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	✓ Charles Burney
✓ Paul Drager	✓ Jason Shaw	✓ Kathy Bizarro-Thunberg
✓ John Friberg, Jr.	✓ Steve Surgenor	✓ Kate Riddell
✓ Marc Hiller	✓ Robert Theriault, Jr.	

Conference Call Agenda

1. Discuss clinical guidelines gaps
    a. Level of specifics
    b. Triage levels and/or steps
    c. Assessment scoring and grouping
    d. Secondary criteria and tie-breakers
    e. Pregnancy
    f. Clinical re-evaluation and re-assignment
    g. Therapeutic trials

2. Process for public comment

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

Riddell: Intensivist, Anesthesiologist

Romanello: NH Department of Safety, EMS Bureau Chief

Shaw: Respiratory Manager at Catholic Medical Center

Surgenor: Critical care physician at Dartmouth-Hitchcock Health

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Theriault: Director of Pharmacy Services at Wentworth-Douglass Hospital

Wold: CMO at Portsmouth Regional

Bizarro-Thunberg: Executive Vice President, NH Hospital Association; SDMAC member

Burney: SDMAC member

Totzkay: NH DHHS Public Health Emergency Planner; NH CSC Facilitator

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Ballard:

- Today we will discuss address gaps in the development of the NH CSC Clinical Guidelines.
- DHHS legal counsel has not approved distribution of the current draft to you as that would require public release of the document, and given the document is incomplete, we will attempt to fill in the gaps in the document today to be able to release and distribute it to members of the STC and the public as soon as possible.

Totzkay:

- Trish Clancy motioned to move to approve the latest edits to the May 15 STC notes distributed electronically on Sunday, May 24, 2020. Justin Romanello second the motion. All approved.
- The 'draft' watermark will be replaced to 'final' and posted to the website.

Ballard:

- How in depth should we go with the clinical guidelines?

Clancy:

- Most hospitals in the state have come up with their own CSC documents.
- We should urge a scoring scale, likelihood of survival, established hospital triage committee, clear civil rights language, institutional parameters, etc., for which the clinical guidelines are to be put into practice.

Hiller:

- Do all 26 hospitals have a document?
- Have we collected CSC documents from other hospitals in the state?

Ballard:

- No. That was not the intent. The goal would be for the hospitals to review the State's document against their own.
- Charlie Burney is reviewing other State's CSC plans within the New England Region.
- The larger hospitals most likely have created documents.
- Would smaller hospitals need an example of scoring system?

Clancy:

- If they do not have an ICU, they probably don't really need it.
- If all hospitals have ventilators or have access to them, doctors to operate them, and an ICU/CCU, then they should have a mechanism in place.

Friberg:

- Non-discrimination language is required. We need to comply with federal HHS Office of Civil Rights and the Department of Homeland Security's Federal Emergency Management Agency (FEMA) ensuring civil rights during COVID and reference guidance that come from both federal agencies.
- In addition, when operationalizing CSCs, we need to ensure that they are consistent with:
    - Patient Bill of Rights, RSA 151:21 (IV) Consent and patient participation in decision-making standards
    - Advance Directives requirements. RSA 137-J:7
    - Standards and processes for withholding or withdrawing life sustaining treatment. RSA 137-J:10
    - And possibly more!

Desrosiers:

- What level of resources would need to be triaged? How would you triage whatever resources you do have?
- The State should provide this overall guidance.

Wold:

- This is a great opportunity for the State to provide a high-level framework that we can all agree to and for which all the facilities can relate to.
- We need at least a:
    - Generalized purpose statement
    - Basic premise(s)
    - Social determinants of health
    - Framework that is uniform and agreed upon

Bizarro-Thunberg:

- In conversations a few months ago with all the hospital CMOs, they are looking for a high-level, over-arching clinical framework for internal comparison.

Drager:

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- Each hospital will have varying capability. Basic standards and prioritization should be the same across all hospitals.

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Ballard:

- A triage system using multiple step.
- We will not use exclusion criteria.
- What if person is immediate or near immediate death? What are the ethical concerns here about using this factor an initial triage?

Clancy:

- I think it is a reasonable thing. It leaves room for judgement.

Wold:

- This is where a triage committee would be helpful. It takes time and logistical efforts.

Ballard:

- In a normal situation, we would immediately provide the resource even if the patient was at near or immediate mortality if they are available, but in this instance, are we saying it will be OK to save these resources for persons who the clinical judgement is clear that is not at immediate near death?

Reeves:

- Scoring would have precluded them anyway.
- No individuals would be excluded.

Shaw:

- Delineate scoring and use reverse triage.
- Who is most likely to survive? What is the standard of care?

Surgenor:

- An immediate assessment would apply with all patients as they present with a host of acute and chronic diseases.
- An established scoring system would work best.

Romanello:

- We are looking at what resources we have to benefit patients with the goal of saving more lives than one.

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Ballard:

- What scoring system or variation of a scoring system would be appropriate in NH?

Drager:

- The question is really dealing with patients that are near or at immediate mortality. What is our goal to save life or life years?
- The State of Colorado just posted their CSC. They look at prognosis for near term survival using Charleston or SOFA.

Desrosiers:

- SOFA and mSOFA scores are valid for NH.

Facilitator Comment:

Rhode Islands' CSC Guidelines, page 20. "SOFA scoring is meaningful for adult critical-care patients, but do not apply to pediatric patients or newborns. Population-specific tools, such as the Pediatric Logistic Organ Dysfunction (PELOD-2) score in children Score for Neonatal Acute Physiology with Perinatal Extension-II (SNAPPE-II), or National Institute of Child Health Extremely Preterm Birth Outcomes Tool (NICHD-OT) in neonates, should be used when possible."

Ballard:

- Hospitals in PA and NY take the SOFA scoring and apply color-coding. What are your thoughts on adding color-coding?

Desrosiers:

- Color helps non-clinical members of the team to understand the clinical situation that they are being asked to assess and triage. There is a range of scores that go into each color that allows the triage team to better understand the strata of each patient.

Ballard:

- Should color be a statewide process across all hospitals?

Reeves:

- Dartmouth-Hitchcock Health elected not to use color.

Wold:

- PA used the color format along with specific statements and principles. Color helps group the SOFA score with a combination of other factors.
- Standardize mortality risk system is a good starting point. Advocate for standardization at a higher level, leave ultimate decision at each individual hospital's triage committee. (Dr. Clancy agreed with this.)

Ballard:

- What about secondary criteria and tie-breakers? Younger vs older without regard to disease.
- NY states the importance of saving the most lives. CHEST's priority if for pregnant women.
- What if there is tie-breaker for one resource, should this be a consistent tie breaker across the state?

Clancy:

- Tie-breakers are tough. It may come down to using a random number or flipping a coin.

Hiller:

- Validated random selection is better approach.

Ballard:

- What if the tie-breaker concerns a female patient who is pregnant?

Clancy:

- It does meet that goal.

Hiller:

- Fairness is the use of validated random selection.

Surgenor:

- We all want to do the right thing. We need the state to provide the higher level guidance.

Reeves:

- We did provide for frontline workers.
- Pregnant women – would allow for subtraction of one point from the score.
- Age – we fell back on everyone deserves life. We did advantage younger over older then used a random number.

Desrosiers:

- In the current draft at our institutions, preference is given to,
    - Frontline workers if they are expected to recover and be able to provide care
    - Patients 17 years or younger
- A random number generator would be used for tie-breaking.

Ballard:

- Sounds like good use of ethics committees throughout the state. These are issues ethically fraught. Each hospital should walk through these issues.

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Hiller:

- We need to account for the variety of NH populations' values.

Romanello:

- If we end up with twenty-six (26) different hospital interpretations versus what the State has provided, it will most certainly raise public distrust.
- Creating one-size standard for the state may be difficult. There should be some standard tie-breaker.

Friberg:

- The more clearly will define the guardrails the more likely it will help with compliance.
- Pregnancy issue: The State of Massachusetts (MA) does not assign a score based on pregnancy status. They modify the score based on fetal survival.
- One idea would be to have DHHS send out a survey based on other states prioritization rubrics.

Burney:

- Each state approaches pregnancy differently.
- MA based on fetal viability and gestational age.
- CHEST 2019 promotes evaluation of fetal heart tones.

Wold:

- New York State's position statement includes 'ethically viable' and leaves it to the individual hospital ethics and triage committees to decide.

Ballard:

- Do we have agreement of reassignment? [Verbal agreement by STC.]
- What are the guardrails for the state on the re-evaluation process?

Clancy:

- Just state, periodically re-evaluation and re-assign.

Ballard:

- Therapeutic trails. Do we provide this resource if they meet criteria?

Clancy:

- It is addressed in re-evaluation and re-assignment.

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Desrosiers:

- We view any of the triaged resources as therapeutic trials. They are applied and then assessed for efficacy. If not effective, these resource would be triaged.

Surgenor:

- You want the ability to reassess patients. COVID is a slow moving disease. Some people improve so you want to provide resources if you have them.

Ballard:

- That is all I had for gaps. Other topics?
- We will review the notes. Meet again to review a draft document.
- We are not a crisis within the state. We are not in resource crisis yet. We have time to get input from the public.

Desrosiers:

- The Governor's Executive Order has us in CSC by definition. As for triage of resources, we have not reached this level as of yet.

Friberg:

- The SDMAC should ensure that the Patients Bill of Rights, RSA 137J, RSA related to advance directives and POLST, and possibly other legal considerations are reviewed for this document and the *NH CSC Plan*.

Totzkay:

- We need to have a "legal considerations" section in the *NH CSC Plan*. We need to put the legal framework back into the guidance! We are not balanced with only an ethical framework! This could be as simple as stating a few laws helpful to healthcare facilities, within the power of the Governor and DHHS, and federal agencies.

Riddell:

- When do we meet crisis standards and trigger use of the clinical guidelines?

Hiller:

- What is the timeframe for this release?

Ballard:

- Once the draft is released to the public, everyone on this committee along with the public will be able to make comments. We can then quickly pivot if a situation arises that requires us to implement the guidelines.

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Public Comments:

- No comments were stated from the public after a long pause and instruction for public present on the call on how to participate.

Burney:

- The CSC De-Escalation and Recovery Subcommittee stated the need to have this STC establish criteria for live saving medications, a plan for allocating vaccine when it becomes available.

Ballard:

- During the SDMAC meeting this Friday, we will review and discuss all subcommittee recommendations.
- I hope to have the draft of the clinical guidelines post on Friday. Public review and feedback would be open for another one to two weeks. The DHHS public information office has a standard protocol used for gathering and reporting the public comment for committees to review.
- Next meeting of the STC will be Friday, June 5 at 9 a.m.

Meeting ended at 10:24 a.m.

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