Crisis Standards of Care Considerations: Anticipating and Mitigating Crisis Care

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When the ability of a healthcare facility to provide conventional care is exhausted, the goal is to avoid crisis care by aiming for contingency care as long as possible. In contingency, spaces, staff, and supplies are adapted to provide care *functionally equivalent* to conventional care. Contingency care is extended through sequential adaptations until a threshold is reached where the care provided must be considered in the context of the overall demand rather than just for the needs of the individual patient. Then, care shifts into crisis mode. During crisis, the care environment places the patient at *substantial risk* of death or disability, and the needs of each patient must be balanced with the needs of others. However, there is often not a bright line between more extreme contingency and less extreme crisis adaptations. ASPR TRACIE identified several factors as helpful to providers and healthcare facilities in determining when crisis conditions exist and how they can shift back to contingency conditions.

Hospital/Health System and Regional Planning

Mitigating crisis situations begins with flexible hospital staffing and capacity plans for both contingency and crisis conditions as well as stocking adequate resources for anticipated needs.[1] When incident command and providers have a joint understanding and mental model of the planned adaptive strategies and when they will be implemented, a coordinated response is possible that can carry over into a regional cooperative response.

Jurisdictional emergency management or the healthcare coalition is often the conduit to getting supplies or staff into damaged or overwhelmed facilities to help mitigate crisis conditions. Medical Operations Coordination Centers (MOCCs) can also be key to maximizing the use of available regional healthcare resources and can enable hospitals to remain in contingency by directing transfers to hospitals with appropriate capacity and capability. In some cases, MOCCs also coordinate movement of patients from overloaded hospitals to those with capacity (load-balancing) or help hospitals obtain resources.[2] Hospitals should understand the resources available in the region, the request process, and the timeline to obtain the resources *prior* to an incident.

Avoiding or minimizing crisis conditions depends on a regional response and maintaining as consistent a standard of care as possible across that region. Common thresholds (triggers) for crisis care, information sharing, and load-balancing/transfer management are key to helping maintain equitable access to care and services and improving consistency of care decisions.

[1] Hospital emergency planners may find the Disaster Available Supplies in Hospitals (DASH) tool helpful in determining appropriate supplies to have on hand.

[2] For additional information on MOCCs, review the MOCC Brief and the MOCC Toolkit.

Crisis Triggers

Providers often struggled during the COVID-19 pandemic with deciding when the line had been crossed between contingency and crisis – that is, when did adaptive strategies (e.g., providing non-invasive ventilation in non-ICU environments) cross the line to pose substantial risk to patients? In many cases, the perceived risk to patients by bedside providers was not shared by hospital leadership, leading to frustration.

To address this uncertainty, a healthcare coalition and/or state should agree on "triggers" for crisis conditions. Consistent regional definitions are important, and the actions they prompt are even more important. One model by Kelen and colleagues describes criteria, including boarding of critical care admissions, delayed care, altering staff ratios or using non-traditional staff or spaces, and rationing life-saving treatments, which coalitions and states may use or adapt to define when crisis conditions exist.

Information Sharing and Coordinated Regional Response

Anticipating and mitigating crisis conditions relies on information sharing as well as agreed-upon actions within the region/state that should be taken to:

- Transfer patients where they can receive the best available care.
- Transfer resources to the most affected hospitals.
- Triage resources in a regionally consistent way.

When crisis criteria are met in one or more hospitals, information sharing within the region/state should be initiated (if not already in progress) regarding the status of resources and impacts occurring in other facilities. Agreements should be in place on expected actions (data exchange, accepting transfers to balance regional loads or receive specialty care, curtailing non-emergency procedures, etc.) by the hospitals in the region to relieve the strain and get back to contingency or, at minimum, provide a regionally consistent standard of crisis care.

Policies and Guidance

Often, crisis conditions can be prolonged (e.g., seasonal epidemic affecting pediatric inpatient resources, severe shortage of chemotherapy agent) and require proactive guidance. National specialty societies may publish recommendations on preserving supplies for the greatest benefit (e.g., American College of Radiology guidance for intravenous contrast conservation during a shortage). However, this guidance may need to be modified or created at the state or regional level. In some jurisdictions, a State Disaster Medical Advisory Committee (SDMAC)[3] – sometimes referred to by other monikers – has anticipated frequent shortage situations and offered proactive guidelines (e.g., the Minnesota Scarce Resource cardset)[4] as well as developed new recommendations based on the situational needs (e.g., framework for allocation of monoclonal antibody treatments for COVID-19).

Clinical guidance, usually in a staged framework that allows more severe restrictions as the shortage worsens, provides consistent strategies to clinicians and eases provider moral and legal burdens. It also ensures that hospitals can coordinate so they are at roughly the same stage of restrictions. For example, one hospital should not be withholding dialysis entirely while others are adjusting the duration of the run to enable more patients to receive treatment.

[3] National Academies of Medicine. 2012. Crisis Standards of Care – A Systems Framework for Catastrophic Disaster Response.
[4] Minnesota Department of Health Science Advisory Team. Patient Care Strategies for Scarce Resource Situations.

Adjusting hospital services to stay in contingency often involves restricting other services (e.g., limiting surgical cases to enable the staff and spaces to be used for critical care). These can be difficult decisions, but they are best made in concert regionally with other hospitals and on the basis of concrete criteria. Having staged restrictions allows hospitals to proportionally and fairly match demand to stay in contingency and avoid or minimize crisis conditions. This can be dynamic. For example, some days a majority of non-emergency cases may be performed and on other days, only emergency cases can be accommodated. Transparency and accountability are keys to hospitals providing a consistent level of service. In the absence of criteria and regional plans, the default will often be to "do as we usually do," which can result in unethical resource decisions and inconsistent application of strategies across hospitals in the area.

MOCCs can help hospitals by providing a "one-call" access point for transfers and to report dangerous patient load conditions. The MOCC should have criteria for when to use load-balancing (i.e., moving patients from an overloaded facility to hospitals with better resource availability to reduce strain) and transfer management (i.e., ensuring that patients requiring a higher level of care have a destination hospital that can provide the necessary services, including the ability to compel transfers on a rotational or other equitable basis when emergency conditions exist and no receiving facility has capacity). Ensuring that the MOCC has the relevant policies and authorities to support its mission of maximizing use of available resources and minimizing the regional impact of crisis conditions is one of the most important extra-facility means of reducing impact.

Conclusion

Anticipating and mitigating crisis conditions by having base surge plans, moving patients and resources, and providing current guidance to providers to remain in contingency as long as possible requires significant work, trust, and coordination. However, these efforts can benefit providers and patients with improved outcomes and equity of access to the available resources.

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