



NORTHWEST OHIO

HEALTHCARE EMERGENCY MANAGEMENT COALITION

**The Northwest Ohio Healthcare Multi-Agency Coordination System (HMAC)
of The Northwest Ohio Healthcare Emergency Management Coalition
Proposed Interim Guidance for Allocation of Scarce Resources
During Catastrophic Disasters in Northwest Ohio
With Specific Attention to COVID-19
April 2020**

Background

Disasters, by their very nature, can be defined as inherent imbalances between the number of victims and the amount of resources. Fortunately, in the United States, the majority of disasters or mass casualty incidents are narrowly located, limited in scope, victims, and duration. Any imbalance that occurs is temporary and quickly remedied because the healthcare infrastructure remains intact. The need to allocate scarce resources is virtually non-existent. For complex disasters, such as Hurricane Katrina, the imbalance is more prolonged because the infrastructure is reduced to shambles. The tendency to allocate those resources to a stricken population can be more problematic. Life and death decisions without the proper planning, guidance and training can be arbitrary, opaque and erroneous without any opportunity for review and accountability.

Since the SARS global epidemic in 2005, intensivists and ethicists have published a myriad of literature addressing the issues of allocation of scarce resources, inclusion/exclusion criteria, and withdrawal of care issues if the world would ever be faced with a catastrophic disaster, such as a pandemic or a nuclear holocaust. While there is much agreement among published articles, there are also marked differences. There is no “one-size-fits-all” dogma. The federal and state governments have not yet enforced one standard set of guidelines. To assist institutions with developing and updating policies or guidelines, regional and state organizations are releasing common ethical, legal and clinical frameworks that document the allocation of scarce resources.

In keeping with the basic tenet that “all disasters are local,” the Northwest Ohio Healthcare Emergency Management Coalition (“Coalition”) through its Northwest Ohio Healthcare Multi-Agency Coordination System (“HMAC”), appointed the Northwest Ohio COVID-19 Care and Resources Task Force (“CCRTF” or “Task Force”) to develop regional guidance (“Guidance”) to assist HMAC hospitals. The Task Force members collectively, have a long history of addressing

these issues within their own professions. This Task Force used its multi-disciplinary expertise from across the Region to construct allocation of scarce resources guidance (also referred to as “Guidance”) for consideration by HMAC hospitals, with the understanding that each hospital has sole authority for the policies and procedures it adopts.

This guidance is based on an ethical framework that’s been promulgated since 2005.

I. **CCRTF’s Ethical Framework**

- a. **Fairness** – This Task Force intends to create standards that are, to the highest degree possible, recognized as fair and non-discriminatory by all those affected by them. That includes those affected in all socio-economic communities, practitioners, and provider organizations. These standards, as much as possible, will be evidence-based and responsive to specific needs of individuals and the population.
- b. **Duty to care** – These standards are focused on the duty of healthcare professionals to care for patients while keeping themselves as safe as possible rendering that care. Additionally, this Task Force recognizes and accepts that healthcare professionals may have conflicting obligations relative to themselves, their families and dependents.
- c. **Duty to steward resources** – Healthcare institutions and public health officials have a duty to steward scarce resources. This reflects the utilitarian goal of saving the greatest possible number of lives.
- d. **Transparency** – In design and decision-making, the ultimate goal is to present this Task Force’s accepted final document to its regional constituency for review.
- e. **Consistency** – The intention is to demonstrate that the proposed Guidance and principles will be applied across all populations within the NWO Region and among its individual constituents regardless of their human condition (i.e., non-discrimination based on race, age, disability, ethnicity, ability to pay, socioeconomic status, pre-existing health conditions, social worth, perceived obstacles to treatment, and past use of resources).
- f. **Proportionality** – The public and individual requirements and sacrifices can change as the pandemic progresses. However, the Task Force will strive to ensure that any change in healthcare delivery must be commensurate with the scale of the emergency and degree of scarce resources.
- g. **Accountability** – The intent is to document and review individual decisions and implementation standards in order to ensure that appropriate protections and just allocation of available resources are maintained.
- h. **Meaningful Access to Care** – The intent is to create meaningful access for all patients without exclusion criteria based on age or disabilities, to ensure that all patients receive individualized assessments by clinicians, based on the best objective medical evidence and to ensure that no one is denied care based on stereotypes or unwarranted judgments about a person’s worth or quality of life based on the presence or absence of disabilities.

II. CCRTF's Legal Framework

This Guidance will operate within local, state and federal legal rules and regulations, including any Ohio directed rationing protocols concerning the allocation of scarce medical resources. The CCRTF's legal framework will be guided by, but not limited to the following regulations and principles:

- a. The U.S. Department of Health and Human Services Office for Civil Rights ("OCR") Bulletin dated March 28, 2020 and the Consortium for Citizens with Disabilities' ("CCD") March 20, 2020 letter to Congress to safeguard disability communities.
- b. The Americans with Disability Act of 1990 ("ADA") and Section 504 of the Rehabilitation Act of 1973 ("Section 504") require that decisions concerning whether an individual is a candidate for treatment should be based on individualized assessments of the person, using current objective medical evidence, and not based on generalized assumptions about a person's disability.
- c. The ADA and Section 504 sections that prohibit treatment allocation decisions from being based on misguided assumptions that people with disabilities experience a lower quality of life or that their lives are less worth living.
- d. The ADA and Section 504 sections that prohibit treatment allocation decisions from being based on the perception that a person with a disability has a lower prospect of survival.
- e. The ADA and Section 504 sections that prohibit treatment allocation decisions based on the perception that a person's disability will require greater treatment resources.

III. **Capacity**

The generic definition of "capacity" deals with the maximum amount of any resource that can be employed to address any given incident, situation, or event. In keeping with the pandemic literature, the Task Force accepted the following criteria:

Capacity definitions (3 stages):

- a. **Stage 1: Conventional capacity** – The spaces, staff, and supplies used are **consistent with daily practices** within any healthcare institution or agency practicing in NWO.
- b. **Stage 2: Contingency capacity** – The spaces, staff, and supplies used are not consistent with daily practices but provide care to a standard that is **functionally equivalent to usual patient care practices** within any healthcare institution or agency practicing in NWO.
 - 1) NWO is in Stage 2 (Contingency Capacity) as of April 20, 2020.
- c. **Stage 3: Crisis capacity** – Adaptive spaces, staff, and supplies are **not** consistent with usual standards of care but **provide sufficiency of care** in the setting of a catastrophic disaster (i.e., provide the best possible care to all patients, given the circumstances and resources available). Crisis capacity activation constitutes a **significant** adjustment to standards of care and could result in the activation of rarely used decision-making principles by clinicians.

The adjustments which are of specific interest to a healthcare institution and which have been extensively discussed, debated, excerpted, and modified include:

Exclusion Criteria:

- 1) There are patients who emergently enter the healthcare environment in extreme circumstances that rapidly exhaust medical resources. Because of their acute medical condition, in the presence or absence of any co-morbidities in an environment that drastically weakens resource thresholds, it has been deemed by their clinicians' expert opinion and evidence-based data, that the expenditure of scarce resources (e.g. ICU rooms, ventilators, PPE, etc.) would not improve or prolong their survival despite intensive care. Additionally, the use of such scarce resources by a patient who has very low probability of survival could preclude their use by another patient who would, according to evidence-based criteria, have a higher likelihood of survival and improved prognosis, based on expert clinical opinion.
- 2) Examples of such Exclusion Criteria accepted by the Task Force are:
 - Sequential Organ Failure Assessment ("SOFA") score equal to or greater than 11 (See Appendix A for SOFA Table);
 - Cardiac arrest unwitnessed and/or recurrent arrest unresponsive to standard measures (defibrillation and pacing);
 - Severe trauma with Trauma Injury Severity Score & predicted mortality of >90%;
 - Severe burns with predicted mortality of >90%;
 - Pre-existing or persistent coma or long-term vegetative state with little or no chance for survival;
 - Documented end-stage organ failure (cardiac, pulmonary, hepatic) with little or no chance for survival; and
 - Patient preference when patient is of sound mind.
- 3) Any patient, who meets these Exclusion Criteria will continue to receive alternative evidence-based medical therapy and/or expert palliative care or be discharged home as deemed clinically appropriate by the immediate care-giver in charge.
- 4) A patient or family member may appeal a decision if they believe there has been an error. An institution's Chief Medical Officer or other qualified surrogate will manage the appeal process to review their Triage Team's analysis and determine whether the aforementioned criteria were applied properly.

Inclusion Criteria:

- 1) Any patient that does not meet the aforementioned Exclusion Criteria will receive any and all available medical resources to improve their survivability.

- 2) However, the utilization of one or more scarce resources by any one patient is not permanent. It is principally conditional, depending on the scarcity of a specific resource (e.g. ventilator) and the evidence-based benefit of a particular scarce resource for a patient.
- 3) The premise behind the reassignment of a particular scarce resource is that there is another patient whose prognosis indicates a more favorable and immediate outcome.
- 4) The inclusion and reassignment of scarce resources' criteria are key accepted aspects of the medical ethical literature. However, the specifics differ from one guideline to another.
- 5) Time trials
 - In order to gauge whether a patient is benefitting from any scarce resource, **SOFA** scores will be the primary means of assessment. In extreme circumstances, possible re-assignment of that particular resource to another patient will be made, only when deemed clinically appropriate by a pre-designated clinical team.
 - The SOFA or modified SOFA score has been deemed the most appropriate and expeditious scoring system in the pandemic and ethical literature. It provides a quantitative prognosis for short-term survival by using only clinical factors (See Appendix A).
 - For each patient, SOFA scores are recorded daily. If there are specific clinical factors that indicate a particular scarce resource may be reassigned, the SOFA time-trial scores at 48 hours, 120 hours, and every 48 hours thereafter have been used for reassignment. These time trials are associated with an influenza pandemic according to prior states' guidelines.

Because COVID-19 patients maintain a propensity for a longer duration in an ICU setting before improvement, the Task Force proposed that the COVID-19 SOFA time trials should be established no later than every 120 hours.
 - If a patient develops an acute and permanent deterioration (based on clinical judgement), the SOFA score at the time of the sudden deterioration may be used if reassignment of that patient's resource is likely.
 - In the event that two or more patients have the same SOFA score, the internal Triage Committee may review additional clinically-relevant data (including other pertinent validated scoring systems) to determine how a resource may best be allocated when necessary.
 - The development of this type of "tie-breaker" should be discussed and determined during planning meetings and then presented to the CCRTF as a "best practice" for further evaluation.

- If a SOFA score tie occurs between two patients, SOFA scores can be run more frequently to monitor changing conditions to arrive at a final decision. The CCRTF will continue to research additional methodologies to resolve ties in SOFA scores. In the interim, it is the responsibility of the institution to develop a methodology to make a decision that is non-discriminatory, utilizing other relevant clinical prediction tools, including other scoring systems, a randomization or similar process.

IV. **Activation**

As it pertains to disasters, an **Indicator** can be defined as any prognosticator or quantifiable measure of change that would require a demand for available services and/or scarce resources. It may represent a stressor for any given facility that could forecast the potential for movement from one level of care to another. The **Trigger** is the decision point, based on major alterations in the availability of commonly-used resources, that would require adaptation or modification to the delivery of a service in healthcare.

Once an Indicator Threshold is reached at a healthcare facility, the following actions should occur:

- a. Healthcare facility notifies Coalition or HMAC of the situation.
- b. Coalition or HMAC performs an immediate needs assessment.
- c. Coalition or HMAC attempts to resolve the resource problem within a reasonable period of time, within the NWO hospital consortium through mutual aid but if resource problems are not resolved, then
- d. Healthcare facility utilizes its internal decision-making process per its policy to determine its level of capacity as follows:
 - 1) Remain at the current stage.
 - 2) Transition from the current Traditional Stage to Contingency Stage.
 - 3) Transition from the current Contingency Stage to Crisis Stage.

Considerations for Allocation of Specific Resources during a Pandemic

a. Blood products

- 1) Review the American Red Cross and the facility's blood bank policies during both Contingency and Crisis Capacities.
- 2) Crisis capacity guidelines
 - Whole blood considerations:
 - Use ABO-type specific whole blood if components cannot be produced.
 - Packed red blood cells (PRBC) considerations:

- Use cell-saver and auto transfusion to the degree possible.
- Limit O-negative usage to women of child-bearing age.
- Use O-positive in emergent transfusion in males or females (no longer childbearing) to conserve O-negative blood.
- Encourage use of blood-sparing protocols for all patients.
- Prioritize the freshest blood for infants and small children.
- Employ aggressive crystalloid resuscitation prior to transfusion in shortage situations (blood substitutes may play future role).
- Use RBC: Plasma in 1:1 ratio in trauma cases.
- Implement lower hemoglobin triggers for transfusion.
- Consider use of EPO in patients with anticipated acute blood loss.
- Further limit PRBC use, if needed, to active bleeding states.
 - i. Consider subsequent restrictions such as transfusion for treatable shock states only.
 - Modification of transfusion thresholds
- Consider Minimum Qualifications for Survival (MQS) limits on use of PRBCs
 - i. Example: Only initiate transfusion for patients who will require <6 units PRBCs and/or consider stopping transfusion when >6 units are utilized.
 - ii. Specific MQS limits should reflect available scarce resources at facility.

3) Plasma considerations:

- Consider increase in Red cell: Plasma ratio (3:1) in massive transfusion protocols in conjunction with a consultation with blood bank medical staff.
- Encourage early use of plasma in trauma with anticipated massive hemorrhaging and/or brain injury.
 - Thaw early and use blood warmer.
 - Consider use of fibrinolysis inhibitors or other modalities to reverse coagulopathic states.
 - i. For example: Tranexamic acid (TXA), aminocaproic acid, activated coagulation factor use, fibrinogen concentrate, prothrombin complex concentrate, or other appropriate therapies.

4) Cryoprecipitate:

- Encourage early use of cryoprecipitate in trauma with anticipated massive hemorrhaging and/or brain injury. Thaw early and use blood warmer.
- Consider use of fibrinolysis inhibitors or other modalities to reverse coagulopathic states (tranexamic acid, aminocaproic acid, activated

coagulation factor use, fibrinogen concentrate, prothrombin complex concentrate, or other appropriate therapies).

5) Platelets:

- Consider use of desmopressin (DDAVP) to stimulate improved platelet performance in renal and hepatic failure patients.
- Consider aliquoting from apheresis platelets. For children, consider splitting whole blood platelets for more than one recipient.
- Transfuse platelets only for active bleeding, further restrict to life-threatening bleeding if required by situation.
- No prophylactic use of platelets.

b. Cardio-Pulmonary Resuscitation (CPR) Administered during Stage 3 Crisis Periods

CPR, under any circumstances, is a highly challenging aspect of acute patient care. The challenge is accentuated whenever the patient's contagious illness can be a risk factor to responders. This would be the case in any infectious disease emergency (e.g. meningococemia) and, is even more problematic when CPR involves a patient who is proven or suspected of having COVID-19.

While a recent report indicates that the short-term and long-term survivability of CPR in a COVID-19 patient is poor, the decision to provide or withhold CPR is not absolute. It remains a clinical decision on a case-by-case basis. To one extent or another, it is based on patient status, clinical experience and expertise, and the available PPE and staff resources that would serve the patient as well as risk to the responders.

When caring for a positive COVID-19 patient or a possible COVID-19 patient (PUI [person under investigation]) consider the following as they relate to CPR:

1) Heightening team safety:

- Dedicated CPR personnel
 - Familiarize status of patients for new team members or during shift change.
- Table-top exercises
- Simulated scenarios
- Limited personnel during the actual resuscitation

2) Determine code status of each patient before administering CPR

- Communications with patient (when feasible), family, and team.
 - Discussion to include prognosis and projected benefits of CPR, the goals and objectives of CPR, any potential CPR technical modifications to improve responder safety.

- Document all discussions and communications with patient, staff and family members.
- 3) Tactical aspects of CPR on a proven or suspected COVID-19 patient should include:
- Limiting responders.
 - Donning appropriate PPE.
 - When feasible, transporting patient to a negative-pressure environment.
 - Utilizing mechanical CPR devices when appropriate.
 - Employing intraosseous insertion if no intravenous line immediately available.
 - Employing airway and breathing tactical considerations with the goal of lowering the risk of aerosolization by:
 - Using HEPA filters whenever possible.
 - i. Bag-valve mask with a HEPA filter, for example, prior to intubation;
 - Using Passive oxygenation with nonbreathing face mask may be beneficial for the short-term until definitive airway management is accomplished.
 - Considering supraglottic airway in difficult airway situations.
 - Utilizing video laryngoscopy, if available.
 - Using cuffed endotracheal tubes.

c. Dialysis Considerations:

- 1) Preparedness:
 - All dialysis providers must advise their patients to develop their own preparedness plans including emergency and contingency plans for food, medications, transportation and emergency contact resources.
 - Dialysis patients need to be self-sufficient for 72-96 hrs.
- 2) Service providers/dialysis clinics should plan for transportation and other assistance during service/transportation interruptions.
- 3) Water supply:
 - Water purification issues should be addressed within facility/hospital especially during Capacity Stages 2 and 3 (Contingency & Crisis)
 - Identify and plan for alternative water sources
- 4) Treatment Options:
 - Consider transferring stable inpatients to outpatient dialysis centers for dialysis treatments and vice versa depending on location of purified water source
 - Optimize the mode of dialysis to provide safe care for the most patients possible during resource compromise.

- if water is scarce, consider PD (peritoneal dialysis) and CRRT (Continuous renal replacement therapy) as modes of dialysis.
 - if water is readily available, restrict management to HD (hemodialysis) or PD and discontinue CRRT due to staff shortages.
 - Shorten duration of dialysis for patients that are more likely to tolerate it safely.
 - Patients may be advised to utilize their home “kits” of medication (Kayexalate) and follow published dietary plans to help increase time between treatments.
- 5) Triage:
- In extreme circumstances, consider changing dialysis from ‘scheduled’ to ‘as needed’ based on evidence-based clinical and laboratory parameters and findings (particularly hyperkalemia and impaired pulmonary function) – parameters may change based on demand for scarce resources.

d. **Pediatric Considerations:**

- 1) Care will be consistent with daily practices (i.e. Stage 1: Conventional capacity) or will be *functionally equivalent* to usual patient care practices (i.e. Stage 2: Contingency capacity) during the current COVID-19 pandemic.
- 2) Currently, there is no necessity for the pediatric patient (<18 years of age) to be included in Stage 3 deliberations (Crisis Capacity).
- 3) Future iterations of this document will need to address this population if the ratio of pediatric cases to resources threatens to overwhelm the NWO Region.

e. **ECMO** (Extra-corporeal membrane oxygenation):

- 1) In NWO, this mode of therapy is not yet widely considered for COVID-19 patients.

Conclusion:

The Northwest Ohio COVID-19 Care and Resources Task Force (“CCRTF”) proposes this Interim Guidance for the Allocation of Scarce Resources to the HMAc Hospital CEOs for adoption as a resource for HMAc hospitals, should the Guidance be needed during the COVID-19 Pandemic. It is understood that this is interim Guidance and it is anticipated that the CEOs will have their respective ethics and medical task forces review and provide additional feedback. It is also understood that the HMAc Hospitals have sole authority for the institutional policies and procedures they adopt.

CCRTF requests that the healthcare institutions’ respective Ethics and Legal departments review this document and no later than 4/30/2020, provide CCRTF with additional feedback. At that time, CCRTF will meet to consider any new suggestions and possible revisions. In the meantime, the members of CCRTF will remain as a standing Task Force of HMAc to revise this document when internal and external exigencies dictate and to assist in interpreting any of the Guidance .

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Appendix A

Sequential Organ Failure Assessment (“SOFA”) Score Table

Table 1. Sequential [Sepsis-Related] Organ Failure Assessment Score^a

System	Score				
	0	1	2	3	4
Respiration					
PaO ₂ /FiO ₂ , mm Hg (kPa)	≥400 (53.3)	<400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation					
Platelets, ×10 ³ /μL	≥150	<150	<100	<50	<20
Liver					
Bilirubin, mg/dL (μmol/L)	<1.2 (20)	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (204)
Cardiovascular					
	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose) ^b	Dopamine 5.1-15 or epinephrine ≤0.1 or norepinephrine ≤0.1 ^b	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1 ^b
Central nervous system					
Glasgow Coma Scale score ^c	15	13-14	10-12	6-9	<6
Renal					
Creatinine, mg/dL (μmol/L)	<1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440)	>5.0 (440)
Urine output, mL/d				<500	<200

Abbreviations: FiO₂, fraction of inspired oxygen; MAP, mean arterial pressure; PaO₂, partial pressure of oxygen.

^a Adapted from Vincent et al.²⁷

^b Catecholamine doses are given as μg/kg/min for at least 1 hour.

^c Glasgow Coma Scale scores range from 3-15; higher score indicates better neurological function.

Modified Sequential Organ Failure Assessment Score

Organ System	0	1	2	3	4
Respiratory SpO ₂ /FiO ₂	>400	≤400	≤315	≤235	≤150
Liver	No scleral icterus or jaundice			Scleral icterus or jaundice	
Cardiovascular, hypotension	No hypotension	MAP <70 mm Hg	Dopamine ≤5 or dobutamine, any dose	Dopamine >5, epinephrine ≤0.1, norepinephrine ≤0.1	Dopamine >15, epinephrine >0.1, norepinephrine >0.1
CNS, Glasgow Coma Scale	15	13-14	10-12	6-9	<6
Renal, creatinine, mg/dL	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5.0

Dopamine, dobutamine, epinephrine, and norepinephrine doses in micrograms per kilogram per minute. CNS, central nervous system; MAP, mean arterial pressure.

Northwest Ohio COVID-19 Care and Resources Task Force (“CCRTF”)

The COVID-19 Care and Resources Task Force (“CCRTF”) includes medical, legal, and ethics experts assembled to assist the Northwest Ohio Healthcare Multi-Agency Coordination System (HMAC) in formulating guidance to assist hospitals in allocating scarce medical resources using agreed-upon frameworks pertaining to medical, ethical and legal disciplines.

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