AMERICAN PUBLIC HEALTH ASSOCIATION

and

THE NATIONAL ACADEMY OF MEDICINE

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RESPONDING TO COVID-19: A SCIENCE-BASED APPROACH

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WEBINAR #4: CRISIS STANDARDS OF CARE DURING COVID-19

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WEDNESDAY
APRIL 15, 2020

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The webinar convened at 5 p.m. Eastern Daylight Time, Lawrence Gostin, JD, Moderator, presiding.

PRESENT

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CARLOS DEL RIO, MD, Distinguished Professor of Medicine and Professor of Global Health and Epidemiology, Emory University
JOHN L. HICK, MD, Professor of Emergency Medicine, University of Minnesota; Faculty Emergency Physician, Hennepin Health Care
REBEKAH E. GEE, MD, CEO, LSU Health Care Services Division
JEFFREY KAHN, PhD, MPH, Andreas C. Dracopoulos Director and Robert Henry Levi and Ryda Hecht Levi Professor of Bioethics and Public Policy, Johns Hopkins Berman Institute of Bioethics
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1 P-R-O-C-E-E-D-I-N-G-S

2 5:00 p.m.

3 DR. LURIE: Good afternoon or evening,
4 depending on where you are. This is Dr. Nicole
5 Lurie. I'm the former Assistant Secretary for
6 Preparedness and Response at HHS and co-Chair of
7 the Advisory Group for this webinar series.
8 Alongside Dr. Carlos del Rio of Emory University.
9 And we're both thrilled to be here.
10 Welcome to the 4th webinar on the
11 COVID-19 Conversations series brought to you by
12 the National Academy of Medicine and the American
13 Public Health Association.
14 The purpose of this series is to
15 explore the state of the science on COVID-19 and
16 to inform policy makers, public health and health
17 care professionals, scientists, business leaders
18 and the public. More information on the series
19 and recordings of past webinars are available at
20 the covid19conversations.org website.
21 Today's webinar has been approved for
22 1.5 continuing education credits for CHES, CME

1 and CPH. None of the speakers has any relevant
2 financial relationships to disclose.
3 Please note that if you want
4 continuing education credit you should have
5 registered with your first and last name.
6 Everyone who wants credit must have their own
7 registration.
8 All of the participants today will
9 receive an email within a few days from
10 cpd@**confex**.com with information about claiming
11 those credits.
12 If you have questions or topics you
13 would like to address today or on any future
14 webinars, please enter them in a Q&A box or email
15 us at apha@apha.org.
16 If you experience technical
17 difficulties during the webinar, please enter
18 your questions in the box. Please pay attention
19 to the chat for announcements about how to
20 troubleshoot. They'll probably come up early and
21 often.
22 This webinar will be recorded and the

1 recording, transcript and slides will be
2 available also on covid19conversations.org.
3 Before I introduce our moderator for
4 today, Dr. Gostin, I thought I might just make a
5 quick remark about how I spent my day. The day
6 before yesterday.
7 In back-to-back calls, I was on a call
8 first with all the hospitals in New York City who
9 were talking about taking care of COVID patients
10 in ICUs who had developed kidney failure.
11 And they were talking about the fact
12 that they were out of dialysis machines, they
13 were out of dialysis fluids and they didn't have
14 enough nurses. And so they weren't able to offer
15 dialysis for patients who were sick in their ICUs
16 and who they felt were very likely to get better.
17 An hour later I was on a call with
18 fellows at an Indian Reservation in South Dakota.
19 And South Dakota, as you know, is an emerging hot
20 spot for COVID.
21 These fellows were telling me that
22 they're trying to think about how to implement

1 crisis standards of care but don't even have
2 access to the basic laboratory tests to calculate
3 any kind of scores with which to think about how
4 to make any assessment about how one is likely to
5 be.
6 And so, it is very minor for me that
7 it's just a huge country. Crisis standards mean
8 different things in different places. And I'm
9 really looking forward to today's speakers to
10 help guide us through how we might be thinking
11 about this.
12 We are thrilled to have Professor
13 Larry Gostin as our moderator. Professor Gostin
14 is a Professor at Georgetown University and the
15 Director of the O'Neill Institute for National
16 and Global Health Law.
17 He's a member of the Advisory Group
18 for this webinar series. And he served as chair
19 of a major Institute of Medicine consensus report
20 recommending the original framework for crisis
21 standards of care.
22 Larry, over to you to frame today's

1 conversation. And thanks for all of your
2 contributions.
3 MR. GOSTIN: Well, thank you, Nikki.
4 And thank you for all of your contributions. And
5 on behalf of the National Academy and the
6 American Public Health Association, I'm really
7 delighted to welcome you to today's webinar.
8 And our hats go off to these two
9 leading organizations for helping to guide the
10 country and educate the country at a moment when
11 we're experiencing a once in a century event. A
12 public health crisis that we know has no modern
13 precedent.
14 As we speak, we understand all of us
15 that there has been a deep concern in the United
16 States of America about scarcity. The scarcity
17 effects the health system and hospital
18 functioning, which in turn places patients at
19 risk because we don't have enough medical
20 resources like diagnostic testing kits,
21 ventilators and other necessary medical equipment
22 to keep patients safe.

1 And of course, it's not just COVID
2 patients because all of us may have had other
3 health conditions. And that's being put on hold
4 as well. And so you got an overload of the
5 health system.
6 Beyond that, it turns out sadly that
7 COVID-19 SARS-CoV-2 is highly contagious. And so
8 health workers are at risk.
9 And keeping them safe with personal
10 protective equipment is critically important.
11 Not just to our mission but to our ethical values
12 to be faithful to first responders.
13 And as you may have seen from the
14 public discussion, the World Health Organization
15 has been much in the spotlight and has really
16 been thought of about how it's handled this
17 pandemic.
18 But we do need the World Health
19 Organization more than we've ever needed it in
20 the past. And we need to come together.
21 Not just as a community of Americans,
22 but it's a community of the world. Because this

1 is truly going to affect every community, every
2 country in the world. And so we need a robust
3 World Health Organization to lead us through it.
4 And if we think about what Dr. Lurie
5 talked about in terms of the high variability of
6 capacities here in the United States, think about
7 that high variability globally. There will be
8 many countries in the world that have very weak
9 health systems, fragile governments and
10 governance.
11 And as we speak, COVID-19 is posed to
12 run through some of the lower income countries at
13 most at-risk. In places like Sub-Saharan Africa,
14 the Middle East and the Indian subcontinent.
15 And we're going to have to make hard
16 choices there too about the crisis standards of
17 care. And we need the World Health Organization
18 to help set those standards, set those norms,
19 provide guidance, provide technical assistance.
20 And also, to help beef up health systems to deal
21 with the kinds of scarcity we see.
22 And so, this webinar could not be more

1 timely. On today's webinar we're going to
2 examine crisis standards of care within the
3 context of the developing and ongoing COVID-19
4 crisis.
5 We'll begin with an overview and learn
6 about some of the real-time decision making
7 that's being made at state health departments and
8 hospital systems. And then we're going to delve
9 into the complicated and very hard ethical
10 questions of how do we act and implement crisis
11 standards of care and what we do going forward in
12 the United States and hopefully globally.
13 For this we've got really an unrivaled
14 series of experts and they're going to help guide
15 the discussion.
16 John Hick, who served with me on the
17 Crisis Standards of Care Committee for the
18 Institute of Medicine is currently the Deputy
19 Chief Medical Director for Emergency Medical
20 Services and Director for Emergency Preparedness
21 for Hennepin Health care, which serves
22 Minneapolis and the surrounding county.

1 Dr. Hick is one is one of the nation's
2 leading experts on crisis standards of care. And
3 we all turn to him when we have hard problems.
4 Rebekah Gee is the former Secretary of
5 Health for the State of Louisiana. Currently the
6 head of the Louisiana State University Health
7 Care Services Division.
8 She's going to share with us her
9 perspectives on the challenges that are faced by
10 state health departments and hospital systems.
11 And as know, COVID is being fought from city-to-
12 city, county-to-county, state-to-state. And so
13 her perspective is going to be critically
14 important.
15 And then Jeff Kahn, who has been
16 working tirelessly, both as a member of the
17 National Academy of Medicine and as a public
18 figure, is the director of the Johns Hopkins
19 Berman Institute of Bioethics and sits on the
20 hospital's decision-making committee with regard
21 to COVID-19 care.
22 He's going to help walk us through the

1 ethics of enacting crisis standards of care.
2 So, I thank all of you for joining us
3 today. I thank the National Academy and the
4 American Public Health Association. And
5 particularly our panelists.
6 And so, to get us started I'm going to
7 turn it over to you, Dr. Hick, and we'll look
8 forward to your giving us an overview of what
9 crisis standards of care are and how we can
10 implement them.
11 DR. HICK: Thanks so much, Larry. And
12 just much appreciation to you and to Nicki.
13 Nicki had charged us at the Institute
14 of Medicine in 2009 with coming up for a
15 framework for how we might make difficult
16 resource allocation decisions with the H1N1
17 pandemic. And we fortunately got off a little
18 bit easy in that pandemic but not so much this
19 time.
20 And so, it's a privilege to be working
21 with you again. And unfortunate as this
22 situation is, I think that we have some good

1 foundations anyway to respond from.

2 So, this is going to be a little bit

3 of a book jacket version of crisis standards of

4 care and its impact and what we can use

5 principally to apply to the COVID-19 pandemic.

6 But there's a lot of nuance here that I'm not

7 going to be able to cover but that some of you

8 are more familiar with than I am even because of

9 your personal experiences with this disease.

10 Next slide please. So, I just want to

11 draw a little bit of a distinction between crisis

12 standards of care, which is the systems response

13 and includes government support for the care and

14 the changes in care that we need to provide

15 during a disaster, and particularly in a

16 pandemic, a long-lasting event like this where

17 those emergency orders that official support of

18 the disaster response efforts are so important to

19 promote consistency, to promote fairness, to

20 promote equity across the care system.

21 Crisis care is really situational.

22 And to Nicki's point, it is the inadequate

1 resources that you are faced with in front of
2 you. And you must do the best you can to provide
3 the best care possible in that situation.
4 Regardless of the number of patients you have,
5 you will do the best you can.
6 But the systems and the processes need
7 to adapt to that situation. And so, there is a
8 not a one-size fits all here.
9 Next please. So I think we need to be
10 careful not to think of crisis standards of care
11 as a light switch that we flip on and off.
12 Next. It's much more a set of tools.
13 And whether that is adaptations of personal
14 protective equipment, whether it is adaptations
15 of a respiratory care profiles to encourage high-
16 flow nasal cannula oxygen in patients we might
17 normally intubate.
18 Whether it gets all the way to the
19 point of having to reallocate ventilators, crisis
20 standards of care really provides the set of
21 tools that can be applied to the clinical
22 situation.

1 And it's our job to make sure that we
2 have processes in place, that we have clinical
3 input into those decisions and we create
4 processes that will be the most fair, equitable,
5 accountable and proportional to the needs of the
6 incident.
7 Next slide please. This was a
8 framework slide that I think a lot of you are
9 probably familiar with, but on the left-hand side
10 is our conventional patient care status.
11 We use our usual spaces, our usual
12 staff, our usual supplies. In the middle is
13 where we really have the opportunity to prevent
14 getting into crisis.
15 And I want to emphasize this because
16 I think in some cases it becomes almost too easy
17 to say, we're going to make triage decisions and
18 withhold care from certain individuals or
19 reallocate care.
20 And in reality we probably haven't
21 done the best that we absolutely can to extend
22 that contingency space, to provide the

1 functionally equivalent care that we can in re-
2 purpose areas by extending our staff, by
3 conserving supplies, but also by transferring
4 patients from an overwhelmed area to an area that
5 has capacity to moving when needing resources to
6 the patients or patients to the resources.
7 And making sure that within a hospital
8 that we're not having pockets of care that are
9 very, very different from an equity and from a
10 consistency standpoint. Of even patients in that
11 same facility.
12 So making the maximum use of these
13 resources, what we have. Making sure that we
14 thought through the adaptations before we get
15 into them is important. Because under stress our
16 brain really narrows its scope and ability to
17 problem solve.
18 And we tend to just do what's in front
19 of us and keep doing it over and over. And a lot
20 of times that's not a really good strategy, as I
21 often tell my 16-year-old daughter.
22 On the right-hand side is when we get

1 into crisis. And really moving from a patient
2 focus to a population focus based on us saying,
3 what can we do that's going to do the greatest
4 good for the greatest number.
5 And in that case we really are putting
6 the patients under a degree of risk. We may even
7 be putting providers at a degree of risk if what
8 we're talking about from a crisis standpoint is
9 conversation of PPE, for example.
10 But it's a calculated risk and we need
11 to make sure that we're balancing those risks
12 against the potential benefits. So, with that in
13 mind I'll talk through just a few of the specific
14 applications of some of this framework to COVID-
15 19.
16 Next slide please. Part of doing the
17 greatest good is making sure that you have strong
18 incident management and the strong search
19 capacity plans going into an incident and during
20 the incident.
21 And that you're adapting those plans
22 and technics to the demands of the day. And

1 making sure that you're not siloing yourself and
2 thinking just about one department, just about
3 critical care but thinking about the health care
4 system as a whole, thinking about other partners
5 down the street, over a state line, wherever else
6 you need to look. Under the couch cushions. You
7 need to find the resources that you can find and
8 apply them in a systematic way.
9 But you need support from your
10 administration, from your incident command system
11 for doing the things that you may have to do if
12 it comes down to difficult resource choices and
13 allocation decisions.
14 The farther ahead you can anticipate
15 resource shortfalls the better position you're
16 going to be in to compensate for that when those
17 happen. So think ahead about what might happen
18 and what your contingency plans are now.
19 And then solve the imbalance. As I
20 mentioned, bring the resources in and know where
21 those resources exist and how fast you can get
22 them, transfer patients to other locations that

1 have capacity.

2 And when you have to, triage
3 resources. But don't triage before you've done
4 those other things.

5 Get help. Don't be an island in these
6 situations.

7 Next slide. So the core strategies
8 you can really use are to conserve, substitute,
9 adapt, reuse and reallocate.

10 And we've seen examples of each of
11 these in COVID-19. Whether it's conserving and
12 putting people on ventilators on a more delayed
13 basis or conserving in some cases medications,
14 sedative and otherwise.

15 Substituting different technologies
16 when we need to. So, meter dose inhalers for
17 nebulizers for example.

18 Adapting. You know, putting two
19 patients on one ventilator. If you carefully
20 select them and keep them paralyzed that may be a
21 very short-term stopgap maneuver that you can do
22 while you look for an alternative anesthesia

1 machine or something else, now that you might use
2 to bridge those patients.
3 Reuse. Whether it's reusing
4 ventilator circuits or other things that we
5 normally don't reuse but you can with high-level
6 disinfection is extremely important.
7 And at the end, if we have to,
8 reallocating resources from one patient, one
9 location to another, may be the only option that
10 we have.
11 Next slide please. Some of the
12 hospital challenges that have been faced with
13 COVID-19 are space, and in particular, expanding
14 critical care.
15 So looking hard at your post-
16 anesthesia care units, procedure areas,
17 intermediate care units. Even ambulatory surgery
18 centers.
19 There's many locations where a fairly
20 high-level of monitored care is provided that can
21 easily adapt and provide staff for ongoing
22 critical care. And we need to make sure that

1 we're really emphasizing the maximization of
2 those spaces, utilization of those spaces.
3 Our staff will need to step up and
4 step over. And what I mean by that is, it
5 doesn't make any sense to train a dermatologist
6 to operate a ventilator. I mean, they're
7 probably brighter than I am but it's just not a
8 skill set that they have for the most part or are
9 familiar with.
10 So, stepping up the intermediate care
11 nurse, stepping up the hospitalists, stepping up
12 care providers that are very close to an
13 intensive care unit care on a daily basis, to
14 provide them a little more orientation, a little
15 more familiarity, a little more comfort with that
16 level of care.
17 And then stepping over. Taking
18 critical care domains such as anesthesia and some
19 of our other colleagues that aren't used to
20 provide ongoing critical care but are more than
21 familiar with managing a ventilated patient,
22 doing airway procedures, medicating and keeping

1 patients sedated.
2 Those are techniques that they can
3 step over into critical care with very little
4 additional training and provide a significant
5 augmentation of staff.
6 On the stuff or supply side, we've
7 seen pretty consistent shortages with sedative
8 medications, personal protective equipment.
9 Fortunately nowhere yet has run out of
10 ventilators, knock on wood, but airway supplies
11 have been critically short in some institutions.
12 So, thinking hard again about how we
13 allocate, reuse. Where some alternative
14 ventilators might be out in the community and
15 dental practices and other places with anesthesia
16 machines or transport ventilators, other sources
17 of ventilators, even veterinary might be an
18 option.
19 But we are seeing more and more
20 ventilators coming into the system now and that
21 is a good thing. But that doesn't mean by
22 putting somebody on the ventilator you provide

1 effective critical care.
2 So there is other things like the
3 monitors, IV pump tubing or making use of IV
4 drips where we actually get back to counting
5 drops again. And other ways of measuring giving
6 IV medications.
7 On the special consideration side,
8 knowing where we can cohort patients and how to
9 preserve some of our specialty services, like
10 trauma care and other things is important and
11 making sure that we're able to take appropriate
12 isolation practices with our staff is critical.
13 Next slide please. In general our
14 focus, if we take the left side as a daily basis,
15 and this is from the ACCP 2014 document on
16 critical care expansion and the taskforce for
17 mass critical care, which has some really good
18 articles I think on expansion of critical care.
19 But this is the general framework is
20 that as we expand critical care in the hospital
21 during COVID-19 or other similar situations,
22 we're forcing patients who need lower acuity care

1 out into the community, out into alternate care
2 sites and other locations. And we need to be
3 prepared for that potential flow.
4 These patients are very ill. They
5 remain quite unstable at times for days and even
6 weeks afterwards. And it's a difficult
7 transition. But we may need some alternate care
8 sites. Those need to be carefully thought out.
9 Next slide please. The usual
10 framework for an alternate care site is a
11 situation like this, where we have three-inch
12 couch mattresses and maybe some, if you're lucky,
13 some draping in a flat space area such as a
14 gymnasium.
15 And these work well for certain
16 applications. But for the type of older, weak,
17 convalescent care individuals, this is probably
18 not a good environment for them to be cared for.
19 We're going to need good mattresses and locations
20 that are close to bathrooms.
21 And so things like long-term care
22 facilities that have been recently decommissioned

1 and hotels and other places that place the
2 patients in a care environment where they can be
3 better isolated from each other, receive better
4 care, better comfort and better support in their
5 convalescence are probably better choices than
6 some of these open flat spaced areas.
7 The other thing that should be
8 emphasized is that there is tremendous potential
9 for alternate care locations, for crisis care
10 locations, on hospital campuses and in owned
11 facilities that are already operating as health
12 care facilities.
13 Whenever possible, we should try to
14 keep hospital patients in hospitals and within
15 the health care infrastructure. Particularly
16 with a potential for decompensation, like we've
17 seen with a number of COVID-19 patients.
18 Next slide please. So when we have to
19 make difficult triage decisions there is
20 basically the three Cs. There needs to be the
21 concept of operations.
22 How decisions are made at the

1 institution, there need to be criteria for making
2 those decisions and there needs to be
3 coordination in that process and amongst those
4 criteria within that regional area so there's
5 consistency. And the patients aren't getting a
6 different standard of care at one location than
7 another.
8 Next slide please. So an example of
9 a crisis standards of care concept of operations
10 might be your triggers. And this is just a
11 diagram from a Minnesota document that's
12 available on the web.
13 The triggers and notifications for CSC
14 activities, how it's integrated with incident
15 command, who participates in a triage team and
16 what is the process for making those decisions.
17 Because ideally, you wouldn't like the bedside
18 provider to be making those decisions, how those
19 are communicated and what sort of appeals process
20 or quality assurance is in place.
21 And we have to remember too that those
22 processes need to adapt to the circumstances at

1 hand. That if you literally have half a dozen
2 people at any given moment in the emergency
3 department presenting that need intubation, it
4 won't be possible to go through some of these
5 frameworks in the most ideal way.
6 And we will have to adapt them to the
7 circumstances at hand, just as we always do with
8 crisis standards of care. But we need to set out
9 the ideal first and work backwards from there.
10 Next slide please. As far as criteria
11 goes, we need to remember that whatever criteria
12 are out there, and the SOFA score gets used a
13 lot, and I'm one of the primary sort of
14 perpetrators of that, if you will, after
15 publishing one of the initial articles, but let's
16 remember that SOFA is a really lousy predictor
17 for outcomes in these cases.
18 In cases of respiratory failure, SOFA
19 does not have very good predictive value. And so
20 it may be very attractive to compare patients in
21 the general scheme of things, but I would really
22 caution strongly against using SOFA as a decision

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1 tool unless it's coupled with COVID related
2 mortality predictors.
3 I would also be very careful, this is
4 from the Minnesota Department of Health card set,
5 I would make sure that whatever state criteria
6 you're doing you go through that and make sure
7 there are not exclusion criteria, particularly
8 those that are based on, and anything to do with
9 functional scores or anything to do with
10 preexisting disabilities.
11 There's already a couple of states
12 that are in court because of some of the existing
13 language. And some of that language was included
14 in some of the initial recommendations that
15 different specialty societies had made.
16 But we've really appreciated over the
17 years that we need to be very careful about sort
18 of preexisting conclusions and exclusion
19 criteria. We need to consider everyone that's
20 coming in the door.
21 And we need to consider them in the
22 context of whatever process they have. Whether

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1 it's for the subdural bleed or COVID-19, we need
2 to take the prognostic features that we know are
3 appropriate for that condition and apply that to
4 what we think their prognosis is.
5 Next slide please. So when we talk a
6 little bit more about criteria, I just want to
7 emphasize again the importance of including
8 COVID-19 in specific prognostic factors.
9 And I will disagree with Doug White.
10 I don't think that everyone agrees that the
11 spectrum of age or that we should give resources
12 to the younger population is generally accepted
13 across cultures.
14 I think we have to be very careful
15 about age discrimination when we talk about
16 triage decisions. And yet in this case, advanced
17 age no question confers additional mortality with
18 COVID-19.
19 So, in consideration of that,
20 consideration of increased mortality and the
21 setting of cardiac injury of very high D-dimers,
22 of the severity of co-morbid conditions, renal

1 failure, there is many prognostic factors that as
2 we get more evidence we'll be able to hone these
3 even more carefully to be able to predict outcome
4 with COVID-19.
5 And these need to be living documents.
6 We need to update them as better evidence becomes
7 available so we can put the best predictive tools
8 into the hands of clinicians that are trying to
9 work to save these lives.
10 So in order to keep up with that, it's
11 strongly recommended to have a clinical care
12 committee or a similar body that's keeping an eye
13 on that literature and keeping an eye on updated
14 specialty society recommendations, such as those
15 from the American College of Chest Physicians,
16 available on the ChestNet website.
17 And these need to be specific enough
18 so that we avoid ad hoc decision-making at the
19 bedside. We really want to give the clinicians
20 constructs on which to make decisions.
21 And ideally, have someone above them
22 make those decisions so they can concentrate on

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1 the care of the patient. And ideally, make that
2 in partnership with a couple of people so there
3 is not one individual on whose shoulders that
4 moral injury will come to rest.
5 Next slide please. Coordination is
6 the final three, third of three legs of this
7 stool. We really need to make sure there is
8 consistency.
9 So, regional coordination with the
10 health care coalitions is so important. And
11 communication about what level of care is being
12 provided and a cooperative mechanism to
13 facilitate transfers, intensive care unit
14 transfers into a major metro area from an out of
15 state area or within a metro area to assure that
16 we have consistency, and again, the equity of the
17 care provider is very important.
18 And also, coordination within the
19 states and even interstate for the guidelines
20 that we're using, the criteria for decision-
21 making, advisory committees and then brokering of
22 transfers across regional lines.

1 I think this is so important to make
2 sure that we're providing as consistent and as
3 fair care as we can provide given our system and
4 given its limitations. And a lot of times we
5 don't think about the smaller hospitals in non-
6 metro areas and what they can contribute
7 potentially towards these responses and how best
8 to utilize them in the process.
9 So, coordination ahead of time can pay
10 off big when COVID-19 really hits your area.
11 Next slide please. Now, I just want
12 to put in a plug for ASPR TRACIE, which I'm
13 blessed to be the editor for.
14 ASPR TRACIE does have some great topic
15 collections. That we have some shrunk down topic
16 collections specifically for COVID-19, and we
17 also have some broader ones for crisis standards
18 of care, for a broad range of topics that are
19 directly applicable to some of the critical care
20 surge capacity and other planning that you're
21 doing. So please take advantage of those
22 resources.

1 And, Larry, again, thanks to you and
2 thanks to Nicki. Not only for having me on today
3 but for your leadership in this topic area across
4 the years.
5 MR. GOSTIN: Well, thank you, John.
6 That was a truly splendid overview of the topic.
7 It really laid the framework.
8 And what I particularly liked was your
9 emphasis on equity and planning. And also, non-
10 discrimination. Not using a person's status as a
11 determining factor. Whether it's age, race,
12 disability, gender or other kinds of status of
13 the individual.
14 I think those are critically
15 important, both legally and ethically. And I
16 know we're going to return to that with Rebekah
17 and Jeff.
18 So with that, thank you. We take our
19 hat off to you, John, for all you do for the
20 country. And for patients around the country.
21 And now it's a great pleasure to ask
22 you, Rebekah, invite you to give your perspective

1 from state health departments and hospital
2 systems. Over to you, Rebekah.
3 DR. GEE: All right, thanks. Thank
4 you, Larry.
5 And thanks to Victor and to Nicki who
6 have had the great pleasure of being a warrior
7 with when we had the Baton Rouge area floods in
8 2016 and 100,000 structures were under water,
9 including part of our governor's mansion. I'm
10 really grateful to her and to the Academy for
11 leading these discussions.
12 From Katrina to COVID, Louisiana has
13 not been a stranger to tragedy. Next slide.
14 In the first two weeks of this
15 epidemic, likely in part due to the Mardi Gras
16 celebrations that had some of the largest number
17 of people in close proximity during the time this
18 virus was circulating, and before that was widely
19 known, we had the largest percentage increase in
20 the world, include at that time, compared to New
21 York City.
22 Currently Louisiana has 21,000 cases

1 and we've lost over 1,100 of our citizens. We do
2 however hope that the dark days are behind us.
3 Two weeks ago was when our ICUs had
4 patients spilling over and one of the hospitals
5 that our colleagues work in, at LSU, was within
6 two beds of running out. Today we have 150 fewer
7 patients on vents than one week ago.
8 Next slide. And you can see here the
9 case numbers and death counts are going down.
10 The next slide. Death counts are
11 going up but case numbers are going down.
12 And here you can see that we have
13 fewer patients on vents and the hospital beds are
14 going down.
15 So, we're hoping that we're starting
16 to see some improvement here because of efforts
17 to social distance and so on.
18 Next slide please. But the journey
19 was not easy, and a lot of what John said I'm
20 going to reiterate, and I really appreciate his
21 leadership, but our journey was shocking.
22 And for me, you know, having been a

1 health secretary and led responses to weather
2 events, this has been unprecedented in that this
3 was the first time that in my career where we've
4 had, as a nation, and many of us, to address
5 something together. And simply we're not
6 prepared.
7 And in particular, the journey to get
8 protective equipment for our staff or PPE was
9 shocking. And then it laid bare the lack of
10 federal and state preparedness in coordination
11 for this scale of an epidemic.
12 In fact, there was great confusion
13 about the federal assets available, PPE supply
14 and when that supply would come. And the federal
15 stockpiles were not adequate.
16 And as a result, at LSU and at the
17 command center at GOHSEP, we were extremely
18 confused. And what we did get was inadequate.
19 At one point we got N95s, a large supply from the
20 strategic national stockpile, but they were well
21 past their recommended shelf life.
22 We called other academic medical

1 centers in states where there were few cases and
2 plenty of resources, but fear combined with a
3 scarcity mentality meant that I was told that no
4 PPE could be spared or sent from other
5 institutions. So therefore we looked locally.
6 We unloaded PPE from dentist's office
7 and veterinary clinics. We vetted our health
8 systems in Louisiana, sources from China. People
9 that had been selling tchotchkes weeks before are
10 now sourcing PPE.
11 And as demand increased, the prices
12 did as well and the quality of products was
13 unclear.
14 And so, given that there was no clear
15 path to having appropriate supply and given our
16 numbers, really indicating at that time that we
17 were going to run out of ventilators and run out
18 of PPE, we did extraordinary measures such as
19 resorting to 3D printers and even commandeering a
20 furniture store in New Orleans to print shields
21 and to start making face masks and gowns.
22 Ventilators of course were another

1 challenge. And lack of clarity about when they
2 would come, what kind of ventilators would come
3 and who they would be sent to added to confusion.
4 And health systems and states were
5 bidding against each other, and sometimes against
6 FEMA. Incredibly frustrating. You'd find
7 ventilators and they would be swiped by FEMA.
8 We really had no surety of what would
9 come and when. And it really felt to our faculty
10 on the front lines that it was like we were in an
11 auction for our lives and the lives of our
12 patients.
13 And sadly, this waste in redundancy
14 really, even more so than places like LSU and
15 Ochsner, disproportionately impact our rural
16 hospitals and federally qualified health centers
17 that simply weren't going to win this eBay
18 bidding game or the power struggles about where
19 resources would go.
20 And the 25 bed hospital we run, Lallie
21 Kemp, even today was out of gowns and we had to
22 order some and get them there today.

1 There were well meaning private
2 solutions developed such as projectn95.org for
3 PPE and vents. But during our search there was
4 no way to prioritize based on need, it was first
5 come, first serve. And FEMA could take whatever
6 they wanted before states could get it.
7 Really, solutions are needed. Both
8 public and private sectors solutions that use
9 algorithms for prioritization during times of
10 disaster and scarcity.
11 There are several examples of ones
12 that have been developed. Notably the University
13 of Washington has some algorithms that have been
14 helpful for planning, Johns Hopkins University
15 and the Louisiana Department of Health have
16 partnered.
17 However, they are still inadequate.
18 They need to be invested in and matured and the
19 ability to do predictive modeling bolstered
20 because we overestimated the need and
21 underestimated results of measures for
22 distancing.

1 And so, clearly we're not correct at
2 what our numbers, what the numbers we thought
3 would be.
4 You know, some good news has come last
5 night at the White House. The Dynamic Ventilator
6 Reserve was announced. That's really a no
7 brainer but a good thing that it's happening.
8 Adam Boehler and Ochsner together
9 announced it. And this idea is that places like
10 Ochsner right now that actually have excess
11 ventilator use could deploy to somewhere like New
12 York or Minnesota or wherever these ventilators
13 are needed so that we don't oversupply and take
14 too much for ourselves when they're not needed.
15 I mean, a similar reserve could be set up for
16 PPE.
17 And we need leadership from
18 professional associations. Both from facilities,
19 places that represent hospitals, like the
20 American Hospital Association and professional
21 societies like my society, ACOG to give us
22 guidance on what should be done, as John

1 mentioned.

2 And so, for example, one hospital in
3 New Orleans asked employees to put their N95 mask
4 in a paper bag and reuse them and spray hydrogen
5 peroxide on it.

6 Other hospitals were able to give
7 employees new masks daily. And that
8 inconsistency led to panic and concern. And it
9 certainly would have been helpful to have AHA
10 guidance or CDC protocols that are published for
11 mask reuse.

12 As well as to provide selective
13 guidance that is triggered by scarcity dynamics
14 so that you don't have these practices that are
15 either unproven, unwarranted or inconsistent in
16 regions because you can't allocate PPE
17 effectively or because of concern over scarcity
18 or because of lack of preparation.

19 Also, we need recommendations on how
20 to best sterilize the scarce PPE. People are
21 talking, you know, we've used ozone in one
22 setting, we're using UV radiation. What is the

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1 right way to do it, how do you scale this and
2 what is the evidence.
3 That's something we had to wade
4 through, and still have confusion over.
5 And over the past few weeks as well
6 we've used our pluripotential, smart people at
7 LSU to redeploy, as John mentioned, to other
8 fields. As one of my favorite social media posts
9 said, stay at home because you don't want to be
10 intubated by a gynecologist.
11 We have used people like surgeons and
12 anesthesiologists in critical care settings to do
13 lines. We have up-trained nurse practitioners
14 and individuals who do primary care to work in
15 intensive care units.
16 But we could have done a lot better
17 job. If the professional societies could help
18 guide us as to how do you move up the ladder and
19 help train people up, this should be done prior
20 to a disaster, it should be done with training
21 and it should be done before those essential
22 workers on the front lines get exhausted or

1 overwhelmed and are really unable to function
2 optimally.
3 Finally, there has been a lot of
4 confusion around workplace safety procedures in
5 the wake of this pandemic. I think that work,
6 essential worker protection is a health equity
7 issue. We're treating essential workers as if
8 they're disposable.
9 We've had three bus drivers die just
10 in New Orleans because they had no protection and
11 were getting breathed on all day by all kinds of
12 people. Essential workers need, there need to be
13 national guidelines.
14 There should be a coordinated effort
15 by entities such as OSHA and NIOSH to address
16 these important questions as they relate to
17 pandemics so that folks who are particularly low-
18 income and unempowered have somewhere to turn for
19 protection.
20 Next slide. Oh, so there are a couple
21 of more slides so I'll just keep going.
22 So, what actual decisions are state

1 health departments having to make and what
2 information or guidance could help them better
3 make these decisions.
4 So, at LSU our doctors would like to
5 know what type of PPE, here we go, what type of
6 PPE are needed and for what type of procedures,
7 and when is protection needed, how is protection
8 best utilized, sterilized and disposed of, how
9 best to prioritize and schedule patients.
10 For example, should we mirror what
11 some grocery stores are doing and set special
12 morning hours for the most vulnerable patients
13 after the night team has come in and cleaned and
14 which patients are a priority, these ethical
15 issues for urgent but non-emergent procedures.
16 For example, should a 31-year-old mother of three
17 with breast cancer have priority versus a 75 year
18 old with bladder cancer and severe dementia and
19 other chronic diseases, so who gets priority.
20 And also, who gets priority for
21 testing. You know, as we move into the next
22 stages of this, who gets the antibody test, who

1 gets the COVID tests.
2 And right now in New Orleans, if you
3 don't have transportation and you haven't been
4 able to get to a walk-in clinic, you don't have a
5 test. So we need to address those issues through
6 mobile testing, which is what LSU aims to do by
7 next week.
8 We need health disparities data and
9 ongoing measurements so that if implicit bias is
10 getting in the way of providers' decision-making
11 about these critical resources that we can
12 address it.
13 We know right now that African-
14 Americans are dying at disproportional rates.
15 Sixty percent of the deaths in Louisiana are
16 African-Americans versus the 32 percent that
17 African-Americans make up of our population. Why
18 is that? We need to be able to address some of
19 these things in more real time.
20 And finally, better evidentiary
21 support for severe scarcity scenarios. For
22 example, vent sharing guidelines.

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1 And then support for situations where
2 end of life care must be provided without family
3 members. And finally, crisis counseling services
4 should be available for care givers who are
5 dealing with unprecedented numbers of dead.
6 And the next slide. And then in the
7 face of rapidly changing protocols for clinical
8 care, what can be done for the care of COVID-19.
9 So, early on in the epidemic there was
10 very slow diffusion of information. Both to
11 providers and the public.
12 And so we, I'm sorry this slide isn't
13 available to you but there was not a good COVID
14 screener. The COVID screener that came out from
15 the CDC was not particularly friendly in terms of
16 being literacy and numeracy adequate.
17 It asked questions that many people
18 don't know the answers to. And in fact, some of
19 the questions were, are you about to just stop
20 breathing. Which you hopefully should not be
21 filling an online questionnaire out if you're
22 going to answer that question yes.

1 So really slow response. Difficult
2 for state health departments to communicate with
3 the public about where they should go, when they
4 should go to emergency rooms.
5 And very also difficult for front line
6 providers to cull through journal articles and do
7 lit reviews and figure out what knowledge is
8 happening.
9 And then just to underscore, it's
10 extremely difficult when politicians make
11 statements about certain drugs and that they
12 should be used for COVID.
13 We had runs on several of these drugs
14 in Louisiana, and in fact, our board of pharmacy
15 had to make a statement about not being able to
16 fill these things. So it might be anticipated
17 that we need to have guidelines about what
18 pharmacies are able to fill and for whom during
19 these types of events.
20 Social media has been very effective
21 for our clinicians to help them vet and curate
22 information. And it's often reassuring for them

1 to know that others are also going through
2 similar situations.
3 So, it would be helpful for the AHA to
4 support hospital level decisions, such as
5 scarcity and reuse models, as mentioned before,
6 and specialty societies to support spread of
7 information. And rapidly disseminate promising
8 clinical protocols in the National Academy of
9 Medicine or another scientific body that can
10 curate this so that there can be public trust in
11 this information.
12 And these types of vetted curated
13 messages could help bolster local networks such
14 as COVIDNOLA here in New Orleans that help the
15 public understand why we have stay at home orders
16 for as long as they are and help them understand
17 admonitions.
18 And for COVID, there is an urgency of
19 timelines obviously and needs to bolster the
20 COVID clinical trials network. Oh, can bolster
21 and create a COVID clinical trials network
22 similar to what's being done for cancer and

1 private solutions such as the website.
2 World Without COVID was launched
3 yesterday morning with a goal of connecting
4 patients to coronavirus clinical trials. More of
5 that is needed.
6 And finally, if a single medication
7 back to medication scarcity is found to be
8 effective and there are shortages, we should
9 consider 1498 authority for the U.S. to
10 manufacture these pharmaceuticals or a national
11 subscription model similar to what Louisiana has
12 implemented to try to eradicate Hepatitis B in
13 our state.
14 In conclusion, we've been reminded by
15 this epidemic that the health of one individual
16 can have profound impacts on the health of the
17 community. And my hope is that our experience
18 with COVID will bolster a national dedication to
19 the universal coverage.
20 And certainly reinvestments in public
21 health. Because what we didn't pay for we are
22 certainly paying for now.

1 On the crisis standards of care that
2 John and Nicki and others at the National Academy
3 of Medicine advanced and first promoted in 2009
4 are a good start, but there is a lot more work to
5 do. So thank you, and sorry about this slight
6 guffaw.
7 MR. GOSTIN: Well, thank you, Rebekah.
8 You gave us a wonderful view from what it's down
9 like in the health and hospital system. And
10 that's crucial.
11 And I particularly liked the idea that
12 you put forward, that Nicki had also mentioned,
13 which is equity and why we're having these kind
14 of different scenes, kind of differential impacts
15 on certain communities like African-American
16 communities or American Indian communities.
17 And not only do we need to understand
18 it but we can't understand it unless we have more
19 granular data that separates out diagnosis,
20 illness, hospitalization and death with more
21 specificity.
22 I also of course appreciated very much

1 your attention to front line workers. You know,
2 people who are putting themselves at risk every
3 day and our core ethical duty to keep them safe.
4 Because they're out there working for
5 us every day, we need to be out there working for
6 them every day because ethical duties are
7 reciprocal.
8 And so, as we are transitioning to
9 ethics and the ethics of crisis standards of care
10 and scarcity, I'm really delighted to welcome
11 Professor Jeff Kahn.
12 Jeff and I go way back in thinking
13 about the hard-ethical problems that occur in
14 relation not only to medical and health care but
15 also public health and population-based
16 evaluations of what works, what doesn't work,
17 what's fair, what's not fair.
18 So, thank you very much, Rebekah. And
19 thank you, Jeff, for joining us. I'm delighted
20 to turn it over to you now.
21 DR. KAHN: Thanks, Larry. And let me
22 say thank you to the APHA and the NAM for hosting

1 this really critical conversation.
2 I should say great to see you, and
3 great to see Nicki and John too. And it's making
4 me realize all roads lead through Minneapolis.
5 So good to see everybody, old friends and new
6 acquaintances alike.
7 So I'm going to talk without slides.
8 Not because I don't like slides, but because I'm
9 going to share some of the work that we're
10 engaged in at Johns Hopkins in the midst of
11 planning for the outbreak. And for those of you
12 who live in Maryland or are paying attention to
13 what's happening, we have not yet had an
14 executive order come from our Governor.
15 So I am hesitant to get ahead of the
16 release of what will be the state level guidance.
17 So I'm going to speak from notes rather than show
18 slides. I will say too, that the comments that
19 I'm making relate to the work that we're engaged
20 in as a scarce resource planning committee. It
21 isn't specific to ISA standards of care, but of
22 course, we're in a crisis and trying to establish

1 standards of care for this particular crisis.
2 So let me take the questions that were
3 posed to us on the panel in turn, which will be
4 the way I'll organize my comments. The first
5 was: what ethical considerations must be taken
6 into account when planning to enact crisis
7 standards of care? Of course a crucial question,
8 and both John and Rebekah have signaled to them,
9 and Larry in his comments as well.
10 And John I think said: best care
11 possible. And of course that's a critical
12 commitment. That's not just a medical and
13 professional commitment, but an ethics
14 commitment.
15 And so just to sort of frame the
16 conversation that we're engaged in, and I note
17 lots of other people around the country and
18 around the world are engaged in, we need to think
19 about the ethics commitments and principles that
20 are at issue and need to be attended to as we
21 craft frameworks and plans for implementing them.
22 So I would list in that collection the

1 duty to provide care. So that's about the best
2 care possible. And of course that's a
3 professional commitment of our health
4 care providers and our health care institutions.
5 At the same time, and this is where
6 the tension comes in, we have a duty to steward
7 resources. And in the context of crisis care
8 planning, and in particular as we're talking
9 about the COVID-19 outbreak, we are facing
10 potential shortage of lifesaving resources.
11 So duty to provide care, and duty to
12 steward resources are coming into conflict, at
13 least in theory if not in practice. And of
14 course we hope they never will come into conflict
15 and practice, but we're preparing just the same.
16 As we think those through, and that
17 tension of course is at the crux, we have to
18 think about how to allocate in ways that respect
19 distributive and procedural justice in ways that
20 are equitable. So this goes to Larry's points
21 about equity and consideration of people where
22 their needs are, rather than what they look like

1 or where they come from.

2 So equitable approaches to

3 distributing scarce resources in ways that are

4 standardized and clear, so they can be followed

5 by the providers. And I'll talk more about that

6 in a moment.

7 And done so transparently. So I think

8 that's a really critical point, that transparency

9 as a sort of ethics commitment. So that not only

10 the providers understand, but the public who will

11 be affected, understand the way that these

12 decisions will be made.

13 And in particular, attending to

14 vulnerable parts of our communities and peoples

15 who have been historically marginalized and

16 therefore may be distrustful of the health

17 system.

18 So we I think have real concerns to

19 face about saying, well we're not going to treat

20 certain people in certain ways in the context of

21 people mistrusting health systems and not feeling

22 like they would be fully treated under the best

1 of circumstances. So we need to be really
2 careful as we face down these difficult
3 conversations related to crisis standards of
4 care.
5 So those are the high level
6 principles, with a primary goal, which I don't
7 know I need to articulate, but I'll do it anyway,
8 of maximizing the benefit of treatment, and
9 enhancing survival for as many patients as
10 possible. That's what we want to do.
11 And of course then it's sort of all,
12 the devil's in the details. So let me move to
13 the second question, which was: what sort of
14 ethics framework or decision making assistance to
15 government leaders, hospital and health system
16 administrators, clinicians, et cetera, need to
17 plan and prepare to enact for crisis standards of
18 care?
19 And so I will say that the committee
20 that I'm part of, and as I mentioned, we're not
21 calling it a crisis standard of care committee,
22 we're calling it an allocation of scarce

1 resources committee. But it's performing that
2 function in the context of the COVID outbreak.
3 We have been meeting, this is the
4 fifth week we've been on remote work, and we
5 started the Monday of our first week. So now
6 into the fifth week, we're meeting every single
7 day, twice a day for an hour each time, seven
8 days a week.
9 And that's a group of 20 people from
10 across the Johns Hopkins Health System, who are
11 working hard to craft not just sort of high level
12 guidance, which is sort of the kind of principles
13 that I mentioned a few moments ago. But really
14 clear frameworks and guidance documents and
15 implementation plans not just in general for what
16 we face when there's a shortage, but with
17 specific flow diagrams.
18 Triggers for when we would invoke
19 making triage decisions. The steps that would be
20 involved. The individuals who would be involved
21 in making triage decisions. The roles that those
22 people would play. The time frames for those

1 decisions. So how quickly they would need to be
2 made, and each for specific resources that may be
3 scarce.
4 And so I'm sure it doesn't bear
5 repeating, but let me just make the list here, or
6 offer the list of the things that we have been
7 working through. And I'm sure others around the
8 country and around the world are thinking about
9 the same things.
10 Lots of attention has been paid to ICU
11 beds and ventilators. And of course, we all hope
12 that we won't face the situation where we have to
13 make decisions about which patient gets the
14 ventilator if we're down to more than one patient
15 and fewer ventilators than patients available.
16 But it also turns out that there are
17 other resources that are potential to be --
18 potential to be scarce or likely to be scarce.
19 And among the things that have received less
20 attention, and I think worth saying, is blood.
21 The blood supply is under a threat.
22 Not because of people needing to be transfused

1 when they're infected by COVID-19, but because
2 people are staying home and not donating blood.
3 And blood is, of course, a perishable commodity
4 that relies on altruistic donors.
5 And people who need transfusion will
6 need transfusion before and after and during the
7 current pandemic. And so the blood supply is in
8 peril, and we need to have a plan for how to
9 allocate it.
10 A little bit of a quick sideline,
11 which makes it for an interesting ethics
12 discussion. Is that unlike ICU beds, which are
13 one patient, one bed, or ventilators, you know,
14 one ventilator, one patient, unless they're
15 multiplex. A lot of it is a variably used
16 commodity. Some people need only one or two
17 units, and other cases require literally hundreds
18 of units of blood.
19 And it's possible for these massive
20 transfusion protocol cases to sometimes wipe out
21 a supply of a blood bank in a single case,
22 especially if the blood supply is already

1 suppressed. And so we have a difficult ethics
2 question to answer about, at what point do you
3 trigger restrictions on the use of blood, if
4 doing so would eradicate the blood supply so that
5 there was none left for other patients?
6 It's do we use it at all on one or two
7 patients, or do we spread it out and use it maybe
8 on 100 or 200 patients?
9 And that's a different ethics
10 calculation than is ventilators and ICU beds. So
11 very specific frameworks in terms of how those
12 particular decisions would be made for the very
13 particular resources that would be involved.
14 We've included -- and I'm sure this is
15 true of other places too -- transfer policies.
16 How do we decide when it's appropriate to have
17 patients come to Johns Hopkins? And in what
18 order when we have a shortage? And what order of
19 priority would we offer access to hospital or ICU
20 beds in our hospital?
21 And most recently, we've been trying
22 to work through issues related to allocation of

1 convalescent plasma in the research context. But
2 nonetheless, there are likely to be more patients
3 eligible for receiving convalescent plasma than
4 there are units of plasma to go around.
5 So very specific guidance is the
6 answer to my question about what sort of ethics
7 framework or decision making assistance. The
8 more specific, the better, because these are
9 decisions not being made in hypothetical, but in
10 actual.
11 Among the things I want to say before
12 I leave that is, it's really important and it's
13 an ethics point I should have made earlier. That
14 we need to protect clinicians from having to make
15 decisions about what's good for their patients
16 versus what's available to offer to patients.
17 And so that means creating triage
18 teams with a very specific membership, to make
19 decisions and take them out of the hands of the
20 bedside care providers. That's a really
21 important point as part of the planning.
22 And among the things that relate to

1 protecting clinicians, is making sure that
2 they're protected from liability. And maybe we
3 can talk about that during the Q&A. It's not an
4 ethics issue per se; it's more of a legal issue.
5 But obviously we don't want to put clinicians in
6 the position of making decisions that will leave
7 them in legal liability for not providing an
8 adequate standard of care.
9 The third question was: who should be
10 involved in this planning and decision making?
11 And I made a brief reference to the fact that
12 we've had a group of 20 that involve clinicians
13 of all the relevant sub-specialties of medicine.
14 It is, in our case, chaired by the VP
15 for Quality and Patient Safety. It includes
16 three members who have ethics expertise. So I am
17 on the committee. And then my two colleagues who
18 chair the ethics committee at Johns Hopkins
19 Hospital. So we have ethics, we have nursing, we
20 have clinic -- medical care of various types, and
21 we have the General Counsel for our hospital and
22 health system.

1 So very interdisciplinary is the
2 answer to the question about who should be
3 involved. And as I said, we've been meeting
4 very, very frequently. And I think that part of
5 the answer is you need to talk about these things
6 not only in prospect, but as you are living
7 through them, because conditions change, as we
8 heard from both John and Rebekah.
9 How should the resulting standards
10 that are crafted be communicated to hospital
11 staff, health care workers, patients and families,
12 and the public? I will say nature and humans
13 abhor vacuums. And it's really critical to share
14 the information as soon as you possibly can,
15 because people will otherwise try to figure it
16 out for themselves, and that tends to be
17 inaccurate.
18 And so we are trying to be proactive
19 in doing things like hosting townhalls. FAQs are
20 being created. Talking points for people when
21 they are called by members of the media to talk
22 about what the planning looks like. And trying

1 to be clear about what will and will not happen.
2 So just by way of example, there was
3 a kind of rumor moving around through some of our
4 communities that if you came into the hospital
5 and were COVID positive, you would automatically
6 be declared a do not resuscitate patient, which
7 is not the case. And we've had to work hard to
8 get ahead of that so that those sorts of rumors
9 don't take hold among the public.
10 Lastly, the last question, and then
11 I'll stop and turn it back over to Larry. In the
12 face of rapidly changing protocols for clinical
13 care of those with COVID-19, how should or can
14 committees adapt to ensure their decisions are
15 always being informed by them as up to date and
16 appropriate ethical guidance?
17 So when we started the process that I
18 have briefly described now almost five weeks ago,
19 I think we all thought, and I think we were
20 actually told we would be at this for just a few
21 weeks, two or three weeks. And we would craft
22 the framework and implementation plans, which

1 would then be shared with our colleague hospitals
2 around the state, and eventually become part of
3 the state level approach.
4 And so we would do that work. Work
5 very hard at it, very fast. And then turn it
6 over to those who would implement it. That has
7 not proven to be the case. And that's because as
8 we have been working, things have continued to
9 change.
10 And so my answer is: you need to keep
11 at it with a group of people who are committed to
12 helping think through the issues as they arise in
13 an ongoing way. Remarkably, lots of busy people,
14 20 very busy people show up every day at 1:00 and
15 7:00 p.m. for an hour, and we work through
16 whatever the issue of the day is.
17 I don't think anybody's missed a
18 single meeting. We have come to think of each
19 other as sort of family. We're living through a
20 little bit of what feels like wartime. And we're
21 not even the ones who are at the bedside trying
22 to make theses hard decisions.

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1 So I think this is something that
2 people need to be prepared for. It's a
3 commitment, but we're all I think feeling like we
4 need to step up and see this through to the end.
5 So that's all I think I wanted to
6 include in my notes. I guess the last thing I
7 will say is it's critical to share and coordinate
8 among all of the affected parties.
9 In our case, it's the hospitals across
10 our state. But like I'm sure all of those of you
11 watching and listening, the email listservs that
12 I'm part of just sort of exploded when we ended
13 up starting to talk about scarce resource
14 planning.
15 And the level of willingness to share
16 what people were working through in draft form,
17 and just sharing ideas and helping to figure out
18 what best practice was, has been remarkable. And
19 people have been really willing to do that in
20 ways that I think will lead everybody to make
21 better and more thoughtful decisions.
22 And so I think coordinating and

1 sharing is a really important takeaway from what
2 we have experienced so far. So with that, I will
3 stop.
4 MR. GOSTIN: Thank you, Jeff. That
5 was a real tour de force. And I think you've
6 told us that, you know, we need a good multi-
7 disciplinary transparent process. That once you
8 come up with those ethical standards, you need to
9 have good health communications so that people
10 understand and are educated.
11 And then you talked about medical
12 malpractice liability. Of course I'm a law
13 professor. And I think that if a health worker
14 is following good ethical standards, he or she
15 should be protected against liability. And so
16 ethics and law go hand in hand.
17 So we've got about 20 to 25 minutes
18 for questions and answers. I've got a lot. I'm
19 going to send them -- I'm going to read them.
20 But I would like, if we can, to have you answer
21 them as quickly as possible, so we can get
22 through as many as we can. And I've got them by

1 text message.

2 So this first one is for John or Jeff.

3 Can you talk about the concepts of health

4 literacy and patient-centered care in the context

5 of COVID-19? How do we make sure patients

6 understand their choices? How can we make sure

7 patients have people to speak for them and

8 support them when families can't be in the room,

9 as we know, is all too common during COVID-19?

10 So who wants to take this? John or

11 Jeff?

12 DR. KAHN: I think John is muted.

13 Maybe I'll start while John unmutes.

14 MR. GOSTIN: Okay. Well I mean I'm

15 hoping that just one of you will do each so that

16 we can get through this.

17 DR. KAHN: Okay. Well I'll tell you

18 want we're doing really fast.

19 MR. GOSTIN: Yeah.

20 DR. KAHN: There's been a really

21 important point. And so we've crafted materials

22 for patients and families that are going to be

1 shared with them, that are, you know, reading
2 level appropriate, as well as scripts for
3 clinicians to use to make the points that need to
4 be made to families and patients.
5 So we're highly attuned to exactly
6 these concerns. And there need to be materials
7 crafted, and early on, before you need to use
8 them obviously.
9 MR. GOSTIN: Thank you very much. So
10 I've got another question. This one is for John
11 or Rebekah.
12 And if we're expecting a second surge
13 after social distancing is lifted, and many
14 public health experts think that that's likely,
15 are there things that we can be doing now to
16 prepare in terms of training, equipment,
17 guidelines?
18 Is there bandwidth or attention to
19 start term preparedness right now, figuring that,
20 you know, we're going to be in incremental stages
21 with waves of COVID that are impacting the health
22 system? So John, are you still muted, or are you

1 able to jump in here? If not, Rebekah, would
2 you mind?
3 DR. GEE: Yes. So John mentioned some
4 of these. And I would echo what he said. I
5 also, you know, the types of research protocols,
6 registries, health disparities data, we can start
7 bolstering those information systems.
8 National guidelines, professional
9 guidelines, workplace safety standards, these are
10 all things that can be done, you know, working on
11 -- we can be working on now.
12 Algorithms for decision making. And
13 information for the public that is appropriate
14 for literacy. Really focus on communities of
15 color and other communities, Native American,
16 Spanish speaking folks, Vietnamese community here
17 in New Orleans, we need materials for them. We
18 can be working on that.
19 And definitely telemedicine resources
20 and support. And then certainly professional
21 societies creating, you know, better protocols
22 for PPE use. The sterilization protocols have

1 been used throughout many hospital systems. And
2 by this point we ought to know what works best.
3 We need to disseminate that quickly.
4 And professional organizations should
5 be helping to guide hospitals, hospital
6 administrators and systems on what types of
7 persons are best deployed to what types of
8 situations, and start giving guidance.
9 And you can start doing drills and
10 training. If, you know, New Orleans in a week or
11 two, if things are better, we should be training
12 and drilling for the next one.
13 MR. GOSTIN: And that's --
14 DR. HICK: And Larry, I'll just make
15 a quick mention here.
16 MR. GOSTIN: Yes. Please do.
17 DR. HICK: I think it's so important.
18 You know, we haven't gone through our first major
19 peak here. But I think it's so important to
20 learn from the health care workers who have
21 been through that: what do you need?
22 Because the mental toll, the physical

1 toll, but also the opportunity to improve
2 practices in that next wave. I think learning
3 from the front line providers is something that
4 we have to do.
5 And also have to help support them.
6 Because this is one of the most mentally, you
7 know, taxing things, I think, that any of these
8 providers are ever going to face in their
9 careers.
10 MR. GOSTIN: It is. You know, and I
11 would just add one other thing. Which is that,
12 you know, by the second wave, I hope that we're
13 going to know more about risk.
14 In other words, what are the
15 procedures? And what are the infection control
16 measures that we can do that actually -- the
17 procedures that raise risk, the infection control
18 standards that can reduce risk?
19 And also I think by that time we
20 should have antibody tests. We should have a
21 better idea who might be more immunologically
22 protected from SARS-CoV-2. And so we're going to

1 need to be able to apply science in more
2 sophisticated way in the service of not only
3 treating patients, but protecting health workers.
4 So you know, this next question is --
5 was addressed to John or Jeff. But I think
6 Rebekah could easily do it as well.
7 I mean one of the things, you know,
8 we've all noticed is that, you know, probably the
9 highest risk settings in addition to the
10 hospitals, would be congregate settings. Places
11 like nursing homes, prisons, jails, homeless
12 shelters.
13 And so the question is: how can we
14 apply crisis standards of care in these settings,
15 where you've got both highly vulnerable patients,
16 and also high at risk settings for contagion?
17 Who would like to jump in there?
18 DR. HICK: I think I'll defer to Susan
19 as the state, you know, state health director to
20 start anyway.
21 MR. GOSTIN: Okay.
22 DR. GEE: So I'll just start. I mean

1 look, I think it's very challenging. We are --
2 we've had several clusters of nursing home cases.
3 A veteran's home, we lost 25 people in one
4 veteran's home. Just tremendous compression.
5 And the Governor issued a proclamation about who
6 could go back to nursing homes, because it's very
7 challenging.
8 We've set up a 2,000 bed location at
9 our convention center so that we could offload
10 patients who are COVID positive who are
11 recovering and convalescent, but don't really
12 need critical care.
13 It's difficult to use something like
14 that in New Orleans for a patient who is in
15 Minden or Bunkie. So it's a big challenge, and
16 certainly as you've seen in these reports. The
17 other question is public reporting. There's a
18 lot of controversy right now on: do we report
19 these hot spots? How do you report these hot
20 spots? And lots of politics and politicking on
21 that. So I know these are very difficult
22 problems.

1 MR. GOSTIN: Okay. Thank you.
2 DR. HICK: And just to emphasize.
3 MR. GOSTIN: Yeah.
4 DR. HICK: Larry, these are such
5 vulnerable populations. And we just owe a lot of
6 proactive defensive efforts to each of these
7 facilities. And really thinking through what
8 that means, and trying to get ahead of some of
9 those outbreaks. And then, you know, isolate and
10 quarantine, and do the best we can to protect
11 those.
12 But I think too, with long term care,
13 I think it's so important that we're thinking
14 through end of life wishes. And the context of
15 some of the level of critical care that's
16 required to get people through these illnesses.
17 And just making sure that we're being
18 consistent with people's wishes. It's so
19 important to have that outlined ahead of time to
20 reduce the moral distress for families as well as
21 for caregivers.
22 MR. GOSTIN: Yes, indeed. And we have

1 to also remember that in this environment there,
2 these are not just vulnerable, but they're
3 isolated. And they're removed from their family
4 and their loved ones that can provide the kind of
5 support that they need.
6 The next question is actually near and
7 dear to my heart, because we spent most of our
8 time talking about the hospital system and the
9 health care system. But remember, we have
10 a health system, which includes a public
11 health workforce and community health workforce.
12 So how in these more population-based
13 workforce environments, public health or
14 community health workers, how does a crisis
15 standards of care apply? And how can we best
16 equip and inform the public health workforce?
17 And I think that can, you know, it was addressed
18 to John. But frankly, all three of you know this
19 stuff really well. So any of you, please jump
20 in.
21 DR. HICK: Yeah again, I think I'll
22 defer that one back to Susan, as you know, as

1 being in charge of state public health. I think
2 you're probably in the better position to start
3 with that than I am.
4 DR. GEE: So it's Rebekah. So I think
5 that number one --
6 DR. HICK: Rebekah.
7 DR. GEE: With some of these community
8 health workers and public health professionals,
9 one thing we're looking at is similar to what New
10 York City has done, is to use a platform like
11 Unite Us.
12 We have to recognize that although
13 people are dying of COVID, and of course, you
14 missed my last three slides. One of them was of
15 Ellis Marsalis, who is a jazz great, a phenomenal
16 teacher, father to some incredible jazz
17 musicians, who has died.
18 And so we can't lose sight of that.
19 But there are also people who are going to die of
20 hunger, of neglect, of abuse, of violence. That
21 the social needs that we are encountering in
22 Louisiana and that will be encountered elsewhere

1 as this epidemic advances, are tremendous and
2 unprecedented.
3 And so using something like community
4 health workers in partnership with Unite Us, we
5 created a volunteer registry of 3,000 students,
6 nurses, doctors, dentists, social workers who
7 have volunteered to help to use phone banks to
8 get people the resources they need.
9 And I think we really have to think
10 about that. And our Office of Public Health,
11 we're fortunate that we have 64 parish or county
12 health units. And those individuals right now
13 are not doing the normal vaccine and family
14 planning type of work they do. They actually are
15 staffing the command center and helping to deploy
16 resources throughout the state.
17 And so I think this is a real wake up
18 call for states that don't have that type of
19 public health resource. That local public health
20 is extremely important. And when you don't have
21 that local trust in public health leaders, the
22 doctors, the nurses, the social workers, on the

1 ground, in communities that are vulnerable, you
2 really lose out.
3 And we had lost a lot in the general
4 administration. In fact, 500 nurses were let go.
5 But fortunately, we have what we have.
6 And it's been a game changer here.
7 MR. GOSTIN: Yeah. Thank you,
8 Rebekah. That's -- and you made some important
9 points. And we've talked about how we apply
10 these ethical and legal standards in hospitals,
11 and we've also looked at congregate settings like
12 prisons or nursing homes.
13 But we have to remember the vast bulk
14 of people are sheltering in place. They're on
15 stay at home orders. Many of them are
16 vulnerable. Many of them need care.
17 And we need to think about how we can
18 triage care for them. And not just physical care
19 for their health conditions, but also mental
20 health and emotional health. I think these are
21 really critical.
22 So the next --

1 DR. KAHN: Larry?
2 MR. GOSTIN: Yes, please. Just jump
3 in.
4 DR. KAHN: Let me just, yeah, let me.
5 One of the things you said, I think it bears
6 emphasis, which is the health system that we
7 have.
8 And you know, we all know this, but
9 I'll say it out loud. I was on a call earlier
10 today with a colleague in the UK, and talking
11 about what we were facing.
12 And he said, you know, the NHS would
13 just move ventilators from one place to another
14 as they're needed, where the outbreak demands.
15 And it, you know, makes the point that what we
16 call a health system is quite different than what
17 health systems are like around the rest of the
18 world.
19 And it's shining a light, a very, I
20 don't want to say harsh light, on some of the
21 aspects of what is our fragmented health
22 care system. And the kinds of things that
we're,

1 Rebekah and you were talking about in terms of
2 the fragility of this safety net for things like
3 housing and food security, and providing
4 health care.
5 So by way of an observation rather
6 than something we ought to do, but maybe we learn
7 from this, what we're going through, and do
8 better going forward.
9 MR. GOSTIN: Yeah. You know, we've
10 never seen anything quite like this. And you
11 know, with the sheer scale for what we're seeing.
12 Not just the health consequences, but
13 the vulnerability and the social isolation in
14 various settings, whether it's long term care,
15 hospital care, acute care, or in the home or
16 homeless shelters. These are critical things.
17 DR. HICK: Yeah. At the same time,
18 Larry, just a quick point. This has the
19 potential to be transformative for American
20 medical care. And the use of telemedicine and
21 the leveraging of --
22 MR. GOSTIN: Right.

1 DR. HICK: Many other techniques, you
2 know, to deliver medical care. And I'm
3 profoundly concerned about some of the chronic
4 illness care that's not happening.
5 And even some of the acute illness
6 care that isn't happening because of COVID.
7 People not seeking care for their chest pain, for
8 their stroke symptoms.
9 MR. GOSTIN: Yeah.
10 DR. HICK: For other things they need
11 to be seeking care for. So we have challenge but
12 also opportunity even, you know, to redesign
13 things essentially for the future here.
14 MR. GOSTIN: Mm-hmm. Yes.
15 DR. GEE: So John, I just want to
16 weigh in. In Louisiana we've had a 30 percent
17 decrease in some hospitals in stroke and MI
18 presentation, which is highly concerning. So
19 it's reinforcing your point.
20 MR. GOSTIN: Yeah. I mean one of the
21 things we know, and from epidemics from Ebola to
22 any of the other major epidemics, is that

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1 actually more people die of ongoing conditions
2 than they do of the -- the focus disease itself.
3 And so that's a really very important
4 reminder. And the other thing that you said was
5 really critically important, is that we're going
6 to have to learn from this, because one day
7 COVID-19 will be over.
8 And we're going to have to restructure
9 things. We'll have to restructure our health
10 system, our hospital system, the way we do remote
11 medicine, and also the kind of social and income
12 supports that we give to our vulnerable
13 populations.
14 So these are really, you know, crucial
15 ideas. Let me -- this next one is for Rebekah to
16 start, but anybody can jump in. Rebekah, you
17 mentioned that training and guidelines are needed
18 for clinicians to step into emergency roles. Can
19 that happen in real time soon enough to make a
20 difference?
21 Could you comment on medical and other
22 health professionals, students, coming into high

1 intensity situations?

2 DR. GEE: So we've had big challenges.
3 And we created this volunteer network and
4 partnership with UL, our University in Lafayette
5 and LSU.

6 And 3,000 people signed up, 2,000 of
7 them health professional students. And we're
8 really having challenges with schools and
9 facilities. For example, our convention center
10 not wanting students there. Worried about PPE,
11 worried about exposure.

12 So I think we need to do a better job.
13 Certainly the accrediting body is ACGME, and AAMC
14 can work to come up with guidelines for what is
15 an appropriate role for a medical student, for a
16 nursing student, or a PA.

17 You know, and let's get that done.
18 There's no reason to delay that. And we have
19 lots of folks who are sitting at home now who
20 could be doing, you know, including our fourth
21 year medical students, many of them.

22 You know, NYU graduated early. Ours

1 are here. We're worried about them not having
2 enough practice and some other considerations.
3 And so why can't they be doing some of this? Why
4 can't individuals who are getting ready to start
5 residencies or who are, you know, off duty right
6 now be doing some drilling?
7 So I don't see any reason why this
8 couldn't start now. And many parts of this
9 country are not under extreme risk like we were
10 for the past two weeks.
11 And we need to be prepared. And
12 again, the one thing I've learned, and I'm sure
13 Nicki could reinforce this, is that one of the
14 things you see in a crisis is this false scarcity
15 mentality.
16 You see -- I saw it on September 11th
17 when we emptied the hospital. When I was doing
18 my sub-I, thinking that you'd have tons of trauma
19 patients coming in. They never came. And we
20 actually put really vulnerable people in the
21 community who didn't need to be there.
22 And in Baton Rouge where we had

1 shelters, and we were giving people medications
2 out of whatever stock that might not have been
3 safe, thinking oh, they won't have it. And of
4 course, there was a Walgreens a mile and a half
5 away. So we've got to be able to be logical when
6 these things happen. And planful. And have
7 these things planned ahead of time.
8 And it's exactly what should be
9 happening in parts of the country now that are
10 not yet hit. And in parts of the country that
11 have been past their peak.
12 MR. GOSTIN: Thanks. We've only got
13 a few minutes. So I'm going to summarize a few
14 questions. And then if each of you just gives us
15 say a 30 second take away.
16 You know, one is, you know, how can we
17 embed local and cultural values into these
18 decisions? Whether we can offer any resources
19 for clinicians to learn about the ethics of
20 crisis standards of care?
21 And then finally, and most
22 importantly, and we've raised this before. But

1 as we learn from this, and we think toward the
2 future, what is the biggest take away that you've
3 got about what knowledge we've gained, what
4 lessons we've learned, and what we can do in the
5 future?
6 So why don't we take 30 seconds from
7 each of you? Perhaps John, Rebekah, and then
8 Jeff.
9 DR. HICK: Wow, with 30 seconds. Okay.
10 I think we've learned --
11 MR. GOSTIN: Yeah, sorry.
12 DR. HICK: I think we've learned that
13 the 2012 principals that the IOM outlined, you
14 know, fairness, transparency, proportionality,
15 accountability, all those things are absolutely
16 critical.
17 And the conversation with the
18 community and determining their priorities, you
19 know, now and as we go into the future, is
20 absolutely critical. And trying to defuse the
21 care that we provide across as much of a region
22 as possible, and use those resources maximally

1 and consistently.
2 And having clinicians applying a
3 uniform set of criteria and in a systems way, so
4 that they're not burdened with that moral injury
5 at the bedside of having to make tough choices.
6 I think all of those things, the
7 strength of those principles and those practices
8 has been emphasized throughout this. And we want
9 to continue to emphasize our commitment to
10 fairness and equity, and all of those values
11 across the community as we go through this and
12 beyond.
13 MR. GOSTIN: Thank you. And Rebekah,
14 what do you think are the top lessons we've
15 learned to make us better prepared in the future?
16 DR. GEE: Well I think it's -- I guess
17 it's a shock to me, but it shouldn't be, that we
18 were unprepared. We were grossly unprepared for
19 this. That we did not have a supply of
20 ventilators. We didn't have a plan for PPE. We
21 had not done the kind of drills.
22 We hadn't thought about where things

1 were being sourced from. You know, running out
2 of fobs because they were made in northern Italy.
3 So now we can't test patients.
4 And all of these things are things
5 that hopefully we'll learn from. Planfulness,
6 number one. Number two is public health. Is
7 that public health disinvestment and the lack of
8 support for public health, we are paying the
9 price for it.
10 In the CARES Act there is a
11 tremendous, trillions of dollars will be spent on
12 this. Many people will die. You know, if we had
13 had better systems of surveillance and testing,
14 some of this, much of this probably could have
15 been avoidable. Shame on us if we don't fix it
16 going forward.
17 And if we don't invest in the types of
18 people in public health infrastructure that help
19 us deal with these types of pandemics, because
20 they are not ending. It's a global world.
21 You're in Wuhan one day, in Wisconsin the next.
22 And then finally I think some are

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1 surprised by, but shouldn't be, that this is
2 really a stress test showing the disparities and
3 the inequalities in our society. And that
4 health care should be, in my view, and
5 hopefully in others', a human right. But that
6 even if you don't believe that, that the health
7 of one person impacts the health of entire
8 communities.
9 And even for that reason alone, for
10 selfish reasons, we should want the American
11 public to be healthy. And help support efforts
12 that bolster health, whether through health
13 care or efforts that promote healthy
14 communities. So I think all that are -- all
15 those things are important learnings.
16 MR. GOSTIN: Thanks Rebekah. Jeff,
17 you are our last take away before I turn it back
18 over to Nicki to conclude.
19 DR. KAHN: Great. Thanks. And I'll
20 be quick. I want to just reiterate. Public
21 health planning matters. We've learned that in
22 spades. We can coordinate rapidly when we need
to, which has been a really interesting lesson to

1 me. So things that seemed insurmountable and
2 would take weeks or months, can happen now within
3 hours and days when it needs to.
4 And then the last thing I'll say is,
5 the idea about community priorities that John
6 mentioned, I think is really interesting. But I
7 think it's -- we're seeing that people think a
8 little differently as we're living through this
9 than they did in prospect.
10 So I think there will be some good
11 work to be done in retrospect, learning from
12 this, so that we can embed community values into
13 the next time we need to plan for this.
14 MR. GOSTIN: Well that's wonderful.
15 I just want to thank John, Rebekah, and Jeff for,
16 you know, a wonderfully educational and vital
17 discussion about how we get through this pandemic
18 with an intact and functioning health system.
19 I also want to thank the academies and
20 the American Public Health Association. And turn
21 it over to Nicki with our thanks for planning and
22 leading this. Nicki, over to you for the final

1 concluding remarks.

2 DR. LURIE: Great. Well thank you.
3 And let me just reiterate my thanks to you,
4 Larry, and to the panelists and all of the staff
5 and our advisory committee who have really helped
6 to plan this.

7 You know, as I have listened to this
8 incredibly rich and robust conversation, you
9 know, I think back to many of the things that I
10 used to talk about when I was in government, and
11 that I still really firmly believe.

12 And the first thing I would say is
13 that good response is built on the back of strong
14 day to day systems. You respond with the system
15 you have in hand, not the system that you wish
16 you had in hand.

17 And so as I think about this
18 conversation, I think about: in our strong day to
19 day system, are we always providing the best care
20 possible? I think we probably have to say in
21 many circumstances the answer is no.

22 In our strong day to day system, are

1 we always stewarding scarce resources? You know,
2 I volunteer in a community clinic where resources
3 are scarce. And I see lots of probably not very
4 necessary tests get done all the time. So the
5 answer there is probably we have room for
6 improvement.
7 John and I have worked together on a
8 number of shortages day to day. Not things that
9 ever required crisis. Whether it's a shortage
10 of blood or a shortage of normal saline, or a
11 shortage of an anesthesia medicine, or anything
12 else.
13 I think what we've seen there is that
14 institutions that have come together and thought
15 about how not to get into a crisis, but plan,
16 make these contingency plans and conserve and
17 reuse and substitute, those folks that have put
18 those day to day systems in place seem to have a
19 leg up in dealing with the very difficult
20 situations that we have now.
21 A strong day to day system does better
22 if you have a structure. And so we've talked

1 about, and John talked about working through an
2 ICS structure in this kind of a situation.
3 And one of the things that that does
4 a well, is it helps mitigate the panic, and I
5 think the rush to crisis standards of care. You
6 have to go, or you ought to go through the
7 contingency process before you get to crisis.
8 Strong day to day systems know their
9 communities in advance and incorporate their
10 communities into planning and execution. And
11 strong day to day systems do everything they can
12 to ensure equity.
13 It's not just about a ventilator here.
14 What we know, it's about PPE. It's about
15 testing. It's about people who have to stay at
16 work driving buses, working in grocery stores, et
17 cetera. And thinking about now equity, as we
18 think about who's going to be able to return to
19 work, right? And are you going to need a test?
20 Are you going to have to pass certain
21 other requirements? What's going to happen here?
22 There's a lot of equity considerations still

1 ahead of us that we need to think about.
2 You know, I think we all know that no
3 plan, no matter how good it is, survives first
4 contact with the enemy. But it sure is easier if
5 you've thought through these circumstances before
6 than if this is the first time you are thinking
7 about crisis standards of care.
8 And then finally, while we would not
9 have wished this disaster on anyone anywhere in
10 the world, never let a good crisis go to waste.
11 And so as I think we've heard, I mean, we're all
12 impressed by the amazing creativity we've seen.
13 The amazing state and local and institutional
14 leadership we've seen.
15 And as John said, this is an
16 opportunity for us to think about important
17 aspects of redesign. Whether it's we're on the
18 cusp of something that looks closer to universal
19 coverage that we can expand access through health
20 system reform, and through telemedicine, and
21 through other sorts of things.
22 But there's tremendous opportunity

1 here. And it's probably a good thing for us all
2 to be thinking about that as well. So with that,
3 I will just say that this all concludes today's
4 webinar. Our next webinar will be next
5 Wednesday, April 22nd, again at 5:00.
6 And we'll focus on COVID-19 and
7 testing. And what this next generation of
8 testing might look like. Everyone who registered
9 for the webinar will receive an invitation to the
10 next one. And for those of you who missed parts
11 of this or want to share this with friends, this
12 webinar has been recorded.
13 And as I said in the beginning, the
14 recording, a transcript and slide presentations
15 will be made available on the website,
16 covid19conversations.org.
17 Again, thank you so much to our
18 panelists, to APHA, to NAM for sponsoring this
19 series. And thanks for our listeners for joining
20 us today. Stay healthy and safe. Take care.
21 (Whereupon, the above-entitled matter
22 went off the record at 6:32 p.m.)