COLORADO CRISIS STANDARDS OF CARE: PALLIATIVE CARE AND HOSPICE, 2020

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A bit of history:

- *National Crisis Standards of Care over the years…..2009,*
  - *Focus on allocating scarce critical care resources*
  - *"….palliative care should be available to all people affected by a disaster. The key services include comfort, compassion, and maintenance of dignity—services that can be provided with essentially no physical resources other than the presence of another human being."*
- *The 2012 Institute of Medicine National Crisis Standards of Care states that the "provision of palliative care in the context of a disaster with scarce resources can be considered a moral imperative of a humane society."*

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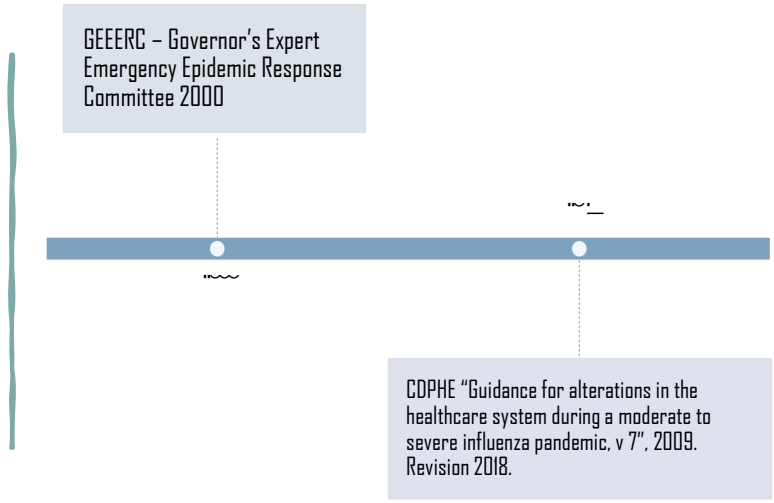
IN COLORADO



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COLORADO HEALTHCARE ETHICS RESOURCE (CHER) GROUP

- Variety of healthcare professionals interested in "duty to plan"
  - "Contingent" actions to avoid degradation of care with "crisis standards"
- Around the state, mainly acute care hospitals, but adding more from long-term care communities, hospices, ethics committees, etc.
- How do we fairly allocate scarce resources if there are not enough to go around?
  - ICU beds, ventilators….
  - Change from individual clinical ethical framework to public health framework.
  - "Save the most lives…."

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But Wait……

- ….the “magic arrows…”

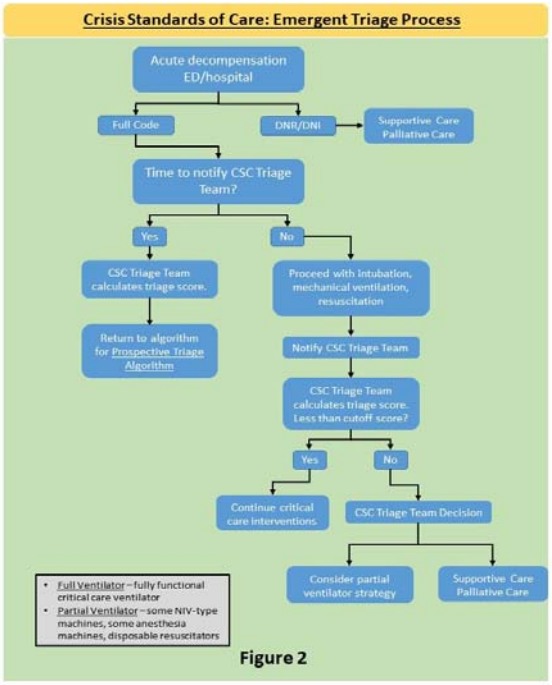

Figure 2

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But Wait……

- ….the “magic arrows…”

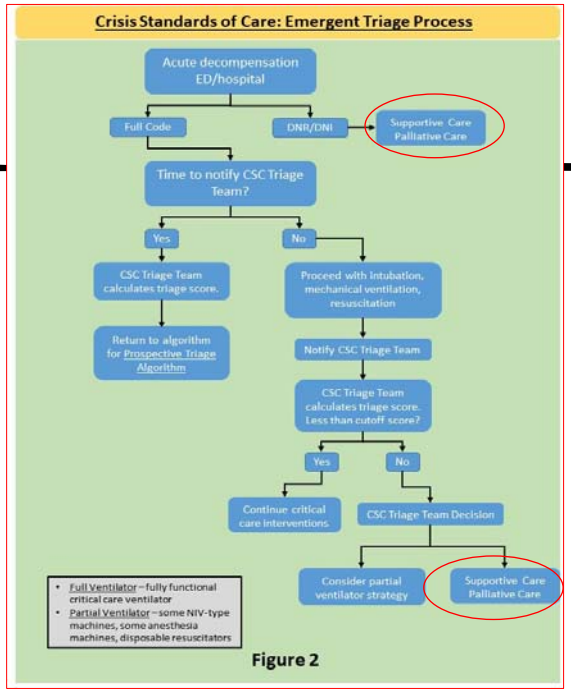

Figure 2

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WHO NEEDS SUPPORTIVE CARE in a crisis?

- Hospice patients at home
- Hospice patients in care facilities or GIP sites
- People moving into hospice care (without COVID)
- Patients with serious chronic diseases + COVID and wanting hospice or supportive care
  - Wanting to stay for care in the residence they call "home"
  - Community dwelling but requiring increased support
- Patients from acute care hospitals: ICU/vent care denied, refused, or needing convalescence, hospice transition

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WHAT DO HOSPICE & PC PATIENTS NEED IN A CRISIS?

- Support:
  - Advance Care Planning, verbal ACP authorization, Good symptom management, Visitation by consultants, family….
- Staff:
  - Skilled symptom training & management across sites; telehealth system for consultation
- Sites:
  - Alternative care sites with symptom-management medicines, O2, visitation ability, nursing staff ratios that are appropriate
  - Designated clustered comfort care sites in rural institutions?
- Supplies:
  - PPE for staff, visitors, providers, chaplains, SW & volunteers
  - Adequate essential meds in institutions and homes
  - Adequate video-devices for ACP and EOL communications
  - Adequate and repeated testing for patients, staff & visitors

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CURRENT ACTION PLAN SUGGESTIONS FOR COLORADO I

- Work with CDPHE, Joint Command Center, GEEERC, Health Action Notification, Colorado Hospital Association, COPIC?
- Push for Advance Care Planning in Community, Residential Centers, (Admission to Hospital)
  - Working upstream with hospice staff, volunteers
  - Avoiding barriers to practicalities of getting authorized documents/formats
  - Adequate devices for ACP and EOL communications

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CURRENT ACTION PLAN SUGGESTIONS FOR COLORADO II

How to expand hospice capability??

- Education and skill dissemination:
  - Videos, quick references on management skills across sites/providers/nursing
- Mobilizing video-health consultation support regionally
  - NYC Command Center x 4 weeks at height of surge

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CURRENT ACTION PLAN SUGGESTIONS FOR COLORADO III

- Authorize visitation by Hospice professionals, volunteers, family and loved ones in all sites *(nobody should die alone)*
- Develop overflow beds/sites appropriate to PC/hospice
  - Staffing, meds, visitation rules, PPE
- Develop plan to inventory/share PPE, meds, testing, staff, with pharm consultation
- Manage distribution of adequate PC/hospice meds to home, residential units

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Conclusions

- WHO just apologized for leaving out PC & hospice in pandemic planning
- Advocacy needed
- Numbers count, examples count
- Strength together

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