Crisis Standards of Care
Public Communication
Technical Assistance Panel Meeting
March 16, 2023
9:00 am -11:00 am

Meeting Notes
Meeting Materials:
- Agenda
- Working Draft
- Environmental Scan

Agenda:
9:00 am – Task Overview and Workflow with Joint Meeting
9:05 am – Communicators – Managed Care Organizations (MCOs) and PACE Program
9:45 am – Review Responses from CAB and TAP
10:30 am – Brainstorm FAQs, additional resources and development of regional resource cards.
10:55 am – Questions for CAB and TAP at Joint Meeting
11:00 am – Adjourn

Attendees
Public Communication Task Team members: Ami Hyten, Topeka Independent Living Resource Center; Monica Cissel, Sedgwick County Department on Aging and Central Plains Area Agency on Aging; Dr. Dennis Cooley; Alice Weingartner, Community Care Network of Kansas; Irene Caudillo, El Centro

KDHE: James Roberts, Ed Bell

Guests: Lea Chaffee, Midland Care Connection; Darby Cochran Wilson, United Healthcare; Cynthia Houser, Aetna

KHI Staff: Hina Shah, Emma Uridge

Discussion with Communicators

Managed Care Organizations (MCOs) – United Healthcare and Aetna
Background: Guests from United Healthcare and Aetna discussed with task team members the role of care coordinators and whether they could be a resource to disseminate information when crisis standards of care are activated. The MCOs also reflected on lessons learning during the COVID-19 pandemic.
- **Care Coordinator Role.** Coordinators are responsible for coordinating services and providers to ensure smooth transitions between hospitals, nursing facilities, and homes for beneficiaries.
- **Advocate for Members.** Care coordinators are also involved in advocating for members during emergencies, including crisis interventions and natural disasters, and are able to communicate with members via phone calls, text, and by videoconferencing.
- **Hospital and Community Provider Requests.** MCOs indicated the importance of care coordinators being able to respond to requests for help from hospitals and community providers and discussed how their organization worked to locate nursing facility members during the COVID-19 pandemic.

- **COVID-19.** During the COVID pandemic, long-term care facilities were on lockdown and not accepting new members, so the team continued to support them with HCBS services and family support until they could be accepted.
- **Care Transitions.** Care coordinators, providers, and community health workers will help a member locate placements and move as needed. During a crisis, members can choose to live with loved ones or go back home, and the team works with them to identify the appropriate services and resources needed to support them. MCOs discussed that some members can go home quickly, while others take longer due to the need to find natural support, coordinate with care coordinators, and deal with the shortage of workers. During the pandemic, Community Developmental Disability Organizations (CDDOs) were instrumental when assembling a care team for transitions for people with intellectual and developmental disabilities.
- **Deciding to Transition Members.** MCO representatives noted that discussion with members about transitioning home are part of an ongoing process, and that quarterly Minimum Data Set (MDS) assessments are established for members to update their preference. These touch points provide opportunities to discuss whether the member wants to go home and if they need assistance with housing, food, or other necessities. A functional care assessment is used to determine if a resident can go home.
- **Surge Information:** MCOs noted that during the COVID-19 pandemic, they did have information about what facilities were letting people in, infection rates, bed levels and what facilities were on diversion – no longer taking new patients and diverting patients elsewhere.
- **Discharge Planning.** MCOs discussed not knowing when residents were quickly discharged from a hospital during the pandemic. MCOs can assist with care transitions and discharge planning if they receive a notification.

Program of All-Inclusive Care for the Elderly (PACE) and Meal Services
Background: The Pace program provides care for elderly Kansans and includes physicians, nursing services, home care services, therapy, social work, recreational therapy, necessary medications, and medical equipment.

- **Program Eligibility.** To be eligible for the program, the person must be 55 years or older and live in the county where the Pace program is provided, and be nursing home-eligible as indicated by the care assessment.
- **Communication Barriers.** Communication can be a challenge with seniors during emergencies, but they have a care access line that people can call during any emergency.
- **COVID-19.** PACE used virtual communication to overcome communication challenges during the pandemic.

Group Discussion on MCOs and PACE
Background: Group members discussed role of MCOs and PACE in crisis standards of care guidance.

- **Reliable Information.** Group suggested that all stakeholders should be included in the communication process, and it is up to each stakeholder to take on a role with which they are comfortable.
- **Modes of Communication.** The communication to individuals on the Home and Community Based Services (HCBS) waiver is typically through a letter, but sometimes care managers may connect with individuals who are unable to read or speak a different language.
- **Staff Capacity.** Group discussed how staff levels may affect ability to communicate with members.
- **Statewide Operations.** MCOs operate on a statewide level and facilities should consider inviting a diverse group of stakeholders during a crisis.

- **Single Message.** The group discussed the need for a "single message" approach, with accurate information to be disseminated to the groups in plain language.

Emergency Planning for Long-Term Care Facilities
Background: The group discussed emergency planning for long-term care facilities. The participants discussed the importance of identifying key local contacts for crisis situations and making sure the organizations involved in emergency planning are included in the emergency plan.

- **Facility Plans.** Every long-term care facility has an annually reviewed emergency operation guide. The Fire Marshall is tasked with review.
- **LTC Task Team.** The long-term care facility group is requesting help in identifying who to call during an emergency.
- **Populations Served.** The group also discussed the importance of knowing the population the facility serves, including different languages and cultural backgrounds into communication considerations.

FAQ Section and Questions for Consideration
The task team proposed the following consideration:
The group agreed that accurate and specific information should be disseminated by as many entities as possible.

- **Questions for Public Information Officer (PIO).** Group discussed having a list of questions that the PIO spokesperson should know. Group may consider having a list of questions in a question format instead of bullet points or paragraphs.
- **FAQ Section.** The group agreed that some FAQs in the appendix can provide detailed answers.
- **Legal Liability.** Communication guidance should keep in mind wording questions and draft messaging carefully to avoid creating liability issues for facilities.

Training Organizations
The task team proposed the following consideration:
The Public Information Officer or spokesperson should consider working with community-based organizations and the Area Agencies on Aging (AAAs).

- Training for organizations can be administered to help move the messages forward to their respective constitutes and those they trust. KDHE will be proposing training in the next fiscal year.
- The training could include how messages must stay consistent when released by a lead PIO group (if applicable for area of the state).

Wrap Up and Adjourn

Action Items

- Members were asked to identify Draft Lead for the question considerations section for the Public Information Officer.
    - Current tables around Stakeholder Information Sharing Systems and Partnership and Statewide Information Sharing Systems tables will be modified into questions for consideration as a starting point for the draft.

- Review questions in ASPR Tracie document to consider added to guidance or FAQs. Crisis Standards of Care Brief: Public Messaging (2022). ASPR Tracie.
- KHI will review state plans and the KS Response Plan for FAQs and questions to consider.