Principles in Promoting Health Equity During Resource Constrained Events

I. Background

In the event of a public health crisis, healthcare demands may overwhelm available capacity to offer potentially life-saving care to all who need it.

Since 2014, Oregon health care providers, ethicists and emergency preparedness experts have invested significant time and effort to plan for this scenario as captured within Oregon's former crisis care guidance. In September 2020, the Oregon Health Authority (OHA) announced its decision to no longer reference or depend on previously established guidance, due to its potential for perpetuating discrimination and health inequities. Over the past month OHA has begun meetings with community partners and health care experts in order to co-create a new and inclusive process with the goal of developing revised crisis care guidance centered on health equity. Further engagement and planning are underway to co-create that process.

With the recent surge of COVID-19 cases and emerging health system capacity constraints, as well as in response to community partner input thus far, we recognize the pressing need to articulate and assert health equity principles, mitigate the impacts of implicit and explicit bias, and prevent discrimination at this critical time. Therefore, **OHA is issuing this interim statement outlining principles in promoting health equity in resource constrained settings**.

This document has been informed by advocates from the disability community, communities of color, health system ethicists, and public health community advisors. While this interim step is necessary to address the risks of worsening health inequities during the current crisis, we recognize it is also iterative. OHA plans for robust, transparent and continued community engagement and collaboration to develop Oregon's future equity-centered crisis care guidance, including consultation with Oregon's nine Federally Recognized Tribes. We encourage community members, advocacy organizations, health system experts, and everyone with an interest in informing the process to reach out to OHA.[1] OHA will begin publicly summarizing input received and identifying next steps and how people can provide input in the coming weeks.

As we issue this initial statement of principles, OHA remains committed to urgently continuing our parallel work to co-create new crisis care guidance with our community partners and healthcare providers in Oregon. We recognize that extensive work lies ahead to produce not only a new guidance document, but to ensure that health equity is

[1] Interested individuals should contact OHA at OR.CCG@dhsoha.state.or.us.

systematically at the center of our health system's response in the time of a public health crisis and beyond.

II. Key Principles

When allocating scarce critical resources in the face of a public health crisis, such as a surge in patients requiring hospital level of care during the COVID-19 pandemic, the key principles of ***non-discrimination, health equity***, ***patient-led decision-making***, and ***transparent communication*** should be applied.

a. Non-Discrimination

There are unambiguous state and federal laws in place to protect the people of Oregon from discrimination based on their protected class, including race, ethnicity, color, national origin, disability, age, sexual orientation, sex and gender identity.[2] As reinforced by the United States Health and Human Services' statement on crisis standards of care and civil rights laws, "civil rights norms and laws, including in the context of declared disasters, are not suspended or waived in times of disaster."[3] Since the beginning of the COVID-19 pandemic, the U.S. Department of Health and Human Services Office of Civil Rights has worked with multiple states to resolve discrimination complaints and to ensure that crisis care standards do not discriminate against persons on the basis of protected class.[4]

While decision-making as informed by crisis care guidance must align with non-discrimination laws, these legal obligations may not go far enough. Rather, crisis care guidance must also take into account the longstanding systematic racism and health inequities that have contributed to poorer health for communities of color, tribal communities, and individuals with disabilities. Crisis care plans should take an additional equity-based approach to resource allocation by considering longstanding disparities and proactively work to reverse those inequities in concert with policies of non-discrimination protections.

b. Health Equity

Health equity must be at the center when considering the allocation of scarce critical resources in the face of a public health crisis such as COVID-19. As developed by the Oregon Health Policy Board's Health Equity Committee, OHA defines health equity as follows:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation,

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[2] See OHA document "Non-Discrimination in Medical Treatment for COVID-19" at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2288R.pdf

[3] See https://files.asprtracie.hhs.gov/documents/crisis-standards-of-care-and-civil-rights-laws-covid-19.pdf

[4] See https://www.hhs.gov/about/news/2020/08/20/ocr-resolves-complaint-with-utah-after-revised-crisis-standards-of-care-to-protect-against-age-disability-discrimination.html

social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices

The primary goal of crisis care guidance has traditionally been to save the most lives or life-years[5] through the allocation of scarce health care resources during a public health crisis, with limited explicit mention of health equity as a priority.[6,7] However, an approach that doesn't take into consideration historical and current health inequities may lead to further inequitable access to life-saving resources and health inequities.[8] With Oregon's deep inequities in health and healthcare access, any system relying solely or primarily on saving the most lives or life-years systematically disadvantages Oregon's communities of color, tribal communities and people with disabilities. It is the goal of this current document to support a process of restructuring Oregon crisis care guidance with health equity as a fundamental principle.

A health equity approach recognizes that systemic discrimination and racism have deeply and pervasively impacted individual and community health prior to this pandemic. In Oregon and beyond, characteristics such as race and ethnicity, along with pre-existing conditions such as disabilities, are linked to critical inequities in access to needed health care, safe and supportive housing, adequate food and nutrition, and more. When coupled with significantly elevated risks for systemic trauma and injustices (both current and historic), these factors combine to routinely undermine health status and health outcomes of affected individuals and communities, including life expectancy. Crisis care guidance must consider and account for these realities; without such intentional consideration, guidance will likely perpetuate and deepen health inequities.

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[5] Daugherty Biddison, E.L. et al. (2018). Too Many Patients…A Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation During Disasters. *Chest Journal*, 155(4) 848-854. https://journal.chestnet.org/article/S0012-3692(18)32565-0/fulltext

[6] Piscitello, G.M., et al. (2020). Variation in Ventilator Allocation Guidelines by US States During the Coronavirus Disease 2019 Pandemic. *Jama Network Open*, 3(6):e2012606. https://jamanetwork.com/journals/jamanetworkopen/fullarticl e/2767360

[7] Berlinger, N. et al. (2020). *Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic*. https://www.thehastingscenter.org/ethicalframeworkcovid19/

[8] Manchanda, E.C., Couillard, C., and Sivashanker, K. (2020). Inequity in Crisis Standards of Care. *New England Journal of Medicine,* 384(4), e16(1-3). https://www.nejm.org/doi/full/10.1056/NEJMp2011359

c. Patient-led Decision Making

Patient care and treatment preferences, patient decision making support needs, and patient communication needs must be considered during the allocation of scarce resources for all patients. New state law establishes that this may include having support persons accompany the patient to provide communication, decision making or physical support. Hospitals must, under this state law, allow a patient to designate at least three support persons and allow at least one support person to be present at all times with the patient at the hospital, if necessary to facilitate the patient's care and treatment, even during a pandemic.[9]

***Patient decision-making*.** A patient is entitled to partner with their care team in making decisions guided by their values, and as directed by the patient, informed by their advance directive or POLST[10] (Portable Orders for Life Sustaining Treatment) (if any). A patient may also choose to have a support person attend the care team meetings if needed to help communicate their medical decisions. If a patient lacks decision-making capacity and has an authorized decision-maker, the clinical team must work with the patient (to the extent possible) and that person to ascertain what care and treatment the patient would want, based on advance directives if any, or any patient preferences the patient is currently or has previously communicated to the decision-maker. If the patient has not appointed a decision-maker, the clinical team should work with the patient and their spouse, partner, family, or close friend. Clinicians and health care organizations must follow Oregon law on surrogate decision-making and supported decision-making principles. [11] As early as possible in the care for a patient whose capacity for medical decision-making may be diminished, the care team should make sure to note in the patient's records how to reach the authorized decision-maker rapidly in the event an emergent triage situation arises.

Treatment cannot be conditioned on a patient having an advance directive, a guardian, or a POLST.[12]

d. Transparent Communication

Transparency and clear and effective communication for the public and patients is always important but especially so during a public health crisis. Having access to needed health care information is life saving and people must not be disadvantaged in receiving timely and understandable health information because of their language, culture, or access to technology and other supports.

Transparency demands that the public be informed when crisis standards of care have been triggered. The public should have up-to-date and transparent information about

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[9] See SB 1606, 1st Special Session 2020 available at https://olis.oregonlegislature.gov/liz/2020S1/Downloads/MeasureDocument/SB1606/Enrolled. Additional details are provided in the hospital licensing rules, OAR 333-505-0030, found at: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1365.

[10] https://oregonpolst.org/

[11] See https://ncler.acl.gov/pdf/Legal-Basics-Supported-Decision-Making1.pdf

[12] SB 1606, 1st Special Session 2020.

health system crisis care plans, including how resources will be allocated differently than conventional standards of care, and when crisis standards have been activated.

Within a health care system, transparent and timely communication with all patients or their authorized decision-maker should occur when the hospital is facing resource constraints, including the nature of the constraints and how resource allocation decisions will be made. Any decision regarding resource allocation (i.e., eligibility for a ventilator or intensive care unit level of care) should be clearly communicated with patients or their authorized-decision maker and documented.

All communication during a public health emergency should be provided in a culturally responsive and linguistically accessible manner and meet the needs of individuals with intellectual, developmental or other disabilities.[13] This may include, but is not limited to: providing effective communication using qualified interpreters, making emergency messaging available in plain language and in prevalent languages, using multiple formats such as audio, large print, and captioning, providing access to support persons chosen by the patient who can help ensure effective communication, and ensuring websites providing emergency information are disability-accessible as required under federal civil rights laws.[14]

III. Recommended Application of Principles to Triage and Decision-making

During the process of allocating scarce health care resources, such as may be required during the COVID-19 pandemic, OHA strongly recommends that the use of a scoring rubric or similar triage framework for decision-making should incorporate the principles outlined above. In addition, hospitals and health care providers must comply with laws and regulations that prohibit discrimination.

In OHA's judgement, when applying the principles of non-discrimination and health equity, the following factors should be excluded from consideration when allocating scarce resources in a public health crisis:[15]

Underlying conditions or disability. Any approach to triaging care for the purposes of resource allocation in face of limited resources should not exclude patients on the basis of a known or suspected co-morbidity or underlying condition/diagnosis - including, but not limited to, disability status such as the presence of physical health, mental health, behavioral health conditions, intellectual, developmental or other disability. Excluding persons for possible life-saving treatments on the basis of co-morbidity and underlying

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[13] See e.g. DOJ, Emergency Management Under Title II of the Americans with Disabilities Act at 1 (July 26, 2007), available at https://www.ada.gov/pcatoolkit/chap7emergencymgmt.htm.

[14] See https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf

[15] As part of the Office for Civil Rights' (OCR) early case resolution with seven states regarding discrimination concerns, these states have *removed various language* from their crisis standards of care, thereby no longer permitting the use of factors such as these in the allocation and re-allocation of scarce medical resources; furthermore, these states have instructed providers to remove such factors from existing provider crisis standards of care plans. See https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/index.html

conditions, resulting from centuries of oppression, racism, and the structures and systems they have constructed, will further perpetuate unlawful discrimination and health inequities.

Life expectancy. Use of life expectancy criterion in assessing prognosis or in scoring (e.g., "life years" or "1 or 5-year mortality assessments") will also perpetuate inequities,[16] since disadvantages in life expectancy have been created for People of Color, people with disabilities and other communities subjected to long-standing toxic stress, trauma, systematic genocide, colonization and the intergenerational transmission and epigenetics of such. For this reason, life expectancy as a criterion in scoring should not be used in decision-making about the allocation of scarce resources during a public health crisis.

Resource utilization and quality of life. Measures that consider resource utilization or assessments of quality of life (i.e., clinician-perceived quality of life) should also be excluded from any process to allocate scarce resources, as these will systematically deprioritize the allocation of resources for individuals with developmental, intellectual, and other disabilities, older adults, and individuals from communities of color.

Personal ventilators. Patients who are chronically ventilator-dependent outside of the critical care context should not have their ventilators withdrawn in order to extend supplies. Furthermore, the baseline need for a ventilator should be excluded from consideration when allocating scarce resources in a public health crisis.

OHA recommends that any approach to triaging care in face of limited resources- such as the use of a scoring rubric or point system to determine hospital survival- *should*:

- Protect against discrimination. Importantly, to protect against discrimination, a triage protocol should NOT be based on morally or scientifically irrelevant considerations such as socio-economic status, race, ethnicity, gender identity, sexual orientation, national origin, immigration status, faith orientation, parental status, ability to pay, insurance coverage, disability, or solely on the basis of age.
- Utilize the best available medical information to assess patient short-term prognosis ***in terms of likelihood of surviving their current illness to hospital discharge.***[17]
- Apply reasonable accommodations to ensure equal treatment of individuals with disabilities or pre-existing organ conditions.
- If two patients have identical triage priority scores, consider random selection.

Finally, the **desirable qualities of triage team members** should include expertise in anti-racism and equity principles, and commitment to mitigating the impacts of implicit and explicit bias and stereotyping (including those based on race, ethnicity, and disability).

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[16] Stone JR. (2020). Social Justice, Triage, and COVID-19: Ignore Life-years Saved. *Medical Care,* 58(7), 579-581. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7297070/

[17] In addition to prognosis of surviving current illness to hospital discharge, some states allow consideration of whether a patient is imminently and irreversibly dying or terminally ill with life expectancy under 6 months (e.g., eligible for admission to hospice) as part of allocation decisions. Potential use of this factor in resource allocation in Oregon requires further exploration in consideration of the non-discrimination and other principles outlined in this statement.

Members of a clinical care triage team with the responsibility to determine allocation of scarce resources should be separate from the care team involved directly in the medical care of patient(s) being triaged and have training in implicit bias and anti-racism practices.

IV. Next steps

OHA recommends that health systems take immediate next steps to incorporate these principles into crisis care planning and procedures. In addition, routine retrospective review of rationing decisions should be conducted to ensure crisis care decisions are made without bias, and that no groups are being disproportionately impacted in a way that leads to systematic disadvantage or worsens health inequities.

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.

In our work ahead with community, health care experts, and ethicists, OHA looks forward to exploring how a triage rubric can achieve the health equity principle of "recognizing, reconciling and rectifying historical and contemporary injustices".[18] Concepts that deserve further exploration include but are not limited to:

- Adjusting points to give preference to essential workers[19] (e.g., agriculture and food production workers, childcare workers, and beyond) working in a high-risk occupation.
- Using points to correct for structural inequities such as by applying the Area Deprivation Index (ADI).[20]

OHA recognizes that this document of principles is an important but limited, interim step. We look forward to convening community partners, health care providers including critical care physicians, and hospital ethicists in the near future, incorporating input from community to ensure a co-created and inclusive process. Through this partnership, OHA looks forward to expanding on the principles in this document and the development of triage criteria that can be readily implemented in face of urgent, scarce resources.

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Health Information Center at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us

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[18] From OHA's health equity definition, page 1.

[19] See https://www.ncsl.org/research/labor-and-employment/covid-19-essential-workers-in-the-states.aspx

[20] For more information on the area deprivation index, visit https://www.neighborhoodatlas.medicine.wisc.edu/