Roles and Responsibilities (*from Phase 1 guidance*)

The hospitals and hospital systems involved in treating patients during crisis may be different in size and location. Some will be large hospitals located in big cities. Some will be smaller hospitals located in towns in rural areas of the state. Even with these differences, personnel in every size of hospital must be prepared to decide who gets scarce medical resources and when. The KSCSCG gives recommendations to hospitals about who might be assigned to do the work of helping their facility respond in crisis. The KSCSCG includes general descriptions of the kinds of employees who should be doing specific tasks and how those types of employees should be prepared before a crisis happens.

Communication Systems (*from Phase 1 guidance*)

Communication is one of the most important parts of responding to crisis. Trust in medical systems is built when there is clear communication about how the system is responding to crisis. Community members are better able to make decisions about how they will use the hospital or medical system if they have an understanding about whether the hospital is operating under crisis standards, and if so, what that means for patients. The KSCSCG provides recommendations for communications to the public at large. The KSCSCG also offers suggestions for how individuals in the system will receive information about decisions that impact the care that is available to them.

The section outlines the communication pathways during the activation of CSC to direct and coordinate communication activities.

Steps to Build Capacity for Crisis	
Conventional	**Contingency**
• Communication strategies should be tailored to meet the needs of individuals with limited English proficiency, individuals with disabilities and those with limited access to healthcare services and providers. Messages should use plain, linguistically and culturally appropriate language. • Community members should be notified about the level of resource availability, hospital emergency level, and triage process in plain language, using multiple different communication methods including, but not limited to, email, radio, television, text, calls and websites. • Patients and patients' families should be informed about the process in a timely manner in which resource allocation decisions are made. • KDHE will explore the feasibility of collaborating with partners, including community organizations around the state, to provide education and training to the public around the crisis standards of care. • Communicate discharge instructions in the patient's preferred language. Provide written materials at an appropriate literacy level (5th grade or lower whenever possible) and in the preferred language of the patient and/or caregiver. Simply translating written instructions may be insufficient to ensure patient understanding. • Ensure that patients with limited English proficiency, including those who use sign language, are aware of and have access to professional medical interpreter services during inpatient stays, during discharge, and when accessing post-hospital care.	

Note: The above recommendations may also apply during crisis.

Steps to Build Capacity for Crisis
Conventional
• Connect patients with community-based resources such as adult day health programs, personal care, home-delivered meals, and services that address social determinants of health (e.g., housing and food security, transportation, employment) and financial barriers that disproportionately affect racial and ethnic minorities. • Connect uninsured and underinsured patients with supplemental health insurance, when possible. • Encourage social support through community connections, use of health information technology, and community-based interventions that reduce social isolation and loneliness. • Facilities should have a human resource plan to recruit and retain people from excluded communities so a greater pool of potential team members that reflect the community's demographic are available. • Engage family and patients in discharge planning. • Listen to and make efforts to honor the patient's and family's goals, preferences, observations, and concerns. • Ensure that patients with limited English proficiency, including those who use sign language, are aware of and have access to professional medical interpreter services during inpatient stays, during discharge, and when accessing post-hospital care.

Statewide Information Sharing Systems *(consider adding for Phase 2)*

System	Description	System Administrator	Target	Modes of Communication
Kansas Health Alert Network (KsHAN)	KS-HAN is an invitation-only, internet-based, secure, emergency alerting system that allows general public health and emergency preparedness information to be shared rapidly.	Kansas Department of Health and Environment	Federally Qualified Health Centers, Community Developmental Disabilities Organization, Mental Health Centers, Local Health Departments	Email, work and cell phone and SMS text
System for Emergency Response Volunteers in Kansas (SERV-KS)	The System for Emergency Response Volunteers in Kansas is a web-based alerting, management, and credentialing system for the	Kansas Department of Health and Environment, Kansas Medical Reserve Corps (MRC) Unit Leaders	Volunteers of all backgrounds	

System	Description	System Administrator	Target	Modes of Communication
	management of volunteers.			
EMResource		Kansas Department of Health and Environment	Hospitals and Emergency Medical Services	
Communication System used by KDHE + KDADS + DCF			State agency administrators	

Stakeholder Information Sharing Systems and Partnerships *(consider adding for Phase 2)*

System Administrator	Description	Partnership(s)	Target	Modes of Communication
		County Emergency Management	HD Hospitals etc.	
		Healthcare Coalition (HCC)	Emergency Management System, Member facilities (hospitals, LTC), Health Departments, Emergency Medical Services	Facebook, Twitter, Distribution lists
Kansas Association of Area Agencies on Aging (K4AD)	K4AD oversees the eleven Area Agencies on Aging and the Aging and Disability Resource Centers in Kansas to ensure all Kansans have dignity, health, independence, and enduring self-sufficiency.	EOC Partners group in Sedgwick Local Health Departments	Area Agencies on Aging, Adults 60+, unpaid and professional caregivers, Aging and Disability Resource Center, persons with disabilities; BI; general public	Facebook, Local newspapers, Newsletters, Advocacy distribution list, Silver haired legislators
El Centro	linguistically and culturally responsive	LHD Kansas Department of	Hispanic Populations	Spanish language radio, Facebook, some

System Administrator	Description	Partnership(s)	Target	Modes of Communication
		Health and Environment		Spanish language newspapers
Kansas Statewide Homeless Coalition		Local Health Departments	Provider agencies that provide direct services to those experiencing homelessness	Facebook KSHC website Canva Constant contact Text messaging School districts (liaisons)
Kansas Long-Term Care Ombudsman	A Long-Term Care (LTC) Ombudsman is a designated individual or organization responsible for advocating for the rights and well-being of residents of long-term care facilities, such as nursing homes and assisted living facilities.		The inclusion of the long-term care ombudsman is critical to facilitate communication between family members, multiple providers and the residents.	Operates on complaint-basis only

Resource Load Balancing Communications (consider for Phase 2)

Agreements Between Facilities

Use of EMResource

General Public

- Hospital – Public Information Officers
- Nursing Homes
- EBP/PP considerations

Public Information

In events leading to the crisis standards of care being declared, hospitals should notify community members about the level of resource availability (i.e., what resources are limited), hospital emergency level, and triage process in plain language, using multiple different communication methods including, but not limited to, email, radio, television, text, calls, websites and social media platforms (e.g., Twitter, Facebook, Instagram, and TikTok). Whatever communication method is used, accessibility in the form of captioning, transcription, American Sign Language (ASL), large print, and Braille must be included. The hospital's public information officer (PIO) (or equivalent) should ensure that communication strategies are tailored to meet the needs of individuals with limited English proficiency and individuals with

disabilities, and that messages use plain, linguistically and culturally appropriate language. In addition, PIOs (or equivalent) should ensure that patients are notified of this information when they arrive at the hospital. Hospitals also should consider developing guidance for when and how patients should seek care while CSC is activated. Hospitals should collaborate with community partners such as nonprofits, community advocates and local government officials to develop and distribute this information.

Communication Resources (Lead: James Roberts)

Flow Chart (Appendix item?)

Message Map (Appendix item?)

Scenario:
Target Population:
Stakeholder(s):
Concern:

Key Message 1	Key Message 2	Key Message 3
1.1 Support Point	2.1	3.1
1.2		
1.3		

Plain language Glossary (Appendix Item?)

Technical Term/Phrases	Plain Language Term	Description

Communication Resource Allocation Decisions

If crisis standards of care are declared, the medical team should make patients and families aware of the declaration as early as possible in the admissions process and, if possible, prior to admission to an ICU. Once a final triage decision and allocation of scarce resources has been determined, the information needs to be clearly communicated to the patient and their family using plain, linguistically and culturally appropriate language per facility protocols.

Depending on staffing availability, the hospital should determine who would be designated to communicate the information to patients and families, which in most cases would be the medical team. Hospitals also should consider providing additional support for providers who are delivering difficult news, in order to reduce the risk of burnout and moral distress. Triage decisions may not strictly follow a clinician's or patient's preference. They are enacted only in the time of crisis. However, at all times,

patients should be treated with respect and compassion regardless of CSC triage decisions. The goal of the communication team is to ensure that final decisions and allocation processes are communicated clearly to patients.

Communication Team

Only if additional resources are available, hospitals may explore the development of a communication team, separate from the Triage Team, to support staff who are delivering difficult news as well as ensuring the news is communicated in plain, linguistically and culturally appropriate language. Adapted from the *Washington State Crisis Standard of Care Triage Team Operational Guidebook* (WA CSC), the goals of the communication team are to ensure that final decisions and allocation processes are communicated clearly to patients and to provide additional support for providers who are delivering difficult news, in order to reduce the risk of burnout and moral distress. However, it is understood that this is dependent on staff availability at hospitals since not all hospitals may have enough resources to support the team. If the hospital does have the resources for a separate communication team, this team should be available to support the bedside medical team and the communication of triage-related decisions to families. This communication strategy will need to be collaborative between the communication team, the Triage Team, and the medical team to ensure the communication team has sufficient clinical information.

If a hospital considers developing a communication team, the following are recommended background and experiences for the team, as adapted from the WA CSC:

- Have a background in community health, case management and social services, social work, health ethics and supportive palliative, and spiritual care, and/or behavioral health, and have participated in goals of care discussions or similar types of transitional care conferences including end of life.
- Must have the ability to express difficult decisions simply and plainly, in a culturally and linguistically appropriate way, as well as the ability to explain to non-medical audiences the basics surrounding the difficult decisions required during crisis standards of care.
- Must understand the triage process and the underlying tools and principles for how decisions are made in order to address any questions or concerns that arise from the patient and/or their family in a transparent manner.

Long Term Care Communications (consider for Phase 2)

Staff And Service Entities

- Corporate
- Private

Residents

Family Members and Loved Ones

Communications Considerations by Population

- Older Adults

- Older Adults in Rural and Frontier Areas of Kansas
- Older Adults in Non-Nursing Facilities
- Older Adults Receiving Home and Community Based Services

Equity Considerations by Population

- Deaf and Hard of Hearing Populations
- Refugee/immigrant (cultural/structural barrier)
- Rural and Frontier

Other staffing sources

Section will describe other staffing sources that can be utilized when crisis standards of care are activated in long-term care facilities.

- Community Health Workers (CHWs)
- Social Services
- Medical students
- Public Health Students
- High-school students
- Volunteers (e.g., RSVP; Americorps; campus – more independent residents)

Talking Points and FAQs

As part of the communication to patients and families, it is important to relay information in a compassionate and understandable way. The KSCSCG provides "Talking Points" or frequently asked questions (FAQs) handouts that can be used and given to the healthcare staff, patients, and their families. These documents should be readily available at any conventional-contingency-crisis (CCC) level of care for healthcare staff and communities to access. The following should be considered:

- Provide the patient and family with mental health resources.
- Provide the patient and family with alternative options or resources if current hospital resources are unavailable, which includes getting help for patients and families for advance care planning to name and agent and document treatment preferences (i.e., living will).
- Provide the patient and family with supportive and palliative care and/or hospice care contacts and referrals.
- Obtain contact information for a designated family member and schedule specific follow-up discussions as needed.
- Contact the patient's primary care provider and notify them of any resource allocation decisions and plans.
- For more information on CSC talking points for healthcare staff, please refer to Appendix F: Crisis Standards of Care FAQ for Healthcare Staff [Template] for a template of talking points that can be modified to best meet hospitals' needs.
- For more information on CSC talking points for patients and families, please refer to Appendix G: Crisis Standards of Care FAQ for Patients [Template] for a template of talking points that can be modified to best meet patients' and families' needs.

Appendices

Appendix A. COVID-19 Experience

During 2019 through nearly the end of 2021, the United States was gripped in a biological battle that has not been seen since the avian virus called H1N1 sparked the worldwide Spanish Flu pandemic of 1918. This new pandemic, driven by SARS-CoV-2 and its variants, affected 516 million people worldwide and generated 6.24 million deaths per the Centers for Disease Control and Prevention's pandemic tracking numbers for the early part of May 2022. Over the decades, improvements have been made in public health initiatives, medical science, and research, and the public's knowledge of viruses has increased. These improvements helped combat the virus as it spread like wildfire across the globe. The downside of this increase in knowledge was the creation of disinformation and misinformation based on biased opinion and general distrust of the government regarding how the virus worked, what the disease process was, and how to prevent it. This atmosphere was furthered by ongoing supply chain issues, equipment shortages, medical staff burnout and shortages which worsened as each new variant washed across the globe.

Initially, Kansas healthcare coalition (HCC) response was limited to the parameters of their response plans. However, this changed quickly once KDEM, through KDHE, determined that the HCC members along with their Readiness and Response Coordinators (RRCs) and Clinical Advisors (CAs) would be an additional source of information and resource management from the field. The HCCs began to expand their response plan capabilities and enhanced the state's response by providing additional patient information and situational awareness to the state's Emergency Operations Center (SEOC). This led to several additional activities that the HCCs were asked to assist the state in the response effort.

Information Sharing *(consider modifying for long term care for Phase 2)*

The HCCs provided a source of field information to the state that served to provide additional information to what the state's hospital association was reporting. The RRCs were able to report needs and concerns through KDHE which were included in the daily briefings with the SEOC. Their reporting to the SEOC helped to improve the SEOC's and KDHE's situational awareness.

This level of involvement proved important later into the second year when staffing shortages became a major issue. RRCs and HCC members were working within their own regions as well as outside their regions to assist with the rapid placement and transport for those patients who had transitioned into a post-acute care setting. During the Delta and Omicron surge, HCC members were aware that hospital bed tracking and allocation efforts to find appropriate beds either in the state or outside of it had become strained. HCC RRCs worked with their contacts and networked with associates to assist in identifying additional beds.

The seven HCCs all presently have access to the state information sharing platform. This was a primary mode of communication between the hospitals in the state as well as a platform that the RRCs had access to. During the pandemic hospitals have been required to meet additional federal reporting requirements in which multiple databases need to be updated on a regular basis. One challenge to this is that not all reporting systems are linked electronically which can create a situation where duplicate entry into multiple systems is required. Unfortunately, the state platform did require duplicate entry, which many facilities found taxing due to the pandemic, and the use of the state platform was overshadowed by the additional reporting requirements. When the state platform was de-emphasized, the hospitals and RRCs lost a source of useful information. As a result, the HCCs purchased an additional

communications system to assist with the communications and information sharing between the HCCs and their members.

Patient Movement and Transportation *(consider communications strategies for Phase 2)*

While the HCCs and HCC RRCs were not asked to assist with this, there were growing concerns and issues from acute-care providers and facilities with finding and transporting patient out of an acute care setting to a post-acute care setting. When holding times were leading to days of delays, some critical access hospitals (CAHs) were being forced to act as impromptu ICUs and holding facilities which caused patient care and transport back-ups to occur. The RRCs, with their HCC members and clinical advisors, worked to develop a transfer document that would assist in hand-off processes, assisting acute care facilities with finding appropriate staffed post-acute care beds for those needing them, and worked with emergency medical services (EMS) to provide transportation for patients once those beds were located and locked in. This effort, when combined with the memorandums of understanding (MOUs) and other agreements, helped to ease this problem during the peak times of the pandemic.

Appendix B. Preparation Before Crisis

Communication Systems

- **Communication strategies should be tailored to meet the needs of individuals with limited English proficiency and individuals with disabilities. Messages should use plain, linguistically and culturally appropriate language.*
- **Community members should be notified about the level of resource availability, hospital emergency level, and triage process in plain language, using multiple different communication methods including, but not limited to, email, radio, television, text, calls and websites.*
- **Patients and patients' families should be informed about the process in a timely manner in which resource allocation decisions are made.*
- **KDHE will explore the feasibility of collaborating with partners, including community organizations around the state, to provide education and training to the public around the crisis standards of care.*
- **Communicate discharge instructions in the patient's preferred language. Provide written materials at an appropriate literacy level (5th grade or lower) and in the preferred language of the patient and/or caregiver. Simply translating written instructions may be insufficient to ensure patient understanding.*
- **Ensure that patients with limited English proficiency, including those who use sign language, are aware of and have access to professional medical interpreter services during inpatient stays, during discharge, and when accessing post-hospital care.*

Appendix C: Roles and Responsibilities Detailed Chart

Roles and Responsibilities of Different Entities During Crisis

ENTITIES	ROLES	RESPONSIBILITIES
Hospital Administration	Development of Crisis Standards of Care	1. Develop CSC protocols for EMS and healthcare. 2. Identify priorities for allocating scarce resources (e.g., space, staff, supplies). 3. Activate CSC. 4. Ensure communication to local officials and community. Other Responsibilities: 5. Develop a human resource plan to recruit and retain people from populations of focus so a greater pool of potential team members that reflect the community's demographics are available. 6. Ensure that patients with limited English proficiency, including those who use sign language, are aware of and have access to professional medical interpreter services during inpatient stays, during discharge, and when accessing post-hospital care.
Healthcare Coalition (HCC)	Regional; Communication Between Hospitals	HCC Readiness and Response Coordinator- liaison to their region, assists with information sharing within the region as well as provides real-time updates with the response authority, same information provided to KDHE; assists with resource management at the HCC level and provides that information into the incident command system (ICS) operations section; provides additional support to patient movement and can coordinate transportation to patient-appropriate bed; provides additional situational awareness to the response authority regarding patient, resource/staffing issues, and bed availability.
Scarce Resource Allocation Team	Resource Management	1. This is a functional team under existing incident command system (ICS)/hospital incident command system (HICS)/emergency operations. It should not be a separate structure. 2. Acquire the information necessary to facilitate and oversee informed and ethical triage and scarce resource allocation decisions. 3. Make judgments in collaboration with healthcare organization leaders and staff to implement appropriate alternative standard protocols of care that address the special demands that an emergency imposes on the healthcare organization or demands that could imminently be expected. 4. Meet often, at least daily, during an emergency. 5. Advise and assist, as required, and make definitive decisions, if necessary, to resolve uncertainties and disputes that affect the healthcare organization's capacity to carry out its mission during an emergency. 6. Be involved in the real-time appeals process regarding triage decisions described in this document (excluding decisions made by members of the Triage Team that should not be subject to appeal). 7. Prepare information briefs to the chief executive officer, chief of staff or designee(s) about the emergency's status and the healthcare organization's response so that the information may be communicated to appropriate staff and stakeholders.
Triage Team and Team Lead	Triage	Triage Team: 1. The Triage Team will monitor survival to discharge for patients on an ongoing basis, and revise recommendations based on any changes. All hospitalized patients should be subject to continual triage, and there should be no distinction between decisions to initiate use of scarce resources and decisions to discontinue the use of scarce resources. Triage decisions should be applied to all hospital patients, regardless of their underlying condition. In other words, pandemic or disaster victims

ENTITIES	ROLES	RESPONSIBILITIES
		do not represent a special class, even though they may represent a temporarily large population of patients. 2. The Triage Team should meet at least daily (or more often as needed) to collate information, assess all patients who have clinical indications to receive life-saving scarce resources, and discuss triage decisions. 3. The Triage Team should maintain a record of all patients discussed, the data upon which triage decisions are made, outcome of the discussion, documentation of communication with attending physicians, and documentation of actions taken and the timing of those actions. 4. The chair or a designated member of the Triage Team, the Triage Team Lead, should be available at all times. However, it is understood that treatment decisions must, in many circumstances, be made quickly. Treating clinicians should specifically not be concerned with resources or triage criteria, but only with their patients' treatable conditions. Appropriate clinical actions should be taken, with Triage Team review to follow, unless patients presenting to the emergency department (ED) meet any of the allocation non-survivability criteria in bold in Appendix D. In such a circumstance, allocation of scarce resources would not be made available but supportive comfort care measures would be maintained. 5. Daily triage decisions should be communicated with attending physicians. For triaged patients who will not receive life prolonging treatments, comfort measures will continue, and palliative care consults will occur as available. Transition to comfort measures only should be undertaken as soon as possible. No patient abandonment will occur. Attending physicians may consult the palliative care service, at their discretion, if one is available. Withdrawal or withholding of scarce resources should optimally be undertaken within two hours of the communication. Triage Team Lead: 1. Lead the Triage Team in day-to-day operation. 2. Appoint a representative to lead in their absence. 3. Be the primary triage contact for hospital incident command. 4. Preferably, have experience in urgent decision making in life-threatening circumstances and in the appropriate discontinuation of life-sustaining measures. The composition of the Triage Team will depend upon the size of the hospital, and whether sufficient personnel are available to both care for patients and perform blinded triage. Some small hospitals may cooperate with larger hospitals for triage assistance. Please see the section in this document titled: Triage and Management of Resources, subsection: Triage Team/Team Lead, for a list of recommended team members.
Triage Oversight Group	Triage Appeal Process	1. Does not have the authority to change a decision made by the Triage Team, except when there is clear evidence that the triage protocol was not applied as planned. 2. Should be appointed by the CEO or, at their direction, by Incident Command and should include no more than three members. Recommended members are the CMO, COO or CNO, and hospital counsel. 3. Should entertain appeals only on the basis of: a. Adherence to the defined procedure by the Triage Team. b. Information that would change the objective data available to the Triage Team. 4. May request additional deliberation by the Triage Team, if it believes that the initial decision was lacking in either aspect listed above.

ENTITIES	ROLES	RESPONSIBILITIES
		5. Will regularly review Triage Team decisions for adherence to protocol, equity, etc.
Treating Clinicians	Acute, Emergency, and Palliative Care; Includes Advanced Practitioners	1. Should not have the responsibility of deciding whether to institute or remove a patient from life-saving resources. This is the role of the Triage Team/Triage Team Lead. These functions should be kept separated to reduce the emotional impact of these decisions on healthcare providers. 2. Will implement a treatment plan consistent with the Triage Team's decision regarding patient triage category. 3. Will conduct a DNR discussion with patients who do not qualify under the triage protocol for scarce life-saving resources. 4. Will offer palliative and other appropriate care, consider use of Transportable Physician Orders for Patient Preference (TPOPP)/ Physicians Orders for Life Sustaining Treatment (POLST) processes. ***Emergency Care*** 1. Apply initial resuscitation, if applicable, with simple measures such as fluids oxygen by nasal cannula, mask, and control of bleeding, etc. (unless other exclusion criteria are present). 2. Report initial assessment to the Triage Team.
Governor and County Commissioners	Emergency Order	1. Enact executive and/or local emergency orders.
Kansas Department of Health and Environment (KDHE)	State Agency Support for Crisis Care	To support the regional needs to the state and to provide guidance regarding crisis standards of care activation at the local level.
Emergency Management	State and County Support for Crisis Care	1. Lead response and recovery. 2. Operational management and support.
Community Liaisons (Communication Information Officer/Public Information Officer)	Community Engagement, Education and Communication Activities	1. Engage community members though community conversations and other ways to understand concerns and provide this information to hospital staff. 2. Work with hospital to ensure its transparency and accountability to the approach decided upon. 3. Notify community members about the level of resource availability, hospital emergency level, and triage process in plain language, using multiple different communication methods. 4. Connect patients with community- based resources that address social determinants of health, persons with physical and mental disabilities, and financial barriers that disproportionately affect racial and ethnic minorities. 5. Work with community organizations to develop clear, culturally and linguistically appropriate educational information and guidance for patients and to disseminate this information to the community.

Appendix F. Crisis Standards of Care FAQ for Healthcare Staff [Template]

The section was adapted from the Washington State Crisis Standards of Care Triage Team Operational Guidebook *and modified for the Kansas Crisis Standards of Care Guidance.*

What are Crisis Standards of Care?

In the *Kansas Crisis Standards of Care Guidance*, crisis standards of care (CSC) are defined as:

> *A document providing all-hazards guidance to regional and local healthcare entities during a disaster where timing and severity of the disaster make it difficult to predict and anticipate resource needs in an abbreviated timeframe. It would be used during a disaster event or any scenario causing either a short-term or long-term strain on resources – like intensive care unit (ICU) beds, staff, medical equipment, or proper personal protective equipment (PPE) – that impacts patient care for those requiring critical or acute care.*

CSC happens when there are not enough healthcare staff, space, or supplies to provide usual care to patients. Usually, this is related to an event when there is a large number of people needing care, such as COVID-19. When circumstances such as a catastrophic incident or a disaster occur and the healthcare system becomes overwhelmed, it enters "crisis standards of care." The goal of planning for crisis standards of care is to consider all options and work to mitigate the need to implement CSC.

When a facility becomes overwhelmed and has difficulty providing care in the way it typically would, it takes steps to modify care. Those might include adjusting standard staffing approaches, asking staff to work and perform care outside of their normal duties, treating patients in spaces not usually used to provide care, and not having access to supplies such as masks and other personal protective equipment, sometimes requiring that they be re-used. This is called contingency care and is an essential part of planning to avoid CSC.

If a hospital simply cannot manage the number or the severity of patients, it may reach out to other hospitals and transfer patients to another facility if that is possible. However, it may not always be possible to level-load when all facilities across the region and state are at the same level of patient surge and have the same critical resource limitations.

When all other options have been exhausted to adapt care in a hospital, and if all the other hospitals are in the same position so that there is nowhere to transfer patients, the healthcare system moves into CSC. CSC means that difficult decisions have to be made about who gets certain kinds of care, and there are not enough resources to provide care to all patients in the way expected.

How was Crisis Standards of Care Planning Developed?

Planning and discussions about the most equitable ways to provide care to as many people as possible when experiencing CSC has been ongoing for several years both locally and nationally. Many physicians, nurses, other hospital and outpatient staff, emergency planners and experts on ethics have wrestled with these hard decisions.

The *Kansas Crisis Standards of Care Guidance* is the state's second effort addressing issues of scarce resources during disasters. The first iteration of the plan in our state was the *Guidelines for the Use of Modified Health Care Protocols in Acute Care Hospitals During Public Health Emergencies,* which was

developed in 2009 with the final version being completed in 2013. With the occurrence of the COVID-19 pandemic in 2020, it became clear that most CSC plans in the country, including the plan in Kansas, had significant gaps. Many sources have been used in the development of this new plan, such as literature reviews, input from medical/healthcare experts and community stakeholders, focus groups and key informant interviews. Hospitals may elect to use the CSC guidance document to create a standard operating procedure during a disaster. These voluntary guidelines may be used as the basis for healthcare providers and systems to make decisions on care, in as equitable a way as possible, when there aren't enough resources, and a surge in patients.

How Does the Triage Process Work?

In crisis standards of care, if there are a number of patients who would normally be admitted to an intensive care unit (ICU) or perhaps a burn unit, requiring special care, procedures and medical equipment (e.g., a ventilator), and if there are not enough beds, staff, or equipment to provide that level of care to all of them, those patients would be referred by their treating physicians to a Triage Team.

The Triage Team is comprised of experienced medical personnel and a medical ethicist. The Triage Team evaluates patients and then must decide who would get the scarce resource, based on hospitals' triage process and protocols. The composition of the triage team will depend upon the size of the hospital, and if insufficient personnel are available to both care for patients and perform blinded triage, some small hospitals may cooperate with larger hospitals for triage assistance.

In the Triage Team, physicians may participate in triage team activities during periods when they are not actively caring for hospital inpatients, but not when they are engaged in patient care. However, palliative care team members will not participate in triage team activities. Patients who have experienced barriers to health care access in the past because of socio-economic, race, or other characteristics should not be further disadvantaged through the facility's scoring system. The triage team will not have access to the information that leads to the scores, to minimize individual identification of patients. For example, if two patients needed an ICU bed or a ventilator and one of them had no pre-existing medical conditions with the exception of the current illness and the other person had additional medical comorbidities, they would be evaluated using the same criteria of the likelihood of survival if given the scarce resource.

Patients who receive the scarce resource after being screened by the Triage Team will be reevaluated every 24 hours. If further demands on the resource continue, the patient will continue to be re-triaged based on how they are progressing clinically with the resource. Reallocation of the scarce resource may occur if other patients are evaluated and considered to have a higher likelihood of survival to discharge.

What Are Next Steps After Triage?

Understanding why care options may have changed and resources need to be allocated can be very difficult for healthcare providers who have been trained, and expected, to provide all appropriate care to all patients.

When care has to shift from conventional care to the adjustments made during a disaster, care should be offered at the highest level to ALL patients.

The types of care may differ from person to person, depending on the severity of their illness, other factors (such as whether staff or equipment is available), and the level of care needed. For example:

- Some patients who might ordinarily be admitted to an intensive care unit may need to be cared for on regular medical floors.
- Some who would usually be admitted to the hospital might instead be sent home with care planning for the home setting.
- Some will need to be treated with other methods because not all procedures or equipment, such as ventilators, will be available to all patients.
- Some patients have an extremely low chance of surviving their illness, in spite of all efforts to save them, or may not want care. Those patients will be offered palliative care, home hospice care or other care aimed at managing their pain and distress effectively and providing support to them and their families.

All Triage Team members and all staff who must be engaged in CSC are encouraged to allow some time for self-reflection about their roles and experiences. Be mindful of engaging in regular self-care practices and reach out for additional support if needed. More information can be found below:

Disaster Distress Line to speak to someone and obtain support related to working in a disaster: https://www.samhsa.gov/find-help/disaster-distress-helpline

Post-Traumatic Stress Disorder (PTSD) Coach and other mobile apps to help manage symptoms of stress: https://www.ptsd.va.gov/appvid/mobile/index.asp

National Suicide Hotline: https://suicidepreventionlifeline.org/talk-to-someone-now/

If you have thoughts or concerns about what you've learned, please reach out to the Communication Information Officer for your hospital.

Appendix G. Crisis Standards of Care FAQ for Patients [Template]

The section was adapted from the Washington State Crisis Standards of Care Triage Team Operational Guidebook and modified for the Kansas Crisis Standards of Care Guidance.

What are Crisis Standards of Care?

Crisis standards of care (CSC) happens when there are not enough healthcare staff, space, or supplies to provide normal care to patients. Usually, this is where a large number of people need care, such as a pandemic or a disaster (natural or man-made).

When a lot of people need the same kind of help at around the same time, a hospital may become overwhelmed. The hospital and its staff may have difficulty providing care in the usual way. To meet the needs of patients, a hospital may need to take steps to adjust. Those might include assigning more patients to nurses than would normally be assigned, putting patients in spaces not usually used to provide care, and being careful to save supplies such as masks and other personal protective equipment.

If a hospital can't manage the number of patients or provide the right care for patients, it may reach out to other hospitals and move patients to another facility if that is possible.

CSC happens when all other options have been exhausted to adapt care in a hospital, and there is no other hospital to take the many very ill patients. CSC may mean that patients staying at the hospital will not all have full access to all types of treatments. Hospitals and their staff will have to make difficult decisions about who gets certain kinds of care.

How was Crisis Standards of Care Planning Developed?

Since CSC means that all patients will not receive the same access to treatments, people involved in disaster preparedness want to provide guidance for effective and non-discriminatory practices. Planning and discussions about how to provide care to as many people as possible and not unfairly exclude some people during CSC has been ongoing for several years both locally and nationally. Many doctors, nurses, hospital and outpatient staff, people who plan for emergencies, and experts on ethics have wrestled with these hard decisions.

Those individuals also have looked at planning and care decisions from healthcare organizations across the country. The groups also have considered the recommendations from experts within the scientific and medical communities. The discussions have included experts on ethics, who help healthcare organizations make sure that the decisions are not based on racial or ethnic discrimination or based on the ability to pay or having a disability. In Kansas, the thoughts and considerations of people who use healthcare, especially people who may have experienced discrimination, were gathered and included for consideration.

As a result of this long-term and very thorough process, Kansas has created a CSC guidance document. The *Kansas Crisis Standards of Care Guidance* has voluntary recommendations to help hospitals create a procedure for how to make limited resources go as far as they can. This procedure is called "crisis standards of care." Hospitals use this procedure to help the doctors, nurses, and other healthcare

providers make decisions about how to help as many people as possible, without unfairly leaving any people out when there aren't enough resources (such as funding, services, supplies) to go around.

Many people around Kansas worked to make these recommendations equitable. Equity/equitable means that no person or group of people have greater barriers to getting the services and supports they need than other people experience. This may mean that all people are not treated the same in every situation. For some people, outside factors may influence their health. Outside factors could include poverty, discrimination, or a lack of access to housing, jobs, or healthcare. People who have these factors in their lives may not be as healthy as people who do not have these factors in their lives. In supporting health equity, the *Kansas Crisis Standards of Care Guidance* provides specific considerations to remove the influence these outside factors may have on how people may be offered limited hospital care or resources.

How Does the Triage Process Work?

Triage is a term used in hospitals to describe how patients (based on their symptoms) are moved into different types of care. Triage happens on some level in many emergency departments on a day-to-day basis. CSC uses the triage process in a more serious way. For example, if there are a number of patients who are very ill and would normally be admitted to an intensive care unit (ICU) or burn unit, requiring special care, procedures and medical equipment (such as a ventilator), and if there are not enough beds, staff or equipment to provide that level of care to all of them, those patients would be referred by their treating doctors to a Triage Team.

The Triage Team, made up of medical personnel and a medical ethicist, is responsible for deciding who would get the scarce resource (for example, a bed in a particular unit, or certain types of treatment like a ventilator).

The Triage Team does not know who the patient is. The Triage Team does not have direct information about the patient's race/ethnicity, sex (gender identity, sexual orientation), any disabilities, or financial status. Only the details about the patient's current medical condition are available to the Triage Team. This is so they can make their decision based only on the patient's medical condition, rather than other information that might impact their opinion. The Triage Team sees the exact same information for every patient under consideration. The information given to the Triage Team is only the information needed to help them decide if it is likely that the patient would survive, if they received the resource. So, for example, if two patients needed an ICU bed or a ventilator and only one is available, the two patients would be evaluated exactly the same way, using the same information in order to make this process as fair as possible.

If a patient comes to the hospital with their own personal medical equipment which includes medical devices the patient owns (for example, a catheter or ventilator owned by the patient), the hospital may give the patient different hospital equipment. However, the hospital will never take away a patients' personal medical equipment to give it to another patient to use.

What Steps Are Taken When There Are Too Many Patients?

Understanding why care options may have changed can be very difficult. It's perfectly normal and expected that families want all possible care options to be open and available for their loved one. Even when a Triage Team recommends a limited resource be offered to one patient over another, CSC recommend other care options to the patient who didn't receive the limited resource.

When care has to shift from "normal" care to the adjustments made during a disaster (CSC), we want to make sure that we are offering care at the highest level we can to ALL patients given the resources we have at the time.

The types of care may differ from person to person, depending on the severity of their illness, other factors, such as whether staff or equipment are available, and the level of care needed. For example:

- Some patients who might ordinarily be admitted to an intensive care unit may need to be cared for on regular medical floors.
- Some who would usually be admitted to the hospital might instead be sent home with a care plan to use at home.
- Some will need to be treated with other methods because not all procedures or equipment, such as ventilators, will be available to all patients.
- Some patients have an extremely low chance of surviving their illness, in spite of all efforts to save them, or may not want care. Those patients will be offered comfort care aimed at managing their pain and distress effectively and providing support to them and their families.

If you have thoughts or concerns about what you've learned, please reach out to a member of your loved ones' care team at your hospital.

Must I Always Agree to Receiving Medical Treatment or Resources?

All patients will receive information about the treatment, its risks and its benefits. Those who understand this information and do not wish to receive treatment can talk to their doctor about "opting out" of receiving treatment or resources.

Appendix H. Crisis Standards of Care FAQ for Long-Term Care Residents

Many older adults rely on visitors and family care for social support and to maintain their health, well-being, and safety in long-term care facilities, and therefore need to stay connected to their families.[1]

How can I talk to or see my family, friends and loved ones during a crisis?

Will my personal medical equipment be taken?

Appendix I. Crisis Standards of Care FAQ for Family and Loved Ones

Who do I contact to learn about a crisis?

Will access to my loved one change during a crisis?

[1] Hado E, Friss Feinberg L. Amid the COVID-19 Pandemic, Meaningful Communication between Family Caregivers and Residents of Long-Term Care Facilities Is Imperative. J Aging Soc Policy. 2020;32(4-5):410-415. https://pubmed.ncbi.nlm.nih.gov/32441209/