

**Arizona Crisis Standards of Care
Legal/Ethics Work Group
July 17, 2013 8:30-10:00
Black Canyon Conference Center**

Meeting Minutes

Presiding: Peter Kelly, M.D.

Infectious Disease Specialist, AzDHS

Attendees: Connie Belden, AzDHS Division of Licensing Aubrey Joy Corcoran, Office of Arizona Attorney General
Jan Elezian, Scottsdale Healthcare Cheryl Frush, Arizona Board of Pharmacy
Tim Hartin, Tucson Medical Center James Hodge, ASU, Sandra Day O'Connor School of Law
Daniel Orenstein, ASU, Public Health Law and Policy Greg Vigdor, Arizona Hospital and Healthcare Association
Lisa Wynn, Arizona Medical Board Frank Walter, U of A, Department of Emergency Medicine
Gregory Measer, Arizona Center for Disability Law Asim Varma, Arizona Center for Disability Law
Karen Ashley, Chief, Maricopa County, Office of the Attorney General
Joel Bunis, Maricopa County Department Office of Public Health. Emergency Preparedness
Don Herrington, AzDHS, Public health Preparedness

Staff: Teresa Ehnert, Bureau Chief, AzDHS, Public Health Emergency Preparedness
Andrew Lawless, Project Manager, AzDHS, Public Health Emergency Management

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| | <p>ethical aspects related to crisis standards of care (CSC) was stressed. The tasks of the work group were delineated in the Charter (appended to these minutes). Information on the recent Institutes of Medicine (IOM) Crisis Standards of Care Project was presented. Examples of the type of crisis that CSC would need to be invoked were discussed. A diagram (appended to these minutes) was used to further clarify the relationship of number of people to amount of resource needed during normal day to day operations. The three “Cs” were presented (see appended diagram)</p> | | |
| Today’s Work | <p>The focus of the work group for this meeting was the potential legal issues associated with CSC and identifying the legal barriers that may exist in implementation. Discussion ensued regarding the current protections in place in the state of AZ and at the federal level. A handout was distributed by ASU, College of Law regarding “selected legal issues of concern to health care practitioners and entities responsible for emergency preparedness” from <i>Legal Issues in Emergencies</i></p> | | |
| Liability | While there is sufficient liability | Using the IOM policy approach in the | Develop plan to create |

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| <p>Protections</p> | <p>protections in place for individual professionals there are none for hospitals/healthcare organizations in general. These are critical for healthcare institutions due to their role as custodians of resources: the fundamental way they operate and prioritize and distribute/allocate resources. There is a critical need for broad language to cover liability/financial damages and to avoid malpractice defense costs.</p> <p>What needs exist for rural hospitals that do not have the resources urban ones have?</p> <p>EMTALA limits hospitals flexibility in moving patients to right level of care. A federal waiver by HHS can alleviate this but for those in the Medicare Program, CMS must waive the requirements at a regional level</p> | <p>plan may afford some coverage.</p> <p>Experts from ASU indicated that when a state declares a disaster and is implementing federal remedies, institutions are covered.</p> <p>Prep Act: Activated by HHS in public health emergency. HHS can authorize federal declarations for states and regions.</p> <p>The AG's Office cautioned that there is still a need for AZ state liability protection for medical institutions.</p> <p>Under a declared disaster public health can waive all state licensing regs EXCEPT the requirement for hospitals to implement their disaster plans and does NOT APPLY to those hospitals receiving Medicare reimbursement.</p> <p>Rules and regs can be waived by a directive from the state health director.</p> <p>CMS for those participating in Medicare and Medicaid require an institutional waiver that can only be issued under a federal declaration of emergency.</p> <p>No federal act exists that provides</p> | <p>institutional liability protections. Borrow from states that have enacted the same.</p> <p>Match rural hospitals with urban hospitals via MOUs. Do the same for tribal healthcare resources.</p> |
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| <p>Scope of Professional Practice</p> | <p>Healthcare Professional practice is governed by the state practice acts and monitored by specialty professional boards. In the event of an extreme disaster, at what point could the scope of practice be broadened to care for a greater number of the community. Do the professional boards have the ability to change the scope of practice in an extreme emergency? What type of training will be required to ensure public safety?</p> <p>Reciprocity for out of state practitioners?</p> <p>Discussion ensued regarding limitations of practitioners.</p> <p>MDs' focus of practice is medicine, in the state they are limited by their liability insurance and hospital credentialing.</p> <p>PAs' have a supervision issue.</p> <p>NPs and APNs are a vital resource.</p> <p>Pharmacists can provide injections.</p> | <p>blanket liability coverage in a disaster.</p> <p>Changes in scope must address; Patient safety Professional liability Supervision</p> <p>Discuss possible recommendations with Medical Board, Board of Nursing, Board of Pharmacy. Board of Osteopathy, and Mental Health</p> <p>Determine education and training needed for increased scope of practice. Would require executive orders addressing what the medical professionals can do in a disaster. There needs to be some specifics decided upon to enable the appropriate training whether 'just-in-time' or over the long haul.</p> <p>Review military training model and enhanced scope of practice. Medics in the military are not authorized to practice in the civilian setting at the level to which they are trained. His is a natural assist for medical support for surge.</p> | <p>Summarize current scope of practice by profession for next meeting.</p> <p>Professional Boards make recommendations on crisis care scope of practice.</p> <p>Obtain legislation passed in Colorado as a guide.</p> <p>Propose legislation for Arizona regarding enhanced scopes of practice during times that CSC is implemented. The SDMAC should have authority to call the question.</p> |
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| | <p>RNFAs' to what extent can their scope be broadened to preform minor surgery</p> <p>Nurse Anesthetists ability to function independently, supervision issues</p> <p>EMTs' ability to function at a level of LPN/RN</p> <p>Mental Health providers broaden CISM training</p> | | |
| Ambulatory Setting | <p>The plan and recommendations must address the continuum of care and encompass all at risk populations. Safe guards to protect at risk populations (i.e. those with disabilities, children, and seniors) in providing care with qualified medical personnel vs. personal caregivers, family members and specialized equipment must be a major consideration. These resources are an asset if appropriately recognized by the healthcare community.</p> | | |
| Summary and Next Steps | <p>Issue identification:</p> <p>Institutional liability protections</p> | | <p>Next Meeting</p> <p>October 2013</p> |

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| | <p>Enhances scope of practice for identified professionals</p> <p>Just-in-time training, examine military model, recognition of same by professional boards</p> <p>Legislation</p> <p>Clarification on CMS, HHS and state waivers</p> <p>Next Steps;</p> <p>Gather information requested</p> <p>Meet with professional boards</p> <p>Review Table 3.1 <i>Legal issues in Emergencies, Crisis Standards of Care</i></p> | | <p>Ethical Issues and CSC</p> |
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Respectfully submitted,

Wendy H. Lyons, RN, BSN, MSL