

# COVID-19: Crisis Care — Resources for California Hospitals

## Overview

In June, the California Department of Public Health (CDPH) issued its [California SARS-CoV-2 Pandemic Crisis Care Guidelines: Concept of Operations/Health Care Facility Surge Operations and Crisis Care](#). On December 28, CDPH issued [All Facilities Letter \(AFL\) 20-91](#), which provides additional guidance and requirements for implementing the Crisis Care Guidelines, as well as new notification requirements for facilities regarding their crisis care guidelines and when they implement them. Together, these materials provide a framework to help health care facilities plan for an overwhelming medical surge due to the pandemic. The guidelines include an overview of surge capacity and crisis care operational considerations, a decision-making framework for allocating ventilators, and pandemic patient care strategies for scarce resource situations.

## Notification Requirements

Note that AFL 20-91 adds several new notification requirements:

- As of January 6, 2021, all facilities must notify their local CDPH district office and local public health department via email that they have adopted and publicly posted (including a link to the posting) one of the following: their own crisis care continuum guidelines, another facility's guidelines, or the state's California Crisis Care Continuum Guidelines.
- Facilities that need to implement crisis care, including triage of critical care resources, must notify their local public health department and local CDPH district office via email and phone call immediately when initiating crisis care to ensure the state is aware of conditions at the facility.

## In This Document

Importantly, while AFL 20-91 and the guidelines provide information to support individual health care facility or health system operations, CDPH makes clear that they do not replace the judgment of operational management, medical directors, legal advisors, or clinical staff, or consideration of other relevant variables and options. To assist hospitals should they need to consider crisis care, CHA has prepared several resources that summarize the Crisis Care Guidelines and AFL 90-91 in order to highlight their key concepts and planning considerations for allocating scarce medical resources during surge operations:

- FAQs about crisis care
- A checklist for preparing for the possibility of moving to crisis care
- A step-by-step guide for implementing crisis care
- Key messages for use or customization with the media or public

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## Frequently Asked Questions

### WHAT IS CRISIS CARE?

According to the state's [Crisis Care Guidelines](#), crisis care is: “[d]isaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances.”

Crisis care occurs when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population that can be offered under the circumstances. As the state's Guidelines recognize, “Hospitals will not have an option to defer caring for patients in a crisis. Demand, guided by ethics, will drive the choices that have to be made.”

### HOW IS CRISIS CARE DIFFERENT FROM THE CARE HOSPITALS USUALLY PROVIDE?

Crisis care is not a separate triage plan but is a part of the care continuum. It is an extension of a hospital's surge-capacity plan, which addresses the ability to manage a sudden influx of patients, and its surge capability — the ability to manage patients requiring very specialized medical care. During conventional care, customary routine services are provided through standard operating procedures. During contingency care, the care provided is functionally equivalent to routine care but equipment, medications, and even staff may be used for different purposes or in a different manner than typical daily use. Crisis care falls at the far end of the spectrum, when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population.

### WHO DECIDES WHEN CRISIS CARE IS IN EFFECT AND HOW IT SHOULD BE IMPLEMENTED?

The decision that medical surge requires the implementation of crisis care, and the steps and actions that should be taken in response, rests at the hospital/system level, based on the particular environment, hazards, and resources available and the hospital's own allocation framework. A hospital should not delay implementing crisis care when its own situation warrants it even if a declaration has not yet been made at the state, regional, or local level. However, when a hospital needs to implement crisis care, including triage of critical care resources, it must notify its local public health department and local CDPH district office via email and phone call to ensure the state is aware of conditions at the hospital. Hospitals should be supported by regional Health Care Coalitions, their Medical and Health Operational Area Coordinator (MHOAC) Regional Disaster Medical and Health Specialist (RDMHS), the California Department of Public Health (CDPH), the Emergency Medical System Authority (EMSA), and public safety partners, local EMSA, state and local government agencies, and their parent health system (if applicable).

A hospital should not work on surge and crisis care plans in isolation, but in concert with local and regional partners, public health, the MHOAC, and its parent health system (if applicable). Consistency of plans and knowing what other health care facilities in the region are planning are critical to success. Hospitals' surge strategies and standard procedures do not have to be identical, but similarity among them will help greatly in education, training, and mutual aid response.

### WHEN IS CRISIS CARE IMPLEMENTED?

When an incident or circumstances such as a pandemic continue to overwhelm the health care system after initial stabilization and delivery of resources, decision-making must turn to whether resources can continue to be expended given the patient prognosis and availability of resources — in other words, triaging (prioritizing) the

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limited care or resources available among the patients for whom it would be appropriate. The conditions to engage in such proactive triage are:

- Critically limited resource(s) and infrastructure are identified.
- Surge capacity is fully employed within health care facilities (and regionally) if capacity/space is the limited resource.
- Maximum efforts to conserve, substitute, adapt, and re-use are insufficient if supplies are the limited resource.
- Patient transfer or resource importation is not possible or will occur too late for bridging therapies (such as bag-valve ventilation or other temporizing measures) to be considered.
- Necessary resources have been requested from local and regional health officials (as applicable).
- A state of emergency has been declared, or other health powers (as applicable) have been activated.
- Regional, state, and federal resources are insufficient or cannot meet demand.

The key is to implement crisis strategies only when assistance from regional and state partners is inadequate (too little or too late), and no “bridging” therapies or patient transfers can address the need.

## HOW DOES MEDICAL DECISION-MAKING FOR PATIENTS CHANGE WHEN CRISIS CARE IS IMPLEMENTED?

In customary circumstances, clinical care is focused on the individual patient, and treatment decisions are made by the patient’s care team (subject to the patient’s/representative’s consent and decision-making rights). A public health emergency compels transition from this individual patient-focused clinical care to a population-oriented public health approach with the goal of providing the best possible outcome for the largest number of impacted people. In such emergencies, it is recommended that decisions to allocate and reallocate scarce health care resources be made by a triage team or committee composed of people who have no clinical responsibilities for the patient’s care. This separation of the triage role from the clinical role is intended to enhance objectivity, avoid conflicts of commitment, and minimize psychological and moral distress for caregivers.

## HOW DO WE ENSURE THAT SCARCE MEDICAL RESOURCES WILL BE ALLOCATED FAIRLY WHEN CRISIS CARE IS BEING PROVIDED?

Basic biomedical ethical principles are incorporated into decision-making about allocation of health care resources. In general, triage decisions must meet the following basic requirements:

- **Fair and Equitable:** Process recognized as fair, equitable, evidence based, and responsive to specific needs of individuals and the population; focused on a duty of compassion and care, a duty to steward resources, a duty to abide by nondiscrimination laws, and a goal of maintaining the trust of patients and the community
- **Transparent:** In both design and decision-making
- **Consistent:** In application across populations and among individuals with reasonable modifications for disability
- **Proportional:** Public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources (i.e., the restrictions on care should not be more restrictive than the situation requires – and this may require re-evaluation as more resources become available).

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- **Accountable:** Individuals making the decisions, as well as the facilities and governments that support the processes and the providers

**Prohibited considerations:** Consideration of certain patient characteristics in allocating scarce resources is prohibited by law. Health care decisions, including allocation of scarce resources, cannot be based on age, race, disability (including weight-related disabilities and chronic medical conditions), gender, sexual orientation, gender identity, ethnicity (including national origin and language spoken), ability to pay, weight/size, socioeconomic status, insurance status, perceived self-worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources.

## *Ethical Principles*

The ethical principles used to triage and allocate scarce resources include:

- Duty to implement distributive justice (a socially-just allocation of goods)
- Duty to care: treat people with dignity and respect and make decisions according to an individualized assessment based on objective medical evidence.
- Duty to plan: steward resources and promote instrumental value.
- Duty to transparency (in planning and implementation)

## *Goals of Pandemic Planning Allocation Framework*

Any pandemic planning framework should be designed to ensure:

- Meaningful access for all patients. All patients who are eligible for ICU services during ordinary circumstances remain eligible, and there are no exclusion criteria based on age, disabilities, or other prohibited considerations listed above.
- Individualized assessments for all patients by clinicians, based on the best available objective medical evidence
- No one is denied care based on stereotypes, assessments of quality of life, or judgments about a person's "worth" based on the presence or absence of disabilities or other factors, including those listed in the prohibited considerations above
- A diminished impact of social inequalities that negatively impact patients' long-term life expectancy by keeping in mind historic disparities and inequalities

## **WHO SHOULD MAKE DECISIONS ABOUT ALLOCATING SCARCE RESOURCES?**

Decisions to allocate and reallocate scarce health care resources should be made by a triage team or committee composed of people who have no clinical responsibilities for the patient's care in order to, among other things, enhance objectivity and avoid conflicts of commitment on the part of caregivers.

## **CAN A HOSPITAL AVOID HAVING TO IMPLEMENT CRISIS CARE?**

Hospitals develop plans for addressing surge capacity (managing a sudden influx of patients) and surge capability (managing patients requiring very specialized medical care). This includes planning for the need for additional supplies and equipment (including PPE), staff, and space in order to care for patients during periods of high demand. But if patient care demands become high enough and necessary resources are scarce, hospitals will not have an option to defer caring for patients; the focus will change from delivering individual patient care to delivering the best care for the patient population. Demand, guided by ethics, will drive the

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choices that will have to be made in this situation. In the setting of limited resources and strain to the health care delivery system, hospitals are expected to actively work with their health care networks, local health care coalition, local public health, and their local MHOACs for supply, equipment, and staffing support. If a hospital nonetheless needs to implement crisis care, including triage of critical care resources, it will immediately notify its local public health department and local CDPH district office via email and phone call, which may result in access to additional resources and decompression measures.

### **HOW WILL PROSPECTIVE PATIENTS KNOW THAT A HOSPITAL HAS REACHED THE POINT THAT IT MUST IMPLEMENT CRISIS CARE?**

Before a hospital implements crisis care, it will first notify its local public health department and the CDPH local district office. According to CDPH, the local jurisdiction will develop a communications plan to notify the public that impacted facilities are operating at crisis care.

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## Hospital Checklist: Advance Planning for Crisis Care Decision Making

- Review available resources and determine potential strategies to address the state Guidelines across the surge capacity continuum from conventional to crisis care.
- Review the hospital's capabilities in managing surge, critical care (as appropriate), infectious disease, isolation, just-in-time training, critical care, and pediatrics to meet their objectives.
  - Involve in this review: nursing, administration, emergency management, emergency services, ancillary and support services — lab, radiology, respiratory therapy, pharmacy, facilities, etc. — and physician personnel.
- Determine the number of pandemic patients to plan for, taking into account the hospital's role in the community and the presence or absence of other health care facilities in the area.
- Incorporate indicators and triggers (surge capacity information throughout the care continuum) into the hospital's Emergency Operations Plan (EOP).
  - Include notifications to supervisors and partner agencies that need to occur when triggers are activated.
  - When possible, delegate authority to activate the disaster plan to emergency department (ED) staff or nursing supervisors/charge nurses to facilitate rapid action.
- Educate and train staff to ensure successful implementation of the EOP.
  - Educate personnel in tiers to the extent needed: **knowledge** (awareness of the plan), **competency** (the ability to do something successfully or efficiently in relationship to the plan), and **proficiency** (high degree of competence or expertise).
  - Staff who are fulfilling incident command roles should understand facility operations and how to interface with the local Health Care Coalition, where to get help or expertise, and be prepared to adopt proactive crisis care strategies with input from subject matter experts.  
  
*CDPH recommends that all health care facilities should have three-deep personnel for each hospital incident command system position.*
  - Prepare job aids — such as brief task cards or job action sheets — to help front-line personnel with initial decisions and actions.
  - Exercise the plan to help train and test it, pushing the exercise into the crisis care mode.
  - *Note:* Education prior to crisis events, as well as appropriate reminders integrated into job aids and training materials, should increase awareness of antidiscrimination responsibilities and the role that explicit and implicit bias can play in reinforcing health disparities affecting at risk populations.
- Develop decision-making tools and triage process for allocating scarce medical/critical care resources (“allocation framework”).

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- CDPH Guidelines contain resources to assist in the development of the allocation framework and decision-making; see Guidelines Appendix A and Appendix B. However, it is ultimately up to the hospital to determine and implement its own processes.
- The ethical goal of the allocation framework should be to maximize benefit for populations of patients and honor the ethical commitments to ensure meaningful access for all patients. Determinations should be based on individualized patient assessments, without regard to the following factors:
  - **Prohibited considerations:** Health care decisions, including allocation of scarce resources, cannot be based on age, race, disability (including weight-related disabilities and chronic medical conditions), gender, sexual orientation, gender identity, ethnicity (including national origin and language spoken), ability to pay, weight/size, socioeconomic status, insurance status, perceived self-worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources.
- Include an appeals process for individual triage decisions. See CDPH Guidelines, pp. 23-24.
- Take necessary steps to prepare to implement the allocation framework.
  - Create triage teams (to the extent resources allow) responsible for implementing the allocation framework; patients' treating physicians should not make triage decisions.
  - Train and prepare triage teams.
    - Triage team(s) should have expertise in public health ethics, anti-discrimination responsibilities, the elimination of implicit and explicit bias, and the hospital's allocation framework.
    - Triage team members should receive advanced training to prepare them for the role, including training in:
      - Applying the allocation framework
      - Communicating with clinicians and families about triage
      - Avoiding implicit and explicit bias, including with regard to age, race, disability (including weight-related disabilities and chronic medical conditions), gender, sexual orientation, gender identity, ethnicity (including national origin and language spoken), ability to pay, weight/size, socioeconomic status, insurance status, perceived self-worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources
      - Respecting the rights of all individuals, including individuals with disabilities
      - Diminishing the impact of social inequalities on health outcomes.
  - Appoint and train a group of triage officers to oversee/implement the triage process.

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- Ensure the triage team has appropriate computer and IT support to maintain updated databases of patient priority levels and scarce resource usage.
- Develop a written, plain language explanation of the triage and appeals process to be provided to patients, family, and/or surrogate if patient receives adverse triage decision.
- Palliative care services: Devise plans to accommodate the surge in demand for palliative care services and the adaptations that will be required to deliver those services.
- During an event response, review and modify procedures as needed as part of the incident action planning process. Plans should be adaptable and not “lock in” disaster response protocols for the duration of an incident but allow flexibility and transition toward conventional care as more resources arrive or demand falls, or both. Review and update the plan when new information is available.

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## Implementing Crisis Care: A Step-by-Step Guide for Hospitals

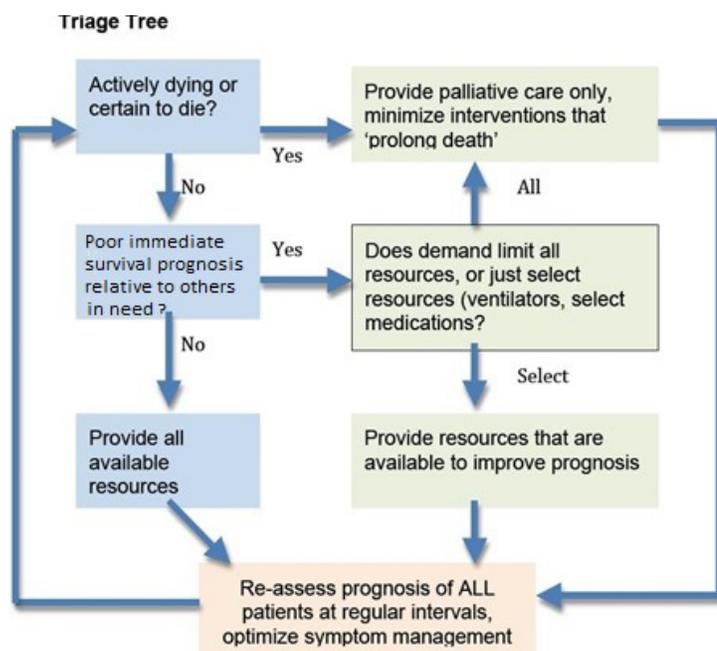
- **Pre-Implementation Checklist:** Before implementing crisis care guidelines, the hospital should go through all possible contingency planning. If applicable, has the facility implemented some or all of their surge strategies to include consideration of allocation of scarce resources in the following buckets?
  - ✓ PPE, Supplies, and Equipment
    - Have you confirmed the numbers of ventilators for patient care that are available meet the needs of available ICU licensed, surge, and ED overflow space?
    - Exhausted all contract options?
    - Submitted resource requests through the MHOAC up to the state for resupply?
    - Implemented re-use and extended use practices, as necessary?
  - ✓ Staff
    - Have you applied for ICU staffing waivers and exhausted all efforts to augment critical care staffing?
    - Have you defined a process to extend critical care staffing by using noncritical care staff (nursing teams, non-critical care physicians assigned to ICU spaces (Cardiology, Anesthesia, Emergency))?
    - Procure contract and registry staff
    - Submit staffing waiver(s)
    - Adopt other staffing models
    - Develop isolation and quarantine guidelines for infected or exposed staff, including CDC and CDPH strategies to maintain staffing during times of staffing shortages
  - ✓ Space (Internal and External)
    - Have you defined the maximal expansion of surge ICU spaces (PACU, Telemetry, other surge ICU spaces)?
    - Activate traditional internal and external surge space
    - Repurpose non-patient care spaces as necessary for decompression, both internally and externally
- When an incident continues to overwhelm the hospital after initial stabilization and delivery of available resources, proactive triage of resources should only occur when the following conditions are met:
  - Critically limited resource(s) and infrastructure are identified.
  - Surge capacity is fully employed within health care facilities (and regionally) if capacity/space is the limited resource.
  - Maximum efforts to conserve, substitute, adapt, and re-use are insufficient if supplies are the limited resource.
  - Patient transfer or resource importation is not possible or will occur too late for bridging therapies (such as bag-valve ventilation or other temporizing measures) to be considered.
  - Necessary resources have been requested from local and regional health officials (as applicable).

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- A state of emergency has been declared, or other health powers (as applicable) have been activated.
- Regional, state, and federal resources are insufficient or cannot meet demand.

The key is to implement crisis strategies only when assistance from regional and state partners is inadequate (too little or too late), and no “bridging” therapies or patient transfers can address the need.

- Facilities that need to implement crisis care, including triage of critical care resources, must notify their local public health department and local CDPH district office via email and phone call immediately when initiating crisis care to ensure the state is aware of conditions at the facility.
  - CDPH advises that this notification will serve as a warning system of where the state may need to provide resources or plan for transfers or diversions; it will also assist the state in ensuring California’s surge response is guided by ethical and equitable principles.
- When allocating scarce medical resources, decision-making should include a basic triage tree based on objective medical evidence:



- ✓ **Ethical considerations:** Basic biomedical ethical principles (autonomy, beneficence, justice, fairness/equity, transparency, consistency, proportionality, accountability) should be incorporated into decision-making for allocation of scarce critical resources (see CDPH Guidelines, pp. 15-17).
- ✓ **Prohibited considerations:** Health care decisions, including allocation of scarce critical resources, cannot be based on age, race, disability (including weight-related disabilities and chronic medical conditions), gender, sexual orientation, gender identity, ethnicity (including national origin and language spoken), ability to pay, weight/size, socioeconomic status, insurance status, perceived self-worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources.

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- ✓ Implementing the hospital's decision-making tools and triage process for allocating scarce critical care resources ("allocation framework").
  - Triage officer and triage team should use the allocation framework to determine priority scores of all patients eligible to receive the scarce medical/critical care resource.
    - For patients already being supported by a scarce resource, the evaluation should include reassessment at pre-specified intervals to evaluate for clinical improvement or worsening.
  - Make daily determinations of how many priority groups can receive the scarce resource.
    - All patients should be eligible to receive critical care resources regardless of their priority score. The availability of critical care resources should determine how many eligible patients will receive critical care.
  - Triage officer should review the comprehensive list of priority scores for all patients and should communicate with the clinical teams immediately after a decision is made about allocation or reallocation of a critical care resource.
    - Underlying health conditions should not form the basis of the determination of the immediate or long-term survivability of the patient.
  - Triage decision should be communicated/disclosed to patient/family/surrogate. Provide a written, plain language explanation of the triage and appeals process to the patient, family, and/or surrogate.
    - Consider explaining the medical factors that informed the decision, as well as the factors that were not relevant (e.g., race, ethnicity, disability, or other factors listed under "prohibited considerations" above).
  - In response to objection/request by patient/family/surrogate, implement appeal process.
  - Conduct periodic reassessments of patients who are receiving critical care services in accordance with the allocation framework in order to determine whether the patient should continue with the treatment.
  - Patients who are no longer eligible for critical care treatment should receive medical care including intensive symptom management and psychosocial support.
- ✓ The need for ongoing utilization of crisis triage protocol should be continuously evaluated. Triage should be suspended immediately once critical resources are no longer scarce.
  - Hospital/health system leadership should consult with local health authorities about these decisions.
- ✓ At the conclusion of an emergency triggering crisis care and implementation of the triage protocol, a formal report describing the hospital/health system's experience, patient outcomes, community response, and lessons learned should be developed and shared with providers, system leaders, governing authorities, patients, and the public. Feedback from these stakeholders should be used to evaluate and update, as appropriate, all aspects of the triage framework.

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## Key Messages: Crisis Care Guidelines Provide Framework for Clinicians to Provide Care When Faced with Insufficient Resources

- 1. The latest COVID-19 surge has resurfaced the potential need to draw upon the California SARS-CoV-2 Pandemic Crisis Care Guidelines, a document released by the California Department of Public Health in June that no one whose daily work involves saving lives would prefer to ever need to use.**
  - This unprecedented crisis has resulted in a new, harsh reality – the possibility of health care professionals having to manage scarcity.
  - The numbers and projections, as we approach 2 million cases in California, suggest health care workers may not have enough of what's needed — staff, personal protective equipment, testing capabilities, ventilators and other life-saving machines — to provide maximum care to each and every patient.
  - This is a grim prospect, and one whose gravity is deeply felt by health care leaders and clinicians.
- 2. The Crisis Care Guidelines – a framework for health care professionals to plan for a surge of unimaginable proportions – were developed by the state based on best practices throughout the country and guided by ethical principles.**
  - The framework aims to ensure that if there is a shortfall of what's needed, health care systems respond in a coordinated, thoughtful manner to make decisions that protect the health of all Californians as best we can with the resources available.
  - Every hospital in California has access to these guidelines, and will operationalize them, if needed, in a way that will meet the needs of their patients to the best of their ability.
  - **INDIVIDUAL HOSPITALS SHOULD USE THIS SPACE TO EXPLAIN HOW THEY ARE IMPLEMENTING THE GUIDELINES**
- 3. Crisis care happens only when all other avenues are exhausted. Right now, there is still time to help reduce the need for these measures – by avoiding all unnecessary outings/travel and gatherings for the next several weeks.**
  - Many regions in the state are near, at, or exceeding the current hospital ICU capacity, and models suggest more patients will be flooding hospitals in the coming weeks.
  - This could be exacerbated by non-essential travel and gatherings over the Christmas and New Year holidays.
  - AAA projects as many as 84.5 million Americans will journey 50 miles or more from Dec. 23 to Jan. 3, 2021; that's a 30% drop compared to last year, but it's not enough. Hospitals ask all Californians to do their part to alleviate the strain on critical resources, so we can do our part to care for those in need and save lives, including those of our friends and families.