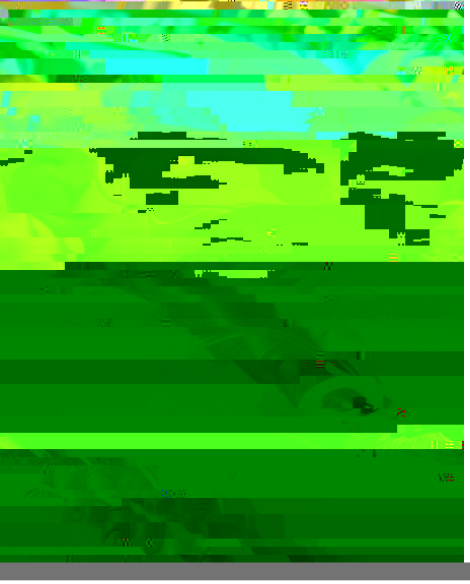

CRISIS STANDARDS OF CARE

COVID-19
Issue Summary

December 2020

At the start of the COVID-19 epidemic, crisis standards of care (CSC) plans were reviewed and updated across the United States in anticipation of the potential need to ration ventilators and other critical equipment. As the epidemic has gone on, we have had the opportunity to learn from experiences both domestic and international. The below highlights some key updates and changes to the implementation of CSC as summarized by John L. Hick, MD, editor of the Technical Resources, Assistance Center, and Information Exchange (TRACIE) of the Office of the Assistant Secretary for Preparedness and Response.

CSC d e n need a a e decla a i n. Although some states have "declared" CSC, CSC conditions may occur wherever demand exceeds resources. The crisis care techniques that health care facilities must implement will not wait for state actions. Hospitals and systems must have plans in place to ensure that crisis conditions are mitigated through movement of patients and resources to minimize the time spent in crisis.

T an fe di ib e l ad . Medical Operations Coordination Cells (MOCC) are critical to the "load-balancing" between hospitals that can help to equitably distribute patients across facilities in the area. In many areas, hospitals have been disproportionately burdened—particularly those in highly impacted border areas and those that serve at-risk communities—often inner-city trauma centers. One issue that has arisen with MOCC operations is the relatively frequent need for clinical providers to work with transferring and receiving hospitals to ensure that the patient is appropriate for the recommended transfer and advise on care-in-place until the transfer can be accomplished, as EMS resources are often taxed and transfers often delayed.

S a f CSC. A key goal should be to avoid CSC entirely and get back to contingency (functionally equivalent) care as soon as possible. Unfortunately, sometimes, rather than look outside the facility or system for supplementary resources, providers have made choices they didn't have to make—restricting services and adversely impacting the care of individual patients. Planning for a step-wise degradation of services that is aligned with other hospitals in the area is key to equitable care.

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track recurrent or systems issues, reduce provider moral injury in decision making, and ensure consistency. Further, the availability of expert consultants reduces "freelancing" triage decisions that some providers might be apt to make and enhances reasoned decision-making.

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