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Crisis Standards of Care and COVID-19

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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,

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00:00:34,854 --> 00:00:37,134
you'll notice that your microphone is muted,

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00:00:37,405 --> 00:00:39,655
you're unable to see the other participants,

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00:00:40,554 --> 00:00:41,695
but you are

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00:00:41,695 --> 00:00:45,625
we ask that you please submit questions via the chat room,

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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.

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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.

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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,

15
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.

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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 2011hit 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

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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,

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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.

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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.

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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

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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.

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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 in 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.

112
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

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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.

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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

125
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.

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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?"

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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

144
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,

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

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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.

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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

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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

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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.

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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,

161
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.

165
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,

166
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.

169
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,

241
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 GADAHA 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

250
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 befitting 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.

271
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.

281
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

292
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

295
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.

304
00:40:10,585 --> 00:40:12,594
There is still a liability risk,

305
00:40:12,655 --> 00:40:16,405
and we'll talk about those and find this coming out,

306

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.

307
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.

316
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

320
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,

342
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

343
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.

344
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,

352
00:47:42,414 --> 00:47:44,514
it's an operations plan,

353
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 comobidity,

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,

415
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.

450
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