



Guidelines on Emergency Preparedness for Hospitals During COVID-19 Updated November 8, 2021

As the State of Illinois faces an unprecedented public health emergency, hospitals are faced with an extraordinarily high demand for health care services and must quickly implement actions to address the COVID-19 crisis. When health care providers are forced to operate at increased or full capacity, they must address not only the needs of their individual patients, but the collective needs of the community.

The Illinois Department of Public Health's (IDPH) mission includes preventing disease and injury, developing population-based strategies to address public health issues, and advocating for equitable health care treatment during a pandemic such as COVID-19. This guidance provides a description of Illinois's emergency operation framework, an overview of standards of care during COVID-19, and an ethical framework for administering health care during a pandemic.

This guidance is largely based on the prior work of the State of Illinois's Crisis Standard of Care Workgroup (Workgroup), which was established in 2014 to develop a statewide crisis of care plan in response to the Institute of Medicine's "Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report (2009)." The ethics subcommittee of the Workgroup focused on the ethical framework for delivery of health care in crisis situations and produced a whitepaper entitled, "[Ethical Guidance for Crisis Standards of Care in Illinois](#)" (Ethics Whitepaper) (attached as Appendix A). The Ethics Whitepaper has been a crucial tool to assist health care entities in developing ethically sound policies. In addition, the [IDPH's ESF-8 Plan: Catastrophic Incident Response Annex](#) (ESF-8 CIR Annex) provides facility-specific "Crisis Care and Resource Allocation Tactics" to provide health care providers with resource allocation strategies that may be implemented during catastrophic incidents. Additionally, the Department reviewed resources and best practices adopted by the U.S. Department of Health and Human Services' Office of Civil Rights.¹

Illinois has more than 200 hospitals ranging from small-scale community hospitals to large-scale academic institutions, all of whom may face numerous and novel obstacles to providing care during the COVID-19 pandemic. In the short term, hospitals have needed to take steps such as increasing their bed capacity and temporarily suspending categories of service to increase resources for COVID-19 patients. In addition, hospitals may need to coordinate with other hospitals, local health departments, or alternate care facilities in order to increase capacity. Given the severity of the COVID-19 pandemic, hospitals must be ready to deploy crisis standards of care as they move towards a highly critical stage in their operations.

¹ Available at: <https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/index.html>

I. Illinois's Emergency Operations Framework

Gubernatorial Disaster Proclamations declaring a public health emergency caused by the COVID-19 pandemic have been in effect since March 2020.¹ With the issuance of the Gubernatorial Disaster Proclamations, IDPH activated the Illinois Emergency Operations Plan (IEOP)² and the [Emergency Support Function 8 Plan](#) (ESF-8).³ IDPH also activated the ESF-8 CIR Annex,⁴ which describes the responsibilities of various stakeholders in response to a catastrophic incident such as a public health emergency. Together, these plans outline the activation of state resources when hospitals are overburdened and in need of governmental assistance.

Activation of the IEOP and ESF-8 allows the State to release resources from the State or national stockpile and engage in coordination tactics with various state and local partners. The Illinois Emergency Management Agency (IEMA), the Illinois Medical Emergency Response Team (IMERT), and the Federal Emergency Management Agency (FEMA) have all been deployed to assist hospitals in their response to the COVID-19 pandemic.

Regional health care coalitions are groups of hospital, local health departments, and emergency management personnel that also serve a pivotal role in assisting during a pandemic or disaster and are a crucial resource to hospitals when they are experiencing surges or resource limitations. Each regional health care coalition has a regional hospital coordinating center (RHCC) which serves as the lead entity responsible for coordinating health and medical emergency response in its region. Specifically, RHCCs, in coordination with the regional health care coalition, can coordinate distribution of resources during a public health emergency to hospitals and health care providers. Hospitals should actively utilize their RHCCs to offset shortages and avoid moving towards crisis standards of care.

Each hospital must have a medical disaster preparedness and response plan that contains responses related to a catastrophic incident (referred to as disaster response plan). Disaster response plans should anticipate the need for crisis levels of care, which may be required when standard space, staff, or supplies are unavailable, and providers must implement alternate methods or interventions in order to provide a sufficient level of care. Hospitals should activate crisis care when resources are exhausted and pre-identified triggers have been reached as described in the ESF-8 CIR Annex.

On April 16, 2020, IDPH notified the State Emergency Operations Center (SEOC) that hospitals may need to implement crisis standards of care pursuant to their disaster response plans. Each hospital must notify IDPH when it activates its disaster response plan. Hospitals can provide such notification by informing the RHCC that its disaster response plan has been activated. The RHCC will notify the IDPH Regional Emergency Medical Services Coordinator (REMESC), who will notify IDPH's Incident Command. Hospitals should provide such notifications using the Catastrophic Medical Incident Response Form from

¹ Gubernatorial Disaster Proclamations and related executive orders available at

<https://coronavirus.illinois.gov/resources/executive-orders.html>

² Information about the Illinois Emergency Operations Plan (IEOP) is available at:

<https://www2.illinois.gov/iema/Preparedness/Pages/IEOP.aspx>

³ Illinois Dep't of Public Health, "Emergency Support Function 8 (ESF-8) Plan," Feb. 2018, available at:

<https://dph.illinois.gov/content/dam/soi/en/web/idph/covid19/healthcare-providers/idph-esf-8-plan-2018.pdf>

⁴ Illinois Dep't of Public Health, "ESF-8 Plan: Catastrophic Incident Response Annex," March 2018, available at:

<https://dph.illinois.gov/content/dam/soi/en/web/idph/covid19/healthcare-providers/catastrophic-incident-response-annex.pdf>

the ESF-8 CIR Annex (Attachment 4).⁵ The form assists in communicating vital information to all healthcare and emergency management partners during a disaster in a uniform manner. The ESF-8 CIR Annex (Attachment 5) also provides a Catastrophic Incident Management Pathway that outlines common communication pathways for the sharing of vital information, including communications to IDPH and other partners.⁶

Because the COVID-19 pandemic will hit regions of the State in different phases, each hospital, in consultation with their local health department, RHCC, IDPH, and their regional health care coalition, are best equipped to assess whether and when crisis standards of care are required in their own institution.

II. Standards of Care During the COVID-19 Pandemic

In evaluating necessary changes to the delivery of health care services, hospitals follow a tiered system that escalates from conventional to contingency to crisis standards. Conventional care in a hospital is a stable phase where patients are treated with the usual standard of care.⁷ During such a phase, hospitals have adequate patient care space, appropriate staffing, and sufficient supplies. As hospital resources become strained due to a pandemic such as COVID-19, the hospital may move to a contingency level of care, during which hospitals will experience increased hospitalizations and intensified demands on staff. At the extreme stages of a pandemic, hospitals may need to effectuate a crisis standard of care, which will be needed when the demands for space, supplies, and staffing are highly disproportionate to the available resources such that the hospital is forced to ration supplies and modify its standards of care. Specifically, crisis standards of care are “a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster.”⁸

Hospitals implement crisis standards of care to identify how to deliver the best care possible given the extenuating circumstances, including when there are significant risks to patient safety.⁹ Crisis care standards should be triggered based on the “exhaustion of specific operational resources that require a community, rather than an individual, view be taken in regard to resource allocation strategies.”¹⁰ During this stage, hospitals may seek governmental intervention, legal and regulatory support, and coordination with other health care providers.¹¹

⁵ *Id.* at 28.

⁶ *Id.* at 29.

⁷ The flow chart in Figure 1 is modified from a chart established by the Institute of Medicine, now known as National Academies of Science (IOM/NAM).

⁸ Institute of Medicine. (2012). *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13351>

⁹ *Id.*

¹⁰ Committee on Crisis Standards of Care: A Toolkit for Indicators and Triggers; Board on Health Sciences Policy; Institute of Medicine; Hanfling D, Hick JL, Stroud C, editors. *Crisis Standards of Care: A Toolkit for Indicators and Triggers*. Washington (DC): National Academies Press (US); 2013 Sep. 27. 2, Indicators and Triggers. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK202381/>

¹¹ Institute of Medicine. (2012). *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13351>

The COVID-19 pandemic may lead to such a depletion of resources that many hospitals may need to activate crisis standards of care, although hospitals may determine that it is not necessary to implement a crisis standard of care for all elements of care at the same time. As an example, “certain medications may be in critical shortage, but staff and space are adequate. Providers should be encouraged to identify the specific issue and the relevant coping strategies to balance supply and demand and adjust as required.”¹² Hospitals may use the following guideposts in applying crisis care:

- 1) Crisis care should cover strategies that *extend or go beyond* surge capacity plans.¹³ Surge capacity is generally described as the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity.
- 2) Crisis care is likely to be activated during long-term events such as a pandemic like COVID-19 when there is no practical way to obtain critical resources.
- 3) Crisis care does not allow hospitals to delay patient care; the critical nature of the necessary health care will force immediate decisions.
- 4) Crisis care must gradually move backwards to contingency or conventional care as additional resources become available such as medication, equipment, and staffing.
- 5) Crisis care strategies should be updated throughout a crisis as needed, depending on ongoing resource shortages or increases.

¹² Hick, J. L., D. Hanfling, M. K. Wynia, and A. T. Pavia. 2020. Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2. *NAM Perspectives*. Discussion paper. National Academy of Medicine. Washington, DC. <https://doi.org/10.31478/202003b>

¹³Minnesota Department of Health, “Minnesota Crisis Standards of Care Framework, Health Care Facility Surge Operations and Crisis Care,” March 2020, available at https://www.health.state.mn.us/communities/ep/surge/crisis/framework_healthcare.pdf

III. Ethical Principles and Crisis Standards of Care for COVID-19

In responding to the COVID-19 pandemic, hospitals must make decisions about the delivery of care within an ethical framework. When faced with matters of life and death, decisionmakers must operate from agreed-upon principles of fairness, equity, and non-discrimination. Hospitals have an affirmative duty to plan for disaster and emergency responses in order to protect the greater good.

As health care providers review their crisis standards of care, the following ethical framework should guide patient care and allocation of resources:

- **Trustworthiness.** Hospitals must foster trust, paying special attention to relationships that differ in terms of power, voice, and influence (e.g., administration/staff, clinician/patient/family).
- **Fidelity to and non-abandonment of patients, staff, and community.** Hospitals must ensure the dignity and comfort of all patients, even when they cannot ensure that all of their needs are optimally fulfilled.
- **Benefitting persons and not harming them.** Hospitals must identify and weigh potential benefits, harms, and risks associated with clinical treatments with particular attention paid to ensuring the availability of supportive and palliative care to all.
- **Equity, fairness, and justice.** Hospitals should distribute essential health care supplies pursuant to a prospectively determined ethics framework. The framework may evolve as the pandemic and means to address it change. Processes should be transparent and take into consideration the voices and perspectives of those who are most affected and most vulnerable.
- **Privacy/Confidentiality.** Hospitals must protect patient privacy and ensure the confidentiality of communications required by conventional care standards. Crisis standards of care do not weaken fundamental obligations to protect the privacy and confidentiality of patient information.
- **Solidarity and community.** Hospitals must be guided by a principle of dignity for all persons and a shared responsibility for and to one another.
- **Stewardship of resources.** Hospitals must protect and conserve available resources in order to fulfill their obligations to provide essential patient care.¹⁵

The State of Illinois's Ethics Whitepaper and the ESF-8 CIR Annex provide essential guidance to hospitals during implementation of crisis standards of care, including the importance of non-discrimination in the delivery of health care, the ethical conservation and distribution of scarce resources, and the composition and role of triage teams.

¹⁴ State of Illinois. (2020). Executive Order 2020-19. Retrieved from <https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-19.aspx>

¹⁵ University of Virginia Health System Ethics Committee. (2020, Mar. 26). *Ethical Framework and Recommendations for COVID-19 Resources Allocation When Scarcity is Anticipated*, available at <https://med.virginia.edu/biomedical-ethics/wp-content/uploads/sites/129/2020/03/Ethical-Framework-for-Covid-19-Resources-Allocation-3.26.20.pdf>

A. Non-Discrimination in the Delivery of Health Care

An ethical framework does not permit withholding treatment or prioritizing resources based on one factor, judgments that some individuals have a higher quality or value of life than others, or judgments about greater “social value” in comparison to others. As noted by the Illinois Ethics Subcommittee, “every personal effort must be made not to distribute services on the basis of gender, race, ethnicity, citizenship, national origin, religious belief, sexual orientation, cisgender/transgender status, social value, pre-existing physical or mental disability unrelated to the medical diagnosis or need, or socioeconomic status.”¹⁶ On April 10, 2020, the Office of the Governor of Illinois, along with IDPH, the Illinois Department of Human Services, Illinois Department on Aging, and the Department of Human Rights issued [Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 \(COVID-19\)](#). This guidance was supplemented on January 6, 2021, with [Guidance Affirming Non-Discrimination in Medical Treatment, Including Administration of the COVID-19 Vaccine](#). Together these guidance documents provide specific recommendations for the delivery of health care, including COVID-19 vaccinations, in a manner that promotes the fundamental principles of fairness, equity, and non-discrimination. It also highlights the need for hospitals to prevent biased decision-making that could result in discrimination based on disability or exacerbate racial disparities. Hospitals must adopt resource allocation plans and provide health care consistent with civil rights laws that prohibit discrimination in the delivery of health care.

B. Ethical Conservation of Scarce Resources

Throughout the COVID-19 pandemic, many health care systems in Illinois have faced periods of resource scarcity, such as personal protective equipment, testing materials, and ventilators, and increasing demands for health care workers. Hospitals should prepare for potential resource scarcity by conserving resources where necessary and implementing strategies for shortages of space, supplies, and staff. Hospitals can use the following core strategies to prevent depletion of resources:

- **Prepare.** Pre-shortage actions such as stockpiling essential equipment can minimize the impact of resource scarcity.
- **Substitute.** Identify equivalent drugs, devices, or staff members that can be substituted when ordinary resources are scarce.
- **Adapt.** Use a drug, device, or staff member that will provide sufficient care when typical resources are unavailable.
- **Conserve.** Use less of a resource by lowering dosage or changing utilization practices. Conservation of face masks, medications, or other supplies, where appropriate, may allow hospitals to maintain some adequate level of resources.
- **Re-use.** Re-use items that might ordinarily be considered single use if appropriate sterilization or disinfection is possible.
- **Re-allocate.** Restrict use of resources to those patients with a greater need.

¹⁶ Appendix A, Illinois Crisis Standards of Care Ethics Subcommittee, “Ethical Guidance for Crisis Standards of Care in Illinois.”

C. Allocation of Scarce Resources

When conservation of supplies is insufficient to meet the needs of the crisis, hospitals will face decisions regarding how to allocate resources, including determinations of which patients will receive equipment, testing, treatment, or services. An ethical framework for allocation of scarce resources must include a fair and transparent process that considers factors such as the following:¹⁸

- **Non-discrimination.** As discussed in Section 3(a), allocation of resources must be grounded in principles of non-discrimination.
- **Team decisions.** As discussed in Section 3(d), hospitals should implement triage teams, rather than allowing individual providers to make allocation decisions.
- **Factors for allocation of resources.** Determinations about allocation of scarce resources should be based upon patients' likelihood of short-term survival to hospital discharge. Patients should not be de-prioritized based on age, disability, long-term life expectancy, or the intensity or duration of resource needs.
 - **Allocation decisions may not be based on:**
 1. Race, gender, age, religion, citizenship, sexual orientation, pre-existing physical or mental disability, or socioeconomic status (including the ability to pay)
 2. Judgements that some people have greater quality of life than others
 3. Judgements that some people have greater "social value" than others
 4. Judgements based on the duration or intensity of the resources
 - Facilities may not use categorical exclusion criteria and must conduct individualized assessments based on the best available objective medical evidence.
 - Facilities must be able to make reasonable modifications to the use of any clinical instruments for assessing likelihood of short-term survival to hospital discharge when necessary for accurate use with patients with underlying disabilities. A reasonable modification means a change to a rule, policy, practice, or service needed to ensure the clinical instrument does not downgrade a patient based on the patient's disability. For example, a reasonable accommodation would be necessary where a clinical instrument automatically lowers the assessment score of a patient due to disability.
- **Randomized selection.** After application of the above criteria, randomized selection processes may still be necessary if two patients are equally likely to benefit from a resource.
- **Palliative care.** Palliative care resources should be available to any patient to minimize pain and suffering.
- **End of life decision-making.** Healthcare providers may not exert undue influence, "steer" or pressure patients into agreeing to the withdrawal or withholding of life-sustaining treatment or require patients or their families to consent to a particular advanced care planning decision in order to continue to receive services from a facility. Further, providers may not impose blanket Do Not Resuscitate (DNR) policies. Patients must be given information on the full scope of available alternatives. [Civil Rights and COVID-19 | HHS.gov.](#)
- **Medical Treatment Policies.** Healthcare providers should have policies in place and appropriate training for medical staff that further prohibit steering or influencing patients with disabilities and their families into consenting to withdrawal of or withholding of life-sustaining treatment.
- **Civil rights protections.** While the pandemic brought forth the suspension of various federal and state laws, the Office of Civil Rights (OCR) emphasized that civil rights laws remained in effect. <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>. Hospital licensing regulations in Illinois require hospitals to have policies on patients' rights and an established

process on filing a grievance based on discrimination. Hospitals must ensure that their patients' rights policies protect the most vulnerable populations and those individuals with disabilities who may face discrimination and unfair treatment during COVID-19. Hospitals must also follow the Medical Patients' Rights Act, 410 ILCS 50, by providing each patient, including those with a disability, a patient bill of rights. Providers should ensure that their patient bill of rights includes protections for those with disabilities, emphasizing fairness and ethical treatment when it comes to the allocation of scarce resources.

- **Essential workers.** Hospitals may need to prioritize essential or key workers within the health care system in order to maintain acceptable staffing levels. This includes prioritizing available personal protective equipment to health care workers so they can continue to provide essential care.
- **Re-assessment.** Hospitals should continually assess the availability of resources in order to reallocate resources as needed.

Perhaps the most difficult issue facing hospitals during the COVID-19 pandemic is the shortage of ventilators. Confronted by this issue, hospitals must rely upon a principled framework to guide their decisions for ventilator allocation when need exceeds supply. This framework should always aim to maximize positive health outcomes, consistent with the allocation principles described above. Health care providers should begin their decision-making process with the premise that all patients should have the opportunity to be eligible for ventilator support. In order to prevent compounding existing health care access disparities, ventilator policies should not be based on a "first come, first serve" basis. If the treating hospital does not have capacity to provide a ventilator, it should attempt to transfer a patient to another facility with available resources. If the potential receiving hospital has excess capacity, it should be willing to accept the transfer of patients or to provide unused ventilators to hospitals that are in high need of such resources and able to use them. Hospitals may not re-allocate personal ventilators or other life-sustaining medical equipment brought to the facility by a patient themselves.

In addition to scarcity of supplies, essential health care workers may be scarce due to high demand and exposure to the virus. Hospitals must have contingency plans in place for the possibility that the number of staff available will be inadequate due to fatigue, illness, or increased hospitalizations. The Illinois Department of Financial and Professional Regulation (IDFPR) has taken several actions to increase the health care workforce, including the issuance of temporary licenses to out-of-state and inactive physicians, nurses, physician assistants, and respiratory care practitioners.¹⁹ The IDPH has taken similar actions regarding certified nursing assistants.²⁰ Hospitals may also consider using disaster privileges to bring additional staff from other hospitals without having to complete separate credentialing.²¹ Accessing these additional staffing resources may be necessary to alleviate hospital staffing shortages as the COVID-19 outbreak progresses.

Providers should be transparent about treatment plans when operating in crisis standards of care and accountable towards the communities they serve. The public should not be left in doubt as to how the health care system intends to respond to a pandemic like COVID-19.

¹⁸ These values are derived from the Ethics Subcommittee whitepaper "Ethical Guidance for Crisis Standards of Care in Illinois."

D. Composition and Function of Triage Teams

One of the key elements of crisis standards of care is having an established triage plan that removes decision-making from one individual. A triage plan matches patients with the appropriate resources based on their need or the potential benefit from a certain medical treatment. Hospitals should already have established triage teams in place to provide a consultative process on difficult treatment decisions. Triage teams are particularly crucial when hospitals are in contingency or crisis levels of care to ensure that decisions are being made consistently and fairly. Triage teams prevent a single individual from having to make a unilateral decision on treatment and allocation of resources. Hospitals can adopt many different approaches to triage teams.²²

A triage team should have an assigned leader to manage the decision-making and should be comprised of a staff physician who specializes in infectious disease, nursing staff, hospital administration, and medical ethicists who have the ability to provide peer review. The bedside care team (i.e. the team providing treatment to the patient) should not be part of the triage team in order to maintain objectivity and avoid conflicts of interest. Instead, the treating physician should communicate the relevant medical background to the triage team.

The triage team is responsible for making scarce resource allocation decisions based on the hospital's ethical framework, as described above. The team then makes treatment recommendations to the appropriate medical staff. The hospital should have an appeals or review process in place to immediately review the triage team's decision or recommendation in the event new information becomes available that would change the course of treatment. The appeals process should be conducted by a clinical care team or individuals who were not part of the triage team in order to avoid bias in a final decision.²³

During the COVID-19 pandemic, hospitals must not simply employ existing triage plans; instead, they should immediately review their triage team structures and principles to prepare for a potential crisis standard of care phase.

IV. Conclusion

As hospitals in Illinois continue to face the challenges caused by COVID-19, they must immediately assess their plans for addressing significant increases in demand that require balancing staff and supplies, review their crisis standards of care, and integrate these standards within the IEOP as necessary. Applying a strong ethical lens to any rationing strategies will help reduce health care disparities and adverse outcomes.

¹⁹ Additional resources from IDFPR for Illinois licensees impacted by COVID-19 are available at: <https://www.idfpr.com/COVID-19.asp>.

²⁰ Additional resources from IDPH regarding flexibility for Certified Nursing Assistants is available at: <http://www.dph.illinois.gov/covid19/governor-pritzkers-executive-orders-and-rules>.

²¹ 77 Ill. Adm. Code 250.310(b)(18).

²² These recommendations are derived from the Ethics Subcommittee whitepaper "Ethical Guidance for Crisis Standards of Care in Illinois."

²³ University of Virginia Health System Ethics Committee, (2020, Mar. 26). *Ethical Framework and Recommendations for COVID-19 Resources Allocation When Scarcity Is Anticipated*, available at: <https://med.virginia.edu/biomedical-ethics/wp-content/uploads/sites/129/2020/03/Ethical-Framework-for-Co-vid-19-Resources-Allocation-3.26.20.pdf>