Crisis Standards of Care Considerations: De-escalation of Care

October 2024

The term "de-escalation of care" is often equated with discontinuing life-saving care, such as mechanical ventilation, but such measures are seldom necessary. De-escalation of clinical care includes considering available space, staff, and supplies (interventions) and how the facility may adapt these resources to avoid or reduce crisis care. Under crisis standards of care (CSC) conditions (i.e., when adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the context of a disaster or shortage of a key resource), clinicians should be prepared to de-escalate care across a spectrum depending on available healthcare resources and the patient's clinical situation. This spectrum ranges from implementing alternative care strategies that are appropriate to the patient's clinical condition to discontinuation of elements of care. These care adaptations can help prioritize selected resources for patients who need them most and remove them from patients who will suffer least from their absence. The de-escalation process is intuitive, but not simple, as it involves awareness of current resources, implementation of alternative care methods, assessment of patient prognosis and trajectory, and knowledge of the patient's wishes for care.

De-escalation of Care Based on Resource Availability

De-escalation should be a temporizing measure implemented when no other alternatives exist. It assumes that regional resources are exhausted and that regional information-sharing and coordination are ongoing, ideally leveraging regional constructs such as healthcare coalitions and Medical Operations Coordination Centers (MOCCs).

Space: Usual critical care spaces should be prioritized for patients who are both least stable *and* have a relatively good prognosis. Patients who have stabilized or who have a poor prognosis should be selectively moved to critical care surge spaces (e.g., post anesthesia care unit [PACU], intermediate care areas). Whether the facility is the best location for the patient should also be considered. For example, stabilized patients could be moved from a tertiary care hospital to a community hospital or post-acute care facility (e.g., long term acute care facility) for convalescence. Discharge criteria from lower acuity units should also be adjusted to improve movement from the intensive care unit (ICU) to other units. Admission critieria for intermediate care/stepdown units should be adjusted to allow higher acuity care (e.g., use of non-invasive ventilation, care for chronically vent-dependent patients).

Staff: As with prioritization of space, usual critical care staff should attend to the patients who are most critically ill *and* have a relatively good prognosis. Staff should be able to care for a higher number of stable patients than their usual assignment. Staff with critical care expertise should be assigned to supervise less specialized staff (e.g., hospitalists, nurses without ICU training) who perform the majority of the patient care duties, particularly for more stable patients.

Supplies/Interventions: The resources in demand should be shifted to patients with the most acute need and/or who stand to benefit the most. Providers may not necessarily need to make a binary choice between patients. For example, graded use of resources could transition stable critical care patients to transport ventilators rather than full-featured ventilators. Dialysis runs can be adjusted to the minimum necessary to avoid severe hyperkalemia or volume overload.

De-escalation of Care Based on Patient Characteristics

Each patient should receive an individualized assessment that is updated at least daily and with a significant change in clinical condition. These assessments should include a short-term prognosis relative to the underlying condition(s), response to treatment, and patient and family wishes. In some cases, only selected treatments may be discontinued (e.g., certain medications in shortage if they are not showing benefit or if the patient no longer qualifies for them) and in other cases the care team may more systematically discontinue aggressive treatment based on trajectory and prognosis. However, this does *not* mean that the patient is certain to die. In many cases, continuing the majority of treatment but in a less aggressive environment/through less aggressive methods will still result in a good outcome.

Each hospital should have a rounding process to evaluate the care being provided, prioritize/de-escalate care to patients as appropriate, and develop transfer lists for patients who can be moved to a lower level of care or transferred to other hospitals or post-acute care facilities for ongoing care. The rounding teams should evaluate patients and determine modifications to care when the patient falls into one of the following groups:

- *Patient stabilized enough to no longer require interventions/care can be safely modified*: If a patient is stabilizing, de-escalation of care is a normal next step and should be expedited to free critical resources. For example, this may involve more rapid weaning from ventilators, medications, and other resources.

- *Patient trajectory or prognosis disqualifies patient from receiving a specific treatment based on guidelines*: If a patient can no longer receive a treatment based on current guidelines, the providers should clearly understand their authority to de-escalate the care based on that guidance. In unusual cases where removal of resources is likely to contribute to death, consultation should be sought consistent with the hospital triage/CSC plans.

- *Patient trajectory or prognosis makes maximal care non-beneficial or inappropriate*: When treatments are judged non-beneficial or inappropriate, the care team can de-escalate them as long as they do not pose a substantial risk of death. For example, continuing the same treatment on an intermediate care unit rather than in the ICU due to poor prognosis would not require a consultation process, but discontinuation of mechanical ventilation or dialysis would require the providers to follow their hospital triage/CSC plans.

- *Patient wishes for care:* Documenting patient wishes in a meaningful way includes asking them/their loved ones to consider not only resuscitation status, but also whether longer-term mechanical ventilation, dialysis, or hemodynamic support are consistent with the patient's wishes as well as how much value is placed on recovery to the patient's baseline state. Care conferences should provide reassurance that comfort and dignity remain priorities no matter what treatments the patient is

receiving. Ideally, these discussions are held while the patient is able to participate prior to deterioration. Treatment provided should be continued or reduced in concert with these discussions.

Conclusion

Prioritizing patients for available resources based on their trajectory and prognosis and appropriately assessing and de-escalating treatments that are no longer necessary or no longer beneficial/appropriate can help to maintain equitable access to care when demand exceeds the resources available. Hospitals should ensure they have processes in place to accomplish this de-escalation and that the space, staff, and interventions the patient receives are aligned with their clinical course and prognosis and are supported by hospital leadership.

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