

Michigan Crisis Standards of Care Workshop 2024

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Overview

- The Origins of Crisis Standards of Care Guidance in Michigan and Nationally
- Michigan Guidelines
 - Applicability
 - Goals
 - Ethical Considerations
 - Allocation Criteria
 - Specific Guidance
- Revising Allocation Guidance for COVID-19
- Next Steps and Lessons Learned

Michigan Guidelines: Phase 1 process

- First phase of project began project in August 2007 and lasted through 2014
- Developed concurrently with national efforts
- Creation of Ethics Advisory Committee began in 2007 and was functional by late 2008
- Drafted general Guidelines between 2009-2012
- Developed hospital, EMS, legal guidance between 2010-2012

Michigan Guidelines: Phase 1 goals

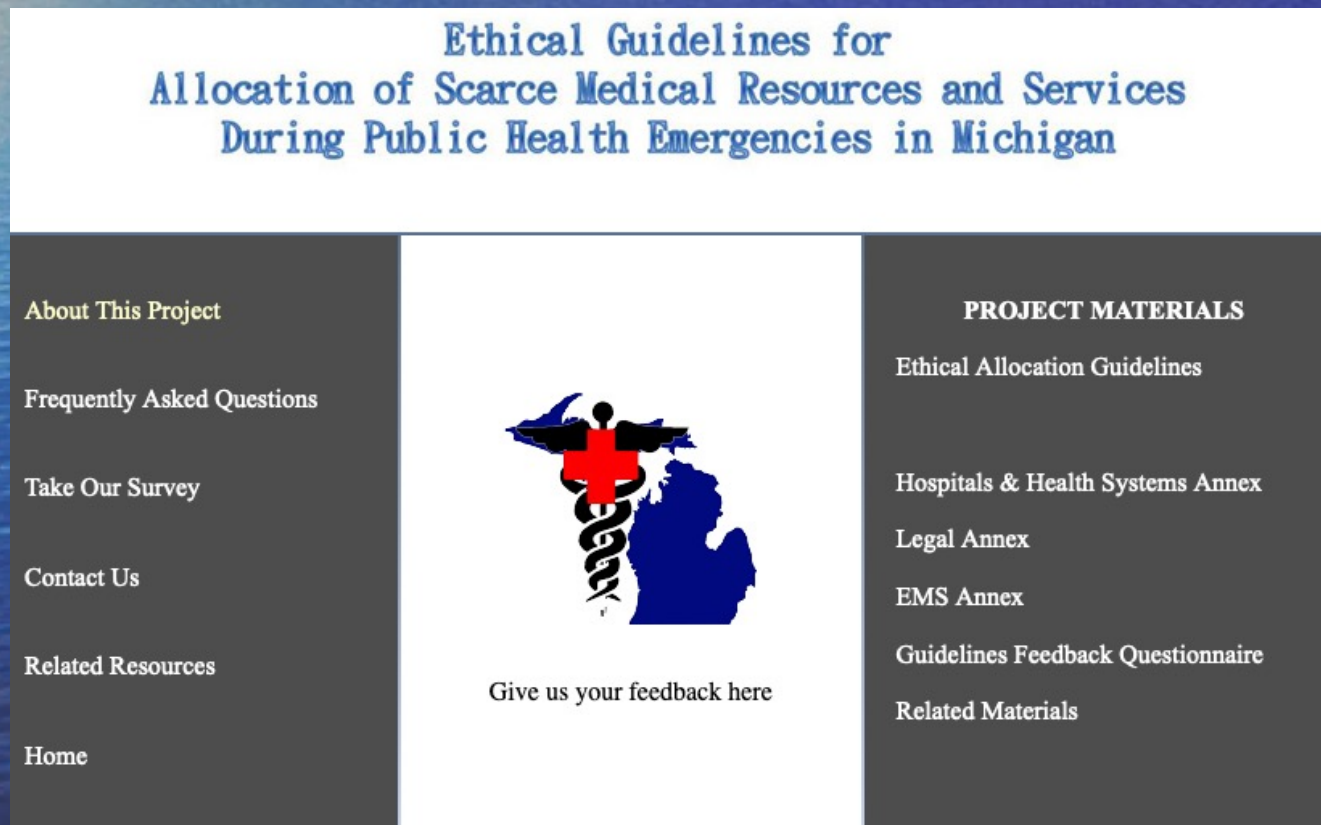
- Develop guidelines for ethical allocation of scarce medical resources and services during emergencies and disasters in Michigan
 - Review and discuss important ethical issues surrounding allocation decisions
 - Define contingency and crisis standards of care
 - Provide practical guidance to decision-makers at all levels
- Integrate with and supplement existing emergency preparedness efforts in Michigan

Michigan Guidelines: Phase 1

- MI Guidelines were developed along with national CSC efforts
- Jan. 2011 survey of states found few had completed CSC guidelines
- Public engagement and outreach across hospital systems, associations, and community from 2010-2013
- Presentations at regional and national conferences

Michigan Guidelines: Phase 1

- Public Engagement
- MI Medical Ethics Website



National CSC Guidelines

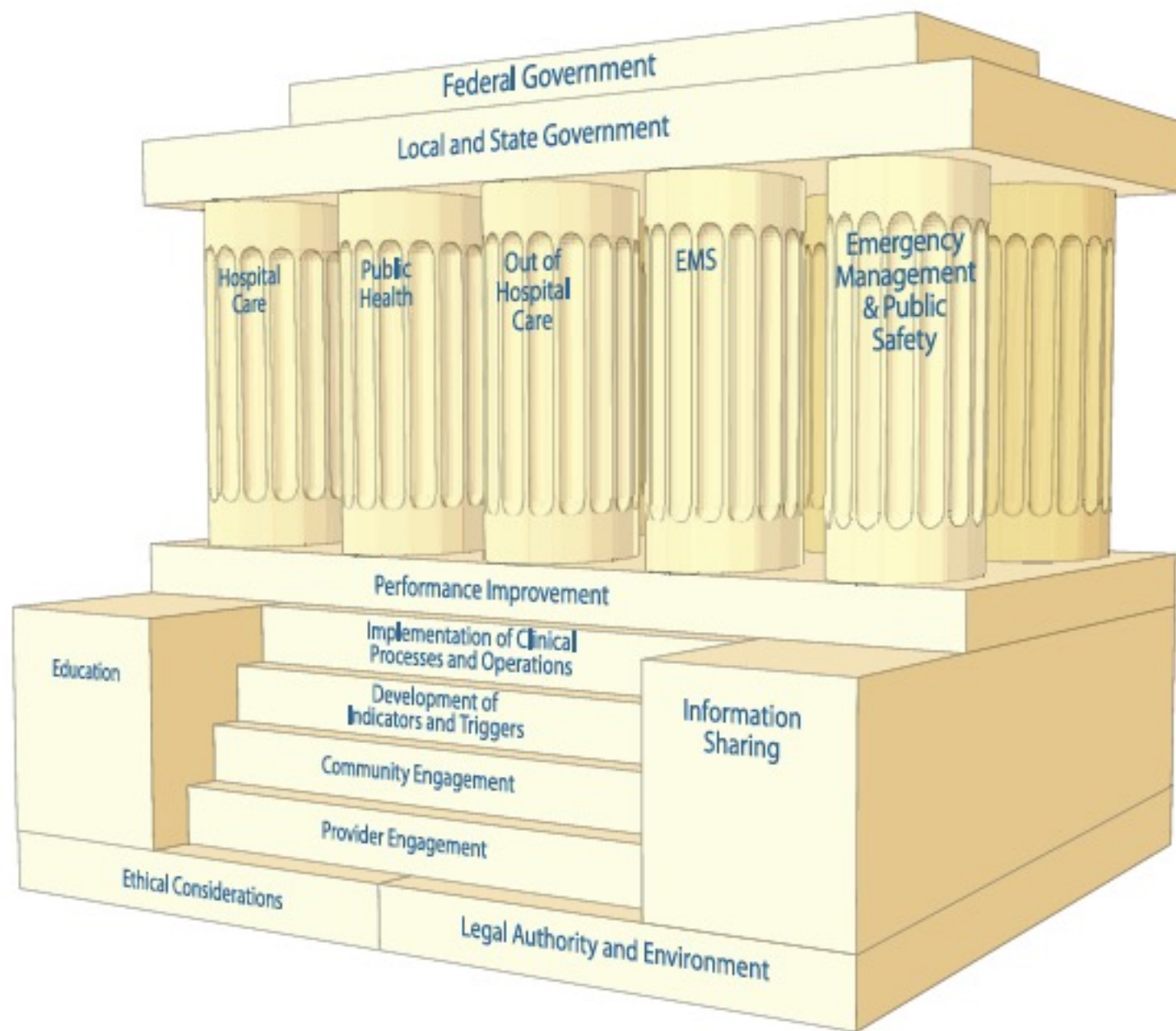
- IOM released their Crisis Standards of Care letter report in Fall 2008
- Defined CSC as a “substantial change in the usual health care operations and the level of care it is possible to deliver....justified by specific circumstances and....formally declared by a state government in recognition that crisis operations will be in effect for a sustained period”

National CSC Guidelines

- IOM released their Crisis Standards of Care: A Systems Framework report in 2012
- Seven volumes
- Expanded CSC to apply this framework to multiple systems and outlined the interaction between these systems

National CSC Guidelines

- IOM released their Crisis Standards of Care: A Toolkit for Indicators and Triggers report in 2013
- Indicators are “measurements or predictors of change in demand for health care service delivery or availability of resources.”
- Triggers are “decision points that are based on changes in the availability of resources that require adaptations to health care services delivery along the care continuum.”



National CSC Guidelines

Conventional, Contingency, and Crisis Care

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.

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).

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.

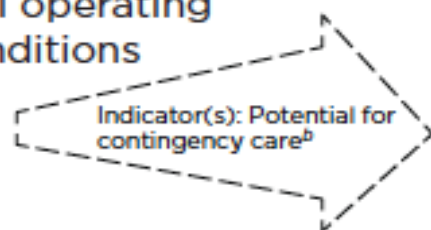
SOURCE: Hick et al., 2009.

National CSC Guidelines

Incident demand/resource imbalance increases →
 Risk of morbidity/mortality to patient increases →
 ← Recovery

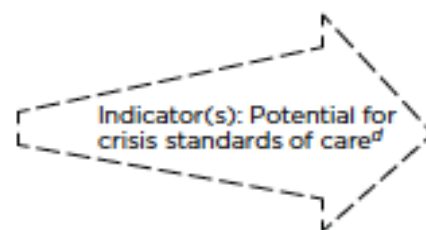
	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible re-allocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care ^a

Normal operating conditions



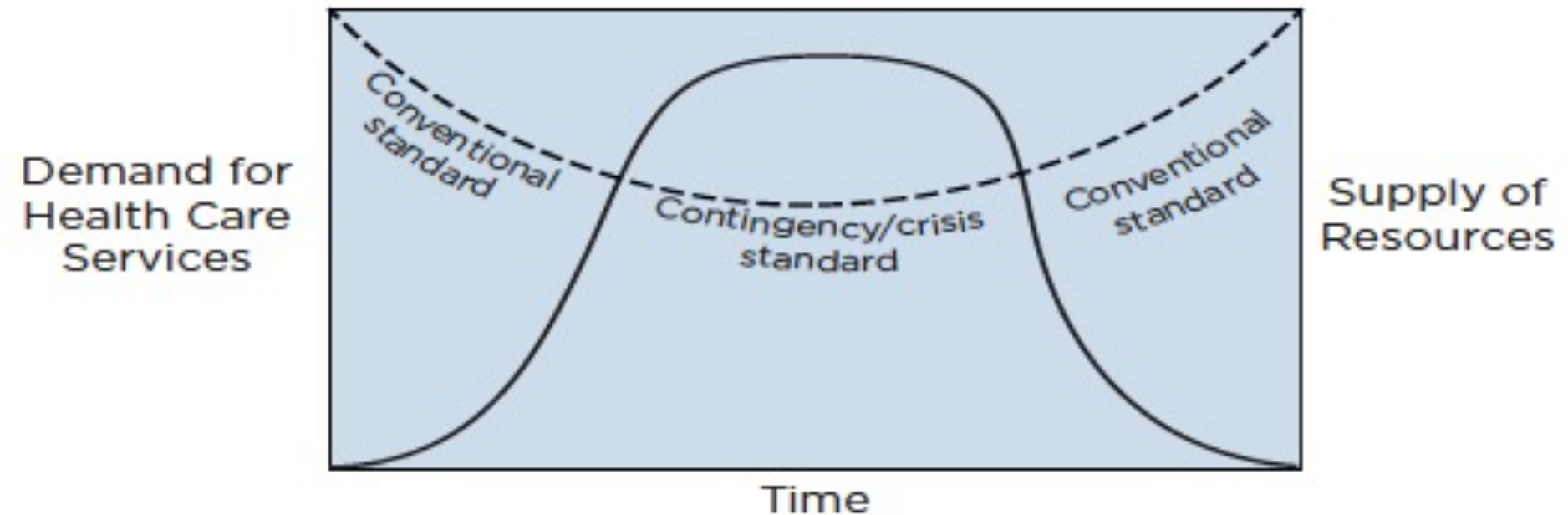
Trigger(s):
Decision point for contingency care^c

Extreme operating conditions



Crisis care trigger(s):
Decision point for crisis standards care^e

National CSC Guidelines



National CSC Guidelines

- NASEM released additional reports in response to COVID-19
- Rapid Expert Consultation on Crisis Standards of Care for the COVID-19 Pandemic (March 2020)
- Framework for Equitable Allocation of COVID-19 Vaccine (2020)
- Crisis Standards of Care: Ten Years of Successes and Challenges (2021)
- Rapid Expert Consultation on Allocating COVID-19 Monoclonal Antibody Therapies and Other Novel Therapeutics (2021)

Michigan Guidelines

- Second phase began in 2020 and continues
- Developed rapid COVID-19 allocation guidance
- Reformed of Ethics Advisory Committee
- Revised Guidelines and hospital, EMS, legal guidance
- Developed new guidance for state/local government, long-term care, palliative care
- Consulted on multiple real-time COVID-19 allocation plans
- Public engagement and outreach
- Planned for ongoing CSC infrastructure

Michigan Guidelines: Applicability

- Emergencies and disasters that impact public health give rise to unique challenges that can lead to, and be exacerbated by, scarcity of medical resources and services.
- The likely conditions during emergencies—including conditions of medical resource and service scarcity—may be anticipated even in emergency circumstances that arise from sudden, extraordinary, or temporary events.
- Emergency planners have an ethical duty to plan for and provide guidance related to the ethical allocation of scarce medical resources and services during emergencies or disasters.

Michigan Guidelines: Applicability

- The Guidelines apply to serious emergencies and disasters, not everyday scarcity of medical resources and services (crisis standards of care apply).
- The Guidelines apply to allocation decisions made by decision-makers at different levels of government as well as the private and nonprofit sectors.
- The Guidelines apply to allocation decisions affecting all medical resources and services that may become scarce during an emergency or disaster.

Michigan Guidelines: Applicability

- The Guidelines employ ethical principles that take into account both individual health and population health.
- The Guidelines should be implemented in ways that comply with all relevant laws at the federal, state, and local levels

Michigan Guidelines: Goals

- Minimizing morbidity, mortality, and suffering
- Sustaining a functioning society
- Ensuring equity

Michigan Guidelines: Ethical Considerations

- Beneficence
- Utility
- Fairness (procedural justice and distributive justice)
- Equity
- Transparency
- Accountability
- Trust
- Respect for persons
- Proportionality
- Solidarity
- Reciprocity
- Stewardship
- Veracity

Michigan Guidelines: Allocation Criteria

- Acceptable Allocation Criteria:
 - Medical prognosis
 - Supporting critical infrastructure
- Situation-Dependent Allocation Criteria:
 - Lottery
 - First Come/First Served
 - Age
- Unacceptable Allocation Criteria:
 - Social characteristics
 - Social worth

Acceptable Allocation Criteria

- Medical prognosis:
 - patient's medical condition,
 - the likelihood of a positive medical response,
 - the relative risk of harm posed by not treating the patient,
 - other indicia of survivability and favorable medical outcomes.



Acceptable Allocation Criteria



- Supporting critical infrastructure:
 - Workers that perform essential functions that support critical infrastructure

Acceptable Allocation Criteria

- Essential personnel may include:
 - health care workers who are directly treating patient affected by the emergency or disaster (doctors, nurses, behavioral and mental health professionals, etc.);
 - personnel key to responding to the emergency or disaster (first responders, public health scientists, etc);
 - personnel key to public safety (police, fireman, military, etc.); and
 - personnel key to critical infrastructure (energy grid , telecommunications, food access, etc.).

Situation-Dependent Allocation Criteria

- Lottery

- Fair and random opportunity
- Not conducive to minimizing morbidity or mortality, stewarding resources, or advancing equity
- Complex to administer, and could be manipulated



Situation-Dependent Allocation Criteria



- First come/first served
 - Easy to administer and wide accepted
 - Not truly fair since favors those with built-in advantages

Situation-Dependent Allocation Criteria

- Age

- Fair innings: prioritize younger
- Problems of measuring age
- Age discrimination



Unacceptable Allocation Criteria



- Social characteristics
 - Age, color, criminal history, disability, ethnicity, familial status, gender identity, height, homelessness, immigration status, incarceration status, marital status, mental illness, national origin, poverty, race, religion, sex, sexual orientation, socio-economic status, substance use disorder, use of government resources, veteran status, or weight
 - Improving equity

Unacceptable Allocation Criteria



- Social worth
 - For example, job status, training or education, social standing, relationships or affiliations, ability to pay
 - Limited exception for essential personnel

Specific Guidance Annexes

- Prehospital entities (EMS and Medical Control Authorities)
- Hospitals and health care facilities
- Legal issues
- State and local government (including public health)
- Long-term care settings
- Palliative care

Indicators, triggers, and tactics

- Outlines factors and scenarios that can implicate contingency or crisis standards of care
- Provides possible tactics to mitigate or avoid scarcity
- Addresses slow-onset and no-notice emergencies
- Addresses various categories of potential scarcity

Implementation

- Avoiding scarcity
- Assessing probability, nature, duration, and severity
- Process
- Transparency
- Consistency
- Review and reassessment
- Decision-making
- Palliative care

Michigan CSC Guidelines



the best choice.

It's important to stay up-to-date with regular health care check-ups and appointments. Don't miss routine physicals and immunizations.

Not sure what to do? Contact a local health provider or call 211 for assistance.

MDHHS Ethical Guidelines

The Michigan Guidelines for Implementation of Crisis Standards of Care and Ethical Allocation of Scarce Medical Resources and Services During Emergencies and Disasters Response Plan serves to inform local, state, and federal governments; Regional Healthcare Coalitions (HCC); relevant agencies and organizations; and other stakeholders of the preparedness and response plans specific to a mass casualty incident within the State of Michigan.

[View the Michigan Guidelines for Implementation of Crisis Standards of Care and Ethical Allocation of Scarce Medical Resources and Services During Emergencies and Disasters.](#)

The information and links below are intended for Medical Providers who wish to enroll with the State of Michigan Systems to participate in the CDC COVID 19 Vaccination Program.

Michigan CSC Implementation

- Many hospitals, EMS providers, and long-term care facilities experienced resource challenges during COVID-19
- State ethics committee reviewed guidance on allocating new therapies
- Monoclonal antibodies and new COVID-19 therapeutics

Michigan CSC Implementation

- Federal staffing teams assisted in increasing staff capacity
- 9 facilities were assessed in MI
- 6 teams were allocated to MI
- 30-day deployments (30-day extensions granted to some facilities)
- Typical team was 23 persons, command and clinical staff

Michigan CSC Implementation

- SDMAC – State level committee to advise on CSC and scarce resource allocation
- RDMAC – Regional committees to advise regional healthcare coalitions and partners
- SRAC – Scarce Resource Allocation Committees within individual institutions

SRAC Implementation

- SRAC should have full authority to make necessary allocation or conservation decisions and determining when CSC will be activated and deactivated
- Membership could include Medical Care Director, Director of Nursing, Ambulatory Care, ICU, Respiratory Therapy, Emergency Medicine, Admissions Manager, Ethicist, DEI Officer, Pharmacist, Lawyer

CSC implementation: additional questions

- How well have CSC protocols worked during the COVID-19 response?
- Where have CSC protocols fallen short?
- Where is there room for improvement?
- What area should specific CSC guidance address?
- How can CSC guidance better strive for equity?

CSC implementation: additional questions

- How much should ethical allocation criteria differ according to resource and setting?
- Example: comparing hospital settings and hospice settings; or provision of curative care and palliative/comfort care
- Example: allocation of new resources versus shortages of existing resources

Lessons Learned

- Planning at all levels is important
- Ongoing training and updates are essential
- New leaders must be updated on past planning
- State ethics committee and other partners should remain engaged



Discussion?