Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response

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Objectives

- Review the background leading to Crisis Standards of Care (CSC) planning
- Provide an overview of the 2009, 2012and 2013 IOM Crisis Standards of Care Reports
- Review link to CSC planning in PHEP (2011) and HPP (2012) grant guidance

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Catastrophic Disasters in US

1865	Steamship *Sultana*	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 *General Slocum*	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+

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KATRINA: THE STORM WE'VE ALWAYS FEARED

The Times-Picayune

'HELP US, PLEASE'

AFTER THE DISASTER, CHAOS AND LAWLESSNESS RULE THE STREETS

KATRINA: THE STORM WE'VE ALW

The Times-Pic

CLEAR OR EL

KATRINA: THE STORM WE'VE ALWAYS FEARED

The Times-Picayune

CATASTROPHIC

STORM SURGE SWAMPS 9TH WARD, ST. BERNARD

LAKEVIEW LEVEE BREACH THREATENS TO INUNDATE CITY

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Accused Doctor Said to Have Faced Chaos at New Orleans Hospital

By CHRISTOPHER DREW and SHAILA DEWAN

NEW ORLEANS, July 19 — She arrived at Memorial Medical Center to treat several patients as Hurricane Katrina's winds were gathering and did not leave until days later, when the water and the temperature and the body count had risen beyond endurance.

By the time the ordeal ended, her friends and supporters say, Dr. Anna M. Pou was one of the few doctors left in a hospital that had become a nightmare.

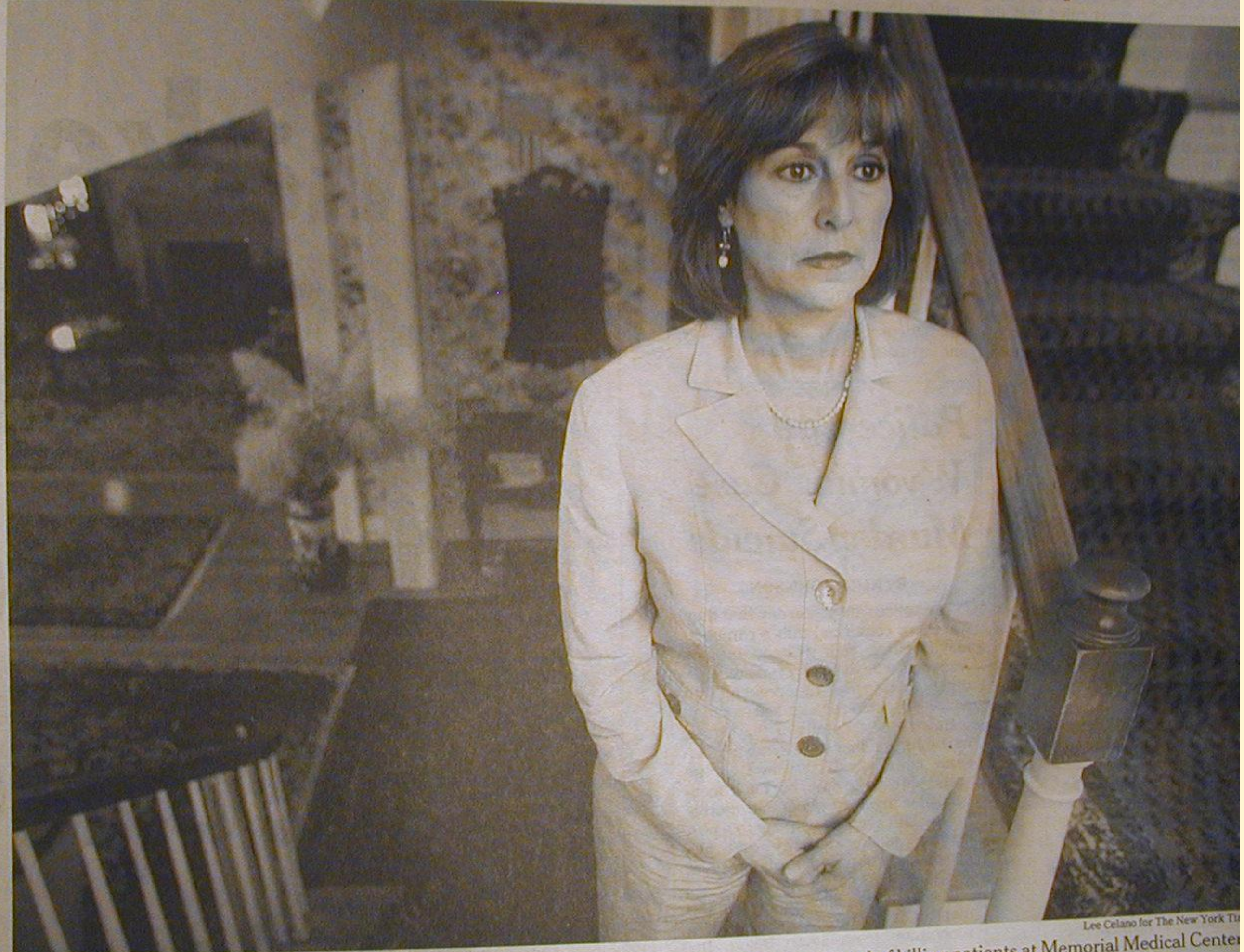
Overheated patients were dying around her, and only a few could be taken away by helicopter, the only means of escape for the most fragile patients until the water receded. Medicines were running low, and with no electricity, patients living on machines were running out of battery power. In the chaos, Dr. Pou was left to care for many patients she did not know.

But did she cross a line during those harrowing days, using lethal injections to kill several patients who were in extreme distress? The attorney general of Louisiana says Dr. Pou did, and on Tuesday recommended that she be prosecuted for murder.

Her supporters, though, say there is another explanation: she was using drugs to try to calm and comfort patients who had nearly reached their limit.

Eugene Myers, a professor at the University of Pittsburgh who helped train Dr. Pou, said that what she had told him shortly after the hurricane sounded heroic.

He said Dr. Pou had told him that she and Lori Budo and Cheri Landry, two nurses who have also been arrested in the case either helped evacuate the last patients or tried to make them comfortable with pain medications.



Lee Celano for The New York Times

Dr. Anna M. Pou at her mother's home yesterday in New Orleans. She and two nurses are accused of killing patients at Memorial Medical Center.

New York Times

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GABE RAMIREZ/CNN

Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations

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Duty to Plan

"Note that in an important ethical sense, entering a crisis standard of care mode is not optional – it is a forced choice, based on the emerging situation. Under such circumstances, failing to make substantive adjustments to care operations – i.e., not to adopt crisis standards of care – is very likely to result in greater death, injury or illness."

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.

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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.

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THE CONTINUUM OF CARE: CONVENTIONAL, CONTINGENCY AND CRISIS				
	Effect on 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*

USAID Responds to Haiti Earthquake

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A Systems Framework for
Catastrophic Disaster Response

Introduction and CSC Framework

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CSC Framework and Report Structure

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Conceptualizing a Systems Framework for Catastrophic Disaster Response

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

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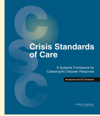
Structure of the Report



Introduction

- Introduction, Framework, Legal Issues, Cross-Cutting Themes (ethics, palliative care, and mental health)

Four discipline-specific volumes

- State and local, EMS, health care facilities, out-of-hospital care
- Includes the roles of each stakeholder, relevant CSC operational considerations, template(s) description, and the template(s) (functions and tasks to develop and implement CSC)

Public Engagement

- The case for and challenges of public engagement
- Public Engagement Toolkit

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REPORT BRIEF • JULY 2013

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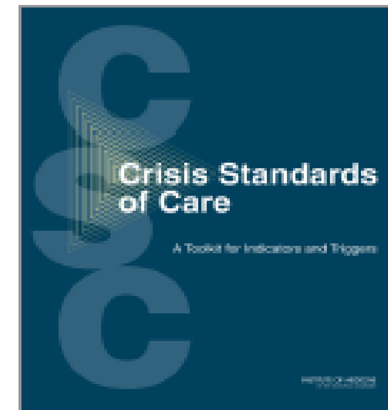
For more information visit www.iom.edu/csctoolkit

Crisis Standards of Care

A Toolkit for Indicators and Triggers



Disasters and public health emergencies can stress health care systems to the breaking point and disrupt delivery of vital medical services. During such crises, hospitals and long-term care facilities may be without power; trained staff, ambulances, medical supplies, and beds could be in short supply; and alternate care facilities may need to be used. Planning for these situations is necessary to provide the best possible health care during a crisis and, if needed, equitably allocate scarce resources.

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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.204 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

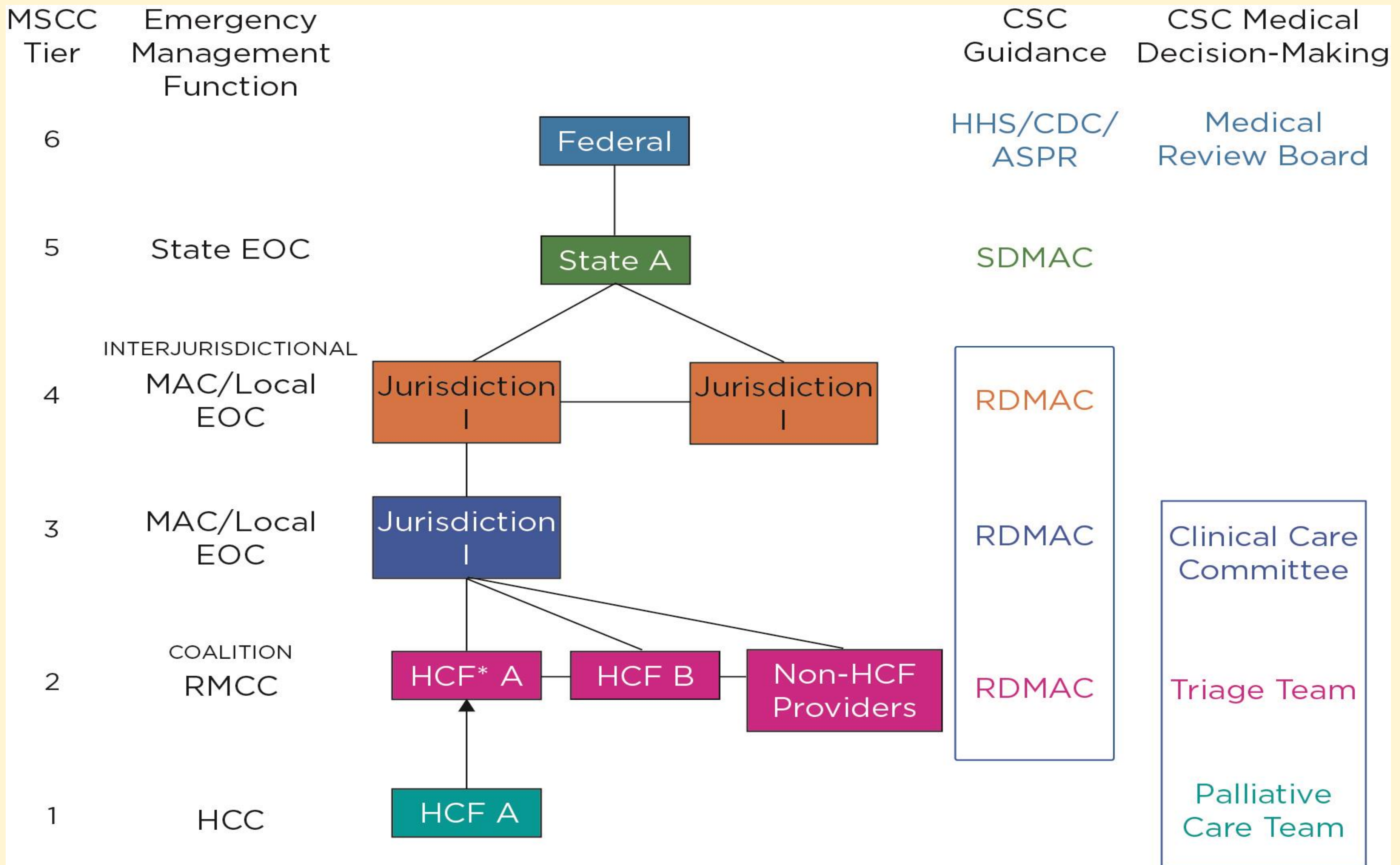
Examples of State Liability Protections

Virginia

§ 8.01-225.01. Certain immunity for health care providers during disasters under specific circumstances

A. In the absence of gross negligence or willful misconduct, any health care provider who responds to a disaster by delivering health care to persons injured in such disaster shall be **immune from civil liability** for any injury or wrongful death arising from abandonment by such health care provider of any person to whom such health care provider owes a duty to provide health care when (i) **a state or local emergency has been or is subsequently declared**, and (ii) the **provider was unable to provide the requisite health care to the person to whom he owed such duty of care** as a result of the provider's voluntary or mandatory response to the relevant disaster.

B. In the absence of gross negligence or willful misconduct, any hospital or other entity credentialing health care providers to deliver health care in response to a disaster shall be immune from civil liability for any cause of action arising out of such credentialing or granting of practice privileges if (i) a state or local emergency has been or is subsequently declared; and (ii) the hospital has followed procedures for such credentialing and granting of practice privileges that are consistent with the Joint Commission on Accreditation of Healthcare Organizations' standards for granting emergency practice privileges. (Va. Code Ann. § 8.01-225.01)



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