

# Utah Pandemic Influenza Hospital and ICU Triage Guidelines

Prepared by UTAH HOSPITALS AND HEALTH SYSTEMS ASSOCIATION  
for the Utah Department of Health

Version 1, January 10, 2009

## Purpose:

These guidelines were developed by the Utah Hospitals and Health Systems Association (UHA) Triage Guidelines Workgroup. The purpose is to guide the allocation of patient care resources during an influenza pandemic or other public health emergency, when demand for services dramatically exceeds supply. **Application of these guidelines will require physician judgment at the point of patient care.**

## Basic premises:

- **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- **Priority should be given to patients for whom treatment would most likely be lifesaving** and whose functional outcome would most likely improve with treatment. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.

## Scope:

- **These triage guidelines apply to all healthcare professionals, clinics, and facilities in the state of Utah.**
- **The guidelines apply to all patients ages 2 and over.** Until guidelines are developed for infants, physician judgment determines treatment of pediatric patients.

## When activated:

Guidelines should be activated in the event of pandemic influenza or other public health emergency declared by the governor of the state of Utah.

## Hospital and medical staff planning:

- **Each hospital should:**
  - **Establish a peer-based structure** for the review of hospital admission, ICU admission, and termination of care. Consider a team of at least 3 individuals, including an Intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians.
  - **Institute an action team** to provide counseling and care coordination and to work with the families of loved ones who have been denied care.
- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

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**Malpractice Liability:** In the 2007 legislative session, SB 153 (Malpractice Liability During Pandemic Event) was passed and incorporated into law (53-13-2.6, Utah code annotated 1953). This bill protects healthcare providers, including facilities, from malpractice liability when they respond to a natural disaster, pandemic event, or bioterrorism. Activities that are protected include:

- Implementing measures to control the causes of epidemic, pandemic, communicable diseases, or other conditions significantly affecting public health as necessary to protect the public health;
- Investigating, controlling, and treating suspected bioterrorism or disease in accordance with Title 26, Chapter 23b; or
- Responding to the following: a national, state or local emergency; a public health emergency as defined in Title 26, Chapter 23b, 102; or a declaration of the President of the United States or other federal official requesting public health related activities.

**EMTALA:** EMTALA provisions may be waived by the Secretary of Health Human Services during a declared public emergency and under the Stafford act. The Secretary can issue the Section 1135 Waiver to waive sanctions for the "transfer of an individual who has not stabilized for both transfers and redirection for a medical screening examination. Waivers are generally limited to a 72-hour period beginning upon implementation of a hospital disaster protocol, unless the Waiver arises out of a public health emergency involving a pandemic. If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.

## OVERVIEW OF PANDEMIC TRIAGE LEVELS

### Triage Level 1 Early in the pandemic

- Hospitals recognize the need to surge bed capacities.
- Emergency departments (EDs) are experiencing increased numbers.
- Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.

### Triage Level 2 Worsening pandemic

- Hospitals have surged to maximum bed capacity, and emergency departments (EDs) are overwhelmed.
- There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure.
- Hospital staff absenteeism is 20% to 30%.

### Triage Level 3 Worst-case scenario

- Hospitals have already implemented altered standards of care regarding nurse/patient ratios and have already expanded capacity by adding patients to already occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40%.

## PRE-HOSPITAL SETTINGS

### Initial Triage

**Applies to:** Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments;

**Implemented by:** Physicians, clinic staff, pre-screening staff

**Other uses:** Publish in newspapers, place in websites, etc. for self-use by public.

**ALL Triage Levels:** Use **INITIAL TRIAGE TOOL** (Appendix A) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

### EMS, Physician Offices, and Clinics

**Applies to:** Patients who present for care or call for guidance for where to go or how to care for ill family members;

**Implemented by:** Primary care staff, hospital help lines, community help lines, and health department help lines

#### Triage Level 1:

- Use **INITIAL TRIAGE TOOL** (Appendix A) to evaluate patients before sending to hospital ED or treating in an outpatient facility.

#### Triage Levels 2 and 3:

- Continue to use **INITIAL TRIAGE TOOL** (Appendix A).
- Initiate **EXCLUSION CRITERIA** (page 5) for hospital admission to evaluate patients. Do not send patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Send home with instructions for care (Appendix B).

### Home Care, Long-term Care Facilities, and Other Institutional Facilities (e.g., mental health, correctional, handicapped)

**Applies to:** Patients in institutional facilities

**Implemented by:** Institutional facility staff

#### ALL Triage Levels:

- Ensure that all liquid oxygen tanks are full.
- Limit visitation to control infection.
- Use **EXCLUSION CRITERIA** for hospital admission (page 5) to evaluate patients. Do not transfer patients meeting exclusion criteria to the hospital for treatment.
- Give palliative and supportive care in place.

# HOSPITAL SETTINGS

## Hospital Administrative Roles - General

### Triage Level 1:

**1) Preserve bed capacity** by:

- Canceling all category 2 and 3 elective surgeries, and advising all category 1 elective surgery patients of the risk of infection.
- Canceling any elective surgery that would require postoperative hospitalization.

**Note:** Use standard operation and triage decision for admission to ICU since there are still adequate resources to accommodate the most critically ill patients.

**2) Preserve oxygen capacity** by:

- Phasing out all 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 with respiratory failure.

**4) Control infection** by limiting visitation (follow hospital infection control plan).

### Triage Level 2:

**1) Preserve bed capacity** by:

- Canceling all elective surgeries unless necessary to facilitate hospital discharge.
- Evaluating hospitalized category 1 elective surgery patients for discharge using same criteria as medical patients.

**2) Preserve oxygen capacity** by stopping all hyperbaric treatments.

**3) Improve patient care capacity** by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to already occupied hospital rooms.

**4) Provide emotional support** by initiating pre-established action team to provide counseling and care coordination and to work with the families of loved ones who have been denied care.

### Triage Level 3:

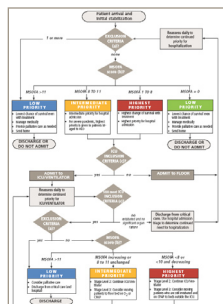
**1) Preserve bed capacity** by limiting surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

## Emergency Department, Hospital, and ICU - Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm and tools (pages 4 and 5) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in hospital or ICU. Note that the *lowest* priority for admission 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.

Physician judgment should be used in applying these guidelines. Other factors to consider when applying triage guidelines include:

- Whether the patient is homeless or has someone to care for them at home
- Whether the patient is in the 2nd or 3rd trimester of a pregnancy



See pages 4 and 5 for triage algorithm and supporting tools.

### Triage Level 2:

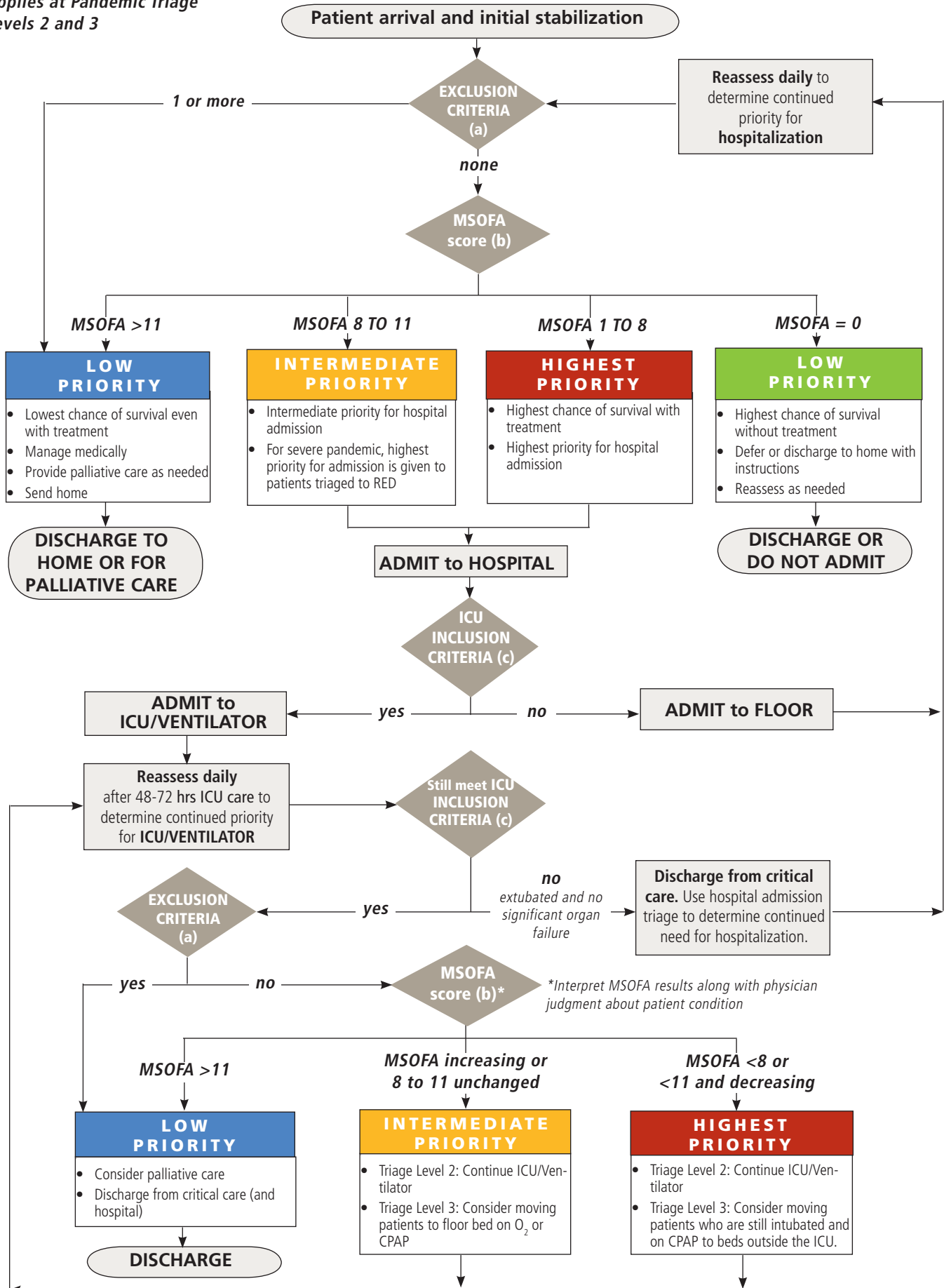
- Initiate **HOSPITAL AND ICU/ VENTILATOR TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation, and/or mechanical ventilation.
- Reassess need for ICU/Ventilator treatment daily after 48-72 hours of ICU care.

### Triage Level 3:

- Continue to use **HOSPITAL AND ICU/ VENTILATOR TRIAGE** algorithm (page 4) to determine priority for ICU, intubation, and/or mechanical ventilation.
- Triage more **yellow** patients to floor on oxygen or CPAP.
- Triage more **red** patients who are intubated and on CPAP to floor.

# ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Pandemic Triage Levels 2 and 3



## TRiage TOOLS AND TABLES

### (a) EXCLUSION CRITERIA for Hospital Admission:

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Known "Do Not Resuscitate" (DNR) status.**
- (2) **Severe and irreversible chronic neurologic condition** with persistent coma or vegetative state
- (3) **Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke, hypoxic ischemic brain injury, and intracranial hemorrhage.
- (4) **Severe acute trauma with a REVISED TRAUMA SCORE <2** (see (d) and (e))  
GCS: \_\_\_\_\_ SBP: \_\_\_\_\_ RR: \_\_\_\_\_  
Revised trauma score: \_\_\_\_\_
- (5) **Severe burns with <50% anticipated survival** (patients identified as "Low" or worse on the **TRIAge DECISION TABLE FOR BURN VICTIMS (f)**). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances). **Score:** \_\_\_
- (6) **Cardiac arrest not responsive to ACLS interventions within 20-30 minutes.**
- (7) **Known severe dementia** medically treated and requiring assistance with activities of daily living.
- (8) **Advanced untreatable neuromuscular disease** (such as ALS, end-stage MS, or SMA) requiring assistance with activities of daily living or requiring chronic ventilatory support.
- (9) **Known chromosomal or untreatable disorders** that are uniformly fatal in the first 2 years of life.
- (10) **Incurable metastatic malignant disease.**
- (11) **End-stage organ failure** meeting the following criteria:
  - Heart: NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM Class III or IV (g).** **Class:** \_\_\_\_\_
  - Lung** (any of the following):
    - Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV<sub>1</sub>) < 25% predicted baseline, PaO<sub>2</sub> <55 mm Hg, or severe secondary pulmonary hypertension.
    - Cystic fibrosis with post-bronchodilator FEV<sub>1</sub> <30% or baseline PaO<sub>2</sub> <55 mm Hg.
    - Pulmonary fibrosis with VC or TLC < 60% predicted, baseline PaO<sub>2</sub> <55 mm Hg, or severe secondary pulmonary hypertension.
    - Primary pulmonary hypertension with NYHA class III or IV heart failure (g), right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
  - Liver: PUGH SCORE >7 (h)**, when available. Includes bili, albumin, INR, ascites, encephalopathy.  
**Total score:** \_\_\_\_\_
- (12) **Age:**
  - Triage Level 1: >95 years
  - Triage Level 2: >90 years
  - Triage Level 3: >85 years

### (b) Modified Sequential Organ Failure Assessment (MSOFA)

The MSOFA requires only one lab value, which can be obtain using bedside point-of-care testing (creatinine obtained through ISTAT). MSOFA has not been validated in children, but is currently under study.

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

\* SpO<sub>2</sub>/FIO<sub>2</sub> ratio:

SpO<sub>2</sub> = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO<sub>2</sub> = Fraction of inspired oxygen; e.g., ambient air is 0.21  
Example: if SpO<sub>2</sub>=95% and FIO<sub>2</sub>=0.21, the SpO<sub>2</sub>/FIO<sub>2</sub> 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

### (c) ICU/Ventilator INCLUSION CRITERIA

Patient must have **NO EXCLUSION CRITERIA (a) and** at least one of the following **INCLUSION CRITERIA:**

- (1) **Requirement for invasive ventilatory support**
  - Refractory hypoxemia (SpO<sub>2</sub> <90% on non-rebreather mask or FIO<sub>2</sub> >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 for patients age >10 years old, or <70 + (2 x age in years) for patients ages 1 to 10, or relative hypotension;
  - \*\***Clinical evidence of shock** = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure

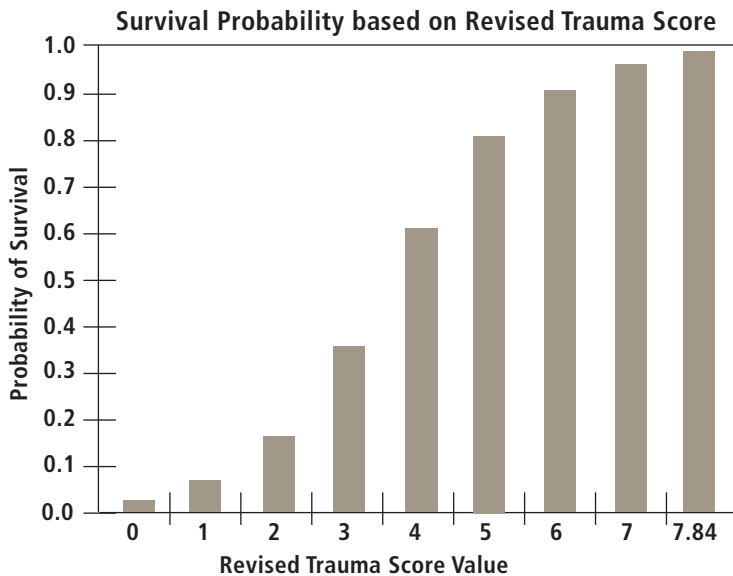
**(d) GLASGOW COMA SCORE (GCS)**

The GCS score is used as part of the Revised Trauma Score (table (e)) in determining exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

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

**(e) REVISED TRAUMA SCORE (RTS)**

Values for the REVISED TRAUMA SCORE (RTS) range from 0 to 7.8408. The RTS is heavily weighted towards the GLASGOW COMA SCORE (GCS) to compensate for major head injury without multisystem injury or major physiological changes. The RTS correlates well with the probability of survival. A Revised Trauma Score of <2 is an exclusion criterion for hospital admission during a pandemic flu at triage levels 2 and 3.



Revised Trauma Score Calculation				
Criteria	Score	Coded value	Weighting	Adjusted Score
<b>Glasgow Coma Score</b>	3	0	x 0.9368	_____
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 16	4		
<b>Systolic Blood Pressure (SBP)</b>	0	0	x 0.7326	_____
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		
<b>Respiratory Rate (RR) in breaths per minute (BPM)</b>	0	0	x 0.2908	_____
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		
<b>Revised Trauma Score</b> (add 3 adjusted scores):				_____



## (f) TRIAGE DECISION FOR BURN VICTIMS

A burn score of "Low" or worse on this table is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Age (yrs)	Burn Size (% total body surface area)									
	0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91%+
0-1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/expectant
2.0-4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0-19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0-29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0-39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0-49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0-59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/expectant	Low/expectant
60.0-69.9	Very high	Very high	Medium	Medium	Low	Low	Low	Low/expectant	Low/expectant	Low/expectant
70.0+	Very high	Medium	Medium	Low	Low	Low/expectant	Expectant	Expectant	Expectant	Expectant

**Outpatient:** Survival and good outcome expected, without requiring initial admission; **Very high:** Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, LOS <14-21 days, 1-2 surgical procedures); **High:** Survival and good outcome expected (survival ≥90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission ≥14-21 days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50-90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission ≥14-21 days, multiple surgeries and prolonged rehabilitation; **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant:** Predicted survival ≤10% even with unlimited aggressive treatment.

## (g) NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM

The NYHA functional classification system relates symptoms to everyday activities and the patient's quality of life. NYHA Class III or IV heart failure are exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

NYHA Classes	
Class	Patient Symptoms
<b>Class I</b> (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, or dyspnea.
<b>Class II</b> (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitations, or dyspnea.
<b>Class III</b> (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations, or dyspnea.
<b>Class IV</b> (Severe)	Unable to carry out physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

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## (h) PUGH SCORE

A total PUGH SCORE >7 is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Scoring criteria			
Criteria	Value	Points	Total for criteria
<b>Total Serum Bilirubin</b>	<2 mg/dL	1	_____
	2-3 mg/dL	2	
	>3 mg/dL	3	
<b>Serum Albumin</b>	>3.5 g/dL	1	_____
	2.8 - 3.5 g/dL	2	
	<2.8 g/dL	3	
<b>INR</b>	<1.70	1	_____
	1.71-2.20	2	
	>2.20	3	
<b>Ascites</b>	None	1	_____
	Controlled medically	2	
	Poorly controlled	3	
<b>Encephalopathy</b>	None	1	_____
	Controlled medically	2	
	Poorly controlled	3	
<b>Total Pugh Score</b>			_____
Score interpretation			
Total PUGH SCORE	Class		
5-6	A	Life expectancy 15-20 years Abdominal surgery perioperative mortality 10%	
7 to 9	B	Liver transplant evaluation indicated Abdominal surgery perioperative mortality 30%	
10 to 15	C	Life expectancy 1-3 years Abdominal surgery perioperative mortality 82%	

## 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.
- **Elective surgery:**
  - **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.
- **Long-term Care Facility:** A residential program providing 24-hour care, to include: Nursing Homes, Skilled Nursing Facilities, Assisted Living 1 and 2, Residential Care Facilities, and Intermediate Care for the Mentally Retarded (ICFMR) facilities.
- **Palliative care:** To make a patient comfortable by treating symptoms from an illness and by addressing issues causing physical or emotional pain or suffering.

## REFERENCES

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

- Christian MD, Hawryluck L, Wax RS, et al. Development of a triage protocol for critical care during an influenza pandemic. *CMAJ*. 2006;175(11):1377-1381.
  - *Commentary:* Melnychuk RM, Kenny NP. Pandemic triage: the ethical challenge. *CMAJ*. 2006;175(11):1393.
- Hick JL, O’Laughlin DT. Concept of operations for triage of mechanical ventilation in an epidemic. *Acad Emerg Med*. 2006;13(2):223-229.
- Grissom CK, Orme JF, Jensen RL, Jephson AR. A modified sequential organ failure assessment (SOFA) score to predict mortality in critically-ill patients (abstract). *Crit Care Med* 2007;35(12):A9.
- Champion HR, Sacco WJ, Carnazzo AJ, Copes W, Fouty WJ. Trauma score. *Crit Care Med*. 1981;9(9):672-676.
- Champion HR, Sacco WJ, Copes WS, Gann DS, Gennarelli TA, Flanagan ME. A revision of the Trauma Score. *J Trauma*. 1989;29(5):623-629.
- Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet*. 1974;2(7872):81-84.
- New York Heart Association. The stages of heart failure – NYHA classification. Heart Failure Society of America Web site. [http://www.aboutf.org/questions\\_stages.htm](http://www.aboutf.org/questions_stages.htm). Published 2002. Updated September 28, 2006. Accessed December 5, 2007.
- Pugh RNH, Murray-Lyon M, Dawson JL, Pietroni MC, Williams R. Transection of the oesophagus for bleeding oesophageal varices. *Br J Surg*. 1973;60(8):646-649.

## ACKNOWLEDGMENTS

- Brent Wallace, MD, Chief Medical Officer, Intermountain Healthcare – chair
- Andy Pavia, MD, Chief, Division of Pediatric Infectious Disease, University of Utah
- Ben Buchanan, MD, Emergency Physician, Emergency Physicians Integrated Care
- Boaz Markewitz, MD, Assistant Professor, Pulmonary/Critical Care, University of Utah
- Brad Poss, MD, Critical Care Physician, Primary Children’s Medical Center/UofU
- Chris Johnson, RN, Pioneer Valley Hospital
- Colin Grissom, MD, Critical Care Medicine, LDS Hospital
- Colleen Connelly, RN, Emergency Manager, University Health Care
- Deb Wynkoop, MPA, UHA Director of Health Policy
- Edward H. Redd, MD, Deputy Director/Medical Officer, Bear River Health Department
- Gail M. McGuill, RN, MS, Past-President, Utah Organization of Nurse Leaders
- Gary Nelson, PA, Intermountain Health Care
- Jan Buttrey, MBA, UHA Disaster Consultant
- Jay A. Jacobson, MD, Chief of Med Ethics/Prof, Internal Med/Div, Infectious Disease
- John A. Gezon, MD, Emergency Dept Medical Director, VA SLC Health Care System
- Peter Talliac, MD, Medical Director, Utah Department of Health, EMS
- Richard J. Sperry, MD, Associate Vice President, Health Sciences, University of Utah
- Robert T. Rolfs, MD, State Epidemiologist –CAPT, USPHS, Utah Dept of Health
- Ronald J. Gebhart, MD, Chief of Staff, VA SLC Health Care System
- Scott D. Williams, MD, Chief Medical Officer, HCA MountainStar Healthcare
- Tamara Lewis, MD, Medical Director, Community Health Prevention, Intermountain Healthcare

This project was made possible through funds from the Centers for Disease Control and Prevention, Public Health Emergency Preparedness Cooperative Agreement, CFDA#93.283.