

HAWAI'I CRISIS STANDARDS OF CARE

TRIAGE ALLOCATION FRAMEWORK

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Hawai'i Crisis Standards of Care Triage Allocation Framework

Introduction

This triage allocation framework was developed through the collaborative efforts of the State of Hawai'i Critical Care Collaborative Committee and the Chief Medical Officers, in coordination with the Hawai'i State Department of Health (DOH). This State overarching guide acts as a foundational document.

Representatives were appointed by hospital leadership to serve on a group to develop, write and harmonize a triage allocation schema that would be utilized by the State's leaders in the event that medical treatment resources are scarce, and a State of Emergency is declared.

The core development team includes specialists in anesthesiology, critical care, emergency medicine, hospital medicine, infectious disease, internal medicine, neurology, oncology, palliative care, pediatrics, physical and rehabilitation medicine, radiology, transplant surgery and trauma surgery.

Health care entities additionally obtained input from ethics consultants, pharmacists, respiratory therapists, hospital leadership and members of the community. The plan was also reviewed by the DOH Developmental Disabilities Division. Triage models were created based on extensive review of current literature and in-depth discussion of the ethical principles involved.

This document is a living document, intended to be updated and revised to reflect timely advances. It was first promulgated by the Hawai'i Emergency Management Agency (HI-EMA) in August 2020 and posted on the HI-EMA website. The September 2021 version is promulgated by DOH and posted on the DOH website.

Whereas the current COVID-19 pandemic requires expeditious recommendations, this framework is created with the ability to be adapted for a future public health State of Emergency where conventional and contingency capacity is exhausted and crisis capacity is necessary.

Promulgated by:



Elizabeth A. Char, M.D., FACEP
Director of Health
September 15, 2021

Hawai'i Crisis Standards of Care Triage Allocation Framework

Core Development Team

To our patients, families and community:

Governor David Ige has declared a public health emergency. During this time, there has been thoughtful due diligence and planning for the management of resource and personnel shortages, all of which are critical to pandemic response.

Usually, there are no shortages and everyone who needs and wants advanced life-saving care can receive it. If the public health emergency moves into a public health crisis, our supply of some life-saving medical resources may become hard to find. In this very tough situation, when there is not enough, doctors will work with a team of other doctors, nurses and specialists in ethics to decide (triage) which patient is most likely to be helped by the scarce resources.

Every hospital is working together to use resources in a way that is fair for everyone. The State of Hawai'i has developed this Triage Allocation Framework, which includes guidelines to help doctors make these tough decisions in a worst-case scenario. National and international literature was reviewed to develop guidelines for Hawai'i. These guidelines help distribute scarce resources equally, fairly and consistently. The goal is to do the greatest good for the greatest number of people in a consistent way.

Please know that we care deeply about you and your family's health and are doing our best to protect and serve you and our community.

What this means for you and your family:

1. This plan does NOT take your physicians away from your care.
2. Decisions will not be based on reasons such as race, ethnicity, gender, sexual orientation, disability status, limited English proficiency, perceptions of societal worth, immigration status, religion, insurance status or socio-economic and housing status.

Decisions will be based on the patient's current medical condition and the possibility of getting better.

There are additional questions answered in the Frequently Asked Questions.

Our Promise:

- We honor patients and families through our life saving efforts knowing that we will not be able to save everyone, but we will try our best.
- We believe all people deserve compassion and dignity.
- We are committed to supporting our community, utilizing every resource we have.
- We will strive to make a difference each day and will never stop caring for you and your loved ones.

Sincerely,

Triage Allocation Framework Core Development Team

Hawai'i Crisis Standards of Care Triage Allocation Framework

Core Development Team

The following is a list of the representatives and their role at the time of this document's core development:

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** The opinions and assertions expressed herein are those of the individuals and do not necessarily reflect the official policy or position of the Hawaii Military Health System or the Department of Defense.*

Hawai'i State Crisis Standards of Care Triage Allocation Framework

Executive Summary:

This document provides guidance for clinicians in the State of Hawai'i in the event of a pandemic, mass casualty situation, and/or a natural disaster where the demand for critical care resources outstrips supply and triage and allocation of resources throughout the State becomes paramount to the well-being of its People.

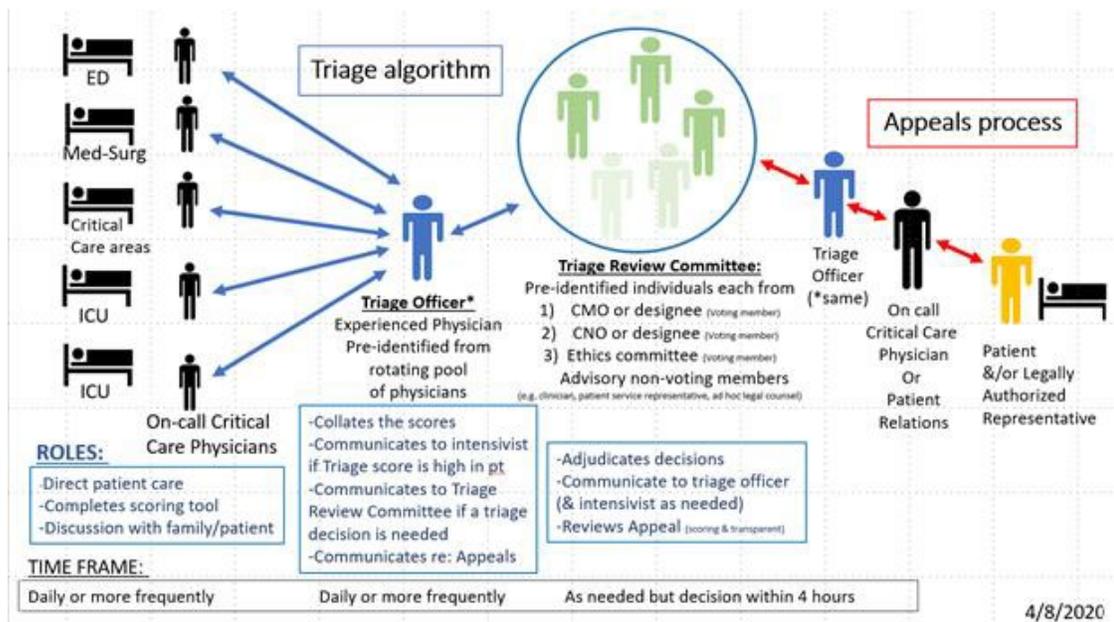
Under the directive of the State of Hawai'i, Hawai'i Emergency Management Agency (HIEMA) and the Healthcare Association of Hawai'i (HAH) and through the collaborative efforts of the State of Hawai'i Critical Care Collaborative Committee and the Chief Medical Officers represented by HAH, this harmonized triage allocation schema has been developed following extensive review of the current literature, in-depth discussion of the ethical principles involved and extended reach with clinicians and key representatives throughout the healthcare delivery system.

The allocation framework is grounded in ethical obligations that include the duty to care, duty to steward resources to optimize population health, distributive and procedural justice, and transparency. It is consistent with current recommendations for how to allocate scarce critical care resources during a public health emergency.

The plan will be enacted only if: 1) critical care capacity is, or will shortly be, exceeded; or 2) a state-level authority has declared a State of Emergency. The triage plan should be implemented Statewide to avoid large variations in critical care access.

The Triage Allocation Plan includes the essential components needed to operationalize a plan across the State, including:

1. The triage/prioritization algorithm and the patient characteristics upon which it is based;
2. The process of implementation of the triage algorithm by a triage officer/team at the hospital level which may vary depending on the individual hospital workflow;
3. An Appeals Process available to patients, families, or clinicians who disagree with triage decisions to ensure procedural fairness and provide a mechanism to resolve such disputes; and
4. A Triage Review Committee to adjudicate appeals to which a patient, their legally authorized representative, and/or the bedside health care team on behalf of their patient, can advocate without a conflict of interest.



I. Purpose

To provide guidance for clinicians in the State of Hawai'i in the event of a pandemic, mass casualty situation, and/or a natural disaster where the demand for critical care and/or resources outstrips supply and triage and allocation of resources throughout the State becomes paramount to the well-being of its People.

II. Method

Under the directive of the State of Hawai'i, Hawai'i Emergency Management Agency (HIEMA) and the Healthcare Association of Hawai'i (HAH) and through the collaborative efforts of the State of Hawai'i Critical Care Collaborative Committee and the Chief Medical Officers represented by HAH, this triage allocation plan was developed. Healthcare entities convened members of their critical care providers, ethics consultants, pharmacy, respiratory therapists, hospital leadership, palliative care and members of the community. The plan was also reviewed and approved by the Hawai'i State Department of Health Developmental Disabilities Division. Triage models were created based on current literature. Representatives were appointed by hospital leadership to serve on a group to harmonize a triage allocation schema that would be utilized by the State's leaders in the event that resources are scarce, and a State of Emergency is declared.

III. Ethical Principles

A. This allocation framework is grounded in ethical obligations that include the duty to care, duty to steward resources to optimize population health, distributive and procedural justice, and transparency. It is consistent with current

recommendations for how to allocate scarce critical care resources during a public health emergency.

- B. Consistent with accepted standards during public health emergencies, the primary goal of this allocation framework is to maximize benefit to populations of patients, often expressed as “doing the greatest good for the greatest number of people.” It should be noted that this goal is different from the traditional focus of medical ethics, which is centered on promoting the wellbeing of individual patients. This allocation framework operationalizes the broad public health goal by giving priority for critical care resources to patients who are most likely to meaningfully survive to hospital discharge and beyond.
- C. It is intended for this allocation framework to be applied in a consistent manner, within individual institutions and, to the extent possible, across the State. The principles and processes of this framework have been developed to ensure that like cases are treated alike, and that no person receives better or worse treatment due to factors that are not relevant to medical prognosis such as race, national origin, ethnicity, gender, sexual orientation, disability status, limited English proficiency, perceptions of societal worth, immigration status, religion, insurance status, and socio-economic and housing status.
- D. Decisions by institutions concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient and his or her clinical condition based on the best objective medical evidence.
- E. Based on the inventory of resources that will be maintained by a state command center under the direction of the designee of the Governor of the State of Hawai'i, resources will be provided to the areas and centers of greatest need and where they will do the most good, in keeping with the ethical principles stated above.
- F. Establishment of a framework provides for the description of a reasonable standard of care to be applied in a pandemic/mass casualty, or natural disaster. If critical care resources are exceeded by demand, a previously defined standard needs to be available for reference by healthcare providers. This will allow for patient care decisions to be made using a framework and avoid decisions influenced by advocacy. The presence of a framework serves the public welfare by providing protection of healthcare services following resolution of the pandemic by establishing a standard of care that is reasonable in the circumstances to be applied in future civil or criminal litigation.

IV. Activation of the Triage Allocation Plan

- A. Before the plan is implemented, facilities must develop surge capacity to meet the anticipated demand for critical care beds, ventilators, and other essential resources, equipment, medications and supplies immediately upon awareness or forewarning that a pandemic/disaster is imminent.
- B. The plan should be enacted only if: 1) critical care capacity is, or will shortly be, exceeded; or 2) a state-level authority has declared a State of Emergency. Action must be taken to conserve scarce resources, such as equipment, medication, and staffing with such steps as limiting elective procedures that

require ventilators and by adjusting staff-to-patient ratios, while maintaining safe practices.

- C. This triage plan should be implemented by each hospital statewide to avoid large variations in critical care access, and access to other critical care modalities such as ventilator access or advanced care, to ensure a fair distribution among facilities, and to ensure that the same resources are available to the populace of Hawai'i based on the ethical principles stated above. Public acceptance will be based on the fairness of the triage allocation algorithm and transparency. A fair process would require resources to be fairly distributed to the hospitals in greatest need to provide the greatest good and not to preferentially exclude hospitals based on geographical location or other non-clinical reasons.

V. The Triage Allocation Plan

Triage allocation requires essential components to operationalize a plan across the State.

- A. The triage/prioritization algorithm and the patient's clinical characteristics upon which it is based.
- B. The process of implementing the triage mechanism by a triage officer/team at the hospital level may vary depending on the individual hospital's workflow.
- C. An Appeals Process available to patients, families, or clinicians who disagree with triage decisions to ensure procedural fairness and provide a mechanism to resolve such disputes; and
- D. A Triage Review Committee to adjudicate appeals to which a patient, their legally authorized representative, and/or the bedside health care team on behalf of their patient, can advocate without a conflict of interest.

VI. Triage Mechanism

- A. Includes three key elements: 1) a Rapid Allocation Triage; 2) the Triage Allocation Scoring System and its process of implementation; and 3) Reassessment:
 - 1. Rapid Allocation Triage for Intensive Care Unit (ICU) admission/ventilation/scarce resource **PRIOR** to utilization of the below Triage Allocation Scoring System
 - a) Purpose: Time may be of the essence when evaluating patients for critical care management and mechanical ventilation, as such, there are criteria that have been utilized in other U.S. settings [NY] to rapidly determine when a patient is clinically not a candidate for these advanced services, independent of their infectious status. It is important to note that there are some conditions that lead to immediate or near-immediate death despite aggressive therapy such that during routine clinical circumstances clinicians do not provide critical care services (e.g., cardiac arrest unresponsive to appropriate ACLS/PALS, massive intracranial bleeds, intractable shock). During a public health emergency, clinicians should still make clinical judgments about the appropriateness of critical care,

but in a public health state of emergency, these immediate factors will be triaged differently.

- b) A patient who is not a candidate for scarce critical care resources during State of Emergency (independent of infectious status) include:
 - (1) Cardiac arrest unresponsive to standard interventions and measures;
 - (2) Irreversible hypotension unresponsive to fluid resuscitation and vasopressor therapy;
 - (3) Severe traumatic brain injury with only extensor posturing or no motor response to painful stimulus related to the neurological injury (e.g., not pharmacological effect);
 - (4) Severe burns where predicted survival $\leq 10\%$ even with unlimited aggressive therapy;
 - (5) Any other conditions resulting in immediate or near-immediate mortality even with aggressive therapy; and
 - (6) A valid POLST (Providers Order for Life Sustaining Therapy) or a LAR specifies comfort measures or limited interventions only.
 - c) Patients who are not critical care candidates will continue to receive medical care including intensive symptom management and psychosocial support. Where available and appropriate, specialist palliative care teams will provide additional support and consultation.
2. Triage Allocation Scoring System and Process (Table 1A/B)
- a) All adult patients who meet usual medical indications for ICU beds and services will be assigned a priority score using a 1-8 scale (lower scores indicate higher likelihood of benefit from critical care), derived from: 1) patient's likelihood of surviving to hospital discharge, assessed with an objective and validated measure of prognosis based on acute physiology such as the Sequential Organ Failure Assessment (SOFA) score (Table 2); and 2) patient's likelihood of achieving longer-term survival based on the presence or absence of comorbid conditions that may influence survival.
 - b) Point total is the summation of: a) the adult patient's SOFA score (range from 1 to 4 points) (or mSOFA score, see below); and b) the presence of comorbid conditions (2 points for major life-limiting comorbidities and 4 points for life-limiting comorbidities) likely to cause death within a year (Table 4).
 - c) Every effort should be made to complete the initial triage assessment within 30 minutes of the recognition of the need for the scarce resource using a SOFA score. However, in an emergent situation where laboratory results are not able to be

obtained in a timely manner, a Modified Sequential Organ Failure Assessment (mSOFA) may be utilized (Table 3). Literature supports the use of the mSOFA score (Table 3) as a surrogate for a traditional SOFA score. [Grissom]

d) Point assignment for SOFA scores of adult patients who have a documented COVID-19 infection will be different given known prognostic data specific for COVID-19 infection. [Zhou]

- e) Short-term prognosis (SOFA) and long-term prognosis points are then added together to produce a total priority score, which ranges from 1 to 8. Lower scores indicate higher likelihood of benefiting from critical care, therefore priority will be given to those with lower scores.
- f) **Pediatric patients (<18 yo)** will be assessed using physician clinical judgment as no assessment scores (e.g., PELOD-2, PRISM III, PIM2) have been validated for the pediatric population (see below Pediatric Considerations).
- g) For each critical care patient, a clinician will provide a triage score at least daily. Similarly, each patient being evaluated for admission to critical care services (e.g from the emergency department or medical surgical floor), will also be given a triage score by a clinician providing care to that patient.
- h) Scoring sheets will be given to the Triage Officer who will collate the information.
- i) The Triage Officer identifies those patients that have the highest triage score (i.e. lowest priority) and will communicate this to the intensivist/physician managing that low priority patient.
- j) The physician managing this patient will communicate to the patient/legally authorized representative (LAR) the severity of the patient's illness and the high likelihood that removal of intensive care modalities and institution of palliative measures is likely and provide emotional support and resources. Additionally, if the patient/LAR discusses concerns, they will be informed regarding the appeals process.
- k) In the event that a conflict for a scarce resource is identified, the Triage Officer will contact the Triage Review Committee.
- l) The Triage Review Committee will review the case and make a decision based on medical factors that informed the decision. Factors that are not relevant are listed in section III.C, above.
- m) Of note, advanced age was rejected as a primary triage criterion because it discriminates against the elderly. Age already factors indirectly into any criteria that assess the overall health of an

individual because the likelihood of having chronic medical conditions increases with age and there are many instances where an older person could have a better clinical outlook than a younger person. Thus, clinical factors (with the exception of the COVID-19 disease-specific age criterion based upon the known poor prognosis with older age) will be used to evaluate a patient's likelihood of survival and to determine the patient's triage priority unless there is a case of equal priority and can be a factor in as a "tie-breaker" (see below).

- n) In the event that there are ties in priority scores between patients, the Triage Review Committee shall make the final determination of priority and may take into other clinical considerations that are not reflected in the Triage Score including life-cycle considerations.
- o) Available critical care resources will be allocated according to priority score, such that the availability of these services will determine how many patients will receive critical care.
- p) Patients who are triaged to not receive critical care services will be offered medical care including symptom management and psychosocial support through social work and spiritual support. Where available and appropriate, palliative care teams will provide additional support and consultation.
- q) The attending physician or designee will document the DNAR status in the chart that may be modeled after language found in Appendix A.

Table 1A. COVID-19 PANDEMIC - Adult Triage Allocation Scoring System

(Highest priority to lowest score of A+ B)

Scoring	Principle	Specification	Point System*			
			1	2	3	4
A	Save the most lives	<i>Prognosis for short-term survival (SOFA score*)</i>	SOFA score ≤ 8	SOFA score 9-11	SOFA score 12-14	SOFA score >14
	COVID-19 Negative**					
	OR					
	Save the most lives	<i>Disease-specific prognosis for short-term survival specific to COVID-19</i>	SOFA score ≤ 4		SOFA score $\geq 5-14$	SOFA score >14
	COVID-19 Positive**					
PLUS						
B	Save the most life-years	<i>Prognosis for long-term survival (medical assessment of comorbid conditions)</i>	...	Major comorbid conditions* with substantial impact on long-term survival	...	Severely life-limiting conditions; ** death likely within 1 year

8/7/2020

Scoring: **A + B = Total Priority Score**

(Minimum score is 1; Maximum score is 8)

** The first line of A should be used to score the COVID -19 negative patient; however, if the patient is COVID-19 positive, the second line of A, "Disease-specific prognosis for short term survival specific to COVID-19" should be utilized instead to score that patient with SOFA. The lowest score assigns the highest priority for critical care services.

*SOFA= Sequential Organ Failure Assessment

* Consideration to use mSOFA score (See Table 3) if unable to obtain laboratory tests in a timely manner.

Table 1B. Sample- Adult Triage Allocation Scoring System -
 (Highest priority to lowest score of A+B)

Scoring	Principle	Specification	Point System*			
			1	2	3	4
A	Save the most lives	<i>Prognosis for short-term survival (SOFA score*)</i>	SOFA score ≤ 8	SOFA score 9-11	SOFA score 12-14	SOFA score >14
	OR					
	Save the most lives	<i>Disease specific prognostic factors if information exists for disease</i>				
PLUS						
B	Save the most life-years	<i>Prognosis for long-term survival (medical assessment of comorbid conditions)</i>	...	Major comorbid conditions* with substantial impact on long-term survival	...	Severely life-limiting conditions ** death likely within 1 year

Tables 1A and 1B Clarification: Triage criteria in a pandemic/mass casualty/natural disaster would utilize the triage prioritization criteria in Table 1B. This allocation tool, based on previous published work, included input from clinicians, ethicists, public health lawyers, communication experts with citizen participation and community engagement forums [Daughtery Biddison EL 2019]. The pandemic (COVID-19) that emerged in 2020 is caused by a

novel Severe Acute Respiratory Distress Syndrome due to the novel Coronavirus-2 (SARS-CoV2). Table 1A should be utilized in this situation. Current literature (reviewed up to Aug 2020) and expert opinion recommend that a triage allocation scheme should, if possible, account for known disease-specific prognostic indicators, so such a triage tool can be fairly utilized for both the non-infected patient and the patient infected with COVID-19. Literature from China, the US, and other parts of the world, show that a lower SOFA score than normal would be considered deadly (i.e. SOFA > 4), and older age are independently associated with a higher short-term mortality. For this reason, in Table 1A, the score found in the A column for a COVID-19 infected patient, accounts for the changes of cut-points for SOFA score. Age will not primarily be used in this triage scoring tool and can be considered in a tie-breaker situation. In the situation that more data emerges that will help further define short-term prognostic indications for this specific disease, i.e., COVID-19, Table 1A will be modified accordingly. In the event a disaster occurs in the future with known prognostic indicators, Table 1B allows the addition of these clinical factors as was done for the COVID-19 pandemic.

Table 2: Sequential Organ Failure Assessment (SOFA score)

Organ System	0	1	2	3	4
Respiratory: PaO ₂ /FIO ₂ mm Hg	>400	301-400	201-300	101-200 with respiratory support	≤100 with respiratory support
Liver: Bilirubin mg/dL	<1.2	1.2-1.9	2.0-5.9	6.0-11.9	>12.0
Coagulation: Platelet (x10 ³ /mm ³)	>150	101-150	51-100	21-50	≤20
Cardiovascular : Hypotension	MAP >70	MAP <70 mmHg	Dopamine ≤5 mcg/kg/min OR dobutamine any dose	Dopamine >5mcg/kg/min OR Epinephrine ≤0.1 mcg/kg/min OR Norepinephrine ≤0.1mcg/kg/m in	Dopamine >15 mcg/kg/min OR epinephrine >0.1 mcg/kg/min OR norepinephrine >0.1mcg/kg/min
Nervous system: Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal: Cr mg/dL	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5.0

Table 3. Modified Sequential Organ Failure Assessment (mSOFA) Score

May be utilized to obtain a triage allocation score when time is of the essence and laboratory testing will delay scoring

Organ System	0	1	2	3	4
Respiratory: SpO ₂ /FIO ₂	>400	≤400	≤315	≤235	≤150
Liver:	No scleral icterus or jaundice			Scleral icterus or jaundice	
Cardiovascular: hypotension	MAP >70	MAP <70 mmHg	Dopamine ≤5 mcg/kg/min OR dobutamine any dose	Dopamine >5mcg/kg/min OR Epinephrine ≤0.1 mcg/kg/min OR Norepinephrine ≤0.1mcg/kg/min	Dopamine >15 mcg/kg/min OR epinephrine >0.1 mcg/kg/min OR norepinephrine >0.1mcg/kg/min
Nervous system: Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal: Cr mg/dL	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5.0

Table 4. Examples of Major Comorbidities and Severely Life Limiting Comorbidities

Examples of Major comorbidities* (associated with significantly decreased long-term survival)	Examples of Severely Life Limiting Comorbidities** (commonly associated with survival < 1 year)
<ul style="list-style-type: none"> · Moderate Alzheimer’s disease or related dementia (Functional Assessment Staging Test [FAST] 5-6) · Malignancy with a < 10 year expected survival · NYHA Class III heart failure · Moderately severe chronic lung disease (COPD, IPF) · Primary pulmonary HTN with WHO Class III heart failure · Severe multivessel CAD · ESRD (ie. on dialysis) · Cirrhosis with history of decompensation 	<ul style="list-style-type: none"> · Severe Alzheimer’s disease or related dementia (FAST ≥7) · Cancer being treated with only palliative interventions including palliative chemotherapy or radiation · Advanced lung disease w/FEV1<25% predicted, total lung capacity< 60% predicted; baseline PaO2 <55 mm Hg · Severe chronic lung disease plus frailty · NYHA Class IV heart failure plus frailty · Primary pulmonary HTN with WHO class IV heart failure · Chronic liver disease Child-Pugh >7

3. Reassessment for ongoing provision of critical care/mechanical ventilation
 - a) During a public health emergency when there are not enough critical care resources for all, the goal of maximizing population outcomes would be jeopardized if patients who were determined to be unlikely to survive were allowed indefinite use of scarce critical care.
 - b) Periodic reassessments will be performed on all patients receiving critical care services during times of crisis (i.e., not merely those initially triaged under the crisis standards).
 - c) The timing of reassessments will be at least once a day with more frequent assessments as necessary.
 - d) Assessments should be based on an evolving understanding of the causative disease trajectories and severity of the crisis.
 - e) A multidimensional assessment should be used to quantify changes in patients’ conditions, such as recalculation of severity of illness scores, appraisal of new complications, and treating clinicians’ input.
 - f) Patients showing improvement may continue to receive critical care services until the next assessment.
 - g) If a patient's clinical condition deteriorates to a point that implies a low likelihood of survival, the care team will initiate a discussion with the

family and withdraw life sustaining treatment as appropriate. If the family is not in agreement, the patient will be prioritized as usual by the triage allocation scoring system.

- h) If critical care and mechanical ventilation are withdrawn, the patient will receive medical care including intensive symptom management and psychosocial support. Where available and appropriate, specialist palliative care teams will provide additional support and consultation.

VII. Implementation process

A. Triage Officer (Figure 1)

1. Purpose: The patient's treating physicians will not make triage decisions. Conversely the triage officer and triage review committee members will not have direct patient care of the patients involved in a specific triage decision. Separating the triage role from the clinical role is essential for effective scarce resource allocation to enhance objectivity, avoid conflicts of commitments, minimize moral distress/burnout and for clinicians to sustain their integrity as healers.
2. Responsibility: This individual will oversee the triage process, review the triage scores, communicate with treating physicians, and direct attention to the highest priority patients, and in times of lack of resources, identify patients based on the scoring system who have a lower priority for those resources. S/he is expected to make decisions according to the allocation framework which is designed to benefit the greatest number of patients, even though these decisions may not necessarily be best for some individual patients.
3. With input from the Triage Review Committee described below, s/he is also empowered to make and communicate decisions regarding reallocation of critical care resources that have previously been allocated to patients, again using the principles and processes in this document.
4. Process of Selection: A pool of triage officers will be pre-identified and selected by representatives of the clinical areas responsible for direct patient care. A process for approval of the roster will be reflective of the organizational/functional structure of the healthcare entity (e.g., CEO or designee, on recommendation of the MEC). Desirable qualities of triage officers include a physician with established expertise in the management of acutely ill patients (e.g., critical care, emergency medicine physicians, anesthesiologists, hospitalists), strong leadership ability, and effective communication and conflict resolution skills.
5. Duty Hours: The triage officer(s) will always be available on short notice, and they will have sufficient rest periods between shifts. A call schedule will be made when a disaster is identified. Ideally, the triage officer on call will have no other clinical responsibilities at the time s/he is serving in this role. Optimally, the triage officer should function in shifts lasting no

longer than 13 hours (to enable 30 minutes of overlap and handoffs on each end). Therefore, there should be two shifts per day to fully staff the triage function. The triage officer will be readily available to the clinical teams during their call period.

B. Triage Review Committee (Figure 1)

1. Purpose: It is possible that patients, families, or clinicians will challenge individual triage decisions. Procedural fairness requires the availability of an appeals mechanism to resolve such disputes. Initial triage decisions for patients awaiting the critical care resource will likely be made in highly time-pressured circumstances. Therefore, an operationally feasible real-time appeals process is necessary. This committee will provide consistency, transparency, and fairness in the decision-making process; and may mitigate the burnout, stress and moral injury experienced by healthcare providers on the front lines during a public health emergency.
2. Members: A Triage Review Committee is composed of at least three (3) voting members:
 - a) The Chief Medical Officer or his/her designee (Physician)
 - b) The Chief Nursing Officer or his/her designee (Nurse)
 - c) A member of the Ethics Committee
3. In the event a hospital does not have an ethics committee, an ethics representative may be consulted from the State Emergency Ethics Resource Pool. (see below).
4. Additionally, other non-voting, advisory members of this committee might include:
 - a) A Patient Services Representative or community member if possible.
 - b) A clinician who is not involved in the direct care or triage of the patients who are the subjects of a specific triage decision. In this setting, the role of the clinician is to give additional clinical perspective to other committee members.
 - c) Ad hoc legal counsel as necessary.
5. In difficult decisions, even if a member of the hospital's ethics committee is available, the Triage Review Committee might consider input from members of the State Emergency Ethics Consultation/Resource Pool.
6. A roster for each position including alternatives for each position will be identified in advance with a call schedule that is readily available.
7. Decision-making:
 - a) Quorum: Three committee members are needed for a quorum to render a decision, using a simple majority vote. The process can happen by telephone, in-person, or by teleconferencing.
 - b) Timeliness: This committee will meet in a timely manner as clinically indicated, but no more than 4 hours after identification of the need for decision-making.

- c) Documentation of the decision and discussion with the patient/legally authorized decision maker will be placed in the electronic medical record.
 - d) For future reference and as may be needed for appeals, scoring sheets may be archived as per hospital policy.
8. Difficult decisions or “tie-breakers”: in the event that the triage algorithm scores equally for patients, other factors should be considered by the Triage Review Committee. These include: a) Life-cycle considerations; b) Age; c) Additional clinical considerations; d) Pregnancy; and e) Contribution to the public health response.
- a) Life-cycle considerations will also be used as a tiebreaker, if there are not enough resources to provide to all patients within a priority group, younger patients will be prioritized.
 - b) Age is used only in a tie-breaking situation. Evidence from multiple countries including the U.S. show that age >65 yo is an indicator for poor prognosis in COVID-19 patients. If the triage score is equal between two individuals, the Triage Officer/Review Committee should use the consideration that a patient >65 yo who is also COVID-positive is less likely to benefit from the scarce resource.
 - c) Additional Clinical Conditions: the clinicians in the Triage Review Committee can help inform the group of additional clinical factors that may impact long-term or short-term survival and inform the decision further.
 - d) Special considerations for pregnant women: while pregnant women will undergo the same initial triage mechanism as all adult patients, those eligible for ventilator allocation may receive priority over other adults of the same priority group in the case of a tie if an obstetrical evaluation confirms the viability (≥ 24 weeks of gestation) and health of the fetus. This decision is not based on a social valuation of parenthood, which may unfairly favor those who desire to have children or disadvantage those unable to become pregnant. Rather, this criterion affirms the triage protocol’s goal of saving as many lives as possible by protecting the health of both mother and fetus.
 - e) When the above considerations as tiebreakers are unable to prioritize the individuals, the premise of “doing the greatest good for the greatest number” should be operative.

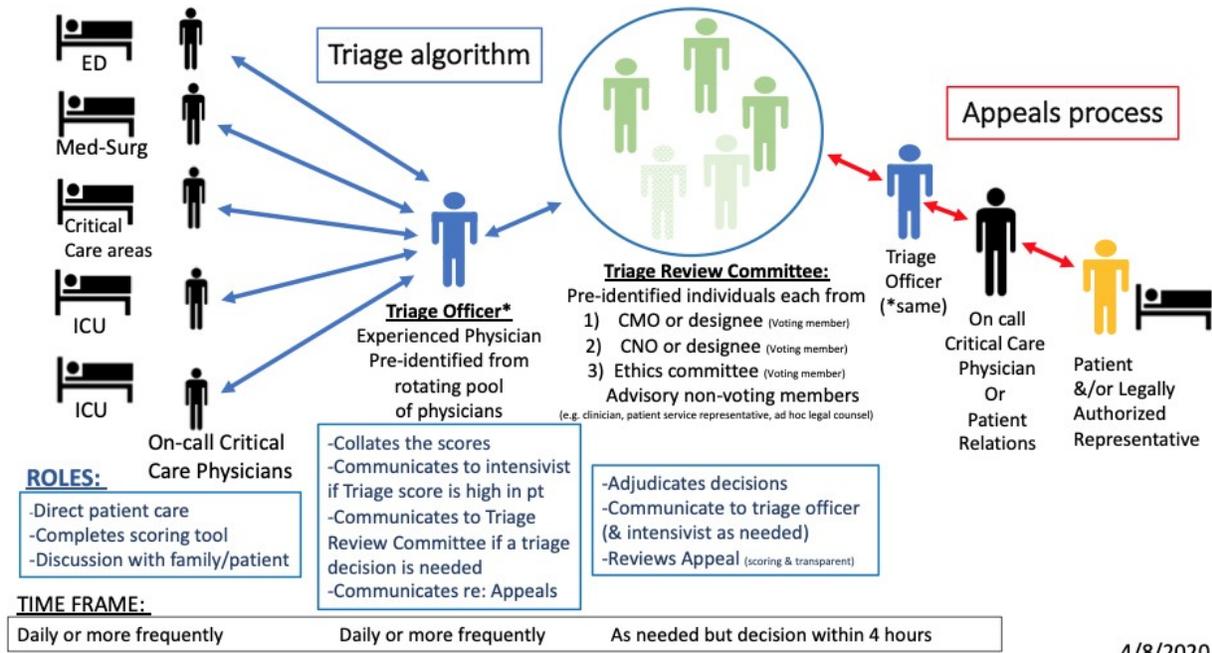
VIII. Appeals Process for individual triage decisions

- A. Purpose: Procedural fairness requires the availability of an appeals mechanism should patients, families, or clinicians wish to challenge individual triage decisions. On practical grounds, different appeals mechanisms are needed for the initial decision to allocate a scarce resource among individuals, none of whom are

currently using the resource, and the decision whether to withdraw a scarce resource from a patient who is clinically deteriorating. Initial triage decisions for patients awaiting the critical care resource will likely be made in highly time-pressured circumstances. Therefore, an operationally feasible appeal process will need to be adjudicated in real time.

- B. For the initial triage decision, we recommend that the only permissible appeals are those based on a claim that an error was made by the triage team (bedside critical care physician and triage officer) in the calculation of the priority score. The process of evaluating the appeal should include that the triage officer verifies the accuracy of the priority score calculation by recalculating the score.
- C. For appeals of decisions including withdrawal or withholding a scarce resource from a patient who is already receiving it or for unilateral Do Not Attempt to Resuscitate (DNAR), there is a robust appeals process that depends upon more clinical judgment than initial allocation decisions. The appeals process includes the following steps.
 - 1. The appeal should be immediately brought to a Triage Review Committee.
 - 2. The Triage Review Committee members who review the appeal are NOT the same individuals that made the original triage decision.
 - 3. The individuals who are appealing the triage decision should explain the grounds for their disagreement with the triage decision.
 - 4. An appeal may not be brought based on an objection to the overall allocation framework.
 - 5. The triage officer/team should explain the grounds for the triage decision that was made.
 - 6. The appeals process must occur quickly enough that the appeals process does not harm patients who are in the queue for the scarce resource.
 - 7. The decision of the Triage Review Committee for a given hospital will be final.
 - 8. Periodically, the Triage Review Committee should retrospectively assess whether the review process is consistent with effective, fair, and timely application of the allocation framework.

Figure 1. Triage Algorithm and Appeals Process



4/8/2020

IX. Establishing Resuscitation Status

A. Process for unilateral DNAR

1. Clinicians should pre-identify patients with severe life-threatening comorbidities (e.g. death is likely within one year (Table 4): 1) in the emergency department, medical-surgical floor, or critical care area; 2) currently on mechanical ventilation; and 3) other patients not currently mechanically ventilated, but clinically appear to be at high risk for mechanical ventilation or needing critical care services.
2. The attending physician should explain to the patient/LAR regarding the criteria and process that is used in the decisions for resuscitation (CPR) and mechanical ventilation when needed and discuss the appropriateness of DNAR status.
3. If the patient and/or LAR disagree with a DNAR status, a triage allocation score will be obtained by the attending physician or designee and the triage officer will be notified. The triage officer will inform the patient/LAR regarding the patient's severity status and if not meeting the criteria for resuscitation and/or critical care, then that patient will have a DNAR status.
4. Informed assent of DNAR status should be obtained but is not required.
5. The patient/LAR can use the same appeals process as delineated above.
6. The attending physician or designee will document the DNAR status in the chart that may be modeled after language found in Appendix A

B. Process for unilateral removal of mechanical ventilation

1. In the extreme situation where all ventilator resources have been used, fair reallocation must be considered to maximize benefit for the greatest number. The same triage scoring system will be applied to all patients on ventilators in the fashion stated above. The triage officer will notify the attending physician of those patients with the highest scores, the attending physician will work with the triage officer to determine the most appropriate person to communicate with the patient's legally authorized representative notifying him/her of the possibility for removal of mechanical ventilation
2. Appeals can be made according to the appeals process. If the triage review committee supports the removal of mechanical ventilation, this will be communicated to the attending physician and family and the care team will proceed accordingly.
3. Social work and hospital ministry should be made available to the patients, families, and the health care team.
4. After extubation, these patients will continue to receive medical care including intensive symptom management and psychosocial support. Where available and appropriate, specialist palliative care teams will provide additional support and consultation.
5. Family presence may happen in accordance with visiting rules of the hospital.
6. The attending physician or designee will document the DNAR status in the chart that may be modeled after language found in Appendix A.

X. Legal Liability During a Public Health Emergency

- A. The standard of care against which clinicians and health care entities will be judged in a public health emergency (e.g. a pandemic) when this triage allocation plan is activated is not the same as the standard of care under ordinary circumstances.
- B. Therefore, a Governor's proclamation or order to expressly immunize all healthcare clinicians and healthcare entities from civil and criminal liability for decisions made in good faith application of this Hawai'i triage allocation framework is critical for its effective implementation.
- C. Such language should specifically state that "A health care provider-- including healthcare facilities and committees described in the Hawaii triage allocation framework -- is immune from civil or criminal liability if the health care provider acts in good faith and under a catastrophic health emergency proclamation"

XI. Central Ethics Consultative/Resource Pool

- A. Purpose: The State Triage Allocation Plan is centered on the important ethical obligations of the duty to care, duty to steward resources to optimize population health, distributive and procedural justice, and transparency. As healthcare entities implement this framework there will be value in ethics expertise. For

example, a person trained or experienced in ethical principles is a key element of a Triage Review Committee. As this is an expertise that may not be found in all centers, having a central statewide consultative resource pool will ensure broader access. Additionally, a healthcare entity's triage review committee may wish to seek additional expanded input.

- B. Constituents: Current or previous experience on a hospital ethics committee as an ethicist (which may include a background as a clinician, chaplain, social worker) and available on short notice.
 - 1. Process of selection. Hospital leadership may sponsor an individual with the above qualifications to be a member of the pool. Individuals wishing to volunteer, without a hospital sponsorship (e.g., retired clinician or ethicist who previously served on a hospital ethics committee) may be sponsored through the HAH.
- C. Activation: Immediately or with initial warning of an impending pandemic, natural disaster, or mass casualty event; a roster of available ethicists as above will be made available to healthcare entities through HAH and/or the incident command designee.

XII. Pediatric Considerations

- A. Pediatric prognostic scoring systems currently available (e.g., PELOD2) are unable to accurately predict patient outcomes and thus should not be used as a sole indicator of prognosis especially in a disaster situation. Adult scoring systems such as SOFA have not been validated in the pediatric population and should not be used. When considering critical care resource allocation in a crisis, it is recommended that decisions be made by a Triage Team ideally comprised of clinicians skilled in the care of children (i.e., clinicians, triage officer). Decisions should be made based on best clinical judgment with full knowledge of regional resource availability.

XIII. Special circumstances

- A. Patient with an FDA-approved long-term ventilator from home
 - 1. A situation may arise in which a patient who requires chronic ventilation on an outpatient basis, requires hospital admission. In a scarce resource situation, that patient may delay seeking immediate and timely acute care due to concerns of "losing" their personal long-term home ventilator to the general ventilator pool of the hospital or State. To allay concerns that would result in delay in care and worsen outcome the following guidelines will be followed:
 - a) That patient will not enter the triage allocation plan for prioritization of the ventilator as long as the long-term home ventilator is adequate for the patient's clinical needs, i.e. the patient will remain on his/her own home ventilator.

- b) If the patient worsens and requires a higher performing ventilator for survival, the patient will be scored by way of the triage allocation scoring system.
 - (1) If the patient does not prioritize to a ventilator, the patient will not receive a hospital-supplied critical care ventilator but may remain on his/her own ventilator
 - (2) If the patient is prioritized to a hospital-supplied ventilator, the patient will be placed on a hospital-supplied ventilator. The patient's home ventilator will be utilized by another patient requiring mechanical ventilation if that ventilator is deemed safe and functioning properly as evaluated by the hospital's biomedical technicians and by respiratory therapy. It will be tagged so that the ventilator will be RETURNED to the owner/patient when the owner/patient is able to be transitioned back to that ventilator. The non-owner/patient who was using that home ventilator, will be transitioned to a hospital ventilator since one will then be available by the owner/patient's ability to relinquish a hospital ventilator back to the hospital ventilator pool.

B. Extracorporeal Membrane Oxygenation- [see ECMO protocol shared by QMC]

C. Research subjects: It was considered to extend higher prioritization of resources to individuals who are research subjects of studies directly related to the public health emergency, since their participation in the study trial may provide information that will contribute to the public health response by increasing the scientific knowledge of how to prevent or treat the cause of the State emergency. However, this would be considered undue influence in the voluntary consent of participation in a research study.

XIV. Alternative ventilation:

- A. **Manual ventilation-** Families may not manually ventilate the patient. This poses an exposure safety risk to families, as well as potential moral distress when artificial ventilation can no longer be maintained.
- B. **Sharing mechanical ventilators (co-ventilation)-** Although technically feasible, using one ventilator for more than one patient is not advisable unless it is for the most extreme circumstances. If done, it should be used for the briefest time while actively trying to find alternative ways to individually ventilate patients mechanically. Given the uniqueness and complexities of critically ill patients with severe respiratory illness who have dynamic variations in lung volume, air flow resistance and compliance, co-ventilation could lead to poor outcomes and high mortality rates for all patients cohorted to a single ventilator.
- C. The US Public Health Service Commissioned Corps published a statement on March 31, 2020, that cited a Joint Consensus Statement from the Society of Critical Care Medicine (SCCM), American Association for Respiratory Care (AARC), American Society of Anesthesiologists (ASA), Anesthesia Patient Safety

Foundation (ASPF), American Association of Critical-Care Nurses (AACN), and American College of Chest Physicians (CHEST) issued on March 26, 2020, that recommended that “clinicians do not attempt to ventilate more than one patient with a single ventilator while any clinically proven, safe, and reliable therapy remains available.” The US Public Health Service recommended that the strategy to ventilate two patients with a single mechanical ventilator is a decision that as an absolute last resort judged against the alternative of death “must be made on an individual institution, care-provider, and patient level. However, we know that many institutions are evaluating this practice, and protocols are being developed and tested, and in some places, preliminarily implemented.” Any institution implementing this strategy of ventilation should fully inform the patient/LAR of the lack of safety and efficacy data.

- D. **“Bridge” ventilation-** In the current pandemic, intensive care units are being overwhelmed with a shortage of standard, FDA-approved ventilators. Nationwide, collaboratives are emerging to conceive and design a “bridge” ventilator that is inexpensive and quick-to-manufacture. This type of collaborative or consortium includes clinical experts (e.g., critical care, pulmonary, anesthesia, respiratory therapy) and biomedical engineers. The use of a ventilator that is developed in this fashion should be the decision of the individual institution. However, that institution should have clinicians with the expertise to utilize these types of ventilators in a patient care setting and should require full informed consent of the patient/LAR including the lack of safety, reliability, and efficacy data.
- E. **Individually (home)-made ventilators** will not be supported in the hospitals due to technical and safety concerns.

XV. Resource Update Protocols

- A. During response: It is understood that during a public health emergency, the clinical situation may change depending on resource availability, new epidemiologic information, new treatment protocols and guidelines, etc. The entire healthcare community must maintain accurate situational awareness and consensus regarding local triage recommendations with appropriate changes made in real-time.
- B. During preparedness: Scarce resource algorithms, tools and supporting documentation will be reviewed and updated every 3 years.

XVI. Novel medications

- A. Medications being utilized for a non-FDA approved medication will not be addressed in this document.

XVII. Research options

- A. It is recognized that research protocols may become available
- B. Participation in a research trial related to the State of Emergency will not confer special prioritization in the allocation of scarce resources (see above).

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APPENDIX A: Sample Language Templates

EHR documentation for Unilateral DNAR or Triage to no Critical Care Services

Unilateral med-surg DNAR for patient not currently meeting Critical Care admission criteria (e.g. ED or med-surg floor status)

I spoke with *** (patient, legally authorized representative) at *** (time)

The conversation took place *** (at bedside, on the unit, by phone, by two-way video teleconference)

I summarized the patient's clinical course, present condition and treatments.

I explained that the State of Hawaii has declared a State of Emergency. As such *** Medical Center has a activated and operationalized its ***Disaster Plan.

At the present time, due to resource limitations, #patientname, does not meet current eligibility for critical care according to the *** Triage Allocation Plan triage protocol. Therefore, I explained, a DNAR order will be entered for #name. All appropriate tests and treatments will continue in the hopes that #name will recover. However, in the event of clinical decline, #name will not be transferred to an ICU and no resuscitative efforts will be initiated. Symptoms will, of course, continue to be carefully assessed and treated.

I provided active listening, emotional support, and answered all questions to the best of my ability. I informed *** (#name and/or LAR) about the appeals process for such decisions under our *** Triage Allocation Plan. #name and/or legally authorized representative expressed understanding and did/did not wish to pursue an appeal.

I contacted *** (SW, Hospital Ministry, P&PC) to request they provide additional emotional support and counseling.

Unilateral Ventilator and critical care services Withdrawal (e.g. for a ventilated patient for whom ventilator withdrawal is planned with the expectation that death will follow [palliative extubation])

I spoke with *** (legally authorized representative) at *** (time)

The conversation took place *** (at bedside, on the unit, by phone, by two-way video teleconference)

I summarized the patient's clinical course, present condition and treatments.

I explained that the State of Hawaii has declared a State of Emergency. As such *** Medical Center has activated and operationalized its ***Disaster Plan.

At the present time, due to resource limitations, #patientname, does not meet current eligibility for continued ventilator support and critical care according to the ***triage allocation protocol. Therefore, I explained, a DNAR order will be entered for #name and mechanical ventilation will be withdrawn and trial of mechanical ventilation discontinued according to the hospital policy. Symptoms will continue to be carefully assessed and treated.

I provided active listening, emotional support, and answered all questions to the best of my ability. I informed *** (#name and/or LAR) about the appeals process for such decisions under our *** triage allocation plan. #name and/or legally authorized representative expressed understanding and did/did not wish to pursue an appeal.

I contacted *** (SW, Hospital Ministry, P&PC) to request they provide additional emotional support and counseling.

Unilateral DNAR/ Assent

I spoke with *** (patient, legally authorized representative) at *** (time)

The conversation took place *** (at bedside, on the unit, by phone, by two-way video teleconference)

I summarized the patient's clinical course, present condition and treatments.

I explained that the State of Hawaii has declared a State of Emergency. As such *** Medical Center has activated and operationalized its ***Disaster Plan.

At the present time, due to resource limitations, #patientname, does not meet current eligibility for cardiopulmonary resuscitation according to the ***triage protocol. Therefore, I explained, a DNAR order will be entered for #name. All appropriate tests and treatments will continue in the hopes that #name will recover. However, in the event of clinical decline no resuscitative efforts will be initiated at the time of death. Symptoms will, of course, continue to be carefully assessed and treated.

I provided active listening, emotional support, and answered all questions to the best of my ability. I informed *** (#names and/or LAR) about the appeals process for such decisions under our *** triage allocation plan. #name and/or legally authorized representative expressed understanding and did/did not wish to pursue an appeal.

I contacted *** (SW, Hospital Ministry, P&PC) to request they provide additional emotional support and counseling.

Appeals Documentation:

An appeal was brought before the Triage Review Committee on behalf of #name.

The Triage Review Committee evaluated the patient's case and made a final determination based on the following clinical factors and considerations: ***

The following factors are irrelevant to medical prognosis and therefore were explicitly not considered in the decision-making process: race, national origin, ethnicity, gender, sexual orientation, disability status, limited English proficiency, perceptions of societal worth, immigration status, religion, insurance status, and socio-economic and housing status.

The Triage Review Committee supports / opposes the Triage Officer's decision regarding *** (withdrawal of ventilator support / not meeting eligibility criteria for critical care admission / change in code status to DNAR).

#name and/or their legally authorized representative was informed by phone/video conference/in-person of the Triage Review Committee's final determination by *** (Triage Officer / Attending) on *** (Date / Time).

Appendix B: Sample Triage Scoring Tool

TRIAGE SCORING SHEET

STEP 1. Exclusion Criteria (If present then stop. Notify attending physician)

Cardiac arrest unresponsive to ACLS Irreversible hypotension Severe traumatic brain injury (GCS Motor ≤ 2)
 Severe burn w/ $\leq 10\%$ survival Immediate or near-immediate death Valid POLST/LAR present w/comfort care only

STEP 2. Sequential Organ Failure Assessment (SOFA) and Modified SOFA Scores (mSOFA in bold letters)

Org. Syst.	0	1	2	3	4	Score
PaO ₂ /FIO ₂ or O ₂ Sat	>400 > 90% RA	301-400 >90% 1-3 LPM	201-300 >90% at 4-6 LPM	101-200 >90% at 7-10 LPM	<100 >90% at >10 LPM	
Liver: Bilirubin	<1.2 or No scleral icterus or jaundice	1.2-1.9	2-5	6-11.9 or scleral icterus or jaundice	≥ 12	
CVS: Hypotension	MAP >70	MAP <70	Dopamine ≤ 5 or Dobutamine any dose	Dopamine 5-15 Epinephrine ≤ 0.1 Norepinephrine ≤ 0.1	Dopamine >15 Epinephrine >0.1 Norepinephrine >0.1	
CNS: GCS	15	13-14	10-12	6-9	<6	
Renal: Cr	<1.2	1.2-1.9	2-3.4	3.5-4.9	>5	
Platelet	>150	101-150	51-100	21-50	<20	

Total Score: _____

STEP 3. Multi-principle Point System (add rows A + B = Total Priority Score)

Scoring	Principle	Point System			
		1	2	3	4
A	Save the most lives COVID-19 Negative	SOFA score ≤ 8	SOFA score 9-11	SOFA score 12-14	SOFA score >14
	Save the most lives COVID-19 Positive	SOFA score ≤ 4		SOFA score $\geq 5-14$	SOFA score >14
OR					
PLUS					
B	Save the most life-years		Major comorbid conditions: <ul style="list-style-type: none"> Mod. dementia FAST 5-6 Malignancy <10 yrs. survival NYHA Class III heart failure Mod. Chronic lung disease Primary Pulm HTN w/ WHO class III heart failure Sev. multi-vessel CAD ESRD on HD Cirrhosis w/ hx decomp 		Severely life-limiting conditions: <ul style="list-style-type: none"> Sev. dementia FAST >7 Cancer treated w/ palliative tx Adv. lung disease w/FEV1 <25% Sev. Chronic lung disease + frailty NYHA Class IV + frailty Primary Pulm HTN w/ WHO class IV heart failure Chronic liver disease Child-Pugh >7

Total Priority Score (1-8): _____

MRN #: _____

Completed by (Print): _____ Date: _____

Account#: _____

Triage Officer (Print): _____ Time: _____

**TRIAGE SCORING SHEET
(PART 2)**

Patient label	Age	Family Contact (name, number):
---------------	-----	--------------------------------

Hospital Admission Date:
ICU Admission Date:

COVID Positive:
Intubation Date:

Date	Time	SOFA Score	Long-term Prognosis	Total Score	Score by:	Updated Family?	Medical and Surgical History

Hawai'i Crisis Standards of Care Scarce Resource Triage Allocation Plan

Twelve Frequently Asked Questions

What is a “triage allocation plan”?

When there is a disaster, there may be a greater number of very sick people that need medications and treatments such as breathing machines and intensive care. In the worst-case scenario, there may not be enough for everyone. In this very tough situation, when there is not enough, the doctors will work with a team of other doctors, nurses, and specialists in ethics to decide (triage) which patient is most likely to be helped and live with the breathing machine and advanced care.

What is a specialist in ethics and why is this important?

All health care providers are educated in medical ethics. Experts in medical ethics further study these principles (beliefs) that guide health care which include: 1) beneficence (doing good); 2) justice (being fair); 3) transparency (being truthful); 4) non-maleficence (doing no harm); 5) keeping promises; and 6) autonomy (respecting a person's wishes). If a disaster happens and there are not enough life-saving supplies (such as a breathing machine) for everyone, the goal will be to do the most good for the most people through a fair, truthful, and caring process.

What has been done to prevent hospitals from reaching this point?

Before having to triage patients, hospitals have done their best to prepare to have enough supplies and ICU beds. These include stockpiling, extended use or limiting use of supplies which may also mean that they have cancelled surgeries that can be done safely at a later time.

How will I know if this is going to happen to me or my loved one?

No matter what, every patient will be cared for. If there are not enough beds or breathing machines, doctors will look at each patient when he or she comes to the emergency department or every day in the patients who are in the intensive care unit (ICU) to look at how sick a patient is. The doctor will give a “score” to the patient to determine which ones are sickest and which ones are most likely to live if they are given a breathing machine and/or put in the ICU. An expert doctor called a “triage officer” will look at the “scores” of patients every day. If there is someone who is not likely to get better from the machines, and that person is you, the triage officer will tell your doctor, who will explain to you, the patient, or your loved ones, that you are not expected to live, and to help someone who could, you may need to be removed from, or never be placed on a breathing machine.

If your heart has already stopped and cannot be restarted, or your blood pressure is very low and cannot be corrected with medicines, or your brain is severely damaged, or you are severely burned and not likely to live, or you have a valid Physician Order for Life Sustaining Treatment (POLST), and/or a loved one states that you want comfort measures, your doctors will make sure you are comfortable and are free of pain, but you will not be put on a breathing machine or be put in the ICU.

How is a “score” created?

The score used by our Hawai'i hospitals comes from expert studies that included community input and information from other States across the country. The scoring system that our hospitals in the State of Hawai'i use looks at how sick the patient is including how well the brain, heart, lungs, kidneys, liver, and the ability to clot are working. Very bad (life-threatening) illnesses that can make a difference if someone is not likely to live for very much longer are used to help the doctors decide. These include

advanced cancer that has spread and can no longer be treated, very bad (severe) lung or heart disease that keeps a patient from being able to walk, or severe liver disease or severe dementia where the patient cannot smile, speak, sit up or walk. Race, national origin, ethnicity, gender, sexual orientation, immigration status, physical or developmental disability, ability to speak or understand English, religion, insurance status, perceptions of societal worth, and socio-economic and housing status have no place in scoring.

I am old or disabled. Will I be able to receive care during this pandemic?

Yes. You will be treated fairly like everyone else that needs care. During this Public Health Emergency concerning the coronavirus disease 2019 (COVID-19), the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) gave public notice that laws and regulations that prevent discrimination on the basis of race, color, national origin, and disability, must be followed. Even in this time of emergency, the goal is to give excellent care to patients quickly to save lives, and to be fair and treat people equally and with compassion. The law prohibits discrimination on the basis of disability (Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act). This means all persons, including those with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative "worth" based on the presence or absence of disabilities or age. Decisions by health care providers concerning whether a person receives treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence.

Does this apply to my child(ren)?

Children (people under 18 years old) are not small adults and because they are still growing both in their body and brain (physical and psychologically) and are learning and developing, they are not able to be scored using tools that are used for adults. Children will be looked at by expert doctors who are specially trained in the care of children.

I am pregnant. Does this apply to me?

Pregnant patients will be scored using the triage plan. In the ethical interests of doing the most good for the most lives, pregnancy will be used as a tiebreaker. This means if there is only one needed treatment available and two people have the same health problems and need the same treatment, the pregnant patient may be chosen to get the treatment. This is based on the idea to save the most lives possible (that is two lives (baby and mother) are more likely to be saved than one person).

What can I do if my family or I do not agree?

Based on the ethical principles noted above, the triage process gives you and/or your loved ones a chance to "appeal" or ask for the decision to be looked at again and possibly changed. Since this is an emergency situation, this must happen fast. You should tell your doctor or nurse immediately if you wish to appeal (ask others to look at) this decision.

What happens if I appeal?

If you appeal, the hospital has a formal process to ask a group called a Triage Review or Appeals Committee that includes experienced doctors, nurses, and ethics specialists, and may include other members of the community to review the decision. This committee will meet in an emergency meeting with no more than 4 hours to make a decision. This group will not include the same group of people that might have made the decision to take away or not give a ventilator or other advanced medical care. You or your family or people appealing on your behalf will share with your providing physician your concerns or additional information and can inform the Triage Review/Appeals Committee of these issues.

Can I be transferred to another hospital?

The triage allocation process is one that all the hospitals in the State of Hawaii have agreed to follow. The State has a way to find out which hospitals have breathing machines and ICU beds. The State leadership will help to send patients to another hospital that has breathing machines or ICU beds. The State also will use this method to send breathing machines to a hospital if a hospital has ICU beds, but no breathing machines. Therefore, you can ask. But also know that the doctors and hospital will likely already have tried to get a machine or transfer you or your loved one if there is somewhere else that has more machines or ICU beds.

What happens to me (or my family member) if it is decided that I (he/she) will not be the one to get the breathing machine or go to the ICU?

Our goal is to always care for you or your loved one. All people deserve compassion and dignity. Pain control, and things that help with a patient's comfort will be our primary goals of care. This will include bodily, psychological, and spiritual comfort.