

South Dakota Crisis Standards of Care

for Adult Hospital and ICU Triage

2022



Crisis Standards of Care for Adult Hospital and ICU Triage

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INTRODUCTION

The South Dakota Pandemic Crisis Standards of Care and ICU Triage Guidelines were originally developed back in 2009 by the Sioux Falls Bioethics Network and fellow stakeholder organizations in response to H1N1. The guidelines were ultimately adopted in 2009 by the health systems, but never activated.

In 2020, due to the COVID-19 pandemic, LifeCircle SD suggested a study of the 2009 plan to ensure compliance with the Office of Civil Rights guidelines and to re-evaluate the clinical algorithm to provide ethically sound, clinically objective, practical, non-discriminatory and transparent assessment and triage standards for allocation of limited resources in the event of a mass critical care situation during which the demand for hospital and critical care services exceeds capacity.

As a member of LifeCircle SD, SDAHO volunteered to facilitate a legal and medical workgroup with members from the health systems, SD Department of Health, South Dakota State Medical Association and other key stakeholders to review and update the 2009 plan as hospital capacity in 2021 was reaching a crisis level. Input was also received from the independent hospitals and a partnership was formed with the South Dakota Healthcare Coalition.

The updated plan, modeled after the West Texas plan, was approved by the workgroups in October 2021 with formal endorsement by SDAHO, SDSMA and DOH in November 2021.

The South Dakota Crisis Standards of Care Plan will be implemented when a public health or disaster event overwhelms usual health and medical resources, capabilities, and capacities, resulting in an inability of the healthcare system to provide the standard levels of care to patients. This plan provides the guidelines needed for collaborative development of crisis standards of care across the state of South Dakota and throughout each community.

The goals for the South Dakota Crisis Standards of Care Plan are to:

- Unify South Dakota hospitals and work with a common purpose
- Prioritize critical care resources during a public health emergency
- Help inform local plans
- Identify state vs. hospital roles and responsibilities

CONTRIBUTORS

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PURPOSE:

- To provide ethically sound, clinically objective, practical, non-discriminatory, and transparent assessment and triage standards for allocation of limited medical resources in the event of a mass critical care situation during which the demand for hospital and critical care services exceeds capacity.

Basic Premises:

- **Goal:** The overall goal is to save as many lives as possible. When a patient is so ill due to any cause that survival to hospital discharge is unlikely, it is not reasonable to allocate scarce life sustaining resources to that patient. Such patients will be triaged to supportive palliative care or hospice care, allocating the scarce life sustaining treatment to patients judged more likely to survive to discharge.
- **Non-discrimination:** Each patient will receive medical treatment delivered with respect, care, and compassion and without regard to basis of race, ethnicity, color, national origin, religion, sex, disability, veteran status, age, genetic information, sexual orientation, gender identity, or any other protected characteristic under applicable

law. Further, medical treatment should not be allocated under these Standards based on the patient's ability to pay, insurance status, socioeconomic status, immigration status, incarceration status, homelessness, past or future use of resources, perceived self-worth, perceived or assessed quality of life, or weight/size.

- **Reasonable Accommodation:** Take appropriate steps to accommodate and provide individuals with disabilities meaningful access and an equal opportunity to participate in, or receive the services and benefits under these Standards, as required by hospital policy, and in accordance with the Department of Health and Human Services Office of Civil Rights guidance¹. Reasonable accommodation may include, but is not limited to the following:
 - Providing effective communication with individuals who are deaf, hard of hearing, blind, have low vision, or have speech disabilities through the use of qualified interpreters, picture boards, and other means;
 - Providing meaningful access to programs and information to individuals with limited English proficiency through the use of qualified interpreters and through other means;
 - Making emergency messaging available in plain language and in languages prevalent in the affected area(s) and in multiple formats, such as audio, large print, and captioning, and ensuring that websites providing emergency-related information are accessible;
 - Addressing the needs of individuals with disabilities, including individuals with mobility impairments, individuals who use assistive devices, auxiliary aids, or durable medical equipment, individuals with impaired sensory, manual, and speaking skills, and individuals with immunosuppressed conditions including HIV/AIDS in emergency planning;
 - Respecting requests for religious accommodations in treatment and access to clergy or faith practices as practicable.
- **Patient Ventilator/Equipment:** Hospitals may not re-allocate a personal ventilator (or a ventilator brought by the patient to the facility at admission to continue the patient's personal use).
- **Hospital Policies:** These Standards should be read in concert with current hospital policies, procedures, and/or guidelines. Implementing facilities may consider adding direct references to relevant policies.
- **Standards Prerequisites:** These Standards should be used only in genuinely extraordinary situations in which the demand for services overwhelms capacity and when activated by appropriate governmental and/or institutional authorities.
- **Standards Application:** Whether applied by individual treating clinicians, clinical triage committees, or clinical triage officers, these Standards require assessment of each patient's treatment preferences and likelihood of survival, giving priority to likelihood of survival to hospital discharge with treatment.
- **Physician Judgment:** Application of these Standards is primarily a physician responsibility and must include: 1) a physician's reasonable medical judgment based upon an individualized assessment of each patient's treatment preferences and survival likelihood based on best available, relevant, and objective evidence; and 2) as-needed modification and accommodation of these Standards and any tools the physician might select to support reasonable medical judgment based on the individual patient's clinical circumstances including any disabilities and/or chronic conditions the individual may have.
- **Patient Treatment Preferences:** Patient values and preferences related to life sustaining treatment should be assessed with the patient (or surrogate decision-maker if patient lacks decisional capacity), if feasible. If the patient is unable to communicate and is judged to be terminally or irreversibly ill, patient treatment preferences as expressed in an advance directive [Directive to Physicians/Living Will, Medical Power of Attorney, Out of Hospital DNR (unless pregnant)] or other clear evidence indicating the patient prefers a "comfort only" treatment approach should be given strong consideration.

¹ For COVID-19 please refer to the Office of Civil Rights, BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19), <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>.

Physicians must be careful not to exert pressure on patients or surrogate decision-makers to decline life sustaining treatments in the process of discussing advance care planning decisions or to make particular advance care planning decisions for the good of the provider or due to judgments regarding quality of life or relative worth. Providers must provide information on treatment options, including both “comfort only” and continued life sustaining treatment, as long as the treatment option is medically appropriate based upon reasonable medical judgment and current medical evidence. Physicians may not require patients to complete advance directives and may not issue blanket Do Not Attempt Resuscitation (“DNAR”) orders for reasons of resource constraint, except as consistent with or allowed by law.

- Likelihood of Survival:** For purposes of these Standards, likelihood of survival primarily means the physician’s reasonable medical judgment about survival to hospital discharge. This relies on clinician judgment of the patient’s risk of dying even with disease modifying treatment during the current acute care hospitalization. This clinician judgment should be informed as much as medically reasonable by objective clinical parameters and should not consider perceived quality of life or age. A physician’s reasonable medical judgment about likelihood of survival may be further informed by the MSOFA assessment tool, as well as various proprietary artificial intelligence based tools a clinician might have access to when approved for use in the facility where the patient is being treated, eligibility for additional treatments if indicated for other conditions such as bone marrow or solid organ transplants, LVAD as bridge or destination therapy, dialysis, and more.
- Use of Assessment/Prognostication Tools:** The decision to utilize any specific clinical assessment/prognostication tool is solely at the discretion of the responsible treating physician(s) and may change over time as patient characteristics and/or clinical science changes. No matter the clinical criteria utilized, clinical trajectory over time is often more important than any single point in time criteria. If one patient’s likelihood of survival is declining more rapidly than the other patient needing the same limited resource, the limited resource should be assigned to the patient with the less rapid rate of decline. Additional survival beyond hospital discharge may only be considered after all clinical factors related to achieving hospital discharge have been considered, and the likelihood of survival to hospital discharge is, in reasonable medical judgment, the same for two (2) patients but treatment is available only for one. This is hopefully a rare situation, but if it occurs, consideration may only be given to the short- term post-hospitalization survivability of the patient, provided neither disability, age, nor perceived quality of life are part of that consideration. In all cases, clinical judgment about survival should be based upon an individual patient assessment including reasonable modification of any clinical assessment/prognostic tool(s) utilized as necessary to accommodate for patients with a disability, and in line with the principles of non-discrimination outlined above.
- No Categorical Exclusions:** Neither these Standards nor the tools referenced are intended to create any categorical exclusions from life sustaining treatment. However, a patient may have an advance directive (Directive to Physicians/ Living Will, Medical Power of Attorney, Out of Hospital DNR) or other clear evidence indicating the patient prefers a “comfort only” treatment approach if the patient is, in reasonable medical judgment, terminally ill and unable to express her or his wishes.
- No Consideration of Resource Intensity:** Neither these Standards nor the tools referenced are intended to allow for consideration of a patient’s use of resources or duration of need. These Standards favor saving as many lives as possible and patients with better likelihood of survival; thus resource intensity and duration are likely to be increased. Responsible parties should plan for the need of increased resource intensity not only during hospitalization but in the post hospitalization time frame.
- No Consideration of Perceived Quality of Life:** Quality of life may not be used as a consideration in resource allocation decisions except as consistent with patient treatment preferences and in accordance with state law.

²Many clinical prognostic assessment tools are better validated for some conditions than others. For example, SOFA or MSOFA are best validated in the setting of sepsis with multi-organ system failure and may have less utility as a supplement to physician judgment in isolated single organ lung failure from an infectious disease like COVID-9. < https://nam.edu/wp-content/uploads/2020/12/csc-issue-summary_updated.pdf >

- **Triage priority:** Optimally, intensive treatment should be provided to every patient who meets treatment inclusion criteria, but if demand exceeds capacity, triage first according to the clinician, triage committee, or triage officer's reasonable medical judgment based upon objective clinical criteria as outlined above about survival to hospital discharge. Consultation across specialties, including but not limited to critical care, infectious disease, hospital medicine, surgical, palliative medicine, and other subspecialties relevant to serious illness care is useful in refining clinical judgment and sharing the burden of decision making. If the hopefully rare circumstance arises in which likelihood of survival to hospital discharge is, in reasonable medical judgment, the same for two (2) patients, but treatment is only available for one, a secondary triage decision may be made. If one patient's clinical trajectory is declining more rapidly than the other patient needing the same limited resource, the limited resource should be assigned to the patient with the less rapid rate of clinical decline, and thus the greatest prospect of survival. If the rare circumstance arises in which the physician's reasonable medical judgment is that both the likelihood of survival to hospital discharge and the rate of clinical decline are the same for two (2) patients, but treatment is only available for one, the first patient to present will be given priority. If both patients presented at the same time, a decision may be made favoring the patient with the more favorable short-term post-hospital survivability, as long as this is not based on any of the factors listed in the non-discrimination premises of these Standards.
- **Standards Application and Appeals:** Individual hospitals may select different methods for applying these Standards in a manner they believe best allows Standards compliance to save lives, promote transparency, and prevent discrimination. This includes application of these Standards by 1) treating clinicians at the bedside (may include emergency medicine, critical care, infectious disease, and/or hospitalist physicians); 2) clinical triage committees; and/or 3) clinical triage officers. Whichever method is used, application monitoring, support for those engaged in application, and an appeals process should be provided. Appeals process means that a member of the clinical treatment team, the patient, or the patient's surrogate decision-maker may appeal.
- **Application by Bedside Clinicians:** If a hospital chooses application initially by bedside clinicians, those clinicians will complete the basic assessment of patient preferences, likelihood of survival, including if necessary clinical trajectory and then make the triage decision supported by the best available objective clinical evidence as outlined above. Bedside clinicians may seek consultation from a clinical triage committee or clinical triage officer for assistance in applying these Standards. If a member of the clinical team or triage committee learns that a patient, surrogate decision-maker or another member of the clinical team disagrees with a decision made pursuant to these Standards, an appeal process should be available to a clinical triage committee or clinical triage officer who will have the authority to make the final decision unless further appeal is requested to a hospital or health care system clinical ethics committee or triage review committee, established specifically for the task of triage review.
- **Application by a Clinical Triage Committee or Clinical Triage Officer:** If a hospital chooses application initially by a clinical triage committee or officer, the clinical triage committee or clinical triage officer may obtain information from the bedside clinicians and/or medical record, including information relating to patient preferences and the likelihood of survival, and, if necessary, clinical trajectory. The clinical triage committee or clinical triage officer will then make the triage decision(s) supported by the best available objective clinical evidence, as outlined above. If a member of the clinical treatment team, a patient, or surrogate decision-maker informs another member of the clinical treatment team, a member of the clinical triage committee or clinical triage officer, or the Chief Medical Officer, they disagree with the triage decision made pursuant to these Standards, an appeal process should be available to a hospital or healthcare system triage review committee or clinical ethics committee, established specifically for the task of triage review, who has the authority to make the final decision.
- **Governor's Authority:** Under a declared state of emergency, the governor maintains the authority to supersede healthcare regulations or statutes that may come into conflict with these Standards.
- **New Clinical Information:** New clinical information may emerge over the course of a pandemic or other mass critical care situation, and these Standards may be modified accordingly. To the extent the federal, state or local government issues laws, regulations or guidelines regarding triage of patients or assignments of ICU beds, ventilators, or other medically necessary limited resources, these Standards may be modified to comply with those federal, state or local laws, regulations or Standards. If an objective, validated pandemic or other mass critical care specific scoring system which more accurately predicts survival than current tools becomes available, this may be used in place of the MSOFA based scoring system and/or other tools referenced in these Standards, provided that the new scoring system aligns with the basic non-discrimination premises of these Standards.

SCOPE:

These Standards apply to _____ (the hospital) and all healthcare professionals and staff working at the hospital.

The Adult Standards apply to all patients 14 years and older.

When activated:

These Standards should be activated in the event the governor declares a pandemic crisis or other public health emergency that has the potential to overwhelm available intensive care and/or other healthcare resources and implemented when the hospital and surrounding healthcare community reaches Level 3 Crisis Standard of Care.

During a Crisis Standard of Care, the hospital in conjunction with its medical staff will use these Standards to allocate scarce resources in a manner that respects the human dignity of each patient and saves as many lives as possible.

HOSPITAL PLANNING:

Individual hospitals have variable characteristics and thus may select different methods for applying these Standards in a manner that best allows compliance to save lives, promote transparency, and prevent discrimination.

Each hospital should (or within the context of a broader healthcare system):

- **Establish a clinical triage committee and/or clinical triage officer.** A clinical triage officer should have expertise in emergency medicine, critical care, or hospital medicine and may have experience in clinical ethics. For a committee, consider a team of at least 3 individuals, at least 2 of whom should be physicians, including an intensivist and 1 or more of the following: the hospital medical director, a nursing supervisor, a board member, a member of the hospital ethics committee, a pastoral care representative, a social worker, and 1 or more additional physicians. If a hospital has decided to vest primary or initial application of these Standards to the clinical treatment team, then a clinical triage committee may provide either consultation to treating physicians at the bedside or make treatment decisions in the setting of an appeal of a triage decision made by the clinical treatment team. Alternatively, a hospital may decide to vest primary or initial application of these Standards to the clinical triage committee and/or clinical triage officer.
- **Establish a triage review or clinical ethics committee or officer** to monitor and review 1) clinical treatment team decisions or 2) clinical triage committee or clinical triage officer decisions, and to serve as appeal process when requested by the patient, surrogate decision-maker, or the clinical treatment team.
- **Establish an appeal process** to review appeals to the decisions made under these Standards by a member of the clinical treatment team, patients, and surrogate decision-makers.
- **Communication of triage decisions** may be completed by 1) a member of the clinical treatment team, 2) a member of the clinical treatment team in conjunction with a member of the clinical triage committee, the clinical triage officer, a member of the clinical triage review or clinical ethics committee, or 3) the hospital Chief Medical Officer or designee. Supportive palliative care consultation is strongly encouraged as early as possible, especially when the likelihood of survival to hospital discharge is deemed low and/or when possible withdrawal of non-comfort treatment is being considered.
- **Institute a supportive and/or palliative care team** to provide symptom management, counseling, and care coordination for patients, and support for families of patients who do not receive intensive care unit services.
- Establish a method of providing **peer support and expert consultation** to clinicians making these decisions.

OVERVIEW OF CRISIS OF CARE CONTINUUM

Conventional Standard of Care Level 1

- The conventional standards of care are followed. The hospital may need to call in additional staff, but has sufficient supplies and equipment, either at hand or available to it.
- As the threat of activation of the triage protocol increases, the federal, state or local government may consider cancelling elective surgeries/procedures. If not, the hospital may consider cancellation of elective surgeries/procedures that require a back-up option of hospital admission and/or ventilator support.³
- Note: In the event of a severe and rapidly progressing public health emergency, start with Level 2 Contingency Standard of Care.

Contingency Standard of Care Level 2

- Conventional standards of care may be minimally impacted. The scarce resources at the hospital can expand to accommodate the surge above its baseline capacity through internal and external resources. The hospital may need to repurpose physical space to accommodate patients.

Crisis Standard of Care Level 3

- The hospital has implemented altered standards of care as demand for scarce resources (for example, ICU beds, ICU ventilators and staff) exceeds internal and readily available external resources. The hospital may need to activate its triage committee.
- Hospital staff absenteeism may be so severe as to become a rate limiting factor leading to Level 3 Crisis Standard of Care.

³Cancellation of surgeries should be done in accordance with the Basic Premises including providing individual patients reasonable accommodations as needed.

HOSPITAL SETTINGS

Contingent Interventions by Level of Care

Crisis Care Continuum

Conventional Standard of Care Level 1:

1. Preserve bed capacity by:
 - Consider delaying/cancelling any elective surgery that would require postoperative hospitalization.⁴
 - Note: Use standard operation and triage decision for admission to ICU because resources are adequate to accommodate the most critically ill patients.
2. Preserve oxygen capacity by:
 - Phasing out all non- acute hyperbaric medicine treatments.
 - Ensuring that all liquid oxygen tanks are full.
3. Improve patient care capacity by transitioning space in ICUs to accommodate more patients
 - Control infection by limiting visitation (follow hospital infection control plan), consistent with any federal, state, or local government laws, regulations, or rules.⁵

Contingency Standard of Care Level 2:

1. Preserve bed capacity by:
 - Delaying/cancelling category 2 and 3 elective surgeries unless necessary to facilitate hospital discharge.
2. Improve patient care capacity by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to occupied hospital rooms.
3. Institute a supportive and/ or palliative care team to provide symptom management, counseling and care coordination for patients, and support for families of patients who do not receive intensive care unit services.

Crisis Standard of Care Level 3:

1. Alternative Standard of Care is implemented by hospital and community to allocate scarce resources. The clinical triage committee/clinical triage officer may be activated.
2. Preserve bed capacity by limiting surgeries to patients whose clinical condition is a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

⁴Cancellation of surgeries should be done in accordance with the Basic Premises section including providing individual patients reasonable accommodations as needed.

⁵Limited visitors should be done in accordance with the Basic Premises section including providing individual patients reasonable accommodation and access to necessary support personnel.

Clinician Responsibilities and Utilization of the Algorithm and Tools

Given the charge to do the best for the most, saving as many lives as possible with a marked scarcity of resources (including, but not limited to, general hospital and ICU services, personnel, equipment, and/or drugs) there are certain situations where maximally aggressive treatment cannot be provided to every individual. At that point, the following process should be activated:

Physician clinical judgment regarding differential likelihood of survival among patients should begin, following the Basic Premises outlined above. This should include: 1) an individualized assessment of each patient's treatment preferences and survival likelihood based on best available, relevant, and objective evidence; and 2) as-needed modification of these Standards and any tools utilized as needed to accommodate for the individual patient's clinical circumstances, including disabilities.

These Standards provide a **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE ALGORITHM** and recommends various clinical assessment and/or prognostication tools both in the Basic Premises section and in the following pages to help the responsible treating physician(s), triage committee, and/or triage officer determine which patients should be medically managed and/or receive palliative care at home or in the hospital and which patients to admit to hospital and/or receive priority for interventions including but not limited to medications, ICU beds, ventilators, ECMO or other scarce resources. The choice of which clinical assessment/prognostication tools to use to further inform clinician judgment should be determined on a case by case basis by the responsible treating physician(s). Any tool chosen should be modified as necessary to accommodate for disability⁶. The basic triage principle however remains: the lowest priority for admission and/or access to intensive care services is given to patients with the lowest chance of survival with or without treatment, and to patients with the highest chance of survival without treatment. Thus, in a crisis situation when there are not enough resources to provide intensive treatment to every patient, a patient judged to have lower likelihood of survival should be triaged to a "comfort only" plan of treatment and the patient with higher likelihood of survival triaged to intensive treatment. In all cases, clinical judgment may not be based on any unlawful considerations including discriminatory practices prohibited in the Basic Premises outlined above. Clinicians, the clinical triage committee/clinical triage officer, and any ethics or review committee using these Standards should receive training on the use of these Standards including the Basic Premises, if feasible. An admirable long-term goal for health care organizations is to provide implicit bias and non-discrimination training when feasible.

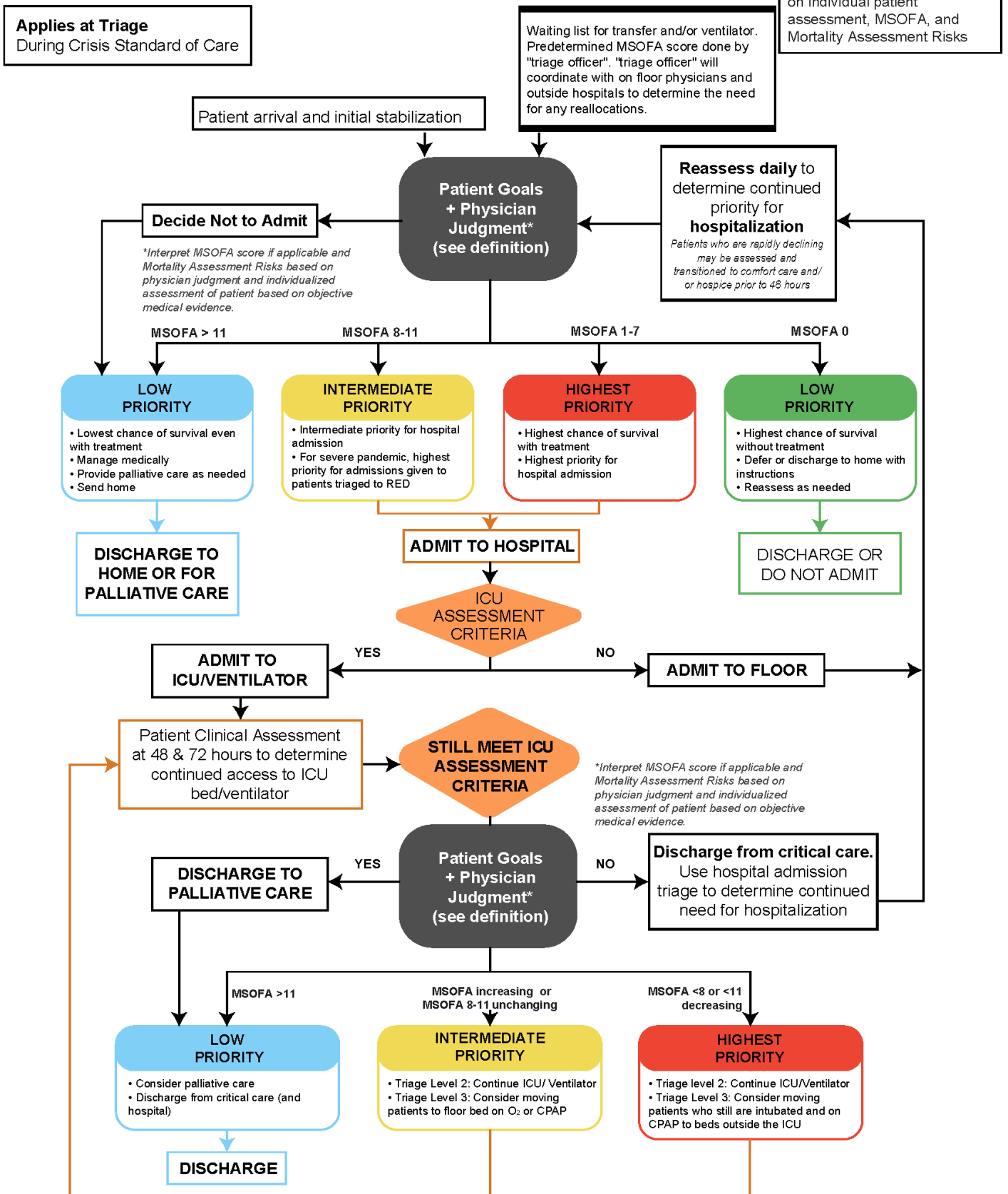
Crisis Standard of Care Level 3:

- Utilize physician clinical judgment and if deemed appropriate to the circumstance, initiate HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE algorithm to determine priority for ICU admission, intubation and/or mechanical ventilation.
- Reassess need for ICU/ventilator treatment on a regular basis as is needed and feasible.
- Continue to use physician clinical judgment and if deemed appropriate to the circumstance, HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE algorithm to determine priority for ICU, intubation and/or mechanical ventilation. The responsible physician and/or clinical triage committee/clinical triage officer should make determinations as frequently as needed, about which patients are at risk of dying during the current acute care hospitalization even with disease modifying treatment, as further informed by application of objective prognostic tools as outlined in the Basic Premises to prioritize which patients will have access to critical care services if demand exceeds supply of such service. Further, if the above does not allow adequate differentiation between two patients otherwise judged to have the same likelihood of survival to discharge, and Crisis Standard of Care has been triggered, the responsible physician and/or clinical triage committee/clinical triage officer may allocate the scarce resource to the patient who presented for treatment first; or if both patients presented at the same time or are currently being treated, then to the patient with the more favorable short-term post-hospital survivability, as long as this is not based on any unlawful considerations prohibited in the Basic Premises outlined above. If it becomes necessary,
 - Triage more **YELLOW** patients to floor on oxygen or CPAP.
 - Triage more **RED** patients who are intubated and on CPAP to floor.

See pages 10-13 for triage algorithm and supporting tools for adult criteria.

⁶Assessment tools or individual components of such tools may need reasonable modification to ensure that disability related characteristics unrelated to survival do not worsen any score applied to a patient. For example, the Glasgow Coma Scale, a tool for measuring acute brain injury severity in the MSOFA/SOFA, adds points to the MSOFA/SOFA score when a patient cannot articulate intelligible words or has difficulty with purposeful movement. For patients with pre-existing speech disabilities or disabilities that affect motor movement, these may result in a higher MSOFA/SOFA score even in instances where the patient's disability is not relevant to short-term mortality risk. Similarly, individuals who use personal ventilators or oxygen may score higher as a result of their typical usage and these may also result in a higher MSOFA score even where these would not be relevant to short-term mortality risk.

ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE



(a) Modified Sequential Organ Failure Assessment (MSOFA) Score:

MSOFA Scoring Guidelines						
Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
SpO2/FIO2 ratio* or nasal cannula or mask O2 required to keep SpO2 >90%	SpO2/FIO2 >400 or room air SpO2 >90%	SpO2/FIO2 316-400 or SpO2 >90% at 1-3 L/ min	SpO2/FIO2 231-315 or SpO2 >90% at 4-6 L/ min	SpO2/FIO2 151-230 or SpO2 >90% at 7-10 L/ min	SpO2/FIO2 <150 or SpO2 >90% at >10 L/ min	
Jaundice	no scleral icterus			clinical jaundice/ scleral icterus		
Hypotension†	None	MABP <70	dop <5	dop 5-15 or epi <0.1 or norepi <0.1	dop >15 or epi >0.1 or norepi >0.1	
Glasgow Coma Score	15	13-14	10-12	6-9	<6	
Creatinine level, mg/dL (use ISTAT)	1.2	1.2-1.9	2.0-3.4	3.5-4.9 or urine output <500 mL in 24 hours	>5 or urine output <200 mL in 24 hours	
MSOFA score = total scores from all rows:						

A reasonable modification of MSOFA may be a necessary accommodation for patients with a disability (including but not limited to deafness, cognitive or mobility limitations).

*SpO2/FIO2 ratio:
SpO2 = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO2 = Fraction of inspired oxygen; e.g., ambient air is 0.21
Example: if SpO2 = 95% and FIO2 = 0.21, the SpO2/FIO2 ratio is calculated as 95/0.21 = 452 †

Hypotension:
MABP = mean arterial blood pressure in mm Hg [diastolic + 1/3(systolic - diastolic)]
dop= dopamine in micrograms/kg/ min
epi = epinephrine in micrograms/ kg/min
norepi = norepinephrine in micrograms/kg/min

(b) ICU/Ventilator INCLUSION CRITERIA:

Patient has at least one of the following **INCLUSION CRITERIA:**

1. Requirement for invasive ventilatory support

- Refractory hypoxemia (SpO₂ <90% on non-rebreather mask or FIO₂ >0.85)
- Respiratory acidosis (pH <7.2)
- Clinical evidence of impending respiratory failure
- Inability to protect or maintain airway

2. Hypotension* with clinical evidence of shock refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.**

- *Hypotension = Systolic BP <90 mm Hg or relative hypotension.
- **Clinical evidence of shock = altered level of consciousness, decreased urine output or other evidence of end-stage organ failure.

(c) Continuous Clinical Assessment:

All patients who are allocated critical care services will be allowed a therapeutic trial of a duration to be determined by the clinical characteristics of the disease. Patients should generally be given an initial 48 to 72-hour trial. Although patients should generally be given the full duration of the initial 48 to 72-hour trial, if patients experience a precipitous decline, the treating physician(s), the clinical triage committee, or the clinical triage officer may make a decision before the completion of the specified trial length that the patient is no longer eligible for critical care treatment. Patients who have not declined will continue receiving the scarce resources allocated until the next assessment. If there are patients in the queue for critical care services, then patients who upon individualized reassessment show substantial clinical deterioration (as compared to baseline) as evidenced by overall clinical judgment informed by any objective prognostic tools as deemed appropriate will be eligible to have critical care interventions withdrawn if necessary to save the life of another patient.

(d) Glasgow Coma Score (GCS):

The GCS is used as part of the MSOFA score. Any decisions made based on the Glasgow Clinical Scale will consider the base line responsiveness of a person with a disability (including but not limited to deafness, cognitive or mobility limitations) but to the extent this information is readily available and modify the result accordingly.

Glasgow Coma Scoring Criteria				
Criteria	Adults and Children	Infants and Young Toddlers	Score	Criteria Score
Best Eye Response (4 possible points)	No eye opening	No eye opening	1	
	Eye opens to pain	Eye opens to pain	2	
	Eye opens to verbal command	Eye opens to speech	3	
	Eyes open spontaneously	Eyes open spontaneously	4	
Best Verbal Response (5 possible points)	No verbal response	No verbal response	1	
	Incomprehensible sounds	Infant moans to pain	2	
	Inappropriate words	Infant cries to pain	3	
	Confused	Infant is irritable and continually cries	4	
	Oriented	Infant coos or babbles (normal activity)	5	
Best Motor Response (6 possible points)	No motor response	No motor response	1	
	Extension to pain	Extension to pain	2	
	Flexion to pain	Abnormal flexion to pain	3	
	Withdraws from pain	Withdraws from pain	4	
	Localizes to pain	Withdraws from touch	5	
	Obeys commands	Moves spontaneously or purposefully	6	
Total Score (add 3 subscores; range 3 to 15):				

DEFINITIONS USED IN THIS DOCUMENT

- **Emergency Patients:** Those patients whose clinical conditions indicate that they require admission to the hospital and/or surgery within 24 hours.
- The federal, state or local government or a government agency may determine when and the type of elective surgeries that can be scheduled while an emergency declaration is in place.

If a government or governmental agency has not made this determination, **elective surgery means:**

- **Category 1:** Urgent patients who require surgery within 30 days.
- **Category 2:** Semi-urgent patients who require surgery within 90 days.
- **Category 3:** Non-urgent patients who need surgery at some time in the future.
- **Palliative Care:** In the setting of an overwhelming medical crisis, palliative care helps improve patient symptoms such as shortness of breath, pain and anxiety. Palliative care teams also support patient and family spiritual and/or emotional pain

RESOURCES

State

South Dakota Office of Public Health Preparedness and Response

<https://doh.sd.gov/providers/Preparedness/>

South Dakota Hospital Preparedness Program

<https://doh.sd.gov/providers/preparedness/hospital-preparedness/>

South Dakota Office of Emergency Management

<https://dps.sd.gov/emergency-services/emergency-management>

South Dakota Healthcare Coalition

<https://www.southdakotahcc.org/home>

Federal

OCR Provides Technical Assistance to Ensure Crisis Standards of Care Protect Against Age and Disability Discrimination (January 14, 2021)

<https://www.hhs.gov/about/news/2021/01/14/ocr-provides-technical-assistance-ensure-crisis-standards-of-care-protect-against-age-disability-discrimination.html>

CMS Emergency Preparedness Rule

<https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/SurveyCertEmergPrep/Emergency-Prep-Rule>

Centers for Medicare and Medicaid Services (CMS) Emergency Medical Treatment and Labor Act (EMTALA)

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html>

Employee Retirement Income Security Act (ERISA)

<https://www.dol.gov/general/aboutdol/majorlaws#workerscomp>

Fair Labor Standards Act (FLSA)

<https://www.dol.gov/general/aboutdol/majorlaws#workerscomp>

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<https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policyframework/summary-pahpras-mcm-provisions>

Federal Volunteer Protection Act (VPA).

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

<https://www.hhs.gov/hipaa/for-professionals/privacy/index.html>

National Security Presidential Directive (NSPD) 15/Homeland Security Presidential Directive (HSPD) 20, May 9, 2007

<https://fas.org/irp/offdocs/nspd/nspd-51.htm>

National Disaster Medical System (42 U.S. Code § 300hh–11)

[http://uscode.house.gov/view.xhtml?req=\(title:42%20section:300hh-11%20edition:prelim\)](http://uscode.house.gov/view.xhtml?req=(title:42%20section:300hh-11%20edition:prelim))

Occupational Safety and Health (OSH) Act

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Public Law 104-321. Emergency Management Assistance Compact (EMAC).

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U.S.C. Title 42-139 Sec. 14503 Liability protection for volunteers

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This document was developed following review and partial adaptation of the following articles:

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RECORD OF CHANGES

Change Made	Date of Change	Posted By

Original copies of this plan are saved: <https://sdaho.org/sd-crisis-standards-of-care/>