



Interim Guidance on Critical Care Resources Allocation for Direct-Service IHS Hospitals

Date Implemented: January 6, 2021

Purpose:

This guidance was developed to ensure that IHS hospitals have in place ethically and clinically sound processes for allocating critical care resources in the event of a surge of critically ill patients due to the COVID-19 pandemic or similar public health or national emergencies in which need for critical care resources may exceed the capacity of IHS hospitals and their regional referral resources. These critical care resources may include, but are not limited to, mechanical ventilation.

This policy is intended for situations in which critical care resources are insufficient to provide the indicated volume of services and in which all other reasonably available resources and strategies have been considered (e.g. conserving, substituting, adapting, reusing, reallocating) or exhausted for securing critical care without the need to ration such care. At all other times, services and resources at all IHS facilities shall continue to be made available to all persons who are within the scope of the IHS programs and prioritized on the basis of relative medical need and access to other arrangements for obtaining the necessary care in accordance with 42 C.F.R. § 136.12 (c) and the Indian Health Manual, Chapter 1, Part 2, Section 2-1.5. This policy may be modified to suit the particular needs of individual medical facilities and their tribal communities provided such modifications are consistent with the principles set forth in this document and governing law.

Consultation with tribes that the facility serves should inform the principles to be used for resource triage in the event that critical care resources, locally and through referral, cannot meet need. If this consultation has not yet taken place and is not feasible under the circumstances, each hospital should engage tribal leadership and community leaders, as soon as is feasible, to inform these principles.

Resource Triage Team Implementation Protocol:

Implementation Timing and Circumstances-The hospital's Chief Executive Officer (CEO), in consultation with the Clinical Director, is responsible for determining the circumstances that warrant implementation of the actions dictated in this policy and for determining when the circumstances allow discontinuation of those actions. The CEO is responsible for initiating a Resource Triage Team (RTT) for the facility based on the possibility that:

1. Critical care resource use is or may be at or near capacity; or
2. There is or may be inadequate staffing to manage critically ill patients; and
3. There is or may be an inability to transfer critically ill patients safely to another hospital with adequate and available critical care resources.

Resource Knowledge- The CEO, directly or through delegation, should maintain an adequate and frequently updated knowledge of:

1. Availability of beds, staffing, personal protective equipment, and ventilators.
2. Availability of intensive care beds at available referral hospitals.
3. Availability of any appropriate therapeutic agents that may be in limited supply.

Resource Triage Team Composition and Structure:

1. The Resource Triage Team should consist of at least three and no more than five individuals.
2. The individuals may not be members of the patient's treatment team.
3. The team members should include physicians, experienced nursing staff or other staff that would be comfortable in following guidelines to triage resources.
4. Each position in the RTT should have one or more identified alternate(s) such that a full team is available at all times.
5. Once initiated, the RTTs must be available 24/7 to meet the needs of the clinical teams.

Decision-Making Guidelines:

If the need for treatment resources exceeds availability and safe transfer to another facility with adequate, available resources is not possible, due to the patient's circumstances or the emergency situation, the Resource Triage Team is responsible for allocating or re-allocating critical care resources. Decisions made regarding allocation or reallocation of critical care resources in an extreme scenario should be evidence-based and applied uniformly and consistently. Deliberations of the RTT are privileged and confidential in accordance with 25 U.S.C. § 1675. The following principles shall apply to such decisions:

1. Every patient is eligible to receive critical care beds, resources and services ("treatment resources").
2. Every patient must receive consideration for treatment resources.
3. All decisions must be based on an individualized assessment of the patient's ability to benefit from treatment resources based on the best available objective medical evidence and not on mere categories or categorical exclusions such as existing disability diagnoses, age or broad functional impairments.
4. Treatment-allocation decisions may not be made based on the perception or assessment that a person's disability will require the use of greater treatment resources, either in the short or long term.
5. Treatment-allocation decisions may not be made based on judgments as to long-term life expectancy but should instead be based on anticipated short-term survival – defined as survival to hospital discharge.
6. Reasonable accommodations must be made where they are needed in order for a person with a disability to have equal opportunity to benefit from treatment resources. For example, clinical instruments being used to assess short-term mortality risk, such as the Sequential Organ Failure Assessment or the Revised Trauma Score, may need reasonable modifications to ensure that disability-related characteristics unrelated to short-term mortality risk do not worsen the patient's score. The Glasgow Coma Scale, a tool for measuring acute brain injury severity in

these instruments, adds points (reflecting greater mortality risk) when a patient cannot articulate intelligible words or has difficulty with purposeful movement. For patients with pre-existing speech disabilities or disabilities that effect motor movement, this may result in a higher score indicating a higher short-term mortality risk due to the patient's disability even in instances where the patient's disability is not relevant to this risk.

7. Social characteristics, including but not limited to race, color, national origin, age, sex, exercise of conscience, religion, creed, ethnicity, sexual orientation, gender identity, assessments of quality of life (both pre- and post-treatment), judgments about a person's relative "worth," and disability unrelated to near-term survival, should not be used as criteria in making resource-allocation decisions.
8. IHS employees have an obligation to follow all applicable anti-discrimination laws and regulations even in emergency situations.
9. Staff should ascertain whether the patient has a valid, operative advanced health care directive or living will that expresses the patient's wishes on initiating or continuing life-sustaining treatment. Otherwise, staff should engage in conversations to elicit the patient's goals of care.
10. If reallocation decisions are permitted, providers may not re-allocate a personal ventilator (defined as a ventilator brought by the patient to the acute care facility at admission to continue the patient's pre-existing personal use with respect to a disability).

Palliative Care:

Each hospital should provide palliative care to all patients with serious illness due to COVID-19 or similar public health or national emergencies.

Avoiding Coercion:

In communicating with patients and their families, providers must be careful not to exert pressure to decline life-sustaining treatment in the process of discussing treatment goals or advanced care-planning decisions. Patients and their families should not be subject to pressure to make particular treatment or advanced care-planning decisions, including for reasons of resource constraint or due to perceptions of quality of life or relative worth.

Providers must continue to provide information on the full scope of available alternatives, including the continued provision of life-sustaining treatment, and may not impose blanket Do Not Resuscitate policies for reasons of resource constraint. Providers may not require patients to consent to a particular treatment or advanced care planning decision in order to continue to receive services from a facility or lead patients to believe that such consent is necessary to continue to receive services.