Emergency Management

Getting started with the crisis standards of care, part 1

Whether it's a natural disaster, an act of terrorism, or a sustained public health crisis, rare but catastrophic disasters can stress a health system to its breaking point and threaten its ability to safely and reliably deliver patient care.

This is the first of a two-part series of articles that addresses the crisis standards of care (CSC). Part 2 will appear in the December 2015 issue of this newsletter.

In 2012 the federal government required the 62 jurisdictions receiving federal emergency management funding to develop CSC in collaboration with the hospitals and other medical and mental health providers in their states, municipalities, and territories. Leading up to this mandate, the US Department of Health and Human Services (HHS) had turned to the Institute of Medicine to research and develop guidance to support decision making on the allocation of scarce medical resources. This information served as the basis for the HHS policy, which requires each state to implement the CSC[1] framework.

"The goal of the CSC is to help organizations and communities plan for how to move along the continuum from providing conventional care, to a contingency response, to a crisis response," says Lynne Bergero, HHS, project director for the Division of Healthcare Quality Evaluation at The Joint Commission. "While all accredited organizations have a plan in place to respond to various contingencies—as per the Joint Commission Emergency Management [EM] standards—the crisis standards of care prompt organizations to look beyond those plans and anticipate the absolute worst-case scenario—in other words, when the organization is overwhelmed by a mass casualty event [MCE] affecting the entire community."

Taking planning to the next level

The CSC framework addresses the following eight key areas[1]:

1. Ethical Considerations and Legal Authority and Environment
2. Education and Information Sharing
3. Provider and Community Engagement
4. Development of Indicators and Triggers
5. Implementation of Clinical Processes and Operations
6. Performance Improvement
7. Hospital Care, Out-of-Hospital Care, EMS, Public Health, Emergency Management and Public Safety
8. Local, State, and Federal Government

EM standards, as well as some Leadership, standards support organizations in working with their staff, government authorities, and other stakeholders to proactively plan for response and recovery from catastrophic events.

Where to begin the journey?

Implementing policies and protocols to move toward the CSC framework is a complex and long-term endeavor, requiring attention not only to operational, facilities, and clinical issues, but also to legal and cultural changes related to how care is delivered. Beginning the process with the following areas can lay a useful foundation for even more complex issues later in the planning effort:

- ***Ethical considerations:*** "One of the fundamental differences between contingency and crisis planning is the focus of care," Bergero says. "During most emergencies—ones that only affect the hospital or health system and maybe extend to some of the surrounding community—the focus of care is on the individual patient, meaning that an organization addresses each patient's needs following the standard of care. With crisis planning, the focus of care shifts. At its simplest formulation, during an MCE affecting an entire region, a health care organization may have 60 patients to treat but only enough space, supplies, and staff to effectively treat 40. What kind of treatment do you give? To which patients? For how long?" The CSC are designed to help senior leaders, emergency managers, clinicians, and staff work through these ethical and allocation issues in advance, ideally with the ongoing participation of an ethicist, in a framework of principles that includes transparency, consistency, and fairness.
- ***Legal authority***: Organizations also have to work through the legal issues surrounding crisis care, asking questions of their legal advisors and state authorities related to concerns such as:
  - Alternate use of facilities and any related licensure issues
  - Mutual aid agreements to expand surge capacity
  - Scope of clinical practice and credentialing
  - Legal liability for health care workers
  - Federal waivers related to EMTALA, HIPAA, and other regulations
- ***Community engagement***: While organizations should already be working with their community to plan for contingencies, CSC planning guides hospitals and health care coalitions to collaborate around key issues, such as the following:
  - Designation of specific facilities for specific response needs
  - Proactive identification and care coordination for vulnerable populations

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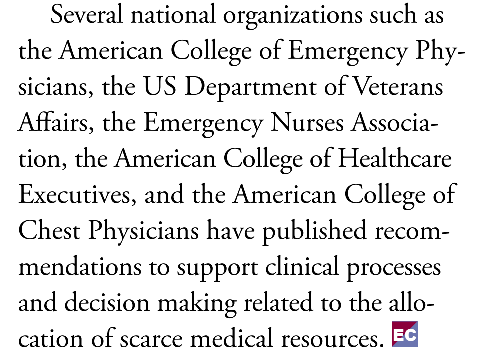
- Crisis risk communication strategies regarding the allocation of scarce resources.

- ***Provider engagement***: The clinical disciplines will be directly affected by certain legal and regulatory changes under CSC. Emergency physicians and hospitalists, pediatric advanced practice nurses and hospice nurses, pharmacists, psychiatrists, respiratory therapists—and provider types across the health care coalition—are on the front lines of care and clinical decision making; their representation on internal planning efforts will provide essential perspective to the organization's CSC planning.
- ***Indicators and triggers***: Joint Commission standards require organization leaders to maintain situational awareness and adjust response actions as an emergency evolves. CSC planning requires organizations to expand upon their existing indicators and triggers to address transitions from contingency to crisis situations (for example, related to utility system failures, structural damage, communication system failures, alternate use of space for triage or surgeries, shortage of critical equipment or supplies, or local events impacting the water supply or access to electrical power), engaging stakeholder and community input in the process.
- ***Clinical process and operations:*** A clinical review process or committee can consider planning issues, staff education, and staff support related to the full spectrum of clinical issues; examples of key issues include the following:
  - Awareness of surveillance, reporting, testing, and quarantine mandates
  - Awareness of the organization's shift to CSC based on triggers
  - Changes to triage and treatment processes
  - Providing palliative care
  - Communication and support needs of patients and families
  - Communication and support needs of physicians, nurses, and clinical and nonclinical staff and leaders



Several national organizations such as the American College of Emergency Physicians, the US Department of Veterans Affairs, the Emergency Nurses Association, the American College of Healthcare Executives, and the American College of Chest Physicians have published recommendations to support clinical processes and decision making related to the allocation of scarce medical resources. EC

References

1. Institute of Medicine. *Crisis Standards of Care: A Toolkit for Indicators and Triggers.* Jul 31, 2013. Accessed Oct 2, 2015. http://iom.nationalacademies.org/Reports/2013/Crisis-Standards-of-Care-A-Toolkit-for-Indicators-and-Triggers.aspx.
2. Institute of Medicine. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response.* Mar 21, 2012. Accessed Oct 2, 2015. http://iom.nationalacademies.org/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx.

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