Avian Flu- Do the OHA Crisis Care Guidelines Prepare Us for the Next Pandemic?

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Disclosures: no disclosures from…

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Dr. Jaime Fair, Intensive Care Medicine, Peace Health, Eugene, Oregon

Objectives in a pandemic

1. Know the ethical concepts in clinical ethics and public health
2. Understand a framework of the current versus the ideal versus the future states of bioethical responses
3. Enumerate major challenges in health care resource allocation
4. Address sources of moral injury & ethical tension to support health care workers, patients and communities

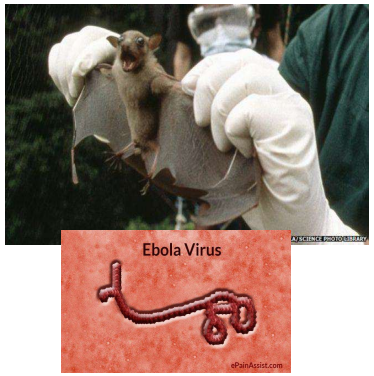
Key Points

1. There will be another pandemia – avian flu?
2. Difference between Clinical Ethics and Public Health
3. Necessity for Public Health and Clinical Ethics to collaborate effectively

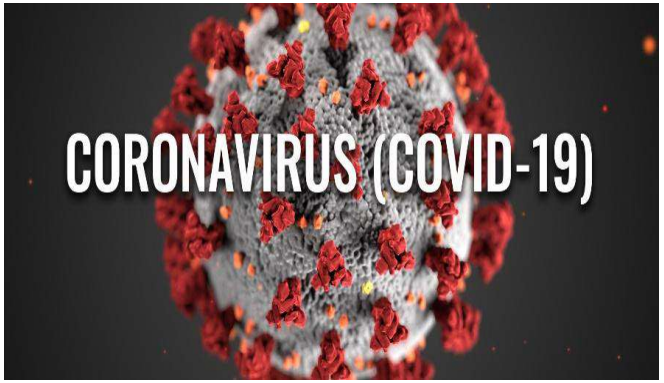
Why discuss pandemics now? There will be another

Infections resulting in recent widespread pandemics

- ***-> All single stranded RNA viruses***
- 1918/2009 Influenza H1N1*
- 1980s HIV/AIDS*
- 2000s SARS/ MERS*
- 2010s Ebola*
- 2010s Measles*
- 2020s COVID*
- ***future ?avian flu***



www.bbc.com



Why discuss pandemics now?
There will be another – Avian flu??

Highly pathogenic avian influenza (HPAI) A(H5N1) emerged in 1997.[1]

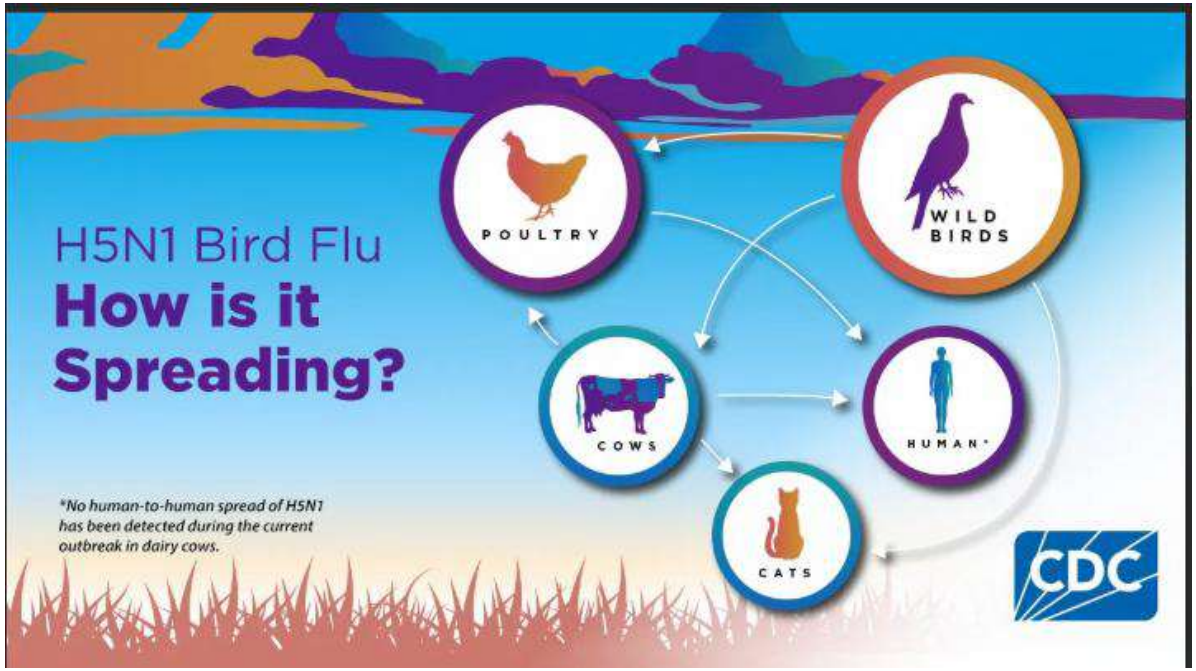
Since then, it has spread globally by migratory birds, resulting in infections in animals on every continent. HPAI A(H5N1) clade 2.3.4.4b emerged in 2021 and resulted in fatal infections in poultry as well as terrestrial and marine mammals.[1]

In early 2024, influenza A infection was first recognized in dairy cows with mastitis in Texas.

Infection in dairy cows is now widespread in the United States, affecting more than 875 herds in 16 states.

Most cow infections are genotype B3.13, whereas most outbreaks in wild birds and poultry are genotype D1.1.

Avian flu H5N1 HPAI
Highly Pathogenic Avian Influenza



Has struck >19million birds
113 flocks in 1 month,
(USDA)

No
human – to – human
transmission

Several Avian flu H5N1 variants: B3.13 in dairy herds throughout the U.S.

Has infected more than 950 herds / 16 states.

- Likely jumped to cows from birds in 2024 in TX
- Likely difficult to stamp out
- Likely posing a persistent risk to the people who work in the dairy industry

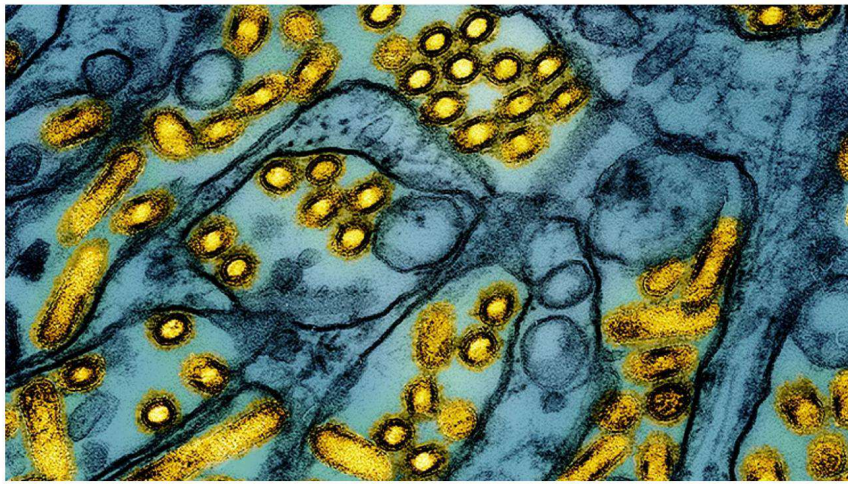
Several Avian flu H5N1 variants: D1.1 in dairy herds in Nevada

Several strains initially B3.13

Six dairy herds in Nevada with **D1.1** associated with severe infections in humans,

Now found in dairy cattle, meaning these ***cows caught it from wild birds,*** instead of another infected herd

Scientists say it may be here to stay



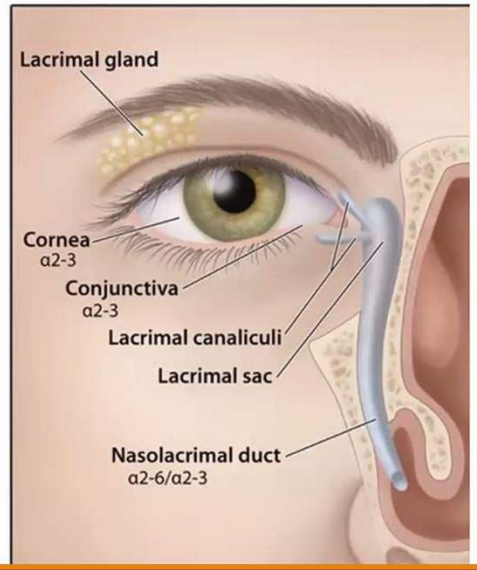
EM: avian influenza A H5N1 virus particles, . CDC/NIAID/AP

New Avian flu variant: H5N9

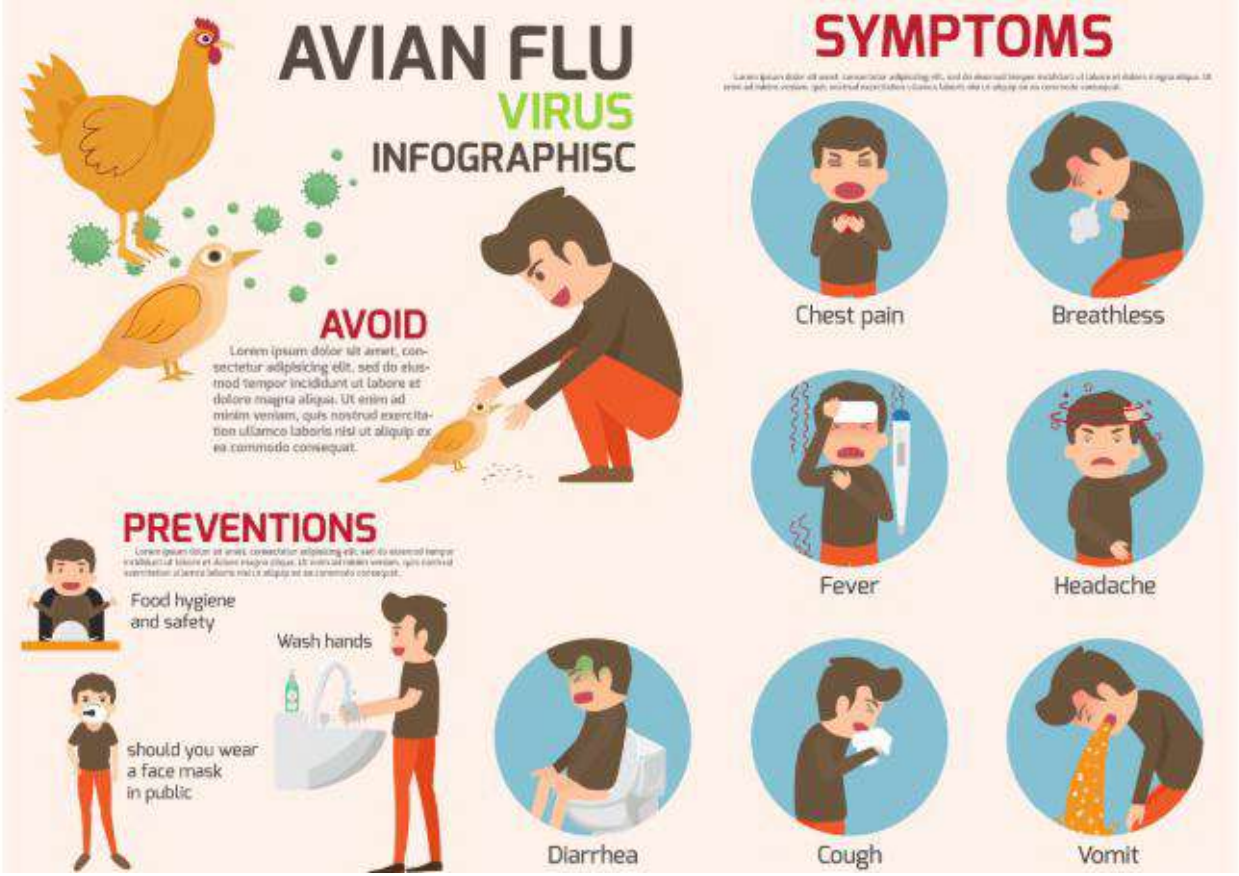
Avian flu H5N9 is now in CA,
a North American N9 reassortant of H5N1
- Likely more virulent

Most common symptom is conjunctivitis

Multiple influenza subtypes have been documented to infect ocular surfaces



- Over 80% of documented human infections from H7 subtype (HPAI and LPAI) have been associated with ocular symptoms
- not typically reported with seasonal influenza infections



How will avian flu affect us?

In 1997 described in Hong Kong, mortality ~50%

Current avian flu has not been severe

46 cases between Mar-Oct

- 90% with conjunctivitis
- treated with oseltamivir

NEJM Dec 31, 2024

What to know: H5 avian influenza

H5 bird flu is widespread in wild birds worldwide

- Outbreaks in poultry and U.S. dairy cows, and more recently sheep (UK)
- Several recent human cases in U.S. dairy and poultry workers, 1 death (in Louisiana)

- current public health risk is **low**
- CDC is watching the situation carefully and working with states to monitor people with animal exposures
- In Oregon, All persons interacting with these diary and poultry farms are being closely followed

KEY treatment: H5 avian influenza

Seasonal flu vaccine is not protective

Oseltamivir still works for treatment for H5-avian flu

- General guidance – start treatment when (any) flu is suspected

-No human-to-human transmission has been documented

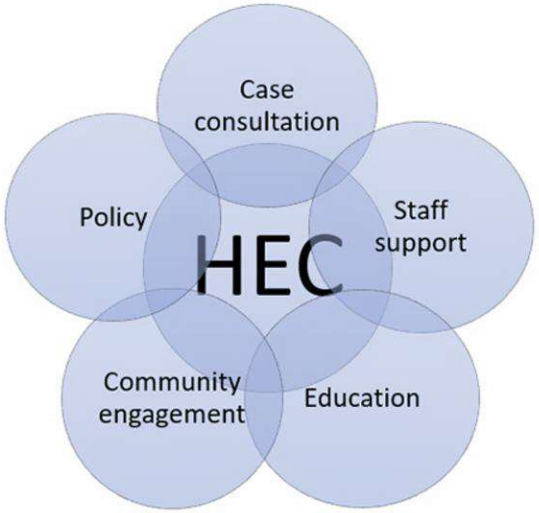
How can Clinical Ethics partner with Public Health Ethics to address this?

Leila-billing.medium.com

Clinical Ethics is separate from Public Health – siloed in training, practice

HEALTHCARE ETHICS CONSULTATION

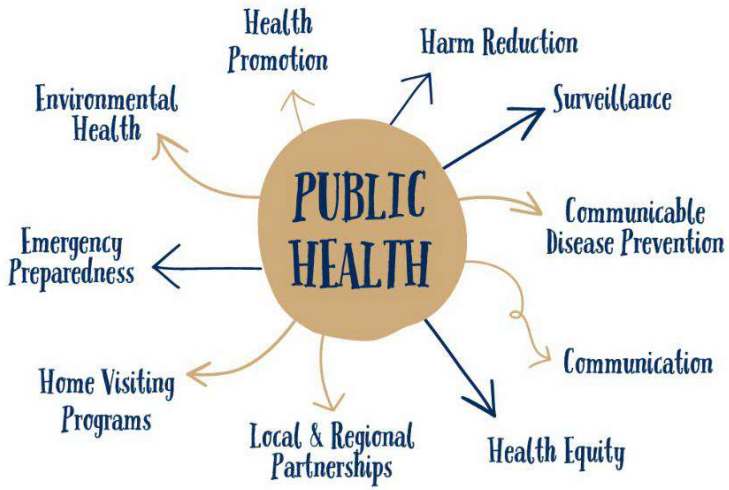
BIOETHICS PRINCIPLES



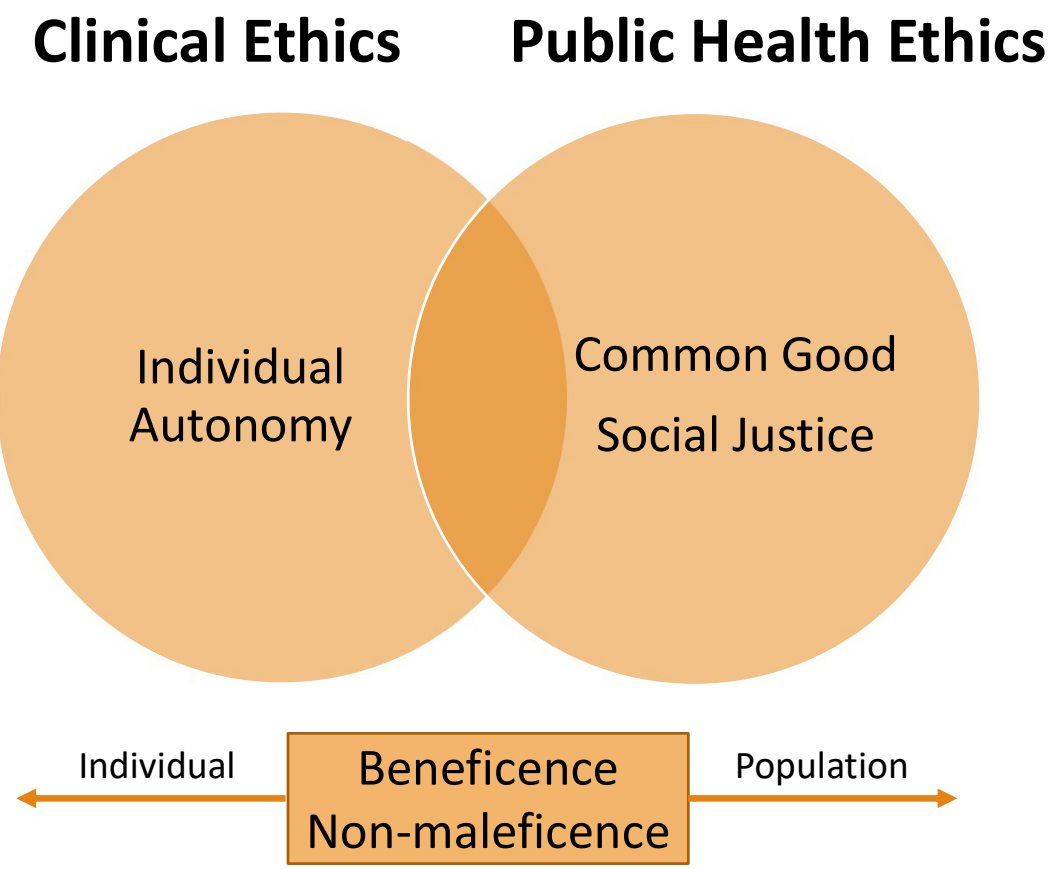
University of Rochester

PUBLIC HEALTH

SCIENCE OF COMMUNITY HEALTH



Lincoln County HHS


Clinical Ethics
Public Health Ethics
Individual Autonomy
Common Good
Social Justice
Individual
Beneficence
Non-maleficence
Population

Bioethical Concepts: Clinical Ethics

- Individual
- Autonomy
- Treatment

Focus on patient-provider interactions

Bioethical Principles

- *Individual autonomy and liberty*
- *Justice focused on access to care*

Focus on treatment, patient consent

Individual benefit and harm

Authority based more on prestige of the medical profession than the law

Bioethical Concepts: Public Health

- Populations
- Public Health
- Prevention

Focus on Community – gaining trust, consent

Respect Community members' rights

Achieve health equity

Address root cause(s) for prevention

Display cultural competence

Maintain confidentiality

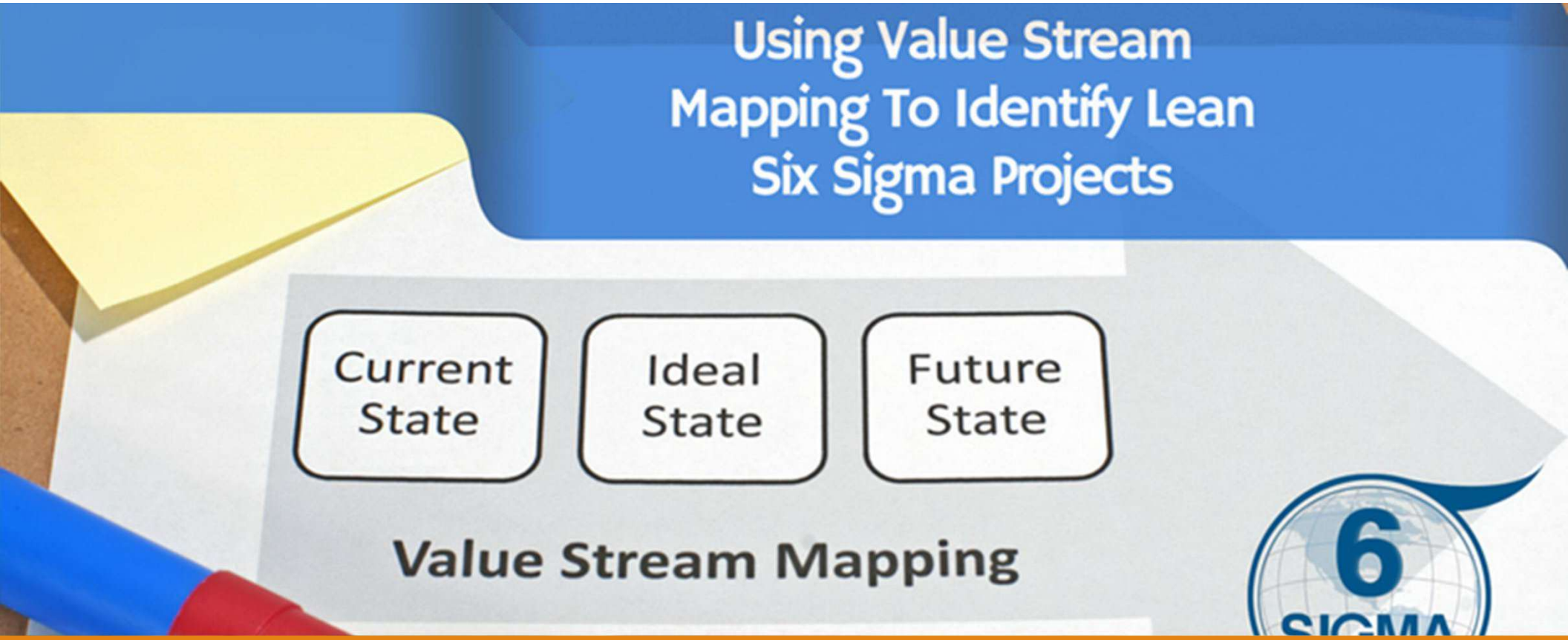
Give stakeholders a fair hearing

Ensure competence of practitioners

We need social cohesion, collaboration and community leadership

Medicine has a duty to save lives,
prevent spread of disease, and
prevent discrimination
- A pandemic forces clinical ethicists
and public health to work together
to care for individual patients
and focus on populations and prevention

How can medicine align with
different beliefs about
- *treatment, prevention, access?*



Current vs Ideal vs Future States of Bioethical Responses

Prasanna Krishnasamy, MD, MPH, FACP, HEC-C
Medical Director, Clinical Ethics, Legacy Health
Clinical Assistant Professor, OHSU

Crisis Standards of Care

"…a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a…disaster. This change in the level of care delivered…is formally declared by a state government.…The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers…"

- Institute of Medicine, National Academies Press, 2010

Continuum of Standards of Care

Incident demand/resource imbalance increases →
Risk of morbidity/mortality to patient increases →
← Recovery

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas repurposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional reuse of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[a]

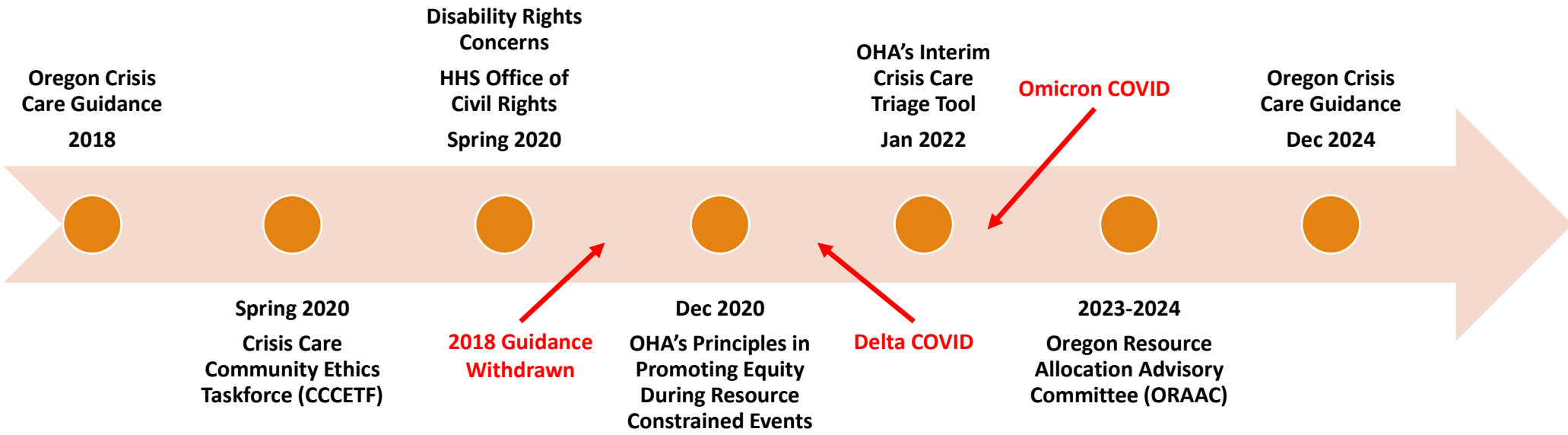
Usual operating conditions

Indicator: potential for crisis standards[b]

Trigger: crisis standards of care[c]

Austere operating conditions

Oregon Crisis Care Guidelines



Public Health Division

Health Security, Preparedness and Response Program

OREGON HEALTH AUTHORITY

December 16, 2024

Oregon Crisis Care Guidance

- Guidance Goals
  - Saving lives
  - Not worsening health inequities
- Hospitals may activate CSC
- Hospitals should take all possible steps to extend capacity…
- Hospitals should coordinate with OHA, regional hospitals, EMS and local/state partners…
- OAR 333-505-0036
  - Notify OHA and the public
- Hospitals may use their own crisis care triage tool, consistent with OHA's Principles:
  1. Non-discrimination
  2. Health equity
  3. Patient-led Decision Making
  4. Transparent and Effective Communication

Public Health Division

Health Security, Preparedness and Response Program

OREGON HEALTH AUTHORITY

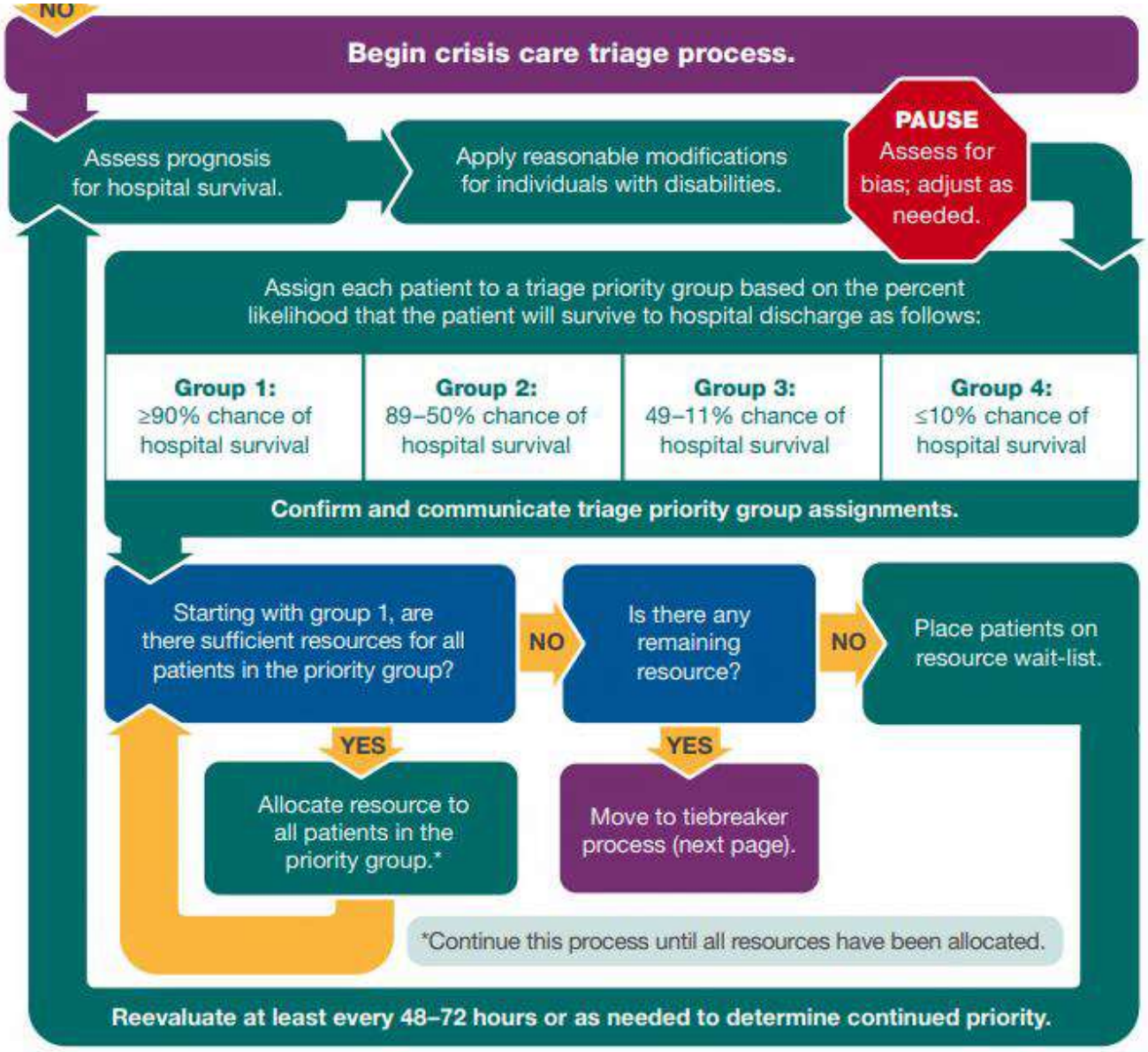
December 16, 2024

Oregon Crisis Care Guidance

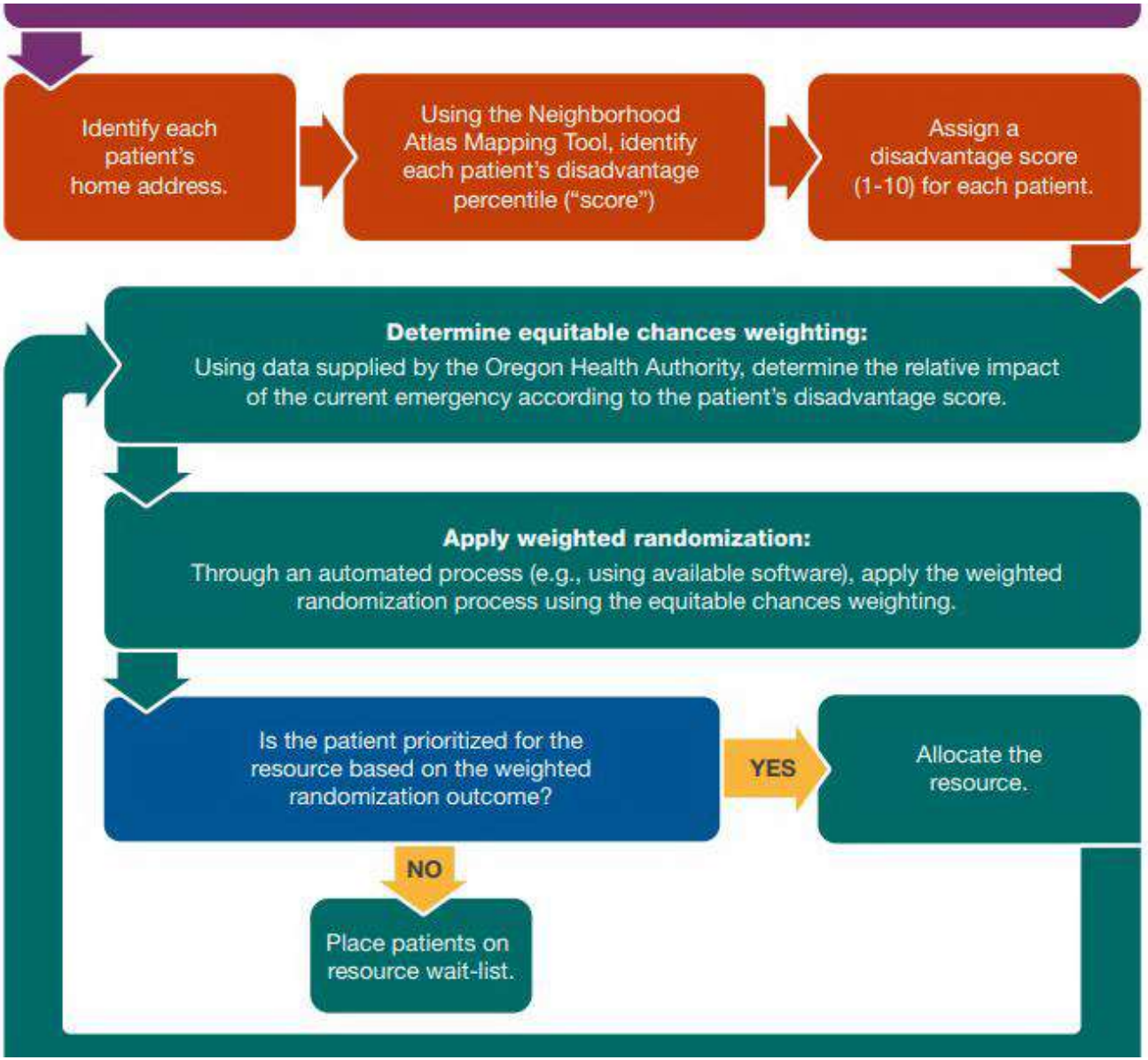
- Individualized assessments
  - Prognosis for hospital survival, using best objective medical evidence
  - Triage decisions must not be based on clinically or ethically irrelevant considerations such as race, ethnicity etc.
  - Reasonable accommodations for persons with disabilities
- Patient preferences
  - All efforts should be made to determine patient's goals of care and treatment preferences, with regards to hospitalization and intensive care

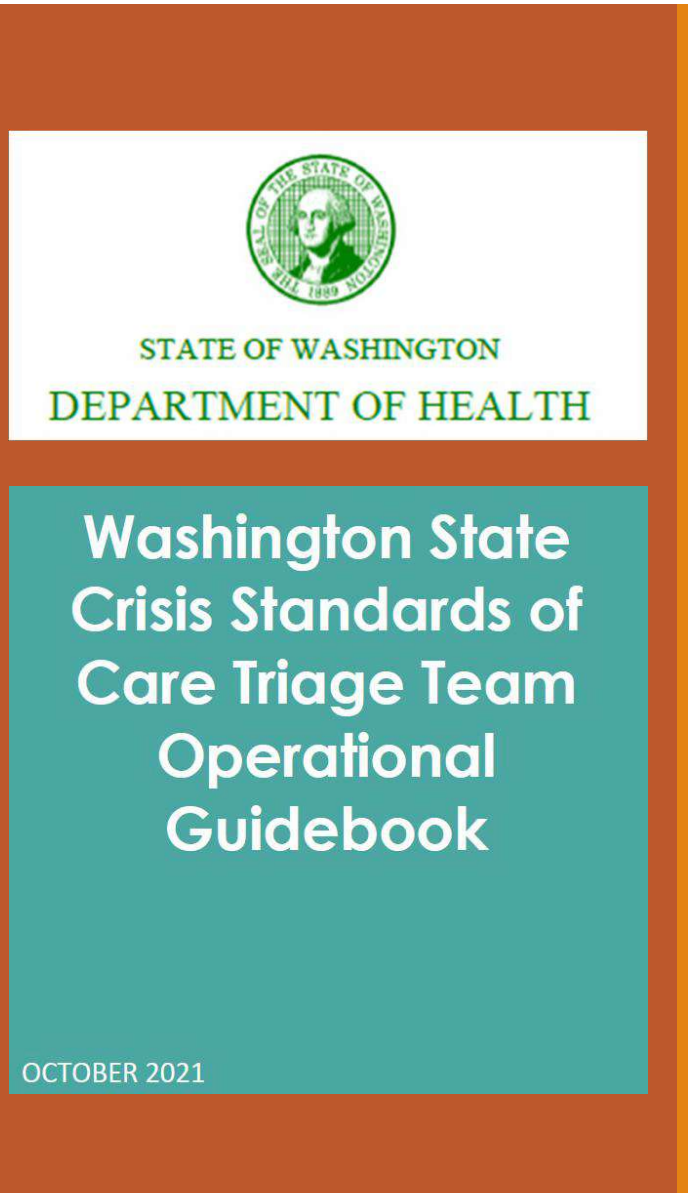
- CSC Triage Team
  - Recommended team composition:
    1. 2 or 3 senior clinicians with experience in triage
       - At least 1 physician and 1 nurse
    2. Medical Ethicist
    3. Expert in DEI
    4. Disability rights representative
    5. Non-clinical community representative
    6. Administrative Assistant
  - Training in bias, trauma-informed care, and anti-discrimination

Crisis Care Triage Algorithm



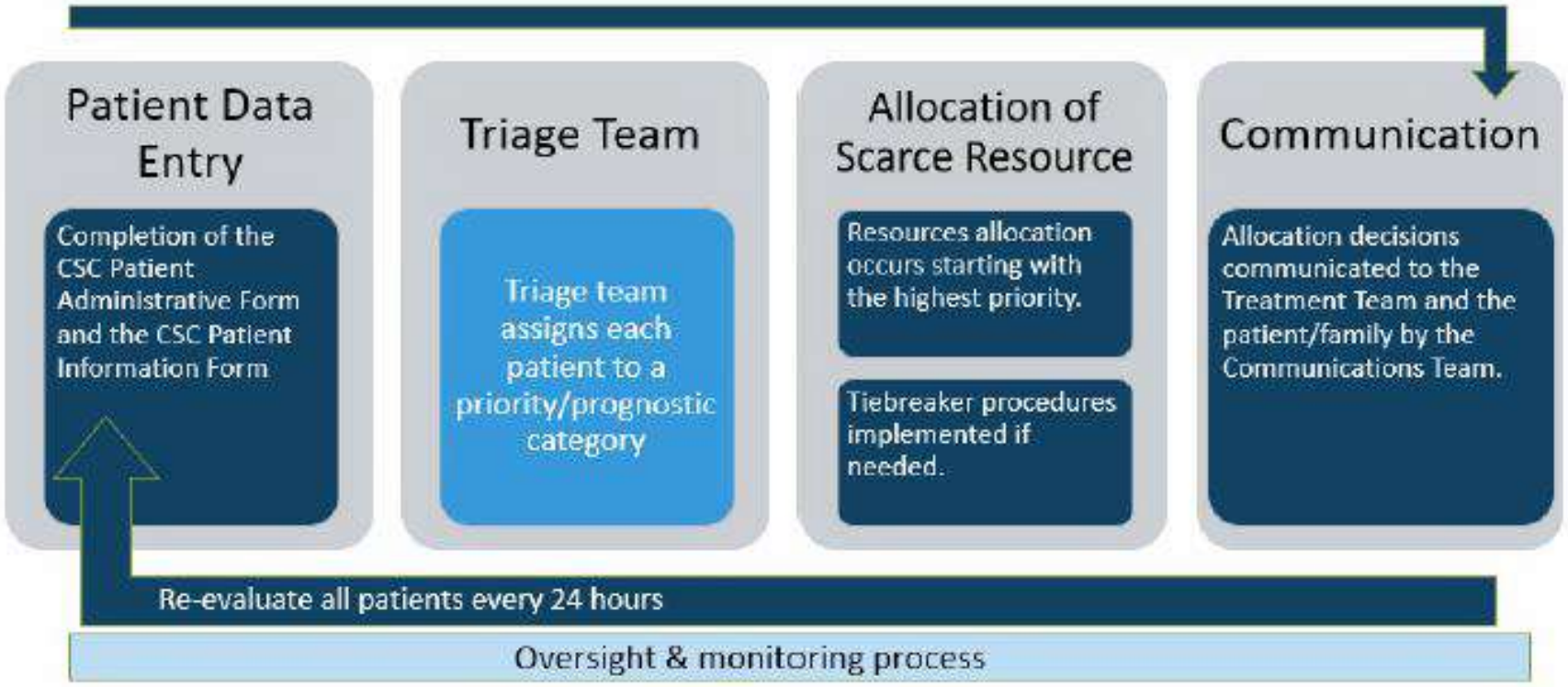
Equitable Chances "Tiebreaker"





- State-wide commitment
  - Work together
  - Share info & resources
- CSC will be declared at the state level
- No hospital (or region) will go into CSC alone
- Ethical Framework
  - Fairness
  - Duty to care
  - Duty to steward resources
  - Transparency
  - Consistency
  - Proportionality
  - Accountability

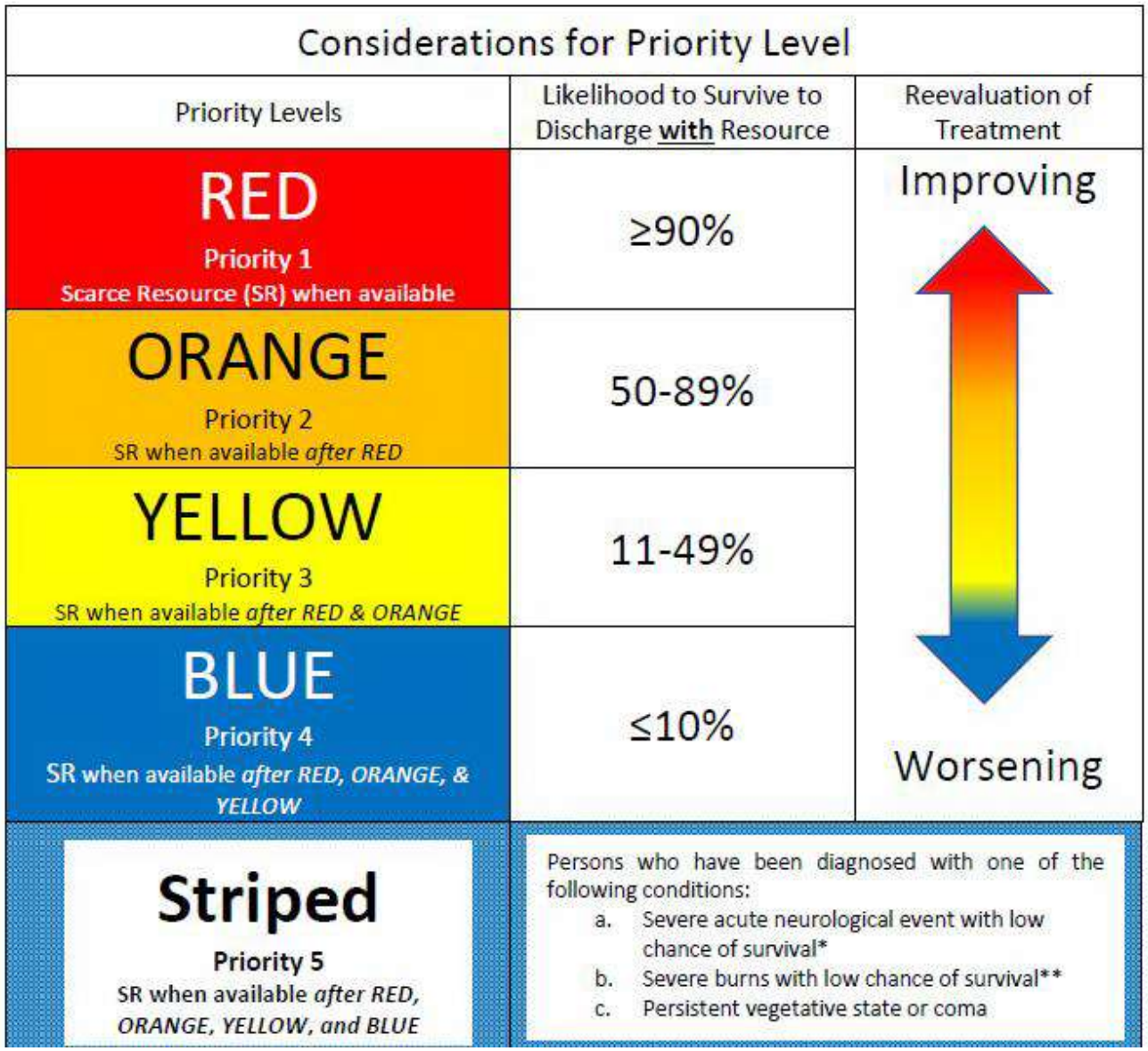
Washington CSC – Operational Steps



Washington Crisis Standards of Care

- CSC Triage Team
  - Recommended team composition:
    1. 2 to 3 senior clinicians with experience in triage
       - At least 1 physician
    2. Medical Ethicist
    3. Administrative Assistant
- CSC Triage Team
  - Does not have to be at the hospital level
  - Regional teams to address staffing shortage

Crisis Care Triage



Tiebreaker Process

When crisis standards of care and CSC Triage Teams are implemented, in the case of a tiebreaker situation, the resource will be allocated in the following manner:

- **Level 1:** The resource remains with the patient who already has the resource as long as the patient is not clinically worsening.
- **Level 2:** The resource goes to a pregnant patient.
- **Level 3:** The resource goes to the patient with the highest SVI score based on the following:
    - i) SVI score (highest rank = 10, based on home address).
    - ii) Unhoused individuals will receive a score based on their last known address (i.e., shelter, hospital) or the current location of services.
- **Level 4:** Randomization using the Excel Randomization Tool (located here).

Strengths & Opportunities

OREGON

- Strengths
  - Emphasis on equity, non-discrimination & communication
  - Individualized assessments, based on clinical factors and judgment (and no scoring systems like SOFA)
  - Equitable Chances "Tiebreaker"

WASHINGTON

- Strengths
  - Statewide commitment to work together and share resources
  - CSC declared at the state level
  - No hospital or region will go alone
  - Sense of cohesion, collaboration and community during meetings

Strengths & Opportunities

OREGON

- Opportunities
  - State level CSC declaration, coordination and support
  - Explicitly allowing hospitals and regions to support each other
  - Simulation exercises on the triage tool (when not in crisis)
  - Liability protections for hospitals and healthcare providers

WASHINGTON

- Opportunities
  - Integrate equity and non-discrimination considerations
  - Simulation exercises on the triage tool when not in crisis (may be this was already done)
  - Liability protections for hospitals and healthcare providers (may be less of an issue when CSC declared by WA Department of Health)

Oregon CSC - Ideal State

- CSC that is widely accepted (may not be universally accepted)
- State level CSC declaration, coordination and support for hospitals
- Explicitly allowing hospitals and regions to work with each other
- CSC Triage Tool informed and modified by simulation exercises and real-time data during pandemics and natural disasters.
- Liability protections for hospitals and healthcare providers

Oregon CSC - Future State

- Ongoing work to engage various stakeholders
- Simulation exercises on existing approach & tool
- Refine current guidance & tool based on input and data
- Explore State level declaration & liability protections

Challenges with Health Care Resource Allocation

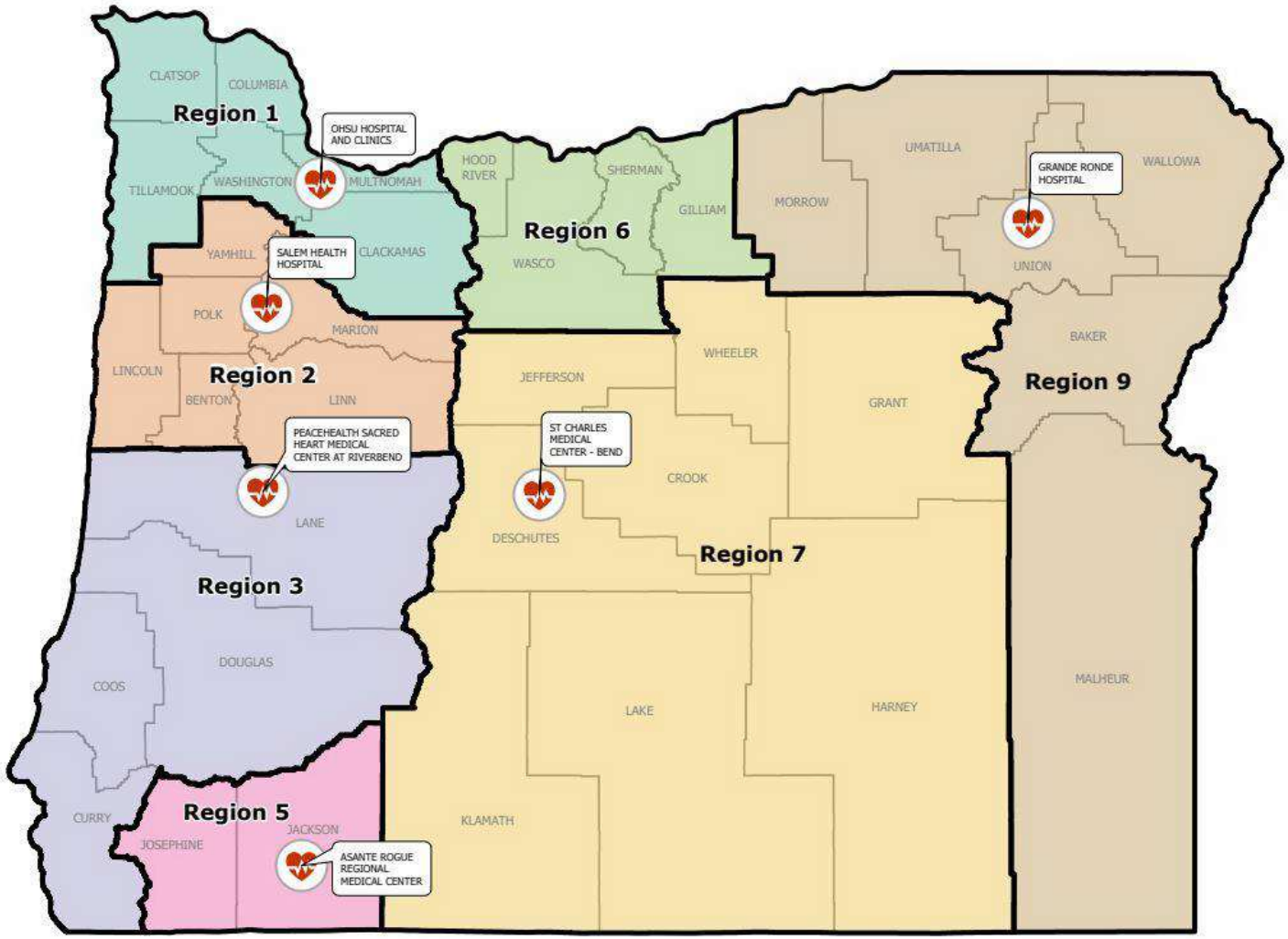
DR. LAURA MAVITY

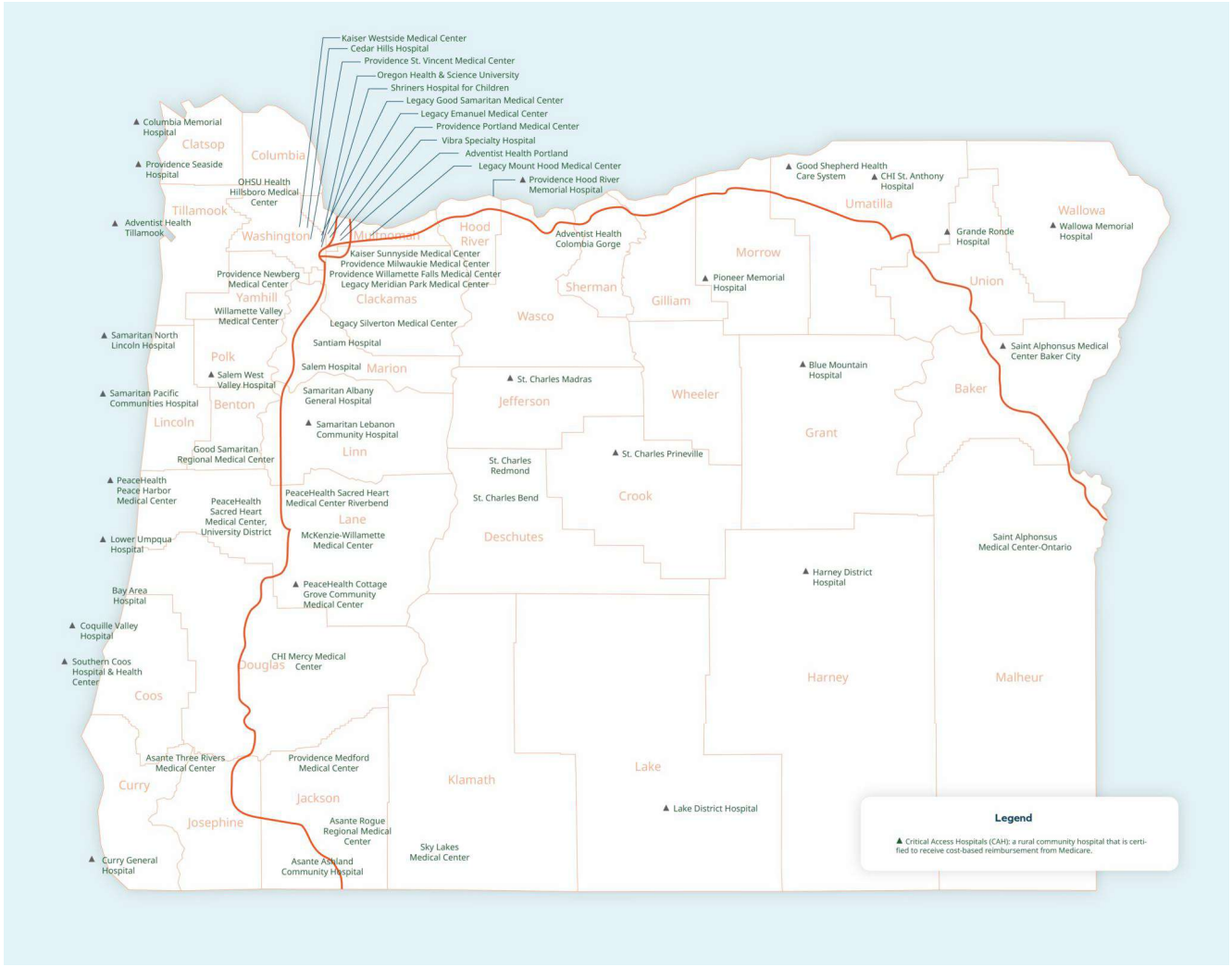
HOSPICE & PALLIATIVE MEDICINE

ST CHARLES HEALTH SYSTEM, CENTRAL OREGON

Key Points:

1. Health care systems in rural Oregon are geographically isolated and lack same resources as metropolitan systems
2. Lack of framework for collaboration in Oregon Crisis Standards of Care exacerbates isolation for health systems in rural areas
3. Impacts are devastating


Region 1
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
OHSU HOSPITAL AND CLINICS
Region 2
YAMHILL
CLACKAMAS
SALEM HEALTH HOSPITAL
POLK
MARION
LINCOLN
BENTON
LINN
PEACEHEALTH SACRED HEART MEDICAL CENTER AT RIVERBEND
Region 3
LANE
COOS
DOUGLAS
CURRY
Region 5
JOSEPHINE
JACKSON
ASANTE ROGUE REGIONAL MEDICAL CENTER
Region 6
HOOD RIVER
SHERMAN
GILLIAM
WASCO
Region 7
JEFFERSON
WHEELER
GRANT
ST CHARLES MEDICAL CENTER - BEND
CROOK
DESCHUTES
LAKE
HARNEY
KLAMATH
Region 9
UMATILLA
MORROW
WALLOWA
GRANDE RONDE HOSPITAL
UNION
BAKER
MALHEUR


Kaiser Westside Medical Center
Cedar Hills Hospital
Providence St. Vincent Medical Center
Oregon Health & Science University
Shriners Hospital for Children
Legacy Good Samaritan Medical Center
Legacy Emanuel Medical Center
Providence Portland Medical Center
Vibra Specialty Hospital
Adventist Health Portland
Legacy Mount Hood Medical Center
Providence Hood River Memorial Hospital
Columbia Memorial Hospital
Clatsop
Columbia
Providence Seaside Hospital
OHSU Health Hillsboro Medical Center
Tillamook
Adventist Health Tillamook
Washington
Multnomah
Hood River
Adventist Health Columbia Gorge
Kaiser Sunnyside Medical Center
Providence Milwaukie Medical Center
Providence Willamette Falls Medical Center
Legacy Meridian Park Medical Center
Providence Newberg Medical Center
Yamhill
Willamette Valley Medical Center
Clackamas
Legacy Silverton Medical Center
Santiam Hospital
Samaritan North Lincoln Hospital
Polk
Salem West Valley Hospital
Salem Hospital
Marion
Samaritan Albany General Hospital
Samaritan Pacific Communities Hospital
Benton
Lincoln
Samaritan Lebanon Community Hospital
Linn
Good Samaritan Regional Medical Center
PeaceHealth Peace Harbor Medical Center
PeaceHealth Sacred Heart Medical Center, University District
PeaceHealth Sacred Heart Medical Center Riverbend
Lane
McKenzie-Willamette Medical Center
Lower Umpqua Hospital
PeaceHealth Cottage Grove Community Medical Center
Bay Area Hospital
Coquille Valley Hospital
Southern Coos Hospital & Health Center
Coos
Douglas
CHI Mercy Medical Center
Asante Three Rivers Medical Center
Curry
Providence Medford Medical Center
Jackson
Josephine
Asante Rogue Regional Medical Center
Asante Ashland Community Hospital
Curry General Hospital
Sky Lakes Medical Center
Klamath
Lake
Lake District Hospital
Sherman
Wasco
Jefferson
St. Charles Madras
St. Charles Redmond
St. Charles Bend
Deschutes
Crook
St. Charles Prineville
Gilliam
Morrow
Pioneer Memorial Hospital
Wheeler
Grant
Blue Mountain Hospital
Harney
Harney District Hospital
Umatilla
Good Shepherd Health Care System
CHI St. Anthony Hospital
Grande Ronde Hospital
Union
Wallowa
Wallowa Memorial Hospital
Baker
Saint Alphonsus Medical Center Baker City
Saint Alphonsus Medical Center-Ontario
Malheur
Legend
Critical Access Hospitals (CAH): a rural community hospital that is certified to receive cost-based reimbursement from Medicare.

"Oregon hospitals can choose to use their own crisis care triage tool relating to critical care resource allocation so long as it is consistent with "Principles in Promoting Health Equity in Resource Constrained Events" and does not violate state and federal nondiscrimination laws or any other applicable laws."

On the other side of the Cascades….

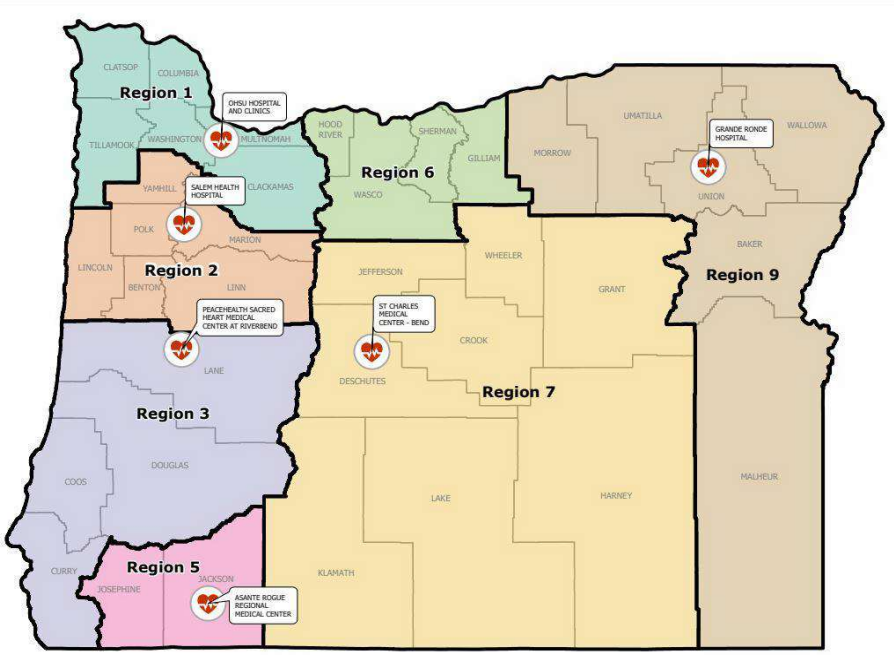
When to activate Crisis Standards of Care?

What triage tool to use?

How to assemble a triage team?

Perceived risk of:

- Providing inequitable care
- Liability



Public Health Division

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OREGON HEALTH AUTHORITY

December 16, 2024

Oregon Crisis Care Guidance

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    3. *Expert in DEI*
    4. *Disability rights representative*
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  - *Training in bias, trauma-informed care, and anti-discrimination*

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On the other side of the Cascades….

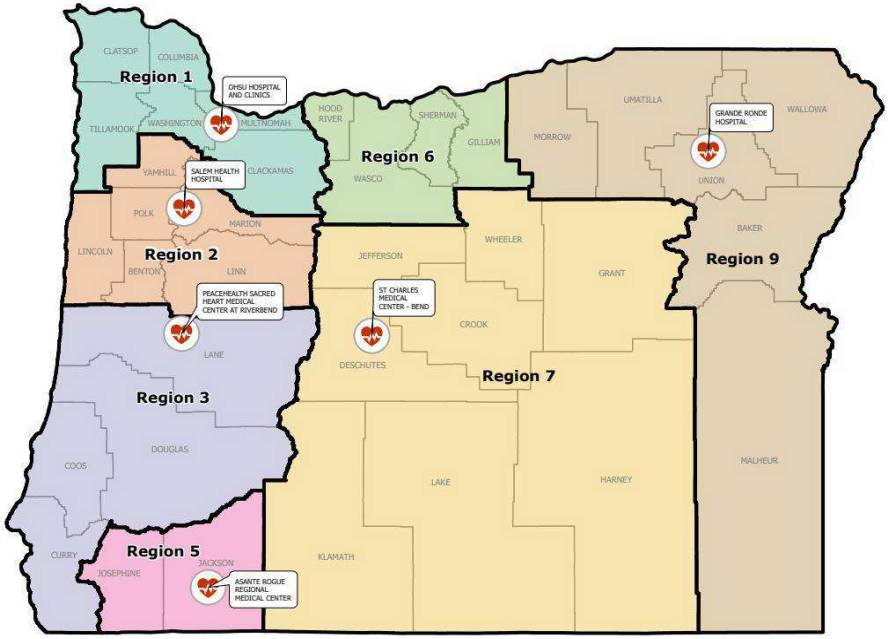
When to activate Crisis Standards of Care?

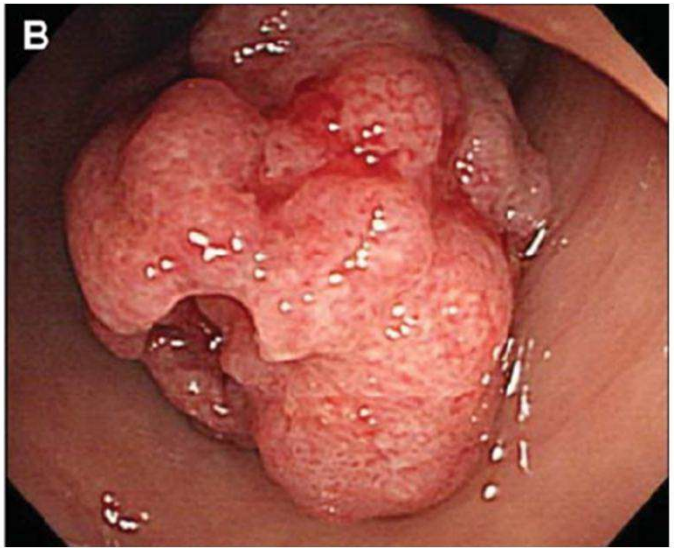
What triage tool to use?

How to assemble a triage team?

Perceived risk, fear of:

- Providing inequitable care
- Liability





Impact on care for other illnesses

DELAYS IN CARE

- Surgeries
  - ***Financial impact on health care systems***
- Cancer care
- Screening/preventive care
  - In 2025 still backlog of colonoscopies, sleep studies

Palliative Care

"Prior to, as well as during implementation of Crisis Standards of Care, ***all efforts should be made to determine a patient's goals of care and treatment preferences.***

It is imperative to know whether aggressive interventions such as hospitalization, intensive care unit (ICU) admission or mechanical ventilation are consistent with a patient's preferences."

Oregon Crisis Care Guidance

Is this feasible in a crisis?

Palliative Care – the Oregon stories….

Expectant management

- Coordination of and provision of comfort-focused care
- *Death in the corridor*

Impact on patients and families and end-of life care

- Availability of support persons when transferred out of area
- Difficulty getting patient back home for end-of-life care

PREPARE FOR THE NEXT PANDEMIC

Address sources of moral distress to support health care workers, patients, and communities.

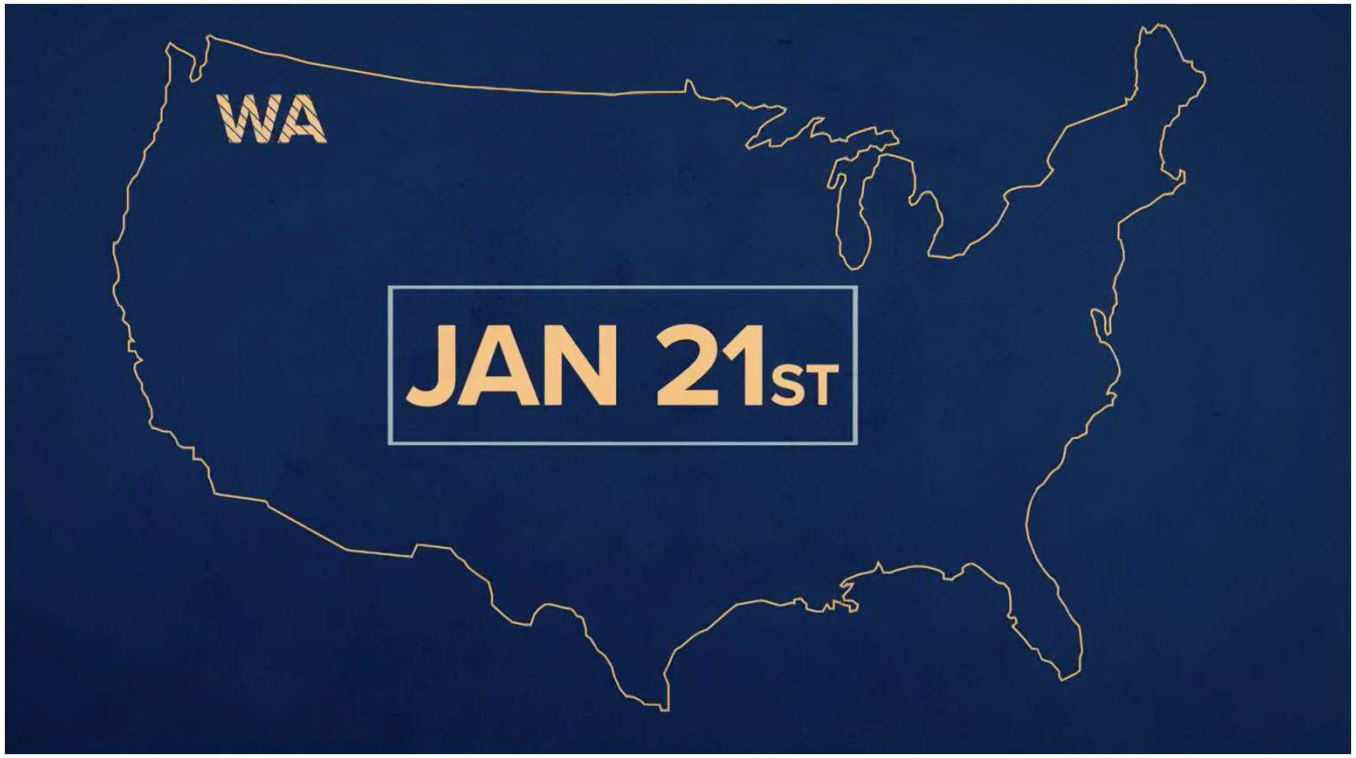
Dr. Jaime Fair
Intensive Care Medicine
Peace Health, Eugene, Oregon

SOURCES OF MORAL DISTRESS DELTA SURGE 2021

What crisis?

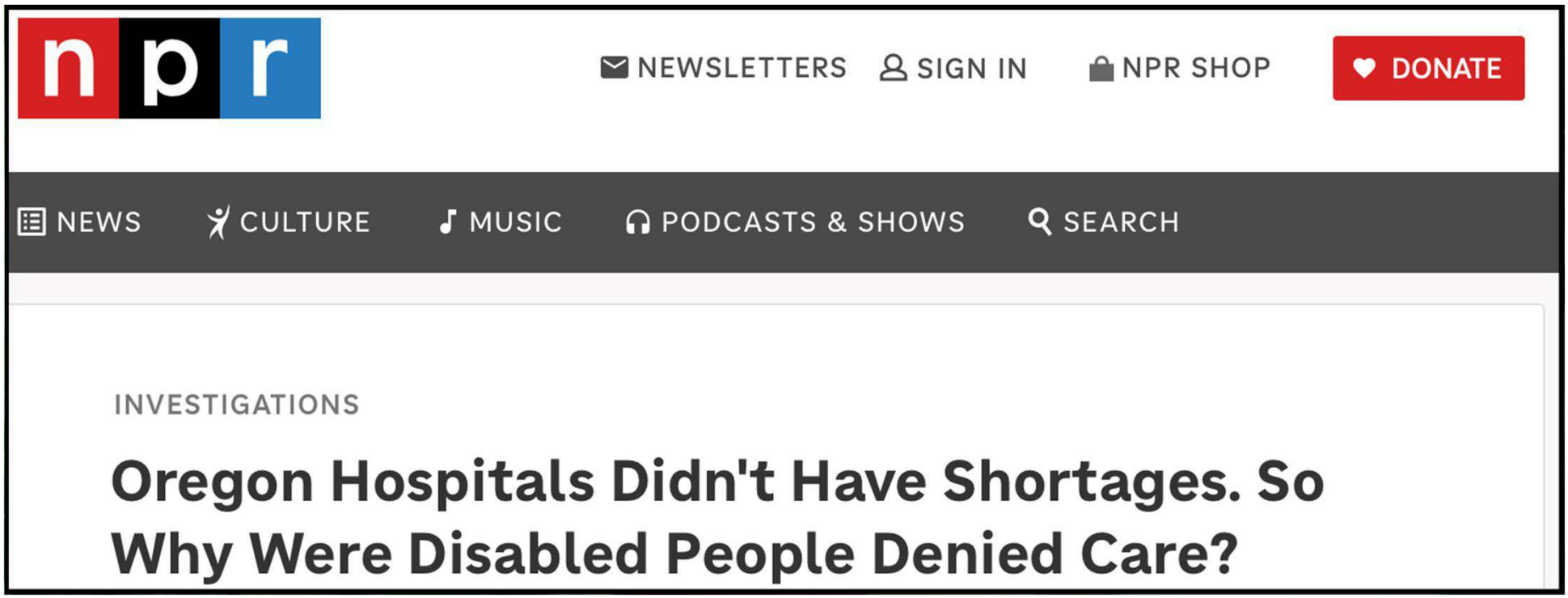
Healthcare Worker Shortage

Culture Wars



January 2020

First US and Oregon COVID cases



April 2020

Disability Rights Oregon (DRO)

May 25, 2020

100 days of protests in Portland

September 2020

Oregon Health Authority (OHA) withdraws Crisis Care Guidance.

Oregon Health Authority

DECEMBER 2024

Crisis Care Guidelines

- Prioritized diversity, equity, and inclusivity
- Mitigated discrimination in triage
- Specified triage team composition
- Involved community stakeholders

PREPARE
FOR THE
NEXT PANDEMIC

Declare Crisis

Coordinate at State Level

Plan for Cultural Divide

Declare Crisis

Public Health Division
Health Security, Preparedness and Response Program

OREGON HEALTH AUTHORITY

December 16, 2024

Oregon Crisis Care Guidance

"Activate Crisis Standards of Care in extraordinary circumstances when critical care resources are severely limited, the number of patients presenting for critical care exceeds capacity and there is no option to transfer patients."

Declare Crisis

Define Crisis –

HCW shortage

No Hospital Goes Alone

HRSA
Health Workforce

Physician Workforce: Projections, 2022-2037

November 2024

Challenges to the Future of a Robust Physician Workforce in the United States

Authors: Rochelle P. Walensky, M.D., M.P.H., and Nicole C. McCann, B.A. Author Info & Affiliations

Published January 15, 2025 | N Engl J Med 2025;392:286-295 | DOI: 10.1056/NEJMsr2412784 | VOL. 392 NO. 3

Widespread Clinician Shortages Create a Crisis that Will Take Years to Resolve

COVID may have eroded doctors' belief that they are obligated to treat infectious patients

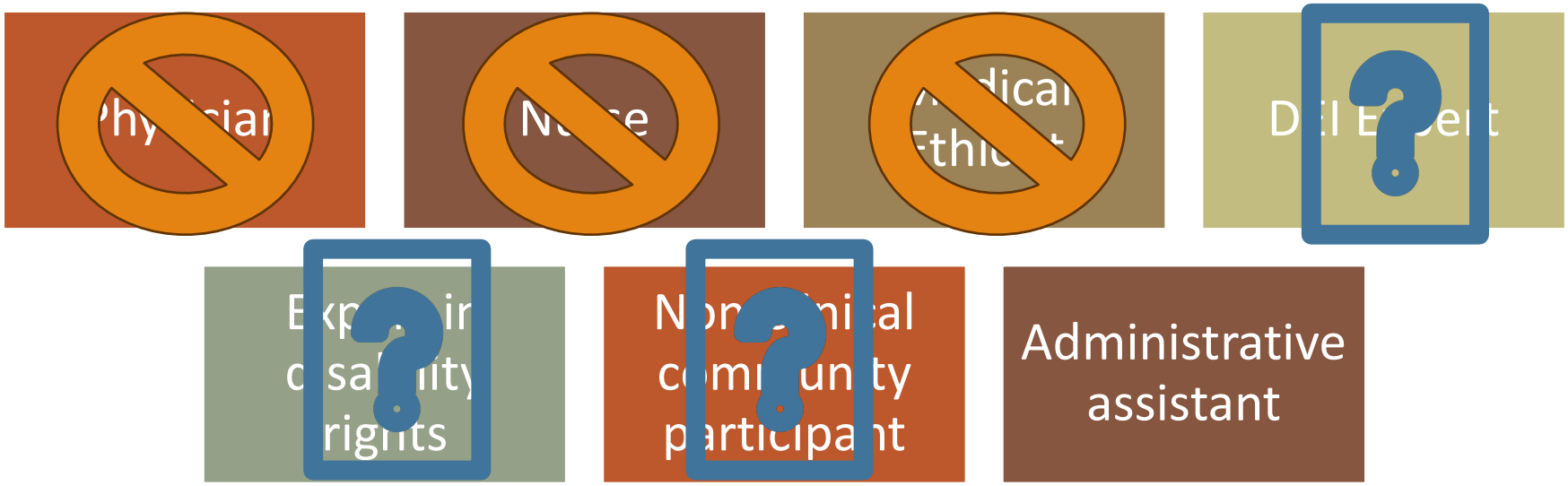
2022
Oregon's Licensed Health Care Workforce Supply
Based on data collected through January 2022

Triage Team

December 16, 2024
Oregon Crisis Care Guidance

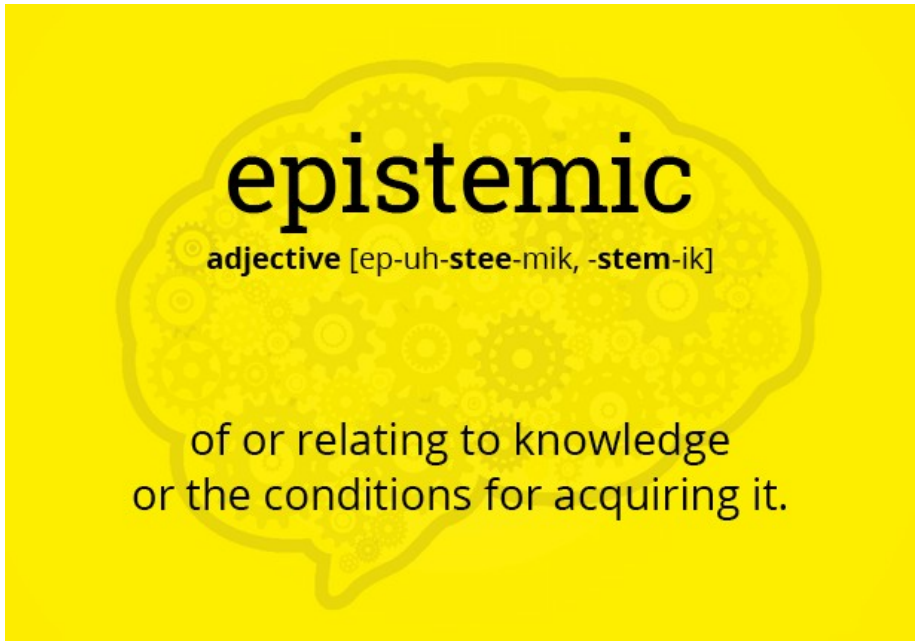
- Physician
- Nurse
- Medical Ethicist
- DEI Expert
- Expert in disability rights
- Non-clinical community participant
- Administrative assistant

Triage Team + HCW Shortage = Unfeasible



Share Regional and State Resources

THE CULTURAL DIVIDE



Epistemological Questions

How do we know what we know?

What is true?

What is the difference between opinion and fact?

The epistemic divide is a divide of understood knowledge or truth.

- Geographic
- Political
- Urban/Rural
- Social
- Economic
- Educational
- Religious
- Medical Resources*

The worldview divide between the healthcare establishment and patients was the primary source of moral distress for HCW and patients in Delta Surge.

The epistemic divide is widening and will be the single biggest problem in the next pandemic.

“I don’t believe you.”

I don’t have COVID—COVID is a hoax.

You won’t let me see my dying son unless I wear a mask?!

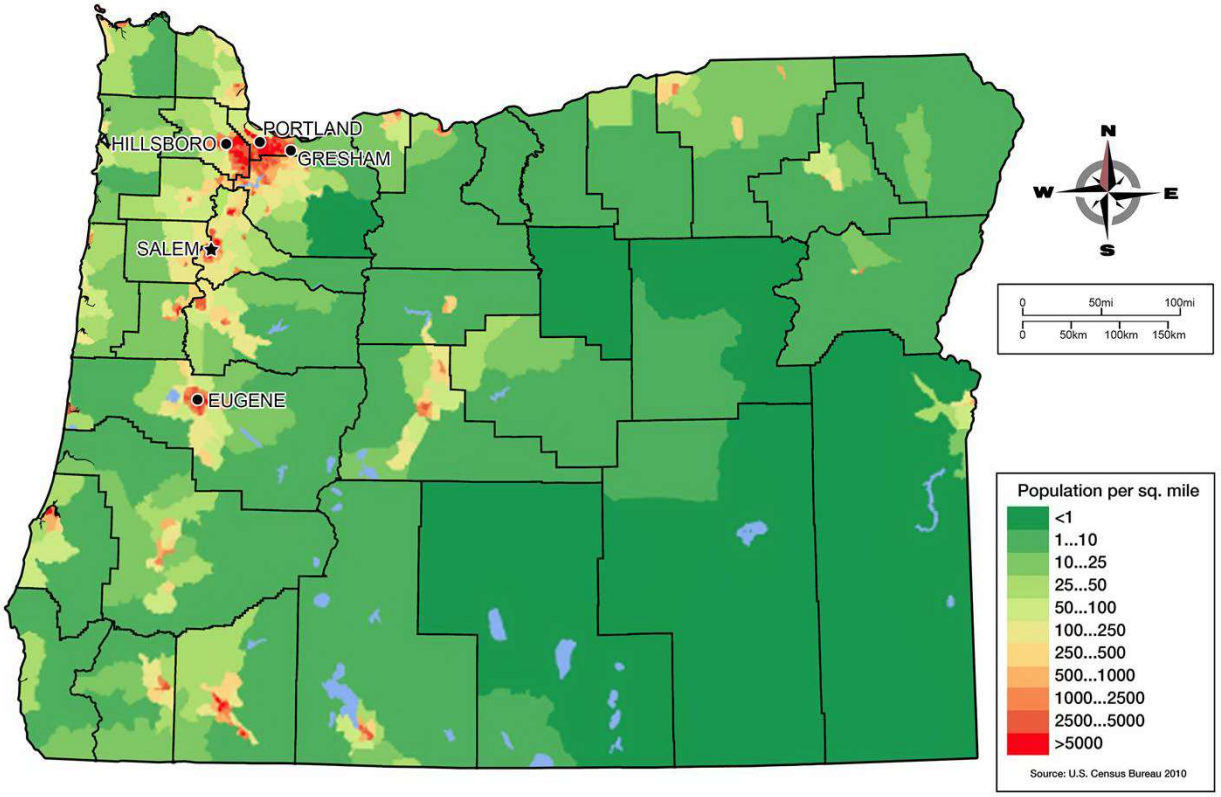
Doctors get money every time someone dies of COVID.

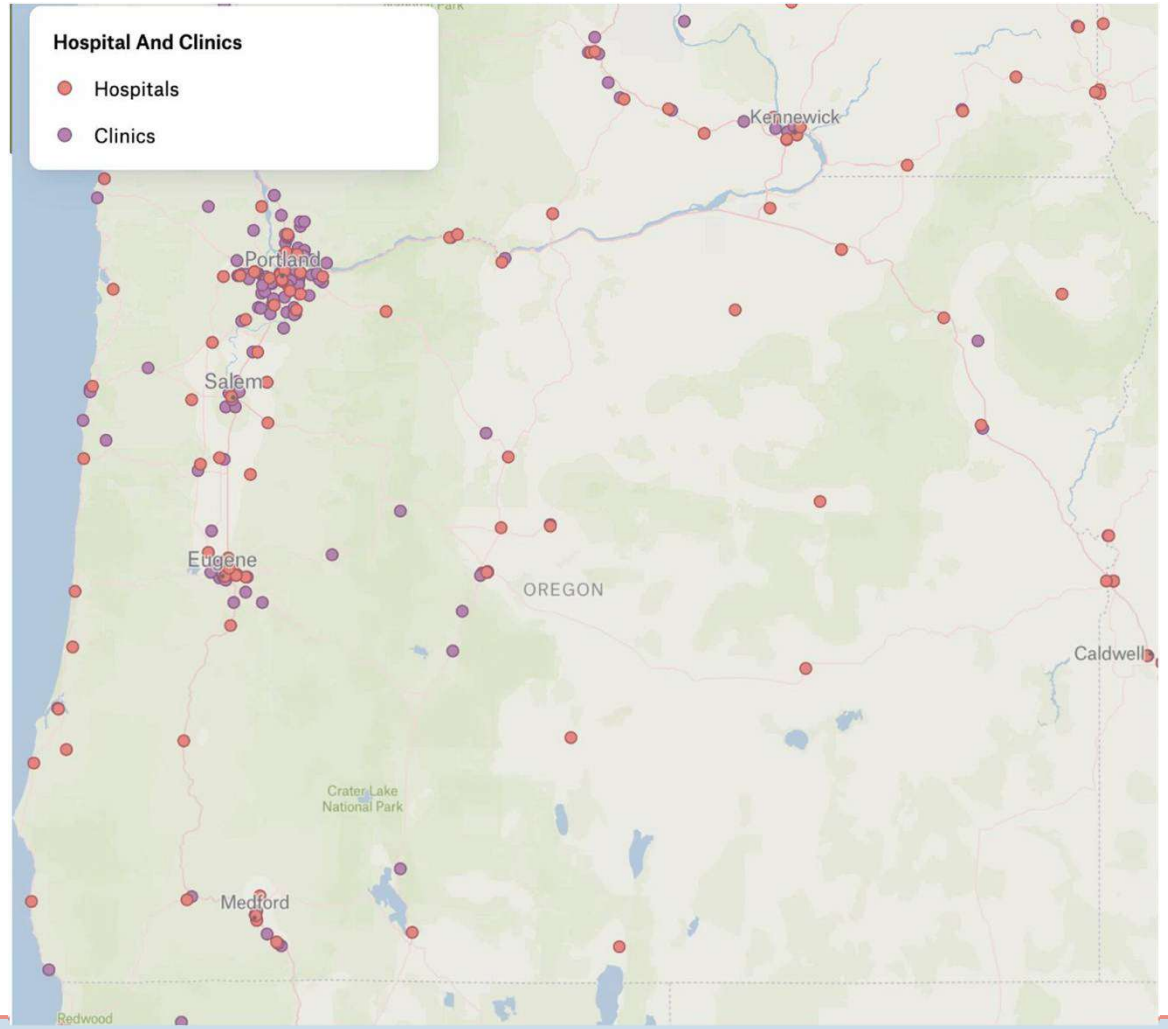
You are in league with the Chinese to kill white Americans.

You are killing my wife.

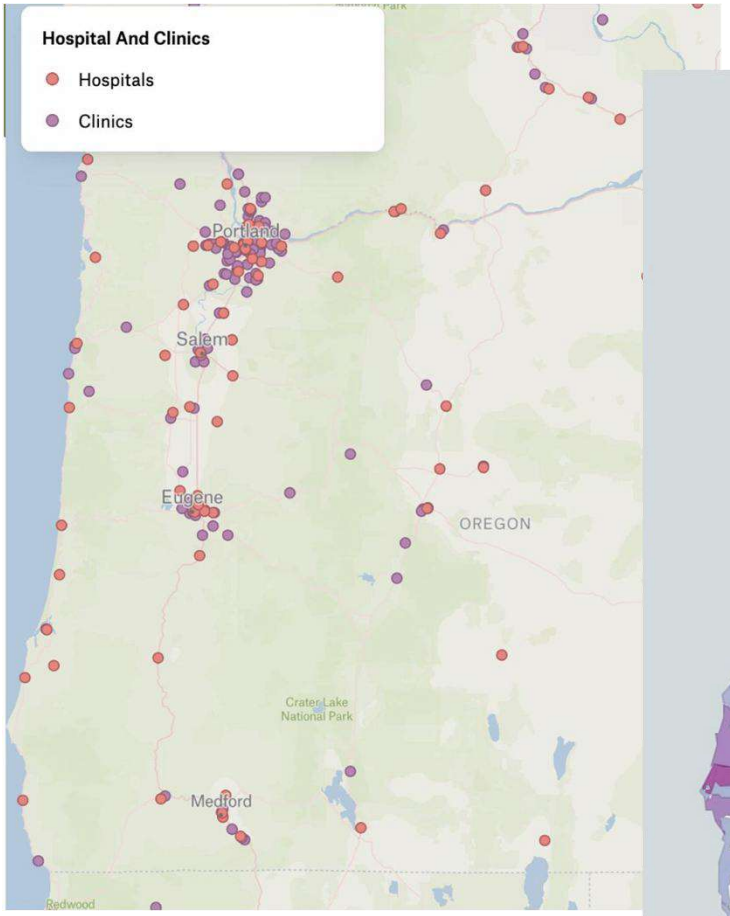
Ivermectin will cure COVID! Why won’t you give ivermectin?

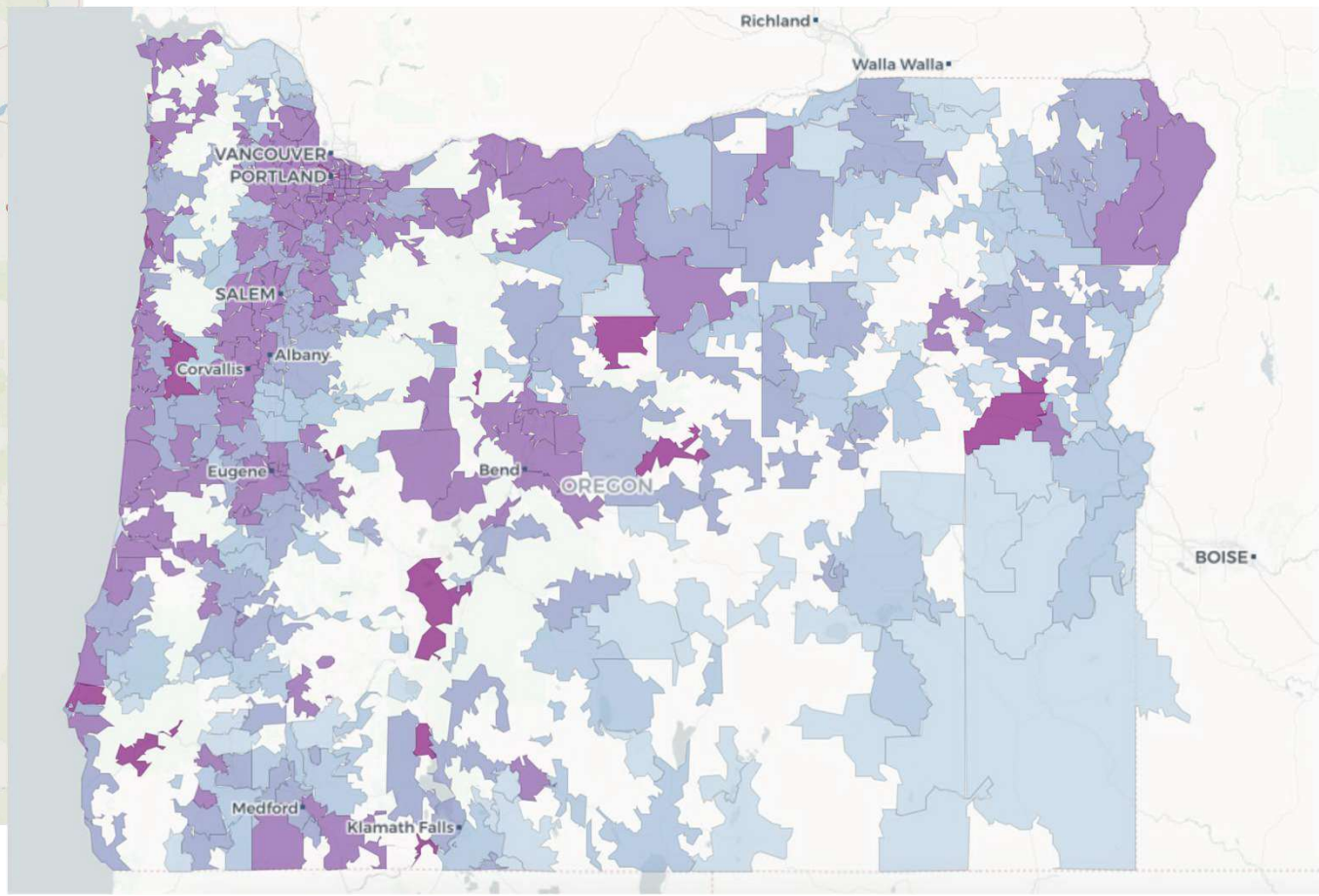
Oregon's Population Density

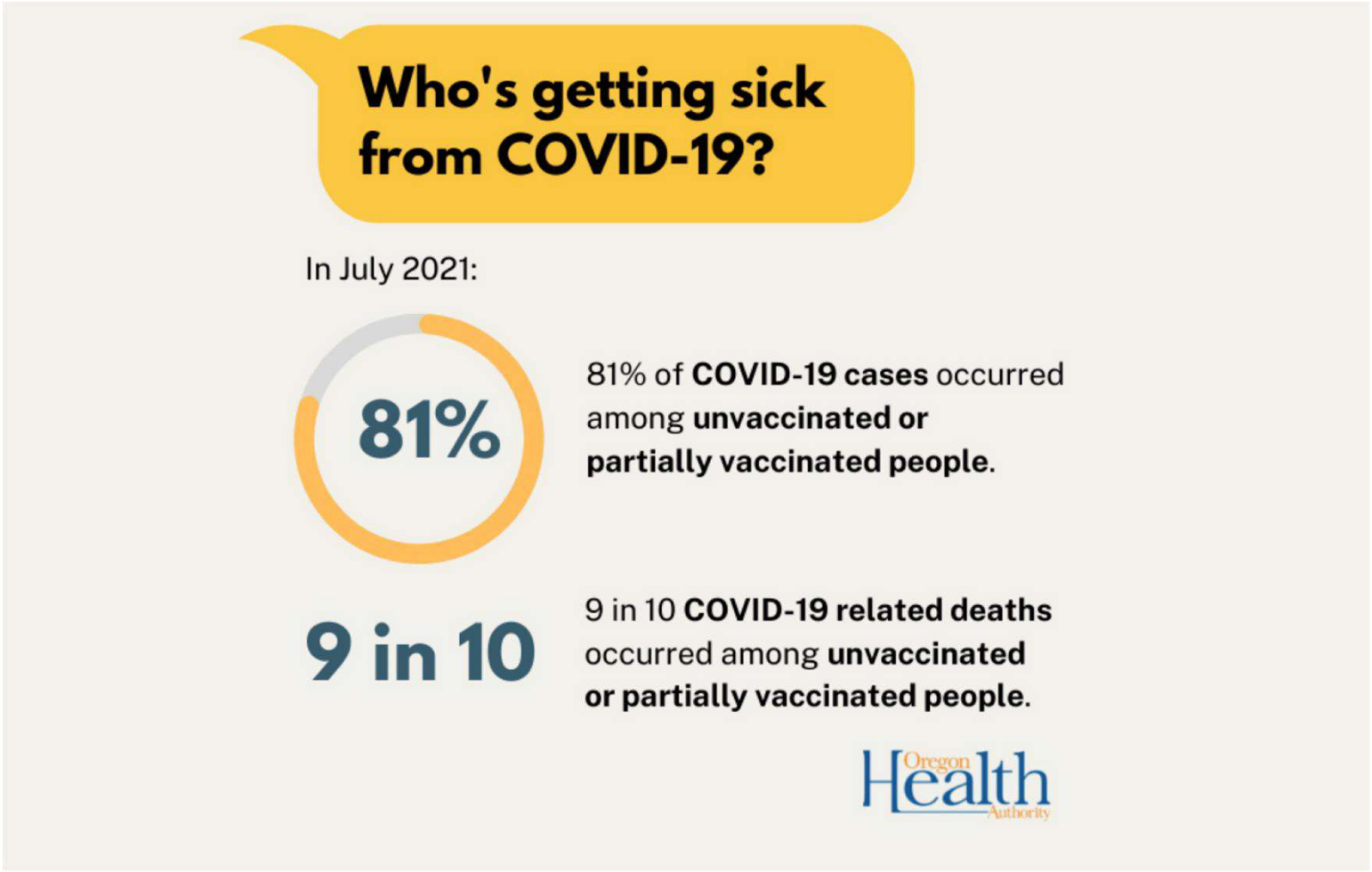


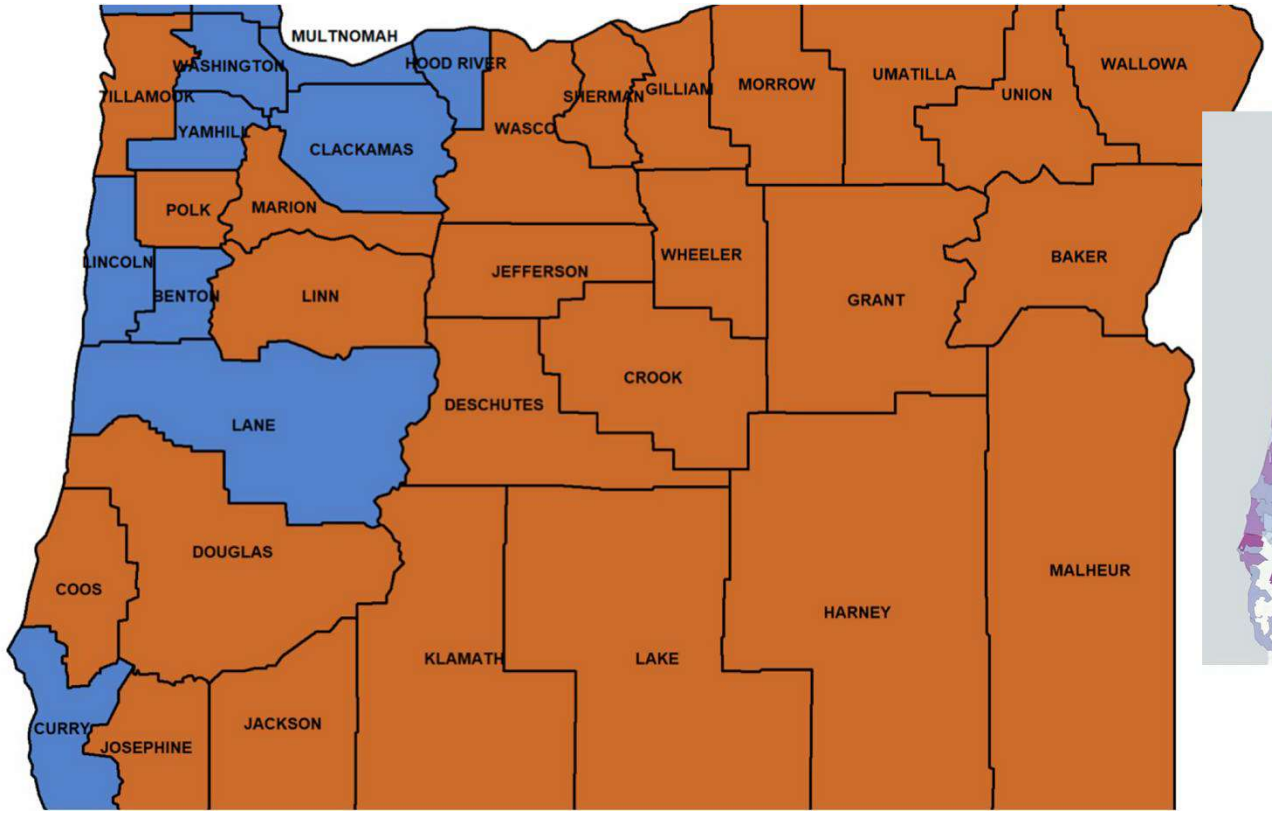

Hospital And Clinics
Hospitals
Clinics
Kennewick
Portland
Salem
Eugene
OREGON
Caldwell
Crater Lake
National Park
Medford
Redwood

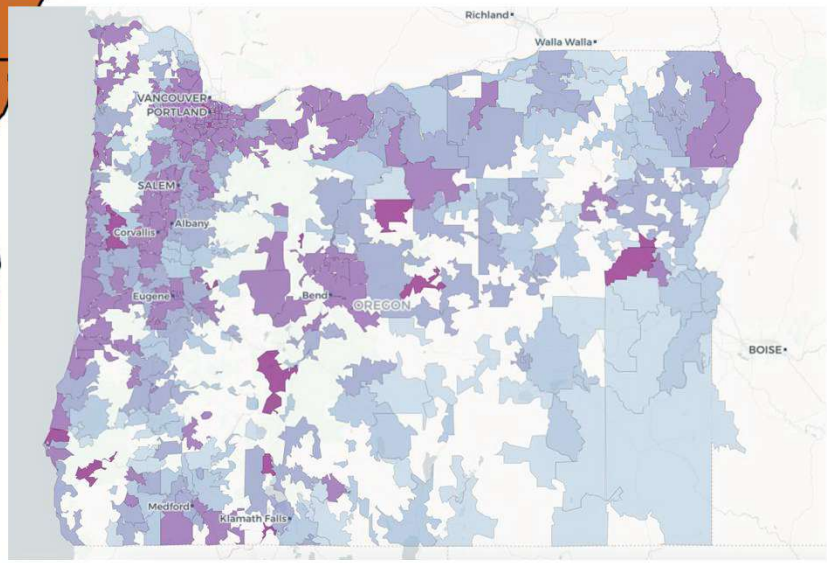
2021 COVID Vaccination Rates



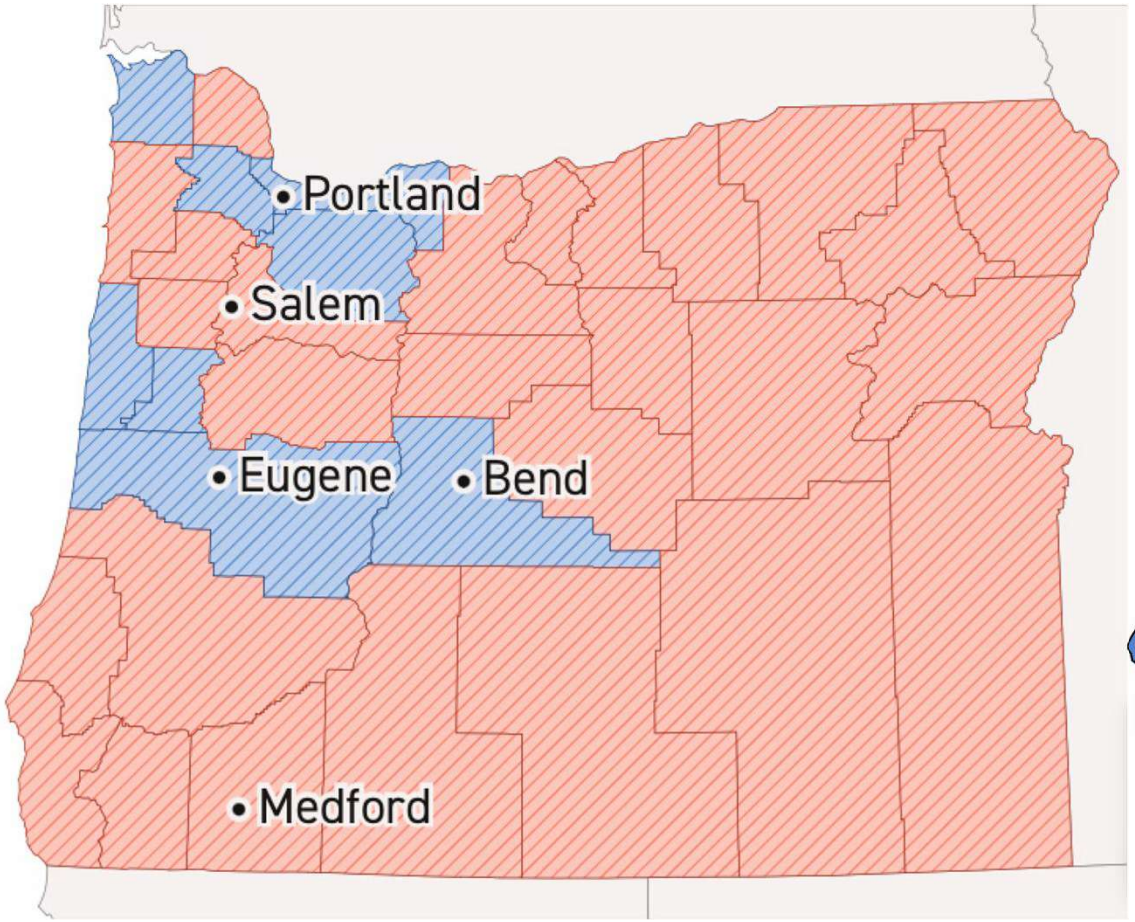



Who's getting sick from COVID-19?
In July 2021:
81%
81% of COVID-19 cases occurred among unvaccinated or partially vaccinated people.
9 in 10
9 in 10 COVID-19 related deaths occurred among unvaccinated or partially vaccinated people.
Oregon Health Authority

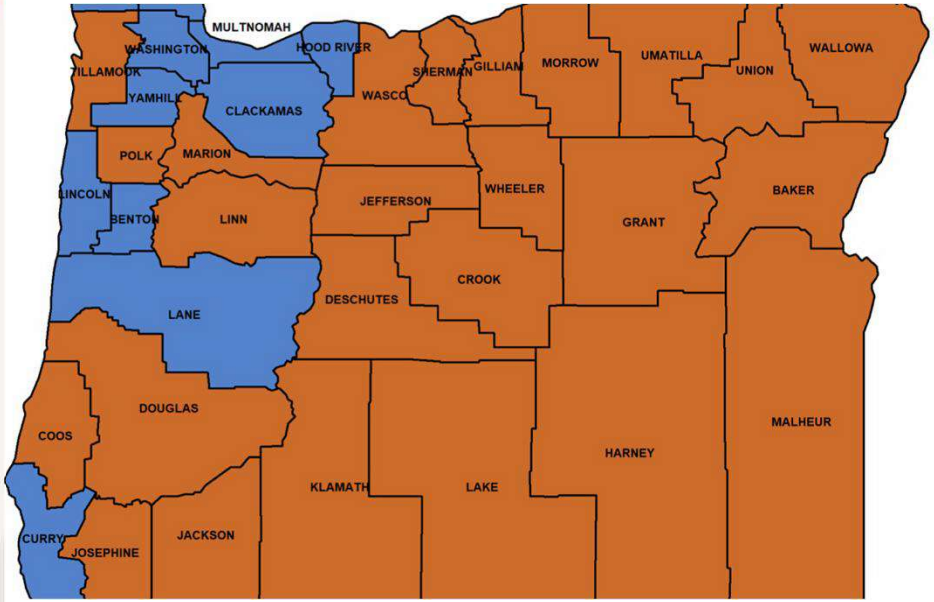




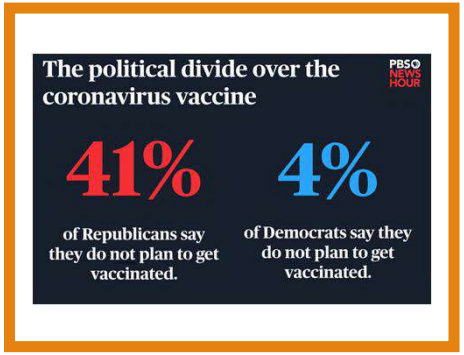
2021 COVID Rates by County (Blue = Low)

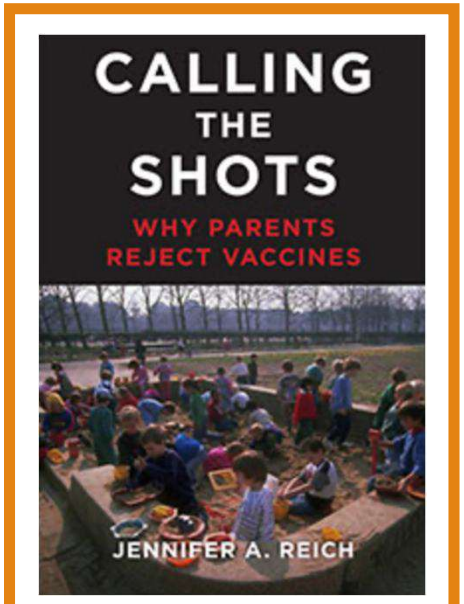


2021 COVID Infections



2024 Presidential Election





Many Oregonians explicitly reject rhetoric and priorities of CSC Guidelines:

-- DEI
-- Medical credibility
-- Public health strategies

THESE OREGONIANS WILL BE PATIENTS IN THE NEXT PANDEMIC.

Antivax Protests 2021

On our current trajectory…

PREPARE HOSPITALS AND HEALTHCARE WORKERS TO BRACE FOR BACKLASH

Prepare for the next pandemic by promoting social cohesion.

Promote	Promote hospital cooperation
Share	Share state and regional resources
Include	Include rural stakeholder input
Bridge	Bridge the divide

Questions?

Thank You!