Access the entire webinar series here:
https://files.asprtracie.hhs.gov/documents/aspr-tracie-healthcare-system-preparedness-considerations-speaker-series-summary.pdf

Access the recording here:
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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Health Care System Preparedness Considerations – Speaker Series

February 26, 2024

ASPR
Administration for Strategic Preparedness and Response

Crisis Standards of Care: Lessons From the COVID-19 Pandemic

Access speaker bio here:
https://www.hennepinhealthcare.org/provider/john-l-hick-md/

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Disclaimer

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Incident demand/resource imbalance increases →
Risk of morbidity/mortality to patient increases →
← Recovery

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[a]

Normal operating conditions

Indicator(s): Potential for contingency care[b]

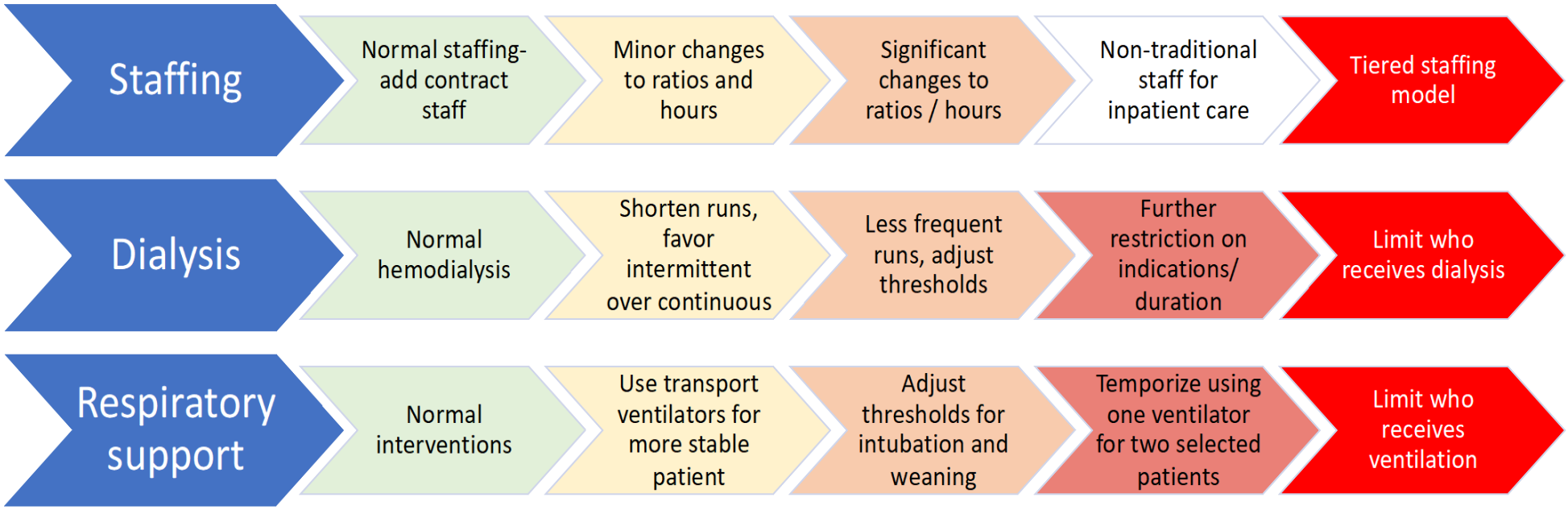
Trigger(s): Decision point for contingency care[c]

Indicator(s): Potential for crisis standards of care[d]

Crisis care trigger(s): Decision point for crisis standards of care[e]

Extreme operating conditions

CSC Graded Strategies



Note: examples only – does not represent all potential adjustments. Increasing risk for poor patient outcome as changes implemented from left to right. Regional agreement on what constitutes significant risk and therefore crisis conditions is needed to facilitate communications, resource distribution, and guide response strategy

CSC Frameworks Prior to COVID-19

- Focused on triage of “binary” resources (e.g., ventilators)
  - SOFA scores
- Assumed clear descent into crisis
- Triage teams
- Emphasized protocols for triage over process for coordination
- Assumed ethical ideals could be operationalized justly

State Actions During COVID – ASPR TRACIE

- Documentation of crisis conditions at times in 48 states
- Nine states (and one county) declared CSC
  - Many at the outset of the pandemic and overbroad
- Twelve states provided liability protection
  - In some states, this only applied to COVID-19 patients
- Eleven states – hospitals or hospital association declared CSC
- Twelve states issued executive orders supporting surge activities
- Fifteen states were operating ACS or had other documentation of crisis conditions without any state actions to support CSC

https://files.asprtracie.hhs.gov/documents/csc-actions-by-states-summary.pdf

COVID-19 CSC Key Issues

- Politics and profit
- Bedside vs. boardroom
- Equity and access to care
  - Urban
  - Racial
  - Rural
  - Insurance status
- Implicit triage/ad hoc decisions
- Failure to acknowledge crisis conditions = no systematic response
- Failure to balance risk across spectrum of care
  - EMS/Rural v. Urban/ED/Inpatient/ICU/ECMO
- CSC plans often separate from disaster plan/daily operations

CSC Key Issues (cont.)

- Health care system refusal to participate in some processes
- Effects were not consistent across hospitals, thus no advocacy for declarations
- Government - reluctant to declare or acknowledge crisis conditions and lacked an “ask” from health care
- “Triage teams” were cumbersome and didn’t apply to most of the rationing
- “Triggers” need to have common definitions
- SOFA scoring limitations/prognosis limitations
- Special interests
- Legal risks/challenges

Quotes from MN State Survey

- “I keep waking up at 4 am and begin fretting about how I am gonna care for all of these patients. How am I gonna convince yet another patient/family that they should change their code status because we do not have the equipment to maintain them?”
- “The inability to help people has been heartbreaking.”
- “Multiple COVID-19 patients…some needing intubation but intubation is delayed as CAH unable to care for vented patients. Many either unstable after intubation or even changed to do not intubate because of bed availability.”
- “Last week, day after day, I took care of multiple patients who had a very-poor prognosis but aggressive cares were still being pursed by families, some even against the advice of our physicians…Over the last weeks in my triage officer role, I was unable to accept patients with acute stroke for advanced therapies…a young renal failure patient with hyperkalemia only needing dialysis, an intubated COVID patient with no comorbities, and a postoperative wound infection with sepsis, among others. The moral distress that I and many others are experiencing is created by actually seeing the futility of care on one-hand and--on the other-- the inability to help those who could actually benefit from life saving medical care.”

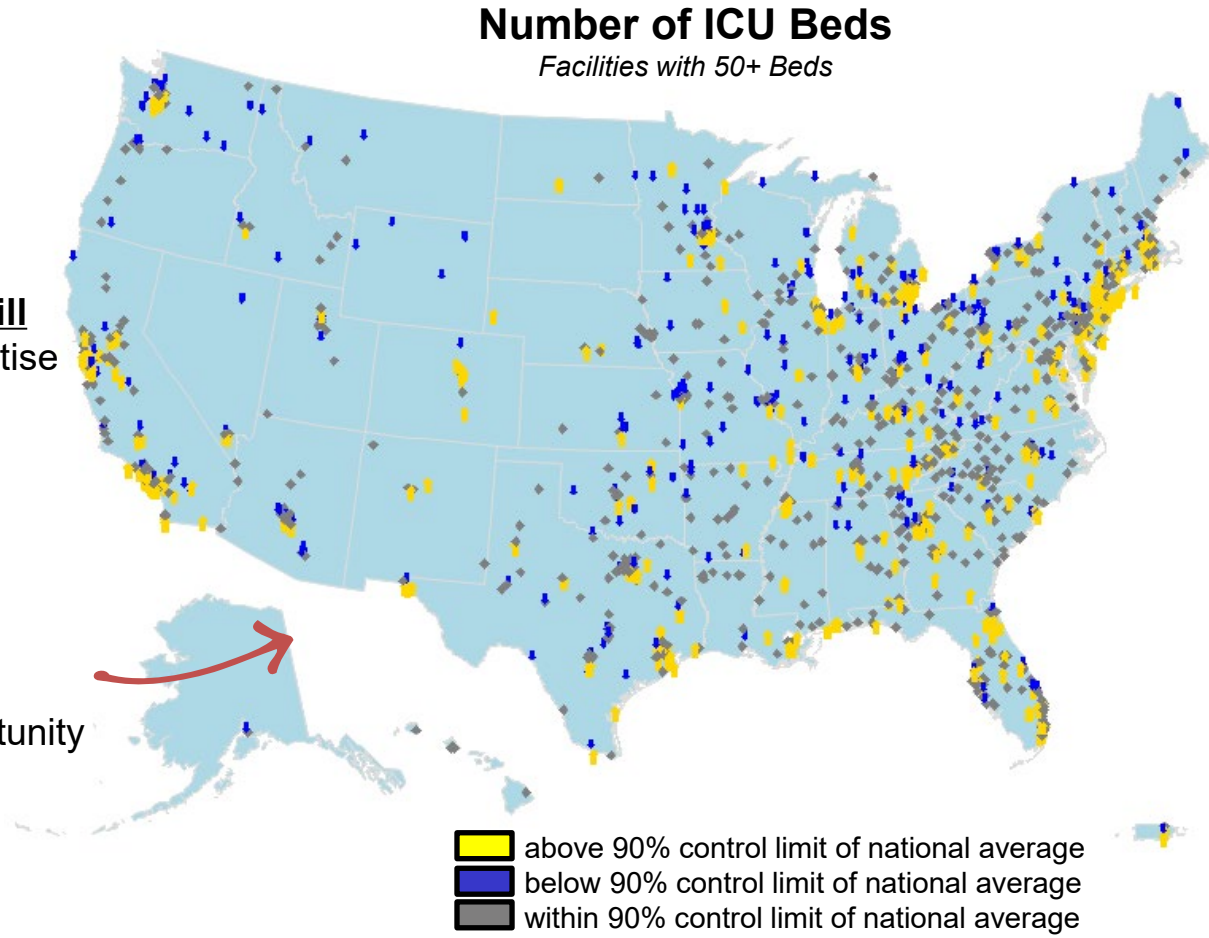
Primary Goal: AVOID Crisis
Regional/State Coordination and Consistency

- Balance the demand (ESF-8/health care coalition)
  - Bring in resources
  - Transfer patients
  - Triage resources
- Regional constructs
  - Medical Operations Coordination Center (MOCC)
  - Qualitative information/strategy sharing
  - “Care-in-place” support
- Data sharing
- Anticipate resource shortfalls and develop contingencies and guidelines
- State legal protection and regulatory support

MOCC Problem Statement

What did we see?

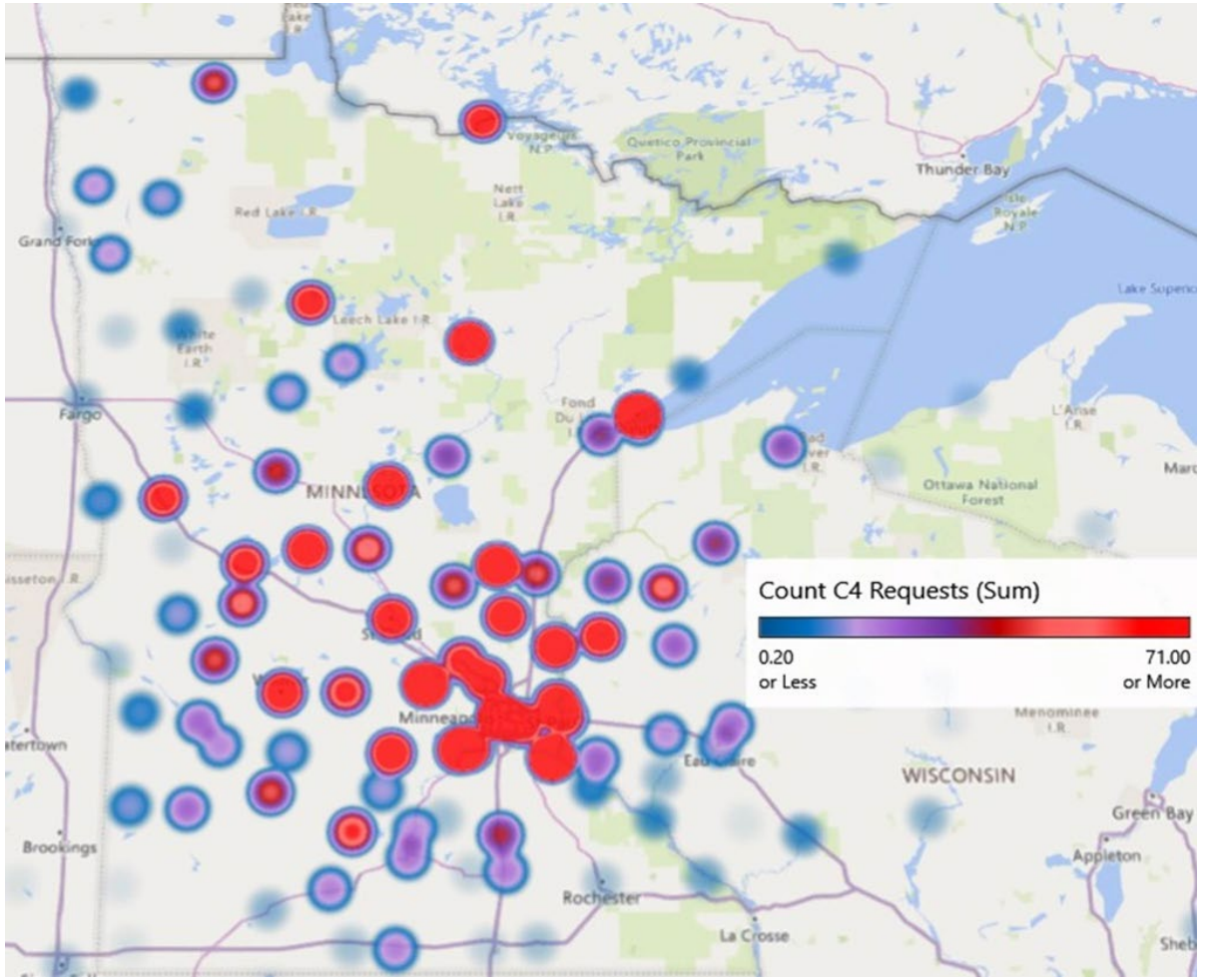
- Hospitals were the **preferred location for seriously ill** COVID-19 patients, due to existing patient care expertise and resources
- Most hot spots were **geographically localized,** overwhelming local health care facilities
- While some facilities were overwhelmed**, successful mitigation in neighboring areas created excess capacity** in nearby hospitals, which created an opportunity to transfer patients



Patient transfer coordination, through dedicated staffing and data collection/analysis, can improve patient allocation at the sub-state, state, and federal levels

Load Balancing

- Key driver - consistency and equity
- Rural and urban needs
- Compulsory component
  - Inbound – on facility
  - Outbound – on patient
- Characterize “ICU” capability
- Transfer times
- Payment
- Prioritization (critical care on-call)
- Coordination with patient transfer center
- Care-in-place support
- Inter-state issues



MN - C4 – over 5000 requests for transfers, over 1800 ICU patients placed

Triage

- Implicit – unconscious triage – VERY common
- Explicit – conscious decision to ration a treatment – uncommon
- Access triage – differences in resources = differences in outcomes
  - Kadri SS, et al. Association Between Caseload Surge and COVID-19 Survival in 558 U.S. Hospitals, March to August 2020. Ann Intern Med– 25% of hospital COVID deaths may be surge related
- Non-beneficial treatment vs. inappropriate care
  - Non-beneficial – no reasonable expectation of benefit
  - Inappropriate – unreasonable given the current situation

Triage Considerations

- Office of Civil Rights – “individualized patient assessment” according to the diagnosis. May not consider age, race, etc. as general variables
- Who benefits most vs. who suffers the least?
- SOFA and other scoring systems
  - Renal scoring particularly problematic
- Age – only included if an independent risk factor for Area Deprivation Index/ Social Vulnerability Index (ADI/SVI)
- Race
- Concentrate on regional consistency, NOT triage of ventilators
- ECMO – regional framework, prognosis

Legal/Regulatory Considerations

- State
  - Legal protections
  - Regulatory/executive orders
- Federal
  - CMS
  - FDA
  - ASPR
  - CDC
- Legal
  - State protections vs. “reasonable provider”
  - Non-beneficial vs. inappropriate care
  - Immunity vs. indemnification

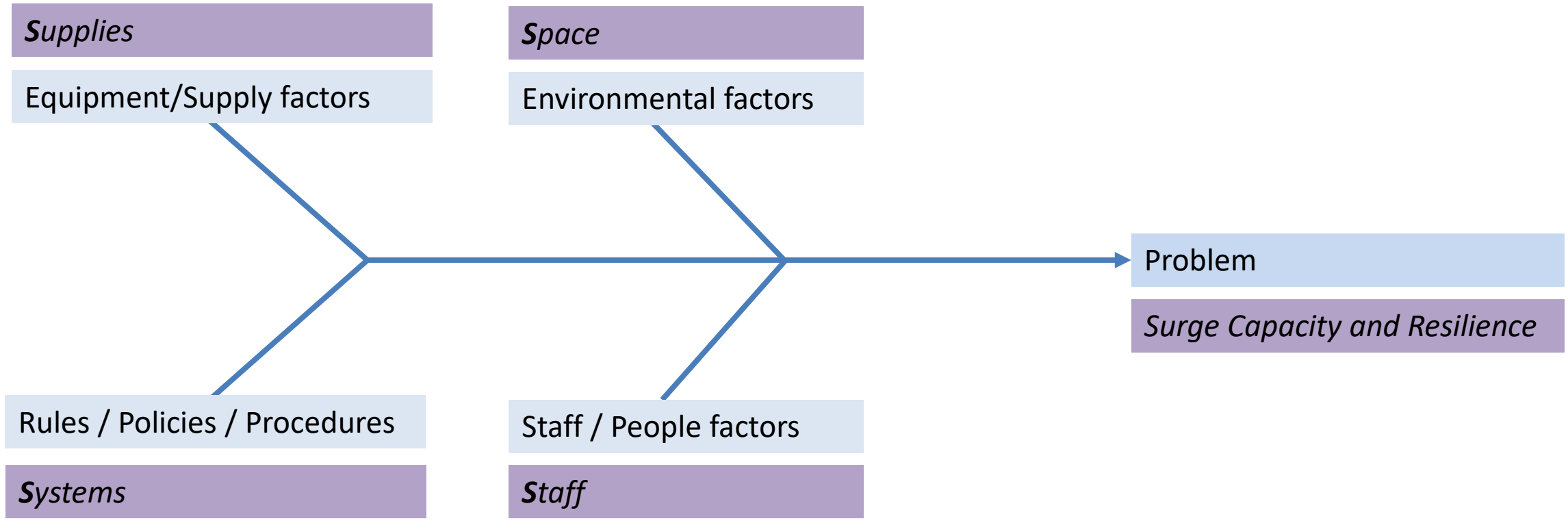
CORONAVIRUS

Mercy Hospital must keep COVID patient on ventilator, judge rules

A temporary restraining order will keep Scott Quiner alive until a hearing set for Feb. 11.

By Tim Harlow Star Tribune | JANUARY 14, 2022 — 6:47PM

Scarcity = Safety Hazard



CSC Plan

- Decrease emphasis on “triage”
- Emphasize coordinated allocation strategies
- Integrate crisis space and staffing plans into general surge plans
- Have separate plan for resource allocation across contingency and crisis
  - Focus on guidance for treatment rationing (e.g., graceful degradation – dialysis) and *proportionality*
- Include “triggers” for crisis – common definitions and actions to be taken
- Reduce/diffuse of risk
- Focus on non-beneficial and inappropriate treatment identification
- Emphasize individual assessment relative to disease/injury
- Increase protections from implicit triage

Key Domains and Requirements in Crisis Standards of Care

Health Care Provider

Information
- Clinical skills
- Current evidence
- Ethical foundations
- Triage principles
- Resources available

Command/Coordination
- Consultation mechanism
  - Clinical
  - Triage team
- Integration with incident command

Policies/Practice
- Make usual scope of practice decisions
- Apply available policy /guidance when allocating resources
- Consult when decisions of high consequence or no policy in existence

Situation report
Resource request
Consultation

Clinical advice/ support

Guidelines
Education
Resources

Health Care Facility/System

Information
- Facility / System status
- State / Coalition status
- Resource status / issues

Command/Coordination
- Recognize/anticipate shortages
- Integrate clinical experts
- Receive info from consultants/triage team
- Develop system policy
- Allocate resources
- Public/provider messaging

Policies/Practice
- Clinical consultant available for advice/decision support
- Triage team available if needed
- Consultation/triage team oversight process
- Clinical guidelines for resource allocation
- Surge policy – space, staffing expansion / models

Situation report
Resource request
Strategies in use

Guidelines
Education
Resources

Coalition*/State

Information
- System status
- State/facility status
- Resource status/issues
- Information/policy sharing

Command/Coordination
- Recognize/anticipate shortages
- Integrate clinical experts
- Make resource requests to coalition partners, state/federal
- Public/provider messaging
- Develop common “triggers” for actions

Policies/Practice
- Regional clinical support per local needs and plans
  - Consultation/advice
  - Triage team
- Guidance (clinical/non-clinical)
- Strategies for allocation
- Regional bed/transfer coordination (MOCC)

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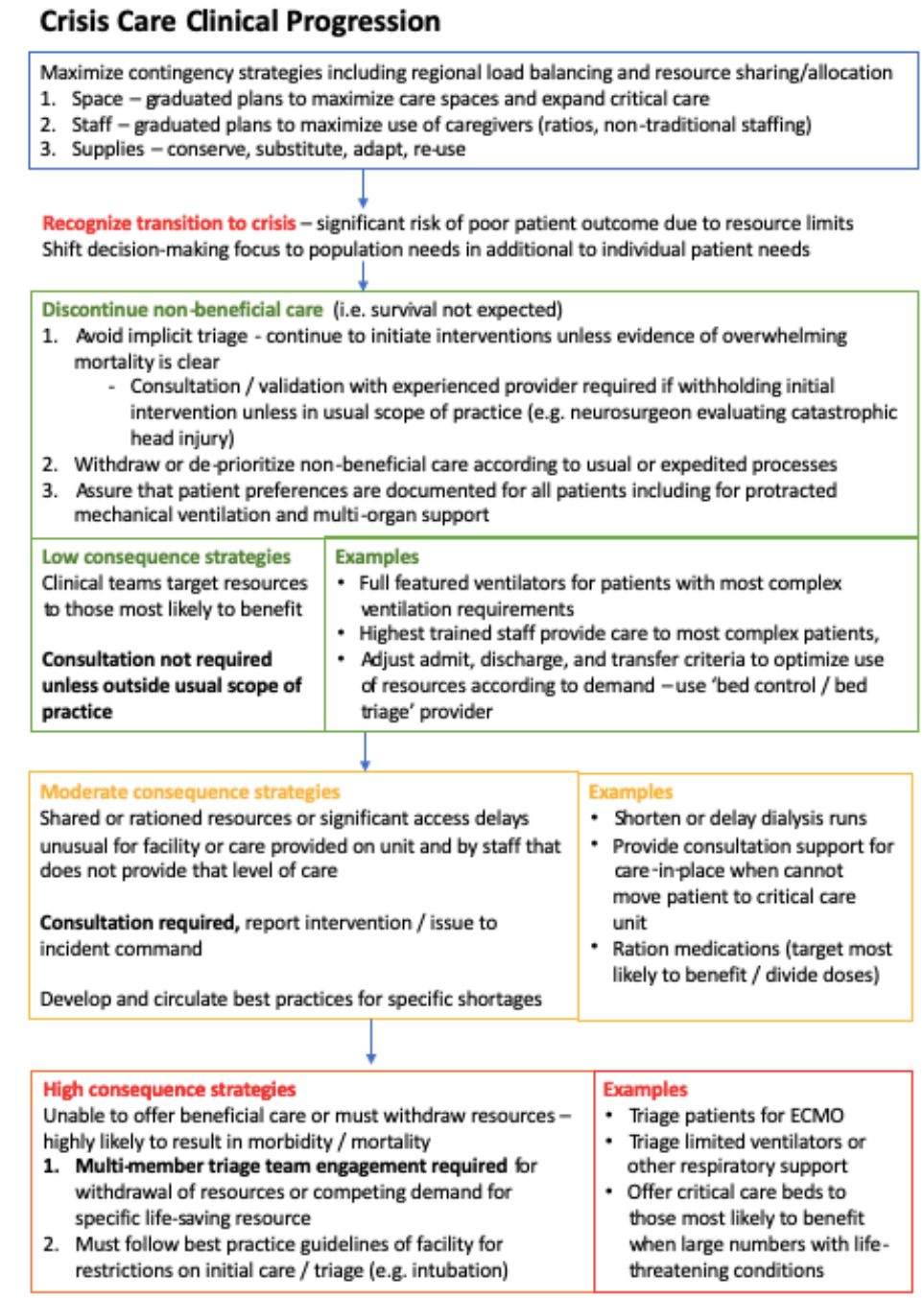
Additional State Gov’t. Functions
- Provider liability relief
- Executive orders
- Regulatory relief

*Need depends on local construct / resources

Hospital Priorities

- Minimize ad hoc decisions
- Emphasize decision support and shared decisions/consultation
- Awareness of resource limitations
- Communication/coordination with hospital leadership
- Guidelines for existing and anticipated resource shortages
- Shared policy process with regional/state



State Priorities

- Load-balancing mechanisms
- Consider *not* requiring a declaration per se, but emphasize the state actions to support the surge strategies and decision-making
  - Triggers
- Data needs and mechanisms (both capacity and acuity)
- Care in place support (including legal protection)
- Guideline development and circulation
- Coordination activities across hospitals
- Legal protections
- Regulatory relief

Resource Articles

- Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. 2021. Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do? *NAM Perspectives.* Discussion, National Academy of Medicine, Washington, DC.
- Hick JL, Hanfling D, Wynia M. 2022. Hospital Planning for Contingency and Crisis Conditions – CSC Lessons from COVID-19. The Joint Commission J of Quality and Safety.
- ASPR TRACIE Crisis Standards of Care Topic Collection

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