

Los Angeles Department of Health Services Guidance for Allocation of Scarce Critical Care Resources During a Public Health Emergency Summary Overview

The COVID-19 pandemic has shown that a surge of COVID-19 patients can overwhelm a health system's ability to treat all patients in need of care. When available resources of a specific kind exceed the demand for those resources, decisions must be made about who will receive them and who will not. As a result, the Los Angeles County Department of Health Services (DHS) has developed guidance for its facilities regarding the triage of critically ill patients and allocation of resources when a public health emergency creates demand for critical care resources (e.g., ventilators, critical care services, staffing, space, etc.) that outstrips available supply. For a more detailed discussion of the guidelines and their background and underlying reasoning, please refer to the full DHS "Guidance for Allocation of Scarce Critical Care Resources During a Public Health Emergency".

The guidance provides for designation of Triage Officers at each hospital who will have authority and responsibility for assessing availability/scarcity of resources and working collaboratively with administrators and clinicians to allocate them according to the principles described below, with the overall goal of doing the most good for the most people.

The Guidelines are intended to be used at a time of "crisis" care, meaning when a facility is so overwhelmed with patients that it is simply unable to deliver typical standards of care (as opposed to "conventional" care, which is normal standard of care provided under normal circumstances, and "contingency" care, often associated with surge conditions, wherein the goal is normal standard of care, but may require changes in standard operating procedures to achieve that). (Appendix A provides information about how resources might be allocated during a crisis, and how to prepare for that process.)

These Guidelines are grounded in the following Ethical and Guiding Principles:

- Maximization of public health – doing the most good for the most people.
- Duty to care – a commitment to delivering the best care possible given the available resources.
- Duty to Steward Resources – all resources should be carefully allocated according to their known scarcity, likelihood of renewal, and the extent to which they can be replaced or reused.
- Distributive and Procedural Justice – allocating resources to maximize the chances of fairness and equity, and minimize the influence of biases such as ageism, sexism, racism, or ableism.
- Autonomy – during a period of crisis care, the principle of autonomy may be offset by other principles; nonetheless, patients should always be treated with dignity and respect.
- Reciprocity – in recognition of their critical role in fighting the pandemic, front-line health care workers (interpreted broadly to include all professions and support personnel) are afforded some preference in the allocation of scarce resources.
- Transparency - the potential for triage and resource allocation should be explained to patients and families when they present to the hospital for care, and individual

decisions should be explained when called for; similarly, staff should be informed when a facility is in crisis status and triage and resource allocation

- **Beneficence** – patients who are not allocated scarce resources will receive medical care that includes intensive symptom management and psychosocial support, reassessed at least daily to determine if changes in resource availability or their clinical status warrant provision of the resource.

The main points of this Guidance are:

Resource limitation and decisions to be made – While the scarce resource can be equipment, supplies, or staffing, the most likely the resource shortage will be that of staffing (e.g., Respiratory Therapy (RT), skilled ICU nursing, or critical care physicians). Because some resources may be used in different manners to different benefit for different patients, allocation decisions may include not only who receives scarce resources and who does not, but also how best to allocate specific resources. For example, an ICU nurse could be assigned to run Continuous Renal Replacement Therapy (CRRT) for one patient or to care for an additional ventilated ICU patient. A decision must be made regarding the comparative benefit to each of the patients. Similarly, in a shortage of respiratory therapists, a decision may need to be made about which ventilated patients should be care for by a respiratory therapist, and which should have their ventilator managed by a physician.

Decisions of allocation will be to decide which patients get which resource, and in some circumstances, may involve decisions to take scarce resources from one patient and give them to another who is more likely to benefit from them. During times of contingency care, when resources are not absolutely scarce, triage officers may prevent patients from receiving care but may not remove care from patients.

Triage Officers – Each facility should designate several Triage Officers who will have the responsibility and authority to apply the principles and processes of the Guidance to make decisions about how to allocate and reallocate resources. In general, activation of Triage Officers will be done by the DHS-wide Surge Planning Committee, based on available data about hospital census, and imminent or current demand for care, staffing, equipment, or supplies.

Allocation Process for Scarce Critical Care Resources – The Triage Officer has the responsibility and authority to apply the Guidance principles and processes to make decisions about how scarce resources will be distributed among all patients, including the reallocation of critical care resources that have previously been allocated to patients, if it becomes clear that another patient is more likely to benefit. The goal of the allocation process is to optimize the use of resources to “do the most good for the most people”. The Triage Officers will work in conjunction with hospital clinical leadership, including medical and nursing directors of the ICUs, hospital wards, and emergency department, along with patients’ attending physicians, Social Work, and Spiritual Care. Whenever possible, a Triage Officer should make scarce resource allocations, rather than patients’ treating physicians.

Communicating Allocation Decisions – After a decision is made, the Triage Officer should first inform the patient’s attending physician about the triage decision. The patient’s attending physician will inform the patient and/or patient’s family/surrogate of the decision and the timeframe within which the action will be taken. The attending physician should explain the circumstances and how the severity of the patient’s condition impact the decision made. There are supporting documents attached to the Guidance with suggested language for these conversations.

Reconsideration of Allocation Decisions – Guidance is provided to allow patients, families, or care team members an opportunity to voice disagreement with a specific decision, first by raising concerns with the Triage Officer, and if necessary, asking the facility CEO or their designee (other than the Triage Officer) to make a final decision. Timeliness of requests for reconsideration will vary on the resource and the level of scarcity, but should be made as soon as possible after the initial determination.

Care Prior to Resource Allocation – During crisis and high-level surge conditions, triage should begin as a history is taken in the emergency department. All patients should be screened for existing advance directives, POLST, or DNR/DNI orders. Following this screening, goals of care and code status should be discussed with/for all patients and should include explanation of the following:

- Due to recent COVID-19 surge, the facility is overwhelmed by the demand for care, is not able to provide “normal” care to all patients, and may have to choose who will get certain services (e.g. a ventilator or highly specialized critical care services), and who will not.
- In such situations, the health care system, including this hospital, must focus on doing the most good for the most people.
- This hospital (system) has established a “neutral” Triage Officer who works with the doctors caring for patients to understand what resources are limited, and how and to whom they should be given, relying on clinical judgment and ethical principles to ensure fairness.
- If the patient chooses to forgo a scarce resource, that resource will be available to someone else.
- If the patient chooses to forgo certain treatments, they will not be abandoned – the facility will still follow their wishes regarding treatment that it is able to provide and will make them as comfortable as possible under the circumstance.

Every effort should be made to ensure appropriate comfort and palliative care to patients who need it, and/or who choose minimal intervention or comfort care. This will likely need to be done by the primary inpatient medical teams in consultation with the facility’s palliative care service.

All unstable patients desiring care should be stabilized according to the resources immediately available in the ED, in compliance with EMTALA requirements, and prioritized according to standard ED triage processes.