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Crisis Standards of Care and COVID-19

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1

00:00:05,035 --> 00:00:16,405

Okay, it's three o'clock, so we're gonna go ahead and get started. I just wanted to thank everybody for joining us today professor Laura Luehrmann and I'm, I'm president of the faculty Senate at Wright

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00:00:16,405 --> 00:00:21,114

State University, and we're really happy to coordinate this talk to the speaker series.

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00:00:21,445 --> 00:00:31,855

And today, we've got an extremely and relevant talk today from two of our nursing professionals and I'll be introducing them in just a minute. For those of you who are just joining us.

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00:00:31,855 --> 00:00:34,104

If you're relatively new to WebEx events,

5

00:00:34,854 --> 00:00:37,134

you'll notice that your microphone is muted,

6

00:00:37,405 --> 00:00:39,655

you're unable to see the other participants,

7

00:00:40,554 --> 00:00:41,695

but you are

8

00:00:41,695 --> 00:00:45,625

we ask that you please submit questions via the chat room,

9

00:00:45,835 --> 00:00:52,494

during the presentation and our two speakers will be happy to address as many of the questions as possible.

10

00:00:52,854 --> 00:01:03,835

Now, if you hover down around the bottom of your screen should be the third circle from the right it's a little our conversation circle.

11

00:01:03,840 --> 00:01:13,980

You can use that to submit questions that you may come up with. I'm going to introduce our esteemed panelists for today's discussion. First Dr Sherry Farra.

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00:01:14,420 --> 00:01:22,160

She is a professor of nursing in the College of Nursing and is the Blanke Endowed Chair of Research at Wright State University.

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00:01:22,820 --> 00:01:37,540

She is certified by the ANCC as a national health disaster professional, and in 2019 Dr. Farra was identified as the National certified disaster nurse by that organization.

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00:01:38,880 --> 00:01:52,740

Dr. Farra has a history of funding and the study of disaster training with inter professionals participants. Her research has focused on the use of digital simulation in a study of low volume,

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00:01:52,760 --> 00:01:55,600

high risk events associated with disaster.

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00:01:56,844 --> 00:02:09,414

As a Red Cross volunteer, she is a member of the leadership of the National nursing network. Her work has been disseminated on a national level, including awards scholars and the expertise.

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00:02:10,824 --> 00:02:14,094

I'm also happy to welcome back to Wright. State University

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00:02:14,094 --> 00:02:26,514

even if it's virtual format Dr Sherrill Smith. Dr. Smith is dean and professor at the University of Washington J.W. Whitney school of nursing in Laramie, Wyoming.

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00:02:28,555 --> 00:02:32,935

She is a former faculty member and assistant dean at Wright State University.

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00:02:34,104 --> 00:02:43,585

She served for twenty six years in the military, both active duty and reserved retiring at the rank of colonel in 2011.

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00:02:44,729 --> 00:02:58,914

Her current research interests include simulation in nursing education and disaster education. She has published collaboratively with Dr Farra on these topics for the past seven years.

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00:02:59,514 --> 00:03:09,594

So, Dr. Smith is gonna serve primarily as moderator today, and I'm gonna kick it off now to Dr. Sherrill Smith to lead us in this presentation. Thank you.

23

00:03:15,444 --> 00:03:21,955

Thank you Laura. So we welcome Dr Farra to the talk on our crisis standards of care. So go ahead. Dr. Farra.

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00:03:23,275 --> 00:03:25,435

And thanks to Dr. Smith,

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00:03:25,645 --> 00:03:26,784

who is a wonderful friend,

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00:03:26,784 --> 00:03:27,955

and collaborator,

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00:03:28,284 --> 00:03:30,264

and I just wanted to point out

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00:03:30,715 --> 00:03:40,360

that we recently published a journal article on the implementation of crisis standards of care in December of 2019

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00:03:40,360 --> 00:03:43,164

in the journal nurse leaders.

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00:03:43,164 --> 00:03:46,615

So, we were just lucky with our timing with that.

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00:03:47,634 --> 00:03:50,995

I'd also like to acknowledge Dr Pei from engineering,

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00:03:51,564 --> 00:04:05,604

Him and I are working with the University of Cincinnati and university hospital on collaborating on a grant that we're submitting this week how to educate hospital leaders in crisis response.

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00:04:05,604 --> 00:04:14,064

So, it's very timely with the topic that we're talking about today and so that's a resubmit. We were scored the first time.

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00:04:14,064 --> 00:04:22,194

So we are hopeful that we will get approved and funded this round next slide.

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00:04:24,930 --> 00:04:28,824

So these are some of the headlines that have been in the paper lately,

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00:04:28,824 --> 00:04:43,644

and these are topics that are all related to shortage and supply staff and space and we're gonna focus on these shortages and how they affect healthcare today and how it can

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00:04:43,644 --> 00:04:54,475

lead to the implementation of crisis standards of care. The objectives today are on the screen.

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00:04:54,685 --> 00:05:08,725

Basically we're gonna talk about crisis standards of care the indicators and triggers for when we implement pricing standards of care. What are the ethical implications and applications to crisis care?

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00:05:09,060 --> 00:05:24,900

And then we're gonna talk about how crisis standards of care implementing supply staff and space related to the COVID-19 disaster that we're currently in or pandemic that we're in.

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00:05:25,020 --> 00:05:28,400

Next.

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00:05:28,520 --> 00:05:29,020

So,

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00:05:29,035 --> 00:05:29,904

on the slide,

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00:05:29,935 --> 00:05:31,615

there's a list of publications,

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00:05:31,615 --> 00:05:34,615

and they all are coming out or Institute of medicine,

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00:05:34,615 --> 00:05:43,975

which is now the National Academy of Medicine but this is pretty much an overview of how the crisis standards of care developed in the US.

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00:05:44,189 --> 00:05:58,254

So, it began 2009 in the middle of the H1N1 pandemic, some of you might remember that. How we were short of vaccines. We had to prioritize how we were treating patients.

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00:05:58,254 --> 00:06:07,045

You might remember healthcare workers and pregnant women got the vaccine before other people did.

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00:06:07,944 --> 00:06:17,995

So that was the first time that we thought about ration of care and how we could more organized the response into crisis standards of care.

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00:06:18,475 --> 00:06:29,035

And so a lot of that 2009 meeting came that on crisis standards, the care, somebody for workshop series and that's the first publication you'll find on the Institute of medicine.

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00:06:29,459 --> 00:06:37,795

If you teach courses and you want really great, rich resources from the Institute of medicine, you probably know they're all free.

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00:06:38,035 --> 00:06:47,305

You can download the PDF, the books, the entire thing, but these on the slide are just a really rich source of information on crisis standards of care.

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00:06:47,970 --> 00:06:53,665

So, following that 2009 meeting, then we came out with a guidance document.

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00:06:54,055 --> 00:07:08,574

But then, there's a little law and then 2011 hit and we had the trade on Joplin, the earthquake and tsunami in Japan the earthquake dealing all of which further demonstrated

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00:07:09,384 --> 00:07:15,954

the need to have some sort of way that we can utilize are allocate resources

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00:07:16,230 --> 00:07:18,535

when we were about beyond capacity,

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00:07:18,774 --> 00:07:25,105

or when we're overwhelmed by the response. So in 2012 and 2013,

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00:07:25,375 --> 00:07:28,254

you see a series of documents that occur,

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00:07:28,435 --> 00:07:35,185

and they all provide guidance, templates, tool kits, on how to actually implement crisis standards of care.

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00:07:35,814 --> 00:07:47,485

And then it goes a little bit quiet again and there's a document that's not on there yet, but it's 2019, they met for the ten year anniversary, right? Before the pandemic hit.

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00:07:47,814 --> 00:07:49,824

And that document is,

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00:07:49,915 --> 00:07:50,305

I think

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00:07:50,305 --> 00:07:51,805

out for publication right now,

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00:07:51,805 --> 00:07:54,750

or it might be a draft form. Basically

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00:07:54,774 --> 00:08:00,204

they talk about how prices standards of care have been implemented in recent years and

65

00:08:00,509 --> 00:08:01,675

you know

what went well,

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00:08:01,675 --> 00:08:03,115

what didn't go well.

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00:08:04,074 --> 00:08:04,675

And so,

68

00:08:04,704 --> 00:08:06,235

the bottom one is

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00:08:06,685 --> 00:08:10,134

the most important document on there,

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00:08:10,134 --> 00:08:12,865

and that's the one on in

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00:08:12,865 --> 00:08:17,845

2020 duty to plan healthcare crisis Anderson care for the novel corona virus.

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00:08:18,295 --> 00:08:23,425

And that's pretty much become a hallmark document for a response for the pandemic.

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00:08:24,660 --> 00:08:39,475

Next, thank you. So, I'm going to spend a lot of time on crisis standards of care and building up to that. I just thought I would give you a little overview

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00:08:39,504 --> 00:08:40,914

so that you know, where we're going.

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00:08:41,759 --> 00:08:55,164

So, just briefly crisis standards of care is a change in care brought on by disaster or emergent event in which we don't have enough supply.

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00:08:55,740 --> 00:09:01,075

So, staff space to respond to the event.

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00:09:01,315 --> 00:09:15,024

And so, the definition of disaster from the World Health Organization is that our need exceeds our supply, that we don't have enough response. So, the need to respond is greater than what we have.

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00:09:15,294 --> 00:09:24,684

And so crisis standards of care are just that. What we're going to do in response to the lack of resources that we have in these circumstances.

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00:09:25,164 --> 00:09:38,904

We always have a formally declared emergency and because of that we have a specific regulatory powers and protection that are in place due to that emergency declaration. Next slide.

80

00:09:44,725 --> 00:09:58,134

So these are the different levels of emergency declaration, and we probably have all witnessed at this point, and are well aware of it from what has gone on with the COVID-19.

81

00:09:58,495 --> 00:10:02,184

So, we had federal declaration of emergency,

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00:10:02,394 --> 00:10:17,394

we had state and state of Ohio, and locally we had Montgomery County health declare, and then we did have the later response at the international level of the World Health Organization declaring to public health emergency.

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00:10:17,725 --> 00:10:22,764

So at this point, with COVID we've had emergencies declared at all possible levels.

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00:10:23,039 --> 00:10:29,455

So that those protections that we talked about our in place that indicate to us

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00:10:29,485 --> 00:10:33,715

that we can start exploring the use of crisis standards of care.

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00:10:33,924 --> 00:10:39,565

We will not always use crisis standards of care just because there's the emergency declaration,

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00:10:40,105 --> 00:10:49,674

and we'll talk about the triggers and indicators that are needed to implement crisis standard of care as we go. Next slide.

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00:10:52,080 --> 00:11:06,144

So the goals decision making during extreme condition needs to be underpinned by an ethical framework, in this case, where you said, you can use utilitarian framework.

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00:11:06,414 --> 00:11:18,595

And basically, what we're saying is, we're going to do the most good for the most people with the greatest chance of survival and that it's really hard as healthcare providers because we're used to doing everything

90

00:11:18,595 --> 00:11:32,754

we can to possibly save the life of an individual. And we have a lot of nurses in the audience, and they know that that's what we do. We know we work on everything, but as we shift to crisis care, that's no longer the case.

91

00:11:32,784 --> 00:11:45,085

Now, we're going to look at the population focused and we're going to be looking at how we do the greatest good for those that have the greatest chance of survival with the caveat that we cannot disproportionately burden

92

00:11:45,085 --> 00:11:52,825

those who already suffer from health disparity in social injustice. And so that's really important

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00:11:53,125 --> 00:12:01,134

and as you can see on some of the news article successor, when we talk about COVID, that's not necessarily occurring right now.

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00:12:01,134 --> 00:12:11,485

That there does seem to be some disproportionate burden onto minorities and to the elderly who are in nursing homes.

95

00:12:11,850 --> 00:12:20,934

So, in that sense, we're not necessarily doing what we need to as we implement the crisis standard care. Next slide.

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00:12:23,519 --> 00:12:34,225

So the guiding principle rule number one don't implement crisis standard of care, unless you have to. Do everything possible, not to implement standards of care

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00:12:34,710 --> 00:12:40,524

because when we implement them, we're going to recognize that people are not gonna get their care that they need

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00:12:40,524 --> 00:12:51,264

and some people may die or have higher rates of mortality and morbidity. And so the guiding principle, the first thing we say, we don't want to do this. We're gonna plan for it

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00:12:51,264 --> 00:13:06,205

so, if we have to do it we can have a really good response but our goal should be to extend the resources we have without impacting care. So we want to save as many lives as possible but we recognize that. Some people may die.

100

00:13:07,705 --> 00:13:22,075

The other piece to the guiding principles is that this is going to be very much a facility response. So that depending upon those three things that we keep talking about staff, staffers supplies and space,

101

00:13:22,644 --> 00:13:30,235

what I have at my facility will impact how I'm able to care for patients. Next slide.

102

00:13:34,434 --> 00:13:45,804

So,

the mission with crisis standards of care is in order to ensure that patients receive the best care possible in the benefit disaster,

103

00:13:46,195 --> 00:13:49,975

the committee from the set forth a vision standards.

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00:13:50,279 --> 00:13:53,784

And then they're on the screen that fairness, equitable processes,

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00:13:54,929 --> 00:14:02,304

transparency which some people say, we're not seeing a lot of right now and how things are being decided. Consistency.

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00:14:02,304 --> 00:14:13,195

It should be what is happening in New York should be similar to what is happening in one hospital in New York, in another hospital, in New York. Proportionality

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00:14:13,404 --> 00:14:22,825

is when we have a response that when we implement the crisis standards of care, we implement at the level of disasters.

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00:14:22,825 --> 00:14:33,205

So we don't over respond to an event or under respond to events. Really important to have community provider engagement, education communication.

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00:14:33,205 --> 00:14:39,235

We're gonna talk about those and we're gonna talk about the law in a minute next slide.

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00:14:43,914 --> 00:14:56,575

So, the purpose of the purpose of crisis standard to allocate resources to patient during all phases of a public health or medical emergency, and remember right now, or in the pandemic

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00:14:56,575 --> 00:15:10,014

but there are other. Think about hurricane season is coming. There are a lot of things that occur beyond a pandemic in, which we would be responding with crisis, standard care.

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00:15:10,440 --> 00:15:25,075

So it provides the clinical framework that we can plan from so that we can think about what we would do, if we're short of ventilators, etc ahead of time, what would we do if we don't have ICU beds so that we can plan ahead of time.

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00:15:25,105 --> 00:15:34,434

So then, when the time come, we can make decisions, ethical decision based on that premise of doing the greatest good for the greatest number persons.

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00:15:35,394 --> 00:15:47,904

And also, the purpose is to empower clinicians at the point of care I have a video later on that we're gonna look at, in terms of the pressure, or how it feels for clinicians

115

00:15:47,904 --> 00:16:02,245

to have to make these types of solutions that the bedside. So the purpose of one of the purposes of crisis standards of care can be to relieve more of the stress of practitioners that are having to allocate the scarce

116

00:16:02,245 --> 00:16:03,144

resources.

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00:16:03,480 --> 00:16:13,195

So nobody goes into nursing to not put somebody on the ventilator. A doctor doesn't go into medicine so that he's not going to intubate a patient.

118

00:16:13,495 --> 00:16:14,245

And so these,

119

00:16:14,784 --> 00:16:18,115

and we're having some reported suicide because now there

120

00:16:18,115 --> 00:16:20,304

are some people will crisis standards

121

00:16:20,304 --> 00:16:20,904

of care

122

00:16:21,144 --> 00:16:23,514

providing clear guidelines to people,

123

00:16:23,845 --> 00:16:24,355

helping them

124

00:16:24,355 --> 00:16:26,725

make decisions on guidelines

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00:16:26,725 --> 00:16:31,434

and take some of that responsibility off the individual clinicians decision.

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00:16:31,434 --> 00:16:43,195

making is important. Next slide. So Dr. Farra, I'm gonna just stop here and see if there's any questions from anyone if they wanna put him in the chat.

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00:16:43,705 --> 00:16:51,299

But I was wondering if well, I give some folks some time, could you explain the significance of the red sofa in your last slide?

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00:16:52,495 --> 00:17:04,914

Yeah, you go so I put that in there I think that's we're gonna talk about sofa scores when we talk about ventilators.

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00:17:05,335 --> 00:17:07,015

And I just stuck that there

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00:17:07,015 --> 00:17:14,335

because I thought that someone might actually ask and you did so it's about some of the criteria that were used

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00:17:14,365 --> 00:17:18,805

the clear cut guidelines that clinicians can use to make decisions,

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00:17:19,109 --> 00:17:25,585

ethical decisions about, hopefully ethical decisions that we might talk about some problems with the sofa score,

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00:17:25,585 --> 00:17:26,095

actually,

134

00:17:27,265 --> 00:17:28,615

when we get to that section,

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00:17:28,615 --> 00:17:30,295

but that's why that focus on there.

136

00:17:31,674 --> 00:17:39,204

Great, thank you. Alright one more. Okay.

137

00:17:39,894 --> 00:17:50,454

So what do I mean, when I talk about standards of care? Last night I was talking to a good friend, and she says, "well, what are standards of care?" and I'm like, "Well, everybody know that?"

138

00:17:50,454 --> 00:18:02,904

Well, everybody's not a nurse, or physicians so that might be new term for you. A standard of care refers to the reasonable care a healthcare provider would typically provide to a patient.

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00:18:03,690 --> 00:18:09,414

So, if you came to my emergency room and your condition was such that

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00:18:11,369 --> 00:18:24,654

perhaps I thought you were having an MI or something and you need an intensive care bed. I could get you in the intensive care unit. I could give you a nitrogen drip. I could put you on some oxygen and I could put you on some Heparin.

141

00:18:25,255 --> 00:18:38,964

I could schedule you very easily for a procedure, that would be the standard of care. Right? So, when we're talking about that would be at the top conventional care I'm pointing my to me, but anyways, conventional care.

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00:18:40,015 --> 00:18:54,805

The next level of care is contingency care. So, when I'm when I've acted as an administrative officer in the hospital, I had to do bed control.

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00:18:54,805 --> 00:19:05,815

So we have a certain number of ICU beds, and if they're full, we need to figure out what we're gonna do. If we have additional patients that need those ICU beds. So typically, on what

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00:19:06,835 --> 00:19:07,855

sometimes we do,

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00:19:07,855 --> 00:19:09,325

is we open up the PACU,

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00:19:09,325 --> 00:19:14,065

which is the post anesthesia care unit, we open that up to additional patients,

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00:19:14,484 --> 00:19:19,224
and we have packing nurses who we have come in,

148
00:19:19,224 --> 00:19:20,184
or stay over,

149
00:19:20,184 --> 00:19:23,664
to take care of those patients in the PACU.

150
00:19:23,904 --> 00:19:35,515
It has the same resources as an intensive care for the most part. The PACU nurses are trained at the level of intensive care nurse. So they're getting a functionally equivalent care.

151
00:19:35,664 --> 00:19:50,035
It's in a different spot if not in the intensive care. But I'm still given them the functionally the same here. It's just we've moved the contingency care. We're delivering a different space in a different way, but the care of equivalent.

152
00:19:50,994 --> 00:19:59,634
When we go to the crisis standard of care, we're no longer given functionally equivalent care. We're no longer meeting a standard of care.

153
00:19:59,845 --> 00:20:09,924
We've gone to a place where resources are depleted and we're having to change how we respond to patient based on the resources

154
00:20:09,924 --> 00:20:24,444
we have so, and what has happened is people that need ICU beds, there's competition, and we have to make decisions about who is going to get that ICU bed of that ICU care. And so that's where we hope

155
00:20:24,444 --> 00:20:28,855
we never get to what we have most recently with the pandemic gotten to that,

156
00:20:28,855 --> 00:20:39,565
where we're having to allow the intensive care beds based on a prioritization. Next slide.

157
00:20:43,164 --> 00:20:57,684

So, when I talked about moving patients to PACU in response to a high number surge patient, that surge capacity planning, surge, capacity planning can

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00:20:58,019 --> 00:21:11,154

even mean, like, in the year I put beds in the hallway, because I'd run out of room and but they're still being cared for by our staff. They still have access to the same level of care.

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00:21:11,154 --> 00:21:23,095

That's a surge capacity plan. Crisis, standards of care go beyond that they're activated only during a long term event with no practical way to obtain critical resources.

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00:21:24,900 --> 00:21:29,515

The critical nature makes you make these decisions immediately,

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00:21:29,904 --> 00:21:32,994

and we've been talking about COVID,

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00:21:32,994 --> 00:21:40,884

but think about other things like explosions, large number of people injured, train derailment,

163

00:21:40,914 --> 00:21:45,444

etc. That can quickly overwhelm an emergency department

164

00:21:45,444 --> 00:21:56,065

and you might have to go into crisis standards of care. Just temporarily until you can get the resources that you need, depending upon the size event, hopefully help coming.

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00:21:58,914 --> 00:22:13,494

In planning, we always are looking and making sure that we have plans for surges, because there's going to be surge that occurs in hospitals on a routine basis, but big surge with large numbers of patients in a pandemic,

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00:22:13,825 --> 00:22:26,904

we can't necessarily plan for. Really key to the continuum is we move back from crisis to contingency contingency to conventional as soon as we get resources.

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00:22:27,329 --> 00:22:39,474

So, you're seeing that in New York, right now we're, they're moving back from crisis and I think probably more of a contingency, or even a conventional level of care at this point.

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00:22:40,015 --> 00:22:50,910

But there's other hot spots in the country that are going up the hill where they're moving from contingency to crisis. Crisis care strategy need to be updated frequently.

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00:22:51,234 --> 00:23:03,894

So you can't say on Monday, we're going into crisis care, not think about it again until Friday. It's daily, even hour we look at what resources do we have? How can we best care for the patients that we have.

170

00:23:06,835 --> 00:23:07,944

Next slide please.

171

00:23:11,454 --> 00:23:26,095

I see a question from Laura over there, Sherrill, but she would like to just talk briefly. Dr Farra about how the example of the priest in Italy.

172

00:23:26,095 --> 00:23:40,105

That was in the news volunteering to give up a ventilator and lose someone else and talk about the issue of how the patient is involved. And I know you're gonna get to your slide about how you have to plan ahead with your community.

173

00:23:40,134 --> 00:23:44,785

Perhaps you could talk a little bit about this right now that the involvement of the patients.

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00:23:46,164 --> 00:23:58,315

So, the patient who is being de-escalated from care, which means there, they're not going to get the routine care that they normally Grandma's

175

00:23:58,345 --> 00:24:10,105

isn't going to go on the ventilator, because we don't have enough ventilators and her sofa score or her for the guidelines. Say that she's not the person that's going to get the ventilator.

176

00:24:10,555 --> 00:24:17,184

The family is supposed to be informed about the decision, and they're supposed to have some input into that decision.

177

00:24:19,674 --> 00:24:33,444

The Italian priest I did not read about it. I can see how that was heart wrenching. I've read a lot out of what happened in Italy. There's actually a resource on the related to that.

178

00:24:34,404 --> 00:24:37,734

They weren't doing a very

179

00:24:39,384 --> 00:24:50,454

sophisticated implementation of crisis standards of care in determining who was getting access here.

180

00:24:50,875 --> 00:25:04,825

But I would say, you know, I think that if that was the case, and he was an older gentleman, and there were younger, healthier patient, according to crisis, standard of care, that decision probably was a good one.

181

00:25:04,825 --> 00:25:17,184

And now probably, what should have been done. I know. I read the news or heard on the news about the gentleman from Texas setback. Basically some other people were gonna have to die.

182

00:25:17,214 --> 00:25:30,684

So, the younger people would have a future whatever that's not really what we're talking about with crisis standard care, not in any way an economic decision.

183

00:25:30,990 --> 00:25:42,505

The decisions are about resources that we have to care for patients and how we're going to care of those patients. And I answer your question more. Okay.

184

00:25:45,055 --> 00:25:55,075

So this slide I really like this slide. If you teach ethics, this Hastings center article that I've reference on the bottom.

185

00:25:55,134 --> 00:26:05,664

It's a really a fantastic article that is free online that you can get. But if you look on this, you can see so it breaks down in the stuff, staff.

186

00:26:06,204 --> 00:26:11,154

Stuff, space and staff or supplies, base, staff.

187

00:26:11,424 --> 00:26:18,055

And you can see that across the board and we have increasing resource scarcity and as we go across,

188

00:26:18,055 --> 00:26:20,515

you can see where you're going from conservation,

189

00:26:21,295 --> 00:26:23,664

accessing emergency stockpiles,

190

00:26:24,025 --> 00:26:25,134

reuse of equipment.

191

00:26:25,134 --> 00:26:36,654

We saw that Patel out of Columbus actually came up with a method to sterilize math and help us on re-allocate resources that way.

192

00:26:36,990 --> 00:26:45,805

And then we get away with the crisis where we start using triage protocol. Some areas could be (audio unclear) patient.

193

00:26:45,984 --> 00:26:58,944

It's more like, if you have an infrastructure, like, during hurricane or a tornado, where parts of the hospital are not stable. I actually was involved in that evacuation of Pre-memorial

194

00:26:58,944 --> 00:27:03,625

when there were the fire in parts of that building the infrastructure was not stable

195

00:27:03,625 --> 00:27:14,694

and we were moving patients out of it. So you can have activation of the hundreds of care where you're moving patients to of an intensive care unit because of a fire

196

00:27:14,724 --> 00:27:26,934

while they're not getting intensive care quality care because the standard we can't meet it because we move the patient down step out in the yard. Right?

197

00:27:27,329 --> 00:27:29,904

So that's more of an immediate type of

198

00:27:31,315 --> 00:27:45,954

application of the crisis standards of care. I really do, if you wanna take your camera and take a screenshot, that is the excellent article that each of these slides I tried to put up on resource

199

00:27:45,954 --> 00:27:49,884

so that if you want to go back and look at it and can find it. Next slide.

200

00:27:56,545 --> 00:28:00,234

So,

as we transition from contingency to crisis care,

201

00:28:00,539 --> 00:28:05,184

what there's an understanding that we're going to have an increase in mortality and morbidity,

202

00:28:05,519 --> 00:28:06,894

But that's her car like,

203

00:28:06,894 --> 00:28:14,545

when you recognize the healthcare provider that you are gonna lose some patients that you normally would stay on.

204

00:28:14,904 --> 00:28:16,375

So, it's only with the,

205

00:28:18,775 --> 00:28:31,615

it's only with the highest level of conditions that we implement these crisis standards of care. So we have to try all of these things. We have to implement the surge fully.

206

00:28:31,825 --> 00:28:37,855

We have to make attempts at conservation reuse, etc, try and get the federal resources.

207

00:28:37,855 --> 00:28:38,515

Unfortunately,

208

00:28:38,515 --> 00:28:42,805

the strategic mask stockpile was depleted in this case.

209

00:28:44,125 --> 00:28:44,724

It's really,

210

00:28:44,724 --> 00:28:58,434

we really can transfer our people because that was not really an option when you have an overwhelming pandemic but we don't want to implement these crisis standards of care if we can possibly avoid it.

211

00:28:59,605 --> 00:29:07,404

Next slide. So I like this slide.

212

00:29:07,615 --> 00:29:09,325

I put it in there and keep bringing (audio unclear)

213

00:29:11,934 --> 00:29:16,345

So this is just a totally a business model.

214

00:29:16,345 --> 00:29:25,375

But the solid line is the demand for health care dash line is that supply of resources,

215

00:29:25,375 --> 00:29:28,315

and you can see and supply goes up,

216

00:29:28,315 --> 00:29:38,424

and the demand goes up, I mean supply goes down demand goes up we move into crisis standards of care and then as the patient decrease in supplies increase

217

00:29:38,730 --> 00:29:45,775

we can move back to conventional care current. We have another comment.

218

00:29:45,775 --> 00:29:54,775

I don't know if you wanna say anything about, "One of the hardest parts about transitioning is knowing what quality and safety benchmarks are used to define a best practice?"

219

00:29:55,589 --> 00:30:08,125

So, with them within the crisis standards of care, depending upon, where you live. So, and I have a slide we're gonna talk about Ohio. What we have in Ohio.

220

00:30:09,265 --> 00:30:20,244

Unless you live somewhere else and you live in Minnesota. In Minnesota they have wonderful standards of care that are statewide and they're very clear.

221

00:30:20,549 --> 00:30:22,585

And when you draw up,

222

00:30:22,585 --> 00:30:28,255

and when you go down. In other places where the crisis standards of care are

223

00:30:28,255 --> 00:30:29,694

maybe not as clear,

224

00:30:29,934 --> 00:30:35,845

it does become difficult to know what the quality and safety benchmarks are.

225

00:30:36,144 --> 00:30:37,884

But you can look at equipment,

226

00:30:37,884 --> 00:30:38,545

and we're gonna look

227

00:30:38,545 --> 00:30:40,285

at some examples,

228

00:30:40,285 --> 00:30:41,515

not just from Minnesota,

229

00:30:41,545 --> 00:30:43,464

but from Massachusetts,

230

00:30:43,464 --> 00:30:46,944

and I think from maybe Illinois,

231

00:30:46,974 --> 00:30:47,575

I forget,

232

00:30:47,575 --> 00:30:52,345

but how we can look at resources and know exactly where we should be,

233

00:30:52,404 --> 00:30:54,174

shouldn't be an eventual.

234

00:30:55,045 --> 00:31:03,355

Should we be in crisis, or should we be in contingency based on the level of supplies and stuff that we have?

235

00:31:05,365 --> 00:31:14,484

Next slide. This is from IOM,

236

00:31:14,724 --> 00:31:23,934

and I like this box. So this is kind of helps us to what are some of the strategy that we can use for scarce resources?

237

00:31:24,480 --> 00:31:36,174

So, preparation is the main thing, and I will tell you from personal experience when I started working at Wright State, and I just find it terrible and I know this is being recorded

238

00:31:36,174 --> 00:31:41,694

so

I want to be careful how I put this. But when I went out to calamity bill,

239

00:31:41,694 --> 00:31:42,684

the first time,

240

00:31:42,714 --> 00:31:45,414

the warehouse was full of supplies,

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00:31:45,444 --> 00:31:51,055

just full of supplies that we're being stored by the state of Ohio,

242

00:31:51,115 --> 00:31:51,744

like personal

243

00:31:51,744 --> 00:31:56,845

protective equipment, stuff to set up a mobile hospital,

244

00:31:56,845 --> 00:31:57,595

etc.

245

00:31:58,045 --> 00:32:11,634

But that was right after a major disaster and then over time, overtime, investment in those resources and stuff became expired, they didn't want to pay the money to replace it.

246

00:32:11,964 --> 00:32:18,595

And so they all went away. The stock pile of supplies went away. Now.

247

00:32:18,595 --> 00:32:30,055

I know GADAHHA which is the Greater Dayton Area Hospital Association has some supplies there, but for the most part, it was nowhere near what there needs to be.

248

00:32:30,474 --> 00:32:34,015

And so there is a reluctance to put money

249

00:32:34,349 --> 00:32:46,704

into disaster planning until something really bad happens and then we're all for it and I look for that to happen after this disaster in that we will

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00:32:46,704 --> 00:32:51,204

probably I already hearing people calling that "What are we gonna do for the next one?"

251

00:32:51,204 --> 00:33:05,065

"How we're gonna make sure this never happens again?" And that means that we're gonna have to stockpile supplies, we're going to have to watch them for expiration dates and we're gonna put money into that pot.

252

00:33:05,964 --> 00:33:07,404

But that's really hard to do

253

00:33:07,855 --> 00:33:10,884
when everybody's short of resources,

254
00:33:11,095 --> 00:33:16,045
etc. So we we can conserve supplies,

255
00:33:16,410 --> 00:33:18,625
but I don't know,

256
00:33:18,805 --> 00:33:22,255
in the hospital in a year ago,

257
00:33:22,255 --> 00:33:27,234
I could've walk in anywhere and change my gloves ten times during the day and

258
00:33:27,234 --> 00:33:33,805
not a thing of it or use six or seven masks going in and out of the room and definitely

259
00:33:35,664 --> 00:33:42,894
I think we're now in a mode where we're conserving substitution or to provide an equivalent or near equivalent.

260
00:33:43,259 --> 00:33:44,815
When you see that with masks

261
00:33:47,575 --> 00:33:50,934
a surgical mask is really not a substitution for,

262
00:33:50,934 --> 00:33:52,825
and M95 respirator,

263
00:33:53,184 --> 00:34:02,005
although we were substituting doing what we had to do in terms of substituting on masks for mask.

264
00:34:02,035 --> 00:34:02,664
Adapt,

265

00:34:02,724 --> 00:34:06,085

use of equipment for ultimate alternative purposes.

266

00:34:06,414 --> 00:34:18,235

And we saw a lot going on with ventilators and bipap and CPAP, and putting two people on a ventilator reuse. We talked about that with the (audio unclear) and then we allocate

267

00:34:19,795 --> 00:34:34,614

in terms of maybe not someone has a higher likelihood of benefiting from a resource, triage that resource to the, a person for whom it would be the most good. Slide.

268

00:34:39,025 --> 00:34:52,855

So, when we are talking about distribution of scarce resources, we have to be non discriminatory in what we do and we're gonna talk about testing in a few slides for now.

269

00:34:52,855 --> 00:35:06,204

But when we talk about testing, we need to see where have we been to discriminatory in our testing? Have we been equal to everybody? Has everyone had an equal opportunity to for testing? And that's something we'll talk about.

270

00:35:07,375 --> 00:35:10,344

The distribution of resources should be a team decision.

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00:35:10,344 --> 00:35:15,894

It should not be an individual decision and then when we start talking about

272

00:35:15,925 --> 00:35:20,125

rationing resources or de prioritization,

273

00:35:20,394 --> 00:35:22,585

which means just what it sounds like,

274

00:35:23,514 --> 00:35:26,275

instead of being the priority patient for something,

275

00:35:26,275 --> 00:35:27,985

you're not gonna be the priority.

276

00:35:27,985 --> 00:35:36,114

You're going to move down the list and so you most likely might not get the resources that you need to have a positive outcome.

277

00:35:36,744 --> 00:35:51,474

So we have with the prioritization again that increased mortality and morbidity likelihood of the person that we treat should have the higher likelihood of good acceptable response to treatment.

278

00:35:51,864 --> 00:36:00,894

And one of the other things we talk about when we're talking about de prioritization is community risk of transmitting infection.

279

00:36:01,230 --> 00:36:11,304

And that's I'm not necessarily something we're considering a lot of Covid because there's patients that are really sick are hospitalized. We need to talk about palliative care.

280

00:36:11,304 --> 00:36:18,474

So, if a person isn't going to get on the ventilator, then we need to make sure that we have ways to minimize their pain and suffering.

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00:36:18,985 --> 00:36:27,295

So, the key pieces we plan for these events is that the people are able to

282

00:36:29,184 --> 00:36:38,005

we just don't have people die. We make sure that we are leaving suffering and pain prioritization of essential workers.

283

00:36:38,005 --> 00:36:52,525

I think we've seen a lot of that happening to maintain acceptable staffing levels. Nursing coming from outside the area to help in New York and other areas that New England

284

00:36:54,715 --> 00:36:55,465

When we get,

285

00:36:55,465 --> 00:37:07,405

I have a slide in there. We'll talk about what we've done for staffing. How what what have we done with the crisis response that we've done to improve staffing? And then again, that important piece of reassessment as needed.

286

00:37:08,664 --> 00:37:09,164

Next.

287

00:37:12,295 --> 00:37:12,894

So,

288

00:37:13,074 --> 00:37:16,644

when we're planning and planning is really important,

289

00:37:16,764 --> 00:37:27,835

these are the five components of planning that the ION says is critical to developing on strong crisis standards of care.

290

00:37:28,105 --> 00:37:40,014

And again, we have the ethical grounding, communication, the legal aspects, the clear triggers evidence based clinical processes in operation. Right?

291

00:37:43,980 --> 00:37:54,295

So these are similar to the ones we talked about again, that ethical grounding fairness duty to care, duty to steward resources, which we don't always do

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00:37:54,295 --> 00:38:03,235

well etc. You know, that photograph moved. All right next slide please. Oh.

293

00:38:07,974 --> 00:38:15,985

So this is a really important thing is that we need to educate healthcare providers about crisis standards of care.

294

00:38:16,500 --> 00:38:28,585

So that they are aware of what they are, but also the possible need for them and support supporting both the patient and the provider

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00:38:28,585 --> 00:38:37,494

If they face the decision that violate usual care standards. So we really have to make sure that we're being transparent

296

00:38:37,829 --> 00:38:43,764

and that would communicate at all level the providers into the public into the patient.

297

00:38:49,440 --> 00:38:55,735

So, there are legal consideration when we don't provide the care that we usually provide

298

00:38:55,945 --> 00:39:09,804

and so there's statutory regulations and permissions that can be altered as necessary in real time. And we've seen a lot of that come out of the health department.

299

00:39:12,414 --> 00:39:24,864

There's also other legal protections that we'll talk about in a minute. My dog is barking. I'm going to let him out. Sherrill, talk about the next slide.

300

00:39:43,195 --> 00:39:54,355

I'm sorry, like a commercial break. Did you actually say anything about the slide Sherril? Nope. So I didn't know if you want to. So you said next slide?

301

00:39:54,355 --> 00:40:04,585

I wasn't sure if when I continue on this one with the legal aspects, or yeah. We can finish with this one and then see, if there's any other questions. So, legal, there's lots of legal protections that are out there

302

00:40:04,585 --> 00:40:05,244

right now.

303

00:40:06,324 --> 00:40:10,164

With that go along with the local declaration of disaster.

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00:40:10,585 --> 00:40:12,594

There is still a liability risk,

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00:40:12,655 --> 00:40:16,405

and we'll talk about those and find this coming out,

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00:40:16,405 --> 00:40:29,454

but there are protections from the etc that give professional healthcare professionals and organization some protection legal protection as they implement the crisis standard.

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00:40:36,894 --> 00:40:46,554

You know what civil liability and it is definitely a possibility that you could face civil liabilities for your actions during the pandemic.

308

00:40:47,244 --> 00:40:53,184

And so right now in the next phase of the care act.

309

00:40:54,385 --> 00:40:58,675

Laura,
my calling it the right thing, my political person anyways,

310

00:40:58,764 --> 00:41:01,465

In the care act in the next version,

311

00:41:01,465 --> 00:41:02,485

the next stimulus,

312

00:41:02,485 --> 00:41:17,215

or whatever that they're going to do president Trump and other are proposing that there'll be liability protections in there for healthcare workers and their employers and

313

00:41:17,335 --> 00:41:31,014

other businesses and so some people have a lot of positive feelings about it and some people have negative feelings about that and I will leave that to you to read what you think.

314

00:41:36,264 --> 00:41:39,744

The only thing that's on here that you might not have heard about

315

00:41:39,775 --> 00:41:54,565

I would think would be the federal prop in the federal prop act is just you can have immunity for liabilities when you're using counter measures during a disaster.

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00:41:54,565 --> 00:42:01,525

So if you're like, a counter measure, in this case, could be an immunization or vaccine.

317

00:42:01,525 --> 00:42:15,505

If the vaccine becomes available, we give the vaccine to somebody they have a bad response according to the prop act you're not going to be able to be held liable for that. But it has a very limited scope to it is not real big.

318

00:42:15,505 --> 00:42:17,724

It's more just related to those

319

00:42:18,059 --> 00:42:26,844

counter measures in, but the rest of the the good Samaritan act, if you're a healthcare worker, that's not doing a lot for you

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00:42:26,844 --> 00:42:34,344

that's more for people that are come upon the scene and render aid or volunteers.

321

00:42:35,425 --> 00:42:49,014

The other thing that's on there, that offers protection would be your liability protection of your organization, or your own personal liability insurance policy that you might have.

322

00:42:49,704 --> 00:42:58,614

The only problem is and some of these liability policies are written that you are hearing to that standard of care.

323

00:42:58,675 --> 00:43:06,864

And so crisis standard of care, not necessarily adhering to the prevailing standard of care.

324

00:43:08,125 --> 00:43:17,304

Next slide. So this is to be much more interesting than civil liability and these are the triggers.

325

00:43:17,304 --> 00:43:29,844

What are the triggers in the indicators that we're going to use to implement crisis standards of care and so we should be have situational awareness.

326

00:43:29,844 --> 00:43:37,945

That's one of the most important things that Governor DeWine had demonstrated,

327

00:43:37,945 --> 00:43:39,414
in a lot of his response,

328
00:43:39,804 --> 00:43:43,135
he said situational awareness and responded very quickly,

329
00:43:43,375 --> 00:43:48,565
to triggers and indicators in his state.

330
00:43:48,594 --> 00:43:52,914
So that's why we flap their curve before others.

331
00:43:52,914 --> 00:44:04,704
Because he quickly altered the standards, not necessarily the standards of care, but definitely altered standards of what we were doing in the community, but also altered standards of care

332
00:44:04,704 --> 00:44:08,125
when you think about stopping elective

333
00:44:10,079 --> 00:44:18,594
procedures, that's an altered standard of care. Now, people that need needing replacement can't get them people that need these routine surgeries can't get them.

334
00:44:19,074 --> 00:44:31,704
So that's an altered standard of care from the stuff around PPE, the initiatives to open up beds and different areas outside of hospitals and stuff like that.

335
00:44:32,034 --> 00:44:37,494
That's all a response to the indicators and triggers that he saw

336
00:44:37,525 --> 00:44:47,784
and that he was responding to. And some people myself included, I think he has done a very good job with that. Next slide.

337
00:44:52,110 --> 00:45:04,675
So, indicators of the measures, their predictors that you can see coming so (unclear audio) turns on in the group. I saw her write something in the chat.

338

00:45:04,675 --> 00:45:16,135

Back I think in December when there were the first two cases in China reported, I'm like, you need I texted or you need to watch. This is not good. Something bad is going on. That's an indicator.

339

00:45:16,224 --> 00:45:31,135

Like, if you are paying attention, and you saw that in China, you could've started immediately doing things and we did at my house. I went and bought all my friends buy maks. My family bought masks.

340

00:45:32,605 --> 00:45:43,885

Most of them didn't do it though. But I'm just telling you, I told. The triggers are the decision points based on changes in those we comment we see it coming, we're predicting that it's coming,

341

00:45:44,155 --> 00:45:55,434

and now we have actual changes and so it's based on those triggers second we're going to begin implementing the crisis standards of care. So we're unable to locate that space,

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00:45:55,434 --> 00:46:05,155

the staff, the supplies that we need to care for patient next. So Dr Farra we have another question. Can you just clarify that with the standards

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00:46:05,155 --> 00:46:16,405

are federal, local both, especially given the current situation. So that is a very good question. I'm not sure who wrote that one, but so.

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00:46:16,710 --> 00:46:25,344

Crisis standards of care are not federal at this point. We don't have an overarching response that's been dictated by the federal government.

345

00:46:25,704 --> 00:46:38,394

Now, there are people that are calling for a vaccine, a federal vaccine response when a vaccine is developed so thus far we don't have that. Some states have

346

00:46:41,005 --> 00:46:55,135

crisis standards of care in place for the entire state Minnesota is a prime example. The people that can be that initial IOM group and they still remain it are a lot of people from Minnesota.

347

00:46:55,405 --> 00:47:10,135

They have excellent if you wanna look for a really great set of crisis standards of care, you can look to Minnesota and look at the documents. They have a pandemic document etc.

348

00:47:11,094 --> 00:47:18,985

It's state. Now in our state, yes Minnesota does rock in public health in that. You wrote that, but that is true.

349

00:47:20,664 --> 00:47:32,545

They rock that's just the truth. But in our state, and I have a slide when we get there, we'll just skip it because I'll talk about it now. So we're in Ohio.

350

00:47:32,545 --> 00:47:41,875

We have an emergency operation plan, which is I want to be careful how I say this.

351

00:47:42,054 --> 00:47:42,414

So,

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00:47:42,414 --> 00:47:44,514

it's an operations plan,

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00:47:44,514 --> 00:47:46,614

basically that I am your boss,

354

00:47:46,644 --> 00:47:47,364

you do this,

355

00:47:47,664 --> 00:47:48,414

you do that,

356

00:47:48,744 --> 00:47:51,144

but it doesn't say if we run out of ventilators

357

00:47:51,144 --> 00:47:57,235

what guidelines are we going to use to allocate these resources?

358

00:47:57,565 --> 00:48:09,775

It's not there. So, the Ohio hospital association came out with a document that they say is, is a resource, not guidance

359

00:48:10,079 --> 00:48:23,094

that helps hospital healthcare members in their thinking and decision making. So Ohio says, we're not going to tell you. Each individual

360

00:48:23,094 --> 00:48:32,965

each individual facility, or group within Ohio is gonna make that decision themselves, Which is really, in my mind,

361

00:48:34,974 --> 00:48:49,704

if a call, when you talk about the things that we need public input, we need to protect minorities, minorities should have a voice. We need an ethical framework, etc.

362

00:48:50,094 --> 00:49:04,284

I think when you have a lot of different places doing that it may not be the best way to get the best outcome. But that's my opinion. That's not Wright State's opinion. That's just Sherry Farra

363

00:49:04,284 --> 00:49:19,284

what I think, okay. if you go on Google, there's several states, and they're even called out in some of the ION documents who has really great crisis standards of care in their area.

364

00:49:20,335 --> 00:49:22,885

It, and I can see.

365

00:49:23,215 --> 00:49:25,224

So the two schools of thinking is,

366

00:49:25,614 --> 00:49:37,585

we're giving you your own independence to do what you want based on what's happening in your facilities and then the other stances we're going to have very informed guidelines,

367

00:49:38,125 --> 00:49:39,925

and we're all going to go lock step.

368

00:49:40,045 --> 00:49:52,164

So those are your choices and there's a lot of variety in how crisis standards of care are implemented. How does that answer your question?

369

00:49:54,324 --> 00:49:56,275

Thank you Doctor Farra we're down to about.

370

00:49:56,579 --> 00:50:11,215

Ten minutes left, if you want to show my, how to help you proceed through this. So let's show the video and then we'll talk about it later and (audio loss) what we think.

371

00:50:28,139 --> 00:50:28,639

Okay.

372

00:50:32,815 --> 00:50:35,635

We would have to listen to the commercial. Sorry.

373

00:50:41,304 --> 00:50:44,425

So, why we're looking for this? Yeah. Oh, maybe.

374

00:50:51,144 --> 00:50:59,454

Video Add: The world needs medical supplies. So we're producing more of the raw materials they're made from and making medical grade hand sanitizer for the first time.

375

00:50:59,460 --> 00:51:06,960

Because we are all in this together.

376

00:51:10,320 --> 00:51:13,220

Video: Imaging you are a physician at a hospital bombed by the

377

00:51:13,260 --> 00:51:23,520

corona virus. Three new patients have just arrived to your ICU each gasping for air. A seventy five year old grandfather who was in perfect health just a week ago,

378

00:51:23,934 --> 00:51:27,925

A thirty year old woman with diabetes and asthma and a fifty year old

379

00:51:28,135 --> 00:51:42,954

ICU nurse who, like, you has been treating corona virus patients for weeks. Without ventilators, they will likely die, though you can't know that for sure. What you do know is at your maxed out hospital, there's only one free ventilator.

380

00:51:43,405 --> 00:51:52,885

Is it up to you to choose who gets a chance to live, play God? That is the worst, possible situation

381

00:51:54,474 --> 00:52:05,065

doctors would be faced with making this tragic choice on their own based on their own moral values.

382

00:52:06,985 --> 00:52:13,824

That's what's happening in Italy where the stress has doctors weeping in the hallways, because the choices they've had to make.

383

00:52:16,195 --> 00:52:30,565

Across the U. S. states are pushing that no doctor is left to make these painful decisions alone and on the fly. They're writing or revising their existing pandemic triage plans, which are meant to guide healthcare workers in crises like this.

384

00:52:30,869 --> 00:52:45,715

But here's the problem. In the United States there's no agreement on how to make these potentially life and death judgment calls. Instead the us take the patchwork approach with different states offering different ethical formulas and some not offering detailed plans at all.

385

00:52:46,255 --> 00:52:59,364

As one Doctor recently wrote, you've taken in every hospital system for themselves, approach. It may be a political problem, as much as a medical one is keeping us from having a national framework. I think the politics

386

00:52:59,364 --> 00:53:10,914

for that would be sensational. I mean, I can't even begin to tell you what it would feel like to know that the White House issued a model for how to do this

387

00:53:11,485 --> 00:53:16,675

that Americans we didn't have to point to and say "Your model killed my grand mother.

388

00:53:16,675 --> 00:53:29,005

They want it to be state driven. But in the face of corona virus, isn't this patchwork inadequate? They need unified thinking on this. A national triage strategy that we can all see and understand.

389

00:53:29,724 --> 00:53:43,465

You cannot have triage decision making that is not transparent. That would be a terrible mistake to have triage decision making taking place and for the public to be aware or to have available

390

00:53:43,885 --> 00:53:54,114

what the criteria are that are being used. Any federal plan will have to wrestle with some profoundly philosophical questions. How do we do the greatest good?

391

00:53:54,534 --> 00:54:08,034

Does that mean saving the greatest number of lives or the most years of life? Does it mean prioritizing people with the best chances of surviving and leaving the sick behind? Soon were in a labyrinth of complex trade offs.

392

00:54:09,655 --> 00:54:11,155

Let's take a few examples.

393

00:54:11,244 --> 00:54:25,255

Starting with age. Should young people get priority access to ventilators? Some ethicists have advocated for cutoff ages often around eighty above, which nobody qualifies for one. But how old is too old?

394

00:54:25,885 --> 00:54:32,545

Some plans do consider age a factor. Others stone or they use it as a tie breaker between patients.

395

00:54:32,905 --> 00:54:38,065

But isn't that ageist? It reaks of age discrimination which is why I said

396

00:54:38,065 --> 00:54:41,275

I would make that a second tier consideration. I would say,

397

00:54:41,275 --> 00:54:42,414

in the first instance,

398

00:54:42,414 --> 00:54:51,625

you're gonna make this decision based on who has a better likelihood of survival. What doctors and nurses? Should they get preferential treatment? Again States are divided.

399

00:54:52,079 --> 00:55:06,534

On the one hand, healthcare workers are essential to fight the pandemic. But on the other hand, it's starting to look like the sickest corona virus patients need weeks if not months to get better. Even if they survive, they may not be able to return to work quickly.

400

00:55:06,594 --> 00:55:17,034

There are other documents. So, one is, you are asking people to show up to work and take risks not just for themselves, but for their families.

401

00:55:17,244 --> 00:55:28,945

So, if you really want people to take that risk, you need to let them know, you have their back. You will honor their risk taking. That's always a bitterly disputed topic

402

00:55:29,514 --> 00:55:43,405

and should be. You don't want to end up with an intensive care unit. That is all of doctors and nurses and the local people are shutdown. That is terrible. And that's wrong. What about Pre existing conditions?

403

00:55:44,394 --> 00:55:49,284

Everything from obesity to cancer. Doctors try to estimate how many years (video audio out)

404

00:55:54,385 --> 00:55:56,065

So, I sent it back to you, Sherrill.

405

00:56:11,335 --> 00:56:11,835

Next slide.

406

00:56:14,460 --> 00:56:25,885

So that is a New York Times video if you wanna watch the whole thing is awesome. I talked too much or we would be watching it. Now, you go to the next slide.

407

00:56:27,360 --> 00:56:42,295

So, you know you have about five minutes. You go to. Yeah. Okay. So the Massachusetts guideline does just what they're talking about, they use this to get the SOFA score. Can you go to the next slide?

408

00:56:44,094 --> 00:56:56,545

And so, the SOFA score is, let's say, your respiratory status, your Glasgow coma scale, or your Neuro status, your mean arterial blood pressure,

409

00:56:56,755 --> 00:57:07,224

your cardiovascular status, liver and kidneys. You also look at saved the most life years here. So, they look at the co morbidities.

410

00:57:07,679 --> 00:57:08,190

So,

411

00:57:08,244 --> 00:57:10,704

when you look at this from an ethics perspective,

412

00:57:10,885 --> 00:57:12,925

and you start looking at comorbidity,

413

00:57:13,315 --> 00:57:15,505

and you look at the higher rate of co

414

00:57:15,505 --> 00:57:19,135

morbidities in some of our minority population,

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00:57:19,945 --> 00:57:30,324

you can see how using the focus scores or the co morbidities or some of these actually have an age component can really we need to think about that.

416

00:57:30,324 --> 00:57:37,494

We need to make sure that we're using sound ethical principles when we make the decision. Next slide.

417

00:57:39,329 --> 00:57:42,655

So, how would the candidate shortages, Some of the stuff that's been done.

418

00:57:43,614 --> 00:57:54,804

We have emergency orders that are giving APRN, advanced practice nurses on the right to prescribe without a physician. States that have staffing requirements have lifted.

419

00:57:54,804 --> 00:58:00,445

Those reassignment or position is the (audio unclear)

420

00:58:01,014 --> 00:58:05,034

We have emergency license and transfer protocol,

421

00:58:07,554 --> 00:58:10,675

nurses that are graduating from school who

422

00:58:10,675 --> 00:58:17,005

or being able to go into practices RN without even taking their board.

423

00:58:17,514 --> 00:58:26,784

And then they talk about pivoting conditions. So that if your specialty is an anesthesia, you can now work in the intensive care unit next.

424

00:58:29,875 --> 00:58:44,304

This is really important. I'm glad I got some fly over in dept. The company GILEAD gave a million doses to the federal government in a presentation yesterday.

425

00:58:44,545 --> 00:58:58,315

(audi unclear) at John Hopkins is out of that whole supply. They've got two doses at John Hopkins. And so there's real questions about the equity of how things are being distributed. Next.

426

00:59:02,844 --> 00:59:08,784

When we talk about rationing, there are places where we can ration vaccine.

427

00:59:09,119 --> 00:59:09,864

Unfortunately,

428

00:59:09,864 --> 00:59:19,764

we're talking about building a vaccine right now and what people are beginning to talk about that some of us have been aware of is there's no syringes,

429

00:59:20,039 --> 00:59:26,215

there's no method to deliver injections.

430

00:59:26,244 --> 00:59:41,034

So, they're trying to gear up mass production of syringes. That hopefully. Right now there's like ten million in the strategic stockpile. We need six hundred million. So we're working.

431

00:59:41,155 --> 00:59:42,204

They're working on that.

432

00:59:42,235 --> 00:59:56,244

So that we can equability, if you listen to the healing hearing at all this week, the question was asked repeatedly, if there was a vaccine with everybody, get it and there was no clear answer that, that everybody would get it for free.

433

00:59:56,275 --> 00:59:58,855

So that's problematic. Next slide.

434

01:00:01,644 --> 01:00:16,465

If you look at this slide here up at the top, it says we shipped a small hospital, even the medical centers were denied access. So we are having some trouble in how we are allocating our resources.

435

01:00:16,465 --> 01:00:20,664

And so hopefully that will get better with time next slide.

436

01:00:22,590 --> 01:00:33,355

So, Farra. doctor Farra if we could just wrap up in the next, we have only about two more minutes. Alright. One minute on testing. That sounds fine to have a. okay. Keep go.

437

01:00:33,355 --> 01:00:46,315

And they say I want to talk about testing and one of the things I want to talk about that how ethical have we been testing? Do we have mobile testing centers that are going you know, it's really nice

438

01:00:46,315 --> 01:00:56,965

If they set up a drive to testing center at Walmart. If you don't drive, you don't have a car, you are not going to get to the testing site. So there are problems with testing.

439

01:00:56,965 --> 01:01:04,700

We were pretty far behind because our strategic stockpile did not have swab medium, etc.

440

01:01:04,700 --> 01:01:15,420

We are getting much much better on our technical side. And then PPE, next slide please, one final thing on PPE is we're starting to see more and more PPE,

441

01:01:15,780 --> 01:01:28,120

but what came out at the hearing this week was unfortunately there are knock offs and the respirators are only thirty percent effective and it's impossible to tell what is a knock off and what is not a knock off.

442

01:01:28,619 --> 01:01:34,735

So we, we have problems implementing our crisis standards of care. But are we getting better?

443

01:01:34,764 --> 01:01:47,875

I would say, definitely, yes, but we continue to have some difficulty in that program from Minnesota, on ethical framework for rationing and ninety sides.

444

01:01:47,875 --> 01:01:51,114

And you guys are all aware of that work with rationing.

445

01:01:52,224 --> 01:02:04,074

So our next series is Bill Irvine, professor of philosophy, responding to the COVID-19 pandemic in proper stoic fashion. That sounds interesting.

446

01:02:04,105 --> 01:02:13,945

So that's next Tuesday at 4:00pm, I hope everybody shows up to listen to Bill. If you have any questions. I think I have thirty seconds.

447

01:02:17,664 --> 01:02:31,014

On behalf of all the attendees I just want to thank Dr. Farra for extremely interesting presentation today. We all learn so much. No matter our background and thanks also to Dean Smith from Wyoming.

448

01:02:31,014 --> 01:02:41,514

Thank you for returning to Wright State and for the wonderful collaboration between you two, we really appreciate it. And we just have so much to learn from you.

449

01:02:41,815 --> 01:02:52,224

I want to remind all of the attendees as well that each one of these lectures is recorded and will be available through the live streaming page at Wright State University.

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01:02:52,494 --> 01:03:07,195

And also, all of our lecture series are archived in the University Libraries, as part of the CORE Scholar, and you can follow up with Dr. Farra at the Wright State University College of Nursing and Health with any other questions from the presentation today.

451

01:03:07,460 --> 01:03:21,940

So, please join me in giving them a round of applause for an extremely interesting presentation today. Thank you all for joining us. We hope to see you next Thursday for Dr. Irvine's presentation and stay healthy, have a great weekend everybody

452

01:03:22,120 --> 01:03:29,200

Thank you, have a great weekend