Crisis Standards of Care

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R_t COVID-19

Tweet Share

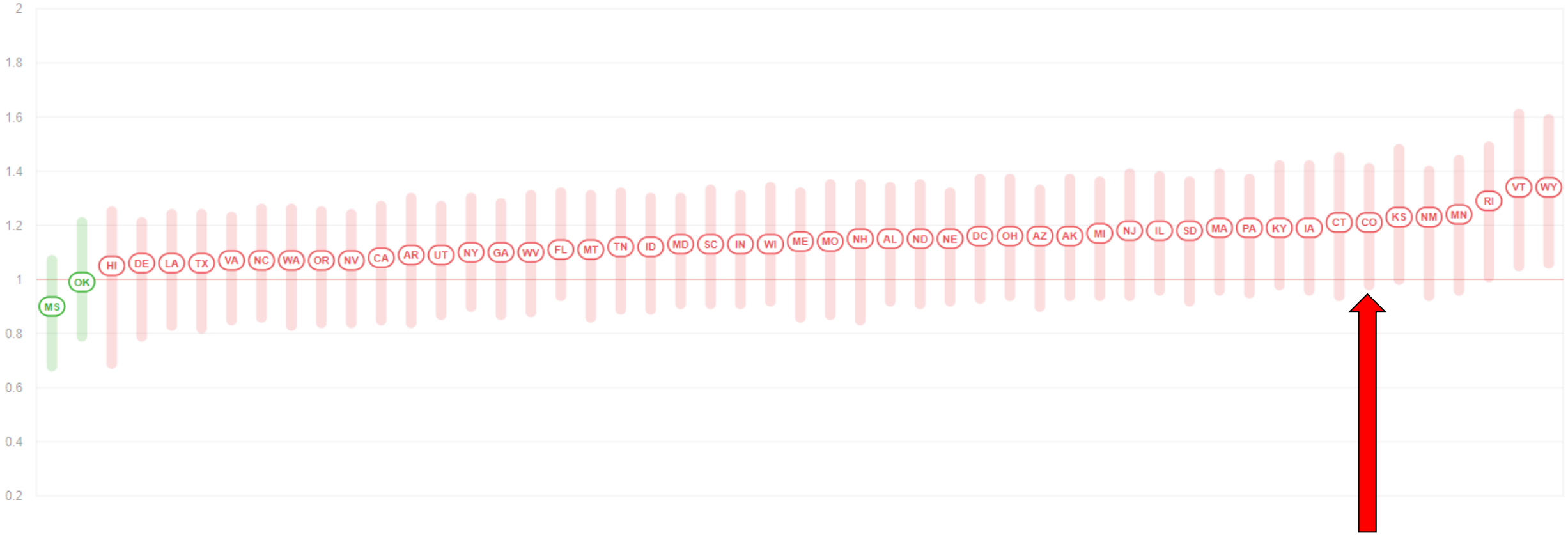
These are up-to-date values for R_t, a key measure of how fast the virus is growing. It's the average number of people who become infected by an infectious person. If R_t is above 1.0, the virus will spread quickly. When R_t is below 1.0, the virus will stop spreading. Learn More.

See details about the spread in Colorado

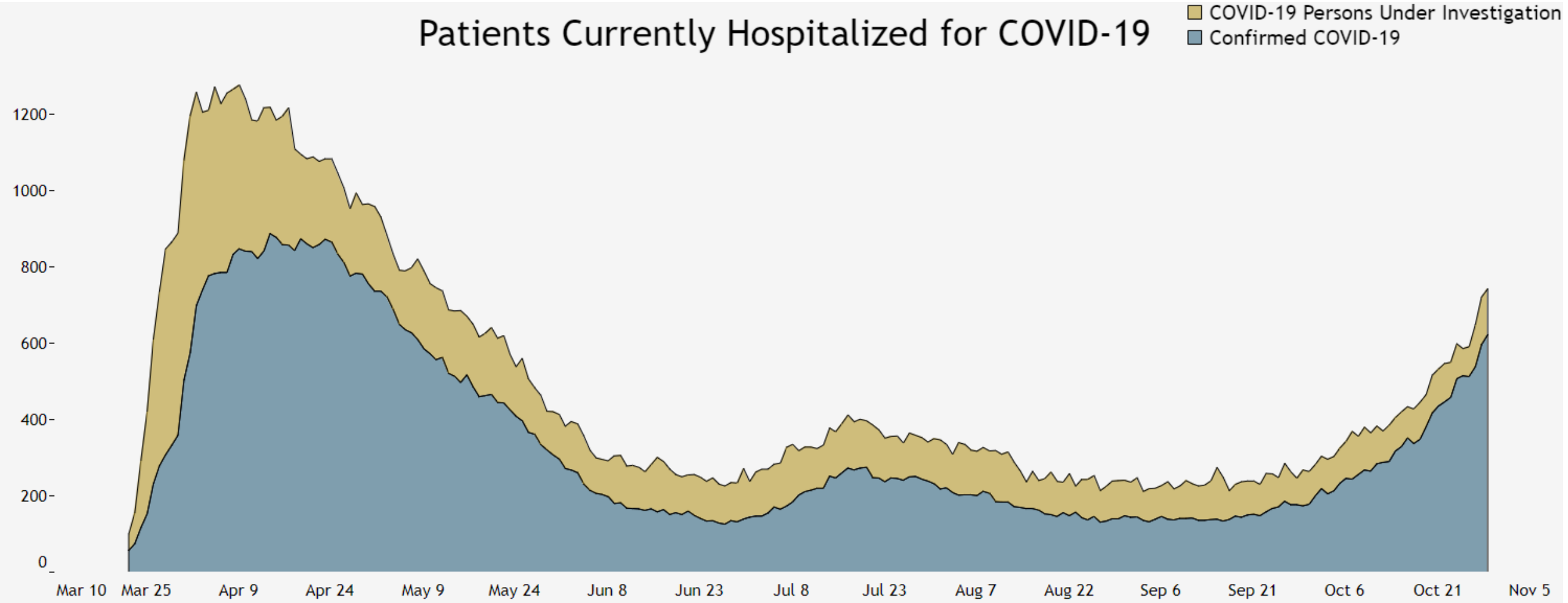
Data Last Updated: 10/29 at 9:45AM

Latest | 2 Weeks Ago | 1 Month Ago | 2 Months Ago | 3 Months Ago

Filter



Patients Currently Hospitalized for COVID-19



Being ethical requires competence

- We typically talk about this in terms of whether practice is "below" the standard of care
- Practice that does not meet doing so can incur the wrath of licensing boards and expose a practitioner to liability
- Although what the "standard of care" can be nebulous
- Back in March, the State started having very frank conversations about the standard of care in a crisis

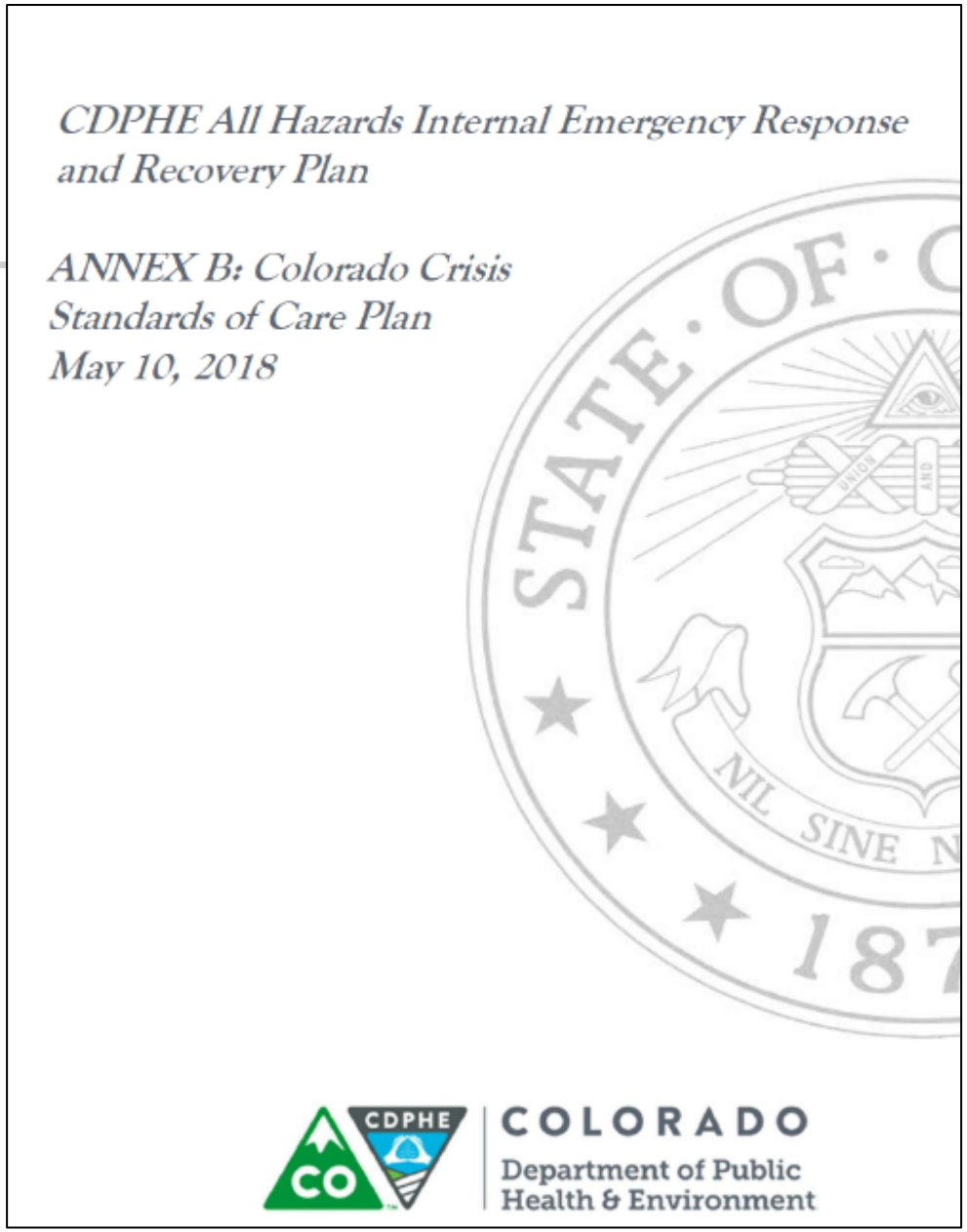
COVID-19 forces Italian doctors to make life-and-death choices about rationing care

New recommendations advise saving 'scarce resources' for those with the 'greatest chance of survival'

CBC Radio · Posted: Mar 13, 2020 6:15 PM ET | Last Updated: March 13

Background: CSC

- Colorado has been concerned about crisis standards of care (CSC) since 2001
- The State's response to an epidemic is to stand up a committee to advise to governor
- During certain circumstances, the standard of care shifts not to what is best for the individual, but what is best for the community



Background: CSC

- Governor's Expert Emergency Epidemic Response Committee
  - Created by statute in response to the 9/11 attack to advise the governor on emerging/ongoing threats to public health
  - The GEEERC convenes SME panel to advise on crisis standards of care

STEP 1:	Disaster Occurs or Escalates to Crisis Level
STEP 2:	Initial Discussion of Local Officials and CDPHE OEPR to Activate the GEEERC
STEP 3:	Decision Is Made by CDPHE OEPR to Activate the GEEERC
STEP 4:	GEEERC and Subject Matter Experts Convene and GEEERC Makes Recommendation to CDPHE to Request Utilization of CSC Plan
STEP 5:	CDPHE Requests Directly to Governor or through State Emergency Operations Center to Request CSC Activation
STEP 6:	Governor Approves Disaster Declaration for a Public Health Emergency with Associated Executive Orders for Execution including CSC activation
STEP 7:	Local Officials Implement CSC Plan
STEP 8:	Governor consults with GEEERC and CDPHE
STEP 9:	Notification of Deactivation of CSC
Step 10:	Deactivation of CSC

CSC

- Describing what **conventional** capacity for the delivery is, what are examples of operating at **contingency** capacity, and at what point are we operating at **crisis** capacity
- Identifying **indicators** and **triggers** in the delivery of care
- Most importantly, developing **tactics** to cope with crisis

BOX 3-1
Key Terms and Concepts

Crisis standards of care: "Guidelines developed before disaster strikes to help health care providers decide how to provide the best possible medical care when there are not enough resources to give all patients the level of care they would receive under normal circumstances" (IOM, 2012, p. 6-14).

Continuum of Care: Conventional, Contingency, and Crisis

Conventional capacity: The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan (Hick et al., 2009).

Contingency capacity: The spaces, staff, and supplies used are not consistent with daily practices, but provide care that is *functionally equivalent* to usual patient care. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources) (Hick et al., 2009).

Crisis capacity: Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care (Hick et al., 2009).

Indicators and Triggers

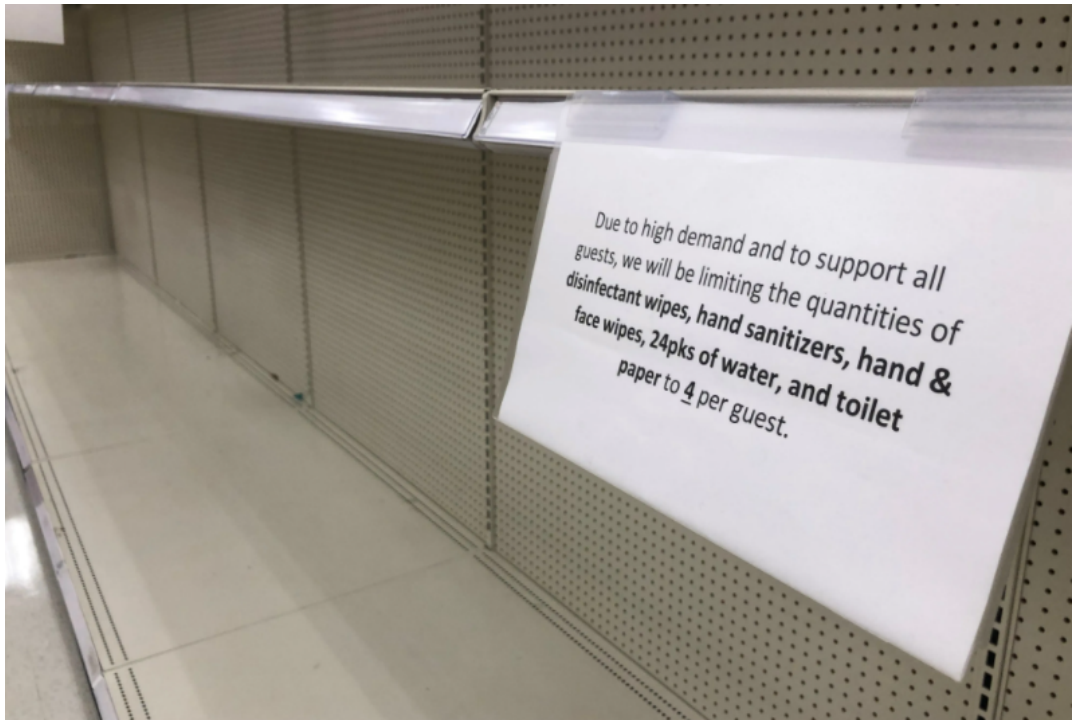
Indicator: A measurement, event, or other data that is a predictor of change in demand for health care service delivery or availability of resources. This may warrant further monitoring, analysis, information sharing, and/or select implementation of emergency response system actions.

Background: Makeup of the GEEERC

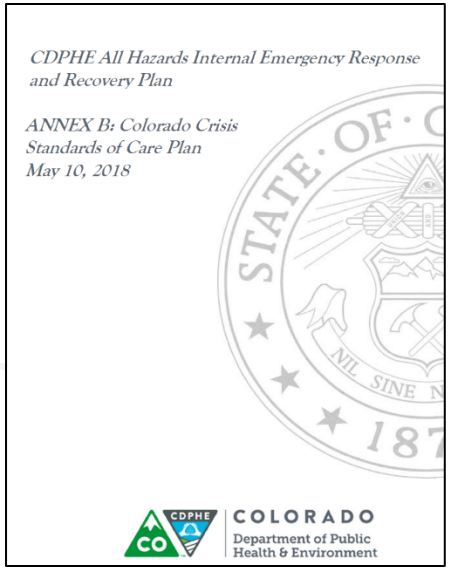
- Executive Director of CDPHE (Chair)
- CMO of CDPHE
- Chief PIO of CDPHE
- Emergency Response Coordinator for CDPHE
- State Epidemiologist for CDPHE
- Attorney General
- President of the Board of Health
- President of CMS
- President of CHA
- State Veterinarian of the Dept of Agriculture
- Director of the Division of Homeland Security and Emergency Management
- Licensed Physician Specializing in Infectious Diseases
- Licensed Physician Specializing In Emergency Medicine
- A Medical Examiner
- Specialist in Posttraumatic Stress Management
- Director of a Local Public Health Department
- Hospital Infection Control Practitioner
- Wildlife Disease Specialist With the Division of Wildlife
- Pharmacist Member of Board of Pharmacy
- Executive Director of the Dept Of Local Affairs
- Colorado Department of Public Safety

GEEERC → SMG → GMAG

- GEEERC needs subject matter experts to advise it
- In March, a subject matter expert group was assembled to create CSC for:
  - Use of Personal Protective Equipment
  - Emergency Medical Services protocols
  - Allocation of scarce medical resources



Colorado CSC Plan



d) Behavioral *Health*

(1) *Individuals with Behavioral Illness*

Upon implementation of CSC, CDPHE and DHS/OBH will consult with GEEERC regarding any modifications that are necessary to attempt to meet the needs of the people with serious mental illness (SMI), serious emotional disorders (SED) and substance use disorders (SUD). Due to the current shortage of behavioral healthcare workers there will potentially be a significant impact on the overall availability of resources for behavioral healthcare within the state. The GEEERC must consider both the ongoing treatment needs of the SMI population, as well as additional emotional and behavioral issues this group may experience as a result of the disaster.

Community mental health centers have developed disaster plans which will facilitate the provision of mental health resources and support. Local public health, local emergency management, and healthcare coalitions will further support the coordination of mental health support during a CSC activation.

Constructing CSC for Behavioral Health

- In April, CDPHE recognized need for Behavioral Health CSC to be created
- To our knowledge, nothing that had ever been done before
- Assembled subject matter expert panel of about 35 – 40 leaders in the field of behavioral health cutting across private practice, academia, public health, and corrections
- Four subgroups (chair) created:
  - Outpatient BH
  - Substance Use Disorder Treatment
  - Corrections BH
  - Intensive/inpatient treatment

BH CSC far more complicated than who gets a ventilator

- Regulated by multiple mental health licensing boards, and the boards of professional psychology and medical examiners
- Several offices of state level oversight
  - Office of Behavioral Health
  - Colorado Department of Health Care Policy & Financing
- As well as federal oversight
  - Centers for Medicare and Medicaid Services
  - Joint Commission for the Accreditation of Health Care Organizations
- Different laws and regulations for treating substance use disorders despite being closely related to mental illness
- All put together by people with day jobs

Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations

September, 2009

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Crisis Standards of Care

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.

Crisis Standards of Care

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.

Crisis Standards of Care With 5 Key Elements

1. A strong ethical grounding
2. Integrated and ongoing community and provider engagement, education, and communication
3. Assurances regarding legal authority and environment
4. Clear indicators, triggers, and lines of responsibility
5. Evidence-based clinical processes and operations

Crisis Standards of Care Based on the Following Key Principles

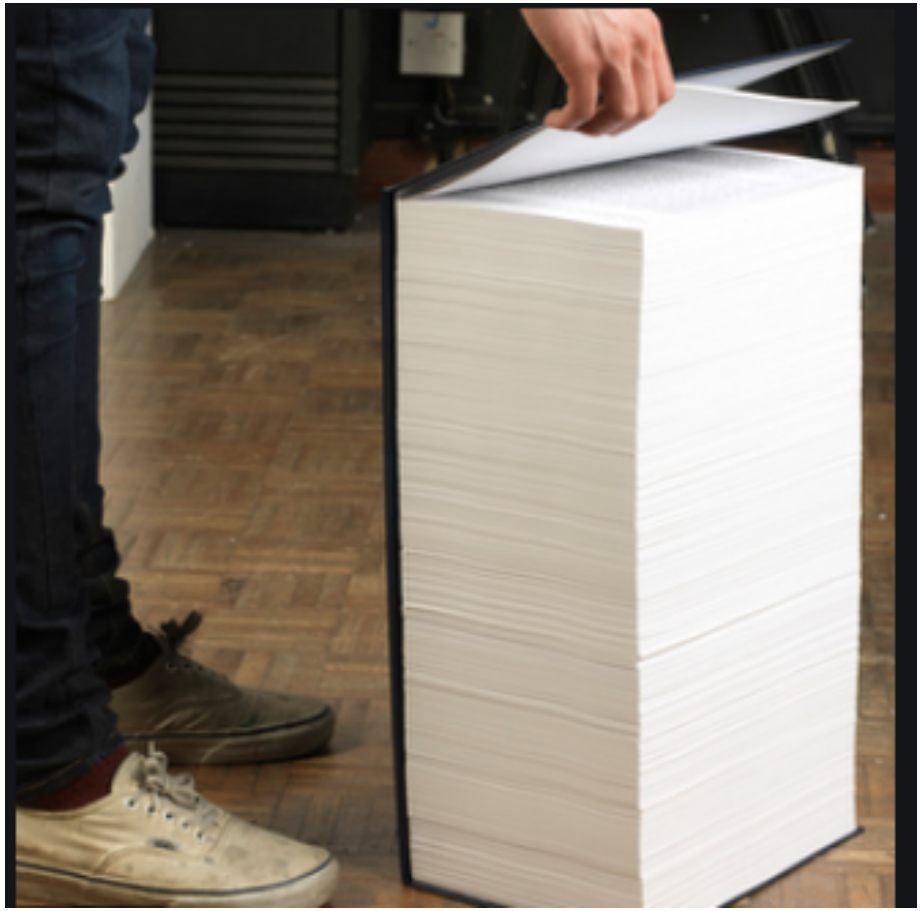
- Fairness
- Duty to Care
- Duty to Steward Resources
- Transparency
- Consistency
- Proportionality
- Accountability

Over several weeks

- Each subgroup identified contingency care and crisis standards
- Corrections
  - Be thoughtful about moving offenders from one site to another to limit spread of the virus
  - Most of their issues resolved around policy
- Inpatient
  - Surging into space that is not accredited for BH patients
  - Triage admissions and considering discharge criteria
  - Moving patients from community hospitals to psych facilities
  - Assuring rights for those being treated involuntarily
- Outpatient
  - Live signatures on documents
  - Telehealth
- Substance Use Disorders
  - Distributing methadone through pharmacies
  - Rapid response teams of prescribers and pharmacists into areas that are hard hit

This generated a huge document

- We decided it was too unwieldly to convert into public health orders to have a broad BH CSC
- The entire document is available to anyone on CDPHE CSC website as a source to anyone about ways to mitigate a surge
- Through CDPHE and the BH CSC committee, we identified some "pinch points" for areas that could be addressed by the governor



Six Topic Areas Under Review

1. Licensing of Mental Health Providers

- Reinstate recently lapsed licenses for those in good standing to practice.

- Recognize out of state licenses for those whose professions are under the jurisdiction of CRS12-43 & CRS12-240 for the duration of the crisis. (Made moot with SB 20-212)

2. Signature Requirements

- Waive the statutory requirement that a signature be obtained on the "mandatory disclosure of information to clients form" (CRS 12-43-214). Allow verbal consent documentation as sufficient.

3. Mental Health Holds

- Licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, psychiatric nurse practitioners, and physician assistants who have received specialized training in evidence-based assessment, suicide prevention intervention and support skills training in behavioral health, and collaborative safety planning will be permitted to evaluate a mental health hold within 24 hours of initiation.

4. Second Opinions for Emergency Medications

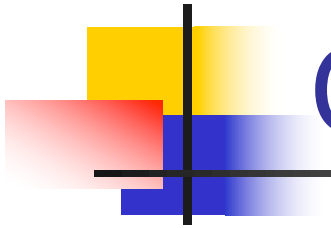
- Licensed psychologists, psychiatric nurse practitioners, and physician assistants who have received specialized training in evidence-based assessment of behavioral health, intervention and safety planning may render a second opinion regarding the continuing of "emergency medication" past three days if no other licensed physician is available. Consider use of telehealth or phone if video is not possible, use of other providers who are not physicians.

5. Addition of Certified EMTs for Transport

- Add certified EMTs and paramedics who have received specialized training in mental health response, de-escalation and safety planning to those permitted to detain and transport individuals by initiating an involuntary transportation hold.

6. Pharmacy Care of Persons with Opioid Use Disorder

- Permit pharmacies and pharmacists to broaden their service to treat those living with opioid use disorder, including permitting legally selling syringes to individuals and syringe service programs; dispense methadone and suboxone to those in medication-assisted treatment.



Questions

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