Multnomah County Public Health Advisory Board
Ethics Committee Minutes
March 2020

Date: Thursday, March 26, 2020
Time: 4 p.m. – 6 p.m.
Location: Remote meeting conducted via phone & GoToMeeting
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:

1. Hear an update on the Multnomah County COVID-19 response
2. Provide input on a draft tool as well as specific questions

Members Present: Suzanne Hansche, Becca Brownlee, Mahad Hassan, Cheryl Carter, Debbie McKissack, Rebecca Lavelle-Register, Hanna Atenafu, Bertha Ferran, Dr. Ryan Petteway, Joannie Tang, Alyshia Macaysa, Daniel Morris, Laurel Hansen
MCHD staff: Jessica Guernsey, Christina Brown, Hilary U'Ren, Jennifer Vines, Mary Margaret Wheeler-Weber

Item/Action	Process	Lead
Welcome, Introductions, & Minutes Review	● Introductions ● Approved February meeting minutes	Suzanne Hansche
Update on COVID-19	● **General** o COVID-19 virus is spreading worldwide; no vaccine and no specific treatment o Most have a relatively mild illness and can stay home to weather through, o Older populations and those with underlying health issues are getting quite sick and require hospitalizations. o Highest risk scenario for infection is close and prolonged contact o Worldwide recommendations to practice social distancing (spread out 6 feet apart, stay home, and stick to your immediate social circles). The purpose of this strategy is twofold: ▪ By slowing the spread this way, we give health care systems time to set up in preparation, cancel non-urgent surgeries, free up beds, and do general planning. ▪ If the virus does start to spread more severely, if we practice social distancing ideally the bad cases will come in to the hospitals in manageable waves, so that they don't have to grapple with supply and staff shortages. o In Oregon, there is an increasing number of cases, which is to be expected with increased testing capacity. Also seeing increased hospitalization and death numbers – though these are steady, we have not seen the explosion that other places have seen. o Currently modeling to see what stage we're in for the spread of the illness, whether our current interventions are working, how long we might need to do it, what our next steps are, and where to go from here. ● **Multnomah County/Emergency Operations Center** o Multnomah County has been operating an emergency operations center for several weeks, which is part emergency management, part public health. o Focusing on planning and action – large part of our efforts is Public Health messaging and external communications. This includes all web-based messaging, media releases, bilingual and multicultural staff, and community liaisons developing multiple guidances for various settings (i.e., business, childcare, schools, shelters) so that they're receiving technical assistance on how to maintain their essential operations if they're staying open. This is all part of the larger Public Information system. o Working on standing up appropriate structure for homeless services to help them operate with social distance recommendations. We've stood up some	Jennifer Vines & Jessica Guernsey

	alternate shelters (e.g. Oregon Convention Center) to assist with this. o Collaborating with regional health systems to coordinate regionally. o Also looking at how we structure and assist with more high-risk settings, like long-term care facilities and residential care, as well as helping seniors in general. **Questions?** ● How much does this collaboration involve community resources beyond the County & City governments themselves? (i.e., working with hotel rooms for quarantining) o These collaborations are a huge part of our operation. We have a unit called the Logistics Unit that works on donations & volunteers (food, supplies, etc.) We have volunteers helping with a more comprehensive approach to getting folks over 65 access to food outside of Meals on Wheels. We've done some work with hotels related to shelters (getting people rooms to be quarantined). We have a unified command with emergency management, and they're seasoned at these kinds of collaborations. ● Can you say a bit more about the culturally specific liaisons? What are they doing? Reaching out about COVID-19 and how to prevent it and get treatment? o They're doing exactly what you're describing. Dr. Pei-ru Wang in our community partnerships unit in Public Health is leading her staff and a group of folks that work across the county to get info out to specific communities. We want to both share information with them as you've described, specifically as it relates to social distancing at the moment, but also gauge their reactions and input to help understand how we might need to modify our outreach accordingly. ● What are the assumptions we're making about immunity with those who have already had COVID-19, especially those who are frontline caregivers? How are we moving forward to document that as it relates to triaging care? o Currently testing is very limited, so we don't know whether people are immune once they've had it. Currently, the assumption is that once people have it and recover, they have some immunity for some unspecified amount of time. There's talk of some blood tests that show whether people have the antibodies, but these conversations are just starting and it's unclear how good these kinds of tests are right now. ● What do and don't we know about testing, given that that will have impact on what we deliberate today? o Today for the allocation question, COVID-19 patients are being asked to be considered in the same pool as everyone else – like those who have other health issues. Given that, the questions of testing and immunity aren't directly related to today's discussion (and unfortunately we don't have clearer information on testing and immunity at this time). We could come back to discuss testing ethics at a later time since it's a good question. ● Where can people go to get tested besides their personal physicians? o There is not widespread testing available right now, no central site to see where one can get tested.	
	Background ● Today what we're considering is a tool that regional health systems are developing for how to decide who gets what if there are more patients in need than resources for them. ● In a given flu season, hospitals in the region run at or near capacity already and are not designed to have a lot of empty beds or idle staff. ● Currently doing contingency planning – not doing procedures that can wait, trying to free up beds and personnel, preserve masks & gloves, etc. ● If we see a wave of illness (like they did in Italy) called a surge, it can outstrip health systems' abilities to care for patients at the level they normally would. ● Medical ethicists came out with crisis care guidance that formed this tool, which is to be used by a triage team in the ICU – a separate team from the treatment team whose job is to look at each person coming in and give them a score based on this set of criteria. This ranks the patients according to who should get resources. ● Tenants of the tool: o Can't use first come, first served – not a good use of existing resources.	

Background Review/Q&A	- Idea is to use what we have to save the most lives or the most life years. - Taking into account both someone's chances of survival in the short term (how well are each of their organs functioning?) and how likely they are to survive in the long term (do they have existing/serious health conditions like cancer, Alzheimers, or advanced heart disease?) - What we specifically want to discuss are the situations in which several people have the same scores – what do you consider for tiebreakers? - The tool says: - Lottery system (not based on age, ability to pay, disability, race/ethnicity, gender, social worth, etc.) - Some other possible ways to break ties: - Intensity level of resources necessary for survive (i.e., need a ventilator for three weeks, versus someone who will need one for three days?) - Priority to younger patients – inherent life years saved - Health care providers – if they recover, they'll be able to continue helping with the crisis. On the flip side, if they got sick while helping people, should that be honored and prioritized? - What the tool and the research doesn't explicitly discuss is how this intersects with equity. Does the tool have discrimination built into it given that POC are more likely to have underlying health conditions? It's difficult to come up with a way to extract race/ethnicity from that. Could we build in for health systems to make adjustments if they assess their ICUs and realize everyone being prioritized is white? **Q&A / Initial Responses** - When assessing years of life in short term/long term care and trying to break the tie, do social determinants play a role? Whether people's environments are going to add or take away years, is that assessed in their evaluations? - That would not come into play – people making those decisions would see name and DOB, the patient's current condition, and underlying conditions. They would assign the score purely based on that – no consideration for health insurance, where they live or are from, just how likely they are to survive and how many resources they need for that. - I want to articulate that this general approach for the screening tool feels like the opposite of my current approach. In the context of the state of Oregon, white people are the healthiest people. Who is the healthiest, who has the most promising future, who has the best ability to survive, most years of potential life lost – this is the opposite of health equity work that I do, which aims to prioritize the people who had years shaved off their lives by discrimination and inequitable systems. Right now I try to give them the abundance of care and attention and resources, so this is opposite that. - Is this information going to be distributed to all medical facilities, including those in places concentrated with low-income folks, or people of color? - Your feedback is going to go to a group of people employed by local health systems with the goal of finalizing a tool that will be shared and applied uniformly across our the systems. We also have a community communication piece about transparency, what the tool looks like, how it will be used (should it come to that). - Where does self-determination come into the prioritization process? Is there a point where the patient's personal goals and priorities are taken into consideration, or even found out? - The very first step is asking the patient what their goals of care are before any decisions are made. There are also no automatic exclusions – some headlines have indicated that those over a certain age are automatically excluded or not resuscitated, which is not true, everyone is given a fair look. - We keep hearing about shared ventilators or ventilators made with 3-D printed parts, is that a possibility? - I don't know, but we have to believe the health systems are working on those questions. If we look at modeling elsewhere, even under the best of circumstances, we just may not have enough. Additionally, we may not have enough staff or beds. Not only do we need enough ventilators, but we need enough people to know how to work them and enough places to put people	Jennifer Vines

	on them all at the same time. It's a combination of circumstances and resources necessary. ● We should start telling people to talk within their family units about what they need to know and what they should do in worst case scenarios (i.e., they end up in the ICU when it's overwhelmed). We should work on a communications piece around this to let the public know that this is the plan and they should be prepared. ● This is an ethical and political challenge, especially for a county that vocalizes having equity at its core – how do we center and prioritize those who are being excluded? Low-income POC are more likely to have comorbidities and lower survival rate, and this tool is going to leave them out. We should have a publicly articulated rationale that makes it explicit how and why we've made these decisions. There's not a high trust factor in Oregonian POC communities due to historical forms of oppression, and we risk leaving many people wondering how we reached our conclusions and why they weren't in the room when decisions were made. ● Who's using the tool on the ground? The triage team or the treatment team? o It's the triage team, which is separate from the people at the bedside doing the treatment. That distressing decision is not being put on the treatment care team. ● It is important to recognize that this tool is being deployed at a time when a patient or patients are critically ill. This means addressing immediate needs at that time, often in crisis mode/critical care – it's important to realize and recognize that. It would be wonderful if every person who came in had a care directive and was conscious, but if that's not available, the triage team is going to do their best to see what brought them in and assess their symptoms. Though we should acknowledge these community and equity-based thoughts and ideas, keep in mind this is a critical care environment and it has to be fast action. ● When is this tool used? At what point in the process is this tool applied, and is the triage team following course of treatment and outcome? o We go into crisis mode when all beds are full and patients continue to come in (which has never happened in [Dr. Vines'] career). This tool is not being applied right now and the systems are doing okay. When overwhelmed, they all uniformly agree that whatever they have in place applies and this gets employed. People get prioritized and then there's a system of reevaluating people over time given that the situations are obviously dynamic. As more people come in and conditions change, scores vary. There are scenarios of removing people from ventilators or beds to give them to someone else if that person has a higher score. Withdrawing care is not considered the same as not offering care. ● How is the score reached? o It's an established score that checks off how well each of the organs is working, checks for underlying conditions, etc. ● Would you expect that tobacco use is factored in when people are assessing long-term prognosis? o Tobacco use itself is not anything I've seen as criteria, but use as it affects organ use comes into play. However, smoker versus non-smoker is not part of the criteria. ● Would it help to remove or conceal information from the triage team to try to address inherent biases, like hiding people's names? ● Currently discussing an equal application of the review process, but there's a difference between equality and equitable impact. We can do this in an objective way on the surface that follows the science, with calculations to save the most lives and an equal process, but the impact would be inequitable from a population health standpoint. There should be space for that in this conversation around the tool. ● We should also address people who have less complete or accurate health histories – how will that be accounted for? Will they have an advantage, disadvantage? ● Who is comprising these triage teams, are they given training with respect to bias? o The makeup of the teams are people with ICU experience who know how much resources people will require, who can gauge prognoses, etc. ● By being a lottery, is the lottery *actually* not taking into account age, ability to pay, disability, race/ethnicity, etc. considering the long-term inequity of health care for our POC? Should it then be more of a weighted scoring, accounting for equity	

	discrepancies? ● Should the system also consider whether people having dependents should be part of the score? There's population health/equity impact there, if there are people with several kids or family members to care for who will be affected by their loss. o That's part of that social worth, which is set aside in these scenarios. ● There are already some similar processes in place, like rankings for organ transplant candidates – can we talk about how this tool is different or similar from that? o I can't speak to that but I imagine there's a similar approach. ● Though we want to be transparent with the public and we want this to be as equitable as possible, we should also recognize that it could be the most fair and unbiased process, and some people will still take umbrage with it. That inevitability that people will find an issue with it should be considered. **Questions/Topics Sent in Post-Discussion**: • Will COVID-19 patients be directed to the same hospital or care facility to decrease transmission between COVID -19 patients vs other patients? This would impact what pool of patients the triage team must assess as it pertains to care resources. This could also influence how resources are allocated and where (rural vs non-rural Oregon). Travel via Life Flight or ambulance from more rural areas might also need to be considered in the conservation of resources question, which could potentially impact where resources are sent or additional clinics/hospitals set up as it would relate to overall PPE required, etc. • Folks with disabilities and chronic illness - will they make the cut? What comorbidities will be considered? For rare disease patients, this could be worrisome as so many providers already do not know/understand their rare disease. What about patients that require more experienced/expert intubation methods (if it comes down to that) that require fiberoptic intubation and conservative cervical spine protocols - would this need (apart from other potential comorbidities that might decrease survival - also need to be considered? • Is there a way or should there be a line drawn with regard to what or what types of providers are prioritized for care? • Will this be a point system that docks patients or a system that adds points to a patient in the use of this tool? Although a minor detail, docking points vs adding points might be something to consider when it comes to the psychological aspect of being a triage person using this tool as well as how it could relate to public health messaging? • Regarding public health messaging during this time, simple and concrete recommendations with a brief rationale - what to do, what not to do and why vs using more theoretical blanket terms like "social distancing" could be helpful to decrease reinterpretations.	
Large Group Deliberation	**<u>Specific questions to deliberate:</u>** ● **Should healthcare providers themselves get some considerations in the tie-breaker question? To return to work to save others? Do they deserve special consideration by virtue of being on the frontlines and higher risk because of their jobs?** ● If we're talking about people on the front lines, the same could be said for grocery store workers, custodians, delivery drivers, etc. That is a hard question – partly about the training involved in caring for sick people. Do frontline workers who work with sick people tend to get sicker as patients themselves, are they more critically ill? o We hear stories about healthcare workers being sick and dying of COVID and assume it's an occupational hazard, but it's difficult to tell whether they did contract it at work or home. ● Yes, it should count if somebody is risking it on the front lines. Does it count for their families, too? If I get sick and bring it home to my family, will they be covered? o The standard is that the coverage/special consideration stops at the provider, family members don't get extra "points." ● Lean toward yes – healthcare workers are expected to go in without the guarantee that they would get protection for their families. Healthcare providers are critical in that they have necessary training to reach their expertise level. Grocery store workers can be more easily replaced if lost. Though balancing who's more important in that scheme is difficult, some considerations should be made. This thought	Group

	process is dependent on the assumption that people are immune from reinfection once they recover, however, and can return to treating patients. If they're not, this is an invalid argument. o Reinfection is an open question – we assume some protection for some amount of time. Any healthcare provider who is sick enough to be in this scenario will need a long time before they're healthy enough to work. ● Do we know the recovery time for no longer being contagious? o Difficult to answer – currently, we're saying it's 72 hours after the fever is gone and symptoms have abated. There's also more intensive lab criteria, but that's reserved for hospitals. Some people are still testing positive for the virus in their system days after it seems they've recovered . ● Vote yes – though most providers would come into work whether they're guaranteed an extra point or not, if even a few people could be encouraged to stay on the job if they were considering not doing so by the extra value, that could have a bigger benefit in the system and could mean more people could get care. ● Lean toward yes, but want to be careful with regards to language – we want to specify that the point goes to critical healthcare providers, or essential healthcare providers, not just essential workers, so that people know this doesn't include all the essential employees still out there working outside of healthcare systems. ● Consider healthcare workers with specialized skills (intensive care workers, emergency workers) with rationale of incentivizing them to keep working. ● We should include nurses and CNAs, though they're not highly intensive specialists they're doing a lot of patient contact. Where does the line get drawn, though? What about those working in the hospitals to clean? Even though they're not specialists, those jobs are necessary right now. ● What about care workers removed from the COVID context but working with immunocompromised populations? We should think about stratifying the risk, somehow. How well-protected are people in their working environments? Some people have insufficient PPE, should that be factored in? ● **Should people prioritize younger patients in a tiebreaker?** ● It depends on the spread – the difference between 17 and 80 is very different than 17 and 40. ● If we prioritize younger patients, it may make up for some equity issues. We know that POC suffer chronic disease at younger ages. If we build in a tie breaker based on age, we could slightly re-tip the balance in favor of equity. If POC in their 30s or 40s are more likely to have comorbidities but are favored because of their ages, that might offset some of the tool's inequitable impact. ● Is there a way to factor in social behavior? I.e., those who have taken social distancing measures seriously and those who have not? o No, that is part of the social worth question, so it cannot be considered. o However, we do want this to factor into ongoing public health messaging – we want people to know that this behavior is what leads to people having to make these difficult decisions. ● Speaking from a community cultural worker standpoint, this is the opposite of what we would do (in the Pacific Islander community) – we are taught to honor our elders, and this goes opposite to that. However, I understand the value in potentially countering some of the inequity in the tool by skewing toward youth. ● In the messaging, would we openly speak to the fact that we're using age as an equity tool, or leave that unspoken? How would this be shared? The way we framed the age component would be important. ● **What about someone who is clearly going to take a lot of resources to potentially survive – should that be taken into account?** ● Is that something the triage teams can easily tell? o Someone on the triage team that has experience/knowledge would be able to discern that. This isn't just about people with COVID – there may be other people with trauma that would need weeks of ventilator support to survive.	
Conclusions & takeaways	● **Things to be considered in discussion of the tool:** o Remove bias to the extent possible, use info objectively (i.e., remove names or other information if possible)	Jennifer Vines

	o Discussion of health care workers – critical skill is important but difficult to operationalize and differentiate; we don't want to glamorize certain essential jobs o Using youth as a factor might help offset some of the inequity of the original tool o Idea of not just saving lives or life years, but of keeping different communities intact should come into play o Importance of social distancing as it relates to decisions like this (the whole point is to keep us from ever having to use this tool)	
Wrap-up & meeting evaluation	● Please use the online evaluation tool to let us know how you felt this meeting went – it's likely that we'll have several remote meetings over the next couple of months, so we'll use feedback to shape how these meetings are handled moving forward! ● Please feel free to send us any other questions or thoughts you have about this topic as they arise – this is a dynamic process that has room for continued feedback and input.	Christina Brown