M DEPARTMENT OF HEALTH

Crisis Standards of Care Ethical Framework

Ethical Commitments for Crisis Standards of Care

Pursue Minnesotans' common good in ways that:

- Are accountable, transparent and worthy of trust;

- Promote solidarity and mutual responsibility;

- Respond to needs respectfully, fairly, effectively and efficiently.

Ethical Objectives

Promote Minnesotans' common good by balancing three equally important and overlapping ethical objectives.

1. **Protect the population's health** by reducing mortality and serious morbidity from:

   - The public health crisis; and

   - Disruption to health care, public health, public safety, other critical infrastructures.

2. **Respect individuals and groups** by:

   - Promoting public understanding, input, and confidence in CSC plan/response;

   - Supporting a duty to promote the best care possible in crisis circumstances;

   - Ensuring that burdens of CSC response are minimized and justified by benefits.

3. **Strive for fairness and protect against systematic unfairness** by:

   - Utilizing strategies for public education and public engagement that are inclusive and culturally sensitive;

   - Promulgating standardized crisis standards of care response protocols that are publicly available, revised regularly, and tailored to specific crisis responses;

   - Ensuring that burdens and benefits associated with crisis response are equitable;

   - Making reasonable efforts to remove access barriers and address functional needs;

   - Stewarding resources to:

     - Reduce significant group differences in mortality and serious morbidity; and

     - Appropriately reciprocate to groups accepting high risk in service of others;

   - Using decision-making processes that consistently apply only ethically relevant (non-discriminatory, non-arbitrary) considerations**.**

Duty to Plan Strategies

Prospective Planning: The Minnesota Department of Health (MDH), local/tribal health departments, private providers and other partners should plan for CSC, taking expert stakeholder and community input into account.[1] Standardized CSC response protocols should be made available to the public to promote transparency, accountability and understanding.

Process for Review and Tailoring: Processes should be developed to periodically review and revise CSC plans, as well as to tailor them to the specific context of particular disasters encountered. Consultation with State and/or Local CSC Ethics Support Teams should be sought to support these processes.

Public Engagement, Understanding, and Communication Strategies

Public Engagement: Initiatives should reach out to communities and not rely on a standard public comment period for soliciting feedback on the proposed plan. Reasonable efforts should be made to consult with populations with health disparities as well as those with access and functional needs. Input should be gathered on culturally appropriate planning and how to minimize impact of health disparities, access barriers and functional needs in the context of crisis response.[2]

Public Understanding and Communication: Strong communication is critical to an ethically appropriate disaster response. Information regarding crisis response plans should be disseminated as widely as possible, in different languages, using a variety of approaches, materials, and venues for distribution of information. Care should be taken to adequately inform the public without creating fear and to avoid dissemination of misinformation.

Duty to Care Strategies

Obligations to Patients:

- **Best Care Possible:** In CSC, fundamental norms of good care carry over from conventional care standards. Patients should be provided the best care possible given available resources. The plan of care should be based upon the facilities approved CSC plan and explained to patients and their families throughout the patient care process. This may include more explanations to the patient and/or their family about how decisions concerning care are made. Patients should not be abandoned.

- **Palliative and Hospice Care:** CSC plans should address how to meet palliative and hospice care needs, including recommendations for stockpiling; distributing and securely storing palliative care resources; promulgating symptom management protocols and algorithms;

---

[1] Please note, at the facility level your stakeholders could include the patients/clients in addition to the employees and staff.

[2] MDH has conducted and continues to conduct public engagement sessions across the state. Please see the Community Engagement website for a summary of findings.

developing caregiver educational programs for laypersons and clinicians; developing a process for ongoing community engagement and communication; and planning for support of the dying and their caregivers.

- **Mental Health Care:** CSC plans should address how to meet mental health care needs during a CSC event, including identifying disaster mental health providers, both local and electronic; incorporating disaster mental health response into crisis planning and response processes; assuring that protocols fairly triage patients suffering from both mental and somatic ailments; creating a parallel triage protocol for those requiring mental health resources if rationing is required; minimizing disruptions in continuity of care during disasters through planning for alternative treatment modalities (e.g., tele-psychiatry).

- **Appropriate Care for the Dead:** As part of community engagement during CSC planning, solicit public input regarding expectations for appropriate care for the dead during a CSC event. Special efforts should focus on Minnesota's major immigrant populations, tribal communities and faith communities.

Support for Health Professionals:

- **Ethically Appropriate Liability Protections** for providers should be drafted by legal advisors in partnership with the State Ethics Support Team. Providers who act in good faith to meet crisis standards of care must be protected, but even in the highly challenging context of an MCI, providers should not be fully immunized from liability. There must be safeguards and protections for patients as well as for providers (for example, review/appeals processes).

- **Reciprocity:** Fairness requires that society protect those who take on risk on behalf of the public, and that such protections are indexed to level of risk taken by the professionals. CSC plans should include provisions for promoting safety of these professionals (e.g., appropriate personal protective equipment and training, procedures for protection of staff when posed with threats such as active shooter attacks or flooding of facilities). Providers' duty to care for patients may be limited in situations posing imminent danger to providers. In some circumstances, key workers should be prioritized for access to resources when illness or injury is related to provision of care in disaster. Plans should make provisions for mental/behavioral health care for professionals given the stress/trauma of working in disasters.

- **Mandates to provide service:** Where possible, CSC plans should use incentives rather than mandates for health professionals to provide services in mass casualty incidents rather than relying upon state power to mandate provision of services, employers should create emergency plans with employees prior to a disaster to best address issues such as absenteeism (e.g., due to illness or family obligations) and reasonable expectations about length of work shifts.

- **Process for triage/rationing decisions:** Separate triage/rationing decisions from bedside care by using a triage team, to allow clinicians to advocate for patients while following CSC plans for triage/rationing. It may be necessary to construct regional triage teams for Greater Minnesota, depending on the nature of the disaster and given the strain on available staff.

- **Ethics support:** Implement and administer a system for ethics support at the state level, and require and facilitate development of ethics support mechanisms at local levels. The

primary functions of the ethics support process are to facilitate application of ethical frameworks for CSC and to help manage moral distress.

- **State CSC Ethics Support Team** would be responsible for:

  - Providing education to Local CSC Ethics Support Teams regarding state and federal guidance concerning ethical frameworks

  - Review of requests for guidance from Local CSC Ethics Support Teams relative to fair application of ethical frameworks, and

  - Review of systemic issues/challenges regarding the ethics frameworks that arise at the local or state level.

- **Local CSC Ethics Support Teams** would provide support when those attempting to resolve an ethical problem need prospective guidance in decision-making or real time review of a controversial decision, in addition to retrospective review of policies and practices to ensure compliance with and consistency in the application of the ethical framework and to advise MDH on measures to alter or improve policies/practices.

Proportionality and Equity in Freedom Limiting Interventions Strategies

Social distancing techniques, including isolation and quarantine, may be justified when public health interests outweigh the burdens to affected individuals or groups. Evaluation of burdens must consider the impact of these techniques on non-health aspects of well-being, including economic and financial. Decisions to implement restrictive interventions must be evidence-based, and should be made using a fair, transparent process of consultation with public health leaders and the State CSC Ethics Support Team to avoid the influence of political agendas.

Proportionality requires the use of the least restrictive interventions possible to achieve the outcome of interest. Appropriate limits may become unfair as the context changes (for example, further resources arrive or demand decreases). Response plans should be flexible and able to adapt to the situation.

Equity: Liberty-limiting interventions should not disproportionately impact populations with health disparities as well as those with access and functional needs.

Strategies for addressing health disparities, barriers to access and functional needs

Health Disparities, barriers to access and functional needs: CSC plans at all levels should attend to alleviating health disparities, reducing access barriers, and meeting functional needs. Partnerships to promote equity: planning regarding these issues should be conducted in partnerships across systems to best inform and implement relevant interventions.

Public engagement activities for CSC plans should address challenges regarding health disparities, access barriers and functional needs.

Distribution of Resources: Efforts should be made to provide free or low cost services to those with greatest financial need. Distribution of resources that those at highest priority—including health disparities populations--have best access to the resources. Distribution decisions should also take into account availability of infrastructure and trained staff to support use of specialized resources such as ventilators.

Tribes: MDH will engage tribes as equal partners in CSC planning and response and upon request aid tribes during disaster.

Immigrants: Immigration authorities should not be present during allocation of resources in MCI. CSC protocols should not be crafted to allow only legal residents of the state of Minnesota access to scarce resources in the state.

Consultation with the State and/or Local CSC Ethics Support Teams may be sought to support planning and response on issues of equity.

Fair and Consistent Stewarding Resource Strategies

Coordination: Balancing of resources across jurisdictions is required to assure consistency of care and equity of access. Therefore, coordination of response activities and sharing of impact/demand data is critical to a successful response. Regional coordinators, health care coalitions and emergency management must ensure the ability to share information and manage resources to allow this balancing to occur.

General considerations for rationing/triage: Extend supplies and conserve resources before implementing triage or rationing; triage/ration only as a last resort. Expand providers' scope of practice to provide the best care possible in context of the need associated with the mass casualty event. Scale rationing strategies to different levels of scarcity. Generally, de-prioritize people who are unlikely to benefit from the resource.

Processes to promote accountability: Triage/rationing decisions should be reviewed and revised as needed, consistent with this ethics framework.

Data: Care must be given to gathering data to reflect risk across populations in the state, since the state can implement recommendations regarding health disparities only to the extent that it works to understand risks confronting these populations.

Health records as a basis for decision-making: Patients' self-reports about their health should be accepted as guiding triage/allocation decisions where possible.

Key workers: When threats to societal functioning or disaster response are present, prioritize key workers who become ill or injured working in disaster response on a separate track in parallel with a track for the general public, recognizing that in some circumstances a two-track approach might not be justified.

- Two reasons potentially justify prioritizing key workers: First, if societal functioning is at risk in a crisis, it may be appropriate to create a separate priority track for key workers to maintain societal functioning. This reason may justify priority for preventive resources to support professionals' ability to provide services during the MCI, or for treatment resources

if they offer a reasonable prospect that the key worker would be able to return to work and so continue to provide key services during the MCI. Second, fairness requires that society protect those who take on risk to protect the public; this obligation is referred to as reciprocity.

- Ethics Support Teams should work with incident command to determine when and to what extent considerations regarding societal functioning and/or reciprocity justify prioritizing key workers for access to resources, especially given that prioritizing them may affect the general public's fair access to resources. Decisions should consider the professionals' level of risk, the importance of their services, and their ability to benefit from the resources in question.

- The decision about which workers to identify as key is an event-dependent one, and should consider the role of volunteers.

- The two-track approach must reflect a commitment to strive for balance between prioritizing key workers and prioritizing those groups in the general public who are at greatest risk for morbidity and mortality.

Do Not Ration Based On:

- Ability to pay;

- First-come, first-served;

- Judgments that some people have greater quality of life than others;

- Predictions about baseline life expectancy (i.e. life expectancy if the patient were not facing MCI related health crisis), unless the patient is imminently and irreversibly dying, because rationing based on such baseline predictions would exacerbate health disparities;

- Race, gender, religion or citizenship;

- Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication);

- Judgments that some people have greater "social value" than others.

Ration resources based on the following considerations:

- Risk of MCI-related mortality and serious morbidity (due to greater exposure (occupational exposure for key workers) to risk or greater risk given exposure related to co-morbid conditions, etc);

- Good or acceptable response to resource;

- Risk of transmitting MCI-related infection.

- Irreplaceability of key workers

Allocating within priority groups: When the supply is inadequate to serve all similarly prioritized people then use a random process.

Strategies for promoting ethical decision-making among private partners

Partnerships: MDH will continue to treat private entities such as health care organizations as partners in planning disaster response, recognizing the shared planning and response roles of private providers and health care systems as necessary to effective response. MDH will work with other governmental entities and engage non-health private partners (e.g., faith-based organizations or nonprofit service providers) in planning for a disaster.

Coordinating responsibilities: Planning efforts should not unduly burden private partners. Those with greater or unique capabilities should accept concomitant responsibilities in response, and MDH and other private partners should support these organizations in doing so.

Patient transfer and care transition plans: The health care sector should work with MDH to create patient transfer and care transition maps for disaster response. These plans should allow lower levels of care to occur outside of the hospital setting so as to minimize the burden on hospital services, especially critical care. Scope of practice should be expanded so the majority of care may be shifted to community clinics, primary care or specialty offices, and other providers. State and local government should be prepared to support these non-traditional responses both from a financial and regulatory standpoint.

Increasing response capabilities: MDH will support public and private systems aimed at increasing capabilities of health care providers that do not have the infrastructure to meet their accepted roles in disaster response. This may include offering technical support, increasing the availability of telemedicine, and creating helplines for private actors during disaster response and recovery.

To obtain this information in a different format, call: 651-201-5700. Printed on recycled paper.