1) **Triage is not always "life or death**" and shouldn't be characterized this way; it is "best option" vs "other option". We recognize sometimes triage means life or death, but in medical triage (unlike mass casualty) life vs death is less common than "best" vs "less than best".
2) **EVEN if** a patient has a resource **withdrawn or withheld**, we are still going to **give them <u>everything</u> we do have**; we all know that some patients who refuse intubation will, in fact, survive with something less (hi-flo, bi-Pap, etc)
3) **Playbook coming** early this week with details. Our intention is to do absolutely as much for facilities/CMOs as possible. Most triage work is at the **facility level**
4) The tertiary triage officer (TO) **CANNOT be a <u>treating</u>** clinician; so while a physician is best per CSC Job Description attached – consider who has the skills: house sups, RN with triage experience, employees who were in the military and know triage, MDCC?
5) The triage scoring will be **as automated as possible**
    - SOFA scores will be done by the EMR
    - There will be a drop-down menu so someone (likely the admitter) will choose "one year prognosis" or "five year prognosis" if this is known
    - We equate one-year prognosis to "hospice eligible" because hospice criteria are clear and "six months prognosis" will have to suffice; criteria will be provided
    - Five-year prognosis will be harder, we will have tables and pall med available by phone – some amount of judgment will be required
    - The drop down (one year/five year) usually won't change – unless a "one year" condition develops – catastrophic stroke, etc
    - If the one year/five year did not get entered, the **tertiary TO might have to** do it. The admitter might not have the info needed at time of admission.
    - Triage score generated by EMR daily, shows up daily and can be graphed over time
    - **Scoring is primarily for ICU patients**, as that is the cohort needing resources, or from whom resources might have to be re-allocated
    - Will have EMR generated triage scores for very sick ED patients, maybe worsening floor patients
6) **Local resource awareness** is available the same way it is available now. Local bedboard (primary concern is vents).
7) **<u>System</u> awareness of resources and triage scores** –
    - Unclear how "real time" those reports will be
    - Match up highest priority patients with available resources – across the State; BUT the State has already said – that's not possible do between health systems.
    - So backup hope would be to **match highest priority patients in Banner with available resources** in Banner
    - In that "supreme emergency" (- Churchill's words) every facility **will do the best it can with plans and protocols we are creating now**
8) If we get to the worst-case scenario
    - Some patients eligible for resource "reallocation" would be so ill families would **choose to withdraw** before we had to reallocate against their wishes – pall med and communications teams will be essential
    - The **burden of proof to REMOVE**/reallocate a vent **is much higher** than to NOT have one (withhold due to lack). We normally consider the concepts of withdraw and withhold to be ethically equivalent – but that is when consent is given, which is NOT the case in triage.
    - ALL patients are eligible for triage, not just COVID

- **Triage** would be **transparent** (we will tell families in advance this could happen), **public** (begging for resources however we must – VP Pence just promised AZ would "have everything it needs and never have to triage"), **accountable** (we will review decisions every single day), **consistent** (protocol followed without deviation), **accurate** (appeals mechanism present in case score is wrongly calculated), **responsible** (note goes in every chart considered for withhold or withdraw – notes explains the emergency, reality of triage, and gives one of the three possible decisions:
    1. this patient GETS the resource
    2. this patient does NOT get a resource because we don't have one to give
    3. this patient loses a resource because another patient with a far better score will die right now without it) and **non-discriminatory**.
- These decisions will mostly not be rapid – this isn't mass casualty triage where people are bleeding to death. We have some time to think carefully – even if somebody is being bagged while we do it; ICU docs always roughly know the degree of priority in their units – "who can go to the floor", etc.
- There would be **no code beds**, and in triage there would likely **not be codes**. Even if you got ROSC, with no vent or ICU bed, what would you do next?

9) **Staffing ratios** in a "supreme emergency" simply **wouldn't be maintained**. One nurse for 2 patients might be best; 1 nurse for 20 is better than no nurse at all. 1 intensivist for 100 patients is better than no intensivists. And there is now legal coverage for that (see below)
    - The State may start doing front end triage based on triage priority scores (Banner will be attending that meeting this week)
10) **Activation of the CSC is vital for liability protection when activated**. It literally means the normal "standard of care" is gone. The "new" standard is "do the best you can with what you have. Anything is better than nothing." If mistakes are made because you have too many patients, CSC allows coverage. Legal will be releasing a strongly worded statement reassuring caregivers of all kinds that Banner – and the State – is backing them.
11) Lessons from Italy and New York (not criticisms – but we want to use what they learned)
    - We should be conscious of normal futility, so ICUs don't fill with cases that are futile anyway
    - CSC activation important - without that – we are held to "normal standards" (the lawsuits are already starting in NYC)
    - Bad things happen when a hospital is overrun whether or not you say you are triaging; triage can't be hidden and when done wrong is awful (NY news reports) – it's got to be managed actively
    - Coordination is everything in preventing need to triage (BHTS and the Surge Line); NYC had overrun hospitals and others close by with resources
    - Health systems regionally must cooperate – Lombardy, Italy was largely on its own. NYC systems did not cooperate well early on. AZ is collaborating and cooperating
    - Triage protocols ought to be standardized regionally – AZ has accomplished this (decreases doctor shopping)