

**Colorado Healthcare Ethics Resource**

**Meeting Minutes 4/28/20**

Hi all,

We will meet next Tuesday May 5th at 2pm. 303-436-8000 1861#

If you didn’t have a chance, and you were present on the call today, please sign in at: <https://forms.gle/fTJcNjLKDSGsmhva9>

Minutes:

1. Behavioral Health CSC updates – Had their first meeting with a good turnout. Think they will break into subgroups to cover multiple issues including intensive/inpatient needs, OP needs and more intensive treatments as outpatients, substance groups that will span all the groups. They think it will take about 2 ½ - 3 weeks to write.
2. State of the hospitals re covid –
	1. Many hospitals are sort of steady state. Patients are there long term but maybe plateauing.
	2. Boulder had a decrease in covid patients and that has now been steady for the last few days
	3. Some hospitals have had some good discharges of folks who were intubated/hospitalized for prolonged times
	4. Question about how these folks do over time – unclear. There have been some readmission. There have been some re intubation of extubated patients in the hospital
	5. Finding that delirium is profound in long term intubated people. Trachs are becoming standard treatments to help with delirium, though need the right population for better outcomes as some do worse after trach.
	6. Discussed the incorrect 88% mortality reported which has been corrected in JAMA but not really the public. There is a large percent of people who are actually still intubated in that population.
	7. Not all hospitals here using ecmo. Some hospitals don’t have ecmo or don’t have robust ecmo programs. The UH and Childrens are using ecmo.
3. Triage practices – highly encouraged to go through this process. Mitch Gershten wrote their process and pitfalls for their triage team – this is in the OneDrive site under triage practice
4. Triage updates – hospital triage CSC were tweaked with further input from community and approved on Sunday by the GEEERC. A summary of the changes will be put in the OneDrive site
5. Maternal Health updates –
	1. Sending a survey to OB/gyn practices across the state to better understand needs and requests
	2. Some concerns include
		1. Lack of PPE outside the hospital setting
		2. ii. Variations in changes in practice and a need for guidance and support for providers
		3. iii. Help in leveraging the networks
	3. A list of concerns and action plans and resources was sent out and will be posted in the OneDrive site as well
6. Thank you to Megan Morris – chairs a group with members from all over the USA with the goal of non discrimination in hospitals for folks with disabilities, helping both hospitals and folks with disabilities. Is two years old, but are meeting weekly during covid as there are many challenges during this time It’s a learning collaborative to try and come up with solutions. They have a website with resources. People are welcome to join. Meetings are on Fridays.
	1. **ACTION – if interested in joining**, please contact Megan at MEGAN.A.MORRIS@CUANSCHUTZ.EDU
7. Palliative Care updates
	1. CSC – working on version 22.
		1. Working on sorting out what is contingency vs crisis standards
		2. Crisis standards are when practices have changed to a new standard, substandard, and liability protections are needed for health care providers
		3. Meeting with Dr. French and Dr. Cantrill and will send out a draft for folks to look at after the meeting.
	2. Advance directives – thank you to Carl Glatstein and Casey Frank
		1. Seems that groups are working in silos such as attorneys caught up in legal details vs legislative vs providers taking care of patients
		2. Documenting the conversations and values are key
		3. Look for the most recent documentation
		4. Try not to be bogged down in formalities of law so that they become barriers to patients being able to express their wishes
		5. If documenting patients wishes that should be able to go with the patient from place to place
		6. Question – should we document on formal paperwork so less chance it would be challenged from institution to institution
		7. One concern brought up is how do we know if patients are being coerced or actually have capacity when making advance care planning decisions during illness. Conversation about MDPOAs in this setting.
			1. Ideally this is done in advance, but in reality, this is frequently not done in advance.
			2. Also, people may change their minds during illness
			3. It’s felt that who one trusts in the position of making decisions is less complex and more likely to be easier for patients to identify even in illness
			4. One concern is that if we set the bar high re who someone trusts to make decisions that we may end up protecting a few patients, but preventing a majority of people from actually designating a person whom they do trust.
		8. Another concern about those who aren’t proficient in English – need to consider and use interpreters, but again, the thought is that people are likely to be able to identify people who they trust
		9. Agreement that this would be best if done in advance and outside of a hospital setting when able. The trick is to make it happen this way.
8. LTC updates – reaching out to LTC centers beyond advance care planning. Looking at other issues such as staffing and PPE
	1. Thank you to Vanessa Jackson – Medical director for several nursing homes, assisted living – notes every day brings new challenges.
		1. PPE supply is essential for LTC facilities. Have had increased prices and uncertainty if they’ll receive PPE deliveries
		2. Need more pro active testing as well to help keep residents safe
		3. Noting distress of residents now 2 months in of isolation from families, taking a toll
	2. One possibility is including hospice help in LTC facilities.
		1. Have their own PPE
		2. Can help families communicate by facetiming

Thank you so much,

Barbara