Public Input Regarding Crisis Care Triage Options: Final Summary

On May 23, 2023 the Oregon Health Authority (OHA) began requesting public input on crisis care triage options under consideration by the Oregon Resource Allocation Advisory Committee (ORAAC). The document for public comment was made available in 12 languages on OHA's website. The public comment period closed on June 26, 2023.

The following is a summary of public input received by OHA during the public comment period. OHA received 21 comments. This document includes a combination of abbreviated summaries of public input as well as direct quotes when possible.

OHA asked respondents to identify the community or group with which they were most closely affiliated. Comments were summarized based on these groups when possible. Note: OHA did not include input received that is unrelated to the topic of crisis care triage in this summary document.

Culturally Specific Communities

- Prevention is a priority to avoid pain, worry and anguish.
- Equitable chances caught my attention; resources should be distributed equally and impartially; discrimination should be avoided.
- There are barriers that create a huge gap between my community and resources available; the disconnect is due in part to language barriers; interpretation and translation of written materials are needed.
- Urgent resources and care for those with the most serious conditions should be given priority regardless of abilities and background.
- Processes should be clear, smooth and easily understood and available in multiple languages; a fair and just system should perform in an orderly and inclusive manner.
- How will communities be prioritized whose languages are not represented (e.g., as part of the crisis care triage options public input survey)? Language

access for Pacific Islanders has not been achieved through the languages that have been made available.
- Priority should be given to people in the most critical health conditions.
- People with more serious conditions (those who need the resource the most) should be treated; this should be done regardless of age or race; no one should be discriminated against.

Disability or Aging

- This work must consider the intrinsic biases and oppressive factors that exist in our current health care infrastructure; the disadvantage assessment is an essential component and should be included in the final triage approach.
- In 2020 during the COVID-19 pandemic, Oregon, like many states, experienced inequities in how treatment was allocated; under crisis and with limited preparedness, triage approaches typically devalue age and disability.
- Developing guidelines for resource allocation is profoundly difficult, requires thorough analysis, and should be done transparently with genuine public outreach. The work of the ORAAC is applauded.
- Guidelines must build in protections for groups that often face discrimination, including older persons, persons with disabilities, those with lower incomes, BIPOC communities, the uninsured and other groups that are discriminated against.
- Neither age nor ability should be used as criteria in the allocation of scarce resources; any standard that applies these criteria is opposed.
- In addition to crisis care triage development, additional attention is needed including:
    - Adequate emergency planning;
    - Collaboration to identify, develop, fund and implement effective responses for public health crises;
    - A cooperative response to an emergency and avoidance of competition for goods; and

- Collection and public reporting of comprehensive, accurate data during a public health emergency or disaster, including demographic information, race, ethnicity and other key factors.

Hospitals/Inpatient Care

- Feasibility needs to be considered when planning for implementation of a triage approach during a disaster but should not deter from the development of a complex and nuanced triage approach.
- Hospitals should be given flexibility to do what they can with the limited information and resources they have in the wake of an emergency.
- An action plan led by the state should include state-backed triage criteria that can be easily implemented by each location where services will be provided and flexible enough to be able to be adapted to the type of emergency conditions clinicians are working in.
- Combinations of triage criteria may be developed prospectively, though different crises may warrant different triage approaches to be used. "Just-in-time" modifications specific to the crisis will likely be necessary and should be made by the state in consultation with technical, ethics and community representatives.
- Any triage model recommendation must be usable and adaptable to multiple types of public health emergencies. This may necessitate a two-tier approach for an acute natural disaster when resources are practically non-existent and a more detailed approach when the crisis is long-term and resource availability fluctuates over time.
- Concern shared that some of the criteria proposed appear to rely on data that may be impossible to determine at the time of an emergency (e.g., when a hospital could be working with half or less of its staff, has limited electrical power or internet access, and patients are unable to fill out forms or communicate demographic information).
- Triage approaches must consider the nature of a compressed timeline for decision making; concern was shared that there may be insufficient time to deploy the triage tools presented in some emergent situations.

- Clinician assessment of survivability is troublesome and puts the onus on justifying a percentage survivability on a clinician and their care team, as imprecise and implicitly biased/flawed humans are.
- Equitable chances is flawed, illogical and biased; this system will prefer a "disadvantaged" person over an "advantaged" one based on demographic variables. We cannot calculate an individual's complex social situation accurately enough to allow for prioritization of life saving resources.
- Consideration of essential workers and multiplier effect are fair.
- MSOFA/SOFA have been proven effectively useless as the COVID-19 pandemic exemplified; to assume you can prognosticate crisis care mortality with some bloodwork and vitals is arrogance.
- Care must be taken to ensure that criteria are not discriminatory in violation of the law.
- The state should seek written assurance from the U.S. Department of Health and Human Services' Office of Civil Rights that new guidance meets federal non-discrimination criteria, as similarly obtained by other states.
- The state should maintain a roster of trained individuals that can be deployed at the request of impacted hospitals to assist in forming triage teams.
- There are differing opinions about what is fair and equitable in resource decisions; individual hospitals and health care staff should not be left on their own to make these decisions.
- Health care providers deserve support and protection when they show up to do work on behalf of communities in an emergency.
- The state has an indispensable role in convening and educating communities about crisis standards of care and providing support to hospitals to promote the implementation of consistent standards across our state.
- Any recommendation about triage models should ensure that clinical decisions are clinician-led decisions; this could be a team-based approach if clinicians are readily available to support that model under the existing circumstances.
- Facilities and clinicians should have access to state-developed and supported training resources to ensure consistency in training statewide

and the training should include effective evidence-based modules that seek to reduce bias in a clinical setting.
- A robust state infrastructure is needed to develop, manage and activate a triage model including staff training, use of available technology and the standardizing and streamlining of data collection.
- Any data collection included in a recommendation must factor in the nature of the crisis to allow 100% of the focus of clinical teams on saving lives.

Community-based Clinics/Public Health

- This document only addresses survivability for patients who receive the needed resource. A patient's chance of survival if they don't receive the scarce resource should be assessed and factored into resource allocation decisions.
- Triage must consider rural areas with limited resources: rural communities with limited access to a single critical access hospital with few hospital beds should be considered as part of crisis care guidance. For example, supplies may be an issue during emergency situations specific to freeway closures.
- Appreciate the framework suggested, the definition for triage, and the suggested options for focusing care.
- The future of humanity is its children. All children should be given priority in the case of limited resources.
- It is illogical to give intensive care to a patient with a low chance of survival when others could benefit from such care.

Other Comments

- The ORAAC should address withdraw of life support and how their complex triage protocol would work in practice. A triage protocol that does not address the withdrawal of life support may effectively become a first-come, first-served system.
- It is crucial that the committee model which approach will lead to the fewest deaths among patients who are candidates for the scarce resource and the fewest deaths among disadvantaged candidates. In the context of

scarce resource allocation, reducing absolute deaths among disadvantaged candidates should matter more than achieving proportionality.

- Whatever tool for assessing in-hospital mortality is used, it should be proven to be well calibrated. The listed references do not support clinician prognosis as the principal tool for triaging patients based on their probability of hospital survival.
- By lumping almost all patients into priority group 2 (11-89% of chance of survival after resource receipt), the proposed allocation will likely lead to many more deaths by ignoring relevant differences in prognosis.
- The document does not systematically consider whether drawbacks identified for one approach are applicable to multiple allocation approaches.
- The current proposal does not systematically evaluate the advantages and disadvantages of weighted randomization or of excluding outcomes other than survival to hospital discharge.
- The current document lacks sufficient clarity regarding the basis for essential worker and multiplier effect priority and does not fairly evaluate SOFA or modifications to SOFA.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact us by email at OHA.resourceallocation@odhsoha.oregon.gov.