Crisis Standards of Care
Technical Advisory Panel (TAP) Meeting
March 10, 2022
2:00-5:00pm

Meeting Notes
Meeting Materials:

- March 10 TAP Agenda
- TAP membership list
- CAB 3.3. High-Level Overview
- Environmental Scan Summary (draft)
- CAB 3.3 detailed meeting notes
- 2013 Kansas Guidelines for the Use of Modified Health Care Protocols in Acute Care Hospitals During Public Health Emergencies
- Minnesota Crisis Standards of Care Framework, Feb. 25, 2020
- Colorado Crisis Standards of Care Plan, Jan. 4, 2020 (amended Nov. 29, 2021)
- Meeting materials and other resources will be available at the following link: https://www.khi.org/pages/csc

Overall Agenda:
2:00pm – Opening Remarks, Welcome and Introductions
2:10pm – Project Overview
2:20pm – Update from Community Advisory Board (CAB)
2:30pm – Discussion on Core Principles and Planning Assumptions
3:30pm – Break (10 minute)

Equity and Ethics Breakout Room Agenda:
3:40pm – Review of Questions from CAB and Discussion

Indicators and Triggers Breakout Room Agenda:
3:40pm – Review of Minnesota and Colorado plans and Considerations for Kansas CSC Guidelines

4:30pm – Breakout Session Ends and Each Group Report Out
4:50pm – Next Steps
5:00pm - Adjourn

Meeting Commitments:

- Come ready to discuss and compromise
- Keep remarks succinct and on topic
- Don't hesitate to ask clarifying questions
- Start and end on time

Attendees
TAP members: Dennis Cooley, Dennis Kriesel, Steve Simpson, Ron Marshall, Con Olson, Chris Harms, Jean Hall, Dan Goodman, Lillian Lockwood, Gianfranco Pezzino, John Carney, Patrick Gaughan, Jeanne Gerstenkorn, Samer Antonios, Mike Burgess, Jennifer Watts, Kevin Steck (delegate to Amy Kincade), Kelsey Goddard (delegate to Jean Hall), Morgin Dunleavy (delegate to Jennifer Watts)
CAB Liaison: Amy Hyten

KDHE: Michael McNulty, Edward Bell, Rebecca Adamson

Staff: Hina Shah, KHI (lead facilitator); Kari Bruffett, KHI (co-facilitator); Wendy Dang, KHI; Emma Uridge, KHI; Samiyah Para-Cremer, KHI

Crisis Standards of Care (CSC): Project Overview

AGENDA REVIEW

Background: *Hina (facilitator) provided an overview of the discussion that TAP will be having at the meeting.*

- **Announcements:** (1) Draft of the environmental scan has been published and KHI sent link to the group. (2) KHI is currently recruiting participants for the focus group and focus groups questions are being finalized. (3) The website (https://www.khi.org/pages/csc) will have meeting materials, the environmental scan and other resources available to TAP.
- **CSC Timeline:** Hina (facilitator) reviewed the CSC Guideline process timeline and key components of the process (CAB, TAP, Environmental Scan, and Focus Groups). CAB and TAP members will send questions to each other for responses and additional input to ensure collaboration between the two groups and allow the groups to level-set at each meeting. Currently, the CSC Guidelines outline is structured as follows:
    - Introduction
    - Concept of Operations
    - Deactivation, Modification and Maintenance
    - Appendices
        - Definitions/ Glossary

WHY MINNESOTA (MN) AND COLORADO (CO) PLANS?

Background: *Dr. Dennis Cooley and Dr. Gianfranco Pezzino provided a brief overview of the two states' CSC plans and highlighted some components from each plan that may provide some value to the group and could potentially be used as references when TAP drafts the Kansas CSC Guidelines. Dr. Pezzino stated that there was no need to completely start with an empty draft because the two plans are coming from states where the structure of the healthcare delivery and public health services are not too different from Kansas to some extent.*

- **CO's CSC Plan:** CO has a stand-alone ethical framework to clarify their processes and expedite risk framing. Out of the two plans, CO's CSC Plan may be more suited for Kansas. However, both plans are good references to start with. A member shared that the CO CSC Plan's most recent activity was from November 2021 to address populations going to the hospital and populations that could not get out of the hospital. In the CO's CSC Plan, the CSC were broken into several sections, such as emergency medical services (EMS), labor, supplies, and other hospital services. Lastly, the CO CSC plan provides both state and local framework.
- **MN's CSC Plan:** MN has a community risk profile consideration and recommendations that include healthcare coalitions' roles in the CSC.
    - **Question:** *Is there a presumption that the healthcare coalitions will be a reliable or critical component in the plan serving as a resource to either the declaration of CSC or response to CSC?*
        - **Answer:** TAP will be considering that component when discussing planning assumptions later in the meeting.

Update from the Community Advisory Board (CAB)

UPDATE FROM CAB

Background: *Ami Hyten, CAB Liaison, provided an update to TAP about the previous CAB's discussions at the March 3 meeting. She shared that two TAP members provided background and technical information about the existing process and perspective of the scope of CSC and information gathered from other states and their practices, which were helpful for CAB conversation.*

- **Equity:** The CAB liaison shared that the CAB's activities at the last meeting were completed with a mindful lens around equity and all aspects of equity to understand how equity should inform the development of the CSC priorities. CAB critically assessed their own membership to ensure that they are bringing in individuals with different lived experiences. There were discussions about the representation of demographically diverse communities and individuals with lived experiences on TAP and CAB. She stated that CAB wanted to look at equity and ensure that the right people and perspectives are being heard. Examining issues with the lens of equity is an important work that CAB has done so far.
    - **Question:** *The documents that TAP are reviewing talk about implicit bias and how that plays into triage and treatment. Is there going to be any support for addressing that implicit bias and doing training before the next crisis? Is there a mechanism in place to do that?*
        - **Answer:** That was not part of the charge that CAB was given. However, in the discussion, CAB did ask themselves- *is utilitarianism lens the appropriate lens or should we use the distributive justice lens in terms of making recommendation?* From CAB's understanding, the CSC's scope is in hospitals settings and not extending beyond that. As guidelines are being developed for hospitals to consider, the process that CAB discussed was related to the determination of where hospitals are in crisis and how the allocation of resources should not be done on the patient-doctor level.
- **Focus Groups:** Currently, CAB is providing support in the development of focus group questions and processes. These focus groups are crucial to gather feedback on broader perceptions related to CSC, rationing of care, and similar topics.
- **MN CSC Plan:** CAB also looked at MN's CSC Plan specifically to identify what CAB did not want to consider, what to include, what should be changed, and what did not need to be added to provide some specific recommendations to TAP.

Discussion on Core Principles and Planning Assumptions

GOAL SETTING

Background: *Hina (facilitator) posed the following question for TAP to reflect: As you reflect upon the populations you've served, people you've worked with, communities you have worked in and so forth, what is one goal you want to keep front of mind as you develop the Crisis Standards of Care guidelines for Kansas?*

- **CSC Usability:** Several members shared that their goal is to make sure that the CSC guidelines are clear, concise, and easily understood so that hospitals and other entities can easily utilize and implement the guidelines.
- **Addressing Equity:** Several members shared that their goals were to address the issues around equity, ensuring that the guidelines are not increasing inequities that exist, and be aware of equity issues.

- **Scarce Resources:** Some members shared that it is important to keep up with shortages and other scarce resources during crisis situation, because it impacts the ability to provide care and resources to communities in need.
- **Ensuring Voices are Heard and Present:** Several members shared that their goals are to ensure voices from pediatrics, elderly, people with disabilities, marginalized populations, and many more are included in the discussions when developing the CSC guidelines.

PURPOSE STATEMENT

Background: *TAP reviewed the Purpose Statement from the 2013 KS CSC and CO's CSC Plan to identify what elements of both statements TAP would consider adopting.*

- **General Purpose Statements:** A member shared that they like 2013 KS CSC's call out for equitable access to care. However, they had trouble understanding CO's CSC Plan comment about "intention to maximize the patient survival" in the purpose statement because sometimes patients' survival is not the best outcome to look for. Another issue that the member raised is the line "changes to normal operation when the volume of patients surpasses the available copiabilities" because they stated that it is not always the volume of patients. Instead, it is when the demand outweighs resources. Another member agreed to that point and shared that they like how the 2013 KS CSC addressed more about the demands. They also added that they were concern with the term "patients" used in the CO's CSC Plan because it may be exclusive.

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.

  - **Question:** *The CO plan does not limit (their CSC) to hospitals. Given what happened, especially in long term care in KS earlier on and in prison, I didn't know that we were limited to only hospital responses protocol (in the KS CSC guidelines). Is it possible to move in that direction?*
    - **Answer:** For the June deadline, the CSC guideline will be focused on hospital and medical settings. However, future phases could consider other settings and how they are interrelated to update the CSC guidelines. Due to time constraints, the KS CSC guidelines will serve as a foundation, which can be built upon in the future.
  - **Question:** *Is the protocol only being used by hospital or is it to be used in other healthcare settings?... [Because other healthcare settings] have stake in also being considered to be part of the healthcare community this protocol should be governed by [and I] don't know if the point of this [KS CSC] guideline is to make this a living document.*

        - **Answer:** The intent is to make the KS CSC guidelines a fluid, living document that can be adjusted to current situation and be built upon to pull from other aspects of medical healthcare.
    - **Question:** *Do we need to include other health care setting into the KS CSC guidelines?*
        - **Answer:** A member mentioned that they would advise against doing so right now, if the intent for the document is to be a guidance and tool for facilities and hospitals working with their community partners by providing some tools, some outlines of best practices, and thoughts of how address those situations in a scalable manner.
- **Small Hospital**: Regarding the 2013 KS CSC's purpose statement (Chart #2), a member pointed out that they like having the line "consider partnering with larger referral centers" because it brings out subsets of specialized populations into consideration. Another member shared that, although they understand the content of referral patterns and partnering with larger hospitals because that is how it works under normal standards, there are incidents where large numbers of transfers or referral patterns were from large hospitals to smaller hospitals due to lack of beds availability. Because resources vary among hospitals, some members shared that the CSC guidance document should be clear and consistently implemented while also allowing flexibility for some modification at the hospital level to fit the hospitals' need.

PURPOSE STATEMENTS (Chart #2)
2013 KS CSC
The application of these guidelines in small hospitals may not be feasible due to the lack of specialized staff. In these cases, • Small hospitals may consider modifying the implementation of these guidelines to fit their situation while preserving the overarching goal of assuring an objective, clinical set of criteria for the allocation of scarce resources. • Small hospitals should also consider partnering with larger referral centers and delegate some functions described in this document to those centers. • Communication between small and large hospitals can take place using the best and most appropriate means, such as telephone, radio, telemedicine, or face-to-face consultation.

- **CSC Declaration and Response**: Regarding the 2013 KS CSC's purpose statement (Chart #3), there were discussions regarding the CSC declaration and responses as a consideration to be enacted at the local counties and regional level. A member clarified that the levels of responsibilities are at the county-level and not the state-level, according to the KS Emergency Management Statutes. Another member also clarified that healthcare coalition's role is mostly involved in communication, collaboration, and coordination of the CSC implementation. Members had discussion regarding how the governor's declaration of CSC are carried out and what modifications can be made to address nuanced issues, such as allowing professionals with different levels of jobs to provide services that are not typically allowed in normal circumstances during crisis. A member shared that they would be in favor of allowing the KS CSC guidelines to include state and local level indicators, triggers, and declarations to allow flexibility.

PURPOSE STATEMENTS (Chart #3)
2013 KS CSC
While the protocol refers primarily to the COVID-19 pandemic ~~influenza~~, it is applicable to other public health emergencies that may cause a prolonged shortage of life-saving resources, such as chemical disasters, tornado or other weather-induced disasters, or acts of terrorism.

CORE PRINCIPLE

Background: *Hina (facilitator) provided an overview of the National Academy of Medicine (NAM) Toolkit that outlines five principles and showed where the differences of the languages from MN's and CO's CSC Plan. What is marked in green is the language that was adopted in the MN's CSC plan in order to show the differences between the two states' plans. The five principles are:*

1. *A strong ethical grounding based in transparency, consistency, proportionality, and accountability.*
2. *Integrated and ongoing community and provider engagement, education, and communication.*
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.*

After reviewing the five principles, the TAP was asked – "What does the group think about adopting the 5 principles in the 2022 guidelines? Do we want to adopt holistically or parts of it?"

- **Community Engagement:** A member shared that they liked the second principle (listed above) to be listed first. Another member agreed and shared that there should be a stronger word than "engagement," to make it clear that the community is the people potentially impacted. They also shared that the term "community" should be specific to reflect who they actually mean instead of who they are currently seeing. A KHI staff clarified that the language can be looked at to reflect that the engagement refers to consulting and involving the community in the discussions.

PLANNING ASSUMPTIONS

Background: *Hina (facilitator) provided an overview of the planning assumptions that were listed in the Kansas Response Plan (2020), CO's CSC Plan and the MN's CSC Plan. TAP was asked – "What are some assumptions that need to be made knowing the scope is on healthcare? What makes sense to include or exclude?"*

- **KS Response Plan Assumptions:** *See slide below*. A member stated that the points from the KS Response plan assumptions may need to be modified because the points are trauma-related, and the KS CSC guidance document would incorporate assumptions relevant to pandemics and other events of long duration that would be beyond trauma.

KS RESPONSE PLAN ASSUMPTIONS

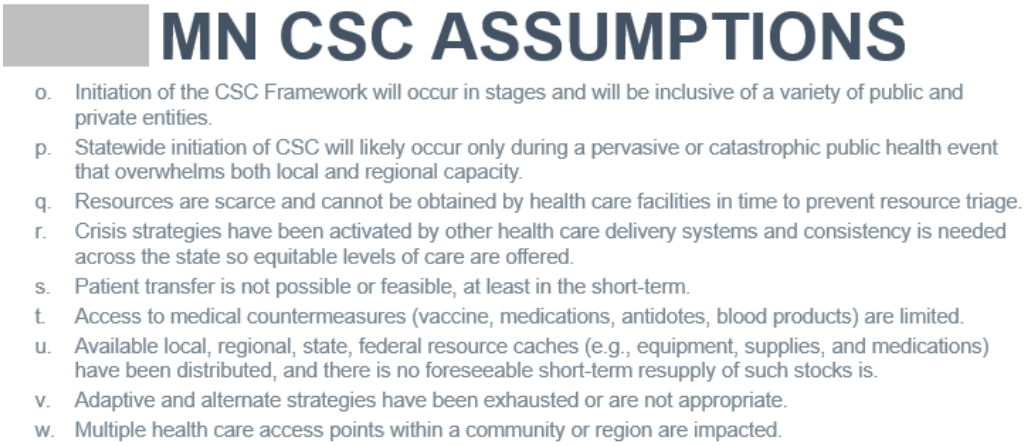
a. There are many different emergencies both natural and human-caused that can result in mass numbers of casualties.
b. The majority of medical material and medical professionals are located at the local level.
c. A mass casualty incident will stress the entire medical system including pre-hospital responders and medical specialties.
d. The Kansas Trauma Program will continue to promote overall trauma preparedness efforts within Kansas including working with interested and capable facilities in achieving state trauma center designation.
e. Kansas has a limited capability for treatment of severe burn cases.
f. Regional Trauma Councils will continue to address topics and issues related to trauma care within their own region and locally.
g. Kansas has a limited capability for treatment of severe trauma injuries.
h. The EMS-C Program will continue to provide child specific planning information and equipment, as funding allows, to medical care entities in Kansas.

- **CO CSC Assumptions:** *See slide below*. A member mentioned that **ITEM K** might be adopted but was unsure if the KS CSC guidance document would be reviewed bi-annually. Another member mentioned that the second line on **ITEM J** regarding healthcare coalitions would be an appropriate language to adopt. Another member raised a thought regarding **ITEM J** that TAP might want to include stakeholders and communities in addition to healthcare coalitions. Another member shared that they like a combination of **ITEM I** and **ITEM N** because it emphasizes that the CSC guidance document is not a mandate that hospitals must follow, so it provides some flexibility.

CO CSC ASSUMPTIONS

i. The CSC is meant to serve as a framework for decisions that must be considered during a catastrophic disaster.
j. Healthcare coalitions will be involved in coordinating planning prior to an event requiring the use of CSC. Healthcare coalitions will also be involved in coordinating information and resources during a CSC activation.
k. This document is not final; it is meant to be fluid, flexible and will be reviewed at least bi-annually and revised as new information becomes available.
l. The CSC applies to medical professionals including those in clinical and private practice.
m. It is important to recognize a catastrophic disaster has a natural progression or arc. Expected resupplies, additional personnel resources and local, state and federal support affect the arc, and excellent situational awareness is critical for making ethical decisions about resource allocation throughout the disaster.
n. While the CSC is intended to provide broad-based guidance, a future catastrophic disaster may have a markedly different course from previous incidents; thus, this CSC may provide little or no value, or may even be counterproductive, depending on specific features of future disasters. Every use of this CSC should be carefully considered in the current context.

- **MN CSC Assumptions:** *See slide below*. A few members liked **ITEM P** because it addresses who would determine whether triggers are met to activate CSC as long as **ITEM P** reconciles with KS statutes. There were some concerns around **ITEM S** because its meaning is unclear. Another member clarified that MN's CSC planning assumptions are more statewide whereas CO's CSC planning assumptions are more regional and local, because the MN CSC was set up so that the public health commissioner would initiate the CSC at a state level.

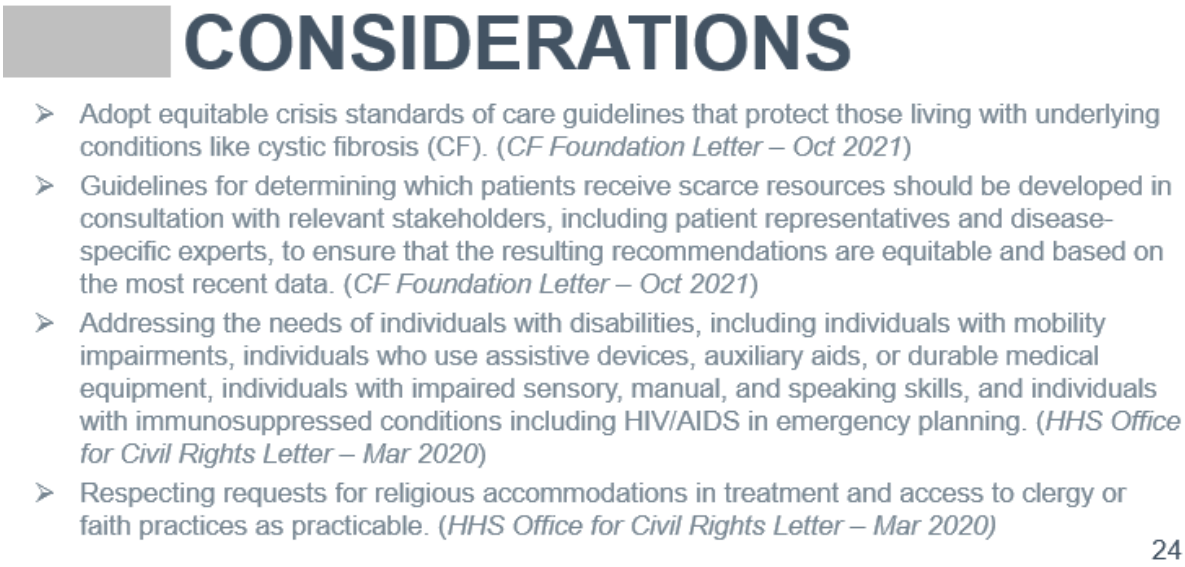


- **Question:** *Is the assumption that <u>all</u> these conditions must take place to institute a CSC?*
  - **Answer:** These are broad underlying assumptions before the CSC provides additional details of how the CSC would be implemented and carried out. Indicators and triggers will be discussed in a breakout session.

Breakout Room Sessions

<u>ROOM 1: EQUITY AND ETHICS</u>

Background: *Hina (facilitator) provided an overview of the required items for the KS CSC Guidelines from KDHE and other considerations from the letters with objections to the previous guidelines.*



- **<u>QUESTION 1 FROM CAB</u> - How to eliminate potential biases when decisions are made about who received what medical resources and when?**

  Background: *<u>Blinded-Decision Making – Inherent Biases</u>*: CAB members said their worry about people making CSC decisions is that people are human and have inherent biases about a patient's race, sexual identity, ethnicity, prior drug convictions, lifestyle, and more that isn't explicitly included into a scoring tool but may impact a person's decision. CAB members discussed that a solution would be to have the decisionmakers not know who the person was and not be able to see them. Another solution proposed by a CAB member was to use an algorithm that could make the decision for them.

  <u>Equity Concern of Objective Indicators</u>: CAB members said that it is important that in addressing these inherent biases, it's important to recognize that historic and systemic bias in the system may have impacts on the health records of patients due to their race and gender presentation even if these characteristics are not used on their own to determine resource allocation.

  Discussion about Question 1 from CAB:
  - **Biases in Algorithms:** A member raised some concerns regarding implicit biases guiding triage decisions and algorithms can include biases directly and indirectly. Another member stated that algorithms can be reviewed beforehand to determine where biases might be. A member added that it is important to recognize that algorithms have biases built in them because humans are writing them. Therefore, it is important that the tools are interrogated, tested, and validated, before they are used.
  - **Concerns about Blinded Process:** A member raised concerned that a blinded process would not necessarily consider the individualized review of each patient's baseline. They stated that there are other triaging tools that are currently being used that directly discriminate against disabilities. However, it is dependent on how the blinded process is applied.

- **<u>QUESTION 2 FROM CAB</u> - To what extent should geographic criteria such as diverse and socially and economically vulnerable census tracts/census blocks be considered in distribution of medical resources?**

  Background: <u>Considerations for Geographic Indicators:</u> CAB members said they were interested in the use of geographic indicators to be incorporated into a scoring system, particularly one that recognizes high poverty rates and racially diverse areas. However, members said that it was important to define poverty rate at a threshold that isn't too low that very few people meet it. Another consideration of CAB is that the data points used to determine these geographic indicators should be easily publicly accessible.

  <u>Social Vulnerability Index</u>: Supplemental experts mentioned the Social Vulnerability Index to calculate geographic indicators. CAB members said they would like to receive information about this over email so they can explore it further.

  Discussion about Question 2 from CAB:
  - **Critical Clinical Decision Making:** A member shared that what comes to their mind at the time when the patient sees them at the clinic or hospital is whether the person is going to benefit from the limited resources that they have to offer regardless of their health status, socioeconomic status, geographic background or distribution, etc. The member clarified that in the moment of crisis when resources are limited, patients are coming in very ill, and they must triage, the critical decision point is - can the person survive or have a chance of surviving if they get the resource? The member acknowledges that there are geographical or socioeconomic circumstances that would put individuals at a disadvantage; however, that is not factored into the decision-making process. Another member stated that the concern from CAB, from what they understand, is that the current clinical decision-making process in triage are perpetuating the inequities that already exists in the system. The CAB liaison shared that fairness in an inequitable system perpetuate inequities. If the discussion around fairness is in its current context without looking from an equity lens, then the group is perpetuating inherent biases and inequities that caused people to make decisions on whether they should go to the hospital in the first place or not. The CAB liaison shared their concerns that there were some levels of self-selection that people with disability made in this pandemic. Another member mentioned that a person with disability may have other medical factors that may play out that is not at fault of the individual, but their disability may play into the clinical decision-making process.

- **<u>QUESTION 3 FROM CAB</u>** - **How can we ensure that the Kansas CSC Guidelines do <u>not</u> include certain criteria as a basis for determining allocation of medical resources, including criteria the MN CSC Plan recommended <u>not</u> be considered, as well as gender identity?**

  Background: CAB identified all items currently recommended by MN to not consider in CSC situations should also be excluded as a basis for decision in KS, including:

  - Ability to pay;
  - First-come, first-served;
  - Judgments that some people have greater quality of life than others;
  - Predictions about baseline life expectancy unless the patient is imminently and irreversibly dying, because rationing based on such baseline predictions would exacerbate health disparities;

- Race, gender, religion or citizenship;
- Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication);
- Judgments that some people have greater "social value" than others.

CAB also recommended the exclusion of the following characteristics as a basis for deciding on allocation of medical resources during a crisis: Gender identity – In addition to excluding gender, gender identity should be excluded as a basis for allocating resources during the pandemic. CAB members gave the example that Trans individuals should not be asked to identify their birth gender in most situations of resource allocation unless considered absolutely medically necessary.

Discussion about Question 3 from CAB:

- **Inclusive Language:** A member expressed that there needs to be a better way to be inclusive in the language that includes gender identity without creating tension with the public who may not be receptive of identifying gender identity. The member shared a similar situation happened with prisoners when the governor was going to treat prisoners as "individuals living in institutions," and there were tension and outrage from the public during the pandemic.
  - ➔ **<u>TAP'S QUESTION FOR CAB:</u>** *Can you recommend best practices for mitigating or acknowledging tension among those who may not be receptive to the use of inclusive and accepting language (e.g.., regarding gender identity)?*

- **<u>Question 4 from CAB</u>** - **How can the CSC be written and implemented in a way that they address the needs of those impacted the most?**

  Background: CAB members proposed prioritizing those who were first impacted, those who were the first to get sick and be impacted by COVID-19 or another crisis because this group was also one of the most vulnerable. However, some CAB members said they were concerned that vulnerable groups who were first impacted may not have enough resources to say they had been impacted and there would need to be mechanism to identify them.

  Discussion about Question 4 from CAB:

  - **First Impacted versus First Through the Door:** There were discussions regarding the differentiation of "first impacted and first served" versus "first through the door and first serve." A member shared that individual who are first impacted are ones who are most vulnerable because their situation may not allow them to seek resources or care. Another member mentioned that although the first person coming to the hospital may be the first person that the clinician sees, there are other individuals who the clinician may not see, and those individuals were not going to seek care because they believe that they were not going to get services. A member shared that, from a critical care lens, the issue making the decision of who would receive the resources when resources are limited at the point in time the clinician see the person.

- **CO'S ETHICAL PRINCIPLES:** Below are the four ethical principles from CO's CSC Plan. TAP was asked – Do these make sense to include in the guidelines?

- 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.

- **Agreement to CO's Ethical Principles**: The members agreed that the four principles should be included in the guidelines. A member expressed that the principles would build a mechanism into a system that would encourage people to seek care, but it is important that the group acknowledge that there are people who may not reach to the hospital doors, so there needs to be effort to reach out to those people.
  - **NOTE:** The CO's CSC Ethical Principles was reviewed again by the rest of TAP towards the end of the meeting for additional thoughts. **TAP posed another question to CAB →** *As the Ethical Principles section is developed, should emphasis be placed on "fairness" or on "equity"?*

Suggested Consideration:

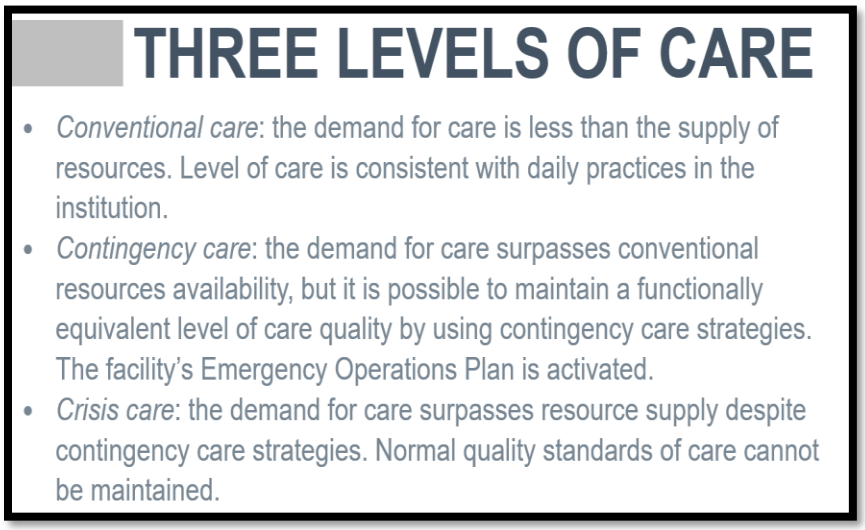
A member proposed the following consideration to TAP:

- **Supplemental Expert:** A member shared that they have a colleague who may be a good resource to help answer TAP's questions regarding the ethical usage of assessment and triage tools.

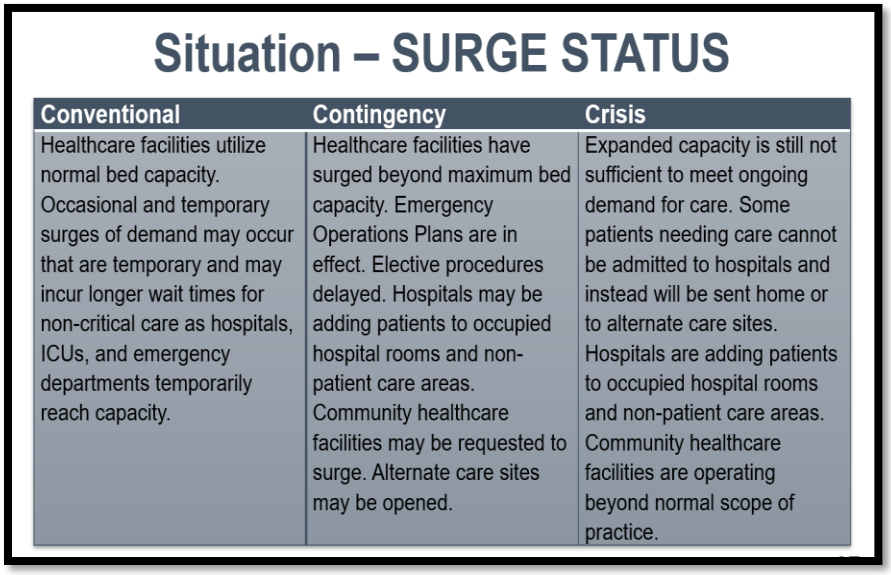
ROOM 2: INDICATORS AND TRIGGERS

Indicators

Background: Group looked at Colorado plan to assess which components could be included for the Kansas CSC guidance document. Colorado plan has facility, local-level and state-level indicators and triggers. Each bolded topic was a slide shown to the group. Dr. Cooley provided background information and explanation for the three levels of care, which include Conventional Care, Contingency Care, and Crisis Care.



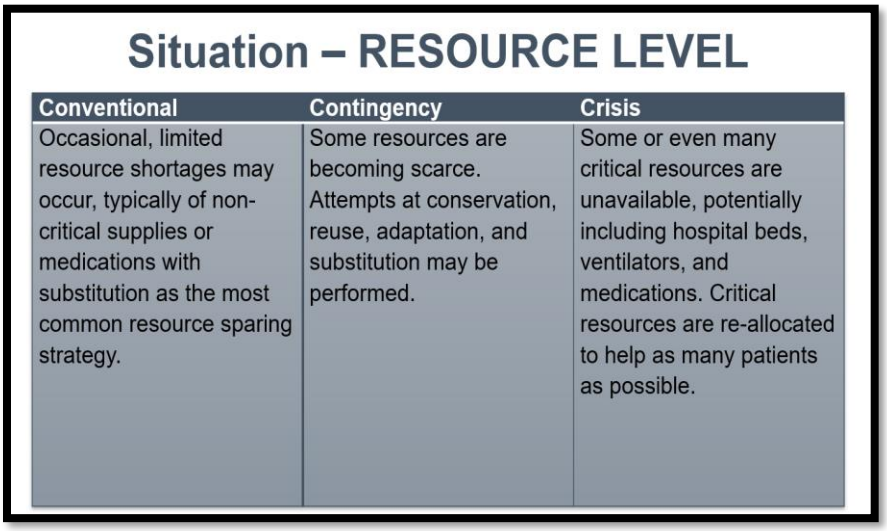
- **Three Levels of Care (definitions):** A member shared that it would be important to include the information because a standard definition would ensure that people reading the guidelines have the same understanding of the term.
    - **Question:** *For last bullet (crisis care) referring to 'Resource Supply', would it make sense to strike the word "supply", as "resource" is sufficient*?



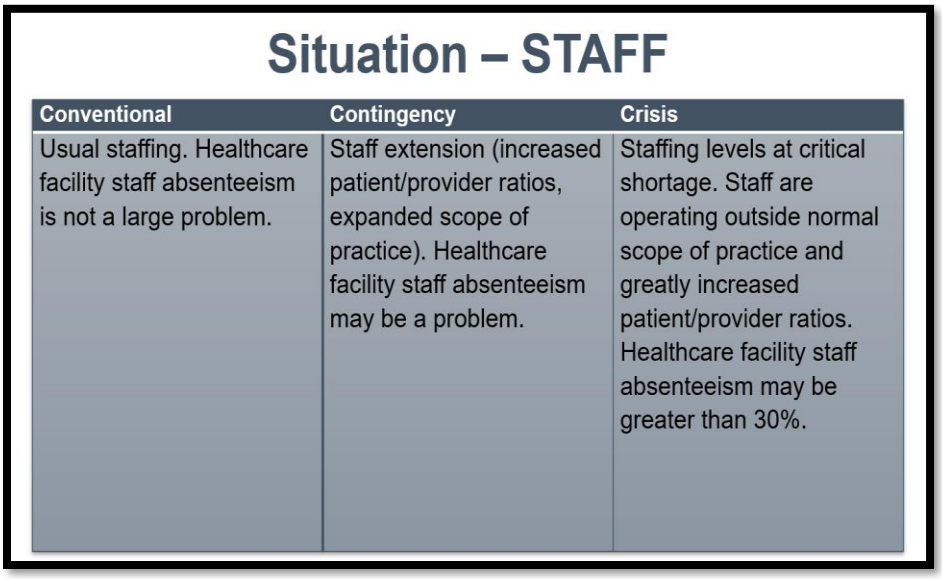
- **Three Levels of Care: Situation – Surge Status**
    - **Question:** *The group was asked - would this make sense to adopt in Kansas plan?*

        - A member stated that under contingency, hospitals had bed capacity, but staffing was the issue. Therefore, the group may want to modify and include 'staffed beds.' Another member stated that they thought these items showed thresholds for each status, but it may not apply with contingency. Example: "Hospitals may be adding patients to occupied hospital rooms and non-patient care areas" is listed under contingency, while "Hospitals are adding patients to occupied hospital rooms and non-patient care areas" is under crisis. Another member agreed that the language is confusing.
    - **Question:** *Operating outside of regular scope of practice, should that be in the crisis column*?
        - **Answer:** That is in staffing.

    - **Comment:** Under contingency, a member stated that they don't know what community healthcare facilities "may be requested to surge" means? (Referring to the "may be")
        - **Consideration**: If terms are unclear in meaning, they should not be in the guidelines.



- **Three Levels of Care; Situation – Resource Level**
    - **Questions:** None



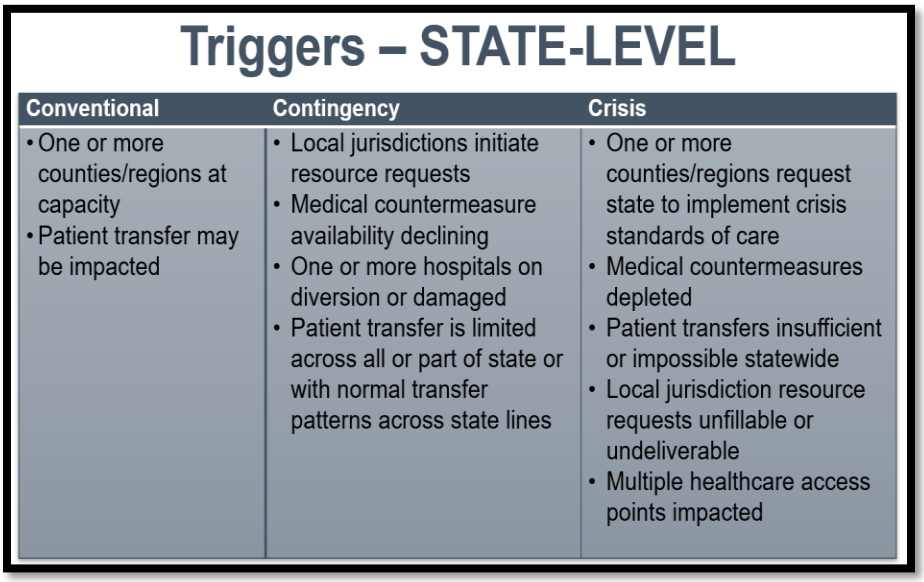
Situation – STAFF

Conventional	Contingency	Crisis
Usual staffing. Healthcare facility staff absenteeism is not a large problem.	Staff extension (increased patient/provider ratios, expanded scope of practice). Healthcare facility staff absenteeism may be a problem.	Staffing levels at critical shortage. Staff are operating outside normal scope of practice and greatly increased patient/provider ratios. Healthcare facility staff absenteeism may be greater than 30%.

- **Three Levels of Care; Situation – Staff:** A member expressed that they don't want the scope of practice modification to appear to be at a facility's discretion. Instead, the member suggested that modifying this item to clarify under which legal conditions scope can be expanded will calm fears for regulators and the Kansas public. Another member agreed that the definition of the scope of practice should be improved. Another member added that hospitals and healthcare entities should be included and more definition for providers acting out of scope.
    - **Absenteeism:** A member pointed out that the table talks about absenteeism, which implies staff are just not showing up. With Covid, staff were unable to be there due to illness and/or exposure. The member shared that the term "Absenteeism" makes it sound like staff chose not to be there. The group liked the replacement word 'shortage' for absenteeism.
    - **(Under Crisis) 30% is an issue for small hospitals**: A member stated that small hospitals can be greatly affected by absence of staff. 30% would be drastic in small hospitals. Another member stated that it also depends on staff roles. It was suggested to not include a specific percentage as an indicator.
    - **Question:** *Is anything missing (from the definitions)?*
        - A member stated that definitions should address that there may not be staff to bring in by supplemental nursing agency, and that current staff may not be used to supplement. The group also talked about Emergency Medical Services (EMS), and asked if EMS was included or is this supposed to cover across the continuum of care? KHI staff clarified that there is an EMS section under triggers but could consider adding to indicators as well.

Triggers

Background: While indicators are measures, triggers are decision points. At any of these levels, there must be professional judgement for addressing each scenario.

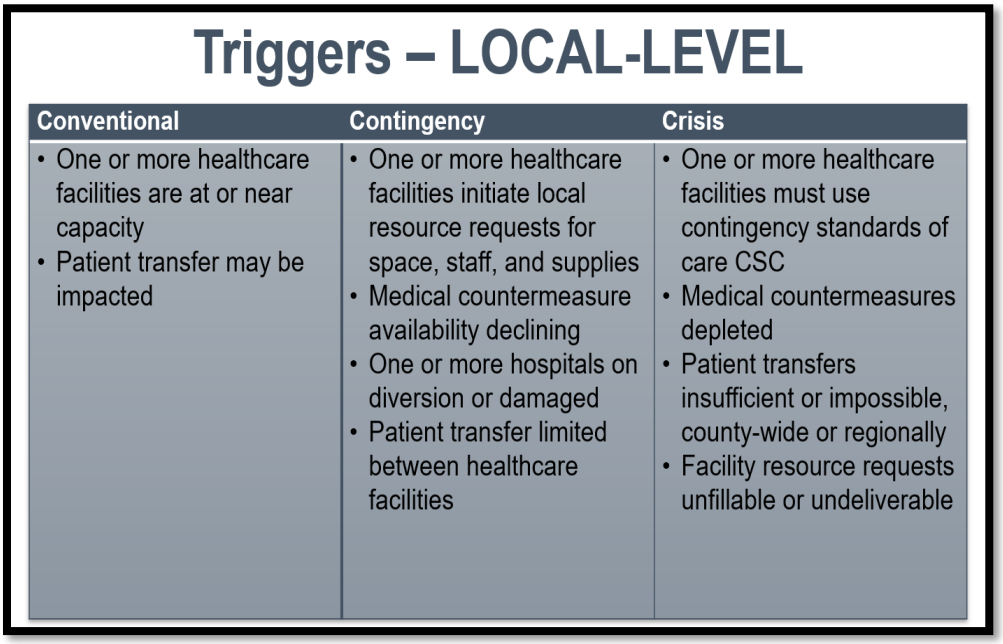


- **Triggers – State Level.**
    - **Question:** *Are we even going to use state level triggers*?
        - **Answer:** Previous modified guidelines had local or state declaration. Is it state level, or local and healthcare facility level triggers?
        - **Discussion:** A member stated that they like options and that it would be realistic for statewide. The member shared that there are not too many plausible scenarios for it to be implemented statewide.
    - **Question**: *If [the KS CSC guidance document is] using state level triggers, these triggers could be used by governor, KDHE, state organization? Is that something where you are coming from*?
        - **Answer:** A member answered that if they did, the governor decides on CSC declaration. From their understanding, in an all-hazards environment that would be held at governor level, not secretary level. Another member added that it is not a problem with having a state level trigger, but they were not sure if hospitals will just look at state declaration if not directly affecting facility. The member shared that most of the time in 2020 during COVID, the facilities weren't at surge capacity, and many facilities won't implement CSC based on a state-level trigger alone.

    - **Legal Considerations:** A member shared that they had been told there is no statute to implement statewide CSC. Another member shared that their thoughts on emergency disaster declaration was that these are guidelines. Another member stated that this may allow facilities a legal basis for making decision is state comes out and says triggers are met, and facility may need to implement CSC plan. Some legal bases would help facility with that. A member shared that they are currently having discussions about legal issues and anticipate having more guidance to discuss in future meeting. KHI staff shared that when the group is thinking about CSC guidelines, also think about them as a tool to communicate to the state and communities; that's why states have overarching guidelines, so decisions can fit under that umbrella.

    - **Question:** *Regarding state level triggers, if the state says that they are triggering CSC statewide, does that have an impact on resource sharing, funds, etc., as we interact with the rest of states in our nation? Is that why it should be left in there*?
        - **Answer:** A member stated that it is not a specific criterion, but another thing to consider is it implemented depending on the crisis and is to look

for federal support. KHI staff shared that they were curious about interstate cooperation and is interested to see if that will be part of the work these next few weeks, and how COVID-19 affect triggers. A member shared that it was interesting that this topic comes up and wanted to note that the HHS Region 7 command structure is starting to lean that way. The member stated that regional integration and cooperation will be more of a thing in the future, so the federal government may be seriously considering the idea. A member clarified that the Emergency Management Assistance Compact (EMAC) already spans across state lines. A member stated that they saw the term 'depleted' and suggested to use the term 'exhausted' because the terminology plays role into overarching EMS when looking for federal resources.



Triggers – LOCAL-LEVEL

Conventional	Contingency	Crisis
• One or more healthcare facilities are at or near capacity • Patient transfer may be impacted	• One or more healthcare facilities initiate local resource requests for space, staff, and supplies • Medical countermeasure availability declining • One or more hospitals on diversion or damaged • Patient transfer limited between healthcare facilities	• One or more healthcare facilities must use contingency standards of care CSC • Medical countermeasures depleted • Patient transfers insufficient or impossible, county-wide or regionally • Facility resource requests unfillable or undeliverable

Triggers – HEALTHCARE FACILITIES

Conventional	Contingency	Crisis
• Usual patient care space fully occupied • Usual staff called in and utilized • Cached and usual supplies being used	• Patient care areas re-purposed (e.g., PACU or monitored unit used for ICU-level care) • Staff extension in place (brief deferrals of non-emergency patient-care services, supervising broader groups of patients, changes in responsibilities and documentation, etc.) • Conservation, adaptation, and substitution of supplies with selective re-use of supplies for an individual patient • Hospital on diversion	• Healthcare facility unsafe or closed • Non-patient care areas used for patient care • Trained staff unavailable or unable to care for the volume of patients • Critical supplies lacking • Re-allocation of life-sustaining resources • Patient transfer not possible or insufficient

- **Triggers – Local Level, and Healthcare Facilities**
  - **Question:** *There were discussion in Shawnee County about whether "diversion" applies to hospital as whole or certain services. Maybe add a point of clarification that this may not apply across the continuum of care?*
    - **Comment:** A member stated that they were looking at deferrals for surgeries and did not know if that should be included in plan. (Ex: routine surgeries) Another member stated that MN included a deferral of elective procedures in contingency, and deferral of non-elective procedures in crisis.

Triggers – EMS

Conventional	Contingency	Crisis
• Public safety answering point/Public safety communication center at or near capacity • Standard response capability at or near capacity • Low acuity calls holding or response with single resource unit • Requests for mutual aid	• Public safety answering point/Public safety communication center capacity fully utilized. Additional communications center staff called in. Incoming calls holding. • Demand surpasses standard response capability. Additional EMS staff called-in. Additional units staffed. • Deferred response for low acuity calls • Closest destination facilities on divert or not accessible • Require mutual aid or air medical to supplement local ambulance transport resources • Limits on staff hours of service suspended • Staff absenteeism adversely affects response capability • Local EOC activated	• Public safety answering point/Public safety communication center overwhelmed. Incoming trunk lines fully utilized, callers get busy signal, 10 percent or more of calls abandoned • Response capability overwhelmed • No response to low acuity calls • Regional multiple casualty transport plans activated • Air medical, ambulance strike teams or other external resources required • Regional destination facilities on divert or not accessible • Staff absenteeism 30 percent of greater

Other Triggers reviewed briefly and distributed after the meeting for additional comment: Healthcare Facilities, EMS.

Proposed Considerations/Guidelines:
The working group proposed the following considerations:

Indicators

- **Three Levels of Care: Definitions – Crisis Care:** For last bullet (crisis care) referring to 'Resource Supply', strike "supply", and replace with "resource".
- **Situation – Surge Status:** Under contingency, modify and include 'staffed beds.'
- **Situation – Surge Status:** Confusing, reader assume Items under each level of care showed thresholds for each status, but it may not apply with contingency.
    - Example: "Hospitals may be adding patients to occupied hospital rooms and non-patient care areas" is listed under contingency, while "Hospitals are adding patients to occupied hospital rooms and non-patient care areas" is under crisis.
- **Situation – Surge Status:** Under contingency, there is confusion for what 'community healthcare facilities may be requested to surge' means. Consider If terms are unclear in meaning, they should not be in the guidelines.
- **Situation – Staff:** Doesn't want scope of practice modification to appear to be at a facility's discretion.
- **Situation – Staff:** Small hospitals can be greatly affected by absence of staff. 30% staff shortage is drastic in small hospitals, modify for scalability.
- **Situation – Staff:** Consider inability to supplement staff during times of staff shortage.
- **Situation – Staff:** Group wants to replace absenteeism with shortage.

Triggers

- **State Level:** The group needs to clarify State and Local triggers, and if facilities will use State-level triggers to implement CSC.
- **State Level:** Saw term 'depleted' under Crisis column, can the term "exhausted" be used? Terminology plays a role into overarching Emergency Management System when requesting federal resources.
- **Local and Healthcare Facilities Level:** Add a point of clarification that diversion may not apply across the continuum of care.
- **Local Level and Healthcare Facilities Level:** Include deferral of elective procedures in contingency levels of care, and deferral of non-elective procedures in crisis levels of care.

Discussion Overview:

- **Declaration of CSC:** Healthcare facilities may or may not use state or local declaration of disaster to implement the use of CSC. Facilities may not implement CSC until crisis level of care indicators are seen.

- **Legal Implications:** What are the legal implications for facilities to implement CSC with or without state or local emergency declaration? KDHE is currently having discussions about legal issues and anticipate having more guidance to discuss in future meeting.

- **Regional integration and cooperation:** Currently being discussed by Federal Government, assume this will be a future consideration

Follow up items

TAP members were asked to:

- Provide any resources relating to COVID-19 experiences, data, and lesson learns that can be helpful for the upcoming meeting. Please send all information and resources to one of KHI staff (Wendy Dang wdang@khi.org or Hina Shah hshah@khi.org).

Additionally, TAP members were advised of the following meetings:

- April 7, *CAB Meeting #3 at 2:00 p.m. to 4:00 p.m.*
- April 14, *TAP Meeting #3 at 2:00 p.m. to 5:00 p.m.*
    - Areas of focus: equity; triage and clinical decision making; supplies; staffing; alternate care sites; categories and nomenclature
    - KS CSC Guidelines' Sections: COVID-19 Experience; Framework for Incident Command; Triage and Management of Resources; Alternate Care Sites

TECHNICAL ADVISORY PANEL (TAP) MEMBERS		
Name	**Title**	**Organization**
Daniel Decker	DCF Director	Kansas Department for Children and Families (DCF)
Dan Goodman	Deputy Commissioner for Long-term Services and Supports	Kansas Department for Aging and Disability Services (KDADS)
Dr. Jennifer Watts	Pediatric Emergency Medicine Physician	Children's Mercy Hospital
Dr. Dennis Cooley	Pediatrician	American Academy of Pediatrics, Kansas Chapter
Con Olson	Administrative Society Representative on the KEMSA Board of Directors	The Kansas Emergency Medical Services Organization (KEMSA)
Dr. Lillian Lockwood	Clinical Advisor, Northeast and Kansas City Metro	Kansas Healthcare Coalition (HCC)
Ron Marshall	Director, Preparedness and Regulatory Affairs	Kansas Hospital Association (KHA)
Carla Keirns, MD Ph.D.	Associate Professor	University of Kansas Medical Center
Jean P. Hall, Ph.D.	Director	Institute for Health and Disability Policy Studies (KU)
Rachelle Colombo	Executive Director	Kansas Medical Society
Jane Kelly	Executive Director	Kansas Home Care & Hospice Association
Dennis Kriesel	Executive Director	Kansas Association of Local Health Departments
Michael McNulty	Emergency Manager	KDHE
Dr. Gianfranco Pezzino	Public Health Expert	Retired, Kansas Health Institute
Patrick Gaughan	Senior Vice President & Chief Values Integration Officer	Centura Health
John Carney	President and CEO	Center for Practical Bioethics
Mike Burgess	Director of Policy & Outreach	Disability Rights Center (DRC)
Dr. Steve Simpson	Professor, Pulmonary, Critical Care and Sleep Medicine	University of Kansas (KU) Medical Center

Amy Kincade	Vice President, Population Health Management	Stormont Vail Health
Christopher Harms	Critical Care/Cardiology Pharmacist	Advent Health
Dr. Dereck Totten	Family Practice Physician	Citizens Health
Dr. Samer Antonios	Chief Clinical Officer	Ascension Via Christi Health, Inc
Michael Lewis, MD, FAAP	Associate Professor Medical Director, Pediatric Inpatient and Intensive Care Units Program Director, Pediatric Cystic Fibrosis Program Division Chief, General Pediatrics	The University of Kansas Health System
Jeanne Gerstenkorn	Vice President for Health and Wellness	Presbyterian Manors of Mid-America

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT (KDHE) STAFF		
Name	**Title**	**Organization**
Janet Stanek	Secretary for Kansas Department of Health and Environment (KDHE)	KDHE
Ashley Goss	Deputy Secretary for Public Health	KDHE
Dr. Joan Duwve	State Health Officer	KDHE
Kendra Baldridge	Bureau Director	KDHE
Rebecca Adamson	Preparedness Program Director	KDHE
Edward Bell	HCC Program Manager	KDHE