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

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ASTHO Webinar
7 September 2012
Objectives

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Location</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1865</td>
<td>Steamship <em>Sultana</em></td>
<td>Mississippi River</td>
<td>1,547 deaths</td>
</tr>
<tr>
<td>1871</td>
<td>Forest fire</td>
<td>Peshtigo, WI</td>
<td>1,182</td>
</tr>
<tr>
<td>1889</td>
<td>Flash flood</td>
<td>Johnstown, PA</td>
<td>2,200+</td>
</tr>
<tr>
<td>1900</td>
<td>Hurricane</td>
<td>Galveston, TX</td>
<td>5,000+</td>
</tr>
<tr>
<td>1904</td>
<td>Steamship <em>General Slocum</em></td>
<td>East River, NY</td>
<td>1,021+</td>
</tr>
<tr>
<td>1928</td>
<td>Hurricane</td>
<td>Okeechobee, FL</td>
<td>2,000+</td>
</tr>
<tr>
<td>2001</td>
<td>Al-Qaeda Attacks</td>
<td>NYC/Wash DC</td>
<td>3,000</td>
</tr>
<tr>
<td>2005</td>
<td>Hurricane Katrina</td>
<td>Gulf Coast/MS/LA</td>
<td>1,000+</td>
</tr>
</tbody>
</table>
KATRINA: THE STORM WE'VE ALWAYS FEARED

HELP US, PLEASE'

AFTER THE DISASTER, CHAOS AND LAWLESSNESS RULE THE STREETS

Katrina: The storm we’ve always feared

CLEAR OR ELSE...

CATASTROPHIC

STORM SURGE SWAMPS 9TH WARD, ST. BERNARD
LAKEVIEW LEVEE BREACH THREATENS TO INUNDATE CITY

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the nation • Improving health
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.

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.
DEFINITIVE CARE FOR THE CRITICALLY ILL DURING A DISASTER

Summary of Suggestions From the Task Force for Mass Critical Care Summit, January 26–27, 2007
Asha Devereaux; Michael D. Christian; Jeffrey R. Dichter; James A. Geiling; Lewis Rubinson

Definitive Care for the Critically Ill During a Disaster: Current Capabilities and Limitations: From a Task Force for Mass Critical Care Summit Meeting, January 26–27, 2007, Chicago, IL
Michael D. Christian; Asha V. Devereaux; Jeffrey R. Dichter; James A. Geiling; Lewis Rubinson

Definitive Care for the Critically Ill During a Disaster: A Framework for Optimizing Critical Care Surge Capacity: From a Task Force for Mass Critical Care Summit Meeting, January 26–27, 2007, Chicago, IL
Lewis Rubinson; John L. Hick; Dan G. Hanfling; Asha V. Devereaux; Jeffrey R. Dichter; Michael D. Christian; Daniel Talmor; Justine Medina; J. Randall Curtis; James A. Geiling

Definitive Care for the Critically Ill During a Disaster: Medical Resources for Surge Capacity: From a Task Force for Mass Critical Care Summit Meeting, January 26–27, 2007, Chicago, IL
Lewis Rubinson; John L. Hick; J. Randall Curtis; Richard D. Branson; Suzi Burns; Michael D. Christian; Asha V. Devereaux; Jeffrey R. Dichter; Daniel Talmor; Brian Erstad; Justine Medina; James A. Geiling

Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care: From a Task Force for Mass Critical Care Summit Meeting, January 26–27, 2007, Chicago, IL
Asha V. Devereaux; Jeffrey R. Dichter; Michael D. Christian; Nancy N. Dubler; Christian E. Sandrock; John L. Hick; Tia Powell; James A. Geiling; Dennis E. Amundson; Tom E. Baudendsite; Dana A. Briner; Mike A. Klein; Kenneth A. Berkowitz; J. Randall Curtis; Lewis Rubinson
Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations
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.”
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.
<table>
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<tr>
<th>THE CONTINUUM OF CARE: CONVENTIONAL, CONTINGENCY AND CRISIS</th>
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<tbody>
<tr>
<td><strong>Effect on Standard of Care</strong></td>
</tr>
<tr>
<td>Conventional</td>
</tr>
<tr>
<td>Contingency</td>
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<tr>
<td>Crisis</td>
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</table>
USAID Responds to Haiti Earthquake

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CSC Framework and Report Structure
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
RECOMMENDATION:

Federal, state, tribal, and local governments should develop a systems-based framework for catastrophic disaster response, which must be integrated into existing emergency response plans and programs. To facilitate the implementation of this framework, the committee specifically recommends that:

• Each level of government should ensure coordination and consistency in the active engagement of all partners in the emergency response system, including emergency management, public health, emergency medical services, public and private health care providers and entities, and public safety.

• Each level of government should integrate crisis standards of care into surge capacity and capability planning and exercises.
• The HHS/ASPR (e.g., through its regional emergency coordinators) should facilitate crisis standards of care (CSC) planning and response among state and tribal governments within their region;

• In CSC planning and response efforts, states should collaborate with and support local governments.

• Federal disaster preparedness and response grants, contracts, and programs in HHS, DHS, DoD, DoT, and VA—such as the Hospital Preparedness Program, Public Health Emergency Preparedness, Metropolitan Medical Response System, Community Environmental Monitoring Program, and Urban Area Security Initiative—should integrate relevant CSC functions.
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
CHEER UP, IT MIGHT NEVER HAPPEN
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