Crisis Standards of Care
Technical Advisory Panel (TAP) Meeting
May 12, 2022
2:00-5:00 p.m.

Meeting Notes
Meeting Materials:
- Agenda
- April 14 TAP Detailed Minutes + High Level Summary
- Environmental Scans
    - *Authority and Legal Considerations* (p22-24)
    - *Communication System* (Q.3. p13-14; Q.4. p15-17)
- May 5 CAB High Level Meeting Summary
- Framework for CAB Equity (Document Title: *Draft CAB Recommendations:*
- *Strategies to Advancing Equity in KS Crisis Standards of Care*)
- Summary of Focus Group and Interview Findings
- Link to materials: https://www.khi.org/pages/csc

Agenda:
2:00pm – Welcome
2:05pm – CAB Update
2:20pm – Focus Group Update
2:30pm – Discussion on Legal Considerations, Plan Activation and Deactivation
2:45pm – Discussion on Roles and Responsibilities
3:00pm – Discussion on Communication
3:45pm – Subgroup Report Out and Discussion on Triage Framework
4:40pm – Discussion on Plan Maintenance
4:55pm – Next Steps
5:00pm – Adjourn

Meeting Commitments:
- Come ready to discuss and compromise
- Keep remarks succinct and on topic
- Don't hesitate to ask clarifying questions
- Start and end on time

Attendees
TAP members: Steven Simpson, Lillian Lockwood, Ron Marshall, Carla Keirns, John Carney, Mike Burgess, Dennis Cooley, Gianfranco Pezzino, Amy Kincade, Con Olson, Dan Decker, Dennis Kreisel, Dereck Totten, Patrick Gaughan, Jean Hall, Kelsey Goddard (delegate for Jean Hall), and Ami Hyten (CAB liaison)

Guests: Matt Wynia, MD MPH FACP, Center for Bioethics and Humanities and University of Colorado; Douglas White, MD MAS, University of Pittsburgh School of Medicine; Russell Dorn

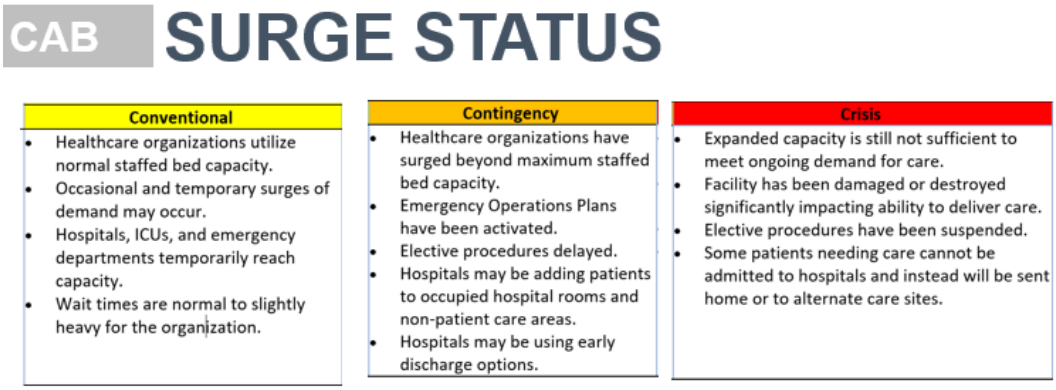
KDHE: Ed Bell, Rebecca Adamson, Michael McNulty

Staff: Hina Shah, KHI (Facilitator); Kari Bruffett, KHI; Tatiana Lin, KHI; Wendy Dang, KHI

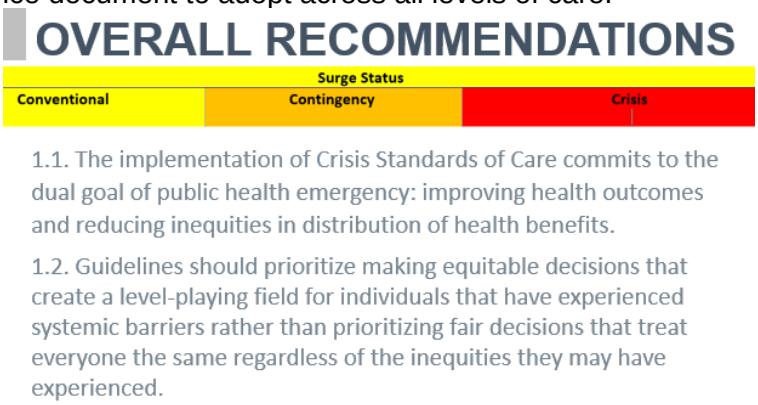
Update from the Community Advisory Board (CAB)

Surge Status

Background: *Dr. Cooley provided an overview of conventional, contingency, and crisis (CCC) levels of care (see below) as context for how CAB developed sets of recommendations for TAP to consider. Some recommendations developed by CAB and finalized during the May 5th meeting fit into the conventional and contingency levels of care because they focused on preparations in advance of the implementation of crisis standards of care (CSC). It also was emphasized that preparations during conventional and contingency status could affect how hospitals will perform in a crisis.*



- **Overall Recommendations:** The overall recommendations (*see below*) are those items that fit in all levels of care. These recommendations are concepts for the authors of the CSC guidance document to adopt across all levels of care.

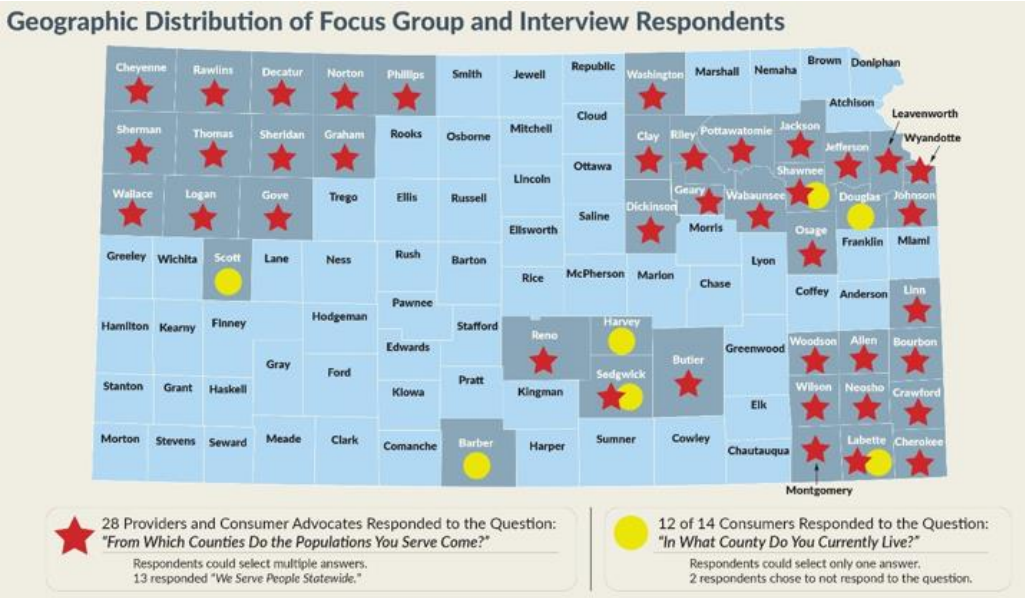


Update on Focus Groups Results

Focus Groups Process and Results

Background: *Tatiana (CAB facilitator) provided an overview of the focus group process and results. The purpose of the focus groups and key informant interviews were to provide additional consumer and provider perspectives regarding the implementation of CSC and other considerations. Focus group findings were embedded in relevant discussions throughout the meeting.*

- **Response Rate:** 45 participants were recruited for the study. 42 of 45 participants voluntarily completed a demographic survey, which was used to help understand the makeup of the participants. 40 of the 45 participants completed the focus group or key informant interviews. The map (*see next page*) shows the geographic distribution of the makeup of participants who voluntarily completed the demographic survey.



NOTE: Some counties were the home of more than one consumer participant, while the stars represent counties in the catchment areas served by the provider and consumer advocate participants.

- **Question:** *There is a good number of counties in the state that were not represented with a star or a dot, especially in the Southwest area. Is there insight as to why those counties did not have anything?*
  - **Answer:** The research team reached out to the CAB and TAP members to suggest those who would be interested in participating. The team recruited participants representing regions across the state. Additional work can be done in the future to reach those counties.

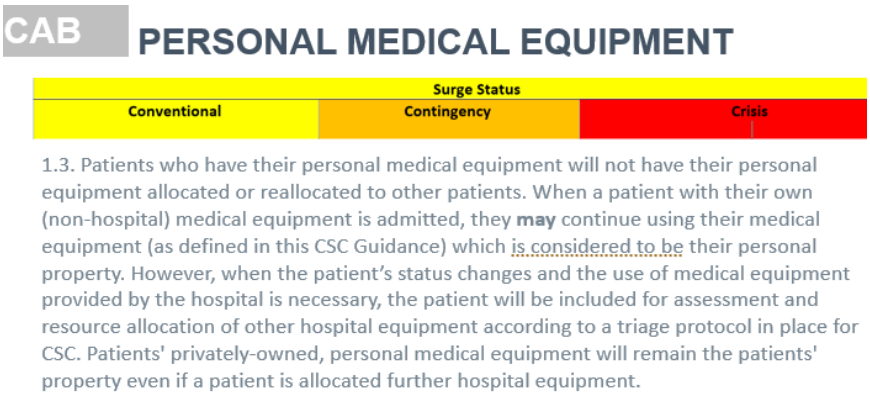
- **Focus Group Findings Related to Concerns and Worries of CSC Process and Implementation**: The chart below is a high-level overview of worries and concerns shared by the individuals who participated in the focus group and key informant interviews. The results were grouped into themes and presented by each stakeholder group.

Question: If your local hospital had to ration medical care, what would worry you most? Consumer follow-up: How might this impact your decision to seek medical care?	
Consumers and Consumer Advocates	• Concerns about discrimination by decisionmaker • Worries about a quality-of-life factor being used in decision making • Worry about a worthiness factor being used to allocate medical resources
Consumers	• Impact of patients' worry about rationing of care on decision to seek care • Patients' worry about understanding CSC process and how to access resources that are available
Consumer Advocates	• Left behind populations
Providers	• Misunderstanding of healthcare resource scarcity* by public

* In the focus group with providers, providers noted that the public usually thinks about scarcity of medical resources in terms of equipment (e.g., ventilators, beds) versus staff such as nurses. During the pandemic, staffing shortages topped the list of issues.

CAB Recommendation 1.3 Personal Medical Equipment

Background: *Dr. Cooley provided an overview of Rec 1.3 (see below) regarding personal medical equipment (PME). TAP members discussed and agreed previously that PME would never be allocated or reallocated to other patients. If the patient with PME switched to hospital resources according to the triage protocol in place, then the PME would remain the patient's property. The CAB liaison stated that the recommendation language was to ensure clarity and set expectations that patients would not be disadvantaged for having PME and that it would not be taken away. It was important to stress that having PME would not automatically give patients priority during triage as well.*



- **Question:** *Regarding the last line, which I may need a little clarification. What would happen if that piece of PME could be a benefit for another patient? Is there an option where that PME can be temporarily reallocated to a patient in need?*
  - **Answer:** Several members stated that it would be unlikely that PME could benefit other patients because the PME would not be hospital-grade medical equipment. In addition, patients would need to consent to having PME used for other patients. Another member stated that PME may not be used due to staffing, training, or legal liability issues. A member shared that reusing or reassigning PME may not work when the patient will eventually need the PME back. However, something to consider is having a process that allows patients or their next of kin to donate the PME if they no longer need it.

AGREEMENTS:

The TAP members agreed to the following consideration:

- **Rec 1.1 and 1.2**: Adding the concept of Rec 1.1 and 1.2 to the Kansas CSC guidance document.
- **Rec 1.3:** Adding the Rec 1.3 language (with minor revisions) to the Kansas CSC guidance document.
- **PME Donation Process:** Consider developing a donation process for patients or their next of kin to donate PMEs that they no longer need.

Discussion on Legal Considerations, Plan Activation and Deactivation

Legal Considerations, Plan Activation, and Deactivation

Background: *Hina (facilitator) provided an overview of the KDHE requirements for the Kansas CSC guidance document regarding the sections on legal considerations, plan activation, and deactivation of CSC. Ed (KDHE) provided an overview of each section from the state level. The Kansas CSC document is meant to provide guidance for local government and facilities in absence of a state declaration. See next page for key points.*

Sections	Key Points
Legal Considerations	• Crisis standards of care recommendations will be presented as a voluntary set of guidelines developed with the input of several different experts and stakeholders. ○ Hospitals may elect to use these recommendations to create standard operating procedures during a public health emergency. • As observed during the recent COVID-19 pandemic, many unplanned legal issues became very apparent, many of them driven by the pandemic's duration. • Further studies will need to be completed and probing the willingness of the state legislature to explore options that will allow for greater flexibility and reach in scope of practice during local, regional, or state disaster situations.
Plan Activation	• Activation of a CSC should be up to the affected facility or facilities. ○ Due to limitations placed on public health facilities and the state health department, activation of a CSC will need to be based on the current status of the affected facility or facilities. • Formal activation of a CSC should always be coordinated with all levels of the hospital infrastructure, local and regional stakeholders and partners, along with local emergency management and public health. • Those standards should be exercised periodically and strategies be updated as often as needed in order to remain relevant in an all-hazards environment.
Deactivation	• The deactivation of the CSC will be at the discretion of the individual hospital(s) and should be based on their surge level or the status of the facility resources that triggered the localized CSC activation. • Hospitals who have activated their CSC may choose to also deactivate their CSC if the regional response needs caused by the triggering event drops below the thresholds developed by that facility or region.

    - **Question:** *Is it clear that an inter-institution or individual hospital have access to the same authority (in terms of reassigning staff or allowing certain staff to do certain things) that the governor has in executive order?*
        - **Answer:** Part of the hospital plan should include an internal shift for accommodating the surge for short term events. For long term events, when the hospitals are not comfortable with the idea of doing what is outside of their scope, the hospitals would turn towards the state for an executive order.
            - **Alternative Perspectives:** A member shared in chat that they are concerned with allowing individual hospitals to decide whether activation of CSC is needed. For example, there have been times during the winters when every hospital in Kansas City is on diversion. The member was concerned that the guidance might allow hospitals to activate CSC unnecessarily.
- **Liability Protection:** A member mentioned that there should be fairly broad liability protections for triage decisions including use of sub-standard, borrowed equipment if that's what is available under an activated CSC plan. One member suggested that even without explicit protections by the state, if hospitals are jointly implementing CSC, that provides legal protection by means of establishing a standard of care. Another member responded that it was true in the past, but the protection had to be extended by the state and through executive orders.
- **Staffing Shortages:** A member stated that some of the staffing shortages, especially nursing staff, are related to staff leaving hospitals for higher paying contracted travel assignments. There are some hospitals with mutual aid agreements that allow for free

flow of staff between facilities or into facilities within the same hospital system. The member emphasized that extending credentialing, knowing where resources are, knowing which hospitals have access to those resources, and knowing what type of event hospitals are dealing with may help address the staffing shortages. Another member shared that reassignment of staff may help address the issue. For example, a PACU nurse can be moved to the ICU unit or floor to alleviate the demand for resources.

- **Related Focus Group Findings:** The focus groups suggested making recertification process easier for staff who are reentering workforce during crisis.

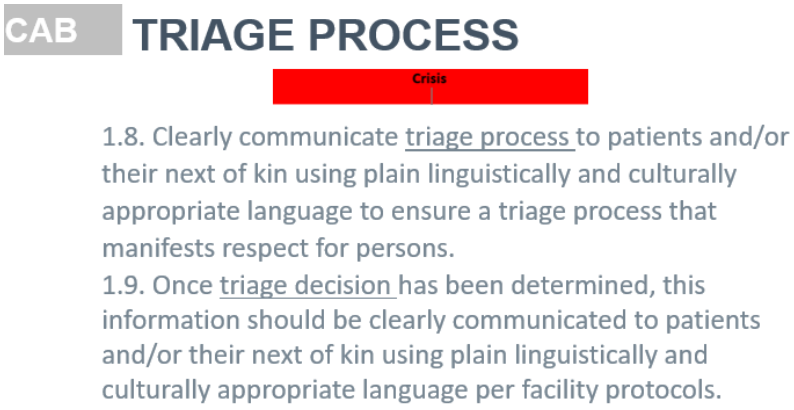
Suggestions:
The following are suggestions made by some members throughout the discussion:

- **Clear Qualifications:** One member was concerned that the legal consideration section (and discussion) was vague regarding providers' protection from liability. The suggestion was to have clear and specific language regarding liability protections and how providers qualify for it.
- **Burnout**: A member stated that the issue with staff shortages is related to staff burnout and suggested that it would be important to include ways to combat burnout in the Kansas CSC guidance document.

Discussion on Communication

CAB Recommendation 1.8 and 1.9 Triage Process

Background: *Dr. Cooley provided context for Rec 1.8 relating to the triage process that needs to be communicated in clear and plain language for patients and the community. Rec 1.9 is related to the final triage decision that needs to be communicated at the individual level in clear and plain language for the patients and their next of kin. CAB liaison clarified that transparency is needed for the public to trust the process. See below for recommendation language.*



- **Related Focus Group Findings:** The findings (*see next page*) provide insights as to what type of information would be beneficial to provide to patients in order to help them navigate the systems during a crisis. The results were grouped into themes and presented by each stakeholder group.

Question: How should people find out their local hospitals are facing shortages and may need to ration care?	
All Stakeholder Groups	• Information should be communicated using multiple communication channels
Consumer Advocates and Consumers	• The public should receive information about resource shortages, allocation protocols, and guidance for patients
Consumers	• All information shared publicly should be in plain language • Hospitals, nonprofits, governments, and advocates roles in communication efforts
Consumer Advocates	• Provide information to patients upon entry to hospital
Providers	• Provide easy-to-understand information

    - **Question:** *Is it possible that the triage situation occurs when there is no CSC declared? If it's true, then why do we assume that triage is endemic to CSC plan?*
        - **Answer:** Yes. It is like any other crisis. If the hospital is prepared, then the hospital should declare CSC. If the hospital is not prepared, it would be a chaotic necessity to just triage. It depends on the hospital's degree of preparation as to whether they activate CSC or not.
- **Questions Needed in FAQs:** TAP members reviewed a list of frequently asked questions (FAQ) pulled from the Washington CSC Plan (*see below*) for hospitals to share with healthcare staff and patients about CSC. A member stated that the FAQ should be written in a way for the public to understand that CSC is like any other emergency management plan where disasters or crisis are handled in an organized, fair process.

FAQs for Healthcare Staff	FAQs for Patients and Families
• What are Crisis Standards of Care? • How was CSC Planning Developed? • How does the Triage Process Work? • What are Next Steps After Triage?	• What are Crisis Standards of Care? • How was CSC Planning Developed? • How does Triage Process Work? • What Are Steps Taken When There Are Too Many Patients? • How will this (i.e., activation of CSC) affect me?

*What is in red was added by KHI team.

Agreements:
The TAP members agreed to the following consideration:

- **Rec 1.8 and 1.9**: Adding Rec 1.8 and 1.9 language (with minor revisions) to the Kansas CSC guidance document.
- **FAQs:** Ensure that hospitals have FAQ documents readily available at any CCC level of care for healthcare staff and communities to access.

Suggestions:
The following are suggestions made by some members throughout the discussion:

- **For healthcare staff FAQs**: a question about how the hospitals' CSC plans were developed before triage.
- **For patient FAQs**: "What alternative options or resources exist?" AND "if possible, FAQs can also be translated in Spanish and other key languages."

Triage Decisions (Relating to Rec 1.9)

Background: *Hina (facilitator) provided an overview of an example from Washington CSC Plan where a development of a communication team (separate from the triage team) was recommended, if staffing is available, to assist in communicating the final triage decisions and allocation processes (alongside with the provider) to the patient or their next of kin. The goal of the communication team is to ensure that final decisions and allocation processes are communicated clearly to patients and provide additional support for and reduce the risk of burnout and moral distress of providers. Although the Washington CSC Plan recommends the development of a communication team, the CSC Plan recognizes the development of the communication team is dependent on staff availability. Hospitals can designate a person to communicate the final decisions. See below for Washington's recommended experiences for a CSC communication team.*

CSC Communication Team Recommended Experiences
Have a background in any of the following areas: palliative care, social work, spiritual care, mental and/or behavioral health training, and have participated in end of life, goals of care, or similar types of patient care conferences and discussions.
Must have the **ability to express difficult decisions simply and plainly**, as well as the ability to explain to non-medical audiences the basics surrounding the difficult decisions required during crisis standards of care.
Understand how the decisions were made and the basic driving principles in a transparent matter in order to address any questions or concerns that arise from the patient and/or their family.

- **Current Practices:** Several members shared that, currently, attending physicians communicate the final triage decisions, allocation processes, and treatment of care to the patients. There were concerns that adding an additional person in the chain of communication may increase the risk of miscommunication and confusion for the patients. Some members stressed that staffing would be difficult during a crisis especially for smaller hospitals, so recommending development of a communication team may add unnecessary burden for smaller hospitals where staffing may already not be available for their own triage team. Another member agreed that the final triage decision and allocation process should be communicated to the patients and their families but stated that the development of a communication team would be a luxury if the hospitals have enough staffing.
    - **Alternative Perspective:** CAB liaison shared their perspective that consumers said they are often feeling confused after attending physicians communicate with them and leave the room. CAB members wanted to see if there was a possibility to ensure that someone who is trained to speak in plain and clear language can help patients and their families better understand and process decisions. Having the communication person or team would help bridge the patient and attending physician. CAB members also understand that hospitals may not have the available staffing to support this, so this is an option for hospitals that do have resources.

Suggestions:
The following are suggestions made by some members throughout the discussion:

- **Considerations related to Rec 1.9 and Communication Team**: A KHI staff suggested that the author of the section could consider acknowledging the underlying concern represented in the concept of a communication team in the rationale for Rec 1.9. The concept could be provided as a potential strategy for hospitals that may view it as a tool to support staff who are delivering difficult news.

Discussion on Roles and Responsibilities

Roles and Responsibilities

Background: *Hina (facilitator) provided a list of roles identified in the 2013 Kansas Modified Protocols and asked the TAP members to identify roles that were missing and should be included in the Kansas CSC guidance document. See below of the list. The red text indicates roles that TAP members identified for inclusion.*

Entities	Roles
Hospital Executive Leadership	Development of CSC
Incident Command Team (ICT)	Assist emergency management planning, response, and recovery capabilities; Includes security
Health Care Coalition (HCC)	Regional; Communication between hospitals
Scarce Resource Allocation Team	Resource Management
Triage Officer (Coordinator) and Team	Triage
Review Committee	Review the decisions of the triage team
Treating Clinicians	Acute, Emergency and Palliative Care; Includes advanced practitioners
Governor, County Commissioner, and Local Board of Health Officer	Emergency Order
KDHE	State agency support for crisis care
Emergency Management	State and county support for crisis care
Community Liaisons (Communication Information Officer/ Public Information Officer)	Community engagement, education and communication activities

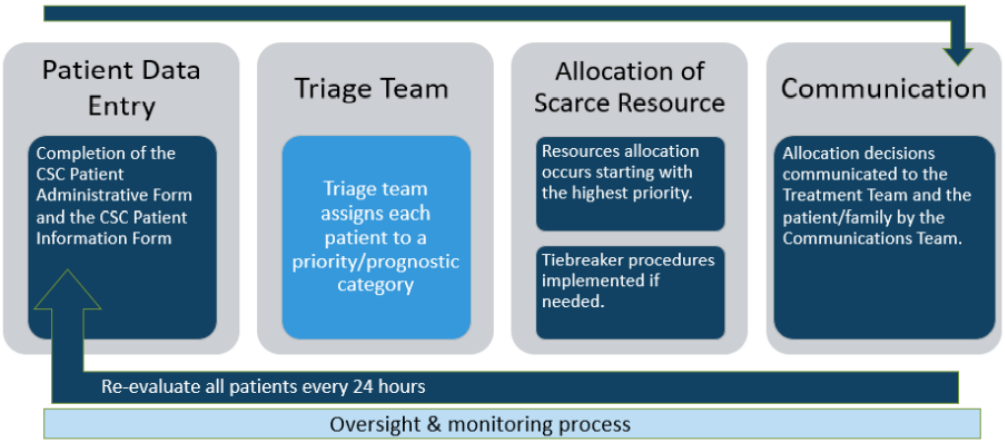
Subgroup Report Out and Discussion on Triage Framework

Background: *Dr. Simpson provided an overview of the subgroup's discussion in its May 6 meeting. TAP members reviewed and made final decisions on proposals from the subgroup. The following were reflections questions that the subgroup needed to answer at the meeting:*

- *What should the triage process look like in the Kansas CSC guidance document (i.e., triage team and triage coordinators)?*
- *What scoring tool(s) should the Kansas CSC guidance document consider?*
- *What elements should be included in the correction factor (e.g., geographic factors)?*
- *What tiebreaker approach should the Kansas CSC guidance document consider?*

Triage Process and CAB Recommendations 1.4, 1.5, 1.6, and 1.7

Background: *Dr. Cooley provided an overview of the triage process (see below), pulled from Washington CSC Plan, that was shown to CAB members so that they are familiar with how the triage process works.*



The following recommendations from CAB members are concepts for inclusion in the Kansas CSC guidance document that can be adopted during conventional care status in preparation for a future crisis.

TRIAGE PROCESS

Conventional

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.

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.

Conventional

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.

1.7. Develop a process to resolve any disputes (placeholder).

- **Rec 1.4, 1.5, and 1.6:** A member mentioned that the triage team would not be picked in advance and that the team should be blinded. If the recommendations are intended for the team who is developing the triage process, then the recommendations make sense to include. Another member stated that the recommendations are important to include since these are more focused on the preparation.

- **Rec 1.7:** This was a high-level placeholder for resolving any disputes regarding triage decisions. CAB members did not have specifics as to what the process would be yet.

Agreements:
The TAP members agreed to the following consideration:

- **Rec 1.4, 1.5, 1.6, and 1.7**: Adding the concepts of Rec 1.4, 1.5, 1.6, and 1.7 to the Kansas CSC guidance document.

Suggestions:
The following are suggestions made by some members throughout the discussion:

- **Intake Form**: A member suggested that the Kansas CSC guidance document should include an intake form for hospitals to use to collect patients' clinical information for the triage team.
- **Add Conventional and Contingency-Related Recommendations to Appendix**: A member suggested that recommendations focused on the preparation for CSC could be included in the appendix instead of the body of the guidance document.

Focus Group Findings

- ***Background:*** *Tatiana (CAB facilitator) provided an overview of the focus group results related to the best way to decide who gets what medical resources and when during a crisis.* The results were grouped into themes and presented by each stakeholder group.

Question: What is the best way to decide who gets what medical resources and when?	
Consumers and Consumer Advocates	• Prioritize those with greatest need and who are most vulnerable
Consumers	• Difficulty making decision about who receives what medical resources • Participant rejected question itself (favoring a focus on prevention) • Impact of patients' use of preventative care on medical resource prioritization • Allowing patients to self-deny* medical resources • Whether or not to allocate based on patient characteristics (age, disability, race), quality of life, or survival
Consumer Advocates	• Need for objective triage process • Challenges with COVID-19 resource allocation processes • Fears about triage process
Providers	• Establish a triage process pre-emergency • Consideration of certain factors could lead to inequities • Implement blinded decision-making process and use factors based on type of emergency

** "self-deny" is the same as informed refusal of treatment.*

- **Informed Refusal:** A member shared that it is standard practice for physicians to inform every patient that they do not have to take every treatment and can opt out of treatments. A CAB liaison mentioned it was interesting that there was a disconnect about the perception of patients feeling like they do not have the opportunity to decline treatment even though it is standard practice for providers to inform patients about informed refusal.

Agreements:
The TAP members agreed to the following consideration:

- **FAQs:** Include a question in the FAQs that patients do have the ability to refuse treatment if they wish to.

Triage Team Make Up

Background: *Hina (facilitator) provided an overview of the subgroup discussion regarding the makeup of the triage team. The subgroup proposed the following team members and recommended experiences to develop a triage team at either the individual hospital, hospital-system, or regional level. What is in red were proposed from the subgroup. The table was pulled from the Washington CSC Plan. TAP members were asked to identify who else should or should not be on the team.*

CSC Triage Team (Hospital, Hospital System or Regional)
Senior (Experienced) clinicians, one of which being a physician. All team members should have experience in triage, with one designated as Lead Triage **Coordinator**. Clinicians must be licensed and actively practicing in their field. Practicing physicians can be on the team if they are off rotation for clinical duties.
Medical ethicist with experience and training as a healthcare ethics consultant and can meet all the requirements under "responsibilities".
Administrative assistant to be designated as responsible for all the administrative duties.

The subgroup mentioned the size of the triage team is dependent on the size of the hospitals and the number of available senior clinicians in those hospitals. Therefore, a specific number of members in the team was not included, but rather have the facilities decide that. The Kansas CSC guidance should include recommended background/ experiences for the team.

Rotating shifts within the team should be included so that team members can complete other duties outside of triage. Subgroup proposed language to clarify that practicing physicians can be on the triage team if they are not required to complete their duties for the day and that the term "experienced" should be considered in place of "senior" to be more inclusive.

Other considerations from the subgroup included the Center for Practical Bioethics to provide medical ethicists for hospitals and that palliative care physicians should not be in the triage team because they can later rotate to a team that provide comfort measures at bedside.

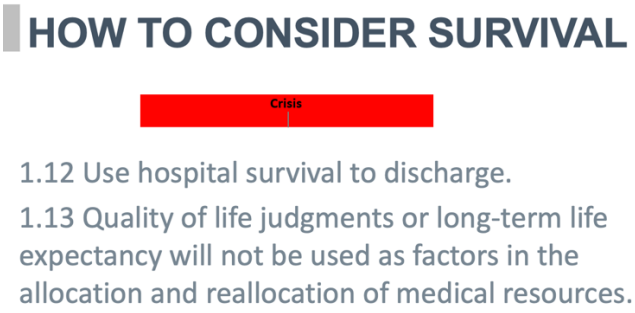
- **Question:** *There is shortage in trained medical consult. Statewide, assuming that this would be remote, right? If so, we can do that, but we might be able to create a pool that could help as well.*
  - **Answer:** Yes. It would be remote.

Agreements:
The TAP members agreed to the following consideration:

- **Triage Team Make Up:** TAP members accepted the subgroup's proposal of the recommended triage team members and experiences.

Scoring Tools

Background: *Hina (facilitator) reiterated that TAP members have agreed to CAB recommendation 1.12 and 1.13 (see below) in previous meetings.*



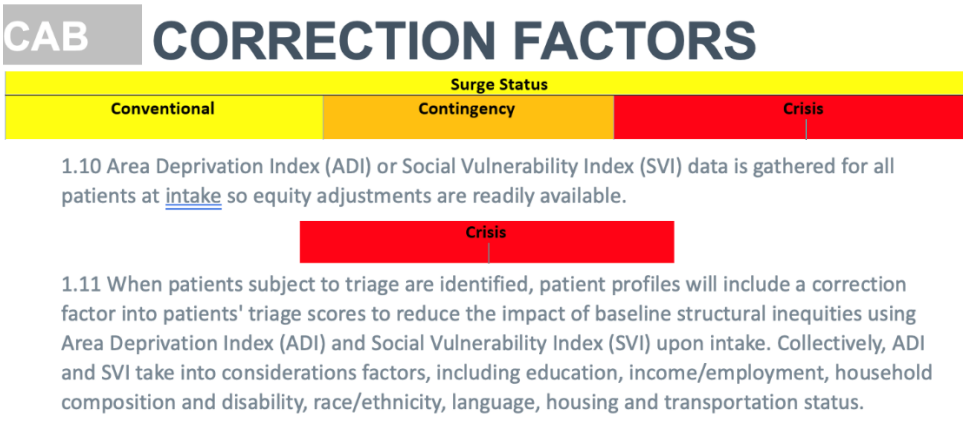
The subgroup identified four potential scoring tools that can be included in the Kansas CSC guidance document. TAP members were asked the following questions:

- *Should the Kansas CSC guidance document include the following scoring tools?*
  - *Sequential Organ Failure Assessment (SOFA) Score*
  - *Injury Severity Score (ISS) for Trauma*
  - *Modified Pediatric SOFA Score*
  - *Pediatric Logistic Organ Disfunction-2 (PELOD-2) Score*
- *Are there other tools that should be included?*
- *Should there be exclusion criteria?*

- **SOFA Score:** A subgroup member shared that the SOFA score was more favored for its objectivity and could be used for trauma related injuries as well. Another member shared that SOFA score uses a Glasgow Coma Scale and that modification of the GCS should be developed for people with chronic stable disability. A guest member cautioned using SOFA score without correction factors could further disadvantage certain populations.

Correction Factors

Background: *The subgroup reviewed the CAB recommendations 1.10 and 1.11 (see below) and determined ADI might be used as a correction factor. [NOTE: ADI is a tool to identify geographic areas with socioeconomic deprivation and could be use as a correction factor in resource allocation protocols to ensure that individuals from disadvantaged communities are not disadvantaged in the triage process.] However, the subgroup acknowledged that it may not be a reliable tool for rural and frontier areas. TAP members were asked if there were other correction factors to be considered.*



- **ADI:** A guest member stated it would be worth critically examining the concern raised by TAP members about the reliability of ADI in rural and frontier areas since ADI is drawn at the census block group level. However, there will be some misclassification of individuals in one census block group. It's a matter of whether the group is willing to accept some misclassification versus not doing anything at all.
    - **Question:** *is ADI sufficient to correct SOFA bias?*
        - **Answer:** A guest member answered that it depends on the correction and how it is used. Not all disadvantaged people live in a highly disadvantaged location. So, it's important to acknowledge that it won't create a perfect or perfectly equitable allocation framework, given very entrenched disparity exists.

    - **Question:** *Is the plan to solely use patients' SOFA scores for the survival estimate or to use it as one consideration to inform the triage team/clinicians overall prognostication?*
        - **Answer:** A member answered that it would be used to inform the triage team with some correction, such as ADI.
    - **Question:** *What are the legal implications of using race or socioeconomic status as a correction factor?*
        - **Answer:** A guest member answered that using race at any capacity would violate anti-discrimination laws. There could be concerns with the Social Vulnerability Index (SVI) because one of the factors is the proportion of minority populations in a census tract. This might be a good question for legal team: **Because the SVI includes race/ethnicity as a measure, would hospitals face legal issues on the basis of discrimination if it were to be used as correction factor?** If the group were looking for something that was a broad corrector for unfair disadvantage, SVI does include a measure of whether households include someone with a disability. The ADI does not include a similar measure.

Tiebreakers

Background: *The subgroup reviewed the following potential tiebreakers: Pregnant patients (WA CSC); Essential workers (WA CSC; UPitt); Significant age difference (UPitt). TAP members were asked the following questions:*

- *Should the Kansas CSC have tiebreakers or go directly to random selection?*
- *Should there be tiered system for tiebreakers?*

- **Significant Age Difference:** A member stated that it would be difficult to use this as a tiebreaker if the age range are too close to each other. Another member stated that this would raise a question about age discrimination and would be unsure if it should be used.
- **Essential Worker:** A member shared that it should not be used because it would require others to judge some lives over others due to their role in society.

Agreements:
The TAP members agreed to the following consideration:

- **Rec 1.12 and 1.13**: Agreeing to Rec 1.12 and 1.13 language to the Kansas CSC guidance document.

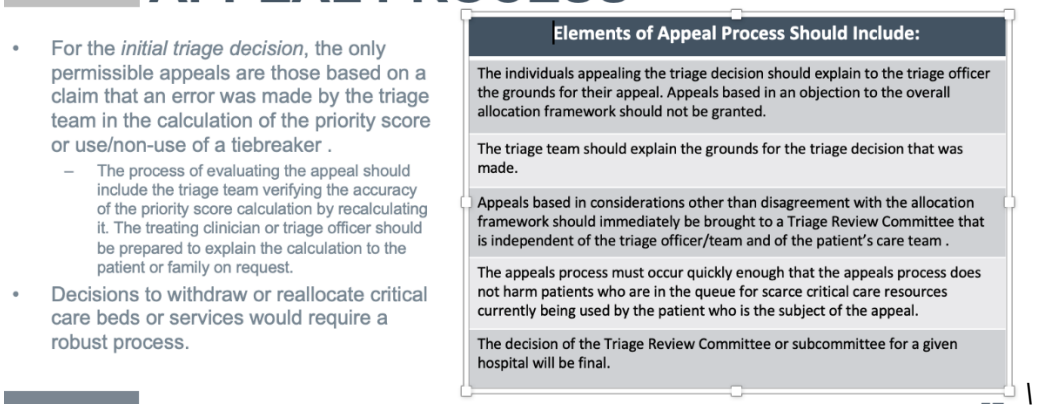
Areas:	Criteria Agreed Upon By TAP:
Promote Population Health Outcomes	• Use hospital survival to discharge. • Use SOFA Scoring Tool • Include the White & Lo statement on chronic stable disabilities NOTE: Pediatrics tools will be selected by TAP members with pediatric experience.
Promote Justice and Equity	• Using ADI as a correction tool for SOFA scores. NOTE: SVI score (especially for individuals with disabilities) may be considered as a potential tool.
Tiebreakers	• Pregnant patients • Random selection

Suggestions:
The following are suggestions made by some members throughout the discussion:

- **ASPR TRACIE**: A member suggested that the author review an ASPR TRACIE document as a consideration for hospitals to use to review and determine their own scoring tools. (Links: Topic Selection: Crisis Standard of Care and SOFA: What It Is and How to Use It In Triage)
- **SVI**: A guest member suggested that the group ask legal team regarding the legal implications of using SVI as a correction factor. (**Because the SVI index score includes race/ethnicity as a measure, would hospitals face legal issues on the basis of discrimination if it were to be used as correction factor?)**

Appeals Process

Background: *Hina (facilitator) shared an appeal process (see next page) from the White and Lo paper for the TAP members to consider. A CAB liaison shared that CAB members wanted an appeal process to give patients the sense of fairness to ensure the process was conducted as designed. To address this issue, CAB included a placeholder (Recommendation 1.7). Develop a process to resolve any disputes.*



- **Appeal Process:** A member shared that the appeal process should be set up in a way that the overall appeal is regarding whether the triage team applied the triage rule to the way it was intended as written in the hospital's CSC plan.

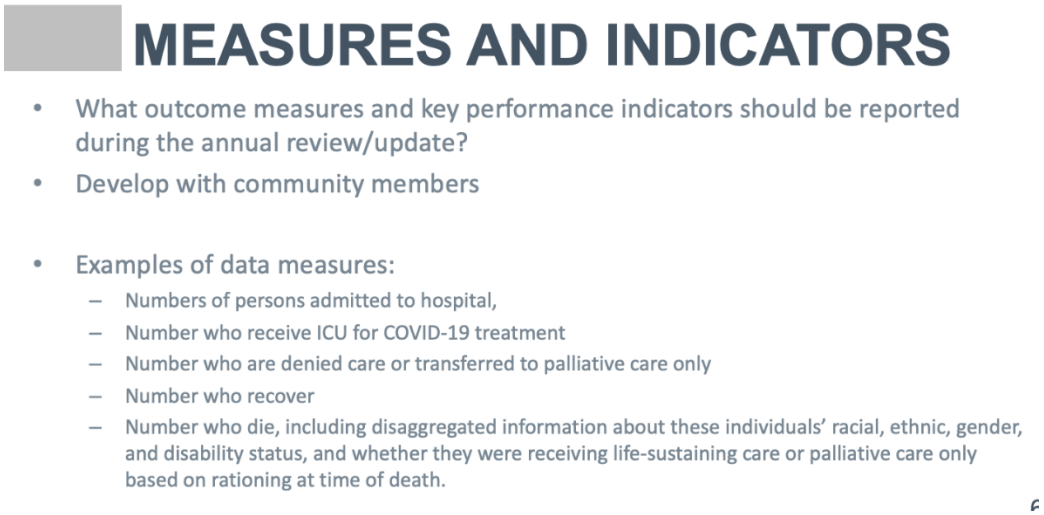
Agreements:
The TAP members agreed to the following consideration:

- **Appeal Process:** TAP members agreed to including the development of an appeal process in the Kansas CSC guidance document.

Discussion on Plan Maintenance

Outcome Measures

Background: *Due to limited time, Hina (facilitator) provided a quick overview of the measures and indicators that TAP members could consider as part of annual maintenance of the CSC. Please review the list of example data measures from other plans and send an email to Hina Shah (hshah@khi.org) and Wendy Dang (wdang@khi.org) of what should be considered or removed from the list. See list below.*



Follow up items

TAP members were asked to review the measures and indicators that would be used for CSC plan maintenance. Members were asked to send an email to Hina Shah (hshah@khi.org) and Wendy Dang (wdang@khi.org) regarding what should be considered or removed from the list by May 27.

Anyone interested in becoming a reviewer for the preliminary draft should send an email to Hina Shah (hshah@khi.org) by May 23. Reviewers and authors will be informed of the next subgroup meeting via email in the near future.

Additionally, TAP members were advised of the following meetings:

- Jun 24, *Joint Meeting #2 at 2:00 p.m.*

TECHNICAL ADVISORY PANEL (TAP) MEMBERS		
Name	**Title**	**Organization**
Daniel Decker	DCF Director	Kansas Department for Children and Families (DCF)
Dan Goodman	Deputy Commissioner for Long-term Services and Supports	Kansas Department for Aging and Disability Services (KDADS)
Dr. Jennifer Watts	Pediatric Emergency Medicine Physician	Children's Mercy Hospital
Dr. Dennis Cooley	Pediatrician	American Academy of Pediatrics, Kansas Chapter
Con Olson	Administrative Society Representative on the KEMSA Board of Directors	The Kansas Emergency Medical Services Organization (KEMSA)
Dr. Lillian Lockwood	Clinical Advisor, Northeast and Kansas City Metro	Kansas Healthcare Coalition (HCC)
Ron Marshall	Director, Preparedness and Regulatory Affairs	Kansas Hospital Association (KHA)
Carla Keirns, MD Ph.D.	Associate Professor	University of Kansas Medical Center
Jean P. Hall, Ph.D.	Director	Institute for Health and Disability Policy Studies (KU)
Rachelle Colombo	Executive Director	Kansas Medical Society
Jane Kelly	Executive Director	Kansas Home Care & Hospice Association
Dennis Kriesel	Executive Director	Kansas Association of Local Health Departments
Dr. Gianfranco Pezzino	Public Health Expert	Retired, Kansas Health Institute
Patrick Gaughan	Senior Vice President & Chief Values Integration Officer	Centura Health
John Carney	President and CEO	Center for Practical Bioethics
Mike Burgess	Director of Policy & Outreach	Disability Rights Center (DRC)
Dr. Steve Simpson	Professor, Pulmonary, Critical Care and Sleep Medicine	University of Kansas (KU) Medical Center
Amy Kincade	Vice President, Population Health Management	Stormont Vail Health
Christopher Harms	Critical Care/Cardiology Pharmacist	Advent Health
Dr. Dereck Totten	Family Practice Physician	Citizens Health
Dr. Samer Antonios	Chief Clinical Officer	Ascension Via Christi Health, Inc

Michael Lewis, MD, FAAP	Associate Professor Medical Director, Pediatric Inpatient and Intensive Care Units Program Director, Pediatric Cystic Fibrosis Program Division Chief, General Pediatrics	The University of Kansas Health System
Jeanne Gerstenkorn	Vice President for Health and Wellness	Presbyterian Manors of Mid-America

COMMUNITY ADVISORY BOARD (CAB) LIAISON		
Name	**Title**	**Organization**
Ami Hyten, J.D.	Executive Director	Topeka Independent Living Resource Center, Inc.

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Ashley Goss	Deputy Secretary for Public Health	KDHE
Dr. Joan Duwve	State Health Officer	KDHE
Kendra Baldridge	Bureau Director	KDHE
Rebecca Adamson	Preparedness Program Director	KDHE
Edward Bell	HCC Program Manager	KDHE
Michael McNulty	Emergency Manager	KDHE

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