Public Input Summary: Oregon Crisis Care Guidance

Oregon Health Authority (OHA) received public input regarding the Oregon Crisis Care Guidance draft during the summer and fall 2024 via email, survey responses, and four public input sessions. This document provides a summary of the public input.

In addition, this document summarizes the changes OHA has made to the Oregon Crisis Care guidance based on review of the public input and latest research.

Finally, this document highlights new and updated resources from OHA in response to public input, including a new operational supplement and updates to the Plain Language Summary and Frequently Asked Questions documents.

Contents

Summary of Public Input

This section includes a summary of public input submitted to OHA regarding the 2024 Oregon Crisis Care Guidance draft organized into 13 topical areas. Public input submitted to OHA that does not relate to crisis care guidance is not included in this summary.

1. Emergency roles

Commenters requested further information regarding how OHA will support hospitals and health care providers prior to and during activation of crisis standards of care; a proposed set of state functions was offered. Another commenter sought acknowledgment that hospitals and providers may be on their own during a crisis and called for a clear, statewide, evidence-based approach to public health emergencies that delegates authority to hospitals and clinicians to care for patients under extreme conditions. An additional comment included a request for OHA to create an online communication tool regarding statewide hospital capacity to support patient movement.

2. Triage team

Multiple commenters recommended additional triage team representation including someone with expertise (and ideally, lived experience) in disability, including disability related anti-discrimination laws and policies. Multiple comments focused on the guidance recommendation to include a community representative on the triage team, including desired assistance from OHA to identify such representation and concerns for how to incorporate this representation considering state and federal privacy laws. Multiple comments shared concern that some hospitals will not be able to staff a triage team as outlined in the guidance; others highlighted concerns for managing administrative tasks. There was a call for the state to provide trained triage team members when needed. Other comments related to needed clarification regarding interpreter representation on the triage team and application of laws pertaining to the collection of race, ethnicity, language and disability data (REALD) and sexual orientation and gender identity (SOGI) data. There was a proposal for state oversight of hospital triage team development and training.

3. Training

Multiple comments pertained to the need for triage team training to include disability awareness and anti-ableism. A need for training regarding hospital survival prognostication methods was also noted. Multiple comments focused on the need for consistency in training statewide; one commenter identified capacity concerns for some hospitals to

accomplish recommended training. A recommendation for the state to provide training was included.

4. Triage process

Commenters recommended additional guidance language to highlight hospital requirements to provide reasonable modifications for people with disabilities. Additional comments highlighted the need to consider prognostication approaches for patients with easily reversible, severe conditions. One commenter highlighted the importance of considering patient care preferences as part of crisis care triage. Concerns about the lack of a “triage tool” were noted.

5. Glasgow Coma Scale (GCS)

Multiple commenters highlighted serious concerns with continued use of the GCS due to the potential for this assessment to discriminate against people with disabilities. Various recommendations were provided for how to address this concern.

6. External triage responsibility

Several commenters inquired about a hospital’s role in triaging patients external to their own facility. One commenter noted that hospitals may receive requests from other facilities to accept patient transfers, such as when a patient needs a higher level of care. Commenters requested information regarding how a hospital should address such requests for triage of patients outside of their facility during a crisis.

7. Equitable chances tiebreaker

Many comments pertained to the equitable chances tiebreaker. Some comments indicated support with this approach and other comments indicated concern. Many comments explored the potential complexity of implementing this approach during a crisis. Commenters posed questions about how data would be accessed for use in the weighted randomization process and how hospitals should proceed if data relevant to the current emergency is not available. Multiple comments related to the need for a coordinated and statewide system to implement the weighted calculations and recommended a centralized approach. One commenter shared concern about how the tiebreaker would be applied for patients who are houseless. Some commenters posed questions about how the use of disadvantage data would apply at the individual level and how it will impact individuals with

disabilities. One commenter noted the need for clarification about how equitable chances would be applied for patients with the same disadvantage score.

8. Appeals process

Commenters highlighted several recommended changes to the appeals process to ensure accessibility for people with disabilities, such as by allowing appeals to be requested orally.

9. Transparent and effective communication

Commenters provided recommendations for ensuring information is accessible in plain language and available orally for people with disabilities. There was also a recommendation that hospitals communicate with the disability community during an emergency to indicate hospitals are a safe place to go.

10. Oversight and accountability

Multiple commenters highlighted concern that hospitals are not required to use the crisis care guidance. Several approaches to accountability were offered.

11. Liability

A commenter requested that the state defend the guidance and assume liability for hospitals and hospital staff in connection to its use.

12. Guidance reassessment

Commenters noted the importance of continually improving the guidance and the important leadership role for OHA in this work.

13. Other

A recommendation to acknowledge the state's new nurse staffing law and how it will impact hospital capacity was provided. One commenter shared concern for incorporating diversity, equity and inclusion approaches in the guidance. Additional comments focused on the importance of infection control, having hubs of information and care, and conducting an evaluation of the guidance.

Summary of Guidance Changes

OHA has made numerous changes to the final 2024 Oregon Crisis Care Guidance after careful consideration of public input. The following is a summary of these changes organized according to the document sections. In the case changes have not been made in response to public input, it is because OHA does not have the authority to implement such changes, OHA lacks the resources to address the suggested changes, or the changes do not align with OHA's goal to eliminate health inequities by 2030.

Preface

An additional introductory statement was added to the guidance that highlights the importance of mitigating the need for heart-wrenching decisions associated with scarce, life-saving resources in an emergency and acknowledges OHA's commitment to partnership in this work.

Background

A new statement highlights that crisis care guidance is an important tool for protecting the health of the public during an emergency.

Crisis care assumptions

Activation

New additions acknowledge that coordination between the state and the hospital may not be possible depending on the event that triggers the need for crisis care. Clinicians and health care staff may be on their own to activate crisis standards of care with limited or no communication tools, internet access or other options to coordinate with external partners.

Individualized assessments

A new statement clarifies that the terms "prognosis for hospital survival" and "prognosis for survival to hospital discharge" are used interchangeably in the guidance.

Another addition provides further description of reasonable accommodations in the health care setting required by federal law and provides resources for health care personnel on this subject.

CSC triage team

A representative with disability expertise, including disability related anti-discrimination laws and policies, has been added as a recommended member of the crisis care triage team.

Clarification has been provided about the non-clinical community representative on the triage team and highlights that this representative will need to complete required training to comply with state and federal privacy laws.

New guidance language provides clarification about the need for qualified interpreters to be available to the triage team.

Anti-ableism training has been added to the list of recommended triage team training.

Crisis care triage

Crisis care triage steps

The updated guidance specifically highlights that the GCS should not be used routinely as part of the individualized hospital survival assessment in Oregon's crisis care triage. New language provides information about the limited utility of the GCS in predicting in-hospital mortality and the potential for discrimination against people with disabilities when it is used. Updates in this section highlight the narrow role for the GCS in life-saving resource allocation and the required modifications for patients with underlying disabilities according to federal law if it is used.

New guidance language uses national percentiles for the Area Deprivation Index (ADI) used in the equitable chances tiebreaker, instead of state-specific deciles, since Oregon hospitals will be caring for patients from other states.

The updated guidance allows for appeals requests to be made orally to ensure equal access for people with disabilities.

Transparent communication

Updated language is added to the guidance pertaining to crisis care plans and hospital survival diagnosis assessments to ensure equal access to information for people with disabilities.

Data collection

Updated language is added to the guidance to align with new Oregon statute pertaining to REALD and SOGI data collection.

Looking ahead: Innovation and prevention

Innovation

New guidance language uses updated terminology (“triage scoring system”) that is more commonly found in the published literature on crisis standards of care and clarifies that this term is interchangeable with the term “triage tool” used in the Oregon Resource Allocation Advisory Committee’s (ORAAC) final report.

Additional Resource Highlights

OHA has created multiple resources to accompany the Oregon Crisis Care Guidance available at www.oregon.gov/crisiscareguidance.

OHA has created a plain language summary of the Oregon Crisis Care Guidance that is easy-to-read and not technical. OHA has updated the *Plain Language Summary* to align with the final 2024 guidance.

OHA has also updated the *Frequently Asked Questions* document regarding the Oregon Crisis Care Guidance in response to public comments.

Finally, the *Oregon Crisis Care Operational Supplement* will provide additional operational details to support hospitals, health care providers, and crisis care triage team members in the implementation of the Oregon Crisis Care Guidance. OHA will periodically update this operational supplement as new resources for hospitals and triage teams becomes available.

Closing

Community engagement and transparency are core OHA values and have been prioritized during the work to update Oregon's crisis care guidance. The public input submitted to OHA named important areas of needed adjustment to the guidance for it to be most useful to hospitals and triage team members and to ensure it does not discriminate against people with disabilities. Public input has also highlighted information that needs to be available to the public such as through the FAQ document. OHA sincerely appreciates all comments submitted by the public regarding the Oregon Crisis Care Guidance draft.

Researchers are studying ways to improve the allocation of critical care resources in a crisis. OHA will monitor for new research and update this crisis care guidance again in the future as needed. Future guidance updates will be transparent and public input from health professionals and community members across Oregon will continue to be important ahead.