

Crisis Standards of Care during COVID-19: Summary of State Actions

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Background

In Spring 2022, ASPR TRACIE conducted a review of open-source materials to determine crisis standards of care (CSC) actions taken by each state during the COVID-19 pandemic. This included review of relevant CSC declarations and media accounts of crisis conditions at healthcare facilities. The team requested additions and validation of the collated information from ASPR regional field personnel, state preparedness directors, and state hospital preparedness program directors. The results of the review were validated by representatives from 80% of states. This document summarizes findings from the 50 states and the District of Columbia; no structured CSC responses were undertaken in the U.S. Territories. Responses were categorized as follows:

- State declaration of CSC
- Hospital declaration of CSC
- State actions/orders directly supporting CSC activities
- States acknowledging CSC conditions
- No declaration or acknowledgement
- Unknown / no response

The next section highlights key findings from the review and recent literature, followed by challenges and suggestions for future work (based on input from ASPR TRACIE subject matter experts) to help ensure a more uniform response in the future.¹

Key Findings

- At the onset of the COVID-19 pandemic, most states had a CSC plan. However, many of these plans focused on protocols for ventilator triage and most relied in large part on [Sequential Organ Failure Assessment scores \(SOFA\)](#) which are problematic in a

¹ Limitations of our dataset include: supplied information may be incomplete or subject to bias during completion; information found or provided may not originate from authorizing agency/entity; unable to confirm crisis conditions in two states with the available information; and categorization was sometimes imprecise (e.g., when a hospital stated publicly that they were “operating in crisis conditions” this may have been adjudicated as having “declared CSC”).

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pandemic scenario.² Some plans inadvertently included age and disability biases and several states were asked to change their plans by the U.S. Department of Health and Human Services Office of Civil Rights to avoid discrimination.³ Few plans described the systems or processes to mitigate crisis conditions or ensure consistency.

- Many state plans allowed hospitals to declare CSC on their own, with no connection to broader state actions to support surge activities, prioritize resources to overwhelmed facilities, or re-distribute patients (load-balance).
- Crisis conditions were experienced during COVID-19 surges in almost every state. Nine state governments (and one county in Texas) declared CSC. Many of these declarations were made at the outset of the COVID-19 pandemic in 2020 and included broad legal protections that may not have been warranted given the situation at that time and subsequently.⁴
- Twelve states provided specific legal relief (e.g., liability protections) to providers during COVID-19. Some of these were limited to COVID-19 patient treatment decisions which could adversely affect a provider's ability to fairly allocate resources.
- In 11 states, hospitals or a hospital association declared CSC in the absence of state action. It is unclear how these declarations assisted the hospitals aside from public awareness of the crisis conditions. In several of these states, the hospital association helped publicize crisis conditions in the absence of a governmental message.
- Twelve states issued executive orders that supported CSC strategies including provider license changes and suspension of certain regulations / conditions of licensure allowing hospitals to adopt novel use of space or staff that otherwise would be impermissible.
- Three states provided public information (via Health Alert Network or press releases) announcing the existence of CSC in the state without further support or action.
- In 15 states, *crisis care* apparently occurred, but no official declaration was made, and no specific actions taken relevant to CSC. This was despite the fact that some of these states were also operating alternate care facilities – a clear sign that the healthcare system was overwhelmed.⁵

Challenges and Considerations

- Significant heterogeneity in state response to crisis conditions occurred which created challenges for providers, healthcare systems, and patients – particularly when adjacent states took very different approaches. In addition to provider moral injury (e.g., not being able to care for patients in the traditional manner), this created potential liabilities for hospitals and risk to patients.

² Hick, J., Hanfling, D., Wynia, M. (2022). [Hospital Planning for Contingency and Crisis Conditions: CSC Lessons from COVID-19](#). Joint Commission Journal on Quality and Patient Safety.

³ HHS Office of Civil Rights. [Civil Rights and COVID-19](#). Accessed 25 March 2026.

⁴ For additional information, visit The Network for Public Health Law's [COVID-19 page](#).

⁵ For example, [State of Texas to Establish Alternate Care Site in El Paso to Expand Hospital Capacity](#).

- Many hospitals declared CSC in the absence of state action. Allowing a hospital to declare CSC on its own does not necessarily improve care and places substantial liability risks on the facility. Without state liability protections, regulatory support, and systems to aid those hospitals, there does not seem a specific need for a hospital to declare CSC conditions. State plans should ensure that any declarations are statewide, emphasizing clear mitigation measures for localized crisis conditions and assisting facilities that are disproportionately impacted.
- Most states did not provide any additional legal protections for healthcare providers working in crisis conditions. This essentially precludes any structured triage of resources as any actions taken could be subject to judicial intervention or civil liability.
- Forty-two states did not declare CSC (despite crisis conditions existing, at times, in at least 39 of these states). Fluctuation between contingency and crisis often led to difficulties deciding when to initiate a declaration, though anecdotal evidence indicates that political and practical pressures also influenced these decisions. Further planning needs to be done to ensure that when crisis care is being provided that appropriate legal and regulatory relief is available from the state whether or not this takes the form of a CSC declaration.
- Early in the pandemic, media accounts focused on impact at urban safety net hospitals. Later in the pandemic, descriptions of rural facilities that were unable to transfer patients to hospitals that could provide the necessary care (particularly critical care, surgical care, and dialysis) resulting in delays in care and preventable deaths were more common.⁶ Both situations raise key access to care issues. State and federal government has obligations to ensure appropriate access to care and consistency of care across the hospital facilities that they regulate. Additional work needs to be done to assure that Medical Operations Coordinating Centers ([MOCCs](#)) and similar patient load-balancing constructs are in place to mitigate crisis conditions.
- Though protocols for triage of critical care resources was a focus of many state plans, it was never systematically required. The focus of CSC planning needs to shift from triage of resources to the dual role of the healthcare system and state in assuring access to care and resources and mitigation of localized CSC conditions as quickly as possible. When mitigation is not successful, the state must provide recommended care strategies to healthcare facilities. There may be a substantial role for inter-state patient and resource movement coordination but there are currently no authorities, resources, or protections supporting those efforts.
- There is significant need to update CSC guidance in light of COVID-19 lessons learned (e.g., support the National Academies of Medicine to undertake a follow-up project focused on updating the [CSC framework](#)).

⁶ Kadri, S. et al. (2021). [Association Between Caseload Surge and COVID-19 Survival in 558 US Hospitals, March to August 2020](#). Annals of Internal Medicine.