

ASPR TRACIE Technical Assistance Request

Requestor: [REDACTED]
Requestor Phone:
Requestor Email:
Request Receipt Date (by ASPR TRACIE): 15 January 2016
Type of TA Request: Standard

Request:

[REDACTED] is seeking best practices for indicators related to crisis standards of care to utilize for their plans as part of their technical assistance needs for BP4.

Response:

Section I provides recommendations from ASPR TRACIE SME Cadre members on their thoughts regarding the CSC planning process and recommendations of the most promising/ best practice plans. Section II includes various resources and guidance documents that may be helpful in the CSC plan development process. And Section III includes Milestones for CSC Planning and Implementation (an excerpt from the IOM documents).

I. Crisis Standards of Care SME Comments:

The current "criteria" used when reviewing CSC guidance/plans is taken from the IOM [Crisis Standards of Care document](#) (Institute of Medicine, 2012) and [IOM Letter Report](#) (Institute of Medicine, 2009). These document highlight "milestones" for CSC planning and implementation (See Section III). In addition, the PHEP and HPP grant language that focuses on CSC planning are also taken into consideration (See Section II.D).

CSC planning is deemed to be based on the key elements that were articulated in the IOM Report (provider engagement, community engagement, indicators and triggers, clinical processes) and building these upon an ethical and legal framework that accounts for the transition of care from conventional to contingency to crisis care and return to conventional care.

It would be helpful for CSC planners to review the IOM CSC document and determine how such indicators/triggers could be used to help formulate a CSC plan. Particular attention should be paid to the transition of care along the continuum from conventional to contingency and crisis care, and the need to return towards conventional care. The entire goal of a CSC plan ought to be identifying ways of avoiding crisis care delivery in the first place.

Additionally, it is important to note that daily opportunities exist to enact crisis care principles such as medication shortages, which will allow the use of the same structures and processes as those in crisis care. An example resource that may be helpful is [ASTHO's Guidance for Medication Shortage](#).

Recent recognition of the limitations of the SOFA score in the setting of respiratory illness have emphasized that it should be used along with disease-specific indicators and other information to compare prognosis between patients requiring the same limited resources rather than to create thresholds that exclude access to resources. An example of this may be seen in the [Minnesota Department of Health Scarce Resources cardset, “Patient Care- Strategies for Scarce Resource Situations”](#). Additionally, ventilator triage would be a highly unusual circumstance occurring only in the setting of a severe pandemic and should not be the focus of crisis care planning.

These are two examples in medical literature regarding the limitations of the SOFA score:

- Khan ZI, Hulme J, Sherwood N. (2009.) [An assessment of the validity of SOFA score based triage in H1N1 critically ill patients during an influenza pandemic](#). *Anaesthesia*. 64(12):1283-8. doi: 10.1111/j.1365-2044.2009.06135.
- Rubinson L, Knebel AR, Hick JL. (2010.) [MSOFA: An Important Step Forward, but Are We Spending Too Much Time on the SOFA?](#) *Disaster Medicine and Public Health Preparedness*. 4(4):270-2. doi: 10.1001/dmp.2010.41.

The following CSC documents are recommended as “promising/best practices” in that they address a number of the elements noted in the IOM report.

- **Washington DC:** [Modified Delivery of Critical Care Services in Scarce Resource Situations, Overview of a strategy to be implemented by the DC Emergency Healthcare Coalition and its member organizations](#)
- **Minnesota:**
 - Strategies for Scarce Resources (available if requested, currently not posted on COI site)
 - [Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic](#)
 - [Science Advisory Team Crisis Standards of Care Charter](#)
- **Hennepin County, MN:** See attached the following guidance documents (**not for further distribution** without approval from ASPR TRACIE):
 - Hennepin County Medical Center (HCMC) Crisis Standard of Care Guidelines- Draft September 14, 2009.
 - Summary of Regional Process for Resource Triage Situation
 - Metropolitan Area Hospital Compact

II. Resources

A. Foundational Institute of Medicine Documents

The [Crisis Standards of Care](#) publication (2012) by the Institute of Medicine (IOM) of the National Academies serves as a key CSC foundational document. It includes seven volumes that provide discipline-specific recommendations and assessments tool for CSC planning. Additional resources below provide detail about the indicators and triggers, and community planning and issues with CSC.

- [Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response](#)
- [Crisis Standards of Care: Summary of a Workshop Series](#)
- [Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report](#)

- [2013 Crisis Standards of Care Indicators and Triggers Report](#)

State, regional, and local staff should utilize the guidance provided in the IOM reports, specifically *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, to help develop an operational CSC plan.

B. ASPR TRACIE Resources

ASPR TRACIE developed a [Crisis Standards of Care Topic Collection](#) that provides plans, tools, templates, and other resources vetted by subject matter experts.

ASPR TRACIE has also provided numerous responses for technical assistance (TA) from states, locals, and regions regarding CSC issues. Sample TA requests can be found in the [Assistance Center](#) and the full redacted versions of the CSC-specific TA responses can be found in the [Information Exchange](#).

The first issue of ASPR TRACIE’s newsletter, *The Exchange*, will be released in early February. This year’s theme is “Critical Issues in Healthcare System Preparedness,” and the first issue focuses on CSC planning and activation. The issue includes articles from authors with experience in local, state, and federal CSC planning.

C. ASPR Community of Interest

ASPR has an active online “[Communities of Interest: For Crisis Standards of Care and Allocation of Scarce Resources](#)” that allows local, state, and regional practitioners to can share various CSC plans, tools, and templates. The site provides a clearinghouse of resources and information, and encourages users to submit their jurisdiction’s/ facility’s CSC plan.

D. Healthcare System Preparedness Capabilities and Implementation Guidance & Public Health Preparedness Capabilities

The following guidance can help jurisdictions develop new and improve existing CSC plans:

- [HHS Healthcare Preparedness Capabilities](#) (January 2012) – provides specific guidance to plan development. Specifically review Capability 10, Function 4.
- [HPP BP3 Implementation Guidance](#) – Per this guidance, Hospital Preparedness Program (HPP) awardees are required to post their approved CSC plan on the ASPR COI site (see page 19) by the end of BP5 (July 2017). It also includes CSC specific indicators (Medical Surge Indicator 1 and Continuity of Healthcare Operations Indicator 3) and assessment factors (Healthcare Coalition Development Assessment Factors, #16).
- [CDC Public Health Preparedness Capabilities](#) (March 2011) – notes indicators for standards of care levels. Specifically review Capability 10, Function 1, Resource P5.

III. Milestones for CSC Planning and Implementation

The following is an excerpt of the [Crisis Standards of Care document](#) (Institute of Medicine, 2012) (specifically, [Crisis Standards of Care, Volume 1: Introduction and CSC Framework](#), pages 1-41) that provides milestones for CSC planning and implementation.

Listed below are critical milestones that can be used to assess the progress of CSC planning, along with the proposed lead agency responsible for facilitating discussion, plan development, and implementation for each milestone. Many of these elements can be conducted in a single project year.

NOTE: Those elements that are designated for subsequent project years are shaded in gray and noted with an asterisk.

- Establish a state disaster medical advisory committee (SDMAC) or equivalent with representation that includes all emergency response partners (EMS, public health, emergency management, health care systems, community-based practitioners, public safety, others) (**governor's office, state health department**).
- Ensure the development of a legal framework for CSC implementation in the state in collaboration with the state emergency management agency and EMS offices and the SDMAC (**governor's office, state legislature, state attorney general's office, state health department, state emergency management agency**).
- Promote understanding of the disaster response framework among elected officials and senior (cabinet-level) state government leadership (**state health department, state emergency management agency**).
- Develop a state health and medical approach to CSC planning that can be adopted at the regional/ local level by existing health care coalitions, emergency response systems (including the regional disaster medical advisory committee [RDMAC]), and health care providers (**RDMAC, state health department**).
- Engage health care providers and professional associations by increasing their awareness and understanding of the importance and development of a CSC framework (**state and local health departments and EMS agencies, health care coalitions and member organizations**).
- Encourage participation of the out-of-hospital medical community in planning for disaster response, including the development of plans to maximize the effective use of all available materiel and personnel resources (**state and local health departments, health care coalitions, professional health care organizations**).
- Ensure that local and state plans include clear provisions that permit an adaptation of EMS systems under disaster response conditions, including changes in protocols, destinations, practices, and personnel (**state and local health departments, state EMS agencies**).

- Develop and conduct public community engagement sessions on the issue of CSC (**state and local health departments**).*
- Support surge capacity and capability planning for health care facilities and the health care system, including the development of plans for allocating scarce resources and promotion of community resilience and mental health in surge response efforts (**state and local health departments, health care coalitions**).
- Plan for an alternate care system capability to manage a surge in demand for health and medical services (**state and local health departments, health care coalitions**).*
- Support scarce resource planning by the RDMAC for health care facilities and the health care system so these plans can coalesce at the (regional) hospital coalition level (**state and local health departments, health care coalitions**).
- Incorporate risk communication strategies into CSC plans (**governor's office, state and local health departments, EMS and emergency management agencies, health care coalitions and member organizations**).
- Exercise CSC plans at the local/regional level with state participation (including having the state exercise regional, intrastate, and interstate coordination if feasible) (**governor's office, state and local health departments, emergency management and EMS agencies, health care coalitions and member organizations**).*
- Exercise CSC plans at the interstate level (**governor's office, HHS regional emergency coordinators, state health department, state EMS and emergency management agencies**).*
- Use information identified during provider engagement, public/community engagement, and exercise events as elements of a process improvement cycle in order to further refine the development of disaster response plans (**governor's office, state and local health departments and EMS agencies, health care coalitions and member organizations**).
- Develop a process for continuous assessment of disaster response capabilities based on existing information and knowledge management platforms, and create a mechanism for ensuring that these CSC planning milestones are being achieved (**governor's office, state health department and emergency management agency**).*