

**Conference Call Convened at 9:00 a.m. Eastern Daylight Time**

✓ **Present**

✓ Jonathan Ballard	Richard Levitan	✓ Carole Totzkay
✓ Trish Clancy	✓ Susan Reeves	✓ Tom Wold
✓ Kevin Desrosiers	✓ Justin Romanello	
✓ Paul Drager	✓ Jason Shaw	
✓ John Friberg, Jr.	✓ Steve Surgenor	
✓ Marc Hiller	✓ Robert Theriault, Jr.	

**Conference Call Agenda**

1. Discuss clinical guidelines
2. What it looks like it
3. Work plan to get there

Ballard: Thank you for joining the call today. I am Dr. Jonathan Ballard, Chief Medical Officer (CMO) at the NH Department of Health and Human Services. Please state your name and the agency/organization you represent.

Clancy: Family doctor and Chair of the Ethics Committee at Concord Hospital

Desrosiers: Critical care physician and CMO Elliot Hospital

Drager: Medical Ethicist

Friberg: Chief Legal Officer at Solution Health

Hiller: UNH Medical Ethics

Reeves: Chief Nursing Officer at Dartmouth Hitchcock Health

Romanello: NH Department of Safety, EMS Bureau Chief

Shaw: Respiratory Manager at Catholic Medical Center

Surgenor: Critical care physician at Dartmouth Hitchcock Health

Theriault: Director of Pharmacy Services at Wentworth-Douglass Hospital

Wold: CMO at Portsmouth Regional

C. Burney: SDMAC member

Ballard:

- Our charge at the State is to gather information, compose a draft clinical guideline for use by hospitals and others, and obtain feedback.
- What should be the essential elements for the clinical triage guidelines?

- The State of Massachusetts (MA) used SOFA scoring in the context to save the most lives and life years possible with existing available resources and supplies.

Desrosiers:

- Step one is to review exclusion criteria: Cardiac Arrest, Severe Burns, Severe Trauma, Acute neurological event with minimal chance of recovery (not dialysis is not on this list)
- Step two is to apply the mSOFA Scoring system to develop a score: Blue MSOFA > 11 - Highest Risk of Mortality, Yellow MSOFA 8-11 Intermediate Priority, Red MSOFA 1-8 – Highest Chance of Survival with treatment, Green MSOFA 0 – Highest chance of survival without treatment
- Limited resources are applied according to the MSOFA triage level as adjudicated by the triage team
- The triage team does not take into account race, age, disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, perceived obstacles to treatment, or past use of resources
- Resource distribution is reviewed every 48 hours or sooner if needed based on clinical situations developing
- The triage team is comprised of members who are not providing care to the patient cohort under consideration
- We have worked with John Friberg's team in trying to achieve immunity from civil and criminal prosecution for the appropriate use of Crisis Standards of Care

Reeves:

- Fair amount of commonality amongst hospitals.
- We used Dr. Doug White's (University of Pittsburg School of Medicine) framework 3 components: Triage team, Methodology for scoring based on near term survival, and process for reassessment for resources.
- We added two addition elements from The Hastings Report, supporting ethical care and supporting our clinicians in moral distress.
- We consulted with colleagues in Vermont and NH.
- We spent a fair amount of time on discrete elements i.e., technology, DNR, CPR, ECMO, Pediatrics, and Neonates.
- Dr. Whites' framework changed ever so slightly due to civil rights. Moved from scoring comorbid to not actually labeling them; not to be specific about comorbid conditions.
- Considering having an assessment of near term survival a year to 5 or more years.
- The Ethics Committee at Dartmouth accepted the guidelines.

Wold:

- Used Minnesota (MN), North Texas (TX), New York (NY), and Pennsylvania (PA) models as reference.
- Inclusion and exclusion criteria, risk assessment, and reassessment; purpose statement, basic premises –ethical issues.

- Red, yellow, green scoring and the need for an age cut off; 1 year and 5 year considerations and how they apply to mSOFA scoring.
- Establishing an appeals process.

Ballard: Let's continue exploring scoring systems.

Romanello:

- Need to include some universal scoring system amongst hospitals so there would be no biases.
- Resources vary across the state.

Ballard: What do you do with high level triage in a facility and for resource allocation? What is the first step for allocation of limiting resource? What does this look like?

Desrosiers:

- In a pervasive catastrophic disaster, essential supplies quickly run out.
- We would need to be able to communicate across the state with other facilities in real time to verify the extent patient care can or cannot be provided in the state.

Ballard: How do we incorporate timeframes? Provide transfer to closest facility?

Desrosiers:

- Many of our nursing homes in the area have affiliation with CMC, Elliott, St. Joseph's Hospital, and Southern NH Medical Center.
- We communicate and distribute the patients based on availability and hopefully resources.

Reeves:

- The resources of the 26 hospitals to support are widely variable. We had some hospitals that were small enough that they may only have one ventilator.
- A one size fits all doesn't work. We need a framework for how the smaller hospitals relate to medium hospitals and how medium hospitals to large hospitals.

Ballard: Should the State approach a scoring system or not?

Reeves:

- The State could provide guidance and suggested models for hospitals that are creating CSC.
- The organizations will need to determine how they apply within.

Wold:

- We have taken a similar approach as Kevin Desrosiers.
- I do think having universal guidelines are important for transparency, consistency, ensuring no discrimination, and how to treat healthcare workers.
- There needs to be flexibility for all the hospitals.

- The document would take into account both legal and medical standard of care.
  - **NH RSA 507-E:2 Burden of Proof**  
<http://www.gencourt.state.nh.us/rsa/html/LII/507-E/507-E-2.htm>
  - **NH RSA 508:13 Professional Malpractice; Evidence**  
<http://www.gencourt.state.nh.us/rsa/html/LII/508/508-13.htm>
- Provide guidelines for hospitals which will likely be responding at different levels and on different timeframes. Nice to have one standard, but it needs to take particular local circumstances into account, such as resources to communicate with the state.
- State should provide elements and parameters for each of the elements.

Desrosiers:

- This subcommittee has the capability to be conveners should one or more hospitals move from contingency to crisis. The goal would be to help hospitals help each other to maintain contingency as long as possible before crisis.
- Kathy's [Bizarro-Thunberg] emails help to keep situational awareness. Our goal is to stay away from crisis and keep within contingency.

Clancy:

- The State is not in charge of any of these hospitals. I agree with concept of the State suggesting elements and parameters. Those are acceptable.

Friberg:

- A convening function of the State would be to delineate when a facility or region has entered crisis standards.
- Massachusetts' plan states that facilities will contact the HHS Duty Officer. Colorado has a web-based tool to communicate with the state.

Surgenor:

- Reduce barriers for transfers. How do we provide guidance so the critical care hospitals can support smaller hospitals?

Drager:

- There is a purpose for a statewide guidance. Reassure its citizens that there will be consistency across all hospitals when needed.
- End of life care issues of patient may not be the same at all the hospitals.

Friberg:

- One other feature would be that actions consistent with the standards are emergency management functions.

Ballard: Special medical conditions. What are some of the essential elements we should consider?

- The Federal Office of Civil Rights (OCR) guidance of no use of categorical exclusion criteria. This should be in all CSC clinical guidance from the State.  
<https://www.hhs.gov/about/news/2020/03/28/ocr-issues-bulletin-on-civil-rights-laws-and-hipaa-flexibilities-that-apply-during-the-covid-19-emergency.html>

Totzkay (facilitator):

- Each state within the New England will most likely have some degree of variation. There's nothing to stop citizens to seek care in another state if they perceive it as better for them.

Friberg:

- Fundamentally, it is a state law issue. I think it would not be a bad idea to explore Regional CSC. Making sure that we are not inconsistent with other New England states.
- As to the OCR guidance, the federal Department of Health and Human Services (HHS) has jurisdiction over discrimination issues in the healthcare delivery context.

Ballard: What of cross-border ethical issues?

Hiller:

- Yes. Differences may exist but fairness and equity should be applied across all states and across the country.

Friberg:

- Discrimination can manifest itself by intent but also by impact. We have to ensure there are not inherent biases that would result in discriminatory impact.
- Need legal and ethics experts to review to ensure no unintentional bias or impact.

Drager:

- Canada has national laws concerning physician standards. Everyone is valued. Consistency and transparency are critical.

Clancy:

- Are we sharing our plans across the states. Sharing with Canada may not be necessary.

Ballard: Many states are sharing plans.

Clancy:

- Is someone from our committee looking at these plans?

Ballard: We can take this on.

Totzkay:

- I have Massachusetts and Vermont. I will look into obtaining Maine, Connecticut, and Rhode Island's CSC Plans.

Ballard: How do the hospitals operationalize the guidance?

Romanello:

- We use Juvare to assess and determine EMS delivery.

Desrosiers:

- Focus on the magnitude of triage needs and how to respond.
- During little surges of crisis during COVID we have tried to communicate CSC and the details of how to participate in a triage team. We have a roster of interested people to participate in triage.

Ballard: Do individual decisions go to a triage committee?

Desrosiers:

- The bedside physicians don't want to be the arbiters of who lives or dies. So the triage committees are accepted provided they have a diverse set of disciplines.
- Key questions: How do you document? There was a JAMA article that came out some time ago that addressed some of the liability issues.

Reeves:

- Our facility accepted having a triage committee. However, we deliberately stopped at not talking about it with the community to avoid anxiety.
- We ran our documents through hospital committees that had community member representation.
- Is there a value for the State to do this? How to provide notification at time of admitting that CSC are in place?

Drager:

- It's really important the nursing homes have designated health care agent (i.e., a loved one or friend) for their patients and checking to see if it is current.
- POLST presentations within the State and perhaps regionally. NY State medical proxy and similar POLST. No reciprocity in NY or in MA. It is unknown if MA General Hospital (MGH) accepts a POLST. We should be make some recommendations to loosen and honor.

Desrosiers:

- We used the hospital's triage review committee as a vetting body.
- Will the DHHS have a triage committee?

Ballard: That is what the STC is charged to do; to assist in answering general questions to hospital triage committees.

- I agree with the possibility of raising concern within the public. One way is to remind the public that by the State working together with all the hospitals, we are all working to support each other and limit the possibility of having to use CSC.

Romanello:

- Education to the public. Start now.
- Education to the entire healthcare system needs to start now.

Friberg:

- Elliot and Southern took a similar approach to Dartmouth-Hitchcock, involving members of the public in formulating standards, but stopping short of notice to the public at this time.

Ballard: Recommendations for hospitals?

Friberg:

- State could assist in advising when and how to give notice to the public, and making the community aware of what it is, why it is necessary, and to provide a level of assurance.

Hiller:

- Gather some information state-wide that would help institutions' ethics committees. What exists in this capacity? Comparing standards with neighboring states?
- Have all of NH's 26 hospitals share their plans with the state? What are the strengths, commonalities, values, etc.?

Drager:

- Although an advanced directive may be recognized in another state, NH doesn't have regulation concerning POLST as being recognized in another state.  
<http://www.gencourt.state.nh.us/rsa/html/X/137-L/137-L-mrg.htm>
- Second, related to transparency and getting information to the public, we discussed this at the initial CSC meeting. Take advantage of DHHS Public Information Office (PIO) and the State's Joint Information Center (JIC) to help educate the public on CSC.

***Facilitator's Note:***

1. Community engagement with CSC has been an established requirement per the IOM reports. Minnesota's Center for Emergency Preparedness and Response has conducted community outreach sessions to gather feedback on Minnesota's CSC Framework. More information is available at <https://www.health.state.mn.us/communities/ep/surge/crisis/engagement.html>
2. Source: National Academies of Sciences, Engineering, and Medicine 2020. *Rapid Expert Consultation on Crisis Standards of Care for the COVID-19 Pandemic (March 28, 2020)*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25765>.

**Engagement, Education, and Communication.** Both providers and the public must be engaged in CSC planning both to ensure the legitimacy of the process and the resulting standards and to achieve the best possible result. Both the public and health care providers must understand these difficult choices and be engaged in developing the criteria for making them. Those criteria must then be clear enough that practitioners can apply them when making decisions at the bedside, especially when the stewarding of scarce resources means withholding or withdrawing critical care services. Those criteria must reflect the values, wishes, and interests of all patients, especially the most vulnerable. In the current pandemic, public trust is essential. To this end, health care leaders must be proactive, honest, transparent, and accountable when communicating the state of their institutions and the system as a whole. Given the resources available at the start of the crisis and expected during the immediate period, demand for health care services, especially in critical care, will soon outstrip health care providers' ability to deliver usual care in many communities, as has already occurred in several metropolitan areas. Reports on extreme conditions elsewhere may not prepare the public for the shift to CSC in their own hometowns. Health care and political leaders have a duty to forewarn the public about what is coming, and the implications of CSC.

Romanello:

- More robust communications are needed. Continued use of Juvare.
- Transparency is important but there are some [individuals] who are a bit guarded. Physicians / Organizations are willing to share but think that a divulged resource will be taken away.

Ballard: Transparency without fear. Any other topics we should include in our draft?

Reeves:

- Next step could be a charge and a set of responsibilities of this group.

Ballard: The NH CSC Plan does have this language as far as implementation. We can re-address this at the next meeting. Thank you for pointing this out. We have a request for neighboring States' plans and a draft, high-level guidance document.

Reeves:

- Is our committee distributing documents to the public?

Ballard: We are required to post all documents and draft notes. I'll inquire with DHHS legal on "draft" documents to share with the public. Would Tuesday, May 26 be acceptable in the morning? Now let's open the line to the public. Hit 5 \* to open your line.

Hiller:

- Why are we using phone vs. Zoom?

Ballard: The NH Legislative Committees are using concall, but no real reason.

## **Public Comments**

Stephanie Patrick, Executive Director of the Disability Rights Center - NH:

- Thank you for your work on this. Life years – how is that being used and implemented? We have some concerns. Please look at this further to avoid discrimination.
- There is an obligation by facilities and the State to give them [the public] information about CSC, to look at these plans, and make it available to groups and organizations.

Ballard: Thank you. We will aim to get the meeting notes and draft guidelines out by end of next week.

**Call ended at 10:39 a.m.**

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