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

Jean Abbott, MD, MH
Center for Bioethics and Humanities, CU Anschutz

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.”
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....”
But Wait……

• ....the “magic arrows...”
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

WHAT DO HOSPICE & PC PATIENTS NEED IN A CRISIS?

- Support:
  - Advance Care Planning, verbal ACP authorization, Good symptom management, Visitation by consultants, family....
  - Skilled symptom training & management across sites; telehealth system for consultation
  - 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
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

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
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

Conclusions

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