Panel Session

December 14
9am-10:30am

2021
Welcome & Training Objectives

1. History & Overview

2. Understand how the CSC Plan fits into the overall SD DOH plan for hospital preparedness

3. Interpret the legal and ethical aspects of the triage process

4. Recognize the role and decisions of the medical director, physician triage officer and administration

5. Examine the actions and discussions of hospice and palliative care

6. Describe the importance of the supporting roles including nursing, advance care planning and pastoral care

7. Discuss how this plan will be operationalized across the state
History and Overview

- Sioux Falls Bioethics Network
- 2009 H1N1 Plan
- LifeCircle South Dakota
- Summer 2020 Began Reworking the 2009 Plan
- Definition of Crisis Standards of Care
- Purpose
- Aims
- Goals
- Activation
CSC and SD DOH

- Scope
- Development
- Framework
- Activation
- Liability
- Protections

Kaitlin Thomas, SD DOH
Legal Considerations

- **Office of Civil Rights** – Cameo Anders JD, MA
  - Authoritative Language
  - OCR Best Practices
  - OCR Technical Assistance to States
  - Recommendations
OCR Authoritative Language

"OCR enforces Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act which prohibit discrimination on the basis of disability in HHS funded health programs or activities. These laws, like other civil rights statutes OCR enforces, remain in effect. As such, persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative "worth" based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence."


Cameo Anders, JD MA
OCR Best Practices

- Resource allocation decisions should be based on individualized assessment of each patient using best available objective medical evidence concerning likelihood of death prior to or imminently after hospital discharge.

- Such assessments should not use categorical exclusion criteria on the basis of disability or age; judgments as to long-term life expectancy; evaluations of the relative worth of life, including through quality of life judgments, and should not de-prioritize persons on the basis of disability or age because they may consume more treatment resources or require auxiliary aids or supports.

- When using prognostic scoring systems with patients with underlying disabilities, reasonable modifications may be necessary for accurate use.

- Healthcare providers should not "steer" patients into agreeing to the withdrawal or withholding of life-sustaining treatment or require patients or their families to consent to a particular advanced care planning decision in order to continue to receive services from a facility. Patients must be given information on the full scope of available alternatives.

- Providers should not consider for re-allocation a ventilator or other piece of life-sustaining equipment that is brought to the hospital by a patient whose life is dependent on that equipment.
OCR Technical Assistance to States

- Prohibition on the use of a patient's long-term life expectancy as a factor in the allocation and re-allocation of scarce medical resources;

- Prohibition on the use of categorical exclusion criteria, instead requiring an individualized assessment based on the best available objective medical evidence;

- Prohibition on the use of resource-intensity and duration of need as criteria for the allocation or re-allocation of scarce medical resources. This protects patients who require additional treatment resources due to their age or disability from being given a lower priority to receive life-saving care due to such need;

- Inclusion of language stating that reasonable modifications to the use of clinical instruments for assessing likelihood of short-term survival should be made when necessary for accurate use with patients with underlying disabilities.

- Inclusion of new protections against providers "steering" patients into agreeing to the withdrawal or withholding of life-sustaining treatment, clarifying that patients may not be subject to pressure to make particular advanced care planning decisions, must be given information on the full scope of available alternatives, and that providers may not impose blanket "Do Not Resuscitate" policies for reasons of resource constraint, or require patients to consent to a particular advanced care planning decision in order to continue to receive services from a facility; and

- Inclusion of language stating that hospitals should not re-allocate personal ventilators brought by a patient to an acute care facility to continue pre-existing personal use with respect to a disability. Under this language, long-term ventilator users will be protected from having a ventilator they take with them into a hospital setting taken from them to be given to someone else.
OCR Recommendations

- "Make resource allocation decisions based on individualized assessments of each patient, using the best available objective medical evidence concerning likelihood of death prior to or imminently after hospital discharge, including clinical factors relevant and available to such determinations, which may include age under limited circumstances.

- However, such assessments should NOT use categorical exclusion criteria on the basis of disability or age; judgments as to long-term life expectancy; evaluations of the relative worth of life, including through quality of life judgments, and should NOT deprioritize persons on the basis of disability or age because they may consume more treatment resources or require auxiliary aids or supports."

https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/index.html
Ethical Considerations

- Ethical Considerations – Mary Hill, Avera Health
  - Exclusion Criteria
  - Basic Premises
  - Physician Judgement
  - Triage Priority
Triage Committee

Triage Committee: The triage committee (or “allocation resource team”) described in the South Dakota Crisis Standards of Care (SD CSC) is specific to each healthcare facility. In accordance with the principles and guidelines set forth in the SD CSC, the triage committee/ART facilitates the allocation of limited medical resources in the event of a mass critical care situation during which the demand for hospital and critical care services exceeds capacity.

No Bed/Resource Currently Available for Transfer: In situations when a bed—or other resource such as dialysis—is currently not available for a facility requesting to transfer a patient, the facility at which the patient is located is responsible for continuing to care for the patient to the best of its ability with available resources.

Facility resources that may be helpful include the ethics committee, palliative care consultation service, and case management. The facility may also decide to activate its triage committee/ART to help determine how to steward available resources pursuant to the principles and goals set forth in the SD CSC.

Transfer Center: The Transfer Center facilitates communication, logistics and transfers to/from healthcare facilities. Transfer Centers stay apprised of transfer requests and capacity to assist with communication and logistics.

Facilities with No Triage Committee/ART: Facilities that currently do not have a triage committee/ART are recommended to consider forming a triage committee. Technical assistance is available through the Healthcare Coalitions/Emergency Response Network.
Medical Decision-Making

- **Medical Director Perspective** – Dr. Wilde, Sanford Health
  - Scope - Adults Age 14+
  - Decision and Support Roles
  - Administration
    - Hospital Planning
    - Triage Committee

- **Triage Officer Role and Responsibilities** – Dr. Kurra, Monument Health
  - Physician Judgement
  - Triage Priority
  - MSOFA Scoring & Algorithm
ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Triage
During Crisis Standard of Care

Patient arrival and initial stabilization

Decide Not to Admit
- Interpret MOSFA score if applicable and Mortality Assessment Risks based on physician judgment and individualized assessment of patient based on objective medical evidence.
  - MSOF A > 11
    - LOW PRIORITY
      - Lowest chance of survival even with treatment
      - Manage medically
      - Provide palliative care as needed
      - Send home
    - DISCHARGE TO HOME OR FOR PALLIATIVE CARE
  - MSOF A 8-11
    - INTERMEDIATE PRIORITY
      - Intermediate priority for hospital admission
      - For severe patients, highest priority for admissions given to patients targeted to RED
    - ADMIT TO HOSPITAL
    - ICU ASSESSMENT CRITERIA
    - Patient Clinical Assessment at 48 & 72 hours to determine continued access to ICU bed/ventilator
    - STILL MEET ICU ASSESSMENT CRITERIA
      - Patient Goals + Physician Judgment
      - (see definition)
      - LOW PRIORITY
        - Consider palliative care
        - Discharge from critical care and hospital
      - INTERMEDIATE PRIORITY
        - Triage Level 2: Continue ICU ventilator
        - Triage Level 3: Consider moving patients to floor based on O2 or CPAP
      - HIGHEST PRIORITY
        - Triage Level 2: Continue ICU ventilator
        - Triage Level 3: Consider moving patients to floor based on O2 or CPAP
    - DISCHARGE TO PALLIATIVE CARE
      - MSOF A > 11
        - LOW PRIORITY
      - MSOF A increasing or MSOF A 8-11 unchanged
        - INTERMEDIATE PRIORITY
      - MSOF A > 6 or < 11 (decreasing)
        - HIGHEST PRIORITY

Reassess daily to determine continued priority for hospitalization

*Physician Judgment is based on individual patient assessment, MSOF A, and Mortality Assessment Risks.
Hospice & Palliative Care

- Goals
- Role
- Location
- Actions & Discussions
Supporting Roles & Perspectives

- **Nursing** – Lori Popkes, Avera Health
- **Advance Care Planning** – Marcia Taylor, Monument Health
- **Pastoral Care** – Sandra Ogunremi, Monument Health
COVID-19 PANDEMIC

FEAR
ANXIETY
CONCERN
STRESS
DEPRESSION
DEATH

Sandra Ogunremi, DHA, MSA, B. Pharm, CDM, CCDP
Director, Diversity, Inclusion and Spiritual Care Services
SPIRITUAL CARE SERVICES

Dr. Sandra Ogunremi, DHA, MSA, B. Pharm, CDM, CCDP
Director, Diversity, Inclusion and Spiritual Care Services
At Monument Health, we make it a **priority to provide spiritual care services** to our patients, family members, providers, caregivers, and leadership.
SPIRITUAL CARE SERVICES

COVID-19 TAKING A TOLL

- Despair in the eyes of caregivers and providers.
- Fear of taking Covid-19 home to loved ones.
- Fear of Covid-19 spreading within the hospital.
- Uncertainty of the future.
- Increased depression.
- Decline of mental health.

OUR RESPONSE

Rounding on caregivers & providers
Rounding on leadership
Debriefing sessions
SPIRITUAL CARE SERVICES
MAKE A DIFFERENCE. EVERY DAY.

PARK AND PRAY
PAUSE FOR PRAYER

PRAYER LINE
BOOKMARKS

PRAYER BOWLS
TREATS/REFRESHMENTS
COMMUNITY PARK AND PRAY
for CAREGIVERS AND PHYSICIANS

You are invited to participate in a Park and Pray on September 29th at 4:45PM at any of our Monument Health Hospital parking lots.

- Those participating should stay in their parked vehicle
- Turn on their flashes
- Tune the radio station to the Breeze 97.9 or KSLT 107.1
- After the prayers and songs are finished, visitors will exit the lot

The radio stations will cut into their regular programming (for approximately 15 minutes) to pray and play a special song for health caregivers and physicians.

This event is in partnership with 29+ The Breeze and Monument Health

PAUSE FOR PRAYER

WHEN
8:30AM & 7:30PM DAILY

THE SOUND WILL BE PLAYED IF THE REQUEST OCCURS PRIOR TO THE IDENTIFIED HOURS AND/OR IF THERE IS A CODE BLUE.

MAY YOUR HEART BE FILLED WITH PEACE.
SPIRITUAL CARE SERVICES

EXAMPLES OF MARKETING CONTENT

SPIRITUAL CARE SERVICES

We want to hear from you!
Send us your prayer requests and reflections!

PRAYER LINE
755-OGOD (755-6463)
Monday-Sunday
5:00 AM-5:00 PM

EMAIL
prayers@Monument.Health

SHAREPOINT
https://regionalhealth.sharepoint.com/teams/SCS

“Everybody, especially in times of hardship or poor health, wants the opportunity to talk about the things they hold in their heart - the joys, the hopes, and even the fears.”

LETTING GO OF 2020

LET GO OF THE PAST, BUT KEEP THE LESSONS IT TAUGHT YOU.

DAILY TIP:
Count your blessings and find five things to be thankful for at the end of each day.

RELAX, BREATHE AND WRITE DOWN
what you are going to let go of from 2020

May your troubles be less and may your blessings be more in 2021.

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Statewide Implementation of Plan

- South Dakota Healthcare Coalition
  - Statewide incident management
  - Healthcare resource support
  - Dynamic response coordination

- Additional Considerations and Discussions:
  - Independent Hospitals
  - Indian Health
  - EMS
  - Pediatrics

Greg Santa Maria, SD Healthcare Coalition
Closing Remarks

Q&A