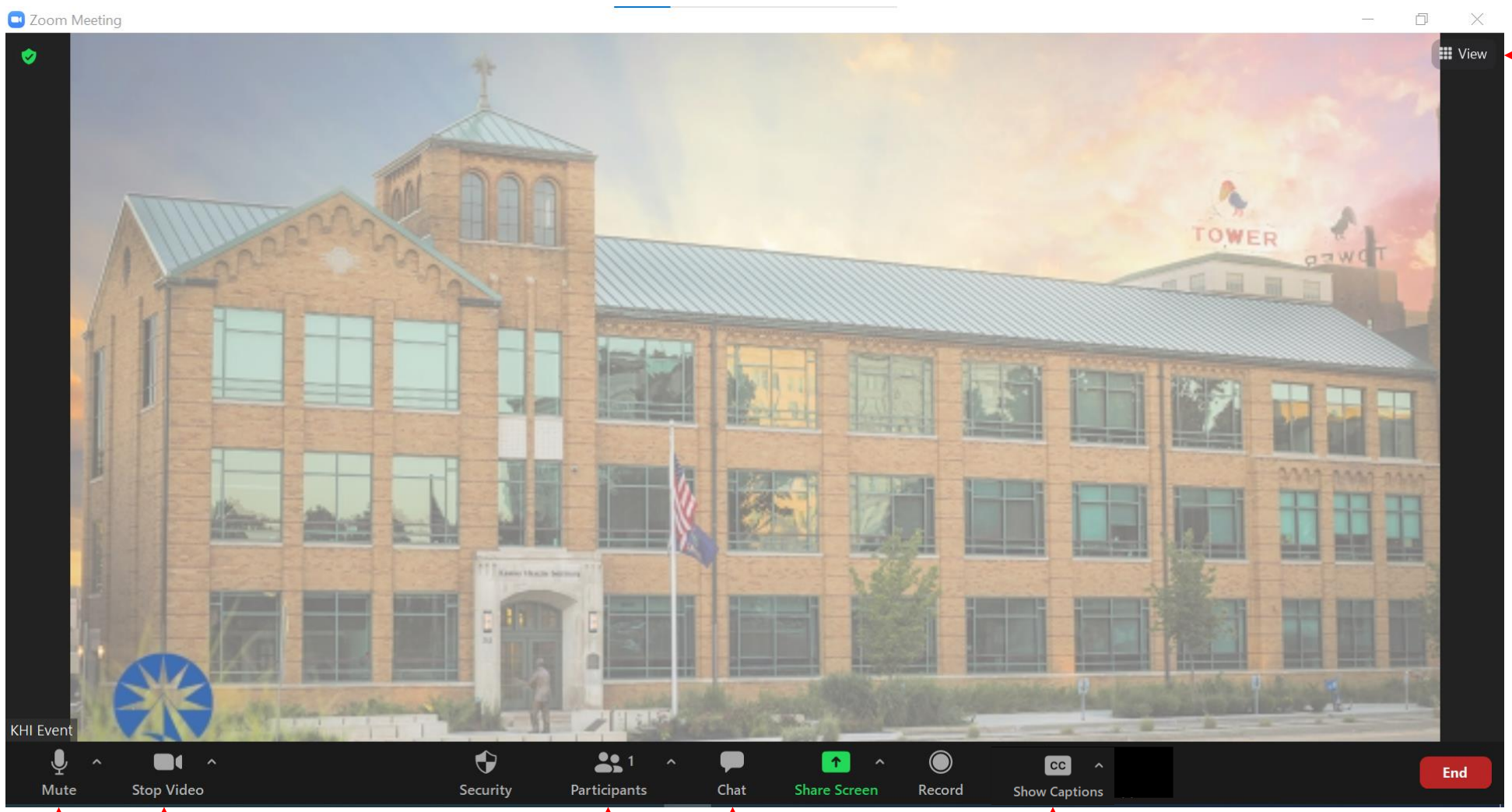
KANSAS HEALTH INSTITUTE

Kansas Crisis Standards of Care Guidance

Phase II: Joint Meeting

February 23, 2023



View: Switch between Speaker and Gallery view.

Helpful Hints for Zoom Meeting

Technical questions about your Zoom connection or functionality?

> Find **'KHI, Valentina Blanchard'** in the Participants list to connect for assistance.

Mute

Video: Stop or start your individual video

Participants listing: Find a participant to message

Chat: Use this feature to enter questions and comments.

Closed Captions: Option for participants

TODAY'S AGENDA

9:00 a.m.	Welcome
9:05 a.m.	Task Team Overview
9:25 a.m.	Resource Load Balancing Overview
10:00 a.m.	Breakout Rooms
11:25 a.m.	Wrap-up
11:30 a.m.	Adjourn

Meeting Commitments

Group Agreements

- Be present
- Listen with curiosity
- Come ready to discuss and compromise
- Don’t hesitate to ask clarifying questions
- Balance between listening and talking
- Keep remarks succinct and on topic
- Lean into discomfort and courage
- Keep it confidential

Project Progression

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Key Components

Community Advisory Board

Up to 20 individuals - Consumer advocacy groups and individuals with lived experience

Technical Advisory Panel

Up to 25 individuals - Clinicians and those with technical knowledge

Environmental Scan

Address key questions to support discussions

Task Teams

3 task teams (one for each topic area) - Assess considerations recommended by the CAB and TAP and develop guidance

Focus Groups

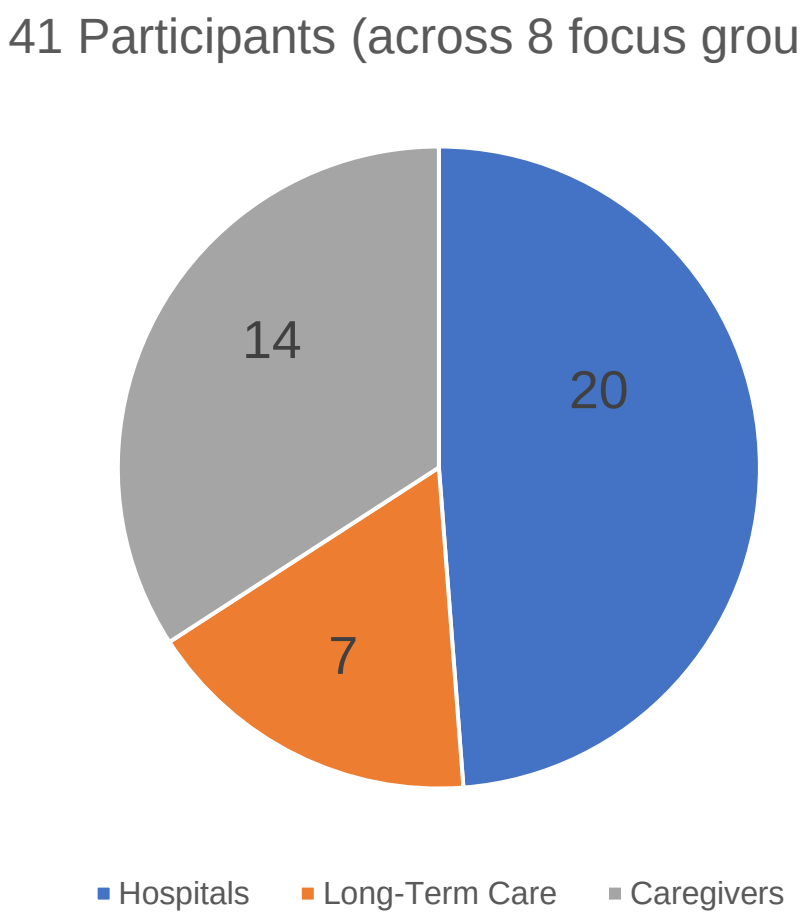
Identify considerations around allocation of scarce medical resources during emergencies

CSC Phase II Timeline

January	February	March	April	May	June
1/20: Convene CAB and TAP groups	2/23: CAB & TAP Joint Meeting	3/23: CAB & TAP Joint Meeting	4/27: CAB & TAP Joint Meeting	5/25: CAB & TAP Joint Meeting	6/22: CAB & TAP Joint Meeting
Assemble Task Teams	2/2: RLB TT Meeting	3/2: RLB TT Meeting	4/6: RLB TT Meeting	5/4: RLB TT Meeting	6/15: Task Teams Meet (if needed)
Environmental Scan	2/9: LTC TT Meeting	3/9: LTC TT Meeting	4/13: LTC TT Meeting	5/11: LTC TT Meeting	Finalize Guidance
	2/16: Comms TT Meeting	3/16: Comms TT Meeting	4/20: Comms TT Meeting	5/18: Comms TT Meeting	
	Publish Environmental Scan	Draft Outline	Draft 1	Draft 2	
	Conduct Focus Groups/Interviews	Analyze and Share Focus Group Data			

RLB: resource load balancing; LTC: long term care; Comms: public communication; TT: task team

Focus Groups (as of 02/23)



Note:

- Focus Groups in Spanish with caregivers will happen in March
- We have received one request for participation in the focus group from a stakeholder who identified themselves as a consumer advocate.
- We are offering about 10 interviews

Focus Groups (as of 02/23/23)

Dates	Time	Organization	Number of People	Stakeholder Type
February 24th	9:30 a.m.	Hospitals	6 people	Nurses
	11:30 a.m.	Long-Term Care Facilities	4 people	Administrators
		Hospitals	5 people	Administrators
March 1st	6 p.m.	Caregivers	5 people	Caregivers
March 3rd	9:30 a.m.	Hospitals	9 people	Administrators, Material Managers, Prep. Coordinators
		Caregivers	4 people	Caregivers
	11:30 a.m.	Long-Term Care Facilities	3 people	Administrators + PEAK (Promoting Excellent Alternatives in KS Nursing Homes)
		Caregivers	5 people	Caregivers

Focus Group Enrollment Links

- LTCs, Hospitals and Advocacy: https://survey.qualtrics.com/jfe/form/SV_7PNsfNl7GJNk2ma

- Caregivers (family members or friends in Kansas who have cared for or supported a loved one in a nursing home or assisted living facility at some point over the past two years): https://survey.qualtrics.com/jfe/form/SV_3Pr2WQpeawvrlye

Task Team Overview

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Resource Load Balancing

Feb. 2 Task Team Meeting

- The most valuable resource is information; as a community's status moves from conventional to crisis, the value of this resource increases exponentially.
- A functional response system needs to have a clear understanding of the resources available, such as transportation to/from/between medical or care facilities, the ability for different types of care facilities to alter operations to meet community care needs, and availability of prescription medications, medical equipment, etc.…
- Resource scarcity may impact a provider or provider system based on a number of different characteristics, including geographic location, race of the population served by the provider, if a provider is part of a larger network or organization, and overall socio-economic factors in the community.

Long-Term Care

Feb. 9 Task Team Meeting

- There was a lack of clarity regarding governing authorities/legal requirements for facilities. There still is.
- Recognition that the people served in LTC are part of at least one special population: aging and/or disabled. Providers felt that equity considerations for their facilities were more related to unique care or characteristics of the facility (ownership, specialty care, location).
- Development of volunteers to fill staffing gaps.
- Support for myriad demands LTC facilities faced that were not “routine”: data collection and reporting; vaccination for staff, residents, visitors; discharge planning into facilities and out of facilities; intensive infection control measures; communication; life enrichment under “shelter in place”/”social isolation” situations.

Public Communication

Feb. 16 Task Team Meeting

- Discussion centered on how information/communication happened in the past, how specific populations received information about the pandemic in general, and how that might inform the best way to support information sharing.
- Access to communication through state systems is sometimes limited to specific professions/provider types.
- Public communication used a variety of mediums, television, radio, social media.
- Grassroots communication using direct service providers, clergy, was key to providing information that people trusted. At this level, messaging and information is more culturally and linguistically responsive.
- Use of templates and making training resources available to help people in charge of communications with message presentation most effective could be helpful.

Today's Speaker

Carla Keirns, MD, PhD, MSc, FACP

- University of Kansas Medical Center
- Associate Professor, Palliative Medicine
- Associate Professor, History and Philosophy of Medicine

Load Balancing across Healthcare Facilities

Carla Keirns, MD, PhD, MSc, FACP, HEC-C
University of Kansas Medical Center
Kansas City, Kansas

ASPR TRACIE MOCC Toolkit

- The goal of the MOCC toolkit is to assist regional, state, local, tribal and territorial (SLTT) governments to ensure load-balancing across healthcare facilities and systems so that the highest possible level of care can be provided to each patient during the coronavirus disease 2019 (COVID-19) pandemic.
- Load-balancing may involve
  - prehospital distribution of patients among area healthcare facilities,
  - transferring patients from overwhelmed healthcare facilities to ones with more capacity (space, staffing, and equipment), or
  - moving resources to support an overwhelmed facility.

- As defined in the ASPR TRACIE MOCC Toolkit, Medical Operations Coordination Centers (MOCCs) are coordination elements at the sub-state, regional, state, or federal levels (e.g., Federal Emergency Management Agency [FEMA]/U.S. Department of Health and Human Services) that facilitate patient movement and resource allocation during a major response.
- These may be configured as
  - a cell within a jurisdictional emergency operations center,
  - a standalone center, or
  - embedded in an existing healthcare system transfer center.
  - They function as a single point of contact (POC) for patient transfer requests from all hospitals in a defined region as well as for other MOCCs.

- How broad a region is impacted?
- Feasibility of Prehospital Coordination
- Feasibility of Redistribution (hospital-to-hospital)
- Licensing and Credentialing issues for sharing of staff

Mass Critical Care Surge Response During COVID-19: Implementation of Contingency Strategies – A Preliminary Report of Findings From the Task Force for Mass Critical Care, Jeffrey R. Dichter et al

- Suggestion 1: We suggest graded staff-to-patient ratios with consideration to experience level, resources, and patient acuity to optimize contingency care and avoid crisis care (Figs 3, 4, 5).
- Suggestion 2: We suggest limiting overtime to less than 50% above normal for all HCWs to minimize the risk of burn-out and exhaustion
- Suggestion 3: We suggest that the mental health needs of all HCWs are priorities for maintaining an effective response and staffing capacity.
- Suggestion 4: During surge, we suggest minimizing redundant clinical documentation requirements to focus on core elements directly relevant to bedside care

Mass Critical Care Surge Response During COVID-19: Implementation of Contingency Strategies – A Preliminary Report of Findings From the Task Force for Mass Critical Care, Jeffrey R. Dichter et al

- Suggestion 5: We suggest that resource strain level be actively monitored and determined by frontline clinical leaders based upon assessment of available resources and conditions.
- Suggestion 6: We suggest there is a transition zone toward the limits of contingency care when increasingly scarce resources are modified beyond routine standards of care to preserve life. This critical clinical prioritization level precedes triage of scarce resources and is a powerful indicator for needed resources to maintain contingency-level care.

Mass Critical Care Surge Response During COVID-19: Implementation of Contingency Strategies – A Preliminary Report of Findings From the Task Force for Mass Critical Care, Jeffrey R. Dichter et al

- Suggestion 7: We suggest that early transfer of patients before a hospital is overwhelmed promotes the effective conservation of resources and less deviation from routine care standards.
- Suggestion 8: We suggest earlier utilization of regional transfer centers for load-balancing during surge for patient transfers and placement. We also suggest having intensivist or hospitalist availability to help prioritize transfers and provide support to bedside clinicians when transfers are delayed.

Mass Critical Care Surge Response During COVID-19: Implementation of Contingency Strategies – A Preliminary Report of Findings From the Task Force for Mass Critical Care, Jeffrey R. Dichter et al

- Suggestion 9: We re-emphasize that designated clinicians who are actively engaged in clinical work (especially intensivists and hospitalists) actively participate in hospital incident command structure; this group should provide updates to clinical staff for improving situational awareness, ensuring bidirectional communication
- Suggestion 10: We suggest hospitals apply telemedicine technology to augment critical care early and in the broadest sense possible

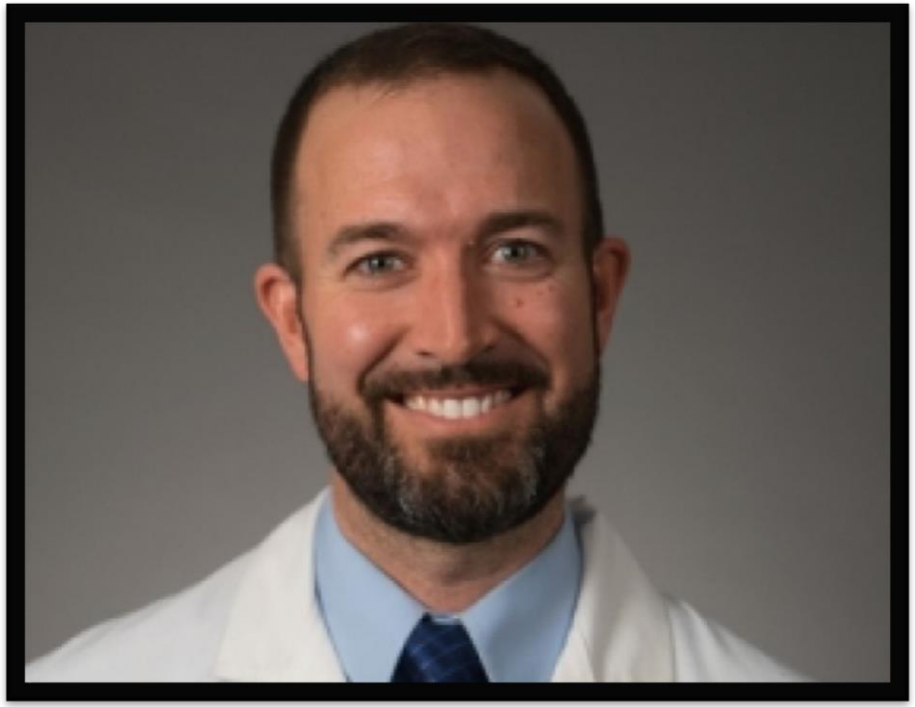
ASPR TRACIE: Medical Operations Coordination Centers (MOCC)/ Patient Load-Balancing: Summary of Lessons Learned during COVID-19, May 2022

- It is evident that MOCCs were useful and can ensure equal access and consistency of regional care in the future, particularly protecting disadvantaged populations.
- MOCC operations during COVID-19 were usually at the state level but can be valuable at the sub-state or inter-state level. Therefore interface, authorities, and operational constructs between MOCCs need to be clearly defined (this was particularly identified as an issue between the states in the northwest but affected many states where referrals often cross state lines).
- Baseline capacity and situational awareness data sharing is helpful even if facilities are not requesting MOCC transfers or resources during an event.
- Policies and mechanisms need to be in place to:
  - Assess patients for care/transfers needs
  - Provide in-place consultation and resource support when feasible/appropriate
  - Monitor hospital capacity and assign transfer/load-balance as appropriate
  - Provide a mechanism to ensure timely transfers when the current hospital does not provide the necessary services (e.g., dialysis) and a critical care consultant for the MOCC deems the need emergent, even if all hospitals are “full.”
  - Enhance EMS engagement in MOCC planning and load balancing. This may include operating the MOCC out of an existing public safety EMS coordination entity.

ASPR TRACIE: Medical Operations Coordination Centers (MOCC)/ Patient Load-Balancing: Summary of Lessons Learned during COVID-19, May 2022

- Hospital associations and major healthcare systems may be well positioned to help lead MOCC planning or potentially host operations and provide subjective information sharing (some hospitals are wary of the state's hospital regulatory powers versus sharing information about surge conditions). However, these associations and systems may not have the authority or desire to compel participation in the MOCC or transfers when inpatient capacity is reached.
- State executive branch and public health authorities, statutes, state rules, and MOUs should all be leveraged to create a system that engages all hospitals and medical transport resources, can transcend jurisdictional boundaries, and defines the operational policies in advance of an incident, with a clear process for incident-specific policy development, approvals, and authorities.
- The federal role in supporting MOCCs, both in the planning and operational phases (particularly as it affects inter-state coordination), should be defined and communicated to states.
- Regulatory and accrediting entities should consider requirements for regional MOCC participation during disasters.
- In some cases, provision of state and federal disaster response or program support to hospitals could be considered contingent on participation in a MOCC during disasters with participation, prioritization, and prescriptive transfer acceptance criteria shared in this resource.
- Further study needs to evaluate the potential impacts of MOCC operations as well as examine the ethics and equity issues associated with the absence of regional coordination.
- Indicators and triggers for initiating MOCC operations and sources of funding identified for operations once commenced should be clearly defined.
- States can identify additional disaster and daily functions that a MOCC may offer to benefit the community/region as appropriate and practical.

Today's Speaker



Douglas B. White, MD, MAS

- University of Pittsburgh, Center for Bioethics & Health Law
- Professor of Critical Care Medicine, Medicine, and Clinical Translational Science
- UPMC Endowed Chair for Ethics in Critical Care Medicine
- Vice-Chair for Faculty Development, Department of Critical Care Medicine
- Director, Program on Ethics and Decision Making in Critical Illness, CRISMA Center, Department of Critical Care Medicine

Equity & Load Balancing in Arizona During the COVID-19 Pandemic

Douglas B. White, MD, MAS

Vice Chair and Professor of Critical Care Medicine

UPMC Endowed Chair for Ethics in Critical Care Medicine

University of Pittsburgh School of Medicine

The CRISMA Center

Center for Bioethics and Health Law

Hypothetical: Overwhelmed Safety Net Hospitals in Kansas

Situation: In Kansas, hospitals in economically disadvantaged areas are overwhelmed with critically ill patients, while private hospitals have available beds.

- Private hospitals refuse to accept transfers.
- The regional health department refuses to intervene to require transfer of hospitals from overwhelmed hospitals to hospitals with available beds.
- Physicians at safety net hospitals are forced to deny potentially beneficial ICU care to patients in need, while beds are open just a few blocks away at a private health system.

Ethical violation: Private hospitals (and public officials) failed to uphold their obligation to the public safety net, causing unnecessary loss of life, which disproportionately affected marginalized groups.

Reality: Overwhelmed Safety Net Hospitals in NY and CA

Why Surviving the Virus Might Come Down to Which Hospital Admits You

In New York City's poor neighborhoods, some patients have languished in understaffed hospitals, with substandard equipment. It was a different story in Manhattan's private medical centers.

By Brian M. Rosenthal, Joseph Goldstein, Sharon Otterman and Sheri Fink

Published July 1, 2020 Updated Sept. 22, 2021

Dying of Covid in a 'Separate and Unequal' L.A. Hospital

Inside an overwhelmed facility in the worst-hit part of California, where the patriarchs of two immigrant families were taken when they fell sick.

By Sheri Fink Photographs by Isadora Kosofsky

Published Feb. 8, 2021 Updated Aug. 4, 2021

The New York Times

One Hospital Was Besieged by the Virus. Nearby Was 'Plenty of Space.'

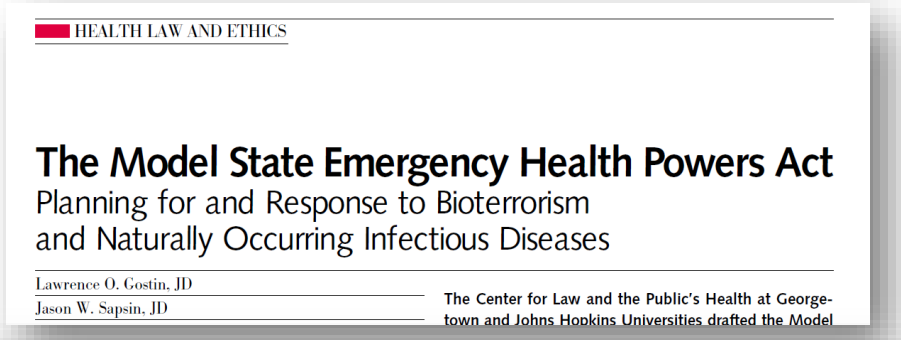
Even as Elmhurst faced "apocalyptic" conditions, 3,500 beds were free in other New York hospitals, some no more than 20 minutes away.

By Jim Dwyer

Published May 14, 2020 Updated July 1, 2020

Strong Justification for Legal Interventions to Require Load Balancing

Ethical Justification: one of states' foremost responsibilities is safeguarding residents' health and well-being, which is threatened when health systems fail to cooperate during the pandemic, leaving hospital beds empty in some hospitals while other hospitals are overwhelmed.

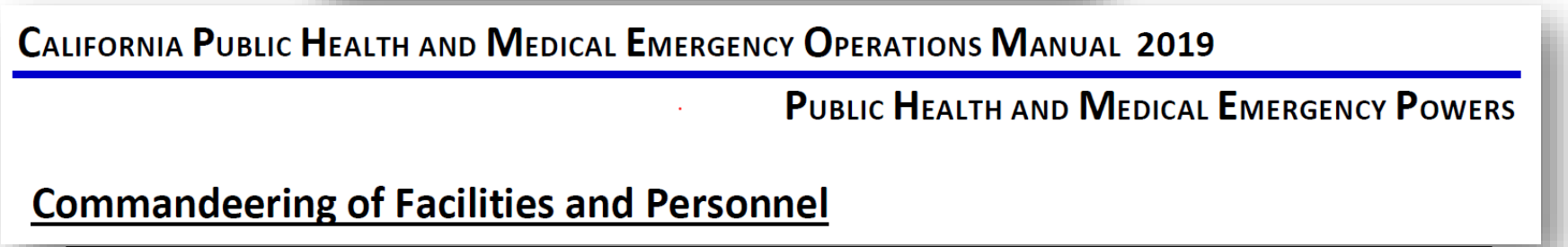


HEALTH LAW AND ETHICS

The Model State Emergency Health Powers Act
Planning for and Response to Bioterrorism
and Naturally Occurring Infectious Diseases

Lawrence O. Gostin, JD
Jason W. Sapsin, JD

The Center for Law and the Public's Health at George-
town and Johns Hopkins Universities drafted the Model



CALIFORNIA PUBLIC HEALTH AND MEDICAL EMERGENCY OPERATIONS MANUAL 2019

PUBLIC HEALTH AND MEDICAL EMERGENCY POWERS

Commandeering of Facilities and Personnel

"During a proclaimed *state of emergency*…the Governor is authorized to plan for the use of private services, facilities, and properties, in addition to procuring services and supplies by contract."

Gostin L. JAMA. 2002

Arizona- Disparities in Access to Hospital Care

www.azdhs.gov/surgeline

Villarroel L. NEJM Catalyst. 2021

Inequitable Access to Hospital Care — Protecting Disadvantaged Populations during Public Health Emergencies

Douglas B. White, M.D., Lisa Villarroel, M.D., M.P.H., and John L. Hick, M.D.

NEJM; Dec 2021

Before any patient in need is refused ICU care, patients at overwhelmed hospitals should be transferred to hospitals with available beds elsewhere in the region (load balancing).

White DB. NEJM. 2021

Proof of Principle: Arizona

THE ARIZONA
SURGELINE

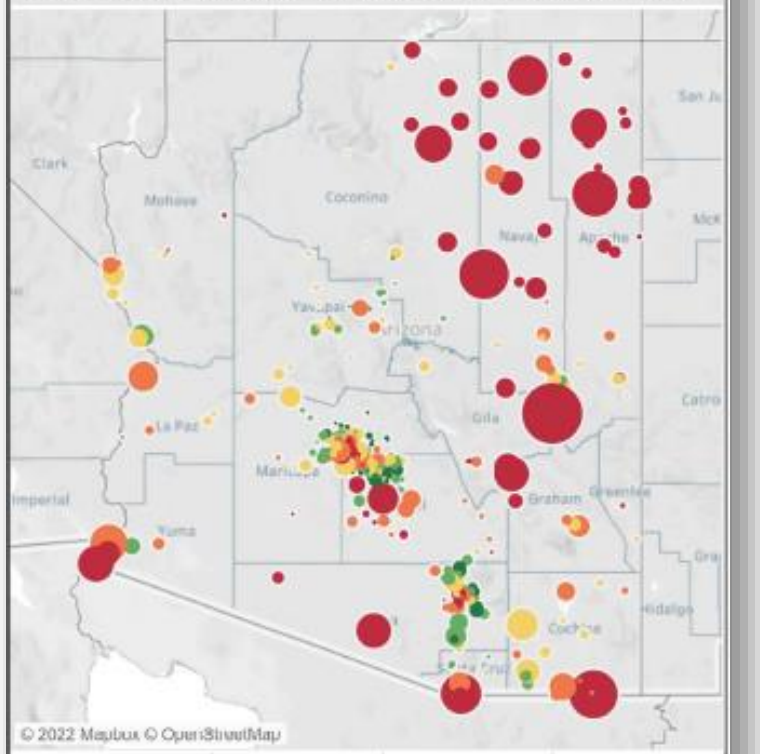
On April 16, 2020, the Arizona Department of Health Services (DHS) activated the Arizona Surge Line, a statewide, centralized bed-placement system that uses a 24/7 call center to facilitate transfers of patients with suspected or confirmed Covid-19 to appropriate levels of care in order to balance hospitals' loads. It uses an electronic, automatic bed-visibility dashboard.

On May 28, 2020, Governor Doug Ducey issued an executive order requiring all Arizona hospitals to use the Surge Line for interfacility transfers and electronically update their bed and ventilator status as specified by the DHS. Ducey also directed the Arizona Department of Insurance to require state-regulated insurers to cover at in-network rates all Covid-19–related transfers and treatment facilitated by the Surge Line.

White DB. NEJM. 2021
Villarroel L. NEJM Catalyst. 2021

Arizona Surge Line: An emergent statewide COVID-19 transfer service with equity as an outcome

Top: Arizona map of home zip codes for patients transferred through the Arizona Surge Line, color coded by CDC/ATSDR's Social Vulnerability index; Bottom: SVI of transferred patients home zip codes, 4/19/20 - 3/16/21.



Overall SVI	Grand Total	Surge 1	Surge 2
.8 - 1	**51.8%**	55.8%	48.7%
.6 - .79	**21.0%**	21.5%	20.5%
.4 - .59	**16.6%**	15.0%	17.9%
.2 - .39	**7.7%**	5.5%	9.5%
0 - .19	**2.9%**	2.3%	3.4%

5657 patients transferred from 160 hospitals

- 73% were from high SVI regions
- 58% from rural hospitals
- 53% of patients were American Indian

Villarroel L. Frontiers in Public Health. 2023

University of Pittsburgh Critical Care Medicine

www.ccm.pitt.edu

Breakout Rooms

5-minute Break

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Breakout Rooms

CAB/TAP Agenda

- Questions from Task Teams
- See supplemental agendas

CAB BREAKOUT ROOM

Questions

Lessons Learned from COVID-19 in Long-Term Care Facilities

1. What were the COVID-19 takeaways, and what did we learn in long-term care facilities for the next crisis?

Emergency Preparedness in Long-Term Care Facilities

2. In crisis, how should LTCs best accommodate those who have unique needs or require specialized care? (For example, in phase 1, the guidance focused on individuals with IDD, Black/African American and pediatrics)

Questions (cont.)

Additional Resources for Long-Term Care Facilities

3. What would be on the top of your list to fund the needs in long-term care facilities?

Civil Money Penalties (CMP) are monetary penalties (fines) imposed by the Centers for Medicare and Medicaid Services (CMS) against nursing facilities that have failed to maintain compliance with federal requirements. A portion of these funds are returned to States and may be used for projects supporting activities that benefit nursing facility residents or that protect and improve their quality of life or care. CMP funds may be used for, but not limited to the following:

- Training
- Transition Preparation
- Culture change/quality of life
- Projects that support resident and family councils
- Resident transition due to facility closure or downsizing

Questions (cont.)

Health Equity and Inclusion in Emergency Preparedness

4. For immigrant populations, how can we frame and disseminate messaging to account for cultural and structural barriers?

5. As Spanish-speaking populations migrate around the state, what is the best mode of communication to reach these new or returning Kansans?

6. What is your primary method of communication for reaching out to your communities?

TAP BREAKOUT ROOM

Discussion Questions

Resource Load Balancing Task Team

1. The group should consider the skillsets available in rural areas and adapt recommendations and guidance to those anticipated skillsets.
2. KDEM's responsibility and role during a crisis and HCC role for resource load balancing
3. When hospitals need to transfer patients between hospitals, what factors should be considered and why? What are the communication strategies that should be in place between hospitals to ensure a smooth and safe transfer process?
4. If residents of nursing homes or assisted living facilities need hospital services while hospitals are rationing care, what are the best ways to address their needs?

Discussion Questions

Long-Term Care Task Team

5. What additional resources through CMP grants would be helpful and allow more flexibility to long-term care facilities?

6. What strategies or resources should be considered for non-corporate, standalone long-term care facilities in rural parts of the state?

7. The COVID-19 takeaways, what did we learn in long-term care facilities for the next time?

Discussion Questions

Public Communications Task Team

8. Would your organization consider enlisting qualified students, community health workers and volunteers to assist LTCF staff with facilitating visitation and communication with residents and their loved ones?
9. Are community organizations able to subscribe to KsHAN? How many are currently signed up?
10. Could Kansas create a statewide, publicly accessible Emergency Alert Network for public messaging during a crisis?
11. Would a Plain Language Glossary or Message Map with tips for clear and concise messaging for different populations be helpful during a crisis?

Wrap Up

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Meeting Materials Webpage

Webpage includes:

- Meeting materials for joint and task teams
- Environmental Scan
- Focus Group Questions

Webpage does NOT include:

- Guidance drafts (sent via Sharepoint)

LINK: 2023 Crisis Standards of Care: Phase 2 | Kansas Health Institute (khi.org)

THANK YOU!

Any Questions?

You can connect with us at: hshah@khi.org or tlin@khi.org

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