

New York State Workgroup on Ventilator Allocation in an Influenza Pandemic

New York State Department of Health/ New York State Task Force on Life & the Law

AMA-CDC CONGRESS ON HEALTH SYSTEM READINESS APPLICATION

1) CATEGORIES

- Medical Surge Capacity
- Emergency Healthcare Delivery
- Legal and Regulatory Policy

2) COMMUNITY DESCRIPTION

a) *Community Demographics*

New York State has an estimated population of 19,254,630, which represent 6.5% of the total United States population. Approximately 13% of New Yorkers are age 65 or older; an estimated 18% of the state population over the age of 5 is disabled.¹

b) *State & Local Public Health Infrastructure*

NYSDOH is empowered to issue voluntary, non-binding guidelines for health care workers and facilities; NYSDOH is also empowered to issue binding regulations for hospitals that would apply to standards of care during a pandemic.

c) *Health Care Delivery System*

There are more than 650 nursing homes in New York State housing 120,000 beds. Of the 240 hospitals in the state, 44 are classified as trauma centers, and 13 are classified as critical access hospitals (CAH) in rural areas. There are 3,981 adult and pediatric staffed intensive care unit beds throughout the state. There are currently 3,861 mechanical ventilators in acute care settings in New York State; at any given time, 85% of these ventilators are in use.

¹ All demographic figures cited from “New York QuickFacts from the US Census Bureau,” website available at: <http://quickfacts.census.gov/qfd/states/36000.html>, accessed February 13, 2007.

3) PLANNING PROCESS

a) *How was the planning process coordinated?*

In March 2006, the New York State Task Force on Life & the Law, at the request of NYSDOH, established a workgroup to review clinical and ethical issues in the allocation of mechanical ventilators in a pandemic. The group brought together experts in law, medicine, policymaking and ethics with representatives from medical facilities and city, county, and state government to address necessary alterations in the standard of care in an emergency.

b) *Community Members, Roles, Affiliations*

Workgroup Co-chairs

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Outside Experts:

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4) NARRATIVE

a) *Why is this topic a priority for New York State?*

This project evolved from a New York City/New York State tabletop exercise that identified the potential shortage of mechanical ventilators during a pandemic and explored the difficulties associated with the allocation of those ventilators.

Though a federal ventilator stockpile exists, and New York State plans to buy additional ventilators to meet demand in a moderately severe pandemic, in a disaster on the scale of the 1918 influenza pandemic, stockpiles would not be sufficient to meet need. Even if the number of ventilators needed for a disaster of that scale were purchased, a sufficient number of trained staff would not be available to operate them. If the most severe forecast becomes a reality, New York and the rest of the country will need to confront the rationing of ventilators.

There is strong motivation within the State Department of Health to overcome barriers and resolve issues. Additionally, the complex legal issues raised by altered standards of care in a public health emergency create vulnerabilities for individual facilities as they draft policies. Facilities have requested detailed procedural advice from the state, and do not seek wide latitude in devising their own policies.

b) *Planning Approach*

The workgroup articulated a set of ethical standards to guide the allocation of ventilators in a pandemic. From these standards they derived an ethically and clinically sound system for ventilator allocation, containing the following elements:

- 1) Pre-triage requirements: Facilities must reduce the need for ventilators and expand resources before instituting ventilator triage procedures.
- 2) Patient categories for triage: All patients in acute care facilities will be equally subject to triage guidelines, regardless of their disease category or role in the community.
- 3) Triage for different facilities: Chronic care facilities will maintain different ventilator allocation standards from acute care facilities.
- 4) Clinical algorithm: Clinicians will evaluate patients based on universally applied objective criteria, and offer time-based trials of ventilator support. These criteria, with inclusion and exclusion criteria, are described in detail in the guidelines, and will be presented at the conference.
- 5) Triage decision-makers: Supervising physicians will be designated as triage officers and will take responsibility for triage decisions. Primary care clinicians will care for patients and will not determine ventilator allocation.
- 6) Palliative care: Palliative care will play a crucial role in providing comfort to patients, including those who do not receive ventilator treatment.
- 7) Review for triage decisions: ethics committee members and others should be prepared to review specific triage decisions to ensure the fair application of standards.
- 8) Communication about triage: Government and clinicians need to provide clear, accurate and consistent communication about triage guidelines. Data gathering and public comment can help improve the triage system.

The workgroup recommends that these guidelines be reviewed in public settings, including medical centers and community forums, with the explicit goals of encouraging education,

comment and revision. After such public review, NYSDOH should incorporate improvements to these recommendations, and issue the revised document as a set of guidelines for acute care facilities. Options for liability protection for facilities and providers who comply with the guidelines are a critical aspect of planning and are addressed as part of the guidelines.

The recommendations are intended to guide health professionals and others to act in a manner consistent with ethical principles while preserving as many lives as possible.

5) CONTACT INFORMATION

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