Oregon Resource Allocation Advisory Committee

Full Committee Meeting Summary
November 29, 2022

Overview

Meeting Purpose

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

Agenda

1. Welcome
2. Public Comment
3. October Reflections
4. Community Impact Presentation
5. Discussion
6. Triage Teams
7. Subcommittee

Meeting Notes

Welcome

ORAAC facilitator Alyshia Macaysa reviewed the zoom features, meeting resources, and meeting purpose. Committee members were asked to highlight a working agreement that the committee has been strong at, and a working agreement that the committee needs to improve on. Committee members responded with the following:

- The sense of direction and clarity of what the committee has been trying to accomplish is appreciated
- The commitment to inclusion and accessibility has been authentic and consistent
- The committee is well-organized with good follow up

Public Comment

No public comments

October Reflections

Dana from OHA provided a brief refresher on the Triage Approaches presentation that she gave in October. Members of the committee were then asked to reflect via a google jamboard and discussion about October's presentation. The information below highlights the main points that were shared:

- What resonates with you from the October presentation? What causes concern?
    - Resonates
        - Acknowledgement that existing triage tools are racist and future tools may not completely erase that
        - Keeping health equity present in the work and lessons from the past
    - Concerns
        - How do we stay hopeful, creative, and systemic in our approach?
        - People with disabilities were absent in many of the tools, particularly those with intellectual/developmental and physical disabilities
        - Need to address the bias and lack of access in non-crisis settings; crisis only amplifies what already exists
            - Triage assumes that all have equal access, this is rarely true.
        - Immigrant, refugee, linguistic abilities and legal statuses are all factors that end up being barriers to access resources and is missing in all parts of current triage approaches
    - Suggestions
        - The tool must be clear in its requirements and give time for providers and patients to "try it out"
        - The focus should not be on years of lives saved which has been a long-term goal of crisis care standards, the focus should be on equity
        - Prioritizing resources by exposure is important but focusing on that alone will not provide an equitable outcome. Prioritization should consider what someone's accessibility is to scarce resources. The trauma for a lack of accessibility to healthcare can be devastating.
            - Focusing on access to healthcare as a start might be an important step, especially for rural Oregon
        - Crisis care guidance must look at optimizing supply.
            - For example: Hospitals in the Bronx were overwhelmed, whereas hospitals on the upper west side of Manhattan had plenty of space. Thus, the right answer for constrained supply would not have been to deny care to someone in the Bronx, but to broaden the supply by requiring Manhattan hospitals to accept patients from the Bronx.
        - Call out age and recognize that the death of a 75 year-old due to a lack of care/services is no less tragic than the death of a 5 year old for the same reason
        - Noticed during the current crisis that pediatric nurses and doctors are effective in sharing these resources. The sharing of healthcare resources during an emergency should be called out and codified.
        - The Triage Tool that the committee puts together must be consistent with federal civil rights laws and Oregon's laws about nondiscrimination in health care
        - It will be important to think through the relationship between providers, institutions, and patients.
            - Feminism and care ethics should be the underpinning of our relationships between providers and caregivers, and social justice is best performed as healthcare policy.

- 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 to inform our work?
    - Creative agencies have a lot to teach us about inclusivity, branding, risk taking, and optimizing limited funds/tools
    - Developmental/Intellectual Disability system is a strong example on how to be as person centered as possible
        - Quality of life concerns can be some of the scariest things to discuss in medical settings for people with disabilities because their quality of life is unfairly compared to neurotypical/non-disabled people.
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- Any additional thoughts?
    - Hospitals continue to be understaffed and workforce is a challenge
    - Patient care is currently prioritized by medical necessity rather than the support or care that is needed which increases chances for additional marginalization
    - Transparency and precision in language in crisis standards is important - is the current crisis standards of care implementation about staffing or denied treatment?

Community Impact Presentation

Facilitator Alyshia Macaysa shared a presentation discussing the strain COVID-19 caused on the Pacific Islander community system in Oregon.

Discussion Groups

The committee split into four discussion groups based on the sector that they represent: 1) culturally specific communities, 2) hospitals/inpatient care, 3) disability and aging, and 4) community-centered clinics/public health. Each breakout group had discussion questions specific to their sector.

General comments

- Notice that all groups that different ORAAC members are focused on are devalued - disabled people, people of older ages, racial/ethnic minorities, women, etc. The same language is coming up in different ways.

Culturally specific communities

- Acknowledged the personal grief stories that highly influence how we see ORAAC and the space of this work
- Research shows how our nervous systems and emotions color the reception of our realities. It is important that we acknowledge how our emotions are impacting the way we show up to ORAAC and some of the biases that we may carry

Hospitals/inpatient care

- Oregon has issues with accessibility - Respiratory syncytial virus (RSV) showed huge gaps in the system
- We need to figure out ways to take historical and societal disadvantages into account
- We should learn from other places who have commonalities with Oregon and modify to fit our specific population
- It is important to make a distinction between accountability and responsibility

    - Responsibility is something someone takes from within
    - Accountability is external and placed on the individual by others
    - Important part of accountability is transparency, taking record, making the process clear, and reporting on the progress of a process

Disability and aging

- Federal law and OHA are very clear that quality of life cannot legally be considered in resource allocation because it is impossible to determine someone else's quality of life
- Debating quality of life highlights the issue that happens in triage where individuals have to justify their value
- Issues of ableism and ageism need to be centered because the survival of an elder in the community matters and their life is not any less valuable
- The intellectual/developmental disability (IDD) community is most disproportionately devastated by the pandemic and continues to suffer the effects of long COVID-19
- COVID-19 was the number one cause of death for the IDD population in 2020 and 2021

Community-centered clinics/public health

- Most triage tools are made for military or mass casualty events. Most people arrive the same in military settings, so triage is more straightforward. Triage tools developed for the military may not work in settings outside of that.
    - The goal and mission of triage in the military is clear and is different from triage in hospitals. What is our goal and what is our mission?
- Triage in COVID-19 is very different - the wealthy family with transportation and a regular doctor will show up first and their family member will have the highest chance of survival compared to someone who immigrated to the US and does not have transportation, speaks limited English, and does not have a support system to urge them to go to the emergency room.
    - Should we really be deciding between these two patients?

Triage Teams

The committee did not have time to review this topic. The slides will be sent out, and committee members can reach out to OHA with any questions or comments.

Subcommittees

1. ORAAC members interested in serving on subcommittees should reach out to Alyshia
2. The full committee is projected to extend through the end of June 2023, the project team will reach out with more information once it is available.