Crisis Standards of Care Plan: Community Advisory Board Meeting

April 7, 2022

KANSAS HEALTH INSTITUTE

Informing Policy. Improving Health.

WHO WE ARE

- Nonprofit, nonpartisan educational organization based in Topeka.
- Established in 1995 with a multi-year grant by the Kansas Health Foundation and located directly across from Kansas Statehouse in downtown Topeka.
- Committed to convening meaningful conversations around tough topics related to health.

TODAY'S AGENDA

2:00 p.m. Welcome and Agenda

2:10 p.m. Project Progress and debrief from TAP meeting

2:40 p.m. Findings from Environmental Scan

3:40 p.m. TAP questions for CAB and Next Steps

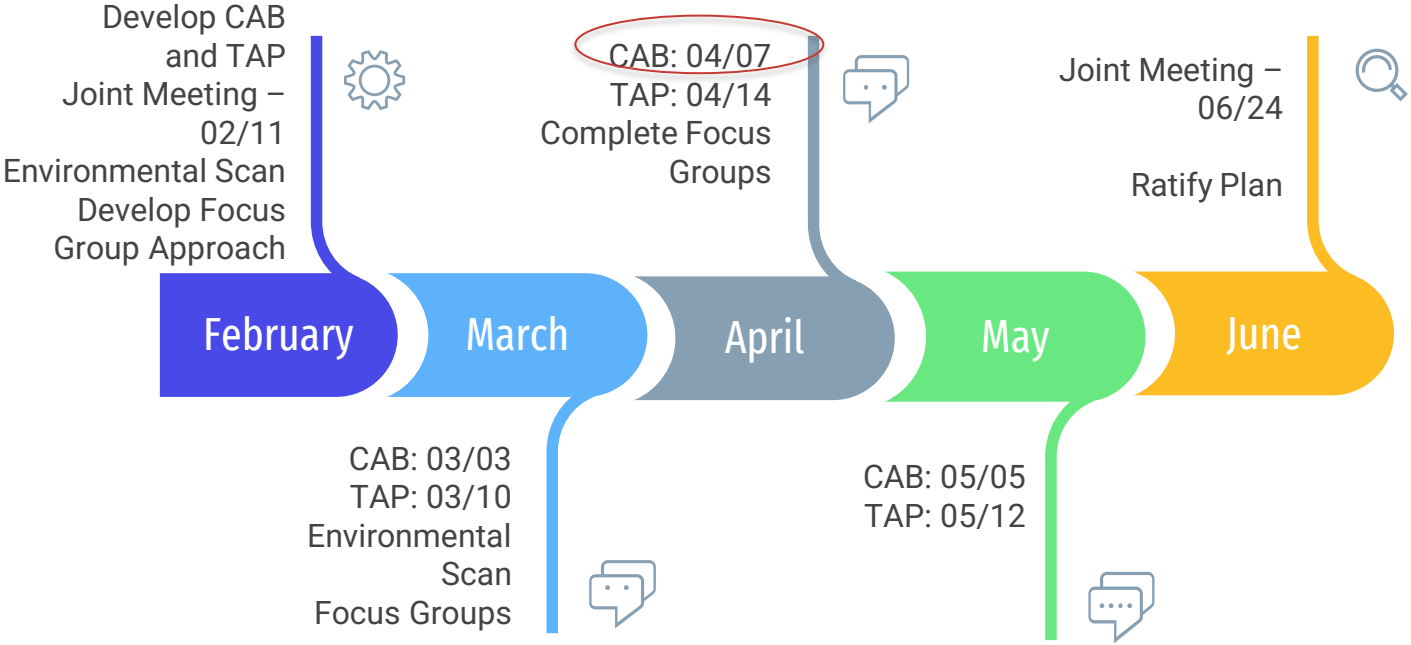
4:00 p.m. Adjourn

WHAT CAME TO YOUR MIND ABOUT CSC SINCE THE LAST MEETING ON 03/03?

2

PROGRESS UPDATES

CSC PLAN TIMELINE



CURRENT DISCUSSION

- Scope of CSC Guidance Document
  - Medical care settings (hospitals, EMS)
  - Initial document will be foundation – a living document that will expand to other settings
- Use Colorado and Minnesota CSC Plans to inform development of CSC Guidance Document
- Goals for the CSC Guidance Document:
  - CSC document provide clear, concise and easy to understand guidance
  - Implementation guidance to address equity and not increase inequities
  - Monitor shortages and scarce resources during crisis situations
  - Elevate voices of populations of focus

CURRENT DISCUSSION

PURPOSE STATEMENTS (Chart #1)	
2013 KS CSC	**CO's CSC Plan**
KDHE recommends that this protocol be used by hospitals throughout Kansas in their emergency planning to ensure that patients have equitable access to life-saving resources when the demand for these resources is greater than the supply, and when use of resources must be optimized.	Provide a framework and tools for altering normal patient care, staffing, medical equipment, supplies, and treatment decisions in any type of healthcare setting. Assist healthcare providers in their decision making with the intention of maximizing patient survival and minimizing the adverse outcomes that might occur due to changes to normal operations when the volume of patients surpasses the available capabilities and capacity of healthcare providers/facilities and normal standards of care can no longer be maintained.

- CSC Purpose Statement
  - Reviewed 2013 KS and current CO purpose statements
  - Groups liked emphasis on equitable access to care
  - TAP was uncertain about Colorado's use of "intention to maximize patient survival" and the term "patients"
  - Focus on demand vs. volume of patients
  - Include additional Kansas language about small hospitals

CURRENT DISCUSSION

Core CSC Principles:

1. *A strong ethical grounding based in transparency, consistency, proportionality, and accountability.*
2. *Integrated and ongoing community and provider engagement, education, and communication.* (Make principle #1; strengthen community engagement language)
3. *The necessary legal authority and legal environment in which CSC can be ethically and optimally implemented* ***OR*** *Assurances regarding legal authority and environment.*
4. *Clear indicators, tactics* ***or*** *triggers, and lines of responsibility; and*
5. *Evidence-based, clinical processes and operations.*

Legend: Grey = CO language; Green = MN language

CURRENT DISCUSSION

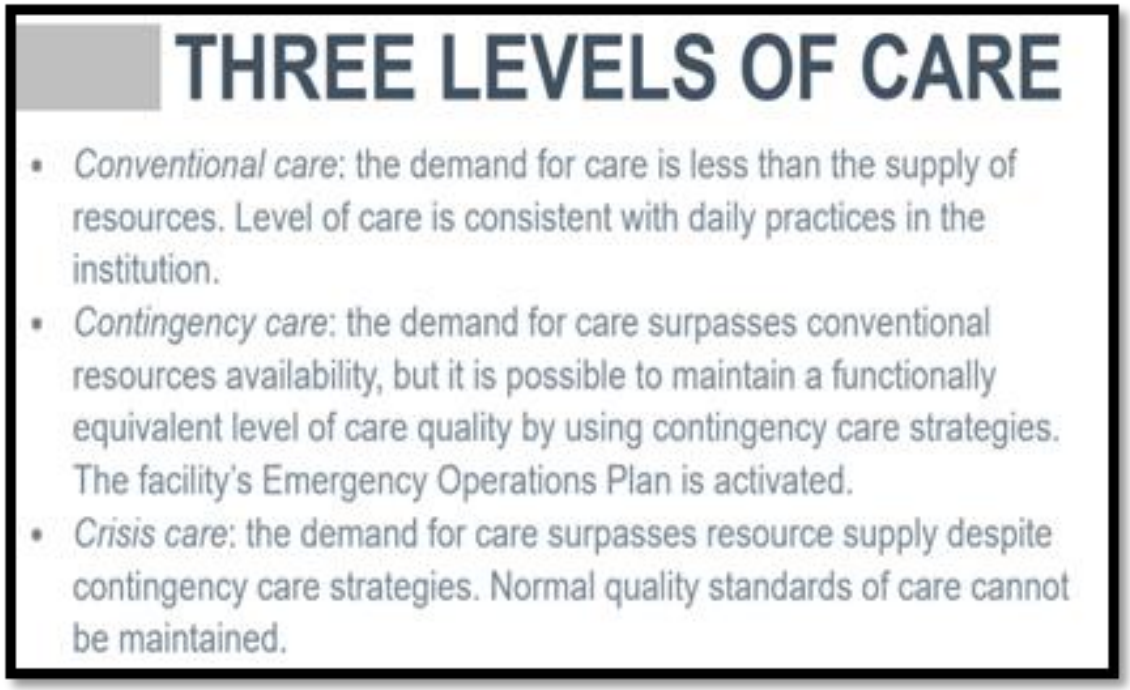
- Adopt the CO Ethical Principles in the updated KS CSC guidance document under the Equity and Ethical Consideration section
  - **Fairness** – Every healthcare provider should attempt to be fair to all those who are affected by the disaster, without regard to factors such as race, ethnicity, socioeconomic status, disability, or region that are not medically relevant.
  - **Proportionality** – any reduction in the quality of care provided should be commensurate with the degree of emergency and the degree of scarcity of resources.
  - **Solidarity** - when limited available resources are unable to meet everyone's needs, all people should consider the greater good of the entire community.
  - **Participatory** – planners and decision-makers should engage the community, healthcare providers, and emergency management agencies during the development of CSC, which can encourage greater understanding, clarity, and trust when CSC implementation is required.

CURRENT DISCUSSION

- Declarations and Response:
  - Discussion of whether declaration is at facility, local/regional, or state level, and whether guidance should be provided for each level
  - Healthcare coalitions - involved in communication, collaboration and coordination of CSC implementation
  - Discussion of how current laws impact allowing professionals who are usually limited in services they can provide to provide more services in crisis situations

CURRENT DISCUSSION

- *Indicators* are measures; *triggers* are decision points
- Both use standard definitions of levels of care



CURRENT DISCUSSION

- *Indicators* were discussed at each level of care for different needs (for example, staff and hospital beds)
- *Triggers* were discussed at each level of care, but based on geography
  - State: Questions about whether state-level triggers make sense if state-level implementation is unlikely
  - Local: Example – If patient transfers are impossible countywide or regionally, that could be a trigger related to the crisis level of care
  - Healthcare facilities: Question about implications of hospitals on diversion
  - EMS: Triggers distributed after meeting for comment

3

EQUITY CONSIDERATIONS IN THE CSC GUIDANCE DOCUMENT: ENVIRONMENTAL SCAN

STRATEGIES

- CSC protocols should not exacerbate underlying disparities.
- No patient should be categorically excluded. All patients should be treated as eligible to receive critical resources and receive a priority assignment based on illness severity.
- Introduce a correction factor into patients' triage scores to reduce the impact of baseline structural inequities.
- Do not use perceived quality of life.

STRATEGIES

- **To what extent should individual's potential to survive be considered when allocating medical resources?**
  - Use hospital survival and near-term prognosis (e.g., death expected within a few years despite treatment) but not long-term life expectancy.
  - Perform a thorough individualized review of each patient without assuming a specific diagnosis is determinative of prognosis or near-term survival.

STRATEGIES

- When patients who use ventilators in their daily lives (e.g., home ventilation) present to acute care hospitals, their personal ventilators should not be reallocated to other patients.
- Designate triage officers as the decision makers and train them to respect disability rights.
- Include disability rights advocates in policy development and dissemination.
- Give heightened priority to individuals in essential, high-risk occupations.

STRATEGIES

Recommendations for addressing the needs of at-risk populations:

- Effective communication with individuals with a disability;
- Meaningful access to programs and information for individuals with limited English proficiency;
- Plain language and emergency messaging in languages prevalent in the area;
- Address the needs of individuals with disabilities;
- Respecting religious accommodations in treatment and access to clergy.

STRATEGIES

In the Guidance Document include the Risk Profile section to describe the demographics of groups that may have different and specialized needs during a disaster.

- Pre- and post-incident assessments are recommended to determine the needs of affected communities, assist in estimating the number of people requiring special services, and the type of outreach needed to reach them.

FOCUS GROUPS: UPDATE

- Protocols approved by KDHE Institutional Review Board (IRB)
- Received suggestions from CAB and TAP Members for consumers, providers and advocacy groups
- As of April 8, recruited 10 consumers, 9 providers and 14 consumer advocates
- Focus groups: April 8, 11 and 12
- Hope to obtain preliminary results by April 14 TAP meeting

4

EQUITY CONSIDERATIONS IN THE CSC GUIDANCE DOCUMENT: QUESTIONS

QUESTIONS FOR DISCUSSION

1. Throughout the guidance document, should we use the term equity or fairness? Please explain why.

QUESTIONS FOR DISCUSSION

2. What can hospitals do when activating CSC to maintain the trust of patients when they make decisions to seek care from the hospital?

QUESTIONS FOR DISCUSSION

3. Given that some terms (e.g., equity, gender identity) might create tension and various interpretations, what are some strategies to make sure that the recommendations are communicated as intended?

QUESTIONS FOR DISCUSSION

4. Based on the COVID-19 experience, what are some suggestions on handling end of life and family visitation?

QUESTIONS FOR DISCUSSION

5. As the Crisis Standards of Care (CSC) Guidance Document is being developed, what else should be considered to make sure that they do not create inequities, especially among populations that historically and currently have experienced barriers in accessing medical resources?

AGENDA FOR 04/14

- Lessons learned from Covid-19 experiences
- Discussion on Incident Management Framework
- Discussion on Scoring Tools and Tier Systems

KANSAS HEALTH INSTITUTE
SINCE 1995
Informing Policy. Improving Health.

THANK YOU

Any questions?

You can connect with us at:

tlin@khi.org or sparacremer@khi.org

KANSAS HEALTH INSTITUTE

Informing Policy. Improving Health.