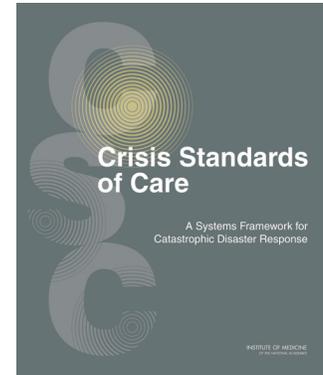


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# Crisis Standards of Care

## A Systems Framework for Catastrophic Disaster Response



**Devastating catastrophes** that took place in 2011—including a tornado that devastated Joplin, Missouri, earthquakes that rocked Christchurch, New Zealand, and an earthquake that struck Japan and triggered a powerful tsunami—underscore how quickly and completely health systems can be overwhelmed. Disasters, whether they occur suddenly and are unexpected or are caused by slow, sustained public health emergencies, can stress health care systems to the breaking point and disrupt delivery of vital medical services.

At the height of the first global influenza pandemic in a generation, the Department of Health and Human Services (HHS) asked the Institute of Medicine (IOM) to convene a committee of experts. During the first phase, finished in 2009, the IOM committee developed guidance that health officials could use to establish and implement standards of care during disasters.

In that report, the committee defined “crisis standards of care” (CSC) as a state of being that indicates a substantial change in health care operations and the level of care that can be delivered in a public health emergency, justified by specific circumstances. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole. CSC is one critical component of disaster planning and is necessary to equitably allocate scarce resources, the committee concluded.

In 2010, HHS, the Department of Veterans Affairs (VA), and the National Highway Transportation Safety Administration asked the IOM expert committee to reconvene to provide concepts and guidance to help state and local officials apply the CSC framework the committee created earlier.

In its report, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, the committee examines the effect of its 2009 report, and

**Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole.**

develops important templates to guide the efforts of professionals and organizations responsible for CSC planning and implementation.

The committee finds that integrated planning for coordinated response by state and local governments, emergency medical services (EMS), health care organizations, and health care providers in the community is critical to successfully responding to disasters.

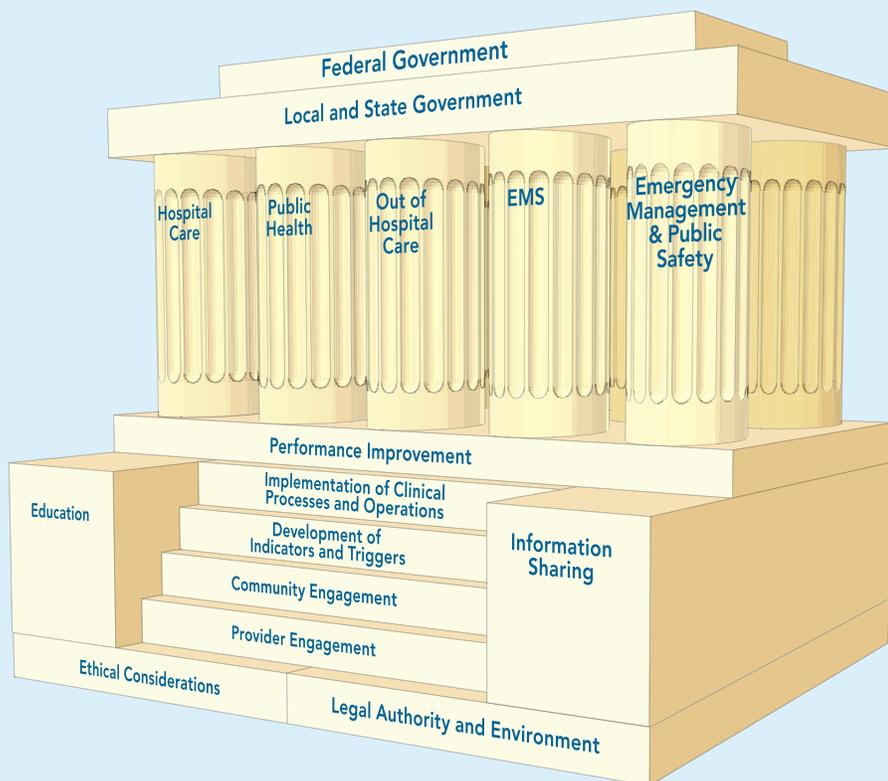
At the core of a well-functioning CSC system are fundamental ethical values to ensure that all providers act with compassion and justice. Having a responsive legal and regulatory environment is also important. An effective and fair legal system encourages all health professionals and volunteers to perform their functions well while also maximizing health resources and protecting patients from unnecessary harm.

## Delivering the Best Care Possible

The committee strongly recommends weaving CSC into the broader context of disaster planning—what it considers a “systems” approach. The entire emergency response system—independent actors who work alone as well as in tandem within a coherent, integrated group—must adopt this type of approach to deliver the best care possible to the largest number of patients.

The committee’s multi-tiered, systems-based framework for catastrophic response (see Figure) can be integrated into existing emergency response plans and programs. For CSC planning to be implemented successfully, it must be embraced by the full spectrum of disciplines that participate in an emergency response, and not simply adopt a narrow focus on the issue of health care delivery. Each key actor—emergency management, public safety, public health, EMS, health

FIGURE: A Systems Framework for Catastrophic Disaster Response



**During ordinary times, facilities providing acute medical care have a duty to serve patients; in anticipation of extraordinary times, such facilities have a “duty to plan” for catastrophic incidents, including planning for delivery of care along the continuum from conventional to crisis surge response.**

care organizations, and community-based health practitioners—greatly influences the success or failure of the system as a whole to provide care during catastrophes.

Local government is uniquely positioned as a nexus connecting state government partners and local communities. Therefore, involvement of leaders of state and local government is paramount to ensure proper CSC planning and implementation.

### **Defining Federal, State, Local Roles**

The systems approach to catastrophic disaster response requires federal, state, and local government to work together to plan and implement CSC while acknowledging their differing authorities and access to resources. The federal government should provide national leadership by supporting and encouraging the establishment of guidelines for crisis standards of care for use in disasters. In particular, HHS should continue to include specific language in program grants to underscore the importance of CSC planning.

A disaster that triggers use of CSC stops at no border and could tax the resources of local, regional, state, and federal authorities. Therefore, the committee finds that coordination between state and federal partners is essential. State health departments are the most appropriate agencies to lead and coordinate CSC planning and response efforts at the state level and to brief state leaders.

While no single agency, health care coalition, emergency responder, or health care practitioner can be expected to grapple with the challenges presented by a CSC event alone, all disasters truly are local. Effective local CSC efforts rely on the state’s leadership. State plans need to be adapted or folded into local planning efforts.

### **Health Care Facilities’ “Duty to Plan”**

During such crises, hospitals may be without power; trained staff may be unavailable; medicines, supplies, and hospital beds could be in short supply; and medical attention may need to be delivered in alternate care facilities. Making the necessary adjustments to the scope of practice, treatment options, ambulance staffing, and call center response all figure into state, local, and EMS agency-specific crisis response plans. Among other duties, the state agency taking the lead in coordinating the response should establish triggers and thresholds that will signal the shift from conventional care to contingency care to crisis care. Public engagement should occur during the planning phase to ensure the plan reflects community values and priorities.

Hospitals, walk-in clinics, and private practices are critical in the response framework, and they also need crisis response plans that designate the shift from conventional standards of care to providing essential services during a disaster. During ordinary times, facilities providing acute medical care have a duty to serve patients; in anticipation of extraordinary times, such facilities have a “duty to plan” for catastrophic inci-



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dents, including planning for delivery of care along the continuum from conventional to crisis surge response.

Though much of the disaster and surge capacity planning focuses on hospital-based care, nearly 90 percent of health care is delivered in the outpatient setting. Efforts to incorporate the medical staff, supplies, and resources of outpatient facilities into the larger disaster response effort are critical and must be incorporated into the comprehensive disaster planning equation.

**Conclusion**

The committee's recommended framework incorporates all necessary emergency response disciplines—including health care, EMS, public health, public safety, and emergency management—as well as requirements for implementing the system. It provides a foundation of underlying principles, steps needed to achieve implementation, and the pillars of the emergency response system, each separate and yet together upholding the jurisdictions—local, state, and federal government—that have the overarching authority for ensuring that CSC planning and response occurs.

The committee's work already has been referred to in HHS cooperative agreements that fund public health and medical preparedness across the nation. If the entire emergency response system embraces and implements this framework, it will help ensure that the largest number of patients receive the best care possible during a public health emergency, while still ensuring that everyone receives fair and equitable care. 

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