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Crisis Standards of Care and COVID-19

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Surges of COVID-19 patients over the pandemic resulted in crisis conditions that placed patients at substantial risk of adverse outcomes in most states. However, states' responses to these conditions differed substantially. An ASPR TRACIE review of Crisis Standards of Care (CSC) declarations, media accounts of crisis conditions at healthcare facilities, and information collected from ASPR regional field personnel, state preparedness directors, and state hospital preparedness program directors found that:

- Crisis conditions could be documented in 48 states but only 9 made a declaration of CSC
- 12 states activated or enacted additional legal protections for providers
- 12 states issued executive orders related to crisis conditions (e.g., authorizing alternate care sites/techniques)
- 15 states took no action that could be documented

There are multiple learnings related to our experiences and findings. CSC was anticipated to be a more pervasive crisis situation. Because COVID-19 waxed and waned it was more difficult to know how and when to take systemic action. It is clear that the focus needs to shift from an "official declaration" of CSC to determining the specific supports that healthcare needs from government during periods of crisis including:

- **Load-balancing and transfer processes that ensure a consistent level of care is provided across a region with maximal use of available resources.** This was accomplished in many states by Medical Operations Coordination Centers (MOCC), facilitating access to care and promoting equity. However, most of these centers do not have the authority to require participation nor can they ensure the transfer of patients with emergency conditions. State powers can be helpful to support the development of MOCCs and effective and fair transfer policies.

Related ASPR TRACIE Resources

- ASPR TRACIE Crisis Standards of Care Briefs-Summary
- COVID-19 Crisis Standards of Care Resources
- Crisis Standards of Care Topic Collection
- Crisis Standards of Care and COVID-19: What's Working and What Isn't (Webinar)
- Crisis Standards of Care during COVID-19: Summary of State Actions

Other Resources

- Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2
- Hospital Planning for Contingency and Crisis Conditions: Crisis Standards of Care Lessons from COVID-19

- **Legal protection for providers and facilities.** A successful restraining order preventing a hospital from stopping futile care to a COVID-19 patient and lawsuits against states that used social factors as a consideration when allocating monoclonal antibodies made it clear that both providers and healthcare systems will be legally challenged and will need both state support and protection (such as qualified immunity) in order to implement just allocation practices.
- **Regulatory and administrative support for hospitals.** This can include waivers of certain conditions of licensure, environment of care, and other factors that may facilitate the operation of alternate care spaces and maximal use of staff.
- **State intervention to ensure fair access to additional staff.** COVID-19 posed unique challenges due to its national impact, but it will be important to ensure that equitable resource allocation processes are in place at the state level and are informed by knowledge of the conditions at each facility.

The public has a right to know the status of healthcare facilities and understand what modifications are being made to care processes due to excess demand. Healthcare systems should work with public health to determine the “how” and “who” of this messaging, as they were often reluctant to share it themselves with the community. Our review indicated that in at least 10 cases, hospitals or healthcare systems declared CSC, which is highly problematic unless it is a trigger for state intervention to help relieve that system and provide regional consistency. It is clear that both states and healthcare systems were often reluctant to share that message with their communities.

Many states had CSC plans prior to COVID-19. However, most of those concentrated on triage of ventilators which did not systematically occur during the pandemic. CSC plans need to be re-examined with a focus on roles, responsibilities, and an emphasis on information and resource sharing, load-balancing, and joint efforts directed primarily at avoiding crisis care and then adapting to it with best-practice recommendations when necessary. Consultation with expert providers is needed when difficult and novel decisions are needed. Sometimes these may require a larger triage team when the decision is life and death; other situations may simply require a telephone consultation.

Healthcare providers, facilities, and local and state government all have a duty to our patients and communities to communicate across systems (and even state lines) during any disaster and attempt to use all available resources to provide the best possible care available given the situation. Many resources are available to support continued planning, including those highlighted in the sidebar of this article. We may not face these situations often, but it is clear that CSC plans are necessary, that current plans are lacking, and that we have an opportunity to better document our commitments to our healthcare providers, hospitals, and our communities when demand exceeds available resources.