

## Appendix E: NM Triage Protocol for the Allocation of Scarce Resources Under COVID-19 CSC (Version October 25, 2021)

### **NEW MEXICO TRIAGE PROTOCOL FOR THE ALLOCATION OF VENTILATORS UNDER COVID-19 CRISIS STANDARDS OF CARE**

#### **EXECUTIVE SUMMARY**

Crisis care must be the best care it can be, given the circumstances and available resources. The purpose of this section is to provide triage guidance for critically ill patients in the event that demand for critical resources outstrips the supply.

This protocol (1) establishes that while healthcare providers are always held to a legal standard that requires them to do what reasonable providers would do under the circumstances, those circumstances are now determined by factors unique to the situation, during the current crisis and (2) provides a consistent way in which providers must triage both COVID-19 and non-COVID 19 patients when there are inadequate healthcare resources, like ventilators, to make them available to every patient who needs them. We recognize that this protocol in treating COVID 19 and other patients does not address every circumstance that might occur in a patient care setting. In those instances where the protocol is silent or unclear as to how to address a specific circumstance regarding patient care or the allocation of scarce resources, healthcare facilities and providers and staff should exercise reasonable discretion developing policies and procedures in light of the available resources of their healthcare facility, as directed by their Local Triage Board.

First, we hope that healthcare providers who treat patients under the extraordinary medical circumstances prevailing during this crisis will not be measured by the ordinary standard of care applied in medical malpractice actions, but, rather by a more limited standard that asked only whether the provider's act was grossly negligent or done recklessly or with willful disregard for the health of the patient. Of course, this standard may be legally imposed only by action of the Legislature.

Second, the protocol provides both a procedure and substantive standards for making triage decisions when two or more patients can benefit from treatment, like ventilator care, but when there are inadequate resources to provide the treatment to all who could benefit. The protocol provides for Triage Boards and Triage Officers at each hospital in the state as well as a Statewide Hub Triage Board and Statewide Triage Officers who will address inter-hospital transfers.

This protocol has been updated based on a review by the MAT of literature on CSC and equity. It is designed to help ensure that every patient has equitable access to care, from which they might benefit. These criteria are meant to be clear, transparent, and as objective as possible to minimize inequitable outcomes.

Triage officers will base their triage decisions on priorities determined entirely by the medical attributes of patients and those patients' prognoses with regard to their chance of survival. The protocol does not permit consideration of any other factor, including gender, race, ethnicity, religion, social status, age, education, sexual orientation, physical or mental disability of any kind,

employment status, immigration status, social worth, value to the health care system, existence of dependents, insurance coverage or ability to pay for treatment, all of which are ethically irrelevant to making allocation decisions. It applies only to patients aged 18 and older.

## INTRODUCTION

This Protocol is issued to allow for appropriate medical care of patients with COVID-19, and patients with other medical conditions who require scarce healthcare resources during the declared public health emergency created by the COVID-19 crisis. The purpose of this Protocol is to establish the New Mexico crisis standards of care under these circumstances. All health care providers in New Mexico are bound by the standards provided in this Protocol, which replace the ordinary standards of care during this emergency. These standards will automatically expire at the termination of the current declared emergency.

These crisis standards of care are required because the ethical and legal obligations of all healthcare providers necessarily change during a crisis of this kind and magnitude. Normally, healthcare providers have an obligation to their patients individually, and both law and clinical ethics counsels those providers to offer what is best for their patients, and then to provide the care chosen by their patients. Under the crisis circumstances which are likely to arise in this emergency, there may be times during which certain scarce resources, such as ventilators and intensive care beds, will be in short supply and cannot be provided to all patients who choose that care, and, thus, they cannot be offered to all patients who might benefit from them.

Under these circumstances, providers have an obligation to the public good to do whatever is necessary to save the most lives. This means that patients with a better chance of survival as a result of receiving scarce resources must be given priority for those resources despite other individual patients' choices, and despite the fact that some of those other individual patients would have had a chance to benefit from the scarce resource.

The allocation method for scarce medical resources must be fair, consistent, and transparent. Being fair means that all patients across the State are subject to the same allocation procedures, and that choices are based entirely on clinical considerations. Patients at all geographical locations will be treated equally and patients with COVID-19 and other acute and critical conditions will be treated identically. Being consistent means the same procedure and substantive policies will apply to everyone in the state.

Finally, it is the intent of the publication of this protocol to make it transparent. COVID-19 in New Mexico has disproportionately affected Native American, African American and Hispanic communities as well as at-risk individuals such as those in skilled nursing facilities, detention facilities and essential workplaces. In no case will any allocation decision consider other patient attributes such as gender, race, ethnicity, religion, social status, age, education, sexual orientation, physical or mental disability of any kind, employment status, immigration status, social worth, value to the health care system, existence of dependents, insurance coverage or ability to pay for treatment, all of which are ethically irrelevant to making allocation decisions.

Additionally, part of the CSC is to provide guidance on how to stay in contingency care as long as possible. The following core strategies should be employed to in order to avoid re-allocation as much as possible.

- Prepare - pre-event actions taken to minimize resource scarcity (e.g., stockpiling of medications).
- Substitute - use essentially equivalent device, drug, or personnel for one that would usually be available (e.g., morphine for fentanyl).
- Adapt – use device, drug, or personnel that are not equivalent but that will provide sufficient care (e.g., anesthesia machine for mechanical ventilation).
- Conserve – use less of a resource by lowering dosage or changing utilization practices (e.g., minimizing use of oxygen driven nebulizers to conserve oxygen).
- Re-use – re-use (after appropriate disinfection/sterilization) items that would normally be single-use items.
- Re-allocate – restrict or prioritize use of resources to those patients with a better prognosis or greater need.

Patient care strategies for scarce resource situations are also outlined in *Appendix F. State of New Mexico Department of Health patient care strategies for scarce resource situations*. The strategies of prepare, substitute, adapt, conserve and re-use should be employed including a palliative care consult should be used before getting to reallocation. The Central Call Center (CCC) is therefore critical to helping keep hospitals in contingency care by supporting access to expert consultation, and situational awareness for level loading patients and providing access for patients throughout the state.

## **LEGAL CONSEQUENCES OF ADHERING TO CRISIS STANDARDS OF CARE**

Health care workers providing care during this crisis will often be severely limited when they are making medical decisions. They often will not have access to all of the information that they would normally consider when making healthcare decisions. For example, they may not have access to medical records of those whom they have been asked to triage or provide care, and circumstances may make it impossible for them to talk to their patients' families. In addition, they may be called to triage or treat far more patients than a reasonable provider would under normal circumstances, and they will be asked to triage and treat those patients much more quickly than they normally would.

Thus, it is important to reassure health care providers that their participation in this protocol, with all of its uncertainties, will not expose them to arbitrary liability. The immediate circumstances must be considered when determining whether a provider met the standard of care expected of that provider during a pandemic. These circumstances lie on a continuum that begins when providers enter contingency planning and continue to the point at which crisis standards are in place. Triers of fact are asked to liberally interpret this emergency protocol, recognizing the extreme pressure and extraordinary burden that is imposed upon providers engaged in treating COVID-19 patients.

## **PROCEDURE FOR ALLOCATION AND SUBSTANTIVE**

## PRINCIPLES OF ALLOCATION

### *Creation of Local Triage Boards and Triage Officers*

In preparation for the implementation of the crisis standards of care, each hospital will create a Local Triage Board, which will have the responsibility to ensure that the appropriate triage and allocation policies and procedures are in place, maintain contact with other Triage Boards to facilitate inter-organization collaboration, maintain contact with the state Medical Advisory Team to preserve state-wide consistency in the administration of this protocol, explain the allocation process to community groups, patients and families, and review appeals of decisions to remove patients from scarce resources.

Each hospital will also appoint Triage Officers who will administer the priority scale to patients requiring intensive care, mechanical ventilation, or another scarce resource, determining who will access those resources in a time of scarcity in that hospital. The Triage Officers will also serve to coordinate allocation of ICU beds with the State Triage Hub when bed capacity becomes available to receive additional patients into that hospital. The Triage Officers should be physicians with the clinical expertise necessary to administer the priority scale. Additionally, in order for the triage officers and boards to be credentialed by the state, they need to complete state training requirements. The Triage officers should serve as members of the Local Triage Board.

### *Statewide Capacity Surge Regional Centralized Triage Hub and Medical Command Center, and the Initial Assessment of Patients*

A Statewide Triage Officer at the Statewide Triage Hub (the Statewide “Hub”), established by the Medical Advisory Team, will receive and resolve requests for intensive care services from throughout the state and will assign patients in need of critical care to scarce resources, applying the substantive principles described below. The Statewide Triage Hub will collaborate with the Local Triage Officers to understand the available ICU capacity in each location, to allow them to use the same priority scale to determine which patients will be transferred to access those beds. In order to respond to a surge of patients requiring critical care and access to scarce resources, all providers are required to assist with the sharing of information and evaluation procedures and to facilitate the orderly transfer of patients from regional hospitals.

Prior to making a triage decision, the Local and Statewide Triage Officers will determine whether a patient has an advance directive or a proxy decision-maker, and whether the patient wishes to receive intensive care services, mechanical ventilation or other scarce resources under the circumstances. Additionally, all efforts should be made to ensure the availability of palliative care providers to support family and patient needs and to facilitate more complicated decision making and encourage best practices of palliative care to enhance the comfort of all patients and ensure that care is consistent with patient wishes.

If the patient expresses the wish not to be placed on a ventilator or receive those services, the patient will continue to receive appropriate hospital care, including treatment of any symptoms arising from their condition. Patients and families may choose to receive care focused on symptom management, which could be delivered in the inpatient setting or in the home.

*Substantive Principle Governing Assessing Patients Under This Protocol*

Because patients differ in the severity of their symptoms and in the probability that they will survive the illness episode, when there is a scarcity of resources, some patients should be prioritized over others in order to maximize the usefulness of resources, save as many lives as possible, while reducing inequitable outcomes. Patients’ priority for treatment under this protocol depends upon those patients’ chance of survival. To facilitate that priority decision, the scoring model described below will be used. This model is similar to those developed at the University of Pittsburgh and proposed for use in other medical systems during a crisis of care.

The model assesses a patient’s clinical and functional state and it yields a Priority Score. The initial step uses the Sequential Organ Failure Assessment, SOFA, to assess the patient’s current clinical status, predicting the likelihood of survival from the acute clinical insult itself and the stresses of undergoing critical care and mechanical ventilation.

**Table 1. Scoring Strategy to Allocate Ventilators During a Public Health Emergency**

Specification	Point System*			
	1	2	3	4
Prognosis for short-term survival (SOFA score#)	SOFA score < 6	SOFA score 6-8	SOFA score 9-11	SOFA score ≥12
Prognosis for long-term survival (medical assessment of comorbid conditions)	...	...	...	Severely life-limiting conditions; death likely within 1 year

The Sequential Organ Failure Assessment (SOFA) scale is used to assess current respiratory, cardiovascular, hepatic, coagulation, renal and neurological systems. It returns a score between 0 and 24. The patient’s SOFA score is used to contribute up to four points on the total Priority Score. SOFA scores of <6 receive 1 priority point; 6-8 receive 2 priority points, 9-11 receive 3 priority points, >=12 receive 4 priority points.

Recent evidence points to the potential of SOFA scoring to worsen existing structural inequities. In an effort to mitigate the negative impact of SOFA scoring on people of color who are disproportionately affected by chronic kidney disease (CKD), any patient with CKD will be assigned no more than 2 points in the SOFA score for elevated Creatinine. Additionally, persons with disabilities who experience baseline levels of impairment prior to the acute care episode, should be given reasonable accommodations to not impact upon their SOFA scoring.

The second step in the model is to assess the impact of comorbidities on short term survival. A patient’s short-term prognosis (survival to discharge) and medium-term prognosis (the initial years following the discharge) are strongly influenced by the number and severity of that patient’s severe life-limiting comorbid medical conditions and prior functional status. Comorbidity is assessed using the following clinical criteria:

Table 2. Severely Life Limiting Comorbidities\*

	<b>Severe Life-limiting Comorbidity</b> (commonly associate with poor 1-year survival. approx. 50% 1-year mortality)
<b>Neurocognitive Disorder (Dementia)<sup>12</sup></b>	<ul style="list-style-type: none"> <li>• Diagnosis of Dementia (or similar progressive neurocognitive disorder) and function <math>\geq 7</math> on <a href="#">FAST scale</a></li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• Locally advanced or metastatic cancer <b>AND</b> ECOG status <math>\geq 3</math></li> <li><b>OR</b></li> <li>• Receiving chemotherapy or radiation under palliative protocols</li> <li><b>OR</b></li> <li>• No longer able to receive treatment</li> </ul>
<b>Heart Failure</b>	<ul style="list-style-type: none"> <li>• <a href="#">NYHA Class 4</a> or AHA Stage D</li> </ul>
<b>CAD</b>	<ul style="list-style-type: none"> <li>• Severe Multivessel Coronary Artery Disease (symptomatic, not amenable to treatment)</li> </ul>
<b>Lung Disease</b>	<ul style="list-style-type: none"> <li>• Pulmonary Hypertension (all Groups): WHO Functional Class III or IV</li> <li>• COPD: FEV<sub>1</sub> &lt;20% predicted</li> <li>• Idiopathic Pulmonary Fibrosis with home O<sub>2</sub> use</li> </ul>
<b>Liver Disease</b>	<ul style="list-style-type: none"> <li>• Childs-Pugh Class C <b>OR</b> <a href="#">MELD Score &gt;20</a> and ineligible for transplant</li> </ul>
<b>Other Neurodegenerative Disorder</b>	<ul style="list-style-type: none"> <li>• <a href="#">Advanced Progressive Neurodegenerative Disorder</a>, such as Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Parkinson’s disease</li> </ul>
<p><sup>1</sup> Xie J, Brayne C, Matthews FE; <i>Medical Research Council Cognitive Function and Ageing Study collaborators. Survival times in people with dementia: analysis from population-based cohort study with 14-year follow-up.</i> BMJ. 2008;336(7638):258–262. doi:10.1136/bmj.39433.616678.25</p> <p><sup>2</sup> Reisberg, B. <i>Functional Assessment Staging (FAST).</i> Psychopharmacology Bulletin. 1988;24: 653- 659.</p> <p>*The clinical references made in this table to define the conditions are illustrative; it is understood that at times, all of the normal clinical information may not be available to healthcare providers, and that those providers will interpret these guidelines and apply them to the best of their abilities. The clinical guidelines may be changed or updated, based on the recommendation of the Medical Advisory Team to the Department of Health.</p>	

A patient who has one or more severely life-limiting comorbidity receives a score of 4 points on the Priority Score. Patients who have no major or life-limiting comorbidities score 0 points. A single score of 0 or 4 will be applied to the Priority Score; there is no additive effect from having more than one condition. The scores reflecting symptom severity (the SOFA) (Table 1) and comorbidity (Table 2) are added to create a patient’s Priority Score, which will range from 1 to 8. High scores reflect high severity and low likelihood of survival following intensive medical treatment. Patients with lower scores are thus prioritized to receive available ventilators or other scarce healthcare resources.

For administrative convenience, the scores may also be translated into color- coded priority groups, although it is the Priority Score, not the color code, that determines the ultimate priority.

**Table 3. Assigning Patients to Color-coded Priority Groups**

Use Raw Score from Multi-principle Scoring System to Assign Priority Category	
Level of Priority and Code Color	Priority score from Multi-principle Scoring System
<b>RED</b> Highest priority	Priority score 1-3
<b>ORANGE</b> Intermediate priority (reassess as needed)	Priority score 4-5
<b>YELLOW</b> Lowest priority (reassess as needed)	Priority score 6-8

*Assessment of Patients for Continuation of Treatment*

The decision to allocate a scarce resource to a patient is independent of the decision to maintain a patient on that resource. If the triage decision allocates a ventilator or another scarce resource to a patient, for example, he or she should be given a fair chance to benefit from it. However, not every patient will benefit from a ventilator, and in an emergency, it will not always be ethical to wait until a patient’s clinical state deteriorates to the point that he or she dies while on a ventilator or making use of the scarce resource, if by waiting other patients are denied the possibility of recovery. In addition, there is no legal obligation to provide treatment which is medically ineffective care, that is, treatment that would not offer the patient any significant benefit, as determined by a physician.

*Review of Decisions*

There is no review of the decision of a Triage Officer, at the Statewide Hub or at local hospitals, in the allocation of a scarce healthcare resource, including the decision not to place a patient on a ventilator. Review of a decision to withdraw a ventilator or another scarce resource from a patient may be requested of the Local Triage Board. This review must happen rapidly, given the demand for scarce resources. At least two clinician members of the Local Triage Board where the patient is being treated will assess any such appeal under processes established by that local Triage Review Board and make a final decision.

**CONCLUSION**

The COVID-19 epidemic is expected to exceed a threshold where many of our normal practices, including the methods of prioritization of available resources, must be reconsidered. This protocol should be used in conjunction with the work of the Central Call Center, which

support the CSC through access to expert consultation and situational awareness to level load and provide access for patients throughout the state to help ensure that those patients who are most likely to benefit will receive priority when scarce resources cannot be provided to everyone who wants or needs that resource.



**Note 1: Triage Roles:**

	Composition	Primary Role	Reports to
Medical Advisory Board	Not reviewed in this document	Not reviewed in this document	Governor; Secretary of Health; Secretary of Human Services
Statewide Triage Hub (the Statewide “Hub”) is established by the Medical Advisory Team	Composed of volunteer physicians (Statewide Triage Officer) with the expertise to review these cases, assisted by administrative staff.	<ol style="list-style-type: none"> <li>1) Will receive and resolve requests for intensive care services from throughout the state;</li> <li>2) Will assign patients in need of critical care to scarce resources, applying the substantive principles described above in Appendix E</li> <li>3) Prior to making a triage decision, the Statewide Hub will clarify whether a patient has an Advance Directive or a proxy decision-maker, has received a palliative care consult, and whether the patient wishes to receive intensive care services and mechanical ventilation under the circumstances.</li> </ol>	Will receive and resolve requests for intensive care services from throughout the state;
Local Triage Officer(s)	A physician or group of physicians with the expertise necessary to administer the priority scale and review progress of patients	<ol style="list-style-type: none"> <li>1) Administer the priority scale to patients requiring scarce resources, getting expert consultation when needed from the centralized call center, determining who will access those resources in a time of scarcity in that hospital.</li> <li>2) If available, facilitate access to a palliative care consult</li> <li>3) Serves as part of a team to review progress of those patients allocated scarce resources.</li> <li>4) Serves to coordinate allocation of ICU beds with the State Triage Hub, when bed capacity becomes available to receive additional patients into that hospital.</li> <li>5) Serves as a member of the Local Triage Board.</li> </ol>	
Local Triage Boards	Clinicians and Administrators	<ol style="list-style-type: none"> <li>1) Ensures that the appropriate triage and allocation policies and procedures are in place; maintains contact with other Triage Boards to facilitate inter-organization collaboration</li> <li>2) Maintains contact with the state Medical Advisory Team to preserve state-wide consistency in the administration of this protocol;</li> <li>3) Explains the allocation process to community groups, patients and families;</li> <li>4) Reviews decisions of Local Triage Officers to terminate scarce resources of patients</li> </ol>	

**Statewide COVID-19 Surge Command Center Triage Form \***

<b>Patient Name:</b>		<b>Date:</b>		
<b>Sequential Organ Failure Assessment: SOFA Score</b>				
<b>Lung: Respiration (use conversion table for patients without ABG and/or not</b>				Circle One
PaO <sub>2</sub> /FiO <sub>2</sub> >400 (not intubated)				0
PaO <sub>2</sub> /FiO <sub>2</sub> 301 to 400 (not intubated)				1
PaO <sub>2</sub> /FiO <sub>2</sub> ≤ 300 (not intubated)				2
PaO <sub>2</sub> /FiO <sub>2</sub> 100 to 200 with ventilator support				3
PaO <sub>2</sub> /FiO <sub>2</sub> ≤ 100 with ventilator support				4
<b>Coagulation: Platelets</b>				Circle One
>150x10 <sup>3</sup> /mm <sup>3</sup>				0
101 to 150x10 <sup>3</sup> /mm <sup>3</sup>				1
51 to 100x10 <sup>3</sup> /mm <sup>3</sup>				2
21 to 50 x10 <sup>3</sup> /mm <sup>3</sup>				3
≤ 20 x10 <sup>3</sup> /mm <sup>3</sup>				4
<b>Liver: Bilirubin</b>				Circle One
<1.2 mg/dL (20 mcmmol/L)				0
1.2 to 1.9 mg/dL (20-32 mcmmol/L)				1
2 to 5.9 mg/dL (33 to 101 mcmmol/L)				2
6 to 11.9 mg/dL (102 to 204 mcmmol/L)				3
>12 mg/dL (>204 mcmmol/L)				4
<b>Cardiovascular: Blood Pressure</b>				Circle One
Hypotension absent				0
Mean arterial pressure <70 mmHg				1
On dopamine ≤ 5 mcg/kg/min or any dobutamine				2
On dopamine > 5 mcg/kg/min, epinephrine ≤ 0.1 mcg/kg/min, or				3
On dopamine > 15 mcg/kg/min, epinephrine > 0.1 mcg/kg/min, or				4
<b>Brain: Glasgow Coma Score (see table below)</b>				Circle One
15				0
13 to 14 (rate this when unable to assess due to being intubated)				1
10 to 12				2
6 to 9				3
< 6				4
<b>Kidney: Renal Function</b>				Circle One
Creatinine <1.2 mg/dL (110 mcmmol/L)				0
Creatinine 1.2 to 1.9 mg/dL (110 to 170 mcmmol/L)				1
Creatinine 2 to 3.4 mg/dL (171 to 299 mcmmol/L)				2
Creatinine 3.5 to 4.9 mg/dL (300 to 440 mcmmol/L) or urine output 200 to 500				2
Creatinine > 5 mg/dL (440 mcmmol/L) or urine output < 200 mL/day				2
<b>SOFA Total Points = _____</b>				
<b>To Convert the SOFA Score:</b>	<b>SOFA Score &lt;6 = 1</b>	<b>SOFA Score 6-8 = 2</b>	<b>SOFA Score 9-11 = 3</b>	<b>SOFA Score ≥ 12 = 4</b>
<b>Converted SOFA Score (Highest score is 4) = _____</b>				

**\*Note:** If laboratory values or other elements needed for the priority score are not available prior to the need for a time sensitive decision by the Triage Officer, the Triage Officer will do his/her best to approximate a priority score.

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Sum of Converted SOFA Score & Chronic Condition Score =  
**Color Priority:** \_\_\_\_\_

<b>Chronic Condition Questions: (Enter Points in Boxes, NO = 0 pts)</b>		<b>Score</b>
<b>1. Dementia or Alzheimer's disease?</b>	No, Score 0	
Speaking only a few words, losing ability to walk, sit up, often referred to as "bed bound" (Fast Scale 7)	Score 4	
<b>2. Cancer?</b>	No, Score 0	
Patient is capable of only limited selfcare, in bed or chair more than 50% of waking hours or bedbound (ECOG status $\geq 3$ ) OR patient is receiving <i>palliative</i> chemotherapy or radiation OR no longer able to receive treatment	Score 4	
<b>3. Heart failure?</b>	No, Score 0	
NY Assoc. Class IV or AHA Stage D: Inability to carry out any physical activity without discomfort	Score 4	
<b>4. Cardiovascular Disease?</b>	No, Score 0	
Severe multivessel coronary artery disease that is symptomatic and not amenable to intervention	Score 4	
<b>5. Lung disease such as Pulmonary Hypertension, COPD, Lung Transplant, Interstitial Lung Disease?</b>	No, Score 0	
Inability to carry out any physical activity without discomfort (NYHF IV) OR COPD: FEV <sub>1</sub> <20% OR Idiopathic Pulmonary Fibrosis (IPF) on home oxygen	Score 4	
<b>6. Liver disease?</b>	No, Score 0	
Cirrhosis, any cause, with MELD score $\geq 20$ OR Childs-Pugh Class C AND ineligible for transplant	Score 4	
<b>7. Other Neurodegenerative disorder</b>	No, Score 0	
ALS, MS, Parkinson's with use of supplemental oxygen or ventilation, or feeding via PEG, or non-verbal communication, or underweight/cachectic, or bed bound state	Score 4	
<b>Chronic Condition Score will be the highest # scored in any 1-8 question (score will = 0 or 4)</b>	<b>Score =</b>	

Sum of Converted SOFA Score & Chronic Condition Score =  
Color Priority: \_\_\_\_\_

<b>Red = 1-3 (Highest Priority)</b>
<b>Orange = 4-5 (Intermediate Priority)</b>
<b>Yellow = 6-8 (Lowest Priority)</b>

## Supplementary Materials

(Statewide COVID-19 Surge Command Center Triage Form)

<b>O2 Liters to Flo2 Table</b>	
<b>O2 Flow (L/min)</b>	<b>Estimated Flo2 (%)</b>
1	24
2	27
3	30
4	33
5	36
6	39
7	42
8	45
9	48
10	51
11	54
12	57
13	60
14	63

For example: 4 LPM = 33% FiO<sub>2</sub>  
 O<sub>2</sub> sat of 91% = 59.9 paO<sub>2</sub>.  
 To calculate the paO<sub>2</sub>/Fio<sub>2</sub> then 59.9/ 0.35 = 171  
 That scores a 2 on the oxygen section of SOFA.

<b>O2 Saturation to Pao2 Table</b>	
	Oxygen tension (mm Hg)
<b>Saturation</b>	<b>Thomas<sup>2</sup></b>
0	0
0-10	10-31184
0-20	15-07883
0-30	19-10322
0-40	22-94330
0-50	26-90743
0-60	31-30776
0-70	36-63698
0-75	39-94493
0-80	44-01368
0-85	49-41240
0-90	57-60025
0-91	59-88959
0-92	62-35021
0-93	65-71481
0-94	69-59593
0-95	74-56080
0-96	81-31437
0-97	91-43363
0-98	109-41959
0-99	155-47307

<b>Glasgow Coma Scale: Rate prior to intubation. If unknown rate 13 which is 1 point</b>		
<b>Best eye response (E)</b>	Spontaneous	4
	To verbal command	3
	To pain	2
	None	1
<b>Best verbal response (V)</b>	Oriented, conversing	5
	Disoriented, conversing	4
	Inappropriate words	3
	Incomprehensible sound	2
	No verbal response	1
<b>Best motor response (M)</b>	Obeys verbal commands	6
	Localizes to pain	5
	Withdrawal	4
	Abnormal flexion	3
	Abnormal extension	2
	None	1

***NOTE: Reasonable accommodations in use of SOFA in patients with disabilities***

The Glasgow Coma Scale, a tool for measuring acute brain injury severity in the SOFA, adds points to the SOFA score when a patient cannot articulate intelligible words, even if this condition is due to a pre-existing speech disability or chronic ventilation. Similarly, patients with pre-existing neuromuscular conditions or spinal cord injuries may be unable to move parts of their body in response to verbal direction. Persons with disabilities who experience baseline levels of impairment prior to the acute care episode should be afforded reasonable accommodations in the scoring process so as not to increase SOFA scores for purposes of this protocol unless those conditions are believed to directly and substantially impact an individual's likelihood of survival of the acute illness with treatment. Additionally, patients with communication disabilities and/or limited English proficiency must be offered full access to interpreter services and, if indicated, assistive technology or other reasonable accommodations in order to appropriately and objectively complete the assessment. For some patients with significant communication disabilities, this may require having a member of the patient's care team (e.g. a family member or personal PCA) present at the bedside with appropriate safety training and PPE. This should be considered a reasonable accommodation even in the context of otherwise restrictive visitor policies.

*(From pg.18, MA Crisis Standards of Care Guidance, April 2020)*

<b>ECOG Performance Status for Cancer Patients</b>	
Grade	ECOG Performance Status
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50%
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined
5	Dead

## FAST: Functional Assessment Staging Test

Stage	Stage Name	Characteristic	Expected Untreated AD Duration (months)	Mental Age (years)	MMSE (score)
1	Normal Aging	No deficits whatsoever	--	Adult	29-30
2	Possible Mild Cognitive Impairment	Subjective functional deficit	--		28-29
3	Mild Cognitive Impairment	Objective functional deficit interferes with a person's most complex tasks	84	12+	24-28
4	Mild Dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling	24	8-12	19-20
5	Moderate Dementia	Needs help selecting proper attire	18	5-7	15
6a	Moderately Severe Dementia	Needs help putting on clothes	4.8	5	9
6b	Moderately Severe Dementia	Needs help bathing	4.8	4	8
6c	Moderately Severe Dementia	Needs help toileting	4.8	4	5
6d	Moderately Severe Dementia	Urinary incontinence	3.6	3-4	3
6e	Moderately Severe Dementia	Fecal incontinence	9.6	2-3	1
7a	Severe Dementia	Speaks 5-6 words during day	12	1.25	0
7b	Severe Dementia	Speaks only 1 word clearly	18	1	0
7c	Severe Dementia	Can no longer walk	12	1	0
7d	Severe Dementia	Can no longer sit up	12	0.5-0.8	0
7e	Severe Dementia	Can no longer smile	18	0.2-0.4	0
7f	Severe Dementia	Can no longer hold up head	12+	0-0.2	0