Crisis Standards of Care

Joint Community Advisory Board and Technical Assistance Panel Meeting

January 20, 2023

9:00am-12:00pm

Agenda

9:00 am	Welcome (Kendra Baldridge, KDHE)
9:05 am	Topic Areas (Ed Bell, KDHE)
9:25 am	Project Overview (Kansas Health Institute)
9:40 am	Review of Phase 1 (Liaisons)
10:00 am	Presentation: Integrating Lived Experience into Process and Guidance Document (Suzanne Schrandt, JD)
10:25 am	Breakout Rooms Technical Advisory Panel (Lead: Hina Shah, KHI) Community Advisory Board (Lead: Tatiana Lin, KHI)
11:55 am	Closing Remarks (KDHE/KHI)

Meeting Materials

Project Overview; Project Membership List as of Jan. 14, 2023; Draft Environmental Scan Questions; Draft Focus Group Questions; Breakout Room Agendas for TAP and CAB

Participants

Community Advisory Board (CAB) Members: Sebe, Amy Burr, Camille Russell, Carter Olson, *Chessa Quenze,* Jamie Gideon, Jan Kimbrell, Liz Hamor, Tony Carter, Irene Caudillo, Kathy Keck, Matthew Neumann, Eric Arganbright, Sheri Hall, Sylvia Garcia, Sherrie Vaughn

Technical Advisory Panel (TAP): Carrie Wendel-Hummell, Steven Simpson, Amy Kincade, Carla Keirns, Chrisy Khatib, Con Olson, Dan Decker, Daniel Goodman, Dennis Cooley, Devan Tucking, Gianfranco Pezzino, James Roberts, Jean Hall, Jeanne Gerstenkorn, Jenifer Clausen, John Carney, Lacey Hunter, Leslie Anderson, Linda MowBray, Mike Burgess, Rachel Monger, Ron Marshall, Scott Brunner, Morgin Dunleavy, Brenda Groves (for Sara Irsik-Good, KFMC)

Presenter: Suz Schrandt

KDHE: Ed Bell, Kendra Baldridge, Rebecca Adamson

KHI: Valentina Blanchard, Hina Shah, Tatiana Lin, Cynthia Snyder, Emma Uridge, Sheena Schmidt

Welcome and Introduction

- Kendra Baldrige (KDHE) provided a welcome and introduction to the first joint meeting and Phase II of the Crisis Standards of Care Guidance.
- Phase I of the Kansas Crisis Standards of Care Guidance (KSCSCG) document is currently being reviewed by the Division of Public Health Deputy Secretary

Topic Areas

- The overall goal of Phase II is to include three topics into the current guidance document:
  - Development of hospital messaging to the public – explore and design a comprehensive guide healthcare can use to develop their own messaging to the public that is easily understood by all populations and conveys accurate information.
  - Integration of long-term care (LTC) – how do the special needs of the long-term care community fit within the hierarchy of the guidance document.
    - Note: Long-Term Care in this instance will refer to long-term care units, nursing homes, assisted living centers, retirement centers, hospice care and the like. This will not include home nursing, home health care, or home hospice services.
  - Resource and patient load leveling - develop resource and patient load-level protocols that could be executed within a county, across a region or spanning the state.

Questions

- Can you describe the goals of Kansas Department of Health and Environment (KDHE), Kansas Department of Emergency Management (KDEM), and Kansas Department of Aging and Disability Services (KDADS) if this document is implemented in Kansas?
  - *Answer:* As the document will serve strictly as a resource, these organizations would not play a specific role, but can also act as resources and answer questions for facilities wanting to implement guidance.
- Some LTC facilities are part of a Continuing Care Retirement Community (CCRC) that includes independent living. Will those residents be included by the CCRCs where they reside?
  - *Answer:* The LTC task team will have the opportunity to discuss and decide on this.

Project Overview

- Key components of Phase II include the Community Advisory Board (CAB), Technical Advisory Panel (TAP), Environmental Scan, Task Teams, and Focus Groups

- The plan process includes:
  - TAP and CAB identifying considerations for each topic
  - Task Teams discussing considerations and drafting guidance
  - TAP and CAB provide input to Task Teams
  - Guidance is created
- General Roles:
  - TAP: assess evidence-based technical information to contribute to the guidance document
  - Task Teams: draft the guidance document
  - CAB: Provide considerations based on lived experience to the guidance document
  - Focus Groups: The purpose of the focus group is to understand the concerns and considerations of individuals representing long-term care facilities, hospitals, consumer advocacy groups, and caregivers regarding the allocation of medical resources, such as staff, supplies (e.g., beds, medication, personal protective equipment, ventilators), facilities, and health care services in nursing homes and long-term care facilities during the implementation of crisis standards of care.
- An analysis of the registration survey was performed and found the following about the group:
  - All six regions of Kansas are represented; 29 statewide organizations.
  - Majority of participants are in age 45-64
  - Majority of participants identify as female
  - Participants have lived experience with many different populations including older adults, caregivers, low-income individuals, providers, etc.
  - Participants have experience with many different facilities including state organizations, long-term care facilities, assisted living facilities, hospitals, etc.

  Note: the survey results will be updated after additional TAP/CAB members complete it.
- The definition of 'caregiver' was discussed to discern whether the term is for staff or encompasses family members who care for a loved one. The CAB and TAP will discuss the definition.

Questions

- None

Phase I Review

- The Liaisons provided an overview of the work completed in Phase I of the project including applying community insights and a health equity lens and lessons learned.
  - KSCSCG is a fluid, living document
  - Phase 1 was framework for hospital planning
  - CSC activation is facility-based
  - Steps for preparation in advance of crisis also was included in guidance (i.e., three levels – conventional care, contingency care, crisis care)

    - Triage framework included health equity promising practices through triage team makeup; scoring included promotion of population health outcomes, promotion of justice and equity and a tiebreaking system; and various communication strategies to the patient and families.
- Discussion in chat:
    - There was group discussion about including older adults as part of those who were impacted during the crisis response for COVID.
        - Considerations were discussed around triage score assessments for frailty and co-morbidities as older adults in LTC setting will have higher risk of survival to discharge.
    - Delay to accessing care is also a concern for the older adult population, especially during a crisis
- *Resource shared:* https://ombudsman.ks.gov/docs/default-source/default-document-library/kansas-long-term-care-ombudsman-healthcare-crisis-passport-revised-9-30-22.pdf?sfvrsn=86dc3007_4

Presentation: Integrating Lived Experience into Process and Guidance Document

- Suzanne Schrandt, J.D., the Founder and CEO of exPPect, an initiative focused on improving healthcare and research through the expertise and partnership of patients, provided perspectives on how to those with lived experience into the creation of the KSCSCG by sharing examples outside of the project and how it can be implemented in the construction of the guidance document.
- Suzanne noted that people with lived experience can bring valuable insights and perspectives to multistakeholder engagement efforts but may lack scientific and medical expertise. Collaboration and co-creation between people with lived experience and other experts can lead to optimal outcomes. To effectively engage people with lived experience in multistakeholder activities, it is important to circulate agenda and meeting materials in advance, in accessible language, develop discussion prompts, designate an acronym and jargon "safe space", allow members to follow up on items, use skilled facilitators and facilitation tools, provide foundational information or onboarding, provide guidance on what is scientifically sound or based in evidence, and to provide a safe and trauma-informed space for people with lived experience to share their stories and provide feedback. It is important to remember that the essence of engagement is collaboration, not letting a single voice lead the process.
- The speaker suggested several ways to be more inclusive:
    - Circulate materials in advance
    - Develop discussion prompts, thought starters
    - Create a jargon dictionary
    - Give people time to sit with new information
    - Don’t distract people from sharing their stories – use purposeful tools
- Susanne recommended asking individuals with lived experience the following questions:
    - Was there a person, system, practice, or set of practices that caused or was a factor in your experience?

- If negative, what could have been done differently by that person, system, practice, or set of practices?
- If positive, what did the person, system, practice, or set of practices do that should be replicated or amplified?
- How can we apply that change (if negative) or that action (if positive) to this body of work?

In summary, the presenter highlighted that people with lived experience is the knowledge these project members bring; onboarding or foundational materials can help level the playing field and foster more effective partnership and communication. The goal is collaboration as equal partners, not ceding complete control to any stakeholder type. There are a wealth of resources and tools; it is okay to modify and adjust as you go, to determine what methods or tools work best for your group and workstream.

Questions from Attendees

- When a person is unable to complete requested information, they're often labeled as "difficult" or "non-compliant." How can we change that narrative?
  - *Answer:* You want to make sure that systems (like electronic health records) have more choices to document those concerns. Even the language we use sounds like a legal deposition (denied, admitted).

Closing Remarks

- The calendar for February 2023 was shared. Important dates:
  - 2/2 – Resource Load Balancing Task Team Meeting
  - 2/9 – Long-term Care Task Team Meeting
  - 2/16 – Communications Task Team Meeting
  - 2/23 – CAB and TAP Joint Meeting #2
  - Publish Environmental Scan
  - Conduct Focus Group Interviews
- Feedback about focus group questions and environmental scan will be collected over the next week
- Continued discussion about trauma-informed questions for focus group participants
  - How can they tell their stories in a safe place?
  - What are we going to do if they have a trauma response?

Crisis Standards of Care

Meeting of Community Advisory Board

January 20, 2023

10:30 AM – 11:55 AM

High-Level Overview of Meeting Notes

The minutes focus on CAB's introductory meeting, key topics and review of focus group questions.

Time	Agenda Item	Presenter
10:30 a.m.	Welcome and Introductions	Tatiana Lin, KHI
10:45 a.m.	Overview of CAB Scope	Tatiana Lin, KHI
10:50 a.m.	Equity Considerations: General Guidance, Resource Load Balancing and Communicating to the Public	Tatiana Lin/Ami Hyten
11:15 a.m.	Feedback on focus group questions	
11:40 a.m.	Next Steps	Tatiana, KHI
11:45 a.m.	Transition to a Joint Meeting and Report Back	Ami Hyten

Welcome and Introductions

- Tatiana welcomed all the members of the CAB and the group did introductions
- Members were asked to introduce themselves and identify a lived experience or a population or group they have experience working with

Overview of CAB Scope

- Role of CAB description (see CAB breakout room slide)

Equity Considerations

- What equity considerations do you have for all three topics?
- Important to take these considerations into account

Presentation

The facilitator gave an overview of several elements commonly included in the crisis standards of care for nursing homes and assisted living facilities. The overview was presented don slides 8 and 9 as shown below. Afterwards, the facilitator asked the CAB members to review potential equity considerations related to these common elements and suggest any changes or identify gaps.

General Guidance

Crisis standards of care for nursing homes and assisted living facilities generally include the following key elements:

- **Prioritization of care:** Care is prioritized based on the individual's likelihood of survival and recovery, with those who have the highest chance of survival receiving care first.
- **Rationing of resources:** Resources such as personal protective equipment (PPE), oxygen, and medication may be limited during a crisis, and may need to be rationed among the residents.
- **Flexible staffing** Staffing levels may need to be adjusted during a crisis, and staff may be reassigned to different roles to meet the needs of the residents.
- **Communication and coordination:** Clear and frequent communication is needed between staff, residents, and families, as well as with local public health officials, to ensure that everyone is informed and aware of the situation.
- **Family involvement:** Family members and loved ones of residents should be kept informed and involved in care decisions as much as possible.
- **Continuous quality improvement:** Staff should continuously evaluate and improve the care being provided to residents during a crisis.

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Equity Considerations

What are your thoughts about these equity considerations? What is missing?

1. **Access to care:** Ensure that all residents, regardless of their race, ethnicity, socioeconomic status, or other factors, have equal access to care and resources.
2. **Communication and translation services:** Provide clear and accessible information in multiple languages to ensure that all residents and their families can understand the situation and make informed decisions.
3. **Cultural competency:** Staff should be trained in cultural competency to understand and respect the diverse backgrounds and needs of residents.
4. **Advance care planning:** Encourage and facilitate advance care planning, including the completion of advance directives, to ensure that residents' end-of-life preferences are respected.
5. **Discharge and transfer:** Ensure that discharge and transfer decisions are made equitably and that residents are not discharged or transferred based on their race, ethnicity, or other factors.
6. **Community engagement:** Work with community-based organizations to ensure that residents and their families have access to the support and resources they need during the crisis.
7. **Protecting the most vulnerable:** Prioritize care for residents who are most vulnerable, including those with disabilities, chronic illnesses, and other high-risk conditions.
8. **Data collection and analysis:** Collect data on the demographic and health characteristics of the affected population, and analyze it to identify and address any disparities in care and outcomes.

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The CAB members provided specific comments related to the equity considerations outlined in slide 9's bullet points:

- **Access to care:** Ensure that all residents, regardless of their race, ethnicity, socioeconomic status, or other factors, have equal access to care and resources.
- **Communication and translation services:** Provide clear and accessible information in multiple languages to ensure that all residents and their families can understand the situation and make informed decisions.

CAB comments:

- **Inclusive access:** Given that the purpose of the statement "*Access to care: Ensure that all residents, regardless of their race, ethnicity, socioeconomic status, or other factors, have equal access to care and resources*" is to eliminate any barriers that may prevent certain individuals from accessing care and resources, and promotes fairness and equity in the provision of healthcare services, the CAB members suggested adding other categories such as age, sexual orientation, gender identity, and rural status. This would ensure that all residents, regardless of their age, sexual orientation, gender identity, rural status, race, ethnicity, and socioeconomic status, have equal access to care and resources, promoting fairness and equity in the provision of healthcare services.
  - **Rural access:** Given the diversity of our state, including a significant rural population, it is important to recognize the unique challenges that rural residents may face in accessing healthcare services. In order to ensure that all residents have equal access to care and resources, regardless of their geographic location, the CAB members suggest including "geographic location" in the Access to Care bullet point, in addition to other factors such as race, ethnicity, and socioeconomic status. This will help ensure that the needs of rural residents are not ignored or discounted in the development of the guidance document. The CAB members also highlighted the importance of addressing the unique challenges faced by facilities in rural areas, such as limited resources and staffing issues. These challenges can create barriers to gathering information about residents and their needs, and it is crucial to advocate for solutions to these issues.
  - **Creating a Safe and Inclusive Environment for Gender Identity and Sexual Orientation:** Ensure that the guidance document is committed to promoting inclusion and equity for individuals of all gender identities and sexual orientations. LGBTQ Perspectives are important. Transgendered individuals are fearful of getting care because they may be mis-

gendered or treated differently. This is especially important for LGBTQ and being a person of color.

  - **Age:** it is important to add age as a consideration because different age groups may have unique healthcare needs and may face different barriers to accessing care.
  - **Recognizing the impact of institutional racism:** The CAB members also noted that is very apparent the diversity within our state (esp. considering rural vs. urban) and it is an opportunity to learn and understand you don't have all the answers. Investing in who we are serving in KS is important. Caution – if we put everything in to address everyone's needs without acknowledging that systems were built with institutional racism – should focus on this as a priority and understanding where the system has failed those that are low income, and non-white individuals.
  - **Individuals with disabilities:** While these factors are important, those with disabilities are also important and the medical community may treat them differently due to bias. For example, a patient was screaming due to pain, but hospital staff stated that was "just how he acts" assuming he did not have pain receptors, when lived experience suggested otherwise.
  - **Tribal communities:** It would be good to engage indigenous tribes into the equity considerations. One member worked on the CSC in South Dakota for years, and they had a standard equity protocol for engaging tribes as equal partners and equitable care considerations.

- **Inclusive communication:** In developing the guidance document, it was suggested to consider not only the communication needs of individuals for whom English is not their first language but also the needs of individuals with disabilities, hearing impairments, dementia, among others. Additionally, The CAB members noted the importance of providing other forms of support for individuals who may be unable to use existing technological tools. This could include providing alternative communication methods, such as phone or in-person support, or accommodations for individuals with disabilities. It is important to consider the diverse needs of the community and ensure that all individuals have access to the information and resources they need.
- **The Importance of Terminology in Advancing Justice, Equity and Inclusion: Moving Beyond Cultural Competency to Cultural Humility:** Justice equity and inclusion – request to shift away from cultural competency as the label and move toward **cultural humility** b/c the former assumes there is a level of competency or doneness that can be achieved in this process. Unless the work is done for understanding and providing space at the table, it doesn't happen. Humility helps to indicate a willingness to learn a variety of cultures (lived experience, racial and ethnic, where you live, etc.).
- **Shared resources:** The development of the guidance document should include a plan for person-centered care in case of a crisis transfer. This includes utilizing resources such as the Kansas Long-Term Care Ombudsman Healthcare Crisis Passport, which can be found at https://ombudsman.ks.gov/docs/default-source/default-document-library/kansas-long-term-care-ombudsman-healthcare-crisis-passport-revised-9-30-22.pdf?sfvrsn=86dc3007_4 Additionally, person-centered care should be incorporated into standard practice and understanding across the board, ensuring that everyone is included and care is inclusive.
- **Challenges in long-term care:** The care of elderly individuals with dementia and those with a history of addiction or other complex issues can present challenges for facilities.

Resource Load Balancing

- As patients are discharged from hospitals, access to acute care for long-term care facilities is crucial. Factors such as patient outcomes, preferences of patients and families, and transportation logistics should be considered when developing the guidance document.
- It is important to assess whether long-term care facilities have the necessary resources to provide adequate care.
- Limited resources in rural areas often result in patients being transferred to unfamiliar environments, which can negatively impact the patient, family and care provided.
- Discrimination and fear of discrimination in long-term care homes can be a concern for LGBTQ individuals and other marginalized groups. It is important to address these issues and create inclusive and welcoming environments for all patients.
- Incorporating person-centered planning into the individual's care plan during crisis situations can increase the acute care staff's understanding of the patient's cultural, identity, routines, and conditions.
- It is important to recognize that some facilities may not act in the best interest of the patients and may use recommendations or guidance in a discriminatory manner.
- Discrimination and fear of discrimination in long-term care homes can be a concern for LGBTQ individuals and other marginalized groups. It is important to address these issues and create inclusive and welcoming environments for all patients.

<u>**Options for Long Term Care and Equity Considerations:**</u>

What are opportunities to discuss options for LTC outside of facilities/nursing homes? Should we think more broadly?

- Facilities may not be the best setting for all individuals, as there are inequities present in terms of access to home-based services. Specifically, black and brown individuals tend to receive less assessments for home and community-based services (HCBS).
- Time constraints can make it challenging to think more broadly about care options and solutions. However, it is still important to capture ideas and identify ways to flag them in the decision-making process.
- There are many seniors who could manage in their homes with appropriate home-based services and support, but lack of availability leads to unnecessary moves into long-term care (LTC) settings. Choice and accessibility are crucial factors to consider:
    - In rural areas, the closest homecare may be over 50 miles away.

Key Themes:

- Access to long-term care in rural areas
- Overwhelmed hospitals and LTCs managing on their own
- Lack of proper understanding and planning in nursing home transfers
- Decrease in comprehensive discharge planning from hospitals
- Trained care assessors as a solution
- Importance of CARE assessments
- Lack of available home-based services and equipment
- Impact of Medicare cuts on home-based services
- Inadequate discharge planning for seniors returning to long-term care facilities

- Hospitals may be overwhelmed and unable to provide adequate care, leading to LTCs trying to manage on their own.
- Sometimes, individuals may be transferred to nursing homes without proper understanding or planning by family, legal representatives, financial experts, or care providers.
- There is a decrease in comprehensive discharge planning from hospitals.
- To address these issues, it may be helpful to consider the use of trained care assessors who can discuss options with individuals and their families, such as home-based care or nursing home placement. The Senior Care Act and Older Americans Act provide funding for home-based services as an alternative to nursing home transfers. Discharge planners may be overwhelmed and unable to provide this level of support, but Area Agencies on Aging (AAAs) can assist in the hospital setting. **It may be worth including this in guidance and recommendations and flagging it for the Task Team to consider further.**
- CARE assessments are crucial for determining the best long-term care options for individuals and their families. They meet both federal and state requirements and provide an opportunity for professionals to discuss all options, including in-home care services, before someone is placed in a nursing facility (NF).
- There is a lack of available home-based services and equipment, which directly impacts people and limits their options for care. This is particularly prevalent in rural areas where the closest homecare may be 50 miles away.
- Hospitals are often overwhelmed and unable to provide comprehensive discharge planning, which can lead to individuals being placed in nursing homes without adequate understanding of the legal, financial, and care-related implications. The Senior Care Act and Older Americans Act provide home-based services as an alternative to nursing home placement, and these services can be discussed by trained assessors.
- The Kansas home care and hospice association has reported a decline in home-based services in certain areas of the state, and the Medicare cuts to home health are not expected to improve the situation. In the past, hospitals have allowed CNAs to perform discharge planning for seniors returning to long-term care facilities, but this has been inadequate and problematic.
- It is crucial for individuals in long-term care facilities to maintain their autonomy and ability to make choices, even during times of crisis. For example, in the past, LTC facilities have faced backlash for allowing family visits for those with dementia during the COVID-19 pandemic. As Medicare and Medicaid certified providers, it can be challenging to reconcile mandates and expectations from the federal government during crises.
- To address these issues, an emergency plan review team should be established to evaluate the emergency planning requirements for LTC facilities. Currently, there is a mandate for an emergency plan, but no entity to review or provide technical assistance. A written plan for compassionate care visits during crises is necessary.
- Additionally, it is essential for LTC facilities to provide continuing education for staff members and empower families to make decisions about patient care and support, particularly during crises. Access to information, education, and options is key in this process.
- Furthermore, a communication tree should be included in emergency plans, and the collection and sharing of data should be considered during load balancing.

Note: *From KDHE staff: Keeping the crisis mind frame is important – what to do in crisis when LTC might have to be evacuated and hospitals are deciding on who to care for. Question: Can the guidance include pre-crisis recommendations? Answer: Pre-crisis and crisis mode will be considered again related to these topics*

Focus Group Questions

TAP Feedback:

- Focus groups should provide space and be trauma informed b/c people will be sharing their stories. How do we provide a safe space for them to share?
- Response from CAB facilitator: No person will be identified in summary/analysis or be able to be identified in the media or publicly shared information. Will discuss and follow up with a survey or mechanism to provide feedback on focus group questions following the meeting.

Hospitals, Providers, and Administrators

Caregivers

From Joint Meeting Discussion:

- The term "caregiver" should be used more broadly to refer to any individual providing care to a resident at the point of need, rather than limiting it to just family members.
- In the field of aging, the term "caregiver" commonly refers to individuals caring for a loved one. It may be beneficial to use the term "family caregiver" to clarify the specific context.
- Additionally, it is recommended that direct care workers (paid caregivers) also be included in stakeholder activities when discussing caregiver.

Crisis Standards of Care
Technical Advisory Panel High-Level Meeting Notes
January 20, 2023
10:30 AM – 11:55 AM

Agenda

Time	Item	Presenter
10:30 a.m.	Welcome and Introductions	Hina Shah, KHI
10:45 a.m.	Topic Area: Resource Load Balancing	Hina Shah, KHI
11:05 a.m.	Topic Area: Communicating to the Public	Hina Shah, KHI
11:20 a.m.	Topic Area: Long Term Care Facilities	
11:40 a.m.	Next Steps	Hina Shah, KHI
11:45 a.m.	Transition to a Joint Meeting and Report Back	Dennis Cooley

Welcome and Introductions

- Hina Shah (KHI) welcomed the group, reviewed the agenda and encouraged group members to put a goal they have as a member of TAP in the chat
  - Goals:
    - Learn how guidance documents are generated.
    - Explore load balancing and how to improve performance, equity and outcomes across the system.
    - Goal is to see a working document to fruition.
    - Provide subject matter expertise as needed to accomplish document completion.
    - To ensure perspectives and expertise from the social sciences is included
    - Better clarity on load balancing and understanding of impact of elected officials on public health policy and preparedness.
    - Create a meaningful useful document that reflects all points of view.
    - Make sure document is equitable and inclusive and that resources are available for entities that will use it.
    - Create resources that are readily available and easy to understand as well as ensuring barriers to entry or usage of such resources are minimal.

Overview of Task Teams/Lead Author/Lead Reviewer

- Phase I participants spoke about their experiences with writing previous document
- Concerns about the ease of use of software (Sharepoint) were raised
- New members were encouraged to take roles for lead author and reviewer

Feedback on Environmental Scan

RESOURCE LOAD BALANCING

- The definition of Resource Load Balancing (RLB) was reviewed and the environmental scan questions were posed to the group for review
- Ed Bell (KDHE) pointed out that Medical Operations Coordination Cells (MOCCs), like Healthcare Coalitions (HCCs), are not recognized by the state as response entities. Kansas Department of Emergency Management (KDEM), who is the response entity, also does not recognize MOCCs or provides set up for them.
- One area to consider for this topic is how facilities and organizations ensure they have the capacity in place before a crisis happens.
- A population of concern is adults who wait in hospitals due to lack of mental capacity and need for guardianship. Barriers include the court process, availability of guardians, funding sources, and when there is no abuse, neglect and/or exploitation (ANE), which is required to take the lead to facilitate guardianship. This can put a strain on hospitals by decreasing the ability to accept truly acute care needs.

Additional Scan Questions/Comments (from Whiteboard)

- Would it be helpful to differentiate between an emergency, crisis, disaster and catastrophe (short- and prolonged)? I don't really see load balancing in short term emergency response having triage considerations that would be the same as those when we face something like a prolonged pandemic.

Questions

- When we're talking about load balancing, are we talking about all populations or mainly with older adults and long-term care (LTC) facilities?
  - *Answer:* All populations, but we will need to talk about LTC facilities too
  - *Discussion:* Hospitals are lacking beds in pediatrics and that puts a different light on some of the patient shifting and load balancing – this task team needs to consider this population
- This topic doesn't just cover those who have COVID, correct? We're talking about everyone within the hospital?
  - *Answer:* There are differences between normal patient transfers and what we're talking about with Crisis Standards of Care. There is also a difference between slow surges and when hospitals experience a surge for a long period of time versus a more short-term event (i.e. example of school bus overturning)
- When it comes to the dynamic between hospitals and nursing homes, is part of it how not to send people to the hospital?
  - *Answer:* This transition between facilities is part of it and the discussion is essential when creating the guidance document. It would also include sending patients that no longer require acute care from hospitals to other facilities or back to the community to free up hospital beds.
- We heard during the height of the pandemic that discharge planners were spending hours on the phone trying to find places to discharge residents. Part of what was

evolving was some type of resource that was trying to track capacity (beds, resources). Is that still out there that we can look at as a resource?
    - *Answer:* EMResource by Juvare is used to give a snapshot of what is available in facilities. KDHE is getting information on spearheading an initiative where EMResource ties into electronic health record (EHR) systems so medical staff do not have additional tasks, however it is still in developmental stages.
- Are we still relying on coalitions to be a functional resource?
    - *Answer:* Kansas has utilized HCCs in other committees, but their main role is information sharing and communication per the Administration for Strategic Preparedness and Response (ASPR).
- Is there a way to share staff between facilities to cover beds more effectively?
    - *Answer:* By Centers for Medicare and Medicaid Services (CMS) rules, there are a limited number of beds that nurses can cover or there are certain personnel that are required to cover certain bed types. It can be common for facilities to have open beds, but not the staff to cover them. This leads into the workforce shortage issue and is a critical limiting factor in healthcare.
    - *Discussion:* There are examples in some of the New England states where hospitals are providing staff, as needed, to LTC facilities to continue the care needed for patients that were in the hospital and then the payment source for those on Medicare and Medicaid can still be accomplished as well.

Lead Author & Reviewer Volunteers
- Authors: Carla Keirns, Ed Bell, John Carney
- Reviewers: Ed Bell

PUBLIC COMMUNICATION
- Person-centered language will be key in developing communication messages.
- Consistency is also key for effective communication. During the pandemic, guidance coming from state and federal organization were not always in the same language or was contradictory.

Additional Scan Questions/Comments (from Whiteboard)
- How can we ensure that communication is accessible to all, including people with disabilities, people in rural areas, people with English as a second language, etc.

Questions
- Is the question of who is going to be in charge of communication addressed?
    - *Answer:* Generally, each facility has a communications officer. This topic is referring to how we take medical language and translate it to digestible information for the public when a crisis plan is activated. KDHE does already provide templates for communication strategies for facilities.
- What role do local health departments play in the communication strategy for facilities?

- *Answer:* During the pandemic, they were looked to as a key part of the communication strategy. There is still an expectation that they are coordinating with facilities and most likely have agreements between them, but emergency management has more authority.

Lead Author & Reviewer Volunteers

- Authors: TBD, Carla Keirns (smaller role if needed)
- Reviewers: James Roberts

LONG-TERM CARE FACILITIES

- Some people in LTC facilities rely on other people to help them make medical decisions, so any information shared with the resident should also be shared with their requested supports.
    - LTC facilities typically capture Power of Attorney (POA) or guardians during the admission process, however the communication process with these supports may be different than with other facilities.
    - The LTC Ombudsman Office and clergy members should also be included, as they were not during the pandemic.
- Comment: Realizing that we need to target subpopulations and specific cohorts to develop sound guidance, we need to remember the risk that poses to how some subgroups get defined. As an example, about 1/3 of all hospice patients receive their hospice care in LTC settings (Nursing Homes and Assisted Living). That's a good number of hospice patients annually nationwide (>350K of 1.2M estimated in 2021).

Additional Scan Questions/Comments (from Whiteboard)

- Remember that younger people with disabilities also reside in LTCFs. They were also disproportionately and negatively affected by the pandemic.

Lead Author & Reviewer Volunteers

- Authors: TBD
- Reviewers: TBD

<u>Feedback on Focus Group Questions</u>

- The stories being told by LTC residents, families and staff may not be taken well by the public because of the severity of some experiences.
- The questions asked to the focus groups should come from a trauma-informed approach
- Several members expressed concern about providing a safe and confidential or anonymous space for focus group members to share their stories.

<u>Next Steps</u>

- Review focus group questions and send additional questions or comments to Hina
- Review environmental scan questions and send additional questions or comments to Hina.