Crisis Standards of Care

Joint Community Advisory Board and Technical Assistance Panel Meeting

February 23, 2023

9:00am-11:30pm

Agenda

9:00am	Welcome
9:05am	Task Team Updates
9:20am	Presentations: Resource Load Balancing Overview
9:55am	Break
10:00am	Breakout Rooms
11:25am	Closing Remarks
11:30am	Adjourn

Meeting Materials

Registration Survey Results from 2/13/23; Environmental Scan; Select Publications from Environmental Scan; Breakout Room Agendas for CAB and TAP

Participants

Community Advisory Board: Alice Weingartner; Ami Hyten; Amy Burr; Delmar White; Sherrie Vaughn; Eric Arganbright; Glenda DuBoise; Irene Caudillo; Jamie Gideon; Liz Hamor; Winona Masquat (Sebe)

Technical Advisory Panel: Amy Kincade; Carla Keirns; Carrie Wendel-Hummell; Chrisy Khatib; Dan Goodman; Devan Tucking; Gianfranco Pezzino; Joan Duwve; Lillian Lockwood; James Roberts; Jean Hall; Jeanne Gerstenkorn; Jenifer Clausen; John Carney; Jonathan York; Lacey Hunter; Leslie Anderson; Linda MowBray; Morgin Dunleavy; Rachel Monger; Sarah Irsik-Good; Scott Brunner

Presenters:

- Dr. Carla Keirns
- Dr. Douglas B. White, MD, MAS, University of Pittsburg School of Medicine

KDHE: Ed Bell, Rebecca Adamson

KHI: Hina Shah; Tatiana Lin; Sheena Schmidt; Valentina Blanchard

Welcome (Hina)

- Reminder of group agreements
- Overview of 5 project components (CAB, TAP, Environmental Scan, Task Teams, Focus Groups)

Focus Groups (Tatiana)

- The focus groups aim to provide additional information for the development of guidance for hospitals and long-term care facilities on resource load balancing. Focus groups will consist of individuals from hospitals, staff and long-term care facilities, caregivers (defined as family members or friends who have provided support or cared for someone in a long-term care facility at some point over the past 2 years (from 2020 - now), and consumer advocates.
- Currently 41 participants have enrolled, including 20 individuals from hospitals, 7 individuals from long-term care facilities, and 14 individuals who are caregivers. However, the number of those who end up participating might be different based on their availability.
    - Focus groups will be conducted by stakeholder type and are currently scheduled on February 24th, March 1st and March 3rd
    - A separate focus group in Spanish for caregivers will take place in March
    - Additional focus groups might be conducted based on available time and resources
    - The goal will be to share preliminary focus group results at the joint March meeting

Questions:

- During the meeting, attendees asked several questions, including whether certified nursing assistants (CNAs) would be included in the focus groups and whether compensation would be provided to the focus group and interview participants. Additionally, the attendees asked whether a two-year timeframe would allow for capturing the experiences of caregivers during the COVID-19 pandemic.
    - Tatiana clarified that individuals were asked to self-identify during the recruitment process, but only one individual identified themselves as a CNA. As a result, they will be combined with other stakeholders. She also noted that they are unable to provide compensation for participants due to grant limitations. Finally, Tatiana clarified that recruitment of caregivers will focus on the timeline from 2020 onward to capture experiences during the COVID-19 pandemic.
- **ACTION ITEM:** For members – share focus group links with anyone who may be interested in joining, with a focus on caregivers and consumer advocates.

Task Team Updates (Ami Hyten, CAB Liaison)

- Task Teams have started working on creating outlines and reviewing environmental scans
- **Resource Load Balancing**
    - The most valuable resource is information – between providers and from providers to the public – and there is a disconnect within the system right now
    - 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.
    - Resource scarcity may impact a provider or provider system based on a number of different characteristics, including geographic location, demographics of the community, if a provider is part of a larger network or organization, and overall socio-economic factors in the community.
- **Long-Term Care**
    - The discussions highlighted the need for greater clarity regarding the governing authorities and legal requirements for long-term care (LTC) facilities, as this was identified as an ongoing issue.
    - Participants acknowledged that the people served in LTC are part of at least one special population, either aging or disabled. However, providers felt that equity considerations for their facilities were more related to the unique care or characteristics of the facility, such as ownership, specialty care, or location.
    - One potential solution to address the staffing gaps in LTC facilities is the development of volunteer programs. However, the group also highlighted that LTC facilities face numerous non-routine demands, including data collection and reporting, vaccination for staff, residents, and visitors, discharge planning into and out of facilities, intensive infection control measures, communication, and life enrichment under "shelter in place" or "social isolation" situations. These demands require additional support and resources to ensure the best possible care for residents.
- **Public Communications**
    - During the discussion, participants focused on how information and communication were handled in the past and how specific populations received pandemic-related information. This analysis was used to identify the best way to support effective information sharing. One notable observation was that access to communication through state systems is often limited to specific professions or provider types.
    - To disseminate information to the general public, a variety of modes were employed, including television, radio, and social media. However, the group emphasized that grassroots communication, led by direct service providers and clergy, was crucial in providing trustworthy information. Messaging and information at this level were also more culturally and linguistically responsive.
    - To enhance the effectiveness of communication efforts, the group suggested the use of templates and training resources. Such resources could help individuals responsible for communications to develop and deliver clear and effective messages.

<u>Presentation by Dr. Carla Keirns" Load Balancing Across Healthcare Facilities"</u>

- Carla C. Keirns, MD, PhD, MSc, FACP is an Associate Professor of History and Philosophy of Medicine and Palliative Medicine at the KU Medical Center
- Load-balancing refers to the strategic management of patient distribution and healthcare resources to optimize capacity and alleviate strain on overwhelmed

healthcare facilities. This can involve several actions, such as prehospital distribution of patients across healthcare facilities, transferring patients from facilities that are overwhelmed with patients to ones with more capacity in terms of space, staffing, and equipment, or mobilizing additional resources to support an overwhelmed facility.

- Dr. Keirns noted that redistribution of patients has been the predominant way to deal with surges in healthcare demand. However, common challenges include credentialing and licensing issues for staff redistribution and the need for efficient coordination and communication among healthcare facilities.
- Dr. Keirns highlighted the lessons learned in New York during the first wave of the pandemic when the mortality rate from COVID-19 varied widely across hospitals in the city.
    - It was discovered that redistribution of patients (rather than staff or equipment) was the most effective way to deal with the surge in cases
    - The process of patient redistribution and transfer, however, was fraught with challenges, including credentialing and licensing issues, and lack of familiarity with the system.
- Dr. Keirns also discussed the findings of Dr. Jack Awashn from Johns Hopkins University, who has studied hospital-to-hospital critical care transfers for decades.
    - He found that the highest morality was seen in hospitals that treat 20-99 cases a year of heart attacks or sepsis, not small hospitals as predicted.
    - Larger hospitals can fail to recognize that medium-sized hospitals may not have all the necessary medical specialties for consultation, overnight coverage or experienced staff (interns rather than critical care professionals).
    - Hospitals can have impressive capacities on paper, but it doesn't always match the current situation.
    - Rural hospitals may be caring for sicker patients than they are used to, so they may require additional support.

- Dr. Keirns provided an overview of the regional strategies for distribution developed by *t*he Task Force for Mass Critical Care and described in the article M*ass Critical Care Surge Response During COVID-19: Implementation of Contingency Strategies – A Preliminary Report of Findings, Jeffrey R. Dichter et al). Note that the list below has been summarized. For a full list, see the original resource listed above.*
    - Graded staff-to-patient ratios, depending on the expertise, resources, and acuity levels of the crisis
    - Limiting overtime to reduce burnout and exhaustion among healthcare workers
    - Addressing mental health needs of healthcare workers
    - Reducing redundant clinical documentation
    - Actively monitoring resource strain levels (i.e., transferring patients early)
    - Involving frontline clinical leaders in decision-making
    - Enhancing engagement with EMS
- During the presentation, Dr. Keirns provided the following suggestions:
    - Use a transition zone to manage hospitals that are approaching their capacity limits.

- Transfer patients earlier to balance the load and prevent overwhelming hospitals.
- Utilize regional transfer centers to manage patient load and improve coordination.
- Utilize telemedicine technology to augment critical care and support patients in need of palliative care, ethics, and other care.
- Improve policies for patient assessment and transfer of care.
- Provide in-place consultation and resource support.
- Monitor hospital capacity and ensure timely transfers.
- Consider ethics and equity issues when load balancing, as the most vulnerable populations are at risk for health consequences during a disaster.

Questions:

- What impact does reallocating resources, including staffing, have on the human element?
  - The issue of moving providers to different locations could be challenging, especially for those with family responsibilities. Healthcare providers should not be required to move and service in a crisis setting should be voluntary.
  - However, as healthcare providers, there may be an obligation to put yourself in personal danger to help others

Presentation: Dr. Doug White

- Dr. White, a critical care, bioethics, and health services researcher from the University of Pittsburgh, gave a presentation on load balancing and its impact on equity in Arizona during the first two surges of the COVID-19 pandemic.
- He used a hypothetical scenario where rural hospitals in Kansas are overwhelmed with critically ill patients while private hospitals with available beds refuse to accept transfers. White argued that this is an ethical violation because private hospitals and public officials have an obligation to the public safety net, causing unnecessary loss of life that disproportionately affects marginalized communities.
- During the presentation, Dr. White provided an example of Arizona and discussed how the state has implemented emergency response strategies to manage patient surge during the COVID-19 pandemic.
  - **Executive Order:** Governor Doug Ducey issued an executive order requiring all Arizona hospitals to participate in load balancing and accept patients for interfacility transfer from overwhelmed hospitals to their hospital if they had available beds.
    - The executive order also required state-regulated insurers to cover patients at in-network rates, so insurance could not be used as a resource to refuse transfer.
  - **Centralized System:**
    - Arizona developed a system to transfer patients from overwhelmed hospitals to those with available beds using the Arizona Surge Line, a centralized bed placement system that facilitates the transfer process.

        - The published results of load balancing from the first two surges found that the surge line was hugely important as an equity intervention.
        - The load balancing efforts in Arizona involved the transfer of more than 5,600 patients from 160 hospitals.
            - The vast majority of transfers from American Indian tribal land were directed to Phoenix and Tucson, while disadvantaged patients from rural hospitals and along the Arizona-Mexico border were also transferred. Urban centers were the receiving hospitals for 98% of the transfers, with 53% of the transferred patients being American Indian, which was disproportionate compared to their proportion of the population in Arizona.
        - The Social Volume Vulnerability Index, which measures place-based disadvantage, was used to identify highly disadvantaged regions from where 73% of the transferred patients came.
    - The utilized load balancing process in Arizona was an equity intervention that disproportionately benefited disadvantaged patients from tribal lands with inadequate healthcare resources.
    - Dr. White encouraged the audience to examine the executive orders issued by the State of Arizona and the publications describing the load balancing process. The availability of beds was based on staffed beds, and separate processes were implemented to bring in staff to convert unstaffed beds into staffed ones.

Crisis Standards of Care

Joint Community Advisory Board

February 23, 2023

10:25 am-11:30 am

Participants

Community Advisory Board: Alice Weingartner; Ami Hyten; Amy Burr; Delmar White; Sherrie Vaughn; Eric Arganbright; Glenda DuBoise; Irene Caudillo; Jamie Gideon; Liz Hamor; Winona Masquat (Sebe)
Facilitator: Tatiana Lin, KHI
Note-taker: Sheena Schmidt, KHI

The Facilitator welcomed the group and started the meeting by posing questions for feedback.

Question asked to CAB Members: What were the COVID-19 takeaways, and what did we learn in long-term care facilities for the next crisis?

Key Findings:

- Many residents in long-term care facilities were not given the option to see their families during the pandemic, despite wanting to.
- Isolation measures during the pandemic had negative impacts on the mental health of residents with Alzheimer's and other mental illnesses.
- There is a need for a middle ground in infection control that balances safety measures with access to loved ones.
- Black and brown residents in long-term care facilities had a higher rate of infection and less access to community-based services.
- Staff shortages were a major concern during the pandemic, and improving staff recruitment and retention through better pay and working conditions is necessary.

List of Questions based on the CAB discussion:

- How can we ensure that residents' preferences for family visits are taken into account during future crises?
- What measures can be implemented to provide residents with access to loved ones while also maintaining infection control?
- How can access to community-based services be improved for marginalized populations in long-term care facilities?
- What steps can be taken to address staff shortages in long-term care facilities, and how can we improve working conditions for staff?
- How can protocols for high-risk populations, such as babies and neonatal care units, be adapted to long-term care facilities?

Summary:

During the meeting, concerns were raised about the isolation of residents in long-term care facilities during the COVID-19 pandemic. Suggestions were made for finding a middle ground in infection control that also provides access to family members and loved ones. One suggestion was to offer options for residents who are willing to take the risk of getting Covid. Additionally, the decisions made to keep residents isolated from their families were noted to have resulted in the death of individuals with mental illness. Keeping the staff safe was also deemed important, as they might take Covid home to their families. It was suggested that finding a middle ground is necessary to keep both the staff and residents safe. Lastly, it was pointed out that black and brown people in facilities have a higher rate of infection and lack access to community-based services. The need for equity in access to those services was emphasized once overall infection control is addressed.

Next, the conversation focused on how to apply the standards of resource load balancing implemented in hospitals in Arizona to long-term care facilities. This led to a discussion about the need for expanded standards for different types of facilities, including long-term care facilities. The group also discussed the challenges faced by these facilities during the pandemic, including staffing shortages and the lack of support and information for front-line workers.

One suggestion put forward was to build up staff recruitment and retention in long-term care facilities by improving working conditions and paying staff better, especially for marginalized populations that are overrepresented in these roles. The group emphasized the need for sustained support to prevent a return to pre-pandemic conditions.

The conversation then turned to the protocols in place for high-risk populations like babies and neonatal care units, and whether similar protocols could be adapted for long-term care facilities. The CAB Facilitator noted the need to look at exceptions made during the pandemic and how they could be adapted to long-term care facilities.

The group agreed that providing staff with appropriate personal protective equipment and specialized training could help meet the unique needs of different populations during a crisis, such as training on how to communicate with children in long-term care facilities.

Overall, the discussion emphasized the importance of paying attention to staffing, sustained support, and adapting protocols to protect the most vulnerable populations during crises, and suggested additional resources for long-term care facilities to address the challenges posed by the pandemic.

Question asked to CAB members: If there was some flexibility in using the Civil Monetary Penalties Fund, what would be at the top of your list for funding the needs in long-term care facilities?

Key Findings:

- The Civil Monetary Penalties Fund could be used to address isolation among residents in long-term care facilities, purchase technology and equipment to enable residents to connect with their families and other facilities and provide for plexiglass and other measures for visitation and staffing needs.
- The group focused on addressing isolation in long-term care facilities during the COVID-19 pandemic, including concerns about how to protect families who visit loved ones while minimizing isolation.
- Equity issues were also discussed, such as the need for broadband access in rural areas and language barriers. The importance of providing access to technology and broadband to all long-term care facility residents and families, particularly those in rural areas, was emphasized.

List of questions based on the CAB discussion:

- How can the civil monetary penalties fund be utilized to address isolation among residents in long-term care facilities, while still ensuring their safety during the pandemic?
- What specific technology and equipment can be purchased using the fund to allow residents to connect with their families and reduce their isolation?
- How can peer groups and interactive activities be created to reduce isolation among residents in long-term care facilities?
- How can equity issues, such as broadband access in rural areas and language barriers, be addressed to ensure that all long-term care facility residents and families have access to technology and communication?
- What privacy considerations need to be taken into account for the LGBTQ population in long-term care facilities, particularly for meetings with their families?

Summary

The group moved on to discuss a civil monetary penalties fund that is used to benefit nursing facility residents and improve their quality of life. The facilitator explained that the fund can be used for various projects and activities, including training, culture change, and resident support. The group was then asked to provide suggestions for utilizing the fund, in addition to the previously mentioned activities. One CAB member suggested that the funds could be used to address isolation among residents, and another CAB member suggested using the funds to purchase technology and equipment to allow residents to connect with their families and other facilities. It was suggested using plexiglass and other measures for visitation, but noted that this could be costly for facilities. The group also discussed the idea of creating peer groups and

other interactive activities for residents. The group did not reach a definitive conclusion on the matter, but several suggestions were proposed for consideration.

The conversation revolved around addressing the issue of isolation in long-term care facilities during the COVID-19 pandemic. The participants discussed the procedures in neonatal care units and the need for protected spaces for babies. They suggested creating spaces like the old Catholic church cry rooms, where families can visit safely, even if physical touch is not possible. Concerns were expressed about how to protect families who visit loved ones in long-term care facilities while still minimizing isolation. In a meeting, participants discussed the considerations for every aspect of care for individuals in the rule and frontier community's lives. One CAB member also shared a concern about the needs of the LGBTQ population, suggesting access to privacy to meet with their families without fear of being outed.

The participants also touched on equity issues, including the need for broadband access in rural areas and language barriers. They highlighted the importance of providing access to technology and broadband to all long-term care facility residents and families, particularly those in rural areas. The need to consider language barriers and ensure that all long-term care facilities have a way for non-English speaking families to communicate with their loved ones was also emphasized.

The conversation concluded by emphasizing the need for broadband to be at the forefront of addressing the issue of isolation in long-term care facilities. Overall, the discussion aimed to find ways to reduce isolation in long-term care facilities while still ensuring the safety of residents, families, and staff during the pandemic.

Question asked to CAB members: For immigrant populations, how can we frame and disseminate messaging to account for cultural and structural barriers? Spanish-speaking populations migrate around the state, what is the best mode of communication to reach these new or returning Kansans? What is your primary method of communication for reaching out to your communities?

Key findings:

- Participants emphasized the importance of trusted relationships with community leaders who speak the same languages and look like immigrant populations when communicating health information.
- The group suggested various modes of communication, including radio, social media, and flyers in multiple languages.
- The group highlighted the role of churches in disseminating information and acknowledged political differences within immigrant populations, particularly among Salvadoran immigrants.
- The importance of cultural humility and building trusted relationships with community members to effectively communicate health information was emphasized.

- Having spokespersons and physicians who look like community members and hosting Facebook conversations was effective in encouraging vaccination in the African American community.
- The Black Nurses Association and churches played a big role in encouraging vaccination in Wichita, while providers and people who looked like them were effective messengers in Topeka.
- The challenges of providing long-term care facilities for individuals with Alzheimer's, especially in faraway facilities, were noted, along with the need for improved communication and transportation services.
- Area agencies on aging and senior centers were mentioned as key partners for outreach efforts, and the Kansas Leadership Center's project was noted for its effective use of listening sessions and trainings.
- The extension office in rural areas was also mentioned as a useful resource for disseminating information, and specific outreach efforts were discussed, including sending postcards with important information.
- Participants also discussed the importance of identifying populations to target for messaging and considering partner organizations for outreach efforts, such as physicians and nurses in the clinic and associations like the Family Practice Association or Nurses Association.

Questions based on the CAB discussion:

1) **How can organizations develop and leverage protocols or flowcharts for messaging and reaching out to partners, and who should be responsible for updating them? What agency or organization could potentially serve as the central point for developing and keeping the protocols updated?**
2) **What agency could serve as a central resource for translating communication messaging into different languages in Kansas?**

Participants shared their experiences communicating with immigrant populations, emphasizing the importance of trusted relationships with community leaders who speak their languages and look like them. One participant shared that communication in a language the population understands and at a meaningful level was crucial. The group suggested various modes of communication such as radio, Facebook, WhatsApp, and flyers in multiple languages. It was noted that some populations change frequently, which can make communication challenging.

During a conversation, members of a Community Advisory Board (CAB) discussed the challenges of communicating health information to immigrant populations, particularly those who may not speak English fluently. They emphasized the importance of providing information in a language and at a level that community members can understand. The group found that radio and social media, particularly Facebook, were effective modes of communication. They also discussed the challenges of reaching community members who may move frequently and

have changing phone numbers. The group emphasized the importance of building trusted relationships with community leaders and organizations that can disseminate information to community members. The members discussed the role of churches in disseminating information, including the recognition that not all Latino immigrants attend Catholic churches. The group also acknowledged political differences within immigrant populations, particularly among Salvadoran immigrants. Overall, the group emphasized the importance of cultural humility and building trusted relationships with community members to effectively communicate health information.

The facilitator, Tatiana Lin, asks members to consider their audiences and identities, and what communication approaches might work for them in a crisis mode and beyond. One participant shared that in the African American community, having spokespersons and physicians who looked like them and hosted Facebook conversations helped with messaging and encouraged people to get vaccinated. The Black Nurses Association and churches also played a big role in encouraging vaccination in Wichita. In Topeka, the African American churches were not as involved, but having providers and people who looked like them as messengers was still effective.

Participants discussed communication strategies and resources for individuals and caregivers in rural areas dealing with Alzheimer's and other diseases. One participant mentioned the importance of reaching out to particular communities, including caregivers, and focusing on rural and frontier areas in the state. The participant noted the challenges of providing long-term care facilities for individuals with Alzheimer's, especially when facilities are far away. The group discussed the need to help with communication between long-term care facilities and the individuals they serve and provide transportation services to bridge the gap.

The facilitator asked about other groups that could be leveraged to help with communication for these audiences. The participants mentioned that they work closely with area agencies on aging and senior centers, which play a key role in providing services and reaching out to caregivers and residents in facilities.

Another participant mentioned the Kansas Leadership Center's project, funded by the Kansas Health Foundation, which ran listening sessions and trainings with small groups of people to get out information. The group thought it would be helpful to obtain a list of all the different projects and outreach efforts that occurred during this project.

Participants also mentioned using the extension office in rural areas as a resource for disseminating information quickly and effectively. The group discussed the need for specific outreach efforts to be targeted to different populations, including sending postcards with important information.

During a meeting, participants discussed identifying populations to target for messaging, as well as considering partner organizations for outreach efforts. They discussed the importance of looking within their own groups to identify potential partners, such as physicians and nurses in

the clinic, and working with associations like the Family Practice Association or Nurses Association.

One participant then continued by suggesting that they identify the specific people they wanted to reach out to and find out where to send the messages. She also recommended targeting certain populations. Another participant added that they should look within their own group to see who their members were and who they might be partners with. For example, her group had physicians and nurses who worked at the clinic, so they would work with the Family Practice Association or the Nurses Association to connect with them.

Tatiana asked if their organizations had a protocol or a flowchart for messaging and reaching out to partners. She wondered if they had something already developed that they could leverage when the need arose. One participant indicated that they had developed new ways to communicate with people during the COVID-19 pandemic, as many people were not able to come into their physical office. They found it vital to communicate with people in different ways and set up different methods to do so. They were able to successfully transition to these new methods and now have them in place in case they need to use them again.

One participant raised the question of who the keeper and the updater of the protocol would be. The group discussed the possibility of using existing databases, such as the volunteer database. They also talked about the idea of having joint communication agreements that leverage existing partnerships, as well as communication strategies.

Crisis Standards of Care
Technical Advisory Panel High-Level Meeting Notes
February 23, 2023
10:00am – 11:25am

Questions from Task Teams to TAP

Resource Load Balancing

1. The group should consider the skillsets available in rural areas and adapt recommendations and guidance to those anticipated skillsets.
    a. This will vary by facility and county; consider skills assessment for conventional stage
    b. Licensing and credentialing boards can provide local, regional, state data
    c. EMResource does not have a dashboard for skills; it displays bed count by bed type

2. KDEM's responsibility and role during a crisis and HCC role for resource load balancing
    a. Crisis response and roles are based off of how the Incident Command System is set up
    b. Response is typically at the local level, with local health departments and agencies coordinating emergency response
    c. Under the KDEM Response Plan, KDHE is primary response with KDEM providing support
    d. The KSCSCG should think through the role advocacy plays (i.e. the pediatric surge did not see the same partnership of agencies

3. When hospitals need to <u>transfer patients between hospitals,</u> what factors should be considered and why? What are the communication strategies that should be in place <u>between hospitals</u> to ensure a smooth and safe transfer process?
    a. Consider whether the patient needs to have a support person with them (i.e. if patient is non-verbal)
    b. Consider the ability to provide the care the patient requires
    c. Additional information is needed on the requirements for transfer during normal circumstances versus a crisis situation, both in-state and out-of-state
    d. How should patient requests for transfer be handled during a crisis? Are there additional resources (like telehealth) that can be utilized?

4. If residents of nursing home are assisted living facilities need hospital services while hospitals are rationing care, what are the best ways to address their needs?
    a. Telehealth
    b. Sending staff to the facility, rather than the resident to the hospital

c. Need to address the issue of residents losing their bed when transferred to the hospital and patients being sent back to facilities who were not able to meet their medical needs
    i. When a crisis is over, who has the rights to the bed?
d. Effective communication with patients and family/friends/caregivers is essential

Long-Term Care

1. What additional resources through CMP grants would be helpful and allow more flexibility to long-term care facilities?
    a. CMP funding is only available for the 323 qualified nursing homes
    b. Additional resources that would be helpful for facilities include recoupment of funds for facilities at risk of closing because of additional strain they took on and staffing

2. What strategies or resources should be considered for non-corporate, standalone long-term care facilities in rural parts of the state?
    a. Corporate facilities have national direction and may have additional resources or modes of communication available to them
    b. Non-corporate/standalone facilities must use other strategies (public and private dollars)
    c. HCC's have started looking at how LTC facilities can work with liaisons, but there is still a lack of awareness and variation on how they fit into their community healthcare structures.

3. The COVID-19 takeaways, what did we learn in long-term care facilities for the next time?
    a. Issues with visitation policies
    b. Financial considerations – are patients paying for facilities and hospitals if transferred?
    c. Transfer/discharge rules were not clear between hospitals and facilities

Public Communication

1. 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?
    a. Some states have already considered this; however, background checks, HIPAA, paperwork and school contracts may need to be in place if there is an ongoing relationship
        i. Risks to organizations if a volunteer was infected would need to be researched
    b. AAAs have helped distribute tablets to increase socialization opportunities, however, there needs to be concise communication and willingness of a coordinated effort

2. Are community organizations able to subscribe to KsHAN? How many are currently signed up?
    a. KsHAN is limited to medical providers and LTC staff due to the information that is shared
    b. There are approximately 2,000 subscribers currently, with the ability to have 3,000 on the network
    c. VA Department of health created a regular communication protocol with their faith-based organization to get them accurate information that could then be transmitted to those who trust those organizations
        i. https://www.vdh.virginia.gov/health-equity/partners-in-prayer-and-prevention-p3/

3. Could Kansas create a statewide, publicly accessible Emergency Alert Network for public messaging during a crisis?
    a. During COVID, KDHE had a hotline that handled 1,000-1,500 calls per day; hotline is still active
    b. Consensus that messages are typically better received when someone at the community level delivers it, but they do not always have the skills, knowledge or resources to do so
    c. With a decentralized state like Kansas, it is hard to make a statewide effort – may need to be done at the local level

4. Would a Plain Language Glossary or Messaging Map with tips for clear and concise messaging for different populations be helpful during a crisis?
    a. Overall, this would be helpful as some information that gets pushed to providers is not in a format that can be shared with the public