UTAH DEPARTMENT OF HEALTH

Crisis Standards of Care – "We Have the Plan, Now What?"

KEVIN M MCCULLEY
PUBLIC HEALTH/MEDICAL PREPAREDNESS AND RESPONSE MANAGER
BUREAU OF EMS AND PREPAREDNESS | UTAH DEPARTMENT OF HEALTH

"Rationing Care Rationally"

MARK SHAH, MD FACEP
UTAH EMERGENCY PHYSICIANS | UTAH DISASTER MEDICAL ASSISTANCE TEAM
INTERMOUNTAIN CENTER FOR DISASTER PREPAREDNESS
EMERGENCY MANAGEMENT, INTERMOUNTAIN HEALTHCARE UCR
ADJUNCT FACULTY, UNIVERSITY OF UTAH, DIVISION OF EMERGENCY MEDICINE

UTAH EMERGENCY Physicians

NDMS UT-1 DMAT

Intermountain Center for Disaster Preparedness

EMERGENCY MEDICAL SERVICES AND PREPAREDNESS

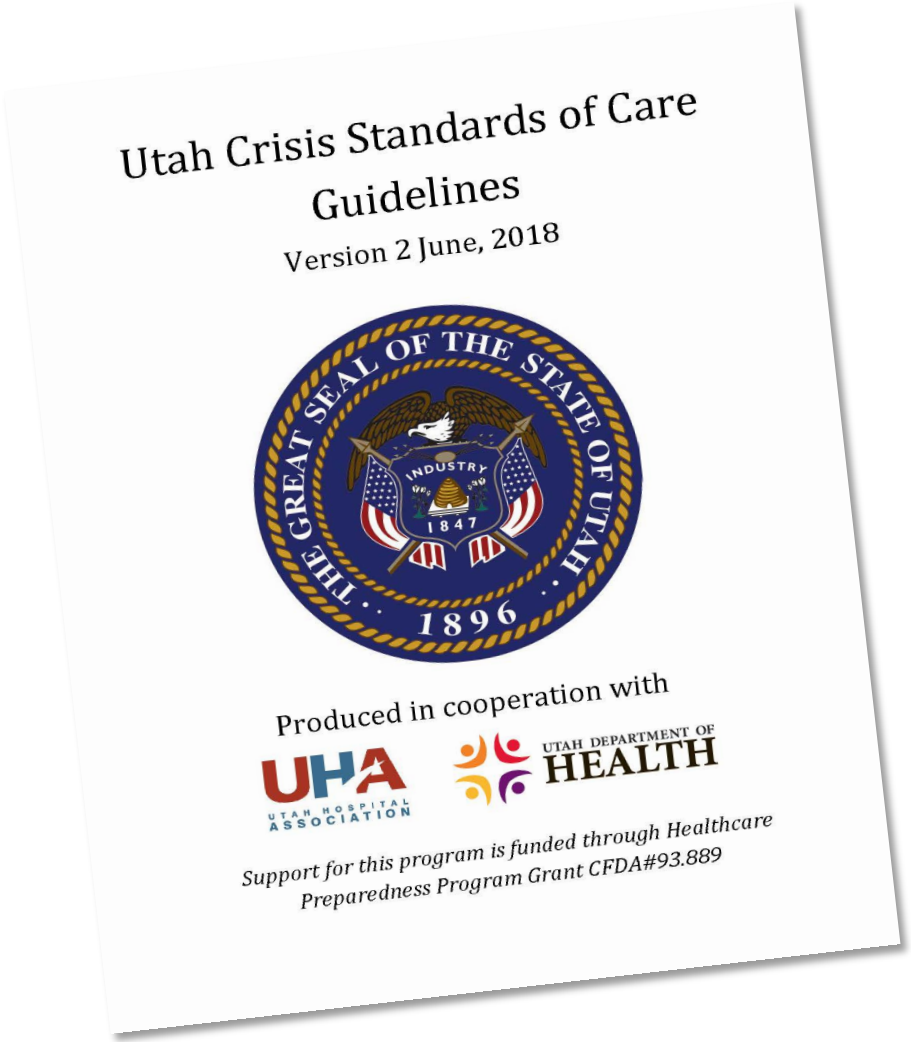
HEALTHIEST PEOPLE | OPTIMIZE MEDICAID | A GREAT ORGANIZATION

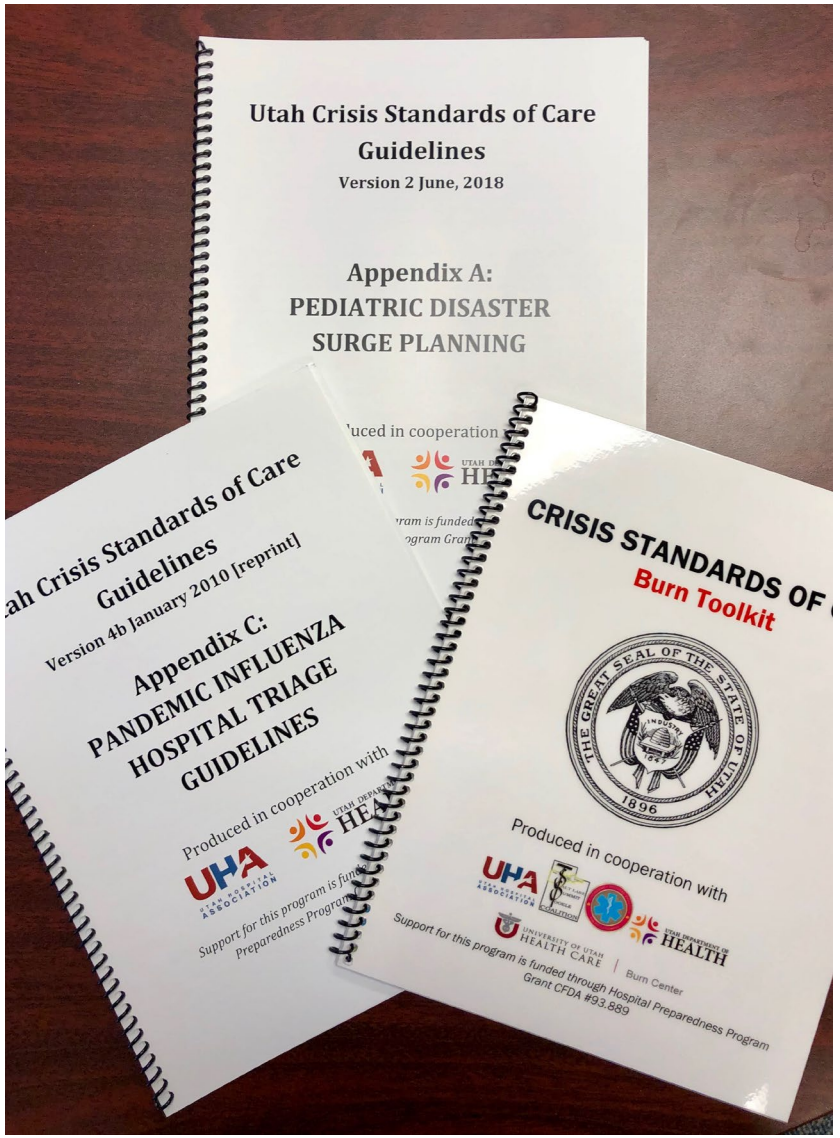
MISSION & VISION

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Our vision is for Utah to be a place where *all* people can enjoy the best health possible, where *all* can live and thrive in healthy and safe communities.

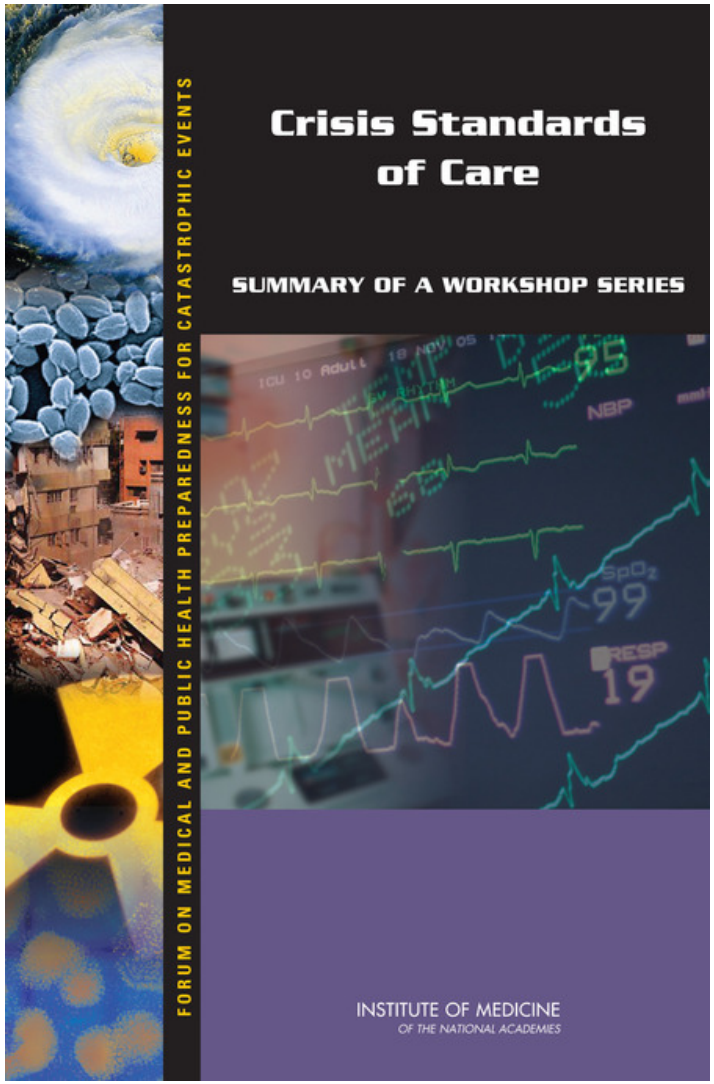
We Have the Plan – Now What?

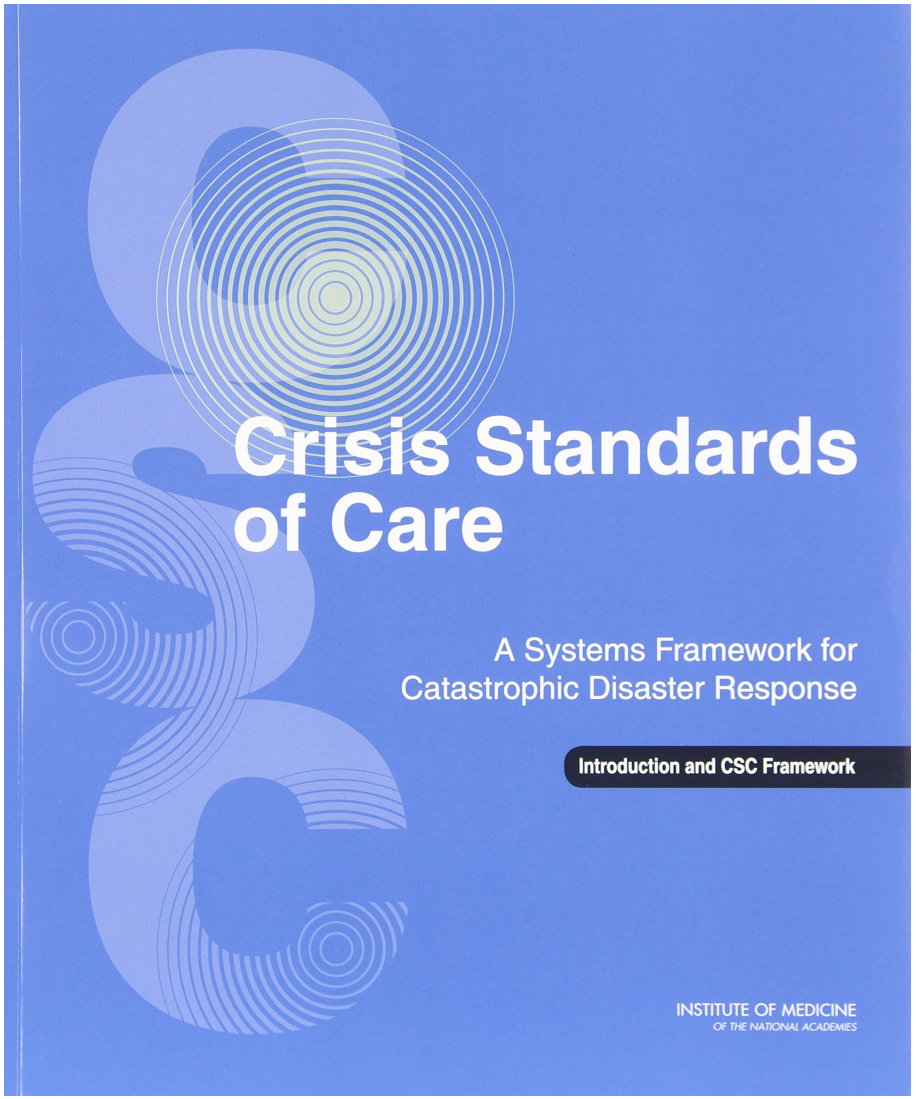




https://www.utahhospitals.org/education/item/29-disaster-preparedness-resources

We Have the Plan – Now What?





We Have the Plan – Now What?

Ground Truths from IOM's Work

- It is a forced choice based on a emerging situation (not optional)
- Often forced into CSC due to extraordinary events
  - Critical infrastructure compromise
  - Patient care areas damaged/unusable
  - Supply, medicine, beds in extended shortage
  - Staff shortage or losses
  - Mutual aid is not available (transfers out etc.)
- All efforts have been made to implement contingency strategies
- A change in focus is required from individual to population care
- Differs from Crisis Care (shorter duration, mutual aid available)
- Requires a formal declaration by state government to enact CSC
- Providers have a "Duty to Plan" for these extraordinary events

We Have the Plan – Now What?

Utah Pandemic Influenza Hospital and ICU Triage Guidelines for ADULTS

Prepared by UTAH HOSPITALS AND HEALTH SYSTEMS ASSOCIATION for the Utah Department of Health

Version 4b, January 28, 2010

Purpose:

These guidelines were developed by the Utah Hospitals and Health Systems Association (UHA) Triage Guidelines Workgroup. The purpose is to guide the allocation of patient care resources during an influenza pandemic or other public health emergency, when demand for services dramatically exceeds supply. **Application of these guidelines will require physician judgment at the point of patient care.**

Basic premises:

- **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- **Priority should be given to patients for whom treatment would most likely be lifesaving** and whose functional outcome would most likely improve with treatment. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.

Scope:

- **These triage guidelines apply to all healthcare professionals, clinics, and facilities in the state of Utah.**
- **The guidelines apply to all patients 14 years and older.** Please see *Hospital and ICU Triage Guidelines for Pediatrics* for patients 13 years and younger.

When activated:

Guidelines should be activated in the event of pandemic influenza or other public health emergency declared by the Governor of the State of Utah.

Hospital and medical staff planning:

- **Each hospital should:**
  - **Establish a peer-based structure** for the review of hospital admission, Intensive Care Unit (ICU) admission, and termination of life-sustaining treatment. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians.
  - **Institute an action team** to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.
- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

Contents:

Utah Pandemic Influenza Hospital and ICU Triage Guidelines for Pediatrics

Prepared by UTAH HOSPITALS AND HEALTH SYSTEMS ASSOCIATION for the Utah Department of Health

Version 4b, January 28, 2010

Purpose:

These guidelines were developed by the Utah Hospitals and Health Systems Association (UHA) Triage Guidelines Workgroup in conjunction with Primary Children's Medical Center. The purpose is to guide the allocation of patient care resources during an influenza pandemic or other public health emergency, when demand for services dramatically exceeds supply. **Application of these guidelines will require physician judgment at the point of patient care.**

Basic premises:

- **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- **Priority should be given to patients for whom treatment would most likely be lifesaving**. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.

Scope:

- **These triage guidelines apply to all healthcare professionals, clinics, and facilities in the state of Utah.**
- **The guidelines apply to all patients 13 years and younger.** Please see *Hospital and ICU Triage Guidelines for Adults* for patients 14 years and older.

When activated:

Guidelines should be activated in the event of pandemic influenza or other public health emergency declared by the Governor of the State of Utah.

Hospital and medical staff planning:

- **Each hospital should:**
  - **Establish a peer-based structure** for the review of hospital admission, Intensive Care Unit (ICU) admission, and termination of life-sustaining treatment. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians.
  - **Institute an action team** to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.
- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

Contents:

Malpractice Liability: In the 2007 legislative session, SB 153 (Malpractice Liability During Pandemic Event) was passed and incorporated into law (53-13-2.6, Utah code annotated 1953). This bill protects healthcare providers, including facilities, from malpractice liability when they respond to a natural disaster, pandemic event, or bioterrorism. Activities that are protected include:

- Implementing measures to control the causes of epidemic, pandemic, communicable diseases, or other conditions significantly affecting public health as necessary to protect the public health;
- Investigating, controlling, and treating suspected bioterrorism or disease in accordance with Title 26, Chapter 23b; or
- Responding to the following: a national, state or local emergency; a public health emergency as defined in Title 26, Chapter 23b, 102; or a declaration of the President of the United States or other federal official requesting public health related activities.

EMTALA: EMTALA provisions may be waived by the Secretary of Health Human Services during a declared public emergency and under the Stafford act. The Secretary can issue the Section 1135 Waiver to waive sanctions for the "transfer of an individual who has not stabilized for both transfers and redirection for a medical screening examination. Waivers are generally limited to a 72-hour period beginning upon implementation of a hospital disaster protocol, unless the Waiver arises out of a public health emergency involving a pandemic. If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.

UTAH DEPARTMENT OF HEALTH

We Have the Plan – Now What?

2012-2017

-HPP Guidance – Requesting State CSC Guidance, Indicators for CSC, Legal protections for providers and institutions, CSC Implementation, Management of scarce resources, CSC training

-Re-established workgroup from H1N1, under guidance from Dr. Mark Shah, with UHA (Jan Buttrey) and UDOH. UHA under contract to facilitate -Big/Small, Rural/urban, clinicians, CMO, healthcare EM, specialty care, EMS MD, palliative care, medical ethicist, AG rep

-Focused on base guidance – Ethical foundations, Legal foundations, Continuum strategies (contingency, crisis), Triage guidelines (inclusion/exclusion)

-More consideration for damaged infrastructure (labs, imaging, etc.)

We Have the Plan – Now What?

2016-2019

-2017 HPP – CSC continues in guidance, but includes Coalitions (integration of Core members, provider engagement, other items)

-Completion of Pediatric CSC Annex, under guidance of Dr. Hilary Hewes and Dr. Brad Poss (Primary Children's Hospital)

-Refinement of Burn CSC, establishment of Burn Care and Mass Casualty Course (BCMCC) – training EMS and providers on initial burn care, burn MCI, extended care strategies (96 hour plan), establishment of Western Region Burn Disaster Coalition.

-Deeper dive on specific elements of the CSC – Activation, Contingency Strategies, Patient Prioritization Tool, Crisis Triage Officer Team, Hospital Triage Guidelines

Rationing Care Rationally

Normal Standards – unlimited resources for the greatest good for each individual patient

Crisis Standards – allocation of limited resources for the good of the greatest number of patients

Rationing Care Rationally

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 acequately 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[a]

Normal operating conditions

Extreme operating conditions

Indicator: potential for crisis standards[b]

Trigger: crisis standards of care[c]

Institute of Medicine - Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations, 2009

Rationing Care Rationally

The goal of any hospital in a disaster or pandemic situation should be to remain in a state of **Contingency** care for as long as possible and avoid having to initiate Crisis Standards of Care.

The Crisis Standards of Care guidelines are to be implemented only when **numbers of seriously ill patients greatly surpass the capability of available care** capacity and normal standards of care can no longer be maintained.

Rationing Care Rationally

- Goal: Provide care to those that need it to survive
  - Don't provide care to those that will likely survive WITHOUT it
  - Don't provide care to those that will likely NOT survive WITH it
- Most important for limited resources
  - Critical Care (ventilators, providers, medications, equipment)
  - Surgical Care (OR space, providers, medications, equipment)
  - Oxygen
  - Hospital Care (space, providers, medications, equipment, water power)
- MUST be done ONLY when resources are limited
  - Not always obvious
- MUST be done in a ethical manner

Crisis Triage Officer

- Problem: How to develop and maintain competency in disaster strategies among providers, especially when these strategies are infrequently used?

- Solution: Focus the development and maintenance of competency on a few providers from each hospital.

Crisis Triage Officer

Crisis Triage Officer [Team]

-Development of CTOT, based on guidance from IOM CSC and Dr. Ken Iserson - https://www.ahls.org/hmadm/file/MDHD_Cases_and_Discussion_Questions.pdf?id=4809

-Senior clinician(s), not engaged in care, allocates limited and critical hospital resources to do the best for the most.

-Differs from EMS triage (transport sorting), CTO will determine access to ICU, ventilators, OR, etc.

-Identify cadre, provide training opportunities through Intermountain Center for Disaster Preparedness (ICDP) and https://crisisstandardsofcare.utah.edu/

Prioritizing Critical Care has Four Components

A. **Exclusion criteria**: Patients meet exclusion criteria when they have a very high risk of death or little likelihood of long-term survival, and a correspondingly low likelihood of benefit from critical care resources.

B. **Inclusion criteria**: These criteria attempt to identify patients who may more likely to benefit from admission to critical care.

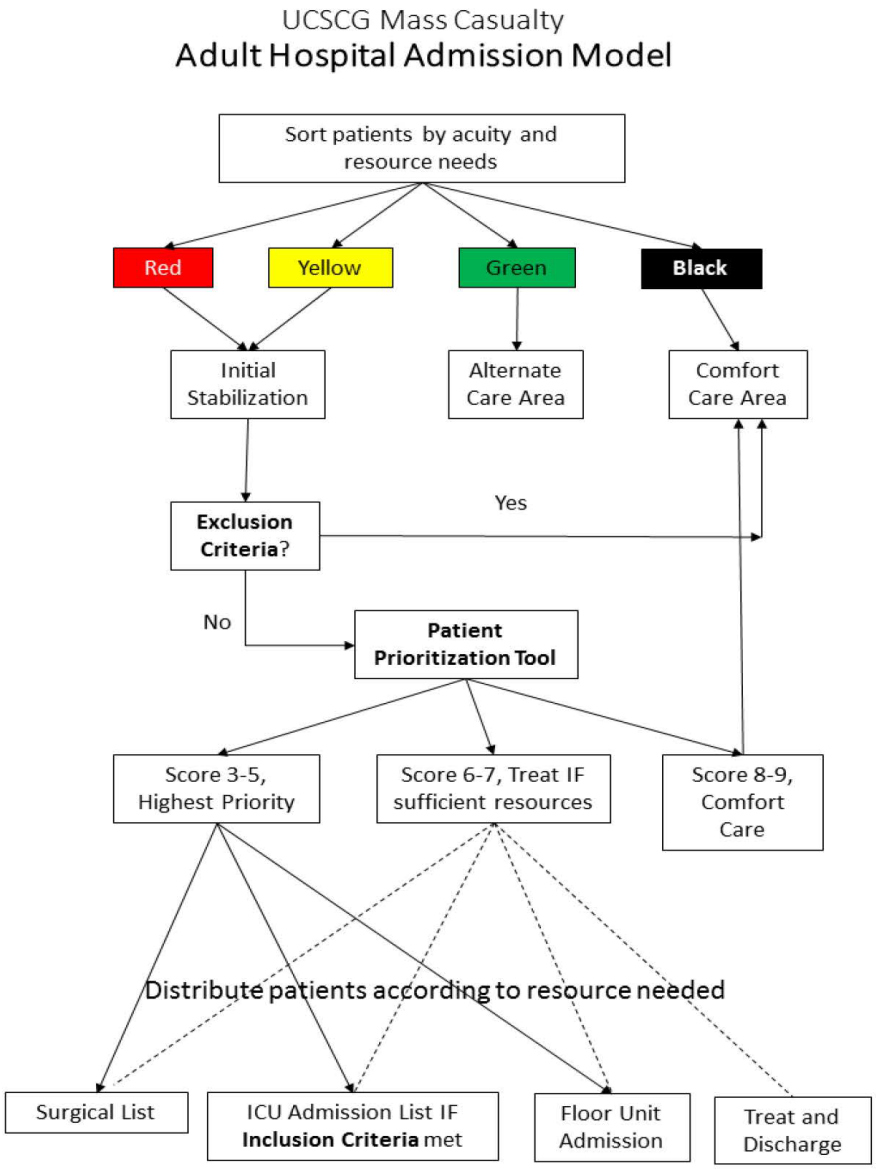
C. **A prioritization tool:** when there is still a greater demand for critical resources than the supply, the CTO will prioritize patients using the UCSC Patient Prioritization Tool.

D. **Criteria for withdrawal of critical care**: If a patient is doing worse and has a low likelihood of a good outcome, care is best reallocated to another patient. All patients receiving critical care resources should be reassessed at 48 and 120 hours.

UCSC Patient Prioritization Tool

Category	1 Point	2 Points	3 Points
AGE	Less than 30 years	30 to 60 Years	Greater than 60 years
ASA SCORE	Healthy	No functional impairment, mild systemic disease	Severe systemic disease with functional impairment
ESTIMATED SURVIVAL	Likely to survive (> 50% chance of survival)	Might Survive (10 -50% chance of survival)	Unlikely to survive (<10% chance of survival)
	Total the 3 categories = _____		
	Pregnancy Adjustment: Subtract one point if pregnant and less than 32 weeks gestation. Subtract 2 if pregnant and 32 weeks or more. Final Score = _____ If score 8 or 9, do not treat IF inadequate resources. Score 1-5 is highest priority. Score 6-7 are second priority IF resources allow.		

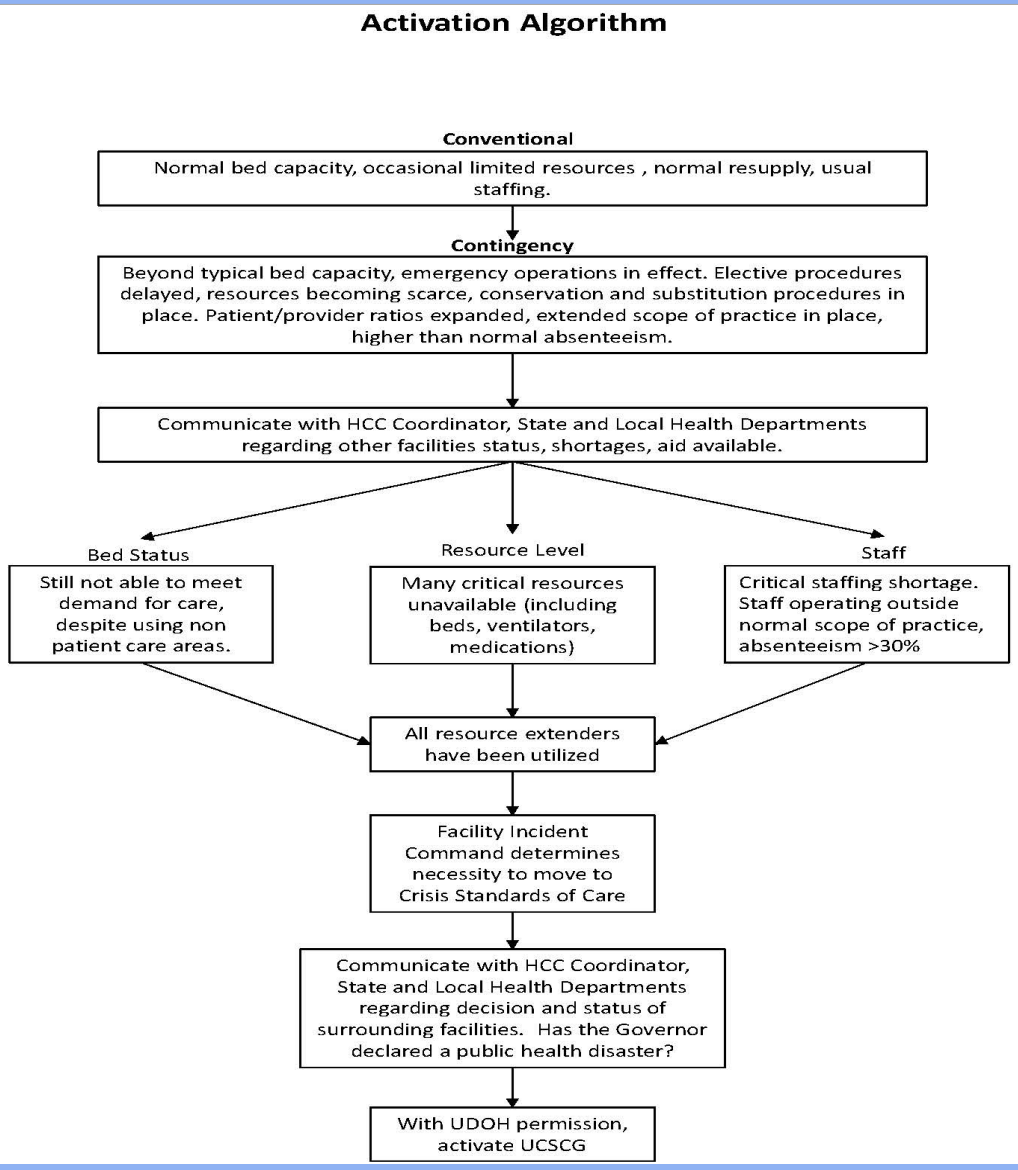
Hospital Triage Guidance



Pediatric Criteria for Withdrawal of Care

If a facility wishes to use a pediatric scoring system, the Pediatric Index of Mortality Score (PIM3) and/or the Pediatric Risk of Mortality score (PRISM III) may be used for patients 14 and under **but ultimate decisions should be based on physician judgement and/or PICU physician consultation**.

We Have the Plan – Now What?



We Have the Plan – Now What?

Contingency Care Strategies

-Patient movement in facility
-Early discharge or transfer to LTC/SNF or home
-Expand patient care areas
-Rapid admission
-Prioritization of procedures and surgeries
-Expanded staff roles/ staff extension
-Open family support centers
-Preserve oxygen capacity
-Alternate care sites
-Conserve, adapt, reuse, substitute
-Leveraging Regional Coalition for mutual aid (space, supplies, staff)

-Minnesota - https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf

We Have the Plan – Now What?

Healthcare Coalition Roles

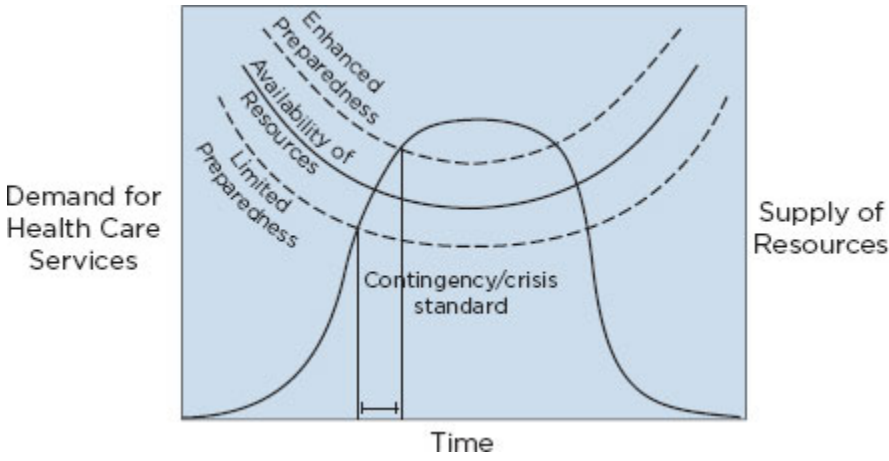
-Integrate CSC into response plans

-Expand mutual aid and contingency strategies for defined geographic areas

-Support indicators, triggers, and actions for CSC, including liaison with state

-Integrate CSC into exercises

-Leverage Clinical Advisor



We Have the Plan – Now What?

EMS CSC

-Refine state EMS MCI template to include CSC and Regional Coalitions

-Expand role of EMS in supporting hospitals after transports are done

-Consider non-transport and leave at scene discretion

Special Update – MPDS® v12.1

Once Officially Enacted… Special Procedures Briefing

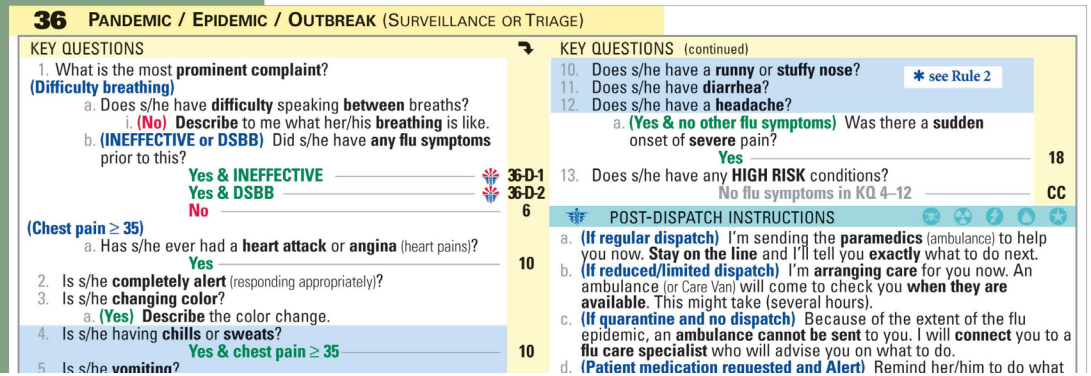
Protocol 36:
Pandemic/Epidemic/Outbreak
(Surveillance or Triage)

The International Academies of Emergency Dispatch® (IAED) has developed Protocol 36: Pandemic/Epidemic/Outbreak (Surveillance or Triage), for managing EMD triage and locally limiting EMS responses in the event of an official pandemic flu outbreak, or for use as a flu surveillance tool to track flu symptoms without changing the EMS response. This protocol exists in both card format and in the computerized ProQA® program.

Because Protocol 36 may **change EMS responses to certain patients,** it must be implemented with a complete understanding of its use and underlying dispatch objectives. Since Protocol 36 is not used during normal (non-outbreak) operations, it requires advanced planning and setup, with "just-in-time" training and orientation for EMDs, as well as for EMS administrators and responders.

This **Special Procedures Briefing** is designed to give you the information needed to implement at dispatch, correctly triage, and set up potentially decreasing response levels to possible flu patients during an **officially declared flu outbreak.**

Protocol 36 will help manage suspected flu patients in a manner that utilizes scarce EMS, hospital, and community health care resources effec-



36 PANDEMIC / EPIDEMIC / OUTBREAK (SURVEILLANCE OR TRIAGE)

KEY QUESTIONS

1. What is the most **prominent complaint?**
(Difficulty breathing)
a. Does s/he have **difficulty** speaking **between** breaths?
i. **(No) Describe** to me what her/his **breathing** is like.
b. **(INEFFECTIVE or DSBB)** Did s/he have **any flu symptoms** prior to this?
Yes & INEFFECTIVE — 36-D-1
Yes & DSBB — 36-D-2
No — 6
(Chest pain ≥ 35)
a. Has s/he ever had a **heart attack** or **angina** (heart pains)?
Yes — 10
2. Is s/he **completely alert** (responding appropriately)?
3. Is s/he **changing color?**
a. **(Yes) Describe** the color change.
4. Is s/he having **chills** or **sweats?**
Yes & chest pain ≥ 35 — 10
5. Is s/he **vomiting?**

KEY QUESTIONS (continued)

10. Does s/he have a **runny** or **stuffy nose?** ✱ see Rule 2
11. Does s/he have **diarrhea?**
12. Does s/he have a **headache?**
a. **(Yes & no other flu symptoms)** Was there a **sudden** onset of **severe** pain?
Yes — 18
13. Does s/he have any **HIGH RISK** conditions?
No flu symptoms in KQ 4–12 — CC

POST-DISPATCH INSTRUCTIONS

a. **(If regular dispatch)** I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.
b. **(If reduced/limited dispatch)** I'm **arranging care** for you now. An ambulance (or Care Van) will come to check you **when they are available.** This might take (several hours).
c. **(If quarantine and no dispatch)** Because of the extent of the flu epidemic, an **ambulance cannot be sent** to you. I will **connect** you to a **flu care specialist** who will advise you on what to do.
d. **(Patient medication requested and Alert)** Remind her/him to do what

We Have the Plan – Now What?

Community and Provider Engagement

Exploring Legal Environment

Building Utah Health Emergency Response Team (UHERT) as additional contingency strategy

Ped CSC refinement of family reunification

Annual CSC updates

Refinement of interstate coalitions for patient movement

Explore expansion of telemedicine/telecritical care

Renew efforts for alternate care locations

THANK YOU!

Kevin McCulley, Program Manager
kmcculley@utah.gov

Mark Shah, MD FACEP
markbshah@gmail.com

crisisstandardsofcare.utah.edu/
bemsp.utah.gov/

Utah Hospital Association – Disaster Preparedness Resources
Facebook – Intermountain Center for Disaster Preparedness