

**DRAFT RECOMMENDATIONS**

**Strategies to Advancing Equity in KS Crisis Standards of Care**

**Figure 1** provides suggestions for recommendations by a surge level. Some recommendations can be implemented across more than one level. The purpose of these draft recommendations is to advance equity considerations in the Kansas Crisis Standards of Care Guidance document. These recommendations are based on the findings from the environmental scan and informed by preliminary results from the focus groups and CAB discussions between February and April. Several recommendations were updated during May 5<sup>th</sup> CAB meeting.

Figure 1. Draft Recommendations to Strengthen Equity Considerations

| Areas                          | Surge Status  |   |  |
|--------------------------------|---|---|--|
|                                | Conventional  | Contingency   | Crisis   |
|                                | Healthcare organizations utilize normal staffed bed capacity. Occasional and temporary surges of demand may occur. Hospitals, ICUs, and emergency departments temporarily reach capacity. Wait times are normal to slightly heavy for the organization.   | Healthcare organizations have surged beyond maximum staffed bed capacity. Emergency Operations Plans have been activated. Elective procedures delayed. Hospitals may be adding patients to occupied hospital rooms and non-patient care areas. Hospitals may be using early discharge options | Expanded capacity is still not sufficient to meet ongoing demand for care. Facility has been damaged or destroyed significantly impacting ability to deliver care. Elective procedures have been suspended. Some patients needing care cannot be admitted to hospitals and instead will be sent home or to alternate care sites. |
|                                | <b>Draft Recommendations</b>  |   |  |
| <b>Overall Recommendations</b> | <ol style="list-style-type: none"> <li>1. The implementation of Crisis Standards of Care commits to the dual goal of public health emergency: improving health outcomes and reducing inequities in distribution of health benefits.</li> <li>2. Guidelines should prioritize making equitable decisions that create a level-playing field for individuals that have experienced systemic barriers rather than prioritizing fair decisions that treat everyone the same regardless of the inequities they may have experienced.</li> </ol> |   |  |

| Areas                             | Surge Status  |             |  |
|-----------------------------------|---|-------------|--|
|                                   | Conventional  | Contingency | Crisis   |
| <b>Personal Medical Equipment</b> | <p>3. Patients who have their personal medical equipment will not have their personal equipment allocated or reallocated to other patients. When a patient with their own (non-hospital) medical equipment is admitted, they <b>may</b> continue using their medical equipment (as defined in this CSC Guidance) which is considered to be their personal property. However, when the patient’s status changes and the use of medical equipment provided by the hospital is necessary, the patient will be included for assessment and resource allocation of other hospital equipment according to a triage protocol in place for CSC. Patients’ privately-owned, personal medical equipment will remain the patients’ property even if a patient is allocated further hospital equipment.</p> |             |  |
| <b>Triage (process)</b>           | <p>4. To best mitigate implicit bias, each facility should have a group of triage coordinators and a triage team that adequately reflects the diversity of the patient population served by the facility in terms of demographics such as race, ethnicity, disability, preferred language, sexual orientation and gender identity.</p> <p>5. 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.<sup>i</sup></p>  |             |  |
|                                   |   |             | <p>6. Clearly communicate triage process to patients and/or their next of kin using plain linguistically and culturally appropriate language to ensure a triage process that manifests respect for persons.<sup>ii</sup></p> |

| Areas   | Surge Status   |   |  |
|---|--|---|--|
|   | Conventional   | Contingency                             | Crisis   |
| <b>Exclusion</b><br><br><b>Correction Factors</b> <sup>iii</sup><br><br><b>How to consider survival</b> <sup>iv</sup> |  |   | 7. Once triage decision has been determined, this information should be clearly communicated to patients and/or their next of kin using plain linguistically and culturally appropriate language per facility protocols.   |
|   | 8. Triage team members and coordinators should receive advanced and ongoing training to prepare them for the role, including training in: 1. Applying the allocation framework; 2. Communicating with clinicians and families about triage; 3. Avoiding implicit bias against persons of color and other marginalized groups; 4. Improving cultural competencies; and 5. Respecting disability rights. |   |  |
|   | 9. Develop a process to resolve any disputes ( <b>placeholder</b> ).   |   |  |
|   | 10. No patient should be categorically excluded. All patients should be treated as eligible to receive critical resources and receive a priority assignment based on triage protocols in place.  |   |  |
|   |  |   | 11. Area Deprivation Index (ADI) or Social Vulnerability Index (SVI) data is gathered for all patients at intake so equity adjustments are readily available.<br>12. When patients subject to triage are identified, patient profiles will include a correction factor into patients' triage scores to reduce the impact of baseline structural inequities using Area Deprivation Index (ADI) and Social Vulnerability Index (SVI) upon intake. Collectively, ADI and SVI take into considerations factors, including education, income/employment, household composition and disability, race/ethnicity, language, housing and transportation status. |
|   |  | 13. Use hospital survival to discharge. |  |

| Areas                                 | Surge Status   |  |  |
|---------------------------------------|--|--|--|
|                                       | Conventional   | Contingency  | Crisis   |
|                                       |  |  | 14. Quality of life judgments or long-term life expectancy will not be used as factors in the allocation and reallocation of medical resources. <sup>v</sup> |
| <b>Communication and Transparency</b> | <p>15. Communication strategies should be tailored to the needs of individuals with limited English proficiency, individuals with disabilities and made in a plain language.</p> <p>16. 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, tv, text, calls and websites.</p> <p>17. Patients and patients’ families should be informed about the process in a timely manner in which resource allocation decisions are made.</p> <p>18. KDHE will explore the feasibility of collaborating with partners, including community organizations around the state to provide education and training to public around the crisis standards of care.</p> |  |  |
|                                       | <p>19. Hospitals should partner with and work to ensure strong public engagement of community and provider stakeholders, with particular attention given to the needs of populations that are at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability:</p> <ul style="list-style-type: none"> <li>• Developing and refining crisis standards of care protocols and implementation guidance;</li> </ul>  | <p>20. Hospitals care staff should seek consultation with unit, facility, leadership, and policies for ethical guidance when altering care practices when shifting from conventional to contingency levels of care (i.e, triage, rationing).</p> | <p>21. Implement robust situational awareness capabilities to allow for real-time information sharing across affected communities. <sup>vii</sup></p>        |

| Areas                            | Surge Status  |             |        |
|----------------------------------|---|-------------|--------|
|                                  | Conventional  | Contingency | Crisis |
|                                  | <ul style="list-style-type: none"> <li>• Creating and disseminating educational tools and messages to both the public and health professionals;</li> <li>• Developing and implementing crisis communication strategies; Developing and implementing community resilience strategies; and</li> </ul>   |             |        |
| <b>Discharge</b> <sup>viii</sup> | <p>22. Engage family and patients in discharge planning.</p> <p>23. Listen to and honor the patient and family’s goals, preferences, observations, and concerns.</p> <p>24. Determine whether the patient is linked to a primary care provider or has a usual source of care. If no linkage exists, attempt to provide a referral and ensure the patient gets connected to a primary care provider.</p> <p>25. Ensure that patients with limited English proficiency are aware of and have access to professional medical interpreter services during inpatient stays, during discharge, and when accessing post-hospital care.</p> |             |        |

| Areas                     | Surge Status  |             |        |
|---------------------------|---|-------------|--------|
|                           | Conventional  | Contingency | Crisis |
| Discharge <sup>viii</sup> | <p>26. 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.</p> <p>27. 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.</p> <p>28. Connect uninsured and underinsured patients with supplemental health insurance, when possible.</p> <p>29. Encourage social support through community connections, use of health information technology, and community-based interventions that reduce social isolation and loneliness.</p> |             |        |

| Areas                        | Surge Status  |   |        |
|------------------------------|---|---|--------|
|                              | Conventional  | Contingency   | Crisis |
| <b>Other Recommendations</b> | <p>30. Hospitals in collaboration with partners should develop a Risk Profile of their community to describe demographics of groups that may have different and specialized needs during a disaster. The assessment results could be used to estimate the number of people requiring specialized services, and the type of outreach needed to reach them.</p> | <p>31. Use results of the Risk Profile to outreach to people that might require special services and tailor outreach efforts during contingency or crisis stages.</p> |        |

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<sup>i</sup> [Crisis Standards of Care-Small and Critical Access Hospitals \(ne.gov\)](#)

<sup>ii</sup> Rationale (Communicating Triage Decisions): Communicating triage decisions to patients and/or their next of kin is a required component of a fair triage process that manifests respect for persons. The triage officer should first inform the affected patient’s attending physician about the triage decision. Those two physicians should collaboratively determine the best approach to inform the individual patient and family. Options for who should communicate the decision include: 1) solely the attending physician; 2) solely the triage officer; or 3) a collaborative effort between the attending physician and triage officer.

<sup>iii</sup> Rationale(Correction Factors): Correction factor for structural inequities affecting triage. Although allocating ICU resources based solely on objective estimates of patients’ chances of hospital survival may seem unbiased, this approach would likely disproportionately deny critical care treatment to persons of color and the poor. The reason is that these disadvantaged groups tend to present for care with higher severity of illness scores—resulting in lower priority during triage-- due to a higher burden of medical comorbidities such as congestive heart failure and chronic kidney disease. Baseline health disparities arise from unjust, avoidable differences in the “social conditions in which people are born, grow, live, work, and age”. These social determinants of health include differential access to health care, job opportunities, income, education, and housing quality, as well as racial discrimination and unfair social patterns of power and advantage. In addition, there is evidence that existing risk prediction scores are miscalibrated for Black patients, such that they overestimate mortality for Black compared to white patients. More broadly, these concerns about unfair triage exist in the context of a pandemic that has laid bare the deep inequities in U.S. society that cause worse health outcomes among disadvantaged groups. Nationally, Black, Latinx, and Indigenous individuals are significantly more likely to be infected, hospitalized and die of COVID-19 compared to White individuals. The pandemic has also disproportionately impacted individuals from economically disadvantaged areas. We therefore believe it is ethically warranted to add a correction factor to triage scores to lessen the disadvantage these groups experience from health inequities, which may be exacerbated by using chances of survival to hospital discharge as a triage criterion. It would be infeasible during ICU triage to conduct a detailed assessment of each patient’s individual degree of disadvantage. However, it would be feasible to use an established composite measure of disadvantage. One such measure is the Area Deprivation Index (ADI), which is a geographic measure of socioeconomic disadvantage in the U.S., which is calculated at the level of census blocks (approximately 1500 people). It creates an aggregate score of disadvantage on a 10-point scale, based on 17 measures of disadvantage related to poverty, education, employment, physical environment, and infrastructure within a neighborhood. The ADI is publicly accessible and is determined by entering a patient’s home address into an online calculator. It takes less than a minute to determine a patient’s ADI score. Because the strongest association between ADI scores and health outcomes occurs at the highest levels of disadvantage, one way to operationalize this allocation criterion would be to incorporate an adjustment into the triage score for individuals that reside in the most disadvantaged neighborhoods (i.e., ADI scores of 8, 9, or 10). Although some commentators have advocated using patients’ race and ethnicity to correct for structural inequities, there are major legal and political barriers to considering patients’ individual race and ethnicity in allocation strategies. Source: [Microsoft Word - Allocation of Critical Care in Public Health Emergency June 2021 FINAL.docx \(pitt.edu\)](#)

<sup>iv</sup> [Microsoft Word - Allocation of Critical Care in Public Health Emergency June 2021 FINAL.docx \(pitt.edu\)](#)



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<sup>v</sup> Rationale (Quality of life): There is no widely accepted and feasible method to measure quality of life in a way that does not unfairly disadvantage persons with disabilities. Prioritizing patients based on overall life expectancy would unfairly disadvantage patients with a decreased long-term life expectancy from disabilities or from diseases exacerbated by social inequalities. An implication of this design choice is that the framework treats as equal all patients who are not expected to die within a year from an end-stage illness. For example, a patient expected to live 3 more years would receive equal priority for ICU treatment as a patient expected to live 30 more years, all other things equal. This step was taken to affirmatively avoid disadvantaging individuals with life-shortening disabilities and those whose life expectancy is lessened due to unfair distribution of the social determinants of health.

<sup>vi</sup> [Summary of Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report - Crisis Standards of Care - NCBI Bookshelf \(nih.gov\)](#)

<sup>vii</sup> [Summary of Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report - Crisis Standards of Care - NCBI Bookshelf \(nih.gov\)](#)

<sup>viii</sup> [Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning | Agency for Healthcare Research and Quality \(ahrq.gov\) Guide to Reducing Disparities in Readmissions \(cms.gov\)](#)