"Community engagement via restorative justice to build equity-oriented crisis standards of care"

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Abstract: The COVID-19 (SARS-CoV-2) Pandemic has revealed multiple structural inequities within the United States (US), with high social vulnerability index communities shouldering the brunt of death and disability of this pandemic. BIPOC/Latinx people have undergone hospitalizations and death at magnitudes greater than White people in the US. The untold second casualties are health care workers that are suffering from increased risk of infection, death, and mental health crisis. Many health care workers are abandoning the profession all together. Although Crisis Standards of Care (CSC) mean to guide the ethical allocation of scare resources, they frequently use scoring systems that are inherently biased. This raises concern for the application of equity in CSC. Data examining the impact of these protocols on health equity is scarce.

Structural maltreatment in healthcare and inequities have led to cumulative harms, physiologic weathering and structural adversities for residents of the US. We propose the use of Restorative Justice (RJ) practices to develop CSC rooted in inclusion and equity. The RJ framework utilizes capacity building, circle process, and conferences to convene groups in a respectful environment for dialogue, healing, accountability, and action plan creation. A phased, non-faith-based facilitated RJ approach for CSC development (or revision) that fosters ethically equitable resource distribution, authentic community engagement, and accountability is shared. This opportunity for local, inclusive decision making and problem solving will both reflect the needs and give agency to community members while supporting the dismantling of structural racism and oppressive, exclusive policies.

The authors are asking legislative and health system policy makers to adopt Restorative Justice practices for Crisis Standards of Care development. The US cannot afford to have additional reductions in inhabitant lifespan or the talent pool within healthcare.

Keywords: Ethics in times of crisis ■ Disparities ■ Policy ■ Community engagement

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INTRODUCTION

High social vulnerable index (SVI) communities, composed of mostly Black, Indigenous, People of Color (BIPOC) and Latinx people, have shouldered the brunt of death and disability of the COVID-19 (SARS-CoV-2) pandemic within the United States (US).[1-3] Indigenous people have been hospitalized at 3.3 times that of White, non-Latinx people.[1,2] Black, Latinx and Indigenous people have rates of death 1.9 – 2.2 times that of White, non-Latinx people.[1,2]

The need for Crisis Standards of Care (CSC) protocols has become a present reality with the emergence of the COVID-19 pandemic. CSC are meant to guide the ethical allocation of scare resources such as ventilators, medications, and hospital beds. At the time of this publication, 48 out of 50 states currently have crisis standards of care dictating resource allocation.[4,5] Over the course of the COVID-19 pandemic, several states (Arizona, Colorado, New Mexico, Idaho, Alaska) and numerous regional hospital systems activated CSC.[5-7]

Although no formal data has been published examining the impact of these protocols, several simulations have been run to understand the impact these protocols may have on equity.[8] The simulations used triage algorithms commonly outlined in CSC protocols that assign points based on the Sequential Organ Failure Assessment (SOFA) score and chronic co-morbidities that intended to estimate one- and five-year mortality, where higher SOFA scores predict increased risk of mortality. Black patients have higher SOFA scores despite no difference in mortality or ICU admission rates.[9,10] These findings suggest that Black patients may not receive lifesaving resources, as these higher scores translate into lower priority assignment for resources under CSC. As the simulations demonstrate, these scores may inaccurately estimate mortality in these patients and unjustly deny resources to an already marginalized patient population.

Public health experts are attempting to develop alternative methods of triage that do not further exacerbate harms and inequities, such as including Area Deprivation Index (ADI)[11] or Social Vulnerability Index (SVI)[12] as part of priority allocations. To date, there has been no consensus on how to fully mitigate further harm with triage tools.[3]

Scarce resource allocation demands a shift from traditional medical ethics[13] that focuses on health at the patient-level to prioritizing health at the population-level.[14] It has been stressed that during crises, core ethical principles must be maintained.[14-16] The theories of distributive justice,[17] utilitarianism,[18-22] Rawls' Distribu-

Table 1. Ethical Frameworks For Crisis Standards of Care (CSC)

Traditional medical ethics	Emphasizes the physician's duty to individual patients:[13] ○ Nonmaleficence: "First, do no harm." ○ Beneficence: Provide benefits to people and contribute to their welfare ○ Respect for patient autonomy: Respect for the decision-making of individuals ○ Distributive justice: Equality of rights amongst all persons
Distributive Justice	• Calls to *evenly distribute* resources among patients, regardless of socioeconomic standing.[17] • Challenging to reallocate resources without a "real time" understanding of available inventory.
Utilitarianism	• The most cited principle in scare resource allocation guidelines (e.g., battlefield triage, organ transplant allocation)[18] • The premise is to produce the greatest good for the *greatest number of people*. • Debate exists over whether to focus on the number of people saved or the number of years of life saved.[19,20,22] • There is disagreement on how to allocate resources amongst patients of the same priority level.[21,22] • Controversy surrounds the ethics of prioritizing specific populations based on their perceived contribution to society.[22,23,77]
Rawls' Distributive Justice Framework	• *Removes knowledge of status*, abilities, and interests in allocation to eliminate the usual effects of self-interest.[23,24] • Predicts that decision-makers would choose two main principles of justice: 1) all persons have equal basic liberties and 2) resource allocation benefits the least advantaged people. • Original theory did not address healthcare resources but has been expanded by others to issues of health[25,26] to discuss the allocation of ventilators,[23] intensive care unit (ICU) beds[27] and drug shortages.[28] • Limited in application, as structural inequities hamper equal liberties for marginalized people.
Modern Political Theory/ "Complex Equality"	• Goods are decided collectively and should be distributed democratically in *proportion to need*.[29,30] • Has had slow uptake as assimilation and hierarchal (top-down) decision-making drive the bulk of healthcare policies in the US.

tive Justice Framework,[23-28] and "Complex Equality"[29,30] are all currently used to develop CSC (Table 1). In practice, these theories may not be pragmatic in real-time, can disadvantage the elderly and those with disabilities[20] or pre-existing medical conditions, and can exacerbate health disparities in high SVI communities.[22]

PROBLEM-SOLUTION PREMISE

We believe that the restorative justice framework outlined here could serve as a valuable tool and foundation in creating more just and equitable crisis standards of care. As states, health systems and individual healthcare facilities develop or revise CSC, we propose that equitable processes are used to develop such guidelines to ensure that resource allocation does not exacerbate existing health and social inequities. The Restorative Justice (RJ) framework as applied to CSC creation seeks to identify and maintain a strong focus on the harms and needs of those directly affected by CSC to ensure equitable processes (Table 2).

RESTORATIVE JUSTICE OVERVIEW

Restorative Justice, originating in indigenous peace keeping traditions,[31,32] is a philosophy and procedural frame-

Table 2. Phased Guidance for Crisis Standard of Care (CSC) development through a Restorative Justice framework

Phases	Purpose	Objective(s)	Restorative Inquiry Application
Preparation	Creation of Brave Space	o Inclusive Participation for stakeholders.	o Who should be here? o Who is not here?
Phase 1	Listening & Understanding	o Understanding community values and identifying harms. o Establishing ground rules.	o Who are we? o What happened/who has been harmed? What has been the impact of the event(s)? o What are our core values?
Phase 2	**P**lanning & **D**oing	o Addressing harms and needs of Phase 1. o Creation of CSC policy and implementation plan.	o What do we need? What does our community need? How do we apply CSC best practices with available resources? Alternatively, how do we align our needs with CSC best practices? o How can things be put right again? How do we execute CSC locally? How can we prevent such events from happening again?
Phase 3	**C**heck & **A**ct	o Process improvement plan to evaluate how CSC is working. o Report out to Phase 1 & Phase 2 stakeholders. o Process modification as necessary.	o Follow up on identified needs. o Review process at regularly scheduled intervals. Monitor application of CSC for adherence to identified principles and evaluate outcomes to ensure these align.

__PDCA__: Plan Do Check Act Process Improvement Technique[78]

work for voluntarily redressing harm amongst people with a shared stake in an event.[33,34] RJ utilizes capacity building, circle process, and conferences to convene groups in a respectful environment for dialogue,[35,36] healing, accountability, and action plan creation.[32] Participants are empowered to speak honestly about the harmful event and the subsequent influence on their lives.[34] These conversations are supported by skilled Restorative Practitioners as facilitators. This format promotes collaborative repair for all involved[34] and promotes health equity through inclusion while building community and provider trust.[15]

There is precedent to use RJ practices in addressing harms caused by healthcare establishments. Canada engaged First Nations, Metis, and Inuit (FNMI) community members to develop RJ patient-centered initiatives titled "Wise Practices."[37] New Zealand applied RJ to address physical and psychosocial harms resulting from surgical mesh implants and to rebuild trust within the health system.[34]

RJ is a unique strategy for problem-solving through which reparative techniques guide individuals to share perspectives and collectively decide on next steps.[32,36] This ensures substantive public input, including marginalized communities' perspectives, is present throughout CSC development.[38] RJ practices increase the buy-in of garnered solutions by all stakeholders. There are essential components of RJ that promote health system accountability to the community after process implementation. This level of community engagement has been lacking in existing frameworks, such as EFIC or Deliberative Democracy.[39,40]

COMMUNITY HARMS

Due to past and ongoing systematic harms to patients from marginalized communities by healthcare systems, members from these communities can provide valuable insight into how health policies, such as CSC, directly impact their health individually and as a group. Historically, the pat-

tern of under resourcing, misinforming, and segregating access to care and training for BIPOC/Latinx communities has been all too common.[41,42] These processes consistently correlate to higher disease burden, death and mental distress amongst BIPOC/Latinx communities.[43-45]

Implicit and explicit racism have negatively impacted marginalized communities.[46,47] Structural maltreatment in US healthcare can be traced from the 1770s US Treaties with Indigenous Nations,[42] through slavery,[43] Jim Crow,[41] and the inhumane experimentation on BIPOC/Latinx community members in the 20th century.[43-45,48-52] More contemporarily, BIPOC and Latinx communities, due to practices such as red-lining, are still more likely to live near environmental toxins, surreptitiously exacerbating health disparities.[53-58] Other harms have been as overt as inadequate medical care for Immigrants within Immigration and Customs Enforcement (ICE) detention increasing the risks of preventable death from COVID-19, influenza and suicide.[59]

Such inequities have led to cumulative harms, physiologic weathering and structural adversities.[22,57,60] The pre-pandemic racial gaps in healthcare that catalyzed these inequities have only widened since COVID-19.[2] Even when controlled for poverty and other systemic factors,[61] communities of color and other marginalized groups bear a disproportionate disease burden from COVID-19.[2,22,62-64]

PROVIDER HARMS

Health care workers (HCWs) represent another group that has been significantly harmed by the pandemic and should be included in CSC development.[65-69] Some physicians and other healthcare professionals have been put in the untenable ethical position of needing to ration resources or provide substandard care to patients during the pandemic. Current research on the impact of the COVID-19 pandemic on HCWs has revealed increased stress and mental distress within this cohort. HCWs working on frontlines in departments more impacted by COVID-19 (i.e., emergency department, intensive care unit, infectious disease) have been at greater risk for anxiety, depression and suicide.[65,67]

A large, national study noted that "1 in 3 physicians, advanced practice providers and nurses" plan to reduce hours worked within 12 months and "1 in 5 physicians, 1 in 3 advanced practice providers, and 2 in 5 nurses" plan to leave clinical practice within 2 years due to the demands caused by the COVID-19 pandemic.[69] Independent protective factors that reduced health care workers intention to leave the profession in the within 1-2 years were "feeling highly valued by organization" and "having a strong sense of meaning/purpose from work."[69] Faced with lim-

ited resources, providing our HCWs with wellness support and mental health interventions in each healthcare setting is challenging.

RJ's collaborative nature has reduced provider moral distress in other contexts by allowing clinicians to recognize they are not alone.[34] **RJ highlighted providers' needs to feel supported in environments with less bullying and safe spaces to build trust with patients.[34]**

RJ practices (e.g., circles) offer accessible, efficient, and formal ways to gather impacted individuals to develop and adopt harm reduction strategies to on-the-job stressors. Through engaging HCW in a restorative circle they can participate in an inclusive process for decision making and expressing/reflecting on their emotions. This sharing strengthens relationships, community connections and provides an increased sense of personal and collective efficacy leading to an increased sense of community and belonging.[70] RJ practices "draw on the life experience and wisdom of all participants to generate new understandings of the problem and new possibilities for solutions… The philosophy of circles acknowledges that we are all in need of help and that helping others helps us at the same time.[71] Such practices equalize power dynamics amongst impacted groups as each voice is held in equal and worth.[34] In his latest book, *Together…,* US Surgeon General Dr. Vivek Murthy concurs and emphasizes the importance of coming together to take on the great challenges before us.[72] He writes that we must take action now to build the connections and "when we strengthen our connection with one another, we are healthier, more resilient, more productive, more vibrantly creative and more fulfilled."[72]

IMPLEMENTATION OF RESTORATIVE JUSTICE FRAMEWORK

RJ is best suited to the task of bringing together affected individuals to solve seemingly intransigent problems,[33] such as the challenge of creating equitable CSC. RJ aligns CSC with the greater community make-up and ethical values, thereby fostering inclusivity and engagement. We suggest applying a macro-level, RJ framework to CSC creation and revision to prevent deepening social and economic inequities and to foster healing.

CSC should not be developed in insolation by medical policy makers. It should be inclusive of those who are most likely to be impacted by CSC protocols. Currently, communities impacted by CSC often lack a meaningful voice in protocol development. This contributes to harms by reinforcing centuries-long patterns of excluding marginalized communities from medical decision-making,[43] and can cause further harm by omitting factors needed to pro-

tect particular communities in crisis. Intentional efforts to heal past hurts through proactive, inclusive community engagement are necessary to build public trust and provide equitable care even amidst crises.[22]

A phased, non-faith-based facilitated RJ approach for CSC development (or revision) that fosters ethically equitable resource distribution, authentic community engagement, and accountability is shared. The process begins with adequate preparation intent on creating inclusive spaces. Phase 1 engages public and medical stakeholders via restorative practices to share perspectives. Phase 2 acknowledges emerging themes, identifies collective needs, and develops CSC guidelines. Phase 3 operationalizes and monitors the new or revised CSC guidelines.

Review of an applied RJ framework is helpful for understanding how RJ can be operationalized. Wailling et al., applied RJ to address harms secondary to surgical mesh implants.[34] The intervention was planned by patients, family members, healthcare professionals, and healthcare stakeholders. The approach included three-phases: (1) listening and understanding (2) planning and acting to redress noted harms, and (3) reporting and evaluating.[34] By developing a similar coalition representative of varied perspectives, each community can ensure that CSC reflect the community's values throughout their development. Table 2 outlines the phased approach to developing CSC using restorative inquiry. It is important to note that all stages should be facilitated by an experienced RJ facilitator.

PREPARATION: (APPENDIX A.)

Preparation and shared responsibility amongst impacted communities are required to develop (or update) CSC guidelines which are responsive to a community's needs. During this preparation, facilitator(s) should identify stakeholder groups to engage. A wholistic approach is necessary, otherwise existing patterns will be replicated.[31] The goal is not to assign blame to individual providers or organizations for past harms. Instead, participants discuss systemic harms and decision-making in the affected communities which contextualizes future policy implications.[31] These collaborative processes build bridges of trust between communities, patients, and providers by allowing each group to understand how others have been impacted by the healthcare crisis.[34,38] The end result is a win-win for equity and health justice in the serviced community.[31]

It may help to review prior events that critically limited resources (e.g., California Wildfire, Hurricane Katrina, COVID-19).[73] Next, generate a list of those people most impacted by such an event (e.g., People experiencing homeless, BIPOC/Latinx people, Families, Frontline Med-

Table 3. Examples of Stakeholders for CSC development	
Community stakeholders	○ Persons with limited English proficiency/English as a Second Language ○ Undomiciled individuals ○ Persons with a disability ○ Immigrant and refugee populations ○ People residing in food deserts (low access to healthy food), public housing, or where the Area Deprivation Index score is 8-10 or the Social Vulnerability Index is 0.8 – 1 ○ Geographically isolated people ○ Advocates for the Aging Community ○ Local Indigenous/ FNMI members ○ Diverse ethnic groups and non-white racialized groups (e.g., African American, Asian Americans, Latinx) ○ Sexual and gender minorities (LGBTQI+)
Healthcare stakeholders	○ Clinicians (nurses, physicians, respiratory therapists, other emergency & critical care clinicians (e.g., dialysis/ECMO staff)) ○ Public health experts ○ Ethicists ○ Pastoral care/counselors ○ Risk Management/legal representatives ○ Diversity, Equity and Inclusion (DEI) experts

ical Providers) and prepare to contact listed groups of people. Lastly, ask: "Who's not (included) here?" and reach out to those communities to participate. Consider Table 3 as a starting place for communities to engage. *If you do not know how to engage potential stakeholders, reach out to local organizations that service the needs of identified stakeholders or engage local Diversity, Inclusion, Equity experts. The approach should be extended in a respectful, equitable manner at all times.

To ensure an equitable process, marginalized communities must be included during the entirety of the process and each stakeholder should be valued for their experience. In order to engage in meaningful dialogue focused on the harms, needs and reparative actions, facilitator(s) must devote sufficient time to creating "brave spaces" for in-person and virtual meetings. Do not rush this process just to get something done. The goal is to create an environment of inclusion where all participants can be vulnerable, candidly share their personal stories, and yield solutions to complex problems. Additional exemplars can be found in Appendix A.

PHASE 1: LISTENING & UNDERSTANDING (APPENDIX B.)

This is a small group process with identified stakeholder subgroups to give voice to all impacted by CSC. Intentional efforts must be made to truly listen to impacted marginalized communities, and not speak over them. Small group engagement is essential here to build rapport with each cohort and to support the larger Phase 2 session. Plan to dedicate 1-2 hours to this session for each cohort.

The goal of this phase is for an RJ Facilitator to meet with individual stakeholder groups to generate positive feelings and identify values of each cohort (e.g., small sessions with health care workers, English as a second language community members, policy makers, etc.). This will help participants focus and connect to the goal of CSC development. Information gained here will be complied into the Phase 1 Summary Report.

In Phase 1, participants will be invited to share their experiences through one-on-one interviews, listening circles, and an online database to capture stories in written, audio, and video form. When listening circles are used, the meetings should start with a configured space in the shape of a circle. The circle configuration (physical or virtual) allows each stakeholder to be seen, valued and equalizes power dynamics. It signifies a collective responsibility to the process and outcomes of the meeting.[34] Honoring everyone as a valuable participant can facilitate productive discussion and promotes inclusivity. A broad-based coalition ensures that CSC truly reflects the needs of both the service providers and healthcare recipients. Intentional efforts should be made to prioritize groups most impacted and marginalized by the health crisis.[74]

Success of Phase 1 depends on establishing collective "agreements" (suggestions of respect) that the small group can support. Facilitator(s) will engage each participant by asking questions to identify the values of the participants. These values will then inform the content of CSC guidelines. Early agreements could include language that the technical experts will write the CSC policy/protocol based off stakeholder input, and the entire stakeholder collective will vet it prior to activation. Additional detail/suggested outline and scripts for Phase 1 can be found in Appendix B.

The material collected during this phase will generate the Phase 1 Summary. The Phase 1 Summary and current CSC will be shared with each Phase 2 participant prior to the collective Phase 2 meeting. If a locale has no CSC established, consider sharing best practices for CSC, such as those developed by physician groups amidst the COVID-19 pandemic.[22,75]

PHASE 2: PLANNING & DOING TO GENERATE CSC CONTENT (APPENDIX C.)

Phase 2 is composed of the health system Policy Implementation Committee/CSC Organizing Committee and is *inclusive* of volunteer Phase 1 participants and the Phase 1 Summary report. The Phase 1 participants and summary report are present during this phase to highlight community needs and inform the next set of CSC guidelines. Plan to dedicate 4-6 hours to this session.

At the start of the Phase 2 meeting, participants should be welcomed and agree on ground rules (collective agreements) that establish respect for one another, awareness of sharing time and the goal of collaboration to solve the identified problem – in this case, the creation of CSC guidelines. The meeting should start with a configured space in the shape of a circle; this equalizes power dynamics and signifies a collective responsibility to the process and outcome of the meeting.[34] Early agreements could include language that the technical experts will write the CSC policy/protocol based off stakeholder input and the entire stakeholder collective will vet it prior to implementation. It is paramount that the collective defines what is important to them to serve as a centering point as they draft CSC. During this discourse, the stakeholders are the experts on the identified needs and the facilitator(s) are the expert on the maintaining a brave space for dialogue. The power of problem-solving through RJ emerges when stakeholders realize their value in the process.

Facilitators will guide participants through rounds of discussion, entitled CSC Structure Rounds. **Round A: Present CSC** provides an overview of the status of local CSC and allows stakeholders to then ask questions or obtain clarification. As a starting point for the creation of CSC, groups may rely on existing CSC or those that have been developed by other groups. In addition, we suggest that stakeholders review suggested best practices for CSC, such as those developed by physician groups amidst the COVID-19 pandemic.[22,75] **Round B: Identifying Harms** should have trained note takers or recorders to capture the sentiment of the Phase 1 summary and identified needs. This material will frame CSC content development. **Round C: Preventing Additional Harms**, **Generation of New CSC** drills down on the essential aspects of the new CSC construct. A working draft of CSC content should be deliverable at the close of this round. Particular attention is given to reducing the chances of harming or failing the serviced community and guarantees that equity orients the CSC construct to include the most vulnerable amongst the health system service area. **Round D: Operationalizing CSC** explicitly defines who should al-

locate resources during CSC implementation (i.e., Triage Teams with oversight committees).[13,22,76] Stakeholders of CSC development should define the makeup of the Triage Team and the Oversight committee. Stakeholders should be mindful of what is feasible with current resources at the local level. The expectation for public feedback and periodic review with the larger collective should be set at this time.[13] Additional detail/suggested outline and scripts for Phase 2 can be found in Appendix C.

Tangible takeaways from the stakeholder collective include a record of identified needs related to CSC, quantified time frames and measures for finalizing the guidelines, and a defined accountability system.

PHASE 3: CHECK & ACT (APPENDIX D.)

To be explicit about accountability in Phase 3, action plans should be developed for each need addressed by the CSC created in Phase 2. It is of utmost importance that reparative actions and preventative measures are outlined to reduce further harms. Organizational and individual commitments to address these plans should be outlined. The resultant CSC draft should be reviewed and approved by both Phase 1 and Phase 2 participants prior to health system leadership (e.g., Board, Executive Team, etc.) presentation. In ideal circumstances, the hospital/ health system would be empowered to institutionalize the guidelines and execute CSC via the defined Triage Team and Oversight Committee. Once complete, CSC guidelines should be publicly accessible in such forms as a hospital website and printed algorithms in patient care areas.

A review panel consisting of volunteers from both Phases 1 and 2 will monitor action plans. Follow-up reviews will continue momentum and ensure accountability for implemented policies.

CONCLUSION

A novel approach is necessary to heal the intentional and unintentional harms resulting from the colliding syndemics of COVID-19 and systemic racism in the United States. The exacerbation of well documented healthcare disparities resultant of traditional ethical theories highlights the need for equitable allocation of healthcare resources for marginalized populations, especially in times of scarcity. The moral trauma experienced by providers and the destabilization of the US healthcare system call for immediate action. Current models for CSC development do not adequately address the communal and provider harms that have occurred from inequitable resource allocation. Until systemic acknowledgement of these harms occurs in an authentic way, the resultant trauma will thrive in systems of silence. We suggest those in positions to develop or revise CSC leverage RJ to heal prior trauma of inequities and allay future harms.

Concurrent efforts must be made at addressing relationships (e.g. provider-patient, provider-administration), institutional racism and implicit bias. Fundamental to the success of RJ is inclusion of community members in a collaborative process of storytelling, decision-making, and accountability. RJ fosters community engagement that equalizes power dynamics (e.g., lived experience is just as valuable as data). This promotes genuine dialogue, building of trust, and the creation of equitable solutions with stakeholders. This framework provides respectful tools for groups to address past injustices and potential landmines. The noted communal and provider harms create an opportunity for RJ to build on prior community engagement approaches and provide healing during the process. RJ has shown to reduce disparate outcomes and improved staff satisfaction.

Organizations tasked with the allocation of healthcare resources must ensure that resources are distributed in a way that mitigates inequities while safeguarding, and in some cases rebuilding, the public's trust. Using RJ for CSC development empowers medical and public communities to address and dismantle structural inequities while ensuring that even amidst crisis, all voices are heard.

DECLARATION OF COMPETING INTEREST

None

APPENDIX

Appendix A. Preparation

The Restorative Justice (RJ) framework used to guide Crisis Standards of Care (CSC) development seeks to identify and maintain a strong focus on the harms and needs of those directly affected by CSC to ensure equitable processes (see Table 1 of manuscript).

Preparation and shared responsibility between impacted communities are required to develop (or update) CSC guidelines that are responsive to a community's needs. During this preparation time, facilitator(s) **should identify which stakeholder groups to engage.** To ensure equitable process, marginalized communities must be included **during the entirety of the process** and each stakeholder should be valued for their experience. Consider Table 2 of manuscript for a starting place for communities to engage. **The approach should be extended in a respectful, equitable manner at all times.**

Exemplar Engagement Model: **1.** Identify event that critically limits resources (e.g., Southern Snow & Ice storm, Hurricane, COVID-19)

2. Generate list of those people most impacted (e.g., People experiencing homeless, BIPOC/Latinx people, Families, Frontline Medical Providers)

3. Then **ask, "Who's not (included) here?"** **Ask** those communities to participate in the entirety of the process. *If you don't know how to engage desired communities, reach out to local organizations that service those needs or engage local Diversity, Inclusion, Equity experts.

To engage in meaningful dialogue focused on the harms, needs and reparative actions, facilitator(s) must devote sufficient time to creating "brave spaces" for in-person and virtual meetings. This will create an environment where all participants can be vulnerable and candidly share their personal stories.

Appendix B. Phase 1: listening & understanding

This is a small group (or individual) process with identified stakeholder subgroups to **give voice to all with particular focus on marginalized communities impacted by CSC.** Small group engagement is essential here to build repour with each community and to support the larger Phase 2 session.

Format may be virtual, a questionnaire or a phone conversation, if attending an in-person (live) Listening Circle is not possible. This is intended to help participants focus and connect to the goal of CSC development. Information gained here will be complied into the Phase I Summary Report.

OUTLINE

1. Welcome by the Lead Facilitator
2. Mindful minute, centering practice
3. Review the process: Preamble, Agreements, Values Questions
4. Close the Listening & Understanding conversation

(Outline modified from International Institute for Restorative Practices. (2020, August 20). Listening circle facilitator script [adapted]. https://learning.iirp.edu/login/index.php)

Suggested Script

1. Welcome

Action: Facilitator will introduce and explain the purpose of the Phase 1 listening circle (e.g., explaining the participants' value as stakeholders for CSC development and collecting values of the collective). "The way mediators are trained and empowered is critical, as it is they who would need to ensure that publicly agreed boundaries were

respected in specific instances as well as having a role ensuring equality and inclusiveness" (Parkinson and Roche 2004, p515).

Script: "Hello, my name is ……… and I will be facilitating this Phase 1 listening circle. The purpose of this circle is to provide an opportunity for people to express their thoughts and feelings about the impact of CSC inciting events (e.g., COVID-19) on their lives. This is a sharing with the purpose of listening, storytelling, and connecting, it is not a debate."

2. Mindful minute, centering practice

Action: Facilitator will set intention with a mindfulness practice to support centering the participants to present time. This will be followed by a short period of guided cleansing breaths where participants could close their eyes and set an intention, meditation, etc.

Script: "Please close your eyes. Take a few cleansing breaths. Please set an intention for today's session."

3. Review Process

Action: Facilitator will share the flow (Preamble, Agreements, Questions) for the session.

Script: Preamble "This is a sharing with the purpose of listening, storytelling, and connecting. It is not a debate. Some of what we are doing may seem quite formal and it is. The reason for this is to ensure everyone is free to respond to the questions without being interrupted or asked to explain themselves. Each of us is being invited to speak and to respectfully listen. This session may be difficult for some, and you may have an unexpected strong reaction. Please remember this is not a therapy session. I encourage you to utilize your supports outside of this circle."

Discuss Agreements: (add more if you feel compelled) o Share what you feel comfortable sharing o You can pass at any time o Be mindful of time o Stay quiet when not talking o Speak from the I perspective o Respect the privacy of those sharing o Does anyone need clarification on the agreements and are there any agreements the group would like to add?" (add additional agreements if necessary)

Action: The Facilitator would ask a few of the following questions to **generate positive feelings.**

Script: "In order to create a space where everyone feels valued and can be brave, let's talk about common values. Feel free to share your responses to the following questions.

1. Can you tell me about a time someone made you feel respected, loved, or cared for? What qualities describe their behavior?
2. What do you value in a health care provider/healthcare system?
3. What defines a good healthcare system?

4. Tell a story about a situation when you felt respected in a health care setting."

Action: Facilitator will engage each participant by asking the following questions to **identify the values** of the participants. These values will then inform the content of CSC guidelines for the Listening & Understanding discussion. Ideally, each stakeholder subgroup will meet the facilitator (via telephone, video submission, or questionnaires) prior to the collective encounter.

Script: Values Questions

1.What will you expect from the others in this Listening & Understanding session?

2.What will you accept from others in the Listening & Understanding session?

3. What is needed for you to speak openly or feel safe to talk about what happened during COVID-19/CSC inciting event? Please share your feelings.

4.What do you wish for yourself as a participant?

5.What do you wish for others during times of crisis?

6.How do you want to be treated in this circle?

7. How do you want to treat others in this circle?

8. What can you offer to the other participants to make this a safe place?

(Questions 1-9 are adapted from The Handbook for Facilitating Peacemaking. Felligi, B., Szego, D., 2013)

4. Close the Listening & Understanding Conversation

Action: Facilitator will ask questions to close the Listening & Understanding conversation.

Script:

1. How do you feel now? Do you have any concerns?
2. What do you expect from such a collective meeting/circle?

These questions help define the goal of the circle to be welcoming and future oriented. This will help participants both focus on and connect to the goal of CSC development.

The material collected during the entire conversation will **generate the Phase I Summary**. The Phase I Summary and current CSC will be shared with each Phase 2 participant prior to the collective Phase 2 meeting. If no CSC established, consider sharing best practices from the manuscript (e.g. Equity in Crisis Standards of Care by SAEM).

Appendix C. Phase 2: planning & doing to generate CSC content

Phase 2 is composed of health system's Policy Implementation Committee/ CSC Organizing Committee and is **inclusive** of volunteer Phase 1 participants and the Phase 1 Summary report which represents **harms and needs of** small groups (subgroups). The Phase 1 participants and summary report are present during this phase to highlight community needs and inform the next set of CSC guidelines.

OUTLINE

1. Welcome by the Lead Facilitator and Participant introductions/sharing of why each participant is present
2. Mindful minute, centering practice
3. Review the process: Preamble, Agreements/Community Building, Introduction of Rounds
4. Reflections from Phase 1 Summary Report Round
5. CSC structure Rounds
6. Close the CSC Content conversation

(Outline modified from International Institute for Restorative Practices. (2020, August 20). Listening circle facilitator script [adapted]. https://learning.iirp.edu/login/index.php)

Suggested Script

1. Welcome

Action: The facilitator would thank stakeholders for attending the circle and for their willingness to come with an open mind and open heart. The Facilitator will introduce and explain the purpose of the Phase 2 listening circle (e.g., explaining the participants' value as stakeholders for CSC development and sharing values of the collective).

Script: "Hello and thank you for participating and bringing an open heart and mind with you. As you may know, my name is ……… and I will be facilitating this Listening Circle. The purpose of this circle is to provide an opportunity for people to express their thoughts and feelings about the impact of CSC inciting events (e.g., COVID-19) on their lives and find collaborative solutions to identified needs."

Action: Participant introductions by each stakeholder and why each participant is present

Script: "Hello, my name is (). I represent people experiencing homelessness."

2. Mindful minute, centering practice

Action: Facilitator will set intention with a mindfulness practice to support centering the participants to present time. This will be followed by a short period of guided cleansing breaths where participants could close their eyes and set an intention, meditation, etc.

Script: "Please close your eyes. Take a few cleansing breaths. Please set an intention for today's session."

Action: Explain the Centerpiece

The keeper will share the meaning of the centerpiece. The centerpiece may include items representing the values of the core self, the foundational principles of the process, or a shared vision of the group. Centerpieces often emphasize inclusion by incorporating symbols of individ-

ual Circle members as well as the cultures represented in the Circle. Whatever is included in the center of the space should convey a sense of warmth, hospitality, and inclusion (Boyes-Watson & Pranis, 2015).

3. Review Process

Action: Facilitator will share the flow (Talking Piece/Agreements, Preamble, Additional Agreements, Introduction to Rounds) for the session.

Action: Introduce the Talking Piece *Modifications may be necessary, being mindful of viral transmission in the era of COVID-19. The talking piece may take a virtual format (e.g. raised hand feature on Zoom/Webex/etc.) or individual replicas.*

The facilitator will explain the meaning behind the talking piece(s) and how powerful and sacred each person's voice is. In addition, one would explain the general rules of the circle (adapted from Boyes-Watson & Pranis, 2015).

Script: Facilitator would remind the participants that their true selves are good, wise, and powerful!

Agreements

- The person holding the talking piece has the right to speak without interruption
- Everyone else has the opportunity to listen without the need to respond
- Only the person holding the talking piece may speak
- It is always okay to pass the talking piece, or hold it silently without speaking
- The facilitator may speak without the talking piece in order to help facilitate the circle

* The Facilitator's role is to support participation that honors these agreements.

Script: Preamble "This is a sharing with the purpose of listening, storytelling, and connecting, it is not a debate. Some of what we are doing may seem quite formal and it is. The reason for this is to ensure everyone is free to respond to the questions without being interrupted or asked to explain themselves. Each of us is being invited to speak and to respectfully listen. This session may be difficult for some, and you may have an unexpected strong reaction. Please remember this is not a therapy session. I encourage you to utilize your supports outside of this circle."

Script: Additional Agreements (add more if you feel compelled)

- Share what you feel comfortable sharing
- You can pass at any time
- Be mindful of time
- Stay quiet when not talking
- Speak from the I perspective
- Respect the privacy of those sharing

- Does anyone need clarification on the agreements and are there any agreements the group would like to add? (add additional agreements if necessary)

Action: Community Building Activities

This is an introductory activity to get to know each stakeholder, create a sense of community, and share common values. Afterwards, there will be a deep dive into the harms and needs experienced in healthcare as it relates to CSC via shared Phase 1 summary report.

Script:

Activity 1: Suggest participants introduce themselves by stating their name and the story behind their name.

Activity 2: Suggest participants share something you wouldn't know about me by just looking at me.

*These are only suggestions of activities. Please be mindful of locale culture to be sensitive to decorum.

4. Reflections from Phase 1 Summary Report Round

Action: Inquiry of participants' responses or insights gleaned from reviewing Phase 1 Summary Report

Script: "What struck you from Phase 1 Summary Report?" Alternatively, did you have any strong reactions to the themes (or needs) of the Phase 1 summary?

5 CSC Structure Rounds

Round A: Present CSC Standards

Action: Facilitator(s) give overview of the local current state of CSC. Create an opportunity for Stakeholders to ask questions or obtain clarification.

Script: "I (We) would like to highlight the information packet sent out previously to set a foundation for today's activities and address major questions. A 10-15 minute discussion could occur to explain the purpose of Crisis Standards of Care and the status of local Crisis Standards of Care. I (we) encourage a few questions to from stakeholders, if there are concepts or terms that need clarification."

Round B: Identifying Harms Round

Plan to document collective activities via trained note takers or recordings to facilitate content development.

Action: Identify blind spots or opportunities for improvement with the current set of CSC guidelines.

Script: "We understand that CSC as it currently stands is not working for everyone. How has the current CSC not worked well or failed the community?

Round C: Preventing Additional Harms, Generation of New CSC

A working draft of CSC content should be deliverable at the close of this session.

Action: Drill down on the essential aspects of the new CSC construct

Script: "What changes need to occur to CSC to reduce the chances of harming/failing our community? How do

we ensure that equity orients our processes to consider the most vulnerable amongst the health system service area?"

Other questions for consideration:

- When should CSC be activated?
- How should CSC activation be communicated to system and public?
- How can CSC best practices be incorporated locally?
- How can things be put right again from the harms occurred from prior CSC/scarcity conditions?
- Are there any special legal precautions/regulations that should be considered during CSC?
- What is necessary to improve collaboration amongst neighboring healthcare facilities?
- How can we prevent CSC activation from happening again?
- How should planning for future crises that are likely to occur?

Round D: Operationalizing CSC

- Who should implement this Process? Triage Team, Oversight Committee, etc.

Appendix D. Phase 3: check & act

OUTLINE

1. CSC Accountability Round
2. Check-Out Round
3. Close circle conversation

(Outline modified from International Institute for Restorative Practices. (2020, August 20). Listening circle facilitator script [adapted]. https://learning.iirp.edu/login/index.php)

1. CSC Accountability Round

Action: In Phase 3 (Check & Act), the resultant draft is approved by the stakeholder collective for finalization and prior to health system leadership (e.g., Board, Executive Team, etc.) presentation, who will, ideally, institutionalize the guidelines as hospital/health system policy. In ideal circumstances, the medical facility/health system would be empowered to incorporate the findings of the collective via a defined Triage Team and Oversight Committee.

Script: "Thank you for your collective efforts at defining content for CSC in the last round. The identified/elected members of the group will finalize our work from today and submit it to all Phase 1 and 2 participants for additional comments and review. At the close of the review period, the CSC guidelines will be submitted to facility/health system leadership in following the chain of command for policy approval."

Action: The medical facility should anticipate follow-up and guideline adjustment as directed by the collective.

Script: "We propose a follow-up schedule to the facility to ensure that the CSC implementation is going as proposed and that opportunities for improvement are promptly identified. Should we define how often the facility/organization reports status updates to local community?"

2. Check-Out Round

Action: Facilitator should gage stakeholder sentiment about the collective meeting that just occurred and thank everyone for being present.

Script: "How do you feel about our circle today? Alternately, can you sum up the way you feel in one word? What are you hopeful about after our meeting?"

3. Close the Circle Conversation
Thank everyone for participating!

REFERENCES

1. National Center for Immunization and Respiratory Diseases (NCIRD) DoVD. Risk for COVID-19 infection, hospitalization, and death by race/ethnicity. Centers for disease control and prevention. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html#print. Published 2021. Updated July 16, 2021. Accessed August 17, 2021.

2. Hill L, Artiga S, Haldar S. Key facts on health and health care by race and ethnicity. https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/. Published 2022. Accessed January 31, 2022.

3. Hick JL, Hanfling D, Wynia MK, Toner E. Crisis standards of care and COVID-19: what did we learn? How do we ensure equity? What should we do? NAM perspective.2021:10.31478/202108e.

4. Cleveland Manchanda EC, et al. Crisis standards of care in the USA: a systematic review and implications for equity amidst COVID-19. *J Racial Ethnic Health Dispar*. 2020.

5. Ioannides KDA, Shen M, Schriger D.. Ambulances required to relieve hospital overcapacity. In.

6. Firozi P, Villegas P. States and health systems activate crisis standards, new protocols as omicron strains U.S hospitals. *Washington Post*. 2022.

7. Clark C. Crisis standards of care reactivated for southwest and south central Idaho. *Idaho Bus Rev*. 2022.

8. Butler C, Webster L, Sakata V, Tonelli M, Diekema D, Gray M. Functionality of scarce healthcare resource triage teams during the COVID-19 pandemic: a multi-institutional simulation study. *Crit Care Explor*. 2022;4(1):e0627.

9. Miller WD, Han X, Peek ME, Charan Ashana D, Parker WF. Accuracy of the sequential organ failure assessment score for in-hospital mortality by race and relevance to crisis standards of care. *JAMA Netw Open*. 2021;4(6) e2113891-e2113891.

10. Roy SSM, Tolchin B, Kashyap N, Bonito J, Salazar MC, et al. The potential impact of triage protocols on racial disparities in clinical outcomes among COVID-positive patients in a large academic healthcare system. *PLoS One*. 2021;16(9):e0256763.

11. Maroko AR, Doan TM, Arno PS, Hubel M, Yi S, Viola D. Integrating social determinants of health with treatment and prevention: a new tool to assess local area deprivation. *Prev Chronic Dis*. 2016;13:E128.

12. CDC/ATSDR Social Vulnerability Index. Agency for toxic substances and disease registry. https://www.atsdr.cdc.gov/placeandhealth/svi/index.html. Accessed January 30, 2022.

13. Association AM. Crisis standards of care: Guidance from the AMA code of medical ethics. https://www.ama-assn.org/delivering-care/ethics/crisis-standards-care-guidance-ama-code-medical-ethics. Published 2020. Accessed January 15, 2021.

14. Giroir AB. Rapid expert consultation." rapid expert consultation on crisis standards of care for the COVID-19 pandemic. *Natl Acad Sci, Eng Med*. 2020.

15. Medicine Io. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework* Washington, DC: The National Academies Press; 2012.

16. National Academies of Sciences E, Medicine. *Crisis Standards of Care: Ten Years of Successes and Challenges: Proceedings of a Workshop* Washington, DC: The National Academies Press; 2020.

17. Gert B. *Common Morality: Deciding What to do* Oxford New York: Oxford; New York: Oxford University Press; 2004 2004.

18. Streat S. Clinical review: moral assumptions and the process of organ donation in the intensive care unit. *Critical Care*. 2004;8(5):382.

19. Mill JS. Utilitarianism: what utilitarianism is. 1863.

20. Europe A. The four common bioethical principles/Justice. *Alzheimer Europe Rep*. 2010.

21. Aea Alperovitch. Ethical issues raised by a possible influenza pandemic. *Natl Consult Ethics Committee Health Life Sci*. 2009.

22. White D, B L. Mitigating inequities and saving lives with ICU triage during the COVID-19 pandemic. *Am J Respir Crit Care Med*. 2020;203(3).

23. Bazerman M. *Harvard Business Review*. How should we allocate scarce medical resources Boston, MA: Harvard Business Publishing; 2020.

24. Rhodes KV, Wei EK, Salway RJ, Natsui S, Silvestri D, Cassel CK. The New York City pandemic resuscitation equitable allocation principles. *Resuscitation*. 2020;156:123–124.

25. Ekmekci PE, Arda B. Enhancing John Rawls's theory of justice to cover health and social determinants of health. *Acta Bioeth*. 2015;21(2):227–236.

26. Fishman J, MacKay D. Rawlsian justice and the social determinants of health. *J Appl Philos*. 2019;36(4):608–625.

27. McMillan JHT. Justice-based obligations in intensive care. *Lancet*. 2010;375(9721):1156–1157.

28. Rosoff PM, Patel KR, Scates A, Rhea G, Bush PW, Govert JA. Coping with critical drug shortages: an ethical approach for allocating scarce resources in hospitals. *Arch Intern Med*. 2012;172(19):1494–1499.

29. Reiner J. Michael Walzer. John Wiley & Sons; 2020.

30. Walzer M. *Spheres of Justice: a Defense of Pluralism and Equality* Princeton: Basic Books; 1983.

31. Davis F. *The Little Book of Race and Restorative Justice: Black Lives, Healing, and US Social Transformation* New York, NY: New York, NY: Good Books; 2019 [2019].

32. Gavrielides Te, Taylor Francis. *Routledge International Handbook of Restorative Justice. 1 ed* Abingdon, Oxon;New York, NY: Routledge; 2019.

33. Behel J. I shall be released. restorative justice techniques can address healthcare burnout & attrition. *Reflective MedEd*. 2019.

34. Wailling J, Marshall, C., & Wilkinson, J.. Hearing and responding to the stories of survivors of surgical mesh: Ngā kōrero a ngā mōrehu – he urupare (A report for the Ministry of Health). The Diana Unwin Chair in Restorative Justice, Victoria University of Wellington December 2019.

35. JUSTICE EFFR. The idea of restorative justice and how it developed in Europe. 2020.

36. Chiste K. The origins of modern restorative justice: five examples from the English-speaking world. *Free Libr*. 2013.

37. Richardson LMT. Bringing reconciliation to healthcare in canada: wise practices for healthcare leaders. 2018.

38. COVID-19 CsPo. *Final report of the citizens' panel on COVID-19*. November 2020.

39. McWhirter RE, Critchley CR, Nicol D, et al. Community engagement for big epidemiology: deliberative democracy as a tool. *J Personal Med*. 2014;4(4):459–474.

40. Biddison ELD, Gwon HS, Schoch-Spana M, et al. Scarce resource allocation during disasters: a mixed-method community engagement study. *Chest*. 2018;153(1):187–195.

41. Downs J. *Sick from Freedom: African-American illness and suffering during the Civil War and Reconstruction*. New York: New York: Oxford University Press; 2012:c2012.

42. Warne Donald FLB. American Indian health policy: historical trends and contemporary issues. *Am J Public Health*. 2014;104(S3):S263–S267.

43. Washington HA. *Medical Apartheid: the Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present* New York: New York: Harlem Moon, ©2006.; 2006.

44. Reverby SM. More than fact and fiction: cultural memory and the tuskegee syphilis study. *Hastings Cent Rep*. 2001;31(5):22–28.

45. Chen JA, Zhang E, Liu CH. Potential impact of COVID-19-related racial discrimination on the health of Asian Americans. *Am J Public Health*. 2020;110(11):1624–1627.

46. Geronimus AT. "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. *Am J Public Health*. 2006;96(5):826–833.

47. Wyatt RLM, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper*. Institute for Healthcare Improvement; 2016.

48. Nakayama DK, Jensen GM. Professionalism behind barbed wire: health care in World War II Japanese-American concentration camps. *J Natl Med Assoc*. 2011;103(4):358–363.

49. Garrison NA. Genomic justice for native americans: impact of the havasupai case on genetic research. *Sci Technol Hum Values*. 2013;38(2):201–223.

50. Mello MM, Wolf LE. The Havasupai Indian tribe case — lessons for research involving stored biologic samples. *N Engl J Med*. 2010;363(3):204–207.

51. Shamoo AE, Tauer CA. Ethically questionable research with children: the Fenfluramine study. *Account Res*. 2002;9(3-4):143–166.

52. Rodriguez MA, García R. First, do no harm: the US sexually transmitted disease experiments in Guatemala. *Am J Public Health*. 2013;103(12):2122–2126.

53. Bailey z. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*.1453-1463.

54. Roy S, Edwards MA. Preventing another lead (Pb) in drinking water crisis: lessons from the Washington D.C. and Flint MI contamination events. *Curr Opin Environ Sci Health*. 2019;7:34–44.

55. Hanna-Attisha M.*What the eyes don't see: a story of crisis, resistance, and hope in an American city.*First ed. New York: One World, an imprint of Random House; 2018.

56. CLIFT TBB. Chemical to be added to Pittsburgh drinking water to reduce lead contamination. *Tribune-Rev*. 2018.

57. LeBrón AMW, et al. The state of public health lead policies: implications for urban health inequities and recommendations for health equity. *Int J Environ Res Public Health*. 2019;16(6):1064.

58. Fretwell S. Unsafe levels of lead found in drinking water around S.C. 'There's no accountability.'. *The State*. MARCH 12, 2019 05:00 AM, UPDATED MARCH 19, 2019 04:35 PM, 2019.

59. Terp S, Ahmed S, Burner E, et al.. *Deaths in Immigration and Customs Enforcement (ICE) detention: FY2018-2020*, 8, AIMS Public Health; 2021:81–89.

60. Matthew DB. Structural inequality: the real COVID-19 threat to America's health and how strengthening the affordable care act can help. 2020; (6). *Georgetown Law J (Georgetown University Law Center)*. 2020;108:1679–1716.

61. Millett GA, Jones AT, Benkeser D, et al. Assessing differential impacts of COVID-19 on black communities. *Ann Epidemiol*. 2020;47:37–44.

62. Falicov C, Niño A, D'Urso S. Expanding possibilities: flexibility and solidarity with under-resourced immigrant families during the COVID-19 pandemic. *Fam Process*. 2020;59(3):865–882.

63. Prevention CfDCa. *CASES, DATA & SURVEILLANCE COVID-19 Hospitalization and Death by Race/Ethnicity*. CDC; Updated July 16, 2021 2021.

64. Ford Tiffany RS, Reeves Richard. *Upfront: Race Gaps in COVID-19 Deaths are Even Bigger than they Appear*. Brookings; 2020.

65. Shreffler J, Petrey J, Huecker M. The impact of COVID-19 on healthcare worker wellness: a scoping review. *West J Emerg Med*. 2020;21(5):1059–1066.

66. Weingarten K, Galván-Durán AR, D'Urso S, Garcia D. The witness to witness program: helping the helpers in the context of the COVID-19 pandemic. *Fam Process*. 2020;59(3):883–897.

67. Gulati G, Kelly BD. Physician suicide and the COVID-19 pandemic. *Occup Med (Lond)*. 2020:kqaa104.

68. Dickert N, Sugarman J. Ethical goals of community consultation in research. *Am J Public Health*. 2005;95(7):1123–1127.

69. Sinsky CA, Brown RL, Stillman MJ, Linzer M. COVID-related stress and work intentions in a sample of US health care workers. *Mayo Clinic Proc: Innov, Qual Outcomes*. 2021;5(6):1165–1173.

70. Proactive restorative practices: Creating the conditions for individuals and communities to flourish. Strengthening the Spirit of Community, IIRP World Conference, Detroit, MI: International Institute for Restorative Practices; 2018.

71. Pranis K. *The Little Book of Circle Processes: a New/Old Approach to Peacemaking* Intercourse, PA: Intercourse, PA: Good Books; 2005 2005.

72. Together: the healing power of human connection in a sometimes lonely world. New York: [New York]: HarperAudio, 2020.; 2020.

73. FEMA. Disasters & Assistance: Historic Disasters. U.S. Department of Homeland Security. https://www.fema.gov/disaster/historic. Published 2022. Accessed February 11, 2022.

74. Frank L, Concannon TW, Patel K. *Health Care Resource Allocation Decision making During a Pandemic*. RAND Corporation; 2020.

75. Equity in Crisis Standards of Care [press release]. 2020.

76. Hick JL, Hanfling D, Wynia MK, Pavi AT. *Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS–CoV-2*. National Academy of Medicine; 2020.

77. Emanuel EJ, Persad G, Upshur R, et al. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *N Engl J Med*. 2020;382(21):2049–2055.

78. Kimsey DB. Lean methodology in health care. *AORN J*. 2010;92(1):53–60.