

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

✓ **Present:**

- ✓ Jonathan Ballard, MD, MPH, MPhil – NH Department of Health and Human Services, Chief Medical Officer
- ✓ Kathy A. Bizarro-Thunberg, MBA, FACHE – Executive Vice President / Federal Relations, New Hampshire Hospital Association
- ✓ Charles P. Burney, MD – Resident, General Surgery and Leadership Preventive Medicine
- ✓ Michael Calderwood, MD – Infectious Disease and International Health, Dartmouth Hitchcock Medical Center
- ✓ Rep. Polly Campion, MS, RN – New Hampshire House of Representatives
- ✓ Patricia E. Clancy, MD – Pleasant St. Family Medicine, Chair, Concord Hospital Ethics Committee
- ✓ Carl Cooley, MD – Developmental Pediatrician
- ✓ Adam Crepeau – Policy Director, Office of Governor Chris Sununu
- ✓ James Culhane – President and CEO, Home Care Hospice & Palliative Care Alliance
- ✓ Kevin P. Desrosiers, MD, MPH – Chief Medical Officer, Elliot Hospital and Elliot Medical Group Acute Care Services, Vice President of Medical Affairs, Physician - Critical Care and Preventive Medicine

Jeff Dickenson – Advocacy Director, Granite State Independent Living

- ✓ Paul Drager, JD – MedEthics Consulting
- ✓ Anne Edwards, Esq. – Associate Attorney General, NH Department of Justice
- ✓ John E. Friberg, Jr. Esq. – Chief Legal Officer, Manchester and Nashua SolutionHealth
- ✓ Marc D. Hiller, MPH, DrPH – Associate Professor, Department of Health Management and Policy, College of Health and Human Services, University of New Hampshire

- ✓ Lucy C. Hodder, JD – Director, Health Law and Policy, Professor of Law, University of New Hampshire, Franklin Pierce School of Law, Institute for Health Policy and Practice

Richard Levitan, MD – Emergency Medicine, Littleton Regional Hospital

- ✓ Kenneth Norton LICSW – Executive Director, National Alliance of Mental Illness, New Hampshire Chapter
- ✓ Debra Pendergast – New Hampshire Department of Safety, Director of the Division of Fire Standards and Training and Emergency Medical Services
- ✓ James G. Potter – Executive Vice President/CEO, New Hampshire Medical Society
- ✓ Susan A. Reeves, EdD, RN, CENP – Chief Nurse Executive, Dartmouth-Hitchcock Health Executive Vice President, Research & Education, Dartmouth-Hitchcock, Clinical Professor, Department of Community and Family Medicine

Kate Riddell, MD – Anesthesiologist, Southern New Hampshire Medical Center

Rae Ritter, MSN, APRN-CRNA – President, New Hampshire Association of Nurse Anesthetists

Luanne Rogers, RN – Administrator, St. Theresa's Rehabilitation and Nursing Center

- ✓ Justin Romello – New Hampshire Department of Safety, Bureau Chief, Division of Fire Standards and Training and EMS
- ✓ David Ross, Administrator – Hillsborough County Nursing Home

Sedden R. Savage, MD, MS – Addiction Medicine and Pain Medicine Clinician, Advisor to Dartmouth Hitchcock Substance Use and Mental Health Initiative

- ✓ Jason Shaw, RRT – Respiratory Therapist Lead, Catholic Medical Center
- ✓ Sen. Tom Sherman – New Hampshire Senate
- ✓ Steve Surgeoner, MD – Anesthesiologist, Dartmouth Hitchcock Medical Center
- ✓ Elizabeth Talbot, MD – New Hampshire Department of Health and Human Services, Deputy State Epidemiologist, Dartmouth Hitchcock Medical Center, Infectious Disease Clinician
- ✓ Robert Theriault, Jr., BSPHarm, MB, RPh – Director of Pharmacy Services, Wentworth-Douglass Hospital

- ✓ Joan C. Widmer, MS, MSBA, RN, CEN – Nurse Executive Director, New Hampshire Nurses Association
- ✓ Tom Wold, DO – Chief Medical Officer, Portsmouth Regional Hospital
- ✓ Carole Totzkay, MS, CHES® - New Hampshire Department of Health and Human Services, Committee Facilitator

Meeting opened by Dr. Jonathan Ballard with roll call. He provided an update on COVID-19 in World, US and within NH.

- Over 9.6 million confirmed cases; 489,990 deaths; and over 4.8 million recovered cases globally
- Over 2.4 million confirmed cases; 126,277 deaths; and 765,061 recovered cases in the US

**New Hampshire 2019 Novel Coronavirus (COVID-19) Summary Report**  
(data updated June 25, 2020, 9:00 AM)

<b>NH Persons with COVID-19:</b>	<b>5,638</b>
Recovered	4,370 (78%)
<b>Deaths Attributed to COVID-19</b>	<b>357 (6%)</b>
Total Current COVID-19 Cases	911
<b>Persons Who Have Been Hospitalized for COVID-19</b>	<b>560 (10%)</b>
<b>Current Hospitalizations</b>	<b>47</b>
Total Persons Tested at Selected Laboratories, Polymerase Chain Reaction (PCR) <sup>2</sup>	113,266
Total Persons Tested at Selected Laboratories, Antibody Laboratory Tests <sup>2</sup>	18,268
Persons with Specimens Submitted to NH PHL	31,479
Persons with Test Pending at NH PHL <sup>3</sup>	250
Persons Being Monitored in NH (approximate point in time)	3,425

<sup>1</sup>Includes specimens positive at any laboratory and those confirmed by CDC confirmatory testing.

<sup>2</sup>Includes specimens tested at the NH Public Health Laboratories (PHL), LabCorp, Quest, Dartmouth-Hitchcock Medical Center, and those sent to CDC prior to NH PHL testing capacity.

<sup>3</sup>Includes specimens received and awaiting testing at NH PHL. Does not include tests pending at commercial laboratories.

Ballard:

- Provided update of SDMAC activities, reference to documents sent to committee yesterday.
- Reviewed charges of the SDMAC:
  - establish clinical crisis standards,
  - provide guidance to health care facilities, and
  - make recommendations to the Governor and SEOC during the incident.
- This committee does not need to approve sub-committee meeting notes. Only the notes generated during SDMAC meetings.
  - Motion to approve the May 29, 2020 notes: Jim Potter
  - Seconded: Jason Shaw
  - Comments: None
  - Vote: 4 members abstained; motion passed and the notes were approved.

**Review of Draft Clinical Guidelines – Public Comment**

Ballard:

- CSC Guidelines draft underwent several revisions and guidelines were posted on the NH COVID-19 CSC website. There were only two comments received from the public (John Friberg and Stephanie Patrick from the NH Disability Rights Center). This feedback was shared with SDMAC and related refinements were integrated into the current Draft #2 of the CSC Clinical Guidelines now on the website.

Romanello:

- NH EMS is officially under the auspice of the Department of Safety Commissioner. Are the CSC developed by EMS considered an attachment to the NH CSC? Would it be incorporated into the State CSC clinical guidelines again as an attachment?

Drager:

- The June 23 Executive Order regarding provider orders for life sustaining treatment (POLST), creates an impression for a POLST document and/or registration.
- Implementation of a POLST registry has not taken place as describe in NH RSA 137 L. Our document creates a mistaken belief that this has occurred in NH. This needs to be clarified.

Edwards:

- Governor currently has authority to create an emergency order to allow for the POLST orders to be implemented during the emergency.

Sherman:

- If law exists, then there is capacity for emergency rule making. It would not require a Governor's emergency order. DHHS could issue emergency rules, which will eventually need to be submitted to JLCAR.

Ballard:

- Were the guidelines written in a way that you (SDMAC members) expected?

Clancy:

- POLST orders as a standalone are fine; suggest removing 3<sup>rd</sup> paragraph and this would solve the problem

Burney:

- Agree with discussion on POLST and with Clancy's suggestion. This is a really good start.
- Comments regarding State oversight (per the NH Disability Rights Center). We have had several discussions on this topic in other subcommittees. We see ourselves as helping others prepare their guidelines. Comments from DRC on state oversight – what the role of the DHHS and the Committee is. DRC raises valid concern – how do we ensure that facilities and the clinical guidelines are being effectively implemented across the state? Need further discussion on the DRC comments.

Norton:

- I agree with Charlie's statement plus the DRC reference of real-time data is needed to inform these decisions.

Widmer:

- Overall, plan is well balanced. Agrees with Burney that state should have some level of oversight, via access to the plans at individual institutions and that suggestion that institutions post their CSC plans on their website to maintain transparency with the public.

Clancy:

- We make guidelines not oversight. Don't want the State to provider oversight to what a physician should do. Oversight of the plans, then that is another thing.

Drager:

- Should have some minimal standards for institutions, with recognition that different organizations serve different populations. The state should set the minimum standard.

Hiller:

- Agrees with Drager and supports the DRC comment's on review of plans.
- DHHS through the SDMAC should access and review all hospital plans and ensure they comply.
- We should be able to say the hospitals guidelines were reviewed and suggestions for improvement were offered.

Sherman:

- Oversight is critical. Mechanisms for oversight exist via professional healthcare boards. This body does not need to be in this role, nor does the legislature. Hospitals and nursing homes are licensed bodies; some policies are tied to licensure (such as drug free workplace). Can add that all organizations have a CSC plan through Administrative Rules. So have the licensing boards have this oversight. Rather, add a paragraph at the end that speaks to oversight as a function of the licensing boards.

Reeves:

- Wanted to ensure the committee that hospitals were relieved with the level of guidelines that have been developed by this committee, recognizing the different levels of resources at these hospitals. Hospitals are seeking some guidance from the state about what CSC guidelines are about and what are the basis elements of these guidelines. Concerned that impression has been given that hospitals wanted to work within a “black box.”

Ballard:

- CDC has requested grant deliverables for CSC. We are exploring these requirements.

Calderwood:

- Regarding page 2 – redistribution and transfer – as it is written now it appears too vague. A Harvard Business Review story looked at mortality pertaining to moving patients vs. moving resources during times of crisis.

Desrosiers:

- We reached out to several hospitals for resource sharing and this was very successful. The NH Medical Society and NHHA have assisted hospitals with coordination of patient moving through the crisis.

Hodder:

- Issues of oversight and transparency is part of the objectives of this process. We need to share how we have experienced this process during a crisis (re comments made by Desrosiers).

Bizzaro-Thunberg:

- Reeves covered many of points she wanted to share. She agrees that CSC needs to be shared. no reluctance by hospitals to do this, just want the timing to be correct.
- Can't use term compliance with respect to guidelines.

Sherman:

- A COVID-19 policy group through MIT developed a load balancing tool. It is in place in Georgia and has been effective. This group is encouraged to look at this tool.

Ballard:

- We will share this feedback to the Commissioner. Moving on to the second topic: Long Term Care CSC.

Talbot:

- Robust interest in primary stakeholder virtual meetings on Wednesday and Thursdays to present new guidance and also hear their experiences. Seeking to be compliant with CMS recommendations, such as opening to visitors 14 days after re-opening begins. Working on visiting plans, doing this carefully, thoughtfully; engaging community in the process. This is being done by each facility based on resources available. CRISP program, early detection of virus in a facility, including staff, regarding turnaround time of PCR testing.

Ross:

- Support Dr. Talbot's comments. Weekly calls have been invaluable to providers. Collaboration has been outstanding. Primary focus has been on steps to enhance quality of life whenever possible. Most facilities have not experienced outbreaks so finding an appropriate balance between infection control and patient quality of life needs.

Sherman:

- Nothing to add; wonderful discussions in LTC sub-committee and collaborative work with DHHS. Limitation on resources early on in this crisis, such as for testing and PPE, we had a marvelous effort on the part of the LTC facilities. He is hoping to add a task to an existing study committee, via legislation, to look at this crisis and what we can learn from it.

Clancy:

- No mention on financial and adjusting the pay schedules.

Ballard:

- I had hoped to have a draft of the CSC Plan for Long Term Care for this committee to review today. It is similar to the CSC for acute care, with some specific guidelines relative to staffing issues, such as alternative types of staffing, changing of work shifts, and other staffing alternatives. Changes in handling such items as meal preparation, managing bed lines, suspending unnecessary medications such as multi-vitamins, changing to times for medication administration, reducing or eliminating care needs that are not essential in the short term (daily weights, lab draws, blood sugar checks, lots of other ideas). The plan speaks to issue of available PPE. Also issues relative palliative care, including the goals of palliative care.

Clancy:

- NH nursing homes were troubled relative to staff long before this crisis. No mention in this plan about adjusting the compensation for LTC staff.

Ballard:

- The EO for emergency pay for LTC workers has been extended through end of July.

Ross:

- Need to make sure our guidelines are in compliance with CMS guidelines.

Totzkay:

- Mental Health & SUD and Reopening Sub-Committees have met and submitted recommendations here today. Time spent talking about the CSC plan and making some recommendations relative to areas that need further clarification and enhancements (details in shared document). Need to include figure 1 on page 3 of the shared document (*CSC Combined Sub-Committee Recommendations form 6-24-20*). It reminds every one of the overarching goals of the CSC plan.
- Please to hear Dr. Sherman's comment relative to a Study Committee being tasked to review lessons learned from this crisis. Biggest concern seems to have focused on the need to broaden the populations definition within the Plan to better reflect persons with disabilities and others with access and functional needs. Where does the document being created by the Equity Committee sit relative to the CSC document? She discussed the various recommendations in the shared document (*CSC Combined Sub-Committee Recommendations form 6-24-20*) from both these sub-committees.

Norton:

- Great conversations in the subcommittee. Recommendation also includes adding the need for evaluation of long-term trauma across the life-span relative to children, first responders, and other populations.

Widmer:

- Carole provided an excellent summary of the work of these subcommittees, as well as with the shared document. Liked the inclusion of figure 1, important to provide a visual understanding of the principles underlying this CSC Plan.
- One minor typo on page 2, Edit #1 of the *CSC Combined Sub-Committee Recommendations form 6-24-20*: The second sentence in the "New Sentence" paragraph is incomplete.

Ballard:

- Have we met the objectives of this committee? Do we need to continue to meet? Do the sub-committees need to continue to meet?

Cooley:

- Carole did a great job summarizing both subcommittees.
- Still not clear on matters relative to individuals with developmental disabilities and TBI. There was some discussion regarding identifying these populations as a vulnerable sub-group. Would like to see language to this effect adopted.

Hodder:

- Carole did a great summary and thanked her for her leadership and support of the work of these subcommittees.
- What do we do with these recommendations? Is there a need to continue to address these recommendations?

Bizzaro-Thunberg:

- Will there be another final document with the DHHS Commissioner's approval? Will this group meet to review her recommendations?

Ballard:

- This will need to be approved by the Commissioner. This group holds an advisory capacity.

Drager:

- Carole provided a great summary of the work of the De-Escalation sub-committee. Some populations have suffered during the crisis because they have been unable to get treatment they needed during the crisis, such as patients with SUD and children needing vaccinations. How will we address these needs going forward? Also, Colorado came out with a contingency CSC plan for palliative care; we should look at this here in NH and look to integrate some of these principals in our CSC plan. We need to make sure that the appropriate comfort care can be provided for the dying in a humane manner.

Hiller:

- Given the work that has been done and that the final approval awaits with Commissioner, we should request an opportunity to review the final/approved document.
- We should consider not disbanding, even though we have completed assigned work to date, but the crisis is still on-going around the country, but perhaps going into hiatus for the time being.

Ballard:

- The EO that created this committee is still in place. Should we schedule a meeting or have a meeting called based on need.

Sherman:

- Strong endorsement of continuing to meet. Touching base on a monthly basis might be helpful as this crisis is continuing to evolve. Disbanding would be premature at this time. Review other states work on CSC - what is working not working in those states.

Campion:

- Carole's summary and leadership recognized. Thanked Dr. Ballard for his leadership.
- Wanted a separate section in the Triage document to address persons with disabilities.
- Agrees with Dr Sherman that we should continue to meet.
- Should we need to implement the CSC standard, then we could assess real-time the implementation aspects.

### Public Comments

Stephanie Patrick – *NH Disability Rights Center (DRC)*:

- Appreciate SDMACs consideration of the perspectives raised in her written comments (circulated to Committee prior to this meeting). Agrees that state should not be entering into oversight of individual physicians, but should provide some oversight/review of hospital CSC plans. Great to hear examples of hospitals working together, but thinks state does play a role here.
- Now is really the time to look at plans. Also emphasized the need for transparency. Sent request to 20 hospitals, but 2 ½ months later they still do not have access to this information. These plans should be posted to a central website.
- Also has some concerns relative to LTC, was unaware that there were ongoing meetings of this sub-committee, she would have participated.
- Need to look at level of dignity of risk. Allow the residents to consciously decide the risk for their quality of life. The DRC is happy to assist ongoing efforts and offered her organization as an available resource.

Ballard:

- Clarified the weekly LTC stakeholder calls are not CSC meetings calls. They are strictly for COVID-19. The call information is posted on the DHHS COVID-19 website.

### Next Steps Planning

Ballard:

- We will identify another date to meet.
- The draft Clinical Guidelines will be posted on the NH CSC website for review.

**Conference Call ended at 10:55 a.m.**

*Respectfully submitted by: Joan Widmer and Carole Totzkay*