Crisis Standards of Care: Pediatric Perspectives

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Pediatric Crisis Standards of Care Plans

- Overlapping issues with adult plans
- Highly dependent on local environment
- Pediatric specific discussions:
  - Sharing of “best practice”
  - A few unique challenges and needs
  - A few unique tools, options, and issues to consider
Challenges

• Consent and parental involvement
• Practical challenges of scoring / algorithms
  • Example metrics with unique practical perspectives
    • Outpatient pulse O2 monitoring
    • Dialysis methodology
    • ECMO capabilities
• System-level load balancing
  • Adult / Pediatric integrated impacts
• Unique considerations for specialty needs / equipment / Supply Chain / Staffing
• Time factor (acute vs extended)
Current Events

• Multiple concerns, challenges and calls for help
  • Similar pediatric concerns:
    • Scores not practical
    • “Withdrawal” or “restriction” of care not acceptable
  • Anxiety, public perceptions and emotional impact
  • Limited alternatives

• Response
  • Collection of existing standards and legal perspectives
  • Consolidate best practice / advice into a bullet point template table
  • Platform for information-sharing
    • Multi-jurisdictional virtual meetings
Summary: Shared Principles

- Stay in Contingency!
  - Load balance across system/region
  - EMS adjustments
- Scoring systems are options – but problematic practical use
- Verbalize what you CAN DO, not what you CAN NOT DO
- “No patient abandoned”
- Pediatric specialty advisory roles
  - Ethics committee integration into HICS: review system
  - Pediatric SME integration into system load balance decisions
# Pediatric Crisis Standards of Care Reference Table

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<thead>
<tr>
<th>Conventional</th>
<th>Contingency</th>
<th>Crisis</th>
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<tbody>
<tr>
<td>Definition</td>
<td>Surge plans unveiled and require to maintain normal standards of staffed bed capacity or supply chain deficiencies resulting in remaining staffing.</td>
<td>Resource demands exceed supplies and capabilities. Unable to provide routine or contingency standards of care despite contingency efforts.</td>
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<tr>
<td>Potential Triggers</td>
<td>Moderate surge and anticipated potential difficulties</td>
<td>Staffed bed capacity or supply chain deficiencies allow no further capacity despite continued demand (i.e., no additional staffed beds or ventilators).</td>
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<td>Sample Activation Requirement</td>
<td>Local Authorities/Facilities - Pediatric facilities should coordinate with the ( ^{\text{Local or state emergency declarations}} ), ( ^{\text{Regional hospital system determinations}} ), and ( ^{\text{Internal hospital committee decisions}} )</td>
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<tr>
<td>Institutional</td>
<td>Institute Hospital Incident Command Structure (HICS) or National Incident Management System (NIMS) early with anticipated need</td>
<td>Options/Examples:</td>
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<td>Agency/Policy/Systems</td>
<td>Consider pre-emptive activation of local incident command system in the event of surge.</td>
<td>Options/Examples:</td>
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<td>Options/Examples:</td>
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<td>1. Institutional load balancing: direct patient transports to like institutions with remaining capacity consistent with EMTALA requirements.</td>
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<td>1. Expand staffing scope of care (i.e., expansion of floor nursing scope of practice, nonclinical personnel to assist with basic care needs, utilization of nursing assistants, etc.).</td>
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<td>2. Activate telemedicine and outpatient resources to support acute care needs.</td>
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<td>2. Increasing standard nursing ratios, and empower facilities to implement team care models. Avoid specific approaches that may lead to unwarranted outcomes.</td>
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<td>3. Utilize non-maximal, acceptable resource requirements for each patient (i.e., step down unit when normally in ICU, CRIP in place of ventilators).</td>
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<td>3. Transfer or divert patients to lower level facilities that have remaining capacity consistent with EMTALA. These are level II balancing efforts with capacity being a factor.</td>
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<td>4. Consider altering resource utilization devoted to palliative care, full care, and extremely poor prognosis patients.</td>
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<td>4. Establish alternate care sites (i.e., ESFR resource mobilization), for focused care needs.</td>
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<td>5. Activate treatment teams models.</td>
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<td>5. Temporary expansion of facility licensure capabilities (outpatient areas allowed to care for inpatient needs) consistent with legal allowances during EMTALA.</td>
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<td>6. Consider utilization of alternate areas of the facility for patient care (i.e., outpatient infusion area converted to hospital beds).</td>
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<td>6. Temporary expansion of licensure requirements for telehealth support (out of jurisdiction licensure reciprocity, Agreeable Medicare/Medicaid).</td>
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<td>7. Activate unconventional staffing to augment licensed capabilities (outpatient providers mobilized to assist in critical care settings). Include utilization of volunteers or nonclinical personnel to assist with basic patient care.</td>
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</table>
| | | 7. Expansion of reimbursement plans for alternate care sites, telemedicine, outpatient/home care models that collectively may decrease acute care needs.
## Contingency

### Institutional options

1. Upstaffing with licensed and trained outside support (e.g., locums, travelers, per diem). Consider strategies from the National Academies of Medicine guidance - [https://www.nap.edu/catalog/25890/rapid-expert-consultation-on-staffing-considerations-for-crisis-standards-of-care-for-the-covid-19-pandemic-july-28-2020](https://www.nap.edu/catalog/25890/rapid-expert-consultation-on-staffing-considerations-for-crisis-standards-of-care-for-the-covid-19-pandemic-july-28-2020) - it's important to compare current staffing contingencies at hospitals within the area (via the Peds Centers of Excellence, RDRHS or healthcare coalition, etc.) to make sure that there's as consistent level of care provided as possible.

2. Restricting elective procedures that are not time sensitive: delay of CHA tier 1 elective surgeries

3. Reverse triage: discharge or ward downgrades wherever clinically safe and appropriate.

### System options

1. Institutional load balancing: direct patient transports to like institutions with remaining capacity consistent with EMTALA requirements

2. Activate outpatient resources that may support acute care needs (telemedicine, primary care system, home nursing, etc)

3. Alter standard EMS operations provided acceptable standards of care are maintained (i.e. - 14-18 year old patients treated at adult or pediatric centers as capacity allows, limits on transport of non-urgent patients consistent with EMTALA requirements).

Tools: Peds Surge Plans

Health Care Coalition Pediatric Surge Annex Toolkit

- Efforts to stay in Contingency
- Pre-identified resources
  - Integration of outpatient and community resources
  - Load balancing plans
  - Pediatric HICS advisory roles
  - Supply chain alternatives
  - National Pediatric Readiness Project Assessment (NPRP champions)
Tools: Telemedicine

• State, Local, Facility Coordination
  • Direct to patient connection
  • Primary care infrastructure as expanded capability

• Special Needs Children / At-Risk Communities
  • Opportunity to address health disparities

• Challenges:
  • Connection reliability
  • Technology access for families
  • Interstate licensing
  • NTCCN – pediatric resources
• Pediatric (or adult) pearls for adult (or Peds) providers:
  • Critical care tools: https://opencriticalcare.org/
  • Courses: https://www.sccm.org/Education-Center/Educational-Programming/Fundamentals
  • Vents: https://www.aarc.org/resources/clinical-resources/strategic-national-stockpile-ventilator-training-program/
  • ACEP simbox: https://www.acepsim.com/
  • Calculators:
    • Supply: https://asprtracie.hhs.gov/technical-resources/resource/4650/aspr-tracie-hospital-disaster-pharmacy-calculator
    • Dosing: http://www-users.med.cornell.edu/~spon/picu/calc/medcalc.htm
  • AACP resource manuscript: in process
  • WRAP-EM “Just in time manual” - coming soon: https://wrap-em.org/
  • Academic manuscripts / experience on cross utilization—multiple!
Tools: Legal Considerations

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