Oregon Public Health Division
MEDICAL ADVISORY GROUP
Meeting Minutes
April 30, 2007

Participating: (Attendance list at end of minutes)

Opening:
Susan Allan began the meeting by noting that it is the 5th meeting of the MAG, with one scheduled meeting remaining, May 31. This meeting is intended to be highly practical, bringing together much of the foundational work that has been done in the previous 4 meetings.

Update on National and State Issues:
National Issues: Paul Lewis provided information on a variety of documents and policies that have contributed to advancing public health preparedness, including the following:
- CDC's recent document, Community Strategies for Pan Influenza (http://www.pandemicflu.gov/plan/community/community_mitigation.pdf)
- CDC's Ethical Guidelines in Pandemic Influenza (http://www.cdc.gov/od/science/phec/panFlu_Ethic_Guidelines.pdf)
- AHRQ's Altered Standard of Care in Mass Casualty Events (http://www.ahrq.gov/research/altstand/)
- New York State Health Department Releases Ventilator Allocation Guidelines (http://www.health.state.ny.us/press/releases/2007/2007-03-16_ventilator_allocation.htm)

State Issues: Susan provided information on the following:
- TOPOFF Exercise: Oregon will be one of 3 jurisdictions participating in this 4th nationally based mobilization exercise, along with Arizona and Guam. The exercise will occur over 10 days in mid-October 2007, sometime after October 10. It will be based on a "dirty bomb" scenario in an urban area, will be highly visible, and will include participation from all hospitals, both ambulance companies, emergency responders, etc. We will discuss possible involvement of MAG at the next MAG meeting.
- HB 2185: Susan noted that the hearing on HB 2185 went well and that it passed out of committee. She thanked Heather Hue, Bob Shoemaker, Dana Braner, and Steve Jones, all of whom attended the hearing and testified in support of the bill. The provisions of the bill include:
  - Authorization for the Health Director to issue guidelines for emergencies
  - Updates to statutory provisions for quarantine and isolation
  - Authorization to close schools during public health emergencies
  - Provision of clearer authorities to the Health Director regarding toxics
  - Authorization to act regarding mass casualties

  The bill now needs to pass out of the respective chambers; signature by the governor is anticipated once the bill passes. The bill is budget neutral.

Ethical Framework: Practitioner's Version:

Paul led a review of the one-page working draft, which was developed by incorporating the major provisions of the longer framework developed principally by John Tuohey. The purpose of the tool during the meeting was to identify any needed modifications and to test its utility through two tabletop exercises. Comments on its content included:

- There is a need for a general intention statement at the beginning that make it clear that the application of the principles are intended to guide population-level decision making in a way that is relationship-based.
- The matrix should be appropriate for use in both times of emergencies and under everyday circumstances.
- Consider using "interdependence" as an ethical principle with Social Solidarity
- Consider using questions as the descriptors for characteristics and ethical principles. Questions could be placed on the back of the matrix
- "Equity" needs to be added back into the Justice part of the matrix

Anthrax Experience:

Susan led the MAG through a review of the Anthrax experience in Florida, NYC, and in particular in the Capitol Region in 2001. A copy of her PowerPoint presentation is available at (website address). She highlighted the several missteps and response problems that occurred at the Federal, State and local levels. The question was then posed, How would this occur in Oregon? Some of the responses follow:

- It would be very helpful to respond in a way that addresses issues related to race and social issues, to prevent the appearance of a two-level response that occurred in the Capitol Region
- In Oregon, the Governor would declare an emergency and put the Health Director in charge, as opposed to the process used in the Capitol Region.
- Even if an emergency wasn't declared, the new bill/law (HB 2185) would help
- There are still challenges to be faced with the Feds
- Metropolitan overlap does exist in the Portland area; however, to some degree this is mitigated through the tri-county health officer pact
- We do have blast fax capability here to rapidly reach providers
- The private medical community is more aware of public health
- The Internet and blogs can put a lot of information out quickly
- Population panic would still be likely to occur
- Messaging would be critical, especially using real-time communication
- A list of "givens" would be helpful for providers and other stakeholders
- How do we increase trust in the state health department (and local health departments) as social institutions?
- Among the population, the lack of control will lead to anger. The question is how angry will people get? The greater that awareness and trust exists, the more likely anger won't reach a tipping point
- We need to take a proactive stance to explain such issues as the value of testing, where testing is not useful, the utility of drug therapies, and explain benefit vs. risk for the population
- A highly visible, credible person with strong credentials would help (the Dr. Koop idea)

- Absolutely need to assure that information that goes out is consistent and as accurate as possible
- However, we need to accept that confusion will simply be part of the context.

Tabletop #1: Tamiflu

Paul Lewis introduced the topic with several slides, available on the website at www.----- . The slides identified the current (planned) availability of Tamiflu to Oregon from the federal stockpile (500,000 doses). The scenario for discussion reflected the real-life availability of an additional 300,000 doses at a discounted cost to Oregon of $5 million, and the interest of state legislators in appropriating funds for that purpose. Paul shared a set of assumptions including the limited effectiveness of Tamiflu. The MAG discussed the advisability of investing $5 million, and the possible consequences of not. Among the ideas shared were the following:

- No shelf life extension is permissible, so the supply could outdate before it is used
- While side effects are minor, instances of psychiatric symptoms have occurred in adolescents
- Given the federal protocol of using it for treatment, and the limited effectiveness after 2-4 days of onset of illness, it would be very difficult to get to patients soon enough to be effective; thus, not a good value
- The legislature understands the limitations but wants to assure that something is done
- The very availability of the Federally-supplied doses will lead to panic among those who can't get it
- "I'm underwhelmed by the efficacy and wouldn't take it unless I was morbidly ill"
- If communication from the state clearly shared the limited effectiveness and potential problems with adolescents, it could help build trust
- There likely would be unintended consequences of making Tamiflu available; remember Swine Flu!
- What is the balance here between doing good and doing harm?
- We could consider this in the context of the long term, and use some of the $5 million for building infrastructure
- There likely will be more money/doses available if an emergency actually happens
- Consider putting the $5 million into a reserve emergency fund, to be used only if necessary, and not buy the extra doses now
- If accepting the 500,000 federal doses makes sense:
    - The obligation to protect is satisfied
    - Buying additional doses strays from the obligation
    - While peace of mind and social solidarity might be addressed, the additional purchase would undermine Integrity, Beneficence, Non-maleficence and Stewardship.
- However, most states are purchasing the extra doses, putting pressure on policy makers here
- However, if we buy more doses, we are not adding more protection but are creating increased competition for doses
- We could offer people something else that would lesson their risk, like highly promoted hand washing, covering the cough, etc.

- We've already given a mixed message by planning to accept the federal doses, and the mixed message is out there simply by having the federal doses available.
- We can't state definitively the utility of the investment
- Legislators are saying "maybe this doesn't work well, but you should try it. If you don't we face the risk of fire and police not going to work.
- Ways and Means Committee might be more hard headed and pragmatic about buying the added doses.
- MDs, RNs, pharmacists and other health professionals have the ethical duty to teach hand washing, covering the cough, and the "elbow bump"
- As an alternative view, if we don't buy the Tamiflu, we risk the consequences of serious criticism from the press and public if an outbreak occurs and goes badly, and we risk credibility with the legislature.
- Based on that, suggest going after the $5 million, spending some on infrastructure and some on Tamifu
- It is difficult to say no to the politicians
- Consider the likelihood that the private sector (Safeway, etc.) will purchase Tamiflu and make it available to the public as they do now for vaccine.

Attempt at a Summary of Opinions:

- The issue is very complex
- Go after the $5 million, and use a portion to build needed infrastructure
- Communication is critical, both to the public and to the provider community
- Transparency is essential
- Providers need to carefully consider the evidence basis for use of the drug
- Continue to build an evidence base
- Continue to develop plans re Tamiflu use before a crisis occurs

Application of Ethical Framework Matrix:

- Some components are satisfied or can be satisfied with purchase of Tamiflu
    - Subsidiarity
    - Transparency
    - Reciprocity
    - Duty to Act
    - Integrity
    - Autonomy
    - Confidentiality
    - Disclosure and Informed Consent
- Those which would be challenging to satisfy:
    - Beneficence
    - Non-maleficence
    - Stewardship

Tabletop #2: Altered Standards of Care

Paul introduced the topic of altered standards of care with a PowerPoint presentation, available on the MAG website at www.-----. Among the points made were the following:

- JCAHO now requires hospitals to relax standards in the event of an emergency, with subsequent verification as soon as possible

- In a public health emergency in Oregon, there is no requirement for pre-certification of providers
- Among the many challenges to altering standards of care are the following:
    - Physician liability
    - Physicians may not be directly responsible for patient outcomes
    - Unless there are clearly stated and specific exemptions from standards, trust among the public will be jeopardized
    - The financial and personal integrity of physicians would be at risk
    - People will be placed in ethical dilemmas that ideally should never happen
- While no examples of physician/provider liability has been observed in Oregon during responses to emergencies, the Oregon law needs to be revised to get the issue of provider liability off the table. It is a red herring.
- The "standard of care" isn't really formally defined to begin with

Discussion #1:

1. What is currently in place?
    - Lane County: a listing of physicians willing to be called for disaster response has been assembled, the "Medical Reserve Corps." The list is coordinated by the Lane County Medical Society and is open ended.
        - An objective is to get physicians to address surge requirements at their practice level
        - Businesses are also doing disaster planning for continuity of operations
    - Oregon HRSA Region II: Has done surge planning among community health centers. Alternative care sites have been identified, and the obligations of clinics and providers have been identified.
    - Local health departments: all have disaster plans, and a hot line to share information. They are part of the HRSA Regional planning efforts underway.
    - Hospitals: Hospital preparedness plans are in place. Provider certification requirements are decreased under urgent conditions. Mass casualty is a focus of hospitals in their planning.
2. What are the gaps and needs?
    - HRSA Regional planning hasn't happened in the other HRSA regions in the state yet.
    - There are significant gaps in hospital mass casualty planning
    - Consistently addressing how to bring physicians into "the system", moving from a patient to a system response perspective.
    - General lack of a state-wide system
    - Lack of consensus on who to look to for guidance and leadership
    - Need tighter relationships, from providers to local health departments to the state
    - OMA not well connected with primary care physicians
    - Urban Indians who are less tied into tribal affairs are more difficult to reach
    - Funerals in the Indian culture are significant cultural issues, and would involve 24 hours in a closed environment. Cultural sensitivity is essential as are creative ways of limiting transmission.
3. What resources are out there?
    - The Lane County Model
    - Most physicians read the Yellow Sheet; it could be considered a resource

- Pharmacists are well equipped to help with surge requirements, but need to get on board with disaster preparations. Pharmacists have a great distribution network for getting drugs "just-in-time," and might assist with drug and supply distribution. They might be able to determine the total capacity of pharmacies to provide medications; a request from DOH to OSPA would help.
- Health Plans. They communicate with provider networks, and could pass information on. ODS could communicate with dentists
- Dentists. During the Anthrax incidents, dentists had little to do as appointments were cancelled. They could assist with information dissemination, possibly help with distribution of supplies, give shots.
- Mental Health Community. The Psychiatric Association has a disaster committee, good email connection with members, and could send information out to its membership. They could also help with consults for somatic patients and help with grief. Networking with psychologists and social workers, psychiatrists could help staff emergency clinics and assist with a community resilience model.
- The Indian Health Service has a long history and ways of extending care to tribal members.

<u>Discussion #2:</u>

1. What are the issues in modifying standards of care?
   - Hospitals:
     - Who is going to call the shots?
     - At what point do you say this is all we can do and is as dangerous as we can get in our care, and then drop productivity to safe levels?
     - Can we really discharge very sick patients?
   - Long Term Care Facilities:
     - We will not be able to send people to hospitals as the outbreak progresses
     - We will run out of capacity for new patients
     - Should we be planning to buy ventilators?
     - We will have equipment and stockpiling issues
     - Our capacity to do respiratory care will need to increase
     - There will be less movement between residential care modalities
     - We will need regulatory changes
     - (The Vulnerable Population Task Force at DHS has on its list Foster Care facilities. A significant problem is that there already aren't sufficient staffing levels)

2. What and When can the State supply to help?
   - The Lane County Medical Society wants a pocket book for disaster
   - Systems training is needed
   - Treatment standards need to be defined by someone; they aren't clear now
   - Clarity on whether to use Hicks or the NY ventilator guidelines
   - A review of both federal and other guidelines to determine which are best

- Provide clear system expectations (what would this look like) and information for families to address fears and emotions about what's going to happen. Physicians can figure out what to do from there.

Next Meeting Considerations:

Susan Allan indicated that she wants the MAG to be a continuing resource to the state. To that end, she requested that MAG members consider a set of questions which would help guide development of a work plan for MAG and a work plan to support MAG member's organizations and their activities related to emergency preparedness. These questions would be discussed at the next and final meeting of MAG on May 31:

1. Do we continue meeting? If so, to what end? How often should meetings occur?

2. Should we create subcommittees to deal with things like crisis management, exercises?

3. What should be the role of this group in the TOPOFF exercise in October?

4. What would you and your organization/association want
   - Regarding ongoing connection with this process?
   - Continuation of your membership in MAG?
   - In the way of MAG activities to support your organization, such as (Note: despite the discussion at the planning meeting, these bullets sound to me like they should be under #5, below)
     - Training (exercises, risk management, ICS)
     - Sharing risk communication tools
     - Surveys of memberships of MAG members
     - Providing access to the Health Alert Network for presentations and updated emergency information
     - Providing emergency preparedness Q&A's for the memberships of the organizations in MAG
     - Other

5. What are the key things that are needed to improve emergency preparedness in the state and your organization's role in preparedness?
   - Does your organization have an emergency plan?
   - Does it need one?
   - What is your organization's role in supporting emergency preparedness activities on behalf of your membership?
   - Is the ethical framework useful for your organization?

Next Meeting: The next meeting will be the last scheduled meeting for the MAG, and will take place on May 31 at the ODS, 601 SW 2nd Avenue Portland, OR 97204. The agenda will go out in advance.

Participating:

Members Present:

Dana Braner, Oregon Health Sciences University Pediatrics, Critical Care; Oregon Pediatric Association, ICU, Disaster Preparedness
Margaret Carley, Deputy Director & Legal Counsel, OR Health Care Association, Nursing Homes / long-term care / community-based care / senior housing in-home care
Thomas Dodson, Oregon Psychiatric Association
Joe Finkbonner, NW Portland Area Indian Health Board, Oregon Native American Tribes
George Gerding, Senior Care Specialist, Oregon State Pharmacy Association
Roberta Hellman, Council of Local Health Officials; public health administrator
Jere High, Oregon Primary Care Association
Heather Hue, staff physician, Legacy Meridian Park, Oregon Medical Association
Steve Jones, Director, Infectious Disease & Internal Medicine Training Program, Legacy; Infectious Disease Society of Oregon
Csaba Mera, Medical Director, ODS Health Insurance
Anne Peltier, Local Gov't Advisory Committee, Public Health Program Manager
Bob Shoemaker, Public Health Advisory Board, OR Assoc. of Attorneys
Jim Shames, Family Physician, Local Health Officer
Jennifer Soyke, Lane Co. Medical Society, Medical Director, Lane Co. Adult Corrections, Palliative Medicine, Medical Ethics, Emergency Medicine
John Tuohey, Providence Medical System Center for Ethics
Larry Wallack, Dean, PSU College of Urban & Public Affairs, Public Health communications and media

Oregon State Public Health Staff:

Susan Allan, Director
Paul Lewis, Medical Epidemiologist
Brian Mahoney, Public Health Planner, Public Health Emergency Preparedness
Paul Ceslak, Epidemiologist

Facilitators:

Casey Milne, Milne & Associates, LLC
Tom Milne, Milne & Associates, LLC

Members Absent:

Roberto DeCastro, Chair, OR Section, American College of OB/GYN
Melissa Doherty, Emergency Medicine and EMS
Judge Steven Grasty, County Judge, Association of Counties
Jim Jensen, Oregon College of Emergency Physicians
Roy Magnuson, Medical Director, OHSU; Oregon Association of Hospital and Healthcare Systems
Bill Zepp, Executive Director, OR Dental Association