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Considerations for Allocating Scarce Medical Resources during COVID-19 Triage Protocol for Catholic Health

Executive Summary with FAQ for Caregivers

For CHS Medical Staff Use Only - Not for Public Distribution (April 6, 2020)

Communication Summary

This communication brief is for our caregivers. The objectives of this guide are to:

- **Inform caregivers** about our duty to plan, safeguard and guide.
- **Discuss Triage Protocol** criteria and process.
- **Address FAQ** (Frequently Asked Questions).

I. Our Duty to Plan, Safeguard and Guide

- The COVID-19 pandemic is likely to stretch our capabilities to provide all the care for every patient that we are accustomed to using our single patient-centered approach to care.
- While we are hopeful that our best efforts to expand resource capacity throughout the region will be sufficient, we need to have a plan if needed resources become unavailable.
- This Triage Protocol is an ethically sound, clinical criteria-based method to guide decision making in the use of limited available treatment in order to promote equity and consistency.
- This Triage Protocol is consistent with the *Ethical and Religious Directives for Catholic Health Services*, state, and national guidelines.
- Our call to reveal the healing love of Jesus to all requires us to safeguard the inherent dignity of each person. Limitation of resources does not mean we limit the basic care and respect for the inherent dignity that is due to and must be provided to every patient.

II. Triage Protocol

- The resources allocation protocol is for ventilators. These same principles and guidelines can equally apply to other scarce resources, such as renal dialysis, ICU beds, or ECMO.
- Triage Decisions to prioritize limited resources to those with the best chance of survival will not occur until all of the following have happened:
    a. We no longer have any available resources (ventilators).
    b. All means of obtaining more resources or the creative adaptation of current resources has already been maximized.
    c. We are unable to transfer patients to other facilities.

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III. Triage Process

- Based on the Sequential Organ Failure Assessment (SOFA) Score derived from 6 evidence-based objective clinical factors, **not** on personal values or subjective judgments such as age, disability, race, religion, marital status or "quality of life" is part of the calculus.
- All patients on ventilators will be assessed utilizing the SOFA Score. A SOFA score assesses the health status and likelihood of survival.
- Patients will be categorized into 4 groups (based on their SOFA score):
    - Blue code patients (lowest access) high risk of mortality even with therapy.
    - Red code patients (highest access) most likely to recover with treatment.
    - Yellow code patients (intermediate access) very sick, intermediate and/or uncertain likelihood of survival with ventilator therapy.
    - Green code patients (defer/discharge) those who don't need ventilators.
- Patients with immediate/near-immediate mortality even with aggressive therapy are excluded from receiving ventilators.
- SOFA scores are recalculated at 120 hours and every 48 hours afterwards.
    - A patient remains on a ventilator based on his/her SOFA score and whether he/she has improved or worsened. These periodic assessments are necessary to determine whether the therapy is effective.
- As soon as ventilators are available, then Triage Decisions will stop, and patients will get ventilator therapy as needed.

Frequently Asked Questions

Who decided that we should do this Triage Protocol?

- The decision to start this Triage Protocol was based on how the COVID-19 pandemic was affecting hospitals in other parts of the world and other locations in the United States. The COVID-19 disease process was overwhelming hospitals' abilities to provide PPE, ICU beds, and ventilator therapy. Catholic Health leadership, through the Ethics Committee, brought together a multi-disciplinary committee to draft these guidelines. Members of the committee include physicians, APP's, nurses, administrators, ethicists (internal and national experts), and representatives from mission services and spiritual care. The **Considerations for Allocating Medical Resources during COVID-19 – Triage Protocol for Catholic Health** was a group effort, based on state and national guidelines, and consistent with Catholic Ethical principles.

Can't we get more ventilators from somewhere else?

- This was our first approach to the solution, and we continue to try to get more resources from all available sources. Unfortunately, this isn't a local problem, it is a world-wide issue, and hospitals around the globe are trying to garner a finite amount of equipment and supplies. We are continually trying to get more of the necessary items we require for all our patients and staff.

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Isn't this just rationing?

- The tragic reality is that based on realistic projections, we are likely to face a situation where we have more patients than resources (ventilators). Our goal is to save as many lives as we can with our resources.

How are we choosing? Are we discriminating against the old or those with a chronic medical condition?

- No, we are basing all our Triage Decisions on the SOFA score, 6 evidence-based objective clinical factors, **not** on personal values or subjective judgments such as age, disability, race, religion, marital status or "quality of life". This method looks at the short-term likelihood of survival from COVID-19 and is not focused on the patient's chronic medical conditions. This approach is based on the New York State guidelines, which is a model for most national guidelines. Other approaches take into account age, chronic conditions, and other factors, but we want to have the most objective and least biased way to make a difficult decision about who gets a therapy that is in limited supply.

Are we playing God?

- No, no one wants this Triage Protocol to be put in place, and we hope that this is a pointless exercise. But hope is not a strategy. We need to determine which patient will have the greatest benefit of ventilator therapy when we do not have enough ventilators for everyone. Whether someone gets a ventilator or not, we will not limit the care and respect for the inherent dignity that is due to and must be provided to every patient.

Are nurses or providers given any priority?

- Persons who perform essential public health functions, deemed indispensable to the continued provision of public health services to the community will be prioritized within their designated color category, not because of an inherent greater dignity over others, but because saving lives during this pandemic can only occur with certain irreplaceable workers. If there is convincing evidence that individuals who perform tasks that are vital to the public health response are likely to recover in time to again fulfill those roles during the current crisis, then these individuals will be given heightened priority.

Will babies born preterm be part of this Triage Process?

- No, a strong preference for saving babies is long-standing societal practice. Our institutional commitment to providing maternity and neonatal care is an integral part of our Mission. Neonatal survival with ventilator support after 24-25 weeks gestation is over 80%, survival after 28 weeks gestation is over 95%. Based on this chance of survival alone, preterm neonates would have the highest access to ventilators because they have the most likelihood to recover with treatment.