

ED Triage Officer

Description of Duties

PRIMARY CONCEPTS

- You **MUST** understand details of the *COVID19 Allocation of Scarce Resources Addendum*
- Be familiar with the Arizona Crisis Standards of Care, 3rd Edition (AZ CSC)
- If scarce resources are medically indicated, patients must be asked first if their goals include use of scarce resources OR NOT (ordinarily this will be done by the primary/secondary triage or treating teams and must be clearly documented)
- Scarce resources at this time are primarily vents and ICU beds
- If a patient doesn't get a scarce resource they **do not automatically go to comfort care; comfort care is a choice for patients who want comfort care**
- Triage is to "optimal treatment" vs "best currently available treatment". It is true that it can (we hope rarely) be "live vs die" triage. That is never the intent; always use the best resources available consistent with patient wishes
- Every patient who wants/needs aggressive treatment is allocated as many needed resources as we have available according to triage priority score
- Only scarce/unavailable resources are triaged

What you would do if triage is activated

- Know that EVERYTHING will be fluid and rapidly changing
- You will be the link between your facility and system triage resources
- Know your ED resources/bedboard in real time
- Be aware of your ED patient priority scores
- Liaison with Tertiary Triage Officer regarding current resource availability
- Communicate with BHTS about whether/when transfers are possible involving your facility.
- Staffing awareness
- Because "standard of care" is now "crisis standards" – you do what you can with what you have, (activation of CSC includes liability shields)
- Be in close communication with your facility Clinical Care Committee (CCC) and Tertiary Triage Officer
- Communicate a hard decision to the ED treating physician when PEG-T confirms

Calling the PEG-T: General Info:

- PEG-T: "Pandemic Ethical Guidelines Team"; their task is to interpret protocols strictly and take responsibility for hard decisions
- They are NOT an ethics consult service
- They can help with general questions about triage protocol - IF no one else can answer

- Remember there are only two of them taking first call
- Available 24/7 when triage is active
- By the time you call for a decision your facility should have exhausted every possible avenue to a) get more of whatever you need or b) get the patient to whoever has the resource.
- You ONLY call the PEG-T for a decision when your facility is totally out of options

Calling the PEG-T for a Decision:

- Call as early as possible if you see a decision looming
- Your call will be to the PEG-ICU doc (Not the e-ICU. PEG-ICU is a non-treating intensivist doing only triage calls for the PEG-T – there will be a dedicated phone number for this service).
- If the PEG-ICU cannot answer the question/dilemma easily he will contact the rest of the PEG-T and get back to you with a decision.
- Articulate your dilemma - for example:
 - one resource left, two patients in need
 - five resources left, 8 patients in need
- Be able to report the triage SCORES of the eligible patients, for example
 - One resource, two patients, triage scores are 3 and 8
- If the triage scores are identical, know the tie breaker criteria in the following order to compare eligible patients:
 - Under 18?
 - HCW or frontline responder?
 - The sole caretaker for dependent minor or adult?
 - Pregnant?
 - Chance to experience life stages? (not solely related to chronological age)
 - The PEG-T can help interpret these criteria: some judgment may be required with treating doc, TTO, and PEG-T collaborating
- DO NOT report the following information to the PEG-T: age, disability status, race, ethnicity, religion, sex, gender, judgment about quality of life, national origin, insurance status, veteran status, genetic information, name.
- PEG-T decisions will be made strictly following the criteria: SOFA score + short term prognosis (1 or 5 years if survives acute episode) – they are not allowed to deviate
- Home ventilators will NEVER be reallocated as indicated in the COVID19 Addendum:

When a chronically ventilated patient with their own ventilator is admitted, they will continue to be ventilated using that ventilator which is considered to be their personal property. While ventilated by their own ventilator, patients will be exempt from the triage process. Under no circumstances will a patient's home ventilator be "reallocated" to another patient. This is likewise true of other durable medical equipment that belongs to a patient.

However, if a chronically ventilated patient's respiratory status changes and they need to be ventilated with a new ventilator provided by the hospital, the patient will be included for assessment and resource allocation if a triage protocol is in place for

crisis standards of care. If this occurs, that patient's home ventilator remains personal property and will not be subject to involuntary reallocation.

- Once the PEG-T reaches a final decision and informs, supply the last name and MRN number of all the patients considered in the decision (both those who do and do not receive a resource) to the PEG-T, so a templated note can be entered in each chart
- The templated note will include one of the following decisions:
 - The decision that **aggressive treatment may proceed** for this patient was made by the centralized PEG-T in accordance with the CSC-COVID19 specifically because this patient has a higher Triage Priority Score than other currently waiting patients.
 - The decision that *admission to the hospital/admission to the ICU/access to a ventilator* **cannot be allocated** to this patient was made by the centralized PEG-T in accordance with the CSC-COVID19 specifically because another patient with a higher priority score is expected to survive if given access to the resource, and there are currently not enough resources for both patients.
 - The decision to **withdraw** a life-sustaining resource from this patient was made by the centralized PEG-T in accordance with the CSC-COVID19 specifically because a) despite receiving this resource for an adequate interval, this patient has the lowest priority score of patients using the resource and b) a waiting patient with a higher priority score is expected to survive if given access to the resource and c) no other such resource is currently available for the waiting patient

What you might need to do

- Select EMR the 5/1 year prognosis drop down menu if not done previously
- Interface between PEG-T and frontline providers as required

What you do NOT do

- You CANNOT BE TREATING any patients who might be triaged
- Supply any extraneous information to the PEG-T: supply scores and “tie-breaker” criteria ONLY
- The actual scoring: SOFA, triage scores
- Make the tough decisions
- Tell families/patients the tough decisions
- Write orders for withdraw/withhold