MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, February 03, 2022
TIME:	9:30 A.M.
PLACE:	Room EW20
MEMBERS:	Chairman Wood, Vice Chairman Vander Woude, Representatives Gibbs, Blanksma, Kingsley, Christensen, Lickley, Erickson (Powell), Ferch, Mitchell, Chew, Rubel, Burns
ABSENT/ EXCUSED:	Representative(s) Mitchell
GUESTS:	The sign-in sheet will be retained in the committee secretary's office; following the end of the session the sign-in sheet will be filed with the minutes in the Legislative Library.

Chairman Wood called the meeting to order at 9:30 a.m.

MOTION: **Rep. Burns** made a motion to approve the minutes of the February 1, 2022, meeting. **Motion carried by voice vote.**

RS 29355C1: **Michael McGrane**, representing himself and Idaho EMS Providers, presented **RS 29355C1**. This proposed legislation for the Emergency Medical Services Fund III (EMSF3) expands the use of the funds to include training, licensing expenses, communication technology, dispatch services, and costs. It stipulates the funds are not to be used for personnel salaries.

MOTION: **Rep. Rubel** made a motion to introduce **RS 29355C1.**

Answering questions, **Mr. McGrane** said this change broadens the funds' use without additional money. The EMSF3 receives $1 from drivers license fees. The change encourages volunteers in rural communities to apply for fund grants.

Rep. Blanksma expressed concern regarding the striking out and removal of "which include highway safety and emergency response to motor vehicle accidents," the tie to receive the drivers license funds. She requested the strike out be removed. After discussion, **Rep. Rubel** said she would be fine with inserting the deleted statement back into the proposed legislation.

UNANIMOUS CONSENT REQUEST: **Rep. Rubel** made a unanimous consent request to withdraw her motion. There being no objection, the request was granted.

MOTION: **Rep. Gibbs** made a motion to return **RS 29355C1** to the sponsor. **Motion carried by voice vote.**

Dave Jeppesen, Director, Department of Health and Welfare (DHW), came before the committee to present an overview of Crisis Standards of Care (CSC). He summarized the CSC definition as something, which is almost always an external event, happening where the demand for health care is bigger than the usual delivery capacity. It is formally declared by a state government as a recognition of crisis operations in effect for a sustained period.

The continuum of care is broken down into space, staff, supplies, and standard of care. Within those categories there are three condition levels: conventional, contingency, and crisis. The contingency level indicates things are a little out of normal and repurposing or substitutions can occur. The crisis level identifies a demand which outstrips supply or capacity. At crisis level, non-patient care areas may be used for patients, trained staff is inadequate for the demand, and a possible redirection of life-sustaining resources is needed.

The State of Idaho Disaster Medical Advisory Committee (SIDMAC) was formed for guidance to hospital facilities during a crisis situation. The SIDMAC publication for patient care strategies for scarce resource situations has been used as a guideline of suggested things to do during contingency and crisis situations. **Director Jeppesen** noted the publication is available on the DHW public records website.

The temporary CSC rule contains standards and processes for the CSC activation and deactivation for healthcare entities. It does not preclude any hospital from implementing their own protocols or utilizing the CSC guidance documents without the state declaration, such as during a specific emergency event in their community. Activation of the plan triggers notification to healthcare entities and the seven public health districts. CSC activation can be statewide, regional, temporary, or conditional.

When a CSC request is received the CSC Activation Advisory Committee (Activation Committee) is convened. The committee will look at the steps taken to address the limitation and evaluate if there is anything else to be done. All options for state and federal assistance will be considered. If the Committee determines the scarcity is sufficient to warrant a shift to CSC, they make a recommendation to the DHW Director who will accept, modify, or reject their recommendation. All of the recommendations are viewable on the DHW website.

When activated, healthcare entities are recommended to utilize the guidance from the SIDMAC CSC plan and guidelines.

Director Jeppesen emphasized the state and DHW do not make healthcare decisions when a CSC is declared. The entities are given the acknowledgement they are in a CSC situation and are then able to implement their protocols, guidance, and approach. Some hospitals may not operate within the CSC guidelines.

Deactivation can be accomplished as soon as sufficient resources are obtained to allow a return to the usual standard of care. To achieve this, specific shortages at the healthcare entities implementing CSC are monitored daily. Ongoing resource shortages and methods of addressing the shortages may be reviewed. When it is determined the resources are available and CSC is no longer warranted, the DHW Director convenes the Activation Committee for a recommendation. The Director can then issue a declaration proclamation to deactivate the CSC.

Responding to questions, **Director Jeppesen** stated there are no new temporary rules while in CSC beyond the temporary rule for activation and deactivation. Many of the facilities have run into unanticipated situations during the CSC and have made their own guidelines. The Director always issues a press release and holds a press briefing to explain what precipitated the CSC.

Dr. Steven Nemerson, Chief Clinical Officer, Incident Commander, St. Alphonsus Healthcare System (St. Al's), with responsibility for COVID management and aspects of St. Al's care delivery, continued the presentation.

CSC is a substantial change in usual healthcare operations because the care delivery focus shifts from the individual patient to the population of patients to assure the greatest number of lives are saved. The shift causes difficult choices for the timing and type of care provided. The original CSC declaration was a result of COVID-19's impact on the hospitals' critical care capacity. The current Omicron surge is a crisis in staffing and resources.

On January 24, 2022, St. Al's found it necessary to continue statewide CSC operation with CSC management due to an increase in COVID patients and a declared blood products crisis. This has greatly impacted the specialty care for patients with acute bleed, blood cancers, and acute trauma events.

Because the CSC designation is so serious, multiple daily meetings determine its continuation. While not at the most extreme CSC condition, St. Al's colleagues are modifying the amount and timing of care so all patients are covered. The shift from conventional staffing to contingent and crisis operation places staff in unusual roles.

Also occurring are larger numbers of staff unable to work due to COVID. This results in difficult and unpleasant choices for medically necessary time sensitive care and surgeries. There are approximately 2k patients requiring necessary surgical procedures or interventions which were delayed. St. Al's team have been prioritizing procedures for those who would suffer the most.

The supply chain shortage has led to a critical medication supply shortage. St. Al's colleagues have been carefully policing medication administration to patients. Negotiated use is also in place to handle the situation without notifying the DHW.

A shortage crisis of blood products has led to statewide collaboration between all healthcare providers. Conservation strategies are based on scientifically valid and best evidence, with stringent criteria. Communication with doctors alert everyone when a patient's overall circumstance does not meet the blood product guidelines, allowing them to omit any outlying conditions.

The CSC is not discriminatory. Medical decisions are made on objective and scientific validated criteria, with no consideration of any circumstance without a bearing on the patient's condition. If the situation worsens, the Triage Committee will ration care. The facilities can shift all resources from one patient to another in real time, insuring the needs of an entire group of patients are met to the best ability possible. St. Al's depends upon their national ministry to get resources.

Idahoans can all help during a CSC by recognizing and thanking those healthcare workers who are witnessing death daily, taking on more shifts, caring for more patients, and having to race between patient rooms to respond to patient needs.

Responding to committee questions, **Dr. Nemerson** said for approximately the last month, St. Al's has a record number of 100 to 140 employees out due to COVID. This doesn't capture those employees who have taken time off due to stress, burn out, or have taken work with other hospitals offering high incentives. On any given day St. Al's is short about 125 colleagues. Those out with COVID are contracting it at home or in their communities. St. Al's is protecting all colleagues appropriately when they are working with patients. Evidence clearly shows the vaccines reduce infection acquisition but doesn't prevent it entirely.

Answering a question, **Director Jeppesen** said clinical Federal Emergency Management Agency (FEMA) personnel are being used to address current hospital needs and the Idaho National Guard is handling non-clinical requests.

Dr. Jim Souza, Pulmonary Medical Care Physician, St. Luke's Healthcare System (St. Luke's) Chief Physician, offered the perspective of someone who has personally cared for critical COVID patients.

In practice, conventional care provides everything each patient needs. Contingency care means care to patients may require creativity to give them most of their needs. In CSC care some patients may receive only comfort and limited care, which may not save their lives. The CSC declaration does not stipulate how the facilities manage the crisis. During the CSC, St. Luke's has not de-escalated treatment from one patient to another. The Idaho usual standard of care is higher than most requirements due to its just-in-case design's layers and backups. Both he and **Dr. Nemerson** lead two of the IBM Watson Health's listed top 15 hospitals.

He described the erosion of quality of care and its impact on surgical procedures, chronic disease management, staff redeployments, expanded hospital team ratios, use of areas for intensive care, lack of code beds, prolonged bag valve mask ventilation, ventilator substitutions, use of high flow oxygen outside of the Intensive Care Unit (ICU), use of vasopressure drugs at non-ICU sites, reduction of drug monitoring for ICU patients, and the reduction of vital sign monitoring.

Although available, St. Luke's did not have to implement their Activation Committees and other CSC tools. This was due to the creativity, innovation and incredible sheer human effort of their health care teams. **Dr. Souza** reminded the committee the current crisis is on the heels of the previous eighteen months of hard work and surges.

The current CSC is related to blood product and staffing shortages. St. Luke's has several days of blood reserve and continues to ration blood, lowering the transfusion threshold to conserve the remaining supply. COVID volumes, although plateaued, still account for one-third of their admissions. Staff shortages due to infection, although declining over the past two weeks, mean tight staffing due to the unrelenting volumes of all types of patients. St. Luke's is still running above normal capacities and have surge units in their large facilities.

The case mix index (CMI) is up significantly with an increase in the average length of stay for both hospitalized and ICU patients. The surgical backlog of 9k cases has decreased with rescheduling. Drug supplies, as indicated by **Dr. Nemerson** are in critical shortage.

ADJOURN: There being no further business to come before the committee, the meeting adjourned at 10:53 a.m.

Representative Vander Woude
Chair

Irene Moore
Secretary