1
00:00:32.990 --> 00:00:43.570
Matt Amundson (he/him): All right. Well, good morning. Everyone welcome to another installment of the Dean's Lecture Series. I'm. At Evansen, one of the Learning and Development managers for the office of diversity, equity, and inclusion.

2
00:00:43.590 --> 00:00:54.300
Matt Amundson (he/him): This session will be recorded and shared out within 2 days to all those who registered for the event. Otherwise the recording can be found under the education and training tab of the Ode I website

3
00:00:54.500 --> 00:01:11.160
Matt Amundson (he/him): Live transcription has been enabled. Please note that the live transcript is not perfect, as this is an audit auto transcript, and we invite you to take care of yourself as necessary during today's session, as we will not be taking a break. Any feedback or issues with accessibility. Please email us at the link you see posted in the chat.

4
00:01:11.420 --> 00:01:29.040
Matt Amundson (he/him): we ask that participants please use the Q. A. Function instead of the chat, and we'll do our best to answer your questions. But please understand that we're working within a set window of time, so should we not get to your question? We will work with the presenters to get unanswered questions posted on the Dean's Lecture Series web page within the next week or so

5
00:01:29.370 --> 00:01:43.110
Matt Amundson (he/him): also pasted in the chat you will find links to the Dean's Lecture series, website, the slides to our presenters lectures, and the Dean's Lecture Series email address, and I will now turn it over to Dr. Nunes to introduce today's Guest Moderator.

6
00:01:43.650 --> 00:02:03.260
Ana Núñez MD: Good morning, Everybody happy May! Hello. So it feels like summertime, but i'll take it. I think we've earned sort of the the the change in climate and the loss of ice and snow. We're delighted to have everybody here. We're also thrilled to have this really wonderful presentation interfacing between medicine and ethics

7
00:02:03.260 --> 00:02:23.060
Ana Núñez MD: in terms of sort of a really salient conversation, you know. Oftentimes the phrase lessons learned is bandied about. You know what were the lessons learned, and if there there was a time in a period in an epic that for us to have some lessons learned. It was in terms of sort of how we collectively moved through sort of

8
00:02:23.060 --> 00:02:24.990
Ana Núñez MD: the worst in terms of Covid.

9
00:02:25.060 --> 00:02:33.610
Ana Núñez MD: So i'm joined today by an amazing panel. Dr. Wolf joins us with Dr. DeBruin, Setos and Dickter

10
00:02:33.860 --> 00:02:49.490
Ana Núñez MD: talking to us. Can we do better in the next pandemic ethics, law and medicine, and they're going to talk about sort of the range in terms of things Professors Wolf and de Bru, and at the you led the Minnesota Covid Ethics, collaborative

11
00:02:49.490 --> 00:03:08.450
Ana Núñez MD: and work with partners across the State and Minnesota Health Department to create ethics, frameworks for ethical allocation of scarce resources and transitions from conventional and contingency care to crisis conditions. Dr. Set us at Pete, and at the end the you were deeply involved in the clinical response in

12
00:03:08.450 --> 00:03:10.240
Ana Núñez MD: this committee's work.

13
00:03:10.240 --> 00:03:31.220
Ana Núñez MD: applying her expertise in health, equity, and family medicine. Dr. Dickter, the You brought long experience in disaster preparedness, including work for the agency for strategic preparedness and response at Hhs. The leadership, the Minnesota Critical Care Working Group, and they'll discuss sort of what we need, what were the lessons learned, and what are some of the challenges? And are we really ready

14
00:03:31.280 --> 00:03:38.330
Ana Núñez MD: in terms of sort of what comes next? So i'm delighted to turn this over to Dr. Wolf to kick us off.

15
00:03:39.070 --> 00:03:49.530
Susan M Wolf, JD: Thank you, Dean, and yes, and thanks to everyone for being with us today, tomorrow ends the Federal declaration of emergency for COVID-19.

16
00:03:49.720 --> 00:03:53.230
And today's New York Times asks

17
00:03:53.420 --> 00:03:55.240
Susan M Wolf, JD: a set of experts.

18
00:03:55.430 --> 00:04:03.170

Susan M Wolf, JD: Are we ready for the next pandemic? It's not going to surprise you that resoundingly, the answer is No.

19
00:04:03.410 --> 00:04:15.080
Susan M Wolf, JD: So this could not be a more timely panel. We all know that the pandemic has posed huge challenges. A lot of those challenges continue to this day

20
00:04:15.280 --> 00:04:26.170
Susan M Wolf, JD: ethical, legal, public health, clinical care, big challenges in the domain of health disparities, and health equity. We want to talk about all of it.

21
00:04:26.410 --> 00:04:34.880
Susan M Wolf, JD: and together, as Dr.Núñez says, we have convened 3 wonderful multidisciplinary experts

22
00:04:34.890 --> 00:04:42.400
who bring different perspectives. Professor Deb de Bru and Dr. Veronica S. Fetaz and Dr. Jeff Dickter.

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00:04:42.530 --> 00:04:51.730
Susan M Wolf, JD: I am going to introduce each of them in turn briefly, because really we want to get to the meat of the discussion.

24
00:04:51.850 --> 00:04:56.520
Susan M Wolf, JD: I each is going to speak for about 10 minutes, and then we're going to open it up

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00:04:56.590 --> 00:05:08.820
Susan M Wolf, JD: for conversation, and very much for your questions. As Matt said, please fire away. Start posting your questions, using the Q. A. Function, not the chat.

26
00:05:09.060 --> 00:05:16.030
Susan M Wolf, JD: and we'll get to as many as we can. I hope. Also we're going to have a wonderful conversation just among this group.

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00:05:16.100 --> 00:05:23.970
Susan M Wolf, JD: because this is such a complex issue. We all bring different perspectives, and I hope that's gonna surface.

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00:05:24.170 --> 00:05:34.350

Susan M Wolf, JD: So let me introduce our first panelist, Professor Debra DeBruin, PhD, is director of the Center for bioethics and associate professor of Medicine here with the you.

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00:05:34.480 --> 00:05:43.780
Susan M Wolf, JD: Her work has long focused on the ethics of public health and health policy with a sustained focus on the ethics of disaster preparedness

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00:05:43.840 --> 00:05:59.460
Susan M Wolf, JD: prior to the Covid pandemic. She co-LED the Minnesota Pandemic Ethics project which focused on avian influenza and the project to develop ethics Guidance for the State of minnesota's Crisis standards of care framework

31
00:05:59.510 --> 00:06:06.910
Susan M Wolf, JD: as Dean on you, as mentioned, She and I co-LED the Minnesota, Covid Ethics collaborative

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00:06:06.960 --> 00:06:10.680
Susan M Wolf, JD: 2020 to 2022. So with that

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00:06:13.650 --> 00:06:22.810
Debra DeBruin,PhD: thank you. Susan I'm really delighted to be here today. Let me see if I can share my screen.

34
00:06:26.470 --> 00:06:27.470
Debra DeBruin, PhD: Look good.

35
00:06:30.110 --> 00:06:37.360
Debra DeBruin, PhD: Okay, that was a thumbs up. I wasn't hearing you. But good. Okay, so let me begin with the

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00:06:38.510 --> 00:06:42.350
Debra DeBruin, PhD: requisite disclosures. I have no financial

37
00:06:42.430 --> 00:06:46.340
relationships to disclose for this particular talk.

38
00:06:46.430 --> 00:07:02.920
Debra DeBruin, PhD: I also want to make clear that, although I will discuss the work of the Minnesota Covid Ethics, collaborative to some extent. The views I express here are my own, and should not be taken to represent the views of my colleagues. I of course acknowledged the co- leadership of

39
00:07:02.920 --> 00:07:10.210
Debra DeBruin, PhD: Professor Susan Wolfe, and want to thank the members of Mcec and our partners who i'll briefly introduce you to

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00:07:10.470 --> 00:07:11.960
in just a moment.

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00:07:14.060 --> 00:07:22.120
Debra DeBruin, PhD: I want to begin by emphasizing the importance of ethics guidance in disaster preparedness and response. We're focusing on pandemics today.

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00:07:22.190 --> 00:07:33.360
Debra DeBruin, PhD: But this point applies to other emergencies as well. Hence the talk of disasters in this quotation from a seminal Institute of Medicine report on crisis, standards of care.

43
00:07:34.100 --> 00:07:53.320
Debra DeBruin, PhD: The authors rightly note that without ethical decision making the system fails to meet the needs of the community, and ceases to be fair, just, and equitable. As a result, trust really is quickly lost. I would add that moral distress for health professionals in these crises can be intense.

44
00:07:54.120 --> 00:07:57.540
Debra DeBruin, PhD: and that should be another concern for planners.

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00:07:59.690 --> 00:08:17.390
Debra DeBruin, PhD: As Susan mentioned, there were 2 projects devoted to developing ethics, guidance for public health emergency response in Minnesota prior to the COVID-19 pandemic I. Letter Co. Led both those projects. Both of them were conducted under contract with the Minnesota Department of Health or Mdh. As I'll say. From here on

46
00:08:17.530 --> 00:08:36.830
Debra DeBruin, PhD: and Mdh. Issued the final guidance for both. The first was the Minnesota Pandemic Ethics project. The central AIM of that project was to develop rationing frameworks for an influenza pandemic specifically for personal protective equipment, vaccines, antiviral meds and ventilators. That guidance was issued in 2,010

47
00:08:36.919 --> 00:08:59.700
Debra DeBruin, PhD: the second project developed ethics, guidance for crisis, standards of care. This guidance was issued in 2,016, and reviewed and reaffirmed by Mdh. In January of 2,020. Both of these projects recommended that a process for ethics support be implemented

in public health emergencies, not only at the level of individual healthcare systems or facilities, but also at the statewide level

48
00:09:00.350 --> 00:09:22.980
Debra DeBruin, PhD: mit they happily accepted the offer. The State Health care, Coordination Center and the Minnesota Hospital Association quickly joined the effort, and Professor Wolf and I began to work with these partners to build the team and develop the process for ethics support

49
00:09:23.290 --> 00:09:34.930
Debra DeBruin, PhD: MCEC As we called the Minnesota Covid Ethics, collaborative, incorporated, multidisciplinary perspectives from ethics, law, public health, medicine, nursing, disaster, planning, and other fields one

50
00:09:34.960 --> 00:09:42.800
Debra DeBruin, PhD: every major health system in the State offered expertise to the collaborative along with experts on tribal health

51
00:09:43.450 --> 00:09:55.030
Debra DeBruin, PhD: and from governmental agencies. Nonprofits and academia. MCEC also worked closely with the statewide critical care work group. Thanks to Jeff. Dickter and our colleague, Sarah Kessel

52
00:09:55.820 --> 00:10:17.140
Debra DeBruin, PhD: MCEC Served an advisory role for MDH (Minnesota Department of Health). We did not issue guidance. We drafted guidance through a process of expert consultation and stakeholder. Input During this process we relied heavily on the foundational guidance that I in that was produced in the 2 projects that I talked about on the previous slide.

53
00:10:17.200 --> 00:10:25.340
Debra DeBruin, PhD: Decisions about what guidance to accept and disseminate were made by the State, not by MCEC. That's an important point.

54
00:10:27.010 --> 00:10:40.630
Debra DeBruin, PhD: Let me offer a few thoughts about the lessons learned from this work. First, our experience in Minnesota confirms for me how important ethic support is not just at the institutional level, but also at the level of the State.

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00:10:41.100 --> 00:10:54.600
Debra DeBruin, PhD: This process would not have been possible without the time and energy and really thoughtful engagement that people volunteered to make the work of MCEC Possible. And again, I want to offer my thanks to everyone who is involved.

56
00:10:55.110 --> 00:11:10.520
Debra DeBruin, PhD: Second inner professional collaboration really is critical. MCEC's work required input from many people, from a variety of fields to identify where guidance is needed, and to draft guidance that's well informed, and that is really operationalizable.

57
00:11:11.400 --> 00:11:25.880
Debra DeBruin, PhD: Third, guidance documents need to be considered living documents. Our understanding evolves over time, and we need to recognize that new information, new data or new realities on the ground can change what should be recommended ethically

58
00:11:25.900 --> 00:11:40.900
Debra DeBruin, PhD: broadening this out beyond thinking about specific guidance documents. I would add that we have a lot to learn from the pandemic response in general, and that work should continue with an ethics lens, so that we're better prepared for next time.

59
00:11:42.160 --> 00:11:57.810
Debra DeBruin, PhD: So now I'd like to focus in on equity considerations. MCEC considered equity issues throughout its work, and recommended a variety of approaches to promote equity. A few of those recommendations are reflected on this slide, for example.

60
00:11:58.590 --> 00:12:13.920
Debra DeBruin, PhD: MCEC Recommended that when making triage, rationing decisions regarding critical care interventions, prognosis should be narrowly understood in terms of likelihood of the patient surviving the current illness to hospital discharge, and not longer term prognosis. One.

61
00:12:13.920 --> 00:12:24.820
it also recommended against consideration of quality of life and decisions about triage and rationing. These recommendations were meant to avoid systematically disadvantaging persons with disabilities.

62
00:12:25.150 --> 00:12:42.140
Debra DeBruin, PhD: MCEC also recommended that personnel involved in making triage. Rationing decisions have anti-racism training, and training about disability bias, and that decisions be routinely reviewed to ensure that particular groups are not disproportionately affected by triage or rationing decision, making processes.

63
00:12:42.890 --> 00:12:56.650
Debra DeBruin, PhD: ethical frameworks for allocation of medical countermeasures, not only provided recommendations about how to allocate supplies to individual patients, but but also about how to distribute supplies across the State to promote equity in access

64

00:12:57.050 --> 00:13:17.190
Debra DeBruin, PhD: for some resources. MCEC drafted recommendations that critical workers who serve in high-risk settings receive some degree of allocation priority. Since racial and ethnic groups most impacted by COVID-19 were over represented among essential workers. This sort of priority may promote equity.

65
00:13:17.960 --> 00:13:29.720
Debra DeBruin, PhD: MCEC also recommended adoption of a centralized web based model for allocation of monoclonal antibody therapies. The system that became known as the Minnesota resource allocation platform or min rep.

66
00:13:29.860 --> 00:13:41.890
Debra DeBruin, PhD: The main goal was to promote equitable access for all Minnesotans, so that patients who are not affiliated with the health systems that offered the therapies would not be disadvantaged in accessing them.

67
00:13:43.960 --> 00:13:52.880
Debra DeBruin, PhD: One of the most troubling aspects of the COVID-19 pandemic was the clear evidence of racial and ethnic disparities in Covid outcomes, such as hospitalizations and deaths.

68
00:13:53.740 --> 00:13:59.230
Ethical questions arose about how to equitably allocate resources. Given these disparities

69
00:13:59.330 --> 00:14:13.000
Debra DeBruin, PhD: a study by Dr. Elizabeth Wrigley Field and her colleagues found that in Minnesota, by pop people aged 50, and above faced comparable risk of dying from COVID-19 as people who are over 65,

70
00:14:13.120 --> 00:14:21.150
Debra DeBruin, PhD: Why does this matter, because commonly used allocation frameworks prioritize patients for access to Kova 19 vaccines based on age

71
00:14:21.190 --> 00:14:40.380
Debra DeBruin, PhD: this study showed that age-based prioritization for vaccination resulted in. And this is a quote, “substantial, racial, and ethnic disparities in deaths averted” end quote, and it demonstrated that an allocation strategy that considered not only age but also race would better target vaccination to high-risk individuals. One.

72
00:14:40.740 --> 00:14:47.100
Debra DeBruin, PhD: and of course, targeting vaccination to high-risk individuals was one of the main goals of vaccine allocation. Strategies.

73
00:14:47.250 --> 00:15:03.910
Debra DeBruin, PhD: However, such a race, conscious allocation strategy, was widely rejected as discriminatory or unconstitutional. So one thing we really need to work on, so that we can do better next time is how to have our respons plans mitigate rather than exacerbate disparities.

74
00:15:06.070 --> 00:15:15.790
Debra DeBruin, PhD: This slide and I apologize if it's a little hard to read, shows how life expectancy declined between 2019 and 2021. Analyzed by race and ethnicity.

75
00:15:15.940 --> 00:15:26.720
Debra DeBruin, PhD: You can see that some groups fared much worse than others. But it's also important to notice a point that Dr. Wrigley Field makes in another of her publications.

76
00:15:26.730 --> 00:15:41.770
Debra DeBruin, PhD: that, despite these declines, life expectancy for whites remained higher in 2,021 than it was for blacks at any previous point represented in the data which here extends back to 2006.

77
00:15:41.790 --> 00:15:55.860
Debra DeBruin, PhD: This brings us to an important point. as Dr. Wrigley Field puts it. “If black disadvantage operates every year on the scale of White's experience of COVID-19. Then so, too, should the tools we deploy to fight it.

78
00:15:56.570 --> 00:16:05.280
Debra DeBruin, PhD: Our imagination and social ambition should not be limited by how accustomed the United States is to profound racial inequality.”

79
00:16:05.770 --> 00:16:14.700
ameliorating persistently long-term health disparities, should help to prevent, or at least diminish disparities in outcomes for future pandemics.

80
00:16:14.770 --> 00:16:26.840
Debra DeBruin, PhD: but that's not the primary reason to address those persistent disparities. There's serious inequities quite apart from their impacts during public health emergencies. Equity requires that we work to diminish them

81
00:16:27.000 --> 00:16:31.130
Debra DeBruin, PhD: with that thought. I'll close for now, and I look forward to the discussion.

82
00:16:34.680 --> 00:16:42.370

Susan M Wolf, JD: Thank you, Deb. Our next speaker is Dr. Maria Veronica.

83
00:16:42.520 --> 00:16:56.820
Susan M Wolf, JD: A doctor's Svetaz is a family medicine physician at Hennepin, health care and associate professor in the Department of Family medicine here at the you, where she's part of the leadership, education in adolescent health Health program.

84
00:16:56.870 --> 00:16:57.810
Susan M Wolf, JD: Leah

85
00:16:58.160 --> 00:17:16.089
Susan M Wolf, JD: at the Society for Adolescent Health and Medicine. She has served as chair of the Diversity Committee, and is now on the Board of Directors. She has been on several Minnesota health Equity, related initiatives, and is a scholar of health, equity, and adolescent health. Veronica.

86
00:17:18.349 --> 00:17:24.760
Maria Veronica Svetaz, MPH: Thank you so so much. It's such an honor to me here today, so let me share my slides.

87
00:17:25.920 --> 00:17:26.869
Maria Veronica Svetaz, MPH: There you go.

88
00:17:28.790 --> 00:17:30.380
Maria Veronica Svetaz, MPH: I think you can see it right.

89
00:17:30.800 --> 00:17:36.150
Maria Veronica Svetaz, MPH: So thanks so much for the introduction and my point today to talk about

90
00:17:36.410 --> 00:17:47.720
Maria Veronica Svetaz, MPH: this endemic right like the next pandemic. We most likely be the syndemic, and we define syndemic as a set of link. Health problems involve

91
00:17:47.720 --> 00:17:59.410
Maria Veronica Svetaz, MPH: 2 or more at fictions together, right? And they interact, and they make the result of that interaction worse outcomes and contribute to the exist version of this season in the population, and we

92
00:17:59.490 --> 00:18:13.220

Maria Veronica Svetaz, MPH: totally so that right, I think, by the second months and the pandemic on the viral pandemic. We realized, like the pandemic, was mapping another pandemic that we have it, the chronic pandemic of inequality in the United States.

93
00:18:14.650 --> 00:18:15.580
Maria Veronica Svetaz, MPH: We

94
00:18:15.660 --> 00:18:32.850
Maria Veronica Svetaz, MPH: typically when we talk about in United States right when we talk about. We know now what health, how health is produce, and how social determinant of health have far more influence in our health that we can do as decisions. And here's it sort of like a mapping

95
00:18:32.850 --> 00:18:39.160
Maria Veronica Svetaz, MPH: what it was lacking some time on the discussion Every time about that we talk about social

96
00:18:39.230 --> 00:18:58.670
Maria Veronica Svetaz, MPH: was the force that produce that unequal distribution. It's not only the impact of the socially termin of health. It's, in fact, like that I'm. Equally distributed by other forces. And I love how in Latin America this is in Spanish, but you can see, like it the same mapping. And here it's called

97
00:18:58.670 --> 00:19:08.120
Maria Veronica Svetaz, MPH: inequality access, and talks about power, and talks about privilege, and how more fluid it's that conversation right? And how

98
00:19:09.600 --> 00:19:10.630
Maria Veronica Svetaz, MPH: awful

99
00:19:11.040 --> 00:19:23.880
Maria Veronica Svetaz, MPH: has been to it the testimony that happened just in our backyard right not only became the epicented about the possibility of talking louder about decisions, but also like it, catalyzed it. And I wonder

100
00:19:24.030 --> 00:19:26.190
Maria Veronica Svetaz, MPH: where we should have been right now, right

101
00:19:26.210 --> 00:19:35.180
Maria Veronica Svetaz, MPH: without that catalyzed, because it's seriously that may like shifted the the force on how we were able to talk about these things.

102
00:19:35.190 --> 00:19:51.670
Maria Veronica Svetaz, MPH: So you just hear about who I am, but I also think like it's super important for you to remember positionality right like what is satellite, and how are lens? It's clearly influence and via identity by the

103
00:19:51.710 --> 00:19:56.450
Maria Veronica Svetaz, MPH: that we can get because of them. And so as that

104
00:19:56.500 --> 00:20:05.980
Maria Veronica Svetaz, MPH: this is a reminder right like I was born in Argentina in rural area that i'm in in, in, in

105
00:20:06.020 --> 00:20:18.930
Maria Veronica Svetaz, MPH: I mean, i'm like 30 primary care provider, right? But I do work on the a/C. Us. The hospital is in, and I work in the safety needs, so I can see. And there on the trenches of the chronic pandemic all the time right.

106
00:20:19.300 --> 00:20:27.940
Maria Veronica Svetaz, MPH: And the reason when I wanted to really think about that is, it's because when we were having this shift in the years previous to the pandemic

107
00:20:28.030 --> 00:20:36.910
Maria Veronica Svetaz, MPH: where the global 2008 economic recession started this shift in the global Listen to national. Listen. We felt that.

108
00:20:37.120 --> 00:20:37.940
Maria Veronica Svetaz, MPH: and

109
00:20:38.190 --> 00:20:47.480
Maria Veronica Svetaz, MPH: I use this to a lot, because even it's like a like in the the naming of the daily macro that we were sustaining as a community.

110
00:20:47.550 --> 00:20:55.330
Maria Veronica Svetaz, MPH: as a provider of the community, right? And how each of these issues generated like a media of

111
00:20:55.370 --> 00:21:01.980
Maria Veronica Svetaz, MPH: activism, an action that we need to put in place to sustain and protect their community right it like that right?

112

00:21:02.230 --> 00:21:04.360
Maria Veronica Svetaz, MPH: And part of that

113
00:21:04.410 --> 00:21:13.720
Maria Veronica Svetaz, MPH: we part of being a teacher at the University Committee with the increase of hate crime right by 2016 by then of 2016,

114
00:21:13.780 --> 00:21:32.080
Maria Veronica Svetaz, MPH: we decided. We need to go. We need to connect the dots we need. We need to have a paper, a position paper from the Society about Listen and medicine that connects race season to health. Most of the hate crime by the United Nations will happen globally, particularly in high schools, and with it.

115
00:21:32.260 --> 00:21:39.510
Maria Veronica Svetaz, MPH: But then something different happened right? We started noticing like they gave that we were providing it was like a different type of crisis.

116
00:21:39.570 --> 00:21:40.890
Maria Veronica Svetaz, MPH: so we would have seen

117
00:21:40.910 --> 00:21:55.640
Maria Veronica Svetaz, MPH: more depression, more anxiety, higher needs. And so we started thinking about this right like how this anti-immigrant state policy is the perception of a hostile and the immigrant environment it's connected with her

118
00:21:55.670 --> 00:22:05.280
Maria Veronica Svetaz, MPH: but different intermediary factor. and because I had the honor to have this in the same community and the enclave

119
00:22:05.330 --> 00:22:11.510
Maria Veronica Svetaz, MPH: of the Latino community. we were able to map what we were seeing.

120
00:22:11.530 --> 00:22:23.300
Maria Veronica Svetaz, MPH: and this is like a slide like we published this paper by, I think, like the end of 2019, and we were grappling with this like we were there. We were a Federal center for insight and depression.

121
00:22:23.330 --> 00:22:25.390
Maria Veronica Svetaz, MPH: I need look at these

122

00:22:25.440 --> 00:22:38.420
Maria Veronica Svetaz, MPH: anxiety over 3 time tires and farming separation, which was something that we were seeing like, was 8 times higher, and so was the suicidality of the things that we were seeing with us.

123
00:22:38.670 --> 00:22:46.000
Maria Veronica Svetaz, MPH: So when March 27, 2022, and it came breaking like, okay. working for business.

124
00:22:46.110 --> 00:22:57.910
Maria Veronica Svetaz, MPH: We feel like no we can't. Look at that, right? And so we continued. And I believe it. At least it can be. We were one of the only few that we were continue to do clinic non-stop

125
00:22:57.930 --> 00:23:01.050
Maria Veronica Svetaz, MPH: and doing like first on telephone, then

126
00:23:01.580 --> 00:23:03.580
Maria Veronica Svetaz, MPH: it's in my chart, then

127
00:23:03.870 --> 00:23:13.810
Maria Veronica Svetaz, MPH: pushing television to be more inclusive and sending a tick. So we became a lighthouse, and we were able to here see to take the post of the community in a way

128
00:23:14.150 --> 00:23:28.930
Maria Veronica Svetaz, MPH: that I don't think it would have been possible if we would have close our our care for our community. So I became involved in what I call the community response. Search. Remember when we were talking about like in inside of the hospital, this search to protect.

129
00:23:29.060 --> 00:23:41.050
Maria Veronica Svetaz, MPH: to protect the ICU and to protect the care. Right? So this is the search for the community. And we created basic need groups basic need responsive. We we wanted to. We wanted to measure right. That need.

130
00:23:41.140 --> 00:23:59.330
Maria Veronica Svetaz, MPH: We would involve one telemedicine, in messages, and the most amazing PC. Is, I was involved in the handiping 3 as a committee where we were trying to play an equity, link and monitoring, and being ready for the possible scarcity of resources, because we have a an icu

131

00:23:59.880 --> 00:24:10.020
Maria Veronica Svetaz, MPH: full or half more than half of the been delayed, or were used by people that were not English speaker think about that.

132
00:24:10.170 --> 00:24:15.240
Maria Veronica Svetaz, MPH: And then we became. I became involved with this amazing group in the Minnesota Covid ethical meeting.

133
00:24:15.640 --> 00:24:21.580
Maria Veronica Svetaz, MPH: And this is a reflection right So here, my my reflex. But, like they, how

134
00:24:21.840 --> 00:24:24.200
Maria Veronica Svetaz, MPH: this the health care

135
00:24:24.560 --> 00:24:33.820
Maria Veronica Svetaz, MPH: who that increases they make with the right. So we know that we are the other factor for in it, with any equipment right?

136
00:24:33.910 --> 00:24:34.770
Maria Veronica Svetaz, MPH: And

137
00:24:34.850 --> 00:24:42.590
Maria Veronica Svetaz, MPH: we were the one to have to be thinking about how to decrease. They have all the inequity happening in the community.

138
00:24:42.800 --> 00:25:01.620
Maria Veronica Svetaz, MPH: And I think, like what I wanted to highlight. Is this this amazing feeling in every space that it was included about this reflectivity? And as we talk about anti races and the oppression, tools, the ability to reflect the ability to foster that reflection right to come

139
00:25:01.630 --> 00:25:14.380
Maria Veronica Svetaz, MPH: we that pretty council of knowledge will have self-examination with our vulnerability. It was really outstanding, and that it's what I feel will allow us to confirm this

140
00:25:14.500 --> 00:25:17.510
Maria Veronica Svetaz, MPH: situation with the innovative shape

141
00:25:18.910 --> 00:25:20.890

Maria Veronica Svetaz, MPH: so we know

142
00:25:20.950 --> 00:25:28.070
Maria Veronica Svetaz, MPH: they did. It was COVID-19 have different dimensions of inequity, and i'm just going to name the rate testing treatment. Here's outcome

143
00:25:28.200 --> 00:25:30.470
ability to social distance.

144
00:25:30.740 --> 00:25:36.410
Maria Veronica Svetaz, MPH: And this piece right. The race is narrative and stigma, and how that influence to the

145
00:25:36.450 --> 00:25:50.000
Maria Veronica Svetaz, MPH: people that we were selling. And I want to remind everyone like this was a tsunami for the Asian community. And may it's an Asian American and Pacific Islander. I've learned that, hey? That's nice, and I just wanted to briefly share with you right?

146
00:25:50.050 --> 00:25:57.950
Maria Veronica Svetaz, MPH: This, like we did. This is the survey that we were able, as we were deploying the response to the community we were making it.

147
00:25:58.190 --> 00:26:05.070
Maria Veronica Svetaz, MPH: and we found what we know like. We want to find in terms of basic needs and this parity.

148
00:26:05.980 --> 00:26:12.340
Maria Veronica Svetaz, MPH: But the piece that I wanted to show is this when we ask fear of going out in public? And why?

149
00:26:12.350 --> 00:26:16.420
Maria Veronica Svetaz, MPH: Look what we found. And this is Dr. Lauren Mike Pearson.

150
00:26:16.650 --> 00:26:24.770
Maria Veronica Svetaz, MPH: looking at this right was I surprise? I have the Latino community with fearful about why now, because of my season. I know you know why.

151
00:26:25.260 --> 00:26:37.970
Maria Veronica Svetaz, MPH: And then we mentioned what happened after the killing, in the murder of Mr. Floyd right? And for the Latinos no different. But it's a difference for everyone else, right for everyone. Community of color. We're softening that

152
00:26:38.530 --> 00:26:41.770
Maria Veronica Svetaz, MPH: we have a lack of racial ethnic testing data.

153
00:26:42.050 --> 00:26:46.040
Maria Veronica Svetaz, MPH: housing and other food, social determinants, inequities.

154
00:26:46.080 --> 00:27:01.030
Maria Veronica Svetaz, MPH: access to economic stimulus with different and I want to end today with this amazing commentary for you to read and to find it's. It's New York, and how the pandemic it. A policy contain

155
00:27:01.130 --> 00:27:03.860
Maria Veronica Svetaz, MPH: flashes of what is possible. Right

156
00:27:03.880 --> 00:27:07.330
Maria Veronica Svetaz, MPH: it doesn't have to be a pandemic. It doesn't have to be.

157
00:27:07.510 --> 00:27:12.660
Maria Veronica Svetaz, MPH: and what we were able to accomplish. So these are some number for you to see

158
00:27:13.030 --> 00:27:14.040
Maria Veronica Svetaz, MPH: Snap.

159
00:27:14.190 --> 00:27:33.220
Maria Veronica Svetaz, MPH: They supplemental nutrition assistant program provided support to 40 million people, and they shared a household with children who have food in security face to 20%, and that number that seems horrific right. It was the lowest number since was tracked

160
00:27:33.340 --> 00:27:35.020
Maria Veronica Svetaz, MPH: in the last 2 decades.

161
00:27:35.450 --> 00:27:43.300
Maria Veronica Svetaz, MPH: So when Snap now will go away, we lose the recipient. We lose a there of their monthly allotment

162
00:27:43.830 --> 00:27:48.820
Maria Veronica Svetaz, MPH: with the child Tax credits from the medical rescue plan the

163
00:27:48.950 --> 00:27:54.510
Maria Veronica Svetaz, MPH: well when when it was measured between the pandemic and late, 2,021

164
00:27:54.570 --> 00:27:57.490
Maria Veronica Svetaz, MPH: child poverty fell by nearly half

165
00:27:58.030 --> 00:28:07.920
Maria Veronica Svetaz, MPH: from 10 to 5%, and the decline was more powerful among Black and Hispanic children, who are the one who are like, impacted disproportionately.

166
00:28:08.660 --> 00:28:13.620
Maria Veronica Svetaz, MPH: and they will use it for the thing that they need to be use full, close, and brain utility

167
00:28:13.820 --> 00:28:17.790
Maria Veronica Svetaz, MPH: mitigate the additional fund for their medicaid programs.

168
00:28:17.910 --> 00:28:22.970
Maria Veronica Svetaz, MPH: We were able to cover 93 million of people. That's means

169
00:28:23.180 --> 00:28:32.370
Maria Veronica Svetaz, MPH: that 1 out of 4 American were able to receive because of that. And now we got the unwinding right

170
00:28:32.610 --> 00:28:40.630
Maria Veronica Svetaz, MPH: where we are going to pull that out of them and around 50 million would blues in students, so they can

171
00:28:41.410 --> 00:28:46.550
Maria Veronica Svetaz, MPH: 3 over an issue rate back to 8%. So my reflection, right?

172
00:28:46.830 --> 00:28:54.270
Maria Veronica Svetaz, MPH: It is possible it is possible for us not to be in a pandemic and to reduce the chronic pandemic.

173
00:28:54.490 --> 00:29:13.220
Maria Veronica Svetaz, MPH: and we know, as we have been talking to some. I read the same New Year article this morning. I was going to go it. The future doesn't look they're more divided

than before, and we are not ready. And if you need this, to think that we need to look right, the baseline and the response and the wasteland is still thinking, will

174
00:29:13.610 --> 00:29:17.800
Maria Veronica Svetaz, MPH: we be able to decrease the equity gap in between pandemics.

175
00:29:17.950 --> 00:29:23.110
Maria Veronica Svetaz, MPH: What happened to, you know? Going back to the old normal look at the number the Russians presented right.

176
00:29:23.300 --> 00:29:24.110
Maria Veronica Svetaz, MPH: And then.

177
00:29:24.150 --> 00:29:34.350
Maria Veronica Svetaz, MPH: if we're going to do like only a response, right? And it will respond, we'll. We'll be able to create a quick equity breach to decrease the effect of less inequity in the next pandemic.

178
00:29:34.440 --> 00:29:37.200
Maria Veronica Svetaz, MPH: We were not able to advance at the baseline

179
00:29:37.310 --> 00:29:53.130
Maria Veronica Svetaz, MPH: and to think about right. The the cultural license type. They think it's in that workforce. Will that be enough? And I wanted to put like as the I see you, leaders, right, and and providers felt the moral injury. So we

180
00:29:53.480 --> 00:30:03.160
Maria Veronica Svetaz, MPH: with us right. They the faculty clinicians, healers, members of the community of color, who felt like we needed to be everywhere.

181
00:30:03.490 --> 00:30:10.930
Maria Veronica Svetaz, MPH: who felt the urge to be everywhere, because we felt like we were the one that we were able to provide that equity lens at some time it was lacking.

182
00:30:11.310 --> 00:30:14.750
Maria Veronica Svetaz, MPH: And how do we prioritize? This is huge

183
00:30:15.080 --> 00:30:27.650
Maria Veronica Svetaz, MPH: hospitals and clinic, working as a safety net to have the same equipment that everyone else and they can tell you about my feeling about going to the viral clinic the first vital clinic March 27

184
00:30:27.890 --> 00:30:28.780
Maria Veronica Svetaz, MPH: when

185
00:30:29.000 --> 00:30:37.500
Maria Veronica Svetaz, MPH: ideal friend of mine put like healthy we're doing testing as we're using it complex Max mask that I've never seen before.

186
00:30:37.530 --> 00:30:39.090
Maria Veronica Svetaz, MPH: What we didn't have, that

187
00:30:39.130 --> 00:30:43.970
Maria Veronica Svetaz, MPH: we shouldn't allow we shouldn't allow the one who here for the most.

188
00:30:44.010 --> 00:30:47.970
Maria Veronica Svetaz, MPH: the one who had the more needs to be in a regular

189
00:30:48.300 --> 00:30:49.190
Maria Veronica Svetaz, MPH: state.

190
00:30:49.270 --> 00:30:55.440
Maria Veronica Svetaz, MPH: So they have the same resources and the rest, but particularly in a pandemic, and my last reflection is like

191
00:30:55.720 --> 00:31:00.610
Maria Veronica Svetaz, MPH: what modified it. Exactly the same thing that

192
00:31:00.840 --> 00:31:05.590
Maria Veronica Svetaz, MPH: we we heard before. Right? What modifier do we use to that that

193
00:31:05.840 --> 00:31:18.310
Maria Veronica Svetaz, MPH: in any inequality where they unequal to the equation. How how do we modify that right? Is it race? And we try and we go home? Or is the social vulnerability index.

194
00:31:19.350 --> 00:31:24.190
Maria Veronica Svetaz, MPH: And with that I thank you for this amazing opportunity to be here.

195

00:31:24.250 --> 00:31:26.830
Maria Veronica Svetaz, MPH: Radical rates, the headline said.

196
00:31:32.120 --> 00:31:34.990
Maria Veronica Svetaz, MPH: Really. thank you so so much.

197
00:31:35.770 --> 00:31:38.780
Susan M Wolf, JD: Thank you so much. Dr. Vet has. That was great.

198
00:31:38.830 --> 00:31:49.220
Susan M Wolf, JD: Our next speaker is Dr. Jeff Dickter. I also want to be, while I introduce Jeff, encouraging you to post your questions

199
00:31:49.300 --> 00:31:57.020
Susan M Wolf, JD: in the chat. We'd really love to hear from you what your own perspective is on, what

200
00:31:57.140 --> 00:32:02.120
Susan M Wolf, JD: what should change, what could be better? What do we learn from the experience of the last

201
00:32:03.730 --> 00:32:05.510
Susan M Wolf, JD: really 2, 3 years?

202
00:32:07.290 --> 00:32:15.690
Susan M Wolf, JD: Dr. Jeff Dickter is associate professor of medicine at the University of Minnesota, and an expert in disaster preparedness.

203
00:32:15.940 --> 00:32:30.080
Susan M Wolf, JD: He served as a member of the Executive Committee for the Task Force for mass critical care, which is a national and international organization that has produced consensus statements and important COVID-19 publications.

204
00:32:30.140 --> 00:32:38.190
Susan M Wolf, JD: In the course of his work he has participated in the Department of Health and Human Services

205
00:32:38.270 --> 00:32:47.210
Susan M Wolf, JD: administration for strategic preparedness and response. Asper. He served as a member of the use containment unit

206
00:32:47.290 --> 00:32:55.100
Susan M Wolf, JD: and was Chair of the Minnesota Critical Care Working Group during the COVID-19 pandemic, Jeff.

207
00:32:56.200 --> 00:33:12.620
Jeffrey R Dichter, MD University of Minnesota (him/he): Thank you, Susan, and good morning to everybody. Just a note. No financial disclosures, and the views are only my own. So just a little bit of background. So the critical care working group was formed at the beginning of the pandemic in March of 2,020, and ran. Really

208
00:33:12.620 --> 00:33:19.630
we're still meeting monthly, but really most of our work was completed by March of 2022 so really about a 2 year period.

209
00:33:20.710 --> 00:33:35.980
Jeffrey R Dichter, MD University of Minnesota (him/he): It was also jumping down a little bit, it not, in addition to intense of us, in critical care leadership from the largest 9 health systems throughout the State, They were ethics and palliative care specialists and representatives from Mcec, particularly Dr. DeBruin and Dr. Walt.

210
00:33:35.980 --> 00:33:47.180
Jeffrey R Dichter, MD University of Minnesota (him/he): It was a gift from God to have Mcc. To help us. It was just an amazing group of really thoughtful, considered and expert academic people. So thank you very much. Susan and Dad

211
00:33:48.070 --> 00:34:04.050
Jeffrey R Dichter, MD University of Minnesota (him/he): and the the group really helped oversee and plan the critical care for the State. One common i'll make is that we also help develop the crew. Minnesota critical Care Coordination Center, which really was responsible for transferring patients

212
00:34:04.050 --> 00:34:08.679
Jeffrey R Dichter, MD University of Minnesota (him/he): coordinating the transfer of patients throughout the State when defined Icu beds.

213
00:34:09.900 --> 00:34:23.159
Jeffrey R Dichter, MD University of Minnesota (him/he): So plans plans, we really spent a lot of time in the first month, really 2 months, setting up a you know, a a critical care triage of scarce resources plan.

214
00:34:23.199 --> 00:34:39.900

Jeffrey R Dichter, MD University of Minnesota (him/he): and you know it had all the elements in terms of planning triage officers and teams and whatnot. We tried to coordinate at the State level, and we didn't complete everything. But for the most part most of the big programs. Most of the big organizations were all on the same page. We worked to

215
00:34:39.900 --> 00:34:48.530
Jeffrey R Dichter, MD University of Minnesota (him/he): plan of how they would be implemented if we ever needed them. And much of the information came from these 2 publications, and chess from the task force of mass, critical care.

216
00:34:49.620 --> 00:35:06.870
Jeffrey R Dichter, MD University of Minnesota (him/he): Just a little bit of background in terms of how we think about crisis standards. That here, which is what we're really talking about today is, if you look at this to the right crisis. This is really where the standard of care changes. Conventional and green is. That's what we do day to day. Usually, you know, as we get towards the

217
00:35:06.870 --> 00:35:15.670
the yellow part, which is really the the beginning of the danger area we call contingency. No, this is your really bad day, and i'll talk more about contingency in a moment.

218
00:35:15.670 --> 00:35:33.500
Jeffrey R Dichter, MD University of Minnesota (him/he): The crisis is when we get to crisis, we're providing the best care we can. But the care we're providing is not the same as it is under normal circumstances or even contingency. Circumstances, things, this resources and the systems are so stressed out that we're really no longer able to provide that same level.

219
00:35:33.830 --> 00:35:42.720
Jeffrey R Dichter, MD University of Minnesota (him/he): The yellow section is what we call contingency. So from a health care, perspective from a critical care perspective, and I want to get too much in the details for all of our audience.

220
00:35:42.720 --> 00:36:08.300
Jeffrey R Dichter, MD University of Minnesota (him/he): But there is a stepwise progression of things we can do to really maintain the same standard of care and the same level of care while stretching our resources. If you will. A little further, we use additional icu bed spaces that we don't usually use for icu. We have adaptive staffing plans, meeting. Everybody is working over time. People who don't work in the Icu, but have similar jobs may be working there. We have procedure teams where.

221
00:36:08.300 --> 00:36:38.040
Jeffrey R Dichter, MD University of Minnesota (him/he): you know, you know, surgeons are placing central lines instead of going to the operating room, for instance, surgeries, and non-emergent surgery so-called elective surgeries are restricted. We augment their telly I see

in their services, so we can add more onsite if you will you know electronic care to other other sites that Don't normally have that much use. We actually use. Pick you bends, pediatric. I see beds for appropriate age, younger adults, and finally the C4 which I had alluded to earlier, the

222
00:36:38.040 --> 00:36:52.420
Jeffrey R Dichter, MD University of Minnesota (him/he): statewide Coordination Center to transfer patients anywhere in the State to an open ICU bed was up and running. These are some of the things we did to prevent a crisis and to maintain the quality of care. But they weren't things that we would normally do all the time.

223
00:36:53.860 --> 00:37:01.660
Jeffrey R Dichter, MD University of Minnesota (him/he): This is what we are facing, and this is a graphic chart. I'll just spend a minute showing you this. This red line is icu beds throughout the State.

224
00:37:01.660 --> 00:37:19.090
Jeffrey R Dichter, MD University of Minnesota (him/he): Okay, this over here on the left is August of 2,020 and on the right is march of 2,022. So this is really the better part of the 2 years we were in the pandemic there were 2 really big surges here. So this is our Icu beds. One was in the fall of 21.

225
00:37:19.160 --> 00:37:32.760
Jeffrey R Dichter, MD University of Minnesota (him/he): These are non covid patients in the yellow. Their numbers went down as the number of covid patients filling our I use went up. This is again 2,020. This is 2,021 this we benefited

226
00:37:32.780 --> 00:37:50.720
Jeffrey R Dichter, MD University of Minnesota (him/he): the first year from having the Governor have the stay at home order from November to January, about a 7 week period. So the spike of these, this terrible spike of patients went up, and then it came down, and for the most part we were able to find a bed for almost everybody during this time, and though we don't have

227
00:37:51.270 --> 00:37:59.410
Jeffrey R Dichter, MD University of Minnesota (him/he): patient level outcome data. We believe that for the most part we were able to maintain most patients provide for most patients needs

228
00:38:00.340 --> 00:38:28.270
Jeffrey R Dichter, MD University of Minnesota (him/he): In 2021, there was no Government order in this curve when exhort inexorably up over months before. Finally, in January, it started to decline, and during this period. It was a terribly difficult time where we did not. We were not able to provide care for everybody, and the system was under terrible dress or statewide coordination center, which, during the first 20, had been able to find beds for every. We were not able to provide beds for many, sometimes not even most patients in need of them at this point

229
00:38:28.270 --> 00:38:29.130
Jeffrey R Dichter, MD University of Minnesota (him/he): in time.

230
00:38:29.690 --> 00:38:49.500
Jeffrey R Dichter, MD University of Minnesota (him/he): So what finally, what what happened as a response? There are 2 things we think about ethically limiting care if you will. And and we're talking about icu beds when we're talking about this now, and it's prioritization versus reallocation prioritization that everybody is going to get critical care to the degree we can provide it. But we have to

231
00:38:49.500 --> 00:38:57.290
Jeffrey R Dichter, MD University of Minnesota (him/he): decide who is the most urgent patient to get the I. You, dad, and most of the patients who are being prioritized were coming out of the emergency rooms.

232
00:38:57.290 --> 00:39:17.030
Jeffrey R Dichter, MD University of Minnesota (him/he): Some were coming from small hospital ice use or other areas, but For the most part the patients throughout the State were in the emergency room. The IC beds were in the Icu, and there were a whole lot more patients in the IC. Care than we could provide IC beds for. So we're prioritizing who got admitted first as opposed to re allocation.

233
00:39:17.850 --> 00:39:22.800
Jeffrey R Dichter, MD University of Minnesota (him/he): meaning we were so overwhelmed that we would actually look at patients who were in the Icu beds.

234
00:39:22.800 --> 00:39:43.160
Jeffrey R Dichter, MD University of Minnesota (him/he): and if there were a criteria by which we decided patients were no longer benefiting or Ben. We were unlikely to get better when there was somebody else who was much likely to get better. Their care would be so called reallocated. They would still get palliative measures, but they wouldn't get critical care. Those were kind of the 2 ends the spectrum that we face

235
00:39:43.260 --> 00:39:53.950
Jeffrey R Dichter, MD University of Minnesota (him/he): when we were severely limited in icu beds and overwhelmed with the number of patients that needed them. There was little scientific evidence to really help guide us to either process.

236
00:39:54.130 --> 00:40:06.790
Jeffrey R Dichter, MD University of Minnesota (him/he): So what finally happened was that prioritization. Decisions absolutely had to be made, the beds were going to be filled with

somebody, and so most of this happened with the point of care, intens of this, making the best decisions that they could.

237
00:40:06.840 --> 00:40:13.430
Jeffrey R Dichter, MD University of Minnesota (him/he): Some of our health care organizations we're able to pull people off the clinical services.

238
00:40:13.490 --> 00:40:32.630
Jeffrey R Dichter, MD University of Minnesota (him/he): critical care people, ethics specialists who they had. Sometimes it was one person, sometimes several, but they were non clinical people who would look at all the patients seeking beds and make best decisions. They were not to take directly part of the clinical care. This was again mostly done by people who were part of the clinical care, critical care doctors at the point of care

239
00:40:32.630 --> 00:40:42.390
Jeffrey R Dichter, MD University of Minnesota (him/he): first year, care systems at times were no longer able to accept patients from smaller hospitals, even some of the hospitals in their own systems. Things were set under such dress.

240
00:40:42.810 --> 00:40:52.070
Jeffrey R Dichter, MD University of Minnesota (him/he): Re Allocation never occurred in Minnesota. To the best of our knowledge it never occurred, and the reason for that is that there was no government support for it.

241
00:40:52.140 --> 00:41:06.130
Jeffrey R Dichter, MD University of Minnesota (him/he): usually for crisis standards of care. It requires a government's tech a governor's declaration to say, Things are terrible. I give you my authority to go ahead and do things that are not normally done that never occurred in Minnesota, and reallocation never occurred

242
00:41:06.220 --> 00:41:09.220
Jeffrey R Dichter, MD University of Minnesota (him/he): prior to the pandemic. These were considered ethically

243
00:41:09.260 --> 00:41:25.470
Jeffrey R Dichter, MD University of Minnesota (him/he): equivalent processes prioritization, on the one hand, as a spectrum with reallocation at the other end of the spectrum. In practice they couldn't be more different. They were diametric opposites. Everybody had to be prioritized because somebody had to get the bed. No reallocation occurred.

244
00:41:26.750 --> 00:41:42.090
Jeffrey R Dichter, MD University of Minnesota (him/he): So who is the best chance of receiving care? There was a lot of discussion about this, and a lot of it came up and is being urban

versus rural, which to a large degree, I think, was probably true. And really what it came down to is, if you had access to a

245
00:41:42.090 --> 00:41:56.840
Jeffrey R Dichter, MD University of Minnesota (him/he): tertiary care center, and you needed to share your your chance of getting it, or better, if you landed in their emergency room. If you had to be transferred from somewhere else. Your chances were increasingly diminished about being able to get that care. Certainly that care in a timely manner.

246
00:41:56.910 --> 00:42:13.540
Jeffrey R Dichter, MD University of Minnesota (him/he): The critical care frameworks, all that triage of scarce resource planning we did, and how to allocate care and the different protocols we had largely fell apart. It just was not used. It wasn't practical. It didn't have a governor's order to support it. It did get used, so i'm going to finish here

247
00:42:13.540 --> 00:42:33.630
Jeffrey R Dichter, MD University of Minnesota (him/he): the recommendations. One of the things we found that did work in the other States, had reported this as well is that, having either a fresh office or small teams to assess who needed to care and make those decisions was really helpful. It offloaded that responsibility from busy clinicians who were tired and exhausted. It took that responsibility away from them. The moral burden away from them if you will.

248
00:42:33.910 --> 00:42:53.260
Jeffrey R Dichter, MD University of Minnesota (him/he): There. The scientific one of the learnings was that we need better scientific data, help guide these these strategies, and finally mechanisms. To maintain contingency, care, and avoid crisis at all possible, is the top priority meaning, trying not to get into crisis. In the first place, by having all those other contingency strategies.

249
00:42:53.260 --> 00:42:57.780
Jeffrey R Dichter, MD University of Minnesota (him/he): and then some to help us prevent that. And on that i'm going to go ahead and finish.

250
00:42:58.140 --> 00:42:59.300
Jeffrey R Dichter, MD University of Minnesota (him/he): Thank you, Susan.

251
00:43:01.950 --> 00:43:13.450
Susan M Wolf, JD: Thank you, Jeff. We're now going to go into Gallery View with everyone. I just want to note that before we began we all agreed to use first names for this conversation.

252
00:43:13.510 --> 00:43:20.640
Susan M Wolf, JD: In reality, we've all collaborated an awful lot, including over the last 3 years.

253
00:43:22.520 --> 00:43:36.060
Susan M Wolf, JD: I I want to encourage also the audience to keep feeding us your comments and your questions. But I want to pick up first with a point you made Jeff, and invite, maybe first Deb and then Veronica to comment

254
00:43:36.670 --> 00:43:44.440
Susan M Wolf, JD: in your presentation, Jeff. You talked about crisis standards of care frameworks not working.

255
00:43:44.590 --> 00:43:47.500
Susan M Wolf, JD: falling apart. So

256
00:43:47.550 --> 00:44:05.510
Susan M Wolf, JD: a a you know a lot of us, Mc. E Mdh. Spent a lot of time during the pandemic, trying to articulate ethics, guidance for how to deal with contingency and crisis standards of care. What do we learn in your view, Jeff.

257
00:44:05.620 --> 00:44:11.230
Susan M Wolf, JD: Did those frameworks help or not start with Jeff and then Deb. And then Veronica.

258
00:44:12.080 --> 00:44:29.960
Jeffrey R Dichter, MD University of Minnesota (him/he): So the frameworks ethically really help frame the work, and they really helpful for those of us who are especially in leadership. But I think for all of us, at the point of care. What happened was that things didn't happen the way we thought they might happen before the pandemic started, meaning that what finally turned out was that everybody was overwhelmed.

259
00:44:29.960 --> 00:44:35.630
Jeffrey R Dichter, MD University of Minnesota (him/he): Everybody did the best to prioritize care, and get as much care for patients as they could.

260
00:44:35.690 --> 00:44:48.930
Jeffrey R Dichter, MD University of Minnesota (him/he): There were only a handful of states that ever really declared so called crisis standards of care, and whether that really resulted in improving care by either prioritization reallocation strategies

261
00:44:48.930 --> 00:44:56.960
Jeffrey R Dichter, MD University of Minnesota (him/he): nobody really knows, because there was no data really capped. We have only anecdotal experiences, so what we thought would work beforehand

262
00:44:56.990 --> 00:45:16.720
Jeffrey R Dichter, MD University of Minnesota (him/he): in practice didn't really work at all. But there were a couple of things, as I said that we learned as number one. We need to do better at thinking about prioritization. because it does happen during conventional periods as well, and the other thing is really thinking about using us, one person or small group to prioritize patients who are not involved in clinical care, which was only done some of the time.

263
00:45:17.790 --> 00:45:26.860
Susan M Wolf, JD: Yeah, how do you see learning on the role of ethics, work and ethics? Frameworks when push comes to shove in a pandemic.

264
00:45:27.530 --> 00:45:39.100
Debra DeBruin, PhD: a a a few things here. One is, I think, during the pandemic we realized that there were gaps in the previous ethics frameworks because they really focused on crisis standards of care, and not on that contingency period.

265
00:45:39.140 --> 00:45:45.110
So, Susan, as you know, we ended up having to develop ethics, guidance for contingency conditions

266
00:45:45.170 --> 00:45:54.770
Debra DeBruin, PhD: during COVID-19 that sort of reflection and review, I think, needs to be ongoing. And so you know, I think, what I want to say

267
00:45:54.790 --> 00:46:06.010
Debra DeBruin, PhD: with respect to the points that Jeff just made one is, I agree. There was a tremendous amount of confusion in this data, as in a number of States about the

268
00:46:06.130 --> 00:46:07.110
Debra DeBruin, PhD: who

269
00:46:07.310 --> 00:46:24.730
Debra DeBruin, PhD: initiates the move to crisis standards of care when that is needed right. Some States did have a formal declaration at the State level. This State never did this, and so a number of health systems. I think health systems just felt that they were not

270
00:46:24.790 --> 00:46:44.640
Debra DeBruin, PhD: empowered. And I think one of the things we really need to do now, in now, in this period, where we have a chance to look back and think is, try and figure out like, come to some sort of consensus about what it means to move. How do you implement or initiate a move to crisis standards of care?

271
00:46:44.640 --> 00:46:52.660
Debra DeBruin, PhD: Because I think people were quite unwilling to do it without there being a clear indication that it was okay to move there.

272
00:46:54.000 --> 00:47:10.060
Debra DeBruin, PhD: The other thing is, with respect to the sort of retrospective looking back and seeing how well the frameworks worked. I mean, I think that is part of the after action work right? I mean, we need to look at the data and and reflect and see. How did they? How

273
00:47:10.390 --> 00:47:19.710
Debra DeBruin, PhD: you know, how did frameworks get operationalized? How well did they work? How can they be improved? That's a lot of the work that should be happening now.

274
00:47:20.290 --> 00:47:21.030
Susan M Wolf, JD: Great

275
00:47:21.060 --> 00:47:31.670
Susan M Wolf, JD: Veronica, I wonder what your perspective is on the strengths, but also real weaknesses in our efforts to come up with ethics frameworks that would function. Well.

276
00:47:33.590 --> 00:47:46.910
Maria Veronica Svetaz, MPH: I think it's the for me. It was like the the discussion right and and sometime like the having the inclusion of people who belong to those groups that has been historically marginalized and and having

277
00:47:47.000 --> 00:47:49.340
Maria Veronica Svetaz, MPH: their voice, is, I remember, one time like

278
00:47:49.370 --> 00:47:59.190
Maria Veronica Svetaz, MPH: appealing to causing right and and like in in one of our discussion, like like showing really like, okay, look at you. We cock us who is here like

279
00:47:59.350 --> 00:48:00.210
Maria Veronica Svetaz, MPH: from

280
00:48:00.560 --> 00:48:09.420
Maria Veronica Svetaz, MPH: those people who got the live experiences about being historically marginalized, that there was like like an emerging different perspective, right?

281
00:48:09.440 --> 00:48:16.540

Maria Veronica Svetaz, MPH: And and how to bring a consensus before the next pandemic happened right particularly now that we have a

282
00:48:16.650 --> 00:48:23.520
Maria Veronica Svetaz, MPH: a society that is even more divided than it was at the beginning. Right? So it's truly

283
00:48:23.660 --> 00:48:32.890
Maria Veronica Svetaz, MPH: a work of probably continues, could could continue. I don't think it's only a location, but I think it's on the protocol. Some processes

284
00:48:32.960 --> 00:48:34.180
Maria Veronica Svetaz, MPH: in place

285
00:48:34.260 --> 00:48:37.130
Maria Veronica Svetaz, MPH: in real time now, right like

286
00:48:37.240 --> 00:48:41.680
Maria Veronica Svetaz, MPH: for people to feel what it means to be inclusive in health care.

287
00:48:42.340 --> 00:48:43.880
Maria Veronica Svetaz, MPH: And so that's my

288
00:48:44.470 --> 00:48:56.340
Debra DeBruin, PhD: Susan. Can I just add one quick note to that which is, I do think, that part of I'm. Part of the process that we need to do to sort of reflect back and then improve, for next time is a community engagement process.

289
00:48:56.340 --> 00:49:14.550
Debra DeBruin, PhD: And, as you know, in this State, we did do extensive community engagement when, in those previous projects where the foundational guidance was really being developed. But now would be a a great time to try to do that again, to reflect and see how

290
00:49:14.580 --> 00:49:21.380
Debra DeBruin, PhD: diverse communities view their response and what they think should happen moving forward.

291
00:49:21.470 --> 00:49:31.970
Susan M Wolf, JD: Yeah, I was gonna ask you, Veronica, too. How do you think we should really optimize community engagement, now debt talked about sort of after action evaluation.

292
00:49:32.040 --> 00:49:35.680
Susan M Wolf, JD: But if we're going to involve our community in that, how do we do it?

293
00:49:37.130 --> 00:49:46.470
Maria Veronica Svetaz, MPH: So there's a lot of like known processes about how to do community based participatory action. It doesn't have to be research right?

294
00:49:46.500 --> 00:49:53.470
Maria Veronica Svetaz, MPH: And there was an amazing question there by Dr. Fuel about, like the the

295
00:49:53.510 --> 00:50:06.620
Maria Veronica Svetaz, MPH: continuous drama, particularly African, American, and native American community, has been suffering. I will add every community of color right? And they me stressed, and probably the amplify, maybe right mixed mistress, that we're having right now.

296
00:50:06.710 --> 00:50:16.350
Maria Veronica Svetaz, MPH: And so I think it's centered in bringing those participatory processes being reflection. That's the number one and the

297
00:50:16.490 --> 00:50:21.600
Maria Veronica Svetaz, MPH: restorative practices right owning owning the fact that we sometimes

298
00:50:21.630 --> 00:50:23.680
Maria Veronica Svetaz, MPH: a harm in something

299
00:50:24.490 --> 00:50:32.850
Maria Veronica Svetaz, MPH: like this. This this this is of harm in the way that we provide health care that it needs to be addressed. And I think that this conversation needs to happen right. Now

300
00:50:32.960 --> 00:50:45.120
Maria Veronica Svetaz, MPH: we're trying to do. We're ringing at Hennepin as an example, something called radical healing, which is sort of like the framework right moving from drama to healing and centering on identity.

301
00:50:45.290 --> 00:50:48.260
Maria Veronica Svetaz, MPH: They are health experiences, and are him

302
00:50:49.740 --> 00:50:53.280
Maria Veronica Svetaz, MPH: so moving along those ways great.

303
00:50:53.290 --> 00:51:04.700
Susan M Wolf, JD: There's a question in the chat, and I think i'll start with you, Jeff? In response to this question. asking us to 0 in on older and institutionalized

304
00:51:04.740 --> 00:51:05.560
Susan M Wolf, JD: people

305
00:51:07.810 --> 00:51:16.880
Susan M Wolf, JD: the question talks about some of the ways. They were disproportionately impacted at different points in the pandemic.

306
00:51:17.200 --> 00:51:21.810
Susan M Wolf, JD: How do we better design our response

307
00:51:21.890 --> 00:51:31.170
Susan M Wolf, JD: to address the particular needs? Those are actually 2 overlapping populations, older and institutionalized.

308
00:51:31.440 --> 00:51:33.310
Susan M Wolf, JD: Give us your thoughts on that.

309
00:51:35.820 --> 00:51:49.080
Jeffrey R Dichter, MD University of Minnesota (him/he): I think that that's a really difficult question, and I think what we learned was by looking at every patient individually, and to, and what were their needs, and how we can best provide for them.

310
00:51:49.210 --> 00:52:02.040
Jeffrey R Dichter, MD University of Minnesota (him/he): It's sort of similar to what we do on every day, anyways, but it really needed to be. If you will couldn't go on steroids. It really required a a different lens when it came to managing the pandemic and trying to understand their needs as well.

311
00:52:02.240 --> 00:52:12.270
Jeffrey R Dichter, MD University of Minnesota (him/he): and I wish I could give some specific guidance or straightforward answer. I don't know that I can. It's just really just trying to really focus as best we can and their needs.

312
00:52:13.230 --> 00:52:15.290
Susan M Wolf, JD: Yeah, do you have thoughts on this?

313
00:52:15.430 --> 00:52:18.920
Debra DeBruin, PhD: I I do so briefly. I think

314
00:52:19.000 --> 00:52:34.080
Debra DeBruin, PhD: there are things we could have done better during Covid and things we should really be working on now. So sort of better protections broadly for staff, for example, in long term care facilities.

315
00:52:34.080 --> 00:52:53.890
Debra DeBruin, PhD: many of whom are not paid Well work multiple jobs, then spread infection from one facility to another. So better working conditions for folks in those positions could actually help improve staffing levels, reduce infection levels and so on.

316
00:52:53.890 --> 00:53:12.520
Debra DeBruin, PhD: One of the things that we did during Covid was when there was a shortage of personal protective equipment or ppe. We preferentially supplied hospitals and clinics over long term care facilities, for example, which left those facilities sort of lacking

317
00:53:12.520 --> 00:53:14.420
unprotected.

318
00:53:14.760 --> 00:53:22.550
Debra DeBruin, PhD: The other thing that we often have a conversation about. As, as you know, Susan, in ethics is about

319
00:53:22.600 --> 00:53:35.050
Debra DeBruin, PhD: rationing based on age, right? Which is one thing that you know it's sort of getting at what Jeff was talking about when he was talking about looking at everyone individually. So in Minnesota we've issued guidance that says.

320
00:53:35.050 --> 00:53:43.760
Debra DeBruin, PhD: You know, to the extent to which age is a kind of proxy for level of risk. By all means take it into account. But it's not okay.

321
00:53:43.760 --> 00:53:58.260
Debra DeBruin, PhD: from an ethics point of view, to discriminate based on age, so is simply because someone is older. If that's not an indicator of elevated clinical risk, it's not okay to say, Sorry you're You're old enough. We're not going to provide you with care.

322
00:53:59.850 --> 00:54:11.220
Susan M Wolf, JD: you know. I wanted to ask you bridging off of that Veronica you mentioned the Sbi. and that just talked about age as one

323
00:54:11.270 --> 00:54:29.930
Susan M Wolf, JD: lens to look at rationing and allocation through. As you know, there there's been a lot of debates about the role of race ethnicity, Various indicators of disadvantage the Area Deprivation index. What do you think? We've learned Veronica about

324
00:54:30.150 --> 00:54:32.370
Susan M Wolf, JD: how to better

325
00:54:32.450 --> 00:54:39.320
Susan M Wolf, JD: address issues of rationing and allocation to promote health equity. In the next pandemic.

326
00:54:42.970 --> 00:54:46.400
Maria Veronica Svetaz, MPH: I think we learned that we need to have this discussion ahead of time.

327
00:54:46.870 --> 00:54:56.250
Maria Veronica Svetaz, MPH: and and I think like we need like. I think science is is great. We didn't have the luxury sometime like to have all those things right, but we may

328
00:54:56.290 --> 00:54:57.350
Maria Veronica Svetaz, MPH: try

329
00:54:57.500 --> 00:55:04.030
Maria Veronica Svetaz, MPH: to to look at which one of those index were the most. But I think, like I will, piggyback with

330
00:55:04.250 --> 00:55:06.740
Maria Veronica Svetaz, MPH: the question about vaccines, and trust

331
00:55:06.780 --> 00:55:22.330
Maria Veronica Svetaz, MPH: right that we cannot think about these issues in terms of the emergency right? We need to start building and having these conversations daily about race season, and any kind of Eastern right age breaks gender, and how that influence health.

332

00:55:22.380 --> 00:55:29.400
Maria Veronica Svetaz, MPH: and i'm bringing that to the patient that we have that away. But I feel like we need to figure it out away

333
00:55:29.460 --> 00:55:41.010
Maria Veronica Svetaz, MPH: to have a like, if if Fix, at least where the majority can, can validate this indicator that will modify the equation to be withable make sense.

334
00:55:41.380 --> 00:55:42.600
Susan M Wolf, JD: Yeah. I think

335
00:55:42.730 --> 00:56:00.340
Susan M Wolf, JD: we have clearly opened up very big questions here, and i'm hoping that this is the start of a conversation we can all continue. I'm getting the signal that we're reaching the end of this time. I feel as if we're just getting started on some of the biggest issues.

336
00:56:00.340 --> 00:56:03.020
Susan M Wolf, JD: but I'm going to turn it over to you.

337
00:56:05.580 --> 00:56:21.570
Ana Núñez MD: Thanks so much. These are big issues, and perhaps we need to sort of about part 2 in terms of some action things, you know, Jeff, when you said we're talking about contingency and crisis, and it's like, Well, what if in health disparities. We're working a crisis, and we're not in the usual. And what how do we sort of sort that out

338
00:56:21.570 --> 00:56:50.940
Ana Núñez MD: talking about sort of cultural brokers and relationships with communities to develop those relationships rather than do patients. Trust us. What have we done to garner those trust? There's so many things here that sort of rich in terms of our conversation. I appreciate you starting this conversation, and look forward to sort of continuing and hope everybody has a wonderful time we will be sort of recording this and posting this, so this will be available, and if there are sort of additional questions.

339
00:56:50.940 --> 00:57:15.520
Ana Núñez MD: those that were not sort of fully addressed in sort of the Q. A. Will be in a timely basis and available to you. I'd like to thank all of you for joining us and appreciate continuing to spell on to get those answers of how do we get those lessons learned? How do we get better to right in terms of addressing both our health inequities as well as sort of the what comes next. So thank you very much.

340
00:57:21.550 --> 00:57:37.450
Matt Amundson (he/him): One final note, a one question survey will appear in your web browser immediately after ending the zoom session. Please take the time to complete the

survey, to inform us of future presentation topics and reminder that the session was recorded, and will be shared within 2 days to all those who registered for the event.

341
00:57:37.450 --> 00:57:46.910
Matt Amundson (he/him): Otherwise the recording can be found under the education and training tab of the Ode I website and make sure to save the date. The next Team's Lecture Series session will be on Wednesday, June fourteenth.

342
00:57:46.940 --> 00:57:51.590
Matt Amundson (he/him): Take good care of yourselves, and take care of others as well. Thank you all so much.