North Carolina Crisis Standard of Care FAQ

What is a Crisis Standard of Care?

A Crisis Standard of Care is a set of clinical guidelines backed by ethical standards of care and best practices meant to facilitate effective, consistent care during a crisis that limits clinical resources.

What is the Scarce Inpatient Critical Care Resource Allocation Protocol?

The Scarce Inpatient Critical Care Resource Allocation Protocol, also known as the "protocol" is a document that outlines a crisis standard of care and provides recommendations to clinicians, hospitals, and health care systems for how to triage adult inpatients in the event that a pandemic creates demand for scarce critical care resources, such as ventilators, that exceeds supply.

Key recommendations include: 1) the creation and utilization of triage teams and review committees to promote objectivity; 2) use of accepted criteria, methodologies, and processes for initial allocation of critical care resources; 3) periodic reassessment to determine whether ongoing provision of critical care treatment is likely to result in improvement for individual inpatients; and 4) effective communication with patients and their representatives regarding goals of care and treatment preferences as well as allocation decision-making processes and results.

This protocol is grounded in ethical obligations that include the duty to care, duty to steward resources to optimize public health, distributive and procedural justice, inclusivity and equity, and transparency. All patients are treated as eligible to receive critical care resources and receive a priority assignment based on potential to benefit from those resources. This is consistent with existing recommendations for how to allocate scarce critical care resources during a pandemic, and has been informed by extensive consultation with state experts in several clinical specialties as well as representatives from community and advocacy groups.

The full protocol can be accessed **here**.

Why is this necessary?

The intensity of the COVID-19 pandemic has exhausted scarce resource supply in other parts of the world, such as Italy. North Carolina experts want our state's health care systems and providers to be prepared in the event that we face a similar situation.

How was the protocol created?

North Carolina initially created a scarce resource allocation protocol in anticipation of the avian flu in 2010; as the COVID-19 pandemic increased in intensity, experts saw the need to revive those efforts.

On March 26, 2020, the North Carolina Institute of Medicine (NCIOM), the North Carolina Medical Society (NCMS), and the North Carolina Healthcare Association (NCHA) convened a Scarce Critical Care Resource Allocation Advisory Group to raise awareness and obtain community input on a draft revised protocol for allocating scarce inpatient critical care resources during the crisis stage of a pandemic. On March 31, 2020, NCIOM, NCMS, and NCHA convened an additional group (health care stakeholder group), comprised of representatives from most major health systems in the state, plus advocacy organizations, ethicists, and legal experts, for additional discussion and review. Ultimately, the groups

decided to adapt a protocol developed at University of Pittsburgh School of Medicine, Department of Critical Care Medicine.

Who was involved in the creation of the protocol?

Advisors included state experts in several clinical specialties (including intensive care, pediatrics, palliative care, emergency medicine, family medicine, psychiatry, infectious disease, nephrology, and anesthesiology), nursing, spiritual care, ethics, law, and public health. Advisors also included representatives from community and advocacy groups representing racial and ethnic minorities, vulnerable populations, people with disabilities, older adults, and faith communities.

What ethical considerations were incorporated?

The overall goal of the critical care resources allocation processes is to maximize benefit to populations of patients, often expressed as doing the greatest good for the greatest number. It should be noted that this goal is different from the traditional focus of medical ethics, which is centered on promoting the well-being of individual patients.

The development of this protocol has been informed by extensive consultation with state experts in several clinical specialties (including intensive care, pediatrics, palliative care, emergency medicine, family medicine, psychiatry, infectious disease, nephrology, and anesthesiology), nursing, spiritual care, ethics, law, and public health. Advisors also included representatives from community and advocacy groups representing racial and ethnic minorities, vulnerable populations, people with disabilities, older adults, and faith communities.

Further, the protocol recommends that facilities create objective triage teams that include the involvement of ethics faculty, an off-duty triage officer, and staff members or employees who function to promote principles of health equity.

When/how will the protocol be implemented?

The protocol will be in effect when 1) the Governor has declared a state of emergency (NCGS §166A) due to a pandemic (such as the current COVID-19 pandemic), and 2) critical care resources are, or shortly will be, overwhelmed.

What should I expect if my hospital implements the protocol?

In the event that 1) the Governor has declared a state of emergency (NCGS §166A) due to a pandemic (such as the current COVID-19 pandemic), and 2) critical care resources are, or shortly will be, overwhelmed, your facility will likely implement the protocol. If the protocol's recommendations are followed, this will likely mean:

1) the creation and utilization of independent triage teams as well as Triage Review Committees tasked with handling potential appeals
2) implementation of accepted criteria, methodologies and processes for initial allocation of critical care resources (this may vary slightly by facility);
3) periodic reassessment to determine whether ongoing provision of critical care treatment is likely to result in improvement for individual inpatients; and

4) emphasis on effective communication with patients and their representatives regarding goals of care and treatment preferences as well as allocation decision-making processes and results.
5) implementation of intensive symptom management and psychosocial support, provided by palliative care specialists where available, for patients who cannot receive critical care. Where palliative care specialists are not available, the treating clinical teams should provide primary palliative care.

How will the protocol affect me and my work?

You, your colleagues, and your facility will be supported by the guidance of triage teams and review committees, and by the protocol. When faced with difficult triage decisions, you will be guided by protocol recommendations backed by a large team of clinicians, ethicists, lawyers, and activists.

It is important to reiterate that all patients will be eligible to receive critical care beds and services, and that the availability of critical care resources will determine how many eligible patients will receive critical care.

Consistent with accepted standards during public health emergencies, the primary goal of the inpatient critical care resources allocation processes is to maximize benefit for populations of patients, often expressed as "doing the greatest good for the greatest number." The allocation process applies to all patients presenting with any critical illness, not merely those with the disease or disorders that caused or resulted from the pandemic.

How can I prepare now for scarce resource allocation?

The hope is that the scarce resource allocation protocol will never be needed. However, to prepare for a situation in which it is implemented, you can prepare by familiarizing yourself with the protocol's recommendations and your organization's triage committee guidelines.

Discussing advance care planning with patients is always encouraged; during a pandemic or other crisis situation in which clinical care resources may become scarce, it will be important to prepare for these discussions potentially happening more quickly and often.