Multnomah County Public Health Advisory Board Minutes May 2020

Date: Thursday, May 28, 2020
Time: 3:30-5:30pm
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. Celebrate receiving NACCHO Model Practice award and determine poster presenters
2. Hear an update on the op-ed letter
3. Provide input on Crisis Care Guidance

Members Present: Suzanne Hansche, Becca Brownlee, Joannie Tang, Daniel Morris, Hanna Atenafu, Rebecca Lavelle-Register, Laurel Hansen, Alyshia Macaysa, Debbie McKissack, Bertha Ferran, Cheryl Carter
Multnomah County Staff: Dr. Jennifer Vines, Kory Murphy, Jessica Guernsey, Nathan Wickstrom
Public: Kevin Dirksen, Bob Macauley, Derick Du Vivier, Molly Osborne, Brittany Fisher

Item/Action	Process	Lead
Welcome, Introductions & Minutes Review	• Minutes from March meeting were approved by consensus	Suzanne Hansche Becca Brownlee
Updates	• Celebrate NACCHO Model Practice award o Submitted application in December o Received notice a few weeks ago that the Ethics Committee had received the award o Asking for two members to make a virtual poster presentation at the NACCHO conference in July • Hear update on op-ed letter o Dr. Vines has been facilitating conversation around Crisis Care Guidance (CCG) o A MCPHAB subcommittee wrote an open letter to discuss what is happening o Wanted to be transparent about the level power and influence we have as MCPHAB and bring concerns forward so that the public is aware o Submitted an op-ed piece to the Oregonian; waiting to hear back	Dr. Jennifer Vines Suzanne Hansche Becca Brownlee
Background Review / Q&A	• State convened process to create the guidelines from 2015-2017 o Goal was to think ahead in case there is a crisis resulting in overwhelmed healthcare resources o Available online o Many people signed on the consensus document, with the understanding that it is living and can be refined • Currently on version 5.1 • If we get to the point of needing these guidelines, what are the decision points? o Are they someone who wants to receive care? o How likely is someone to survive in the short term? o If this person survives this hospitalization, how long are they expected to survive in the long term? o Age is used as a tiebreaker - life cycle principle (someone 70 may have a longer life expectancy than someone younger) o Tiebreakers are listed as options - e.g. VA would make different decisions (first come first serve) o Final decision decided by lottery if this is still undecided o Nobody already on a ventilator would have that removed for equipment needed in a surge scenario • Convened the group in March under the realization that we would not be able to create something from scratch - not in purview to create anew • Looked at the process in 2010, and revisited in 2018 during the ebola outbreak o Did not make it from scratch; went to local guidelines o Living document o The initial document contained many examples • Can you explain the life cycle principle? o How many years does someone have left to live o Stages of life - if you are an older adult, you've already lived through numerous life cycles • Once you get past the quantitative scoring, it isn't super descriptive o Meant to be a guide; these are salient points, but it's just a guide that you can take	Dr. Jennifer Vines

	points from ● State-wide ethics workgroup continues to convene and modify crisis care guidance document ● Each healthcare system is doing it differently - Oregon has been trying to make these guidelines uniform ● If they want treatment, the exclusion would be someone on hospice ● Would come to ICU and everyone (assuming they have equal access), o Scoring looks at how well our body is functioning o Same for everyone coming into ICU o Person who is more likely to survive is the one who would be receiving treatment o Identical across health systems and VA o Not implemented uniformly - would fall to training ● Analogy to military - triage those who will likely survive; may not give preferential treatment to those on the front line ● Similar standards across the country (survival point system) ● Triage team o Team that is separate from bedside staff, looking at scores and distributing resources o Desire to be in alignment and show discretion ● Guidance tool has to be simple, which could make it less effective (e.g. too generic)	
Large Group Deliberation	● Ethics in marginalized communities and medicine - behaviors couched in ethical behavior have actually been inequitable and negatively affected marginalized communities ● Numbers being unbiased not necessarily true ● We see daily that when people of color go in for treatment they are treated differently, which impacts outcomes ● Typically ethics is approached in a healthcare context - folks who are stepping in without a health issue are walking in at a healthcare disadvantage o How do we respond to that? o What do we do as a committee? ● When we talk about traditional ethics, it's grounded in Western thought o A lot of it is grounded in the individual o Communities are a value outside of individuals ▪ e.g. there is a clash of values when it comes to the Native American population ● Create a system that addresses multiculturalism o POC are going to be affected more by these guidelines ● Need to recognize where we are before we can move to a solution ● Overarching goal from triage situation is to maximize the number of people who survive ● Power is the ability to define a phenomena and get it to act in a desired manner o Why can't we just flip this idea of power? ▪ Name the level of power that we have - not just the should ▪ Language in the guidelines is dependant on the should ▪ When can we put protections for people of color in the language of the document? ● Crisis Care Guidance feels like the exact opposite of health equity work o Not starting with the people who need help the most o Survivability framework ● How can we call it an ethical framework if we're basing it on survivability and not everyone has had an equitable chance towards health? ● Need accountability for those who received treatment and those who got turned down o Provide data to communities ● How are organ donations figured out? Is it a centralized or regional system? o Main way solid organs are distributed is based on sickness - someone who will not live without that organ transplant has the highest priority ▪ There is a list/scoring system ▪ Many people have commented that this is an inequitable, broken system ▪ Speaks to power o Varies from organ to organ - sometimes based on first come first served; there are a variety of ways to work the system ● Decisions have to be made rapid fire ● More than a language tweak to the document is needed ● Certain elements of CCG have been taken for granted (e.g. transparency, consistency) o Some of the things emerging from the conversations have challenged ways of thinking o If the playing field isn't the same, we are perpetuating an inequitable system	Dr. Jennifer Vines

	• Equal does not equal equitable
	  o What would be the barrier if we have two patients who are equal in all medical areas and then go to a lottery; why not give it to the person in a marginalized community?
	  ▪ There is concern that this is a form of discrimination
	• Affirmative action framework:
	  o Share this framework as a possible way forward
	  o Look at data, assess what happened over a period of time (last year); who was hired, who was terminated, try to figure out ways forward
	  o Look forward and set goals
	  o Is there a way to look at data and use a similar framework? And look at/track traditionally underrepresented people?
	• How many people think we could work with the existing tool, vs. it's back to the drawing board?
	  o Slightly over half of present board members voted to start over
	• Wordsmithing the current framework would not be effective; worth considering adding points related to marginalized communities
	• Completely start over with a different conversation over assumptions
	• Rather than start from scratch, reconsider fundamental assumptions
	  o Certain elements are sound (e.g. focus on transparency)
	• There was general agreement to work with existing framework
	• It has been an extraordinarily helpful call; consistent with dialogues happening across the country
	  o We've been on a journey and are not yet at the terminus
	• During the AIDS epidemic, Dr. Fauci worked directly with vulnerable populations, putting patients in leadership roles in order to get their input and shape guidelines
	  o We should use a similar approach
	• This is an iterative document that's meant to be built on
	• How far are we willing to go?
	  o It would be bad to rewrite it and come up with the same product
	• Dr. Du Vivier would be happy to continue to participate
	• Kevin, Molly and Dr. Vines have time scheduled to speak with the convener at the state level
	  o Can sum up today's conversation
	• Can those who prefer to start over with the crisis standards of care work live with the approach of first talking with the State to see what they're willing to do/how far they're willing to go?
	  o MCPHAB agreed to this approach
	• Has this been brought to the health equity committee?
	  o It has not at this time
	• Common themes that emerged with regards to the guidelines - consistency, accountability, transparency, does not perpetuate injustice
	
	Actions Items:
	• Dr. Vines, Molly and Kevin will share this conversation with the state
	• Dr. Vines reserved the right to convene the group ad hoc
	• The tool itself needs to be revisited - determine how to keep MCPHAB engaged in process
	• Determine if it is possible for a medical ethicist to host a 1:1 session with MCPHAB members to talk through the tool	

NACCHO Model Practice Poster Presentation	• Deadline for identifying presenters is tomorrow (5/29)
	• July 7-9 is NACCHO 360
	• 2 presenters needed
	  o 1 MCPHAB member, 1 PH staff
	• **Alyshia is happy to present**
	  o Suzanne offered to be a backup
	• Multco staff - either Dr. Vines, Jessica, Christina or Hilary
		Suzanne Hansche
		Becca Brownlee

Wrap-up and Meeting Evaluation	• Prior to our July retreat, need to think about what we bring forward from each of the committees • Complete online meeting evaluation • Meeting adjourned at 5:17pm	Suzanne Hansche Becca Brownlee