Crisis Standards of Care

Joint Community Advisory Board and Technical Assistance Panel Meeting

March 23, 2023

9:00am-11:30am

Agenda

9:00am	Welcome
9:05am	Task Team Updates
9:20am	Role of HCCs & Role of EMS Services
9:50am	Focus Group Findings
10:05am	Breakout Rooms
11:25am	Closing Remarks

Meeting Materials

Breakout Room Agendas; Focus Group Findings and Recommendations; Kansas Response Plan; Kansas Pandemic Plan; Task Team Minutes

Participants

Community Advisory Board: Ami Hyten; Amy Burr; Sherrie Vaughn; Glenda DuBoise; Liz Hamor; Winona Masquat (Sebe); Jan Kimbrell; Carter Olson; Kathy Keck; Matthew Neumann; Monica Cissell; Camille Russell

Technical Advisory Panel: Amy Kincade; Chrisy Khatib; Dan Goodman; Devan Tucking; Joan Duwve; Lillian Lockwood; James Roberts; Jean Hall; Jeanne Gerstenkorn; Jenifer Clausen; John Carney; Lacey Hunter; Leslie Anderson; Linda MowBray; Morgin Dunleavy; Rachel Monger; Sarah Irsik-Good; Scott Brunner; Dennis Cooley; Mike McNulty; Mike Burgess; Ron Marshall; Con Olson; Steven Simpson

KDHE: Ed Bell, Rebecca Adamson

KHI: Hina Shah; Tatiana Lin; Sheena Schmidt; Valentina Blanchard

Task Team Updates

- **Dennis:** The key themes coming up in the task teams include questions surrounding roles and responsibilities, centralization and regionalization, and transfers and discharges. Funding is also being discussed for both facilities and individuals, with a focus on independent facilities. Visitation issues, especially considering COVID-19, have arisen and the question of how to disseminate accurate information has been brought up. Partnerships have also been explored to facilitate coordination of care between facilities, and discussions around long-term care facilities' inclusion in community disaster planning have been ongoing.
- **Ami:** There is often a disconnect between what should happen and what actually happens in long-term care facilities, and that there is a lack of understanding about each

facility's plan and who is responsible for ensuring follow-up. From an equity perspective, resources are not distributed equally, and that long-term care facilities in areas of deprivation tend to have racially marginalized residents and staff who are more impacted by poverty and negative social determinants of health. There is a continued need to bridge the gap between plans on paper and experiences on the ground, and to create more equitable plans. It is also important to address cultural and linguistic barriers, trust issues, and communication access, including the provision of sign language interpreters. The group needs to build these considerations into the structure of emergency preparedness planning and ensure that they become a reality for end-users.

Roles of Health Care Coalitions (HCCs) (Ed Bell, KDHE)

- Kansas has 7 HCCs around the state that help track 142 hospitals, with the Kansas City Metro region being the smallest, but most populous.
- Each HCC has its own Readiness Response Coordinator (RRC), who facilitates meetings and assists members with updating and creating plans, exercises, etc.
- HCCs in Kansas are not recognized as response agencies, so they cannot initiate actions like declaring an emergency or activating a response plan, but they can work with local partners to assist in information sharing, communication, and resource sharing.
    - During COVID, HCCs expanded their mission to include logistical support and maintaining a supply cache, including personal protective equipment (PPE).

Questions/Discussion

- **Frustrations over political versus medical decisions:** During COVID, not all counties health departments followed recommendations. A lot of decisions are made at the local level. The County Boards of Health, which typically in each county are the Commissioners, have the authority for their county to enact public health recommendations.
- **Exercises to test response plans:** HCCs are mandated by ASPR (Administration for Strategic Preparedness and Response) to create and exercise surge plans each year and are required to take input from their region and apply it through tabletop and functional exercises. The role of HCCs in this is to facilitate and participate in the exercise, but they are not responsible for getting the exercises going.
- **Structure of meetings:** Meetings were long and only a handful of nursing homes would participate (3-4 out of 100 facilities). There was also no mechanism to share the information back with others.
    - Potential ideas included breakout sessions or separate long-term care pieces during the meetings (example in NE KS) and asking RRCs to look and expand on this model.

Role of EMS Services (Con Olson, President of Kansas EMS Association)

- EMS is not always involved in the creation of community plans. This can lead to a common misconception written in plans that one just has to make a phone call to request an ambulance and one will show up.

- The EMS field is not immune to the current workforce challenges. Participation rate on a transporting licensed ambulance service is near an all-time low, no matter if it is a small volunteer service or a large metropolitan service.
    - Priority is typically placed on 911 response when a surge happens, which leads to unanswered transfers unless an agency can respond from another county
    - It was not uncommon to get transfer requests for 200-300 miles, as opposed to the usual 60-70 miles during COVID
- Each of the 6 EMS regions meet periodically throughout the year to discuss training, response, plans for mutual aid, and how they can better the current operations.

Questions/Discussion

- **Private versus public limitations:** Regardless of whether an organization is private or public/not-for-profit, considerations about business interests and insurance should be looked at. No one wants to be the one at the patient's bedside talking about transfer abilities and what insurances will cover, but it is essential as EMS staff want to be good patient advocates.
    - There are also concerns around transporting equipment and requests being denied due to equipment being labeled as "in facility use only."

Focus Group Findings and Breakout Room Discussion

- Recruitment strategies included social media advertising, partner outreach to members and networks, and TAP and CAB member recommendations.
- 8 focus groups were conducted with a total of 35 individuals participating (31 in focus groups, 4 in interviews).
    - While most participants were from NE and NC Kansas, there were participants from every KDHE-outlined region in the state.
- The Pre-Focus Group and Interview Survey was completed by 14 of 24 hospital and long-term care facility members and 8 of 11 caregivers.
- Key recommendations were able to be grouped into 6 main categories (Emergency Preparedness and Response, Communication and Collaboration Between Facilities, Technology and Remote Support, Caregivers and Family Involvement, Staffing and Retention, Patient Transfer and Continuity of Care, and Implementation of KSCSC and Support).
    - Some concerns included caregiver access to loved ones, routine disruptions, staffing shortages and ability to meet residents' needs, communication channels, transferring of residents and sharing medical records, and the decision-making process.
- The Healthcare Crisis Passport matches the regulations that LTC facilities have when they do a transfer, and individually addresses each resident or patient's requests. The Long-Term Care Ombudsman Office would be able to provide training that facilities could use as a model for their residents.

- https://ombudsman.ks.gov/docs/default-source/default-document-library/kansas-long-term-care-ombudsman-healthcare-crisis-passport-revised-9-30-22.pdf?sfvrsn=86dc3007_4

Breakout Room Feedback

Recommendation	CAB Feedback	TAP Feedback
Enhance emergency preparedness (2): Long-term care facilities should develop and implement comprehensive emergency preparedness plans to address safety concerns during a crisis and conduct regular drills. Staff members should receive regular training on emergency protocols and procedures to ensure preparedness in the event of a crisis. Potential revised recommendation (based on CAB and TAP): **Enhance emergency preparedness** (2): Long-term care facilities should develop and implement comprehensive emergency preparedness plans to address both safety concerns and infection control during a crisis and conduct regular drills. All staff members, including permanent, temporary, and agency staff should receive regular training on emergency protocols and procedures to ensure preparedness in the event of a crisis. Particular focus should be placed on addressing any non-compliance with emergency preparedness requirements, the inadequacy of training and drills, and maintaining effective infection control measures	• Address non-compliance and ineffective implementation of emergency preparedness plans/protocols • Include temporary and agency staff in training and drill to enhance their preparedness for emergencies • Emphasize the responsibility of staffing agencies to provide emergency preparedness training to staff • Consider changing the language in the recommendation to refer to "providers" rather than "long-term care facilities to ensure that ensure that staffing agencies are also held accountable for compliance with emergency preparedness requirements.	• Infection control should be a part of quarterly drills and exercises. • Staff turnover is a challenge; suggested making protocol easily accessible and included in staff orientation • Member noted making reference to Appendix Z for this recommendation which refers to emergency preparedness requirements • Emergency preparedness should be a daily occurrence and not just reserved for emergencies • Include staffing agencies in emergency preparedness protocols and trainings

Recommendation	CAB Feedback	TAP Feedback
Ethics Training (28): Provide additional training and support for staff to prepare for an emergency, including how to make ethical decisions about resource allocation Potential revised recommendation (based on CAB and TAP): **Ethics Training** (28): Provide additional training and support for staff members, including those that provide care to patients and residents, to prepare for an emergency. This training should include guidance on how to make ethical decisions about resource allocation and during crisis situations. Additionally, incorporate diversity, equity, and inclusion (DEI) training as a fundamental component of ethics training to ensure that staff are equipped to address the diverse needs and identities of individuals, prevent discrimination, and promote equitable care, especially during emergencies.	• Make sure that Diversity, Equity, and Inclusion (DEI) has is part of the training • The training should also focus on the needs of the individuals with disabilities, elderly individuals, and those in rural areas	• There was some confusion around if decision-making at LTCs involved triage process • LTCs should have a working knowledge of acuity of care for residents • There is a need for clarity and formalization of protocols in LTCs to ensure ethics in decision-making occurs during emergencies • Staff understanding decision-making process related to resource allocation is key for communicating with families and caregivers • Need for patient-centered decision-making in these decisions • Group wanted to change resource allocation to make it more broad and not to confuse it for a triage process

Recommendation	CAB Feedback	TAP Feedback
Collaboration with EMT (63): Develop relationships with local emergency management teams to access supplies and resources during crises. **Potential Revision**: **Collaboration with Local Emergency Management Entities (63):** Develop relationships with local emergency management professionals (e.g., Local Emergency Planning Committees, EMS and Healthcare Coalitions) to access supplies and resources during crises	• No specific changes	• Developing relationships and involving EMS in local emergency planning committees and healthcare coalitions is crucial. • Stakeholders such as hospitals, nursing homes, fire, law enforcement, and other businesses in the community should be involved. • Some counties lack active participation in LEPCs, making it difficult to move projects and meetings forward. • The language used, such as "emergency management teams," needs clarification. .

Recommendation	CAB Feedback	TAP Feedback
Prompt alerts (131): Implement a system for prompt alerts through email, fax, phone calls, or text messages, similar to an AMBER alert system, to notify administrators of a crisis in a timely manner. **Prompt alerts (**131): **Utilize state associations, licensing authorities, an existing system (e.g., EMResource), and local health departments as key channels for disseminating critical information and prompt alerts to long-term care facilities (LTCs) in a timely and efficient manner. Alerts can be disseminated through various methods, including email, fax, phone calls, or text messages, to notify LTCs of a crisis promptly. Recognizing that some long-term care facilities may not be members of provider associations, develop and implement alternative methods of communication to ensure that all facilities receive timely and relevant information during a crisis.**	• Utilize state associations and licensing authorities as key channels for disseminating critical information to long-term care facilities in a timely and efficient manner. • Recognizing that some long-term care facilities may not be members of provider associations, develop and implement alternative methods of communication	• Not all long-term care facilities are included in KSHAN alerts, a system that pushes out alerts to hospitals. • Long-term care facilities are being added to EMResource, and there are efforts to push messaging out through that system. • Long-term care facilities would need to individually sign up for messaging, and HCCs could potentially assist with signing them up. • Local health departments could play a role in notifying LTCs about emergency situations • Wanted clarification on who would decide to send out prompt alerts and who would be in charge of monitoring them. • Suggested re-wording recommendation to note existing systems available for such alerts. The inclusion of AMBER alert was confusing, so suggested taking that out.

Recommendation	CAB Feedback	TAP Feedback
Liaison Role (7): Develop a liaison role between long-term care facilities and hospitals to facilitate ongoing communication and collaboration. This could involve designating a staff member from each facility to act as a liaison and setting up regular meetings to discuss shared concerns and updates. Note: The recommendations from CAB and TAP were not combined because they communicate different concepts. CAB suggested that the liaison role could be assigned to an existing staff member within each long-term care facility and hospital and emphasized the need to clearly define the responsibilities of the liaison. TAP mentioned the role of Healthcare Coalitions (HCCs) in acting as the liaison between long-term care facilities and hospitals and highlights the importance of designated staff members attending relevant meetings organized by HCCs.	• Role could be assigned to an existing staff member rather than creating a new position • Roles and responsibilities of liaisons should be clearly defined • There is a need for accountability and mutual understanding between healthcare facilities and hospitals **Potential Revision**: Develop a liaison role between long-term care facilities and hospitals to facilitate ongoing communication and collaboration. The liaison role could be assigned to an existing staff member within each facility, rather than creating a new position. This staff member would act as a point of contact and coordinator between the long-term care facility and hospital. Clearly define the liaison role and its responsibilities, which may include facilitating communication, coordinating patient transfers, and ensuring that essential information is shared between facilities.	• The Facilitator clarified that some communities are already participating in regional facility meetings or ad hoc meetings with facilities they work with regularly. • Healthcare coalition meetings are recommended to break all the members together and take advantage of the opportunity to collaborate. • The recommendation is to have the HCC hold the liaison role in these meetings and hold regular meetings. **Potential Revision:** Ensure Healthcare Coalitions (HCCs) are acting as a liaison between long-term care facilities and hospitals to facilitate ongoing communication and collaboration. This could involve ensuring a designated staff member from each facility is aware of and attends any relevant meetings.

Recommendation	CAB Feedback	TAP Feedback
Regular Meetings (8): Implement regular meetings and ongoing communication between long-term care facilities and hospitals to ensure that all parties are on the same page regarding patient care needs and resources, especially during times of crisis or public health emergencies. Potential Revision (based on TAP): **Regular Meetings** (8) Healthcare Coalitions (HCCs) should hold regular meetings to ensure that long-term care facilities and hospitals are on the same page regarding patient care needs and resources, especially during times of crises or public health emergencies.	• No specific changes	• See notes for Recommendation 7 above (Liaison Role)

Recommendation	CAB Feedback	TAP Feedback
Caregivers as a Resource (42): The focus group suggested involving caregivers as a resource to help meet the needs of residents in long-term care facilities. Potential Revision (based on TAP): **Caregivers as a Resource** (42): Involve able, available, and willing caregivers as a resource to help meet the needs of residents in long-term care facilities when possible. Caregivers can provide valuable support and assistance to residents, contributing to their overall well-being and quality of life.	• No specific changes	• Caregivers and family members can be identified as a volunteer base to help with decision-making. • The lessons learned from the COVID-19 pandemic, including restrictions on facility access, can be used to elevate family members and caregivers as a resource rather than excluding them. • Regulations and laws must be considered, but efforts can be made to explore ways to involve family members and caregivers in decision-making, such as identifying limitations and exploring what can be put in place to allow their involvement. • The group suggested re-wording the recommendation to include able, available and willing caregivers. Given some federal guidelines and other regulations, the group considered softening the language to "when possible" **Potential Revision:** Involve able, available, and willing caregivers as a resource to help meet the needs of residents in long-term care facilities when possible

Recommendation	CAB Feedback	TAP Feedback
Family Members as Decision-Makers (91): Involve family members and caregivers in the decision-making process and the transfer process to ensure the well-being of the resident. Potential Revision (based on CAB and TAP) (91): To prioritize the well-being of residents, facilities are encouraged to take all feasible measures to actively involve family members and caregivers in both the decision-making and transfer processes.	• No specific changes	See notes for recommendation 42 above (Caregivers as a Resource). **The group suggested changing the language to indicate that facilities should involve caregivers "when possible"**

Recommendation	CAB Feedback	TAP Feedback
Transfer protocol templates (67): Establish templates for transferring patients between hospitals (and LTC and hospitals) to ensure that all necessary information is communicated accurately and efficiently. Potential Revision (based on CAB and TAP): **Transfer protocol templates** (67): To improve patient transfers between healthcare facilities, standardized transfer templates should be established with the following key elements: • Include residents' social needs to provide patient-centered care. • Specify minimum information requirements, such as transferable physician orders for patient preferences. • Utilize existing agreements with other facilities to streamline transfers. • Consider a dedicated transfer team to coordinate and manage the transfer process. • Explore the use of a health passport—a portable document with key health information—for transfers.	• Transfer protocols should include information about the social needs of residents • Templates should include minimum requirements for information to be submitted during transfers, with consideration given to including transferable physician orders for patient preferences	• Existing agreements with other facilities should be considered and worked on. • A transfer team may be needed to oversee transfers and ensure all necessary information is communicated. • The idea of including health passport for transfers in the recommendation was discussed.

Recommendation	CAB Feedback	TAP Feedback
Formal Transfer Agreements (75): To improve the ability to transfer patients during a crisis, it may be helpful to establish formal agreements among hospitals and hospitals and LTC for transfers. Potential Revision (based on CAB and TAP): **Formal Transfer Agreements** (75): To enhance the ability to transfer patients during a crisis, it is essential to establish formal agreements between hospitals, and between hospitals and long-term care (LTC) facilities, for patient transfers. These agreements should be established prior to the occurrence of crises and should detail the process for transfers between facilities. An emphasis should be placed on honoring a resident's right to choose, particularly in cases where there may be a difference of opinion between the resident and their family. While hospitals commonly have transfer agreements in place, these may not always prove effective or be utilized during a disaster or emergency situation, especially when hospital beds and staff resources are scarce. Therefore, the establishment and review of these agreements should take into consideration potential challenges in their feasibility and execution during times of crisis.	• Agreements should be established before crises, detailing the process for transfers between facilities • Emphasis on honoring a resident's right to choose, particularly when there's a difference of opinion between resident and family	• Hospitals have transfer agreements, but these may not always be effective or used in a disaster or emergency where beds and staff are scarce. • Consider removing for lack of feasibility

Transfer team (94): Consider using a dedicated transfer team or staff member (in hospitals and LTC) to oversee transfers and ensure that all necessary information is communicated and that follow-up communication occurs after the transfer. Potential Revision (based on CAB and TAP): **Transfer team (**94): Consider using a dedicated transfer team or staff member (in hospitals and long-term care facilities) to oversee patient transfers and ensure that all necessary information is communicated, and that follow-up communication occurs after the transfer. Ensure that individuals who are assigned as part of the transfer team have established communication with potential transfer sites and are responsible for providing oversight to the transfer process, including overseeing that all paperwork, such as medical and social needs, have been adequately communicated. The transfer team could consist of staff, social worker, ombudsman, or volunteer when feasible. Additionally, identify ways to address the feasibility of having dedicated transfer teams available 24/7, especially since transfers often happen outside of regular business hours	• Ensure that individuals who are assigned as part of the transfer team have established communication with potential transfer sites and are responsible for providing oversight to the transfer process, including overseeing that all paperwork, such as medical and social needs, have been adequately communicated • Identify ways to address the feasibility of having dedicated transfer teams available 24/7, especially since transfers often happen outside of regular business hours.	• Hospitals have discharge coordinators and discharge teams. • Long-term care facilities typically have a social service desk or social worker to help with coordinating discharges. • Community health workers could play a role in transfer teams in long-term care facilities, but the workload and facility size could affect their feasibility. • Nurses or staff members are sometimes sent with patients during transfers to ensure that they have everything they need, and the information is communicated properly. • The idea of having volunteers or ombudsman accompany patients during transfers was raised, but the availability of such people would need to be considered. • The circumstances of the transfer, such as whether the patient is going by ambulance or not, would also need to be considered when considering the feasibility of a transfer team. • Volunteers or ombudsmen could potentially help in some cases, depending on the urgency of the transfer. • The group also suggested using the National Guard or other resources for this purpose, but that would require a state declaration of emergency **Potential Revision:** Consider using a dedicated transfer team or staff member (in hospitals and LTC) to oversee transfers and ensure that all necessary information is communicated, and that follow-up communication occurs after the transfer. The team could consist of staff, social worker, ombudsman or volunteer when feasible.

Recommendation	CAB Feedback	TAP Feedback
Discharge Plan (98): Develop a clear discharge plan that includes recommendations for care and involves caregivers in decision-making. Potential Revision (based on CAB and TAP): **Discharge Plan (**98): Develop a clear discharge plan that includes recommendations for care and involves caregivers in decision-making. The plan should be shared with caregivers and the receiving long-term care facility, and it should indicate a recommendation for the facility to proactively engage with patients' caregivers or family members to discuss their concerns, preferences, and any relevant information. Address concerns about residents being discharged too quickly, without proper notification or guidance, by ensuring that the discharge plan is thoroughly communicated and agreed upon by all parties involved.	• Plans should include specific recommendations for the receiving long-term care facility to proactively engage with caregivers or family members. • The plan should be also shared with a patients' caregivers or family members. **Potential Revision:** Develop a clear discharge plan that includes recommendations for care and involves caregivers in decision-making. The plan should be shared with caregivers a long-term care facility and indicate a recommendation for the receiving long-term care facility to proactively engage with patients' caregivers or family members to discuss their concerns, preferences, and any relevant information.	• The group discussed discharge planning during emergencies and the need for clear plans. • A member shared resources in the chat, such as a healthcare passport. • There was concern about residents being discharged too quickly, without proper notification or guidance. • The group noted the requirement for discharge instructions and plans for all hospital patients, but one member explained it can be a slow and cumbersome process of notifying the MCO or care manager when an individual goes to the hospital. • It was noted that involving caregivers in discharge planning is important for keeping them informed. • No specific changes recommended.

Recommendation	CAB Feedback	TAP Feedback
Alternative Approaches (109): Consider alternative approaches to transfers, such as telemedicine or on-site medical care, to minimize the need for transfers and ensure continuity of care. Potential Revision (based on TAP): **Alternative Approaches** (109): Consider alternative approaches to transfers, such as telemedicine (when allowable) or on-site medical care, to minimize the need for transfers and ensure continuity of care. This could include ensuring proper training for the use of technology, auditing to verify compliance, and taking measures to ensure the proper use of these alternative approaches	• No specific changes	• The group noted that there may need to be waivers in place to allow for using telemedicine and other alternative approaches (clarify using telemedicine when allowable) • The group noted grants and funding for facilities to purchase necessary devices and equipment. • Indicated need for auditing of facilities that receive funding to ensure proper use and compliance. • Noted there should be collaboration between long-term care facilities and local hospitals or healthcare providers to establish agreements and contracts for telemedicine services. • Operationalizing telemedicine services at the facility level by ensuring necessary permits and agreements are in place. • Dispersing devices and equipment throughout the community, including to AAAs. •

Recommendation	CAB Feedback	TAP Feedback
Monitor and Evaluate (111): LTC staff should continuously monitor and evaluate the effectiveness of family involvement in decision-making and transfer processes to identify areas for improvement and make necessary changes.	• No specific changes	• Did not discuss
Retention Plan (51): A retention plan that includes competitive salaries, opportunities for professional development, and a positive work environment can help to improve morale and reduce turnover rates.	• Facilities had a tough time offering competitive salaries with some of the other offers that were available (i.e., for travel nurses)	• Did not discuss
Community-driven solutions for staffing shortages (58): LTC facilities should work with local communities to identify and implement strategies for addressing staffing shortages during times of crisis.	• No specific changes	• Did not discuss
Adjust staffing roles and responsibilities (62): Staff members suggested adjusting staffing roles and responsibilities at LTCs to better meet the needs of residents during times of crisis or when care is being rationed.	• No specific changes	• Did not discuss