

COVID-19: Crisis Standards of Care — Resources for California Hospitals

Frequently Asked Questions

WHAT IS CRISIS CARE?

According to the state's [Crisis Care Guidelines](#), crisis care is: "[d]isaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances."

Crisis care occurs when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population that can be offered under the circumstances. As the state's Guidelines recognize, "Hospitals will not have an option to defer caring for patients in a crisis. Demand, guided by ethics, will drive the choices that have to be made."

HOW IS CRISIS CARE DIFFERENT FROM THE CARE HOSPITALS USUALLY PROVIDE?

Crisis care is not a separate triage plan but is a part of the care continuum. It is an extension of a hospital's surge-capacity plan, which addresses the ability to manage a sudden influx of patients, and its surge capability — the ability to manage patients requiring very specialized medical care. During conventional care, customary routine services are provided through standard operating procedures. During contingency care, the care provided is functionally equivalent to routine care but equipment, medications, and even staff may be used for different purposes or in a different manner than typical daily use. Crisis care falls at the far end of the spectrum, when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population.

WHO DECIDES WHEN CRISIS CARE IS IN EFFECT AND HOW IT SHOULD BE IMPLEMENTED?

The decision that medical surge requires the implementation of crisis care, and the steps and actions that should be taken in response, rests at the hospital/system level, based on the particular environment, hazards, and resources available and the hospital's own allocation framework. A hospital should not delay implementing crisis care when its own situation warrants it even if a declaration has not yet been made at the state, regional, or local level. But hospitals should be supported by regional Health Care Coalitions, their Medical and Health Operational Area Coordinator (MHOAC) Regional Disaster Medical and Health Specialist (RDMHS), the California Department of Public Health (CDPH), the Emergency Medical System Authority (EMSA), and public safety partners, local EMSA, state and local government agencies, and their parent health system (if applicable).

A hospital should not work on surge and crisis care plans in isolation, but in concert with local and regional partners, public health, the MHOAC, and its parent health system (if applicable). Consistency of plans and knowing what other health care facilities in the region are planning are critical to success. Hospitals' surge strategies and standard procedures do not have to be identical, but similarity among them will help greatly in education, training, and mutual aid response.

WHEN IS CRISIS CARE IMPLEMENTED?

When an incident or circumstances such as a pandemic continue to overwhelm the health care system after initial stabilization and delivery of resources, decision-making must turn to whether resources can continue to be expended given the patient prognosis and availability of resources — in other words, triaging (prioritizing) the

COVID-19: Crisis Standards of Care — Resources for California Hospitals

limited care or resources available among the patients for whom it would be appropriate. The conditions to engage in such proactive triage are:

- Critically limited resource(s) and infrastructure are identified.
- Surge capacity is fully employed within health care facilities (and regionally) if capacity/space is the limited resource.
- Maximum efforts to conserve, substitute, adapt, and re-use are insufficient if supplies are the limited resource.
- Patient transfer or resource importation is not possible or will occur too late for bridging therapies (such as bag-valve ventilation or other temporizing measures) to be considered.
- Necessary resources have been requested from local and regional health officials (as applicable).
- A state of emergency has been declared, or other health powers (as applicable) have been activated.
- Regional, state, and federal resources are insufficient or cannot meet demand.

The key is to implement crisis strategies only when assistance from regional and state partners is inadequate (too little or too late), and no “bridging” therapies or patient transfers can address the need.

HOW DOES MEDICAL DECISION-MAKING FOR PATIENTS CHANGE WHEN CRISIS CARE IS IMPLEMENTED?

In customary circumstances, clinical care is focused on the individual patient, and treatment decisions are made by the patient’s care team (subject to the patient’s/representative’s consent and decision-making rights). A public health emergency compels transition from this individual patient-focused clinical care to a population-oriented public health approach with the goal of providing the best possible outcome for the largest number of impacted people. In such emergencies, it is recommended that decisions to allocate and reallocate scarce health care resources be made by a triage team or committee composed of people who have no clinical responsibilities for the patient’s care. This separation of the triage role from the clinical role is intended to enhance objectivity, avoid conflicts of commitment, and minimize psychological and moral distress for caregivers.

HOW DO WE ENSURE THAT SCARCE MEDICAL RESOURCES WILL BE ALLOCATED FAIRLY WHEN CRISIS STANDARDS OF CARE ARE BEING USED?

Basic biomedical ethical principles are incorporated into decision-making about allocation of health care resources. In general, triage decisions must meet the following basic requirements:

- **Fair and Equitable:** Process recognized as fair, equitable, evidence based, and responsive to specific needs of individuals and the population; focused on a duty of compassion and care, a duty to steward resources, a duty to abide by nondiscrimination laws, and a goal of maintaining the trust of patients and the community
- **Transparent:** In both design and decision-making
- **Consistent:** In application across populations and among individuals with reasonable modifications for disability
- **Proportional:** Public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources (i.e., the restrictions on care should not be more restrictive than the situation requires – and this may require re-evaluation as more resources become available).

COVID-19: Crisis Standards of Care — Resources for California Hospitals

- **Accountable:** Individuals making the decisions, as well as the facilities and governments that support the processes and the providers

Consideration of the certain patient characteristics in allocating scarce resources is prohibited by law. Health care decisions, including allocation of scarce resources, cannot be based on age, race, disability (including weight-related disabilities and chronic medical conditions), gender, sexual orientation, gender identity, ethnicity (including national origin and language spoken), ability to pay, weight/size, socioeconomic status, insurance status, perceived self-worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources.

Ethical Principles

The ethical principles used to triage and allocate scarce resources include:

- Duty to implement distributive justice (a socially-just allocation of goods)
- Duty to care: treat people with dignity and respect and make decisions according to an individualized assessment based on objective medical evidence.
- Duty to plan: steward resources and promote instrumental value.
- Duty to transparency (in planning and implementation)

Goals of Pandemic Planning Allocation Framework

Any pandemic planning framework should be designed to ensure:

- Meaningful access for all patients. All patients who are eligible for ICU services during ordinary circumstances remain eligible, and there are no exclusion criteria based on age, disabilities, or other prohibited considerations listed above.
- Individualized assessments for all patients by clinicians, based on the best available objective medical evidence
- No one is denied care based on stereotypes, assessments of quality of life, or judgments about a person's "worth" based on the presence or absence of disabilities or other factors, including those listed in the prohibited considerations above
- A diminished impact of social inequalities that negatively impact patients' long-term life expectancy by keeping in mind historic disparities and inequalities

WHO SHOULD MAKE DECISIONS ABOUT ALLOCATING SCARCE RESOURCES?

Decisions to allocate and reallocate scarce health care resources should be made by a triage team or committee composed of people who have no clinical responsibilities for the patient's care in order to, among other things, enhance objectivity and avoid conflicts of commitment on the part of caregivers.