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Hospital Requirements when Implementing Crisis Standards of Care Rule Advisory Committee
October 24, 2022
10:00 a.m. – 12:00 p.m. via Zoom

RAC MEMBER ATTENDEES	
Bob Macauley, Pediatric Palliative Care Physician; COVID Ethics Committee	Oregon Health and Science University (OHSU)
Brian Patrick, Vice President of Nursing	Good Shepherd Health Care System
Courtni Dresser, Vice President of Government Relations	Oregon Medical Association (OMA)
Chris Bouneff, Executive Director	National Alliance on Mental Illness (NAMI)
Emily (Em) Braman (for Micah Ralston)	The Arc Oregon
Kristen Roy, Vice President, Legal Officer & General Counsel	Asante Health System
Matt Calzia, Director of Nursing Practice	Oregon Nurses Association (ONA)
Mariana Garcia Median, Senior Policy Associate	American Civil Liberties Union (ACLU) of Oregon
Meghan Slotemaker, General Counsel	Oregon Association of Hospital and Health Systems (OAHHS)
Melissa Denny, Emergency Medicine Physician, Director of Ethics	Kaiser Permanente
Scott Marsal, Internal Medicine Physician, Chief Medical Officer	Providence Portland Medical Center
INTERESTED PARTIES	
Andrea Seykora	OAHHS
Gregory Miller	PeaceHealth
Jackie Fabrick	Providence
Ryan Fisher	OHSU

Oregon Health Authority/Oregon Department of Human Services/Oregon Department of Justice	
Allison Enriquez	Oregon Department of Human Services, Office of Developmental Disability Services
Anna Davis	Public Health Division, Health Facility Licensing & Certification
Dana Hargunani	Oregon Health Authority, Director's Office
Dana Selover	Public Health Division, Health Care Regulation & Quality Improvement
Erin Williams	Oregon Department of Justice
Mellony Bernal	Public Health Division, Health Care Regulation & Quality Improvement

Welcome, Housekeeping and Agenda Review

Mellony Bernal introduced self and welcomed attendees to this rule advisory committee to discuss hospital requirements when implementing crisis standards of care. The following housekeeping items were reviewed:

- Attendees were asked to enter their name, title and organization into the Chat. Participants not considered a RAC member were asked to identify themselves in the Chat as a public participant.
- Attendees were asked to keep devices muted until called upon.
- RAC members were asked to type the word "Comment" to indicate they want to speak to a particular issue or ask questions. RAC members who do not necessarily want to talk but want the agencies to consider information were asked to type into the Chat “For the Record” and include the information they wish to share. Persons will be called upon in the order appearing on the Chat.
- It was noted that pursuant to the OHA policy, members of the public may attend but may not participate or offer public comment during the meeting. Members of the public who wish provide comments or information should email those comments to mellony.c.bernal@dhsoha.state.or.us at the conclusion of the meeting.
- It was further noted that after the RAC process has concluded, there will be an opportunity to provide oral public comments at a public hearing or to send written public comments during the public comment period. Information about the notice of proposed rulemaking and public hearing will be shared by email using the GovDelivery Hospital Listserv. The link to join the listserv was shared via Chat: https://public.govdelivery.com/accounts/ORDHS/subscriber/new?qsp=ORDHS_16
- The RAC meeting will be recorded for purposes of generating written meeting notes.

Roll call was taken of the RAC members and RAC members introduced themselves as well as Oregon Health Authority staff.

Rulemaking Advisory Committee Overview and Scope

Overview

M. Bernal noted the following:

- State agencies convene RACs for a variety of reasons including when the legislature passes laws that require rules be adopted, when the legislature delegates broad statutory authority and the agency must interpret those laws by rule, and amending, repealing or suspending existing rules.
- RAC members include persons and communities that are most likely affected by the proposed rules including representation from licensed facilities, special interest groups, and associations.
- The Health Facility Licensing and Certification (HFLC) program drafts the rule text and convenes the RAC to seek input and suggestions on the rule text and consider possible changes, concerns, issues, etc. Additionally, the RAC will review the Statement of Need and Fiscal Impact (SNFI) which also includes a statement on how the proposed rules may affect racial equity in Oregon.

- The RACs role is advisory only and consensus is not necessary. The HFLC program retains the final decision on final rule text.
- Considering information provided by the RAC, the HFLC program will finalize proposed rule text and submit notice of proposed rulemaking to the Secretary of State along with the SNFI.
- A public hearing will be scheduled where persons can present oral testimony or submit written comments. The public hearing's officer that presides over the public hearing will generate a report summarizing the comments.
- The HFLC program will review and consider all testimony and comments received and determine whether additional changes to the rule are necessary based on those comments. The HFLC program will provide a response to the testimony and comments received.
- The HFLC program will finalize rule text and determine effective date and file permanent rulemaking notice with the Secretary of State's office.

Scope

- The purpose of this RAC is to consider amending and making permanent the temporary rule on hospital requirements during an emergency impacting standards of care.
- A temporary rule was initially filed on January 11, 2022 for hospital implementing crisis standards of care due to scarce resources and a high demand for services. The temporary rule expired on July 15, 2022. A temporary rule was filed on July 29, 2022 for hospitals implementing crisis standards of care due to staffing emergencies. This temporary rule will expire on January 24, 2023.
- The HFLC program is asking the RAC to consider the proposed amendments including the possible fiscal and economic impact to hospitals, units of local government, the public, small businesses, as well as what affect the rules will have on racial equity in Oregon.
- The program is anticipating only one meeting but based on discussion an additional meeting may be necessary.
- Goal is to have final proposed rules submitted to the Public Health Division's Rule's Coordinator by November 7th for posting in the December 1 Oregon Bulletin. If this time frame is met, a public hearing could be scheduled on or after December 15th and the written public comment period ending on or around December 22nd.

RAC member via Chat inquired whether the Oregon Resource Allocation Advisory Committee (ORAAC) make any comments on the proposed rule or is this outside their scope/mission? Dr. Hargunani responded that the ORAAC has not commented on the draft rule and commenting on rules is not part of their current scope.

Administrative Rule Review
Anna Davis opened discussion on the proposed changes to the administrative rule and summarized requirements of the rule.
OAR 333-505-0036 – Hospital Requirements during Emergency Impacting Standard of Care
The title of the rule was changed removing the term "staffing" to reflect that the rule will cover emergencies beyond staffing and will cover any implementation of crisis standards of care. It

was further noted that the purpose of this rule is to extend beyond the current COVID Public Health Emergency and language was updated to reflect any type of emergency.

Subsection (2)(a) – The 'crisis standards of care' definition remains unchanged except removing the term 'staffing.'

Subsection (2)(b) – A definition for emergency was added to rule as follows: "Emergency" includes but is not limited to a federal emergency declaration, Governor's declared emergency, a determination by the state Public Health Director under ORS 431A.015(1), an epidemic as that is defined in ORS 431A.005, or any other unforeseen event that results in an increased need for scarce hospital resources or a significant reduction of health care staff.

- RAC member via Chat noted misspelling of term 'scarce' which will be corrected.
- Staff noted that there is a lot of interaction with the hospital nurse staffing rule about nurse staffing in an emergency and when a hospital can suspend their nurse staffing plan. It was noted that in the rule relating to suspending a nurse staffing plan in an emergency, an 'emergency' is limited to only a declared emergency by president of the U.S. or the Governor of Oregon. The emergency that results in implementation of crisis standards of care as described in this rule could include emergencies that would meet the requirements for suspension of the nurse staffing plan.

Subsection (2)(c) – It was noted that the definition of hospital will include acute care hospitals and specialty hospitals, as well as special inpatient care facilities (SICF) of which there are three inpatient hospice programs and one drug treatment program. This would also include any other SICF's licensed in the future which could include rehabilitation hospitals.

The definition for "staffing emergency" was deleted since the intent of the amendments is to apply to any type of emergency.

Subsection (2)(d) – The definition for "support persons" remains unchanged.

Subsection (2)(e) – The definition for "triage decisions" refers directly to crisis standards of care adopted by the Authority and related tools **or** similar hospital protocols or standards that ensure equitable care decisions. A hospital would not have to use any specific crisis care tool created by OHA. Whatever tool, policy, protocol or standard used by a hospital to make triage decisions would be covered by this rule.

Section (3) – This rule clarifies that when a hospital is experiencing an emergency and the hospital is making triage decision then the hospital must:
(a) Notify the Authority within 24 hours via email.

- Staff noted that there is a way to notify the OHA through a link on the website that directs the hospital to a Smartsheet form. After completion the OHA is notified, and the hospital receives an email to notify the Authority when crisis standards of care are no longer in use.
- Via Chat, RAC member asked if a hospital develops its own standards, whether there is a preapproval process with OHA. Staff responded that there is not a preapproval process and noted that the Authority does not determine the hospital's standards. RAC member via Chat replied, asking who ensures the protocols are equitable? Staff responded that the expectation is the hospital would use the Authority's, 'Principles in Promoting Health Equity During Resource Constrained Periods' issued on December 7, 2020, to create equitable

protocols. The expectation is that all hospitals develop standards that ensure health equity. The primary purpose of this rule is to help with the transparency and document what has occurred.

- Dr. Hargunani noted that the ORAAC has been convened to inform updates to the current Oregon Interim Crisis Care Tool and the work of the committee is ongoing. It is anticipated that sometime in 2023 the committee will have recommendations on updates to the Interim Crisis Care Tool. Meetings are open to the public and it is anticipated that there will be discussions about equity and crisis care triage which will help inform the question posed by RAC member.

(b) Within 24 hours, inform the public by posting on website and at the hospital in multiple conspicuous locations that the hospital is experiencing an emergency and making triage decisions. Information must also be posted in the five most common spoken languages in the community where the hospital is located.

(c) Make available to the public upon request, the crisis standard of care tool used to make triage decisions.

- RAC member noted that the language is predicated on a hospital entering a crisis standards of care mode and staying there for some time. Hospitals may go in and out of crisis standards of care in certain aspects of care provided. It's not all or nothing. The rule does not address a situation in which a hospital may implement crisis standards of care for 12 hours and then return to non-crisis standards of care. By the time notice occurs and posting requirements complete, the hospital may no longer be using crisis standards of care. Staff responded that information reported by a hospital includes when it started using crisis standards of care; when it stopped using crisis standards of care; and which units are impacted. It was further noted that when posting, hospital can indicate if it's impacting a specific area. This includes posting information on the hospital website. Staff acknowledged that updating the website may be faster than posting signage in the hospital. Staff asked other RAC members if they had other ideas on providing notice to the public, especially to inform persons coming in for care. Public should still be informed during a time when the hospital is implementing crisis standards of care, even if the implementation is intermittent.
- RAC member via Chat noted that the crisis standards of care tool should be available which is easy enough to post. He asked why the rule is set up to force individuals to request the tool; these individuals may be in the middle of their own personal health crisis? RAC member stated if the intent is to be transparent, just being notified that triage decisions are being made is neither adequate nor transparent. Example were provided of how communities had to use rumors and speculation to try and discover how hospitals were responding to COVID. Hospitals should be fully transparent and post how they are triaging individuals. This would allow people who need services or making decisions about those needing services to go to a particular hospital and opens it up to public scrutiny and ensuring that the principles the Authority is trying to promote are being followed. Staff asked hospitals to speak to the practicality of the suggestion.
- Dr. Hargunani noted that this information is important to consider. The interim crisis care tool is focused on critical care resources and the Authority understands that resource~~s~~ decisions can look different in different settings. Crisis care tools may need to be adapted given location or particular limited resources.
- RAC member acknowledged these are complicated issues and noted concern that hospitals have with posting information on doors and what it might mean for patients. Hospitals want

to be a place that welcomes patients and where patients understand what is happening. Postings need to give sufficient notice to the patient so they know what's going on but shouldn't scare persons away who really need treatment.

- RAC member expressed concern since the hospitals are not disclosing what triaging means anyway. If the hospital is going to make its tool available upon request, why not just make it available in advance versus putting someone in a position of having to know they have to request something, when the patient may be in the middle of crisis. Hospitals should be fully transparent and trust the public to be able to decipher information. The current requirement would not work for someone in mental health crisis.
- RAC member commented on the continuum of crisis care standards and noted the OHA triage tool includes care contingencies and regular capacity. It was stated that hospitals make "triage" decisions on a daily basis based on the resources available; however, the purpose of this rule appears to be when there are not enough critical care resources to treat all the patients who need those resources. In those situations critical care resources are exhausted, and life or death crisis care triage decisions are being made regarding patients both in the hospital and those that are arriving. Staff responded that it depends and noted the definition of crisis standards of care which includes reference to:
    - 'Objective prioritization of care' – policies or standards determining which services are a priority to continue among the services usually offered by the hospital in recognition of the fact that not all services will be provided during an emergency;
    - 'Prioritization of patients' – policies or standards determining which patients will receive treatment sooner and which patients who would otherwise receive treatment will not; and
    - 'Limitation on services' – because of the declared emergency policies or standards establishing changes in the way care is provided, services that may be partially offered or discontinued entirely or similar.

  Staff noted that while the current triage tool is designed for critical care units, there are emergencies when triage decisions are made in other units.
- Staff tabled discussion to continue to look at other requirements that may inform whether changes need to occur in this section.

(d) Communicate a triage decision to the patient, the patient's support person or other individual legally authorized to act on the patient's behalf, in an accessible format, language they understand and in a culturally responsive manner, including how the triage decision was made.

- RAC member asked if the communication was one way only – patient being told~~,~~ versus a conversation between the patient and the provider where questions can be asked, and information shared. It was noted that the Arc supports persons with intellectual disabilities and asking questions and getting clarification is critical. Staff responded that given the inclusion of rule language about accessible format, language they understand and culturally responsive manner reflect that it should be a conversation and not a one-way dialogue. Staff noted that in response to a complaint investigation, staff would want to see some communication being shared. It was noted that it is unclear what possible limitations could be to the communication requirement and staff asked other RAC members to comment.
- RAC member indicated that as the rule is written a decision about a triage decision must be communicated and, in a conversation, there would be a 'back and forth' between the patient, support person or legally authorized representative and the hospital staff.

Staff noted that subsection (3)(a) and subsection (3)(b) tell the Authority and the public what will happen, subsection (3)(d) tells the patient what did happen, and subsection (3)(e) documents information about patients for whom triage decisions were made when crisis standards are in use and the OHA can request under section (4) the documentation.

(e) Document for each patient that is subject to a triage decision, the patient's medical record number, the hospital's name and location, the patient's date of birth, the patient's sexual orientation and gender identify; the patient's race, ethnicity, language and disability; whether the patient was using a personal ventilator or other personal medical equipment; the patient's home address, or housing status; the patient's care preferences and the patient's triage prioritization and clinical outcome.

- Staff noted documentation will allow a look back to see who was subject to triage, what were the characteristics, and what were the outcomes. The goal is to ensure that records are maintained so there is a clear picture including what were the equity impacts. It was further noted that should the HFLC program receive a complaint that the crisis standards were applied in a discriminatory manner, the program would look to these records to determine compliance.
- After considering the documentation requirements, staff asked RAC members whether previous concerns were addressed. RAC member responded in agreement with previous comment that for patients with intellectual disabilities as well as their support persons, knowing in advance helps to better advocate while at the hospital then not knowing how triage is being done.
- RAC member reiterated concerns and stated that a circumstance is being created where a decision is made, details are shared, but the patient must request a copy of the document about how a decision was made. In a true emergency when a hospital is making these kinds of decisions, vulnerable populations and their advocacy organizations would be working hard to protect them from these circumstances going awry; good public policy and transparency would be to have the information immediately available.
- RAC member asked whether information is shared about an appeal process or a right to complain when these decisions are made. Staff responded that complaint investigations conducted by HFLC are retrospective and OHA does not have the jurisdiction to intervene in patient care while it's happening. Information about making complaints is posted in the hospitals. Dana Hargunani noted that there were discussions in the current interim crisis care tool about the role of appeals. Other states and health systems approach in a variety of ways and in a crisis situation appeals can be challenging. This is a topic that the ORAAC may consider further. Appeals are also much different than a retrospective complaint-driven process.
- RAC member noted that from the hospitals' perspective they work really hard through advocacy to try and prevent these situations from occurring. Hospitals do not want to implement crisis standards of care and are working diligently with the state to prevent that from being necessary.

ACTION – OHA staff will consider the comments shared and determine whether additional changes should be made to the proposed rules. The spelling error in subsection (2)(b) will be corrected.

Statement of Need and Fiscal Impact

M. Bernal shared that due to legislation that passed in 2021 (HB 2993), state agencies are required to ensure that communities, with a particular emphasis on Black, Indigenous and People of Color are invited to participate Rule Advisory Committees. Additionally, the legislation requires agencies to identify what affect the proposed rules may have on racial equity in Oregon.

In considering how racial equity may be impacted, M. Bernal shared Oregon's racial equity vision and definitions of terms were shared in the Chat. RAC members were asked when considering the rules and reviewing the Statement of Need and Fiscal Impact to consider which racial and ethnic populations are most affected or most harmed by the rules and consider how or in what way these specific communities are affected.

Oregon's racial equity vision:

- Dismantle institutional and structural racism in Oregon state government, and by doing so have resounding impacts on the communities of our great state
- Build a more equitable Oregon where everyone has the opportunity to thrive, and everyone's voice is heard.
- Ensure an inclusive and welcoming Oregon for all by celebrating our collective diversity of race, ethnicity, culture, color, disability, gender, gender identity, marital status, national origin, age, religion, sex, sexual orientation, socio-economic status, veteran status, and immigration status
  - Equity. An acknowledgement that not all people, or all communities, are starting from the same place due to historic and current systems of oppression. Equity is the effort to provide different levels of support based on an individual's or group's needs in order to achieve fairness in outcomes. Equity actionably empowers communities most impacted by systemic oppression and requires the redistribution of resources, power, and opportunity to those communities.
  - Institutional Racism. A form of racism that occurs within institutions that reinforces systems of power. It is often more difficult to name or witness because it is more deeply embedded in practices and policies, often presenting as a norm. Institutional racism refers to the discriminatory policies and practices of particular institutions (schools, workplaces, etc.) that routinely cause racially inequitable outcomes for people of color and advantages for white people. Individuals within institutions take on the power of the institution when they reinforce racial inequities.
  - Structural Racism. A system in which public policies, institutional practices, cultural representations and other norms work in various, often reinforcing ways to perpetuate racial group inequities. It is a feature of the society in which we all exist.

The Statement of Need and Fiscal Impact was shared and summarized including the need for the rule to make permanent the temporary rule to ensure hospitals continue to report data to the Authority when making triage decisions regarding the prioritization of patient care and to ensure continued transparency when crisis standards of care are implemented.

The documents relied upon for purposes of the rule include ORS chapters 413 and 441, as well as the Oregon Health Authority's Interim Crisis Care tool.

The Authority noted the following for how rules may affect racial equity in Oregon:

- Studies across the nation have shown that social determinants of health, such as poverty, access to care, housing, chronic health conditions, etc., contribute to increased risk of COVID-19 infection and fatality for Black, Indigenous and People of Color. As such, hospital triage decisions on prioritization of care during resource constrained periods may adversely impact these communities.
- There is not a single set of crisis standards used across Oregon. Previous standards including the Oregon Crisis Care Guidance developed in 2018 did not take into account equity considerations which made it more likely that decisions on prioritization of care would be inequitable. Due to the potential for perpetuating discrimination and health inequities, the Authority withdrew the 2018 Oregon Crisis Care Guidance in September 2020 and new crisis care principles were published in December 2020. OHA recommended that health systems take steps to incorporate the new principles into crisis care planning . The Oregon Health Authority, Oregon Resource Allocation Advisory Committee, continues to work on improving the equitable allocation of scarce resources, while acknowledging the foundational inequities that begin before the process of triage and prioritization at the time of a crisis.
- The purpose of these rules is to ensure that whatever tool or policy a hospital adopts as crisis standards, there must be overarching equity and transparency requirements

RAC members did not have any comments on the racial equity statement. Staff did recommend that reference to the critical care guidance issued in January 2022 be included in the narrative.

The fiscal and economic impact statement was reviewed noting 65 licensed hospitals in Oregon that are subject to the reporting requirement. It was further noted that changes may be necessary to include reference to the four licensed SICFs. It was noted that since January 17, 2022 when the reporting requirements became effective, one hospital system consisting of four hospitals and one health network with one hospital have implemented triage decisions affecting patient care.

The statement acknowledges:
- Costs for ensuring information is translated into the five most common languages is anticipated;
- There is no anticipated impact or costs to state agencies, units of local government or the public.
- There are no hospitals in Oregon that are considered small businesses.

RAC members had no comments on the fiscal and economic impact statement.

Next Steps

Staff reiterated that comments received will be considered further for possible amendments to the rule text. The goal is to have the rules posted in the December 1, 2022 Oregon Bulletin with a public hearing being held on or after December 15, 2022 and written comment deadline on or around December 22, 2022. Based on public testimony and written comment received, the Authority will reconsider whether any changes are necessary to the rule text and file permanent rules prior to expiration of the temporary rule.

Staff thanked RAC members for their time and commitment for serving on the RAC.

Staff member noted that based on conversation an additional meeting will not be necessary. It was further noted that supportive comments on the rules during the rulemaking hearing process are also welcome.

Meeting adjourned at 11:24 a.m.