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 North Carolina's Crisis Standard of Care?

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 is a triage team?

In the interest of objectivity, equity, and the minimization of moral distress, the protocol recommends that instead of clinicians making final triage decisions, those decisions be made by a triage team consisting of ethics faculty and staff members or employees who function to promote principles of health equity. The protocol recommends that triage teams focus on clinical factors included in the protocol, without use of principles or beliefs that are not included in the protocol.

How will resources be allocated?

It is important to reiterate that all patients are treated as eligible to receive critical care resources and receive a priority assignment based on potential to benefit from those resources. The availability of critical care resources will determine how many eligible patients will receive critical care. The crisis standard of care processes operationalizes this broad public health goal by giving priority for critical care resources to patients who are most likely to survive to hospital discharge and beyond with treatment.

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.

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

What happens to patients who are not triaged to receive critical care?

The protocol recommends that patients who are not triaged to receive critical care resources should receive medical care that includes intensive symptom management, psychosocial support, and spiritual care. They should be reassessed daily to determine if changes in resource availability or their clinical status warrant provision of critical care services. Where available, specialist palliative care teams will be available for consultation. Where palliative care specialists are not available, the treating clinical teams should provide primary palliative care.

Does the patient or family have a say?

Providers are strongly encouraged to solicit patient goals of care and treatment preferences through conversations with the patient or their representative. All patients are treated as eligible to receive critical care resources and receive a priority assignment based on potential to benefit from those resources. It is possible that patients, families, or clinicians may want to challenge individual triage decisions, and an appeals mechanism involving the Triage Review Committee should be available to resolve such disputes.

What does the Triage Review Committee do?

In addition to at triage team, the protocol recommends that facilities create independent Triage Review Committees to handle appeals. These committees will focus on ensuring appropriate documentation of resource allocation decisions and rationale and identifying and evaluating opportunities for process improvement. Like triage teams, the protocol recommends that Triage Review Committees include ethics faculty and staff members or employees who function to promote principles of health equity.