Crisis Standards of Care
Community Advisory Board
April 7, 2022
2:00-4pm

High-Level Overview of Meeting
Detailed meeting notes will be available by April 22 at khi.org/pages/csc

Combined Agenda:
2:00pm – Welcome and Agenda
2:10pm – Project progress and debrief from TAP meeting
2:40pm – TAP questions to CAB
3:40pm – Next Steps and Questions for TAP
4:00pm – Adjourn

Key Considerations for TAP:
CAB discussed the following concerns and considerations for the CSC process:

Diversity in CSC Process:
As in the previous meeting, CAB members explained that it is important that the people at the table are representative of the demographic diversity of those affected by CSC guidance. They identified it was important for both CAB and TAP to include people with lived experience.

People-First- and Plain-Language
CAB members said that it was important that CSC guidance be written in people-first- and plain-language so that patients can read and understand how the guidance applies to them. CAB members said it was particularly important that individuals with disabilities be able to understand how they might be affected by the guidelines so they can make informed decisions about seeking care.

Importance of Active Language
CAB members said that it was important that CSC guidance be written using firmer, active language like *"No patient will be…"* rather than passive language like *"No patient should be…"* to help patients better understand the language.

Concern about 'Fairness' as a 'Business as Usual' Approach:
CAB members recognized that hospitals have limits for how they can address systemic inequities but expressed concern that an approach of distributing resources in a "fair and equal" manner perpetuates business as usual. The emphasis should be on giving resources to those most in need, not the 'fairest' way. ***This involves both being more equitable in distribution of resources and action to address the systems that perpetuate the inequities. CAB members said it was not enough to just not make inequities worse;*** CSC guidelines should work to address the systemic issues that create these inequities. CAB members suggested that CSC guidance should include action that can help prevent diverse communities from being left behind during the next crisis including:

- **Increasing diversity of hospital workers:** Adjusting hiring practices so that practitioners better resemble the patients in their communities.

- **Engaging communities that have less access to health care:** Building relationships with these communities before an emergency occurs and continuing to reach out during times of crisis.
- **Identify where the structural inequities exist and provide guidance for local level:** Using data to identify where communities experience greater inequities in accessing health care and provide guidance for how local hospitals should address these inequities.
- **Incorporate correction-factors into scoring systems:** Using scoring system to recognize that people do not enter hospital on even-playing field because of systemic inequities.

Use of Correction Factors in a Scoring Tool

CAB members were in support of using correction factors in a scoring tool to recognize inequities that may exist. Some ideas for correction factors that were mentioned by CAB members included:

- **Race and Ethnicity:** CAB members mentioned accounting for patients who belong to racial and ethnic groups who have historically had less access to medical care or faced greater inequities
- **Houselessness Status:** CAB members mentioned accounting for patients who do not have stable housing
- **Long-term Severe Illness or Disability**: CAB member mentioned accounting for patients on oxygen
- **Neighborhood:** CAB members mentioned using geographic data to help account for individuals living in neighborhoods that face more inequities
- **Preventative Behavior:** Some CAB members mentioned accounting for individuals who took preventative action and used available resources (i.e., in case of COVID-19, getting vaccinated or wearing masks). *CAB members clarified that this should not penalize patients who were medically unable to utilize offered preventative resources.*
    - **Alternative Perspective:** Some CAB members disagreed about the incorporation of preventative behavior as a correction factor because of the possible application to non-COVID-19 situations such as smokers not taking advantage of cessation resources. Another reason provided was that there is mistrust and misinformation around and differing levels of access to resources like vaccination, particularly in rural, low-income areas and patients and facilities should not be penalized because of the inclusion of a correction factor.
- **Individuals with High-Risk Occupations:** CAB members were divided about whether high-risk occupations (such as frontline workers and those identified as working in essential, high-risk occupations) should be used as a correction factor. Some CAB members said they may support this if and only if the definition of essential was well-defined, clear, and inclusive of those who are often excluded like home-care workers and grocery clerks. However, other CAB members said a person's occupation should not be considered at all because they felt it places a value on a person's life based solely on the perceived value they present to the community.

Question for TAP: *Should correction factors work in both ways (positive and negative) or should factors only work to benefit patients?*

Extent to Which a Patient's Potential to Survive Should Be Considered

CAB members were divided on the question about whether to consider a patient's potential to survive when allocating medical resources. Some CAB members said it *"made them sick to their stomach"* that someone is deciding an individual's hospital survival or near-term prognosis, expressing concern that these prognoses could be wrong. There was also concern that during times of crisis, practitioners do not perform thorough individualized review of each patient due to staff shortages, resulting in errors. Some CAB members said that the decision of survival and resource allocation should be left solely up to the patient and the patient's family/power of attorney. However, CAB members were divided on this issue. Some CAB members said that the reality is that these decisions and prognoses are made, and it does not make sense to provide limited medical resources to the individual with a lower potential to survive in the case of a tie-breaker situation.

Stakeholders Involved on A Triage Team

CAB members suggested the following considerations for who should make triage decisions:

- The triage team should be made up of clinician, patient, the patient's family/power of attorney, and people with lived experiences, particularly those with a disability.
- Require all triage team members to receive training around disability rights.
- Decisions to implement CSC should be made at local level with involvement of consumers.
- Do **not** refer to the team as "triage officers" because this grants authority that shuts down further discussion with patients and their families.

Reallocation of Personal Ventilators

CAB agreed that patients who use personal ventilators ***should not*** have their ventilators taken away and reallocated to other patients.

Additional Answers to TAP Questions

CAB did not have enough time to finish discussing the questions from TAP to CAB. CAB members have been asked to complete a survey by Tuesday, April 12, with their answers to these questions. Results of this survey will be shared during the Thursday, April 14, TAP meeting.