Evolving Crisis Standards of Care: A Workshop Series

CSC: The First Ten Years

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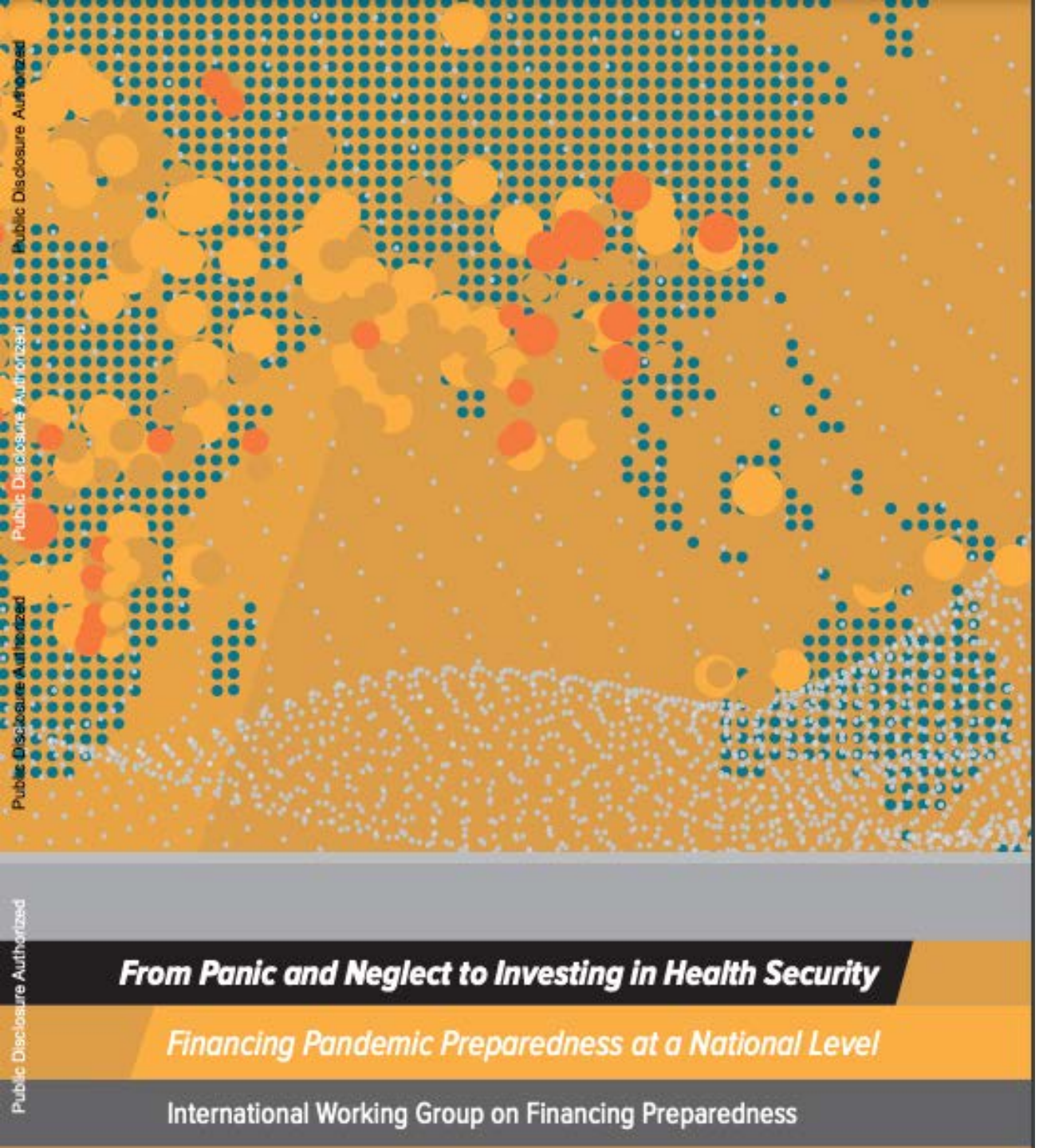
September 27, 2021



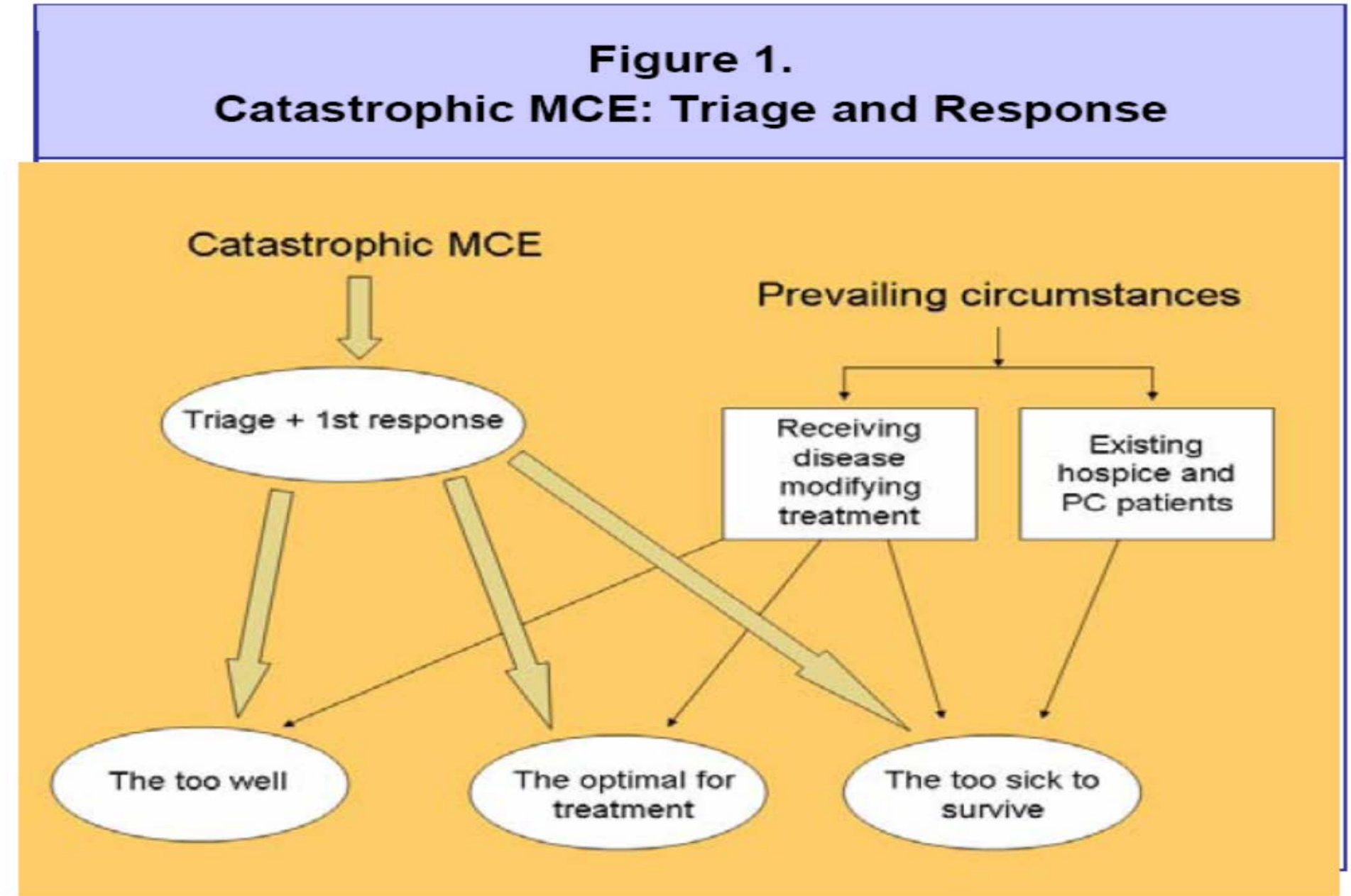
Multiple pandemics, numerous outbreaks, thousands of lives lost and billions of dollars of national income wiped out—all since the turn of this century, in barely 17 years—and yet the world's investments in pandemic preparedness and response remain woefully inadequate.

World Bank, Washington, DC, 2017

A Decade of Disasters

H1N1 Fall 2009	Haiti Earthquake Jan 2010	Joplin, MO Tornado May 2011	NY/NJ Superstorm Sandy Sept 2012	West Africa Ebola 2014/15	Houston, TX Hurricane Harvey August 2017	Puerto Rico Hurricane Maria September 2017	California Wildfires 2018

Presented at the November 2019 CSC Ten Year Workshop



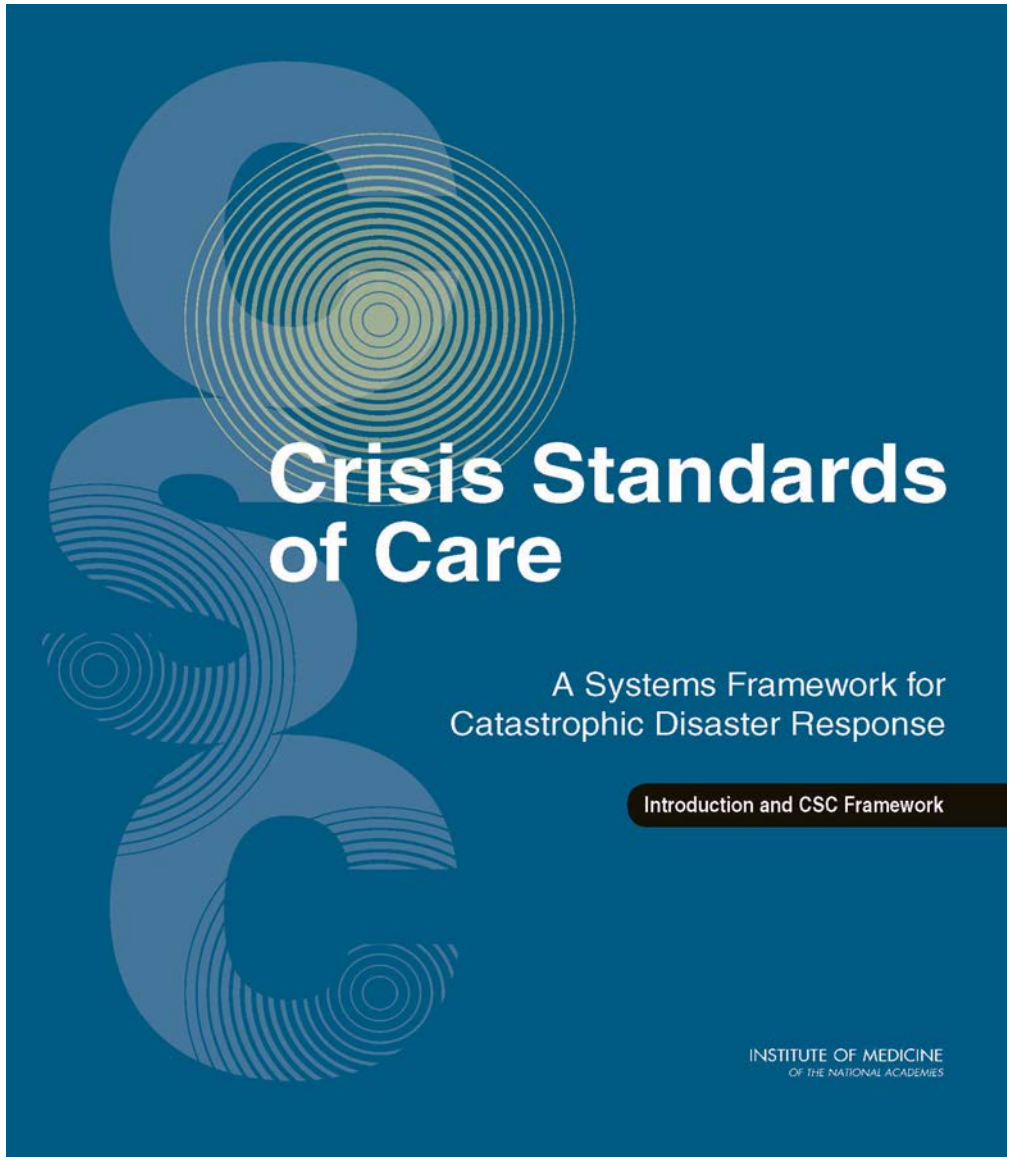
http://www.ahrq.gov/research/altstand, 2007

Source: Dreamstime stock photos

1. Who will receive care when not all can be treated?
2. How should limited resources be applied to managing the requirements of a catastrophic event when the health system will be unable to care for all?
3. How will clinicians make decisions related to the delivery of medical care?
4. Should the standard of care change when healthcare has to be delivered under catastrophic circumstances?

Crisis Standards of Care

A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster.



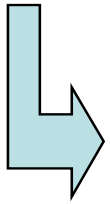
2009 – Establishing Guidance for Standards of Care in Disaster Situations – Letter Report

2012 – A Systems Framework for Catastrophic Disaster Response

2013 – Indicators and Triggers Toolkit

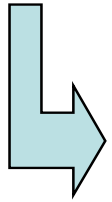
Surge Capacity Planning

‘Conventional’ Surge Capacity



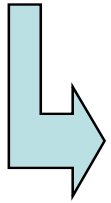
‘Conventional’ Standard of Care

‘Contingency’ Surge Capacity



‘Contingency’ Standard of Care

‘Crisis’ Surge Capacity



‘Crisis’ Standard of Care

Hick JL, et. al, Refining Surge Capacity: *Disaster Med and Pub Health Prep*. 2009; 3 (Suppl 1): S1-S9).
Hanfling D, Institute of Medicine, Altered Standards of Care, Regional presentations, Spring 2009.

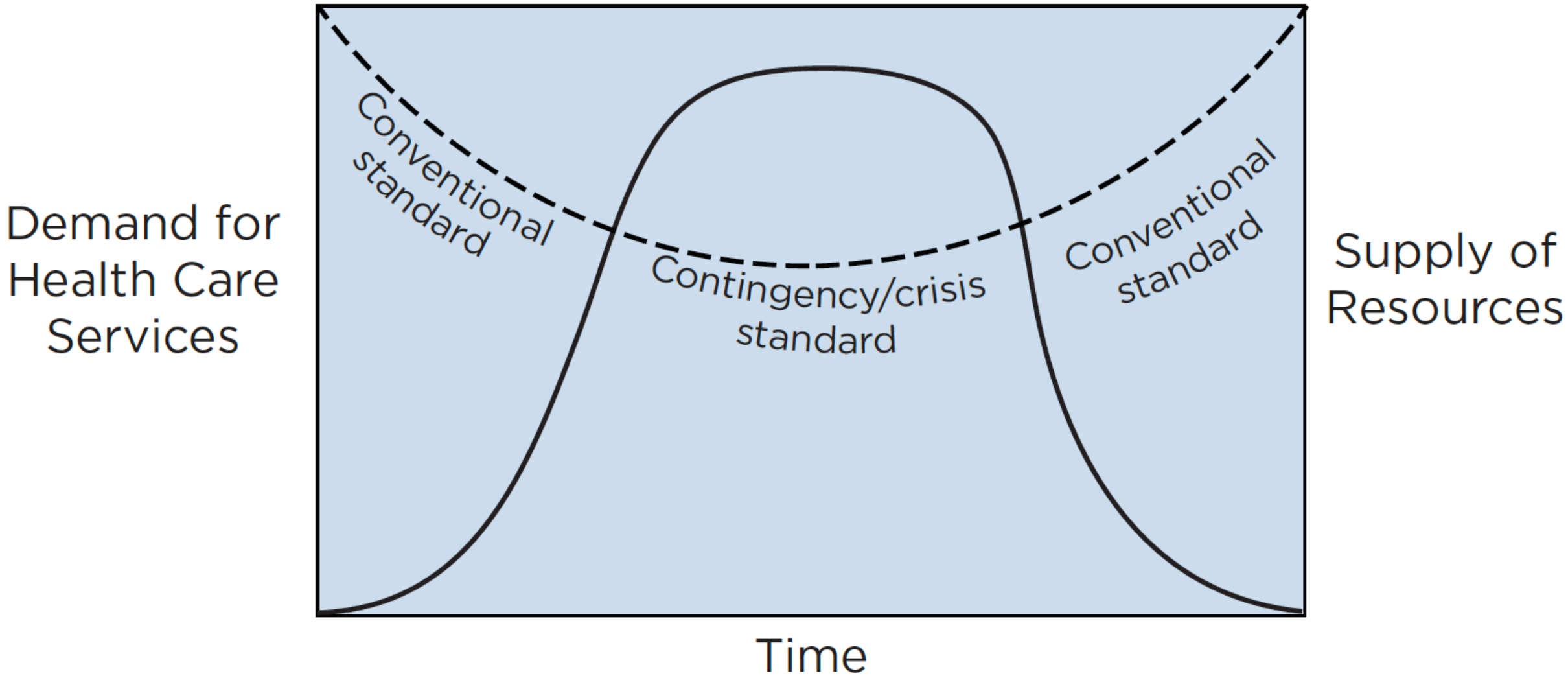


FIGURE 2-3
Demand for health care services and supply of resources as a function of time after disaster onset.

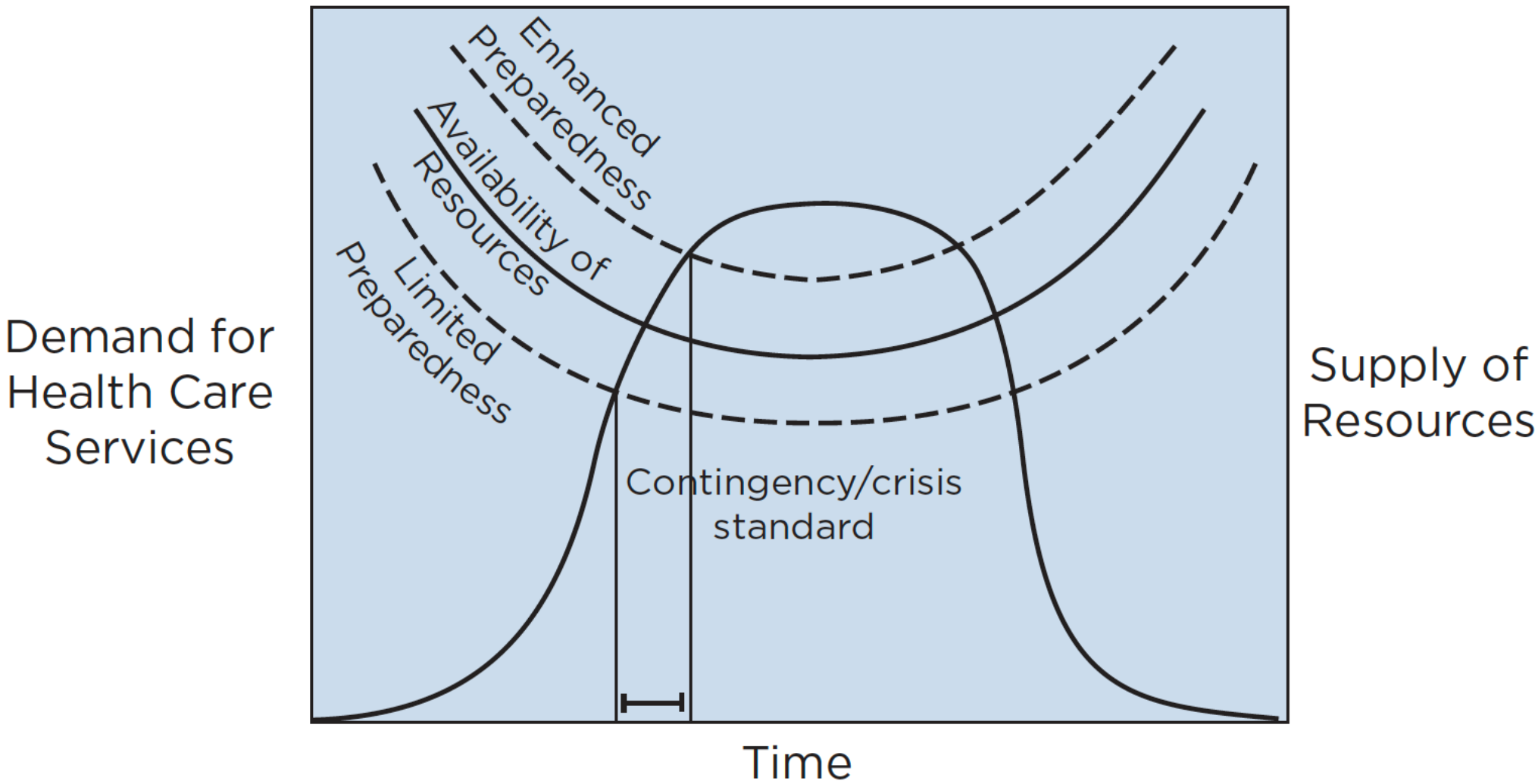


FIGURE 2-4
Demand for health care services and supply of resources as a function of time after disaster onset, taking into account care capacity as a function of time.

Review Article

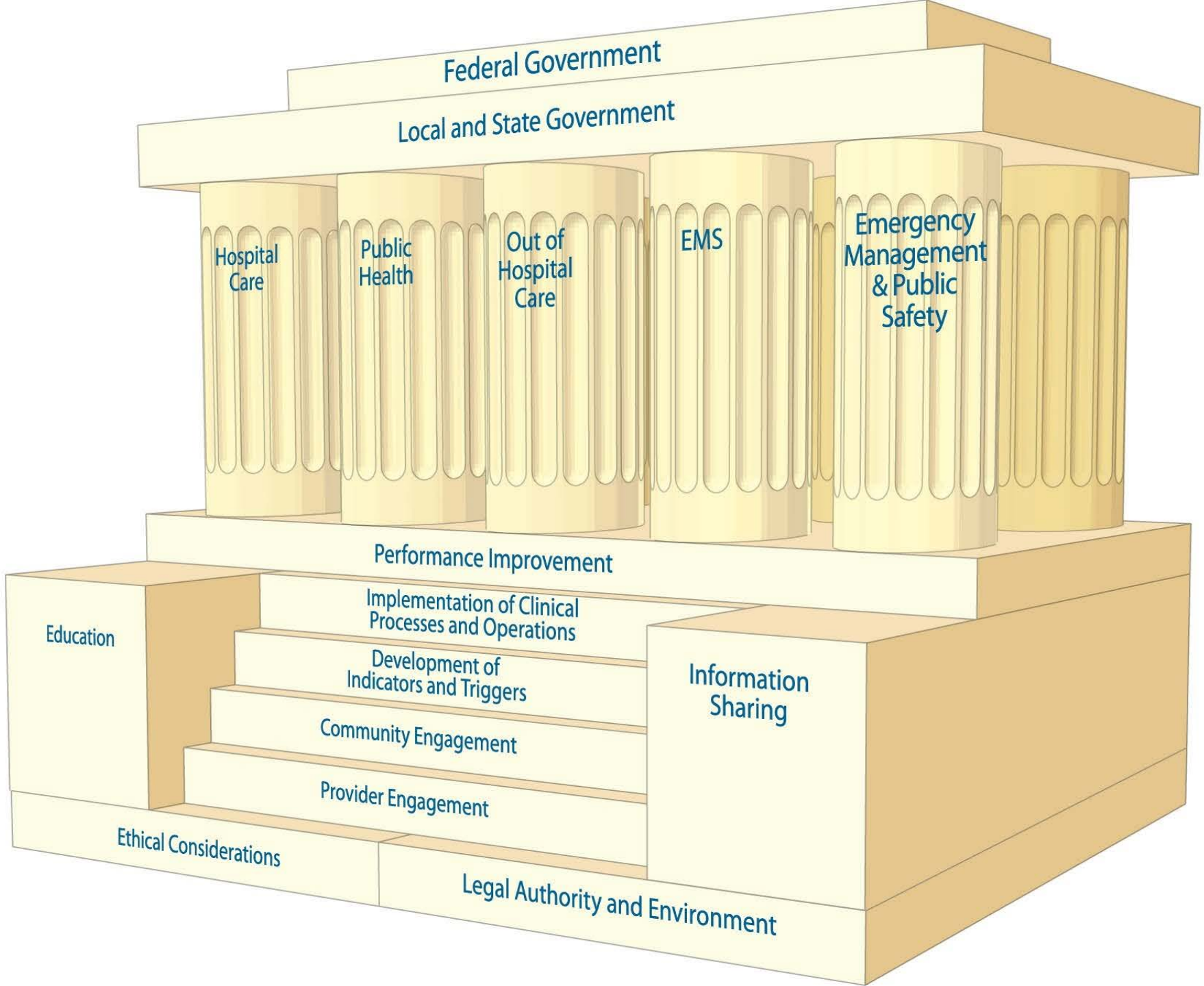
When the Bells Toll: Engaging Healthcare Providers in Catastrophic Disaster Response Planning

Dan Hanfling, MD

Abstract: Catastrophic disaster planning and response have been impeded by the inability to better coordinate the many components of the emergency response system. Healthcare providers in particular have remained on the periphery of such planning because of a variety of real or perceived barriers. Although hospitals and healthcare systems have worked successfully to develop surge capacity and capability, less successful have been the attempts to inculcate such planning in the private practice medical community. Implementation of a systems approach to catastrophic disaster planning that incorporates healthcare provider participation and engagement as one of the first steps toward such efforts will be of significant importance in ensuring that a comprehensive and successful emergency response will ensue

due to severe resource limitations. Emergency departments, ICUs and operating rooms are completely filled. School auditoriums and tents put up in parking lots are used to manage the overflow of patients. Communications, power supplies and the transportation infrastructure are all severely affected.[1]

Could such an event occur? As healthcare professionals, would we know how to respond? Would we be able to prioritize the delivery of lifesaving medical care to the thousands or tens of thousands of patients whose lives depended on our making the correct decision? The answers to these and other related questions must be an unequivocal "yes." The public,


Federal Government
Local and State Government
Hospital Care
Public Health
Out of Hospital Care
EMS
Emergency Management & Public Safety
Performance Improvement
Education
Implementation of Clinical Processes and Operations
Development of Indicators and Triggers
Community Engagement
Provider Engagement
Information Sharing
Ethical Considerations
Legal Authority and Environment

Where Do Things Stand with CSC in 2021?

WHAT WORKED

- The requirement for ‘catastrophic health emergency’ planning was completely validated (“not if, but when”)
- The “systems framework” (with core recommendations) is as solid as ever
- The nomenclature reflects the framework and is largely correct in its description and focus
- The 2009 Letter Report recommendations hold forth.

WHAT DIDN’T

- Dysfunctional government at multiple levels
- “Panic-Neglect” – limited ability to galvanize interest and participation in broadscale planning; limits to engagement (provider; community; political)
- Anticipating the effects of systemic racism in healthcare delivery
- Recognizing the importance of “reciprocity” in meeting the ethical principle of “accountability
- Absence of decision support tools to assist in clinical decision-making

CSC: At an Inflection Point

- Ethical Framework in the midst of a national crisis bears some re-consideration
  - accountability; reciprocity
  - ADI/SVI appropriate for planning, not for response
- Investment in capabilities more important than ever (diagnostics, therapeutics, data analytics → situational awareness)
- Community engagement more important than ever (engage the vaccine hesitators)

Thank you

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