Deans Lecture Series
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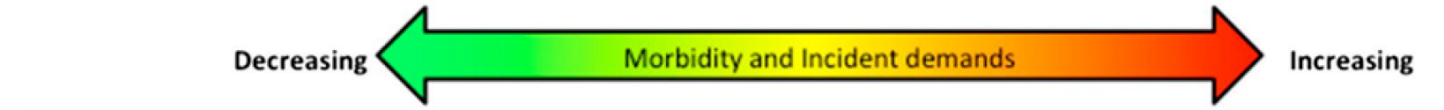
COVID-19 Pandemic: Crisis Standards of Care

- Critical Care Working group (CCWG) formed as an operational working group of the Minnesota State HealthCare Coalition (SHCC)
- Intensivist leadership from nine largest health systems
  - 67% of all Minnesota ICU beds and most (all) tertiary care beds
  - Intensivists, ethic and palliative care specialists, and representatives from MCEC (Minnesota COVID Ethics Collaborative)
- Helped establish the Minnesota Critical Care Coordination Center (C4) which helped identify and facilitate transfer for patients requiring an ICU bed

Crisis Standards of Care (CSC): Plans, Plans, Plans

- CCWG members worked together (Spring 2020)* to establish triage processes
  - Established triage officers and/or teams to triage ICU admissions if CSC encountered
  - Established processes for how to determine patient "priority"
    - Required a degree of infrastructure and personnel investment
  - Worked to establish standards for how to implement CSC consistently across Minnesota

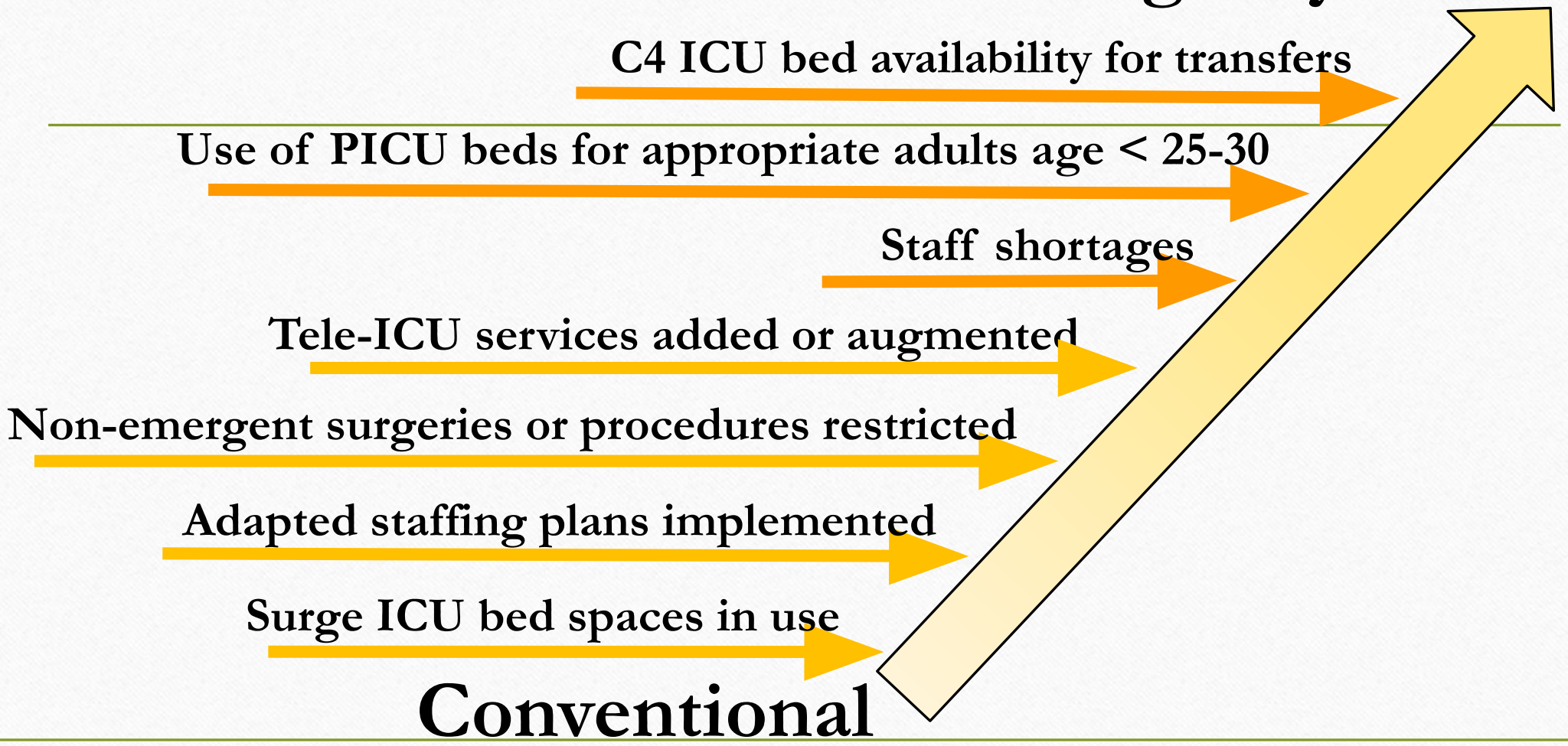
*CHEST 2014; 146 (4_Suppl): e61S - e74S
*CHEST 2008; 133:51S–66S

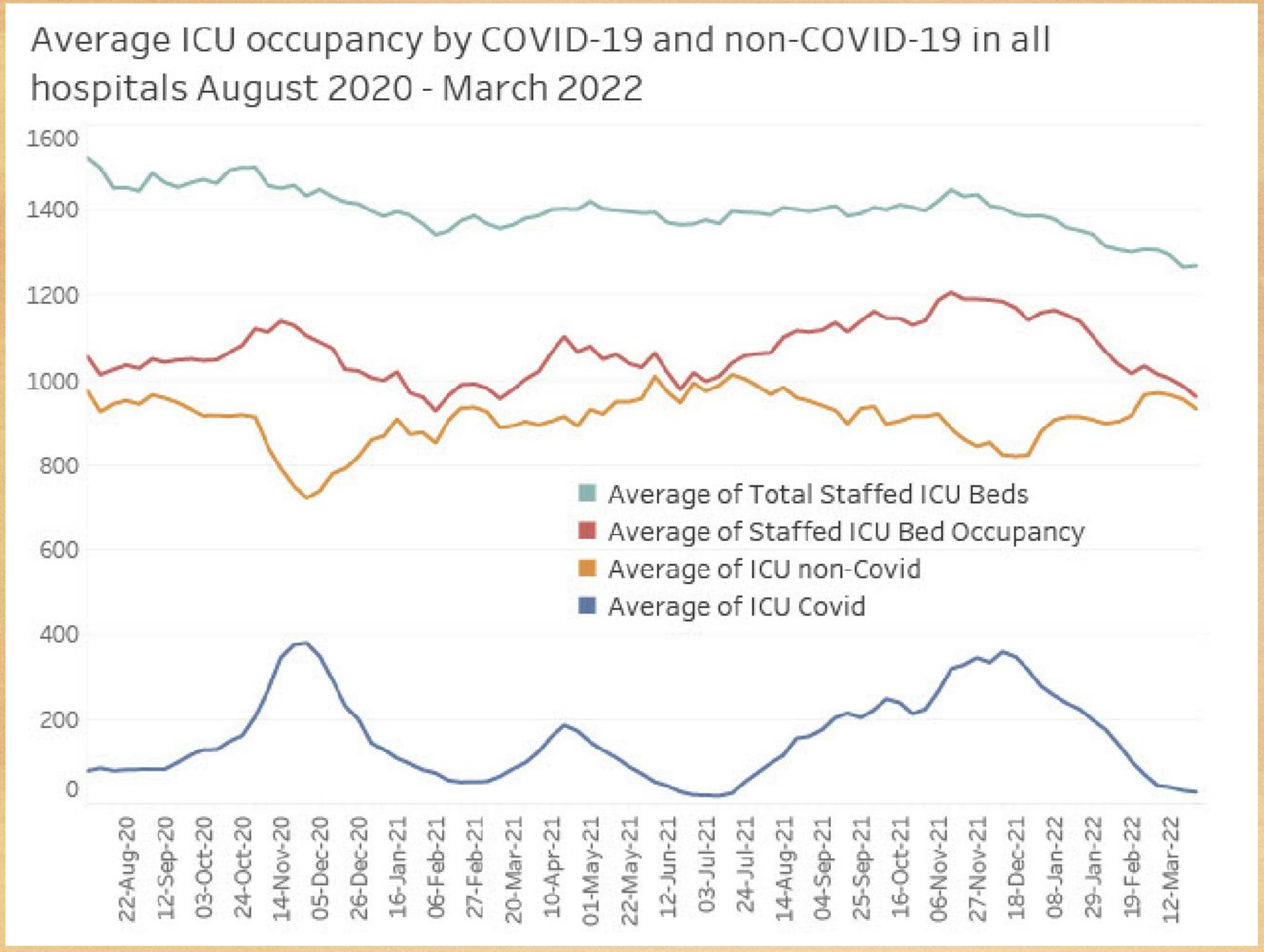


	Conventional	Contingency	Crisis
Space	Usual patient care spaces maximized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Non-traditional areas used for critical care or facility damage does not permit usual critical care
Staff	Additional staff called in as needed	Staff extension (supervision of larger number of patients, changes in responsibilities, documentation, etc')	Insufficient ICU trained staff available/unable to care for volume of patients, care team model required & expanded scope
Supplies	Cached/on-hand supplies	Conservation, adaptation and substitution of supplies with selected re-use of supplies when safe	Critical supplies lacking, possible allocation/reallocation or lifesaving resources
Standard of care	Usual care	Minimal impact on usual patient care practices	Not consistent with usual standards of care (Mass Critical Care)
ICU expansion goal	X 1.2 usual capacity (20%)	X 2 usual capacity (100%)	X 3 usual capacity (200%)
Resources	Local	Regional/State	National

CHEST 2014; 146 (4_Suppl): 8S - 34S

Contingency to Crisis





Data Courtesy Minnesota Department of Health

CSC: What actually happened?

- **Prioritization vs Reallocation**
  - **Prioritization: everyone gets Critical Care, with priority established for who are admitted to ICU beds most urgently**
    - **Most patients waited in ED's for ICU beds**
  - **Reallocation: those most likely to benefit from ICU care receive it; others determined medically to be unlikely (much less likely, usually after a trial of therapy) to benefit have care taken away to be given to those more likely to benefit**
  - **Little scientific data available for decision making for either**

CSC: What actually happened

- Prioritization- Decisions had to be made (and were) as to who received the ICU Resource
  - Some organizations had formal triage officers and/or teams to help determine prioritization
  - Most prioritization were decisions made by on-call Intensivists
  - Tertiary care systems (at times) declined accepting patients from outside their own systems
- Reallocation- No executive government support to implement
  - Reallocation did not occur
- Prior to the pandemic these were (are) considered ethically equivalent process
  - In practice: they were diametric opposites

CSC: What actually happened?

- Who had the best chance of receiving care
  - Urban versus Rural
- CSC frameworks largely fell apart
- Recommendations
  - Triage officers or teams not directly involved in patient care to make decisions
  - Scientific data to help determine effective prioritization strategies
  - Mechanisms to maintain contingency care and avoid CSC as ***the top priority!****

*CHEST 2022; 161(2):429-447