

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

Briefing to: Don Boyce, JD
Deputy Assistant Secretary and Director, Office
of Preparedness and Emergency Operations
Office of the Assistant Secretary for
Preparedness and Response, HHS

John Hick, MD
Clare Stroud, PhD
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The IOM's **Unique Study Process**



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Hallmarks of Catastrophic Disaster Response

- Increasing demand for patient care
- Increasing resource utilization and supply consumption
- Increasing demands placed on available health and medical staff
- Demand requirements that will likely occur in the context of critical infrastructure disruption or destruction



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. Who should make decisions related to the delivery of available care?
4. Should the standards of care change due to the catastrophic circumstances?

Timeline of selected projects

Earliest work:

- AHRQ (2005)
- New York ventilator allocation (2007)
- GAO report highlighting need for guidance on allocating scarce medical resources (2008)
- Task Force for Mass Critical Care: Chest (2008)

IOM work:

- IOM Preparedness Forum regional meetings (2009)
- **Phase 1: Letter report (2009)**
- **Phase 2: A Systems Framework for Catastrophic Disaster Response (2012)**
- **Phase 3: A Toolkit for Indicators and Triggers (planned 2013)**

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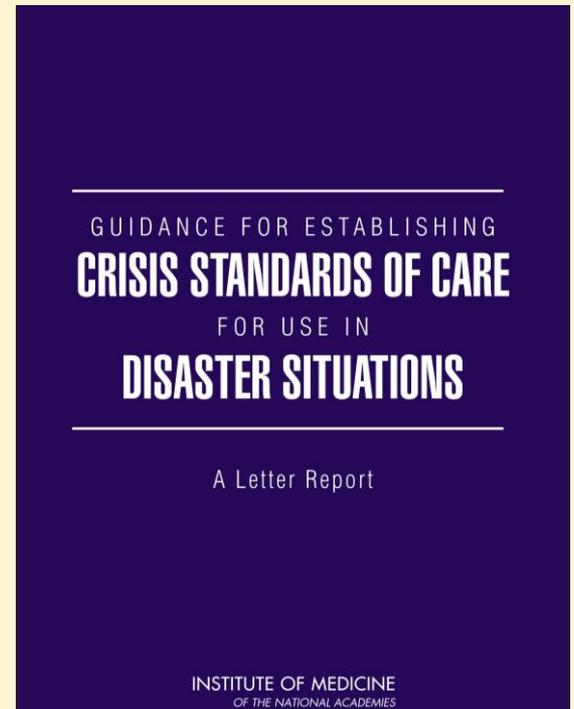


Phase 1: Letter Report (2009)

Fast report requested by ASPR during initial months of H1N1.

Guidance that health officials could use to establish and implement standards of care during disasters.

All-hazard approach, with additional details about specific types of disaster (e.g., no notice vs. slow onset).



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Committee Membership

LAWRENCE O. GOSTIN (<i>chair</i>)	Georgetown University Law Center
DAN HANFLING (<i>vice-chair</i>)	Inova Health System, Falls Church, Virginia
DAMON T. ARNOLD	Illinois Department of Public Health (retired)
STEPHEN V. CANTRILL	Denver Health Medical Center (retired)
BROOKE COURTNEY	Food and Drug Administration
ASHA DEVEREAUX	California Thoracic Society
EDWARD J. GABRIEL*	The Walt Disney Company
JOHN L. HICK	Hennepin County Medical Center, Minnesota
JAMES G. HODGE, JR.	Arizona State University
DONNA E. LEVIN	Massachusetts Department of Public Health
MARIANNE L. MATZO	University of Oklahoma Health Sciences Center
CHERYL A. PETERSON	American Nurses Association
TIA POWELL	Albert Einstein College of Medicine
MERRITT SCHREIBER	University of California, Irvine School of Medicine
UMAIR A. SHAH	Harris County Public Health and Environmental Services, Texas
JOLENE R. WHITNEY	Bureau of Emergency Medical Services and Preparedness, Utah Department of Health

*Resigned from the committee October 2011

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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.” (IOM, 2009)

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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	None	No	No	<i>Patient</i>
Contingency	Slightly	Slightly	No	<i>Patient</i>
Crisis	Yes	Yes	Yes	<i>Population</i>

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Adaptive Measures for Stewardship of Scarce Resources

Prepare

Conserve

Substitute

Adapt

Re-use

Re-allocate

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“The goal for the health system is to increase the ability to stay in conventional and contingency categories through preparedness and anticipation of resource needs prior to serious shortages, and to return as quickly as possible from crisis back across the continuum to conventional care.” (IOM, 2009)

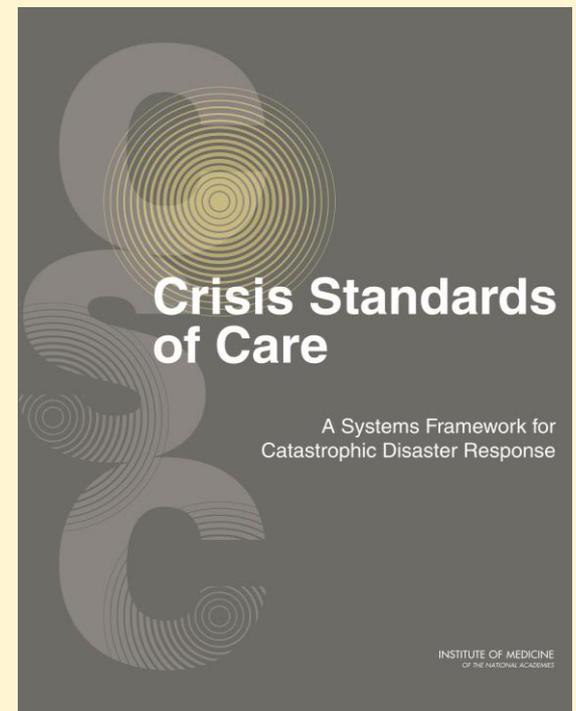


Phase 2: Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response (2012)

Sponsors: ASPR, NHTSA, VHA

Same committee as phase 1

All-hazard approach, with additional details about resource challenges for different types of disaster.



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Structure of the Report



Introduction

- Introduction, framework, legal issues, cross-cutting themes (ethics, palliative care, and mental health)

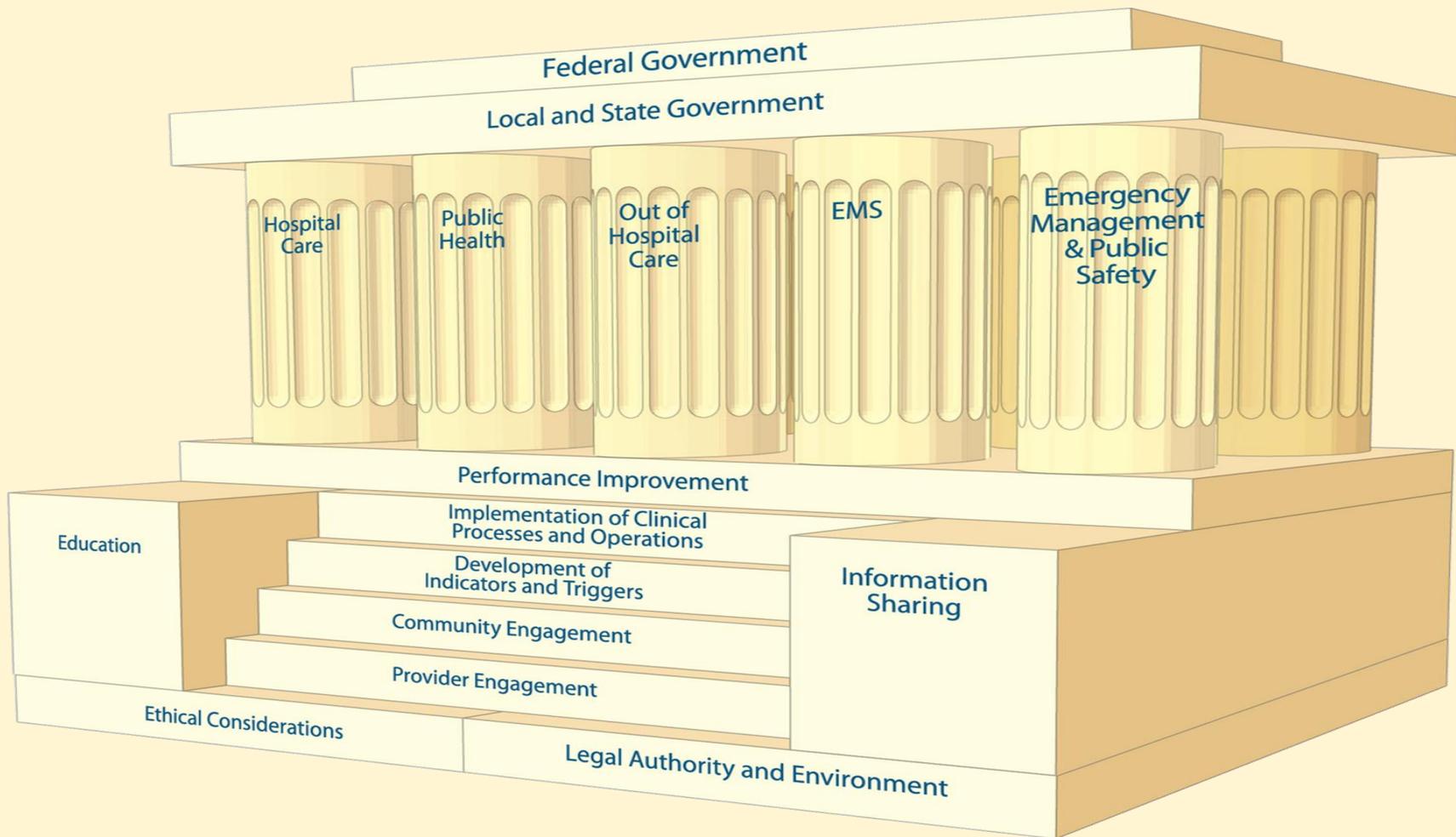
Four discipline-specific volumes

- 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

Conceptualizing a Systems Framework for Catastrophic Disaster Response



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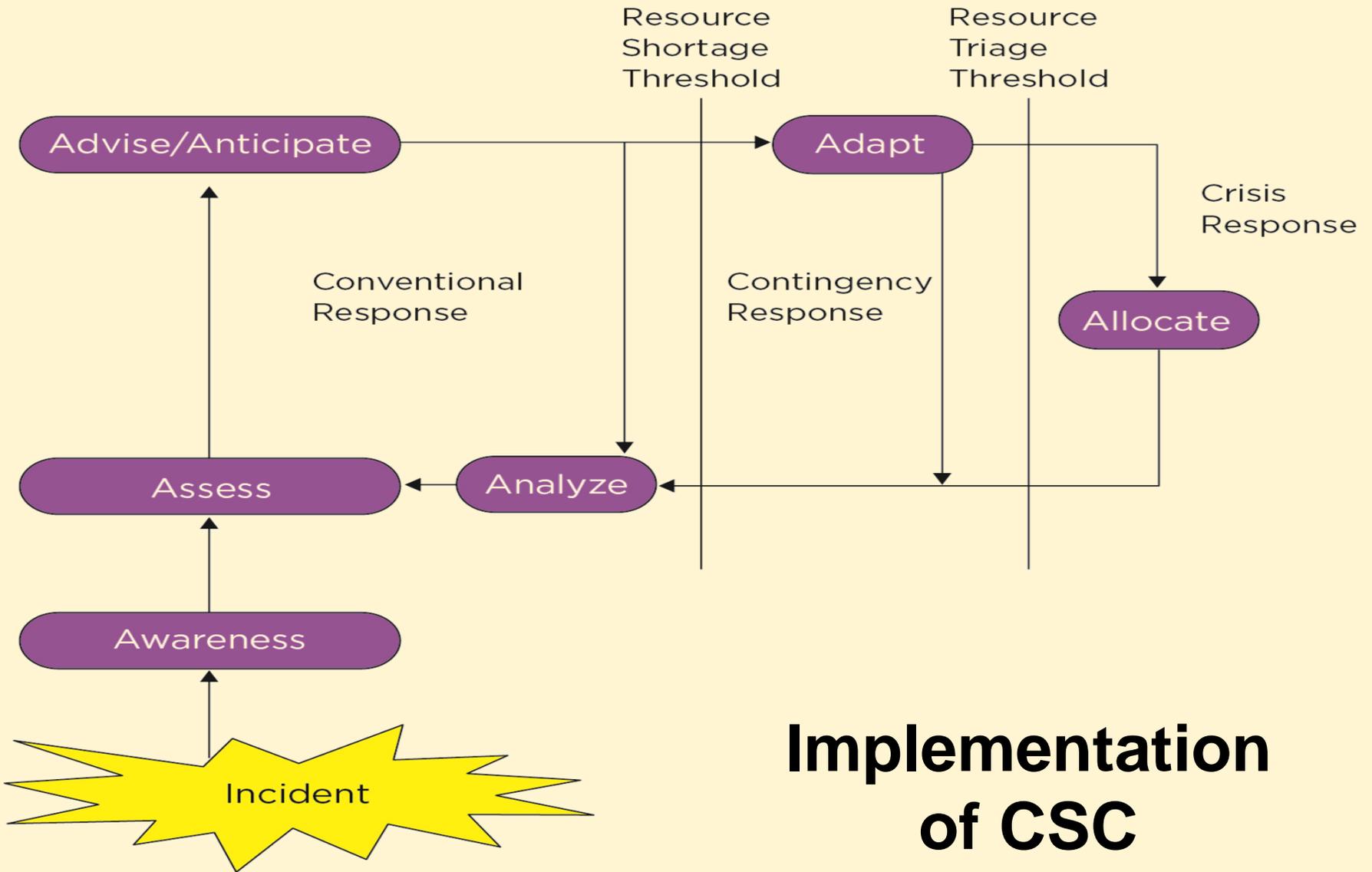
Milestones for CSC Planning and Implementation

1. Establish a State Disaster Medical Advisory Committee (SDMAC).
2. Ensure the development of a legal framework for CSC implementation.
3. Promote understanding of the disaster response framework among elected officials and senior (cabinet-level) state and local government leadership.
4. Develop a state health and medical approach to CSC planning that can be adopted at the regional/local level by existing health care coalitions, emergency response systems (including the Regional Disaster Medical Advisory Committee [RDMAC]), and health care providers.
5. Engage health care providers and professional associations by increasing their awareness and understanding of the importance and development of a CSC framework.
6. Encourage participation of the outpatient medical community in planning.
7. Ensure that local and state CSC plans include clear provisions that permit adaptation of EMS systems under disaster response conditions.
8. Develop and conduct public community engagement sessions on the issue of CSC.
9. Support surge capacity and capability planning for health care facilities and the health care and public health systems.
10. Plan for an alternate care system capability.
11. Support scarce resource planning by the RDMAC (if developed) for health care facilities and the health care system.
12. Incorporate crisis/emergency risk communication strategies into CSC plans.
13. Exercise CSC plans at the local/regional and interstate levels.
14. Refine plans based on information obtained through provider engagement, public/community engagement and exercises, and real-life events.
15. Develop a process for continuous assessment of disaster response capabilities.

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Implementation of CSC

Alignment with HPP and PHEP Capabilities



HEALTHCARE PREPAREDNESS CAPABILITIES

NATIONAL GUIDANCE FOR HEALTHCARE SYSTEM PREPAREDNESS



CAPABILITY 10: Medical Surge

Function 4: Develop Crisis Standards of Care guidance

Suggested resource:

- IOM (Institute of Medicine). 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Washington, DC: The National Academies Press.
- Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: <http://iom.edu/Reports/2009/DisasterCareStandards.aspx>



PUBLIC HEALTH PREPAREDNESS CAPABILITIES:

NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING
MARCH 2011

State & Local Templates

Function 3. Command and Control, Communications, and Coordination

Command and Control

Notes and Resources

Task 1: State EMA (with, as applicable, support of the state health department as the lead state agency for CSC) implements/expands the incident command system (ICS) consistent with event-driven demands and activates the state emergency operations center (EOC) at a level appropriate to the situation. The state EMA makes recommendations, as needed, to local EMAs on activation of local EOCs and response plans (see Chapter 6).

Task 2: State EMA and the state health department ensure that command staff:

- are trained in CSC plan components and response;
- understand their roles, as well as the roles of local, regional, state, and federal stakeholders, in the state CSC response;
- are well versed in incident action planning during longer-term events;
- have access to appropriate resources (e.g., job aids) to guide decision making; and
- understand the role of the SDMAC and any regional medical coordination centers or regional DMACs, as well as the means by which information is received by or communicated to these bodies.

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Public Engagement: Toolkit

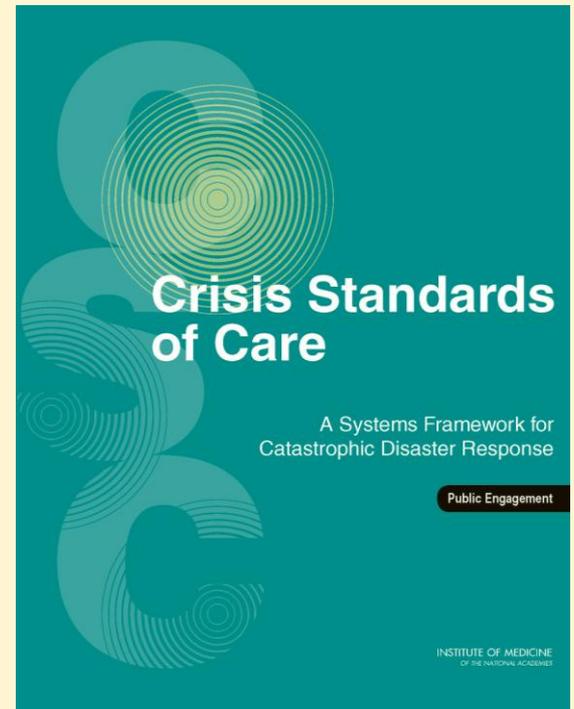
Introduction and guiding principles

Sponsor guidebook

Lead facilitator guidebook

Guidebook for table facilitators and note takers

Introductory slides



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Public Engagement: Test Meetings

Public engagement materials were tested in two meetings (Boston, September 2011; Lawrence, October 2011).

Main takeaways:

- Diverse community participants are willing and able to engage in productive deliberations about CSC.
- The provision of information and a forum for discussion can help shape and elicit public opinion in ways that can be useful to policy makers in developing CSC guidelines.

Phase 3: A Toolkit for Indicators and Triggers (planned for 2013)

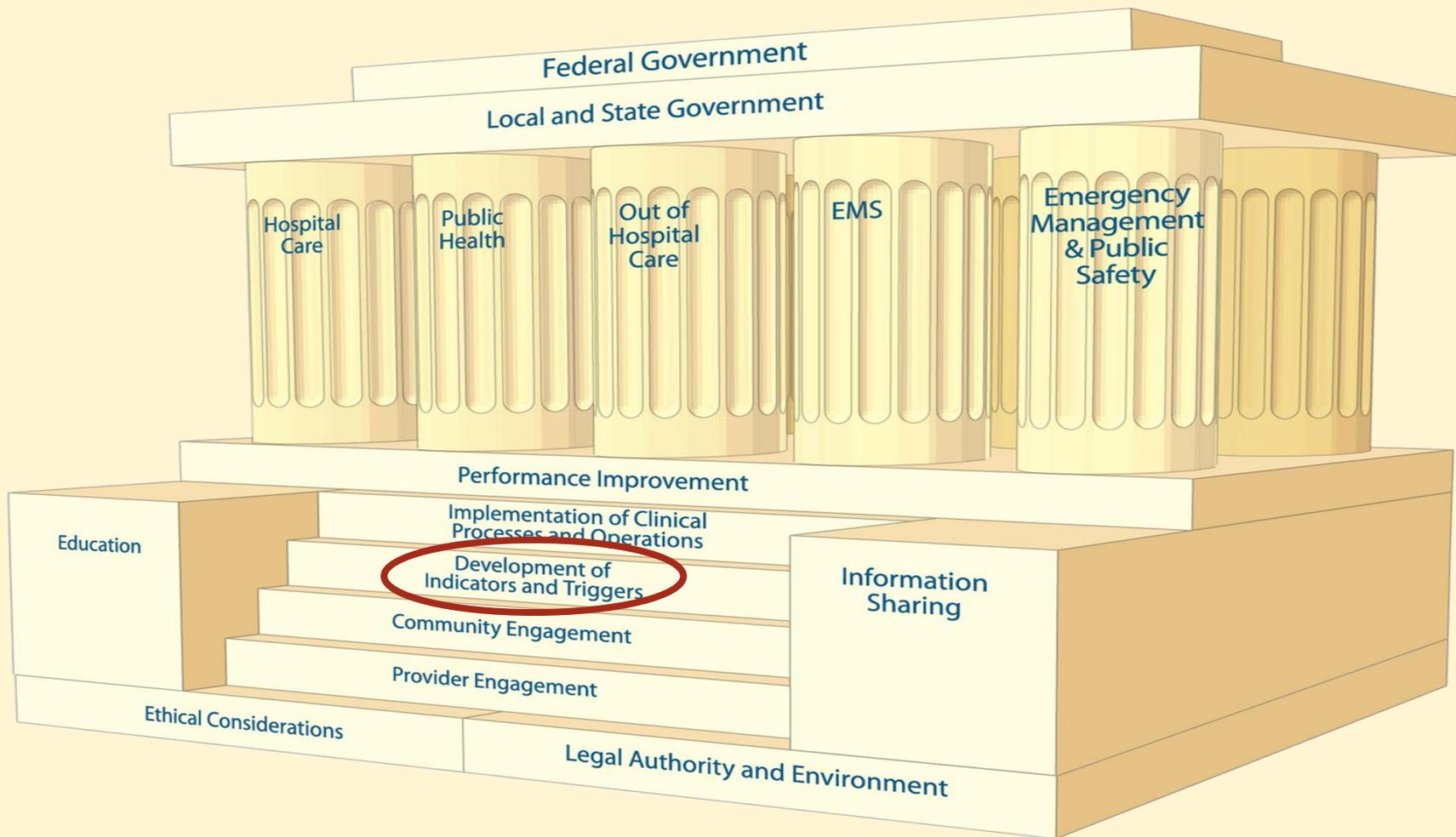
Sponsors: ASPR, NHTSA, VHA

New committee has been nominated:

Dan Hanfling, MD and John Hick, MD (*co-chairs*)



A Systems Framework for Catastrophic Disaster Response



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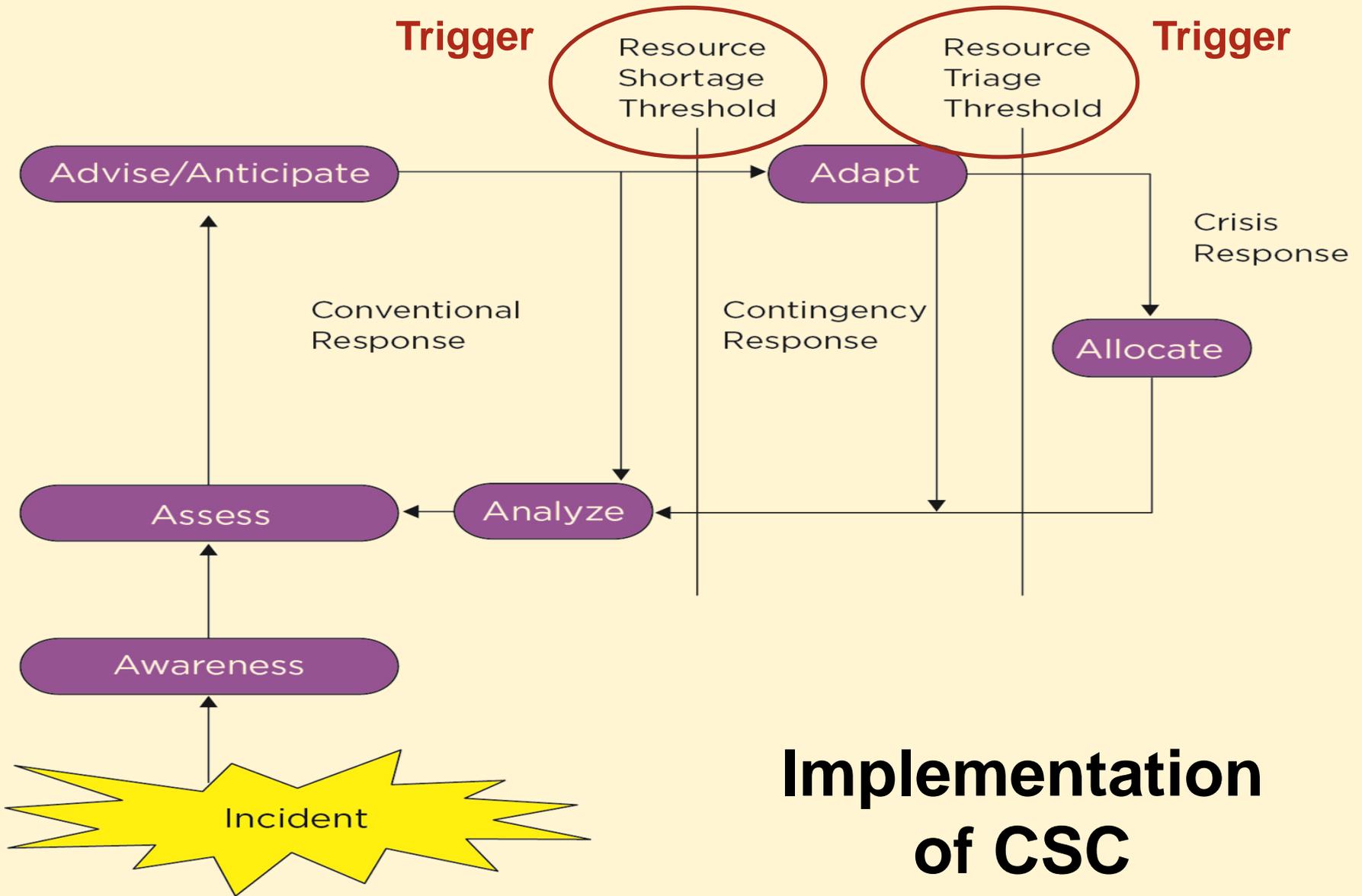
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Indicators and Triggers

Indicators: Measurements or predictors that are used to recognize surge capacity and capability problems within the health care system.

Triggers: Specific values of the measured indicator, which govern these transitions:

- from conventional to contingency surge capacity and standards of care, and
- from contingency to crisis surge capacity and standards of care, and
- from crisis back to conventional care.



Implementation of CSC

Statement of Task

An ad hoc committee will develop a conversation toolkit, which can be used by stakeholders in the development of crisis standards of care plans to guide the identification of clinical and administrative indicators that may govern the transition from conventional and contingency surge response and standards of care to crisis surge response and crisis standards of care, and the return to conventional standards of care.

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Timeline

**October
2012:**
Work
begins

**January 15 & 16
2013:**
1st Committee
Meeting and
Open Session
for Data
Gathering

**May/June
2013**
External
Review

**August/
September 2013:**
Dissemination &
Final Book
Publication

**November-
December
2012:**
Convene
committee

**March/April
2013:**
Second
Committee
Meeting

July 2013:
Sponsor
Briefing &
Report Release

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Preliminary Workplan (1): A Series of Indicators

Develop a series of potential indicators that could be used to assess stressors on the health system.

- Where possible, identify existing surveillance systems and other real-time data sources that can be used to measure these indicators.
- If no tools are available to provide the real-time awareness, describe why it is needed and how it could be measured.

Preliminary Workplan (2): A Toolkit to Guide Stakeholder Conversation

Develop a toolkit to help sectors in the health system have the conversation around setting indicators and triggers for their specific state/region/organization.

- Stakeholders have to customize the indicators described in part 1 for their specific situation, taking into account the real-time data actually available to them in their system.
- Stakeholders have to set triggers for their specific situation, taking into account the normal capacity and practices of their specific system and the point at which it would be overwhelmed.
- The toolkit may include scenarios that would help guide the discussion.

To download the report, templates,
or public engagement toolkit,
please visit:

www.iom.edu/crisisstandardsframework

For questions, please contact:

Bruce Altevogt, Study Director (Phase 1 & 2)
baltevogt@nas.edu, 202.334.3984

Clare Stroud, Study Director (Phase 3)
cstroud@nas.edu, 202.334.1847



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Extra slide

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Crisis Standards of Care: Definition

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. 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. 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.