CRISIS STANDARDS OF CARE

Real World vs. Theory

Presented by:

EMERGENCY MANAGEMENT PROFESSIONALS

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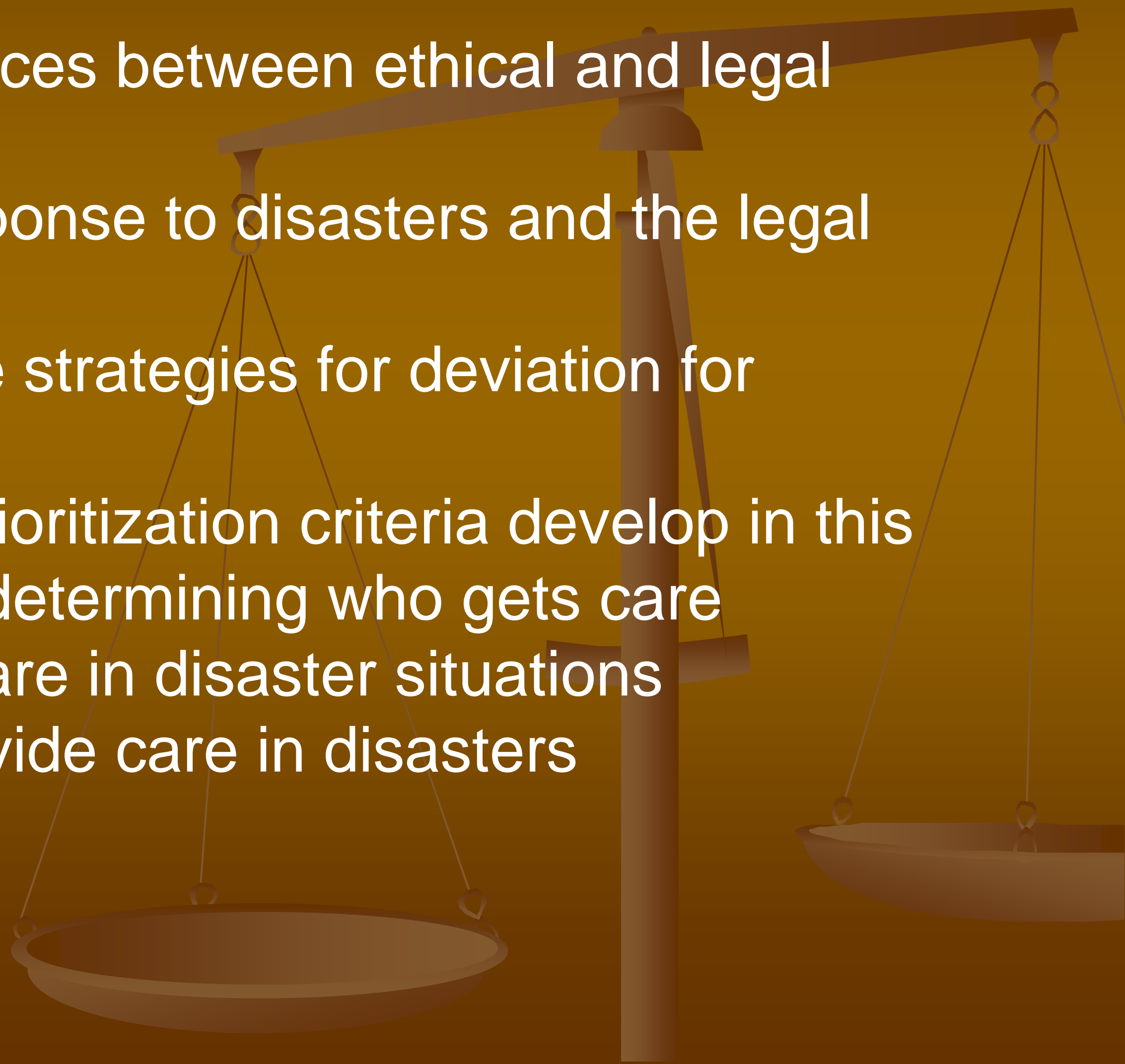
OBJECTIVES

- Discuss the differences between ethical and legal issues in disasters
- Review historic response to disasters and the legal issues created
- Discuss acceptable strategies for deviation for “standard of care”
- Examine existing prioritization criteria develop in this country relative to determining who gets care
- Discuss palliative care in disaster situations
- Discuss duty of provide care in disasters



LEGAL AND ETHICAL PRACTICES IN DISASTERS

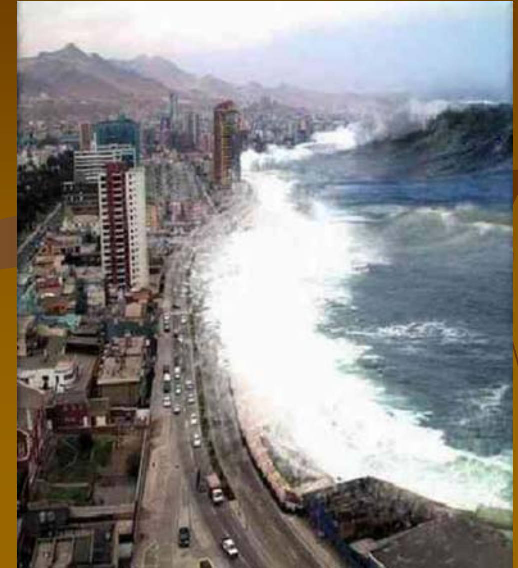
- How do our standards of practice change during disasters?
- When do they change – triggers and indicators
- How do ethics affect our decision making processes in disasters?

AMA Code of Ethics
1847 - 1977
". . . In regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is [physicians'] duty to face the danger . . . even at the jeopardy of their own lives."

THE CHANGING FACE OF DISASTER MANAGEMENT

- The new terrorism
- Shrinking, interdependent world
- Larger urban environments
- Potential for wide spread infectious and emerging diseases

NATURAL DISASTERS



- Large scale natural disasters and climate changes
- Floods, droughts
- Fires (California fires of 1970's)
- Hurricanes

KATRINA

- Over 1500 dead
- 1700 patients left in hospitals, 245 died
- Over 55,000 people had to be rescued
- Over 250,000 evacuees
- 26,000 evacuees in Superdome, 15,000 at Convention Center, 8,000 stranded in streets
- 92,000 square miles of devastation

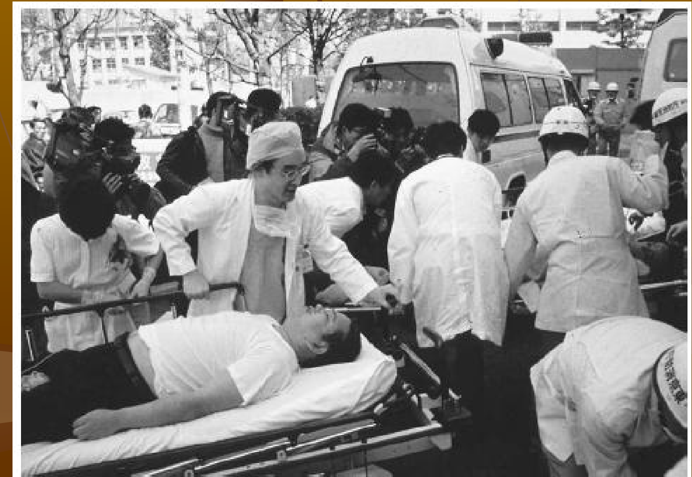
Never Again?

DISASTER ASSUMPTIONS

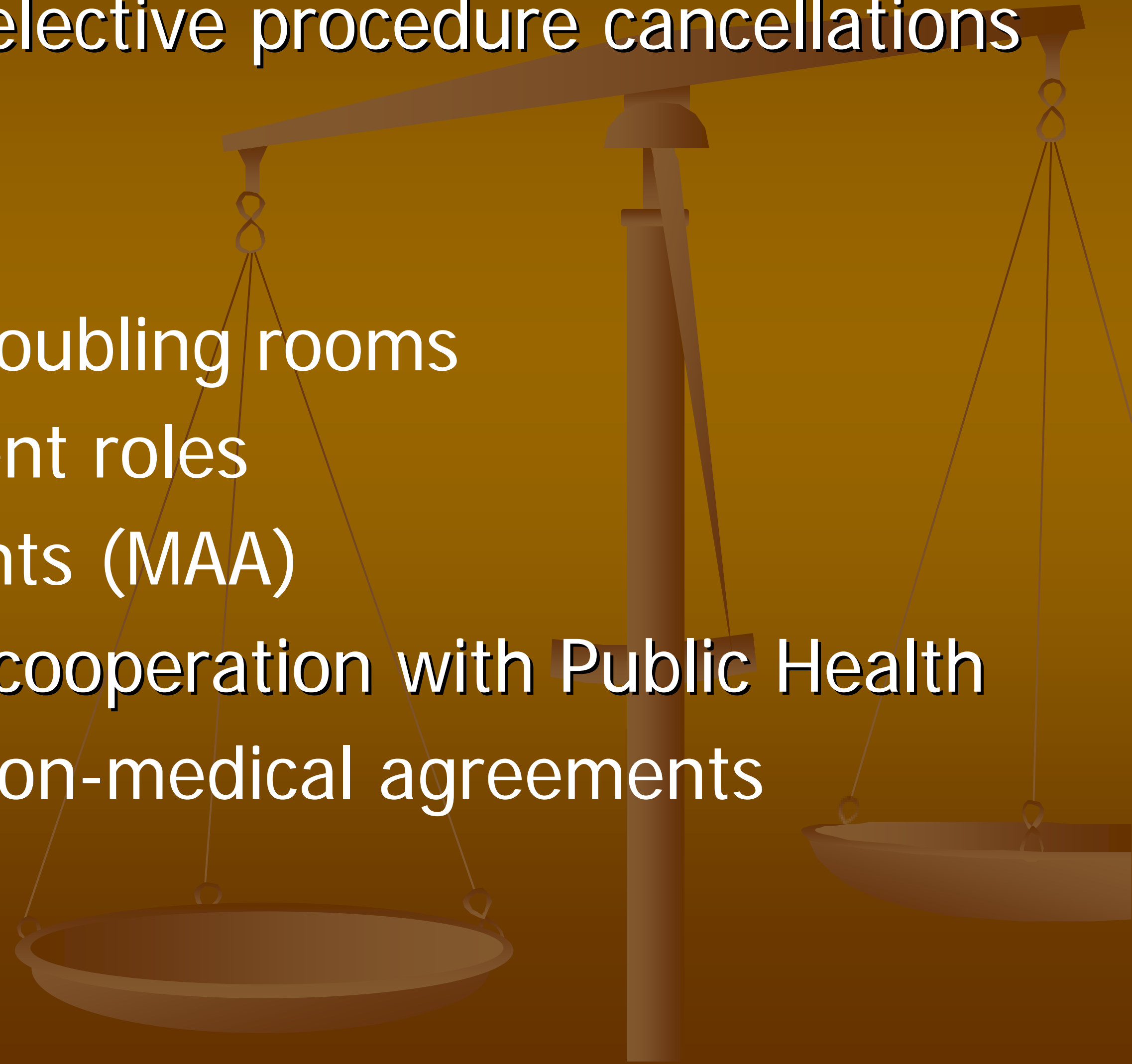
- Emergency Departments already at capacity levels
- Federal government will not be able to help immediately
- Decisions will be made at the local level
- Resources will be overwhelmed or unavailable
- Despite all our planning, situations will arise that are not anticipated

Deviating for the Norm - Acceptable Exceptions

- Granting of extraordinary powers (MSEPA)
- Disaster Declarations (Emergency, State or Presidential)
- EMTALA/HIPAA deviation
- Ability to extend healthcare facilities
- Waiver of licensure via EMAC's/ESAR-VHP
- Just in Time Training
- EUA's



EXPANDING CARE STRATEGIES



- Early discharge and elective procedure cancellations
- Medical Surge Plans
- Patient to staff ratios
- Cohorting patients/Doubling rooms
- Use of staff in different roles
- Mutual Aid Agreements (MAA)
- Home based care in cooperation with Public Health
- Expanding medical/non-medical agreements

- "Crisis standards of care" is defined as 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.

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

Conventional to Crisis Care

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 repurposed (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 reuse of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[a]

Usual operating conditions

Indicator: potential for crisis standards[b]

Trigger: crisis standards of care[c]

Austere operating conditions

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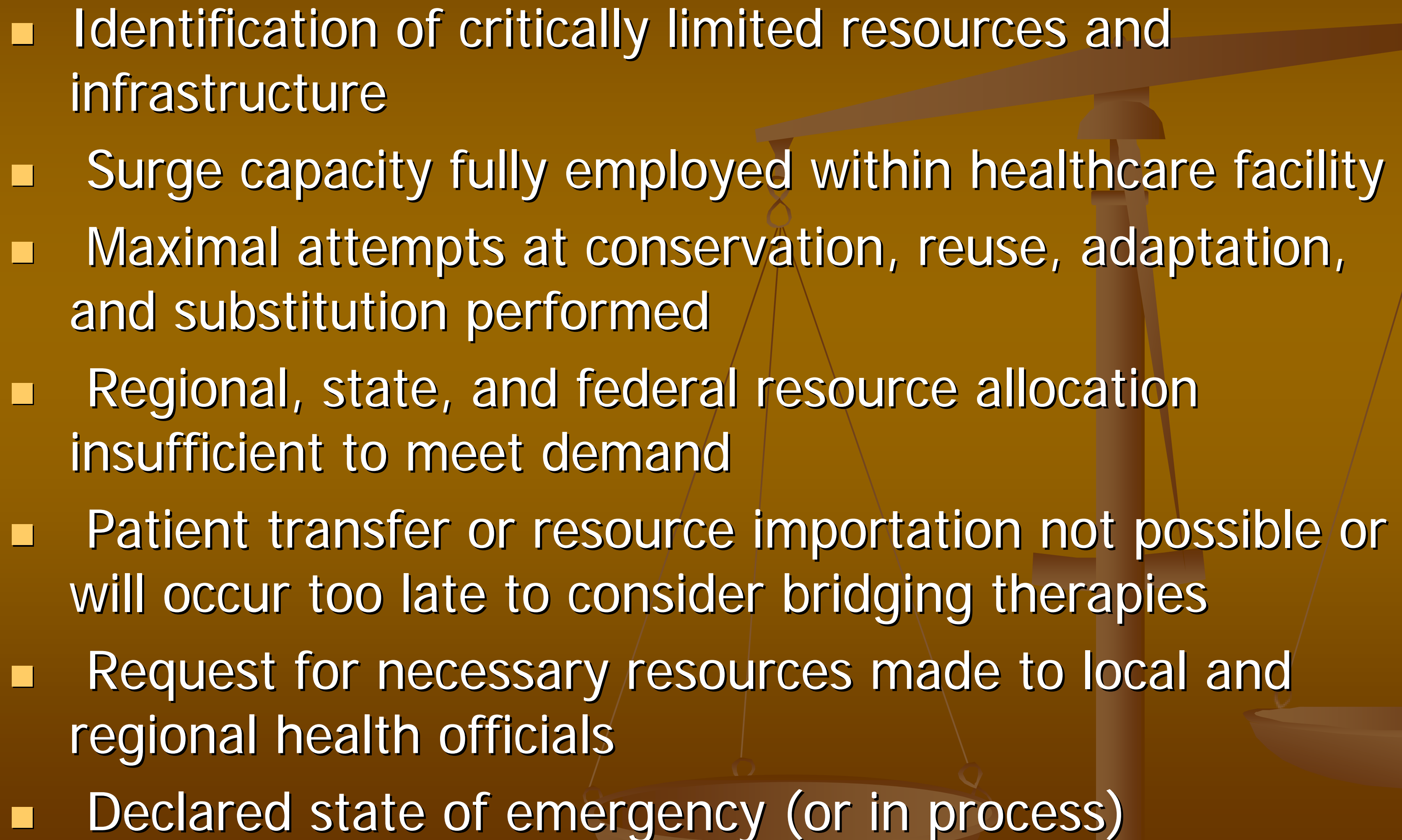
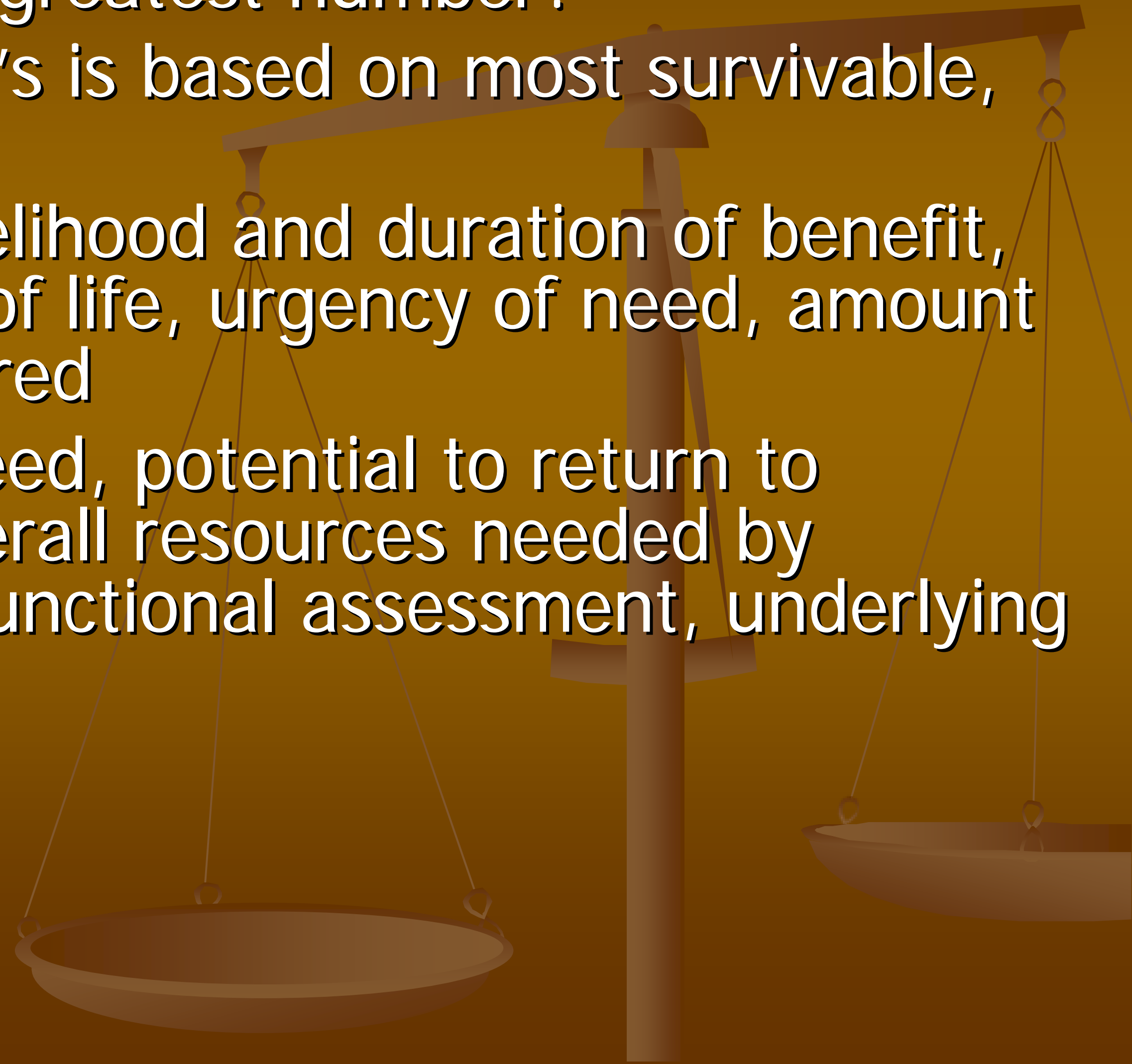
Crisis Standards of Care Implementation Criteria



- Identification of critically limited resources and infrastructure
- Surge capacity fully employed within healthcare facility
- Maximal attempts at conservation, reuse, adaptation, and substitution performed
- Regional, state, and federal resource allocation insufficient to meet demand
- Patient transfer or resource importation not possible or will occur too late to consider bridging therapies
- Request for necessary resources made to local and regional health officials
- Declared state of emergency (or in process)

TRIAGE - PRIORITIZING CARE



- Greatest good for greatest number?
- Field triage in MCI's is based on most survivable, not most critical
- AMA's model – likelihood and duration of benefit, change in quality of life, urgency of need, amount of resources required
- AHRQ – patient need, potential to return to baseline state, overall resources needed by patient, age and functional assessment, underlying health, prognosis

Historic Response to People with Disabilities in Disasters

- People with disabilities comprised 25 to 30 percent of those impacted by Hurricane Katrina
- 50% of the people who died in New Orleans were over 75 years
  - Only 11.7% of total population
- Over 35% of those who did not evacuate in Katrina were either physically unable to leave or were caring for a person with a disability

Prioritizing Care in Disasters

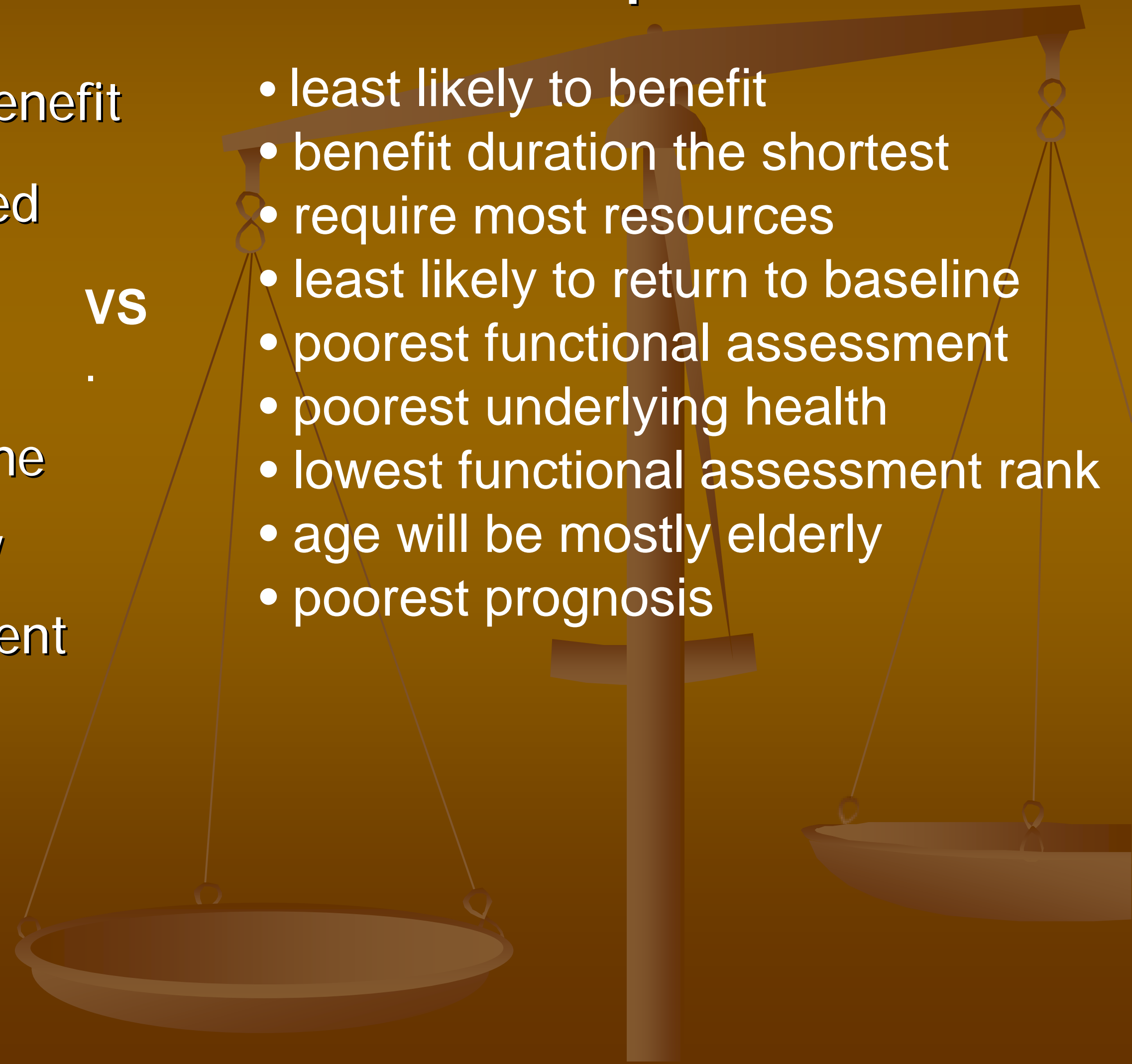
AMA's model

- change in quality of life
- likelihood and duration of benefit
- urgency of need
- amount of resources required

AHRQ

- patient need
- potential to return to baseline state
- overall resources needed by patient
- age and functional assessment
- underlying health
- prognosis

vs.



At Risk Populations

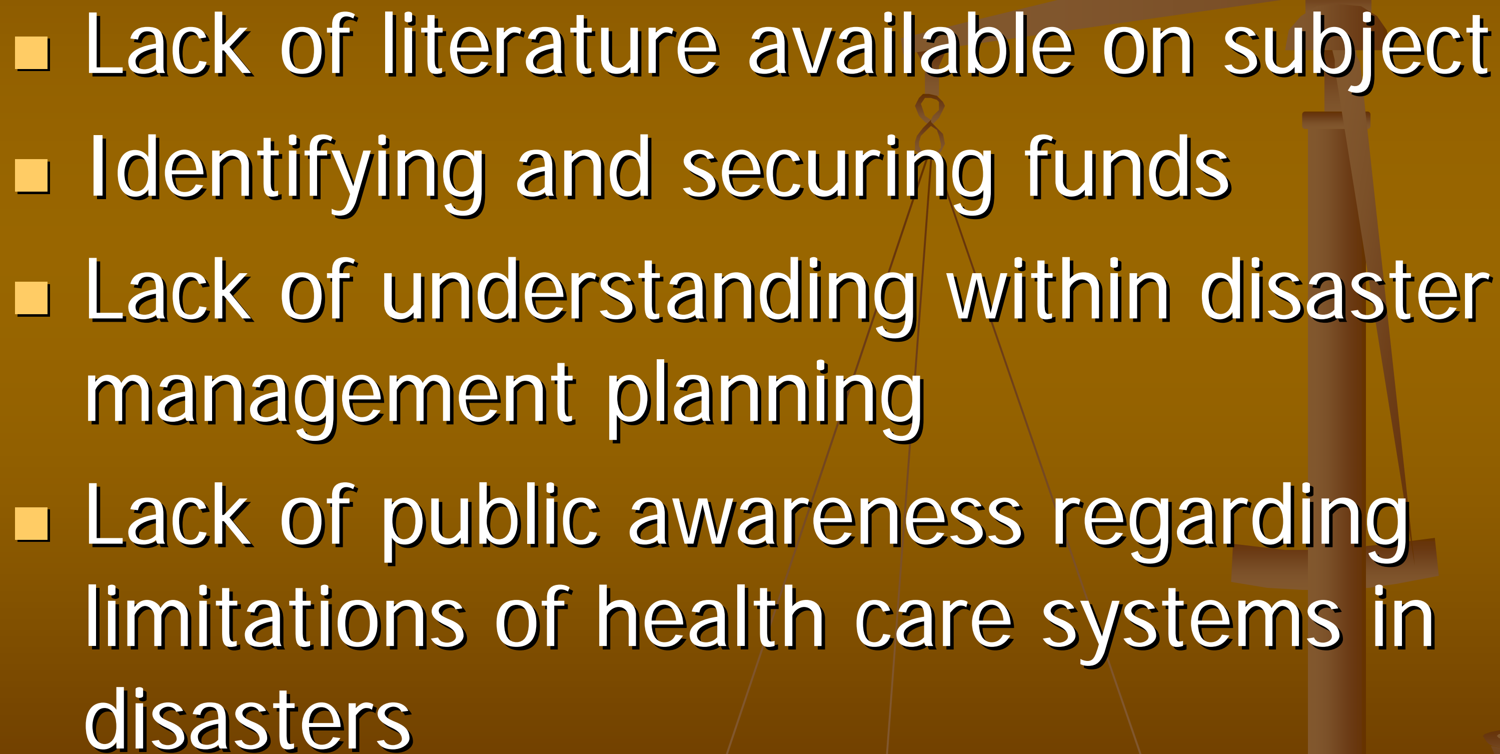
- least likely to benefit
- benefit duration the shortest
- require most resources
- least likely to return to baseline
- poorest functional assessment
- poorest underlying health
- lowest functional assessment rank
- age will be mostly elderly
- poorest prognosis

PALLIATIVE CARE

- To provide the greatest comfort and minimize suffering to those whose lives will be shortened as a result of the event
- Identify who might fit into the "not expected to survive" category
- Palliative care is **not** abandonment, euthanasia, or hastening of death

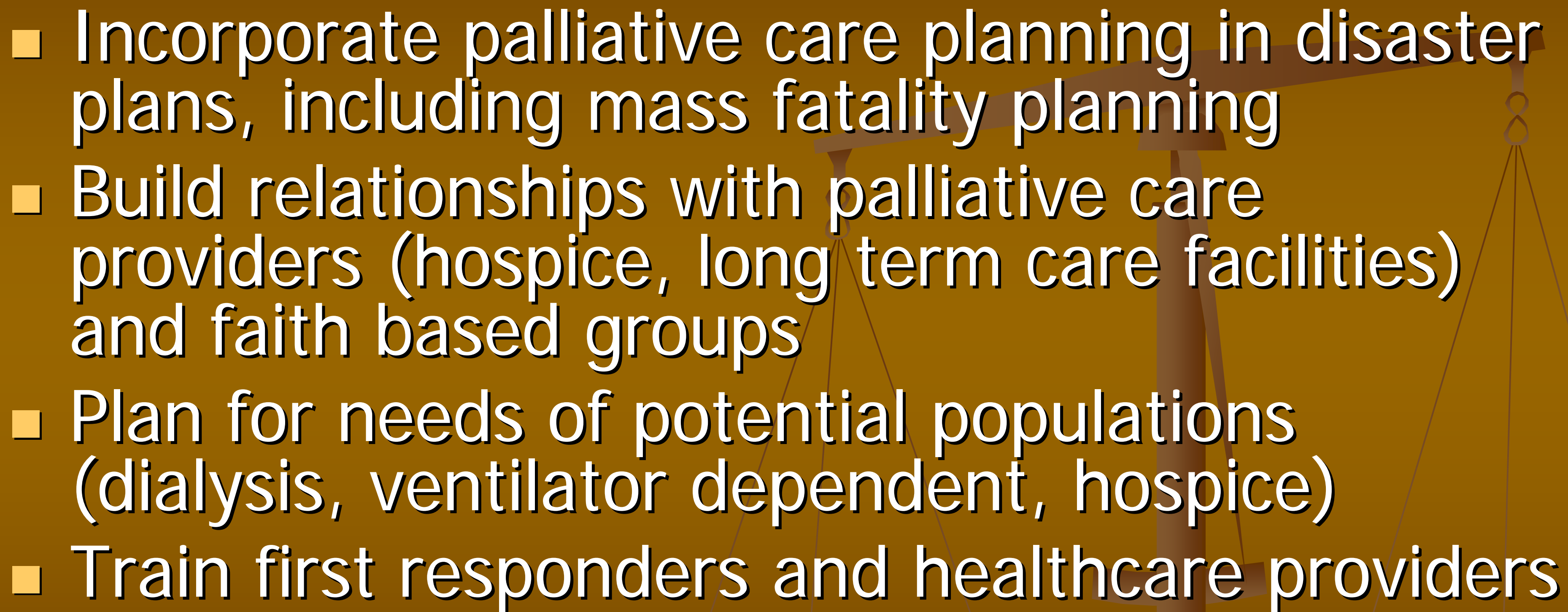
(Memorial Medical Center)

CHALLENGES TO PALLIATIVE CARE



- Lack of literature available on subject
- Identifying and securing funds
- Lack of understanding within disaster management planning
- Lack of public awareness regarding limitations of health care systems in disasters

SUGGESTED APPROACHES



- Incorporate palliative care planning in disaster plans, including mass fatality planning
- Build relationships with palliative care providers (hospice, long term care facilities) and faith based groups
- Plan for needs of potential populations (dialysis, ventilator dependent, hospice)
- Train first responders and healthcare providers

DUTY TO PROVIDE CARE

- Does healthcare provider have a social contract, assumption of risk?
- Involuntary immunization
- Worker's Compensation and liability
- Labor laws, unions, subcontractors

HEALTHCARE'S RECIPROCAL DUTY TO WORKERS

- Consider staff safety and well being
- Provide for family concerns
- Provide liability and other protection for healthcare workers and volunteers
- Discuss issues with staff before the disaster. EDUCATE STAFF

CRISES ARE NOT THE TIME TO DO PLANNING

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Practice ethical preparedness

IOM Recommendations

- Employ ethical considerations
- Develop consistent state crisis of standard of care protocols
- Community and provider engagement, education and communication
- Clear legal authority and environment
- Establish indicators and triggers
- Evidence based clinical processes and operations

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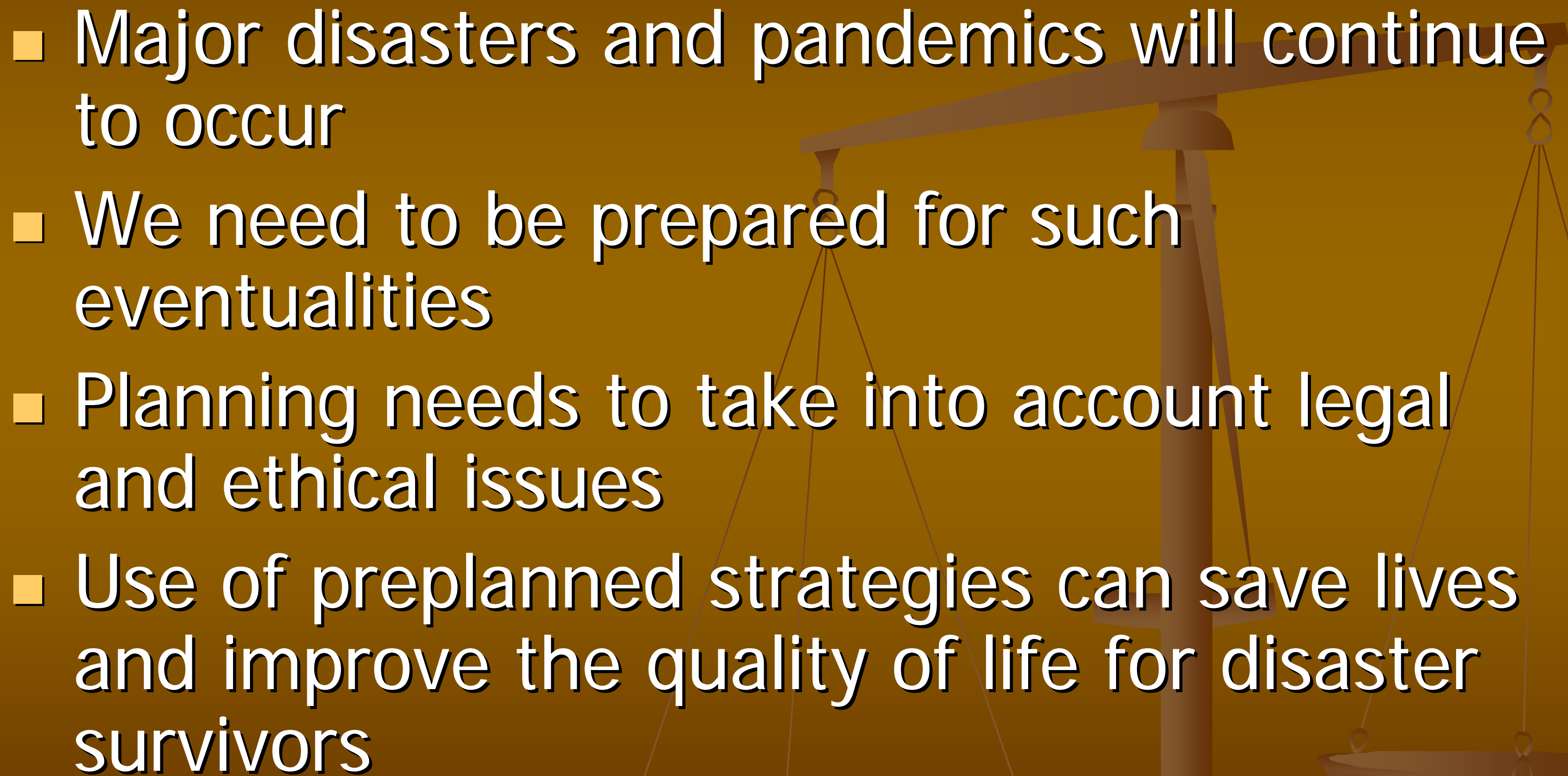
SUMMARY



- Major disasters and pandemics will continue to occur
- We need to be prepared for such eventualities
- Planning needs to take into account legal and ethical issues
- Use of preplanned strategies can save lives and improve the quality of life for disaster survivors

REFERENCES

- Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report, Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations; Institute of Medicine, 2009
- AMA. June 2004. Council on Ethical and Judicial Affairs: Opinion 9.067 - Physician obligation in disaster preparedness and response
- California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, February, 2008
- Barbera, J. A., and A. G. MacIntyre. 2004. Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies.2nd edition
- Centers for Law and the Public's Health. 2004. Public Health Emergency Legal Preparedness Checklist. Civil legal liability and public health emergencies
- Phillips, S., and A. Knebel, eds. 2007. Mass Medical Care With Scarce Resources: A Community Planning Guide. AHRQ Publication No. 07- 0001. Rockville: AHRQ
- Chang, E., H. Backer, T. Bey, and K. Koenig. 2008. Maximizing Medical and Health Outcomes After a Catastrophic Disaster: Defining a New "Crisis Standard of Care." Western Journal of Emergency Medicine 9 (3)
- Devereaux, A. V., et al. 2008b. Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care: January 26–27, 2007, Chicago, IL. Chest 133

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