Key Findings Only: Crisis Standards of Care (CSC) Phase 2

DRAFT FOR DISCUSSION

Long-Term Care Facilities (LTCF)

LTCF Q1. What populations in long-term care facilities might be at risk of experiencing inequities as the result of CSC implementation?

Key Findings

- While the risks of experiencing inequities as a result of CSC implementation are similar in LTC settings to potential hospital-based inequalities, the focus remains on aging and disability.
- Minnesota received strong criticism from their Board on Aging for their consideration of age, not as a stand-alone factor, but as potential discriminatory characteristics in clinical determination in likelihood of survival to discharge.
- Fairness, equitable processes, engagement, education and communication, and rule of law are components of the necessary framework to ensure that CSC are fairly constructed and implemented.

LTCF Q2. What ethical considerations have been used to determine who gets scarce resources in long-term care facilities and who does not?

Key Findings

- In hospital settings, scarce resources related to ICU and medical equipment like ventilators. In LTC, scarce resources my include medical equipment and PPE, but also include palliative and critical care usage medication, therapies, and one-on-one care of a visiting loved one.
- LTC facilities exist in a community of health care systems. Other ethical considerations may include supplies being diverted to higher acuity patients in other systems.

LTCF Q3. What are evidence-based practices or validated tools for guiding triage and clinical decision-making in long term care facilities?

Key Findings

- In hospital centered CSC state plans the primary focus of triage and clinical decision making were the limitations of the SOFA scores and other patient factors (e.g., underlying diseases and current response to treatment) that should be considered when making triage decisions.
- In LTC, the focus is maximizing resources and communication linkages between healthcare system components.
- The Arizona Department of Health Services developed a LTC facility specific guidance to support best practices for the prevention, detection and infection control necessary to contain the spread of COVID-19 within a facility.

LTCF Q4. What strategies have been used to address long-term care staffing concerns during CSC implementation?

Key Findings

- Limited or reduced staffing in times of crisis should be included in CSC planning and continuum of care staffing. Continuum of care for staffing should include alternative staffing options, cross training and training minimums, and family members as caregivers.
- Critical functions are the job functions that your organization does on a daily basis to deliver services and essential to the staffing plan.
- LTC facilities report scheduled staffing, current variance, and minimum number of staff by category needed to meet resident care needs to their local health department. This facilitates the allocation of staffing across systems and the implementation of emergency staffing through advance registered volunteers and medical reserve corps.

Key Findings Only: Crisis Standards of Care (CSC) Phase 2

DRAFT FOR DISCUSSION

Resource Load Balancing (RLB)

RLB Q1. What agreements exist between hospitals?

Key Findings

- A cooperative working agreement exists between participating hospitals, healthcare facilities and medical providers. It includes the following sections:
  - Responsibilities of hospitals
  - Implementation of agreement
  - Limitations of agreement
  - Reimbursement and disputes
  - Worker's compensation for shared staff
  - Severability of agreement
  - Termination of agreement

RLB Q2. What are evidence-based practices or validated tools for guiding triage and clinical decision-making?

Key Findings

- MOCC provides a framework for identifying indicators and triggers for initiating load balancing during critical situations. They also stress the importance of documenting all load-balancing, even non-emergent.
- The U.S. Department of Health and Human Services created an Incident Command System (ICS) that provides a roadmap for disaster management. It can be adapted to fit each facility and provides a standard approach
- The Centers for Disease Control (CDC) developed a planning worksheet for LTC, home health, and hospice facilities for public health emergencies. It includes questions such as:
  - What will you do with residents/patients for whom you no longer have the ability to provide care?
  - What other long-term, home health, or hospice care facilities or agencies can you coordinate care?

RLB Q3. How do states implement resource load balancing into their CSC plans?

Key Findings

- Minnesota has an attachment to the CSC specifically to outline EMS/ambulance service agency responsibilities and considerations. They stress the difference between surge capacity and surge capability and the importance of planning for both situations. They also recognize that surge capacity strategies are not equal and that emergency response services do not always have the option to wait for other agencies or state action.
- Washington includes plan language that includes equity, social justice, community engagement, and disability rights. They encourage re-evaluation of patients every 24 hours and specifically have a Disaster Preparedness Plan Template for use in LTCs.
- California (UC Hospital System specifically) plan outlines a specific Triage Team that is separate from those who provide clinical care to patients. This team should be available 24/7 to consult during a crisis. They also address supportive care and palliative care patients and the importance of setting realistic goals of care with patients and their families. This plan recommends re-evaluation every 72 hours.

RLB Q4. What role do long-term care facilities play in resource load balancing?
Key Findings

- While not required to participate in a healthcare system's crisis standards of care plan, long-term care facilities are encouraged to play a large role. If included, they should be invited to contribute to the creation of the plan, take into consideration each facility's unique patient population and resources, and be able to meet CMS requirements.
- In addition to medical resources, non-medical resources such as food, water, and other non-medical equipment should be considered within the CSC.
- The following sections should be thought through for LTC facilities: coordination of care, legal and regulatory, finance, infection control, resource management, safety and security, mental health, culture and religion, education and training, and communication.

RLB Q5. What do older adults in long-term care facilities experience when hospitals are in crisis mode?
Key Findings

- A change in the threshold for transport to hospitals from LTC facilities for acute evaluations and treatment and non-emergency conditions may need to be considered.
- EMS and healthcare facilities that would normally respond during conventional times may be overwhelmed.
- A contingency plan for respectful removal of remains should be considered as funeral homes or crematoria may be at full or near capacity.

Key Findings Only: Crisis Standards of Care (CSC) Phase 2

DRAFT FOR DISCUSSION

Public Communication (PC)

PC Q1. What public communication strategies exist during crisis standards of care (CSC)?

Key Findings

- Communication coordination and considerations may include family members, multiple providers and the patient. Coordination is considered an ongoing and necessary task throughout a crisis.
- Hospitals must be able to communicate to the public that resources and staff will be strained; interrupting normal care operations.
- Emergency department
- For long-term care facilities, Inclusion of the long-term care ombudsman is critical to facilitate communication between family members, multiple providers and the resident.
- Communication intended for the public provides an overview what to expect from overwhelmed hospitals and how to prepare for difficult medical decisions that may need to be made or anticipated.

PC Q2. How do states implement communication considerations into their CSC plans?

Key Findings

Colorado, Michigan and Minnesota provide Regional Resource Cards in their CSC plan, which uses The CO-S-TR model. This model includes information that is to be communicated to hospitals and healthcare facilities.

- "CO" stands for command, control, communications, and coordination and ensures that an incident management structure is implemented.
- "S" considers the logistical requirements for staff, stuff, space, and special (event-specific) considerations.
- "TR" comprises tracking, triage, treatment, and transportation: basic patient care and patient movement functions.
- State plans emphasize ongoing communication between relevant stakeholders throughout a crisis with tailored messaging for specific populations.

PC Q3. What public communication strategies have been used to maintain transparency around crisis standards of care?

Key Findings

- Community engagement increases awareness for the need of emergency preparedness.
- Engaging the community ensures that the CSC plan reflects the values and priorities of the community.
- Active deliberation at the community level "helps to reveal misunderstandings, biases, and areas of deep disagreement."
- Topics covered in the Minnesota Engagement Framework include patient prioritization methods, factors that matter most when you cannot save everyone, fairness in decision making, and whether certain populations (I.e. health care workers) should receive treatment priority.
- Engage community members representative of the diverse demographics of the state and to ensure equity; engage groups that have been historically marginalized.