Crisis Standards of Care During COVID-19
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.
- COVID-19 has revealed that this construct has not been utilized as such binary decisions are rare.
- However, implicit triage decisions and rationing choices have been frequently reported by providers in COVID-19 surge situations that never rose to a “triage team” level and therefore were ad hoc, and not necessarily the best decisions that could have been made.
- Clinical decision support is an on-call expert that can provide joint decision-making and support to the bedside provider as well as provide a link to the facility incident command structure.

In what situations should the bedside provider seek consultation?

- Many emergency and critical care providers have to make decisions about resuscitation termination and resource prioritization (e.g. priority for CT scan) – any decision that is within the provider’s *usual* scope of responsibilities does not require consultation with another provider.
- Nor is consultation 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 consultation.
- For decisions that meet the following criteria, the clinician should consult 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 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 to ensure awareness of the incident command team so that proactive analysis, problem-solving, and policy development can occur, and to ensure that information can be shared between facilities/systems for consistency. Rarely are these issues a “one-off” problem.
- To improve problem-solving by engaging other expert provider(s).
- To raise awareness of other facility / system resources that may address the issue.
- To reduce legal liability by shared decision-making with another “reasonable provider.”
- To reduce moral distress of 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 to 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 provider, ethics) 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; this has not occurred thus far in COVID-19.

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 provider.
- The bedside provider and the consultant discuss the situation and agree on initial actions.
- The clinical decision support provider 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 as required (but no less than daily) to the incident commander or designee the issues and resolutions 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.
- Policies developed or guidelines modified should be communicated to healthcare coalition / regional facilities for discussion and ensure congruent strategies.
- 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.