Crisis Standards of Care (CSC)
Technical Advisory Panel (TAP) Meeting
March 10, 2022
2:00-5:00pm

High-Level Overview of Meeting
This a high-level summary of TAP's Meeting #3 discussion. For additional contexts and information regarding specific topics, page numbers from the TAP's Detailed Meeting Notes were referenced throughout the summary.

TAP March 10 Meeting Agenda:
2:00pm – Opening Remarks, Welcome and Introductions
2:10pm – Project Overview
2:20pm – Update from Community Advisory Board (CAB)
2:30pm – Discussion on Core Principles and Planning Assumptions
3:30pm – Break (10 minute)
3:40pm – Breakout Rooms (Equity and Ethics | Indicators and Triggers)
4:50pm – Next Steps
5:00pm – Adjourn

Discussion on Core Principles and Planning Assumptions

TAP mentioned the following are goals to keep in front of mind as the CSC guidance document is developed for Kansas:

1) Ensure CSC is easily understood and useable.
2) Address issues around equity.
3) Keep in mind of shortages and other scarce resources during crisis.
4) Ensure that voices from marginalized populations and individuals with special needs are included in the discussion when developing the CSC guidance document.

TAP reviewed the purpose statements from the 2013 Kansas CSC document and Colorado's CSC Plan (*page 4-5*), and identified the following:

1) TAP prefers the language from the 2013 Kansas document's general-purpose statement because it calls out for equitable access to care and addresses the demands for care as opposed to Colorado's CSC general purpose statement, which focuses more on addressing the volume of patients and maintaining capabilities and capacities of the hospital/facilities.
2) The 2013 Kansas CSC purpose statement regarding small hospitals should be included in the KS CSC guidance document because it addresses the coordination and partnerships of large referral centers and small hospitals.

TAP reviewed the National Academy of Medicine (NAM) Toolkits that outline the five ethical principles (*page 6*) and stated that the principle regarding community engagement should be listed first in the KS CSC guidance document's core principles, and to reflect that the engagement refers to consulting and involving the community in the discussion.

TAP reviewed planning assumptions listed in the Kansas Response Plan (2020), Colorado's CSC Plan, and Minnesota's CSC Plan (*page 6-7*) and provided input on the following are items that should be included or suggestions for changes to include in the KS CSC guidance document:

1) The Kansas Response Plan's (2020) planning assumptions should be modified because the assumptions are trauma related.
2) Related to the Colorado CSC Assumptions, members discussed the following:
    a. TAP agreed that the language to state that the KS CSC guidance document is a fluid and flexible document should be adopted. However, they were unsure if the KS CSC guidance document could be reviewed bi-annually.
    b. TAP agreed that the language "*healthcare coalitions will be involved in coordinating information and resources during a CSC activation*" should be adopted.
    c. A TAP member suggested to involve stakeholders and communities, in addition to healthcare coalitions, in the coordination of information and resources.
    d. A TAP member suggested adopting language that emphasizes the CSC guidance document is not a mandate hospital must follow but provides flexibility.
3) Related to the Minnesota CSC Assumptions, members discussed the following:
    a. The language "*statewide initiation of CSC will likely occur only during a pervasive or catastrophic public health event that overwhelms both local and regional capacity*" might be adopted to address concerns regarding declarations of CSC triggers, but it should be reconciled to Kansas statutes.
    b. The language "*patient transfer is not possible or feasible, at least in the short-term*" might be unclear and raises some concerns among the members regarding its current language.

Breakout Room 1: Equity and Ethics

TAP members were broken into two groups for breakout sessions. Members in Breakout Room 1 (Group 1) reviewed and discussed the following questions from CAB: *(For additional contexts and information regarding specific topics, please refer to page numbers from the TAP's Detailed Meeting Notes.)*

- **QUESTION 1 FROM CAB** (*page 8*) **- How to eliminate potential biases when decisions are made about who received what medical resources and when?**
    - Group 1 discussed the potential implicit biases guiding triage decisions and how it is important to recognize that algorithms can potentially include biases, indirectly and directly. Therefore, it is critical that the tools are interrogated, tested, and validated before usage.
- **QUESTION 2 FROM CAB** (*page 9*) **- To what extent should geographic criteria such as diverse and socially and economically vulnerable census tracts/census blocks be considered in distribution of medical resources?**
    - Group 1 discussed how critical clinical decision-making are made during crisis situations. A member mentioned that the first thing that comes to their mind once they see their patient is whether the person is going to benefit from the limited resources that they have to offer regardless of the person's health status, socioeconomic status, geographic background, or distribution, etc. The critical decision point is - can the person survive or have a chance of surviving if they get the resource? Other members mentioned the concerns raised from CAB is that the current clinical decision-making process in triage are perpetuating the inequities that already exists in the system. The CAB liaison shared that fairness in an inequitable system perpetuate inequities. If the discussion around fairness is in its current context without looking from an equity lens, then the group is perpetuating inherent biases and inequities that caused people to make decisions on whether they should go to the hospital in the first place or not.
- **QUESTION 3 FROM CAB** (*page 10*) - **How can we ensure that the Kansas CSC Guidelines do not include certain criteria as a basis for determining allocation of medical resources, including criteria the MN CSC Plan recommended not be considered, as well as gender identity?**
    - Group 1 discussed whether there was a way to be inclusive in the language (when developing the KS CSC guidance document) without creating tension with the public who may not receptive.

    - **Group 1 posed a question for CAB** → *Can you recommend best practices for mitigating or acknowledging tension among those who may not be receptive to the use of inclusive and accepting language (i.e., regarding gender identity)?*
- **Question 4 from CAB** (*page 10-11*) - **How can the CSC be written and implemented in a way that they address the needs of those impacted the most?**
    - Group 1 discussed the differentiation of "first impacted and first served" versus "first through the door and first served." Some members mentioned that clinicians may not see that there are individuals who were impacted and did not seek care or resources due to their situation or circumstances that may prevent them from doing so. Other members mentioned that from a critical care lens, the issue making the decision of who would receive the resources when resources are limited at the point in time the clinician see the person.

CO ETHICAL PRINCIPLES *(page 11)*

- Group 1 reviewed four ethical principles (*fairness, proportionality, solidarity, and participatory*) from the CO's CSC Plan. There was agreement within Group 1 that the four ethical principles should be included in the KS CSC guidance document. A member expressed that the principles would build a mechanism into a system that would encourage people to seek care, but it is important that the group acknowledge that there are people who may not reach to the hospital doors, so there needs to be effort to reach out to those people.
    - **NOTE:** The CO's CSC Ethical Principles was reviewed again by the rest of TAP towards the end of the meeting for additional thoughts. **TAP posed another question to CAB** → *As the Ethical Principles section is developed, should emphasis be placed on "fairness" or on "equity"?*

Breakout Room 2: Indicators and Triggers

Members in Breakout Room 2 (Group 2) reviewed the Colorado's CSC indicators and triggers to assess which components could be included for the Kansas CSC guidance document. The Colorado plan has facility, local-level and state-level indicators and triggers. *In Breakout Room 2, Group 2's discussions were regarding to bulleted items of Colorado's CSC indicators and triggers from PowerPoint slides. Please refer to page numbers from the TAP's Detailed Meeting Notes to review the PowerPoint slides and additional information.*

INDICATORS

- **Definitions of the Three Levels of Care (*Conventional, Contingency, and Crisis*)** (*page 12*) - A member shared that it would be important to include the information because a standard definition would ensure that people reading the guidelines have the same understanding of the term.

- **Modifying Indicators Definitions** (*page 12-14*) – Group 2 reviewed tables of indicators at different situational levels (e.g., surge status, resources levels, and staff). Some members expressed those indicators would need to be modified to provide a clearer definition of scope of practice issues.

TRIGGERS

- **Regarding State-Level** (*page 15-16*), **Local-Level and Hospital-Level** (*page 16-18*) – Group 2 discussed the need to clarify state- and local-level triggers and whether facilities will be using state-level triggers to implement CSC.

BREAKOUT GROUP 2 OVERVIEW:

- **Declaration of CSC**: Healthcare facilities may or may not use state or local declaration of disaster to implement the use of CSC. Facilities may not implement CSC until crisis level of care indicators are seen.
- **Legal Implications:** What are the legal implications for facilities to implement CSC with or without state or local emergency declaration? KDHE is currently having discussions about legal issues and anticipate having more guidance to discuss in future meeting.
- **Regional integration and cooperation:** Currently being discussed by Federal Government, assume this will be a future consideration.

Group 2 also provided considerations (*page 18*) to modify or adopt definitions of indicators and triggers for the Kansas CSC guidance document. Because the considerations are directly in reference to bulleted items on the PowerPoint Slides, please refer to the TAP Detailed Meeting Notes (*page 12-18*) for more information.