Crisis Standards of Care Brief: Planners

April 2022

What is crisis care/crisis standards of care, and when does it occur?

- Crisis standards of care (CSC) is defined as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive public health emergency (e.g., pandemic influenza) or catastrophic disaster (e.g., earthquake, hurricane) (National Academies of Medicine, 2012).
- Patients are at significant risk of poor outcomes when receiving healthcare under crisis care conditions.
- A "declaration" of CSC is not as important as having strategies to recognize and resolve these challenging conditions at the hospitals. When these cannot be resolved in cooperation with other local hospitals, the hospital should engage the state; the state should provide legal, policy, regulatory, and other support to relieve the situation and support the strategies being employed by the healthcare facilities to address the demand.
- Hospitals should always implement the strategies necessary to adapt to the situation and support clinicians in their crisis decision-making; "avoiding" CSC or "waiting until CSC is declared" puts patients and providers at unnecessary risk.
- Strategies used may vary depending on whether it is possible to obtain additional resources or move patients out of the affected area(s) to sites with more resource availability.
- Broad declarations of "crisis standards of care" by a state or region could pave the way for unnecessary triage decisions, especially if declarations, available resources, and expectations of clinicians are not communicated clearly.
- Communication of the crisis situation to the community at large (in addition to existing patients) is important to provide transparency and manage expectations.

What are some key areas of shortage?

- Shortages in supplies such as certain medications, N95 masks, and dialysis equipment have been key drivers of CSC conditions. Local, state, and federal stocks of ventilators have dramatically increased since spring 2020 and hopefully will not be a limiting factor to treating patients in the future.
- Shortages in staff, particularly those with specialized training in areas such as critical care and respiratory therapy have been a key limiting factor to providing comprehensive patient care.
- Space and the ability to transport patients has also been an issue, particularly in smaller communities that may be hit particularly hard and not able to move patients fast enough to other hospitals (due to logistics or distance between facilities).

What should our hospitals be doing?

- Ensure that surge plans for space and staff define the incremental changes that will be used to adapt to increasing demand. This includes defined "triggers" that will prompt a request for regional / state support (e.g., staff to patient ratios > 200% normal, use of non-traditional staff to provide care on inpatient units, use of non-patient care areas for patient care). This includes identifying alternate care areas within the facility that can be readily available and opened for overflow.
- When a crisis "trigger" point is reached all non-emergency procedures should have stopped and all other services need to be directed to supporting acute patient care.
- Facilities should participate in regional Medical Operations Coordination Centers (MOCC) or other patient distribution strategies that aim to load-balance patients across hospitals in an equitable way. This should include mechanisms that prioritize patients for transfer and ensure that those with emergent conditions in a facility that does not provide those services can be transferred in an equitable way to a higher level of care.
- Ensure the facility develops best practices and guidelines for care and is anticipating shortages and issues; regional collaboration to develop best practices for consistency is ideal.
- Ensure that all patients have documented end-of-life care expectations and/or a designated power of attorney.
- Engage with healthcare coalition (HCC), emergency management, and other stakeholders to ensure that essential elements of information are shared to support MOCC activities and decision-making (including state actions to support hospitals and providers during CSC).
- Provide a critical care, chief medical officer, or other on-call expert consultant to be contacted whenever a provider is making an allocation decision that is unusual for them or for which they do not have good guidance (as well as any potential "triage" decision that could result in death; this should be considered by a formal multi-disciplinary triage team). Access to such a consultant ensures:
    - Issues at the provider level are raised to the system level for monitoring and action as they may represent broader issues requiring policy development or a regional response.
    - Development of a plan informed by more than one provider—including one not at the bedside—to reduce bias, improve decisions, and prevent/reduce provider distress.
- Provide education on ethical decision-making. Make sure that the doctors and nurses understand their role, and how to request assistance with making challenging decisions.

What should our state be doing?

- Take action to reduce hospital demand through population-based interventions (e.g., mask mandates, prophylaxis, or early treatment can prevent hospitalizations in select infectious disease emergencies).
- Ensure that providers have adequate legal protections for actions taken when practicing in non-traditional roles or locations, or when providing services and advice that is outside of usual practices but consistent with the response.
- Ensure hospital immunity from legal actions that would block the discontinuation of non-beneficial ongoing care during CSC as assessed by a multi-disciplinary hospital process.
- Identify regulatory barriers that may need to be suspended to support the strategies hospitals are using (e.g., suspension of bed restrictions or staff-to-patient ratios, streamline state licensing requirements for out-of-state providers).

- Prepare and circulate risk communications on the crisis situation to the media and general public, including via social media, to manage public expectations.
- Convene a State Disaster Medical Advisory Council (or similar advisory construct) to provide guidance on best practices as required by the situation and consistent with national guidance from specialty societies and government agencies.
- Operate or support a MOCC or similar entity to facilitate equitable patient distribution across available resources. This center may also coordinate transportation resources and staffing in some areas.
- Support communities when an alternate system of care or hospital or community-based alternate care site needs to open (staffing, licensing, resources) to maximize capacity at hospitals. This may include broadening permissions and reimbursement for telehealth services.
- Coordinate with HCCs that are providing support (expert consultation, coordination of care, situational awareness) during a CSC response.
- Ensure situational awareness and sharing of essential elements of information to confirm relative situational consistency (e.g., degree of patient surge, level of ICU acuity/percentage of ventilated patients, staffing adaptations) across the hospitals and track available beds and resources.
- Ensure that smaller hospitals have a mechanism to obtain critical care consultation, particularly when there may be delays moving a patient to a higher level of care.
- Submit resource requests to state and federal partners to ensure all available resources (e.g., Strategic National Stockpile) are provided to address the crisis situation. In the event that resources are not available, provide or seek technical assistance to solve issues of CSC policy.