Crisis Standards of Care
Meeting of Community Advisory Board
May 5, 2022
2:00-4pm

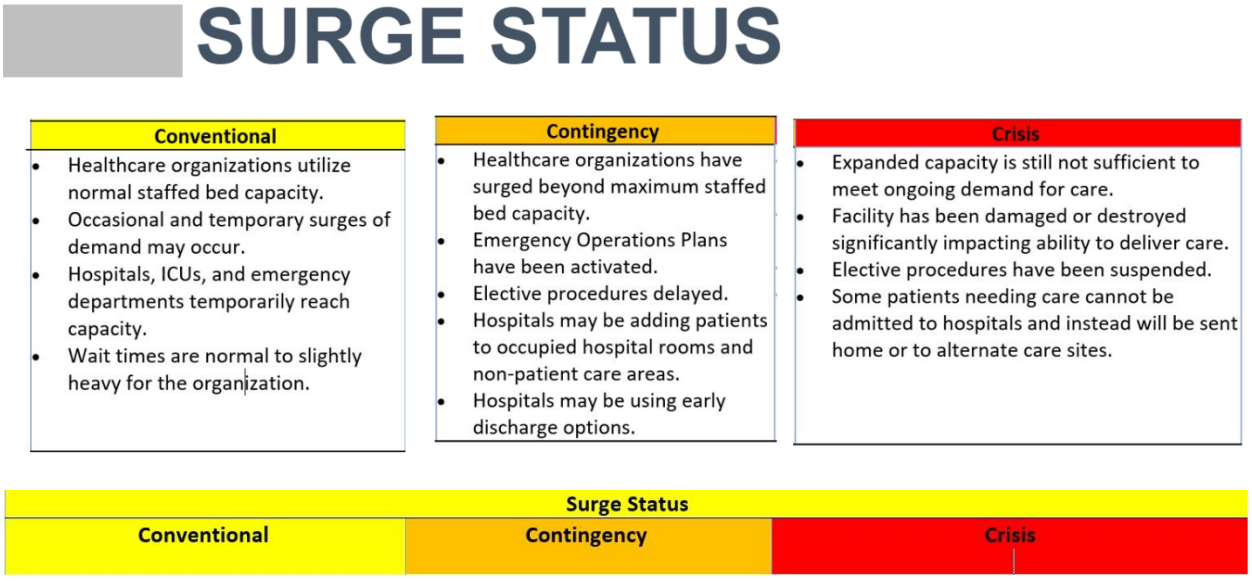
High-Level Overview of Meeting Notes
The high-level minutes focus on CAB's review and revisions of draft recommendations. Detailed *meeting notes with additional CAB discussion will be made available at a later date.*

Agenda:
2:00pm – Welcome and agenda
2:10pm – Project progress and debrief from TAP meeting
2:20pm – Review draft recommendations and provide feedback
3:20pm – Review high-level findings from focus groups
3:40pm – Next steps
4:00pm – Adjourn

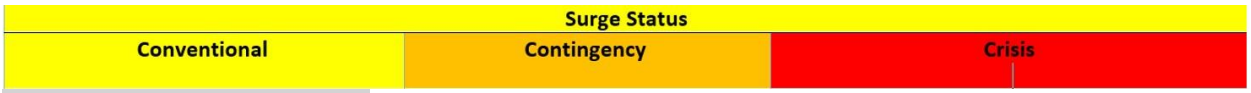
Revised Draft Recommendations
Using the information provided by CAB between February and April, preliminary results from focus groups and interviews, and findings from the environmental scan, KHI staff prepared draft language for CAB to consider as it developed recommendations during its May 5 meeting. Prior to the May 5 CAB meeting, the draft language was also reviewed by several TAP members, a KDHE staff member and the CAB liaison to TAP.

All recommendations were categorized based upon the surge status in which they would be implemented *(Figure 1)*. Recommendations may apply to one or more surge status conditions.

Figure 1: Recommendation Framework



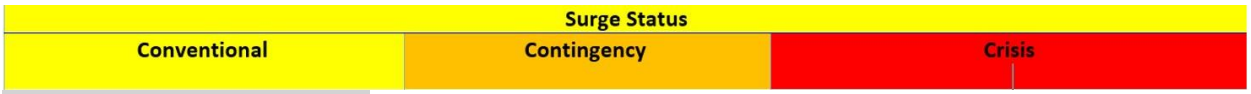
CAB Recommendation *1.1.* The implementation of Crisis Standards of Care commits to the dual goal of public health emergency: improving health outcomes and reducing inequities in distribution of health benefits. *(No revisions)*



CAB Recommendation 1.2. Guidelines should prioritize making equitable decisions that create a level-playing field for individuals that have experienced systemic barriers rather than prioritizing fair decisions that treat everyone the same regardless of the inequities they may have experienced. *(Revision: Quotation marks omitted around "equitable" and "fair")*

Context for Revisions:

- **Rationale:** CAB members said that the quotation marks around these words communicated a lack of commitment to equity. They suggested that removing the quotation marks shows that the recommendation is meant to be implemented as written.



CAB Recommendation 1.3. Patients who have their personal medical equipment will not have their personal equipment allocated or reallocated to other patients. When a patient with their own (non-hospital) medical equipment is admitted, they may continue using their medical equipment (as defined in this CSC Guidance) which is considered to be their personal property. However, when the patient's status changes and the use of medical equipment provided by the hospital is necessary, the patient will be included for assessment and resource allocation of other hospital equipment according to a triage protocol in place for CSC. Patients' privately-owned, personal medical equipment will remain the patients' property even if a patient is allocated further hospital equipment.

Context for Revisions:

- **Rationale:** To further clarify the intent of this recommendation, CAB proposed adding the context that patients would be considered for additional "hospital equipment" and adding an additional sentence at the end of the recommendation to reiterate that patients' medical equipment remains theirs even in situations where they may receive access to additional hospital resources that would replace this equipment during the time the patient was in the hospital.

CAB Recommendation 1.4. To best mitigate implicit bias, each facility should have a group of triage coordinators and a triage team that adequately reflects the diversity of the patient population served by the facility in terms of demographics such as race, ethnicity, disability, preferred language, sexual orientation and gender identity. (Omitted phrases)

Context for Revisions:

- **Rationale:** CAB members suggested removing the phrases "to the greatest extent possible" and "aim to" to show a stronger commitment to this recommendation.

CAB Recommendation 1.5. Facilities should have a human resource plan to recruit and retain people from excluded communities so a greater pool of potential team members that reflect the community's demographic are available.

Context for Revisions:

- **Rationale:** CAB members suggested replacing "promoting representation of" with "to recruit and retain" to clarify the goal of the recommendation.

Conventional

CAB Recommendation 1.6. Triage team members and coordinators should receive advanced and ongoing training to prepare them for the role, including training in:

- Applying the allocation framework;
- Communicating with clinicians and families about triage;
- Avoiding implicit bias against persons of color and other marginalized groups;
- Improving cultural competencies; and
- Respecting disability rights.

Context for Revisions:

- **Rationale:** CAB recommending adding a bullet point about improving cultural competencies of triage team.

Conventional

Draft Recommendation 1.7. Develop a process to resolve any disputes (placeholder). (No revisions)

Crisis

CAB Recommendation 1.8. Clearly communicate triage process to patients and/or their next of kin using plain linguistically and culturally appropriate language to ensure a triage process that manifests respect for persons. (Word "fair" describing triage process omitted)

Context for Revisions:

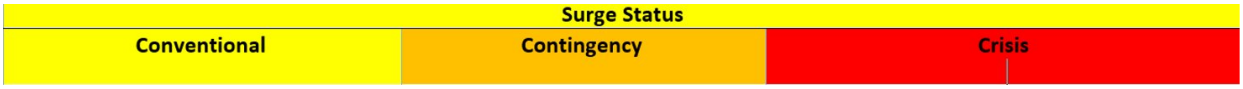
- **Rationale:** Add that the communication will be in "plain linguistically and culturally appropriate language" and remove word "fair" to highlight the importance of focusing on equity versus fairness and place importance on using appropriate language that can be easily understood by patients and patients' families

Crisis

CAB Recommendation 1.9. Once triage decision has been determined, this information should be clearly communicated to patients and/or their next of kin using plain linguistically and culturally appropriate language per facility protocols.

Context for Revisions:

- **Rationale:** Add that the communication will be in "plain linguistically and culturally appropriate language" to place importance on using inclusive language (e.g., acknowledges diversity, conveys respect to all people, is sensitive to differences) that can be easily understood by patients and patients' families.



CAB Recommendation 1.10. Area Deprivation Index (ADI) or Social Vulnerability Index (SVI) data is gathered for all patients at intake so equity adjustments are readily available. (Omitted phrase “in the background” and changed surge level)

Context for Revisions:

- **Rationale:** Changed surge status to apply to all 3 surge conditions because CAB members said that it was important to apply correction factors at all surge stages, not only during a crisis. Also, the phrase “in the background” was removed for clarity.

CAB Recommendation 1.11. When patients subject to triage are identified, patient profiles will include a correction factor into patients' triage scores to reduce the impact of baseline structural inequities using Area Deprivation Index (ADI) and Social Vulnerability Index (SVI) upon intake. Collectively, ADI and SVI take into considerations factors, including education, income/employment, household composition and disability, race/ethnicity, language, housing and transportation status. (No revisions)

CAB Recommendation 1.12. Use hospital survival to discharge. (No revisions)

CAB Recommendation 1.13. Quality of life judgments or long-term life expectancy will not be used as factors in the allocation and reallocation of medical resources. (No revisions)