



ASPR

Crisis Standards of Care

Panel Presentation
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T R A C I E

HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

**ASPR's Technical Resources, Assistance
Center, and Information Exchange**



What is crisis care?

- Crisis standards of care – systems response including formal government recognition of situation and support for crisis actions – prolonged event
- Crisis care – situational – inadequate resources – must provide ‘best care possible’ given the situation despite some risks to the patient(s) – *much* more common

Legal

- Standard of care is situational
- Always better to respond according to a plan – particularly one based on guidance
- ‘Agents of state’ or agents of local gov’t
- Public providers vs. private
- Some potential for emergency orders in protracted events
- ‘Good Samaritan’



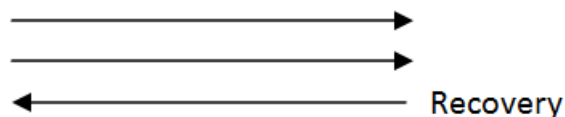


Principles

- Fairness
- Duty to Care
- Duty to Steward Resources
- Transparency
- Consistency
- Proportionality
- Accountability

‘greatest good for the greatest number’

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



	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 re-allocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care ¹

Normal operating
conditions

Indicator: potential
for crisis standards²

Trigger: crisis standards
of care³

Extreme operating
conditions

How to do the greatest good...

- Implement incident management and surge capacity plans
- Anticipate resource shortfalls
- Solve the imbalance:
 - Bring in resources
 - Transfer patients
 - Triage resources
- Get help...



COALITIONS /
NDMS

Crisis Care Planning

- Indicators and Triggers
- Incident management – delegate authority
- Clinical input
- Communications
- ‘Triage’ education, decisions (restrictions, etc.) and processes
- Quality assurance and reporting
- Response actions to return to contingency and then conventional status

Hierarchy of Priorities

- Stabilization
 - Medical
 - Security
- Maintenance
 - Medical / Health
 - Economic – short and long term
 - Security

Considerations

- Resources required
- Return on investment
 - How much required?
 - How difficult?
 - Number benefited
 - Degree of benefit
- Urgency of need
 - Life-threatening situation?
 - Imperils large numbers?
- Ability to ration
- Consequences of not supplying
 - Alternatives available?
 - Critical to life or health maintenance
- Better to move people or resources?
- Alternatives – different mechanisms of supply / storage / etc.
- How much is available?
- How much is expected?

NDMS CSC Issues

- Political / public relations
- Clinical
 - Triage (time, treater, tx)
 - Supplies (e.g. meds)
 - Staff
 - Space
 - Special (e.g. peds, VHF)
 - Local baseline vs. disaster
 - Cultural priorities
- Logistical
 - Fuel
 - Oxygen
 - Power
 - Water
 - Security
 - Food
 - Transportation
 - Infrastructure / access

Responder vs. Response

- Responder Based
 - Narrower / local focus
 - What do you have?
 - What can you get?
 - What can you do?
 - Consistency within team / immediate area

Move from reactive to proactive!
- Response Based
 - Incident management / global focus
 - System-based
 - More partners, politics
 - What do you have?
 - What can you get?
 - What can you do?
 - Consistency across response

Key Points

- Part of the surge capacity / disaster plan
- Don't improvise! – practical and liability issues
- Dynamic situation – flux between contingency/crisis
- Proportionality
- Crisis care will happen regardless of official actions
- Triage – RARE – most crisis care will involve staffing and supply issues
- Don't be an island! Use coalitions, IRCT, other partners – aim for consistency!



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Crisis Standards of Care

Capt. Catherine Witte, USPHS

Ethics and Disaster Response

When an ethical dilemma occurs, it's not so much a question of, "Shall I do the right thing or the wrong thing," it's, "Which good that I'm trying to achieve is the better good?"

George Hanzel, MD



Topics

- Ethics
 - Clinical-Medical
 - Public Health
 - Disaster Response
- Ethical dilemmas encountered by USPHS officers while on deployment (survey and findings)
- 2014 Ebola Response: Experiences at the Monrovia Medical Unit ETU, Team One, Liberia

Public Health and Clinical-Medical Ethics

- Public health ethics requires recognition of complexity and interrelatedness of healthcare systems and implications for population health locally and internationally
- Includes Disaster Response Ethics
- Clinical-Medical ethics focuses mainly on clinical medicine in patient care context – and historically on an individual patient

Clinical-Medical Ethics: 4 Principles

- **Autonomy:** Moral right to choose and follow one's own plan of life. Constraint of free choice is morally permissible only when one person's preferences/actions impinge on another's rights/welfare
- **Beneficence:** Duty to assist persons in need
- **Nonmaleficence:** Duty to refrain from causing harm
- **Justice**

The ethics of fair and equitable distribution of burdens and benefits within a community “giving to each their due”

Jonsen A, Siegler M, Winslade W. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 5th ed. New York: McGraw Hill; 2002

Public Health Emergency: Disaster Response Ethics

- Emphasis on improving and maximizing the population's health while tending to the needs of patients within the constraints of resource limitations
- Fairness-equity: Does not require that all persons be treated identically but requires that treatment differences be based on appropriate differences among individuals
- Should ideally facilitate the delivery of care to patients to the extent possible by allocating resources to those most likely to benefit
- Palliative care: expectation that all patients will receive some care, regardless of the ability or scarcity of resources

2009 Institute of Medicine (IOM) definition from Crisis Standards of Care: a systems framework for catastrophic disaster/Committee on Guidance for establishing Standards of care for Use in Disaster situations

Ethical dilemmas encountered by USPHS officers while on deployment

- Identified and categorized ethical dilemmas
- 33 officers interviewed from November 2010 – June 2011
- Wide range of disciplines and deployment experience
- Approved by OFRD (now RedDog) as quality improvement project
- Findings
 - 72 Ethical dilemmas identified with almost evenly distributed experiences of dilemmas occurring across the categories of **professional, organizational and patient care.**
 - Almost 20% of the dilemmas described by officers were those related to a disconnect between field officers and command perceptions about mission objectives and details in providing clinical care

Ethical Dilemmas: Professional Category

- Mixed agency-conflicting/competing obligations or duty to patient or group
- Moral distress-suffering resultant from inability to act upon moral decision
- Responder suitability-professional competency/mission fitness
- Responder conduct-behavior that results in tension and conflict within mission

Ethical Dilemmas: Organizational Category

- Intra-Agency conflict-conflict between agencies regarding priorities and mission approach
- Communication-effective and appropriate interactions with public and population served
- Force protection-actions taken to prevent or mitigate harm to responders in carrying out mission (non combatant context)
- Research and publications-reporting of deployment findings without causing harm to individuals or populations served.
- Leadership-disconnect between mission assignment and actual mission, including issues related to planning, execution and response to mission needs

Deployment Leadership Operational Goals

- Full understanding by the command of the consequences of their decisions on patient care.
- Structure that offers adequate checks and balances to oversee the command's decision-making.
- Clear policies that articulate which decisions have been vested in the command
- Clear process for collaboration with field officers providing healthcare

adapted from Boyle. P.J., Dubose. E. R., Ellingson, S. J., Guinn, D. E. & McGurdy, D. B. (2001). *Organizational ethics in Health care: Principles, case and practical solutions*. San Francisco: Jossey-Bass/John Wiley & Sons.

Ethical Dilemmas: Patient Care Category

- Crisis standards of care-resource allocation and legal and professional implications resulting in not being able to provide customary level of care
- Cultural-perspectives/beliefs impacting patient care
- Justice-health care disparities, sustainability of care, displacement of local population
- Privacy and confidentiality-protection of health care information
- Patient autonomy-decisional capacity of patient
- Safety-special population needs, security issues

Ethics Training for Monrovia Medical Unit (MMU), Team One, Liberia

Pre-deployment: Training in Anniston -USPHS CC training included:

- Ethical Dilemmas on Deployments: Experiences of USPHS CC Officers

During Deployment: Two formal forums

- MMU Patient Care Ethical Dilemmas: Crisis Standards of Care discussion
- Morbidity and Mortality Conference: patient case and ethics discussion with Team One and Two prior to command transfer

Ethics at the Ebola Treatment Unit

- Patient prognosis and clinical course of illness and treatment perspectives (palliative and end of life care)
- Communication challenges
- Moral distress
- Crisis Standards of care

Patient and responder care decisions

examples: CPR, airway and suctioning on high risk patients and responder access to the “Hot Zone”



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Crisis Standards of Care

**Dan Hanfling, MD ASPR/OEM
VA-1 US&R**



Decisions for Patient Care Engagement (Haiti, 2010)

- Initial Rules:
 - AMCITS ONLY out to Flight Line (US Army CSH) or to US Embassy (Critical Care capability)
 - Haitian Nationals delivered to local assets

**** Initial Plans Rarely Hold Up, Especially in the Disaster Setting ****







Decision Making for Repatriation (Haiti 2010)

- Make decisions based on:
 - likely length of resource use,
 - intensity of use,
 - outcome/survival benefit,
 - ability of local resources at baseline to support patient
- Re-assess and re-triage at scheduled intervals
- Ensure team-wide awareness of triage goals, strategies, and ethical foundations

Operational Considerations in the Delivery of Field Hospital Care

- The standard of care must adjust, but accountability cannot be compromised
- Is there a minimum to which the quality of care can be degraded:
 - What is PERMISSIBLE? WHAT IS LEGITIMATE? WHAT IS MANDATORY?

**** If you expect to work in the international setting, you must be familiar with SPHERE Guidelines and WHO/EMT Classification Standards****

Mandatory

- Maintain human dignity and patients' rights
- Informed consent is critically important (i.e. what are the implications of an arm amputation?)
 - Implied consent is adopted in an emergent situation (no different than in non-disaster setting)

Minimum

- Teams obligated to deliver care that is at least equivalent to the care available (cannot deliver substandard care) in that setting, at that time (i.e. Haiti vs Nepal)

Vexing Decisions (with no clearcut answers)

- How permissible is it manage the airway using only an AMBU bag when there are no longer any ventilators?
- How permissible is it to declare a patient DNR, when those resources could be used on someone more likely to benefit?
- Can you take a patient off a ventilator (withdrawal of care) in order to provide that life sustaining resource to some more likely to survive?
- Is it acceptable for a provider to work outside their scope of practice, experience and expertise?



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Crisis Standards of Care

Murad “Mojo” Raheem, ASPR/NDMS

Crisis Standards of Care (CSC)

- Executive Support
 - The more coordinated the support from all levels of the response, the easier it will be to implement “standards”.
 - Note that “standards” may vary across areas depending on many factors such as;
 - ✓ Local access (roads, air, sea)
 - ✓ Population type
 - ✓ Recovery status of that area

Crisis Standards of Care (CSC)

- Hurricane Maria
 - Two liquid oxygen (LOX) plants unable to re-start due to power outage
 - 2 ISO containers (20 foot long Thermos flasks) needed per day
 - ✓ Any delay (like another storm) and LOX supply would become critical
 - ✓ Very few hospitals had oxygen generation systems
 - ✓ Once the ISOs got to PR, the LOX had to be loaded into smaller trucks for actual delivery, on very bad roads and sometimes with a lack of drivers

Crisis Standards of Care (CSC)

- PR Secretary of Health
 - Issued a letter to authorize hospitals to conserve Oxygen
 - Some hospitals had not used their “emergency supply.” As a result, many hospitals said they could not require their clinicians to conserve due to concerns over altered standards of care.
 - ✓ Comfort makes her own O2. How would we have handled that?
 - ✓ We worked with FEMA, DHS, Port Authority, etc. to keep the lines of supply open
 - ✓ Bio Medical Manufacturing was shut down due to a lack of med gas (many of these plants make items for the global market)
 - ✓ PR Power Authority shut off power to homes to allow the plants to start up (they need a massive current to start the Air Separation Units)

Medication Shortage - Insulin

- Shortage of insulin vials – multi-dose were available
- Refrigeration / cold chain issues
- Solution – insulin clinics
 - Allowed multiple patient dosing from single vial
 - Reduced cold chain requirements at home and clinics
 - Allowed for closer patient monitoring
- Crisis care strategies – substitution, adaptation, re-use (multiple patients / one vial)

Crisis Standards of Care

- All levels of a response are affected.
- Clarity, as much as possible, across the system helps!
- Ask for information!
- Don't let perfect be the enemy of the good!
- Things may be simple, it doesn't mean they are easy.