Crisis Standards of Care Brief: Principles

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The spectrum of disaster care runs from conventional to crisis; the goal is conventional care. When this is not possible, plans and resources to stay in contingency help avoid crisis care and poor outcomes (National Academies of Medicine, 2012 and Hick, et al., 2009).

- **Conventional** - The spaces, staff, and supplies used are consistent with *daily practices* within the institution.
- **Contingency** - The spaces, staff, and supplies used are not consistent with daily practices but provide care that is *functionally equivalent* to usual patient care.
- **Crisis** - Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide *sufficiency* of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis care poses a significant risk of a poor outcome to the patient.

Core principles

- Crisis Standards of Care (CSC) preserves the functioning of the healthcare system by focusing services on acute care during times of scarcity—curtailing services in other areas—and adjusting patient care provided to the resources available. CSC is invoked when resource limitations cannot be easily resolved and affect a specific geographic area for a significant period of time (e.g., multiple facilities, rural areas with fewer options for acute medical care).
- Healthcare must have robust plans to *avoid* CSC, including facility surge plans that adapt incrementally to increasing demand and partnerships with other facilities in the region to move patients and/or resources to equalize the regional impact of a disaster.
- The goal of CSC is twofold: extend the availability of key resources and minimize the impact of shortages on patient care.
- CSC strives to save the most lives possible, while ensuring equal access to care; recognizing that some of the patients who will die might have survived if conventional care was possible.
- Implementation of CSC will require facility-specific decisions regarding the allocation of limited resources, possibly including triage of patients needing life-saving care.
- Crisis situations exist at the hospital level and must be addressed regardless of whether or not CSC has been "declared" by the state.

Core values

- Fairness – treating each patient with equity and evaluating them in the same way
- Duty to care – for each patient, without bias, to the best of our ability
- Duty to steward resources – to do the greatest good for the greatest number
- Transparency – to have shared assumptions, processes, and documentation
- Consistency – to provide a consistent level of care within a facility and region
- Proportionality – to only restrict care to the degree that we have to and no more
- Accountability – to engage experts as needed and document our decisions and process

Foundational elements

- **Ethical grounding** - During crisis, uphold the core ethical values. When resource scarcity reaches crisis levels, clinicians are ethically justified— and, indeed, are ethically obligated—to use the available resources to sustain life and wellbeing to the greatest extent possible.
- **Engagement** - CSC planning must involve both providers and the public to ensure the legitimacy of the process and the policy. These CSC planning processes must be proactive, honest, transparent, and accountable in order to warrant the public's trust. Senior leadership must prepare healthcare workers for crisis decision-making and support them as they face the decisions that differ significantly from usual care standards.
- **Legal basis** - Healthcare workers who must take on non-traditional roles, make difficult decisions, and/or provide advice when implementing CSC must have adequate guidance and legal protections. Under disaster conditions, adherence to core principles remains a constant, but other statutory or regulatory provisions can be altered as necessary in real time. State immunity from legal action against the provider or facility's perceived provision of inappropriate care is critical to being able to adapt the resources to the situation.
- **Indicators and triggers** - Institutions must be alert to indicators that signal a shift toward crisis levels of care. Surge plans should include a series of contingency or crisis care "next steps" at the facility that fluctuate depending on demand. "Triggers" for crisis conditions should be identified (e.g., using non-traditional providers on inpatient units, use of non-patient care areas to provide care) and prompt requests for state/regional support.
- **Evidence-based operations** - Decisions made at the bedside should be evidence-based whenever possible. Current predictive scoring systems of patient outcomes (e.g., SOFA) have limited value in predicting mortality and have been found to discriminate against those with pre-existing renal disease. The focus should be on assessment of individual short-term outcomes relative to the disease / injury and the likelihood of survival.

Planning and implementation principles

- Crisis conditions can exist in only one domain (e.g., shortages in personal protective equipment) or may affect multiple domains (e.g., staffing, space, supplies) all at once.
- Crisis conditions are dynamic; a facility may be in staffing crisis at 2am and in contingency at 3pm. This is particularly true of a no-notice disaster like a mass casualty incident where crisis conditions are quickly mitigated with additional resources and patient transfers.
- Crisis conditions in space, staffing, supplies, and systems (elements of surge capacity) should be anticipated and planned for by the hospital and the healthcare coalition. An incremental, stepwise plan for changing practices (e.g., admission, discharge, staffing, space use, supply conservation) should be described by the facility and integrated into the emergency operations plan.
- Clinical decisions about scarce resource allocation should be consistent and documented in guidelines/policy. Whenever a novel situation or decision occurs that is not in the scope of usual practice or decision-making, additional expert opinion should be sought and the situation documented, with lessons incorporated into planning as practical.
- The hospital incident management team must be aware of any CSC situations and be working to mitigate them, including obtaining resources or developing system policy. Incident management can support allocation decisions by keeping providers informed of resources and recommendations for rationing as needed.
- Individual providers at the bedside should make the fewest ad hoc resource allocation decisions possible; they should be supported by other expert clinicians and clinical guidelines whenever the decision is outside their usual practice.
- All patients should be assessed for degree of benefit of current / needed resources. When necessary, inappropriate care should be withdrawn according to a structured (but expedited in comparison to usual medical futility determinations) multi-disciplinary process.
- Figure 1 provides an example of CSC roles and responsibilities. The provider, facility, and regional structures should be part of an integrated system when CSC is required.

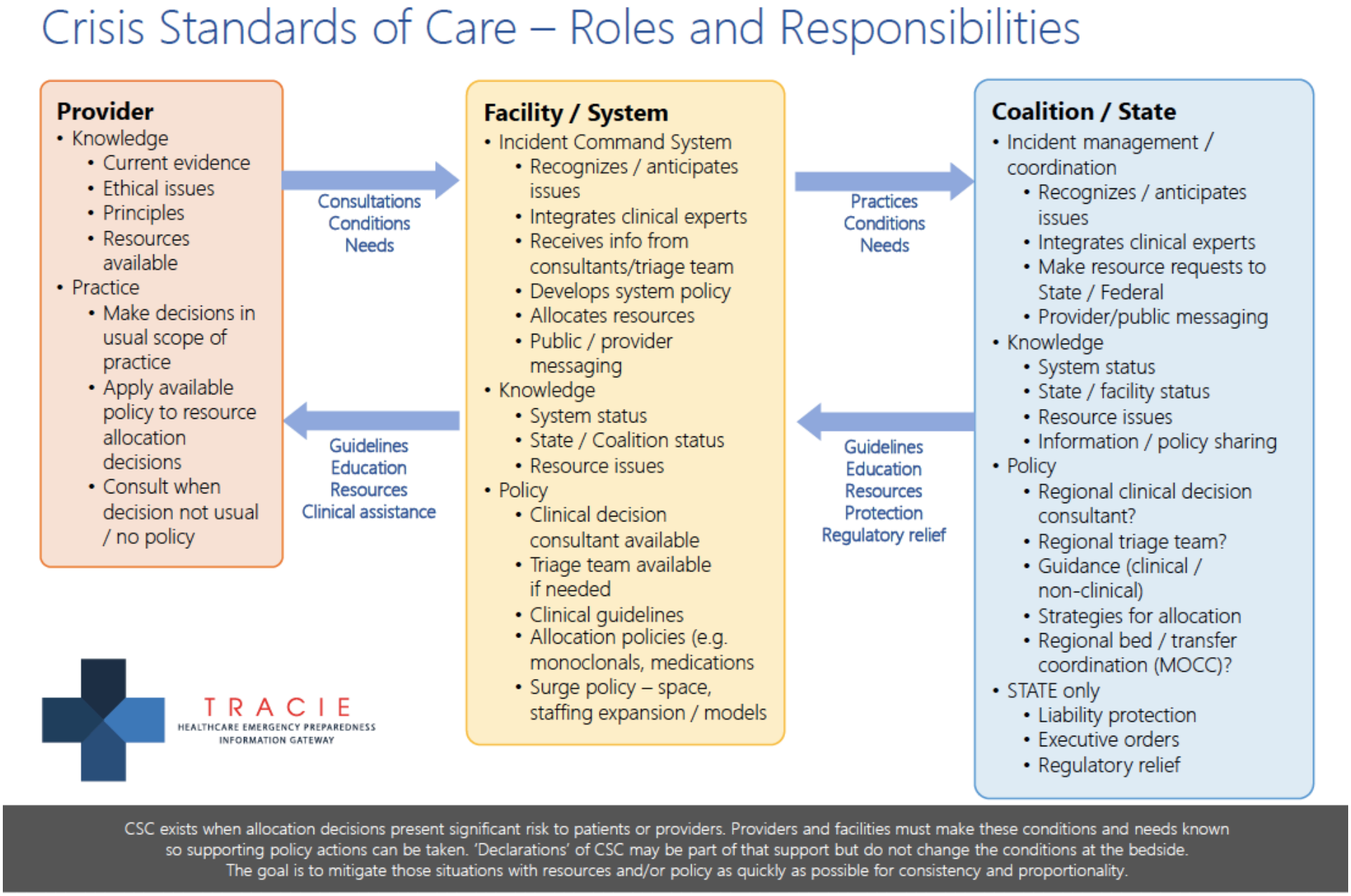

Figure 1. CSC Roles and Responsibilities