Oregon Resource Allocation Advisory Committee Final Report

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Executive Summary

The Oregon Resource Allocation Advisory Committee (ORAAC) met from May 2022- June 2023 to review and provide recommendations to the Oregon Health Authority (OHA) for updated crisis care guidance. Committee members agreed that there is no universally accepted approach to crisis care resource allocation, and that all approaches (including those based on seemingly objective medical data alone) entail value judgements in need of justification. The most commonly recommended approach among committee members for prioritizing scarce, life-saving resources was to prioritize patients based on their prognosis for hospital survival, but members also emphasized that crisis care approaches, at minimum,

should not worsen health inequities. The committee was unable to achieve consensus-based recommendations within the allocated timeline due to a diversity of perspectives and values.

Background

Crisis Care Guidance

Crisis standards of care are rules that guide health care delivery in a widespread public health emergency or overwhelming disaster when there are scarce, life-saving resources. In such situations it may be necessary to provide care differently than during normal operations. Crisis care guidance describes how a community or health care system should respond when there are scarce resources.

A central element in crisis care guidance is known as triage. In this setting, triage refers to the prioritization process to determine which patient(s) will receive life-saving resources when there are not enough for everyone who needs them. For example, in the case of the COVID-19 pandemic, many states prepared sets of rules to decide who should be offered ventilators for mechanically assisted breathing when there were more patients than available ventilators.

Oregon History

The development of crisis care guidance in Oregon began as early as 2010. Oregon's work was informed by federal guidance and growing national attention regarding emergency responses following the H1N1 pandemic and Hurricane Katrina. At the start of the COVID-19 pandemic, the most recent Oregon crisis care guidance had been published in 2018. Representatives of state and local public health, health systems, hospitals, medical and nursing associations, and other medical experts sponsored and led the work to develop the 2018 guidance.

Early in the COVID-19 pandemic, concerns were quickly raised about Oregon's crisis care guidance. The primary concern was that the guidance did not account for the different ways the 2018 guidelines would be experienced. Specifically, communities that had experienced long-standing health inequities due to social injustice, resulting in a higher burden of chronic disease in these communities, would have been disproportionately disadvantaged by the 2018 guidelines if applied. Concerns were also raised that the process to develop crisis care guidelines did not involve or consider the viewpoints and values of Oregon's

diverse cultures and communities, including individuals disproportionately impacted by health inequities.

Informed by the mounting concerns raised about the 2018 guidance, including a complaint submitted to the federal U.S. Department of Health and Human Services' Office of Civil Rights by Disability Rights Oregon and others, OHA recognized that the 2018 guidelines had the potential to perpetuate discrimination on the basis of race, age, or disability. For these reasons, OHA announced its decision in September 2020 to no longer reference the previously published guidance. Facing ongoing risk of COVID-19 cases and hospital capacity constraints, OHA published Principles in Promoting Health Equity in Resource Constrained Events in December 2020. A year later OHA published Oregon's Interim Crisis Care Tool.

Oregon Resource Allocation Advisory Committee

Throughout the COVID-19 pandemic response, OHA remained committed to convene a robust, comprehensive, and inclusive community and clinician engagement process to establish more permanent crisis care guidance for Oregon hospitals. In May 2022, OHA convened the ORAAC to recommend updates to crisis care guidance. ORAAC brought together community members and health care system professionals to ensure a variety of perspectives were represented (see Appendix A). OHA sought two main groups for membership:

- Organizations and community members who can speak to community needs, especially communities of color, tribal communities, and people with disabilities.
- Partners engaged in Oregon's health care delivery system, such as hospitals, healthcare providers, health care ethicists and local public health.

The committee's role was focused on the following activities:

- Review and recommend updates to OHA's previously published Principles in Promoting Health Equity During Resource Constrained Events.
- Review and recommend future updates to Oregon's Interim Crisis Care Tool.

In addition to monthly public ORAAC meetings between May 2022 and June 2023, the seven-member Triage Approaches Subcommittee (subcommittee) met nine

times to review a wide range of potential crisis care triage approaches for the allocation of scarce, life-saving resources. The subcommittee explored the justification and drawbacks for each triage approach and considered how the approaches might be used in a stand-alone fashion or, more likely, combined as part of a multi-criteria approach. This information was brought back to the ORAAC for consideration and deliberation. These triage approaches were also outlined in a publicly posted document for public input from May 23 through June 26, 2023.

These individuals provided expert consultation and support to the committee and OHA staff:

- **Alyshia Macaysa** provided expert consultation and strategic guidance on centering community voice and health equity, meeting planning, and preparation. Alyshia also served as the facilitator for the committee.
- **Ruqaiijah Yearby, JD, MPH** provided expert consultation and guidance on health equity, disadvantage indices, and health justice topics including but not limited to crisis care and resource allocation.
- **Harald Schmidt, MA, PhD** provided expert consultation and guidance relating to scarce resource allocation, reducing disadvantage for marginalized populations, and disadvantage indices.
- **Trey Doty, M.Div., ACC** offered assistance and support for committee members during and outside of committee meetings, as requested, in acknowledgement of the difficult content discussed and ongoing trauma being experienced.

Accessibility was a focus of the committee's work. All committee materials were available in English and Spanish; plain language summaries of key information and research were provided; and meetings included Spanish interpretation. ASL interpretation was also provided during the final three committee meetings to maximize accessibility during public comment. The public comment document and survey were made available in 12 languages.

Health Equity

During its support of the committee, OHA's goal for the ORAAC was transparently stated: to guide who receives scarce, life-saving resources when there is not enough for everyone who needs them, to protect the health of all communities in

Oregon, and to reduce health inequities and the disadvantage caused by oppression.

OHA's definition of health equity:

> Oregon will have established a health system that creates health equity when all people can reach their full potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
>
> Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
>
> - The equitable distribution or redistribution of resources and power; and
> - Recognizing, reconciling, and rectifying historical and contemporary injustices.

ORAAC Input and Recommendations

This report was written by OHA staff. This section outlines the input and recommendations provided by ORAAC members.[1] The information contained within this final report does not represent consensus-based recommendations. While consensus-based recommendations were an initial goal, these were not ultimately achieved due to the limited timeframe for the committee's work and the diversity of perspective and values among committee members.

ORAAC Commitments

At the outset of their work, ORAAC members established and committed to a set of working agreements for how they would conduct themselves during meetings (see Appendix B). ORAAC members acknowledged there is no universally accepted approach to crisis care resource allocation. ORAAC members committed to the following:

- We will center hope and innovation in our work and not be limited by current practices or known options for triage.

[1] This document includes a combination of abbreviated summaries of ORAAC member input as well as direct quotes when possible.

- We will work to promote public health and achieve procedural justice through transparency, seeking community input on emerging recommendations, assessing local cultural values regarding resource allocation, considering this information as part of recommendation development, and addressing concerns that arise. We will prioritize input from communities who face the greatest health inequities.

Committee members acknowledged the difficulty of ORAAC conversations, especially for those who face racism, ableism, ageism and other forms of discrimination; who lost loved ones due to COVID-19; and whose communities were profoundly and inequitably impacted by the pandemic. Health care representatives highlighted the moral injury when providing health care and making decisions in the face of limited resources. The committee discussed the grief, trauma, and deep need for continued healing. This work must acknowledge both the human toll that has already occurred and the profound loss of life that will occur ahead if crisis care triage is activated.

Principles

The ORAAC's core work started with review of four principles published by OHA in December 2020 in the document Principles in Promoting Health Equity During Resource Constrained Events and summarized in a plain language document, including:

- Non-discrimination;
- Health equity;
- Patient-led decision making; and
- Transparent and effective communication.

Overall ORAAC members agreed these are important guiding principles for crisis care guidance development and the allocation of scarce resources in an emergency. The only change that ORAAC members recommended to the four principles is to change the language "patient-led" to "patient-centered, shared decision-making".

The following statements capture the varying perspectives and input across ORAAC members about these principles generally:

- Principles are important, but we need to make sure that they are translated into action. Being well planned to prevent and act effectively during a crisis is critical. Planning and practice are essential.
- Want to see more anticipatory planning to prevent a crisis in the first place.
- Communication must be transparent and accessible; for example, resources must be available in plain language and consider the needs of all ages and abilities.
- These principles are not currently being met as part of routine health care delivery. Training is needed to ensure that health care delivery is in alignment with these principles at all times.
- These principles should represent the healthcare system's everyday practices not just during a crisis.

Patient-Centered, Shared Decision-Making

There was general agreement among ORAAC members that the goal should always be for patients to be centered in decision-making about their health care. The language "patient led" did not seem to capture the full decision-making process at the time of a crisis. ORAAC members asserted that decision-making should include a collaborative, decision-making approach between patients and providers. ORAAC members suggested "patient-centered, shared decision-making" as the best language for this principle.

There was substantial input by various committee members on this topic. The main themes are summarized below:

- Understanding a patient's preferences for care at the time of crisis is really important. One might assume that a patient wants every medical intervention possible; however, asking is important for health care providers to understand and clarify what is important to the patient.
- Patient wishes should be determined as early as possible. Ideally these preferences should be captured prior to an emergency and confirmed before crisis care triage is initiated. Data should be collected to document that this information was obtained and confirmed in a timely fashion.
- When doctors speak to a patient, we need to understand the power dynamics that exist, such as who has access to more information in this scenario.

- Quality of life judgements cannot and should not be made about patients by health care providers.
- Marginalized communities have not been served well by patient-provider relationships. Historical context matters in terms of what relationships with patients and providers have looked like.
- Decision-making with patients might need to include partners, spouses, and other family members. Recognition is needed regarding the pressure that is placed on support persons.
- Feasibility of shared decision-making may be difficult during a crisis; the health care team may not be able to follow the wishes from a patient or their family members (e.g., if there are not enough resources to provide for everyone who wants and needs them).
- Crisis care triage decisions are a form of moral injury for health care providers, patients, and families.

Triage Team

Triage teams play a critical role in the implementation of crisis care guidance. When there is an absolutely scarce life-saving resource, a process must be used to consistently and transparently triage the patients who would benefit from receiving that resource. The triage team is responsible to implement the triage process for all patients needing the scarce resource, such as within a given health care facility or system. This team is described in Oregon's existing Interim Crisis Care Tool (page 4) as follows:

> A CSC [crisis standards of care] triage team should be designated by the hospital for implementing critical care resource allocation determinations. Those serving as representatives of the triage team should not be caring for the patient being triaged, unless that is impossible given the staffing capabilities of the hospital. Triage staff must recuse themselves from triage determinations for patients they are personally treating unless no other option exists.

ORAAC members discussed several aspects of the triage team and offered suggestions to update the current OHA guidance. The following is a summary of these discussions and recommendations. Outstanding questions and concerns expressed by the committee regarding the triage team are included as well.

Role and responsibility of the triage team

ORAAC members identified that the purpose of the triage team is to save lives and prevent discrimination. Various ORAAC recommendations about the role of the triage team include:

- The triage team should operate within a clear, concise definition of the roles of the team.
- The triage team should support one another and hold each other accountable through continuous learning, coaching, and documentation of mistakes that occur.
- The triage team holds the responsibility to work within the timeframe needed for decisions.
- OHA should support the development of the triage team role in the following ways:
    - Outline priorities and provide example processes for use by triage teams; and
    - Set up equity and inclusion metrics.

Triage team representatives

The interim crisis care guidelines from OHA specify that triage teams should consist of clinicians with relevant experience; a medical ethicist; an expert in diversity, equity and inclusion; and an administrative assistant. ORAAC members named the importance of adding a community representative to the triage team when possible. In addition, ORAAC members indicated the importance of culturally responsive and accessible language during the triage process.

Recommendations from various ORAAC members regarding the representation on the triage team are as follows:

- Include a community expert, such as a community health worker, on the triage team to inform and support decision making.
- Include an interpreter as part of the team to support communication with patients involved in the triage process who speak languages other than English.

A question arose about what privacy or HIPAA issues would need to be resolved for a community expert to be involved in the triage team.

Triage team training, experience and support

The triage team should be able to draw upon relevant experience, training, and support to fulfill their role during a crisis. ORAAC members identified several areas of focus when setting up training and support for the triage team. Various recommendations were offered, including:

- Triage teams should receive training on how to communicate with different audiences, in various styles or formats.
- Diversity, equity, and inclusion training is also recommended, including antiracism training as well as identifying and addressing implicit bias, and preventing discrimination based on race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, or other socially determined circumstances.
- ORAAC members recommended that triage teams have a strong understanding of the population the hospital serves prior to a crisis.
- Training and experience in trauma informed approaches are also needed.
- The committee discussed the need to learn how to create, assess, and support an environment that does not activate bias.
- Some members shared concerns about the feasibility for training all health care providers who may respond to a crisis. Others acknowledged that the trainings above would be important for care delivery even during normal operations.
- Triage teams should receive adequate training regarding the implementation of crisis care triage approaches to ensure operational consistency. Members recommend that training is uniform and available across health systems.
    - ORAAC members asked who would provide the recommended trainings to ensure all triage teams get the same information. They asked whether ongoing training would be realistic for a process that might be implemented once every ten years.

ORAAC members identified the following recommendations related to the training and support for triage teams and highlighted a need for OHA or other state assistance:

- Provide consistent content and training for healthcare providers and systems statewide;
- Ensure triage team members have access to emotional and psychological support in recognition of the difficult nature of crisis care triage and decision making;
- Develop or share tools on effective communication with patients, families, and other audiences;
- Educate providers across disciplines about advance directives, physician orders for life sustaining treatments (POLSTs), guardianship, health care advocates and beyond, including the role and authority for each of these;
- Encourage coordination, training, and resource sharing at a regional level;
- Train triage teams on the topic of assumptions and biases related to quality of life;
- Coordinate with health system leadership to provide consistent communication to hospital staff and to affirm the shared values on which the crisis care guidelines rest; and
- Develop or share tools on trauma informed approaches.

ORAAC members recommend that hospital and health system leadership engage in the following three actions to support triage teams:

1. Communicate with staff regarding planning efforts.
2. Hold listening sessions or forums for all who will be involved in providing crisis care.
3. Consider how existing trainings for current standards of care can be leveraged to better prepare staff to serve on a triage team.

Ideas to Consider

ORAAC members proposed several additional ideas related to community-centered approaches, improved understanding of CSC, support for health systems, and regional support for triage team development.

Community-centered. ORAAC members highlighted the importance of community-centered practices to support the triage team. A strong understanding of what health conditions are present in the community should inform the work of the triage team. Hospitals should work to engage and build relationships with community members that face historical and ongoing

marginalization and health inequity to improve care and prepare for a future crisis response. Members noted that recommendations and guidelines will need to be accepted by the broader community.

Education. ORAAC members discussed the importance of ensuring that the healthcare workforce and the general public have an improved understanding of crisis care guidance. This community education should occur before a crisis so that people understand the reasoning behind the standards and how they are implemented. Community members may have questions about what is acceptable during a crisis, what is not possible, and why.

Flexibility. Representatives from the health care sector requested that OHA offer a degree of flexibility as they work towards complying with crisis care guidance, including triage team guidelines, especially at the time of an emergency onset. They had questions about compliance expectations and requested time to develop triage teams before any potential enforcement occurs.

Regional and state resources. There was interest in building on existing regional disaster response planning groups. These groups look at community-wide resource availability and leverage relationships among hospitals regionally to ensure care remains available when one or more hospitals are highly impacted in a crisis. Concern was shared by at least one committee member that the ORAAC's work did not take into consideration existing disaster plans and coordination structures.

There were significant concerns shared by ORAAC members about the capacity for hospitals to form and operationalize a triage team, especially for small hospitals (e.g., critical access hospitals). ORAAC members suggested a regional approach to forming triage teams to serve multiple hospitals or offer a remote, state-wide triage team to support lower-resourced hospitals. There was also a recommendation that OHA should be responsible for maintaining a pool of trained individuals available to support or participate on triage teams, such as equity, diversity, and inclusion experts, community health workers, and other experts.

Liability. Throughout the ORAAC's deliberations, hospital representatives repeatedly voiced the need for broad liability protections for health care providers in Oregon involved in delivering health care during a crisis and

participating in resource allocation as part of a triage team. OHA staff acknowledged this input while also reminding committee members that the topic of liability protections was outside of the scope of the ORAAC and not within the authority of OHA to provide. Broader liability protections would require legislative action.

Crisis Care Triage

Goal

Throughout the ORAAC's work members reviewed and discussed the role of structural discrimination and impacts on health equity, including the potential effect on crisis standards of care. Examples of structural discrimination in medicine, including racism and ableism, and disparate health outcomes were reviewed. The legacy of race correction in clinical medicine and the impacts were also explored and discussed. Experiences of discrimination, including ableism, ageism, classism, and racism were described by ORAAC members.

The subcommittee and the full ORAAC deliberated on the primary intent of crisis care triage: will we worsen, maintain, or reduce health inequities through the crisis care triage approaches chosen?

Many ORAAC members identified with the goal and priority to reduce health inequities through crisis care guidance, including triage approaches. ORAAC members named that crisis care triage approaches should at minimum avoid worsening health inequities.

Some ORAAC members shared concern with the goal of crisis care triage in addressing health equity, stating that clinical care and crisis care triage should not be aimed at rectifying broader, societal health inequities. At least one ORAAC member asserted that triage teams should not shoulder the burden of addressing negative societal impacts and should not be expected to undo existing disadvantage. Other ORAAC members highlighted the need to address health equity in crisis care triage approaches because the decisions made using these approaches can result in health inequities and exacerbate disadvantage.

Triage Options

ORAAC members reviewed six potential approaches for use in crisis care triage, including detailed information regarding justification and drawbacks for each approach as informed by the subcommittee. These triage approaches were considered as standalone options as well as considered for inclusion in a multi-criteria approach. The primary triage options considered include:

- Clinical Prognosis;
- Equitable Chances;
- Essential Worker;
- Multiplier Effect;
- Life Cycle Principle; and
- Sequential Organ Failure Assessment (SOFA) and modified SOFA (mSOFA).

A full overview of each triage approach considered by the ORAAC is detailed in this document which was made available for public comment.

ORAAC members reviewed the concerns raised about past crisis care guidance and emerging research regarding available triage tools. ORAAC members acknowledged there is no universally accepted approach to crisis care resource allocation. They acknowledged that all options must include justification: there are no neutral approaches, and even seemingly objective medical data entails value-judgements. ORAAC members contributed their input on these approaches through small and large group discussions, polling, and a final survey. Among 25 committee members, there was a 40% response rate for the polling and a 72% response rate for the final committee survey. Three committee members chose not to contribute recommendations regarding specific triage options in their survey responses, instead providing more general input or areas of concern. A total of 16 committee members provided specific recommendations for triage options to be used in a multi-criteria approach. ORAAC members' diverse perspectives and input on triage approaches are summarized below.

Clinician Prognosis: Among all triage approaches reviewed, clinician prognosis was the most commonly recommended triage approach for inclusion in a multi-criteria triage process. Fourteen out of 16 survey respondents (87%) who provided input on preferred triage approaches recommend this approach. Many of those who supported this criterion indicated it should be applied as the first step in crisis care triage. Concerns about consistency and feasibility were raised,

especially since this approach is based on clinical judgement without the current availability of an acceptable survivability scoring tool. Some specific comments from surveys and ORAAC discussions about clinical prognosis as a triage criterion include:

- Clinical prognosis should be as objective as possible with checks for bias and clinical consistency.
- Clinical prognosis is the best [option] as it creates an opportunity for personal interaction and prompt decision making based on the situation at hand.
- Sticking with predictable assessments is best.
- Concern for the potential of bias and lack of consistency in clinical prognosis determination across health systems.
- Concern that there is a large gap in the percentages of survivability within each priority group proposed: Priority Group 2 has an 11-89% chance of survival to discharge if provided the resource.

Equitable Chances (and other approaches based on disadvantage): Eleven of sixteen survey respondents (68%) recommended giving priority for individuals experiencing the greatest disadvantage. Of those, nine recommended using the equitable chances approach as described in the public comment document. One of these respondents also advocated for use of additional, individual-level measures to identify further disadvantage beyond the geographic weighting used in the equitable chances approach. Two ORAAC members indicated preference for using the Area Deprivation Index (ADI) to add priority based on disadvantage using a point system or "correction factor" following scoring for clinical prognosis (e.g., rather than use of ADI as part of the equitable chances approach). Some members have remaining questions about equitable chances, such as whether a person's address is really enough information to determine whether or not they have been a victim of inequality. Two respondents strongly recommended against use of equitable chances criterion in scarce life-saving resource allocation.

Comments and input from ORAAC members in support of and against using equitable approaches are below:

- The combination of clinical prognosis and equitable chances eliminates the disadvantage of Black, Indigenous and people of color (BIPOC) communities.[2]
- This approach creates opportunity.
- Recommend [adding] something that could consider the individual in front of us (e.g., race/ethnicity, disability status, income/class, home services recipient, essential worker) that mirrors what we look at in terms of disadvantage index (Social Vulnerability Score [SVI] or ADI) but aren't completely geographically driven. There is concern that folks who are historically marginalized, but live in more affluent zip codes, e.g., due to gentrification, are at risk of being pushed out or missed.
- Prefer equity correction up front (right after clinical prognostication) which means it needs to alter points rather than used in a weighted lottery if were to include further tiebreakers.
- Equitable chances is ill-fitted and problematic for decision-making in emergency rooms and hospitals. [Instead] it should be used in allocating non-emergency resources for chronic, population health care initiatives. Has not been validated at the individual level.
- Equitable scoring at the bedside is inappropriate as it is designed to consider population effects, not specific patient outcomes.
- Physicians and nurses should not be placed in the position to undo society's prejudices when they are trying to save lives. It is too late to apply equity assessments at the bedside during scarce resource allocation.

Occupation Criteria: Seven survey respondents total (43%) recommend use of an occupation approach, with more in favor of using the essential worker criterion (31%) compared to the multiplier effect criterion (12%). An additional respondent recommended considering essential worker prioritization in certain circumstances (e.g., in the setting of workforce shortages). Two committee members shared their opposition with use of the multiplier effect. Additional input regarding use of these approach includes:

[2] This term is used throughout this report to honor the language used by committee members. Of note, OHA's practice is to refer to people in the way they would like to be identified or refer to their specific group in place of using the umbrella term BIPOC. We recognize that this term can oversimplify communities and cultures with diverse identities, world views and experiences.

- If using essential worker criteria for triage prioritization, long term care and home care staff should be included in the definition of essential workers.
- Some recommend that essential workers should be designated based on the disaster type and be considered at the individual patient level; there is concern that regional (geographic) data dilutes the importance of this criterion.
- In contrast, another ORAAC member raised concern that application of the essential worker criterion at an individual level will be logistically difficult to implement.
- There was a question regarding what jobs or occupations would be considered essential, with concern for missing those who work at non-frontline jobs.
- Another member questioned whether a person's profession makes their life more valuable than that of someone who did not have the opportunity to gain a profession.
- Concern for potential conflict of interest with the prioritization of health care workers.
- Multiplier effect can reinforce existing inequity.
- Consideration for prioritizing essential workers may be needed in an emergency if systems and processes cannot be maintained due to personnel shortages during a crisis.

Life Cycle Principle: Six committee members strongly recommend against the use of the life cycle principle. Several committee members shared their profound concern about this approach and disappointment that OHA continued to keep this option open for consideration by committee members or as part of the public comment process. Three respondents did recommend use of the life cycle principle in resource allocation, with a proposal to use life cycle as a tie breaker.

Comments about the life cycle principle included:

- Life cycle can be culturally insensitive. Placing value on younger folks over older folks is not a value that all cultures hold, especially non-Western cultures.

- This approach prioritizes younger people and deprioritizes our elders. Without our elders, many traditions or cultural norms will be lost and forgotten.
- Life cycle is both ageist and ableist.
- Life cycle is fundamentally discriminatory; it infuses age and inappropriate assumptions about quality of life and values about what a "good" life is.
- Life cycle will be seen as a proxy for age creating many issues, including legal challenges.
- Age as a survival factor might apply to clinical prognosis: age above 65 was one of the most powerful, independent mortality predictors among those hospitalized for COVID.
- Belief was shared that most Oregonians, including many seniors, would prioritize our children and grandchildren.

SOFA/mSOFA: Seven ORAAC members shared strong opposition with using SOFA/mSOFA based on published evidence that this tool does not accurately predict survivability and will increase health inequities. Two members did recommend use of SOFA/mSOFA. Comments in support of using SOFA/mSOFA emphasized that hospitals have been trained on and are equipped to apply mSOFA. There was also interest in using this tool because of feasibility of use and opportunity for consistent application.

Input shared by committee members regarding SOFA/mSOFA include:

- SOFA/mSOFA are only validated for sepsis and not applicable for general triage.
- Use of SOFA/mSOFA will worsen health inequity.
- Although it was determined that SOFA was not sufficient to predict the probability of survival in all races, it constitutes a foundation for developing an objective decision-making guideline. Appropriate adjustments are needed for the chemical values and clinical pictures for the ethnic or racial groups that make up the community.
- Folks need to understand the relationship between intent and impact. If a well-intentioned policy or tool consistently worsens health inequity for our most vulnerable communities, then those policies or tools need to be drastically changed or scrapped.

Triage Approach: Ideal Characteristics

With acknowledgement that there is no universally accepted approach to crisis care resource allocation, ORAAC members voiced a shared understanding that any triage tool adopted or any tool that becomes available in the future will need to be assessed. ORAAC members provided feedback on the following list of proposed, ideal triage tool characteristics for such ongoing assessment:

- accurate, reliable, and easy to use;
- applicable to a wide variety of patient conditions;
- applicable to the current emergency;
- unbiased, non-discriminatory, and does not worsen health inequities; and
- acknowledges community-specific health conditions.

ORAAC members provided feedback and suggestions for additional criteria including:

- Applicability for different age groups (e.g., if same tool is used for children and adults).
- Plain language adaptations so everyone can read and understand. Make it accessible to all communities to be able to get a copy in their preferred language.
- Must lend to having data collected and be trackable.
- Supported by clinical diagnosis tools based on objective information, with adjustments that acknowledge the standardized values of the ethnic or racial groups in the population.
- Respect and value each patient including the need for comfort care and palliative care.
- Listening to the patient without tokenizing the issue. Avoiding a cookie cutter approach or making assumptions.
- Includes a clear statement of the goal of the triage tool.
- Free from liability.
- Does not overburden short-staffed, exhausted caregivers in the midst of an emergency with data recording and investigation of patient demographics.
- Feasible to apply in the moment of an emergency.
- Feasibility should not be the focus: feasibility must be recognized as a blunt instrument that can be used to derail innovation.

- The list looks good for an ideal triage tool, but we may have to go with the best designed tool available at any point in time, with its limitations, which may not satisfy the ideal characteristics above. The listed characteristics, however, would help us move in the right direction to design the best possible tool.
- Several respondents reported that the list seems complete and they had no additional recommendations to add.

Other input regarding crisis care triage approaches

ORAAC members shared additional input related to the topic of crisis care triage:

- Considerations to equity, justice, and fairness would warrant consistency in the application of a triage model to all Oregonians regardless of where they live, which requires coordination.
- It is unlikely the proposed standards can be implemented and certainly within the timeframe necessary to make clinical decisions to save lives.
- An adaptable multi-criteria triage model needs to be developed depending on the type of crisis. Different types of crisis may warrant prioritization of different groups.
- Concern was shared that ORAAC was not able to move forward into focusing on hope and innovation due to the desire to use and discuss SOFA/mSOFA and/or life cycle principle even those these criteria worsen health inequities and do not meet OHA's stated overarching guidelines.
- We need acknowledgement and acceptance that the policies and practices prior to, during and after the pandemic (those currently still in use) result in worse outcomes for historically marginalized communities.
- Guidance must specifically address triage for the pediatric population which was not addressed by ORAAC.
- Criteria considered are not validated; we need a method to review outcomes and revisit the criteria going forward.
- Consider partnering with Washington using similar methodology.
- Multiple ORAAC members noted that the committee did not get to consider innovation.

- If we were able to shift our discussions into hope and innovation, maybe we could have been brainstorming the possibility of creating a better standardized tool.
- Overall, the [public comment document outlining triage options] is nicely done but is quite long and not at a sixth-grade reading level.

Data Collection

Triage teams need to collect certain data to inform the triage process and allow for retrospective review. OHA provided a review of Oregon Administrative Rule (OAR) 333-505-0036 for committee members that became effective January 24, 2023. According to this rule, a hospital must document the following information for each patient that is subject to a triage decision[3]:

A. The patient's medical record number.
B. The hospital's name and location.
C. The patient's date of birth.
D. The patient's sexual orientation and gender identity, if known.
E. The patient's race, ethnicity, language and disability, in accordance with OAR chapter 950, division 30.
F. Whether, at the time of presentation at the hospital, the patient was using a personal ventilator or other personal medical treatment equipment or resources.
G. The patient's home address, whether they are unhoused, or whether their housing status is unknown.
H. The patient's care preferences, as documented in an advanced directive, portable orders for life-sustaining treatment (POLST), or as communicated by a health care representative, support person, or a family member.
I. The patient's triage prioritization and clinical outcome.

ORAAC members observed that standard quality assurance practices could support data collection for triage. Such practices include using appropriate technology to gather data, recording triage decision discussions for review and analysis, and auditing records for consistency and quality of data collection. It is important to note as well who is collecting the data and entering it in the record.

[3] According to OAR 333-505-0036, "triage decisions" means the decisions necessary to provide equitable prioritization of critical care resources for patients during an emergency.

ORAAC members raised several considerations for additional data to be collected during triage:

1. Availability of interpretation services, including bilingual, bicultural interpreters.
2. Record the point in time when data on patient care preferences is captured and how it is utilized in the triage process.
3. Documentation beyond whether a patient has their own medical equipment, including whether it is working properly and knowledge of appropriate use when they arrive at a healthcare facility.

Beyond Crisis Care Triage

Overall, the ORAAC's task was to recommend updates to Oregon guidance regarding who receives scarce, life-saving resources when there is not enough for everyone who needs them. During the ORAAC's work, members recognized it will be necessary to frequently evaluate chosen approaches, review data, learn, and refine guidance. Furthermore, health systems should develop ongoing partnerships with the communities most impacted by health inequities to develop and refine crisis care guidelines and other approaches to reducing health inequities.

Committee members also highlighted that crisis care guidance is only one component of broader efforts needed before and during a public health emergency to protect the public and reduce inequities. These broader efforts include but are not limited to:

- Emergency preparedness;
- Broad access to culturally responsive health care and needs;
- Access to supports that allow individuals with disability to achieve desired independence and communicate their needs and goals;
- A diverse, responsive and supported healthcare workforce;
- Local, regional, statewide and interstate communication; and
- Movement of patients to access needed care (also called "load balancing").

Overarching Feedback

OHA received substantial feedback about the committee process and overall work, summarized here:

Committee structure:

- Member feedback included concern that physicians and hospital administrators had an outsized influence on the committee, that trust was not established, and that there was unequal power among committee members.
- A recommendation was given that the membership of any future committee needs to be considered carefully and should be heavily weighted with representation from folks with lived experience from marginalized communities, who disproportionately experience health inequities. More disabled and BIPOC community leaders should be included.
- Additional feedback stated that specific guidelines require more input from professionals.
- ORAAC members not involved in a subcommittee noted disappointment from missing the full deliberations of the subcommittee discussions regarding triage approaches, though appreciated the work and additional time commitment of subcommittee participants. ORAAC feedback also highlighted regret that OHA did not convene a second subcommittee focused on triage teams and data collection as originally intended, stating this as a missed opportunity.
- Members noted that Oregon's inclusion of voices of folks on this committee who are the most vulnerable and who are most impacted by these decisions is unique and trailblazing. Gratitude was shared that OHA made this a priority.

Needs of community:

- Member feedback included appreciation for the work done towards distributing scarce resources based on diversity, equity, and inclusion principles and considering the diverse needs of community.
- One commenter noted that we have spent the entire year hearing from disadvantaged and underrepresented communities about their discrimination experience in the current health care system both over many years of history and during the recent COVID-19 pandemic. Many suggestions made during the meetings have highlighted worthwhile and

necessary changes to be considered both in the everyday delivery of health care services and in how we respond to a disaster or crisis.

Looking ahead:

- Member feedback indicated a sense of optimism, while recognizing there is more work to be done in order to move this work from theory to practice.
- It was noted that the crisis care guidance that was discussed focused on resource allocation in critical care settings such as hospital intensive care units. Broader guidance will be needed to inform all potential resource allocation needs during a crisis (e.g., at the site of a disaster or in pre-hospital settings).
- Feedback highlighted that crisis care guidelines should connect to the state's EMS and trauma system and build on learnings from the response to state disasters during wildfires and COVID-19.
- ORAAC members shared concern that the status of recommendations are far from becoming specific guidance. These members stated the importance of developing guidelines that can be operationalized and supporting training such as through table-top exercises ahead.
- Finally, ORAAC members noted that the pandemic laid bare the deep existing inequities and distrust in our health care system. ORAAC members should all be leaving with a call to action and consider what steps each can take individually. Though the committee's work is done, the work ahead is not.

OHA Acknowledgements and Next Steps

This committee was staffed by OHA with the support of expert consultants. The final report was prepared by OHA staff.

OHA made several decisions that impacted the scope of the committee's work. First, OHA determined that ORAAC would not discuss pregnancy status as a criterion for crisis care resource allocation. OHA recognized that the committee lacked expertise to fully explore this topic. In addition, the agency wished to avoid overlap with legislative deliberations underway on reproductive health as part of Oregon's 2023 legislative session.

OHA also decided to transparently flag concerns with the life cycle principle and the continued use of the SOFA/mSOFA tool in materials. OHA's decision was informed by growing concerns communicated by committee members as well as published research studies, other state's decision not to use SOFA, and critiques by hospitals and ethicists that were identified during the committee's work. However, OHA chose not to remove these options from full deliberation. OHA chose to consider diverse perspectives through public and committee input. OHA acknowledges that continued inclusion of these options in public deliberation was concerning to some members.

Relatedly, OHA also received feedback that the manner in which some of these triage options were flagged may have biased respondents against consideration of these options. This ORAAC member feedback highlighted concern that OHA's framing instilled bias in the process.

Finally, OHA attempted to convene an additional subcommittee focused on triage teams and data collection but was unable to identify enough committee members with diverse backgrounds and capacity to participate in additional meetings. OHA instead incorporated these topics into full ORAAC meetings for deliberation and recommendation development.

In closing, OHA would like to thank members of the ORAAC and consultants for all of their time dedicated to working towards improving Oregon's crisis care guidance. We recognize the potential trauma and impact from this topic. We also recognize the human toll from the COVID-19 pandemic as well as the loss of life that would occur if crisis care triage is ever needed. We appreciate the committee members and consultants for engaging thoughtfully in this difficult work. Finally, we thank everyone for the flexibility and graciousness offered as we worked to maximize accessibility in our work to ensure all ages, abilities, and experiences were included.

OHA will thoughtfully consider the input from ORAAC members and the public as it prepares to update Oregon's crisis care guidance ahead. We also recognize that this work will not be complete with updated guidance alone. Ongoing community engagement, training, and system changes are needed with a focus on hope and innovation.

Resource List

- ORAAC Request for Public Comment Document: triage approaches
- Summary of Community Conversations on Crisis Standards of Care
- Summary of Public Input
- Principles in Promoting Health Equity During Resource Constrained Events
- Oregon Interim Crisis Care Tool

Appendix A

ORAAC Committee Membership:

- Beth Brownhill, Disability Rights Oregon
- Bob Macauley, Oregon Health & Science University
- Daniel Alrick, Oregon Council on Developmental Disabilities
- Derick Du Vivier, Oregon Health & Science University
- Doug Merrill, St. Charles Healthcare System
- Gerald Cohen, AARP Oregon
- Jennifer Gentry, Providence Health and Services- Oregon
- Joannie Tang, Multnomah County Public Health Advisory Board, Asian Pacific American Network of Oregon (APANO), Portland Disability Justice Collective, Unite Oregon
- John Gotchall, The Arc of Benton County, The Arc of Oregon, Disability Equity Center
- John Moorehead, Oregon College of Emergency Physicians, Oregon Medical Association
- Keren Wilson, Jessie F. Richardson Foundation & AGE+
- Kristen Roy, Asante
- Leda Garside, OHSU Health Hillsboro Medical Center
- Liliano Lachino, The Next Door, Inc.
- Marci Ramiro-Jenkins, Virginia Garcia Memorial Health Center & Foundation
- Micah Ralston, Arc of Oregon
- Michael Collins, Confederated Tribes of Warm Springs
- Molly Osborne, Portland Veterans Administration Medical Center
- Pari Mazhar, Cascadia Behavioral Health, Supporting Transgender Immigrant & Refugees
- Prasanna Krishnasamy, Legacy Health
- Robert Dannenhoffer, Douglas County
- Sara Gelser Blouin, Oregon State Senate
- TK Kapurura, Multnomah County
- Todd Woodward
- Veronica Porras, Euvalcree

Past ORAAC Members No Longer Active:

- Amina Afrah, Somali American Council of Oregon
- Arbor Russell, Equi Institute
- Desha Reed-Holden, Multnomah County
- Emily Cooper, Disability Rights Oregon
- Eugenie Adamah-Tassah, African Heritage Education and Empowerment Community, African Women Coalition
- Jennifer Vines, Multnomah County
- Joy Mulumba, African Family Holistic Health Organization
- Stefanny Caballero, Virginia Garcia Memorial Health Center & Foundation
- Zennia Ceniza, Salem Health Hospitals and Clinics

OHA Staff:

- Dana Hargunani
- Lisa Bui
- Kristen Darmody
- Sasha Vine

Consultants:

- Alyshia Macaysa
- Ruqaiijah Yearby
- Harald Schmidt
- Trey Doty

Appendix B

ORAAC Member Working Agreements:

1. Keep the patients and communities who have been marginalized by mainstream institutions, like the healthcare system, at the center of the discussion
2. Be mindful of paternalism in discussions about elders, people with disabilities, and BIPOC communities
3. Acknowledge the importance of all the services, supports, systems, and perspectives that are present in this committee
4. Be cognizant of how you speak and what you say so we can all understand one another
5. Recognize that participation and engagement looks different for everyone
6. Keep an open mind and come with a willingness to learn and to share
7. Move in the spirit of trust and love
8. Be clear in your communication

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