Dana Hargunani: House Interim Special Committee on COVID-19 Response

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Oregon Crisis Standards of Care Amidst Scarce Critical Care Resources

Chair Dexter, Co-Chairs Prusak and Hayden, and Members of the Committee: my name is Dana Hargunani. I am the Chief Medical Officer of the Oregon Health Authority. Thank you for the opportunity to speak with you today.

I am here to share an update regarding crisis care guidance in Oregon. I am going to start with a historical view on this important topic, closing with the latest actions that the Oregon Health Authority has taken a week ago in face of this Omicron surge.

The health authority has had a longstanding role with respect to crisis care guidelines in Oregon. Beginning in 2014, a group of dedicated health care providers and public health experts, with the assistance of the health authority, convened workgroups to discuss and try to agree upon ways to provide health care if we were to face a dire situation in times of scarce healthcare resources such as staffing, ventilators or other critical resources. These actions were part of a national movement to develop crisis standards of care spurred by public health emergencies including Hurricane Katrina in 2005 and the H1N1 pandemic in 2009. These efforts were also sparked by the 2013 publication of a foundational crisis standards of care toolkit published by the Institute of Medicine. By the time the first COVID-19 cases were identified in Oregon, our latest crisis care guidance was just under two years old, published in June of 2018.

Early in the COVID-19 pandemic, concerns were quickly raised that Oregon's crisis care guidance did not account for the fact that communities that have experienced long-standing health inequities due to social injustice and resulting in chronic disease may be disproportionately disadvantaged in the guideline's approach. Concerns were also raised that the process to develop crisis care guidelines did not include individuals most disproportionately impacted by health inequities, such as Communities of Color, Tribal communities, and individuals with disabilities.

As clearly described in a complaint delivered to the Office of Civil Rights, authored by Disability Rights Oregon and multiple other organizations, we soon recognized that the 2018 guidelines had the potential to perpetuate discrimination on the basis of race, age or disability. For these reasons, OHA soon announced its decision to no longer reference the 2018 crisis care guidance and began preparing for a process to co-develop new guidance with a broader set of partners and focused on equity.

Facing a large surge of COVID-19 cases in the fall of 2020, OHA quickly pivoted to publish a set of health equity principles for resource constrained events, while continuing to plan for a more robust, transparent and community-driven set of standards. This 2020 principles document, the *Principles in Promoting Health Equity in Resource Constrained Events*, emphasizes that the key principles of ***non-discrimination, health equity***, ***patient-led decision-making***, and ***transparent communication*** should be applied when allocating scarce critical resources in the face of a public health crisis.

Once published, the health authority recommended that health systems take immediate next steps to incorporate the principles into crisis care planning and procedures. We also specifically asserted that,

when applying the principles of non-discrimination and health equity, the following factors should be excluded from consideration when allocating scarce resources in a public health crisis:

- Underlying conditions or disability; specifically, any approach to triaging care should not categorically exclude patients on the basis of a known or suspected co-morbidity or underlying health condition- including but not limited to, disability status such as the presence of physical, mental or behavioral health conditions, or intellectual, developmental or other disability.
- Long-term life expectancy, such as survival in 5-10 years, in which people of color, people with disabilities and other communities are disadvantaged due to long-standing toxic stress, trauma, systematic genocide, colonization and other factors.
- Resource utilization or judgements about quality of life, which can lead to the systematic deprioritization of resources for individuals with developmental, intellectual, and other disabilities, older adults, and individuals from Communities of Color.
- Personal ventilators, which some patients are dependent upon outside a public health crisis.

Our principles also state that any approach to triaging care when resources are limited should not be based on morally or scientifically irrelevant considerations, such as socio-economic status, race/ethnicity, gender identity, sexual orientation, national origin, immigration status, faith orientation, parental status, ability to pay, insurance coverage, disability, or solely on the basis of age.

OHA recognizes that the principles document was an important but limited step. And throughout much of 2021, we had to focus on mitigating the need for crisis standards of care, through the roll-out of COVID-19 vaccines, the implementation of the regional resource hospital collaborative, therapeutics and much more.

By this December we were finally ready to announce the open application process for the upcoming Oregon Resource Allocation Advisory Committee, just as Omicron was announcing its own arrival. With an Omicron surge expected to top that of the Delta variant, immediate risks to hospital capacity have become ever more real. In response, last Friday the health authority released an interim crisis care tool-based in our equity principles- that hospitals can use to prioritize care in the face of limited intensive care beds, ventilators and other life-saving critical care resources should it be needed.

I know that every healthcare provider wants to do everything they can to take care of patients in the best way possible. Hospitals throughout this pandemic have been maximizing their coordination to manage available resources and coordinate the transfer of patients to the hospital that is best situated to serve the patient's needs. With the rise of Omicron cases in front of us, there may be a future point that our resources and options are limited.

Oregon hospitals may activate crisis standards of care if their critical care resources are severely limited, the number of patients presenting for critical care exceeds capacity, and there is no option to transfer patients to other critical care facilities. The tool we have provided can help frontline healthcare providers make difficult decisions in a way that is fair, nondiscriminatory and focused on health equity.

Communication and transparency amidst a public health crisis have been longstanding, agreed upon principles. As required by a temporary rule filed by OHA this week effective January 17th, hospitals will need to provide notice to the health authority and inform the public when critical care triage decisions are being made. They must make available upon request, the triage decision-making tool, protocol or

standard that the hospital is using to make these triage decisions. They must communicate a triage decision to a patient, their support person, or the individual legally authorized to act on behalf of the patient, in a language they understand and in a culturally responsive manner to the extent possible given the emergency, including how the triage decision was made. Hospitals must provide patients information about how to contact the hospital's Americans with Disability Act coordinator or patient advocate, and document specific information for each patient undergoing triage for scarce resource allocation.

When following the interim crisis care tool, the first steps involve determining if a patient needs critical care resources, and if so, determining whether admission to the intensive care unit aligns with the patient's care preferences. For example, it is important to take care to understand whether or not a patient wants life-sustaining treatments such as being intubated and mechanically ventilated. Supported decision making will be used for patients with limited or low capacity to make decisions about their health. This will allow patients with disabilities to identify support people to help the person with a disability understand, consider, and communicate their own, informed, decisions. If the answer is yes to both of those questions, the next step is to determine if there are adequate resources to meet the critical care needs of all patients. If the answer is no, then the crisis care triage protocol would be activated.

As part of the triage protocol, the treating provider(s) would present the pertinent clinical information about the patient to a separate triage team. The triage team would then assess the likelihood of that patient surviving the hospital stay using objective, medical information. Those patients that are most likely to survive and make it to hospital discharge based on an individualized assessment would be prioritized for critical care resources above those that are less likely to survive the immediate clinical event. The triage team is the one that is faced with the extremely difficult task of determining who would get a life-sustaining treatment based on this prioritization.

While we certainly hope this situation does not come to bare, we want hospitals to have the objective tools they need that are based in fairness and nondiscrimination in the event that critical resources are insufficient to meet the needs of all patients.

For hospitals with an existing crisis care tool relating to scarce critical care resources, they may continue to use the existing tool so long as it is consistent with the principles outlined in Principles in Promoting Health Equity in Resource Constrained Events and does not violate state or federal anti-discrimination laws, or any other applicable laws.

Again, we know that our nurses, doctors and other frontline healthcare workers have been working incredibly hard and they are exhausted, while now facing the rising surge of Omicron. We hope that the interim crisis care tool can assist hospitals at this difficult time and in the event of scarce critical care resources. We recognize that this interim tool remains imperfect and inadequately addresses health inequity, even as it better incorporates Oregon's non-discrimination, health equity principles into difficult triage decisions.

OHA remains committed to urgently continuing our parallel work to co-create new tools for the allocation of scarce resource with our community partners and healthcare providers in Oregon and will convene a new Oregon Resource Allocation Advisory Committee this winter. The call for applications is open through January 28th. This committee will inform revisions to OHA's 2020 published principles and

the interim crisis care tool and guide the development of any additional necessary resources that help to center health equity in processes and decisions when healthcare system resources are scarce.