

# Trustee Insights

## GOVERNANCE



## Crisis Standards of Care and the Pandemic

### Being prepared when a catastrophic event occurs

BY ANN SCOTT BLOUIN

**H**ospitals across the United States have been inundated with an alarming number of very ill, complex care patients diagnosed with COVID-19. Caring for patients with non-coronavirus health care needs, such as cardiac and neurologic emergencies, while managing surges in COVID-19 cases, has presented a serious problem for hospitals. What should senior leaders do when there is no

more space, no more staff, no more equipment and nowhere to transfer these critically ill patients?

Accepting an influx of patients with COVID-19 may require hospitals to prioritize the care of patients. In a severe pandemic, one of the most challenging demands that many hospitals may face is determining objective criteria and clinical guidelines for making decisions regarding the triage and management of COVID-19 patients who may be competing for scarce resources, such as hospital emergency admissions, ventilators and other equipment, medications and intensive care resources.

These critical, ethical and legal

decisions should not be made by one person or even just a few people. The criteria used to make these decisions should be created in advance, formally adopted by the medical team and hospital leadership, and approved by the board.

### Defining Crisis Standards of Care

The Institute of Medicine or IOM (now known as the National Academy of Medicine) first published guidance on crisis standards of care during the 2009 H1N1 pandemic, for hospitals in serious disaster situations. This guidance was most recently updated in 2020, providing a framework and toolkit with indicators for hospitals to use when confronted with these dire circumstances. Considerations include whether essential infrastructure — such as beds, utilities and transportation — are critically compromised; absence or a serious lack of human, equipment and supply resources; and consistent information which eliminates transfer out to other viable alternative hospitals. The focus shifts from the individual patient to the population of patients who must be managed during an extreme emergency.

Movement from “conventional” everyday standards of care — where all efforts are devoted to caring for the individual patient — to “contingency” standards of care — when

alternative, equivalent resources are possible — to the most challenging “crisis” standards of care is a most difficult decision for physicians and senior leaders. There is a duty to plan in advance, with written guidelines, should these circumstances occur.

Both urban and rural hospitals nationwide are facing this challenge. Beginning in 2020, several regions were prepared to activate crisis standards of care as supplies, space and staff became increasingly unavailable. In October 2020, hospitals throughout Utah, in consultation with the governor’s office, developed a statewide plan for implementing crisis standards of care measures. As of November 2021, hospitals in Alaska, Idaho and Colorado have moved to crisis standards of care.

As the United States stands ready for another surge in COVID-19 infections or for natural disasters, boards of trustees need to be aware of how clinical and hospital leaders will proceed should these extraordinary challenges emerge.

## Considerations for Transitioning to Crisis Standards of Care

The Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations noted in their recommendations to the IOM that the norms in medical care do not change during disasters: Health care professionals are always obligated to provide the best care they reasonably can under given circumstances. For purposes of developing recommendations for situations when health care resources are overwhelmed, the committee defined the level of health and

## When to transition to crisis standards of care

The decision to transition to crisis standards of care requires the following considerations, which the board will need to know have been evaluated.

- Legal assurances that federal and state emergency declarations and statutes have authority for hospitals to use crisis standards of care.
- Evidence-based clinical processes, operations and treatment will follow current criteria and research for the population served.
- Clear and detailed indicators, triggers to move to the next stage, and responsibility and authority for decision-making are available.
- Strong ethical guidelines on using available resources to sustain life for the “greatest good” are understood.
- A plan for communication, including transparency to the hospital staff and community about the circumstances, has been developed.

medical care capable of being delivered during a catastrophic event as crisis standards of care.

Perhaps most challenging are the ethical issues that must be considered when transitioning from the usual patient-centered approach of providing the best care for the individual patient to providing resources fairly to the public.

If crisis standards of care are required, with the considerations and approvals secured, hospital leadership needs to be prepared with a crisis communications plan. This is important to develop in advance of the crisis, as management’s attention will be diverted to many different time-sensitive activities. Questions to address in creating the plan include:

- Who is the official spokesperson for the hospital — i.e., the person who gives media updates, answers questions, acts as the contact person for any follow-up required?
- What approvals have been secured?

- What proactive measures have already occurred to try to avoid the crisis?

- How will the community know when the crisis is resolved — i.e., what measures will indicate the crisis standards of care are abated?

As the COVID-19 pandemic continues, weary hospital leaders, clinicians and boards are doing everything possible to continue to provide the best care they can for each patient. Moving to crisis standards of care should be considered a last resort.

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