

## Crisis Standards of Care An Overview of the Illinois Effort

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## Disclaimer

I maintain current consulting arrangements with:  
HHS/ASPR  
New Jersey Hospital Association/HRET  
Illinois Hospital Association

The views and opinions expressed here and during this presentation are mine and are not representative of the Department of Health and Human Services, nor the New Jersey or Illinois Hospital Associations.



## Catastrophic Disasters in United States

1865 Steamship <i>Sultana</i>	Mississippi River	1,547 deaths
1871 Forest fire	Peshtigo, WI	1,182
1889 Flash flood	Johnstown, PA	2,200+
1900 Hurricane	Galveston, TX	5,000+
1904 Steamship <i>General Slocum</i>	East River, NY	1,021+
1928 Hurricane	Okeechobee, FL	2,000+
2001 Al-Queda Attacks	NYC/Wash DC	3,000
2005 Hurricane Katrina	Gulf Coast/MS/LA	1,000+



Charity Hospital, New Orleans



New York Times

Key Questions – Crisis Standards of Care

1. Who should receive care when not all can be treated?
2. How should limited resources be applied to managing traumatic injury, illness and disease, when resources are inadequate to care for all?
3. Should the standards of care change due to the catastrophic circumstances?
4. Should the law grant civil or criminal immunity to professionals acting in good faith?

INSTITUTE OF MEDICINE  
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**Guidance for Establishing  
Crisis Standards of Care for  
Use in Disaster Situations**

**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.

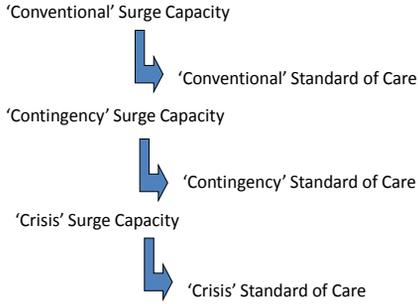
**Crisis Standards of Care**

This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period.

**Crisis Standards of Care**

The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.

## Surge Capacity Planning



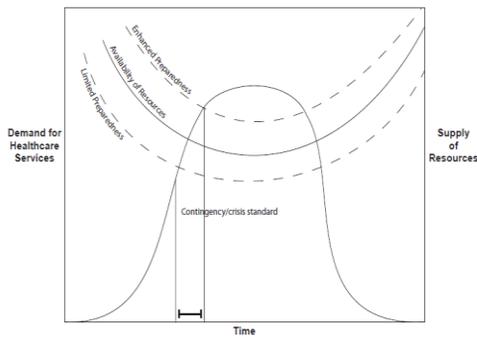
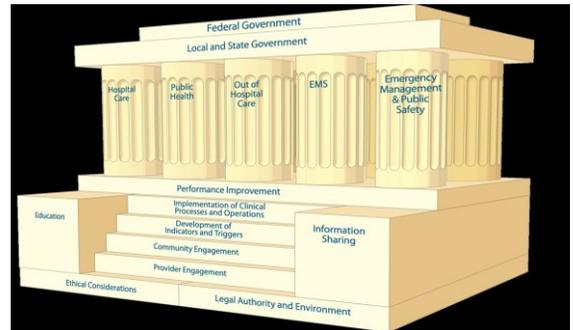
Hick JL, et al, Refining Surge Capacity. *Disaster Med and Pub Health Prep.* 2009; 3 (Suppl 1): S1-S9).  
 Hanfling D, Institute of Medicine, Altered Standards of Care, Regional presentations, Spring 2009.

THE CONTINUUM OF CARE: CONVENTIONAL, CONTINGENCY AND CRISIS				
	Change in the Standard of Care	Resource Constrained	Practicing Outside Experience	Focus of Care
Conventional	No	No	No	Patient
Contingency	Slightly	Slightly	No	Patient
Crisis	Yes	Yes	Yes	Population

## Getting Where We Need to Be



## Systems Approach to Catastrophic Disaster Planning and Response



IOM 2013

## Using Indicators/Triggers

- The goal of CSC planning is to ensure a proactive approach to disaster response is set in motion
  - TIMING is critical
- Event response is very often a reactive affair
  - Absence of a coherent approach
  - Lack of consistency, uniformity
  - Resultant epidemic of FEAR

## Project Overview

- Ethics Subcommittee
- Legal Subcommittee
- Provider Engagement
  - Hospitals/Healthcare
  - EMS/Public Safety
  - Public Health
- Community Engagement

## CSC in PHEP Grant Guidance (2011)

- PHEP Capability 10, Medical Surge; Function 1, Resource: P5. Indicators for standards of care levels
- **P5: (Priority) Written plans should include processes (e.g., MOUs or other written agreements) to work in conjunction with emergency management, healthcare organizations, coalitions, and other partners to develop written strategies that clearly define the processes and indicators as to when the jurisdiction's healthcare organizations and health care coalitions transition into and out of conventional, contingency, and crisis standards of care. Jurisdiction should utilize the risk assessment to build jurisdiction-specific strategies and triggers.**

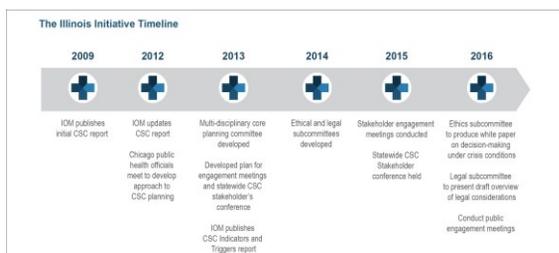
## CSC in HPP (2012) Grant Guidance

- Medical Surge Planning --“Develop CSC guidance”
- P1. State crisis standards of care guidance
- P2. Indicators for crisis standards of care
- P3. Legal protections for healthcare practitioners and institutions
- P4. Provide guidance for crisis standards of care implementation processes
- P5. Provide guidance for the management of scarce resources
- S1. Crisis standards of care training

## Description of Output

Awardees may submit independent plans or annexes to their medical surge plans which address:

- crisis standards of care,
- allocation of scarce resources,
- ethical decision-making in a resource constrained medical environment,
- public engagement processes.



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## PROVIDER ENGAGEMENT

HIGHLIGHTS FROM THE Q SORT DATA COLLECTION

## Key Factors for Healthcare/Hospitals

- Factor 1: Survival/Quality of Life
  - Emphasized statements about increasing survival also indicated how one survives is important (i.e., not in a coma, not requiring a caregiver).
- Factor 2: Health Infrastructure
  - Focus on priority treatment for healthcare providers and first responders

## Key Factors for Public Health

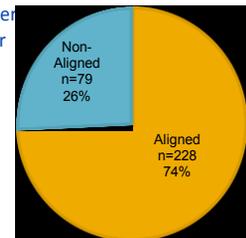
- Factor 1: Treatment volume/Quality of life
  - Important: Prioritize based on odds of survival, being in a coma doesn't count as survival...
- Factor 2: Fairness
  - Highest ranked statement (+4): "Making sure decisions are fair is more important than getting people treated as quickly as possible."
- Factor 3: Protecting vulnerable populations
  - Important: Preserving all generations, priority to parents/caregivers, children, pregnant women, and the disabled.

## Key Factors for EMS/Public Safety

- Factor 1: Treatment Volume/Family
  - Higher ranks for providing faster care, prioritizing care for children, and preserving life across generations
- Factor 2: Health Infrastructure
  - High ranks for two controversial statements that suggest providing priority to health care providers as a "reward"

## Inter-professional Consensus

- Most Important
  - Helping the greatest number
  - Prioritizing medical care for providers
- Least Important
  - Non-clinical prioritization schemes
    - Random order
    - Arrival order
    - Socioeconomic-based schemes



## NEXT STEPS FOR THE PROJECT

COMMUNITY ENGAGEMENT – UNDERSTANDING WHAT THE PUBLIC THINKS  
 DEVELOPMENT OF A CRISIS STANDARD OF CARE (EMS, HOSPITAL AND PUBLIC HEALTH) ANNEX TO THE STATE EMERGENCY OPERATIONS PLAN

## KEY POINTS

## Key Points

- CSC requires not a single government-level plan, but the integration of crisis planning principles into existing response plans (e.g., a crisis annex) at the facility, coalition, regional, state, and federal levels.

### KEY TAKE-AWAYS:

- Avoid the “paper plan” syndrome
- Ensure “proportionality” – being able to determine when such plans are appropriate to use must be part of the planning process

## Key Points

- Recognize the limitations of assigning a “prognosis” – there are no good clinical prognostication tools available

i.e. SOFA can be used to compare patients, but not necessarily to choose one over the other with regards to likelihood of survival



## Key Points

- Instead, promote the importance of developing a “Process” for decision making –
  - the role of the facility/agency,
  - how crisis decisions will be made,
  - which subject matter experts will be involved
  - how the transitions from conventional, to contingency, and to crisis (and back) will be managed.

## Journey Preparation

- “Practice” --
- Must ensure that healthcare administrators and providers are comfortable with the facility plans, and that, in concert with their coalition partners, they understand how those plans interact with agency plans and community expectations. The interaction between the facilities and the state is critical to providing the policy, logistical, and legal support to the clinical efforts,

## Getting Where We Need to Be



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