From email received by DRRI from RIDOH, April 18, 2020

(Exerpt)
The Rhode Island Department of Health (RIDOH), in partnership with experts in bioethics from Brown University, has reviewed drafts of Crisis Standards of Care from all the acute care hospitals in Rhode Island as of April 13th, 2020. RIDOH expresses gratitude for the thoughtfulness and multidisciplinary scholarly work thus far on this complex and uncomfortable topic.

Establishing Crisis Standards of Care in the context of the current pandemic must be accomplished in a thoughtful, multi-disciplinary manner considering the ethical foundations and balancing the real possibility of limited vital resources for our patients. RIDOH recognizes these plans are living documents and will be revised as the pandemic progresses. The pandemic is unprecedented, dynamic, and affected by national supply chain shortages.

If we need to activate these Crisis Standards of Care, it must be done with the approval of the Rhode Island Department of Health and for as short a duration as possible. It is our joint duty to protect the health and safety of all who live in Rhode Island.

RIDOH has received individual plans from hospitals and encourages continued sharing with each other to work together as appropriate. Updated Crisis Standards of Care plans are required to be submitted to RIDOH by **close of business, April 23, 2020.** RIDOH offers this guidance and recommendations to all acute care hospitals for incorporation into all updated plans so that we have a consistent approach.

Each updated Crisis Standards of Care plan must have the following components addressed – these elements must be added to each facility's current Crisis Standards of Care plans if not already incorporated:

1. **Underlying assumptions**

Place the underlying assumptions at the top of the document, these could even be framed as best practices. For example:

i. Some patients will voluntarily refuse life-sustaining medical resources. All patients should receive adequate information about their condition and prognosis to make valid informed decisions using shared decision-making with their physician, including declining to use the life-saving resource. Applicable advance directives for patients unable to speak for themselves will provide guidance in those cases.

ii. Clinicians will use alternative therapies, when possible, to reduce demand for resources that are or will soon be scarce.

iii. All patients are provided needed palliative care.

iv. Lines of communication between treating clinician and patient's surrogate or family are kept open.

v. If critical scarcities are local, utilization of neighboring facilities should occur when feasible

1. **Clarification of ethical principles**

Statewide adoption of an underlying ethics guidance statement furthers the important goal of transparency. Documents should specifically recommend against using assessments of pre-existing quality-of-life, underlying life expectancy, and "social value" in ranking a particular patient's priority score for the critically scarce resource, considering these fundamentally discriminatory.

1. **Intention of Crisis Standards of Care**

Provide an explanation of conversion of patient-focused care to public-focused care. Provide the rational as to why this focus changes during time of disaster such as to maximize population survival and allow for judicious use of the limited resources.
Set consistent standards for clinicians. Stress that this consistency provides for equity, is based in scientific/medical prudence, reduces on-the fly decisions, and reduces the individual burden on providers to make what might be a series of solemn decisions.
Set expectations for the public, patients, and families. Explain how the providers would use the CDC and how the patient, family, and friends would be involved or told of the application of Crisis Standards of Care for them or their loved ones.

1. **Process for allocation**

Routine and recurring assessment of likelihood of survival should occur for all inpatients using a scale that allows for accurate assessment and comparison of the overall and local need for the scarce resource. This should be performed by healthcare workers who are taking care of the patient with reporting up to the hospital and State level.
Hospital and statewide availability of intensive care unit beds and ventilators should be tracked at the local level and shared at the State level.
The goal of being fair and objective must be balanced with the risk of relying too heavily on numerical assessments. The goal of protecting clinicians from moral distress must be balanced with the reality that simply putting their patient's fate into the hands of others will be hard as well. The mechanism of interaction between the clinical team and triage team should be clear and should allow for appeal or reconsideration. A mechanism for oversight of the triage teams' work should be in place. A mechanism of support or relief for the triage officer should be in place as well.
Regular reassessment of those in category 1 (high likelihood of survival) who do not have the scarce resource and those in category 4 (very low likelihood of survival) should be undertaken specifically with regards to possible redeployment of the critically scarce resource. This should occur at the triage team level. Withdrawal of the scarce resource should not occur if transfer to another institution with that resource is feasible.

1. **Prioritization**

Disease-specific exclusion criteria should be avoided if possible. The clinical factors listed in the other documents should be incorporated into the survivability assessment.

The 4-tier level of priority table should appear to be clinically valid, easily completed, and easily standardized.
Assessments of patient's survival likelihood should be called that ("survival likelihood").
Determining priority for access to the critically scarce resource is a separate step.
Decide which specific scales are used to assign likelihood of survivability to 1 of these 4 tiers.
Prioritization for access to critically scarce lifesaving resources should not depend on necessarily subjective assessments of quality of life.
Social value should not be included as a criterion for prioritization unless the category of patient (e.g. healthcare worker, "protector of societal order") is actually also in critically short supply.

1. **Implementation**

Identify thresholds for potential implementation of Crisis Standards of Care.
Clarify authority to implement at state, system, committee, and clinician level.

For your convenience we have provided a few links below to other Crisis Standards of Care documents:

Massachusetts: https://mcusercontent.com/b6fca240156200bca3e026661/files/62a0c5ee-f1fc-4cd0-ae26-1f77884e9508/CSC_April_7_2020.pdf [mcusercontent.com]

New York: https://www.urmc.rochester.edu/emergency-preparedness/preparedness-and-response-tools-resources/alternate-crisis-standards-of-care.aspx [urmc.rochester.edu]

Washington: https://urldefense.proofpoint.com/v2/url?u=https-3A__nwhrn.org_plans-2Dand-2Dtools_&d=DwMGaQ&c=tSLbvWYfvulPN3G_n48TUw&r=wrHkXdNvDmr1OFRGkNE8Z-j0eYX33io2JyYwa5e6ud6DgLuFKse8xK2C0yzickWv&m=-pOeZbDyJrYBHCVN2vKdhYZliRbz2sZdqo9zw4liD6I&s=dvAe-YErRFYoPBp5MjTjH3tphUL9vghEN7RWP2raLIQ&e=

Utah: https://coronavirus.utah.gov/wp-content/uploads/Final_Utah_Crisis_Standards_of_Care_011719-1.pdf [coronavirus.utah.gov]

IOM
Report: https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/flrtc/documents/StandardsofCare.pdf [urmc.rochester.edu]

Thank you.