

Scarce Resource Triage Team Guidelines

To be used in conjunction with Scarce Resource Algorithms during Crisis Standards of Care

Updated: Mar 2020

Introduction

In the event of a large scale disaster—either a no notice event such as a natural disaster or a prolonged situation such as a pandemic—there is the potential for an overwhelming number of critically ill or injured patients. In these situations, certain medical resources may become scarce and prioritization of care may need to be considered.

In 2009 the Institute of Medicine (currently the National Academy of Medicine) published a landmark report, *Guidance for Establishing Crisis Standards of Care for use in Disaster Situation: A Letter Report*. In this report the authors defined surge capacity as a continuum from conventional to contingency and finally crisis. This framework has been nationally accepted and adopted. The definition of “Crisis Capacity” as set by the NAM, is a situation where space, staff and supplies “are not consistent with usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available).”¹

The content of this document 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 Medicine and detailed discussion and deliberation by the WA State Disaster Medical Advisory Committee (DMAC), the Disaster Clinical Advisory Committee (DCAC) Central District and included input from both local and state Community Engagement Reports.^{2,3}

This document is to be used in conjunction with the DOH Scarce Resource Triage Algorithms which were developed by regional workgroups of Subject Matter Experts (SME), and approved by the Disaster Clinical Advisory Committee (DCAC) Central District. Implementation of these algorithms depends upon the development of individual Crisis Standards of Care Hospital, Hospital System, and Regional Triage Teams as outlined below.

Purpose

To provide a transparent, fair, equitable, and consistent approach to allocation of scarce resources during a declared emergency in which Crisis Standards of Care (CSC) has been implemented.

Scope

All healthcare organizations and providers within the affected region of the CSC declaration.

Assumptions

- A Health Officer has declared a crisis situation and crisis standards of care has been activated.
- Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care
- Federal assets have been requested but may be delayed.

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. Washington State Crisis Standards of Care Community Engagement Report, June 2019, WA DOH.

3. 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.

Implementation Recommendations

A. General

All healthcare organizations within the affected region agree to implement a uniform triage process as outlined in this document to be used along with the DOH Scarce Resource Triage Algorithms to include: Adult Critical Care, Pediatric Critical Care and Renal Replacement Therapy (pending) Algorithms.

B. CSC Triage Teams: Identification and Composition

1. CSC Hospital Clinical Triage Team

It is recommended that every in-patient healthcare institution have a CSC Hospital Clinical Triage Team which will report to the Medical Care Branch Director (or equivalent position within organization's command structure) during activation of HICS.

- a. It is recommended the CSC Hospital Clinical Triage Team
 - At least 2-3 senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer who oversees all Triage processes.
 - 1 medical ethicist
 - When possible clinicians on the Triage Team will not be primary providers of the patients under consideration
 - 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 CSC Hospital Clinical Triage Team will be recorded in a CSC Hospital Clinical Triage Team Log, which will include:
 - Date and time of referral
 - Name of referring clinician and contact information
 - Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification but should not be made available to the Triage Team
 - All clinical information presented to the Triage Team at the time of decision
 - Triage Team decision, date and time of the decision, and all supporting documentation reviewed and produced for the decision
 - If patient is referred, date and time of referral and contact information of receiving Clinical Triage Team
 - Patient outcome (if known)
- c. If the patient requires referral outside an individual hospital and the hospital is part of a wider hospital system please see Section 2. If the hospital is not part of a larger hospital system then please refer to Section 3.
- d. It is recommended the CSC Hospital Clinical Triage Team follow the communication guidelines outlined in this document in order to maintain accurate and up to date situational awareness.

2. Hospital systems during CSC

It is recommended every Hospital System maintain good communications between individual hospitals in their system to assist in situational awareness for the scarce resource in question. It is recommended that every hospital system have a mechanism by which a critical resource can be maximized and distributed throughout their system and that all appropriate channels have been exhausted to obtain additional resources. When a specific healthcare facility within a hospital system lacks a specific resource, identifying that resource within their system should be the first step in patient placement. This would be managed by the CSC Hospital System Triage Team.

- a. All patients presented to the CSC Hospital System Triage Team will be recorded in a CSC Hospital System Triage Team Log, which will include:
 - Date and time of referral
 - Name of referring clinician and contact information
 - Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification but should not be made available to Triage Team.
 - All clinical information presented to the Triage Team at the time of decision
 - Triage Team decision, date and time of the decision, and all supporting documentation reviewed and produced for the decision
 - If patient is referred to the Regional Triage Team, date and time of referral and contact information of receiving Regional Triage Team
 - Patient outcome (if known)
- b. Those patients who cannot be managed within their system will need to be presented to the CSC Regional Clinical Triage Team for consideration and prioritization within a different hospital system.

3. CSC Regional Clinical Triage Team

It is recommended a CSC Regional Clinical Triage Team manage prioritization and placement of patients in need of a scarce resource in the affected geographic region who cannot be managed within a specific hospital system.

It is recommended the CSC Regional Clinical Triage Team fairly represent the healthcare facilities and systems within the region. If a region has developed a healthcare coalition DCAC then it is recommended that members of the CSC Regional Triage team be determined in coordination with local DCAC, State DMAC, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the local DCAC, healthcare executives or the clinical community at large.

If a region does not have a local DCAC then CSC Regional Clinical Triage Team members will be determined by the State DMAC in coordination with the SHO, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the DMAC, healthcare executives or the clinical community at large.

Recommended members of the CSC Regional Clinical Triage Team are as follows:

- Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer who oversees all Triage processes.
 - 1 medical ethicist
 - When possible, clinicians on the CSC Regional Clinical Triage Team will not be primary providers of the patients under consideration, nor members of the referring CSC Hospital or Hospital System Clinical Triage Team(s).
 - 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.
- a. All patients presented to the CSC Regional Clinical Triage Team will be recorded in a CSC Regional Clinical Triage Team Log which will include:
 - Date and time of referral
 - Name of referring clinician and contact information
 - Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification, but should not be made available to Triage Team.
 - All clinical information presented to the Triage Team at the time of decision Triage Team decision date and time and all supporting documentation
 - Patient outcome (if known)

- b. It is recommended the CSC Regional Clinical Triage Team follow the communication guidelines below in order to maintain accurate and up to date situational awareness.
- c. The CSC Regional Clinical Triage Team is under the same Oversight and Re-evaluation processes as the CSC Hospital and Hospital System Triage Teams outlined below.

C. Oversight

In order to maintain transparency and ensure a fair, equitable and consistent approach to allocation of a scarce resources it is important that all triage teams have an oversight process for decisions made during an event.

1. CSC Hospital and Hospital Systems Oversight Committee

When an event occurs which requires activation of the CSC Hospital or Hospital System Clinical Triage Team the following documentation will be required and should be maintained and reviewed by the CSC Oversight Committee designated by the Medical Operations Branch Director under HICS.

- a. It is recommended the CSC Triage Team Oversight Committee consist of the
 - Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Chair who oversees all Oversight processes
 - When possible clinicians on the CSC Triage Team Oversight Committee will not be primary providers of the patients under consideration
 - 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
 - At least one medical ethicist
- b. All patients presented to the CSC Hospital or Hospital System Triage Team will be reviewed by an CSC Oversight Committee and will be recorded in an CSC Oversight Triage Team Log, which will
 - All patient demographics
 - Date and time of the case consideration
 - All patient information presented to the Clinical Triage Team at the time of consideration
 - Triage Team decision, date and time of the decision, and all supporting documentation reviewed and produced for the decision
 - If patient was referred, date and time of referral and contact information of receiving Clinical Triage Team
 - Patient outcome
- c. It is recommended that at agreed upon intervals the CSC Oversight Committee will review all cases presented to the CSC Hospital or Hospital System Triage Team to ensure the following:
 - All appropriate clinical information was considered
 - Accurate documentation was recorded
 - Significant variances be reviewed and addressed
- d. Depending on the nature of the incident oversight review may be in real time (e.g. in a prolonged event such as a pandemic). However in no notice, sudden or brief events, this review may be retrospective.

2. CSC Regional Oversight Committee

When an event occurs which requires activation of the CSC Regional Clinical Triage Team the following documentation will be required and will be maintained and reviewed by the CSC Regional Oversight Committee. If a region has developed a healthcare coalition DCAC then it is recommended that members of the CSC Regional Oversight team be determined in coordination with local DCAC, State DMAC, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the local DCAC, healthcare executives or the clinical community at large.

If a region does not have a local DCAC then the CSC Regional Oversight Team members will be determined by the State DMAC in coordination with the SHO, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the DMAC (or their designees), healthcare executives or the clinical community at large. Recommended members of the CSC Regional Clinical Triage Team are as follows:

- Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Chair who oversees all Oversight processes.
 - When possible clinicians on the Regional Triage Team Oversight Committee will not be primary providers of the patients under consideration nor members of the Regional Triage Team.
 - 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.
 - At least one medical ethicist
- a. All patients presented to the CSC Regional Oversight Committee will be recorded in a CSC Regional Oversight Committee Log, which will include:
 - All patient demographics
 - Date and time of the case consideration
 - All patient information presented to the CSC Regional Clinical Triage Team at the time of consideration.
 - The CSC Regional Clinical Triage Team decision date, time and supporting documentation reviewed and produced for the decision
 - Patient outcome
 - b. It is recommended that at agreed upon intervals the CSC Regional Oversight Committee will review all cases presented to the Regional Triage Team to ensure the following:
 - All appropriate clinical information was considered
 - Accurate documentation was recorded
 - Extreme variances be reviewed and addressed
 - c. Depending on the nature of the incident oversight review may be in real time (i.e. in a prolonged event such as a pandemic). However in no notice, sudden or brief events, this review may be retrospective.

D. Re-evaluation Process During Response

1. Request to change process

- a. During an event individual clinicians may request a specific change to the Scarce Resource Cards, Triage Algorithms or protocols based on new clinical information such as changes in prognostic indicators or outcome measure. These requests should be made in writing to the Chair and Vice Chair of the WA State DMAC (or their designee).
- b. WA State DMAC will keep a log and record of every CSC Reevaluation Process Request, date and time of request, and all the supporting documentation presented during the request and evaluation.
 - Each request will be reviewed by the DMAC Chair and Vice Chair or their designee along with all relevant partners including additional input from SME's
 - All request decisions will be made in a timely fashion and will be based on consensus of all relevant partners
 - Final decisions for all CSC Reevaluation Process Requests will be in writing, dated and timed, and include all supporting documentation

2. Request to reevaluate specific case

- a. Any clinician may bring a CSC Request for Patient Reevaluation of a specific case to the respective Medical Care Branch Director and designated ethicist. The Medical Care Branch Director has authority over the respective CSC Clinical Triage Team who made the initial decision under consideration (i.e. individual CSC hospital, hospital system, or regional Clinical Triage Team).
 - At the individual hospital and hospital system, the Medical Branch Director will be determined by standards HICS designations within the organization
 - At the Regional level, the Medical Branch Director will be the Chair or Vice Chair of the State DMAC (or their designee)
 - At all levels, a CSC Request for Patient Reevaluation will be reviewed by the Medical Branch Director, a designated ethicist and any other relevant partners.
- b. A log will be maintained of every Request for Reevaluation, date and time of request, and all supporting documentation presented during the request and reevaluation.
- c. Every case brought to the Medical Care Branch Director and designated ethicist will be reviewed in a timely fashion to ensure the Triage Team documentation was complete and the decision process was consistent with Scarce Resource Cards, Triage algorithms, protocols or any other clinical documentation related to the case *that was available at the time the original decision was made.*
- d. 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.
- e. Final decisions for CSC Request for Patient Reevaluation of a specific case will be in writing, dated and timed, and include all supporting documentation.
- f. Decision made by the respective Medical Care Branch Director and designated ethicist will be final.

1 During response

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 close communication with the Local and State Health Officer and all relevant partners to maintain accurate situational awareness and consensus regarding local triage recommendations.

2. During preparedness

All Scarce Resource Cards and algorithms and any supporting documentation will be reviewed and updated every 3 years.

3. Communications

- a. During response, NWHRN in conjunction with DMAC will be responsible for identifying all pertinent partners during an activation of the Scarce Resource Triage Team Guidelines to include but not limited to: LHO, SME's, DOH and Federal partners.
- b. Depending on the situation, clinical updates may be required at various frequencies, and will be determined by DMAC Chair and Vice Chair, SHO, LHO and all other pertinent partners. State Health officer (SHO) in conjunction with NWHRN will be responsible for disseminating this information in a timely fashion to all appropriate clinical entities.
- c. Communications will be electronically, but if circumstances are such that electronic communication is not possible, secondary communication processes will include FAX, phone and courier.