



Crises Standard of Care

A Prioritized and Streamlined Delivery of Care in Crises Situation : ILPH Approach
(Interim LSU Public Hospital (ILPH) & CLINICS System)

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Acute Care Level 1 Trauma Center
Hospital

Perspective, Planning & Update 2011

Presenting on behalf of ILPH team

LSUHealth
INTERIM LSU PUBLIC HOSPITAL
A LEVEL 1 TRAUMA CENTER

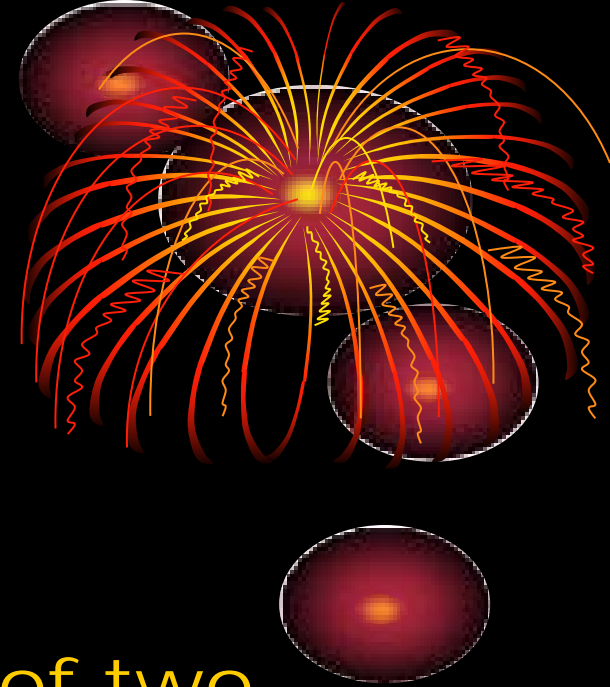
LSU
INTERIM HOSPITAL

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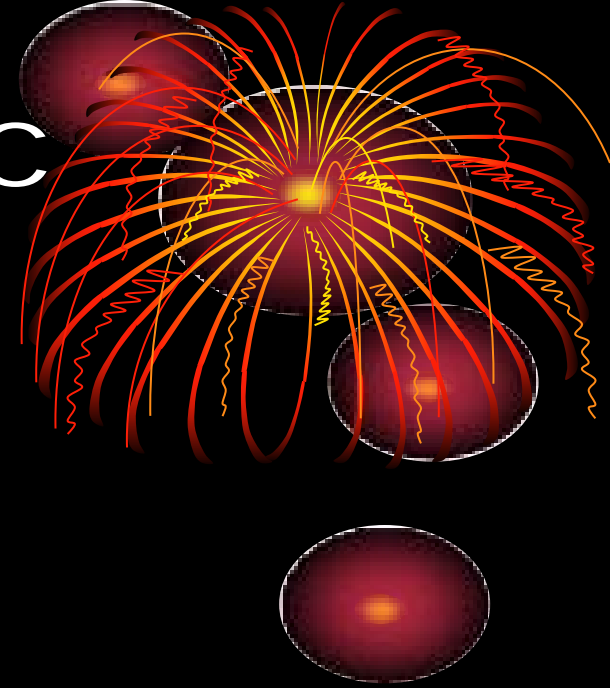


Who are we ...

- Academic
- TEACHING
- Support to GME programs of two medical schools and multiple clinical affiliations
- Public/state
- Supports network and community health systems
- Safety Net for uninsured and under insured



Interim LSU Public Hospital

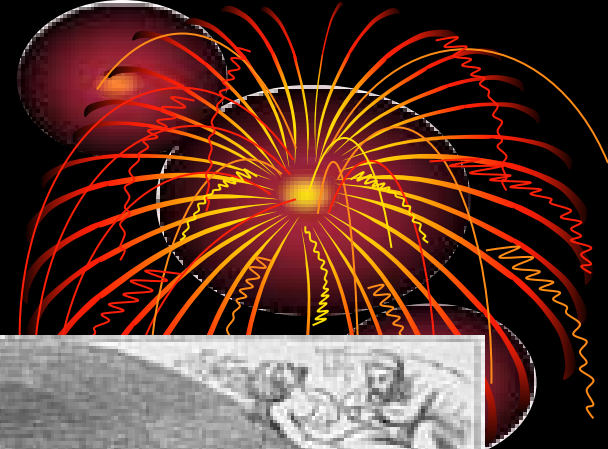


A.K.A.

- University Hospital
- Medical Center of Louisiana
- Charity Hospital
- San Carlos
- Hospital of Saint John or L'Hospital Paurves de la Charity

Different names ; wide experience

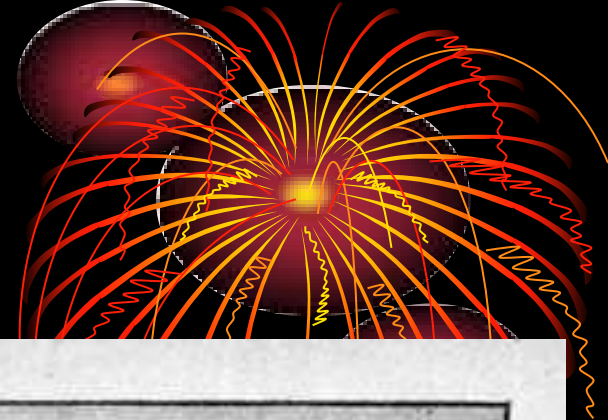
Old Charity Hospital



Charity Hospital on Tulane Avenue

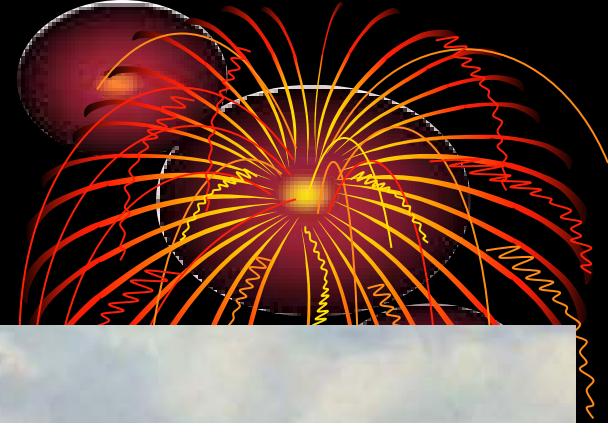


Charity Hospital



THE CHARITY HOSPITAL.

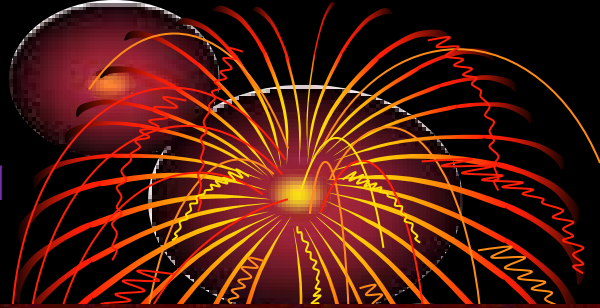
Big Charity



Where we are going both in structure, concept and culture of care

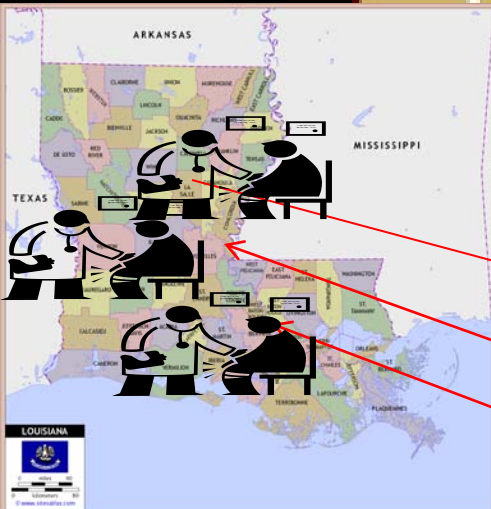


ILH -TELEMED PROGRAM



NEW ORLEANS

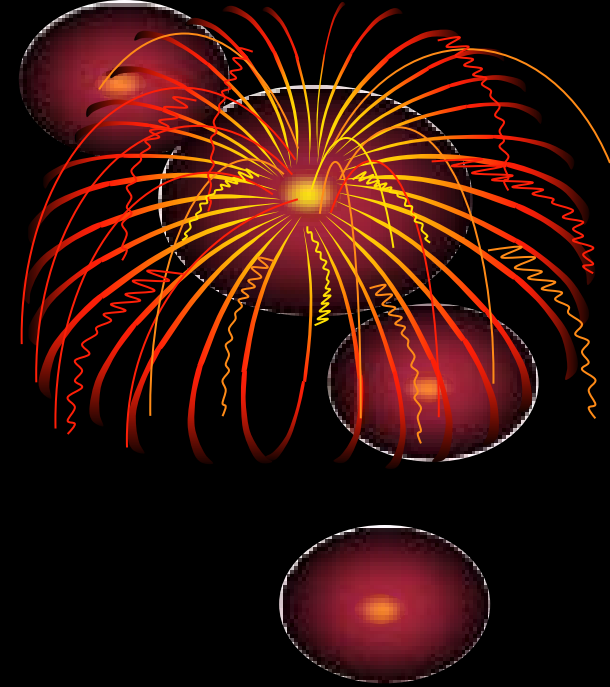
LK/MOSS/BMC



Mature programs

- Hurricane Preparedness with the usual and unusual, with or without help
- Oil spills and coastal disasters
- Events preparedness





Task Force *

Members:

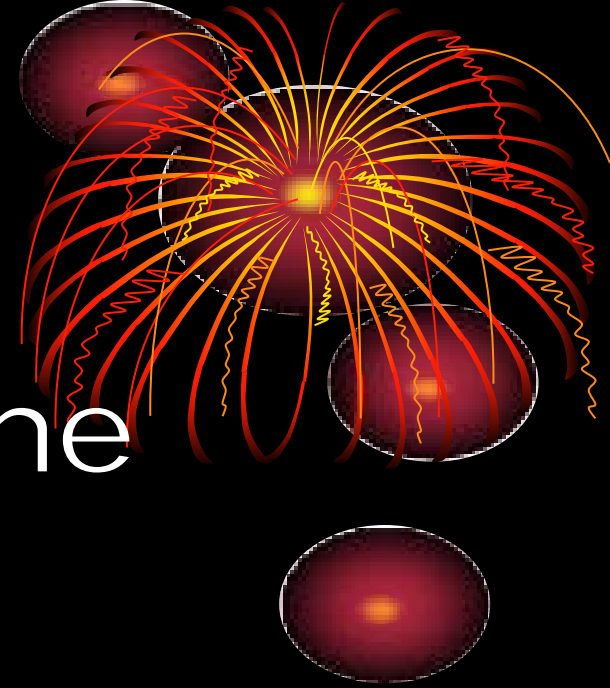
James Aiken M.D. Sean Hardy M.D.
Trauma Team & colleagues

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Preparedness

Coleen Lemoine APRN , CNS, Coordinator
Juzar Ali M.D. , FRCP; Medical Director

- Referenced also from National and State Guidelines, CDCP, DHH , OPH
- Regional Consultant: Cynthia Davidson region1drc@yahoo.com

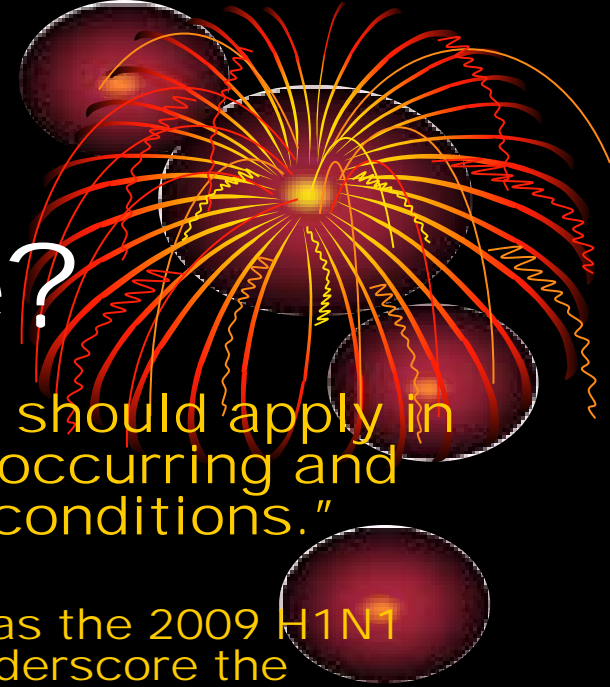
Institute of Medicine



Established Guidance for
Crisis Standards of Care During
Disasters

What are Crisis Standards of Care?

- **Definition** – “Standards of care that should apply in disaster situations—both naturally occurring and manmade—under scarce resource conditions.” (IOM, 2009)
- **Context** – “Public health emergencies such as the 2009 H1N1 pandemic and the 2001 anthrax mailings underscore the immediate and critical need to **prepare for a crisis in which many thousands of people suddenly require and seek medical care**. Without careful advance planning and coordination at the federal, state, and local levels, there is **enormous potential for confusion, chaos, and flawed decision-making**. While efforts have been made to develop policies and protocols for standards of care during a crisis at all levels of government, much still needs to be done. Efforts have been taking place mainly at the community level, leading to a lack of consistency across neighboring jurisdictions and unnecessary duplication of effort. Also, many states have not yet developed plans for crisis standards of care. ” (IOM, 2009)

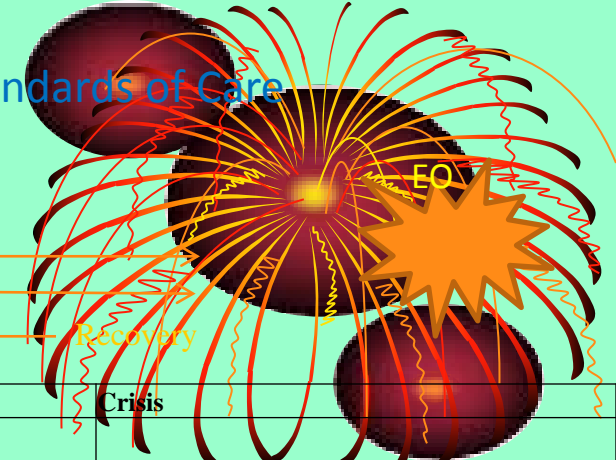


IOM: Levels of Care



- Conventional – routine-“business as usual”
- Contingency – *functionally equivalent* but adapts space, staff, and supplies in response to a surge demand - State Hospital Pan Flu Plan
- Crisis – substantial change in level of care - usual safeguards are no longer possible and available resources are insufficient to meet usual care standards – Altered or Crisis Guidelines

Architecture: IOM Report: Guidance for Establishing Crisis Standards of Care



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

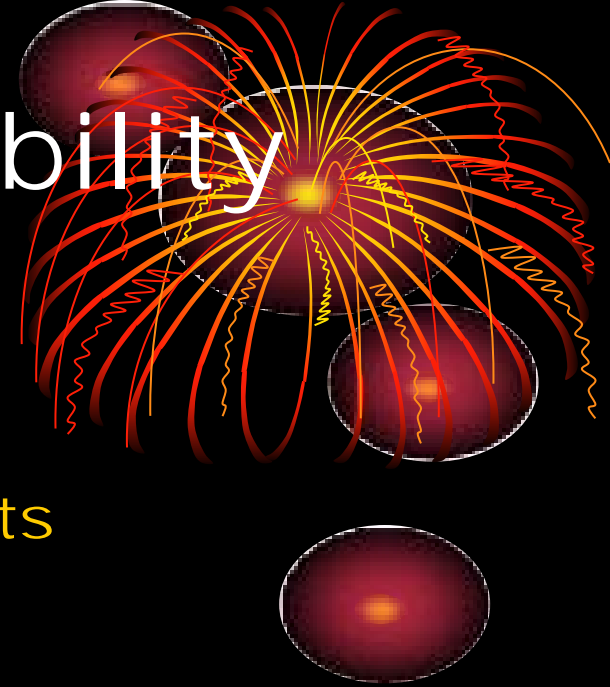
	Conventional	Contingency	Crisis
SPACE	Usual patient care space fully utilized	Patient care areas repurposed (PACU, monitored units for ICU-level care)	Facility damaged/ unsafe or non-patient care areas (classrooms,etc.) used for patient care
STAFF	Usual staff called in and utilized	Staff extension (brief 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 reuse of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
STANDARDS OF CARE	Usual Care	Functionally equivalent care	Crisis standards of care

Usual Operating Conditions ←————→ Austere Operating Conditions

Surge Within walls/Campus Plans

Crisis Standards of Care Plan

Hazard and Vulnerability Assessment Tool

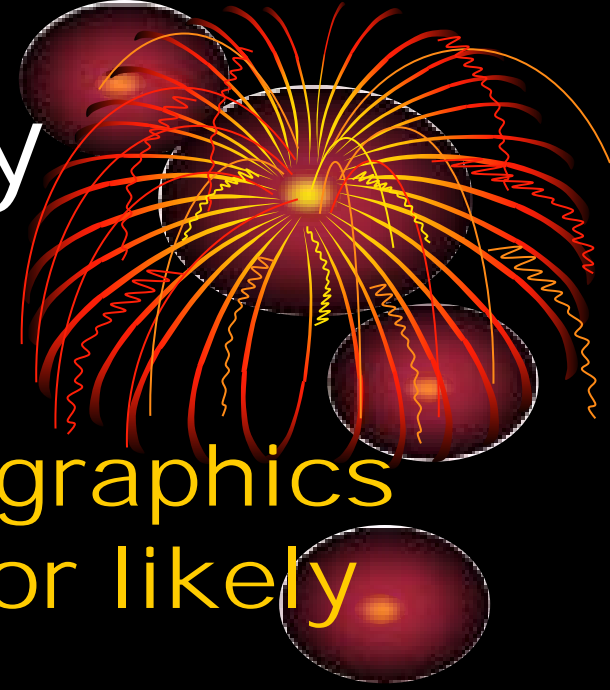


- Anticipated events , sudden events
- Naturally Occurring events
- Technologic Events
- Human Related Events
- Hazardous Materials

- Related to Probability/Severity/Risk
- Severity is Magnitude minus Mitigation

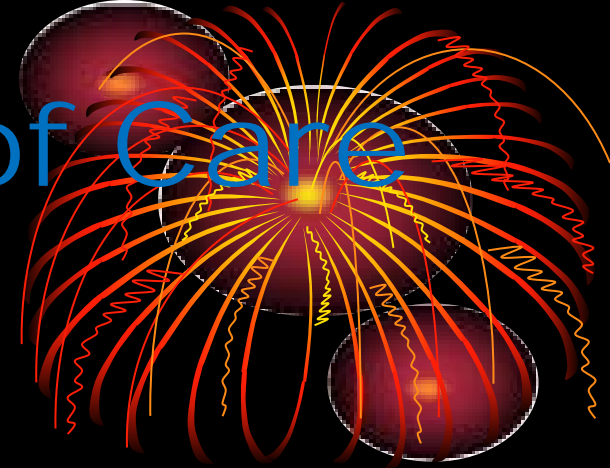
Ref Kaiser Foundation 2001

Population Priority Ranking



- Determination of demographics of population affected or likely to be affected
- Individual and group priority rankings
- Individual and community resources available

Crisis Standards of Care Guidelines



- **MUST promote:**
 - Response offers the best care possible given resources at hand
 - Decisions are fair and transparent
 - Policies and protocols across the state are consistent
 - Medical community and stakeholders are included and heard

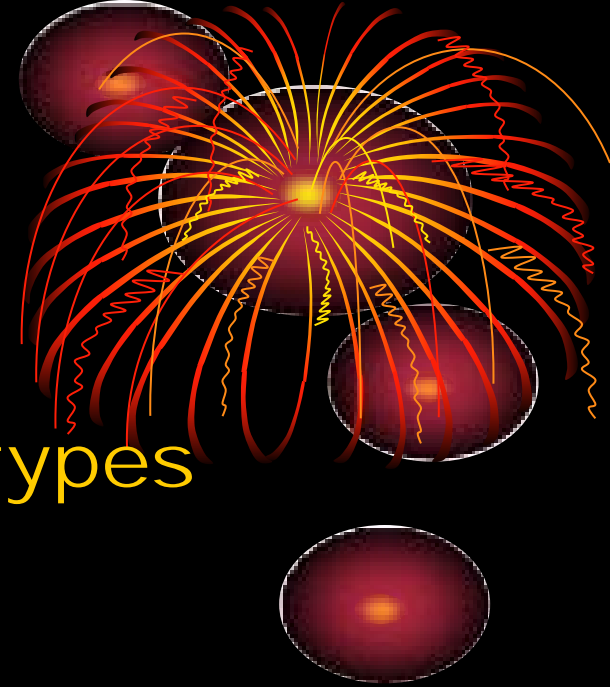
Crisis Standard of Care Guidelines



- **Should Include:**
 - Guiding principles – duty to care, duty to be good steward of resources, duty to plan, distributive justice, transparency
 - Population – those with acute and other health conditions
 - Implementation plan – situational awareness, limiting need protocols, maximizing surge capacity, **only** on an Executive Order
 - Community Communication Plan – open and ongoing at all levels and continuous
 - Termination of Crisis Standards of Care – daily assessments of status , recalibration, and collaboration with regional facilities

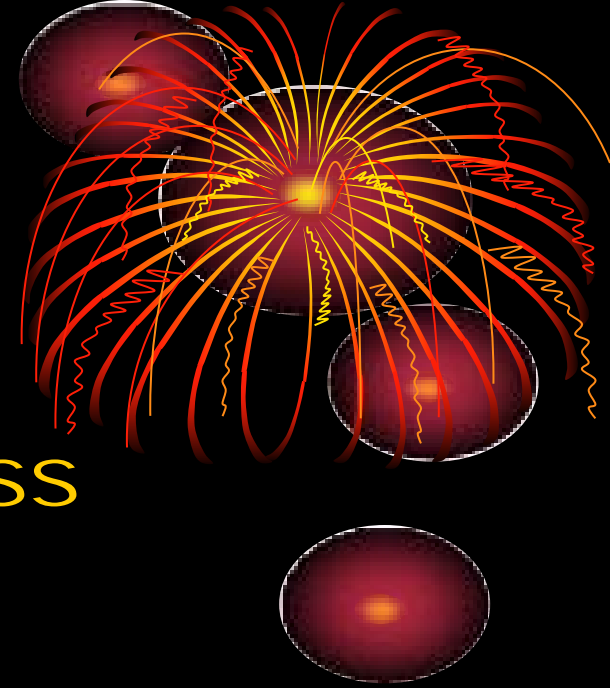
Definitions

- Standards of Care – two types
 - Statutory and regulatory requirements
 - Clinical Judgment: Treatment that would be provided by a similarly qualified, prudent practitioner or facility under the same or similar circumstances

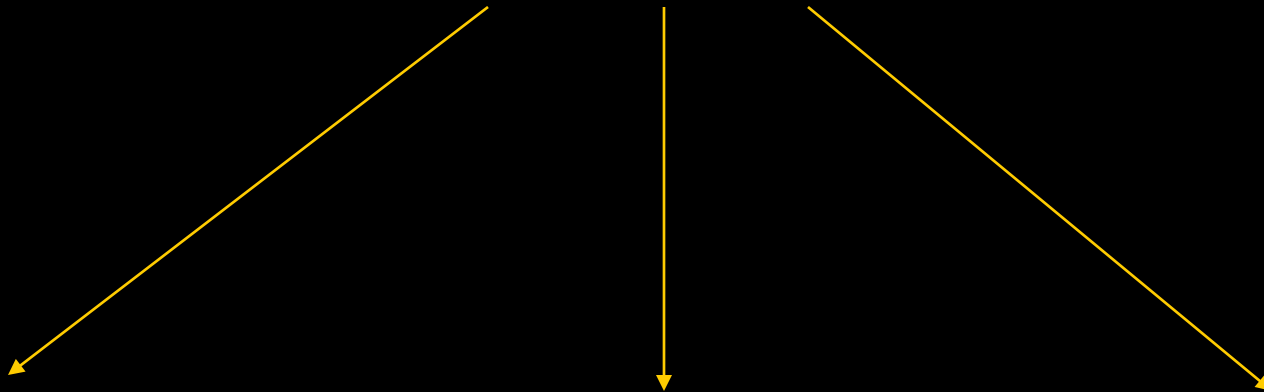
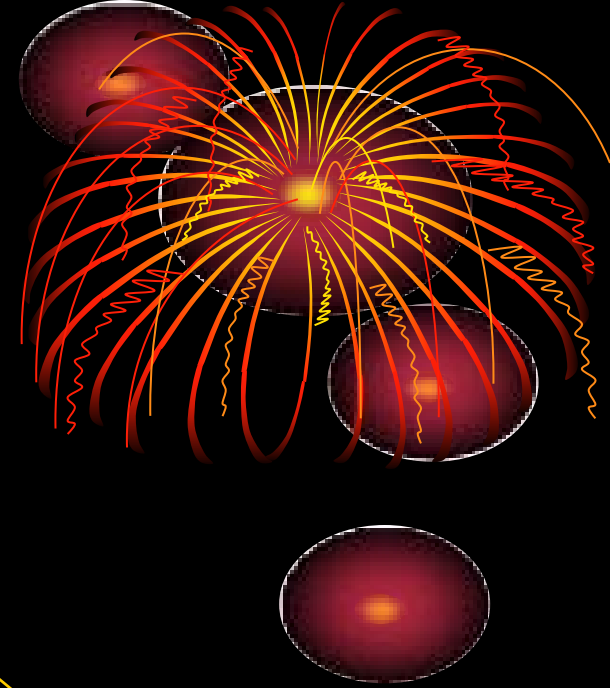


Issue

- Are disaster victims less deserving of care?
- Emphasis should be to get the crisis standard of care as close to "usual" standard of care as possible.



Initial Steps upon Trigger

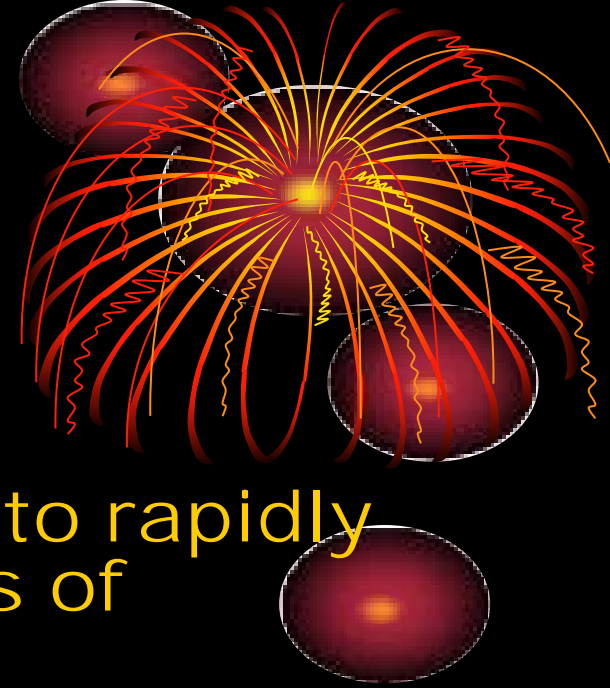


State Declaration
Of Emergency

Hospital Incident
Command system HICS

Incident Action
Plans (IAP)

Key Elements of a Successful Plan



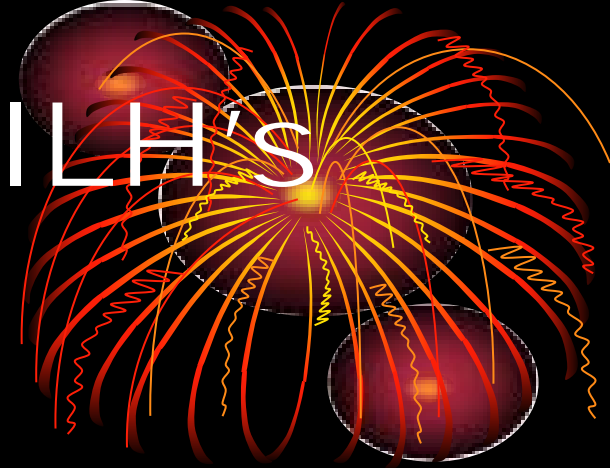
- Must be **flexible** and able to rapidly adapt to a variety of types of disasters.
- Must be able to expand or compress as the disaster **evolves**.
- Must integrate with accepted hospital incident command system principles and operations
- Must have unprecedented oversight and balance.
- Must be **ethically sound** and comply with all laws and regulations.

Key Elements of a Successful Plan as we at ILPH looked at



- The process of developing the plan has been, and must continue to be, **interdisciplinary, comprehensive** and take into account the unique characteristics of our facility.
- **Broad input** into the plan and widespread dissemination of the plan are critical to its successful implementation.
- **Community medical and non medical input and involvement**

Current Status of ILH'S Plan



- Structure of the plan has been generally determined and is similar to the Hospital Incident Command Structure (HICS). And annex of the Emergency Operations plan
- Plan is primarily conceptual with specifics to be put in on a regular ongoing basis

Current Status of ILH's Plan

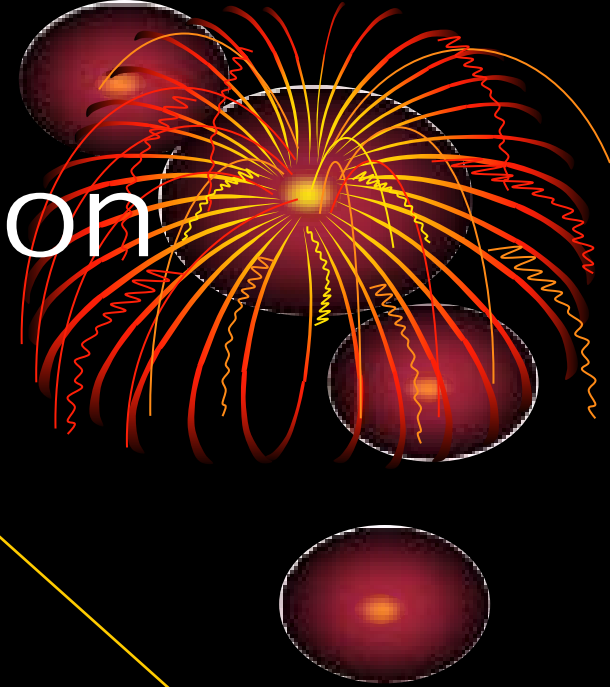
- A **team** approach is being adopted with teams thus far identified including (**but not necessarily limited to**):
 - EMS/Pre-hospital/ED
 - Intensive Care and Vent Triage
 - Dialysis and Special Needs/ Resources
 - Blood and Blood Products
 - Pharmacy and Medication Assets
 - Consultants/adhoc
 - Facility Throughput and Continuity of Care
 - Palliative Care and Family/Staff Support
 - Post Hospital Community Svs ; Home Care ,
 - Alternate areas of care
 - PR/Communication



Equipment
Staffing
Supplies
Facilities

Security
Education

Regional interaction



Regional Coordinator
LA Hospitals
Emergency Response network

Community Sites and leadership
Medical, Nursing, Clinics, Faith based groups,
Ethnic / Multicultural Organizations

THROUGH DEFINED AND PREDETERMINED
COOPERATIVE AGREEMENTS AND MOUs

Specific models /plans



POINT OF CARE MODELS

- Implementation plan based on stages of crises
- Community Communication plan and pre hospital plan
- Hospital Admission triage Plan (HATs)
- In patient Nursing plan with patient care services (Caps)
- The Care teams (Gowns)

DISEASE /POPULATION HEALTH BASED MODELS

- ICU triage Model with Ventilator protocols
- Palliative Care Models
- Termination of Care Model
- Special population models; Pediatrics, Chronic care, Cancer pts, TB (public health issues), Prisoner Care

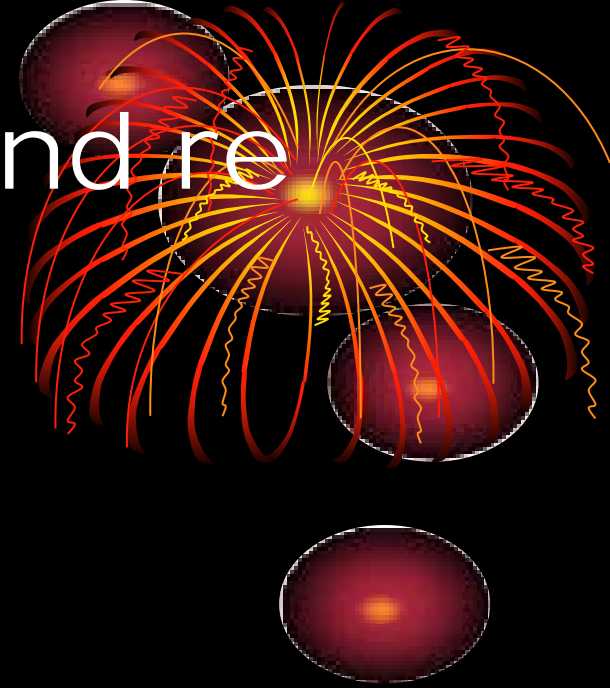
Pre Hospital Triage Model



- Cat 1 : Will survive without hospital care
- Cat 2: Has the highest chance of survival with hospital Rx
- Cat 3: Has a moderate chance of survival with hospital Rx\
- Cat 4 : Has almost no chance of survival even with hospital Rx.

Daily Assessment and re assessment

- Need
- Priorities
- Resources
- Use of resources
- Support system
- Manpower morale and stress



Classifying Work force



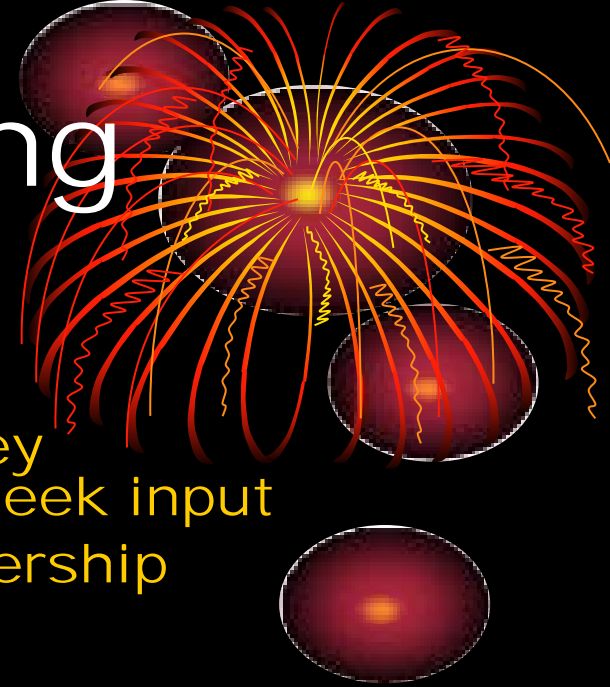
- Continued awareness, education and interaction at multiple points of Care
- Expertise
- Job description
- Safety
- Morale
- Support services

Lessons learnt from H1N1 /Influenza 2010



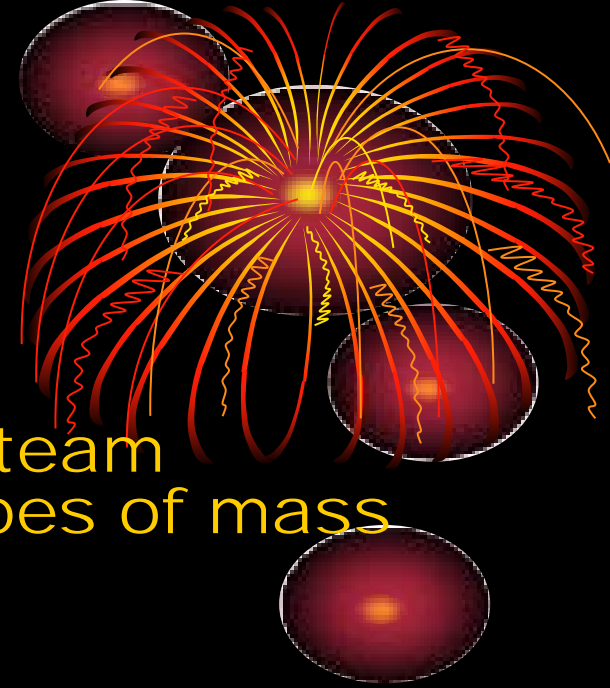
- In H1N1 pandemic , proportionately more children and younger adults were infected , had serious disease; Other patients were spared , but when infected , had high rates of serious disease
- Groups at risk were very young, very old , pregnant women, and those with chronic medical conditions.
- PCR are optimal Dx tests ;
- Early Dx and Rx associated with better outcomes
- Emphasis on aggressive vaccination.
(Bartlett et al)

Steps in Developing ILH's Plan



- Communicate conceptual plan to key interdisciplinary stakeholders and seek input
- Identify team leadership and membership
- Charge teams with
 - Identifying key aspects of service
 - Identifying strategies to respond to increased demand coupled with limited/exhausted resources
 - Document aspects of service and plan for response to be included in comprehensive hospital plan
- Seek specific community input/feedback and use leadership at ILH
- Finalize ILH plan and implement mass dissemination strategies (education, mock drills, etc.)

2011 Next steps



- Inter ILH meeting focusing on team development and scenarios/types of mass emergencies
- Specific POC Drills
- Representation to national meetings
- Liaison through Medical societies , Hospital Association
- Liaison with faith based Organization
- Liaison with Multi-cultural and Ethnic groups/societies through their MD leadership.

Thanks *JA*