

## Crisis Standards of Care: State of Arizona Clinical Workgroup

Arizona Dept of Health Services & Partners  
Phoenix, AZ  
July 17, 2013

Facilitator  
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- Josh Gaither, MD & Dan Beskind, MD
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## Acknowledgements

- Thank you!
  - To all members of the State of Arizona Clinical Workgroup for Crisis Standards of Care, for your
    - Time
    - Dedication
    - Service
    - Expertise
- Resource Materials
  - State of Arizona Crisis Standards of Care Web Page
    - <http://1.usa.gov/148dOtS>

*URL is case sensitive*

## Crisis Standards of Care: State of Arizona Clinical Workgroup

- **Agenda for July 17, 2013**
  - **1430-1440**
    - Introductions
  - **1440-1445**
    - IOM crisis standards of care (CSC)
  - **1445-1500**
    - Recommend activation criteria for CSC
      - Vote on State of Arizona CSC triggers
      - Vote on facility CSC triggers
  - **1500-1600**
    - Recommend primary, secondary, & tertiary triage methods for limited healthcare resources
      - Vote on prehospital primary triage method(s)
      - Vote on hospital/healthcare facility primary triage method(s)
      - Vote on hospital/healthcare facility secondary triage method(s)
      - Vote on hospital/healthcare facility tertiary triage method(s)

## Crisis Standards of Care: State of Arizona Clinical Workgroup

- **Objectives for July 17, 2013**
  - Recommend **activation criteria** for crisis standards of care (CSC)
  - Recommend **primary, secondary, & tertiary triage methods** for limited healthcare resources
    - Using evidence-based guidelines when possible

### Arizona CSC Approved by SDMAC Planning Committee 6/27/13

<b>Desired Future State</b>	Develop and implement a compassionate, ethically-based healthcare response for catastrophic disasters, using crisis standards of care (CSC) co-developed by key stakeholders.
<b>Vision</b>	Arizona will become a national model in CSC planning and implementation by February, 2014.
<b>Mission</b>	Provide framework and standards for response to and recovery from catastrophic disasters, enabling optimal community resilience for the healthcare system, statewide.
<b>Values</b>	<p><b>Transparency:</b> Provide open, honest, factual and timely communication and information sharing.</p> <p><b>Consistency:</b> Implement processes and procedures across the continuum of care; applying the same methodologies to achieve optimal community health.</p> <p><b>Fairness:</b> Support respect and dignity for all populations when providing healthcare across the continuum of care.</p> <p><b>Accountability:</b> Take responsibility for actions, complete work assigned, follow through on requests and communications.</p> <p><b>Resiliency:</b> Provide for the recovery of emotional, spiritual, intellectual and mental health needs and facilitate the well-being of the community.</p> <p><b>Evidence-based:</b> Formulate decisions on medically founded, state-of-the-art, and research tested (when available) facts and processes to promote optimal community health.</p>

## Presentation Outline

- IOM crisis standards of care (CSC)
- Activation criteria for CSC
- Triage systems for CSC

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## IOM Crisis Standards of Care

- Seek community & provider **engagement** preparing for & during CSC
- Adhere to **ethical norms** during CSC
- Provide necessary **legal protections** for healthcare providers & institutions using CSC
- Ensure intrastate & interstate **consistency** during CSC
  - Clear indicators, triggers, & lines of responsibility
  - Evidence-based clinical processes & operations

## IOM Crisis Standards of Care

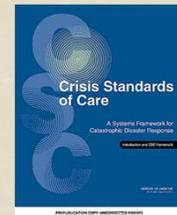
- Substantial change in usual healthcare operations & level of care
- Justified by specific circumstances
- Formally declared by state government
  - Scope
    - $\geq$  Statewide
  - May authorize
    - Alternate care sites
    - Alternate staffing levels
    - Expanded scopes of practice
- Long-term crisis



## IOM Crisis Standards of Care 2012 Systems Framework for Catastrophic Disaster Response

### – Systems

- Governments
  - Local
  - State & Territorial
  - Tribal Nations
  - Federal
- Health systems
  - EMS
  - Hospitals & other healthcare facilities
  - Alternate care systems
    - Out-of-hospital
  - Public Health & Public Engagement



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## IOM CSC:

### Catastrophic Disaster Attributes

- Most or all of community's infrastructure impacted
- Local officials unable to perform usual roles for extended period
- Most or all routine community functions immediately & simultaneously disrupted
- Surrounding communities similarly impacted
  - Therefore, no regional resources



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## IOM CSC: 3 Cs

- **Conventional care**
  - Space, staff, & stuff (supplies) [3Ss] in daily practice
- **Contingency care**
  - 3Ss not used in daily practice
    - Functionally equivalent patient care
  - Patient care areas repurposed
  - Elective procedures & admissions deferred
  - Expanded staff responsibilities
  - Conserve, adapt, & substitute supplies
  - Safely re-use select supplies
- **Crisis care**
  - Adaptive 3Ss not used in daily practice
  - Best possible care in difficult circumstances with limited resources

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### Presentation Outline

- IOM crisis standards of care (CSC)
- **Activation criteria for CSC**
- Triage systems for CSC

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### IOM Catastrophic Conditions: Possible State of Arizona CSC Triggers for Discussion & Vote by CSC Clinical Workgroup

- Resources for healthcare facilities & agencies
  - Unavailable
  - Undeliverable
- Multiple healthcare facilities & agencies similarly impacted
  - Patient transfer not possible
    - ≥ Short-term
- Limited access to medical countermeasures
- Supply caches already distributed
  - No short-term resupply
- State Declaration of Emergency

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### Vote

What is your level of agreement with the CSC Clinical Workgroup proposed State of Arizona CSC triggers:

1) A State Declaration of Emergency  
plus  
2) Any one of the following:

- Resources for healthcare facilities & agencies
  - Unavailable
  - Undeliverable
- Multiple healthcare facilities & agencies similarly impacted
  - Patient transfer not possible
    - ≥ Short-term
- Limited access to medical countermeasures
- Supply caches already distributed
  - No short-term resupply

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### Vote Result

by State of Arizona CSC Clinical Workgroup for this question:  
What is your level of agreement with the CSC Clinical Workgroup proposed State of Arizona CSC triggers:

1) A State Declaration of Emergency  
plus  
2) Any one of the other proposed criteria on last slide?

- A. Strongly Agree (38%)
- B. Agree (43%)
- C. Neutral (5%)
- D. Disagree (10%)
- E. Strongly Disagree (5%)

Response	Percentage
Strongly Agree	38%
Agree	43%
Neutral	5%
Disagree	10%
Strongly Disagree	5%

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### IOM Catastrophic Conditions: Possible Healthcare Facility CSC Triggers for Discussion & Vote by CSC Workgroup

- **Space**
  - Healthcare facilities
    - Need non-patient care areas for patient care
    - Damaged
    - Unsafe
- **Staff**
  - Trained staff unavailable or unable to care for volume of patients at healthcare facility
- **Stuff**
  - Critical items lacking at healthcare facility
  - Possible reallocation of life-sustaining resources at facility

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### Vote

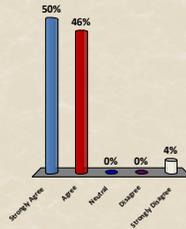
What is your level of agreement with the CSC Clinical Workgroup proposal that a healthcare facility must meet at least 1 of the 3 following proposed CSC triggers to decide to trigger CSC at that facility?

- **Space**
  - Healthcare facilities
    - Need non-patient care areas for patient care
    - Damaged
    - Unsafe
- **Staff**
  - Trained staff unavailable or unable to care for volume of patients at healthcare facility
- **Stuff**
  - Critical items lacking at healthcare facility
  - Possible reallocation of life-sustaining resources at facility

### Vote Result

by State of Arizona CSC Clinical Workgroup for this question:  
What is your level of agreement with the CSC Clinical Workgroup proposal that a healthcare facility must meet at least 1 of the 3 proposed CSC triggers on the previous slide to decide to trigger CSC at that facility?

- A. Strongly Agree (50%)
- B. Agree (46%)
- C. Neutral (0%)
- D. Disagree (0%)
- E. Strongly Disagree (4%)



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### Presentation Outline

- IOM crisis standards of care (CSC)
- Activation criteria for CSC
- Triage systems for CSC

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### Triage

- French verb "trier" = "to sort"
- Do the greatest good for the greatest number
  - With limited resources
- Dynamic
  - Reassess
  - Reprioritize
- 3 types
  - Primary
  - Secondary
  - Tertiary



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### IOM CSC: Triage

- **Primary triage**
  - 1<sup>st</sup> assessment
  - Prior to medical interventions
  - EMS
    - START, etc.
    - Alternate Triage, Treatment, & Transport Guidelines for Pandemic Influenza
      - [http://www.azdhs.gov/diro/admin\\_rules/guidancedocs/GD-PANFLU.pdf](http://www.azdhs.gov/diro/admin_rules/guidancedocs/GD-PANFLU.pdf)
  - Hospital Emergency Department (ED)
    - Level 1-5, normally
    - START, etc. in disaster

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### IOM 2012: CSC Triage

- **Secondary triage**
  - After 1<sup>st</sup> assessment & diagnostics
  - After *initial* medical interventions
  - Hospital surgeons, etc.
    - Determine priority for OR or CT
- **Tertiary triage**
  - After *definitive* diagnostics
  - After *significant* medical interventions
  - Hospital intensivists, etc.
    - Determine priority for ICU

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### Primary Triage Systems

- MASS (Move, Assess, Sort, & Send)
- START (Simple Triage & Rapid Treatment)
  - Both above use **IDME** mnemonic
- JumpSTART<sup>®</sup> for kids
  - Uses **IDMD** mnemonic
- SALT (Sort, Assess, Lifesaving Treatment)
  - Uses **IDMED** mnemonic
- FDNY
- CareFlight
- Sacco or unadjusted Sacco

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## Primary Triage IDME Mnemonic

- **I**mmEDIATE = **RED**
  - Life-threatening injury or illness
  - Lifesaving interventions (LSI)
  - 1<sup>st</sup> to treat
- **D**elayed = **YELLOW**
  - Serious, but not life-threatening
  - Delaying treatment will not affect outcome
  - 2<sup>nd</sup> to treat
- **M**inimal = **GREEN**
  - Walking wounded
  - 3<sup>rd</sup> to treat
- **E**xpectant = **BLACK**
  - Palliative care, unless new resources allow triage upgrade

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## Primary Triage Immediate

- Immediately life-threatening
- High potential for survival
- Examples
  - Airway obstruction
  - Cervical spinal cord injury
  - Tension pneumothorax
  - Exsanguinating hemorrhage
  - Severe nerve agent poisoning



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## Primary Triage Delayed

- Serious injury, but
  - Delaying treatment will not affect outcome
- Examples
  - Complicated fractures
    - Open or
    - Need surgery
  - Paraplegia



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## Primary Triage Minimal

- Abrasions
- Uncomplicated fractures
  - Closed
  - Do not need surgery
- Mild nerve agent poisoning
  - Eye signs & symptoms only



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## Primary Triage Expectant Expectant (SALT)

- Unlikely to survive
  - Very large total body surface area (TBSA) burns
    - 2<sup>nd</sup>, 3<sup>rd</sup>, & 4<sup>th</sup> degree
- Expectant does not mean no care
  - Do the best with what we have

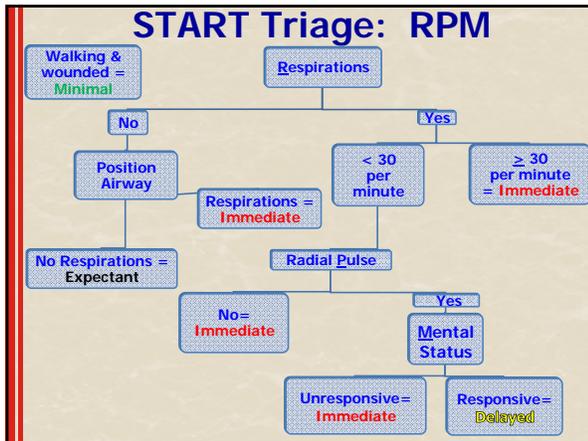


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## Primary Triage Dead = Deceased

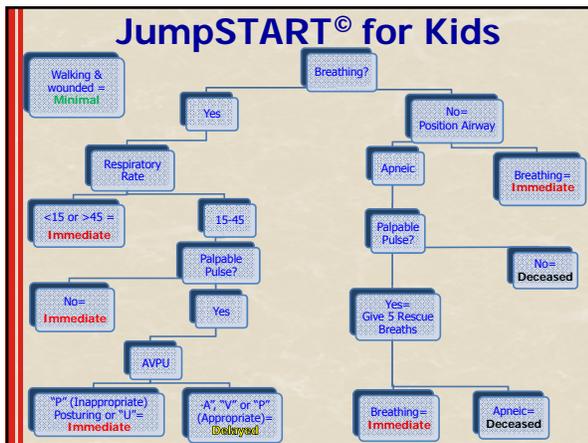
- Not breathing after
  - Opening airway
  - Rescue breaths in kids
    - SALT
      - Consider 2 rescue breaths
    - JumpSTART®
      - If pulse present, give 5 rescue breaths, after positioning airway

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### JumpSTART® for Kids

- Pediatric triage system
  - Use JumpSTART® if patient looks like a child
    - Ages 1-8 years
  - Use START if patient looks like an adult
- Physiologic decision points (RPM) with pediatric values



### Which primary triage system is best?

- Little evidence
- Use system adopted for your area

### Does START triage work?

- *Annals of Emergency Medicine* 2009;54(3):424-430.
  - START evaluated for train crash
  - Compared field & retrospective, outcomes-based triage categories for 148 patients sent to 14 hospitals

### Does START Triage Work?

IDME	Field (n)	Outcomes-Based (n)
Immediate/Red	22	2
Delayed/Yellow	68	26
Minimal/Green	58	120
Expectant/Black	0	0
<b>Total</b>	<b>148</b>	<b>148</b>

Annals of Emergency Medicine 2009;54(3):424-430.

## Does START Triage Work? Conclusions

- **START**
  - Substantial over-triage
  - Acceptable under-triage
- **Over-triage**
  - Human nature not to abandon others

*Annals of Emergency Medicine* 2009;54(3):424-430.

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## START vs. Other Triage Methods

- *Annals of Emergency Medicine*
  - June 2013;61(6):668-676.
  - National Trauma Data Bank
    - N= 530,695
    - Adult, pediatric, & geriatric patients
  - Primary endpoint = hospital mortality
  - No system clearly clinically superior
    - Study unlikely to change practice

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## Systematic Review: Managing & Allocating Scarce Resources During MCE

- *Annals of Emergency Medicine*
  - June 2013;61(6):677-689.
    - Systematic review analyzed 74 studies
  - Points of dispensing (PODs) work for biological incidents
  - No clearly, clinically superior primary (field) triage method
  - Insufficient number of studies for conclusions on secondary triage, etc.

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## Primary Triage

### ▪ Emergency Department (ED) Triage

- **Level 1: Resuscitation**
  - Requires immediate lifesaving intervention
- **Level 2: Emergent**
  - Time critical, high risk condition or vital signs predict rapid decline if not treated quickly
- **Level 3: Urgent**
  - Requires ≥ 2 resources to properly diagnose & treat, e.g., abdominal pain requiring lab, CT, or ultrasound
- **Level 4: Less urgent**
  - Requires 1 resource to properly diagnose or treat, e.g., x-ray or suturing
- **Level 5: Nonurgent**
  - Requires no resources other than evaluation & treatment by physician, e.g., prescription refill

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## Vote

What is your preferred prehospital, primary triage method(s), based on the CSC Clinical Workgroup proposal to choose among the following, with the caveat that the CSC Clinical Workgroup would like the option to modify its recommendation as additional evidence-based guidance is published regarding other primary triage methods, such as SALT, etc.?

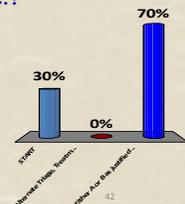
- A. START for adults or JumpSTART® for children
- B. Alternate Triage, Treatment, & Transport Guidelines for Pandemic Influenza
- C. Either A or B as justified by specific circumstances

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## Vote Result

What is your preferred prehospital, primary triage method(s), based on the CSC Clinical Workgroup proposal to choose among the following, with the caveat that the CSC Clinical Workgroup would like the option to modify its recommendation as additional evidence-based guidance is published regarding other primary triage methods, such as SALT, etc.?

- A. START for adults or JumpSTART® for children (30%)
- B. Alternate Triage, Treatment, & Transport Guidelines for Pandemic Influenza (0%)
- C. Either A or B as justified by specific circumstances (70%)



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### Vote

What is your preferred hospital/healthcare facility, primary triage method(s), based on the CSC Clinical Workgroup proposal to choose among the following, with the caveat that the CSC Clinical Workgroup would like the option to modify its recommendation as additional evidence-based guidance is published regarding other primary triage methods, such as SALT, etc.?

- A. START for adults or JumpSTART® for children
- B. Emergency department triage levels 1 - 5
- C. Either A or B as justified by specific circumstances

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### Vote Result

What is your preferred hospital/healthcare facility, primary triage method(s), based on the CSC Clinical Workgroup proposal to choose among the following, with the caveat that the CSC Clinical Workgroup would like the option to modify its recommendation as additional evidence-based guidance is published regarding other primary triage methods, such as SALT, etc.?

- A. START for adults or JumpSTART® for children (0%)
- B. Emergency department triage levels 1 - 5 (33%)
- C. Either A or B as justified by specific circumstances (67%)

Option	Percentage
START	0%
Emergency department triage levels 1 - 5	33%
Either A or B as justified by specific circumstances	67%

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### Vote

What is your level of agreement with the CSC Clinical Workgroup proposal that a hospital/healthcare facility have its secondary triage performed by a facility designated physician or surgeon, after initial assessment, diagnostics, & medical interventions, to determine the patient's priority for the OR (procedures) or CT (imaging), etc.?

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### Vote Result

What is your level of agreement with the CSC Clinical Workgroup proposal that a hospital/healthcare facility have its secondary triage performed by a facility designated physician or surgeon, after initial assessment, diagnostics, & medical interventions, to determine the patient's priority for the OR (procedures) or CT (imaging), etc.?

- A. Strongly Agree (50%)
- B. Agree (41%)
- C. Neutral (9%)
- D. Disagree (0%)
- E. Strongly Disagree (0%)

Level of Agreement	Percentage
Strongly Agree	50%
Agree	41%
Neutral	9%
Disagree	0%
Strongly Disagree	0%

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## Tertiary Triage

### RESEARCH

#### Development of a triage protocol for critical care during an influenza pandemic

Michael D. Christian, Laura Hawryluck, Randy S. Wax, Tim Cook, Neil M. Lazar, Margaret S. Herridge, Matthew P. Muller, Douglas R. Gowans, Wendy Fortier, Frederick M. Burkle, Jr.

See related article page 1377

**ABSTRACT**

**Background:** The recent outbreaks of avian influenza (A/H5N1) have placed a renewed emphasis on preparing for an influenza pandemic in humans. Of particular concern in this planning is the allocation of resources, such as ventilators and ambulatory medications, which will likely become scarce during a pandemic.

**Methods:** We applied a collaborative process using best evidence, expert panels, stakeholder consultations and ethical principles to develop a triage protocol for prioritizing access to critical care resources, including mechanical ventilators, during a pandemic.

**Results:** The triage protocol uses the Sequential Organ Failure Assessment score and has 4 main components: inclusion criteria, exclusion criteria, minimum qualifications for survival and a prioritization tool.

**Interpretation:** This protocol is intended to provide guidance for making triage decisions during the initial days to weeks of an influenza pandemic if the critical care system becomes overwhelmed. Although not designed for use during an influenza pandemic, the triage protocol would apply to patients both with and without influenza, since all patients must share a single pool of critical care resources.

**Methods**

In December 2004, at the request of the steering committee of the Ontario Triage Plan for an Influenza Pandemic (OTIP), a group of clinicians with expertise in critical care, in-

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## Tertiary Triage for Critical Care during Influenza Pandemic

### CMAJ 2006; 175(11):1377-1381.

- Determine need for critical care
  - Assess inclusion criteria
  - Assess exclusion criteria
    - If yes, "blue" triage code
      - Do not transfer to critical care
      - Continue current level of care or palliative care
        - Communicating with patient &/or family, etc.
  - Proceed to triage tool (initial SOFA Score)
    - For all patients, not only influenza patients

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### Tertiary Triage for Critical Care during Influenza Pandemic *CMAJ 2006; 175(11):1377-1381.*

**Inclusion criteria**

- Requires ventilator
  - Refractory hypoxemia
    - SpO2 < 90% on nonrebreather reservoir mask or FIO2 > 0.85
  - Respiratory acidosis (pH < 7.2)
  - Clinically impending respiratory failure
  - Unable to protect or maintain airway
    - or
- Hypotension (SBP < 90 mmHg or relative hypotension) with **clinical evidence of shock** (altered LOC, decreased urine output, etc.)
  - Refractory to volume resuscitation
  - Requires vasopressor or inotrope

### Tertiary Triage for Critical Care during Influenza Pandemic *CMAJ 2006; 175(11):1377-1381.*

**Exclusion criteria for ICU**

- Severe trauma
- Severe burns with any 2
  - Age > 60 years
  - > 40% TBSA 2<sup>nd</sup> &/or 3<sup>rd</sup> degree burns
  - Inhalation injury
- Cardiac arrest
  - Unwitnessed
  - Witnessed, not responsive to electrical therapy (defibrillation or pacing)
  - Recurrent
- Severe baseline cognitive impairment
- Advanced untreatable neuromuscular disease
- Severe & irreversible neurologic condition

### Tertiary Triage for Critical Care during Influenza Pandemic *CMAJ 2006; 175(11):1377-1381.*

**Exclusion criteria for ICU**

- Metastatic malignant disease
- Advanced & irreversible immunocompromise
- End-stage heart failure (NYHA class III or IV CHF)
- End-stage pulmonary disease
  - COPD with FEV<sub>1</sub> < 25% predicted or baseline PaO<sub>2</sub> < 55 mm Hg or secondary pulmonary hypertension
  - Cystic fibrosis with post-bronchodilator FEV1 < 30% or baseline PaO<sub>2</sub> < 55 mm Hg
  - Pulmonary fibrosis with VC or TLC < 60% predicted or baseline PaO<sub>2</sub> < 55 mm Hg or secondary pulmonary hypertension
  - Primary pulmonary hypertension with NYHA class III or IV heart failure or right atrial pressure > 10 mm Hg or mean pulmonary arterial pressure > 50 mm Hg
- End-stage liver disease (Child-Pugh score ≥ 7)
- Age > 85 years
- Elective palliative surgery

### Sequential Organ Failure Assessment (SOFA)

Resusc. Component	Variable	0	1	2	3	4
A & B	PaO <sub>2</sub> /FIO <sub>2</sub> (mmHg)	>400	<400	<300	<200	<100
C	Hypotension	Adults: None Children: >70 + (2 X age in years)	Adults: MABP <70 mmHg Children: <70 + (2 X age in years)	Dop <5	Dop >5, Epi <0.1, Norepi <0.1	Dop >15, Epi >0.1, Norepi >0.1
C	Platelets (x 10 <sup>6</sup> /L)	>150	<150	<100	<50	<20
D	GCS	15	13-14	10-12	6-9	<6
E	Creatinine (mg/dL)	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5
E	Bilirubin (mg/dL)	<1.2	1.2-1.9	2.0-5.9	6.0-11.9	>12

### Tertiary Triage for Critical Care during Influenza Pandemic *CMAJ 2006; 175(11):1377-1381.*

Triage code	Criteria	Action or priority
Blue	Exclusion criteria met or SOFA score > 11*	<ul style="list-style-type: none"> <li>• Manage medically</li> <li>• Provide palliative care as needed</li> <li>• Discharge from critical care</li> </ul>
Red	SOFA score ≤ 7 or single-organ failure	Highest priority
Yellow	SOFA score 8-11	Intermediate priority
Green	No significant organ failure	<ul style="list-style-type: none"> <li>• Defer or discharge</li> <li>• Reassess as needed</li> </ul>

Note: SOFA = Sequential Organ-Failure Assessment. \*If an exclusion criterion is met or the SOFA score is > 11 anytime from the initial assessment to 48 hours afterward, change the triage code to Blue and proceed as indicated.

Fig 1: Prioritization tool used in triage protocol for the initial assessment of patients' needs for critical care during an influenza pandemic. See online Appendix 1 for the SOFA scoring criteria and online Appendix 2 for the complete prioritization tool, which includes details on reassessing patients at 48 and 120 hours (appendices are available at [www.cmaj.ca/cgi/content/full/175/11/1377/DC1](http://www.cmaj.ca/cgi/content/full/175/11/1377/DC1)). See Box 2 for exclusion criteria.

### SOFA scores were significantly associated with survival during 2009 H1N1 in Canada

	Survivors (n = 139)	Nonsurvivors (n = 29)	P Value
SOFA score on Day 1, Mean (SD)	6.4 (3.4)	8.4 (3.5)	0.01

Kumar, et al. Critically Ill Patients with 2009 Influenza A(H1N1) Infection in Canada. *JAMA*, Nov. 4, 2009;302(17):1872-1879.

**SOFA scores were significantly associated with survival during 2009 H1N1 in Mexico**

	Survivors (n = 33)	Nonsurvivors (n = 23)	P Value
<b>SOFA score on Day 1, Mean (SD)</b>	6.7 (3.4)	12.3 (3.2)	<0.001

Dominguez-Cherit, et al. Critically Ill Patients with 2009 Influenza A(H1N1) in Mexico. *JAMA*, Nov. 4, 2009;302(17):1880-1887.

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**Vote**

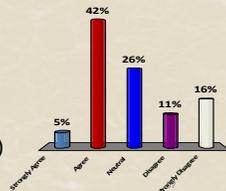
What is your level of agreement with the CSC Clinical Workgroup proposal that a hospital/healthcare facility have its tertiary triage, for initial ICU admission, be based on the inclusion criteria & SOFA scores detailed in this article [*CMAJ* 2006; 175(11):1377-1381. ] & summarized as the CSC Clinical Workgroup proposed in the table below, without using any of the exclusion criteria in this article.

SOFA Triage Color Code	Criteria	Action or Priority
<b>Red</b>	SOFA score $\leq$ 7 or single organ failure	Highest priority for ICU admission
<b>Yellow</b>	SOFA score 8 through 11	Intermediate priority for ICU admission
<b>Blue</b>	SOFA score > 11	Lowest priority for ICU admission Palliative care as needed
<b>Green</b>	No significant organ failure	No need for ICU admission

**Vote**

What is your level of agreement with the CSC Clinical Workgroup proposal that a hospital/healthcare facility have its tertiary triage, for initial ICU admission, be based on the inclusion criteria & SOFA scores detailed in this article [*CMAJ* 2006; 175(11):1377-1381. ] & summarized as the CSC Clinical Workgroup proposed in the table in the previous slide, without using any of the exclusion criteria in this article.

- A. Strongly Agree (5%)
- B. Agree (42%)
- C. Neutral (26%)
- D. Disagree (11%)
- E. Strongly Disagree (16%)



**Crisis Standards of Care: State of Arizona Clinical Workgroup**

- Objectives for July 17, 2013
  - Recommend activation criteria for crisis standards of care (CSC)
  - Recommend primary, secondary, & tertiary triage methods for limited healthcare resources
    - Using evidence-based guidelines when possible

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**Crisis Standards of Care: State of Arizona Clinical Workgroup**

- Objectives for future
  - Recommend method for reporting status of limited space, staff, & supplies (3Ss) at healthcare facility or agency during CSC
  - Recommend expanded scopes of practice for healthcare professionals during CSC

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**Crisis Standards of Care: State of Arizona Clinical Workgroup**

Arizona Dept of Health Services & Partners  
Phoenix, AZ  
July 17, 2013

Facilitator  
Frank G. Walter, MD, FACEP, FACMT, FAACT

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