From: Bob Macauley [redacted]>
Sent: Monday, August 30, 2021 9:03 PM
To: OHA.DirectorsOffice@state.or.us
Cc: Atwal,Kamaljit <[redacted]; Melissa A Denny [redacted]>; Dirksen, Kevin M <[redacted]>; Fair, Jaime (MD) [redacted]>; Heidi Funke <[redacted]>; Kockler, Nick [redacted]>; Hong Lee [redacted]>; Melissa Monner [redacted]>; Molly Osborne [redacted]>; Morrison, Laurie (MD) [redacted]>; David Zonies <[redacted]>
Subject: Allocation of scarce resources

LETTER TO DIRECTOR ALLEN OF THE OREGON HEALTH AUTHORITY

We are writing you as individuals who are helping advise our respective health systems about the ethics of triage plans in the COVID-19 pandemic. Many of us also served as members of the Crisis Care Community Ethics Task Force convened in early 2020: a group which helped formulate a model approach for critical care resource allocation in a crisis. As you may know, this group met regularly from March-August 2020, developing iterative versions of a protocol in dialogue both with other ethics/professional groups around the country, as well as the local community (including initial conversations with representatives from the BIPOC and disability communities). Several traditional elements of medical triage tools (including disqualifying serious conditions and long-term prognosis) were eventually dropped from the algorithm, out of justice and equity concerns. The sole remaining triage criterion was likelihood of survival to hospital discharge, with two additional considerations incorporated in case of a "tie": six-month life expectancy and the "life-cycle principle" (which prioritizes patients who have not lived through as many stages in the normal life cycle). We were aware that this process, including the final algorithm, was initially adopted by the CMOs of at least 10 health care systems/36 hospitals and serves as an important resource for regional partners: especially where reflecting areas of standardization across the community.

The task force's work concluded one year ago at the same time OHA began working with community partners to center equity at the heart of crisis care guidance. Our understanding is that a group was formed and provided recommendations to Governor Brown, but this did not generate a triage algorithm that could be operationalized. This did not have a practical impact at the time, as we all thought we'd "dodged a bullet" with hospital capacity sufficient to meet population needs. During a surge in cases in late 2020, OHA released a document titled "Principles in Promoting Health Equity During Resource Constrained Events" which articulated *inter alia* "OHA encourages coordination across health systems in partnership with community partners to adapt crisis standards of care consistent with health equity in a transparent, unified manner: recognizing that aligned practices will be more just and trustworthy to the communities being served."

The delta variant, tragically, has brought us to the place we feared last year. With capacity stretched to the breaking point, hospitals are being forced to make triage decisions. We strongly believe that "no plan" is the worst sort of plan, often defaulting to a first-come/first-served approach that will only exacerbate already existing societal inequities. Hospitals need operationalizable guidance, ideally standardized across institutions to ensure just access to limited resources. At this time, and in the absence of more definitive guidance from Governor Brown, the state legislature, the Oregon Health Authority, or a new Oregon Crisis Care Guidance, we are aware that regional health care systems are

relying on internal plans shaped by the twin foundations of the task force's model and the OHA equity principles.

The former states that "while it is impossible to erase the devastating health effects of pervasive structural inequalities in our society during triage decision-making, those who have historically suffered discrimination should not be discriminated against further, the marginalized should not be further marginalized, and the community should be accountable for holding to values of social solidarity, justice, and the common good;" the latter offers "concepts that deserve further exploration include but are not limited to…using points to correct for structural inequities such as by applying the Area Deprivation Index." We the signed are recommending that our health systems incorporate use of the ADI to better account for health equity in the Oregon Crisis Care Guidance, the model, and other published resources.

We are writing you and the OHA today to transparently communicate this recommendation to our health system partners and issue a plea for further support: hospitals need practical guidance from the state about how to best account for health equity in the difficult decisions ahead. Unless the OHA is able to provide further guidance, this is the best approach that we can recommend and are hopeful that regional health systems can align practices thereto. However, we are hopeful that the state's efforts to ensure a co-created and inclusive process for crisis care planning has yielded important findings that we rapidly coalesce and share with relevant stakeholders. We would be very grateful for the OHA's input on this critically important and time-sensitive topic.

Sincerely,

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