LEGISLATIVE UPDATE

Alliance of Catholic Health Care

Week of March 23, 2020

State Issues	
News and Expectations from the Capitol	As we reported last week, the Legislature has, in essence, extended its typical one-week Spring Recess to a three-week break (proposed until April 13) to allow Legislators and their staff to return to work in their districts. Capitol staff have the ability to work from home, but each office is making themselves available by phone, and telephone meetings on public policy issues are proceeding. The Joint Recess legislation made it clear that the Legislature could reconvene at any time during this period if it felt it appropriate, and they could extend the break if it was warranted. Regarding the possible next steps for the 2020-21 State Budget, it is important to note that the only Constitutional deadline the Legislature must adhere to is June 15 – the date they must pass a budget bill. All other legislative deadlines are determined by rules of each house. Having a "real" budget by that date will be nearly impossible. While we don't know yet if the State will have a handle on how much is being spent to address the coronavirus by that point, we do know for certain that they will not have a clear picture of the state revenues. The State pushed back the tax collection date from April 15 to July 15. As such, the State will not have a good sense of how much money it has to spend until July or early August. Therefore, we are hearing that the Legislature is likely to come back into session mid-June to pass a "Status Quo" budget – closely mirroring the State's 2019-2020 budget, with perhaps some cost of living adjustments (COLAs) for certain funds, and only coronavirus-related spending will be added. The Legislature may revisit the 2020-2021 budget in late summer. Regarding the hundreds of policy bills that typically make their way through the policy and fiscal committees during this time of year, there will not be a "business as usual" discussion on legislation. Legislative leadership have indicated that only bills that have a direct nexus with addressing either the health or economic impact of the coronavirus will get through, and members are being asked to narrow their bill packages to no more than 3-5 bills each. Some Legislators are making the case that their health care bills – designed well before the pandemic – are directly related to the virus and are needed. Some are talking about the need for California to pass Dr. Jim Wood's bill (AB 890) to allow for nurse practitioners to have independent practice, and Senator Durazo is advocating for her bill (SB 29) that allows undocumented older adults to have access to Medi-Cal, as a push for improving access to care. Both of these bills do have a relation to our health care system and seem like they would be eligible if criteria, described above, is selected. Other bills, such as the establishment of the Office of Health Care Quality and Affordability (AB 2817) or granting the Attorney General greatly enhanced powers to regulate nearly all health care transactions in the State (SB 977 – *see more below*), seem less helpful in addressing the current crisis. It has been made clear that no final decisions on how the Legislature will manage this session have been made, so in the meantime, we should proceed as normal until told otherwise. ***(more)***

Legislative Summary and Status	Attached please find the Alliance's Legislative Summary and Status report on bills of interest to the Catholic health care ministry. One bill of concern that was amended last week is **SB 977 (Monning)**, that would provide the Attorney General (AG) increased authority over hospital partnerships. 1) It extends the AG's approval authority to all hospital system transactions involving nonprofit hospitals, investor-owned hospitals and physician practices. 2) The AG shall deny consent unless the hospital system demonstrates the transaction will result in substantial likelihood of clinical integration, increased availability and access to services in an underserved population (a rural health care system may request a waiver). 3) The bill makes it unlawful for a hospital system that has substantial market power to engage in conduct that has a substantial tendency to cause anticompetitive effects. 4) Creates an advisory board to evaluate and analyze health care markets in California and provide recommendations to the AG. However, we understand that this provision will be removed if the proposed functions of the advisory board remain in the proposals related to the Office of Affordability. 5) Imposes civil fines for violation of the law of $1 million or twice the gross gain to the health care system, or gross loss to any other party multiplied by 2, whichever is greater.
Federal Issues	
Congress Poised to Approve Third COVID-19 Supplemental	On Wednesday, the Senate approved Congress' third COVID-19 supplemental, a $2 trillion package that includes funds and resources to combat the global pandemic as well as economic stimulus measures to address an expected recession. The House is expected to approve the legislation today (Friday) by voice vote. As reported by the Catholic Health Association of the U.S., the bill provides $127 billion for a Public Health and Social Services Emergency Fund, which includes provisions to assist hospitals and other health providers as well as to provide medical equipment and boost vaccine development. Some of the important provisions include: ▪ Reimbursement to Hospitals & Health Care Providers: $100 billion to ensure health care providers continue to receive support for Covid-19 related expenses as well as lost revenue. ▪ Strategic National Stockpile: $16 billion to procure personal protective equipment, ventilators, and other medical supplies for federal and state response efforts. When combined with the first supplemental, Congress has provided approximately $17 billion for the stockpile. ▪ Vaccine, Therapeutics, Diagnostics, and other Medical or Preparedness Needs: $11 billion. Includes at least $3.5 billion to advance construction, manufacturing, and purchase of vaccines and therapeutic delivery. ▪ Hospital Preparedness: $250 million to improve the capacity of health care facilities to respond to medical events. ▪ Health Resources and Services Administration: $275 million to expand services and capacity for rural hospitals, telehealth, poison control centers, and the Ryan White HIV/AIDS program. Language is also included to allow Community Health Centers to use FY2020 funding to maintain or increase staffing and capacity to address the coronavirus. ***(more)***

COVID-19 Information and Resources	
There is much information and many resources emerging on the coronavirus (COVID-19). We have added a new section to our Update that will focus on the ethical issues and concerns in treating patients, as well as provide additional links to resources that may be helpful to those in our communities and parishes.	
Ethical Guidance on Scarce Resource Management and Caring for COVID-19 Patients	This week, *The Washington Post* published a provocative article on "Hospitals consider universal do-not-resuscitate [DNR] orders for coronavirus patients," that has generated much discussion and concern – https://www.washingtonpost.com/health/2020/03/25/coronavirus-patients-do-not-resucitate/. Both Dignity Health and Providence St. Joseph Health (PSJH) have developed guidelines in response to scarce resource management and care for coronavirus patients. While the guidelines make the point that under certain circumstances CPR is not obligated, this is not the same as an imperative to withhold it in every case ("universal mandate"). There is agreement that a "universal DNR mandate" is not ethically justified. Attached are: PSJH Ethics Brief Guide to Scarce Resource Decisions During COVID-19 *(see page 9);* and, CommonSpirit Health (Dignity Health) Health Care Ethics Advisory on Caring for Patients with Suspected or Confirmed COVID-19 *(see pages 4-5).*
Supportive Care Coalition	This week, the Supportive Care Coalition (SCC) held a webinar, "Palliative Care and COVID-19: Implications for Clinical Practice," presented by physicians and bioethicists, and have two more webinars planned over the next two weeks. SCC advances palliative care excellence in Catholic health care settings through education, advocacy, mission and ethical integration as well as the promotion of spiritual care in palliative care. They have a very helpful page of COVID-19 resources that links you to their webinar, key organizational COVID website links, articles of interest, policies and guidelines, caregiver well-being, and other resources: https://supportivecarecoalition.org/resources-blog/2020/3/19/covid-19-resources.
Public Education Video	Providence St. Joseph Heath, in partnership with ACP Decisions, has produced a public-education video that is under 9 minutes and delivers information in easy-to-understand language on what COVID-19 is, its symptoms, and ways to prepare and protect yourself, loved ones and communities: https://coronavirus.providence.org/#tabcontent-38-pane-2.
Dr. Byock's Personal Reflection	Dr. Ira Byock, Founder and Chief Medical Officer at the Providence Institute for Human Caring, has written a thoughtful and personal reflection on the coronavirus, "This Pandemic is Personal" – https://thriveglobal.com/stories/this-pandemic-is-personal/.

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Alliance of Catholic Health Care
Legislative Summary and Status 3/27/2020

Access / Health Care Reform

AB 4 **(Arambula D) Medi-Cal: eligibility.**
Location: 7/10/2019-S. 2 YEAR
Summary: Current law requires that individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, which includes outreach strategies. Current law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination, and requires the department to seek any necessary federal approvals to obtain federal financial participation for purposes of implementing the requirements. Current law requires that benefits for services under these provisions be provided with state-only funds only if federal financial participation is not available for those services. This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status, and would delete provisions delaying eligibility and enrollment until the director makes the determination as specified.

Position
Support

AB 2032 **(Wood D) Medi-Cal: medically necessary services.**
Location: 3/2/2020-A. HEALTH
Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, for individuals 21 years of age and older, a service is "medically necessary" if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Current law provides that for individuals under 21 years of age, "medically necessary" or "medical necessity" standards are governed by the definition in federal law. This bill would provide that the above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.

Position
Watch

AB 2130 **(Arambula D) Health care professionals: underserved communities.**
Location: 2/10/2020-A. PRINT
Summary: Would declare the intent of the Legislature to enact legislation to increase the number of health care professionals in underserved communities.

Position
Watch

AB 2158 **(Wood D) Health care coverage.**
Location: 2/20/2020-A. HEALTH
Summary: Current law requires a group or individual health care policy issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that require a group health plan and health insurance issuer offering group or individual health insurance coverage to, at a minimum, provide coverage for specified preventive services, and prohibits the plan or health insurance issuer from imposing any cost-sharing requirements for those preventive services. Current law requires a health insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the requirement to cover preventive health services without cost sharing to the extent required by federal law, and would instead require a group or individual health insurance policy to, at a minimum, provide coverage for specified preventive services without any cost-sharing requirements for those preventive services, thereby indefinitely extending those requirements.

Position
Watch

AB 2159 **(Wood D) Health care coverage.**
Location: 2/20/2020-A. HEALTH
Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health insurer that issues, sells, renews, or offers plan contracts for health care coverage in the state to comply with the requirements of the PPACA, and any rules or regulations

issued under the PPACA, that generally prohibit a health insurer offering group or individual coverage from imposing lifetime or annual limits on the dollar value of benefits for an insured. Current law requires an insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health insurance policy from establishing lifetime or annual limits on the dollar value of benefits for an insured, thereby indefinitely extending the prohibitions on lifetime or annual limits.

Position
Watch

AB 2817 **(Wood D) Office of Health Care Quality and Affordability.**
Location: 3/2/2020-A. HEALTH
Summary: Would create the Office of Health Care Quality and Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs, and create a strategy to control health care costs. The bill would require the office to be governed by a board with specified membership, and would require the board to hire an executive director to organize, administer, and manage the operations of the office.

Position
Watch

AB 2841 **(Wood D) Health care coverage.**
Location: 2/20/2020-A. PRINT
Summary: Current law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. The act requires a health care service plan to meet specified requirements, including, but not limited to, the requirement that the health care service plan contract provide to subscribers and enrollees certain basic health care services.This bill would make technical, nonsubstantive changes to those provisions.

Position
Watch

AB 3177 **(Wood D) Health care coverage.**
Location: 2/21/2020-A. PRINT
Summary: Current law requires health care service plans and health insurers participating in the Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product in each of these 5 levels of coverage, except as specified. Current law requires a health care service plan or health insurer that does not participate in the Exchange to offer at least one standardized product designated by the Exchange in each of the platinum, gold, silver, and bronze levels of coverage. This bill would make technical, nonsubstantive changes to provisions defining the required levels of coverage applicable to health care service plans and health insurers.

Position
Watch

SB 29 **(Durazo D) Medi-Cal: eligibility.**
Location: 1/3/2020-A. THIRD READING
Summary: Would, subject to an appropriation by the Legislature, and effective July 1, 2020, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status.

Position
Support

SB 65 **(Pan D) Health care coverage: financial assistance.**
Location: 1/23/2020-A. APPR.
Summary: Current law creates the California Health Benefit Exchange (the Exchange), also known as Covered California, for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the PPACA. Until January 1, 2023, current law requires the Exchange, among other duties, to administer an individual market assistance program to provide assistance, including premium assistance subsidies, to program participants with household incomes at or below 600% of the federal poverty level. This bill would reduce premiums to zero for program participants with household incomes at or below 138% of the federal poverty level, and would specify the premium assistance subsidy amount for program participants with household incomes of 139% to 600%, inclusive, of the federal poverty level.

Position
Support

SB 66 **(Atkins D) Medi-Cal: federally qualified health center and rural health clinic services.**

Location: 9/15/2019-A. 2 YEAR

Summary: Current law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.

Position
Support

SB 175 **(Pan D) Health care coverage.**

Location: 1/27/2020-A. DESK

Summary: Current law requires a health care service plan that issues, sells, renews, or offers plan contracts for health care coverage in the state to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that generally prohibit a health plan offering group or individual coverage from imposing lifetime or annual limits on the dollar value of benefits for a participant or beneficiary. Current law requires a plan to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a plan comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health care service plan contract from establishing lifetime or annual limits on the dollar value of benefits for an enrollee, thereby indefinitely extending the prohibitions on lifetime or annual limits, except as specified.

Position
Watch

SB 910 **(Pan D) Population health management program.**

Location: 3/16/2020-S. HEALTH

Summary: Would require the State Department of Health Care Services to require, by January 1, 2022, each Medi-Cal managed care plan to implement a population health management program to identify, assess, and manage the needs of Medi-Cal beneficiaries who are enrolled in each plan. The bill would require a Medi-Cal managed care plan to describe case management services provided to enrollees and to report to the department on specified information, including the number of enrollees receiving in-lieu-of services. The bill would require the department to establish metrics for, and require the federally required external quality review organization (EQRO) to evaluate the effectiveness of, the enhanced care management and in-lieu-of services provided to enrollees, to establish metrics for evaluating the program, and to require the EQRO to conduct an analysis of each Medi-Cal managed care plan's program.

Position
Watch

SB 916 **(Pan D) Medi-Cal: health care services.**

Location: 3/16/2020-S. HEALTH

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services either through a fee-for-service or a managed care delivery system. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Under current law, the Medi-Cal program comprises a department-administered uniform schedule of health care benefits. Current law limits health care services, for purposes of the Medi-Cal program, to a schedule of benefits, as specified.This bill, commencing July 1, 2021, would add enhanced care management, as described, to the schedule of benefits for a beneficiary to obtain as covered Medi-Cal services.

Position
Watch

SB 936 **(Pan D) Medi-Cal managed care plans: contract procurement.**

Location: 2/20/2020-S. HEALTH

Calendar: 4/15/2020 1:30 p.m. - John L. Burton Hearing Room (4203) SENATE HEALTH, PAN, Chair

Summary: Would require the Director of Health Care Services to conduct a contract procurement at least once every 5 years if the director contracts with a commercial Medi-Cal managed care plan for the provision of care of Medi-Cal beneficiaries on a state-wide or limited geographic basis, and would authorize the director to extend an existing contract for one year if the director takes specified action, including providing notice to the Legislature, at least one year before exercising that extension. The bill would require the department to perform specified duties, including establishing a stakeholder process in the planning and development of each commercial Medi-Cal managed care contract procurement

process, and receiving public comment on the model contract, procurement qualifications, and evaluation criteria.

Position
Watch

Behavorial Health

AB 910 **(Wood D) Medi-Cal: dispute resolution.**
Location: 1/30/2020-S. RLS.
Summary: Would require a county mental health plan and Medi-Cal managed care plan that are unable to resolve a dispute to submit a request for resolution to the State Department of Health Care Services. The bill would require the department to issue a written decision to the plans within 30 calendar days from receipt of the request by either the county mental health plan or the Medi-Cal plan. The bill would also prohibit the dispute from delaying the provision of medically necessary services, as specified.

Position
Watch

AB 1861 **(Santiago D) Mental health: involuntary commitment.**
Location: 1/7/2020-A. PRINT
Summary: Under current law, if a person, as a result of a mental disorder, is a danger to others, or to themselves, or is gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services as a facility for 72-hour treatment and evaluation. Current law prohibits specified mental health personnel from taking certain actions that interfere with a peace officer seeking to transport, or having transported, a person detained for 72-hour treatment and evaluation. This bill would make technical, nonsubstantive changes to these provisions.

Position
Watch

AB 1938 **(Eggman D) Mental Health Services Act: inpatient treatment funding.**
Location: 1/23/2020-A. HEALTH
Summary: Would specify, to the extent MHSA funds are otherwise available for use pursuant to the Mental Health Services Act, those funds may be used to provide inpatient treatment, including involuntary treatment of a patient who is a danger to self or others or gravely disabled, in specified settings, including an acute psychiatric hospital, an institution for mental disease, and a mental health rehabilitation center, as defined. The bill would state that this change is declaratory of existing law.

Position
Support

AB 1946 **(Santiago D) Mental health services: involuntary detention.**
Location: 1/17/2020-A. PRINT
Summary: Would state the intent of the Legislature to enact legislation to reform the Lanterman-Petris-Short Act, including expanding the definition of "gravely disabled" to add a condition in which a person is unable to provide for their own medical treatment as a result of a mental health disorder, and emphasizing the necessity to create policies that prioritize living safely in communities.

Position
Watch

AB 2015 **(Eggman D) Certification for intensive treatment: review hearing.**
Location: 2/14/2020-A. HEALTH
Summary: Current law authorizes a peace officer or a professional designated by the county to take a person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, when the person is a danger to self or others, or is gravely disabled, as a result of a mental health disorder. Current law also authorizes a court to order the evaluation of a person who is alleged to be a danger to self or others as a result of a mental disorder, or the evaluation of a criminal defendant who appears to be a danger to self or others, or to be gravely disabled, as a result of chronic alcoholism or the use of narcotics or restricted dangerous drugs. Current law requires that a certification review hearing be held, as specified, and governs the procedure for presenting evidence at the hearing. This bill would authorize the evidence presented in support of the certification decision to include information regarding the person's medical condition and how that condition bears on certifying the person as a danger to themselves or to others or as gravely disabled. The bill would require the hearing officer to consider the information in the determination of probable cause.

Position
Watch

AB 2055 **(Wood D) Specialty mental health services and substance use disorder treatment.**
Location: 3/5/2020-A. HEALTH
Summary: Would require the State Department of Health Care Services to establish, implement, and administer the Behavioral Health Quality Improvement Program to assist county mental health plans and counties that administer the Drug Medi-Cal Treatment Program or the Drug Medi-Cal organized delivery system for purposes of preparing those entities for implementation of the behavioral health components included in the Medi-Cal Healthier California for All initiative, and would establish in the State Treasury the Behavioral Health Quality Improvement Account to fund those efforts. The bill would require the department to determine the methodology and distribution of funds appropriated to those entities.

Position
Watch

AB 2464 **(Aguiar-Curry D) Statewide pediatric behavioral telehealth networks.**
Location: 2/27/2020-A. HEALTH
Summary: Would establish a grant program for purposes of establishing and funding a statewide pediatric behavioral telehealth network, subject to a competitive grant process. The California Health and Human Services Agency shall implement the grant program. The bill would require funding made available for these purposes to be expended to build the clinical infrastructure to support 10 telehealth hubs, as defined, throughout the state.

Position
Watch

AB 2775 **(Ting D) Timely access to health care.**
Location: 2/20/2020-A. PRINT
Summary: Would declare the intent of the Legislature to ensure that patients receive timely access to health care services, including nonemergency followup appointments with mental health care providers within 10 business days.

Position
Watch

AB 2899 **(Jones-Sawyer D) Mental health: involuntary commitment.**
Location: 3/5/2020-A. HEALTH
Summary: Current law provides for the involuntary commitment and treatment of persons for 72 hours following a court-ordered evaluation that determines the person, as a result of a mental health disorder, or as a result of impairment by chronic alcoholism, is a danger to self or others, or is gravely disabled. If a person is involuntarily detained for 72 hours under those provisions, the person may be certified for not more than 14 days of intensive treatment related to the mental health disorder or impairment by chronic alcoholism under specified conditions, including that the professional staff of the agency or facility providing evaluation services has analyzed the person's condition and has found the person is, as a result of a mental health disorder or impairment by chronic alcoholism, a danger to others, or to self, or gravely disabled, and that the person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis. This bill would authorize the person, after being detained for the initial 72 hours, to be certified for that intensive treatment for a period longer than 14 days, as determined by the professional staff providing the evaluation, and under those same conditions.

Position
Watch

AB 3188 **(Wood D) Mental health: involuntary treatment.**
Location: 2/21/2020-A. PRINT
Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of persons with specified mental disorders for the protection of the persons committed. Under the act, when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. This bill would make technical, nonsubstantive changes to those provisions.

Position
Watch

AB 3242 **(Irwin D) Mental health treatment.**
Location: 2/21/2020-A. PRINT

Summary: Current law, the Lanterman-Petris-Short Act, authorizes the involuntary commitment and treatment of persons with specified mental health disorders for the protection of the persons so committed. Current law also specifies that the act does not limit the right of a person to voluntarily apply, at any time, to a public or private agency or practitioner for mental health services, as specified.This bill would make technical, nonsubstantive changes to these provisions.

Position
Watch

SB 855 **(Wiener D) Health coverage: mental health or substance abuse disorders.**
Location: 1/22/2020-S. HEALTH
Calendar: 4/15/2020 1:30 p.m. - John L. Burton Hearing Room (4203) SENATE HEALTH, PAN, Chair
Summary: The California Mental Health Parity Act requires every health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, as specified. Existing law requires those benefits to include, among other things, outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the plan contract or policy includes coverage for prescription drugs. This bill would revise and recast those provisions, and would instead require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions

Position
Watch

Catholic Identity

AB 2781 **(Wicks D) Health care coverage: treatment for infertility.**
Location: 3/2/2020-A. HEALTH
Summary: Would require every health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2021, to provide coverage for the treatment of infertility. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would delete the exemption for religiously affiliated employers, health care service plans, and health insurance policies, from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies.

Position
Watch

End of Life/Palliative Care

SB 1252 **(Moorlach R) Advance health care directives: mental health treatment.**
Location: 3/5/2020-S. JUD.
Summary: Current authorizes an adult having capacity to execute a power of attorney for health care to authorize an agent to make health care decisions for the principal, and authorizes the power of attorney to include individual health care instructions. Current law authorizes the principal in a power of attorney for health care to grant authority to make decisions relating to the personal care of the principal, including, but not limited to, determining where the principal will live, providing meals, or hiring household employees. Current law defines "health care decision" and "health care" for these purposes to mean any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition. This bill would clarify that health care decisions under those provisions include mental health treatment. The bill would revise the statutory advance health care directive form to clarify that a person may include instructions relating to mental health treatment.

Position
Watch

Hospital Operations and Finance

AB 1544 **(Gipson D) Community Paramedicine or Triage to Alternate Destination Act.**
Location: 9/15/2019-S. 2 YEAR

Summary: Would establish within the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for a program and would further require the Commission on Emergency Medical Services to review and approve those regulations.

Position
Watch

AB 1611 **(Chiu D) Emergency hospital services: costs.**
Location: 7/10/2019-S. 2 YEAR
Summary: Would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment.

Position
Oppose Unless Amend

AB 2037 **(Wicks D) Health facilities: notices.**
Location: 2/14/2020-A. HEALTH
Summary: Would require a hospital that provides emergency medical services to provide notice, as specified, at least 180 days before a planned reduction or elimination of the level of emergency medical services. The bill would require a health facility to provide at least 180 days' notice, as specified, prior to closing the facility and at least 90 days prior to eliminating or relocating a supplemental service, except as specified. The bill would require the mandatory public notice to include specific notifications, including, among others, a continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the hospital or health facility is located.

Position
Watch

AB 2157 **(Wood D) Health care coverage: independent dispute resolution process.**
Location: 2/20/2020-A. HEALTH
Summary: Current law requires the Department of Managed Health Care and the Department of Insurance to establish an independent dispute resolution process to resolve a claim dispute between a health care service plan or health insurer, as appropriate, and a noncontracting individual health professional, and sets forth requirements and guidelines for that process, including contracting with an independent organization for the purpose of conducting the review process. Current law requires each department to establish uniform written procedures for the submission, receipt, processing, and resolution of these disputes, as specified. Existing law requires the independent organization, in deciding the dispute, to base its decision regarding the appropriate reimbursement on all relevant information. This bill would require the procedures established by each department to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract.

Position
Watch

AB 2600 **(Kamlager D) Hospitals: licensing.**
Location: 2/20/2020-A. PRINT
Summary: Current law provides for the licensure of health facilities, including general acute care hospitals, acute psychiatric hospitals, and special hospitals, as defined, by the State Department of Public Health.This bill would make technical, nonsubstantive changes to a related provision.

Position
Watch

AB 2747 **(Santiago D) Health data disclosure: health policy organizations and labor unions.**
Location: 3/5/2020-A. HEALTH
Summary: Current law requires an organization that operates, conducts, owns, or maintains a health facility, each hospital, and each general acute care hospital and freestanding ambulatory surgery clinic

to make and file with the Office of Statewide Health Planning and Development certain information regarding patients that is recorded on a Hospital Discharge Abstract Data Record, an Emergency Care Data Record, and an Ambulatory Surgery Data Record, respectively, as described. The information includes, among other things, the date of birth, race, date of services, and principal diagnosis of the patient. Current law requires the office to disclose this information to certain entities, including any California hospital and any local health department or local health officer in California, except as specified. This bill would also require the office to disclose the information to any nonprofit health policy organization and any labor union and would prohibit those entities from disclosing the information, as described above.

Position
Watch

AB 2830 **(Wood D) Health care cost transparency database.**
Location: 3/2/2020-A. HEALTH
Summary: Would state the intent of the Legislature to establish a system to collect health information related to health care cost, quality, and efficiency by January 1, 2022. The bill would direct the office to take a number of actions with respect to developing and implementing the Health Care Cost Transparency Database, including, among other things, ensuring the database can map to other databases, contracting with a data collection vendor, as necessary, collecting and incorporating data from other state and federal agencies, developing and maintaining a master person index, a master provider index, and a master payer index, developing data quality and improvement processes, and developing an information security program to ensure the privacy of individuals and the security of the data collected.

Position
Watch

AB 2928 **(Eggman D) Health facilities.**
Location: 2/21/2020-A. PRINT
Summary: Under current law, the State Department of Public Health is responsible for the licensing and regulation of health facilities, as defined. A violation of these provisions is a crime. Current law authorizes the exercise of privileges in a health facility to be limited, restricted, or revoked for a violation of the health facility's rules, regulations, or procedures, as specified.This bill would make technical, nonsubstantive changes to that provision.

Position
Watch

AB 3083 **(Arambula D) Ambulatory surgical centers.**
Location: 2/21/2020-A. PRINT
Summary: Would enact the California Outpatient Cardiology Patient Safety, Cost Reduction, and Quality Improvement Act. The bill would authorize the State Department of Public Health, within the PCI Program, to certify an ambulatory surgical center to provide elective cardiac catheterization laboratory services that meet certain requirements to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients

Position
Watch

SB 758 **(Portantino D) Hospitals: seismic safety.**
Location: 9/15/2019-A. 2 YEAR
Summary: The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 requires, before January 1, 2020, the owner of an acute care inpatient hospital whose building does not substantially comply with described seismic safety regulations or standards to submit to the office an attestation that the board of directors of that hospital is aware that the hospital building is required to meet a specified deadline for substantial compliance with those regulations and standards. This bill would require, on or before January 1, 2021, the owner of an acute care inpatient hospital to update the above-described submission by reporting the services provided in each building of the acute care inpatient hospital.

Position
Support

SB 901 **(Wilk R) Hospitals: seismic safety.**
Location: 1/30/2020-S. RLS.
Summary: The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 establishes a program of seismic safety building standards for certain hospitals. Current law requires hospitals with buildings subject to a seismic compliance deadline of January 1, 2020, and that are seeking an extension for their buildings to submit an application to the Office of Statewide Health Planning and Development by April 1, 2019, subject to certain exceptions. Current law requires final seismic compliance be achieved by July 1, 2022, if the compliance is based on a replacement or retrofit plan, or by January 1, 2025, if

the compliance is based on a rebuild plan. This bill would make technical, nonsubstantive changes to those provisions.

Position
Watch

SB 1084 **(Umberg D) Pharmacy: dispensing: controlled substances.**
Location: 3/5/2020-S. B., P. & E.D.
Summary: Would, with certain exceptions, on and after June 30, 2021, require a pharmacist who dispenses in solid oral dosage form a controlled substance in Schedule II or Schedule IIN of the federal Controlled Substances Act to dispense it in a lockable vial, as defined, provide an educational pamphlet on controlled substances, and, if the lockable vial uses an alphanumeric passcode or other code, include the code in any patient notes in the database or other system used by the pharmacy in the dispensing of prescription drugs. The patient, or the patient's parent or legal guardian if the patient is a minor or otherwise unable to authorize medical care, would choose the code, except as specified.

Position
Watch

SB 1216 **(Hueso D) Compassionate Access to Medical Cannabis Act or Ryan's Law.**
Location: 3/5/2020-S. HEALTH
Summary: Would require a patient to provide the health care facility with a copy of their medical marijuana card or written documentation that the use of medicinal cannabis is recommended by a physician. The bill would authorize a health care facility to reasonably restrict the manner in which a patient stores and uses medicinal cannabis to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility. The bill would prohibit the department that licenses the health care facility from enforcing these provisions, and compliance with the bill would not be a condition for obtaining, retaining, or renewing a license as a health care facility.

Position
Oppose

Not for Profit

AB 1404 **(Santiago D) Nonprofit sponsors: reporting obligations.**
Location: 9/15/2019-S. 2 YEAR
Summary: The Nonprofit Corporation Law regulates the organization and operation of nonprofit public benefit corporations, nonprofit mutual benefit corporations, and nonprofit religious corporations, including, but not limited to, health care service plans. That law requires a nonprofit public benefit corporation to furnish annually to its members a report that includes the assets and liabilities of the corporation, revenue or receipts of the corporation, and the expenses or disbursements of the corporation. This bill would require a nonprofit sponsor to make specified annual disclosures publicly available by posting those disclosures on the nonprofit sponsor's public internet website in the same location where it posts copies of its annual report.

Position
Watch

AB 2036 **(Muratsuchi D) Nonprofit public benefit corporations: sale of assets: health facilities.**
Location: 2/14/2020-A. HEALTH
Summary: Current law requires any nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified. Current law authorizes the Attorney General to determine what information is required to be contained in the notice. This bill would specify that if the Attorney General imposes a condition on its consent to an agreement or transaction pursuant to the provisions described above, that condition shall remain in effect for the entire period of time specified by the Attorney General, regardless of whether the health facility is subject to an additional or subsequent sale, transfer, purchase, lease, exchange, option, conveyance, or other disposition of assets.

Position
Watch

SB 977 **(Monning D) Health care system consolidation: Attorney General approval and enforcement.**
Location: 2/11/2020-S. RLS.

Summary: Current law requires any nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified. Current law authorizes the Attorney General to determine what information is required to be contained in the notice. This bill would require a health care system, as defined, to provide written notice to, and obtain the written consent of, the Attorney General prior to an affiliation or acquisition between the health care system and a health care facility or provider, as those terms are defined.

Position
Watch

Social Determinants of Health

AB 1845 **(Rivas, Luz D) Homelessness: Office to End Homelessness.**
Location: 3/11/2020-A. APPR.
Summary: Would create, within the Governor's office, the Governor's Office to End Homelessness, which would be administered by the Secretary on Housing Insecurity and Homelessness appointed by the Governor. The bill would require that the office serve the Governor as the lead entity for ending homelessness in California and would task the office with coordinating the various federal, state, and local departments and agencies that provide housing and services to individuals experiencing homelessness or at risk of homelessness.

Position
Support

AB 1851 **(Wicks D) Faith-based organization affiliated housing development projects: parking requirements.**
Location: 1/30/2020-A. L. GOV.
Summary: Would upon the request of a developer of a housing development project, require a local agency to ministerially approve a request to that local agency to reduce or eliminate any parking requirements that would otherwise be imposed by that local agency on the development if the housing development project qualifies as a faith-based organization affiliated housing development project, as defined. This bill would prohibit a local agency from requiring the replacement of religious-use parking spaces proposed to be eliminated by a faith-based organization affiliated housing development project pursuant to a request made and ministerially approved pursuant to the bill, or from requiring the curing of any preexisting deficit of religious-use parking as a condition of approval of a faith-based organization affiliated housing development project.

Position
Watch

AB 2576 **(Gloria D) Mental health: homelessness.**
Location: 2/20/2020-A. PRINT
Summary: Would state the intent of the Legislature to enact legislation to use existing, unspent resources to assist individuals with mental illness who are also experiencing homelessness.

Position
Watch

AB 2909 **(Eggman D) California Emergency Solutions and Housing Program: eligible activities.**
Location: 3/12/2020-A. H. & C.D.
Summary: Current law requires the Department of Housing and Community Development to allocate specified moneys under the California Emergency Solutions and Housing Program to administrative entities, as defined, that submit an application for funding for eligible activities relating to homelessness within specified Continuum of Care service areas in response to a notice of funding availability issued by the department, as provided. Current law specifies the eligible activities for which an administrative entity may use funds allocated to it under the program, including operating support for housing interventions, as specified. This bill would additionally authorize an administrative entity to use funds allocated to it under the program to establish a reimbursement rate for emergency housing interventions, including navigation centers, street outreach services, and shelter diversions, as provided.

Position
Watch

SB 899 **(Wiener D) Planning and zoning: housing development: nonprofit hospitals or religious**

institutions.
Location: 3/16/2020-S. HOUSING
Summary: The Planning and Zoning Law requires each county and city to adopt a comprehensive, long-term general plan for its physical development, and the development of certain lands outside its boundaries, that includes, among other mandatory elements, a housing element. That law allows a development proponent to submit an application for a development that is subject to a specified streamlined, ministerial approval process not subject to a conditional use permit if the development satisfies certain objective planning standards. This bill would require that a housing development project be a use by right upon the request of a nonprofit hospital, nonprofit diagnostic or treatment center, nonprofit rehabilitation facility, nonprofit nursing home, or religious institution that partners with a qualified developer on any land owned in fee simple by the applicant if the development satisfies specified criteria. The bill would define various terms for these purposes.

Position
Watch

Workforce

AB 329 **(Rodriguez D) Hospitals: assaults and batteries.**
Location: 7/10/2019-S. 2 YEAR
Summary: Would make an assault committed on the property of a public or private hospital punishable by imprisonment in a county jail not exceeding one year, by a fine not exceeding $2,000, or by both that fine and imprisonment. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Position
Support

AB 890 **(Wood D) Nurse practitioners: scope of practice: practice without standardized procedures.**
Location: 1/28/2020-S. RLS.
Summary: Would, until January 1, 2026, establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice without the routine presence of a physician and surgeon. The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled

Position
Support

AB 1850 **(Gonzalez D) Employee classification: still photographers, photojournalists: freelancers.**
Location: 2/14/2020-A. L. & E.
Summary: Current statutory law establishes that, for purposes of the Labor Code, the Unemployment Insurance Code, and the wage orders of the Industrial Welfare Commission, a person providing labor or services for remuneration is considered an employee rather than an independent contractor unless the hiring entity demonstrates that the "ABC" test is met. Existing law exempts specified occupations and business relationships, including persons providing professional services under specified circumstances. Current law instead provides that these exempt relationships are governed by the multifactor test previously adopted in the case of S. G. Borello & Sons, Inc. v. Department of Industrial Relations (1989) 48 Cal.3d 341. This bill would replace the submission limit and instead exempt still photographers, photojournalists, freelance writers, editors, and newspaper cartoonists from the application of Dynamex and these provisions based upon different specified criteria, including that these persons provide professional services pursuant to a contract that includes specified items, as provided.

Position
Watch

AB 2537 **(Rodriguez D) Illness and injury prevention program: opioid exposure.**
Location: 3/12/2020-A. L. & E.
Summary: Would require employers of workers who provide direct patient care to patients being treated for opioid overdose in specific settings to create, implement, and maintain an illness and injury prevention program (IIPP) to protect those employees. The bill would require the IIPP to meet specific requirements, including a screening protocol, the provision of personal protective equipment, decontamination and cleaning protocols, postexposure followup, training, and assessment.

Position

Watch

SB 900 **(Hill D) Department of Industrial Relations: worker status: employees and independent contractors.**

Location: 2/12/2020-S. L., P.E. & R.

Summary: Current law expressly authorizes the Department of Industrial Relations to assist and cooperate with the federal Wage and Hour Division and the federal Children's Bureau in enforcing of the federal Fair Labor Standards Act of 1938 within this state.This bill would recast those provisions and would delete the express authorization for the department to assist and cooperate with the bureau.

Position
Watch

SB 965 **(Nielsen R) Worker status: independent contractors: healthcare industry.**

Location: 2/20/2020-S. L., P.E. & R.

Summary: Current law establishes that, for purposes of the Labor Code, the Unemployment Insurance Code, and the wage orders of the Industrial Welfare Commission, a person providing labor or services for remuneration is considered an employee rather than an independent contractor unless the hiring entity demonstrates that the person is free from the control and direction of the hiring entity in connection with the performance of the work, the person performs work that is outside the usual course of the hiring entity's business, and the person is customarily engaged in an independently established trade, occupation, or business. This test is commonly known as the "ABC" test, as described above. Current law exempts specified occupations and business relationships from the application of Dynamex, including licensed insurance agents, certain health care professionals, including physicians and surgeons, dentists, and podiatrists, subject to meeting certain conditions and license requirements. This bill would expand the above-described exemptions to also include health facilities, as defined, which contract with companies that employ health care providers who provide services to patients at those facilities.

Position
Watch

SB 966 **(Nielsen R) Worker status: independent contractors: pharmacists.**

Location: 2/20/2020-S. L., P.E. & R.

Summary: Current law establishes that, for purposes of the Labor Code, the Unemployment Insurance Code, and the wage orders of the Industrial Welfare Commission, a person providing labor or services for remuneration is considered an employee rather than an independent contractor unless the hiring entity demonstrates that the person is free from the control and direction of the hiring entity in connection with the performance of the work, the person performs work that is outside the usual course of the hiring entity's business, and the person is customarily engaged in an independently established trade, occupation, or business. This test is commonly known as the "ABC" test. Current law exempts specified occupations and business relationships from the application of Dynamex and these provisions. Existing law instead provides that these exempt relationships are governed by the test adopted in S. G. Borello & Sons, Inc. v. Department of Industrial Relations (1989) 48 Cal.3d 341. This bill would expand the above-described exemptions to also include individuals who are licensed pharmacists.

Position
Watch

Total Measures: 57
Total Tracking Forms: 57

PSJH Ethics Brief Guide to Scarce Resource Decisions During COVID-19

This document is intended to provide a quick reference to ethical principles and core values foundational to the PSJH response to scarce resource management during crisis standards of care and to provide important information about ethics resources available to the response.

The comprehensive response by our health system to any crisis or natural disaster is rooted in our PSJH Mission and Values and in our Promise, "Know me, care for me, ease my way." Our decision making around preparedness, safety, quality, and care for patients and families affected by the crisis is guided by our Values of Compassion, Dignity, Justice, Excellence, and Integrity. These valuses are especially important during a crisis. Triage decisions should be made using operational and clinical guidelines according to the best available evidence-based clinical criteria related to condition and survivability in crisis standards of care. This policy seeks to embody compassionate care and our Catholic Identity, which is animated by our *Ethical and Religious Directives for Catholic Health Care Services* 6th ed, specifically Directives 3, 6, 23, 33, 55, 56, 57, and 61.

In addition to other values cited in this document, the ethical bases for Allocation of Scarce Resources during Crisis Standards of Care are grounded in these values: social solidarity, professionalism, justice, equity and excellence.

- **Social solidarity:** principles of respect for persons, the common good, public order, and safety for all, especially those who are most vulnerable, maximizing the number of lives saved when the health care needs overwhelm the available resources within a community.
- **Professionalism:** principles of one's fiduciary responsibility as a healer, and the institution's commitment to reciprocity, in this scenario the duty to safeguard caregivers, and integrity regarding evidence based decision-making.
- **Justice, Equity and Excellence:** the equitable distribution of care proportionate to the abilty to benefit patients while avoiding and reducing harm where it cannot be avoided and stewardship of available scarce resources. Triage decisions should be grounded in the best available, objective, and evidenced-based information in order to help determine benefit in any given triage situation. Triage officers and teams should be established within local ministries and connect with local and state crisis response networks.

<u>Issues Pertaining to Stigma, Bias, and Prejudice</u>

The values of justice and care for the common good compels us to provide care to all in need no matter what race, ethnicity, or nationality they may belong to. The best care for the whole person and justice requires us to foster a welcoming environment with solidarity and inclusivity in all our interactions with patients and family facing the uncertainties inherent in crises. The values of dignity, justice, and autonomy also oblige us to respect privacy and confidentiality as well as to neutralize stigma and defend against discrimination.

<u>Issues Pertaining to Those Who Are Poor and Underserved</u>

In fulfillment of the values of dignity and compassion we strive to ensure that those who are poor and underserved receive every effort to keep this population safe and cared for.

<u>Issues Pertaining to the Ethical Duties to Provide Care and Safeguard Caregivers</u>

In fulfillment of the values of dignity, compassion, excellence, and integrity, all health care professionals have a moral duty to respond to the needs of the sick and suffering in proportion to their role and professional capacity. In responding to epidemics and pandemics, and in light of safety conditions at work, caregivers should assess their duty to serve together with other obligations such as to family and personal health. The moral duty to provide care under these circumstances may be outweighed by significant burdens and barriers. Discerning these matters is a collaborative effort between caregivers and leadership.

Ethical Dilemmas in Personal Protective Equipment Shortages

Moral distress regarding a shortage of Personal Protective Equipment (PPE) emerges from competing duties in the context of Crisis Standards of Care. Specifically, institutuional duties to provide a safe working environment for caregivers within the threshold defined by a particular crisis and caregivers' professional duty to provide care.

Decisions that would include optimizing, conserving or reusing PPE such as n95 respirators, will benefit by using CDC updated recommendations for appropriate levels of protection, which includes reuse if necessary due to a shortage (see CDC n95 strategy). These recommendations help caregivers and health care institutions provide appropriate care, ensure safety, and preserve the common good in the midst of scarce resources. These recommendations are consistent with the Providence St. Joseph Health Mission and Values, the *Ethical and Religious Directives for Catholic Health Care Services*, the ethical principles of triage, and professionalism in health care

Leaders should be attentive and immediately responsive to caregiver concerns about the potential for dramatically unsafe working conditions. All available efforts, under the auspices of the local command center, should be deployed to address the concerns using the tools of Caring Reliably. Leaders also have a responsibility to work with caregivers to ensure the burdens of the additional risk are equitable and do not unfairly burden a given caregiver or family. Individual concerns should be addressed on a case by case basis.

We must acknowledge that these recommendations may change as new information is obtained during the course of any developing or ongoing crisis. What will not change is own commitment to know, care, and ease the way of our patients and our care providers.

Framework for Challenging Questions and Issues in Crisis and Disaster Response

Administrative Triage Teams
During a crisis that requires these guidelines, Triage Teams for the review of hospital admission, ICU admission, and transition to comfort care should be established or activated. If there is conflict or disagreement among the Triage Teams, the Regional Director of Ethics or Clinical Ethicist (where available), Ethics Consult Team, Ethics Committee, and/or Mission Leaders are available to assist as needed.

Bedside and Virtual Care Teams
Caring for the whole person: Established or *ad hoc* multidisciplinary teams, including chaplaincy, should be called to support any patient and family in need of additional psychosocial and spiritual support, especially in the setting of a triage decision to limit advanced life-supporting treatments or to transition to care focused on comfort.

Ethics Consultation
The professional Ethicists and Ethics Committees of PSJH are ready and able to support the PSJH response to crisis and disasters and to assist with ethical questions and issues. Caregivers and leaders are encouraged to include our Ethicists in decision making as appropriate. Ethicists' contact information is provided here by region in addition to information for the Theology and Ethics system office.

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ADULT Critical Care Triage Algorithm

Crisis Standards of Care

Updated Version: Mar 2020

This Algorithm is intended to be used alongside the attached Worksheet.
Answering each question requires the supplemental information in the Worksheet.
Please use them together

Assumptions for use:

1. Health Officer has declared a crisis situation requiring scarce resource management and crisis standards of care, where crisis standards of care is defined as *"a substantial change in usual healthcare operations and the level of care it is possible to deliver which is made necessary by a pervasive or catastrophic disaster"*.[1]
2. Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care.

Washington State has adopted and will use the ethical framework developed by the National Academy of Medicine, which stresses the importance of an ethically grounded system to guide decision-making in a crisis standards of care situation. All decisions and communications will be based on the ethical principles below. The National Academy of Medicine defines these ethical principles as:

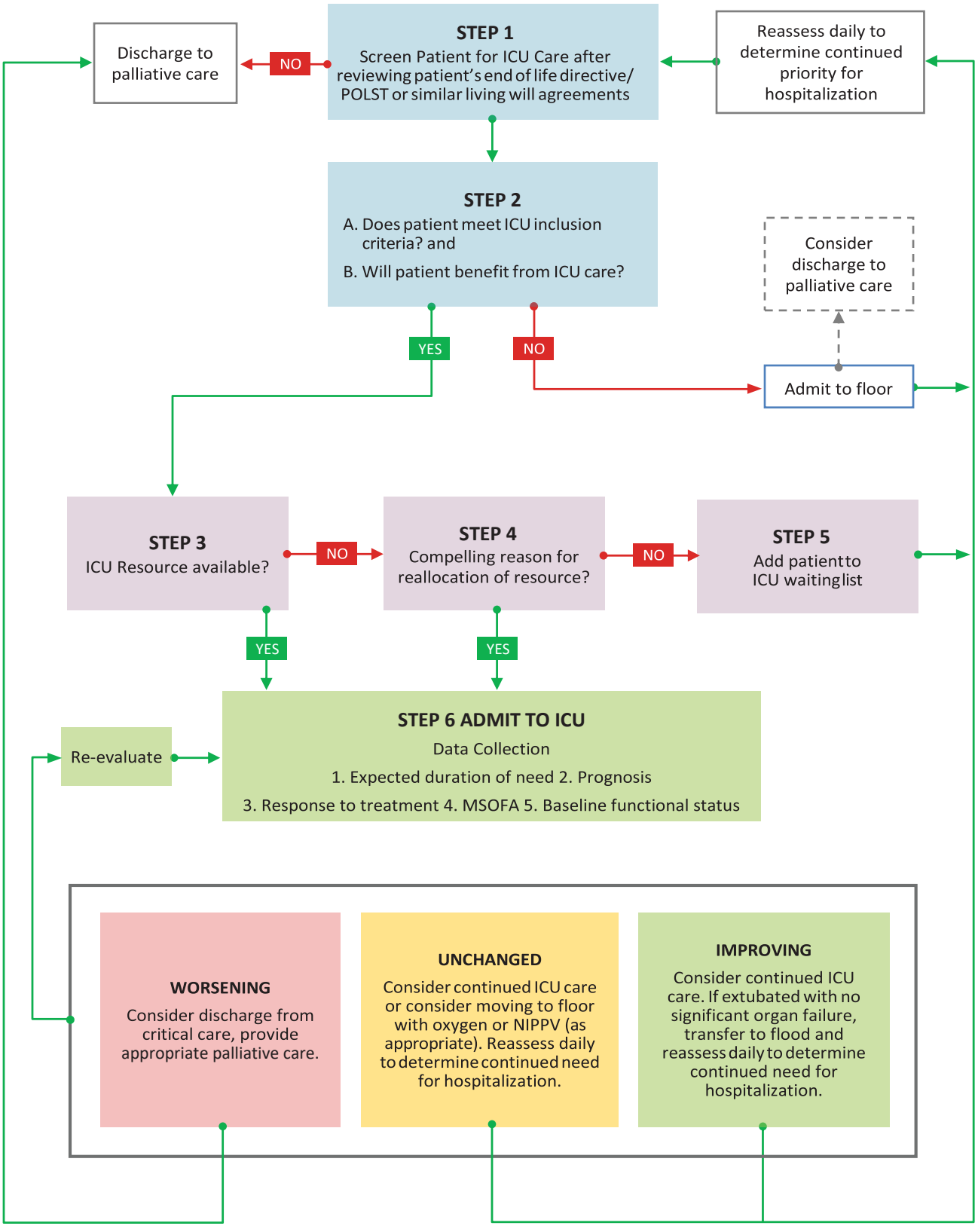
- **Fairness** – Standards that are, to the highest degree possible, recognized as fair by those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.
- **Duty to care** – Standards are focused on the duty of healthcare professionals to care for patients in need of medical care.
- **Duty to steward resources** – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- **Transparency** – in design decision making, and information sharing.
- **Consistency** – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources).
- **Proportionality** – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.
- **Accountability** – of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.[2]

1. IOM (Institute of Medicine) 2009. Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report. Washington, DC: National Academies Press.

ADULT Critical Care Triage Algorithm

Crisis Standards of Care

Updated Version: Mar 2020



ADULT Critical Care Triage Worksheet

Critical Care Guidelines During Crisis Capacity[1]

This Worksheet, along with the corresponding Adult Critical Care Algorithm, are to be used by "Triage Teams" during a declared emergency event whereby an appropriate healthcare official has implemented crisis standards of care. It is recommended that a "Triage Team" be comprised of senior medical personnel, preferably not those primarily taking care of the individual patient under consideration. Please see "Scarce Resource Triage Team Guidelines" for further information.

STEP 1: Screen adult patients for ICU care during scarce resources

Proceed to following after reviewing patient's end of life directives/POLST or similar living will documents. For the following conditions consider available staffing and resources. If resources are inadequate, ***consider*** transferring the following patients to out-patient or palliative care with appropriate resources and support as can be provided.

1. ☐ Pre-existing or Persistent coma or vegetative state
2. ☐ Severe acute trauma (e.g. non-survivable head injury)
3. ☐ Severe burns with Low Survival burn scores based on the Triage Decision for Burn Victims table (See Table A below). See Burn Scarce Resource Card for management of critical burn patient outside of a Burn Center.
4. ☐ Significant underlying disease process that predict poor short term survival*

   **Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*
   - *Severe congestive heart failure*
   - *Severe chronic lung disease*
   - *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
   - *Severe cirrhotic liver disease with multi-organ dysfunction*
5. ☐ Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

STEP 2: Determine if patient meets ICU Inclusion Criteria

2A: Patients must have at least one of the following INCLUSION CRITERIA:

- ☐ 1. Requires ventilatory support, either invasive or non-invasive
  - ☐ Clinical evidence of impending respiratory failure
    - *Refractory hypoxemia (SpO2<90% on FIO2>0.85)*
    - *Respiratory acidosis (pH<7.2)*
  - ☐ Inability to protect or maintain airway
- ☐ 2. Hypotension (SBP <90) secondary to either an acute medical or trauma condition, with clinical evidence of shock (altered level off consciousness decreased urine output, or other evidence of end stage organ failure) refractory to volume resuscitation that cannot be managed in a non-ICU setting.

2B: To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) - *Please see Step 6 regarding use of scoring system*
- Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Severe congestive heart failure*
- *Severe chronic lung disease*
- *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
- *Severe cirrhotic liver disease with multi-organ dysfunction*

STEP 4: Assess for re-allocation of Critical Care Resource

To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) – *Please see Step 6 regarding use of scoring systems*
- Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Severe congestive heart failure*
- *Severe chronic lung disease*
- *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
- *Severe cirrhotic liver disease with multi-organ dysfunction*

STEP 5: Critical care waiting list

If a patient meets ICU inclusion criteria and resources are not available, patient will be placed on an ICU waiting list. As resources become available their clinical situation will be re-assessed and they will be re-triaged based on criteria outlined in Step 6. If a clear distinction cannot be made between patients of similar triage priority, the resource will be allocated to the patient who has been waiting the longest.

STEP 6: Admit to ICU

Patient data collection outlined on Step 6 of the Algorithm will be continuous and ongoing. It is recommended that every 24 hours of a patient's ICU stay, their clinical condition will be reviewed and they will be determined to be "Improving", "Unchanged" or "Worsening". This determination must not only take into account data points as outlined in Step 6 but must also include updated epidemiology, critical care resource availability and census demands.

Previously, recommendations had been made to use MSOFA score alone to determine triage categories. However, based on more recent data[2,3] it is current consensus that a specific SOFA or MSOFA score cannot accurately define clinical categories alone, and therefore all criteria outlined in Step 6 including current epidemiology must be taken into account when deciding if patients are "Improving," "Unchanged," or "Worsening".

Other Adult Considerations

All patients receiving critical care ***before the onset*** of crisis standards will be re-assessed based on the same criteria as all incoming critical care patients. The same Data as outlined in Step 6 should be obtained and resources re-allocated if needed dependent on the Triage Team assessment and decisions.

The use of ECMO should be decided on an individual basis by the ICU attending, nursing supervisor and ECMO representative based on prognosis, suspected duration of ECMO, availability of staff and other resources.

1. 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 patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. (Hick et al, 2009, IOM)
2. Grissom, Colin K, Disaster Med Public Health Preparedness 4(4):277-284, 2011
3. Shahpori, R; Crit Care Med 39(4):827-832, 2011

Code Status and COVID19 Patients

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While much remains unknown about COVID19, particularly in regards to the US population, it is clear the disease is often deadly in elderly patients with co-morbid illness. Care is largely supportive, to include oxygen and respiratory, including ventilator, support. Despite full supportive efforts, many critically ill patients with COVID19 will die, generally of multiorgan failure, sepsis, and/or cardiomyopathy.

All studies and reports regarding COVID19 note an increased mortality associated with both age and the presence of comorbidities including hypertension, diabetes, and coronary artery disease. A retrospective cohort study from Wuhan, China of 191 seriously ill patients with confirmed COVID19 disease reported only a single survivor among 32 patients who received mechanical ventilation.
https://www.thelancet.com/pb-assets/Lancet/pdfs/S014067362305663.pdf

The survival to hospital discharge for critically ill patients receiving CPR is very low (<15%), with already being on mechanical ventilation, older age, and co-morbidities reducing that likelihood even further.
https://www.atsjournals.org/doi/full/10.1164/rccm.200910-1639OC

As such, CPR may be medically inappropriate in a significant portion of elderly, critically ill patients with COVD19 and underlying comorbidities. As per UWMC and HMC policy, clinicians are NOT obligated to offer or provide medically inappropriate treatment, even when requested by patients and/or designated surrogates. (This conclusion is consistent with ERDs.) If treating clinicians, including more than one physician, determine that CPR is not medically appropriate, a Do Not Attempt Resuscitation Order (DNR) may be written without explicit patient or family consent. In all cases, however, the patient and/or appropriate surrogate should be informed of this decision, along with the rationale in support. Patient or family "informed assent" should be sought but is not required. Expert, compassionate communication with patient/family is necessary.
https://www.sciencedirect.com/science/article/pii/S0012369215366332?via%3Dihub

Potential language/points to share with family when CPR is deemed medically inappropriate:

1) Based on our review of your loved one's clinical status, we are worried that this coronavirus along with their previous medical conditions is leading to an end of life process.

2) We are sorry to share that we believe your loved one is dying.

3) Under these circumstances we do not provide CPR. We want to make sure you understand this decision and have the opportunity to ask any questions that you have.

CommonSpirit

Health Care Ethics Advisory

Caring for Patients with Suspected or Confirmed COVID-19

3/23/2020

I. Introduction

> *As CommonSpirit Health (CSH), we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.*

Today, as we respond to the COVID-19 pandemic, health care professionals at CSH find themselves in a situation similar to past situations, one whereby their professional vocation of caring for patients in need could pose risks to themselves. In addition to the multitude of clinical, public health and legal issues, COVID-19 poses ethical questions. In what follows, several of the more salient questions surrounding the ethical care of patients with suspected or confirmed COVID-19 are outlined and ethical responses for each are offered. Because of the complex and changing nature of this situation, the responses provided herein are advisory and subject to further study and revision.

This document draws upon our ethical commitments[1] about the dignity of the human person, special attention to the needs of the most vulnerable members of our community, and full consideration for the common good. It also draws upon the collaborative resources available through broad academic and public dialogue on healthcare issues arising during pandemics and emergency preparedness. Of note, the CSH Ethics department, Division ethicists and local ethics committees are available for consultation as questions arise and are also willing to participate in COVID-19 discussions as appropriate. Specific questions not answered here can be directed to ethics@commonspirit.org or to local CSH ethics leaders and the local Chair of the Ethics Consultation Team.

[1] Guidance for Catholic ministries includes information in the *Ethical and Religious Directives for Catholic Health Care Services*, (6th Ed.) and other sources of Catholic moral teaching.

II. Health Care Professionals and the Care of Patients with COVID-19

Are health care professionals required to care for patients with suspected or confirmed COVID-19?

Ethically, as with previous infectious disease outbreaks, health care professionals are generally required to care for patients with suspected or confirmed COVID-19. In choosing their vocation, health care professionals knowingly and willingly commit to undertaking risks, including those posed by patients with infectious diseases. Although they need not care for patients at all costs, health care professionals are expected to deliver care to patients with infectious diseases when safety measures and procedures can reasonably mitigate the risk of disease transmission. With adequate training, access to and proper use of personal protective equipment (PPE), and adherence to established evidence-based care protocols, health care professionals can safely provide care to these very vulnerable patients. Literally thousands of health care professionals worldwide have met the needs of patients during this COVID-19 outbreak and previous contagious outbreaks without contracting the disease themselves.

Can health care professionals opt-out of caring for patients with suspected or confirmed COVID-19?

Yes, but only under certain circumstances. Health care professionals may opt-out if:

- They are pregnant, nursing, immunosuppressed (medically confirmed) or have some other medical condition that warrants removal from the care team; ***or***
- Their physical abilities make it more difficult for them to follow precise protocols of staff protection with PPE; ***or***
- They have not been adequately trained in safety measures to mitigate transmission risk ***and*** another qualified, properly trained health care professional is available to provide the care to the patient without compromising the safety of the patient.

In addition, where personal protective equipment (PPE) is not available or maybe substandard under the clinical circumstances, a collaborative assessment and decision-making process will need to be engaged.

If I am quarantined as a result of <u>potential exposure</u> to COVID-19 and working from home, or another remote location, will I get paid?

Yes, employees with a non-work-related exposure/potential exposure who are required to self-quarantine based on CDC guidelines, are experiencing symptoms, or have been diagnosed with COVID-19 will be allowed to utilize their applicable EIB/Sick bank(s) and/or employer-paid short-term disability benefits without using PTO first, waiving the elimination period.

- If the employee exhausts all time off banks during the first 14 days off, CommonSpirit Health will pay administrative leave for the remainder of the 14-day period that would otherwise have

been unpaid. This would be administered outside of our normal policies and procedures, in a non-discriminatory basis.

- If a non-exempt employee wishes to take an unpaid leave for a non-work-related quarantine period, the employee may do so, even if they have hours in their time-off bank(s), as long as there is no conflicting information in the local policy.
- If the local facility has a policy that allows donation of PTO/Vacation time, we encourage them to continue to follow that policy in order for employees to support one another through this time. Normal procedures for these donations should be followed.

Should health care professionals who have to be quarantined as a result of work-related exposure to someone with suspected or confirmed COVID-19, or who become ill as a result of caring for a patient with COVID-19 be compensated monetarily?

Yes, employees with a work-related exposure that result in required quarantine will be placed on paid admin leave up to 14 days, and should complete an incident report per the normal workers' comp process, as well as contact Employee Central.

- If an employee is out longer than 14 days, they will have access to their available time off banks (examples of time off banks include: EIB, Sick, PTO and/or Vacation). CommonSpirit Health will help to coordinate pay with other agencies as applicable.
- If the local facility has a policy that allows donation of PTO/Vacation time, we encourage them to continue to follow that policy in order for employees to support one another through this time. Normal procedures for these donations should be followed.

Should there be a financial incentive for healthcare professionals willing to care for and treat patients with suspected or confirmed COVID-19?

Additional pay or financial rewards meant to incent health care professionals to care for patients with COVID-19 are not appropriate. The motivation to care should spring from the virtues that underlie the profession.

Is it acceptable to designate a specific facility and/or select and train a limited number of health care professionals to care for patients with suspected or confirmed COVID-19?

In past pandemic events this approach was acceptable. It could also be acceptable in our current environment if it is deemed the most effective way to reduce public health risks, mitigate the risks to health care professionals, and safely deliver quality care to patients with suspected or confirmed COVID-19.

III. The Provision of Increased-Risk Treatments to Patients with COVID-19

Should health care professionals provide resuscitative measures to patients with COVID-19?

Clinical evidence proposes that coronaviruses spread from person-to-person through respiratory droplets. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit and urine, might put healthcare providers at risk of COVID-19.

The CDC defines high-risk exposures for healthcare providers as,

> *Having had prolonged close contact with patients with COVID-19 who were not wearing a facemask while a healthcare provider's nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the healthcare provider's eyes, nose or mouth were not protected is also considered high risk.*[2]

Generally, health care providers have a duty to provide potentially life-saving treatments to patient such as CPR unless it is impossible to adequately mitigate risk to staff. Codes of ethics of all health care professionals include a duty to provide care for patients even at some risk to themselves. This is a primary ethical duty of the health care professional, but it is not absolute and there are ethically justifiable exceptions. Those exceptions occur when there is disproportionate risk to the health care professionals providing the care.

In considering the risks related to providing CPR to a patient positive for coronavirus disease (COVID-19) who has a cardiopulmonary arrest, we begin with the ethical assumption that patients are entitled to clinically indicated care for which they have provided informed consent. Evaluation of each individual patient is necessary to determine whether CPR is likely to achieve its intended goal of restoring circulatory function and can be provided safely. The determination of disproportionate risk must be based on the best available, if rapidly evolving, evidence about the treatment of patients with COVID-19. Potentially life-saving treatments

[2] Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19) March 7, 2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

such as CPR should be provided to patients unless that treatment is identified as: a) nonbeneficial/inappropriate care based on the patient's values or, b) it is impossible to adequately mitigate risk to staff.

Based on the best available evidence, decision-makers should weigh the potential benefit to the patient of CPR, with the risk that the treatment poses to the patient as well as the health care providers and staff providing it. Even in an emergency situation, such as a cardiopulmonary arrest, health care providers and staff should never compromise safety protocols because doing so results in more overall harm than benefit given the high risk of infection without PPE. Staff should always don appropriate personal protective equipment (PPE) before performing a code for a patient, even if it means delaying the code.

Should other treatments that heighten transmission risks to health care professionals be offered and provided?

Resuscitation is not the only intervention that provides heightened safety challenges for health care professionals. Other invasive treatments may also dramatically increase such risks. Ethically, they should be evaluated in the same way as resuscitation, that is, based on patient/family preference, clinical effectiveness, and the safety protections able to be put in place for health care professionals. In high risk procedures with COVID-19 positive patients, additional PPE is required such as N95 masks.

Treatment should only be limited for patients with suspected or confirmed COVID-19 when the treatment is identified as: a) nonbeneficial/inappropriate care based on the patient's values or, b) it is impossible to adequately mitigate risk to staff.

How should health care professionals respond to a pregnant patient with COVID-19?

As stated by the CDC,

> *It is unknown whether newborns with COVID-19 are at increased risk for severe complications. Transmission after birth via contact with infectious respiratory secretions is a concern. To reduce the risk of transmission of the virus that causes COVID-19 from the mother to the newborn, facilities should consider temporarily separating (e.g., separate rooms) the mother who has confirmed COVID-19 or is PUI (Persons Under Investigation) from her baby until the mother's transmission-based precautions are discontinued.* [3]

[3] Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings. https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html

How do we decide to shift to comfort care? What if family disagrees?
This question has come up in the context of an influenza epidemic when the need for ventilators exceeds resources.

To the extent that it is medically reasonable to determine when a patient's prognosis is such that continued aggressive interventions cannot be reasonably expected to be of benefit to the patient, and/or unnecessarily increase the risk of exposure to COVID-19 to healthcare professionals and staff, it is ethical to recommend a shift to comfort as the focus of treatment. The shift to a comfort care plan will initiate the continuation of a different care plan of treatments and support for the patient.

There may be situations in which the patient and/or surrogate decision-maker/family disagree with this shift; however, given the unique circumstances related to available treatments and resources, it may be necessary to make a unilateral treatment decision (i.e., a decision with which the physician does not have the consent of the patient and surrogate decision maker). This type of unilateral decision should be done in collaboration with an assessment of a second physician. CSH ethicists and local ethics committees are also available to address the relevant ethical considerations of these decisions.

Are family members and friends allowed to visit patients with suspected or confirmed COVID-19?
Per the CDC guidelines, visitors should be avoided. In some regions or counties, such as San Francisco[4], Public Health Officers may have issued limitations on Hospital visitors.

Regarding nursing homes, the CDC has stated,

> *Facilities should **restrict** visitation of **all** visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situations. In those cases, visitors would be limited to a specific room only.*[5]

For patients who do not own a personal communication device, the hospital should attempt to provide a laptop/cellphone, walkie talkie or other device to communicate remotely with family members and friends. Exceptions regarding visitors may be considered on a case-by-case basis, based on the needs, values and clinical circumstances of the patient. An example

[4] City and County of San Francisco, Order of the Health Officer No. C19-06, "Limitations on Hospital Visitors", Date Order Issued - March 13, 2020. https://www.sfdph.org/dph/alerts/files/Order-C19-06-ExcludingVisitorstoHospitals-03132020.pdf
[5] Centers for Disease Control, March 13 CMS Directive Ref: QSO-20-14-NH https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf

of this might be patients who are at the stage of "end of life". In these cases, visitors/family would need to wear appropriate PPE and be symptom free.

In rare cases and with their informed consent, CDC guidelines permit consideration of visitors when deemed "essential for the patient's wellbeing." Potential visitors should receive thorough counseling about the safety precautions they will need to take as well as the risks and consequences of visiting the patient.

What information should be shared about patients with suspected or confirmed COVID-19?
The ethical principle of truth-telling supports informing patients and/or surrogates that in the event of a cardiopulmonary arrest there may be a delay in responding while the code team or other first-responders don the required PPE. However, neither patients nor surrogates have the right to request that any health care professional administer CPR without PPE as this would expose the staff to a disproportionate risk.

Unilateral decisions to limit certain interventions like CPR to all patients with COVID-19 based solely on their diagnosis are ethically problematic because such decisions fail to individualize care based on the relative risks and benefits to the patient and the health care providers and staff involved in the patient's care. Evaluation of each individual patient is necessary to determine whether CPR is likely to achieve its intended goal of restoring circulatory function and can be provided safely. Although it is ethically justifiable to factor in concerns about staff safety when making decisions about the care that will be offered to patients with COVID-19, as a general rule, care should be provided unless it is impossible to adequately mitigate risk to staff.

Because appropriate sharing of accurate information is critical during this time, only a designated representative from the hospital should communicate necessary information with appropriate public health officials. Beyond that, the privacy and confidentiality of the patient should be maintained to the fullest extent possible. Although much of the personal information of patients in the United States who have contracted COVID-19 has become public, health care professionals should not abandon their duty to protect the rights and dignity of patients with COVID-19. The ethical importance of privacy and confidentiality should also be emphasized to employees. In responding to media inquiries, the hospital should strive to maintain the confidentiality of the patient and avoid releasing the patient's name or other identifiers if at all possible. Employees should be reminded that they are not permitted to post any information about suspected or confirmed cases of COVID-19 on social media. This includes a general and non-identifying statement that such a patient has presented in a CSH entity.

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