**SUPPLEMENTARY MATERIAL**

**Supplementary Material A**

Below is a list of all of the triggers and indicators brainstormed and voted on by the group of clinical panelists. Beside each item is the highest percent of agreement achieved for that trigger or indicator; many items did not reach the defined consensus point of ≥70%. If two rankings tied for the highest percentage of agreement they are both listed under the importance ranking.

**Key**

4 or 5 - Important

3 - Neutral

1 or 2 - Unimportant

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| **Decision #1: Resource Conservation -** What is the threshold at which we as a community implement standardized guidelines/orders associated with resource conservations? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When one party's actions significantly impact the larger whole. For example, performance of surgery while the blood supply is significantly impaired. | 4 or 5 | 76% |
| Monitor number of products in community supply, both current and anticipated. ½ to 1 day inventory or less is cause for concern. | 4 or 5 | 100% |
| Enact guidelines (not orders) when we have evidence that the critical resources are becoming limited – (e.g. PPE equipment, we many need guidelines to reinforce appropriate use and perhaps define alternate use (reuse etc.)). | 4 or 5 | 76% |
| Enact Public Health orders when we are in crisis levels of care and patient outcomes and lives are at risk or are affected. | 4 or 5 | 82% |
| Monitor vendor inventory for depletion rate/requests pending. | 4 or 5 | 76% |
| When under 72 hour re-supply or use. | 4 or 5 | 76% |
| When centralized distributors confirm that there is ≤ 3 days’ supply of perishable/disposable items. | 4 or 5 | 88% |
| When 80% of a certain resource is consumed throughout the entire region, and it is known that it cannot be replenished via the conventional supply chain. | 4 or 5 | 82% |
| Trigger such as earthquake would mandate immediate consideration of conservation. | 4 or 5 | 82% |
| When hospitals have to start going out of their standard supply chains to get materials we should consider implementation of standardized guidelines/orders. | 4 or 5 | 71% |
| When shortages begin to interfere with patient care or interferes with provider safety. | 4 or 5 | 94% |
| When shortages begin to interfere with services and diagnostic testing. | 4 or 5 | 71% |
| When more than 50% of healthcare facilities report nearing exhaustion of normal supplies and resources and starting to access their contingency supplies and resources in the setting of restricted or impaired delivery by primary and alternate vendors. | 4 or 5 | 94% |
| If the estimated or potential scope of the crisis is believed to be of a magnitude to exceed contingency capacity, then stronger restriction of use policies need to be quickly developed and implemented. | 4 or 5 | 71% |
| Have an escalating series of actions triggered by the (presumably decreasing) inventory / capacity of the resource in question e.g. 40% triggers one set of actions, 30% triggers another, and 20% triggers the most conservative response. | 4 or 5 | 76% |
| When there is concern about scarcity of pharmaceuticals (e.g. 90% of albuterol used up in King County) -or antibiotic scarcity (90%). | 4 or 5 | 88% |
| When facilities are running out of certain supplies and closing their doors. | 4 or 5 | 88% |
| When supply chain is predicted to be unreliable. | 4 or 5 | 71% |
| If the event significantly impacts the local healthcare network that would result in compromise of patient care. | 4 or 5 | 76% |
| Look at facilities seeking Diversion status for "warning order." | 3 | 50% |
| Use EMS communications to seek and detect facility evacuations (nursing homes). | 4 or 5 | 50% |
| Compare projected need past 96hrs to current resource availability at facilities. | 4 or 5 | 50% |
| When the need outgrows the resources available, or is trending in that direction with no end in sight. | 4 or 5 | 57% |
| When we are at 80% ventilator capacity as a community. | 4 or 5 | 79% |
| When we are at 80% ventilator capacity state-wide. | 4 or 5 | 71% |
| When we are at surge bed capacity. | 3 | 50% |
| If there is a forecasted increased need in supplies. | 3 | 43% |
| When there is evidence of hording or misuse by institutions. | 4 or 5 | 43% |
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| **Decision #2: Regional Medical Staff -** What is the threshold at which we as a community coordinate about regional medical staff? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When nursing demand exceeds capacity. | 4 or 5 | 71% |
| When we are moving out of contingency and into crisis mode. | 4 or 5 | 94% |
| When there are identified barrier to major highway/transportation so it is documented that travel not feasible (i.e.: I-5, 405, 520 [especially bridge impassible] I 90 [especially bridges]). | 4 or 5 | 76% |
| When primary site of practice deemed closed due to structural damage or inability to provide services (water, electricity). | 4 or 5 | 82% |
| When one health care facility is limited to <50% of their staff, or when multiple (>3) healthcare facilities in the area are limited to <75% of their staff. | 4 or 5 | 88% |
| When there is utilization of 120% workforce capacity to share personnel across facilities. | 4 or 5 | 82% |
| When there is prolonged surge in healthcare seeking behavior coupled with some degree of social breakdown would trigger bringing in additional staff resources from outside the area/state. | 4 or 5 | 71% |
| When more than 50% of healthcare facilities report nearing exhaustion of normal part-time and full-time licensed medical staff pools. | 4 or 5 | 76% |
| When there are facilities isolated without appropriate staff. | 4 or 5 | 71% |
| When demand for laboratory testing services, including pre-transfusion testing services, exceeds capacity. | 4 or 5 | 71% |
| 30% loss of staff. | 4 or 5 | 71% |
| 95% capacity for staffed beds. | 4 or 5 | 64% |
| When the staffing is projected to be challenged at the 96 hours. | 4 or 5 | 50% |
| When any event triggers a compromise to patient care - which cannot be resolved by in-place staffing solutions and/or by relocating patients to other facilities. | 4 or 5 | 57% |
| When any event triggers an unsafe compromise to patient care - which cannot be resolved by in-place staffing solutions and/or by relocating patients to other facilities. | 4 or 5 | 86% |
| When any event triggers a compromise to patient care - which cannot be resolved by in-place staffing solutions and/or by relocating patients to other facilities, and we are in altered standards of care. | 4 or 5 | 71% |
| When patterns of absences or workforce shortages indicate a potential for disruption of the system’s capacity to provide care, coordination should occur. | 4 or 5 | 64% |
| At the request of the chief of the medical staff, chief medical officer, or hospital CEO. | 4 or 5 | 50% |
| For highly specialized/scarce medical staff (specialists such as Pediatric Critical Care, Neurosurgery, etc.), when reasonably accurate estimates of volumes of patients requiring acuity-appropriate care exceeds twice that of regional Emergency Operations Procedures. | 4 or 5 | 79% |
| Coordinating the capabilities of medical staffs should be implemented early on. | 4 or 5 | 50% |
| When at the point there is an unmet need for staff that is inhibiting the rest of the response (assuming that logistically, the response is still supportable), and the need is projected to continue longer than whatever time the credentialing process takes. | 3 | 43% |
| This could proceed in a stepwise fashion: As absenteeism reached a trigger (or "management action" point), the credentialing process could begin as part of a contingency plan of the institution or institutions in question. | 4 or 5 | 64% |
| When hospitals start implementing or attempting to implement surge staff planning models, it is probably the threshold to begin looking beyond at shared labor pool models. | 4 or 5 | 86% |
| When there are health care providers not being utilized because unable to get to work. | 3 | 57% |
| When there are health care providers not being utilized because unable to get to work and staffing levels are low. | 4 or 5 | 57% |
| When there is distributional inequity of staff resulting in shortages and over-staffing. | 4 or 5 | 43% |
| When the needs outweigh the resources, then it’s time to share healthcare staff as a resource. | 4 or 5 | 57% |
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| **Decision #3: Changing Standards of Care -** What is the threshold at which we as a community decide to change the standards of care? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When infrastructure damage prevents specialized staff from participating in care. | 4 or 5 | 71% |
| ¼ to 1/2 day supply of blood will require altered standards of care for the community. | 4 or 5 | 88% |
| When patient care is being significantly impacted and patient outcomes/mortality may be other that which would have occurred if we had appropriate resources. | 4 or 5 | 94% |
| When local and regional disasters (earthquakes, epidemics), taxes local resources to the degree of short term non-sustainability for conventional capacity and contingency capacity. | 4 or 5 | 71% |
| When individual institutions report difficulty meeting conventional capacity the discussion should begin, when individual institutions report difficulty maintaining contingency capacity, a community-wide effort needs to occur. | 4 or 5 | 76% |
| When most all hospitals are operating at contingency levels within a state and that there is unlikely to be an influx of new resources for the next 72 hours and conditions indicate that tough decision will have to be made during that time frame. | 4 or 5 | 71% |
| At crisis capacity. | 4 or 5 | 76% |
| The situation will force it upon us without a threshold. | 3 / 4 or 5 | 36% |
| Use ER diversion as a proxy (full and boarding) and would vary by institution. 125%? | 3 | 57% |
| When capacity over 150% at all available local locations (such that all available surge capacity exhausted) and all facilities accept similar shared risk, in coordination of local and/or state health authorities. | 4 or 5 | 71% |
| When the community is into the Contingency capacity greater than the 96 hours and anytime they are in a Crisis Capacity. | 4 or 5 | 57% |
| Only a Disaster Declaration at the State level would qualify. | 1 or 2 | 43% |
| At the request of the chief medical officers of the organization. | 1 or 2 / 4 or 5 | 36% |
| At the request of the chief medical officers (CMO), CEOS, or COOs of the organization. | 3 / 4 or 5 | 36% |
| When there are life threatening conditions where care is not within the confines of a well-equipped well-staffed emergency department. | 4 or 5 | 57% |
| When situations that would otherwise require more evaluation to determine a definitive diagnosis cannot be accomplished, and require care takers to do temporizing care with a "best guess" approach to the underlying diagnosis. | 3 | 50% |
| When using alternate medications that are available but not the "best" for a situation. | 4 or 5 | 57% |
| Whenever the contingency capacity of more than 50% of healthcare facilities/operations are exceeded for any of the following four factors: resource availability, community infrastructure, staff (overall or specialized), and surge capacity. | 4 or 5 | 50% |
| When staff, supplies, or infrastructure are lacking or damaged; as long as the basics for safe care is provided. | 3 | 50% |
| Changes to crisis standards of care is about resources availability at the individual hospitals. | 4 or 5 | 50% |
| Changes to crisis standards of care is about resources availability at the individual hospitals where patient outcomes are now impacted or projected to be impacted. | 4 or 5 | 71% |
| Monitor ED wait times in excess of some percent of normal. | 3 | 57% |
| Monitor EMS call volumes or response times. | 3 | 43% |
| 911 call hold times in excess of some percent of normal. | 3 | 43% |
| When the incident clearly indicates a problem that cannot be solved for the foreseeable future, far exceeding the available resources for the community. | 4 or 5 | 86% |
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| **Decision #4: Liability Protection for Providers -** What is the threshold at which liability protections may be needed to ensure the protection of providers as we change the standards of care? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When using blood products that are not fully tested for transfusion transmissible disease as part of altered standard of care. | 4 or 5 | 71% |
| When we reach a declared Community Crisis level of care and patients are at risk for significantly negative outcomes due to the limited resources/providers. | 4 or 5 | 94% |
| If the physical plant is damaged, electricity unreliable, water possibly contaminated, and supplies limited, protection should be provided. | 4 or 5 | 82% |
| Seems that once any community reaches a Contingency Capacity this should be considered and then absolute in the Crisis Capacity. | 4 or 5 | 71% |
| Once staff are being deployed as regional medical staff. | 4 or 5 | 76% |
| Once facilities are operating at crisis capacity. | 4 or 5 | 88% |
| If the standards of care are NOT changed, but providers are working at a facility on an emergency sharing basis, they ought to have emergency liability coverage. | 4 or 5 | 76% |
| Any event which alters the routine practice of medicine in the community, should trigger liability protection safeguards to take effect. | 4 or 5 | 71% |
| Immediately upon implementation of altered standards of care, community/policy based legal framework for protections for caregivers should be implemented. | 4 or 5 | 76% |
| Whenever treatment is not given because of limitations in the system of supply would qualify for such protection against litigation. | 4 or 5 | 76% |
| Whenever the region identifies and exceeds contingency capacity. | 4 or 5 | 82% |
| Have the liability protection already built in, so when CSC is invoked, it is automatically invoked. | 4 or 5 | 82% |
| Have a low threshold to put protections in place. | 4 or 5 | 64% |
| If patients are boarding in the ER. | 3 | 43% |
| If staffing below triggers from previous section, invoke. Specifically consider extending protection to federal staff working in a state disaster as usually they fall under federal tort, not state civil processes. | 4 or 5 | 86% |
| Seek early federalization of the disaster site. | 4 or 5 | 79% |
| When alternate care standard situation is confirmed by local and/or state local health authorities. | 4 or 5 | 86% |
| Once conservation of resources is occurring. | 3 | 64% |
| Healthcare facilities should have wavers with their insurance / liability providers to cover their staff at all times - to be used when the hospital or facility determines that the needs outweigh the resources. | 4 or 5 | 71% |
| A major disaster should limit liability for health care providers but not exclude from criminal prosecution. | 4 or 5 | 57% |
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| **Decision #5: Pharmaceutical Shortages -** What is the threshold at which we as a community implement guidelines/standards to deal with pharmaceutical shortages? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When there is under 48 hour supply of critical item. | 4 or 5 | 88% |
| When there is ≤ 5 days’ supply, AND access to emergent critical stockpiles not possible. | 4 or 5 | 71% |
| Pharmaceutical resources reduced to ≤ 5 days’ supply of meds pre-determined to be key (IV solutions, antibiotics, pain meds). | 4 or 5 | 76% |
| If lives are threatened and alternate or no care is available. | 4 or 5 | 71% |
| When there is ½ to 1 day community supply. | 4 or 5 | 71% |
| Once it is determined the projected needed resources are and what is on hand exceeds the 96 hours. | 4 or 5 | 57% |
| Once a pharmaceutical is predicted to be short for > 1 week, and >50% of the healthcare facilities in the area anticipate running out during that time window, we should implement community guidelines/standards. | 3 / 4 or 5 | 50% |
| A threshold would vary on the importance of the drug and the accessibility of alternatives. | 4 or 5 | 64% |
| Identifying and setting thresholds should be the domain of Public Health and will need to take into issues of distributive justice and community health, while acknowledging financial vested interests and practicality issues. | 3 | 57% |
| Any event which compromises a facilities ability to provide/maintain contingency level care. | 3 | 50% |
| Once a certain percentage (e.g. 10%) of hospitals in the region are experiencing shortages and have to go outside their standard supply chain. | 3 | 50% |
| When more than 50% of healthcare facilities report nearing exhaustion of normal supplies and resources and starting to access their contingency supplies and resources in the setting of restricted or impaired delivery by primary and alternate vendors. | 4 or 5 | 79% |
| If healthcare facilities are notified that there are or will be impending shortages of a certain medication, the hospital/healthcare community will need to determine how to either replace that medication, or how to do without. | 3 | 43% |
| Begin process at the beginning of the crisis with proactive guidelines for conservation and prioritization of resources relevant to the situation. | 4 or 5 | 64% |
| If the estimated or potential scope of the crisis is believed to be of a magnitude to exceed contingency capacity, then stronger restriction of use policies need to be quickly developed and implemented. | 4 or 5 | 79% |
| Have an escalating series of actions triggered by the (presumably decreasing) inventory / capacity of the resource in question e.g. 40% triggers one set of actions, 30% triggers another, and 20% triggers the most conservative response. | 4 or 5 | 64% |
| When there has been 80% estimated usage we should be at threshold to be preparing to make this decision. | 3 | 50% |
| When there is a projected evolution of the problem that will result in complete consumption at some facilities. | 4 or5 | 71% |
| When there is a forecasted increased need in supplies. | 1 or 2 / 3 | 43% |
| When there is evidence of hording or misuse by institutions. | 3 | 43% |
| When supply chain is predicted to be unreliable. | 1 or 2 / 4 or 5 | 36% |
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| **Decision #6: Increased Surveillance for Healthcare -** What is the threshold at which we as a community implement enhanced surveillance within the community? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| If there is a significant change to the community's health and Public Health is concerned about a potential for an epidemic or outbreak it is acceptable. | 4 or 5 | 71% |
| At the request of CDC, WA state department of health. | 4 or 5 | 76% |
| In any pandemic, (as defined by and identified by the CDC/WHO), and in epidemics of public health concern (essentially most communicable and many infectious diseases). | 4 or 5 | 82% |
| When contingency care is deemed unsustainable. | 4 or 5 | 76% |
| Passive surveillance should be an early part of response with transition to active surveillance upon moving from contingency to crisis capacity stage. | 4 or 5 | 76% |
| For any disaster of any size where large number of casualties are expected community implementation of enhanced surveillance needs to be instituted. | 4 or 5 | 71% |
| Whenever designated regional public health officials deem that a credible and significant threat to public health is likely. | 4 or 5 | 71% |
| Whenever there is a natural or manmade disaster that affects a large part of the community. | 4 or 5 | 76% |
| If there is an impending or current pandemic. | 4 or 5 | 82% |
| Anytime we are trying to assess the community supply for things like ventilators, nurses, pharmaceutical agents. | 4 or 5 | 41% |
| Any time there are rumors and uninformed decisions leading to unnecessary alterations in peoples' ability to be productive (think Ebola and how some people reacted/overreacted). | 3 / 4 or 5 | 29% |
| When there is a 10% estimated disease prevalence for communicable disease if in a relatively static occurrence rates; if rapid increases, then threshold lowers to 5%. | 3 | 35% |
| Once it is determine there is a possible need for surveillance from Public Health. | 3 / 4 or 5 | 35% |
| In response to national news headlines (i.e. current measles outbreak that began in Disneyland January 2015). | 3 | 35% |
| If there is an infectious or toxic exposure, the threshold should be lower than if there was a onetime incident (earthquake, building collapse) that does not offer any further threat to the public. | 4 or 5 | 41% |
| When the threshold for contingency capacity has been reached. | 4 or 5 | 47% |
| Enhanced surveillance should only be used to support actual decision making. Enhanced surveillance should only be implemented after careful consideration of the cost / benefit ratio of the additional information. | 4 or 5 | 47% |
| When it will increase the likelihood of decreasing transmission. | 4 or 5 | 53% |
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| **Decision #7: Healthcare Capacity Issues -** What is the threshold at which we as a community coordinate to handle healthcare capacity issues? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| Monitor magnitude of event or concentration of population involved. | 4 or 5 | 82% |
| When facilities are on divert and there are no accepting facilities in a region that can provide similar levels of care. | 4 or 5 | 71% |
| When there is an unexpected and prolonged surge in healthcare seeking behavior coupled with some degree of social breakdown. | 4 or 5 | 82% |
| When local large healthcare facilities move from conventional to contingency care, with the expectation that contingency care cannot be maintained. | 4 or 5 | 82% |
| When there is implementation of more than one County’s, City’s, and/or Tribe’s Mass Casualty Incident (MCI) plan. | 4 or 5 | 76% |
| When there is a Governor-declared State of Emergency. | 4 or 5 | 82% |
| When there is a request/initiation of regional DMCC for patient distribution. | 4 or 5 | 88% |
| When there is implementation of local and/or State Public Health and medical emergency response plans. | 4 or 5 | 88% |
| When it is determined by officials that regional information sharing is needed to develop common situational awareness and facilitate strategic or policy level coordination. | 4 or 5 | 71% |
| When there is any incident that has a catastrophic impact on critical infrastructure, including communications and transportation systems within the region. | 4 or 5 | 88% |
| This is governed not only by a capacity related to threshold, but also a threshold based on the rapidity of change occurring in an environment (x% change over a prescribed period of time). | 4 or 5 | 71% |
| When South/ west/ Central/north/ eastern parts of the state cannot handle event, even with help from adjacent resources or neighboring states. | 4 or 5 | 79% |
| Available regional bed capacity at > 125% of standard so that such transfers do not occur needlessly taking up significant resources and before reaching > 150% capacity where alternate care standards may need to be invoked. | 4 or 5 | 71% |
| Once any facility has reached capacity. | 3 / 4 or 5 | 36% |
| When >50% of regional healthcare facilities are operating at or above 90% capacity. | 4 or 5 | 57% |
| When there is utilization of 120% workforce capacity. | 4 or 5 | 71% |
| This should be a standard procedure for any time a hospital's systems are overwhelmed (e.g., during flu season). | 3 | 50% |
| When the conventional system cannot accommodate the day to day urgent needs of patients, there will need to be some consideration to these situations which are less than an observed crisis but critical to patient safety on the basis of timeliness. | 3 | 50% |
| When more than 66% of healthcare facilities report implementation of contingency capacity measures. | 4 or 5 | 50% |
| When the needs outweigh the capacity to care for these needs. | 3 | 43% |
| If hospitals are inundated with walking well or wounded, and the hospitals are overwhelmed, the other healthcare facilities should be alerted that they will be expected to help take some of the burden off the hospitals that most patients are going to. | 4 or 5 | 57% |
| When there is a potential or imminent threat of a catastrophic incident. | 4 or 5 | 79% |
| When there is a declaration of emergency by at least one local jurisdiction or tribal authority. | 4 or 5 | 71% |
| When there is distributional inequity of patients resulting in variability of care. | 3 / 4 or 5 | 43% |
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| **Decision #8: Standardized Infection Control -** What is the threshold at which we as a community implement standardized infection control throughout the healthcare community? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When current local containment processes fail and the pathogen is very contagious and/or easily spread. | 4 or 5 | 82% |
| When we are seeing regional trends that are indicative of a public health issues or an outbreak that is beyond contingency or is threatening to become a crisis. | 4 or 5 | 88% |
| Recommend that the local health departments use their authority to determine based upon surveillance of national, state, and local information. | 4 or 5 | 82% |
| The threshold would vary based upon disease, lethality, contagiousness. | 4 or 5 | 76% |
| Should be turned on when a disease presents that has high morbidity and for which actions can be taken for innocent exposed personnel that can lead to limited or cessation of spread and which otherwise would continue to amplify without such action. | 4 or 5 | 88% |
| Whenever designated regional public health officials deem that a credible and significant threat to public health is likely/evolving or the threshold for contingency capacity has been reached. | 4 or 5 | 71% |
| In the event of an epidemic affecting a large portion of the population. | 4 or 5 | 76% |
| Assessments of disease prevalence is sufficiently high - estimate of 20% population affected. | 4 or 5 | 57% |
| Assessments of disease prevalence is sufficiently high - estimate of 20% population affected, and the severity is high. | 4 or 5 | 86% |
| When the infectivity is sufficiently high that lesser prevalence still indicates a high local risk. | 4 or 5 | 57% |
| As soon as it is determine that a community has an outbreak. | 3 | 43% |
| Guidelines should always be formed at the local level with assistance/input from other agencies. | 3 / 4 or 5 | 36% |
| Any healthcare facility could call for stricter infection control protocols at any time. | 3 | 50% |
| Depends upon the event (epidemic versus earthquake), lower threshold for community response for infective episodes like epidemics versus other natural disasters. | 3 | 50% |
| Immediately upon identification of a communicable disease threat. | 3 | 43% |
| As soon as we note that the infection is increasing at a faster than normal rate. | 4 or 5 | 50% |
| Shouldn't wait for a crisis to do this should be standardized now. | 3 / 4 or 5 | 43% |
| Should come from the DOH. | 3 / 4 or 5 | 36% |
| Evidence of institutions not following the standard of care. | 4 or 5 | 43% |
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| **Decision #9: Standardized Regional Healthcare Practice Guidelines -** What is the threshold at which we as a community might implement regional guidance that supplements or supplants national guidance for local healthcare, to preserve local resources? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When national and or community trends are appearing to indicate a need (contingency level) then guidelines should be issued. | 4 or 5 | 71% |
| When localized conditions mandate deviations from standards, local needs should supersede national guidance- this could be based on resource scarcity, lack of caregivers, etc. | 4 or 5 | 71% |
| No trigger, national guidelines should always be vetted and tailored to the local situation. | 4 or 5 | 64% |
| When national guidelines are based "upon an abundance of caution" and are not supported by facts, epidemiologic data. | 4 or 5 | 50% |
| When local health authority acknowledging the national recommendation notes that the local situation is dire with supplies, scarce resources down to ≤ 3 days or if there is no expectation that current supply levels would be replenished within 3 days. | 4 or 5 | 79% |
| Once it is determined the current resources on hand does not sustain the projected time of the incident. | 4 or 5 | 64% |
| Regional guidance should take precedence early in an epidemic, as only local communities will know their specific epidemiology, resource constraints, barriers to use, etc. | 4 or 5 | 64% |
| All facilities should have identified critical resources which could diminish rapidly in a crisis. Events that would trigger above average use/overuse of these resources would also trigger local guidance response. | 4 or 5 | 64% |
| Once it appears that local resources are going to be used up. However, a local community should not typically go against national guidelines being adhered to by other communities being affected by the same situation. So the threshold should be very high. | 4 or 5 | 71% |
| Whenever designated regional public health officials deem that a credible and significant threat to public health is likely/evolving. | 4 or 5 | 79% |
| When hospitals are receiving patients with a certain illness or condition and don't have the experience to know the most current and updated plan of care. | 4 or 5 | 64% |
| Should occur only when all facilities in the region reach crisis capacity. | 3 | 57% |
| Providers will be very wary about going against national standards. This may be unrealistic in our current environment. | 3 | 50% |
| When there is an epidemic affecting a large portion of the population. | 4 or 5 | 57% |
| When there is evidence of institutions not following the standard of care. | 3 | 43% |
| Having a hard time envisioning a scenario where we wouldn't follow the CDC recommendation (except for modifications necessitated by PPE shortages, for example). | 4 or 5 | 57% |
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| **Decision #10: Healthcare Mutual Aid -** What is the threshold at which we as a community might implement regional healthcare mutual aid agreements to share resources, staff, etc.? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| In a crisis scenario for the community. | 4 or 5 | 76% |
| If one organization has experienced a local disaster and the impact is significant on the community. | 4 or 5 | 94% |
| For staff sharing – When major transportation limits and/or physical damage rendered institutions incapable of care. | 4 or 5 | 88% |
| When regional assessment of impact by health authorities deem one location capable of continuing care when another is not. | 4 or 5 | 82% |
| When one facility is operating at crisis capacity. | 4 or 5 | 76% |
| Any event which compromises a facility’s ability to provide/maintain contingency level care. | 4 or 5 | 71% |
| When the region moves to crisis capacity stage. | 4 or 5 | 94% |
| Once a hospital's resources are overwhelmed, at the request of the CEO, CMO, or chief of staff. | 4 or 5 | 82% |
| For highly specialized/scarce medical staff (Pediatric Critical Care, Neurosurgery) and resources, when reasonably accurate estimates of volumes of patients or consumption of available resources exceeds twice regional contingency capacity or Emergency Operating Procedures. | 4 or 5 | 88% |
| When the information obtained leads the healthcare facilities to determine that a large influx of patients will be arriving at certain hospitals. | 4 or 5 | 71% |
| If there is a natural/man-made disaster in our community. When one hospital becomes overwhelmed, the call should go out to implement the mutual aid agreements to share patients. | 4 or 5 | 71% |
| When facilities are running out of certain supplies and closing their doors. | 4 or 5 | 88% |
| When there are ED diversions with boarding. | 3 | 57% |
| When critical supplies at ≤ 3-5 days on hand for resource sharing. | 3 | 50% |
| When critical supplies at ≤ 1-2 days on hand for resource sharing. | 4 or 5 | 71% |
| Once it is determine that any of the facilities in the region have reached capacity. | 4 or 5 | 43% |
| Once it is determine that any of the facilities in the region have reached capacity and cannot arrange for others to safely provide care in a normal process. | 4 or 5 | 71% |
| For overall medical staff and resources, when more than 50% of healthcare facilities report nearing the upper limits of their contingency capacity plans. | 3 | 50% |
| Implement early on in the process. | 4 or 5 | 57% |
| Implement at contingency with no improvement predicted. | 4 or 5 | 50% |
| The decision to request mutual aid, as well as a decision to provide mutual aid, are the responsibilities of the individual institutions, systems. | 3 / 4 or 5 | 43% |
| When surge plans have been implemented. | 4 or 5 | 57% |
| When there is a forecasted increased need in supplies. | 3 | 43% |
| When there is evidence of hording or misuse by institutions. | 1 or 2 | 43% |
| When supply chain is predicted to be unreliable. | 4 or 5 | 43% |

**Supplementary Material B**

Below is a list of all of the triggers and indicators evaluated by the group of public health and healthcare coalition participants. Beside each item is the highest percent of agreement achieved for that trigger or indicator; a few items did not reach the defined consensus point of ≥70%. If two rankings tied for the highest percentage of agreement they are both listed under the importance ranking.

**Key**

4 or 5 - Important

3 - Neutral

1 or 2 - Unimportant

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| **Decision #1: Changing Standards of Care -** What triggers/indicators may warrant State officials to declare Crisis Standards of Care in effect? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When the loss of inpatient capacity (some %) cannot be absorbed within neighboring counties or within systems/hospital and there is no clear ability to recreate or find new capacity. | 4 or 5 | 100% |
| When there is a loss of specialty care capacity (some %) (e.g. pediatrics, obstetrics/gynecology, burn). | 4 or 5 | 67% |
| When essential resources are restricted to a point where care is compromised and will be for greater than 24 hours and no viable alternative available for >48hrs. | 4 or 5 | 100% |
| When there is an inability to access essential medical supplies due to impacts to roads or other essential infrastructure systems. | 4 or 5 | 89% |
| When the patient load exceeds region/facility ability to address due to limitations to space, staff and supplies. | 4 or 5 | 94% |
| When staffing limitations affect the provision of critical care for greater than 24 hours. | 4 or 5 | 78% |
| When the loss of essential supporting infrastructure will compromise critical care or specialty care for greater than 48 hours. | 4 or 5 | 94% |
| When 50% of healthcare facilities have notified local health departments that they are operating under crisis conditions. | 4 or 5 | 94% |
| When regional (cross-state) areas are also in crisis. | 4 or 5 | 83% |
| When a known/anticipated shortage of essential resources exists with no replenish/alternative for 48 hrs. | 4 or 5 | 83% |
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| **Decision #2: Resource Conservation and Rationing -** What are the triggers/indicators for State officials to ration or alter the use of medical resources? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When a medical resource that is utilized by majority of providers/systems in the state experiences short-term multi-state/national supply limitations that interferes with appropriate patient care. | 4 or 5 | 72% |
| When sustained infrastructure impacts prevent replenishment of essential resource supplies in a timely manner, resulting in crisis conditions. | 4 or 5 | 94% |
| When >50% of target/patient population is in need of the one limited resource (e.g. vaccine), and availability of the resources within 48 hours will meet less than 50% of demand. | 4 or 5 | 100% |
| When >50% of essential healthcare facilities are in need of a limited resource and have exhausted mutual aid, resulting in crisis conditions. | 4 or 5 | 100% |
| When facility-/system-based conservation strategies have been maximized across the state, mutual aid and care resources are compromised, or national/regional supply chain shortages for greater than 48 hours put healthcare worker safety and protection at risk with no clear resolution | 4 or 5 | 94% |
| When essential care resources can't be replenished for a period of time. | 4 or 5 | 72% |
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| **Decision #3: Pharmaceutical Shortages and Rationing -** What are the triggers/indicators for State officials to ration medications? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When a pharmaceutical that is utilized by majority of providers/systems in the state experiences short-term multi-state/national supply limitations. | 4 or 5 | 61% |
| When sustained infrastructure impacts prevent replenishment of pharmaceutical in a timely manner, resulting in crisis conditions. | 4 or 5 | 94% |
| When >50% of target/patient population is in need of the one limited resource (e.g. vaccine), and availability of the resources within 48 hours will meet less than 50% of demand. | 4 or 5 | 83% |
| When >50% of essential healthcare facilities are in need of a limited resource and have exhausted mutual aid, resulting in crisis conditions | 4 or 5 | 100% |
| When facility-/system-based conservation strategies have been maximized across the state, mutual aid and care resources are compromised, or national/regional supply chain shortages for greater than 48 hours put healthcare worker safety and protection at risk with no clear resolution. | 4 or 5 | 89% |
| When essential care resources can't be replenished for a period of time. | 4 or 5 | 72% |
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| **Decision #4: State Issuing Guidance for Healthcare Operations - Resource Prioritization -** What is the threshold at which the State implements standardized guidelines associated with resource prioritization? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When an organization(s), LHOs, other SMEs (2 or more) makes a request that reflects a greater regional need. | 4 or 5 | 72% |
| When the lack of guidelines may create adverse outcomes for patients. | 4 or 5 | 78% |
| When disparate guidelines across regions impact care and compromise the ability to provide consistent care across the healthcare system. | 4 or 5 | 89% |
| When expert agencies (CDC) or regulatory agencies (OSHA) issue conflicting guidelines. | 4 or 5 | 78% |
| When disparate/insufficient healthcare practices are observed. | 4 or 5 | 89% |
| When DMAC advises DOH that a lack of clear guidance exists on an issue regarding patient care worker safety/provider or resource use. | 4 or 5 | 89% |
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| **Decision #5: State Issuing Guidance for Healthcare Operations - Coordinate Staff -** What is the threshold at which the Washington Department of Health issues guidelines to coordinate healthcare medical staff across institutions or jurisdictions? This may include changing the scope of practice regulations to support sharing of staff. | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When there is an absence of critical/specialty care staff in one or more hospitals that cannot be overcome by mutual aid from other region/states and provider emergency credentialing within 48hrs. | 4 or 5 | 94% |
| When one or more hospitals throughout the state must reassign staff outside scope of practice to maintain essential medical care functions at contingency level. | 4 or 5 | 94% |
| When an organization(s), LHOs, other SMEs (2 or more) makes a request that reflects a greater regional need. | 4 or 5 | 78% |
| When changing the regulations will prevent or lessen impact of crisis conditions. | 4 or 5 | 89% |
| When existing regulations are creating or potentially creating adverse outcomes for patients. | 4 or 5 | 100% |
| When systems are relying on volunteers (including family) to assist with care. | 4 or 5 | 67% |
| When the nurse to patient ratio exceeds 1:10 med/surge or 1:5 ICU. | 4 or 5 | 67% |
| When Crisis Standards of Care has been declared. | 4 or 5 | 83% |
| When staffing cannot support continuous 24hr operations. | 4 or 5 | 89% |
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| **Decision #6: State Issuing Guidance for Healthcare Operations - Infection Control -** What is the threshold at which the Washington Department of Health establishes standardized infection control guidelines? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When an organization(s), LHOs, other SMEs (2 or more) makes a request that reflects a greater regional need. | 4 or 5 | 67% |
| When changing the regulations will prevent or lessen impact of crisis conditions. | 4 or 5 | 83% |
| When systems are relying on volunteers (including family) to sustain essential care. | 4 or 5 | 61% |
| When nursing to patient ratio exceeds 1:10 med/surge or 1:5 ICU. | 4 or 5 | 67% |
| When Crisis Standards of Care has been declared. | 4 or 5 | 89% |
| When adequate staffing cannot support 24hr shifts. | 4 or 5 | 67% |
| When there is evidence that the situation may affect worker/provider safety. | 4 or 5 | 94% |
| When there is a novel/global threat. | 4 or 5 | 83% |
| When there is a lack of and/or conflicting guidelines that potentially create adverse outcomes for patients. | 4 or 5 | 83% |
| When there is a need to allay healthcare worker fear and/or public panic in a statewide event or a local event that cannot be managed by local jurisdictions. | 4 or 5 | 83% |
| When there are disparate information or insufficient healthcare practices which may lead to increase in exposures, injuries, or accidents. | 4 or 5 | 100% |
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| **Decision #7: State Issuing Guidance for Healthcare Operations - Clinical Practice/Treatment Guidelines -** What is the threshold at which the Washington Department of Health establishes standardized clinical practice/treatment guidelines? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When there is disparate or insufficient healthcare practices related to increase in exposures, injuries, accidents, or negatively affect patient care/outcomes or healthcare worker practices. | 4 or 5 | 94% |
| When an organization(s), LHOs, other SMEs (2 or more) makes a request that reflects a greater regional need. | 4 or 5 | 67% |
| When there are disparate guidelines (could be by expert agencies (CDC) or regulatory agencies (OSHA)) across regions interfering with the ability to provide consistent care across the state. | 4 or 5 | 78% |
| When the WA State DMAC advises DOH that a lack of clear guidance exists on an issue regarding patient care worker safety/provider or resource use. | 4 or 5 | 78% |
| When existing guidelines are not appropriate for current conditions. | 4 or 5 | 78% |
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| **Decision #8: Requesting Interstate or International Mutual Aid – Staff -** What is the threshold at which the Washington Department of Health requests interstate or international mutual aid for staff? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When there is a shortage of specialty care healthcare workers. | 4 or 5 | 78% |
| When the volume of need for essential healthcare workers for the emergency or to sustain contingency standards exceeds supply. | 4 or 5 | 94% |
| When the duration of the incident dictates a need to rotate healthcare workers through for multiple weeks which cannot be supported by state healthcare workers. | 4 or 5 | 100% |
| When in-state healthcare staff resources are exhausted and the need is beyond what is available in the state. | 4 or 5 | 100% |
| When Federal resources are exhausted, not sufficient, or not appropriate for the need. | 4 or 5 | 89% |
| When patients from other impacted areas (WA is an NDMS receiving) start coming into Washington and WA State needs staff to support patients arriving from out of state impacted areas. | 4 or 5 | 72% |
| When the proximity of asset (e.g. Staff) are more efficient from other States or Canada than other parts of WA State. | 4 or 5 | 61% |
| May invoke EMAC when it is more expediently availability than other national assets beyond PNEMA resources. | 4 or 5 | 78% |
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| **Decision #9: Requesting Interstate or International Mutual Aid – Stuff -** What is the threshold at which the State requests interstate or international mutual aid for resources (mostly state-held resources like SNS)? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When the proximity of asset more efficient from other States or Canada than other parts of WA State. | 4 or 5 | 78% |
| May invoke EMAC when it is more expediently availability than other national assets beyond PNEMA resources. | 4 or 5 | 83% |
| When a medical resource that is utilized by majority of providers/systems in the state experiences short-term multi-state/national supply limitations. | 4 or 5 | 61% |
| When sustained infrastructure impacts prevent replenishment of essential resource supplies in a timely manner, resulting in crisis conditions. | 4 or 5 | 94% |
| When >50% of target/patient population is in need of the one limited resource (e.g. vaccine), and availability of the resources within 48 hours will meet less than 50% of demand. | 4 or 5 | 78% |
| When >50% of essential healthcare facilities are in need of a limited resource and have exhausted mutual aid, resulting in crisis conditions | 4 or 5 | 94% |
| When there are shortage of critical care or specialty resources for the emergency or to sustain contingency standards, and cannot be replenished for a period of time. | 4 or 5 | 89% |
| When the duration of the incident dictates a need for additional resources. | 4 or 5 | 61% |
| When in-state healthcare resources are exhausted and the need is beyond what is available in the state. | 4 or 5 | 94% |
| When Federal resources are exhausted, not sufficient, or not appropriate for the need. | 4 or 5 | 83% |
| When patients from other impacted areas (WA is an NDMS receiving) start coming into Washington (we need more resources). | 4 or 5 | 89% |
| When facility-/system-based conservation strategies have been maximized across the state, mutual aid and care resources are compromised, or national/regional supply chain shortages for greater than 48 hours put healthcare worker safety and protection at risk with no clear resolution. | 4 or 5 | 100% |
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| **Decision #10: Requesting Federal Resource – Staff -** What is the threshold at which the State makes a request to federal agencies for staff resources? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When there is a shortage of critical care/specialty care healthcare workers for the emergency or to sustain contingency standards. | 4 or 5 | 83% |
| When in-state staffing resources are exhausted. | 4 or 5 | 94% |
| When patients from other impacted areas (WA is an NDMS receiving) start coming into Washington (we have the resources, we need the staff). | 4 or 5 | 94% |
| When the Governor has proclaimed an emergency. | 4 or 5/3 | 44% |
| When there is a multi-state impact. | 4 or 5 | 61% |
| When federal staffing assets are more efficient than from other parts of the state, the closest and fastest. | 4 or 5 | 78% |
| When the staffing resources needed are beyond what is available within the state. | 4 or 5 | 100% |
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| **Decision #11: Requesting Federal Resources – Stuff -** What is the threshold at which the State makes a request to federal agencies for resources? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When there is a mismatch between bed availability and EMS availability (may result in a request for federal EMS resources). | 4 or 5 | 78% |
| When mutual aid has been exhausted. | 4 or 5 | 89% |
| When the volume of resources required exceeds the capabilities within the state. | 4 or 5 | 100% |
| When the Governor has proclaimed an emergency. | 4 or 5 | 56% |
| When there is a multi-state impact. | 4 or 5 | 72% |
| When the Federal resource assets are the most efficient, the closest and fastest. | 4 or 5 | 78% |
| When requested Federal resources would come within the timeframe in which it is needed. | 4 or 5 | 67% |
| When patient movement across or out of state exceeds local EMS capability and we have done our due diligence to locate beds within the state. | 4 or 5 | 89% |
| When there is a specialty shortage/need specialty care resources. | 4 or 5 | 67% |
| When a medical resource that is utilized by majority of providers/systems in the state experiences short-term multi-state/national supply limitations. | 4 or 5 | 61% |
| When there are sustained infrastructure impacts preventing replenishment of essential resource supplies in a timely manner, resulting in crisis conditions. | 4 or 5 | 83% |
| When >50% of target/patient population is in need of the one limited resource (e.g. vaccine), and availability of the resources within 48 hours will meet less than 50% of demand. | 4 or 5 | 72% |
| When >50% of essential healthcare facilities are in need of a limited resource and have exhausted mutual aid, resulting in crisis conditions | 4 or 5 | 89% |
| When there are shortages of critical care or specialty resources for the emergency or to sustain contingency standards, and cannot be replenished for a period of time and mutual aid is exhausted. | 4 or 5 | 83% |
| When the duration of the incident dictates a need for additional resources and mutual aid is exhausted. | 4 or 5 | 89% |
| When in-state healthcare resources are exhausted and the need is beyond what is available in the state. | 4 or 5 | 83% |
| When patients from other impacted areas (WA is an NDMS receiving) start coming into Washington, (we need more resources) and mutual aid is exhausted. | 4 or 5 | 83% |
| When facility-/system-based conservation strategies have been maximized across the state, mutual aid and care resources are compromised, or national/regional supply chain shortages for greater than 48 hours put healthcare worker safety and protection at risk with no clear resolution. | 4 or 5 | 83% |
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| **Decision #12: Exercising Authorities of the WA State Secretary of Health - Isolation and Quarantine -** What is the threshold at which the Secretary of Health establishes isolation or quarantine? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When morbidity and/or mortality of illness exceeds agreed upon % (90%). | 4 or 5 | 67% |
| When known illness spreading from outside state/region with known high morbidity/mortality. | 4 or 5 | 89% |
| When a LHO makes a request to the Secretary of Health (e.g. for political or economic reasons). | 4 or 5 | 67% |
| When multiple local health jurisdictions are affected. | 4 or 5 | 72% |
| When, to protect public health, the Secretary of Health needs to supersede action or inaction of LHJ. | 4 or 5 | 83% |
| When the LHO is unable to act and has no line of succession. | 4 or 5 | 89% |
| When there is a novel threat with high health risk. | 4 or 5 | 83% |
| For one of CDC "quarantine" diseases. | 4 or 5 | 61% |
| When not enacting isolation or quarantine could put many others at risk. | 4 or 5 | 72% |
| When the enacting of isolation or quarantine will likely have a benefit on protecting public and it is not too late. | 4 or 5 | 72% |
| When the national guidance supports the enacting of isolation or quarantine. | 4 or 5 | 61% |
| When the benefits of public health actions, outweigh negative impacts to individuals and society. | 4 or 5 | 67% |
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| **Decision #13: Exercising Authorities of the WA State Secretary of Health - Social Distancing -** What is the threshold at which the Secretary of Health enacts social distancing measures (closes or cancels events, child care, schools)? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When an LHO asks for help. | 4 or 5 | 89% |
| When an LHO cannot or does not act or has no line of succession. | 4 or 5 | 78% |
| When there is a novel threat with high health risk. | 4 or 5 | 78% |
| For one of CDC "quarantine" diseases. | 4 or 5 | 56% |
| When not enacting social distancing could put many others at risk. | 4 or 5 | 78% |
| When enacting social distancing will likely have a benefit on protecting public and it is not too late. | 4 or 5 | 89% |
| When the national guidance supports enacting social distancing. | 4 or 5 | 72% |
| When the benefits of public health actions, outweigh negative impacts to individuals and society. | 4 or 5 | 83% |
| When there aren't other strategies that could prevent the spread of illness to the extent that social distancing does. | 4 or 5 | 89% |
| When morbidity and/or mortality of illness exceeds agreed upon % (90%). | 4 or 5 | 83% |
| When there is a known illness spreading from outside state/region with known high morbidity/mortality. | 4 or 5 | 83% |
| When a LHO (one or more) makes a requests to the SHO (e.g. for political or economic reasons). | 4 or 5 | 83% |
| When multiple local health jurisdictions are affected. | 4 or 5 | 83% |
| When, to protect public health, the Secretary of Health needs to supersede action or inaction of LHJ. | 4 or 5 | 83% |
| When the clinical input from the WA State DMAC advises enacting social distancing. | 4 or 5 | 83% |
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| **Decision #14: Exercising Authorities of the WA State Secretary of Health - Adapting National Guidance -** What is the threshold at which the WA State Secretary of Health adapts national guidelines for local use? | | |
| **Items** | **Consensus** | |
| **Importance Rating** | **Percent Agreement** |
| When local/regional experts agree that national guidelines are not in line with State needs. | 4 or 5 | 56% |
| When national guidelines are controversial. | 4 or 5 | 44% |
| When the State resources required at the local level need to meet state adopted requirements. | 4 or 5 | 61% |
| To adapt national guidelines to match local resources. | 4 or 5 | 61% |
| When an organization(s), LHOs, or other SMEs (2 or more) makes a request that reflects a greater regional need. | 4 or 5 | 56% |
| When changing regulations will prevent or lessen impact of crisis conditions. | 4 or 5 | 78% |
| When there is evidence that the situation may affect worker/provider safety. | 4 or 5 | 78% |
| When there is a novel/global threat. | 4 or 5 | 61% |
| When there is a lack of and/or conflicting guidelines that potentially create adverse outcomes for patients. | 4 or 5 | 83% |
| When there is a need to allay healthcare worker fear and/or public panic in a statewide event or a local event that cannot be managed by local jurisdictions. | 4 or 5 | 78% |
| When the WA State DMAC advises DOH that a lack of clear guidance exists on an issue regarding patient care worker safety/provider or resource use. | 4 or 5 | 83% |
| When the existing regulations are creating or potentially creating adverse outcomes for patients. | 4 or 5 | 78% |
| When there is disparate or insufficient healthcare practices related to increase in exposures, injuries, accidents, or negatively affect patient care/outcomes or healthcare worker practices | 4 or 5 | 83% |
| When there are disparate guidelines (could be by expert agencies (CDC) or regulatory agencies (OSHA)) across regions that impact care and/or compromise the health systems’ ability to provide consistent care across system. | 4 or 5 | 89% |
| When existing guidelines are not appropriate for current conditions in WA State. | 4 or 5 | 78% |