Crisis Standards of Care Brief: Support for Clinical Allocation Decisions

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What is the difference between clinical decision support and a triage team?

- Crisis Standards of Care work classically refers to a "triage team" that provides consultation and makes decisions about providing / re-allocating life-saving interventions.
- Anecdotal evidence from COVID-19 revealed that this construct has been rarely utilized as triage of ventilators and similar equipment was not systematically needed.
- However, providers reported having to frequently make bedside rationing choices during COVID-19 surge situations. These decisions did not rise to a "triage team" level, were essentially ad hoc, and were not necessarily the best decisions that could have been made.
- Clinical decision support should be available that provides an on-call expert who can engage in joint decision-making and support the bedside provider, as well as serve as a liaison to the facility incident command structure.

In what situations should the bedside provider seek consultation?

- In crisis care situations, many emergency and critical care providers have to make decisions about resuscitation termination and resource prioritization (e.g., priority for dialysis) and could benefit from consultant advice. However, any decision that is within the provider's *usual* scope of responsibilities does not require consultation.
- Consultation is not required if the facility has adopted policy about how to allocate a resource (e.g., policies to allocate a specific COVID-19 treatment) unless the policy requires a consultation.
- For decisions that meet the following criteria, the clinician should obtain consultation per the facility plan:
    - Allocation of scarce resource (e.g., determination not to offer intervention or to ration a resource) that may have serious impact on the patient's health for which there is no facility provided guideline or policy (e.g., medication shortage situation, shortage of dialysis);
    - Determinations of medical futility / non-beneficial care not normally within scope of practice; and/or
    - Determination to withhold or limit treatment based on amount of resource consumption.

Why should providers obtain consultation?

- To raise the issue to a systems level and inform the incident command team so that proactive analysis, problem-solving, and policy development can occur.
- To ensure that information can be shared between facilities/systems for consistency. Rarely are these issues a "one-off" problem. Facilities should not be providing crisis care without requesting regional assistance to improve the local situation and balance patient loads – if aid is not possible, then consistency is the goal.

- To improve problem-solving by engaging other expert provider(s).
- To determine if there are other available facility/system resources that may address the issue.
- To reduce legal liability by sharing decision-making with another "reasonable provider."
- To reduce the moral distress staff may experience when making allocation decisions.

Who should provide consultation?

- The initial on-call provider should be an experienced critical care or other clinician with resource allocation experience.
- This may be a current on-call critical care provider, or be a designated chief medical officer, critical care, or emergency medicine provider.
- This initial consultant should be able to reach usual on-call specialty providers (e.g., nephrology for dialysis question) for support.
- In case of true "triage" decision-making, additional consultation may be recommended or required (e.g., additional providers, an ethicist) and other procedures will be required for process and documentation. The facility may elect to have the same consultant serve as the "gateway" for true structured triage decisions regarding life-saving interventions such as ventilators (highly unusual situation).

What is the process for consultation?

- A provider that is making a resource allocation decision which is outside of usual practice contacts the on-call clinical decision support consultant.
- The bedside provider and the consultant discuss the situation and agree on initial actions.
- The clinical decision support consultant makes additional inquiries to other specialists or the incident management team as needed.
- The providers agree on the most fair and proportional strategy available.
- The bedside provider documents the discussion in the medical record.
- The consultant tracks the issue and resolution and reports out as required (at least on a daily basis) to the incident commander or designee the events that occurred in the operational period. If an issue occurs that warrants immediate action, the consultant may contact the incident command team at any time to initiate a search for resources, guidance, or information.

What should the follow-up be for consultation?

- Based on identified or anticipated issues, facilities should provide clinical information or may need to develop or modify best practices for resource use to promote consistency.
- Hospitals should communicate any new policies or modifications to guidelines to healthcare coalition / regional facilities for discussion and to ensure congruent strategies.
- If care or access to critical care resources is being rationed, a process to identify potential non-beneficial / inappropriate care based on the resource demands should be in place to examine current patients and decide if it is reasonable to continue providing that type of care to those who will not benefit from it.