



May 23, 2020

Re: Comments on Ventilator Allocation Considerations for Wisconsin Hospitals

Dear Dr. Hamedani, State Disaster Medical Advisory Committee (SDMAC) Chair and members of the committee:

The **Wisconsin Aging Advocacy Network** is a collaborative group of individuals and associations working with and for Wisconsin's older adults to shape public policy to improve their quality of life.

Core member organizations:

Aging and Disability Professionals Association of Wisconsin (ADPAW)

Alzheimer's Association Wisconsin Chapter

Wisconsin Adult Day Services Association (WADSA)

Wisconsin Association of Area Agencies on Aging (W4A)

Wisconsin Association of Benefit Specialists (WABS)

Wisconsin Association of Nutrition Directors (WAND)

Wisconsin Association of Senior Centers (WASC)

Wisconsin Institute for Healthy Aging (WIHA)

Wisconsin Senior Corps Association (WISCA)

Wisconsin Tribal Aging Unit Association

The Wisconsin Aging Advocacy Network (WAAN) appreciates this opportunity to comment on the Ventilator Allocation Considerations because older adults have been disproportionately affected by this disease. Those age 60 and older who contract the virus are suffering much greater health consequences from the disease, including death. As of May 22, 2020, 4% of all positive cases (14,396) in Wisconsin received any intensive care. Yet, of the 535 individuals receiving intensive care over 60% were people age 60 and older.¹ While the death rate from COVID-19 is currently at 3% of all positive cases; of the nearly 500 deaths, 87% are among adults age 60 and older.² The possibility of COVID-19 leading to a shortage of mechanical ventilators in Wisconsin remains a very real threat. While presently only 23% of the available ventilators are in use, as communities begin to re-open a surge in positive cases is expected. It is unquestionable that some of these cases will need intensive care. Even if we avoid a shortage of ventilators in the near future, a resurgence of COVID-19 is expected this fall. This second wave of the virus is likely to coincide with the start of flu season and is expected to put a heavy strain on the health care system.³ This is of great concern to the Wisconsin Aging Advocacy Network (WAAN).

WAAN feels strongly that Wisconsin must continue all efforts to secure additional ventilators and supplies, develop ventilator exchange programs, and explore options for creating ICU beds in times and areas of shortage to help ready us for what may come. Additionally, **we believe it is not only feasible but imperative that we use this time, as many other states have done, to prepare guidance (not considerations) for our state's hospitals for the triage of critically ill patients before COVID-19** (or another public health emergency) **creates demand for intensive care resources that exceed our state's supply.** Older Wisconsinites, and patients of all ages in need of intensive care, must be protected against potentially discriminating allocation decisions and from the inequities that may exist as each hospital develops its own guidelines with little or no transparency or community input. As stated by DHS Chief Medical Officer Westergaard and Meiman in the Ventilator Allocation Considerations document, "Ideally, uniform guidelines would exist across the state in order to avoid 'hospital shopping' and to prevent understandable distress in individuals who see different criteria being used in different hospitals." WAAN strongly agrees that there is a need for the development of uniform guidelines for Wisconsin hospitals and asks that this work begin immediately, and that the work be informed by ethicists, disaster medicine experts, and citizens (including those at higher risk of severe illness from COVID-19 – older adults and people of any age who have serious underlying medical conditions). State established guidelines would provide hospitals that have already developed their own policies an opportunity to review them and make any necessary changes to ensure consistency. For those hospitals that have not yet developed their policies, state guidelines would provide the needed framework for development of their plans.

Contact WAAN

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WAAN supports some of the ventilator allocation considerations prepared by DHS (and would support their inclusion in state issued guidelines), specifically that the allocation guidelines should: 1) be transparent; 2) include input from the community; 4) apply to non-COVID-19 and COVID-19 patients equally; 7) be mindful of greater co-morbidity burden for patients harmed by health disparities; and 9) should clarify that patient's home ventilator should not be considered community property.

WAAN also supports the two additional guiding principles included in the document: 1) A patient's refusal of mechanical ventilation should always be respected; and 2) All patients are entitled to palliative care.

WAAN has specific concerns about and suggestions for the following considerations – Allocation guidelines should:

3) be based on medical considerations only (no discrimination based on ability to pay, race, ethnicity, sex, gender, gender identity, self-identification as LGBTQ+, disability status, incarceration status, and immigration and citizenship status). WAAN supports the allocation of critical resources based on medical considerations and feels that **no discrimination based on age** (among all the other factors listed) **should also be included** as it relates to allocation based on medical considerations;

5) treat withholding and withdrawing life-sustaining treatment as ethically equivalent. WAAN supports treating withholding and withdrawing life-sustaining treatment equally, but we believe the appeals process for withdrawing a scarce resource should be more robust than for withholding a scarce resource;

8) consider the ethical principle of 'fair innings.' **While it is not uncommon for this life cycle principle to be incorporated into triage guidelines, it is generally part of a multi-principle strategy.** Some critics contend the use of fair innings as a criterion in any triage plan is ageist, while others feel this principle is justified as it seeks to give *all individuals* equal opportunity to live a normal life span (and therefore treats all people equally). **WAAN feel it is insufficient for the considerations to include, "While this should not be the overriding factor, it should be considered in allocation guidelines," without providing additional details as to where this principle fits in a multi-principle strategy.** What are the principles included? What are the levels? When should it be used/not used? Is this principle to be used as a tiebreaker if patients score equally on multiple other principles; and

10) should ideally be executed by a Clinical Triage Team that reports to a Clinical Triage Team Oversight Committee. WAAN wholeheartedly supports the use of a clinical triage teams and a clinical triage team oversight committee; however, **WAAN believes the Oversight Committee should not avoid an appeals process** [as suggested in the considerations], **but should be actively involved in establishing, implementing, and monitoring an appeals process.**

Bioethicists at the University of Pittsburgh Medical Center (UPMC) in consultation with citizens and disaster medicine experts developed a framework to allocate medical resources to patients based upon how they score on an 8-point scale. The framework created by UPMC includes three sections. Section one describes the creation of triage teams that will apply the allocation framework developed by UPMC, assist with appeals of triage decisions, and in collaboration with the attending physician communicate triage decisions to patients and families. Section two addresses the allocation criteria for ICU admission/ventilation based upon likelihood of surviving to hospital discharge (e.g. SOFA score) and the presence of underlying medical conditions that severely limit prognosis for *near-term* survival even if the patient survived the acute critical illness. Section three outlines a **reassessment process** for ongoing provision of critical care/ventilation (there is no mention of reassessment in the DHS considerations). UPMC guidelines state the triage committee will conduct periodic reassessments of all patients receiving critical care services during times of crisis -- not just initially. The UPMC framework does not use categorical exclusion criteria, gives priority to patients expected to survive to discharge and who do not have a poor prognosis for near-term survival, and does not incorporate long-term life expectancy into priority scores. The latter could disadvantage patients with decreased long-term life expectancies from disabilities or diseases exacerbated by social inequities.⁴ The UPMC guidelines suggest life-cycle (fair innings) considerations be used as a tiebreaker after applying the scoring from the 8-point scale (which includes two separate assessments). They also recommend specific age categories for the life-cycle principle.

As of mid-April, several hundred hospitals nationwide were planning to either adopt or consider UPMC's guidelines, including those of Pennsylvania State University, Yale, and Kaiser Permanente.⁵ The state of Pennsylvania was expected to endorse the UPMC framework for its 300+ hospitals and several other states are considering following suit.⁶ Massachusetts recently released guidance to hospitals in their state regarding rationing of ICU beds and ventilators and indicated their guidelines "closely follow" the UPMC proposal.⁷

WAAN appreciates the countless hours of work the SDMAC and its subcommittees and workgroups have devoted to these critical issues. We encourage you to engage with citizens and their advocates to develop guidelines to provide much needed direction on ventilator allocation and other critical resources (ICU beds, ventilator supplies, and in the future vaccines.) Resources are available from other states, local hospitals, and the CDC. WAAN and other stakeholders and partners remain available to assist in the development of allocation guidelines. Your leadership is needed to ensure the citizens of Wisconsin will receive the best care possible if demand for life-sustaining resources ever exceeds Wisconsin's available supply.

WAAN is a collaborative group of 10 statewide associations and numerous individuals working with and for Wisconsin's older adults to shape public policy to improve their quality of life.

Sincerely,



Robert J. Kellerman

WAAN Chair

References

¹<https://www.dhs.wisconsin.gov/covid-19/cases.htm>

²<https://www.dhs.wisconsin.gov/covid-19/deaths.htm>

³<https://www.cnn.com/2020/05/02/health/coronavirus-second-wave-fall-season/index.html>

⁴https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy_2020_04_15.pdf

⁵<https://www.beckershospitalreview.com/supply-chain/upmc-develops-8-point-system-to-allocate-scarce-ventilators.html>

⁶<https://www.statnews.com/2020/04/02/ventilator-icu-rationing-pittsburgh-framework/>

⁷<https://www.boston.com/news/local-news/2020/04/08/massachusetts-guidance-ration-ventilators-icu-beds-coronavirus>