# Crisis Standards of Care
## *Meeting of Community Advisory Board*
*May 5, 2022*
*2:00-4pm*

# Detailed Meeting Notes

**Meeting Materials**
*Meeting materials available at khi.org/pages/csc*

- Agenda CAB_0.5.05.2022
- CAB Meeting Minutes_04.07.2022
- TAP Meeting Minutes_04.14.2022
- Summary of Focus Group and Interview Findings

**Agenda**:
2:00pm – Welcome and agenda
2:10pm – Project progress and debrief from TAP meeting
2:20pm – Review draft recommendations and provide feedback
3:20pm – Review high-level findings from focus groups
3:40pm – Next steps
4:00pm – 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

CAB members: Glenda DuBoise, AARP Kansas; Irene Caudillo, El Centro; Alice Weingartner, Community Care Network of Kansas; Kathy Lobb, Self-Advocate Coalition of Kansas (SACK); Sherrie Vaughn, National Alliance on Mental Illness, Kansas; Ami S. Hyten, Topeka Independent Living Resource Center, Inc.; Matthew Neumann, LGBTQ Foundation of Kansas; Rev. Tony Carter Jr, Salem Missionary Baptist Church; LT. Sebe Masquat, Haskell Indian Health Center; Tawny Stottlemire, National Community Action Partnership

KDHE: Edward Bell, Preparedness Healthcare Coalition Program Manager Bureau of Community Health Systems; Rebecca Adamson, Preparedness Program Section Director Bureau of Community Health Systems

Supplemental Experts: Dennis Cooley, American Academy of Pediatrics, Kansas Chapter; John Carney, Center for Practical Bioethics

Staff: Tatiana Lin, KHI; Hina Shah, KHI; Samiyah Para-Cremer, KHI

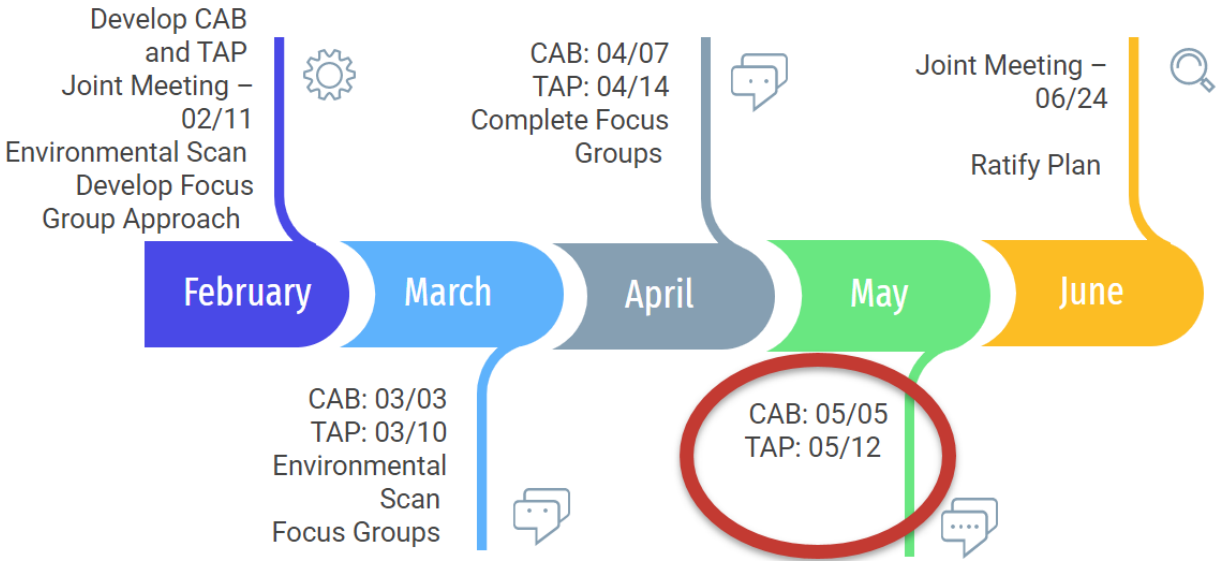
## *Welcome and Agenda*
CAB introduced themselves and the organization they represented as it was the first meeting for some members and some CAB members had changed organizations since the last meeting.

## *Project Progress and Debrief from TAP meeting*

**Update on Project Timeline**

KHI provided a general update on the timeline *(Figure 1)* of the CSC guidance document development process. KHI noted that focus groups and interviews with consumers, providers and consumer advocates had been completed and asked CAB to review the focus group results. KHI also explained that this is currently the second to last CAB meeting in this process, although there is a potential of adding an additional meeting in early June.

*Figure 1: CSC Project Timeline*




**Debrief from TAP March 10 Meeting**

Ami Hyten, CAB liaison to TAP provided her key takeaways from the April 14th TAP meeting including:

- TAP discussed equity in detail in relation to CAB's recommendations.
- TAP explained some concerns related to CAB recommendations being outside of the scope of the CSC guidance document. Ami stressed that it is important that crisis does not happen outside of a vacuum, and she explained the importance of including preventative steps recommended by CAB during the last TAP meeting.
- TAP identified concerns about the time and professional pressures placed on medical professionals during a crisis and that it was important recommendations were implementable so that people affected by triage decisions as well as those implementing the decisions were protected.

***Discussion:***

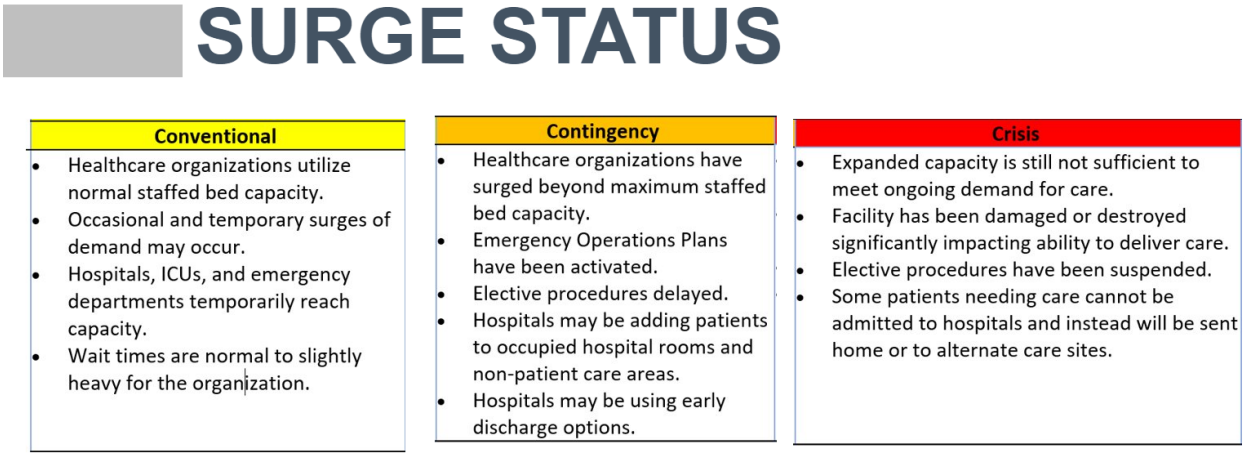
- A CAB member asked if TAP understood the importance of using plain language in the CSC guidance document so that it could be communicated easily to the public.
    - Ami explained that TAP is still working to determine the best way to implement this and would likely need assistance from CAB to translate guidance into plain language. SACK offered to assist
    - KHI also suggested the option of including a one-page summary document in plain language as a supplement to the plan so that consumers can better understand the guidance.

## *Review Draft Recommendations and Provide Feedback*

Using the information provided by CAB between February and April, preliminary results from focus groups and interviews, and findings from the environmental scan, KHI staff prepared draft language for CAB to consider as it developed recommendations during its May 5 meeting. Prior to the May 5 CAB meeting, the draft language was also reviewed by several TAP members, a KDHE staff member and the CAB liaison to TAP.

All recommendations were categorized based upon the surge status in which they would be implemented *(Figure 2)*. Recommendations may apply to one or more surge status conditions.

*Figure 2: Recommendation Framework*




**Overall Recommendations:**

| Surge Status | | |
|---|---|---|
| Conventional | Contingency | Crisis |

***CAB Recommendation 1.1.*** 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. *(No revisions)*

***CAB Recommendation 1.2.*** 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. *(Quotation marks omitted around "equitable" and "fair")*

***Context for Revisions:***

- **Recommendation 1.1:** No revisions suggested
- **Recommendation 1.2:** CAB members said that the quotation marks around these words communicated a lack of commitment to equity. They suggested that removing the quotation marks shows that the recommendation is meant to be implemented as written.

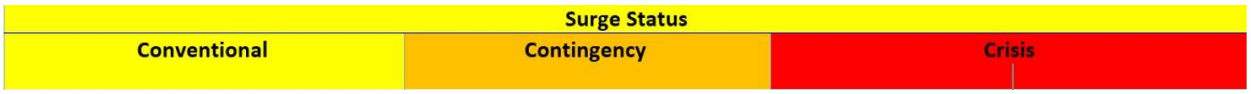
***Discussion***:

- **Appreciate Equity Focus:** The majority of CAB members appreciated the equity focus of these recommendations and felt that this better represents what CAB identified should be the focus for CSC guidance. CAB members said that the guidance document should fully commit to an equity focus.

- **Importance of Defining Equity in Plain Language:** Some CAB members identified that equity is not as clearly understood by the public as fairness and could also cause confusion as people with different political ideologies can have different interpretations of the word 'equity.' CAB members felt despite this, it was essential to use the terminology of equity and recommended defining it in plain language so that it can be used as a common term among readers. Some CAB members highlighted the importance of this definition incorporating ideas of justice.

**Personal Medical Equipment:**

Dr. Cooley presented the next recommendation to CAB. He explained that the intention was to include an explicit statement saying that patients' privately owned personal medical equipment would not be removed from them in the event that they entered a hospital using CSC standards.




***CAB Recommendation 1.3.*** 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 may 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.

***Context for Revisions:***

- **Recommendation 1.3:** To further clarify the intent of this recommendation, CAB proposed adding the context that patients would be considered for additional "hospital equipment" and adding an additional sentence at the end of the recommendation to reiterate that patients' medical equipment remains theirs even in situations where they may receive access to additional hospital resources that would replace this equipment during the time the patient was in the hospital.

***Discussion***:

- **Need for Greater Clarification:** Some CAB members interpreted the last sentence of this recommendation to say that the triage team would still discuss what to do with patients' personal medical equipment and reallocate it. Dr. Cooley clarified that was not the intention of the recommendation and CAB identified ways to clarify the language.

**Triage Process**


***CAB Recommendation 1.4.*** 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. (Omitted phrases)

***CAB Recommendation 1.5.*** 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.

***Context for Revisions:***

- **Recommendation 1.4:** CAB members suggested removing the phrases "to the greatest extent possible" and "aim to" to show a stronger commitment to this recommendation.
- **Recommendation 1.5:** CAB members suggested replacing "promoting representation of" with "to recruit and retain" to clarify the goal of the recommendation.

***Discussion***:

- **Language Provides Cover for Inaction:** CAB members said that language like "to the greatest extent possible" and "should aim to have" in recommendation 1.4 provided too much cover to hospitals to give the impression that they were working on this recommendation without authentically engaging with the action. Some CAB members said this "sounds like an out." Some CAB members said this language could give rural hospitals more flexibility to collaborate with external partners rather than attempt to do this on their own when it may not be feasible. CAB decided that it was still important to strengthen this language, particularly given the CSC guidance is already guidance so hospitals are not required to implement recommendations as written.
- **Recruitment and Retention:** CAB members said that for recommendation 1.5, the goal was less about promoting existing representation and more about recruiting and retaining people who fit the description. Some CAB members said that this may not always be possible, particularly for smaller rural hospitals but agreed with this being a goal.

## Triage Team Training and Dispute Process

**Conventional**

***CAB Recommendation 1.6.*** Triage team members and coordinators should receive advanced and ongoing training to prepare them for the role, including training in:

- Applying the allocation framework;
- Communicating with clinicians and families about triage;
- Avoiding implicit bias against persons of color and other marginalized groups;
- Improving cultural competencies; and
- Respecting disability rights.

***CAB Recommendation 1.7.*** Develop a process to resolve any disputes (placeholder). (No revisions)

***Context for Revisions:***

- **Recommendation 1.6:** CAB recommending adding a bullet point about improving cultural competencies of triage team.
- **Recommendation 1.7:** No revisions suggested

***Discussion***:

- **Cultural Competency:** CAB members said training in cultural competency was missing from recommendation 1.6

- **Importance of Appeal Process:** CAB members said it was important to have an appeal process to address concerns about how triage decisions are being made. However, CAB members were more comfortable with TAP drafting this appeals process because of TAP's expertise in the hospital environment. CAB members would like to review this process once drafted.

## Communication During Triage


**CAB Recommendation 1.8.** 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. (Word "fair" describing triage process omitted)

**CAB Recommendation 1.9.** 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.

***Context for Revisions:***

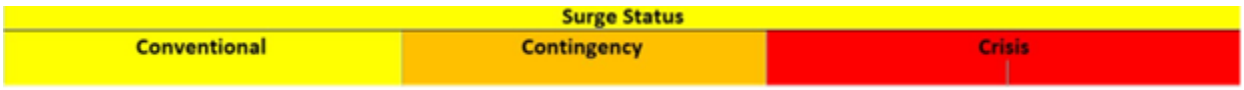
- **Recommendation 1.8:** Add that the communication will be in "plain linguistically and culturally appropriate language" and remove word "fair" to highlight the importance of focusing on equity versus fairness and place importance on using appropriate language that can be easily understood by patients and patients' families
- **Recommendation 1.9:** Add that the communication will be in "plain linguistically and culturally appropriate language" to place importance on using inclusive language (e.g., acknowledges diversity, conveys respect to all people, is sensitive to differences) that can be easily understood by patients and patients' families.

***Discussion***:

- **Using appropriate language:** CAB members said it was important that language used to communicate triage processes and decisions should be linguistically and culturally appropriate for the consumers and appear in plain language so that it is easily understood by all patients and patients' families.
- **Consistency with previous recommendations:** CAB members said that the word "fair" should be removed from recommendation 1.8 to prevent confusion given the equity focus of recommendations 1.1 and 1.2

## Correction Factors

Dr. Cooley provided an overview of the Social Vulnerability Index and Area Deprivation Index and the intent of using these tools to correct for social and geographic factors that could contribute to patients' health outcomes.




**CAB Recommendation 1.10.** Area Deprivation Index (ADI) or Social Vulnerability Index (SVI) data is gathered for all patients at intake so equity adjustments are readily available. (Omitted phrase "in the background" and changed surge level)

**CAB Recommendation 1.11.** 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. (No revisions)

***Context for Revisions:***

- **Recommendation 1.10:** Changed surge status to apply to all 3 surge conditions because CAB members said that it was important to apply correction factors at all surge stages, not only during a crisis. Also, the phrase "in the background" was removed for clarity.
- **Recommendation 1.11:** No revisions suggested

***Context for Revisions:***

- **Rationale:** Changed surge status to apply to all 3 surge conditions because CAB members said that it was important to apply correction factors at all surge stages, not only during a crisis. Also, the phrase "in the background" was removed for clarity.

***Discussion***:

- **Importance of Collecting ADI or SVI data at All Surge Stages:** CAB members said that it was important to consider patients' characteristics and potential vulnerabilities due to social determinants at all surge stages, not only during a crisis.
- **Confusion about "In the Background":** Some CAB members said the phrase "in the background" felt unnecessary for recommendation 1.10 and that the quotes suggested to them that there was a hidden meaning to this phrase. CAB members recommended removing this phrase.
- **Data Should be Available upon Patient Request:** One CAB member said it was important to provide information about a patients ADI or SVI score if the patient or the patients' family requested this information and suggested this be considered for future recommendations

**Survival as a Factor**

John Carney explained potential applications of these recommendations to CAB.


***Draft Recommendation 1.12.*** Use hospital survival to discharge. (No revisions)

***Draft Recommendation 1.13.*** Quality of life judgments or long-term life expectancy will not be used as factors in the allocation and reallocation of medical resources. (No revisions)

***Discussion***:

- **No revisions:** CAB members did not provide any suggestions for revisions or additional feedback regarding recommendation 1.12 and 1.13

## *Focus Groups*

KHI provided a brief update on the focus group results including response rate, demographics, and geographic distribution of participants across the state. Although there was insufficient time to go over all focus group results, KHI referred CAB members to the Focus Group Summary Document.

***Questions:***

- Are the demographics of participants representative of the state?
    - No, the participant demographics only provide a snapshot of those who participated in the focus groups
- Were these recommendations made mostly by older people?
    - We have not done this analysis to identify the age trends for each recommendation due to protect participants identities; however, across all participants 33.3% of respondents were aged 55 or older, 56.4% were aged 35 – 54 and 10.3% were aged 25-34.
- In relation to the question about the best way to decide who gets what medical resources and when, does the number of themes for consumers mean that they didn't agree or had challenges answering the question?
    - Consumers did not fully agree about which approach was best and also often suggested multiple approaches. We kept the number of themes for this question to capture consumers' many approaches
- Will you be able to present a shorter overview than the 30-page document?
    - KHI offered to record a short video recording reviewing the key findings from the PowerPoint that were not presented due to time constraints.

## *Next Steps*

KHI asked CAB members about their interest in and availability for attending an additional CAB meeting in June before the final meeting to ratify the plan if an additional meeting was offered. Some CAB members said June 16 after 3pm would work well for them. KHI said they would follow up with more information.

CAB members were asked to:

- Review the other recommendations shared in the framework document and provide feedback over email

Additionally, CAB members were advised of the following meetings:

- Thursday May 12, from 2-5pm, *Technical Assistance Panel (TAP) Meeting*
- Friday June 24th, from 2-5pm, *Final Joint CAB and TAP Meeting*