

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

✓ **Present:**

✓ Jonathan Ballard	Jeff Dickenson	✓ James Potter	✓ Elizabeth Talbot
✓ Kathy Bizarro-Thunberg	✓ Paul Drager	✓ Susan Reeves	✓ Robert Theriault, Jr.
✓ Charlie Burney	✓ Anne Edwards	✓ Rae Ritter	✓ Carole Totzkay
✓ Michael Calderwood	✓ John Friberg	✓ Luanne Rogers	✓ Joan Widmer
✓ Polly Campion	✓ Marc Hiller	✓ Justin Romanello	✓ Tom Wold
Trish Clancy	✓ Lucy Hodder	✓ David Ross	
✓ Adam Crepeau	✓ Richard Levitan	✓ Jason Shaw	
✓ James Culhane	✓ Ken Norton	✓ Tom Sherman	
✓ Kevin Desrosiers	✓ Deborah Pendergast	✓ Lori Shibinette	

Lori Shibinette: Welcome and thank you for participating in this committee. Key is to not have frontline clinicians making the triage decisions when there are scarce resources. Two areas of focus are triage for respiratory care and long term care facilities. Lori will not always be present at the meetings but is available for consultation. Dr. Ballard will conduct meetings.

Overview of State CSC Plan

Ballard – The plan is essentially guidelines for a standard of care that is an unusual departure from usual standards of care. Activation of the Crisis Standards of Care (CSC) Plan itself does not necessarily constitute implementation of CSC clinical guidelines. Activation of the CSC Plan allows for assembly of the SDMAC and creation of a State Triage Committee (STC).

CSC clinical guidelines will only be implemented when:

- Resources have been, or will imminently be, overwhelmed despite exhaustive efforts to augment and share resources with the assistance of state and federal resources.
- The need for implementation of resource rationing and triage has been approved by the DHHS Commissioner in consultation with appropriate authorities and stakeholders.

Three areas for determining activation of the NH CSC Plan:

1. Situational awareness indicators: monitoring of ongoing regional, national, and global events;
2. Indicators: measurements, events, other data that predict a change in demand for healthcare;
3. Triggers: decision points based on availability of resources along the continuum of care.

State Disaster Medical Advisory Committee (SDMAC)

SDMAC has three main functions:

1. Develop clinical guidelines,
2. Provide guidance to healthcare facilities, and
3. Make recommendations to the Governor and State Emergency Operations Center (SEOC).

State Triage Committee (STC)

STC is a sub-committee of the SDMAC. It consists of subject matter experts familiar with the crisis at hand. The STC is looking for additional members. The guidelines drafted must be based on science, survivability and benefit from treatment, but not have any absolute exclusion criterion. Each hospital and skilled nursing facility should create their own triage committee for their facility.

The STC will:

- Develop the CSC clinical guidelines, which will establish recommendations for the triage of critical health care resources and
- Provide guidance to hospital triage officers/committees and the SDMAC.

Action Item: Email Dr. Ballard directly if interested in joining the STC.

Outlining the Path for the SDMAC

C. Tatzkay: Shared Institute of Medicine (IOM) *CSC: A Systems Framework for Catastrophic Disaster Response*. March 2012 document.

Consider establishing a Clinical Care Committee (CCC) to address the following items below:

- a. Review resource availability and requests
- b. Develop strategies to meet clinical demand with resources available
- c. Develop and issue clinical guidance as appropriate (usually based on state)
- d. Appoint triage team if ventilators or other definitive care triage required
- e. Review triage decisions and improve process

The CCC at the state and local levels should ensure consistent implementation of CSC in response to COVID-19. These efforts should include:

1. Using “triage teams,” and the SDMAC that will evaluate evidence-based, peer-reviewed critical care and other decision tools and recommend and implement decision-making algorithms to be used when specific life-sustaining resources become scarce.
 2. Providing palliative care services for all patients, including provision of comfort, compassion, and maintenance of dignity.
 3. Mobilizing mental health resources to help communities---and providers themselves---to manage the effects of CSC by following a concept of operations developed for disasters.
 4. Developing specific response measures for vulnerable populations and those with special health care needs, including pediatrics, geriatrics, and persons with disabilities.
 5. Implementing robust situational awareness capabilities to allow for real-time information sharing across affected communities and with the SDMAC.
- A. Determining sub-committees
1. **State Triage Committee**
 2. **Long Term Care Subcommittee**
 3. **Mental Health and SUD Subcommittee**
 4. **COVID-19 Literature Surveillance Subcommittee:** Reviewing updates to critical care literature / clinical information
 5. **Community Engagement:** How can we be transparent with the community?
 6. **De-escalation and Recovery Subcommittee**
- B. Identifying CSC Issues for Clinical Guidelines
1. Romanello: An EMS issues subcommittee may not be needed
 - Calderwood: important discussion point here, both in initial transports and later transports between facilities.
 - Burney: Agree with Calderwood on EMS role

Action Item: Attached to the meeting notes are the NH Bureau of EMS established *NH EMS CSC Guidance* and *NH EMS CSC Protocol* for review by the SDMAC and STC.

2. Cooley: subcommittee focused on areas of health disparities, and vulnerable sub-populations
3. Culhane: overarching component basic communications in transitions of care between care areas.
 - o Ballard: EMS could be included in this sub-committee
 - o Culhane: more looking for a focus on the communications aspects
4. Hodder: thinking about a sub-committee on de-escalation and communications and protecting various facilities as emergency orders unwind
5. Champion: consideration/principal that older adults are experiencing significant bias during this pandemic, targeted protective measures and some comments/decisions in parts of the country seeing different values placed on age. Age in and of itself should not be a criteria.
6. Norton: concerns relative to guidelines related to mental health issues.
7. Widmer: agree with a mental health subcommittee, and should include mental health of health care workforce.
8. Shaw: identify resources/supplied needed by respiratory resources. o Ballard: could this be part of the State Triage Committee?
9. Hiller: need an ethics subcommittee
10. Wold: According to the CSC Plan, we need to develop plans for each of the sub-areas within the plan (e.g. hospital, surgi-centers, LTC, home care, etc.) o It is not required we address every one of these areas, rather just be aware of these areas and consider if a specific plan/process is needed.
11. Calderwood: lots of areas of concern listed; each will take time to develop so we should consider prioritization of these needs.
12. Sherman: consider disabled individuals, use the Alliance SST to look at these populations, for STC can look at Javari software tool to load balance all require resources: PPE, beds, etc. are doing this in other states.
13. Burney: Long term care facilities and respiratory care needs are the highest priority for now. We need a workable, applicable scoring system across the state, hopefully we will never have to use this, but need this in place.
14. Calderwood: agree with this statement and also emphasized the need to get a handle on EMS issues.
15. Roger: LTC facilities are having a really hard time, particularly in the area of staffing. PPE continues to be a big issue, inclusive of costs associated with it. Relationships with hospitals are also challenging.
16. Hiller: reiterate need to establish an ethics committee or assign an ethicist to each of the subcommittees. Also need to look at testing issue; it will have a big impact on all of these issues.
17. Drager: testing could be considered as a part of a de-escalation committee.

C. Survey of Landscape

Bizarro-Thunberg: all hospitals started hospital incident command system (HICS) in early March, and all are still running at some level now

Ballard: Have any hospitals created a scoring plan for CSC?

1. Desrosiers: Yes, Solutions Health has one for SNHMC and Elliot
2. Reeves: Yes, DHMC has developed one and should be approved within next few days.
3. Norton: Concord Hospital is developing one.
4. Shaw: CMC is developing one, parts are approved other parts being worked on.
5. Wold: WDH has a triage committee and are working off several source documents (Massachusetts, North Texas, and Minnesota), but are waiting to see what NH SDMAC creates.
6. Ballard: What should the SDMAC keep in mind when developing the plan? What should be the approach?
7. Romanello: How does state plan interact with hospital plans?
8. Ballard: It's unclear, but important for this committee to examine/evaluate differences across the various plans within healthcare institutions.
9. Wold: Most state plans have used SOFA score, differences in how handled short and long term prognosis issues and how they handled healthcare workers. Look at the ethics of how the state would intervene.
10. Reeves: Usefulness of state plan guidance should be to articulate areas of consideration, but there is not a one size fits all approach because resources within institutions are very different. Helpfulness of state architecture: the principals, standards and ethics being applied. Abilities of different institutions to execute the plan are diverse. Joint Commission sets standards, but how organizations demonstrate how they meet those standards varies.
11. Desrosiers: sees local CSC plans as operationalizing state guidance.
12. Hodder: the challenge is that this description of the CSC, need to have on-going and continuous communications between SDMAC and the hospitals. Need a group that is collecting and reviewing the hospital CSCs that are being developed.

D. Health Disparities

Ballard: We now have sufficient data to create demographic reports showing disparities. For instance, black Americans have 1.4% of pop./5.4% of disease. We talked about having a sub-committee on health disparities. How should we talk about this as a group?

1. Desrosiers: Some scoring systems have inherent bias against individuals who have less routine access to healthcare, they chose not to use these systems. How do you determine when to apply the CSC standards, in particularly when the case load varies

across the state? The state could play a role in helping determine where capacity might exist within the state.

2. Burney: Agrees with these thoughts. Relative to disparities the CSC standards apply at the hospital level and should be blind to healthcare disparities, certain scoring systems have inherent bias here (e.g. existence of chronic illness is higher in communities with less access to healthcare). All hospitals need to be able to adjust their standards rapidly as things evolve.
3. Calderwood: Acute measures of illness and some that look at chronic illness (with bias), some have excluded some individuals. No one should be excluded. The acute measure of illness should be weighted higher than the chronic illness.
4. Campion: NHPHA has a group that is actively looking at health disparities, might be a good resource for engagement around this work. Those deemed essential workers are more often minorities.
5. Wold: CSC are generally not invoked until in true crisis exists. We are more often fluctuating between conventional and contingencies standards of care at this time. They have a crisis care committee that meets weekly. Could something like this be set up at the state level?

E. Process for Transparency & Accountability

Ballard: How can we share this information without creating fear in the public?

1. Romanello: We [EMS] issued a protocol for addressing transport issues and developed a PSA to communicate this protocol. Use a soft approach.
2. Drager: Discussed this when developing the CSC Plan, to get word out to the public a department within DHHS should be handling this communication. They can reach out to media resources: we exist, this is what we are about and solicit community feedback.
3. Totzkay: The SDMAC would work with the DHHS Public Information Officer (PIO) who is in the State's Joint Information Center (JIC) during this COVID-19 emergency activation. The JIC has public information officers whose job it is to craft messages from the state to the public. We can draft a short memo of who we are, why we exist, what we are doing and the benefit we provide to the public. This needs to be a collective approach between State, local hospitals, and other healthcare entities/organizations.
4. Norton: NAMI has experience with messaging around suicide prevention. Agree with what the two prior speakers said, transparency is key. However, some of the ethical pieces may become contentious with the public. We need to focus on stories that are hopeful and show how CSC has been successful.
5. Bizarro-Thunberg: Agrees with Totzkay's process for developing messaging. Also agrees with Norton on providing context of what is happening every day. Hospitals are having conversations about this and how we can avoid needing to implement CSC.

6. Widmer: Agreed with Bizarro-Thunberg, need to focus on positive aspects of this communication, how this plan is focusing on communication between various healthcare organizations to optimize the availability of care across the state.
7. Norton: This can be a positive message. Message is we hope we don't need this, but want to develop some guiding principles in case the situation necessitates need. We want to avoid being too prescriptive.
8. Hodder: The communications need to be clear.
9. Ross: Avoiding CSC and how long term care can avoid hospitalizations. Encouraged by how hospitals are communicating to avoid CSC and need to work within the LTC area to implement the same.

De-escalation, Termination, Recovery, and Evaluation

Totzkay: Post-meeting note based on the Institute of Medicine (IOM) *CSC: A Systems Framework for Catastrophic Disaster Response. Vol. 2 State and Local Government. Template 5.2. Core Functions for Implementing CSC Plans in States During CSC Incidents*. March 2012 document. With support of the SDMAC, the state health department and state EMA, as well as local government response partners, should understand when to deactivate or scale down the state CSC plan and what their roles in deactivation are. Through established communication systems, they will need to notify stakeholders, media, and the public of the rationale for deactivating the state CSC plan and shifting back to contingency or conventional care, and what such deactivation means. If possible, health care stakeholders should receive advance notice of deactivation so they can plan appropriately for the shift to contingency or conventional care. Given the critical need for demobilization efforts to be coordinated, state agencies should make every effort to work with local and other partners to ensure that demobilization activities are appropriate and effective.

To document response efforts and improve future disaster responses, government response partners in the state, with support of the SDMAC, should coordinate a comprehensive evaluation of the response, including developing an after-action report and implementing improvement plan items. This documentation should be coordinated with appropriate other players in the response, including regional partners and local government, as well as health care and other partners. Government response partners also should understand their roles in the recovery phase, including ongoing mental health operations for the public and for health care practitioners.

Ballard: We talked about having a committee for this, including testing issues.

Totzkay: What types of serology testing should be discussed related to COVID?

Ballard: Should this committee look at resource availability, i.e., PPE, etc?

1. Potter: There needs to be an ability to flex back as we re-open if there are waves/surges as we reopen.
2. Drager: Dr. Fauci says to expect a second and/or third wave in the winter. This committee will be reacting to COVID-19, but also have something in place if there is a recurrence. What are the priorities, such as testing?
3. Hiller: As the State opens up, large segments of population will be at greater risk due to proximity. Need to look at these larger population-based areas.
4. Hodder: This bleeds into the public health consideration. Also need to look at impact of Remdizivir as a treatment. Need to look at need for waivers/legal impacts.
5. Widmer: This committee needs to look at the availability of contact tracing as we open up.
6. Ballard: The Division of Public Health Services (DPHS) has moved the COVID response teams to a conference center in Concord and are supported by National Guard troops. As testing increases, this work will also increase. We will need to be able to scale up rapidly.

Next Steps

The sub-committees should meet next. What should be the time line for this? How about next week?

Ballard: State Triage Committee to be appointed by Commission, other Committees can be appointed by SDMAC. All meetings are public and need to be noticed.

Totzkay: Advocate for members. The meeting notes will be sent to Dr. Ballard by end of Tuesday and he will review them with Lori. Look for the final meeting notes by Friday, May 8th. All subgroups should convene by phone. The larger group will meet again by the end of the month to discuss information prepared by the sub-committees.

Action Item: Please send email notice to Dr. Ballard ASAP if interested in participating in smaller subgroups.

Conference Call ended at 11:00 a.m.

Respectfully submitted by: Joan Widmer and Carole Totzkay