Oregon Resource Allocation Advisory Committee

To provide verbal public comment send a ZOOM chat message to meeting host Lisa Bui, or text 503-576-9321 and request public comment by 1:10 PM.
Please do not submit written public comment through the ZOOM chat; we will unmute you when it is your turn to speak.

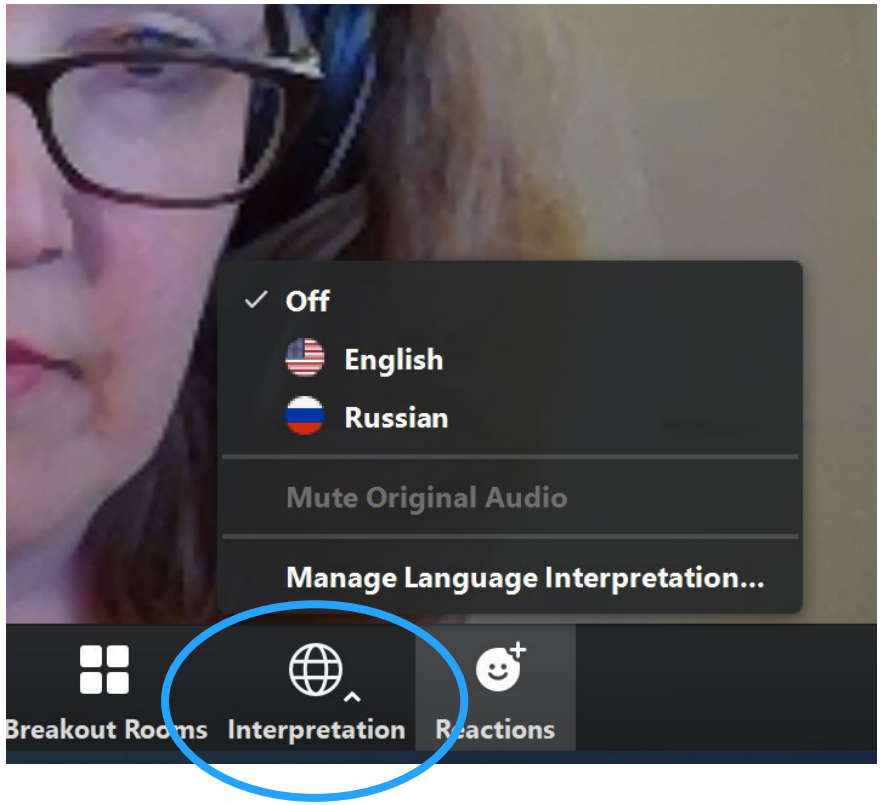
Advisory Committee Meeting

November 29, 2022

Guidance on submitting public testimony is here: https://www.oregon.gov/oha/Documents/ORAAC-Public-Comment-Process.pdf

Oregon Health Authority

Interpretation



- Click the globe to enable interpretation options.
- Select the language.
- You can choose to hear the original audio at a lower volume or select “mute original audio” to stop hearing the original audio.

Meeting Resources

If you need support, we have:

Simultaneous Spanish language interpretation

Technology support

Note taker

- **If you have a need, contact Lisa Bui at: 503-576-9321**

Please note that this meeting will be open to the PUBLIC

1. The general public may be in attendance
2. The meeting summary will be posted to OHA's website

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This Content May Be Difficult

If today's content is difficult for you, please take the steps you need to care for yourself. This might include:

- Turning off your video
- Stepping away from the meeting
- Contacting Trey Doty at Responder Life during or after the meeting for individual support:
    - 503.320.8775
    - trey.doty@responderlife.org

Purpose

Finalize introduction to triage concepts in order to launch subcommittee work.

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Agenda

1. Welcome
2. Public Comment
3. Review and Reflections from October Meeting
4. We are Oceania: Oregon's Pacific Islander Community System
5. Break
6. Triage Teams
7. Subcommittee Q&A

Total 120 minutes (2 hours)

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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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Public Comment Period

October Review and Reflections

Triage in Crisis Care Guidelines

For our purposes: “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

Ideal Properties:

- Advances health equity
- Mitigates bias
- Validated and reliable
- Can be operationalized, ideally across a range of emergencies/disasters/settings

Triage Tools: current status

Evidence for structural discrimination in existing tools

Risk for bias

Development often lacks involvement of community

Limited experience operationalizing emerging approaches

Limited research on emerging approaches, unknown impact

- Health equity and non-discrimination principles must remain core to our work

Approaches to Prioritization in Crisis Care Triage

Survivability: *save the most lives*

Health justice: *reduce or eliminate health inequities*

Prioritize by exposure: *e.g., essential workers*

Random allocation: *prioritization is “random”; a lottery system*

Use modifications, a combination of the above, other

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 and redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices

Our Work

Guiding Principles

Non-discrimination

Health Equity

Patient-informed Decision Making

Transparent Communication

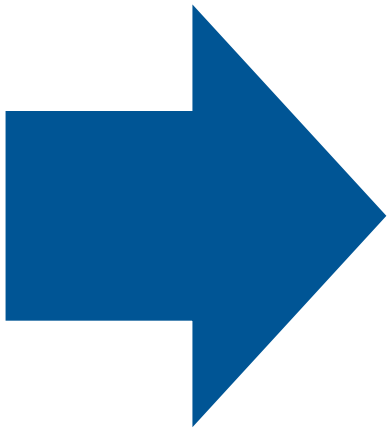
Challenges

Dominant tools with evidence for structural discrimination

Insufficient research

Lack of prior community involvement

Risk of propagating inequities



Community-informed crisis care guidance

Committed to health equity

Questions for Jamboard

What resonates with you from the approaches that were described? What causes concern?

The landscape of research and examples of the equitable distribution of crisis care resources is limited. As we move into future recommendations on triage tools, are there lessons from other sectors that we can pull from into our work?

Community Impact

We are Oceania: Oregon's Pacific Islander Community System

Triage Teams and Data Collection

Triage Teams: Crisis Standards of Care (CSC)

- A team should be designated by each hospital for implementing critical care resource allocation determinations
- Triage team should *not* be providing direct care to patients undergoing triage
- Recommended to consist of:
    - Two-three senior clinicians with experience in triage (e.g., critical care, emergency medicine, trauma surgery, etc.)
    - A medical ethicist with experience as a healthcare ethics consultant
    - An expert in diversity, equity and inclusion
    - An administrative assistant to record all triage team discussions and maintain records

Triage Teams Continued

To the greatest extent possible, each hospital should have a triage team that:

- Reflects the diversity of the community and patient population served
- Has training in implicit bias and antiracism

Considerations:

- Hospital size
- Staff capacity, training and skillset

Data Collection

In order to retrospectively assess for the potential that this triage prioritization process may exacerbate health inequities and in order to inform future updates, the following data must be collected:

- Patient's medical record number
- Hospital name and location
- Date of birth
- Patient's sexual orientation and gender identity, if known
- Patient's race, ethnicity, language and disability data (in accordance with REALD requirements
- Home address, unhoused or unknown
- Whether the patient was using a personal ventilator/ other personal medical equipment or resources
- 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.
- Triage prioritization and clinical outcome

Subcommittees

Subcommittees

Email alyshia@alyshiamacaysa.com by **Friday, December 2, 2022** if you are interested in serving on the following subcommittees:

1. Triage Approaches OR
2. Triage Teams and Data Collection

Review the subcommittee overview document for details on purpose, expectations, and criteria.

Questions?

Thank You

Oregon Health Authority