

Faculty Disclosure

Craig A. DeAtley, PA-C

Mr. DeAtley has listed no financial interest/arrangement that would be considered a conflict of interest.

Altered Standards of Care - Planning for Providing Care Under Stress and Duress

Craig DeAtley PA-C

Director IPHER

Washington Hospital Center

Ph: 202-257 4714/craig.deatley@erols.com

Today's Objectives



- Identify three sources of information that can be used to address the issue
- Identify three problems that planning entails
- Discuss three parts to planning for altered standards of care
- Outline three elements of a plan to address the issue

DISCLAIMER!

- The topic is too broad, the time too short and my expertise too limited to solve this problem here today
- We will discuss it and hopefully give you some useful takeaway points



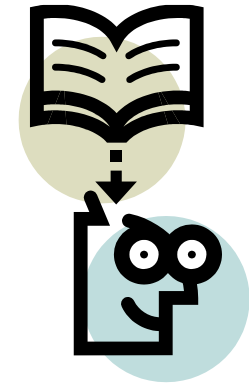
Lets Get Started



- **Who is here today?**
- **Who sees this as a real issue for your agency/facility**
- **Who has actually needed a plan already?**

Where Can WE Find Information on the Topic ?

- Talking with others
 - State agencies
 - Attorneys /ethicists and others
- Internet
- Publications
 - Mass Medical Care with Scarce Resources – AHRQ-February 2007 Contract number-290-04-0010
 - Altered Standards of Care in Mass Casualty Events –AHRQ-2005
 - CHEST January 2007



What Disaster Assumptions Should be Kept In Mind?



- Sudden influx of patient arrival vs. gradual will increase in numbers growing to a problem level
- Healthcare facilities will already be near or at capacity
- Healthcare resources will be overwhelmed
- Staffing changes will need to be made
- Decision making will be local first and foremost
- Planning must be community based, comprehensive and regionally coordinated

Other Assumptions

- **Clear communication with staff and the public at all times is essential**
- **There must be adequate legal framework for the actions that need to be taken**
- **Individual rights will be protected to the extent possible and reasonable given the circumstances**
- **Vulnerable populations (kids, elderly) must be protected to the extent possible**

Our Ultimate Practice



- **WE will do the greatest good for the greatest number is the guiding principle**
- **We ration only after all efforts at augmentation have been exceeded**
- **Rationing will occur uniformly, be transparent and abide by objective criteria**
- **Rationing will apply equally to withholding and withdrawing life sustaining treatments**
- **Patients not eligible for critical care will receive supportive or palliative care**

What Does Altered Standard of Care Mean?



- No accepted standard definition
- Is misnamed- allocation of scarce resources is the real issue
- Need Scare Resource Allocation Plan
- There is no case law to provide clarity
- “The healthcare provider and /or the healthcare facility is not able to render the customary level of care during an emergency or untoward situation”

When Might WE Need This Type of Plan?

- In conjunction with a surge in patients
 - MCEs – natural or manmade
- When a medication(s) or specific treatment is not available (i.e. H1N1 vaccine)
- Absence of normal operational capability (i.e. flooded hospital in New Orleans)

Lets Make Sure WE Know What Our Current Standards of Care Are?

- Access to emergency care
- Patient confidentiality and privacy protection
- What and how we use our healthcare facilities
- Staff numbers and how we use them
- Liability protection for staff
- Facility space usage
- Institutional/agency autonomy



What Should Be Defined Through the Planning Effort?



- Powers of authority
- When is deviation acceptable
- What level of deviation is permissible
- Local/state/federal relationships and responsibilities
- Mutual aid cooperation
- Training /exercises
- Recovery and reimbursement

What are Key Issues Related to Dealing With The Problem?



- **WE don't have a lot of experience in this area**
- **It takes time to devise and a multidisciplinary approach**
- **The work is continuously revisited**
- **Is NOT a topic that we are particularly comfortable with tackling**

Ethical Considerations are Paramount



- *Limitation of Individual Autonomy*
 - Decisions based on objective factors rather than individual choices
 - ALL individuals receive the highest level care given the resources available at the time

Ethical Principles

- *Transparency*
 - Resource allocation decisions are transparent, open and publicly debated
 - Restrictive policies must be understood and supported by medical providers and public
 - Institutions and providers will be acting in good faith and legally protected in their efforts

Ethical Principles

- *Justice /Fairness –*

- Maximization of benefit to the population served
- Patients treated equally based on objective physiological criteria
- “First come first served” applies when criteria don’t distinguish
- Procedural justice –a standardized and equitable practice that conforms to rules in place should be regularly and repeatedly evaluated to guarantee it has been followed fairly

Other Ethical Needs

- **Solidarity between/within the profession**
 - **Duty to care regardless of danger/risk**
- **Solidarity within and between institutions**
- **Solidarity between the providers and the community**
- **Shared duty between patients –providers-social community**

Legal and Regulatory Issues

- What do local and state laws say?
- Providers should be legally protected for providing care when following accepted protocol
- Triage algorithm approved and followed
- Resident work rules
- Union contract work rules
- OSHA/NIOSH workplace rules
- Building codes
- Drug and device governance – certification and licensure
- Scope of practice
- Documentation

What are We Worried About Will Become Scarce?

- **Staff**
- **Ventilators**
- **Medications**
- **Space**
- **Other**

Planning Guide Content

- **Definitions**
 - **Austere care**
 - **Critical resource**
 - **Critical resource shortage**
 - **Palliative care**
 - **Critical Resource Shortage Response Plan**
- **Activation Authority**
- **Legal and Regulatory Information**

Austere Care and Allocation of Resources -Who Gets the Resources

- **Field triage – Red, Yellow, and Green**
- **AMA Model- considers likelihood of benefit change in quality of life, duration of benefit, urgency and resources required**
- **AHRQ- addresses patient need, potential for baseline return, overall resources needed, age PMH and prognosis**
- **Emergency severity index–five groups(most urgent to least) based on acuity and resources needed**

Austere Care

- Altered standards pertaining to scope of practice, emergency credentialing, surge capacity plans
- Lower standards of care – reuse supplies, pulse ox instead of cardiac monitor, family assistance in providing care
- Suspend or lower legal requirements – EMTALA, labor laws, patient nurse ratios, informed consent
- Cohorting of contagious patients
- Treatment at Alternative Care Site
- Home based care

Palliative Care

- Provide greatest comfort and minimize pain and suffering to those not expected to survive
- NOT abandonment, euthanasia or hastening of death
- Planning should include hospice, SNFs, faith based groups, and mental health workers

Other Plan Elements

- **Staffing**
 - Regular
 - Volunteers
 - Use of special treatment teams (i.e. Palliative Care)
- **Alternative Care Site**
 - Facilities of opportunity, mobile, portable
 - Primary triage vs. ambulatory care vs. low acuity care site
- **Public messaging/risk communication**
- **Non clinical issues**
 - Finance and reimbursement

Summary



- **Altered standards of care is a complex topic**
- **Now is the time to address it**
- **Multidisciplinary team approach likely to work best**
- **Planning should address ethical, legal, and implementation concerns**
- **Thank you for coming and hopefully this was helpful**