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fortunate outcome is primarily attributable to a disproportionate *excess* of relative capacity and resources allocated to a low rate of admission of COVID-19 patients. This contention implies that limiting the number of COVID-19 patients below an individualized threshold should be associated with a reduction in the overall mortality rate.

The development of regional and national policies³ allowing for rapid, safe, and effective dispersal of patients between medical institutions that have experience and expertise in treating patients in acute respiratory failure, rather than increasing capacity to accommodate more patients in a given institution, could well represent the primary remedy to this burden/mortality relationship.

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Response



To the Editor:

We appreciate Dr Patel and colleagues' response to our article.¹ Their experience mirrors findings of others that suggest the case fatality from coronavirus disease 2019 (COVID-19) rises with increasing burden ratio placed

on medical centers.² We agree that hospitals should attempt to mitigate this effect by following surge capacity principles such as those laid out in the CHEST Consensus Statement.³ These may include sharing of resources among hospitals in a health care system, as well as timely and safe transportation of patients between centers based on utilization. We also agree that transfer of patients to regional centers that have developed experience and expertise in treating these challenging patients would be useful and may indeed lead to improved outcomes.

The focus of our message remains, however, that preparation by individual medical centers will likely be insufficient when there is a catastrophe that affects an entire region. Referring back to the analogy used in their letter, let us imagine that all of the hospitals in their entire health system reached full ICU capacity, but excess ICU capacity remained in neighboring regions.

This type of catastrophe would require a coordinated response across county, state, and corporate lines. Surge capacity preparations by individual health systems and interfacility transfers, while crucial, may be insufficient to deal with such a surge of COVID-19 patients, for several reasons. Interfacility transfers of patients, which are neither timely nor efficient during the best of times, would be impractical during a mass disaster. The available mechanisms to transport patients would likely become saturated in such situations. In addition, if all of the facilities in a given region have reached their surge capacity, the distance to transport patients to an available facility may be too great.

In such situations, it would be most efficient to bring critical care resources to the patients, a concept endorsed by CHEST Consensus Statement.³ Unfortunately, health care systems cannot do this on their own. Regional control of the critical care supply chain requires the coordination of a patchwork of health systems, private companies, and government agencies. As cases of COVID-19 increase in multiple states,⁴ it is imperative that government agencies work quickly to create the framework allowing for the rapid reallocation of critical care supplies within and across their borders.

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