

Oregon Public Health Division
MEDICAL ADVISORY GROUP
Meeting Minutes
October 26, 2006

Participating:

Members:

Heather Hue, MD, Internal Medicine
Steve Jones, MD, Infectious Disease
Roberta Hellman, RN, Local Health
Bill Zepp, OR Dental Assn.
Margaret Carley, RN, JD, OHCA
Anne Peltier, RN, Local Health/Govt
Jennifer Soyke, MD, Palliative Med.
George Gerding, RPh, Pharmacy
Jim Jensen, MD, Emergency Med.
Thomas Dodson, MD, Psychiatry

Roy Magnuson, MD, Hospital Admin.
Jim Shames, MD, Public Health Officer, Fam Prac.
Dana Braner, MD, Pediatrics, Critical Care
Jere High, OR Primary Care Assn.
Bob Shoemaker, JD, Public Health Advisory Comm.
Dane Nichols, MD, Internal Medicine, Critical Care
Joe Finkbonner, RPh, MHA, NW Portland Area
Indian Health Bd.
Roberto DeCastro, MD, Obstetrics and Gynecology
Steven Grasty, Local Govt. (participating by telephone)

Guests:

Lewis Rubinson, MD, PhD

Mike Adler, MD, OB-GYN

State Public Health Staff:

Susan Allan, MD, JD, MPH
Brian Mahoney, MPH

Paul Lewis, MD

Facilitators:

Casey Milne, Milne & Associates, LLC
Tom Milne, Milne & Associates, LLC

Opening:

- Susan Allan provided an overview of the work to be performed by the Medical Advisory Group:
 - Purpose: to assist the Public Health Division to develop a framework for making decisions about allocation of scarce resources and altered standards of care in the event of a pandemic or other health emergency; specifically, to develop principles and guidelines
 - Members of the MAG represent a broad range of health care and other organizations that would have to implement decisions in a pandemic
 - Members of the MAG bring their individual experience and perspectives, but are asked to think broadly, on behalf of the whole system
- Statutory basis for response to pandemics:
 - Federal:
 - Federal authorities are limited; federal agencies develop emergency response plans and issue guidances that states may follow

- Federal funding to states for emergency preparedness is accompanied by very specific grant requirements and expectations
- State:
 - Police powers related to health and safety are a state responsibility
 - The state emergency response plan parallels the federal plan
 - The state's Office of Emergency Management has general responsibility for the state's emergency system; in the state's system and general emergency plan, the DHS Public Health Division has significant responsibilities
 - The Governor can declare an emergency, which triggers a state response and, in some instances, the availability of resources
 - The current state public health laws have significant gaps and lack of clarity regarding state and local authorities
- Local:
 - Local government in Oregon has a great deal of authority
 - Response plans are in place in all counties and are consistent with state and federal plans
 - The direct delivery of services to people happens at the local level

Ground Rules: Facilitators Casey & Tom reviewed draft ground rules, developed to help assure highly productive meetings with full participation of all members. Copies of the ground rules were included in the notebook provided at the meeting.

Oregon Preparedness Planning:

Nan Newell, DHS Public Health Division, described the state preparedness planning process. Copies of her slides will be provided.

- Preparedness plans define the trigger points required to define and declare an emergency
- The U.S. Department of Homeland Security defines 15 emergency support functions. Health & Medical is Emergency Support Function #8; it includes 15 specific functions.
- Most actual service capacity for health and medical issues is in the private sector.
- The DHS Public Health Division role includes coordination, planning, relationships with other states and the federal government, providing frameworks for local response.

- A 24/7 emergency response capacity is in place in the Division.

Paul Lewis, DHS Public Health Division, reviewed the 3 major pandemics of the 20th century and described the potential impacts of both a moderate and a severe pandemic on hospitals in Oregon today. Copies of his slides will be provided.

- In the event of a widespread pandemic, the state can expect little material or personnel assistance from the Federal Government; similarly local communities will receive little assistance from the state. Both federal and local health authorities will be able to provide technical assistance and coordination of communication.
- Preventive measures – quarantine, isolation, vaccines, and antivirals are of uncertain value because efficacy and supply are unknown. Decreasing the peak and spreading out the epidemic curve may allow health care capacity to better absorb the surge.
- Major issues in a pandemic will be maintaining infrastructure, surge capacity, rationing scarce resources, and community containment.
- Plans need to assume the need to shift into alternative ways of providing care as part of the response – so called “managed degradation.”

National Work in Preparedness: Dr. Lewis Rubinson:

A copy of Dr. Rubinson’s slides will be shared. The following is a brief summary of major points:

- Community perceptions of classism/racism have the potential to create major disruptions if distribution of resources (vaccine, etc.) not done consistently
- Numbers of human cases of H5N1 flu are increasing, and the case fatality rate is high, although the baseline number of cases isn’t known.
- CDC’s goal is to delay the peak rate of infection in a pandemic to give more time for vaccine and antiviral production, ventilator distribution, etc.
- Planning is based on a number of untested assumptions about what works; information from a retroactive study of 50 cities of measures taken and outcomes is helping inform planning
- It is anticipated (based on history) that the first wave of Pandemic Flu would last 6 to 8 weeks, and would be followed by 2 to 3 more waves
- Clear and consistent communication is always a problem during outbreaks
- A number of strategies can be taken to augment staff, including:
 - Memoranda of Understanding between states, regions
 - Disaster Medical Access Teams (but only move resources from one place to another, not a new resource nationally)
 - ESAR-VIP: volunteer health professionals, pre-credentialed, made up of professional society volunteers, Medical Reserve Corps members

- CCRF: but most don't do clinical care
- DHHS volunteers
- Veterans Administration/Department of Defense
- Need regulations on how to recruit/credential MDs without a lot of paperwork
- An important principle: First "surge up" then triage. Triage needs to be standardized in a transparent way to assure equity.
 - Will need to triage based on who is most likely to benefit the most from ICU and use of other resources
 - Need better guidelines on benefit-response
 - All people (with and without flu and needing hospital care) would be triaged
 - All people would receive SOME care
 - Triage algorithms are being developed at the federal level
 - States would generate triage process guidelines

Preparedness Planning – Lane County Medical Society: Jenny Soyke, MD:

A copy of Dr.Soyke's slides will be shared. The following is a brief summary of major points:

- Lane County has done significant work in defining ethical standards in resource allocation during a pandemic
- The process has included a series of community forums; invited participants included school districts, clergy, elected officials, leaders of medical groups, etc.
- The average physician knows no more about this than the average lay person
- Future forums will be used to stimulate discussion between MDs and community leaders
- The focus of the forums is and will be the ethics of disaster/pandemic illness planning and community awareness
- The major principal is Survival of the Community (as opposed to survival of individuals)
- A core resource being developed is a *Community of Practice Model* with a web-based portal

Oregon State Statutes – Proposed Changes: Susan Allan & Bob Shoemaker:

- Several bills are being prepared for the 2007 Oregon legislative session addressing inadequate/outdated public health statutes
- A major issue is the need to clarify state and local authority and when each applies

- There is a proposal for a procedure to invoke state and local authority to take certain extraordinary actions during health emergencies without requiring the Governor to declare an emergency
 - Historically, disease outbreak emergencies have not resulted in gubernatorial declarations of emergencies
- Proposed legislation would
 - Define triggers for invoking additional state public health authorities
 - Define when the state public health officials would have lead responsibility
 - Identify additional disease control measures that state and local authorities could use to respond
 - Update and clarify current law regarding quarantine and isolation
 - Specify authority to set guidelines and altered standards of care
 - Provide authority to enter property to assess health hazards
- Drafts are expected in early or mid November; comment by members of the MAG is welcome (feel free to share perspectives with Bob Shoemaker)

Comments:

- Modified standards of care impact the physician-patient relationship
- Experience shows that if the rationale is clear, and if medically appropriate standards of care are arrived at through a meaningful process, the standards are credible to the public
- Passive dissemination of care guidelines doesn't work and the guidelines tend not to be followed. Use a carrot – liability protection for the physicians.
- It is important to protect medical personnel and other essential service providers (law enforcement, fire, utilities) and their families with preferential treatment to assure that the essential workers show up to provide services (the "Katrina lesson")

MAG work on Preparedness Issues:

- Within each of the areas of focus that are to be addressed, focus needs to be not on "planning" but rather on
 - Guidelines
 - Principles to use in making decisions
 - Consequences
 -
- MAG brainstormed issues that could be addressed, and then prioritized those to be addressed in the 3-5 meetings to be held. The 45 issues were narrowed to the following:

- Communications
 - Developing consensus in communities
 - Decision making
 - Ethics/equity in care
 - Care for essential personnel and their families
 - Out-of-Hospital care
 - Alternative standards of care/malpractice
 - Prioritizing resources
 - Surge capacity
- A paper, "Critical Care During a Pandemic," published in Toronto, Ontario, provides a wonderful framework, and will be shared prior to the next meeting; the paper addresses
 - Consensus as a principle
 - Stabilizing communities
 - Meetings were scheduled with agendas for each (see attachment, Meetings Schedule)
 - Interest was expressed in identifying, for each of the issues, where appropriate:
 - What information is needed
 - For whom
 - When should information be disseminated
 - Is this the "big one?"
 - What do my patients need to know?
 - Evaluation of "Who Was Missing From the Table?"
 - Health care payers, Family Practice were mentioned and are represented on the MAG
 - Emergency medical services representation was intended and will be included in future meetings
 - Mercy Corps and home health care were suggested; those perspectives are partially represented, and there will be interim discussions to identify whether additional representation would be helpful
 - National Guard is engaged at other aspects of the state's public health emergency planning
 - Information requested for next meeting:
 - Ontario paper (mentioned above)

- Summary from "Engaging Communities" – an assessment of past community engagement activities in Oregon; the assessment is part of another project jointly sponsored by the DHS Public Health Division, the NW Health Foundation and the Oregon Health Policy Commission
- Format of information for MAG: Electronic
- Meeting on November 13 was proposed; it was agreed that if fewer than 15 members could attend on that date, the meeting would be cancelled

Next Meeting:

- Date: Wednesday, December 20
- Place: Oregon Dental Association (ODA), near North Wilsonville Exit from I-5 (address and map coming)
- Time: 8:30 a.m. to 3:30 p.m.

Meeting of October 26 adjourned: 3:30 p.m.