Crisis Standards of Care Phase II
Resource Load Balancing Task Team

May 04, 2023
2:00pm – 4:00pm

Agenda

2:00 p.m. Welcome
2:05 p.m. Review Joint Meeting Discussion
2:15 p.m. Check in on Draft Sections
2:25 p.m. Review and Refine RLB Recommendations
3:55 p.m. Next Steps

Attendees

Task Team Members: Dennis Cooley; Jan Kimbrell; Devan Tucking; Ron Marshall; Ami Hyten; John Cooley; Chrisy Khatib; Glenda DuBoise

KHI: Sheena Schmidt, Valentina Blanchard

KDHE: Rebecca Adamson; Ed Bell

Joint Meeting Review

- ***Task Team Updates:*** The discussion focused on resource turnover and the role the legislature could play in supporting long-term care facilities and hospitals recovering from the recent pandemic. Additionally, the conversation centered on the prevention of future pandemics and how to work towards that goal while still recovering from the current one.
- ***Draft Outline Updates***: The second part of the meeting reviewed the outline of the draft and emphasized the need to identify community network partners and their needs for effective resource load balancing.
- ***TAP Breakout:*** The session focused on specific populations that require additional considerations, such as pregnant women and maternity patients. The group discussed the need to include pediatric patients in the special group as they have different resource needs and care requirements. The discussion emphasized the importance of considering equity for all patients, not just special groups, and how to address transportation complexity, including transfers.
- ***CAB Breakout:*** The CAB group had specific points to address regarding resource load balancing, including defining it to include long-term care, identifying resource needs, and outlining a plan for resource distribution. There was discussion on these points as they relate to equity and who and how to include community-based organizations in the resource load balancing process.

Draft Sections

- ***RLB Definition:*** How do we weave equity into the definition?
    - The definition should address the issue of facilities being historically under-resourced and unequipped to handle crises.

- A suggestion was made for a quarterly check-in by an appointed person at each facility to a central person or place that would assess staffing levels and identify areas where the facility may need additional resources. This may help facilities from getting lost in the day-to-day operations and forget to plan for crises.
- It was noted that many facilities do not like sharing information unless asked, and some may cross-barter equipment during a crisis. He indicated that adding more people to the problem is not the solution, and many hospitals only do what is necessary to keep their doors open. However, a recommendation could be made in the draft, whether or not facilities follow it.
- A suggestion to include a recognition in the definition that there is a disparity in resources and that facilities in under-resourced areas may need assistance to provide quality care to their residents.
- A question was raised around existing mandates or rules in CMS or HHS that demand long-term care facilities to maintain a certain level of resources, even if they do not report on it.

- ***Community Network Partners***
  - Additional partners to include:
    - State organizations such as KDHE and KDADS
    - Adult Protective Services / Child Protective Services
    - AARP
    - Critical Access Hospital Networks
  - The group discussed the possibility of splitting the list into agencies that aid with resource load balancing for hospitals and those that are more related to public communication.
- ***Resources for Hospitals***
  - Hospital Supplies – the emphasis on not taking personal equipment from one patient to be given to another patient was discussed in Phase I and can be carried over to this section.
  - Alternative Care Sites – there was discussion on whether HCBS and in-home care options should be added as potential options to consider.
    - There are staffing considerations with this option.
    - The overall definition of ACS needs to be clarified, as an ACS would be a place that could be set up in case of an emergency, while in-home care and HCBS are already established services (e.g., setting up a school for treatment when a hospital is impacted by a tornado).
- ***Special Populations***
  - Resource-poor areas
    - Resource-poor areas refer to places where there is a lack of resources, including medical, and where accessibility to medical services is limited
    - The term “resource-poor” may not be the best wording to use, as there is not a clear definition or way to assess it. Alternative wording suggestions included “areas with a lack of resources” or simply, “lack of resources.”
  - Physical and Cognitive Disabilities

        - There are issues with transfers and documentation when dealing with cognitive disabilities, which can be exacerbated by distance and a lack of trained personnel.
        - This section will be addressed in other sections of the guidance (e.g., health passport) as well as the LTC Guidance, which we can provide links to in the RLB section.
    - Pregnant and Maternity Patients
        - This is an important section to add to the guidance.
        - A recommendation was made to also include post-partum considerations.
    - Mental Health Conditions
        - The group agreed to change this to "Behavioral Health Conditions" to include mental health and substance use disorders.
- ***Appendices***
    - Resource Challenges by Disaster Type
        - Additional Disasters should include:
            - Natural Disaster (Flood, Tornado, Earthquake, Wildfire, Windstorm, Dust Storm)
            - Man-Made Disasters (Power Outage, HVAC Outage, Water Supply, Security-based Event, Technological Hazards, Active Shooter, Civil Unrest in the Community, "Brownout," Supply Chain Issues, Train Derailment)
        - KDEM noted the top 10 disasters in Kansas:
            - Tornado
            - Windstorm
            - Winter Storm
            - Wildfire
            - Agricultural Infestation
            - Hailstorm
            - Hazardous Materials
            - Utility/Infrastructure Failure
            - Drought
        - This section could also refer/link to the Kansas Response Plan
    - EMS Triage
        - No discussion
    - Lessons Learned From COVID-19
        - Additional lessons may include:
            - The roles recognized during the pandemic, such as the role of local authorities, elected officials, etc.
            - Critical Access Hospitals acting as ICUs and holding facilities – challenging the assumption that their sickest patients could be transferred to regional medical centers. Their plans should not assume that you can always transfer patients out.

Recommendations

Recommendation	Task Team Discussion
91. Family Members as Decision-Makers Joint Meeting Wording: To prioritize the well-being of residents, facilities are encouraged to take all feasible measures to actively involve family members and caregivers in both the decision-making and transfer processes.	One participant suggests including language about different types of conversations in the recommendations, and making suggestions for staffing options. Another participant suggests including reminders for communication with families during emergencies and providing accurate information to avoid stress and confusion. A participant also distinguishes between acute care and long-term care, suggesting that the recommendation belongs in the population/residents section. Finally, it is suggested that communication with family members should also be a priority in hospitals when residents are in long-term care facilities.
101. Transportation Contingency Planning: Planning is recommended that involves collaboration with transportation services in case of a crisis involving multiple residents returning to the long-term care facility. This plan should address transportation for residents who may live far away or have limited access to transportation. **Proposed Added Language:** The use of other transportation options other than EMS including school bus, vans, etc. Considerations include condition of patients, equipment needed, credentials, depends on the disaster.	The participants talked about a contingency plan for transportation services during a crisis in which multiple residents need to return to a long-term care facility. The recommendation suggested collaborating with transportation services to address the challenges of residents located far away or with limited access to transportation. The participants discussed the feasibility of this recommendation and the challenges of providing transportation services, especially during emergencies or when resources are limited. They also discussed the possibility of using non-emergency transportation services such as funeral homes to transport residents, and the need to consider the type of equipment required for transportation based on the needs of the residents. The participants acknowledged that transportation is a challenge every day, and they agreed that a contingency plan for transportation during a crisis is important.

94. Transfer Team Joint Meeting Wording: Consider using a ~~dedicated transfer~~ team or staff member (in hospitals and long-term care facilities) to oversee patient transfers and ensure that all necessary information is communicated, and that follow-up communication occurs after the transfer. Ensure that individuals who are assigned as part of the transfer team have established communication with potential transfer sites and are responsible for providing oversight to the transfer process, including overseeing that all paperwork, such as medical and social needs, have been adequately communicated. The transfer team could consist of staff, social workers, ombudsman, or volunteers when feasible. Additionally, identify ways to address the feasibility of having dedicated transfer teams available 24/7, especially since transfers often happen outside of regular business hours.	There were some considerations on the feasibility of always having a dedicated person available, especially in small hospitals. The group discussed alternatives, and it was suggested that in a 24-hour facility, the charge nurse could take responsibility for overseeing transfers. It was also noted that the person in charge of the shift should be responsible for ensuring that the right information accompanies the patient during transfers. The group acknowledged that there is already an assigned individual for overseeing transfers, but there may be a need to reframe the idea to explore it further. A suggestion was made to pilot a project to explore this idea further.
100. Communication: Ensure clear communication and collaboration between healthcare providers, caregivers, and residents to ensure the best possible outcomes. This collaboration should involve follow-up care and communication between nurses in the hospital and long-term care facility. Improve communication between the hospital and caregivers by providing them with updates on the resident's condition and discharge plan.	Participants agree that this collaboration should follow up carrying communication with the nurses in the hospital. They also suggest that long-term care facilities should improve communication between the hospital and caregivers by providing them with updates on the patient's condition and discharge plan. There is a consensus that this should be the standard for all stages of care, as it is crucial to ensure the best possible outcomes for patients.
95. Universal documentation system: Develop and implement a universal documentation system to facilitate the exchange of medical information between facilities and hospitals.	The discussion highlighted the significant resource challenge in implementing a universal documentation system, and it was suggested that hospitals would choose to go with whatever system they wanted to use. The idea was referred to as "pie in the sky" and was considered not very feasible as long as there was a choice. A participant mentioned the creation of a whole industry in the last 20 years to address the issue of sharing health information, and the Federal Government has invested billions of dollars in healthcare systems in the United States. There was uncertainty about how this recommendation fits into the plan, given the significant resources that have been invested in the healthcare system already.

96. Technology Training: Provide training and support for staff on the use of technology, including electronic health records and video conferencing, to ensure effective communication between healthcare providers.	The discussion focused on two areas: the use of technology to communicate with caregivers and other healthcare professionals, and technical communication, such as sharing health records. Suggestions were made to have resources available or know where to quickly obtain them to respond to the constantly changing technology needs. It was suggested to have a list of partner entities that could help onboard technology quickly for a facility. An example was cited where the Assistive Technology Center of Kansas helped configure iPads and provided training, but they had to deploy the information quickly because people did not understand how to turn on the iPad.