DEPARTMENT OF HEALTH

Critical Care Guidance for Contingency and Crisis Conditions[1]

CLINICAL COMPANION TO "ETHICAL FRAMEWORK FOR TRANSITIONS BETWEEN CONVENTIONAL, CONTINGENCY, AND CRISIS CONDITIONS IN PERVASIVE OR CATASTROPHIC PUBLIC HEALTH EVENTS WITH MEDICAL SURGE IMPLICATIONS"

11/20/2021

Summary of Recommendations

- Health care facilities/systems must determine whether they can maintain care practices typically used in conventional conditions or whether they face contingency conditions or crisis conditions. They have **duties to implement strategies to extend resources** to avoid crisis conditions and understand and support the providers who are making decisions that place patients at increased risk based on the circumstances.
- **When functional equivalence can no longer be maintained, then crisis conditions exist and crisis standards of care should be implemented,** whether or not state authorities have issued a formal declaration of crisis. Incident command should 'own' the decisions and assure maximal resources are devoted and that strategies implemented are proportional to the shortage.
- Establishing **transparent and fair processes** for the equitable allocation of ICU resources is paramount, both within and between facilities.
- It is essential that **patients and the public understand** current conditions -- including whether crisis standards of care are in effect -- and how those conditions may affect care.
- **Regional and statewide coordination** is required in both contingency and crisis conditions to centrally coordinate load balancing and consistent care of patients across all ICUs by objective criteria, managed by dedicated non-bedside staff with the clinical experience and expertise required for triage.
- A **common ethical framework should guide allocation** of critical care resources across the state to promote fairness and equity. While it may be ethically appropriate to allocate resources on a first-come, first-served basis in some contexts in conventional conditions, in conditions of scarcity, it is not equitable to allocate resources first-come first-served, or for

[1] This document summarizes guidance from MDH and tailors it to conditions in the COVID-19 pandemic. Please see "Ethical Framework for Transitions Between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications," 05/18/2021, https://www.health.state.mn.us/communities/ep/surge/crisis/framework_transitions.pdf.

health systems to prioritize patients on the basis of whether or not they have a pre-existing relationship with the system.

- An ethical process for making alterations to care practices is required in both contingency and crisis conditions. **Ad hoc triage or rationing by bedside clinicians should be avoided**.
- Changes to care practices that may significantly compromise patient outcomes may not be implemented unless they are unavoidable.
- Health care facilities/systems have **duties to support health care workers**.
- Conflicts regarding the withdrawal or withholding of **futile, potentially inappropriate, or non-beneficial treatment** will continue to routinely occur in acute care settings.[2] Hospital incident command should implement expedited decision-making procedures regarding futile, potentially inappropriate, or non-beneficial treatment, when necessary to reduce the expenditure of resources that might be used during normal conflict resolution procedures in providing care to patients for whom there is no reasonable expectation that the patient will improve sufficiently to survive outside the acute care setting.
- Decisions to withdraw or withhold treatment should **transparently indicate whether the reason** relates to futility, potentially inappropriate treatment, non-beneficial treatment, or scarcity. Conflict resolution processes may be streamlined in contingency and crisis conditions but **must be procedurally fair and protect due process**. This requires that patients/families (or other authorized decision makers) be notified of the conflict, told the grounds for the conflict, notified of the conflict resolution process, and provided support to engage in that process.
- The **process and outcome of triage and rationing decisions should be documented, and retrospectively reviewed,** to promote fairness and equity.

Discussion

In some Minnesota hospitals, demand for critical care staffing and space may continue to outstrip availability. Patients may endure lengthy stays in emergency departments as they await transfer to beds, and face delays in being discharged from hospitals due to staffing and space limits in transitional care facilities. Health care institutions and systems must determine when and how they implement contingency strategies and when they transition from contingency strategies to crisis standards of care.[3]

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[2] Futile, potentially inappropriate, and non-beneficial care are defined in "Ethical Framework for Transitions Between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications," 05/18/2021, https://www.health.state.mn.us/communities/ep/surge/crisis/framework_transitions.pdf.

[3] "Ethical Framework for Transitions Between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications," 05/18/2021, https://www.health.state.mn.us/communities/ep/surge/crisis/framework_transitions.pdf. Cf. ASPR TRACIE Technical Assistance Request: Crisis Standards of Care. 11/18/2020.

Making these determinations, and following through with transparent implementation of appropriate plans, is critical to providing ethically appropriate care to patients and adequately supporting providers.

The core goal in contingency conditions is to adapt care practices—e.g., through conservation or substitution of resources, postponement of elective procedures, changes in staffing plans or use of space—to avoid crisis conditions while striving to maintain usual standards of care. The care delivered may be different but should be functionally equivalent to care that is provided in conventional conditions.

Functional equivalence requires that (1) **outcomes** of care are expected to be substantially similar to those in conventional conditions -- death or serious adverse outcomes should not be expected because of altered care delivery; and (2) the **aim** of care should continue to be to provide individual patient-focused care while upholding the traditional balancing of autonomy, beneficence, non-maleficence, and justice. **When functional equivalence can no longer be maintained, then crisis conditions exist and crisis standards of care should be implemented, whether or not state authorities have issued a formal declaration of crisis.**

In crisis conditions, the goal is to promote overall benefit to the population, to try to minimize morbidity and mortality, while also respecting rights and promoting fairness across our population.

Note that contingency conditions may apply to some resources while crisis conditions apply to others. Additionally, conditions may shift across the surge continuum as scarcity and the ability to maintain care that is functionally equivalent to that provided in conventional conditions waxes or wanes. Experience in COVID-19 response demonstrates that distinguishing between conventional, contingency, and crisis conditions may be challenging in real time, and pivoting between contingency and crisis conditions can be difficult when transitions happen repeatedly. Therefore, **establishing transparent and fair processes for the equitable allocation of ICU resources is paramount. It is also critical that patients and the public understand current conditions and how they may affect care.**

Managing Resources (space, staff, supplies)

- **Regional and statewide coordination is required in both contingency and crisis conditions.** Facilities/systems should work together with their regions and the state, to allow for coordination of resources to optimize capacity and equitably allocate resources. This process should involve:
    - centrally coordinated load balancing of patients across all ICUs by objective criteria, managed by dedicated non-bedside staff with the clinical experience and expertise required for triage,

https://files.asprtracie.hhs.gov/documents/aspr-tracie-ta-patient-surge-management-strategies-and-crisis-standards-of-care-during-covid-19-11-18-2020.pdf.

- assuring equal access to critical care services, with priority given to those who can most benefit from the ICU staff and environment, and
- a common ethical framework for allocation of critical care resources across the state to promote fairness and equity.

It is not equitable nor therefore ethical to allocate resources first-come first-served, or for health systems to prioritize patients based on whether or not they have a pre-existing relationship with the system, are insured, or other such factors.

- **An ethical process for making alterations to care practices is required in both contingency and crisis conditions**. Alterations in care practices should not be made by individual clinicians at the bedside. Rather, changes to care practices should be made in consultation with unit, facility, and system leadership, and follow explicit institutional policy if available or relevant ethics guidance such as ethics frameworks disseminated by MDH (see, e.g., https://www.health.state.mn.us/communities/ep/surge/crisis/index.html).
  - If, in **contingency conditions**, the bedside clinician must make a very time-sensitive decision about patient care that they do not routinely make -- e.g., deciding which patients can safely remain on BIPAP and which should be intubated, or which can wait for dialysis and which need treatment more urgently -- the provider should consult with at least one other provider with relevant expertise, consider applicable institutional policy and MDH guidance if any, and then rapidly notify leadership about the resource shortage and the decision that was made.
  - **Changes to care practices that may significantly compromise patient outcomes may not be implemented unless they are unavoidable**. Such changes to care practice mean the institution is no longer providing care that is functionally equivalent to conventional care and is therefore operating in crisis conditions. Specific scarce resources may require triage or rationing or other alterations to care practices, but this does not mean that clinicians are free to triage or ration unrelated resources or to change practices more widely than necessary. Systems should take steps to avoid the need for triage or rationing including maximal allocation of space and staff to acute medical care and take steps to mitigate shortages by reaching out to other facilities, systems, regional Health Care Coalitions, or statewide authorities.
  - In **crisis conditions**, **prioritization of patients for allocation of resources** – e.g., triaging patients for ICU beds, assessing patient prognosis to determine if continued ICU care is warranted given other patients' needs for resources, deciding who needs inpatient treatment and who can be discharged with home care or primary care support -- should be done by non-bedside providers, to:
    - avoid ad hoc triage/rationing,
    - ensure triage is done effectively by using people who are familiar with protocols and guiding principles, and

    - monitor for bias and promote equity. This requires that data about decisions be gathered and routinely reviewed.
        - Facilities should have transparent processes with decision-makers who are designated by facility or system leadership to make allocation decisions. These decision-makers should follow ethical guidance for allocation, whether or not the facility is able to stand up a formal triage team as recommended by the MDH framework on "Allocation of Ventilators and Related Scarce Critical Care Resources During the COVID-19 Pandemic."
- Health care facilities/systems have a **duty to provide support for health care workers**, including by communicating clearly about scarcity and plans for addressing it, designating leaders authorized to address questions about how to adapt care to evolving conditions, protecting workers with adequate personal protective equipment (PPE), and addressing their psychological and moral distress.

Managing decision-making and conflict resolution processes in contingency and crisis conditions

- Conflicts regarding the withdrawal or withholding of **futile, potentially inappropriate, or non-beneficial treatment** will continue to routinely occur in acute care settings.[4] **Hospital incident command should implement expedited decision-making procedures regarding futile, potentially inappropriate, or non-beneficial treatment,** when necessary to reduce the expenditure of resources that might be used during normal conflict resolution procedures in providing care to patients for whom there is no reasonable expectation that the patient will improve sufficiently to survive outside the acute care setting.
- **Decisions to withdraw or withhold treatment should transparently indicate whether the reason relates to futility, potentially inappropriate treatment, non-beneficial treatment, or scarcity.** It is ethically problematic to mislabel a decision to withdraw or withhold treatment based on scarcity as a decision about futile, potentially inappropriate, or non-beneficial treatment.
- Ethical obligations of justice also require that resource allocation is **procedurally fair**.
    - In **contingency conditions** hospitals should conserve and extend resources but must still meet essential due process requirements if a conflict arises between patient expectations and facility resources. Essential due process requirements include that patients/families (or other authorized decision makers) should be:

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  - made aware of the resource limitation,
  - informed of the grounds of the decision (e.g., the reasons for a decision to admit to lower level of care or not admit a patient who would normally be admitted),
  - informed of the viability of options to transfer to another facility,
  - given notice of the conflict resolution process, and support to engage in the process, and
  - given an opportunity to obtain a second opinion, and an impartial review of contested decisions.
- Under **crisis conditions**, it may no longer be possible for patients to access secondary review of triage or rationing decisions for specific resources. Health care systems and facilities should maintain functionally equivalent procedures for conflict resolution whenever possible. **Under all circumstances**, patients/families (or other authorized decision makers) should promptly be made aware of the conflict, informed of the grounds for the conflict, and given notice of the conflict resolution process and support to engage in that process. Opportunities to seek a second opinion may be suspended if necessary due to scarcity.

Documentation and Retrospective Review

- The process and outcome of triage and rationing decisions should be documented by the institution managing the decision process – e.g., by hospitals for patients in their care, by the Critical Care Command Center (C4) for regional or statewide transfers of patients.
- Processes should be established at each of these institutions or systems to conduct periodic retrospective review of all triage and rationing policies and decisions, to promote fairness and equity. Retrospective review should be completed as often as feasible given available staffing resources to allow timely adjustment of policies or processes as needed – ideally weekly or every other week.

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11/20/21

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