

April 18, 2020

## **IDPH Guidelines on Emergency Preparedness for Hospitals During COVID-19**

### **Overview**

On April 16, 2020, the Illinois Department of Public Health (IDPH) notified the State Emergency Operations Center (SEOC) that hospitals may need to implement crisis standards of care pursuant to their disaster response plans.

Today, April 18, IDPH issued "[Guidelines on Emergency Preparedness for Hospitals During COVID-19](#)" (Guidelines). As IDPH noted, given the severity of the COVID-19 pandemic, hospitals must be ready to deploy crisis standards of care as they move towards a highly critical stage in their operations.

The guidance is largely based on the prior work of the State of Illinois's Crisis Standard of Care Workgroup, which was established in 2014 to develop a statewide crisis of care plan in response to the Institute of Medicine's "[Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report \(2009\)](#)." The ethics subcommittee of this workgroup focused on the ethical framework for delivery of health care in crisis situations and produced a whitepaper entitled, "[Ethical Guidance for Crisis Standards of Care in Illinois](#)" (Ethics Whitepaper). The Ethics Whitepaper has been a crucial tool to assist health care entities in developing ethically sound policies. In addition, the [IDPH's ESF-8 Plan: Catastrophic Incident Response Annex](#) (ESF-8 CIR Annex), provides facility-specific "Crisis Care and Resource Allocation Tactics" to provide health care providers with resource allocation strategies that may be implemented during catastrophic incidents.

Because the COVID-19 pandemic will hit regions of the State in different phases, each hospital, in consultation with their local health department, regional hospital coordinating center (RHCC), IDPH, and their regional health care coalition, are best equipped to assess whether and when crisis standards of care are required in their own institution.

### ***When to Activate Crisis Standards of Care***

IDPH notes that each hospital must have a medical disaster preparedness and response plan that includes responses related to a catastrophic incident (Disaster Response Plan). Disaster response plans should anticipate the need for crisis levels of care, which may be required when standard space, staff, or supplies are unavailable and providers must implement alternate methods or interventions in order to provide a sufficient level of care.

The new Guidelines instruct hospitals to utilize their RHCC, which serves as the lead entity responsible for coordinating health and medical emergency response in its region, to offset shortages and avoid moving towards crisis standards of care if possible.

Hospitals should activate crisis care when resources are exhausted and pre-identified triggers have been reached as described in the [ESF-8 CIR Annex](#).

### ***Notifying IDPH of Activation of Crisis of Standards of Care***

Each hospital must notify IDPH when it activates its disaster response plan.

Hospitals can provide such notification by informing the RHCC that its disaster response plan has been activated. The RHCC will notify the IDPH Regional Emergency Medical Services Coordinator (REMSC), who will notify IDPH's Incident Command.

Hospitals should provide such notifications using the [Catastrophic Medical Incident Response Form](#) from the [ESF-8 CIR Annex](#). The form assists in communicating vital information to all healthcare and emergency management partners during a disaster in a uniform manner. [Attachment 5](#) of the [ESF-8 CIR Annex](#) also describes a Catastrophic Incident Management Pathway that outlines common communication pathways for the sharing of vital information, including communications to IDPH and other partners.

### ***Standards of Care during the COVID-19 Pandemic***

In evaluating necessary changes to the delivery of health care services, hospitals follow a tiered system that escalates from conventional to contingency to crisis standards.

At the extreme stages of a pandemic, hospitals may need to effectuate a crisis standard of care, which will be needed when the demands for space, supplies, and staffing are highly disproportionate to the available resources such that the hospital is forced to ration supplies and modify its standards of care. Specifically, crisis standards of care are “a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster.”

Hospitals implement crisis standards of care to identify how to deliver the best care possible given the extenuating circumstances, including when there are significant risks to patient safety.<sup>9</sup> Crisis care standards should be triggered based on the “exhaustion of specific operational resources that require a community, rather than an individual, view be taken in regard to resource allocation strategies.”

Hospitals may use the following guideposts in applying crisis care:

1. Crisis care should cover strategies that *extend or go beyond* surge capacity plans. Surge capacity is generally described as the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity.
2. Crisis care is likely to be activated during long-term events such as a pandemic like COVID-19 when there is no practical way to obtain critical resources.
3. Crisis care does not allow hospitals to delay patient care; the critical nature of the necessary health care will force immediate decisions.
4. Crisis care must gradually move backwards to contingency or conventional care as additional resources become available such as medication, equipment, and staffing.
5. Crisis care strategies should be updated throughout a crisis as needed, depending on ongoing resource shortages or increases.

Providers should be transparent about treatment plans when operating in crisis standards of care and accountable towards the communities they serve. The public should not be left in doubt as to how the health care system intends to respond to a pandemic like COVID-19.

### ***Ethical Principles and Crisis Standards of Care for COVID-19***

As health care providers review their crisis standards of care, the following ethical framework should guide patient care and allocation of resources:

- **Trustworthiness.** Hospitals must foster trust, paying special attention to relationships that differ in terms of power, voice, and influence (e.g., administration/staff, clinician/patient/family).
- **Fidelity to and non-abandonment of patients, staff, and community.** Hospitals must ensure the dignity and comfort of all patients, even when they cannot ensure that all of their needs are optimally fulfilled.
- **Benefitting persons and not harming them.** Hospitals must identify and weigh potential benefits, harms, and risks associated with clinical treatments with particular attention paid to ensuring the availability of supportive and palliative care to all.
- **Equity, fairness, and justice.** Hospitals should distribute essential health care supplies pursuant to a prospectively determined ethics framework. The framework may evolve as the pandemic and means to address it change. Processes should be transparent and take into consideration the voices and perspectives of those who are most affected and most vulnerable.
- **Privacy/Confidentiality.** Hospitals must protect patient privacy and ensure the confidentiality of communications required by conventional care standards. Crisis standards of care do not weaken fundamental obligations to protect the privacy and confidentiality of patient information.
- **Solidarity and community.** Hospitals must be guided by a principle of dignity for all persons and a shared responsibility for and to one another.
- **Stewardship of resources.** Hospitals must protect and conserve available resources in order to fulfill their obligations to provide essential patient care.

### ***Non-Discrimination in the Delivery of Health Care***

On April 9, 2020, the Governor's Office, along with IDPH, Illinois Department of Human Services, Illinois Department on Aging, and the Illinois Department of Human Rights, issued [Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 \(COVID-19\)](#). This guidance provides specific recommendations for the delivery of health care in a manner that promotes the fundamental principles of fairness, equity, and non-discrimination. It also highlights the need for hospitals to prevent biased decision-making that could result in discrimination based on disability or exacerbate racial disparities. Hospitals must adopt resource allocation plans and provide health care consistent with civil rights laws that prohibit discrimination in the delivery of health care.

### ***Ethical Conservation of Scarce Resources***

Shortages of supplies nationwide (such as personal protective equipment, testing materials, and ventilators) and increasing demands for health care workers, means that hospitals experiencing these situations must implement strategies now to conserve resources while they are available to prepare for rationing when they are not. When there is an imminent shortage of space, supplies, and staff, hospitals can use the following core strategies to prevent depletion of resources:

- **Prepare.** Pre-shortage actions such as stockpiling essential equipment can minimize the impact of resource scarcity.
- **Substitute.** Identify equivalent drugs, devices, or staff members that can be substituted when ordinary resources are scarce.
- **Adapt.** Use a drug, device, or staff member that will provide sufficient care when typical resources are unavailable.
- **Conserve.** Use less of a resource by lowering dosage or changing utilization practices. Conservation of face masks, medications, or other supplies, where appropriate, may allow hospitals to maintain some adequate level of resources.
- **Re-use.** Re-use items that might ordinarily be considered single use if appropriate sterilization or disinfection is possible.
- **Re-allocate.** Restrict use of resources to those patients with a greater need.

### ***Distribution of Scarce Resources***

An ethical framework for distribution of scarce resources must include a fair and transparent process that considers factors such as the following:

- **Non-discrimination.** As discussed in Section 3(a), rationing of resources must be grounded in principles of non-discrimination.
- **Team decisions.** As discussed in Section 3(d), hospitals must implement triage teams, rather than allowing individual providers to make allocation decisions.
- **Factors for de-prioritization.** The system of rationing resources should allow for de-prioritization of patients who are unlikely to benefit from the scarce resource or treatment based on factors such as: (1) risk of mortality or morbidity for a particular patient; (2) likelihood of good or acceptable response to a treatment or resource for a particular patient; and (3) community risk of transmitting infection and ability to reduce that risk by using a particular resource.
- **Palliative care.** Palliative care resources should be available to any patient to minimize pain and suffering.
- **Essential workers.** Hospitals should prioritize essential or key workers within the health care system in order to maintain acceptable staffing levels. This includes prioritizing available personal protective equipment to health care workers so they can continue to provide essential care.
- **Re-assessment.** Hospitals should continually assess the availability of resources in order to reallocate resources as needed.

- **Randomized selection.** After application of the above criteria, randomized selection processes may still be necessary if two patients are equally likely to benefit from a resource.

### ***Ventilators***

Perhaps the most difficult issue facing hospitals during the COVID-19 pandemic is the shortage of ventilators. Confronted by this issue, hospitals must rely upon a principled framework to guide their decisions for ventilator allocation when need exceeds supply. This framework should always aim to maximize positive health outcomes. Health care providers should begin their decision-making process with the premise that all patients should have the opportunity to be eligible for ventilator support. In order to prevent compounding existing health care access disparities, ventilator policies should not be based on a “first come, first serve” basis.

If the treating hospital does not have capacity to provide a ventilator, it should attempt to transfer a patient to another facility with available resources. If the potential receiving hospital has excess capacity, it should be willing to accept the transfer of patients or to provide unused ventilators to hospitals that are in high need of such resources and able to use them.

### ***Composition and Function of Triage Teams***

One of the key elements of crisis standards of care is having an established triage plan that removes decision-making from one individual. Triage teams prevent a single individual from having to make a unilateral decision on treatment and allocation of resources. Hospitals can adopt many different approaches to triage teams.

Hospitals should already have established triage teams in place to provide a consultative process on difficult treatment decisions. A triage team should have an assigned leader to manage the decision-making and should be comprised of a staff physician who specializes in infectious disease, nursing staff, hospital administration, and medical ethicists who have the ability to provide peer review. The bedside care team (i.e. the team providing treatment to the patient) should not be part of the triage team in order to maintain objectivity and avoid conflicts of interest. Instead, the treating physician should communicate the relevant medical background to the triage team.

The triage team is responsible for making scarce resource allocation decisions based on the hospital’s ethical framework. The team then makes treatment recommendations to the appropriate medical staff.

The hospital should have an appeals or review process in place to immediately review the triage team’s decision or recommendation in the event new information becomes available that would change the course of treatment. The appeals process should be conducted by a clinical care team or individuals who were not part of the triage team in order to avoid bias in a final decision.

During the COVID-19 pandemic, hospitals must not simply employ existing triage plans; instead, they should immediately review their triage team structures and principles to prepare for a potential crisis standard of care phase.