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OREGON PUBLIC HEALTH DIVISION • OREGON HEALTH AUTHORITY

OREGON CRISIS CARE GUIDANCE: WHEN THE GOING GETS TOUGH...

I have no idea what's awaiting me, or what will happen when this all ends. For the moment, I know this: there are sick people, and they need curing.

Albert Camus. The Plague, 1947

In a public health crisis, healthcare resources may be overwhelmed. Hospitals and other buildings may be damaged. Healthcare workers may be dead, ill or injured. They may be caring for loved ones, or simply unable to reach their work location. At the same time, many in the community may be ill or injured and need care. This *CD Summary* introduces the Oregon Crisis Care Guidance, an ethically grounded framework for providing the best care possible in a public health crisis.

ORIGINS OF THE GUIDANCE

Nationally, the Institute of Medicine[1] and the Agency for Healthcare Research and Quality[2] in the Department of Health and Human Services have urged healthcare communities in all states to develop guidance in this area. In Oregon, efforts to develop an ethical framework for crisis care began in 2006. Healthcare preparedness experts from across the state re-affirmed the importance of this work, identifying crisis care guidance development as a priority during a statewide hospital preparedness summit in 2008.

Efforts in this area heated up in the fall of 2009, not coincidentally about the time that H1N1 influenza began stressing intensive care unit capacity in several regions of the state. Soon, six workgroups, consisting of 80-plus members, representing an array of disciplines (e.g., clinical, adminisrative, social, ethical) were hard at work drafting crisis care guidance for various healthcare sectors.

OVERARCHING PRINCIPLES

Early in the process, workgroup participants recognized that, when it comes to strategies to expand healthcare surge capacity, one size does not fit all. Accordingly, the guidance provides a flexible menu of options, some of which may be more useful in more rural communities with smaller hospitals, some of which may work best for larger, urban medical centers. The goals were to:

- promote efficient use of scarce resources to save as many lives as possible
- encourage consistency in crisis care provided across healthcare facilities and communities, while not tying the hands of clinicians who must make challenging treatment decisions
- stimulate planning and training at the facility and community level so that Oregon can prepare an effective response should a public health crisis occur.

KEY COMPONENTS

The Ethical Framework for the document is the foundation of the Crisis Care Guidance and intended to ensure that key ethical principles were addressed and that, even in a crisis, healthcare decisions would be made in a fair and unbiased fashion. These principles include:

- An effort to maintain *social solidarity* to preserve our sense of interdependence and our commitment to one another as a community. Decisions in a crisis must support efforts to maintain these relationships.
- *Justice*, ensuring that everyone is treated equitably; access to particular types of health care should not be based on social position or relationships.
- *Respect for persons*. A person's dignity must be maintained and information about the person's condition and services available must be shared truthfully and candidly, even as it may not be possible to provide all types of care to all people.
- *The common good*. Healthcare decisions and actions in a crisis should serve the good of the whole community, rather than some "few" in the community.
- *Adherence to professional codes of conduct.* Healthcare workers have an obligation to act responsibly and in keeping with professional standards.

Practical implementation

- In the event of a major disaster, the safety of the public at large may require measures by public safety and health officials that limit people's individual choices.
- The best way to manage the ethical challenges inherent in triage during a disaster is to plan now to maximize available materials and personnel.
- In a crisis, it may be appropriate and necessary to have flexibility in the community standard of care, but the ethical requirement to provide quality care remains.
- In the event of a public health crisis, healthcare demands may overwhelm available capacity to offer potentially

Keeping an eye out for MERS-CoV and H7N9

We're not saying these illnesses are necessarily going to show up in your exam room, but it doesn't hurt to be prepared! At press time, no cases of influenza H7N9 or Middle East Respiratory Syndrome Coronavirus (MERS-CoV) have been detected in the U.S.

Consider testing for H7N9 in people with influenza-like illness **and**:

- Travel within 10 days of illness onset in areas where H7N9 is known to be circulating. (Currently, that's China.), or
- Close contact (within six feet) in the 10 days prior to onset with a person ill with confirmed H7N9 infection.

Consider testing for MERS-CoV in persons with pneumonia, fever **and**:

- Travel in countries on or near the Arabian Peninsula in the 14 days before illness onset, or
- Close contact with a recent traveler from this area who was ill with fever and acute respiratory illness at the time of contact.

For more information on diagnosis, specimen collection, and infection control recommendations in the care of people who might have these infections,

- Google: "Recognizing and Diagnosing Influenza A H7N9 and MERS-CoV", or
- Visit Oregon Health Authority Interim Guidance: Recognizing and Diagnosing Influenca A H7N or Middle East Respiratory Syndrome Corona Virus (MERS-CoV) http://1.usa.gov/1hrBtvc

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Figure. The Great Pandemic: United States 1918–1919. (Office of the Public Health Service Historian)

life-saving care to all who need it; a just plan of resource allocation must be ready to be enacted.

- Decisions about who should receive critical care and other medical services should be based on clinical experience using objective clinical information, just as they are in non-crisis situations.
- To promote the most effective use of limited resources and to save the greatest number of lives, decisions about which patients receive critical care should be made by a triage team or officer.
- The very nature of triage during a crisis will mean some people may be excluded from some types of medical attention, perhaps even life-sustaining treatment (for example, ventilator or ICU bed access).
- The highest possible quality of palliative care and symptom management should be offered to all patients, and especially to those who do not receive advanced life support or ventilator management.
- Individual hospitals and healthcare delivery systems need to protect the safety and security of employees and their families during a crisis.
- A thorough and transparent communication process with public input and comment is essential to earn and maintain the public trust that will be critical in a major health crisis.

The Guidance is organized into the following areas:

Planning Strategies help healthcare providers, facilities, and communities prepare for effective response before crisis occurs.

Surge Capacity Strategies help expand the number of people who can receive treatment with limited resources. (Some may not be easy, like convincing your financial people it really *is* a good idea to cancel elective surgeries.)

Triage Strategies help determine how available resources can be used most effectively to save lives when resources are overwhelmed, even with surge capacity strategies implemented (i.e., how will I decide which of these 10 critically ill people will get the remaining ICU bed?) (Figure).

The guidance also describes Benchmarks, based on the ability (or lack thereof) to perform critical healthcare functions. These benchmarks allow a community to recognize when surge capacity or triage strategies would need to be implemented.

Finally, several appendices describe the legal framework for liability protection, disaster declarations and the powers of the Public Health Director and Governor in a declared emergency; planning resources for care clinics, hospitals, and communities; and a triage model for clinical assessment and for allocating critical care resources in the crisis setting. To date, 23 professional organizations, health systems, and medical societies are co-sponsors of the Guidance. Organizations and communities are reviewing the document and beginning to incorporate it into their emergency response planning. This truly is the ultimate endorsement.

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CD Summary is going paperless in July 2014. Unless you sign up for e-mail delivery, you will no longer receive the yellow missives in your postbox.

Save a tree, tell a friend, don't miss a single issue. Topics might include: outbreak reports, animal bites, communicable disease summaries, and much much more.

Sign up at *www.healthoregon.org/cdsummary.*

RESOURCES

You can access and review the *Oregon Crisis Care Guidance* document at Oregon Medical Association. See *www.theoma.org/*

Workgroup members are interested in your feedback. This document will be revised as new information becomes available. Share your comments by e-mail at: *Crisiscare.comments@state.or.us*

REFERENCES

1. Institute of Medicine. Crisis Standards of Care: A systems framework for catastrophic disaster response. Mar 2012
2. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. Medical Surge Capacity Handbook: A management system for integrating medical and health resources during large-scale emergencies. Sept. 2007.