ASPR TRACIE Webinar Transcript
Crisis Standards of Care and COVID-19: What's Working and What Isn't
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Transcript:

Shayne Brannman: On behalf of the US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, I'd like to welcome you to ASPR's Technical Resources, Assistance Center and Information Exchange Webinar titled "Crisis Standards of Care and COVID-19: What's Working and What Isn't." Before we begin, we have a few housekeeping items to note. The webinar is being recorded. To ensure a clear recording, everyone has been muted. However, we encourage you to ask questions throughout the webinar. If you have a question, please type it in to the question section of the GoToWebinar console. During the Q&A portion of the webinar, we will ask the questions we received through the console. Questions we are unable to answer due to time constraints will be followed up directly via e-mail after the webinar. To help you see the presentation better, you can minimize the GoToWebinar console by clicking on the orange arrow.

Today's PowerPoint presentation and speaker bios are provided in the handout section of the GoToWebinar console and will be posted along with the recording of this webinar within 24 hours on ASPR TRACIE. The opinions expressed in this presentation and on the following slides by non-federal government employees are solely those of the presenter and not necessarily those of the US government. The accuracy or reliability of the information provided is the opinion of the individual organization or presenter represented. My name is Shayne Brannman and I serve as the Director of ASPR TRACIE and I want to welcome new and old friends to this webinar. I want to thank you for what you do daily to enhance the preparedness, response and recovery activities of your healthcare entities and communities. Your role is so vital to addressing the daily and arduous challenges being presented.

So your willingness to spend the next hour or so with us to further advance your knowledge is noteworthy. I also want to convey my heartfelt thanks to our awesome lineup of panelists and our moderator for this webinar. Their willingness to lend their precious time and share their substantive expertise so others might benefit is commendable and generally appreciated. And lastly, thanks so much to the TRACIE crew for coordinating this webinar and ensuring that it's widely disseminated after it's concluded. For our new friends to ASPR TRACIE on the webinar

today, this slide depicts the three domains of ASPR TRACIE. Technical Resources, Assistance Center and Information Exchange.

An important point to note though, if you can't find on the technical resources webpage for TRACIE the resources you are looking for, please do not hesitate to e-mail, call or complete an online form and we will respond to your inquiry very quickly through the Assistance Center. We're here to serve you and to make your daily challenges be reduced or mitigated. It's now my pleasure to turn it over to the hard-working Meghan Treber from the ICF TRACIE team, who will serve as the moderator for today's webinar. Meghan, over to you, ma'am.

Meghan Treber: Thank you very much and thanks to everyone for joining this webinar, which will address the continuum of crisis standards of care and decision making and scarce resource situation. We have three distinguished experts in this field discussing considerations and approaches to the allocation of scarce resources during COVID-19. ASPR TRACIE has many virtual resources that are available to you on this topic, so please check them out and return often as resources are continually added or updated. Next slide.

ASPR TRACIE has worked with the COVID-19 Healthcare Resilient Taskforce and Working Group, ASPR National Hospital Preparedness Program staff and subject matter experts from across the country to develop and compile resources available on overall patient surge management in resource constrained environment. Next slide.

This webpage is a one-stop location for these resources. This page also includes a link to a set of considerations specific to COVID-19 that has been developed by a collaborative group of subject matter experts all three of them on the phone today and reflects real-time observations of crisis standards of care during COVID-19. A link to this webpage and to those specific resources is being placed in the chat box of the GoToWebinar console for your convenience today to take a look at. As mentioned already, speaker bios for today's webinar are available in the handout section of the GoToWebinar console. And we have a tremendous panel of speakers today. So without further interruption, let's get started. Our first speaker is Dr. Eric Toner from the Johns Hopkins Center for Health Security. Eric?

Eric Toner: Thank you, Meghan. And thank you, Shayne for inviting me to participate in this webinar today. This is a vitally important topic, incredibly timely as hospitals across the country are beginning to see what New York experienced in April of this year. So I'm going to speak to you today about a report that my organization and the Center for Health Security issued about two weeks ago. And this is a report of the experience of ICU doctors in New York City during the peak of the pandemic there and their experiences with trying to implement crisis standards of care. Next slide, please.

So just to refresh your memories if it needs it. The peak surge in New York City occurred on April 3rd, at which time there were 1650 new hospitalizations each day and there are many reports of hospitals being overwhelmed and many reports that conventional standards of care were unable to be maintained. And therefore, the healthcare workers were forced to adjust the way that they provided cares, the policies and procedures that they followed in order to do the greatest good for the greatest number. Next slide.

So let's just touch on a few definitions, standard of care. This is typically defined as the level of care that can be provided or that is provided by the average prudent provider in a given community. It is, in other words, it's what a similarly qualified trained practitioner would do in the same circumstances. Crisis standards of care refers to a substantial change and I understand and underline substantial. In the usual healthcare operations and the level of care, it is possible to deliver and which is made necessary by pervasive or catastrophic disaster. Next slide, please.

So in order to understand in more detail what happened in New York and what the physicians there experienced, we conducted a project, which was designed to convene ICU doctors from across New York City in a frank discussion of their experiences with implementing crisis standards of care and to provide them an opportunity to engage with crisis standards experts from outside of New York City. Next slide.

So we at the Hopkins Center for Health Security in collaboration with New York City Health and Hospitals, which is the country's largest public health system convened a virtual working group in late October of this year. We had 15 ICU directors from across New York City and three crisis standards of care experts, two of whom are my colleagues on this webinar today. We convene them for four hours of semi-structured facilitated discussion following Chatham House Rules. Chatham House Rules means that nothing that sit in the room can be quoted or attributed to an individual or to an institution. So what I'm going to talk to you about today is a thematic analysis of the four hours of conversation, but none of it is attributed to anyone who is in the room. Next slide, please.

So seven themes basically emerged in the conversation. And these were that the crisis standards plans that had been drawn up did not align well with the realities of what happened, particularly, as it relates to clinical issues. The surge response was chaotic. It was creative. It was innovative. There was trial and error, but it was eventually fairly effective if messy. The inter-hospital collaboration turn out to be especially important and we'll talk about this more, but particularly in the realm of load balancing and information sharing. Situational awareness on the part of the clinicians with regards to patient load and resource availability was a huge problem.

The doctors didn't know when supplies or resources were running short until they were nearly out. There are multiple challenges involved in implementing crisis standards of care, especially with regards to decision-making, with regards to allocating scarce lifesaving resources. And healthcare workers were profoundly psychologically affected by having to deal with these morally distressing and crisis standard issues at the same time they were dealing with a surge of patients they had never imagined they would receive. Next slide, please.

So for the rest of my talk, I'm going to go over what the participants in this meeting felt where things that had to happen going forward. So first of all, they said that CSC planning needs to be more operational and there needs to be more clinical involvement. They felt that it in general, the plans were too theoretical -- too theoretical to abstract and didn't get down to the nitty-gritty of what clinicians have to do at the bedside. Clinicians must be taught that crisis standards of care fundamentally is not about who gets the last ventilator or not, it's really about making the best decision one can in an unfamiliar situation that involves risk to the patient or the provider.

And because of these two bullets, there is general feeling among the participants, it needs to be revised guiding -- guidance around crisis standards. They also expressed strongly that there is a difference in understanding of the legal aspects, the crisis standards that their legal advisors did not understand the situation that the doctors were in and the doctors didn't understand the points of view of their legal advisors. Next slide.

So in a crisis the participants all largely felt that they needed a clear declaration that a crisis contest -- context exists. But this doesn't necessarily mean that a declaration by the Governor. It doesn't even mean something that's called a declaration, but it needs to be a clear statement or proclamation or acknowledgment that a crisis exist and that there is a critical resource at least one that is in short supply. And it needs to be - the statement needs to be made at the hospital, hospital system, healthcare coalition and jurisdictional levels. Everyone needs to know that somewhere someone at the hospital level is dealing with a critically short supply situation. And this statement of a critical -- of a crisis needs to include specifics about the scope of the declaration of the crisis.

So specifically, what resources or processes does it apply to? And crisis plans need to factor in the fact that the declaration may not be made in a timely fashion. And so, clinicians will need to know what to do if there is not such declaration. As I mentioned earlier, situational awareness on the part of clinicians was a big problem to us as it related to patient load, to resources and to changing guidance and policies. And there needs to be effective ways found to keep staff informed of this information. And this applies to both clinical and operational information. And it requires sharing among the hospitals, across hospital systems and across the city or state. They felt strongly that triage decisions cannot wait for a cumbersome committee structure, which is what many plans had envisioned.

They said that these decisions had to make rapidly and there must be a way for physicians to get some help in making these decisions without having to wait for a committee. And they felt that clinicians need education on how to make these decisions and where they can get expert guidance. Next slide, please.

So they also felt there needed to be real clarity on the difference between the triage decisions that hospital clinicians can make every day or on particularly busy days and the shift in thinking that occurs during crisis standards. The point was made that a crisis is not the same thing as a busy Saturday night. There is a further education on the spectrum of crisis care from conventional to contingency to crisis. And we're going to hear more about that in the subsequent talks today. There was a feeling that future pandemic planning should be integrated with guidance that currently exists on futility of care with various ICU patients. And there was also general agreement and I think universal agreement that staff shortages was the highest priority, that that staff shortages are a critical issue now and were much worse during the height of pandemic.

They also brought up that we need to find ways to engage families in the essential end-of-life discussions when families can’t have access to the hospitals the way they normally would. They were of the fact that when they're having discussions with family members over the phone, when the family can't see the condition of their loved ones, it's very hard to convey the actual situation.

And when they found when they were able to get, allow family members in towards the end of their care when they were talking about these end-of-life issues and they can see their loved one was comatose on life support that these discussions were much more fruitful. Next slide, please.

And lastly, we have to find ways to lessen the incredibly heavy emotional toll placed on healthcare workers who are suffering under the combined stress of the surge and the moral toll that making these crisis care decisions places on healthcare workers. Next slide, please.

So I just want to acknowledge my colleagues, my co-authors in this report. Dr. Mukherjee from Bellevue. Dan Hanfling and John Hick who we're going to hear from in a few minutes. Lee Biddison from Hopkins. Amesh Adalja, my colleague. Mat Watson, also my colleague. And Laura Evans from the University of Washington. So, thank you so much.

Meghan Treber: Thank you.

Eric Toner: And here is our reference to the report should you want to read it. And back to you, Meghan.

Meghan Treber: Thanks very much. Thanks very much, Eric. And for those that have asked questions these PowerPoints will be available, so you'll have this link after the webinar, we'll send it within about 24 hours along with a link to the recording. So Eric, I just have a couple of questions or some follow ups. This was really great information and it covered a lot of the avenues and a lot of issues across a wide spectrum of facilities. But for those on the phone who are either anticipating or are already in crisis situation based on your project findings, what are some solid or initial steps that a hospital can take right now to quickly establish scarce resource allocation protocols and crisis care procedures and rapidly institutionalize and operationalize them. Really, what are the one or two actions that you think could go the furthest to help right away?

Eric Toner: Implement your plan. And if you don't have a plan, better write one quick and there are plenty of references and resources to help you do that. Number two, communicate your plan to your doctors and nurses so that they know what's expected of them. They know what resources and support they have. And three, ensure that there is good information flow up and down from bedside to boardroom, so that the incident commanders understand this situation at the bedside and the people at the bedside know what resources are running short before they run out.

Meghan Treber: Great. Thanks so much. So next, we will hear from Dr. John Hick from Hennepin Health in Minnesota. Dr. Hick?

John Hick: Thanks, Meghan. Next slide please. So it was interesting, this is our sort of original construct for crisis standards of care from 2009 and I think it still holds a lot of relevance today. It is interesting though that we had a workshop in November of 2019, which was the 10-year retrospective of crisis standards of care sort of where we come from, where are we going, what did we learn. And a lot of the things that Eric just mentioned that were discovered in New York City were exactly the things that got brought up at that workshop that there had been too much of

a focus on triage mechanical ventilation and I felt myself for that a little bit as one of the original publishers with some of that work.

There had been too much focus on specific protocols in the scoring systems and not enough on the systems of getting help, recognizing when you are in a crisis situation and trying to get back to contingency as quickly as possible. There was also too much of an emphasis on the legal declarations, which we recognized that always crisis decisions are going to occur at the bedside. And so if a tornado has just hit your community or you're at a critical access hospital and the school bus just overturned, you're going to be in crisis for a little while. That's not going to rise to the systems level of crisis standards of care that the COVID-19 or other more pervasive and lasting disasters or epidemics is going to have, but you're going to have to make some crisis decisions. But how do you get back to that contingency space as quickly as possible? So conventional, I think goes without saying contingency.

The main thing here is, is the care good enough? You know, even if we're going to discharge a TIA patient to get a follow-up MRI, the next day, okay, good enough. You know, we've ruled somebody out by Troponins in the emergency department and we normally might admit them to observation. Don't have that option, but we're very comfortable that they've got good follow-up, good enough, nominal risk to the patient. When we get into the not good enough territory and more of the crisis standards of care or at least a crisis condition where the clinician at the bedside says, “Not really comfortable with this.” Where we get to a staffing level that we say, we have said, once we get to this point that we're going to consider ourselves in crisis. That's a point where you need to reach up as a clinician reaching up to, another consultant reaching up to the incident command system.

The incident command system from one facility reaching out to their network or reaching to their healthcare coalition. Healthcare coalitions and networks reaching up to the states, Department of Health or emergency management just trying to get the advice and the information for the next level and we'll talk about that in a minute here. But to be clear, this looks like these are divided into very nice boxes. And true, especially when it comes to elastic things like staffing where you can bend a lot or not break between contingency and crisis there is some pretty uncomfortable terrain there. And just being able to share information between even units, systems, hospitals, coalitions about where, what are you doing, what are the adaptations, how do we make sure to kind of balance these assets to maintain consistency of care within our area is really, really important. Next slide.

So a couple issues and I'll just mention the emphasis on definitive triage. Again, a lot of time spent in a lot of state plan, spend a lot of time on like SOFA scores and things like that. Well, I mean, let's be clear. SOFA doesn't perform very well in respiratory, primary respiratory failure. We know that from H1N1. We also know that SOFA does tend to especially in those cases way to too much patients with pre-existing renal disease. So you've got to be really careful with SOFA. And I think, two, I'm much more of a proponent and making sure that the providers know who to call and know what the system is to get help and consultation, rather than emphasizing a lot on protocol development especially, since the actual triage of binary resources, resources that we can't flex like ventilators is really unlikely to happen during this pandemic. We talked about the Bright Lines issue.

And again, I've heard many times. Well, we're not going to make any triage decisions until the state tells us that we're in crisis standards of care, that's not going to happen. The clinicians are going to have to make decisions at the bedside. And the goal is to recognize that those decisions at the bedside are not usually unique decisions. They are reflective of systems issues. So if you don't have enough dialysis machines on a given night in a given hospital, that's probably not going to be a unique circumstance to those patients and that provider. So that needs to be pushed up to the systems level as quickly as possible. And then ideas shared between those hospitals in that system maybe move patients, maybe move resources, but try to achieve some balance there and get back to contingency.

And if you can't get back to contingency then what are some common practices that we can use to spread those resources as best we can and do the best we can for those patients with what we have available. So the decisions can't wait. But they do need to be more proactive rather than reactive as time goes on and develop a system’s response. Hopefully, there are, you know, formal recognitions of the crisis situation that follow, that might just be from the healthcare system itself, it might be from the Governor, it might be from a variety of sources. But we really want to try to avoid those ad hoc decisions. So a 100 providers making 100 different decisions in the same situation depending on their training, their comfort level, their perception of the resources available.

And this is really, really important because a number of providers during COVID-19 have made implicit triage decisions or even overt triage decisions that based on their immediate knowledge of the resources available to them seemed like the right thing to do. But in reality, at the 10,000 foot level there were more resources and there were more opportunities to provide care. So elevating those issues up is really, really important. And making that transition out of the provider’s hands up to facility coalition, state level to try to make sure there is balancing of those resource needs. And again, when that can't be done, then that's a great opportunity to develop guidelines and develop policies around those specific issues to help guide those clinician decisions. Next.

So I want to spend a little bit - this is a little bit of a complicated slide. But I think it captures a number of issues that we need to keep in mind. Starting with the provider at the bedside. If that provider doesn't have awareness of the current evidence for prognosis or treatment, if they're not familiar with some of the basic ethical issues and principles around rationing of care, principles like proportionality in particular. And if they don't know the resources available then good decisions really can't be made. So the job at the bedside is to make decisions that are within usual scope of practice. And when there is a level of discomfort where the decision is not within the usual scope of practice, consult, push that up a level.

And the triage team concept, unfortunately, was overly complex and was definitely in case of fire break, glass sort of thing that a lot of clinicians were like, well, we're not really do that point so, I don't want to activate the triage team because I'm not deciding to not give any resources to this patient. And we definitely need to lower the threshold in that and lower the complexity so that they feel they are phoning a friend or calling for help. But that does a couple of things. It reduces the moral distress of the provider making the decision. It gets them in touch with

hopefully another expert that may have more of a systems level perspective and it elevates that to the systems level. So that then gets in front of the incident command team the following morning or whenever it needs to be brought up to say, “hey, we've got an issue here that came up that I think we need to develop some thoughts or policy around and share this information.”

So the arrow is here, going from the provider up to the facilities system level, those consultations and then communication of conditions and needs. What is going on at the bedside and what are our needs from bedside to boardroom, as Eric said and rightfully so because a lot of times there is a pretty significant disconnect between the C-Suite and what the providers are experiencing on the ground. And then, coming back down from the facilities system level to the providers, any guidelines that are developed educational resources, clinical assistance, those are the kind of things that can support the provider decisions at the bedside.

At the facility and system level, it's really important that there is medical input into the incident command system decisions that there are clinicians that are really embedded within ICF that know what is going on, on the units that can really help to drive some of that system policy development, allocation of resources, message to the public and the providers and the patients about what their conditions are and what they can expect during their care and during their stay. And hopefully, anticipate some of these issues because if you can think about these ahead of time and not wait until you are completely out of dialysis machines or until you're out of a particular drug or you realized you're going to have to ration monoclonal antibodies anticipating and figuring out assistant beforehand is always preferable.

Knowledge of essential elements of information like the system status. Where are we for capacity? Are we at 120% of our usual ICU capacity? Are we at 90%? What are we doing for staffing ratios? What do we have for open beds? And knowing that across the system and across the coalition is incredibly important because especially, early on, we were seeing a lot of inner city trauma centers that because the populations that they served are being disproportionately burdened. And Dan will talk a little bit about some of the systems manage some strategies there. But that is one of the best ways to stay out of crisis care is to load balance across many hospitals and across systems. And that there is some tremendous equity implications there as well that I think really bear a fair amount of thought that we want to make sure we're distributing patients and resources equitably to make sure that the needs of all communities are met equally. And then policy development.

Again, making this less about ad hoc decisions but actually getting a decision pushed up to a clinical consultant that could be the on-call critical care provider, it could be the Chief Medical Officer. There is a number of ways that you can make good clinical input available to the bedside clinicians and elevate it to the systems level. And if it does come down to a true triage decision, having a plan in place for how that is handled that might be a decision about ECMO. We certainly are seeing decisions being made about that less likely to be made about ventilators. And then clinical guidelines, allocation policies, and then a documented surge policy. Here is the stepwise approach we're going to take for our staffing expansion for our staffing model. Here is how ratios are going to change, here is how a tiered staffing model would work.

When we get to this point, we're going to recognize we're in crisis standards of care, we're going to communicate that to our partner facilities, etcetera. So from the facility and system level up to the coalition or the state level, a lot of similar things here about resource requests up and down the chain, recognizing and anticipating issues, provider public and patient messaging, analogous system status. And then, at the policy level, this becomes more of a regional process. Maybe there is a clinical provider that's on-call for an entire region especially when there is a greater state region, a more rural region that does not have access to critical care providers, but might be having trouble referring patients. And to have a mechanism to decide priority on referral of those patients into the available beds and discussion of care in place really important to have those kinds of resources available that could happen at a coalition level, it could happen at the state level.

And then at the state level, you know, what liability protections exist for providers, and are those sufficient. Are there additional executive orders needed, is there regulatory relief that can be provided as far as caps on bed licenses, conditions of operation, environment of care. You know, many things at the state and other level that can be relieved and waved so that the state is really supporting it from a legal and regulatory standpoint as well as from a information coordination and policy development standpoint. They're supporting those clinician actions at the bedside and supporting the surge strategies of facility and system. Next slide, please.

So from a planning standpoint, I really discourage having a separate crisis standards of care plan at the hospital level in particular. It really needs to be an extension of your usual surge plans. So just say, when we hit this threshold, we're going to recognize that we're in crisis and we're going to push that up to the administrative coalition level, etcetera. But we might be in crisis in the daytime and then on the night shift back out of crisis from a staffing standpoint. Also, build in some assumptions when we're at this level and we do go into crisis staffing then we're going to cut all elective surgeries off. We're going to do, you know, X, Y, and Z other things to focus all of our service lines on acute care. So what happens when we go to those levels and how does that correspond with what other hospitals in the area experience. But that help staff get oriented too.

These are going to be the expectations with me and this is what I can expect when we get to this point. And this is what I know that the community response is going to be. So changes to those unit policies, flexibility of practice, I'm sure most of you have been dealing with this too. It's like, well, "We don't normally take patients with that blood pressure on this unit." It's like, "Well, we do now." This is the best that we can offer of given the circumstances and so critical care is not necessarily confined to the ICU. Intermediate care is not necessarily confined to the intermediate care units. The level of acuity increases across the entire facility.

And the clinical decision support for the bedside providers, again, that should be a pretty low bar for them to get in contact with an on-call person whenever they feel like the patient is being put at significant risk or that decision is out of their usual scope. And managing expectations. A patient coming in maybe told we might not have a bed for you here. You might have to be transferred to a different facility. You might not get the care exactly as you would like. We might not be able to schedule your surgery, etcetera. I think it's really important that people are coming into the hospital with an awareness of what the resource situation is and what they can expect. Dan will talk a little bit more about the systems level of response. It's really important that the

provider understand what state protections exist from a legal standpoint and what the process is going to be. Declarations don't mean a whole lot, but kind of knowing what your provider level protections are going to be given the circumstances is important.

And it's always really important to document your decision making and what the exact circumstances are. Using a dot phrase or something that goes into an electronic health record about our decision-making was affected by COVID-19. That's not going to be as helpful as due to the complete lack of in-patient beds our rapid outpatient follow-up was arranged for Mrs. Smith, who will receive an MRI tomorrow and see Dr. X in neurology at 2:00 pm tomorrow afternoon. That's the kind of thing that will help potentially keep you out of any legal jeopardy as well as documenting who the consultant was that you spoke with or how that that situation was managed with pushing information up the chain to get further assistance in a difficult resource situation. So again, making this much more of a process issue rather than ad hoc decisions. Next, please.

Reasonable agreement can be really important to and I'll just by way of example, say that this is a model that we're using with our critical care coordination centers, so that we've got an easy way for hospitals to compare where they are from a staffing standpoint. So any of the any one item that pushes you over that red threshold whether it's a staff to patient ratio that increases over 150% usual, whether you're moving to tiered staffing, etcetera, then you would report out that you're in a crisis staffing model. And the goal is going to be to try to get anybody out of red and back to yellow by providing some more resources or load balancing patients.

And if we can't do that, we for all slipping into crisis because of the patient volumes then we want to make sure we're kind of at similar depths of the water. But this gives us a common nomenclature, a common set of assumptions we can compare between facilities and help each other out. So I think the main message that I would have is make sure that your providers to the bedside have easy access to colleagues with a lot of critical care or resource triage decision making experience. And that that information then gets integrated back into the incident command system. And that your facility or health care system is not operating as an island that you are in constant contact, routine contact with your other facilities, with your parent systems and with the state. Next, slide. Back over to you, Meghan.

Meghan Treber: Yeah, thanks, John. So you sort of helped to summarize there at the end about and I just want to put a pin in it for everyone. How would a hospital today operationalize this concept immediately? What would be the best way for them to transition from the triage team model to the clinician consultant model or at least to lower that threshold for activating their triage team to get the bedside support that these providers need for the decisions that maybe they didn't think originally raised to the level of a triage team that we're seeing in COVID-19 that really does?

John Hick: You bet. I think for most systems right now, we are really tied who are not in a position to truly have to ration resources. So I think it needs to be communicated to the providers really clearly that we should not be making decisions about true rationing or restriction or resources where the care provided is "not good enough." Or if you're making decisions about futility of care that you normally wouldn't be making then you need to call whoever the

designate is for that hospital facility system coalition. Wherever that person exist there needs to be a pretty clear expectation that provider get in touch with our consultant and that may be as simple as the on-call critical care, critical telemedicine is usually provided for that facility or a Chief Medical Officer. There is a lot of avenues there, but just making sure that providers understand that expectation is really important.

And then making sure that incident command is integrating realistic clinical information into their assessments, anticipating conditions and making sure that the written plan especially for staffing is really well communicated. So there is no surprises to the staff when the PACU nurses has to work in the ICU for example. And then just making sure that there is good, open communication that's scheduled between the different hospitals within a healthcare coalition within a region. That information flow is uniform that the elements information are being reported and communicated. And there is also an opportunity to share this objective stuff because the data on beds available share a certain amount. But there is an awful lot of things that are being done from a strategy standpoint that are really helpful to share and might be adaptable by other facilities.

Meghan Treber: Great. And I would just mention that the clinical consultation component has been described in a two pager that's at that link that we've put in the chat. So if anyone is looking for additional information on how to operationalize that, that is included in those sheets. And John, I do just have one more follow up question, just a clarification of something that you said in your presentation. The adoption of crisis standards of care or the implementation of these principles in a facility or at the bedside, is that or is that not dependent upon any kind of formal government declaration. And could you just clarify the sort of comments that you made about not relying too much on the declarations in the status -- those statuses?

John Hick: Yeah, great question. So and this has been really commonly misunderstood, you know, issue particularly since our original 2009, 2012 definitions talk about formally declared. We don't make a lot of specificity about what type of declarations, but unfortunately that has not really been the case in a lot of circumstances, including the State of New York never declared in a crisis standards of care, and then it's politically very convenient to say, you know, therefore those never existed. But in truth, crisis standards of care always exist at the bedside and that's where they happen first. The question is, how quickly can you mediate that, mitigate those circumstances by pushing that up to the hospital level, to the healthcare system level, to the coalition level, to the state level.

And once it gets to the state level if there is no way to remediate that situation by load balancing or moving resources then there are obligations at the state level to provide some legal and regulatory relief. And it may not be a “Governor’s declaration.” But the standards of care exist in and of themselves at the bedside and the coping strategies have to be implemented to reduce the number of ad hoc decisions made by clinicians at the bedside. So we're really aiming for, you know, more uniform resource sharing, load balancing. And when that fails, guideline and policy development to support the clinician's decisions.

Meghan Treber: Because the resource scarcity occurs independent of any external factor, is it either is or isn't right?

John Hick: Exactly. You can't just declare that the weather today will be sunny when it's pouring rain outside.

Meghan Treber: Right. Thank you very much and we'll have time for some questions for everybody afterwards. Finally, we have Dr. Dan Hanfling from In-Q-Tel and Clinical Professor from the Department of Emergency Medicine at George Washington University. Dan?

Dan Hanfling: Great, thanks, Meghan. And thanks to the entire TRACIE team, also to John and Eric for making all of the excellent points that you've made. So I'm left as the caboose on this short train to foot stomp some of the key take home messages. And before I start, I guess, I would just remind you all that in 2009, when the National Academies was asked to convene an ad hoc committee to address the question of standards of care, we were brought together in the intervening period between the first and second wave of the H1N1 influenza not knowing what was coming. And really, what was essentially a hurry up often is we developed that definition of crisis standard of care that Eric described at the beginning and as John alluded to called for some formal declaration.

In 2012, when we reconvened and wrote the full report on crisis standards of care, we turned the systems approach to catastrophic disaster response. And I think that in the intervening years, that's what's been lost. People focused on the definition and lost sight of the fact that what we were really trying to articulate was an extension of some of the excellent work that really came from GW, Joe Barbera, Anthony Macintyre and others around surge planning, the medical surge, care and capabilities work. And that we were really just trying to extend to pushing the envelope in terms of what might happen in a catastrophic disaster response. So that being said, next slide please.

What I want to do is highlight some of the issues that have been already articulated. Eric, I think, highlighted in the New York City report two critical points. One is that the inter-hospital collaboration was deemed to be especially important and did not always occur. And that situational awareness became recognized as a huge problem both for clinical and operational information sharing and the mechanisms for each of those were not readily available. And John highlighted a number of times in his excellent overview, the importance of elevating decision making, whether it’d be about use of resources or plans for delivering care to the system level and really the importance of having a system level view.

So as you've heard now twice, you know, moving this conversation from the bedside to the boardroom and I'm going to say from the bedside to the boardroom and beyond. And let's focus on the beyond because the place where there is broad visibility on what is happening, to whom, where and why, is really what we are trying to get at in the context of ensuring the best possible care that we can deliver. Now one thing to highlight is that John and Eric and I and others focused on the concept of healthcare coalitions almost a generation ago, recognizing the importance that coalitions play in developing a common platform. It's a common platform for decision-making. It's a common platform for information sharing, even for just in time education. And on the economic side even for purchasing with interoperability and driving down

costs and so on. And that common platform becomes critically important when we talk about the execution of care under crisis standards.

With crisis care implementation, nothing is as important as making sure that you are doing things the same way. And so we noted in the 2009 letter report, where we defined crisis standards of care and where we laid out a number of key recommendations said ensuring consistency in crisis standards of care implementation should be a goal. And I think that is what we are learning from the New York City report and from other experiences that has been so difficult. And in that 2009 report, we highlighted the importance of having robust situational awareness capabilities that would allow for real-time information sharing. And this is something I can tell you I've been calling for from the beginning of this crisis as have many others. But the topic of sort of the future of public health and healthcare is not what we're going to address today, although suffice it to say in the absence of a fully integrated national public health data infrastructure and backbone, we are going to be hamstrung in making some of these capabilities come to bear. Next slide, please.

So what is the history? Well, actually in February of 2007, Art Kellermann, who recently was appointed the Head of VCU Healthcare Enrichment, he just left as Dean of the Uniformed Services University of Health Sciences presented at a meeting that I was presenting on in the HHS Committee on Vital and Health Statistics around Disaster Planning. And said, let's look at developing five or six regional, not air traffic control centers, but ambulance traffic control centers that would function on a day-to-day, night-to-night basis to monitor occupancy rates, emergency department crowding, call-on specialty coverage, etcetera. That year, in the Disaster Medicine and Public Health Preparedness journal, Skip Burkle described for the first time, a Health Emergency Operations Center, which I'll show you that in a second. And a number of years later, actually in 2015, John Halamka, who is now at Mayo, I think, then he was at Harvard coined the phrase "Care Traffic Control."

So these are issues that we have been talking about and promoting and trying to implement for a number of years. But it really took COVID to bring front and center the recognition that we had to do better, then our siloed balkanized approach to information sharing and situational awareness. And so The Health Resilience Task Force, the Health Resilience Working Group under the auspices of FEMA and HHS earlier this year gave it a new name, the Medical Operation Coordination Cell. And hopefully, many of you are familiar with this term. There is an excellent ASPR TRACIE webinar that highlights a toolkit that was developed to describe how to use and implement this concept of the medical operation coordination cell. And the bottom line is that it was created to address the fact that in New York and elsewhere in that first wave of COVID surge, we were hearing about asymmetrical hospital utilization.

There were certain regions where healthcare systems were experiencing a tremendous surge in in-patient care - patient care requirements, while others maintained excess capacity and were barely affected at all. And so the notion of a Medical Operation Control Center is coordination cell, sorry, is to optimize patient distribution by augmenting existing jurisdictional emergency operations centers with clinical experts that can synthesize and coordinate a healthcare capacity. And the idea is to achieve, as is noted on the slide, a load balance where you can try to maximize

availability of beds, staff, key resources and even sharing existing strategies, what works and what doesn't. All with the goal of establishing consistency in the delivery of care. Next slide.

Let me show you what Skip Burkle detailed with regards to the Health Emergency Operations Center. This was something that in practice, we were already putting in place in Northern Virginia, in Minneapolis and Seattle King County. They were already in Texas. They were already communities that were beginning to build on this notion of a health emergency operations center. And I share this with you because again, what's old is new and there really isn't a whole lot more here then, what the medical operation coordination cell describes, which is the linkages at the local and then the local, regional and ultimately to the state and providing ultimately a conduit to the federal decision making process. And we'll talk about what this means. So, next slide.

If you are a clinician and you walk into your Emergency Department, this is a picture of our bed board from the first wave in Northern Virginia. And you see this board and I hope that it copies reasonably well, looks a little fuzzy. But this is something where you should be able to know that others in other hospitals in your region are facing the same. Are they or aren't they? Or is this just something particular to where you happen to work? That's the kind of notion that is, is really at the heart of "moving the conversation" from the bedside to the boardroom and beyond. In other words, what are other people experiencing and how is this going to affect the ability for us to deliver care? Next slide.

So essentially the notion of a Medical Operation Coordination Cell, the Health Emergency Operations Center, etcetera, etcetera is all about being able to share good ideas, share your experience, understand what your situation is relative to others and then figure out how to utilize available resources recognizing that there is an opportunity for maximizing those resources in order to affect the best possible outcomes. With regards to policies, this is something I think that really lends itself to being able to share.

So if you know within a region that there is a hospital that seems to have their act together, hopefully they are being able to share that expertise more broadly. It should provide you a mechanism to obtain critical care consultation and given where we stand right now with tele-critical care, tele-ICU care and so on and so forth. There are a number of opportunities where you don't have to move personnel but you can make a couple of linkages and really dial right in and get bedside expert consultation from others who may be in your region or beyond if that's a relationship that you are able to establish. You should be able to coordinate resource requests at the state and federal level, which is critically important. So that you're making those kinds of requests as a coordinated entity at the regional level not just at the individual facility level.

And ultimately, these are really intended to promote coordinated decisions that reflect the healthcare system not just what the provider at the bedside thinks is important. Again, with the goal of consistency. Last slide, please.

So a number of us I know there are many, many people on this webinar and we appreciate your interest and attention. And I think that many of you hopefully are familiar with the dilemma of the cube. After our last great critical emergency of 9/11, CDC supported a couple of folks up at

Harvard, Barry Dorn and Lenny Marcus and others to create the National Preparedness Leadership Institute. And some of their teaching and comments still resonate with me today maybe the most important and most relevant to this discussion being the dilemma of the cube where a 9/11, it was a matter of two different operation centers, two different operational commands, I should say having a completely different perspective of the burning Twin Towers in Lower Manhattan and taking two completely different operational decisions. One that cost the lives of 343 firefighters, the other saving almost all of the police that were in and around those buildings on that morning. So until we achieve a coordination of effort that is required to match the overwhelming demand for resources that we see hospitals facing now, resources are going to be squandered and lives are going to be lost.

And in part, that may occur on account of the inability to develop a common operating picture. And so the foot stomping here is that as important as it is to develop the kinds of capabilities that will affect changes at the bedside and as difficult as that will be given all of the challenges we know that exist with regards to staffing, particularly nursing staffing, it's going to be really important to try to put in place a strategy that achieves the very best for the most possible by working outside of your individual provider perspective, outside of your individual unit perspective, outside of your individual facility perspective and being coordinated with those around you in the region and beyond to try to gain the best possible outcomes for the patients who either are here or will be coming. So with that Meghan, I'll actually turn it back to you. We certainly want to leave some time for questions and discussion and I appreciate the opportunity to present.

Meghan Treber: Absolutely, thank you so much, Dan. Just a follow up clarifying question for you. So from your perspective and with your experience, who is best positioned to lead this sort of patient load balancing process, this awareness process? And at what level do you think it works most effectively at the coalition or substate regional level, the state level, interstate or is it really necessary to have some component of that at all three?

Dan Hanfling: Yeah, I mean, the simple answer is there is certainly a component at all three. But again, as we've highlighted over the course of the last hour since care is delivered at the bedside and everything that happens really is about trying to affect those decisions at the bedside. I think that at the very least, leadership, the C Suite leadership, I would say, the Chief Medical Officer and Chief Nursing Officer at each hospital should get with the head of public health, the director of public health. And maybe a senior government official, whether it'd be in emergency management or at the Mayor's office or someone at the jurisdiction and talk about how to coordinate information sharing in real-time with regards to availability and needs and run that meeting every day. And share that information with clinicians at the bedside so they understand that their facility is not an island, that they are connected above and beyond just what's happening at the facility level.

And then that group in turn, I think it certainly at the coalition level where there are coalitions. I know there are over 400 some odd coalitions across the country. But if there aren't coalitions then a direct connection into the state EOC and Director of the State Health Department, I think it's critically important. And creating the kinds of real-time communications to share information is important. I mean, this disaster is different than other disasters that we faced in that I have not

been privy to a whole lot of incessant conference calling. Now maybe that's happening and I'm missing it. But that's the kind of real-time situational awareness that is going to be important, particularly as we get to these increasing numbers of patients and the increasing stresses on the health systems to make sure that we're connected certainly at the – at this regional level and at the state level.

Meghan Treber: Thanks, Dan. So we will now begin the question and answer portion of our webinar. As a reminder, due to the number of participants on the webinar, please submit your questions through the question section of the GoToWebinar console and I'll ask your questions directly to the presenters. If you have a question for a specific presenter, please note that in your comments. Questions that we are unable to answer today due to time constraints will be answered directly to you via e-mail and we'll post [Indiscernible] [1:01:55] Q&A document on ASPR TRACIE shortly after this webinar so everybody can benefit from the answers. So, we do already have quite a few questions. So I'm just going to get started here. I think let's go to Dr. Hick for this first question and then we'll have all of you join in. But how do we balance between a cumbersome committee and having the treating physician make the decision while being affected by tunnel vision?

John Hick: Yeah, great question. You know, the treating physician with a tunnel vision is exactly the kind of thing we wanted to avoid. At the same time, like I said, we want to avoid a really cumbersome, difficult to access process. So my thought on this would be that the first reach is to, you know, a designated person within the facility, the region, you know, wherever it is that that's their call for help and that should be somebody with a good amount of experience in critical care and resource decision making. If there is a true triage decision to be made that person ideally would be the gateway then to engage with another provider or the ethics consultant or whoever else is on your particular triage team.

Generally speaking in the IOM documents, we have recommended two non-bedside providers so there is no, you know, implicit bias in the decision-making and then, you know, make whatever decision needs to be made and document that process, etcetera. But a lot of times, it's not going to come down to that. You know, we do have a regional process in place, you know, right now for ECMO, you know, triage of ECMO resources and regionalization of those resources. But aside from that, we don't, you know, really anticipate a lot of hard, you know, triage decisions or definitely the softer ones where when do we decide – decide that the care is futile. And we do this every day with catastrophic head leads and the other night respiratory failure [Indiscernible] [1:03:54] had renal failure and in our long-term care resident who is DNR, but hadn't specified other particular intervention.

So there is - we do some of this stuff on a routine basis, but some of it gets more uncomfortable. And it's at that point where it gets uncomfortable or we feel like we're making a decision because of perceived resource shortage that’s when that needs to be elevated up. But I would make that a simple call to an on-call provider or someone of similar band that can easily be made available. And if you need to get more process oriented than that because of the gravity of the decision then let that person be the gateway to triage and more robust triage team process.

Meghan Treber: Anything to add Doctors Toner and Hanfling?

Eric Toner: Yeah, Meghan, I'll just add one thing, which is that, you know, we need to create the ability to learn from what we're doing. We really need a learning health system. And again, in the absence of these data systems and with limited reporting and with everyone up to their elbows in patientcare needs, that's hard to do. But with the time set aside ideally daily, but certainly a couple of times a week to be able to go over some of the difficult triage decisions that are taken in the context of what we're describing now would be helpful for the rest of the medical staff and nursing staff to learn from. And I think that should be built into what we're trying to achieve now with an ideal of creating a learning system that allows us to learn from what experience we're having with regards to COVID care.

Dan Hanfling: And the only other thing that I would add and it's implicit in what John said, but just to be explicit about it. When the bedside clinician calls for that consults, that consult should notify if they're not already a part of the incident command system so that the institution knows the situation and can relay that information down to the clinician who gratefully probably has tunnel vision. But the incident command system should not and that information should flow directly to them whenever anybody -- whenever anybody at the bedside feels like they're in a crisis situation.

Meghan Treber: Thanks. I have a little bit of a follow-up question in terms of implementation of this. How can a small, rural hospital with 12 beds or something equivalent translate this excellent information into something that can be implemented in such a small facility?

John Hick: I guess, John, I can start here again. So again, I think this is where and I'll just mention the model that Minnesota has which is our Critical Care Coordination Center, which is a toll free number that the smaller facilities that are looking to refer into a tertiary center can call if they're having any trouble finding a bed through their usual referral partners. And then will, based on information available and negotiations sometimes will find that patient the most appropriate bed and the most appropriate closest facility. Sometimes that's halfway across the state.

But we do have always hospitalists and critical care providers on-call that if needed can provide some advice for care and place. Or if we do run in a situation where we've got multiple pending transfers for too few beds that are immediately available that we can prioritize those transfers. So having the availability of a person that is in that position even statewide, but it also could be regionally could be coalition based and certainly looking at who your usual referral partners are. Some most critical access hospitals tend to refer into tertiary center for their trauma or their medical conditions. And partnering with those facilities to make utilization of their on-call critical care and other providers can be really helpful.

Dan Hanfling: Yeah. And I would say if there aren't existing telemedicine capabilities, it's not too late to explore how you could set something up even something relatively simple in order to tap into some of that regional center expertise that would lend some additional input with regards to decision-making in the critical access hospital facility.

Eric Toner: And I would just add that in addition to the information sharing that Dan and John just described if this small hospital doesn't have a plan they should get a plan and they should communicate to their clinicians.

Meghan Treber: Great. Thanks to all three of you. Another question here. How or what can jurisdictions and facilities do to ensure that they're implementing crisis standards of care policies and resource allocation policies that are not either actually discriminatory or perceived as discriminatory or don't negatively impact vulnerable populations such as older adults, persons with disabilities who have racial or ethnic bias. We can start. John, you keep answering. We'll start with Eric.

Eric Toner: Well, first of all, I'd say as John has said so eloquently, most of this is not about making black and white triage decisions. It's about avoiding having to make those decisions and finding ways to stretch resources or steward resources. But when it comes to making start allocation decisions, should that happen, it should absolutely not include anything that is not strictly medical. So, of course, it would not include anything having to do with someone's -- someone's race or ethnicity or age unless age itself is a prognostic factor. So, it's about treating everybody fairly, which means treating everybody equitably. That doesn't mean equally, but it means approaching them in the same fashion.

Meghan Treber: Dan and John, any follow-up?

Dan Hanfling: I'll just say, the summer of 2020, you know, has highlighted and made very stark and clear some of the institutional racism that exists in a number of sectors not the least of which is the healthcare sector. And these are extraordinarily challenging issues that unfortunately, crisis standards of care are not going to solve. I think we, the three of us were on a call recently where that issue came up. And I think what we have to do is, is be cognizant of those challenges. And again to Eric's point and to John's point earlier to try to be as equitable, as transparent and as fair as can possibly be with regards to making these scarce resource decision-making. And to my point earlier about the importance of a learning health system learn in real time, where we're making decisions and where there are either benefits to be recognized or problems that need to be addressed.

So as to improve, this is something that we talked about in the 2012 report that performance improvement is got to be a critical function of crisis standards of care decision making. We need to be able to learn as we go along and that should help at least address some of the challenges with regards to equity and health equity as was raised in the question.

John Hick: Yeah, I think this is such a huge domain and I think we have recognized with COVID-19 that a lot of the structural racism and inequities within our system and that can be related to communities of color or it can be a rural urban. There is a lot of areas where you've got at-risk populations that are really being pretty poorly served and have poor access to care. That compounded by a lot of our at-risk communities that that's our essential workers, they're living in much closer confines and close contact. And so driving access for vaccine, for testing, for general medical care down to those individuals, those communities is something that private healthcare is not doing because unfortunately there is not mission conflict, but the financial

realities are that you just can't keep clinics open in certain areas that aren't able to be financially viable.

So I think following this, we're going to need a much more aggressive public-private partnership to make sure that we are really addressing the needs of these communities that have been chronically underserved that have tremendous suspicions of organized medicine. At the same time, we have to be careful as providers not to bring some of those - some of that desire to provide equity to the bedside because we come to the bedside always with biases. And again, that's why involving a clinician that's not with the bedside can be very helpful. But we have to be very cognizant of the ageism, the racism, the other things we bring to the bedside and really strive to look at clinical factors.

And what do I know about prognosis? And unless the community has dictated very specifically that we should be considering different factors then we should be just doing the best we can for a medical standpoint recognizing that some of like the SOFA scoring system, especially with respiratory failure if you come in with end stage renal disease and the proportion of African-Americans with end stage renal disease is much higher than the Caucasian population, you're going to wind up scoring disproportionately high, and not because of the acute illness. So I think we've got to be careful to recognize some of the limitations there of some of the scoring systems. And again, not basing on race necessarily but basing on the recognized limitations and the fact that those may have implications for poor treatment of some of our communities of color.

So a lot to unpack there, but I think making sure that we're providing our at-risk communities access to services especially those that prevent illness that mitigate early aspects of illness. But you've got to be a little bit careful. Again, it really needs to come down to prognosis when you're talking about allocating medical treatment resources because once people are in the hospital, there really is not substantial differences in the outcomes. And so when do you come to the hospital, that should be about prognosis.

Meghan Treber: Thanks, John. I have a question for Dr. Toner. Back from your research with New York this question is that it sounds like several of some of the key issues identified situational awareness, supply, status, staffing, legal support, it could have been supported or it sounded like it could be supported by an effective incident command system in the hospital command center. Did you find that this function was established and are sufficient to meet the clinician needs or not?

Eric Toner: No. Well, first of all, many of these clinicians that participate in this meeting came from institutions that have very robust, very sophisticated incident command systems. But that wasn't sufficient for - to the clinicians at the bedside. It didn't address the clinical issues that they were facing. The incident command system would focus more on processes and to some extent, supplies, to a large extent supplies. But the clinicians didn't feel like they had any support or guidance or help when it came to decisions about which patients should get which kind of dialysis or if there is not a dialysis -- if it's not hemodialysis available, who gets peritoneal dialysis or who gets which kind of ventilator when there is not a full functional ventilator available, doesn’t get to put on an anesthesia machine instead. And so the incident command

system did not function well for that. So they felt a need for additional consultation, additional clinical information and additional information sharing among the clinicians.

Meghan Treber: Great. Thanks, Eric. I'm going to move on to - back to John. So a two part question here. On the last slide of your presentation, it indicated the use of COVID positive staff without signs and symptoms for patient care and we just move back to those slides. First of all, is that that's the intent of what you posted here. And then second, what are the legal ramifications? And if you can speak to those, none of these guys are our attorneys. So what legal ramifications or HR implications do you see in that kind of crisis staffing?

John Hick: Right, so you're asking me for legal advice, obviously bad idea. But what I will say is that's, you know, on the spectrum of at what point do we consider that the risk to the patient is such that we would rather have them cared for especially if they're in a COVID positive unit and you've got a COVID positive staff that can take precautions in the brake areas about not infecting other staff that is it better to have a person that's trained to work in that unit or trained at that skill level back to providing bedside care rather than have a nurse who doesn't have that sort of training, providing care for that patient.

And I think most of us would say once we get to a certain point and we've cleared other hurdles, we're not doing elective as we've pulled in all available nurses, you know, we've pulled back nurses on quarantine, we've adjusted our ratios to the point where we feel like this is the best alternative then, you know, that is definitely a next step. Ideally, we want to be taking that in step with the rest of the community, and I think that's why comparing those notes is so important and provides a lot of protection because when you're practicing to a community standard, you're basically meeting the reasonable provider threshold of what a reasonable provider do under these similar circumstances, such that it's going to be pretty hard to get any kind of a legal judgment if that is common practice in the community that once you get to a certain point, better to have the trained providers at the bedside.

But that's conditional on a lot of other options being exhausted once you get there. So having a consistent approach and implementing that across multiple facilities in a region is always going to put you on safer legal footing then if you are an outlier or you're making those kinds of decisions lacking the context of trying to find contract employees and canceling electives and doing other things to free up an appropriately trained workforce.

Meghan Treber: Thanks. And here is another interesting question. Can this model that you all three have sort of presented that you've discussed it really in the scope of acute care facilities, how could a crisis standards of care model be applied to long term care facilities? How about we go with Dr. Hanfling first?

Dan Hanfling: Yeah, so it's an important question. And it's a question actually that I recall addressing over the years, particularly around the resources that are shared between long-term care facilities and either surrounding or partner health systems. And this becomes, again, very challenging in the context of specific durable goods like a ventilator and so on. But the bottom line is, is that regardless of whether you're in an acute care facility or a long-term care facility, there are going to be certain resource decisions that have to be made. And in that context, the

sorts of preparations that particularly that John highlighted around end of life decision making and wishes of the patient and the family and so on really need to be re-examined and clarified.

There also needs to be a plan for understanding what to do if a patient becomes ill and if that patient becomes ill in the context of overwhelming burden of care at the acute care facilities. Can you maintain a level of care again with telemedicine and tele-critical care in consultation and other similar strategies that we highlighted to try to keep that patient in place, let them hold onto the resources that they're already using and try to affect the best possible outcome. So I think the bottom line is in the context of a systems approach, making sure that those long-term care facilities are connected to other facilities, be they academic medical centers or part of a larger health system to be able to avail themselves if not of specific resources then certainly of clinical expertise.

Eric Toner: And I would just add that in addition to what Dan just said, there are - long-term care facilities don't have all the same issues as state care hospitals. They do have scarce resource issues in the pandemic there that PPE can be short. Certainly, staffing can be short. And so, the long-term care facilities should be planning for those eventualities and should be communicating that information to their staff so that they have a plan and then you know what the plan is.

John Hick: And I think a lot of long-term care facilities are members of healthcare coalitions and already are exhibiting quite a degree of coordination. But again, I think to the degree possible, you're aiming for consistency within the region and sharing of best practices and sharing of situational awareness. And those things are absolutely critical I think to helping define what is the community standard right now and are we meeting it.

Meghan Treber: Great. Very helpful. Another question. Are there recommendations that any of you have for helping raise awareness at that tunnel vision bedside provider level that it might be important to consult this designated decision maker? Or how could a facility train the bedside clinician to best utilize this since attending physicians may assume that they have or should continue making decisions with their usual autonomy? How do you communicate? And I think we'll go with Dr. Toner because you've really been hitting have a plan, execute the plan, communicate the plan and then communicate the activities. So let's go to you. How do we communicate to and train the bedside clinician in this process?

Eric Toner: Well, every facility that I've ever been associated with it has a way of communicating to the medical staff and to the nursing staff. And so there is no lack of ability to get a message to them that the challenge is getting them to pay attention to the message. And so, I think it needs to come from the highest authority, it needs tuition from the Chief Medical Officer or from the CEO. And say, we are in a crisis or we're in an impending crisis here is what we're going to do, here are the resources that you need that you will need and that we will make available to you and here is the process by which you need to do it. And so it needs to be said with authority and it needs to be said repeatedly.

Dan Hanfling: Yeah, and I'll just follow that up. I think you're absolutely right, Eric. And I alluded to I think in my comments, and that is, every hospital should be conducting if not a daily then a few times a week, MNMs specifically focused on the management and decision making

around scarce resource allocation. And it should be open to all providers from medical students all the way to the most senior staff, it should be physicians and nurses and technicians. And people should hear about experiences with regards to the challenges of care delivery, so as to foster, again, a learning environment where – where you will be less likely to sort of try to charge ahead like a bull recognizing actually that there are others who are participating in the same sort of decisions that you are and you can learn from your colleagues. So I think that's something that, if it's not happening already, the Chief Medical Officer and the Chief Nursing Officer at every facility ought to figure out how to create those sorts of MNM or Town Hall type meetings on a regular basis to learn from the experience and learn as an entire facility going forward.

John: And socially distance. So yeah, I would second all of those comments and I think to just making sure that people know the threshold for engaging consultation is not like the disaster plan or in case of fire break glass. It's if you are in a situation where you think you need to ration resources in a way that you don't do on a daily basis or you're facing a clinical decision that you don't normally encounter then the expectation is, you will call, so that we can not only provide help, but also raise this to a system’s level and say, is there something we need to be taking on more as a policy guideline development rather than regard this as a one-off clinician decision. So I think, as Eric says, repeatedly setting those expectations.

As Dan says, communicating the type of situations that providers are facing, where they're making some of those decisions and then the provider can say, okay, yeah, no, that gives me an idea of when I might need to get in contact with someone. But making sure that it is okay and in fact, it is required that you reach out if you are making those kind of decisions because the institution is not at a point where we would want the providers making implicit and triage decisions right now.

Meghan Treber: Thanks to all of you for that question. I think we have probably have time for about one more question. And I want to make sure that we talk about this next issue, I want to make sure we discuss it. How can individual clinicians and facilities and coalitions in states, how can we all help to prepare staff mentally to enter a resource allocation decision making construct or a crisis standards of care mode? What work is being done on moral injury, clinician well-being, it’s such a critical issue during this response. I want to make sure that we give you all the opportunity to discuss it.

I'll also take this one second just to plug that ASPR TRACIE also has been working on this issue and we will be releasing a new - one of our large exchanges on newsletters next week that has quite a few articles, resources and information about clinician well-being during COVID-19. So stay tuned for that, that'll be coming out next week through our Listserv, so make sure you register for that. But I'll turn that over to you, guys. Let's talk a little bit about how we can support our clinicians when they are facing these kinds of decisions in and this kind of crisis environment. Let's go to Dr. Hanfling first.

Dan Hanfling: Yeah. So this is a critical portion of this discussion and unfortunately, it always gets left almost to the end. But I'm glad that you bring it up because it is about the sustainability of healthcare delivery going forward. And it's about the really the well-being of our own

colleagues who are in the trenches day in and day out. So a couple of things. One, in my own experience during the first wave in Northern Virginia was the tremendous community support to healthcare workers. Food that was delivered on a daily basis for three meals a day, I work in the emergency department. The recognition of the hard work that healthcare workers are doing, I think that's important. In New York City people banging pots and pans and so on and standing and giving a clap out. These are all morale boosters. But beyond that, we need to make sure that the EAP and other mental health support services are really primed.

We need to make sure that there is a mental health surge capability to meet the needs of healthcare providers, particularly in the coming months as this onslaught continues. And be cognizant of the fact that some of our colleagues maybe putting up a brave face but they need time away and allow them that time away and recognize that in certain circumstances that may not be possible. But if somebody is demonstrating signs of unwell thoughts and so on, that they ought to be highlighted and cared for and not just put back on the line, so to speak which will only do more harm to them and probably not serve their patients very well. So I think that bring the behavioral health and mental health specialists to be able to surge along with us now is going to be critically important.

Meghan Treber: Dr. Hick?

John Hick: Yeah, I think Dan had a lot of the key points here. One of the key things is just to manage our expectations. If I know what sort of the next steps are or if I know how my roles are going to change during a response, that's super important in providing some context and some education about how I step up into that role is just critical. And then making sure that I have either mentoring or support that's available to me so that I don't feel like I'm left alone in an unfamiliar environment with unfamiliar decisions. And then providing either a buddy system or somebody to kind of check in and just say, hey, this is tough, how are you doing? And also, what can we do to improve? How can we, as Dan talked about maintain this is sort of a QI process to continue to hone those provider experiences and make them better and more manageable?

Now but knowing this is going to have a very long tail once the cortisol wears off, there is going to be a pretty major crash. And I expect a lot of people honestly to leave healthcare, which is going to be tragic and is going to just exacerbate some of the nursing shortages and other shortages that we have. So really supporting our providers in the subsequent months here even after we get vaccine and the volumes start to taper is going to be absolutely critical because that is a very, very vulnerable period.

Meghan Treber: Dr. Toner.

Eric Toner: I agree completely with everything that John, Dan, had said. I think if the model that we've discussed today about having someone to call when you're facing a difficult allocation decision works, that should help with some of the moral injury that the person having to make those decision faces. And so beyond that, I think from what we heard from New York, if they had known what the plan was, if they had known what was expected of them, if they knew what was happening elsewhere, it would have felt less stressful and maybe that would have made a difference. But as the others have said, it's beyond what happens during the crisis itself. It's the

recovery from the crisis. It's providing the support and the after action support that people are going to need on a very large scale. And so the military has done a lot of work on this and I think we can learn from them about kind of supply, psychological first aid like how to help people recover from PTSD.

Meghan Treber: Thanks, Dr. Toner. I'm glad we have the opportunity to address this issue. This is all the time that we have today. I want to thank all the panelists for taking the time to speak today. And again, this webinar will be archived and posted on our website at asprtracie@hhs.gov within the next 24 hours. We do want your candid feedback on today's webinar and how ASPR TRACIE can better serve your needs going forward. So to that end, we have started a few threads on the ASPR TRACIE Information Exchange to continue the conversation from today and to get your feedback on future webinar topics. On behalf of the ASPR TRACIE team and all of today's speakers, thanks for joining and have a great day.

[Video ends]