit the form to the respective Medical Operations Branch Director (or equivalent).
- Every case brought to the Medical Operations Branch Director (or equivalent) and designated ethicist will be reviewed to ensure the CSC Triage Team documentation was complete and the decision process was consistent with the state CSC Triage Team Operational Guidebook *that was available at the time the original decision was made*.
- Depending on the event (i.e., no notice vs. prolonged) it is understood that this process may be retrospective. However, if the event is more prolonged and the potential outcomes of the patient may be affected, then processes should be in place to allow a sufficiently rapid decision.
- Final decisions for CSC Request for patient re-evaluation of a specific case will be in writing, dated, and timed, and include all supporting documentation. All documentation including the final decision will become part of the patient's permanent medical record.
- The decision made by the respective Medical Operations Branch Director (or equivalent) and designated ethicist will be final.
- *With respect to the RTT, the requesting facility should manage the request for re-evaluation through their own HICS. If they are unable to staff this capacity, they can request either a Medical Operations Branch Director (or equivalent) or a medical ethicist as needed through recommendations by the state DMAC.

Request to change forms or documents

- During an event, individual clinicians may request a specific change to any of the forms or the CSC Triage Team Operational Guidebook based on new clinical information, such as changes in prognostic indicators or outcome measures. These requests should be made in writing to the Chair and Vice-Chair of the Washington State DMAC (or their designee) by using the CSC process re-evaluation form (Appendix C).
- Washington State DMAC will keep record of all CSC process re-evaluation forms, date, and time of the request, and all the supporting documentation presented during the request and evaluation.
 - Each request will be brought to the Chief Science Officer (or designee), reviewed by Washington State DMAC, along with all relevant partners, including additional subject matter experts (SMEs) as required.
 - Final decisions will be determined by Chief Science Officer (or designee)
 - All decisions will be made in a timely fashion.
 - Final decisions for all CSC re-evaluation process requests will be in writing, dated and timed, and include all supporting documentation.

Section 6: Allocation of Scarce Resource

Once the CSC Triage Team has prioritized all patients under consideration for a scarce resource in question the allocation of the scarce resource can occur.

It is recommended that the final allocation decisions be made in a transparent way and include more than one individual if possible. Allocation decisions should not be made by anyone on the treatment or Triage Teams. The individuals responsible for determining the final allocation decision are not required to be clinicians if the Triage Team's final decision has been recorded and signed. However, the individual(s) responsible for the allocation should fully understand the allocation process, including how to apply the tiebreaker procedures if indicated.

The individual(s) responsible for the allocation process will report directly to the Medical Operations Branch Director (or equivalent).

The following are recommendations for hospital staff who could fulfill the role of allocation:

- Designated managers appointed by the Medical Operations Branch Director.
- House supervisors or shift leads.
- Other clinicians that are not involved in the CSC Treatment or Triage Team processes.

Allocation Example:

Below is an example of the allocation process for a scarce resource.

50 patients	35 ICU Staffed Beds
(35 left) 7 Red Patients	1 st in line for resource <u>Gets Resource</u>
(28 left) 13 Orange Patients	2 nd in line for resource <u>Gets Resource</u>
(15 left) 11 Yellow Patients	3 rd in line for resource <u>Gets Resource</u>
(4 left) 17 Blue Patients	4 th in line for resource <u>Resource runs out in this group</u> <u>Use of Tiebreakers & Randomize</u>
(0 left) 2 Striped patients	5 th in line for resource <u>Is behind level that ran out</u> <u>Does <u>not</u> get resource</u>

In this example, there are 50 total patients requiring a resource that is considered “scarce,” which in this case is a staffed ICU bed. There are 35 total resources (i.e., staffed ICU beds) available.

The CSC Triage Teams have categorized all 50 patients eligible for the staffed ICU bed into the 5 different priority levels (for more information on the priority levels, please refer to [page 21](#)). Of these 50 patients, 7 patients were considered “red” priority level, meaning they have the highest likelihood to survive to discharge. These 7 patients are first in line for the resource, meaning they receive the resource, and the number of resources available decreases to 28. From there, the individual(s) responsible for the allocation process moves through the priority levels in order and allocates 13 staffed ICU beds to the “orange” priority level who is second in line for the resource, 11 staffed ICU beds to the “yellow” priority level who is third in line for the resource. After the “yellow” priority level, there are 4 staffed ICU beds available, but there are 17 remaining patients needing the resource. Because of this situation, a tiebreaker will need to be implemented to determine which 4 of the 17 patients will receive the last of the resource.

Tiebreaker Process

A tiebreaker situation occurs *only* when there are not enough medical resources for patients who have **the same likelihood to survive to discharge (i.e., are in the same priority level in the prioritization scale)**. There are many factors that clinicians must consider when determining prognosis prior to this step but it is important to be mindful of equity and to ensure implicit bias does not impact these decisions.

When crisis standards of care and CSC Triage Teams are implemented, in the case of a tiebreaker situation, the resource will be allocated in the following manner:

- **Level 1:** The resource remains with the patient who already has the resource as long as the patient is not clinically worsening.
- **Level 2:** The resource goes to a pregnant patient.
- **Level 3:** The resource goes to the patient with the highest SVI score based on the following:
 - i) SVI score (highest rank = 10, based on home address).
 - ii) Unhoused individuals will receive a score based on their last known address (i.e., shelter, hospital) or the current location of services.
- **Level 4:** Randomization using the Excel Randomization Tool ([located here](#)).

Social Vulnerability Index

For the purposes of implementing a tiebreaker resolution for patients who fall into level 3, the patient's appropriate address will be entered into the Washington Tracking Network, [located here](#) to determine the patient's Social Vulnerability Index (SVI) Score.

For more information on how to use the Washington Tracking Network's mapping tool to locate the patient's SVI, please refer to [page 7](#).

For more information about the Washington Tracking Network's mapping tools, [please click here](#).

- ***If the patient is unhoused, please use the patient's last known address (i.e., shelter or location where they received services).***
- ***If there is no address available for any reason, or there is no ability to calculate an SVI, then Level 3 Tiebreaker will not be used and allocation should move to randomization.***

As mentioned on [page 7](#), a social vulnerability index (SVI) score will be determined for all patients under tiebreaker consideration for a scarce resource during CSC implementation. Though some in the field have argued against using a population-level tool in bedside clinical decision-making,

when allocation approaches the point of a tiebreaker, those patients who have privilege have exercised that privilege (whether actively or passively), and those patients who have disadvantages have overcome that disadvantage to reach a point where they have an equal likelihood to survive to discharge.

The SVI tool acknowledges past and current healthcare inequities and aims towards a process whereby groups are not further disadvantaged. The intent is to promote health equity whenever possible, in order to reduce inequities and avoid further harm.

The use of SVI in this protocol will be monitored and tracked closely by DOH. If any additional empirical evidence suggests that the use of SVI has the opposite effect, reappraisal/revision will occur.

For more information on the SVI score and how the score is obtained, please refer to [page 7](#).

Final Allocation Decision

The final allocation decisions will be documented, securely saved, and delivered to the Medical Operations Branch Director (or equivalent) and the communications team.

It is important to note that although a patient may not receive the resource under question, this does not mean they will not receive care. Every patient will have a continued care plan with or without the resource under question.

Section 7: Communication of Allocation Decision

Following the final decision making and allocation of scarce resources, the allocation decisions need to be communicated to the treatment team, the patient, and their family. The development of a specific communications team is recommended, though it is understood that this is dependent on staff availability. This communications task is a difficult one. It not only requires skill in messaging, but in personal resilience, training, and self-awareness to manage personal moral distress and compassion fatigue. Even if the main communication person is a single individual, that person should have others to share the responsibility because of the risk of burnout and moral distress.

Operationally, the allocation decisions will be sent from the Medical Operations Branch Director (or equivalent) to the communications team, or the individual designated to deliver the final communications. It will be the responsibility of the communications team (or designated individual) to develop processes to communicate these decisions to the treatment team, the patient, and their families.

Communication Team Composition

It is recommended that the communications team (or individual), whenever possible, have a background in any of the following areas: palliative care, social work, spiritual care, mental and/or behavioral health training, and have participated in end of life, goals of care, or similar types of patient care conferences and discussions. While it is appreciated that some facilities may need to depend on a single individual for day-to-day work, that individual would benefit from a partner to discuss and debrief with, to prevent burnout.

The communications team or individual must have the ability to express difficult decisions simply and plainly, as well as the ability to explain to non-medical audiences the basics surrounding the difficult decisions required during crisis standards of care. Although the communications team will not need to explain the science and the clinical nuances of these decisions in detail, they do need to understand how the decisions were made and the basic driving principles in a transparent matter in order to address any questions or concerns that arise from the patient and/or their family.

Recommended Team Member Experience:

- Palliative Care
- Home Hospice Care
- Spiritual Care
- Social Worker
- Mental Health Provider
- Patient Relations Professional

Recommended Procedures:

- It is recommended that a communications team lead be designated if there is more than one person involved. The communication lead will have responsibility for adapting these CSC communication processes to fit their facility staffing capabilities. The lead is also responsible for developing and maintain procedures to communicate to non-medical audiences such as the patient and/or their family.
- It is recommended to first talk with the treatment team to communicate the final decision-making and allocation process, then work to arrange for a member of the communication team *and* a member of the treatment team to speak with the patient and/or their family together.
 - If it is not possible to have a member of the treatment team and a member of the communications team speak together with the patient and their family, it is important to establish and clarify the roles of communication prior to engaging with the patient and/or the family.
- The communications team must support the triage decision that was made and not question the decision, as they will not have enough clinical information to make recommendations about the patient’s care. Additionally, mixing triage and patient care is strongly discouraged. If the communications team has concerns about the decision(s) made, please refer to Request to Re-evaluate Specific Patient Case on [page 26](#). before proceeding to patient and family discussion
- The treatment team member should align the patient’s plan of care with the Triage Team decision and should emphasize that medical treatment will be provided to the best of the facility’s ability, despite the resource limits, and engage with palliative care for a plan of care.
- Every attempt should be made to find a translator or interpreter in the patient’s primary identified language either in person or through remote or phone interpreter services if needed.

1. Communication to the Treatment Team:

- The communications team (or individual) will be responsible for developing a process/procedure for communicating the allocation decision to the treatment team. It should be considered that this communication involves giving the allocation decision to a colleague rather than the patient or family themselves. Additional communications perspectives below should be considered when relaying this information to the treatment team. Treatment team members are likely experiencing substantial stress, and the communications team members should aim for interactions that are timely, brief, and empathetic.
 - Example: “I am calling on behalf of the crisis standards of care Communication Team. Could you manage a few minutes to discuss [patient name]?”
- Communications team members should remember that the treatment teams may only remember a few details about how crisis standards of care are operationalized.

- Example: “Would you like a one-sentence refresher on how we make these decisions?” followed by, “The Triage Team reviews a subset of clinical information that is meant to enable them to make allocation decisions based on each patient’s likelihood to survive to discharge, while minimizing bias.”
- Give the treatment team the triage decision in a one-sentence headline.
 - Example: “A ventilator is not available for [patient name].”
- Expect that the treatment team will not be accepting or welcoming of the triage decision and ensure responding in a brief but empathetic way.
 - Example: “It sounds like you have worked really hard with [patient name]. This is a tough situation.”

2. Communication to the Patient and Families:

The communications team (or individual) will be responsible for developing a process/procedure for communicating the allocation decision to the patient and their family members when a patient does not receive the scarce resource. It should be considered that this communication is giving unfortunate news to the patient or family themselves. Below is an example of a conversation that relays this decision from the perspective of both the communications and treatment team:

Scenario: The treatment team, communications team, and the patient/family are convened to discuss the patient and relaying the patient will not receive the scarce resource (for example: ventilator).

- *Treatment team:* “Hello [patient/family member name]. I am following up regarding the review of [patient’s name] case. I have a member of the communications team that can tell us about that review process.”
- *Communications team:* “My name is [name], and I am part of the hospital communication team. We are in a state-wide hospital crisis situation, which means that we have more patients in our hospitals than we have resources for. We look at every case to try to use our resources fairly. Every patient is treated the same. We have reviewed [patient’s name] case, and a ventilator is not available for [patient’s name]. We just do not have as many ventilators as we need. I am sorry because this is an impossible situation. We will provide as much medical care as we can, given this situation. Your treatment team will talk more about the medical plan.”
- *Treatment team:* “I wish things were different. We will do everything we can, given this situation, and I will talk about the medical plan in more detail. But before the communications team member leaves, do you have any questions for them?”

When a patient keeps or receives the scarce resource, the treatment team will document the Triage Team’s decision and that the patient’s plan of care remains unchanged (i.e., the patient will keep the resource, or will receive the resource and move forward with treatment).

Scenario: The treatment team, communications team, and the patient/their family are convened to relay the patient is receiving/keeping the scarce resource (for example: ventilator).

- *Treatment team:* “Hello [patient/family member name]. I am following up regarding the review of [patient’s name] case. I have a member of the communications team that can tell us about that review process.
- *Communications team:* My name is [name], and I am part of the hospital communication team. We are in a state-wide hospital crisis situation, which means that we have more patients in our hospitals than we have resources for. We look at every case to try to use our resources fairly, and every patient is treated the same. We have reviewed [patient’s name] case, and it was decided that they will be receiving the ventilator because they have been viewed as most likely to benefit from this limited resource. You may be aware that others that need a ventilator may not receive one as there are not enough to provide for everyone who needs it. Some may find themselves feeling uncomfortable or even guilty about this process, knowing that not everyone who needs this type of care is able to receive it. Understand that these feelings are normal and understandable. If you find that your distress levels are hard to manage, consider reaching out to spiritual advisors or seek professional counseling care. If you need resources for mental health care, please let us know and we will work with our hospital staff to provide you with some resources.

Common patient/family questions and suggested responses:

- *Question:* Are you not giving my father a ventilator just because they are [of a particular cultural/ethnic group]/doesn’t have insurance/is poor?
 - *Answer:* We review cases based on medical details only. We are doing our best to treat every patient the same.
- *Question:* How can you do this? They will die, won’t they?
 - *Answer:* We are doing our best in an impossible situation. Your [family member] is very sick and their chances are very slim even if we had every resource possible. We all wish we had more resources, but we don’t.
- *Question:* I want to transfer my [family member] to another hospital.
 - *Answer:* Every hospital in our region is in crisis and we are all sharing our resources. Another hospital will make the same decision. I do realize you are just trying to do everything you can do.

As part of the communication to the patient/family, it is important to relay information in a compassionate and understandable way. The Washington State Disaster Medical Advisory Committee has developed a “Talking Points” handout that can be used and given to the patient and/or family members. The following should be considered:

- Provide the patient and family with mental health resources.
- Provide the patient/family with palliative care and/or hospice care contacts and referrals.
- Obtain contact information for a designated family member and schedule specific follow-up discussions as needed.
- Contact the patient’s primary care provider and notify them of any resource allocation decisions and plans.
- For more information on CSC talking points for healthcare staff, please refer to Appendix E.
- For more information on CSC talking points for patients and families, please refer to Appendix F.

3. Debrief with all Hospital Staff:

During the implementation of this Guidebook, it is recommended that the entire facility staff be updated and aware of what Triage Teams are, how they function, how decisions are being made and how patients are still receiving care even if they do not receive a resource. Hospital staff who may be distanced from the specifics of CSC may be called to fill in or provide extra staffing assistance therefore it is important to keep everyone updated. Transparency, empathy, and providing staff support during CSC implementation will help build staff resilience during this extremely stressful time.

The hospital incident command system and communications team (or designee) will be responsible for developing a process/procedure for debriefing allocation decisions with the hospital staff. The communications team should consider communication during a crisis surge should be timely, brief, and empathetic. It is recommended to consider larger debriefs after the return to conventional or low contingency.

Scenario: Discussing with hospital staff the decision and asking for representation within the communication discussion with the patient and/or family.

- Example: “The triage and communications teams are making very tough decisions and may ask that you be involved in a conversation with the patient and/or their family. Please make every effort to be present at those conversations because clear communication and a smooth handoff will help every person in this hospital. This decision-making process is incredibly stressful for everyone – Triage Teams, communications teams, and treatment teams – and we need to support each other. Supporting each other is important for our sustainability. Please be conscious that we are all under extreme stress. Thank you all for your work, empathy, and compassion.”

4. Internal Touching Base and Follow-up:

The discussions and responsibilities of the communications team will be demanding. It will be important for the communications team to develop internal plans to touch base and follow-up with their own team members ensuring appropriate support and resources as needed.

5. Communication Team Documentation:

The communications team will be responsible for documenting the communication information within the patient's chart and within any other Triage Team and crisis standards of care forms. It is recommended within the documentation to include:

- Triage decision
- Date of triage decision
- Content of triage decision
- Communication to patient and/or family was by [communications team member name]
- Modifications to plan of care when applicable

Resources:

For more information on communications skills, consider referring to [Vital Talk's COVID-19 Ready Communication Playbook](#).

Section 8: Training on CSC Triage Team Operational Guidebook

Implementing crisis standards of care is a process that few in the medical profession, whether clinicians, administrators, or support staff, have ever trained for. It is only implemented at the end of medical surge, which in and of itself is a stressful and difficult situation. Much work has been done to ensure that the instructions and procedures outlined in this Guidebook are as simple and straightforward as possible, however, the process and concepts are complex.

It is imperative that all facilities that may at any point in time implement CSC, regularly review and train on the contents of this Guidebook. All clinicians should be familiar with and understand the principles and concepts of CSC data entry, Triage Team implementation, the allocation process, and communication procedures so that they can implement these processes if needed.

It is also the intent of DOH to regularly review and improve this process. At the time of this writing, solid, evidence-based data on CSC implementation is slim. This is an iterative undertaking based on regular review and data analysis leading to revisions and improvements as needed. Although not included in this Guidebook, additional training material will be developed to support this process.

Section 9: CSC Triage Team Operational Guidebook Updates

It is understood that during an event, the clinical situation may change depending on resource availability, new epidemiologic information, new treatment protocols, and guidelines, etc. **It will be the responsibility of the entire healthcare community** to maintain accurate situational awareness and consensus regarding local triage recommendations. DOH, the DOH Chief Science Officer, and all relevant partners will continuously monitor the situation and provide guidance and updates as appropriate.

Communications:

- DOH will be responsible for maintaining a communication plan to keep all relevant partners and stakeholders informed when CSC Triage Teams have been implemented.
- Clinical updates may be required at various frequencies and will be determined by DMAC Chair and Vice-Chair, Chief Science Officer, or designee, local health officer (LHO), and all other pertinent partners. The Chief Science Officer, in conjunction with DOH, will be responsible for disseminating this information in a timely fashion to all appropriate clinical entities.

For any questions about this Guidebook or the contents included, please reach out to DOH.Secretary@doh.wa.gov

Section 10: Appendices:

Appendix A: Crisis Standards of Care Patient Administrative Form

Appendix B: Crisis Standards of Care Patient Information Form

Appendix C: Crisis Standards of Care Process Re-evaluation Request

Appendix D: Crisis Standards of Care Patient Case Re-Evaluation Request

Appendix E: Crisis Standards of Care Talking Points for Healthcare Staff

Appendix F: Crisis Standards of Care Talking Points for Patients and Families

APPENDIX A: CRISIS STANDARDS OF CARE PATIENT ADMINISTRATIVE FORM

Name of person completing form: <i>(First Last)</i>	Click or tap here to enter text.
Email address of person completing form:	Click or tap here to enter text.
Date of Form Completion: (M-D-Y)	
Patient's MRN:	Click or tap here to enter text.
Hospital name and location:	Click or tap here to enter text.
Patient's Date of Birth: <i>(M-D-Y)</i>	Click or tap here to enter text.
Patient's Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, unknown, declined to answer
	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient's Race/Ethnicity:	<input type="checkbox"/> Declined/unknown <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latinx <input type="checkbox"/> Multiracial <input type="checkbox"/> Other: Click or tap here to enter text.
Patient's Address:	Home address: Click or tap here to enter text. <input type="checkbox"/> Unhoused (include last known address (i.e., shelter, hospital, or current location of services): Click or tap here to enter text. <input type="checkbox"/> Unknown
Patient's Social Vulnerability Index (SVI) Score: <i>(to be entered only in case of a tiebreaker situation)</i>	Click or tap here to enter text.

Unique Triage Tracking ID**:	Click or tap here to enter text.
Random Triage ID Number Generator	**Triage tracking ID <u>MUST</u> be entered into patient's Medical Record. <i>Please use locally approved system to create a Triage Number. If none exist, the "Random Triage ID Number Generator" can be used</i>
Current Resource Status:	<input type="checkbox"/> Patient has the resource currently (e.g., is in the ICU) <input type="checkbox"/> Patient does not have the resource (e.g., is an ICU boarder or on the floor)
Patient's Care Preferences:	<input type="checkbox"/> Wants ALL medically appropriate ICU treatments <input type="checkbox"/> LIMITS to ICU, advance care planning documents (POLST, AD, etc.) states <input type="checkbox"/> LIMITS to ICU, patient with decisional capacity <input type="checkbox"/> LIMITS to ICU, patient's substitute decision-maker
Details for any limits:	Click or tap here to enter text.
Patient Outcome at Time of Discharge (if known):	<input type="checkbox"/> Discharge to community (e.g., home, shelter, non-acute LTC facility) <input type="checkbox"/> Discharge to Skilled Nursing Facility (SNF) or Long-Term Acute Care (LTAC) facility <input type="checkbox"/> Death <input type="checkbox"/> Unknown <input type="checkbox"/> Other: Click or tap here to enter text.
Patient Final Triage Priority:	<input type="checkbox"/> Red <input type="checkbox"/> Orange <input type="checkbox"/> Yellow <input type="checkbox"/> Blue <input type="checkbox"/> Striped

APPENDIX B: CRISIS STANDARDS OF CARE PATIENT INFORMATION FORM

Unique Triage Tracking ID**	Click or tap here to enter text.
**Triage tracking ID <u>MUST</u> be the same as that found on the Patient Administration Form	

Patient's Age: _____ (To be consider in combination with all information on this form and used only for prognosis to discharge)
--

ALL Free text information entered MUST be objective, clinically relevant to survival to discharge, and based on the best evidence and clinician judgment.

PAST MEDICAL HISTORY

<input type="checkbox"/> NO known SEVERE or END-STAGE conditions in medical history <input type="checkbox"/> UNKNOWN, no information is available at this time

Only enter severe or end-stage ailments that affect the likelihood to survive discharge.

Chronic Lung Disease	<input type="checkbox"/> SEVERE = Assessed and charted as severe (On home oxygen or NIPPV) <input type="checkbox"/> END-STAGE = Assessed and charted as End-stage
Chronic Heart Failure	<input type="checkbox"/> SEVERE = NYHA Stage III - OR- Ejection Fraction = 21 - 40% <input type="checkbox"/> END-STAGE = NYHA Stage IV - OR- Ejection Fraction < 20%
Coronary Artery Disease	<input type="checkbox"/> SEVERE = Assessed and charted as severe, multiple stent placements and/or CABG <input type="checkbox"/> END-STAGE = Assessed and charted as end-stage, not subject to intervention

Chronic Kidney Disease	<input type="checkbox"/> END-STAGE = Receiving maintenance Renal Replacement Therapy (RRT)
Chronic Liver Disease	<input type="checkbox"/> SEVERE = Assessed and charted as severe (If known, MELD score greater than 15) <input type="checkbox"/> END-STAGE = Assessed and charted as end-stage
Malignancy	<input type="checkbox"/> SEVERE = Metastatic or unresponsive to interventions <input type="checkbox"/> END-STAGE = Metastatic having exhausted treatment options
Patient has been diagnosed with one of the following: <i>Mark all that apply</i>	<input type="checkbox"/> Severe acute neurologic event with low chance of survival (e.g., non-survivable head injury, cerebral herniation with no option for intervention) <input type="checkbox"/> Severe burns with low chance of survival (*See Burn chart below) <input type="checkbox"/> Pre-existing or persistent coma or vegetative state
OTHER SEVERE/END-STAGE ailment: <i>assessed and charted as severe</i>	Click or tap here to enter text.
Prior to this hospitalization, is death within 6 months expected (from either an underlying terminal/end-stage condition or irreversible cause) based on the best evidence and clinician judgement?	<input type="checkbox"/> NO. Prior to the current ailment, death in 6 months is not expected. <input type="checkbox"/> YES. Prior to the current ailment death in less than 6 months is expected.
Clinicians should include active mindfulness to ensure implicit biases** did NOT influence clinical judgment and are committed to non-discrimination. <i>**Implicit biases include those based on stereotypes, assessments of quality of life by persons other than the patient/surrogate, judgments about a person's "relative worth," etc.</i>	

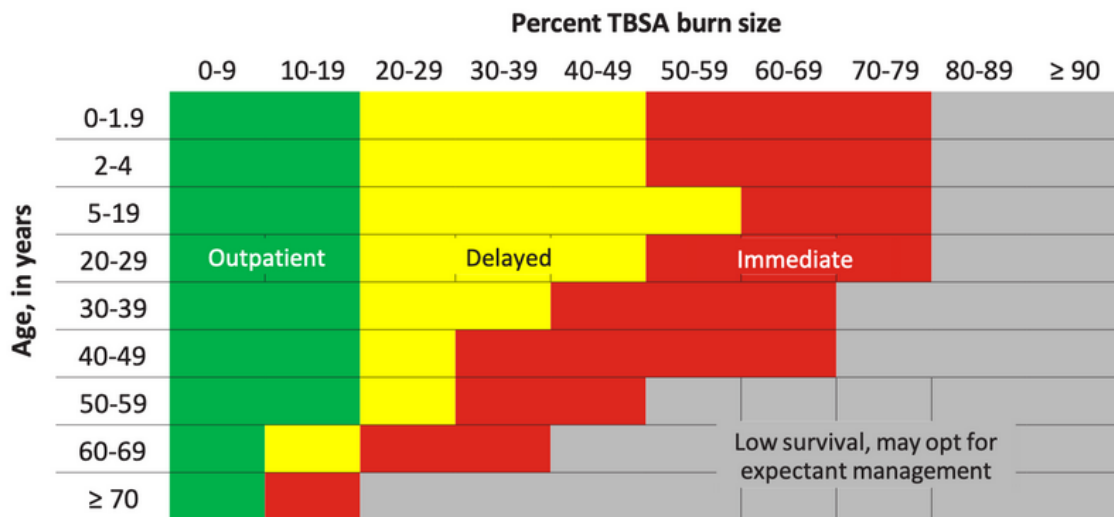


Table A

CURRENT ASSESSMENT:

DATE OF ADMISSION: <i>If transferred, use the date FIRST admitted to a hospital. (M-D-Y)</i>	
Date of Assessment (must be within 24 hours of submitting PIF). (M-D-Y)	
Primary diagnosis/diagnoses/reason(s) for hospital and ICU admission:	

ICU ADMISSION CRITERIA:

1. Requires ventilatory support, either invasive or non-invasive:

- Clinical evidence of impending respiratory failure
 - Refractory hypoxemia (SpO2 < 90% on FIO2 > 0.85)
 - Respiratory acidosis (pH < 7.2)
- Inability to protect or maintain airway

2. Hypotension (SBP < 90) secondary to either an acute medical or trauma condition, with clinical evidence of shock (altered level of consciousness decreased urine output, or other evidence of end stage organ failure) refractory to volume resuscitation that cannot be managed in a non-ICU setting.

3. "Other" as determined by intensivist (or intensivist equivalent)

Does the patient meet above ICU Criteria?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

IF YES	
Date ICU Criteria was 1st met on: <i>(Note: this may be different than the date of admission)</i>	Click or tap here to enter text.
Current indications for admission to the ICU: <i>(choose ALL that apply)</i>	<input type="checkbox"/> Requires ventilatory support <input type="checkbox"/> Inability to protect or maintain airway <input type="checkbox"/> Hypotension with clinical evidence of shock refractory to volume resuscitation that cannot be managed in a non-ICU setting <input type="checkbox"/> Other (as determined by intensivist or equivalent): Click or tap here to enter text.
COVID Test Status (for current hospitalization)	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Pending-suspected positive <input type="checkbox"/> Pending-no clinical suspicion <input type="checkbox"/> Not sent. Reason: Click or tap here to enter text.
Current level of respiratory support:	<input type="checkbox"/> Ventilator <input type="checkbox"/> CPAP or bi-PAP <input type="checkbox"/> High flow oxygen (>6 LPM) <input type="checkbox"/> Low flow oxygen (<6 LPM) <input type="checkbox"/> No support <input type="checkbox"/> Other: Click or tap here to enter text.

<p>What degree of ARDS does the patient have?</p> <p>ARDS Definition:</p> <ul style="list-style-type: none"> • Impaired oxygenation AND: <ul style="list-style-type: none"> ○ Within 1 week of a clinical insult/new or worsening respiratory symptoms ○ Bilateral opacities not fully explained by effusions, lobar/lung collapse, or nodules ○ Respiratory failure not fully explained by cardiac failure or fluid overload 	<ul style="list-style-type: none"> <input type="checkbox"/> None/no ARDS <input type="checkbox"/> Mild (PaO₂/FiO₂ =200-300 with PEEP or CPAP≥5) <input type="checkbox"/> Moderate (PaO₂/FiO₂ =100-199 with PEEP or CPAP≥5) <input type="checkbox"/> Severe (PaO₂/FiO₂ <100 with PEEP or CPAP≥5) <input type="checkbox"/> Unable to evaluate based on current information 	
<p><i>To Calculate ARDS Severity:</i></p>	$\frac{PaO_2}{FiO_2} =$	<p>Click or tap here to enter text.</p>
<p>What is the patient's response to current treatment <u>with the scarce resource</u>?</p> <p>(See "Scoring Systems Statement" below)</p> <p><i>When answering this question, the Treatment Team should not use any scoring systems in determining patient's response to treatment.</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Improving = a patient who clinically improves <input type="checkbox"/> Unchanged / Expected Disease Course = a patient who remains clinically unchanged or the clinical course falls in line with an expected disease course with or without minor complications <input type="checkbox"/> Worsening = a patient who clinically declines more than the expected disease course and changes their overall likelihood to survive to discharge even with scarce resource <input type="checkbox"/> Unknown - Treatment just began < 24 hours ago 	

Scoring System Statement:

Scoring systems are frequently used in all areas of medicine to assist with diagnosis and prognosis for individual patients. However, most scoring systems contain biased information leading to incorrect conclusions, especially when used during crisis allocation.¹⁻² The data collected to support many scoring systems are oftentimes derived from patient populations not reflective or inclusive of historically oppressed communities and can use factors without supportive data, like race, to change the score.³⁻⁴ Therefore, scoring systems should not be used in the allocation of scarce resources in WA State Crisis Standards of Care.

1. Raschke RA, Agarwal S, Rangan P, Heise CW, Curry SC. Discriminant Accuracy of the SOFA Score for Determining the Probable Mortality of Patients With COVID-19 Pneumonia Requiring Mechanical Ventilation. *JAMA*. 2021;325(14):1469–1470. doi:10.1001/jama.2021.1545
2. Schmidt H, Roberts DE, Eneanya ND. Rationing, racism and justice: advancing the debate around 'colourblind' COVID-19 ventilator allocation [published online ahead of print, 2021 Jan 6]. *J Med Ethics*. 2021;medethics-2020-106856. doi:10.1136/medethics-2020-106856
3. Gumbsch, Thomas et al. (2021) **Ethnicity-based bias in clinical severity scores** The Lancet Digital Health, Volume 3, Issue 4, e209 - e210
4. National Kidney Foundation. Establishing a Task Force to Reassess the Inclusion of Race in Diagnosing Kidney Diseases. A joint statement from the National Kidney Foundation and the American Society of Nephrology July 2, 2020
https://www.kidneynews.org/fileasset/sites/default/files/NKF-ASN%20eGFR%20Statement_July%202020.pdf

TRIAGE TEAM DECISION:

- Red
- Orange
- Yellow
- Blue
- Striped
- Unable – need input from specialist first
- Unable – need clarification on data entered (for example acronym clarification)

Signature:	Click or tap here to enter text.
Triage Team Lead Name (printed)	Click or tap here to enter text.
Date:	Click or tap here to enter text.
Time:	Click or tap here to enter text.

Triage Team members may encounter situations and decisions which increase or create psychological and moral risks for themselves, as part of their role. DOH strongly encourages all Triage Team members to allow some time for self-reflection about their roles and experiences. Be mindful of engaging in regular self-care practices and reach out for additional support if needed. More information can be found below:

- To learn how to self-triage for events which may create risk, and develop a personal coping plan, reach out to DOH-Bhadmin@doh.wa.gov and request information on PsySTART-Responder, a virtual 30-minute training which is offered regularly.
- [Click here](#) for Disaster Distress Line to speak to someone and obtain support related to working in a disaster.
- [Click here](#) for PTSD Coach and other mobile apps to help manage symptoms of stress.
- [Click here](#) for National Suicide Hotline.

APPENDIX C: CRISIS STANDARDS OF CARE PROCESS RE-EVALUATION REQUEST

*This form is to be used to request review and re-evaluation of a Crisis Standards of Care (CSC) process or form. This form must be reviewed and signed by the Medical Branch Director (or equivalent) under your Healthcare Incident Command System (HICS). After completion, please submit to the Washington State Department of Health at DOH.Secetary@doh.wa.gov. **Please ensure all updated documents are attached to this form for re-evaluation consideration.***

RE-EVALUATION REQUEST:

Date of re-evaluation request:	Click or tap here to enter text.
Time of re-evaluation request:	Click or tap here to enter text.
Name of person submitting request:	Click or tap here to enter text.
Phone Number:	Click or tap here to enter text.
E-mail:	Click or tap here to enter text.
What specific concern regarding the CSC process or CSC form would you like re-evaluated? ?	Click or tap here to enter text.
Which document (if any) is being requested to be re-evaluated? <i>**Document under consideration <u>must</u> be included when submitting this form for re-evaluation consideration**</i>	<input type="checkbox"/> Administrative form <input type="checkbox"/> Patient Information Form (PIF) <input type="checkbox"/> CSC Triage Team Operational Guidebook <input type="checkbox"/> Scarce Resource Card <input type="checkbox"/> Other: Click or tap here to enter text.
Other information to be considered:	Click or tap here to enter text.

Signature:	Click or tap here to enter text.
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Branch Director (or equivalent) Name:	Click or tap here to enter text.
Branch Director (or equivalent) Signature:	Click or tap here to enter text.
Date:	Click or tap here to enter text.
Time:	Click or tap here to enter text.

APPENDIX D: CRISIS STANDARDS OF CARE PATIENT CASE RE-EVALUATION REQUEST

*This form is used to provide re-evaluation for a specific patient case under consideration for a scarce resource. Please complete this form and submit it to the Medical Branch Director (or equivalent) in your Healthcare Incident Command System (HICS). **Please ensure all updated documents are attached to this form for re-evaluation consideration.***

Date of re-evaluation request:	Click or tap here to enter text.
Time of re-evaluation request:	Click or tap here to enter text.
Name of person submitting request:	Click or tap here to enter text.
Phone Number:	Click or tap here to enter text.
E-mail:	Click or tap here to enter text.

PATIENT INFORMATION: (Please attach the completed CSC PIF)

Patient Information Form (PIF) Tracking ID:	Click or tap here to enter text.
Reason for Request: <i>(All requests for re-evaluation must pertain to the information on the PIF only)</i>	Click or tap here to enter text.

TO BE COMPLETED BY MEDICAL BRANCH DIRECTOR:

<p>Reviewer Decision of patient case re-evaluation: <i>Please provide any supporting documentation that aided in decision-making.</i></p>	<p>Click or tap here to enter text.</p>
<p>Date:</p>	<p>Click or tap here to enter text.</p>
<p>Time:</p>	<p>Click or tap here to enter text.</p>

<p>Branch Director Name:</p>	<p>Click or tap here to enter text.</p>
<p>Branch Director Signature:</p>	<p>Click or tap here to enter text.</p>
<p>Date:</p>	<p>Click or tap here to enter text.</p>
<p>Time:</p>	<p>Click or tap here to enter text.</p>

<p>Ethicist Name:</p>	<p>Click or tap here to enter text.</p>
<p>Ethicist Signature:</p>	<p>Click or tap here to enter text.</p>
<p>Date:</p>	<p>Click or tap here to enter text.</p>
<p>Time:</p>	<p>Click or tap here to enter text.</p>

APPENDIX E: CRISIS STANDARDS OF CARE TALKING POINTS FOR HEALTHCARE STAFF

What is Crisis Standards of Care?

Crisis Standards of Care (CSC) happens when there are not enough healthcare staff, space, or supplies to provide usual care to patients. Usually, this is related to an event when there is a large number of people needing care, such as COVID-19. When we experience circumstances such as a catastrophic incident or a disaster and the healthcare system becomes overwhelmed, we enter “crisis standards of care.” The goal of planning for crisis standards of care is to consider all options and work to mitigate the need to implement CSC.

When a facility becomes overwhelmed and has difficulty providing care in the way it typically would, it takes steps to modify care. Those might include adjusting standard staffing approaches, asking staff to work and perform care outside of their normal duties, treating patients in spaces not usually used to provide care, and not having access to supplies such as masks and other personal protective equipment, sometimes requiring that they be re-used. This is called *Contingency Care* and is an essential part of planning to avoid CSC.

If a hospital simply cannot manage the number or the severity of patients, it may reach out to other hospitals and transfer patients to another facility if that is possible. However, it may not always be possible to level-load when all facilities across the region and state are at the same level of patient surge and have the same critical resource limitations.

When all other options have been exhausted to adapt care in a hospital, and if all the other hospitals are in the same position so that there is nowhere to transfer patients, the healthcare system moves into CSC. ***CSC means that difficult decisions have to be made about who gets certain kinds of care, and there are not enough resources to provide care to all patients in the way we expect.***

How was Crisis Standards of Care Planning Developed?

Planning and discussions about what are the most equitable way to provide care to as many people as possible when we are experiencing CSC has been going on for several years both locally and nationally. Many physicians, nurses, other hospital and outpatient staff, emergency planners and experts on ethics have wrestled with these hard decisions.

As a result of this long-term and very thorough process, Washington State has developed and adopted a plan and procedures for how limited resources can be extended as far as possible to benefit as many patients as possible.

When the entire healthcare system in Washington is in the status of crisis standards of care, these guidelines and recommendations are used as the basis for healthcare providers and systems to

make decisions on care, in as equitable a way as possible, when there aren't enough resources, and a surge in patients.

How Does the Triage Process Work?:

In crisis standards of care, if there are a number of patients who would normally be admitted to an Intensive Care Unit (ICU) or perhaps a Burn Unit, requiring special care, procedures and medical equipment (e.g., a ventilator), and if there are not enough beds, staff, or equipment to provide that level of care to all of them, those patients would be referred by their treating physicians to a Triage Team.

The Triage Team is comprised of two-three clinicians and an ethicist. The Triage Team evaluates patients and then must decide who would get the scarce resource, based on Washington State's plan for crisis standards of care. There can be a Triage Team for a specific hospital, or some hospital systems may decide to have a Triage Team for their hospital system rather than a team for each hospital. Smaller hospitals may not have physicians that can objectively participate (i.e., are not providing care to patients under consideration), or access to an ethicist within their hospital. For those facilities, Regional Triage Teams are available for consultation and assistance.

The Triage Team does not include anyone who is on the patient's treatment team. Information on the patient's race/ethnicity, gender, any disabilities, or financial status is NOT included in the information provided to the Triage Team. The Triage Team does not know anything about the patient's situation with the exception of the details about the patient's current medical condition, and factors that might tell the Triage Team the likelihood that this patient would survive to discharge if they got an ICU admission or a ventilator. For example, if two patients needed an ICU bed or a ventilator and one of them had no pre-existing medical conditions with the exception of the current illness and the other person had additional medical comorbidities, they would be evaluated using the same criteria of the likelihood of survival if given the scarce resource.

Patients who receive the scarce resource after being screened by the Triage Team will be re-evaluated every 24 hours. If further demands on the resource continue, the patient will continue to be re-triaged based on how they are progressing clinically with the resource. Reallocation of the scarce resource may occur if other patients are evaluated and considered to have a higher likelihood of survival to discharge.

What are Next Steps After Triage?

Understanding why care options may have changed and resources need to be allocated, can be very difficult for healthcare providers who have been trained, and expected, to provide all appropriate care to all patients.

When care has to shift from conventional care to the adjustments we make during a disaster, we want to make sure that we are offering care at the highest level we can to ALL patients.

The types of care may differ from person to person, depending on the severity of their illness, other factors, such as whether we have staff or equipment available, and the level of care needed. For example:

- Some patients who might ordinarily be admitted to an Intensive Care Unit may need to be cared for on regular medical floors.
- Some who would usually be admitted to the hospital might instead be sent home with care planning for the home setting.
- Some will need to be treated with other methods because not all procedures or equipment such as ventilators will be available to all patients.
- Some patients have an extremely low chance of surviving their illness, in spite of all efforts to save them, or may not want all care. Those patients will be offered palliative care, home hospice care or other care aimed at managing their pain and distress effectively and providing support to them and their families.

We strongly encourage all Triage Team members and all staff who must be engaged in CSC to allow some time for self-reflection about their roles and experiences. Be mindful of engaging in regular self-care practices and reach out for additional support if needed. More information can be found below:

To learn how to self-triage for events that may create risk related to behavioral health conditions, and develop a personal coping plan, reach out to DOH-Bhadmin@doh.wa.gov and request information on PsySTART-Responder, a virtual 30-minute training which is offered regularly.

Disaster Distress Line to speak to someone and obtain support related to working in a disaster: <https://www.samhsa.gov/find-help/disaster-distress-helpline>

PTSD Coach and other mobile apps to help manage symptoms of stress: <https://www.ptsd.va.gov/appvid/mobile/index.asp>

National Suicide Hotline: <https://suicidepreventionlifeline.org/talk-to-someone-now/>

If you have thoughts or concerns about what you've learned, please reach out to the Communication Team for your hospital.

APPENDIX F: CRISIS STANDARDS OF CARE TALKING POINTS FOR PATIENTS AND FAMILIES

What is Crisis Standards of Care?

Crisis Standards of Care (CSC) happens when there are not enough healthcare staff, space, or supplies to provide normal care to patients. Usually, this happens in an event when there is a large number of people needing care, such as a pandemic, or a disaster (natural or man-made).

When a hospital starts to become overwhelmed and to have difficulty providing care in the usual way, it takes steps to adjust. Those might include assigning more patients to nurses than would normally be assigned, putting patients in spaces not usually used to provide care, and working to be careful and save supplies such as masks and other personal protective equipment.

If a hospital simply can't manage the number or the severity of patients, it may reach out to other hospitals and transfer patients to another facility if that is possible.

When all other options have been exhausted to adapt care in a hospital, and if all the other hospitals are in the same position so that there is nowhere to transfer the many very ill patients, the healthcare system moves into CSC. CSC means that difficult decisions have to be made about who gets certain kinds of care.

How was Crisis Standards of Care Planning Developed?

Planning and discussions about the fairest way to provide care to as many people as possible when we are experiencing CSC has been going on for several years both locally and nationally. Many doctors, nurses, other hospital and outpatient staff, emergency planners and experts on ethics have wrestled with these hard decisions.

Those individuals have also looked at planning and care decisions from healthcare organizations across the country, as well as the recommendations from experts within the scientific and medical community. The discussions have included experts on ethics, who help healthcare organizations make sure that the decisions are not biased against racial or ethnic groups or based on ability to pay or having a disability.

As a result of this long-term and very thorough process, Washington State has adopted a procedure for how we can make our limited resources go as far as they can. This procedure is called "crisis standards of care." When our state is in CSC use this procedure to help the doctors, nurses, and other healthcare providers make decisions they need to about how to help as many people who need it, as fairly as possible, when there aren't enough resources to go around.

How Does the Triage Process Work?

If there are a number of patients who are very ill and would normally be admitted to an Intensive Care Unit (ICU) or perhaps a Burn Unit, requiring special care, procedures and medical equipment e.g., a ventilator, and if there are not enough beds, staff or equipment to provide that level of care to all of them, those patients would be referred by their treating doctors to a Triage Team.

The Triage Team is comprised of 2-3 clinicians, as well as at least one medical ethicist whose responsibility it is to decide who would get the scarce resource (for example, a bed in a particular unit, or certain types of treatment like a ventilator).

The Triage Team does not know who the patient is, nor the patient's race/ethnicity, gender, any disabilities, or financial status. Only the details about the patient's current medical condition are available to the Triage Team so that they can make their decision based only on that, rather than other information that might bias their opinion in any way. Also, the Triage Team sees the exact same information for every patient under consideration when resources are scarce. The information given to the Triage Team is only the information needed to help them decide, the likelihood that this patient would survive, if they received the resource. So, for example, if two patients needed an ICU bed or a ventilator-they would be evaluated exactly the same way, using the same information in order to make this process as fair as possible.

What are steps taken when there are too many patients?

Understanding why care options may have changed can be very difficult. It's perfectly normal and expected that you might want all possible care options to be open and available for your loved one.

When care has to shift from "normal" care to the adjustments we make during a disaster (CSC), we want to make sure that we are offering care at the highest level we can to ALL patients given the resources we have at the time.

The types of care may differ from person to person, depending on the severity of their illness, other factors, such as whether we have staff or equipment available, and the level of care needed. For example:

- Some patients who might ordinarily be admitted to an Intensive Care Unit may need to be cared for in regular medical floors.
- Some who would usually be admitted to the hospital might instead be sent home with care planning for the home setting.
- Some will need to be treated with other methods because not all procedures, or equipment such as ventilators will be available to all patients.
- Some patients have an extremely low chance of surviving their illness in spite of all efforts to save them or some patients may not want all care. Those patients will be offered comfort care, with all care aimed at managing their pain and distress effectively and providing support to them and their families.

If you have thoughts or concerns about what you've learned, please reach out to a member of your loved ones' care team, or to the Communication Team for your hospital.