<table>
<thead>
<tr>
<th>Time (MT)</th>
<th>Presentation</th>
<th>Presenter(s)</th>
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</thead>
<tbody>
<tr>
<td>1 – 1:05 pm</td>
<td>Welcome, Announcements, Introductions</td>
<td>Lachelle Smith, Director, ECHO Idaho</td>
</tr>
<tr>
<td>1:05 – 1:10 pm</td>
<td>Idaho Epidemiology Curves and Public Health Updates</td>
<td>Carolyn Buxton Bridges, MD FACP</td>
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<tr>
<td>1:10 – 1:15 pm</td>
<td>COVID-19 Medicaid Updates</td>
<td>Magni Hamso, MD MPH FACP</td>
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<tr>
<td>1:15 – 1:25 pm</td>
<td>Scarce Resource Allocation: Aspects of Bioethics in a Pandemic</td>
<td>Alicia Carrasco, MD</td>
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</table>
| 1:25 – 1:45 pm | Outpatient and ED COVID-19 Case Conversations and Q&A                        | Alicia Carrasco, MD
Benjamin Cornett, MD
Magni Hamso, MD MPH FACP
Cathy Oliphant, PharmD
Andrea Christopher, MD MPH
Megan Dunay, MD MPH |
| 1:45 – 1:55 pm | Panelist Pearls and Takeaways                                                | Alicia Carrasco, MD
Benjamin Cornett, MD
Cathy Oliphant, PharmD
Andrea Christopher, MD MPH
Megan Dunay, MD MPH |
| 1:55 – 2:00 pm | Closing, Announcements, Call to Action                                       | Megan Dunay, MD MPH
Lachelle Smith, Director, ECHO Idaho |
COVID-19 Scarce Resource Allocation, Outpatient/ED Case Conversations

April 24, 2020

Alicia Carrasco, MD
Benjamin Cornett, MD
Magni Hamso, MD, MPH, FACP
Cathy Oliphant, PharmD
Carolyn Buxton Bridges, MD FACP
Andrea Christopher, MD MPH
Megan Dunay, MD MPH
Idaho Epidemiology Curves and Public Health Updates

Carolyn Buxton Bridges, MD, FACP
Governor’s Coronavirus Working Group, Former CDC Public Health Physician and Researcher
Case Counts and SARS-CoV-2 PCR Testing in Idaho

• Total lab-confirmed and probable cases: **1,836**
• Deaths: 54 (2.9%)
• At least 166 (9.0%) hospitalized
• At least 63 (3.4%) ICU, ~ 37.9% of hospitalized in ICU
• At least 226 (12.3%) HCP
• Number of people tested: 19,091

Cumulative number of people tested
- Through the Idaho Bureau of Laboratories (IBL)*
  - 3/30: 1,567
  - 4/6: 2,263
  - 4/13: 2,828
  - 4/16: 3,041
  - 4/20: 3,211
  - 4/23: 3,329

- Through commercial laboratories**
  - 3/30: 4,145
  - 4/6: 8,983
  - 4/13: 12,284
  - 4/16: 13,142
  - 4/20: 14,351
  - 4/23: 15,762

https://coronavirus.idaho.gov
Cases in Idaho, and by Date, and Age Group

COVID-19 by Date of Onset

COVID-19 by Age-Group

https://coronavirus.idaho.gov
Emergency Department Visits for COVID-like Illness, Idaho

Number of Emergency Department Visits for COVID-Like Illness

https://coronavirus.idaho.gov
• Goals: Protect vulnerable, preserve healthcare capacity, safely open businesses

• Staged approach – timelines are estimates

• Epi/capacity criteria required to move to next stage – See website for details
  • Epidemiology data examples
    • Downward trend or <20/day on average over 14 days lab confirmed COVID-19 cases
    • Downward trend or <20/day on average over 14 days ED visits for suspected COVID-19 cases
  • Patient care and healthcare worker
    • No crisis standard of care required
    • At least 50 available (unused) ventilators, 50 ICU beds, and available 10-day supply of N95 masks, surgical masks, face shields, gowns, and gloves
    • Robust testing program for at-risk healthcare workers
Core preparedness responsibilities:

- **Testing and Contact Tracing:**
  - Ability to quickly set up safe screening and testing sites for symptomatic individuals, including mild symptoms
  - Contact tracing in place for all COVID-19 positive results
  - Screening and testing locations in all regions of the state, including for all vulnerable groups and rural areas

- **Healthcare System Capacity:**
  - Ability to quickly supply sufficient PPE, medications, and medical equipment to handle dramatic surge if needed
  - Ability to test symptomatic healthcare workers rapidly
  - Ability to surge ICU capacity

- **Plans and Strategies:**
  - State and local preparedness plans in place, including surge plans
  - Crisis Standards of Care Plan established
  - Long-Term Care Task Force operational to support long-term care facilities
  - Testing strategy developed
  - Contact tracing strategy developed

Scarce Resource Allocation: Aspects of Bioethics in a Pandemic

Alicia Carrasco, MD
Internist, Boise VA
Usual Standard of Care

Overarching guiding principle is **autonomy**.

Patients decide (within reason) what resources they would like to receive.
Crisis Standards

In a crisis there are not enough resources to go around.

- The medical teams must decide who will get what resources.
- That can lead to significant **moral injury**

We want to minimize moral injury as much as possible.

- Maximize use of existing resources
- Transparent and objective allocation process
Overarching principle is **utilitarianism**, or the greatest good for the greatest number of people.

We must prioritize who will be offered life-supporting treatment without discriminating against certain groups (i.e. disabled, elderly, poor, etc.)

The process must be relatively simple, quick and reliable.

The primary care team is not part of the allocation decisions.
# Triage

## Life-Saving Resources Triage Tool for INITIAL ASSESSMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Initial Criteria</th>
<th>Priority</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>Exclusion Criteria or SOFA &gt; 11</td>
<td>None</td>
<td>Do not use life-saving resources Use other resources including palliative measures</td>
</tr>
<tr>
<td>Red</td>
<td>SOFA ≤ 7 or Single Organ Failure</td>
<td>Highest</td>
<td>Use lifesaving resources, as available</td>
</tr>
<tr>
<td>Yellow</td>
<td>SOFA 8 - 11</td>
<td>Intermediate</td>
<td>Use life-saving resources, as available</td>
</tr>
<tr>
<td>Green</td>
<td>No requirement for life-saving resources</td>
<td>None</td>
<td>Use other medical management Reassess as needed</td>
</tr>
</tbody>
</table>

## Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PaO2/FiO2 mmHg</td>
<td>&gt; 400</td>
<td>301-400</td>
<td>201-300</td>
<td>101-200</td>
<td>≤100</td>
</tr>
<tr>
<td>Respiratory SpO2/FiO2</td>
<td>&gt;400</td>
<td>≤400</td>
<td>≤315</td>
<td>≤235</td>
<td>≤150</td>
</tr>
<tr>
<td>Platelets, x 10^9</td>
<td>&gt;150</td>
<td>101-150</td>
<td>51-100</td>
<td>21-50</td>
<td>&lt;20</td>
</tr>
<tr>
<td>Bilirubin, mg/dL</td>
<td>&lt;1.2</td>
<td>1.2-1.9</td>
<td>2.0-5.9</td>
<td>6.0-11.9</td>
<td>&gt;12</td>
</tr>
<tr>
<td>Hypotension</td>
<td>None</td>
<td>MABP &lt;70mmHg Dop ≤ 5 or any dobutamine</td>
<td>Dop 6-15 or Epi &lt; 0.1 or Norepi &lt; 0.1</td>
<td>Dop &gt;15 or Epi &gt; 0.1 or Norepi &gt; 0.1</td>
<td></td>
</tr>
<tr>
<td>Glasgow Coma Score</td>
<td>15</td>
<td>13 - 14</td>
<td>10 - 12</td>
<td>6 - 9</td>
<td>&lt; 6</td>
</tr>
<tr>
<td>Creatinine, mg/dL</td>
<td>&lt; 1.2</td>
<td>1.2-1.9</td>
<td>2.0-3.4</td>
<td>3.5-4.9</td>
<td>&gt; 5 or anuric</td>
</tr>
</tbody>
</table>
Tie-Breaking
Outpatient and ED Case Conversations and Q&A

Alicia Carrasco, MD, Internist, Boise VA
Benjamin Cornett, MD, Emergency Physician, Boise VA, Medical Director, ISU Paramedic Education Program
Cathy Oliphant, PharmD, Infectious Disease, Professor & Interim Chair, ISU College of Pharmacy
Andrea Christopher, MD MPH, Internist, Boise VA; Associate Program Director for UW Boise Internal Medicine Residency
Megan Dunay, MD MPH, Geriatrician, Boise VA and Medical Director for Geriatrics and Extended Care for VA Pacific Northwest Region
Case 1

Lakeisha Smith is a 42 year old woman with well-controlled diabetes who works as a grocery store cashier. She lives with her husband (who is currently furloughed and staying home) and their 10 year old daughter.

She calls into her primary care clinic reporting 24 hour history of fever to 101 deg F, chills, rhinitis and pharyngitis. She denies cough, dyspnea, GI symptoms, GU symptoms.

• How would you triage this patient?
• Do you pursue PCR test for SARS-CoV2?
• How do you counsel her regarding what to do at home (regarding family)?
• What do you advise regarding returning to work?
Case 2

Roy Redfeather is a 63 year old man with heart transplant, hypertension, and chronic kidney disease who has routine follow-up in clinic, scheduled as a televisit.

His annual transplant team follow-up visit was cancelled and routine colonoscopy to screen for colon cancer was also cancelled. He wonders if he should come in for his routine labs. He was planning to celebrate his 25\textsuperscript{th} wedding anniversary with his wife in August with a party for 30 family members and wonders if this needs to be rescheduled.

- When do you advise he should get his routine labs?
- How do you advise about specialty clinic follow-up visits?
- What guidance do you give on what to expect when stay-at-home order is lifted?
When does normalcy return?

- US has not had uniform experience
- Critical care needs & mortality lag 2-3 weeks behind peak cases
- Anticipate rolling re-closures

How does US return to normal activities?

- Diffusing density
- Testing is critical
- Attend to vulnerable populations
Case 3

Diana Eneko is a 38 year old woman with exercise induced asthma who works at an IT company, working remotely since the stay at home order was issued. Diana heard that her work is considering letting employees return to the office building after the stay-at-home order is lifted if they have testing to prove their recovered from COVID19 or have a recent negative test.

She recalls she had an illness in late February where she had fever, dry cough and dyspnea and wonders if she had COVID19. She calls into clinic asking if she can get testing.

• How do you counsel her about testing?
Panelist Pearls and Takeaways

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More to come...

**Tuesday:** Noon to 1 p.m. Mountain time, 11 a.m. to noon Pacific time
- Topic: Pediatric Considerations

**Friday:** 1 – 2 p.m. Mountain time, noon to 1 p.m. Pacific time