Multnomah County Public Health Advisory Board Minutes July 2020

Date: Wednesday, July 1, 2020
Time: 1:45-3:45pm
Purpose: To advise the Public Health Division on several areas of work with a strong focus on ethics in public health practice and developing long-term public health approaches to address the leading causes of death and disability in Multnomah County.
Desired Outcomes:

- Gain an in-depth understanding of the Crisis Care Guidance tool
- Provide input and feedback on the tool
- Have any questions regarding the tool answered by those who have been instrumental in its creation

Members Present: Suzanne Hansche, Joannie Tang, Daniel Morris, Rebecca Lavelle-Register, Alyshia Macaysa, Debbie McKissack, Cheryl Carter, Maher Lazeg
Multnomah County Staff: Dr. Jennifer Vines, Nathan Wickstrom, Bernadette Nunley, Mary-Margaret Wheeler-Weber
Public: Kevin Dirksen, Bob Macauley, Molly Osborne

Item/Action	Process	Lead
Welcome, Introductions & Minutes Review	• Minutes from May meeting were approved by consensus	Suzanne Hansche
Crisis Care Guidance Tool Walkthrough	• Crisis Care model is currently on version 5.1 o It is iterative and a work in progress • There will likely be no surge with ventilators Kevin: • Clinical ethics o Individual treatment ▪ Seeking good of the patient ▪ Narrow view • Public Health ethics o Focus on the community, not the individual o Use a public health ethics framework ▪ e.g. How do we distribute the vaccine? • Triage ethics o Battlefield tactics ▪ How can we save as many people as possible? • What does this look like in Oregon? o A framework was already developed during H1N1 o Used this existing framework as a starting point • Values o Maximize the number of saved lives o Social solidarity - all in this together o Justice o Respect for persons o The common good • Suzanne's questions: o How do we act on the equity statement listed under Goals of Resource Allocation? ▪ Specifically, how will we act to ensure that "those who have historically suffered discrimination should not be discriminated against further"? ▪ Specifically, how will we act to ensure "the community should be accountable for holding to values of social solidarity, justice, and the common good"? ▪ (See document shared with us by Nathan on 6/30 - recent new addition to the guidelines, is it not?) o Why would we need to and/or how could we justify employing crisis care guidance critical care triage after the initial stages of a pandemic once we have early on identified limitations/gaps in resources and taken steps to address those gaps? o Is there any serious attempt to revisit/"start over" to revise the Crisis Standards of Care Guidelines? If there is or will be, how will inclusiveness of "those who have historically suffered discrimination" be handled? • Health equity is a gap that is being circled back to	Molly Osborne, Kevin Dirksen, Bob Macauley

	o The Oregon Crisis Document is statewide and will be hard to change o The local document (see attached) is much easier to change • Need to invite people to the table who are impacted most to see what they think • Need to ensure that people are trained and able to share stories and have conversations up front with patients Bob: • Thinking has changed on the topic o Used to think in terms of saving the most people, life in years, etc. o People of color are dying at much higher rates o Saving the most people will perpetuate the inequity of the system • 3 choices moving forward: o Be colorblind, which will perpetuate inequity o Avoid areas that will continue unfair treatment o Remedy the problem ▪ How do we come up with solutions? ▪ People are coming up with creative solutions, but this is a large issue • Questions: o Why can't we give advantages to those who are hurting? o It's a struggle to balance serving the community with a tool that can't remedy hundreds of years of structural racism ▪ What will the community look like in the future? Will it still be intact? • How can we use this as a document to go beyond? The model tells something about who we value. Molly: • The model was co-signed by the State • 10 healthcare systems have adopted the framework • Dr. Vines convened the group to bring together ethicists and physicians • They have been late in getting this out to the community • Not everyone was at the table during its creation o Other community stakeholder bodies could provide valuable input, such as Washington County Ethics Committee or the ethics committee that Dr. DuVivier is a part of • There has been collaboration between hospitals during the pandemic (e.g. Yakima transferred patients to Seattle) • No VA facility has been in a crisis state • Quality of life judgements are not part of the assessment • Questions: o How are you defining survivability? ▪ Not sure yet ▪ Cancer is in terms of 5 years ▪ Hospice is 6 months ▪ There is a sense that this is more accurate and better in terms of metrics, given the shorter time period. Longer period of time could give more potential for bias ▪ Survivability is different than life expectancy ▪ Survivability is an individualized assessment ▪ Life expectancy is a population metric Kevin: • Class 4 heart failure is objective o Prognosis is basically going to be this • Comorbidities can be discriminatory o Incompatible with Civil Rights Law o May allow bias to creep back in, not having a more objective prognosis Molly: • Tiebreaker o Life-cycle principle ▪ Doesn't take into account the value that elders bring to the community o Tiebreaker is a suggestion ▪ VA uses first come first serve ▪ Life stages lived is another option ▪ During planning discussions, elders offered to step down if there was a lack of resources o There is an opportunity for course correction if there is a tiebreaker	

	• SOFA score
	  o Add language for areas we know can be corrected
	  o SOFA score is automatically put in the system, which makes correcting it more difficult
	  o An African American male will automatically get 1 point due to GFR (kidney function score), which is a major inequity
	• How do we ensure that those discriminated against aren't again?
	  o Need to have the opportunity to talk to stakeholders
	  o Suggest that there are other opportunities to engage BIPOC communities
	  o Suzanne suggested engaging with existing community advisory groups not limited to but including: Ethics Committees at local public health authorities including MCPHAB, and same at Washington and Clackamas counties as well as other counties statewide/ engaging Oregon Health Policy Board Health Equity Committee (Dr. DuVivier is a member, we think he said)/ Kevin asked MCPHAB for feedback on this thus the email address
	Action Items:
	• Molly will share information from the VA with Nathan
	• Molly will send the powerpoint to Nathan with descriptions
	• Kevin invited board members to send feedback, suggestions for opportunities for engagement with BIPOC communities, and questions to the following email address: **crisiscareethicstaskforce@gmail.com**	

Wrap-up and Meeting Evaluation	• Meeting adjourned at 3:55pm	Suzanne Hansche