Pandemic Triage Team
July 4, 2020

Tertiary Triage Officers (TTO) 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 facility resources/bedboard in real time: vents and ICU beds most important
- Be aware of your patient priority scores – mostly ICU
- Know which patients are using a scarce resource AND now have high triage number scores (meaning lower priority for resources)
- You will always try to match highest priority patients with available resources
- Be aware of system resources generally – are there any vents? Any transfers happening?
- Communicate with BHTS about whether/when transfers are possible involving your facility.
- Staffing – be aware that under CSC there are literally no limits on staffing ratios
- 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 ED, primary/secondary triage/COO/CMO/CNO. (CCC = "incident command" in AZ CSC)
- Communicate a hard decision to the treating physician when PEG-T tells you

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
- There are three primary reasons to contact the PEG-T:

    - To clarify questions regarding the triage process (IF no one else can answer)
    - To approve the involuntary and medically suboptimal withholding of any treatment resource(s) from an existing patient, based on the triage process
    - To approve the involuntary and medically suboptimal removal of any treatment resource(s) from an existing patient for use in an alternate patient, based on the triage process
- 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
- Be able to discuss the scores over time if there is a patient who might be eligible for reallocation
- 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 ventilator 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 in the ventilator triage and resource allocation process (if active) for the hospital ventilator. 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 <u>all</u> 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 <u>and</u> b) a waiting patient with a higher priority score is expected to survive if given access to the resource <u>and</u> c) no other such resource is currently available for the waiting patient

<u>What you might need to do</u>

- Select EMR the 5/1 year prognosis drop down menu if not done previously
- Change drop down 1 year prognosis if an in house catastrophe occurs to give the patient one of the diagnoses and treating team doesn't make the change in the EMR
- Liaise between PEG-T and frontline providers – if they are swamped

<u>What you do NOT do</u>

- 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