



Equity in Crisis Standards of Care

Crisis standards of care (CSC) are necessary to guide equitable distribution of healthcare-related resources during epidemics, disasters, and other periods of resource scarcity. For CSC to ensure both the fair allocation of resources and promote equitable health outcomes through resource distribution, they must take into account historical and contemporary social, health, and healthcare inequities. Accordingly, the equitable allocation of scarce resources demands a holistic approach whereby we mitigate unintentional harms associated with care delivery during times of crisis and work towards greater justice.

The COVID-19 pandemic has brought inequities in US healthcare into sharp focus. The unequal distribution of personal protective equipment, testing availability, ventilators, hospital beds, and other scarce resources has resulted in disproportionately high mortality rates among marginalized populations, particularly communities of color, low income people, people experiencing homelessness, and people who are [incarcerated](#). Some [states](#) and hospitals have already developed CSC, however many existing CSC have the potential to bias the allocation of resources away from historically and contemporarily marginalized groups, either through intentional resource allocation or unintentional use of criteria that focus on elements that are unfairly apportioned based on social determinants of health. Here, we recommend 1) modifications to existing CSC to ensure greater equity, and 2) a Restorative Justice (RJ) framework for developing CSC to engage all affected stakeholders and build trust.

Improving existing CSC

Until inclusive processes for CSC development can be undertaken, the following measures are recommended to ensure more equitable allocation of resources under CSC:

1. **Resource allocation.** CSC must be applicable to any type of resource that may become scarce. This includes ventilators, other durable equipment, evidence-based treatments, hospital beds, and staff (e.g., respiratory therapists or dialysis nurses). Investigatory treatments should be equitably allocated among the subset of patients expected to benefit from treatment in accordance with the best available scientific evidence.
2. **Implementation.** Resource sharing between regional institutions should be exhausted before applying CSC at a single facility. State Departments of Health should preemptively facilitate the development of coordination agreements for procurement and sharing of resources, as well as for patient transfer, particularly from safety-net hospitals, which may have a more limited ability to adapt in anticipation of patient surges. Such collaborative efforts should be pursued across state lines as necessary and reasonable.
3. **Treatment exclusion criteria.** If required by state or local government, exclusion criteria should be limited to objective conditions for which a dire prognosis is immediately apparent. Similar to non-crisis situations, clinicians remain empowered to avoid the provision of futile care.
4. **Consideration of near-term mortality.** CSC should only consider only near-term mortality (within 1 year) when prioritizing patients to receive scarce resources. [New York](#) and [California](#) provide examples. Consideration of comorbid conditions and longer-term mortality (e.g. 5-year) introduces systemic racism into the resource allocation process by discriminating against populations with higher prevalence of chronic illness, which disproportionately impacts low income populations and people of color. This reflects the individual-level impact of structural racism and poverty.
5. **Disease-specific decision making.** Ideally, a disease-specific triage tool would be used to determine who is most likely to benefit from critical care resources in any given crisis. Currently recommended

scoring systems (SOFA/MSOFA) were not developed for triage assessments and are not validated in surgical or other non-sepsis patient cohorts. Until improved triage tools are developed, these may represent the most objective means of quantifying the severity of acute illness. They should be applied with consideration of their limitations.

6. **Disability considerations.** CSC scoring must explicitly ensure that people with disabilities have equal opportunity to access scarce resources, and reasonable accommodations for support persons during hospitalization. See, e.g., [Massachusetts guidelines](#) (p.17).
7. **Lotteries.** If additional differentiation is needed, a lottery should be used. Consideration should be given to using a [weighted system](#) through which historically disadvantaged groups (e.g., patients living in poverty) and individuals who bear greater risk (e.g., healthcare workers, bus drivers, grocery clerks, etc.) are given increased priority.
8. **Patient re-evaluation.** CSC must ensure patients are periodically reevaluated to determine their priority for continued resource allocation. After initial resource allocation decisions are made and critical care is initiated, the criteria that are used to consider reallocation (including withdrawal) of resources may differ from criteria used to determine who is most likely to benefit on arrival to the emergency department.

Improving the process of CSC development

Restorative Justice (RJ) offers a framework by which community and clinical stakeholders can collaborate to develop CSC that address the needs of those affected, and to make the CSC more responsive to their local communities during any crisis situation. ([Rx for RJ](#)). RJ processes build trust by allowing people to increase understanding through communication. While ideally this process would be used from the start, it could also be used to revise existing CSC.

- **Recognition of prior inequities:** Communities have experienced significant emotional and mental trauma during times of crisis ([RAND](#)). In the United States, communities of color and other marginalized groups have sustained a disproportionate disease burden from COVID-19 ([CDC](#)) .
- **Use of restorative justice to address prior harms:** These inequities spur us to collectively call for creating and implementing CSC through a RJ framework. Intentional efforts at healing prior harms and proactive, inclusive community engagement are necessary for the rebuilding of community/public trust, improving health outcomes, and promoting health equity. RJ allows all affected parties to address their needs by giving the parties a dignified voice and an opportunity to be heard with respect ([Routledge](#)).
- **Implementation of restorative justice practices:** It should be explicitly stated that the participants/stakeholders are the experts on the issue(s) and the RJ facilitator is the expert on the process. By focusing on the key RJ questions that follow, a trusted and transparent CSC statement can be developed.
 1. Who are we? (e.g., patients, families, providers, community organizations)
 2. What are our core values? (e.g., save the most lives, equity)
 3. What is happening and how are you impacted? (e.g., shortages, rationing care)
 4. What do we need in a CSC framework?
 5. How could CSC help put things right?

During this conversation, participants should speak one at a time and share their perceptions, thoughts and feelings. Once each participant has spoken, invite the collective group to collaborate on addressing the identified needs ([Routledge](#)) and CSC content. Record identified needs, ensure time frames and measures are quantified. This framework should be revisited on a routine basis to meet the needs of the community ([RAND](#)) and societal norms.