Frequently Asked Questions:
New York State Task Force on Life and the Law and the New York State Department of Health's Ventilator Allocation Guidelines

These FAQs answer commonly asked questions about the 2015 Ventilator Allocation Guidelines (the Guidelines). For a comprehensive overview, see the Executive Summary of the Guidelines.

General Overview

Q: Why are these Ventilator Allocation Guidelines necessary?
A: The Task Force and the Department of Health recognize that the government has a duty to prepare for a severe influenza pandemic and other health-related emergencies. One anticipated problem during a severe pandemic is the shortage of life-sustaining equipment such as ventilators. A safe, equitable, and efficient mechanism is needed to determine whether a patient will or will not receive ventilator therapy. The Guidelines create an ethical and clinical framework for making such decisions and are crafted to provide the greatest benefit to as many patients as possible. Prudent planning can limit loss of life in the face of such a mass disaster.

Q: Can the State stockpile as many ventilators as would be needed in a severe pandemic?
A: Even if New York State purchases additional ventilators, the demand would quickly outpace supply in a severe pandemic. No matter how many ventilators are available, in a severe pandemic there will be shortages because so many people will be sick at the same time. In addition, even with enough ventilators, a sufficient number of trained staff may not be available to operate them, particularly because health care workers will be among the ill.

Q: Who developed the Guidelines?
A: The New York State Task Force on Life and the Law, the State's bioethics commission that recommends public policy on issues arising at the interface of medicine, law, and ethics, was specifically charged by the New York State Department of Health with examining ventilator allocation in an influenza pandemic.

Q: How were the Guidelines developed?
A: These Guidelines were developed by incorporating comments and feedback from numerous stakeholders, including members of the general public and experts in the fields of medicine, ethics, law, and policy. The Guidelines draw upon the expertise of clinical workgroups and committees, literature review, public feedback, and insightful commentary. Because research and data on this topic are constantly evolving, the Guidelines are a living document and are subject to revision. The Guidelines incorporate an ethical framework and evidence-based clinical data that support the goal of saving the most lives in an influenza pandemic where there are a limited number of ventilators.

Q: What are the differences between the 2007 and 2015 Guidelines?
A: The 2007 Draft Guidelines included an ethical framework, a clinical ventilator allocation protocol for adults, and a brief legal issues discussion. To obtain additional public comment, the Task Force oversaw an extensive public engagement project in 2011 and incorporated these results and prior public feedback into the 2015 revision. The 2015 Guidelines are more comprehensive and include several new chapters. The ethical framework is more detailed, and the adult clinical ventilator allocation protocol has been expanded to include a more robust discussion of the reasoning and logic behind certain features of the protocol. Additionally, the 2015 version examines special considerations and ethical issues related to the treatment of children in a pandemic, and it includes two new detailed clinical ventilator allocation protocols – one for pediatric patients (17 years old and younger) and another for neonates (infants less than 28 days old). Finally, the brief summary on legal issues from 2007 has been replaced with a substantial exploration of the various legal issues that may arise when implementing the clinical protocols for ventilator allocation.

Q: How are the Guidelines organized?
A: The Guidelines consist of four chapters: (1) Adult Guidelines, (2) Pediatric Guidelines, (3) Neonatal Guidelines, and (4) Implementing New York State's Ventilator Allocation Guidelines: Legal Considerations. For ease of reference, at the end of the report are the adult (Appendix A), pediatric (Appendix B), and neonatal (Appendix C) clinical ventilator allocation protocols (the Clinical Protocols for Ventilator Allocation).

Q: Are the clinical protocols for ventilator allocation for adults, children, and neonates the same?
A: No. The Guidelines provide separate and distinct protocols for each of these three populations. While the ethical framework and clinical steps to evaluate patients are the same, the specific clinical tools used to evaluate patients are different. However, the underlying principle of all three protocols is the evaluation of a patient's likelihood of survival with ventilator therapy.

Q: Why do we need separate protocols for adults, children, and neonates?
A: A one-size-fits-all approach to emergency planning is not appropriate, and the differences between adult and pediatric patients warrant specialized attention. Children are not just small versions of adults; their immature anatomy and developing physiology often result in a distinct response to disease. In addition, neonates' (infants less than 28 days old) physiologic and pathophysiologic processes are different than those of pediatric and adult patients. For example, care given to neonates must often also consider physiologic maturation (e.g., lung development). To account for these differences, separate protocols must be in place for each population.

Q: How were the three specific clinical protocols for ventilator allocation developed?
A: For each protocol, the Task Force convened separate population-specific clinical workgroups, consisting of specialists in critical care, respiratory therapy, palliative care, public health, and ethics, as well as in pediatric, neonatal, emergency, and maternal-fetal medicine. Each workgroup examined possible components of a clinical protocol for ventilator allocation and weighed its advantages and disadvantages. The members analyzed the logic of and reasoning why specific

triage components should or should not be included and ensured that all factors incorporated into the protocols are evidence-based.

Q: For whom are the Guidelines intended?
A: The Guidelines are primarily intended for implementation in hospitals by health care providers and workers. The ethical and clinical framework is also being made available for public review.

Q: Was the public invited to comment during development of the Guidelines, and will they have an opportunity to comment on the Guidelines?
A: To ensure that the Guidelines reflect the values of New Yorkers, the Task Force made extensive efforts to obtain public input. Public engagement and outreach is important to not only inform the public but to also gather feedback to modify the Guidelines. For the Guidelines to be accepted, the public and stakeholders need to provide input so the Guidelines reflect the public's values.

The 2007 Draft Guidelines were published in the State Register and on the Department of Health's website. The Task Force sought additional feedback from stakeholders and specialists both in and outside of New York. Public outreach efforts also included presentations on the Guidelines at professional medical associations, bar associations, and medical centers; meetings with regional hospitals and local health departments; and webinars and video/audio conferences for county health officials, senior hospital administrators, and physicians. In addition, the content of the Guidelines was presented at numerous community meetings on pandemic flu preparedness throughout the State and at three half-day tabletop exercises with health care and allied professionals to obtain comment and feedback. In addition, in 2011, the Task Force oversaw a special public engagement project, conducting focus groups throughout the State. Finally, the Guidelines have been presented at national professional conferences to reach a broader audience. The Task Force considered all comments and incorporated them where appropriate. Similar public outreach efforts will be conducted regarding the 2015 Guidelines and the public will have an opportunity to comment on the revised Guidelines.

Q: How did SARS, Hurricane Katrina, novel H1N1 influenza, Superstorm Sandy, and the ebola outbreak of 2014 influence the development of the Guidelines?
A: Respiratory-related diseases, viral infectious diseases, and natural disasters in the past decade have highlighted the need for preparedness plans. With each event, the Task Force and Department of Health have made significant efforts to make the Guidelines as comprehensive as possible. These events have also emphasized the need for ventilator allocation protocols because it is highly likely a similar type of event could occur in the foreseeable future.

Q: Can the Guidelines be applied to another public health emergency?
A: While the Guidelines were written to address the allocation of scarce ventilators during an influenza pandemic, the potential exists for broader application in other public health emergencies that require allocation of scarce ventilators. The general framework could be adapted with appropriate modifications to the clinical protocols.

Q: Are the Guidelines final?
A: No. The Guidelines are a living document, intended to be updated and revised in line with advances in clinical knowledge and societal norms. As data on the pandemic viral strain and best practices for treatment become available during a pandemic, the clinical protocols for ventilator allocation may be revised accordingly to ensure that patients receive the most appropriate care. The Task Force and the Department of Health will continue to seek feedback from stakeholders and especially the public, and further revisions may occur.

Implementation of the Guidelines

Q: What can hospitals do to reduce the demand for ventilators in a pandemic?
A: Before the Guidelines are implemented, hospitals should practice "surge capacity" to reduce the need for ventilators. For example, elective procedures that require ventilators should be canceled and/or postponed during the period of emergency. For a moderate pandemic, surge capacity practices may be enough to meet the increased demand for ventilators. However, in the event of a severe pandemic, surge capacity measures would still fall short of addressing the anticipated demand for ventilators.

Q: Will the Guidelines be implemented Statewide? What if I want to take my family member from our local hospital to someplace else in the State (or to another state) where ventilators might be more available?
A: The Guidelines should be implemented Statewide in the event of an influenza pandemic that necessitates ventilator allocation. Although a pandemic will likely strike different regions of the State at different times, and it is probable that different facilities will experience ventilator shortages at different times. Consistent Statewide policies are crucial to avoid large variations in ventilator access and distribution among facilities. Otherwise, inequities may result in excess mortality of disadvantaged and vulnerable populations. Furthermore, ill individuals will most likely be too sick to be transported, and because other states are developing similar guidelines, they may be subject to clinical protocols for ventilator allocation there.

Q: Can ventilators from one part of the State be transported to another part of the State that is particularly affected by the pandemic?
A: While outside the scope of the Guidelines, the Guidelines encourage hospitals within close geographic proximity to coordinate and plan transfer and loan agreements before a pandemic occurs. However, in a severe pandemic, it is likely that all regions of the State would be affected at some point. Thus, the Guidelines anticipate that ultimately there will be shortages of ventilators throughout the State.

Ethical Considerations and Guidelines' Framework

Q: What are the ethical principles that are the foundation for the Guidelines?
A: The Guidelines provide an ethical framework to serve as the foundation for the clinical ventilator allocation protocols. This framework is premised on the following:

- Respecting the fundamental obligation of health care providers to care for patients (the "duty to care").
- Preventing inequities by devising a just system in advance for allocating ventilators in a time of critical shortage (the "duty to steward resources", "duty to plan", and "distributive justice").
- Ensuring transparency by engaging in clear, consistent communication among health care providers, patients, their families, and the general public ("transparency").

Q: What is the goal of the Guidelines?
A: The goal of the Guidelines is to save the most lives in an influenza pandemic where there are a limited number of available ventilators. Patients for whom ventilator therapy would most likely be lifesaving are prioritized. Thus, patients who are most likely to survive without the ventilator, together with patients who will most likely survive with ventilator therapy, increase the overall number of survivors.

Q: Under the Guidelines, will patients with pandemic influenza be treated differently than other patients?
A: No. All hospital patients who need a ventilator are subject to clinical protocols for ventilator allocation, regardless of their disease category (e.g., influenza or other condition), race, ethnicity, sexual orientation, socio-economic status, perceived quality of life, ability to pay, or role in the community.

Q: How do these Guidelines apply to persons who are ventilator-dependent in chronic care (long-term) facilities?
A: The Guidelines do not apply to patients who are ventilator-dependent in chronic care facilities. However, if a ventilator-dependent individual requires hospital care for an urgent medical condition, s/he is subject to the clinical protocol for ventilator allocation. Once a patient arrives at a hospital, s/he is treated like any other patient who requires ventilator therapy. This policy balances the need to protect vulnerable populations with the principle of treating all patients in need of a ventilator equally. Thus, long-term care facilities should treat their patients as much as possible and only transfer patients to hospitals for serious and urgent conditions.

Q: Will health care workers or other first responders get first access to ventilators?
A: No. Health care workers and other first responders do not get priority treatment under the Guidelines. In a pandemic, if a health care worker with influenza needs ventilator therapy, s/he will be unlikely to return to work or care for patients. Also, if ventilators are in short supply, prioritizing first responders may leave no ventilators for community members, including children. Instead, health care staff should have priority access to vaccines and medicines that prevent influenza to protect them from becoming sick and enable them to provide care to patients.

Q: What methods of ventilator allocation were considered?
A: Various non-clinical approaches to allocating ventilators, including distributing ventilators on a first-come first-serve basis, randomizing ventilator allocation (e.g., lottery), requiring only informal physician clinical judgment in making allocation decisions, and prioritizing certain patient categories (i.e., health care workers, patients of advanced age, and patients with certain social criteria) for ventilator therapy were examined. However, the Task Force determined that these

methods should not be used as the *primary* triage strategy because they are often subjective and/or do not support the goal of saving the most lives. Instead, an allocation protocol should utilize *clinical* factors only to evaluate a patient's likelihood of survival and to determine the patient's access to ventilator therapy.

Q: Is quality of life a consideration when determining who is eligible for ventilator therapy?
A: No. Third-party assessments of quality of life are based on biased personal values and may impose on the rights of the disabled. Subjective opinions should never be part of a triage decision.

Q: How do the Guidelines establish how decisions to withhold or withdraw ventilator therapy should be made?
A: The Guidelines are specific about the circumstances under which a decision to withhold or withdraw ventilator therapy should be made. They call for health care providers to evaluate patients based on universally-applied clinical criteria. Under the Guidelines, under no circumstance will a decision regarding ventilator allocation be based on non-clinical factors such as race, ethnicity, sexual orientation, socio-economic status, perceived quality of life, ability to pay, or role in the community.

Q: Can a person opt out of the clinical protocol for ventilator allocation and "give" the ventilator to another specific person (e.g., a family member)?
A: Under the Guidelines, while a patient (or a designated surrogate decision-maker) may decline ventilator therapy and instead seek alternative forms of medical intervention and/or palliative care, the patient cannot "give" the ventilator to another patient. Because all patients must be clinically evaluated under the protocol, only those patients who are deemed likely to survive with ventilator therapy would be eligible.

Q: Will pregnant women receive special access to ventilator therapy?
A: No. Pregnant women are subject to the adult clinical ventilator allocation protocol. However, while outside the scope of these Guidelines, pregnant women should be prioritized for vaccines and other prophylactic measures to *prevent* influenza. By preventing influenza, they would have better outcomes, including averting preterm delivery.

Q: Does age play a role in the triage decision?
A: Yes, age plays a role in ventilator allocation decisions under limited circumstances. The Task Force rejected using advanced age as a triage criterion, but, because of a strong societal preference to save children, the Guidelines recommend that *young* age may be considered as a *tie-breaking criterion in limited circumstances*.

Clinical Protocols for Ventilator Allocation

Q: Who makes the decision to allocate ventilator therapy to a patient?
A: To ensure that patients receive the best care possible in a pandemic, the Guidelines provide that a patient's attending physician does not determine whether his/her patient receives or continues with ventilator therapy; instead, a triage officer or triage committee makes the decision. This role sequestration allows the clinical protocol for ventilator allocation to operate smoothly.

The decision regarding whether to use either a triage officer or committee is left to each hospital, because available resources will differ at each site.

Q: Under the Guidelines, will patients be compared or compete against each other for ventilator therapy?
A: No. Under the Guidelines, patients will not be compared against each other or compete with one another for ventilator therapy. Comparing patients could require the withdrawal of the ventilator if another patient has a better prognostic health assessment. To compare patients with each other could force a triage officer/committee to prematurely withdraw ventilators from patients more often, and could lead to fewer patients surviving. In addition, such comparisons may intensify inherent biases in the health care system and the disproportionate and disparate provision of care for already disadvantaged populations.

Q: What are the steps of the clinical protocols for ventilator allocation?
A: For all three clinical protocols for ventilator allocation, there are three steps: (1) application of exclusion criteria, (2) assessment of mortality risk, and (3) periodic clinical assessments ("time trials"). While the clinical tools used to evaluate patients are different for the adult, pediatric, and neonatal protocols, the overall framework is the same.

Q: What are the exclusion criteria in Step 1?
A: The purpose of applying exclusion criteria is to identify patients with a short life expectancy, in order to prioritize patients most likely to survive with ventilator therapy. The medical conditions that qualify as exclusion criteria are limited to those associated with immediate or near-immediate mortality even with aggressive therapy. Advanced age, disability, "social worth," and other judgments not related to immediate or near-immediate mortality are NOT exclusion criteria. A patient with a medical condition that is an exclusion criterion is not eligible for ventilator therapy and will receive alternative forms of medical intervention and/or palliative care.

Q: Is a DNR order an exclusion criterion?
A: No. A DNR (Do Not Resuscitate) order informs health care professionals that a patient does not wish to receive cardiopulmonary resuscitation (CPR), which is a procedure to restart a patient's heartbeat and breathing after cardiac arrest. Such an order is only a decision about CPR and does not relate to any other treatment, including ventilator therapy.

Q: Is renal dialysis an exclusion criterion?
A: No. While the 2007 Draft Guidelines included renal dialysis, the 2015 Guidelines do not include this medical condition as an exclusion criterion. Because the purpose of applying exclusion criteria is to identify patients with an immediate or near-immediate probability of death even with aggressive treatment, renal dialysis does not fit into this framework or predict mortality.

Q: What does Step 2 (assessment of mortality risk) involve?
A: While the adult, pediatric, and neonatal protocols do not utilize the exact same clinical tools to assess patients' mortality risks, the overall framework of all three clinical protocols for ventilator allocation is the same. Patients who have the highest likelihood of survival with ventilator therapy have the highest access to this treatment. The adult protocol uses SOFA (Sequential Organ Failure

Assessment), a clinical scoring system, to assess mortality risk. The pediatric and neonatal protocols assess mortality risk utilizing physician clinical judgment, a structured decision-making process that carefully considers only specific clinical factors based on available medical evidence.

Q: Why is physician clinical judgment used in Step 2 for the pediatric and neonatal clinical ventilator allocation protocols?
A: At this time, SOFA is not validated for use for patients 17 years old and younger or as a tool to triage children. In addition, there are no pediatric clinical scoring systems that have been validated to triage children. Thus, because there are no evidence-based data to endorse the use of any clinical scoring system for these populations, physician clinical judgment is used. With a framework that only examines specific clinical variables, physician clinical judgment can be used to make allocation decisions in a uniform manner.

Q: What does Step 3 ("time trials") involve?
A: In a public health emergency, periodic evaluations of a patient at 48 and 120 hours after s/he has begun ventilator therapy are necessary to determine whether the therapy is effective for that patient. No formal triage decision or action may be taken until a patient's official assessment. Patients showing improvement in overall health continue with ventilator therapy until the next assessment, and those who no longer meet the criteria for continued use receive alternative forms of medical intervention and/or palliative care. The use of time trials ensures uniform official assessments and provides valuable information about the status and real-time availability of ventilators.

Q: Why are time trials set at 48 and 120 hours after a patient has begun ventilator therapy?
A: The time trial intervals of 48 and 120 hours were selected because they reflect the expected duration of beneficial treatment for acute respiratory distress or other likely complications of severe influenza. Shorter trials (e.g., 24 hours) permit more patients access to ventilator therapy, but require more frequent extubations of more patients, a situation the Guidelines attempt to minimize. In contrast, long time trials result in fewer patients receiving ventilator therapy. As data about the pandemic viral strain become available during a pandemic, the length of the time trials may be adjusted.

Q: At an official time trial assessment, how are decisions made regarding continuation (or discontinuation) of ventilator therapy?
A: Although the clinical elements for evaluating patients in each of the clinical protocols for ventilator allocation are different, the justification for continuing ventilator eligibility is consistent across all three protocols. Triage decisions are made based on ongoing clinical measures and data trends of a patient's health condition, consisting of: (1) the overall prognosis estimated by the patient's clinical indicators, which is indicative of mortality risk by revealing the presence (or likelihood), severity, and number of acute organ failure(s), and (2) the magnitude of improvement or deterioration of overall health, which provides additional information about the likelihood of survival with ventilator therapy. Thus, the guiding principle for the triage decision is that the likelihood of a patient's continuation of ventilator therapy depends on the severity of the patient's health condition and the extent of the patient's medical deterioration. The less severe a patient's

health condition and demonstration of improvement with ventilator therapy, the higher the likelihood s/he continues with this form of treatment.

Q: What happens after a patient receives 120 hours of ventilator therapy?
A: After the 120 hour clinical assessment, patients who are eligible to continue with ventilator therapy are reassessed every 48 hours using the same clinical framework used in previous time trial assessments.

Q: Should pediatric or neonatal patients have longer time trials?
A: No. At this time, there is no evidence-based data to suggest a different time trial for ventilator use for children. The clinical workgroups agreed that for ease of use and consistency, the time trials should be the same as the adult intervals. However, when more data about the viral strain become available during a pandemic, the length of the time trials may be adjusted not only for children and neonates, but also for adults.

Q: In Steps 2 (assessment of mortality risk) and 3 (time trials), what do the color codes mean and how are they assigned?
A: A triage officer/committee examines a patient's clinical data and uses this information to assign a color code to the patient. The color (blue, red, yellow, or green) determines the level of access to a ventilator (blue = lowest access/palliate/discharge, red = highest access, yellow = intermediate access, and green = defer/discharge). Patients with the red color code have the highest level of access to a ventilator. The Task Force selected these colors because they are consistent with other tertiary triage protocols and are universally recognized for triage purposes.

Q: In Steps 2 and 3, how does a triage officer/committee determine whether a patient should receive ventilator therapy (in Step 2) or continue/be removed from ventilator therapy (Step 3) when there are more eligible patients than ventilators?
A: A triage officer/committee makes triage decisions according to a specific, multi-step clinical framework that is explained in the adult, pediatric, and neonatal clinical ventilator allocation protocols. A patient's likelihood of survival is the most important consideration when evaluating whether a patient will receive ventilator therapy. A patient whose health continues to improve remains eligible for ventilator therapy and a patient who does not show signs of improvement receives alternative forms of medical intervention and/or palliative care. A patient may only be removed from a ventilator after an official time trial clinical assessment demonstrates that such a step is appropriate, including where the patient develops a medical condition on the exclusion criteria list.

When there are no other evidence-based clinical factors to consider that would further differentiate patients' likelihood of survival, a secondary triage criterion may be used. Different criteria will be considered based on whether the eligible patient pool consist of only adults, only children, or both adults and children. If the patient pool consists of *only adults* or *only children*, a randomization process, such as a lottery, is used each time a ventilator becomes available because there are no other evidence-based clinical factors available to consider. However, in limited circumstances, if: (1) the pool of patients eligible for ventilator therapy includes *both adults and children*, and (2) all available clinical data suggest that the likelihood of survival among the pool of

patients have been found equivalent (i.e., all patients are assigned a red color code), then young age (i.e., 17 years old and younger) may be utilized as a tie-breaker to select a patient for ventilator therapy.

Q: Why is resource utilization/estimated duration of ventilator need not a factor in the clinical allocation protocols?
A: Such a criterion does not affect a patient's likelihood of survival, which is the key consideration when determining access to ventilator therapy. Furthermore, while accurately predicting the estimated length of time a patient may need ventilator therapy would be helpful when triaging patients, at this time, it is impossible to offer any reasonable quantitative projection regarding need without data about the pandemic viral strain. For example, until the pandemic is occurring, no one knows what the average number of ventilator days an influenza patient will need to survive.

Q: How do the Guidelines address medical care for patients who are not eligible for ventilators? Or those who are eligible but are waiting for a ventilator to become available?
A: Patients who have a medical condition on the exclusion criteria list or who no longer meet the clinical criteria for continued ventilator use receive alternative forms of medical intervention and/or palliative care. The same applies to patients who are eligible for ventilator therapy but for whom no ventilators are currently available. Alternative forms of medical intervention, such as other methods of oxygen delivery and pharmacological antivirals, should be provided to those who are not eligible or waiting for a ventilator. In addition, actively providing palliative care, especially to patients who do not or no longer qualify for ventilator therapy, decreases patient discomfort and fulfills the provider's duty to care, even when the clinician can no longer offer ventilator therapy.

Q: What if a patient tries to obtain ventilator therapy by not disclosing relevant medical history?
A: Failure to disclose pertinent medical information is unlikely to lead an individual to more easily access ventilator therapy. While it is possible that a patient may try to hide certain details of his/her medical history in an effort to obtain ventilator therapy, and s/he may be able to bypass Step 1 (Exclusion Criteria), it is likely that the patient will be ruled ineligible for ventilator therapy during the subsequent triage steps, because precise real-time clinical data about the patient's health continue to be gathered.

Q: How will data collection and analysis during a pandemic affect the triage process?
A: There must be real-time data collection and analysis to modify the Guidelines based on new information. Data collection and analysis on the pandemic viral strain, such as symptoms, disease course, treatments, and survival, are necessary so that the Guidelines may be adjusted accordingly to ensure that patients receive the best care possible. In addition, data collection must include information regarding real-time availability of ventilators so that resources can be allocated most effectively. Knowing the exact availability of ventilators also assists a triage officer/committee in providing the most appropriate treatment options for patients.

Legal Considerations

Q: Will the Guidelines be issued as binding law?
A: No. A clinical ventilator allocation protocol must be designed to allow for sufficient flexibility to adjust to changing clinical information. The static nature of regulation could make it an inadequate approach for clinically detailed recommendations. For this reason, voluntary guidelines are preferable to regulations or law in this instance.

Q. Do the Guidelines describe an appeals process for ventilator allocation decisions?
A. Yes. Experts agree that review of allocation decisions during a pandemic is necessary to ensure that the process is followed consistently and fairly. A hybrid system of review – combining limited on-going individual appeals with retrospective periodic review – which incorporates the advantageous features of both under the constraints of the pandemic. Under this system, individual appeals would be limited to procedural/technical injustices only (e.g., when a withdrawal decision was made without considering all relevant clinical triage criteria) that could remedy a potential injustice prior to the implementation of a triage decision. Retrospectively, all cases would be reviewed periodically to verify adherence with the Guidelines, and would enable evaluation of triage decisions to improve subsequent decisions.

Q: Will health care facilities and providers be shielded from liability if they follow the Guidelines and deny ventilator therapy to patients?
A: Current law may provide some liability protection, but there is no immunity from liability. Under current law, courts may consider the Guidelines to be evidence of the medical standard of care in an influenza pandemic, upon which facilities and providers can rely, thereby providing some liability protection.

Next Steps

Q: How will the public be informed of the Guidelines?
A: Efforts will be made to inform and gather feedback from the public, and may include posting of the Guidelines on government websites; open comment periods; presenting the Guidelines at conferences, meetings, webinars, community meetings; and conducting tabletop exercises and focus groups. In addition, a public awareness and education campaign on the Guidelines using various print, radio, and social media outlets will be performed.

Many people, however, will not be aware of the Guidelines until a pandemic is declared. At that time, the public must be informed about the goals and steps of the clinical ventilator allocation protocols. Information should emphasize that pandemic influenza is potentially fatal, that health care providers are doing their best with limited resources, and the public must adjust to a different way of providing and receiving health care than is customary. Patients and families must be informed that ventilator therapy represents a *trial* of therapy that may not improve a patient's condition sufficiently and that the ventilator will be removed if this approach does not enable the patient to meet specific criteria. Training of staff for pandemic readiness should include guidance on how to discuss the clinical ventilator allocation protocols. Communication should be clear upon hospital admission and ICU admission, as well as upon initiation of ventilator therapy.