

Florida Department of Health

Pandemic Influenza: Triage and Scarce Resource Allocation Guidelines

DRAFT

Pandemic Influenza Technical Advisory Committee

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INTRODUCTION

In the event of a pandemic influenza or other public health emergency, the demand for healthcare resources and services will dramatically increase. Out of necessity, scarce resources and patient care will have to be allocated so as to generally “do the greatest good for the greatest number”. Towards this end, the Florida Department of Health has prepared this guidance document to assist public and private medical and healthcare entities statewide in dealing with such events.* The Department’s responsibilities in such events include: 1) development and coordination of a State Pandemic Influenza Response Plan and other health/medical emergency response annexes included in the State Comprehensive Emergency Management plan, 2) epidemiology surveillance/situational awareness, and investigation, 3) implementation of Governor and Surgeon General directives, including, but not limited to, executive order(s), emergency declaration, or a declaration of public health emergency, 4) coordination of resource requests through Emergency Support Function (ESF) 8 at the State Emergency Operations Center (SEOC), 5) provision of guidance for healthcare facilities in a pandemic, and 6) issuance of patient triage and care recommendations.

The recommendations shown below: 1) identify a triage methodology that enables healthcare institutions to make decisions on patient admission and treatment, and 2) make use of charts that identify needed actions at particular levels of a pandemic and also aid in the allocation of scarce resources.

Education as part of a comprehensive communication strategy before and during an event is essential to maintain public trust and cooperation. Working together, public and private medical and healthcare entities across Florida can help ensure a successful response to any emergency or disaster situation that may occur.

*We would like to thank and acknowledge the Utah Department of Health, the Utah Hospital and Health Systems Association, the Minnesota Department of Health, the Colorado Department of Health and the Alaskan health care providers who worked in conjunction with the Medical Emergency Preparedness Pediatrics Project for the incorporation of several of their documents into these Florida **Draft** Guidelines. Please note some appendices were modified to align more closely with recommendations made for Florida.

PURPOSE

These guidelines were developed by the Florida Department of Health (FDOH). Their purpose is to provide guidance on patient triage and care during a pandemic or other public health emergency when the demand for resources and/or services dramatically exceeds supply.

The Institute of Medicine has provided a framework that allows consistency in establishing the key components required of any effort focused on crisis standards of care in a disaster situation. These guidelines are based on that framework.

GOALS

These guidelines seek to:

- 1) provide the “greatest good for the greatest number,”
- 2) foster coordinated efforts between facilities and agencies,
- 3) help allocate scarce resources,
- 4) reduce or eliminate healthcare worker liability,

- 5) provide a common ethical framework for patient care and resource allocation,
- 6) encourage actions that are operationally focused,
- 7) promote communication to the public during pandemics or other public health emergencies, and
- 8) promote the coordination of community control with clinical activities.

BASIC PREMISES

An influenza pandemic will impose substantial burdens on society. Given current planning assumptions, resources will need to be fairly allocated. Resources will be limited, and even when allocated fairly, providing resources to some residents of and visitors to Florida means withholding from others. The plan to allocate resources should be ethically justifiable.

Ethical goals informing the department's recommendation to allocate resources include: reducing harms and promoting benefits; respecting equal liberty and human rights; ensuring that the burdens imposed by allocation are shared fairly and do not fall disproportionately on some of Florida's residents. Public officials and healthcare workers should be professional and accountable, and their decision-making process should be open and transparent, culturally sensitive, and sustain public trust. The department recommends focusing on the treatment that would most likely be lifesaving and on those whose functional outcome would most likely improve with treatment. The ethical rationale for this recommendation is that it most likely secures the goals of public health emergency preparedness, including allocating resources, and minimizes the burdens that might result if decisions were made unfairly.

Hospitals, healthcare professionals, and county health departments integrate explicit consideration of ethical issues when developing plans for alternate standards of care. Recognizing that decisions about allocation of care will shift from the individual physician to emergency protocols and emergency mechanisms, alternate standards of care should be designed and implemented in ways that:

- are consistent with the values of public health and clinical care, to the extent possible,
- involve fair decision-making processes,
- should not disproportionately shift burdens to some groups or populations in order to benefit others,
- actions taken are in proportion to emergency needs,
- are responsive and accountable to members of the public, and
- are culturally sensitive.

In scarcity, efforts should focus on treatments most likely to be lifesaving and on patients most likely to improve with treatment. Decisions should minimize the burdens on others. This necessitates utilizing prioritization criteria for hospital and ICU admission as modeled in Figure 1 of this document. This model includes use of specific criteria for excluding certain patients from hospitalization as well as specific inclusion criteria for admission to an intensive care unit.

The principles embodied in these guidelines provide broad guidance for resource allocation in other public health emergency settings, especially those due to other infectious diseases. It is essential to stress the importance of prevention and control in the community. Prevention serves to mitigate, though not eliminate, the need for allocation of resources.

The definitions of the three situation levels that are probable during a pandemic influenza or other public health emergency are provided by the Institute of Medicine and are the basis for determining likely levels of surge, resources and absenteeism.

- **Conventional capacity:** the space, staff and supplies used are consistent with daily practices in the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility's emergency operations plan.
- **Contingency capacity:** the space, staff and supplies used are not consistent with daily practices, but maintain or have minimal impact on patient care practices. These spaces or practices may be used temporarily during a mass casualty incident or on a more sustained basis in a disaster (when demands of the incident exceed community resources).
- **Crisis capacity:** adaptive space, staff and supplies that are not consistent with usual standards of care, but provide sufficient care in the setting of a catastrophic disaster (provide the best possible care to patients given the circumstances and resources available).
Hick et al 2009

SCOPE / ACTIVATION

This document provides guidance for all Florida-licensed healthcare professionals and facilities during a pandemic influenza event or other declared public health emergency.

NON-HOSPITAL HEALTH CARE SERVICES AND STAFF PLANNING

Each community must plan for health care services that are delivered outside of acute care hospitals. The planning for both non-hospital based care and hospital care must be congruent, complementary, and consistent with the existing health care delivery system of the community. Each health care provider needs to address questions of staff shortages, surge capacity and continuity of operations. Non-hospital providers need clear, regular information on hospital admission criteria and hospital bed capacity. Hospital plans shall define processes for regularly disseminating information to non hospital health care providers. Additionally, reports will be sent to and further disseminated by local emergency management. A non-inclusive list of community-based providers includes pre-hospital EMS, home health agencies, hospice, outpatient medical offices (including private primary care offices), long-term care facilities, outpatient surgery centers, pharmacies, diagnostic facilities, county health departments, and community health centers.

HOSPITAL AND MEDICAL STAFF PLANNING

Each hospital should establish or task a peer-based structure for the review of hospital admission, ICU admission, termination of care, and ethical issues. This peer-based structure should develop a mechanism that has sufficient standing, authority and independence to make decisions about ethical issues in large scale emergencies. These committees may need to be trained in decision-making processes involving the ethical dimensions of large scale emergency response. Hospitals are encouraged to make these review structures public as part of the goal of promoting and maintaining public trust.

Consideration should be given to the development of a team of at least three individuals to include an intensivist and two 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.

Also, a qualified team composed of facility and/or community members should be established to provide counseling / care coordination and to work with the families of loved ones who have been denied some medical resources. Medical staff should establish a method of providing peer support and expert consultation to physicians making these decisions.

Each hospital should also have in place a plan for managing exposed employees and patients, and managing visitors to minimize the chances of an ill health care worker or visitor infecting patients and visitors, or of a patient developing influenza and infecting others while hospitalized for another reason. Such a plan would take into account the immune status of the employees (e.g. susceptible, vaccinated, recovered), and would include provisions for screening of workers arriving for their shifts. Hospitals should implement an aggressive vaccination policy when vaccine is available as part of a hierarchy of infection control protection practices.

SITUATION LEVELS

In a pandemic influenza event it will be important to determine which people need hospitalization and which people can be cared for at other facilities or at home. To apply “inclusion” and “exclusion” criteria, it is necessary to identify what circumstances will be evident at various stages of the pandemic. The chart below identifies three situations and what surge, resource level, and absenteeism will likely be in the three stages of a pandemic. Note that this chart will be referenced in subsequent detailed guidance in this document.

SITUATION	Conventional	Contingency	Crisis
SURGE STATUS	Hospitals realize the need to surge bed capacity.	Emergency departments are overwhelmed and hospitals have surged to maximum bed capacity.	Hospitals have already implemented crisis standards of care regarding healthcare team/patient ratios and have already expanded capacity by adding patients to occupied hospital rooms. Alternate Care Site strategies are applied. Community health care facilities have been requested to surge.
RESOURCE LEVEL	Emergency departments are experiencing increased numbers and increased demand for resources.	There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure. Resources are becoming scarce.	Resource levels are at a critical stage, necessitating triage along with conservation, reallocation, and reuse strategies.
STAFF ABSENTEEISM	Hospital staff absenteeism is not a problem	Hospital staff absenteeism is 20-30%	Hospital staff absenteeism is 30-40%+

PREHOSPITAL SETTINGS

HOME CARE

- Applies to people at home who are contemplating hospital admission or home care guidance.
- Implemented by household members or friends.
- Used to encourage people to stay at home, if at all possible, thus limiting exposure and reducing surge at hospitals and other medical care facilities.

TECHNOLOGY ASSISTED ASSESSMENT METHODS

- TELEPHONE ASSESSMENT
 - Applies to people at home or who request care from physician offices, clinics, or community healthcare facilities
 - Implemented by physicians, clinic staff, pre-screening staff
 - Used as a tool to provide guidance about the appropriate location (home, physician office, clinic, community healthcare facility, alternate care site, etc.) for people, along with instructions and direction for additional care or screening
 - Implemented at all three “triage levels”
 - Relies on a “telephone assessment tool” that assesses a person’s condition and needs
- On-line self-assessment tools
- Video/Telemedicine

EMERGENCY MEDICAL SERVICES

- Used to provide guidance on patient care location, evaluate patients before they are sent to a hospital facility, and to provide those sent home with instructions for care
- Patients should be transported to the hospital consistent with the **EXCLUSION CRITERIA**.

PALLIATIVE AND HOSPICE CARE

- *Palliative care* is the prevention and relief of suffering and to support the best possible quality of life regardless of the stage of disease or the need for other therapies.
- *Hospice care* can be defined as a program that provides a continuum of palliative and supportive care for the terminally-ill patient and his / her family.
- When conducting palliative care and hospice operations, the aim of actions is to keep existing health care delivery systems operational and to deliver acceptable quality of care. Anticipated support needs include additional health care workers and support staff to care for the surge in patients requiring comfort care, medical equipment / supplies and medications used for symptom control.

LONG-TERM CARE AND OTHER INSTITUTIONAL FACILITIES

- Applies to patients in institutional facilities
- Implemented by institutional facility staff
- Used to provide guidance on patient care for those in long-term care facilities
- Ensure that all liquid oxygen tanks are at full capacity and limit visitation to control infection
- Healthcare providers should prioritize patients for hospital admission. Do not transfer patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Give palliative care and supportive care in place.
- Decisions to exclude patients from admission or otherwise to alter decision standards are difficult and should be informed by process. The following list of criteria is neither dispositive nor exhaustive. For instance, while it is recommended that patients with DNR orders be excluded, there might be circumstances in which it would be permissible to treat such a patient. Decisions whether to invoke specific policy recommendations are ethically optimized accordingly as they are made under the umbrella of a comprehensive institutional policy that includes a robust ethics process. It might sometimes be the case that the physician writing a Do Not Resuscitate Order is also responsible for invoking or acting under the protocol. Such cases constitute a conflict of interest or conflict of commitment and, absent oversight or review, might undermine public trust. As a matter of fairness, triage decisions should be free of conflicts of interests and external pressures.

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) order status per 64J-2.018, Florida Administrative Code**, if DNR is indicative of prognosis.
- 2) **Severe and irreversible condition** with persistent coma or vegetative state.
- 3) Acute severe neurologic event that in the judgment of the attending physician indicates minimal chance of functional neurologic recovery. This includes traumatic brain and/or high level spinal cord injury, severe hemorrhagic stroke, hypoxic ischemic brain injury, and intracranial hemorrhage.
- 4) **Severe acute trauma** with a **Revised Trauma Score < 2**. (See Appendix 3)
- 5) **Severe burns** with **< 50% anticipated survival** (patients identified as **“Low” or worse on the Triage Decision Table for Burn Victims** (Appendix 5) . Burns not requiring critical care resources may be cared for at the local facility (e.g. burns that might have been transferred to a burn center under normal circumstances).
- 6) **Cardiac arrest** not responsive to Advanced Cardiac Life Support (ACLS) interventions within 20-30 minutes.
- 7) **Advanced untreatable neuromuscular disease**.
- 8) **Known chromosomal or untreatable disorders** that are uniformly fatal in the first 2 years of life.

9) **Incurable metastatic malignant disease.**

10) **Irreversible end-stage organ failure** meeting the following criteria:

Heart: Refractory NYHA class III or IV heart failure (Appendix 7).

Lung: (any of the following per known medical history)

- COPD with Forced Expiratory Volume in one second (FEV₁) < 25% predicted baseline, PaO₂ < 55 mm Hg, or severe secondary pulmonary hypertension.
- Cystic fibrosis with post-bronchodilator FEV₁ < 30% or baseline PaO₂ < 55 mm Hg.
- Pulmonary fibrosis with VC or TLC < 60% predicted, baseline PaO₂ < 55 mm Hg, or severe secondary pulmonary hypertension.
- Primary pulmonary hypertension with NYHA class III or IV heart failure, right atrial pressure > 10 mm Hg, or mean pulmonary arterial pressure > 50 mm Hg.

Liver: Pugh score > 7, when available (Appendix 6). Includes bilirubin, albumin, INR, ascites, encephalopathy.

11) Those patients who meet “low priority” criteria (MSOFA score= 0) as defined in Figure 1.

ICU / Ventilator INCLUSION CRITERIA

Patient must not meet any of the **EXCLUSION CRITERIA AND must meet at least one of the following INCLUSION CRITERIA:**

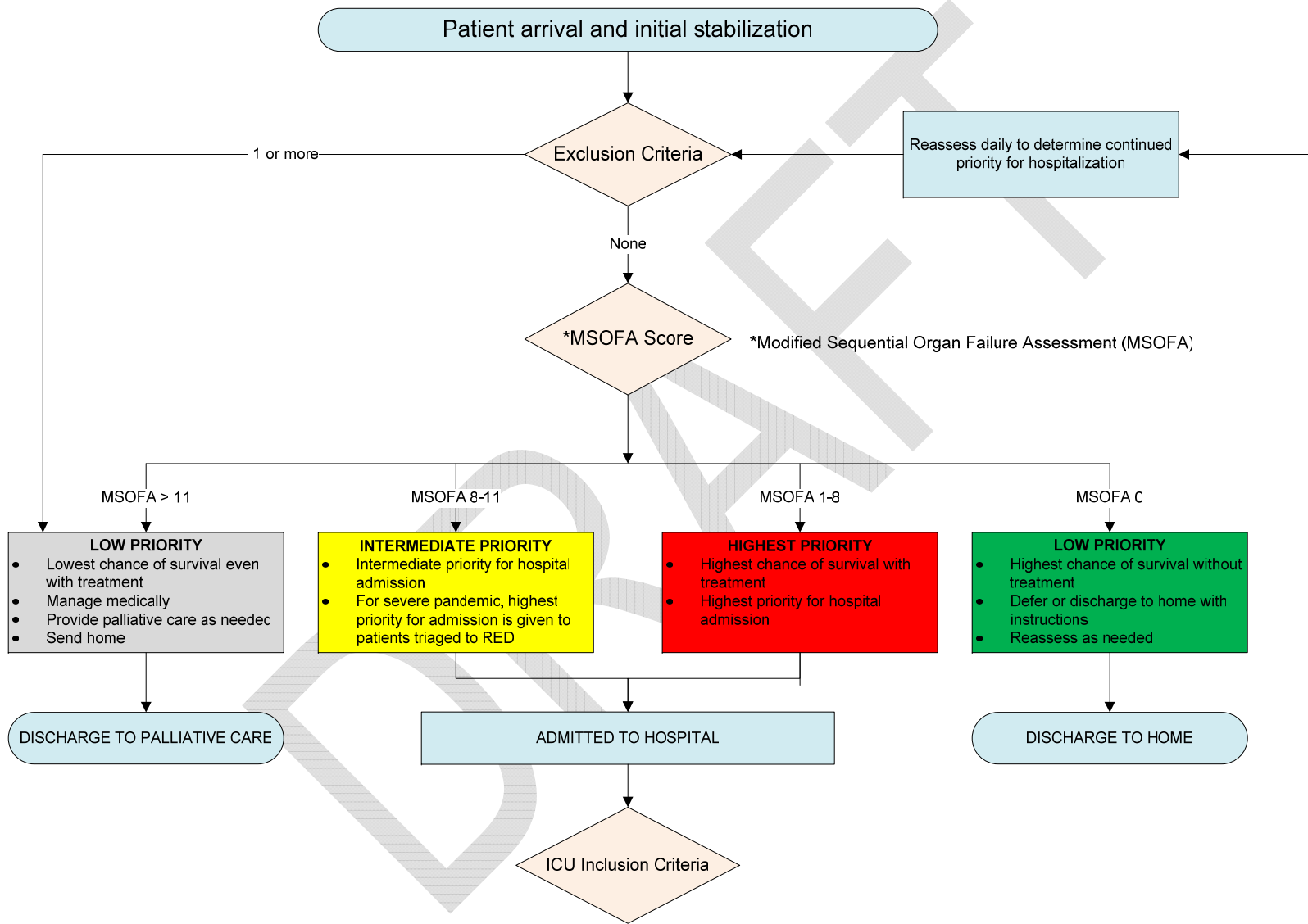
1) **Requirement for invasive ventilator support (reasonable expectation of short-term use)**

- Refractory hypoxemia (SpO₂ < 90% on non-re-breather mask or FIO₂ > 0.85)
- Respiratory acidosis (pH < 7.2)
- Clinical evidence of impending respiratory failure

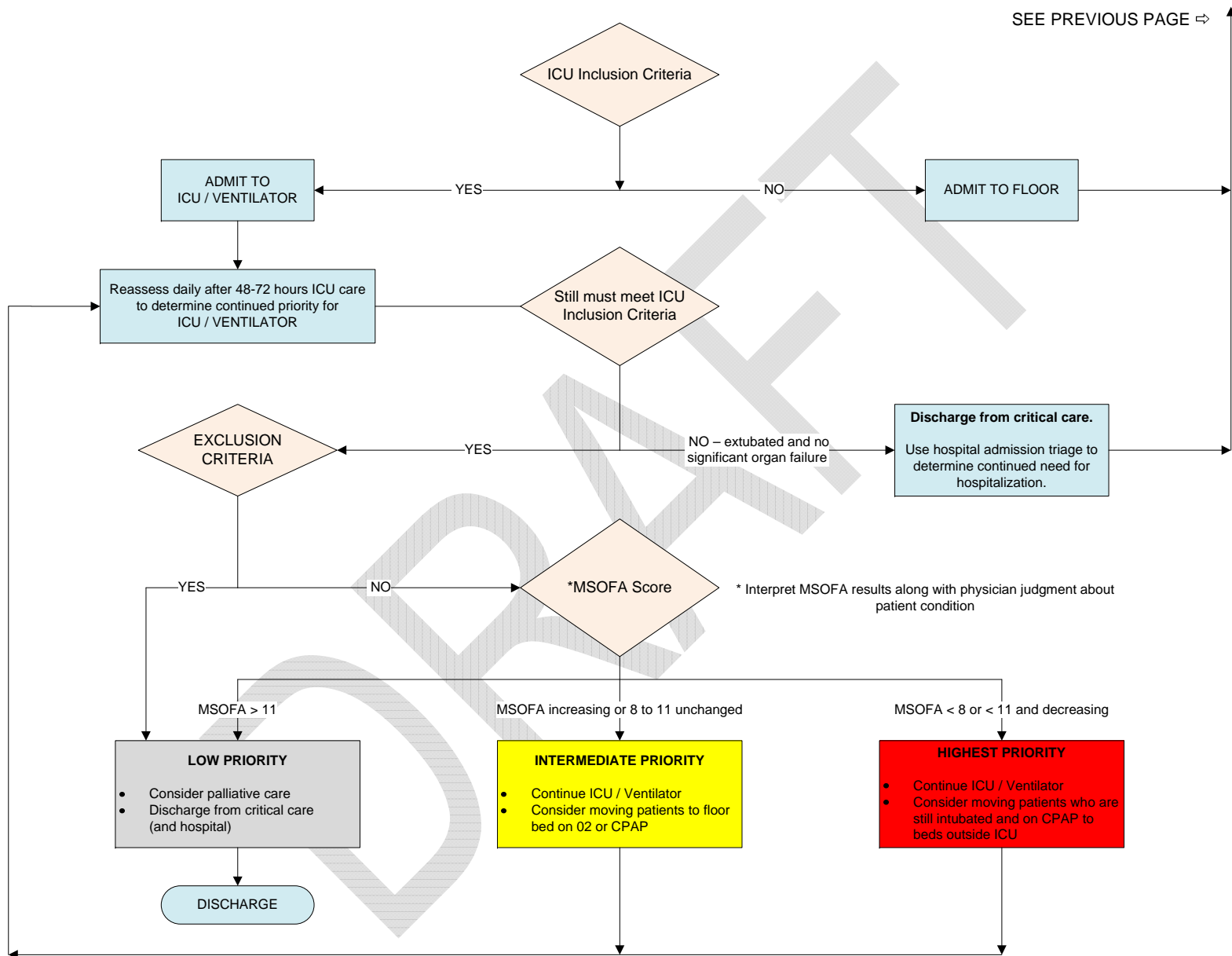
2) **Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.**

Hypotension** = Systolic BP, <90 mm Hg for patients > 10 years old, or < 70 + (2 x age in years) for patients ages 1 – 10, or relative hypotension; *Clinical evidence of shock** = altered level of consciousness, decreased urine output, or other evidence of end-organ failure.

Figure 1: HOSPITAL ADMISSION AND ICU / VENTILATOR TRIAGE MODEL



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Recommended Actions for Healthcare Facilities

CONVENTIONAL		CONTINGENCY		CRISIS
Overwhelming number and severity of cases beyond the capacity of the healthcare system				
<u>Administration/Planning</u>	<u>Administration/Planning</u>	<u>Administration/Planning</u>	<u>Administration/Planning</u>	<u>Administration/Planning</u>
<ul style="list-style-type: none"> -Establish and maintain emergency notification list of key personnel. -Discuss at facility and regional level, contingencies for scarce resource situations [see AHRQ document at www.ahrq.gov/research/mce/] including involvement of ethics committee members, administration, and medical staff on a facility clinical care committee that will determine which services may be offered during a pandemic. -Conduct Continuity of Operations Planning (COOP) for pandemic situations – assume schools may be out and staff may need housing during pandemic. -Write pandemic annex to all-hazards emergency response plan. -Develop security plans for buildings including augmentation of staff and ingress/egress control -Stockpile personal protective equipment and create contingencies for when supplies run low. -Determine staff expectations -Plan for surge capacity, including accommodating patients in non-traditional areas both on-site and off-site. 	<ul style="list-style-type: none"> - Cancel or deny employee travel/leave, as appropriate. -Conduct education about staff protection and healthcare facility expectations. -Activate a clinical care committee to examine situation and determine when and how to change services provided (e.g., canceling elective surgeries/appointments) based on the severity and expected arrival time of the pandemic. -Determine triggers to move from this level to yellow level and further adaptive strategies. -Track financial impact (direct and indirect) and staff time carefully for reimbursement. 	<ul style="list-style-type: none"> -Have a clinical care committee determine (on a daily basis) which (if any) modifications in facility services are necessary. -Conduct appropriate case-finding and reporting. -Open staff housing areas, as needed; open auxiliary rest, clinical care, and family areas as needed. -Begin limiting non-urgent surgeries and procedures. -Implement access controls and institute visitor and family member policies according to institutional procedures. 	<ul style="list-style-type: none"> -Have a clinical care committee determine each day the administrative and clinical changes needed to cope with demand for resources; this may include appointment of triage team to decide which patients receive certain therapies (e.g., ventilators) based on prognosis; conduct bed management to move beds and patients with authority of administration. -Set up Multi-Agency Coordination (MAC) with public health agencies, other hospitals, and EMS; determine when to open on-site and/or off-site alternate care sites, as needed and as staffing and resources are available. 	<ul style="list-style-type: none"> -Triage team appointed by a clinical care committee makes medical allocation decisions. -A clinical care committee continues to make daily decisions about which hospital services can be maintained. -Cohorting of patients no longer possible-emphasis on respiratory hygiene and masks, based on clinical situations and ethical standards.

CONVENTIONAL		CONTINGENCY		CRISIS
<p>-Contact local public health agencies and area hospitals to formulate regional plans for capacity, including alternate care sites, as determined by regional needs.</p> <p>-Encourage employees to have personal emergency plans in place, including emergency day-care arrangements and family communications.</p>				<p>Overwhelming number and severity of cases beyond the capacity of the healthcare system</p>
<p><u>Operations</u></p> <p>-Stress good infection control practices.</p>	<p><u>Operations</u></p> <p>-Partially activate the Hospital Command Center and begin daily planning cycle and information updates.</p> <p>-Have staff wear PPE when treating suspected cases and place in isolation room, per infection control recommendations.</p> <p>-Separate suspected cases in ED and clinics; follow FDOH case definitions and protocols. Provide masks for all suspect cases and post signage for patients regarding respiratory hygiene.</p> <p>-Review number of elective appointments and procedures and prepare to surge by canceling electives when necessary.</p> <p>-Assess supplies and vendor inventory, place orders as needed; communicate with partner agencies about supply needs.</p>	<p><u>Operations</u></p> <p>-Isolate or cohort cases.</p> <p>-Determine whether staff wears PPE for all patient encounters.</p>	<p><u>Operations</u></p> <p>-Fully activate Hospital Command Center with action-planning cycles for next operational period.</p> <p>-Mask all patients and visitors presenting to facility; staff wear PPE continuously to prevent exposure.</p> <p>-Triage use of ED, clinic, and in-patient resources as required (e.g. what conditions will be evaluated in the ED? What surgeries will be done today?).</p>	<p><u>Operations</u></p> <p>-Work with area hospitals, clinics, and public health to open alternate care sites when possible to reduce burden on hospitals, based on clinical situations and ethical standards.</p> <p>-Concentrate critical care in hospitals; work with homecare and public health to assure appropriate homecare instructions are being given.</p>

CONVENTIONAL		CONTINGENCY		CRISIS
	-Screen patients, staff and visitors prior to building entry, assigning infectious or suspect cases to appropriate care areas with appropriate PPE and respiratory hygiene. Screening should be appropriate based on severity of the disease, potential impacts to the patients, and resources available.	-Consider restricting visitors. -Screen patients, staff and visitors prior to building entry, assigning infectious or suspect cases to appropriate care areas with appropriate PPE and respiratory hygiene. Screening should be appropriate based on severity of the disease, potential impacts to the patients, and resources available.	-Consider restricting visitors. -Screen patients, staff and visitors prior to building entry, assigning infectious or suspect cases to appropriate care areas with appropriate PPE and respiratory hygiene. Screening should be appropriate based on severity of the disease, potential impacts to the patients, and resources available.	Overwhelming number and severity of cases beyond the capacity of the healthcare system -Consider restricting visitors. -Consider use of family members or others as caregivers for assistance with personal care support. -Screen patients, staff and visitors prior to building entry, assigning infectious or suspect cases to appropriate care areas with appropriate PPE and respiratory hygiene. Screening should be appropriate based on severity of the disease, potential impacts to the patients, and resources available.
<u>Pre-event Training/education</u>	<u>Pre-event Training/Education</u>	<u>Pre-event Training/Education</u>	<u>Pre-event Training/Education</u>	<u>Pre-event Training/Education</u>
-Encourage personal preparedness planning. -Provide pandemic education to employees and fit-test personnel, and/or have ability to provide just-in-time fit testing for N95 or other appropriate respirators. -Promote "Cover Your Cough" campaign. -Conduct exercises to practice pandemic responses; stress long-term response and incident action planning cycles consistent with Hospital Incident Command System (HICS) and National Incident Management System (NIMS).	-Conduct just-in-time education for employees, including fit-testing when required. Work with public health agencies and hospitals to craft public messages about symptoms and when (and when not) to come to hospitals/clinics.			

CONVENTIONAL		CONTINGENCY		CRISIS
Overwhelming number and severity of cases beyond the capacity of the healthcare system				
<u>Public Health Agency Responsibilities</u>	<u>Public Health Agency Responsibilities</u>	<u>Public Health Agency Responsibilities</u>	<u>Public Health Agency Responsibilities</u>	<u>Public Health Agency Responsibilities</u>
<p>Immunization: Encourage participation in influenza and pneumonia vaccines.</p> <p>Surveillance: Test and exercise surveillance systems.</p> <p>Community Intervention: Implement state protocol containment measures appropriate for WHO Phases.</p>	<p>Immunization: Promote pneumonia vaccine.</p> <p>Surveillance: Alert flu sentinel physicians to begin reporting flu-like illnesses.</p> <p>Physician Offices/Clinics: Promote pneumonia vaccination to broader audience.</p> <p>Long-Term Care Settings: Promote pneumonia vaccination to broader audience.</p> <p>Hospital: Promote pneumonia vaccination to broader audience.</p> <p>Community Intervention: Vaccinate high-risk non-immune contacts with pneumonia vaccine.</p>	<p>Immunization: Make it a HIGH priority to promote pneumonia vaccine.</p> <p>Case Intervention: Ensure aggressive investigation and ensure containment measures are being taken consistent with rapid response and containment protocol.</p> <p>Surveillance: Make routine contact with hospital EDs to increase speed of reporting.</p> <p>Physician Offices/Clinics: Advise physician and patient of results and prescribe oseltamivir only if novel strain per containment protocol.</p> <p>Long-Term Care Settings: Advise physician and patient of results and prescribe antivirals only if novel strain per containment protocol.</p> <p>Hospital (ED): Advise physician and patient of results and prescribe oseltamivir only if novel strain per containment protocol.</p> <p>Community Intervention: Issue antivirals, if effective, to all home contacts if positive for novel strain. Fully implement rapid response and containment protocol.</p>	<p>Immunization: Continue making it a HIGH priority to receive pneumonia vaccine.</p> <p>Community Intervention: Coordinate actions with regional and state FDOH offices.</p> <p>Surveillance: Shift focus from “individual containment” measures to “community containment” measures. Obtain daily reports from hospitals on number of people admitted with influenza-like illness and the number dying from influenza-like illness within the facility. Work with hospitals to obtain specimens for culture for selected persons with influenza-like illness to monitor what strains are circulating.</p> <p>Medical Infrastructure: CHDs will collect reports daily on primary care capacities for adults and children in the local community. Implement public health COOP plans. Receive daily reports from CMS on care capacities for eligible children.</p> <p>Community Intervention: Implement enhanced surveillance protocols for rapid identification of focal outbreaks.</p>	<p>Immunization: Continue pneumonia vaccinations and introduce pan-flu vaccinations when vaccine becomes available.</p> <p>Surveillance: Continue reporting aggregate number of cases, hospital bed availability, community resources, alternate medical treatment site status.</p> <p>Community Intervention: Support all healthcare facilities with limited staffing, equipment, and supplies.</p> <p>Long-Term Care Settings: Identify any shortages of supplies.</p> <p>Hospital (ED): Identify any shortages of supplies.</p> <p>Medical Infrastructure: Implement daily reporting of health assets through ESS. Identify diversion at healthcare facilities when known through ESS. Implement reporting structure for non-ESS providers through FHCA and APD. Receive daily reports of CHD capability</p>

CONVENTIONAL		CONTINGENCY		CRISIS
Overwhelming number and severity of cases beyond the capacity of the healthcare system				
<u>General Public Responsibilities</u>	<u>General Public Responsibilities</u>	<u>General Public Responsibilities</u>	<u>General Public Responsibilities</u>	<u>General Public Responsibilities</u>
<p>Prevention: Obtain influenza and pneumonia vaccinations.</p> <p>Treatment of Ill at Home: Isolate the ill in separate rooms and stockpile medications and medical supplies.</p> <p>Public Information/Education: Monitor official Public Health recommendations and instructions.</p>	<p>Prevention: Obtain influenza and pneumonia vaccinations.</p> <p>Treatment of Ill at Home: Isolate the ill in separate rooms and stockpile medications and medical supplies. Finalize plans for caring for the sick at home.</p> <p>Public Information/Education: Monitor official Public Health recommendations and instructions.</p>	<p>Prevention: Obtain pneumonia vaccination.</p> <p>Treatment of Ill at Home: Isolate the ill in separate rooms and stockpile medications and medical supplies.</p> <p>Public Information/Education: Monitor official Public Health recommendations and instructions.</p>	<p>Prevention: Continue to isolate the ill, use personal protective equipment, wash hands and soiled patient items often and thoroughly.</p> <p>Treatment of Ill at Home: Monitor health care supplies and medications for early replenishment.</p> <p>Public Information/Education: Monitor official Public Health recommendations and instructions. Monitor public health messages about who should receive care at home and who should go to a hospital.</p>	<p>Prevention: Continue to isolate the ill, use personal protective equipment, wash hands and soiled patient items often and thoroughly.</p> <p>Treatment of Ill at Home: Monitor public health messages for where and how to access emergency medications and medical supplies.</p> <p>Public Information/Education: Continue to monitor official Public Health recommendations and instructions.</p>

Patient Care Strategies for Scarce Resource Situations

Resource	Strategy	Tactic
Oxygen	Conservation	Use minimum liter flow to keep O ₂ saturation > target (85-95% depending on situation). Use O ₂ conserving devices. No oxygen driven nebs. Eliminate or reduce equipment with high O ₂ consumption. See more complete oxygen document.
	Re-use	Appropriately disinfect and re-use cannulas, masks, and tubing.
	Re-allocation	May have to base therapy on triage decision tool similar to ventilator allocation.
Medication Administration	Substitution	Use alternative inexpensive medications (morphine, lorazepam, doxycycline) that are easily stockpiled prior to the event.
	Adaptation	Use morphine and benzodiazepines for sedation drips when possible; run drips via gravity rather than IV pumps if needed. Administer more medications via subcutaneous or intramuscular route than intravenous.
	Conservation	Give adjunctive non-steroidal and other analgesics / medications including orally when possible.
Hemodynamic Support and IV Fluids	Substitution	Use alternative vasopressor agents such as epinephrine (inexpensive)
	Adaptation	May have higher threshold to initiate vasopressors, may use gravity drips (e.g.: 1mg epi in 100cc NS) instead of infusion pumps. Consider nasogastric fluid replacement or subcutaneous hydration rather than IV.
	Conservation	Minimize invasive monitoring.
	Re-use	Consider reusing central venous catheters, other tubes and catheters with appropriate sterilization / disinfection.
Mechanical Ventilation	Adaptation	Use of anesthesia machines, BiPAP, short-term manual ventilation and other strategies
	Conservation	Adjust threshold for intubation, decrease elective surgeries to free up ventilators / anesthesia machines.
	Re-use	Re-use of ventilator circuits after appropriate sterilization / disinfection.
	Re-allocation	Last resort, allocating ventilators to patients who can most benefit / will use least resources – must be according to pre-planned process using decision support tool and expert clinical judgment.
Nutrition	Adaptation	Have family or ancillary staff provide meals. Simpler meals, fewer choices for those that can take oral intake. Tube feedings in preference to TPN. May delay feedings longer than usual.
	Conservation	See above.
	Re-use	May need to re-use NG and other feeding equipment with appropriate disinfection / sterilization.
Staffing	Substitution	Outside, equally-qualified staff brought in to institution via compact agreements or other mechanism (DMAT, Medical Reserve Corps, other local, regional, state, federal sources). Use family or non-professional staff to provide basic patient care (non-clinical).
	Adaptation	Less qualified staff from sources as above or volunteers provide basic patient care with critical care nursing and physician staff monitoring larger number of patients. Just-in-time training and orientation to job duties. Change shift duration. Use family or non-professional staff to provide some clinical care with training / in-service.
	Conservation	Reduce administrative demands (teaching and administration, documentation, etc.)

Oxygen Use Strategies for Scarce Resource Situations

Potential Trigger Events	Strategy	Recommendations												
<p>INTERNAL DISRUPTION OF HOSPITAL MEDICAL GAS SYSTEMS</p> <p>INTERNAL SURGE TO HOSPITAL CAPACITY</p> <p>EXTERNAL NOTIFICATION BY GAS SUPPLIER OF DELAYS OR SHORTAGES</p> <p>EXTERNAL NOTIFICATION BY FLORIDA DEPARTMENT OF HEALTH</p> <p>Oxygen</p>	Substitute	<p>1. Oxygen Conservation Devices</p> <ul style="list-style-type: none"> Use oxygen conservation type cannulas at 1/2 the flow setting of standard cannulas. Replace simple & partial rebreather mask use with oxygen conservation cannulas at flow rates of 6-10 LPM. 												
		<p>2. Inhaled Medications</p> <ul style="list-style-type: none"> Restrict the use of Small Volume Nebulizers when inhaler substitutes are available. Restrict continuous nebulization therapy. Minimize frequency through medication substitution that result in fewer treatments (6h-12h instead of 4h-6h applications). 												
	Conserve	<p>3. Oxygen Concentrators if Electrical Power Is Present</p> <ul style="list-style-type: none"> Use hospital-based or independent home medical equipment supplier oxygen concentrators, if available; use to supplement low-flow cannula use, and preserve the primary oxygen supply for more critical applications. 												
		<p>4. Monitor Use and Revise Clinical Targets</p> <ul style="list-style-type: none"> Employ oxygen titration protocols to optimize flow or % to match targets for SPO₂ or PaO₂. Minimize overall oxygen use by optimization of flow. Discontinue oxygen at earliest possible time. <p>Note: Targets may be adjusted further downward depending on resources available, the patient's clinical presentation, or measured PaO₂ determination.</p> <table border="1"> <thead> <tr> <th>Starting Example</th> <th>Initiate O2</th> <th>O2 Target</th> </tr> </thead> <tbody> <tr> <td>Normal Lung Adults</td> <td>SPO2 <89%</td> <td>SPO2 90%</td> </tr> <tr> <td>Infants & Peds</td> <td>SPO2 <90%</td> <td>SPO2 91-94%</td> </tr> <tr> <td>COPD History</td> <td>SPO2 <88%</td> <td>SPO2 90%</td> </tr> </tbody> </table>	Starting Example	Initiate O2	O2 Target	Normal Lung Adults	SPO2 <89%	SPO2 90%	Infants & Peds	SPO2 <90%	SPO2 91-94%	COPD History	SPO2 <88%	SPO2 90%
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<p>5. High-Flow Applications</p> <ul style="list-style-type: none"> Restrict the use of high-flow oxygen devices as these can demand 12 to 40 LPM flows. Restrict the use of simple and partial rebreathing masks to 10 LPM maximum. Restrict use of Gas Injection Nebulizers as they generally require oxygen flows between 10 LPM and 75 LPM. Eliminate the use of oxygen-powered venturi suction systems as they may consume 15 to 50 LPM 														
<p>6. Air-Oxygen Blenders</p> <ul style="list-style-type: none"> Eliminate the low-flow reference bleed occurring with any low-flow metered oxygen blender use. This can amount to an additional 12 LPM. Reserve air-oxygen blender use for mechanical ventilators using high-flow non-metered outlets. (These do not utilize reference bleeds). Disconnect blenders when not in use. 														
Re-use	<p>7. Expendable Oxygen Appliances</p> <ul style="list-style-type: none"> Use terminal sterilization or high-level disinfection procedures for oxygen appliances, small & large-bore tubing, and ventilator circuits. Bleach concentrations of 1:10, high-level chemical disinfection, or irradiation may be suitable. Ethylene oxide gas sterilization is optimal, but requires a 12-hour aeration cycle to prevent ethylene chlorhydrin formation with polyvinyl chloride plastics. 													
Re-allocate	<p>8. Oxygen Re-Allocation Implementation</p> <ul style="list-style-type: none"> Prioritize patients for oxygen administration during severe resource limitations. 													

Medication Utilization Strategies for Scarce Resource Situations

Potential Trigger Events	Strategy	Recommendations													
MASS CASUALTY EVENT INFRASTRUCTURE DAMAGE OR LOSS INTERRUPTION IN SUPPLY CHAIN PANDEMIC INFLUENZA OR OTHER EPIDEMIC Medications	Prepare	1. Cache / Increase Supply Levels for Common Medications <ul style="list-style-type: none"> Examine formulary to determine commonly-used medications and classes that will be in immediate / high demand. Increase supply levels or cache critical medications - particularly for low-cost items and analgesics. Key classes include: <table border="0"> <tr> <td>Analgesia</td> <td>morphine, other narcotic and non-narcotic (non-steroidals, acetaminophen) class - injectable and oral (narcotic conversion tool at http://www.globalrph.com/narcoticconv.htm)</td> </tr> <tr> <td>Sedation</td> <td>particularly benzodiazepine (lorazepam, midazolam, diazepam) injectables</td> </tr> <tr> <td>Anti-infectives</td> <td>narrow and broad spectrum antibiotics for pneumonia, skin infections, open fracture care, sepsis (cephalosporins, fluoroquinolones, doxycycline, gentamicin, clindamycin, metronidazole), select antivirals</td> </tr> <tr> <td>Pulmonary</td> <td>metered-dose inhalers (albuterol, inhaled steroids), oral steroids (dexamethasone, prednisone)</td> </tr> <tr> <td>Behavioral Health</td> <td>haloperidol, other injectable and oral anti-psychotics, common anti-depressants, anxiolytics</td> </tr> <tr> <td>Other</td> <td>sodium bicarbonate, paralytics, induction agents (etomidate, propofol), propofol/tetracaine, atropine, pralidoxime, epinephrine, local anesthetics, antiemetics, insulin, common oral anti-hypertensive and diabetes medications</td> </tr> </table>	Analgesia	morphine, other narcotic and non-narcotic (non-steroidals, acetaminophen) class - injectable and oral (narcotic conversion tool at http://www.globalrph.com/narcoticconv.htm)	Sedation	particularly benzodiazepine (lorazepam, midazolam, diazepam) injectables	Anti-infectives	narrow and broad spectrum antibiotics for pneumonia, skin infections, open fracture care, sepsis (cephalosporins, fluoroquinolones, doxycycline, gentamicin, clindamycin, metronidazole), select antivirals	Pulmonary	metered-dose inhalers (albuterol, inhaled steroids), oral steroids (dexamethasone, prednisone)	Behavioral Health	haloperidol, other injectable and oral anti-psychotics, common anti-depressants, anxiolytics	Other	sodium bicarbonate, paralytics, induction agents (etomidate, propofol), propofol/tetracaine, atropine, pralidoxime, epinephrine, local anesthetics, antiemetics, insulin, common oral anti-hypertensive and diabetes medications	
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Conserve	2. Reduce Use During High Demand <ul style="list-style-type: none"> Restrict use of certain classes if limited stocks likely to run out (restrict use of prophylactic / empiric antibiotics after low risk wounds, etc.). Decrease dose; consider using smaller doses of medications in high demand / likely to run out (reduce doses of medications allowing blood pressure or glucose to run higher to ensure supply of medications adequate for anticipated duration of shortage). Allow use of personal medications (inhalers, oral medications) in hospital. Do without - consider impact if medications not taken during shortage (statins, etc.). 														
Substitute	3. Use Equivalent Medications <ul style="list-style-type: none"> Obtain medications from alternate supply sources (pharmaceutical representatives, pharmacy caches). <table border="0"> <tr> <td>Analgesia/</td> <td>- consider lorazepam for propofol substitution.</td> </tr> <tr> <td>Sedation</td> <td>- ICU analgesia/sedation drips morphine 4-10mg IV load then 2mg/h and titrate / re-bolus as needed (usual 3-20mg/h); lorazepam 2-8mg or midazolam 1-5mg IV load then 2-8mg/h drip</td> </tr> <tr> <td></td> <td>- refractory agitation add haloperidol 5-10mg IV (may repeat q30min) then final dose scheduled q6h (5-20mg/dose usual)</td> </tr> <tr> <td>Anti-infective</td> <td>- examples: cefazolin, gentamicin, clindamycin for broad-spectrum antibiotics</td> </tr> <tr> <td></td> <td>- Target therapy as soon as possible based upon organism identified.</td> </tr> <tr> <td>Pulmonary</td> <td>- metered dose inhalers instead of nebulized medications</td> </tr> <tr> <td>Other</td> <td>- beta blockers, diuretics, calcium channel blockers, ace inhibitors, anti-depressants, anti-infectives</td> </tr> </table>	Analgesia/	- consider lorazepam for propofol substitution.	Sedation	- ICU analgesia/sedation drips morphine 4-10mg IV load then 2mg/h and titrate / re-bolus as needed (usual 3-20mg/h); lorazepam 2-8mg or midazolam 1-5mg IV load then 2-8mg/h drip		- refractory agitation add haloperidol 5-10mg IV (may repeat q30min) then final dose scheduled q6h (5-20mg/dose usual)	Anti-infective	- examples: cefazolin, gentamicin, clindamycin for broad-spectrum antibiotics		- Target therapy as soon as possible based upon organism identified.	Pulmonary	- metered dose inhalers instead of nebulized medications	Other	- beta blockers, diuretics, calcium channel blockers, ace inhibitors, anti-depressants, anti-infectives
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Other	- beta blockers, diuretics, calcium channel blockers, ace inhibitors, anti-depressants, anti-infectives														
Adapt	4. Modify Medication Administration <ul style="list-style-type: none"> Emphasize oral, nasogastric, rectal, subcutaneous routes of medication administration. Administer medications by gravity drip rather than IV pump if needed: IV drip rate calculation - drops / minute = amount to be infused x drip set / time (minutes) (drip set = qtts / mL - 60, 														

<h1>Medications</h1>	Adapt	10, etc.). <ul style="list-style-type: none"> Consider use of select medications beyond expiration date. Consider use of veterinary medications when alternative treatments are not available. NOTE: For further information and examples, see http://www.cityofsomerset.com/ems/IV%20Drug%20Calculations.pdf
	Re-allocate	5. Restrict Allocation of Select Medications <ul style="list-style-type: none"> Allocate limited stocks of anti-viral medications with consideration of regional/state guidance and available epidemiological information. Allocate limited stock to support other re-allocation decisions (ventilator use, etc.). Unit dose or sealed medications from patients.

Hemodynamic Support and IV Fluids Strategies for Scarce Resource Situations

Potential Trigger Events	Strategy	Recommendations
<h1>Hemodynamic Support and IV Fluids</h1>	Prepare	1. Cache Additional Intravenous (IV) Cannulas, Tubing, Fluids, Medications, and Administration Supplies
	Conserve	2. Use scheduled dosing and drip dosing when possible <ul style="list-style-type: none"> Reserve IV pump use for critical medications such as sedatives and hemodynamic support.
		3. Minimize invasive monitoring <ul style="list-style-type: none"> Substitute other assessments of central venous pressure (CVP). When required, assess CVP intermittently via manual methods using bedside saline manometer or transducer moved between multiple patients as needed, or by height of blood column in CVP line held vertically while patient supine.
	Substitute	4. Emphasize oral hydration instead of IV hydration when possible Utilize appropriate oral rehydration solution - Oral rehydration solution: 1 liter water (5 cups) + 1 tsp salt + 8 tsp sugar, add flavor (e.g., 1/2 cup orange juice, other) as needed. - Rehydration for moderate dehydration 50-100mL / kg over 2-4 hours Supplement for each diarrhea or emesis - Pediatric maintenance fluids: 4 mL/kg/h for first 10kg of body weight (40 mL/h for 1st 10 kg) 2 mL/kg/h for second 10kg of body weight (20 mL/h for 2nd 10kg = 60 mL/h for 20kg child) 1 mL/kg/h for each kg over 20kg (example - 40 kg child = 60 mL/h plus 20 mL/h = 80 mL/h) NOTE: Clinical (urine output, etc.) and laboratory (BUN, urine specific gravity) assessments and electrolyte correction are key components of fluid therapy and are not specifically addressed by these recommendations. NOTE: For further information and examples, see http://rehydrate.org and http://www.bt.cdc.gov/disasters/hurricanes/pdf/dguidelines.pdf .

Hemodynamic Support and IV Fluids		<p>5. Provide nasogastric or subcutaneous hydration Instead of IV hydration when practical</p> <ul style="list-style-type: none"> Patients with impediments to oral hydration may be successfully hydrated and maintained with nasogastric (NG) tubes. For fluid support, 8-12F (pediatric: infant 3.5F, < 2yrs 5F) tubes are better tolerated than standard size tubes.
		<p>6. Substitute epinephrine for other vasopressor agents</p> <ul style="list-style-type: none"> For hemodynamically unstable patients who are adequately volume-resuscitated, consider adding 6mg epinephrine (6mL of 1:1000) to 1000mL NS on minidrip tubing and titrate to target blood pressure. Epinephrine 1:1000 (1mg/mL) multi-dose vials available for drip use.
	Adapt	<p>7. Consider use of veterinary and other alternative sources for intravenous fluids and administration sets</p>
	Re-allocate	<p>8. Re-use patient devices/supplies (nasogastric tubes, central lines) after appropriate sterilization/disinfection</p> <ul style="list-style-type: none"> Cleaning for all devices should precede high-level disinfection or sterilization. High-level disinfection for at least twenty minutes for devices in contact with body surfaces (including mucous membranes); glutaraldehyde, hydrogen peroxide 6%, or bleach (5.25%) diluted 1:20 (2500 ppm) are acceptable solutions. <p>NOTE: chlorine levels reduced if stored in polyethylene containers - double the bleach concentration to compensate.</p> <ul style="list-style-type: none"> Sterilize devices in contact with bloodstream (ethylene oxide sterilization for CVP catheters).

Mechanical Ventilation Strategies for Scarce Resource Situations

Potential Trigger Events	Strategy	Recommendations
PANDEMIC INFLUENZA	Prepare	<p>1. Increase hospital stocks of ventilators, ventilator circuits and related supplies, and suction equipment/supplies for both adults and children</p>
	Substitute	<p>2. Access alternative sources for ventilators</p> <ul style="list-style-type: none"> Obtain ventilators from vendors / healthcare partners / Federal stockpiles via usual emergency management processes.
	Adapt	<p>3. Use alternative respiratory support technologies</p> <ul style="list-style-type: none"> Use transport ventilators with appropriate alarms - especially for stable patients without complex ventilation requirements. Use anesthesia machines for mechanical ventilation as appropriate. Use Bi-level Positive Airway Pressure (Bi-PAP) equipment to provide mechanical ventilation. Consider bag-valve ventilation as temporary measure while awaiting definitive solution (as appropriate to situation).
	Conserve	<p>4. Decrease demand for ventilators</p> <ul style="list-style-type: none"> Increase threshold for intubation / ventilation. Decrease elective procedures that require post-operative intubation. Decrease elective procedures that utilize anesthesia machines.
OTHER EVENT THAT OVERWHELMS VENTILATOR CAPACITY		

Mechanical Ventilation

	<ul style="list-style-type: none"> Use non-invasive ventilatory support when possible. 																																																								
Re-use	<p>5. Sterilize ventilator circuits after cleaning.</p> <ul style="list-style-type: none"> If using gas (ethylene oxide) sterilization, allow full 12 hour aeration cycle to avoid toxic byproducts from accumulating on surface. Use chemical sterilization, irradiation, or other techniques as appropriate. 																																																								
Re-allocate	<p>6. Assign limited ventilators to patients most likely to benefit if no other options are available</p> <p>Step one: assess patient acuity using Modified Sequential Organ Failure Assessment (MSOFA) scoring table. The MSOFA requires only on lab value, which can be obtained using bedside point-of-care testing (creatinine obtained through (ISTAT).</p> <table border="1"> <thead> <tr> <th colspan="7">MSOFA scoring guidelines</th> </tr> <tr> <th>Variable</th> <th>Score 0</th> <th>Score 1</th> <th>Score 2</th> <th>Score 3</th> <th>Score 4</th> <th>Score for each row</th> </tr> </thead> <tbody> <tr> <td>SpO₂/FIO₂ ratio* or nasal cannula or mask O₂ required to keep SpO₂>90%</td> <td>SpO₂/FIO₂>400 or room air SpO₂>90%</td> <td>SpO₂/FIO₂ 316-400 or SpO₂>90% at 1-3 L/min</td> <td>SpO₂/FIO₂ 231-315 or SpO₂>90% at 4-6 L/min</td> <td>SpO₂/FIO₂ 150-230 or SpO₂>90% at 7-10 L/min</td> <td>SpO₂/FIO₂ ≤150 or SpO₂>90% at >10L/min</td> <td></td> </tr> <tr> <td>Jaundice</td> <td>no scleral icterus</td> <td></td> <td></td> <td>clinical jaundice/scleral icterus</td> <td></td> <td></td> </tr> <tr> <td>Hypotension†</td> <td>none</td> <td>MABP<70</td> <td>dop<5</td> <td>dop 5-15 or epi≤0.1 or norepi≤0.1</td> <td>dop>15 or epi>0.1 or norepi>0.1</td> <td></td> </tr> <tr> <td>Glasgow Coma Score</td> <td>15</td> <td>13-14</td> <td>10-12</td> <td>6-9</td> <td><6</td> <td></td> </tr> <tr> <td>Creatinine level, mg/dL (use ISTAT)</td> <td><1.2</td> <td>1.2-1.9</td> <td>2.0-3.4</td> <td>3.5-4.9 or urine output <500 mL in 24 hours</td> <td>>5 or urine output <200 mL in 24 hours</td> <td></td> </tr> <tr> <td colspan="6" style="text-align: right;">MSOFA score = total scores from all rows:</td> <td></td> </tr> </tbody> </table>	MSOFA scoring guidelines							Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row	SpO ₂ /FIO ₂ ratio* or nasal cannula or mask O ₂ required to keep SpO ₂ >90%	SpO ₂ /FIO ₂ >400 or room air SpO ₂ >90%	SpO ₂ /FIO ₂ 316-400 or SpO ₂ >90% at 1-3 L/min	SpO ₂ /FIO ₂ 231-315 or SpO ₂ >90% at 4-6 L/min	SpO ₂ /FIO ₂ 150-230 or SpO ₂ >90% at 7-10 L/min	SpO ₂ /FIO ₂ ≤150 or SpO ₂ >90% at >10L/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:						
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Mechanical Ventilation

* SpO_2/FIO_2 Ratio:
 SpO_2 = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO_2 = Fraction of inspired oxygen; e.g., ambient air is 0.21
 Example: if $SpO_2 = 95\%$ and $FIO_2 = 0.21$, the SpO_2/FIO_2 ratio is calculated as $95/0.21=452$

† Hypotension:
 $MABP$ = mean arterial blood pressure in mm Hg (diastolic + $1/3(\text{systolic} - \text{diastolic})$)
 dop = dopamine in micrograms/kg/min
 epi – epinephrine in micrograms/kg/min
 $norepi$ = norepinephrine in micrograms/kg/min

Re-allocate

STEP TWO: Compared to other patient(s) requiring and awaiting mechanical ventilation, does this patient have significant differences in prognosis or resource utilization in one or more categories below that would justify re-allocation of the ventilator? Factors listed are in order of importance / weight.

1. Organ System function+	Ventilator re-directed High Potential for death (MSOFA score ≥ 12)	→ Intermediate potential for death (MSOFA score 8-11)	Patient keeps ventilator Low potential for death (MSOFA score ≤ 7)
2. Duration of benefit / prognosis	a. Poor prognosis based upon epidemiology of specific disease/injury (e.g. pandemic influenza) b. Severe underlying disease with poor short-term (e.g. <1 year) prognosis++	a. Indeterminate / intermediate prognosis based upon epidemiology of specific disease/injury b. Severe underlying disease with poor long-term prognosis and/or ongoing resource demand (e.g. home oxygen dependent, dialysis dependent) and unlikely to survive more than 1-2 years.	a. Good prognosis based upon epidemiology of specific disease/injury b. No severe underlying disease
3. Duration of need	Long duration – e.g. ARDS, particularly in setting of pre-existing lung disease (estimate >7 days on a ventilator)	Moderate duration – e.g. pneumonia in healthy patient (estimate 3-7 days on ventilator)	Short duration – flash pulmonary edema, chest trauma, other conditions anticipating <3 days on ventilator
4. Response to mechanical ventilation	Worsening ventilator parameters over time+++	Stable ventilator parameters over time	Improving ventilator parameters over time

+ The Modified Sequential Organ Failure Assessment (MSOFA) score is the currently preferred assessment tool but other predictive models may be used depending on the situation / epidemiology. Note: MSOFA scores were not designed to forecast mortality, and thus single or a few point difference between patients may not represent a 'substantial difference' in mortality, but larger differences and trends can be extremely helpful in determining resource assignment.

++ Examples of underlying diseases that predict poor short-term survival include (but are not limited to):
 1. Congestive heart failure with ejection fraction < 25% (or persistent ischemia unresponsive to therapy or non-reversible ischemia with pulmonary edema)
 2. Severe chronic lung disease including pulmonary fibrosis, cystic fibrosis, obstructive or restrictive diseases requiring continuous home oxygen use prior to onset of acute illness

	<p>3. Central nervous system, solid organ, or hematopoietic malignancy with poor prognosis for recovery 4. Cirrhosis with ascites, history of variceal bleeding, fixed coagulopathy or encephalopathy 5. Acute hepatic failure with hyperammonemia</p> <p>+++ Changes in Oxygenation Index over time may provide comparative data, though of uncertain prognostic significance. OI = MAWP x FIO2 / PaO2 where: OI = oxygenation index MAWP= Mean Airway Pressure FIO2 = inspired oxygen concentration PaO2 = arterial oxygen pressure (May be estimated from oxygen dissociation curve if blood gas unavailable.)</p> <p>STEP THREE: Re-allocate ventilator only if patient presenting with respiratory failure has significantly better chance of survival / benefit as compared to patient currently receiving ventilation. Follow additional regional and state/federal guidance and institutional processes for scarce resource situations.</p>
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Staffing Strategies for Scarce Resource Situations

Potential Trigger Events	Strategy	Recommendations
STAFF UNABLE TO REPORT STAFF ILLNESS AT HOME WITH FAMILY UNABLE TO GET TO FACILITY STAFFING LEVELS INADEQUATE FOR DEMANDS OF DISASTER	Prepare	<p>1. Staff and supply planning</p> <ul style="list-style-type: none"> Encourage employee preparedness planning (www.floridadisaster.org and other resources). Cache adequate personal protective equipment (PPE) and support supplies. Educate staff on institutional disaster response and requirements. Educate staff on community, regional, state disaster plans and resources. Develop facility plans addressing staff's family / pets or staff shelter needs. Just in time training for respiratory care, oral rehydration and basic patient care. Develop agreements with universities, colleges and technical schools for the use of health and medical students in expanded roles.
	Substitute	<p>2. Use supplemental staff</p> <ul style="list-style-type: none"> Bring in equally trained staff (burn or critical care nurses, other health system, or Federal sources). Equally trained staff from administrative positions (nurse managers). Utilize medical and allied health students in expanded roles.
	Adapt	<p>3. Use alternative personnel to minimize changes to standard of care</p> <ul style="list-style-type: none"> Use less-trained personnel with appropriate mentoring and just-in-time education (e.g., healthcare trainees or other health care workers, Medical Reserve Corps, retirees). Use less-trained personnel to take over portions of skilled staff workload for which they have been trained. Adjust personnel work schedules (longer but less frequent shifts, etc.) if this will not result in skill / PPE compliance deterioration. Use family members/lay volunteers to provide basic patient hygiene and feeding – releasing staff for other duties.
	Conserve	<p>4. Focus staff time on core clinical duties</p> <ul style="list-style-type: none"> Minimize meetings and relieve administrative responsibilities not related to event. Use personnel with specific critical skills (ventilator, burn management) to concentrate on those skills; define other job duties that can be safely performed by other medical professionals. Have specialty staff oversees larger numbers of less-specialized staff and patients (for example, a critical care nurse oversees the intensive care issues of 9 patients while 3 medical/surgical nurses provide basic nursing care to 3 patients each).

Staffing

	<ul style="list-style-type: none">• Reduce documentation requirements.• Limit use of laboratory, radiographic, and other studies, to allow staff reassignment and resource conservation.• Reduce availability of non-critical laboratory, radiographic, and other studies.• Cohort patients to conserve PPE and reduce staff PPE donning/doffing time and frequency.• Restrict elective appointments and procedures.
Re-allocate	5. Divert staff to emergency response <ul style="list-style-type: none">• Cancel non-emergent appointments and procedures, and reassign staff to emergency duties including in-hospital or assisting public health at external clinics/screening/dispensing sites.

DRAFT

Appendices

- 1) Pediatric Medical Resource Allocation
- 2) Modified Sequential Organ Failure Assessment
- 3) Revised Trauma Score
- 4) Glasgow Coma Score (adult and pediatric)
- 5) Triage Decision for Burn Victims
- 6) Pugh Score
- 7) New York Heart Association Stages of Heart Failure
- 8) Emergency Medical Treatment and Active Labor Act
- 9) Sample Governor Executive Orders

APPENDIX 1

PEDIATRIC MEDICAL RESOURCE ALLOCATION*

Purpose: The purpose of this appendix is to provide guidelines to health care entities to direct pediatric medical resource allocation during a severe pandemic or other public health emergency when demand for services dramatically exceeds supply. Children require different skills and resources to treat their illnesses and injuries as compared with adults. Research in adults has shown that it is possible to predict the likelihood of a person surviving an illness or injury based on how well or poorly their major organs are working. A score is based on specific clinical information (such as blood pressure and level of consciousness) and lab information (such as blood oxygen levels) and is used to predict who is likely to survive. It is necessary to modify these scores for children because they have different normal numbers (such as blood pressure) when compared to adults, depending on the child's age. Children also show the seriousness of their organ damage differently, so different lab data are being used than those used for adults.

Scope: In the context of this appendix, pediatrics is defined as pediatric patients post-nursery until 18 years of age. The recommendations for triaging newborns are still under discussion and development.

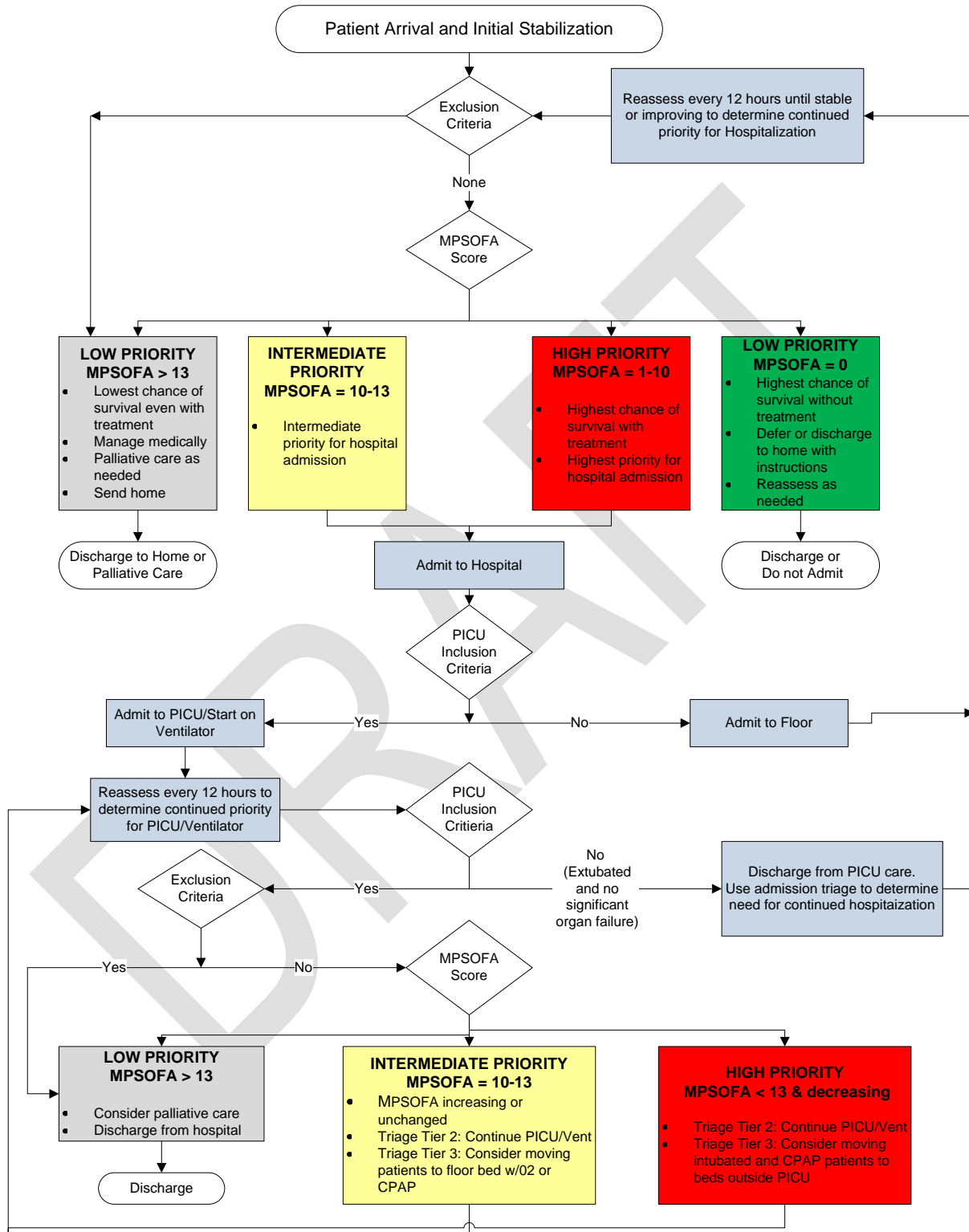
Clinical Triage Recommendations for Emergency Department, ICU and other Hospital Departments

- Use **HOSPITAL AND PICU/VENTILATOR ADMISSION TRIAGE ALGORITHM** to determine who to send home for palliative care or medical management and who to admit or keep in hospital or PICU. 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.
- If at all possible, health care providers applying the algorithm should **NOT** be responsible for the care of patients to whom it is applied.
- **Triage Tier 2:**
 - Initiate **HOSPITAL AND PICU/VENTILATOR TRIAGE ALGORITHM** to determine priority for PICU admission, intubation, and/or mechanical ventilation.
 - Reassess need and qualification for PICU/Ventilator treatment every 12 hours
- **Triage Tier 3:**
 - Continue to use **HOSPITAL AND PICU/VENTILATOR TRIAGE ALGORITHM** to determine priority for PICU, intubation, and/or mechanical ventilation.
 - Triage more **YELLOW** (Intermediate Priority) patients to floor on oxygen or CPAP.
 - Triage more **RED** (High Priority) patients who are intubated and on CPAP to floor.

***Adapted from Alaskan Technical Recommendations for Pediatric Medical Triage and Resource Allocation in a Disaster**

HOSPITAL and PICU/VENTILATOR TRIAGE ALGORITHM

For Triage Tiers 2 - 3



TRIAGE TOOLS AND TABLES

EXCLUSION CRITERIA (for hospital admission)

1. **The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:**
2. **Known “Do Not Resuscitate: (DNR) status**
3. **Severe and irreversible neurologic event or condition with persistent coma and Glasgow Coma Score (GCS) < 5** (Includes traumatic brain injury, severe hemorrhagic stroke, hypoxic ischemic brain injury, and intracranial hemorrhage).
4. **Severe burns** requiring critical care resources and those who would be transferred to an out-of-state burn center under normal circumstances. If circumstances prohibit out-of-state transfer, patient with >20% Total Body Surface Area (TBSA) full thickness burns will only be provided palliative care. Patients with <20% TBSA burns will be considered for critical care resources based on their MPSOFA score. Severe burns not requiring critical care resources may be cared for at the local facility.
5. **Cardiac arrest** not responsive to 25 minutes of Pediatric Advanced Life Support (PALS) or Basic Life Support (BLS).
6. **Complex disorders** with significant neurological component and prognosis for imminent expected lifelong assistance with most basic activities of daily living (i.e. toileting, dressing, feeding, respiration).
7. **Incurable malignant disease**
8. **Irreversible end-stage organ failure**

PICU / Ventilator INCLUSION CRITERIA

To qualify for PICU admission or ventilatory support, the patient must have **NO EXCLUSION CRITERIA AND at least one of the following INCLUSION CRITERIA:**

1. **Requirement for invasive ventilatory support**
 - Refractory hypoxemia ($\text{SPO}_2 < 90\%$ on non-rebreather mask or $\text{FiO}_2 > 0.85$)
 - Respiratory acidosis ($\text{pH} < 7.2$)
 - Clinical evidence of impending respiratory failure
 - Inability to protect or maintain airway
2. **Hypotension[†] with clinical evidence of uncompensated 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 + (2x age in years) for patients ages 1-10, or relative hypotension;

Clinical evidence of uncompensated shock = altered level of consciousness, decreased urine output, or other evidence of end stage organ failure.

Modified Pediatric Sequential Organ Failure Assessment (MPSOFA)

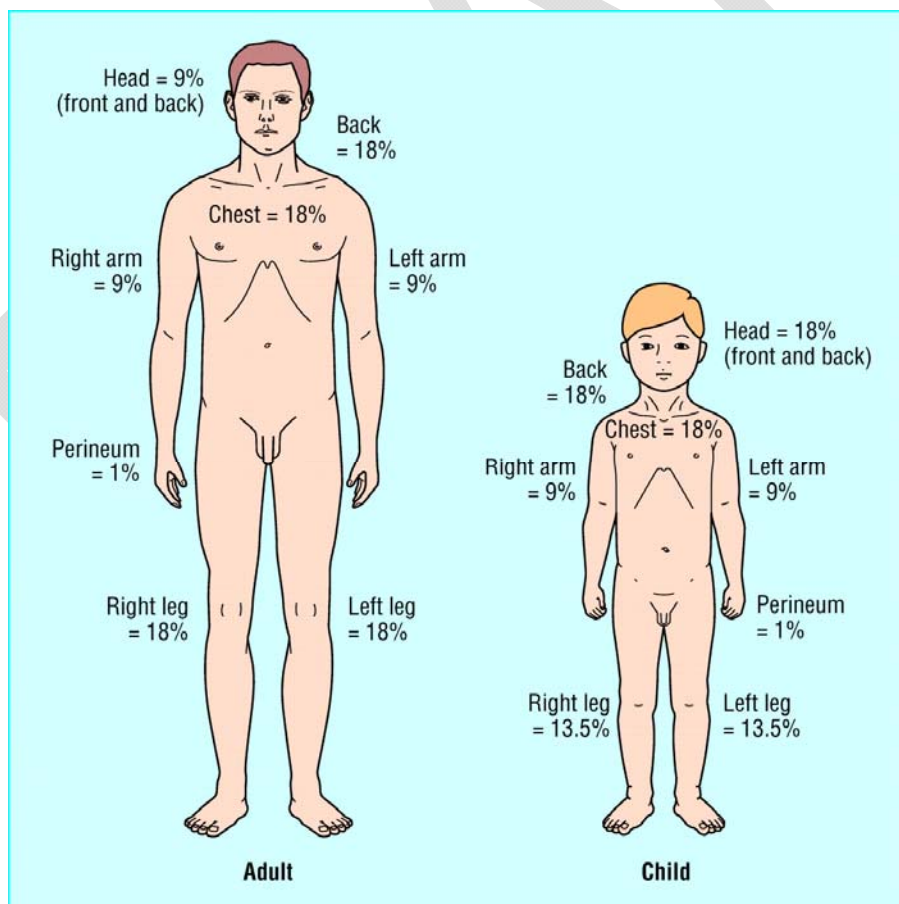
MPSOFA Scoring Guidelines						
Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Row Score
SpO₂/FiO₂ ratio or Nasal cannula or O₂ mask required to keep SpO₂ > 90%	SpO ₂ /FiO ₂ > 400 or Room air SpO ₂ > 90%	SpO ₂ /FiO ₂ 316-400 or SpO ₂ > 90% at 1-3 L/min	SpO ₂ /FiO ₂ 231-315 Or SpO ₂ > 90% at 4-6 L/min	SpO ₂ /FiO ₂ 151-230 Or SpO ₂ > 90% at 7-10 L/min	SpO ₂ /FiO ₂ ≤ 150 or SpO ₂ > 90% at > 10 L/min	
Total Bilirubin (mg/dL)	< 1.2 or no scleral icterus	1.2 - 1.9	2.0 - 5.0 or scleral icterus	6.0 – 11.9 or clinical jaundice	≥ 12	
Hypotension	None	MABP < 2 Std. Deviations for age Reference: Harriet Lane MABP table	DOP < 5	DOP 5-15 or EPI ≤ 0.1 or NOR-EPI ≤ 0.1	DOP > 15 or EPI > 0.1 or NOR-EPI > 0.1	
Glasgow Coma Score	14-15	11-13	9-10	7-8	< 6	
Lactate (mmol/L)	< 2.0	2.0 – 4.0	4.1 – 6.0	6.1 – 8.0	> 8.0	
MPSOFA Score = Total of Row Scores:						

Explanation of Variables

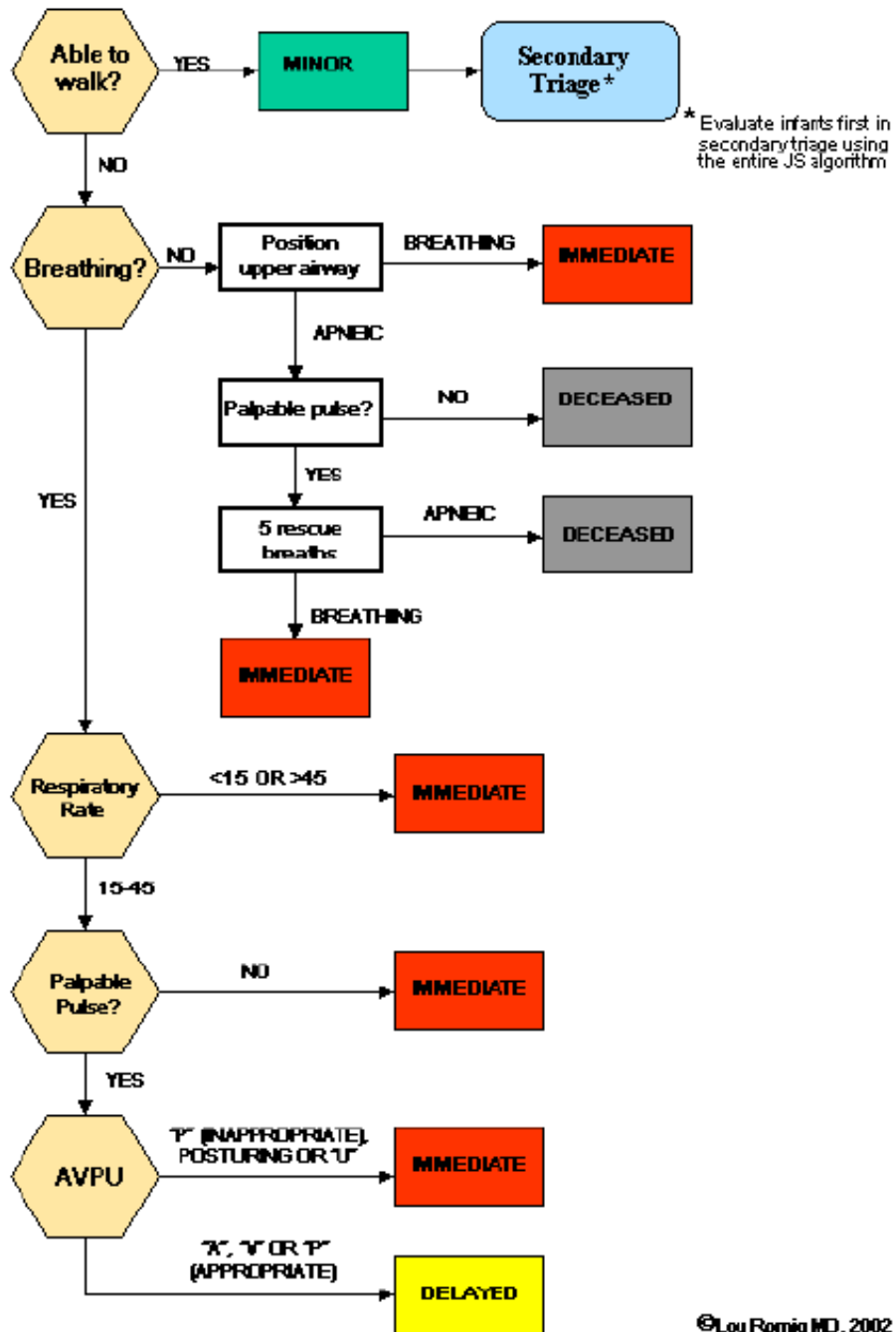
- **SpO₂/FiO₂ ratio** indicates the level of oxygen in the patient's blood. SpO₂ = Percent oxygen saturation of hemoglobin, expressed as %, e.g. 95%; FiO₂ = Fraction of inspired oxygen, e.g. ambient air is 0.21. Example: SpO₂ = 95%, FiO₂ = 0.21; SpO₂/FiO₂ ratio = 95/0.21 = 452
- **Bilirubin** is measured by a blood test and indicates liver function
- **Hypotension** indicates low blood pressure; scores of 2, 3 and 4 indicate that blood pressure must be maintained by the use of powerful medications that require ICU monitoring, including dopamine (DOP), epinephrine (EPI), and norepinephrine (NOR-EPI). MABP = Mean Arterial Blood Pressure in mm Hg (diastolic + 1/3 (systolic – diastolic))
- **The Glasgow Coma Score** is a standardized measure that indicates neurologic function; low score indicates poorer function
- **Lactate** is measured by a blood test (i-STAT CG4+ Cartridge recommended)

Glasgow Coma Scale				
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 verbal command	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	Confused infant is irritable and continually cries	4	
	Oriented	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):				

Total Body Surface Area (TBSA) Estimation Tool for Burn Triage



JumpSTART Pediatric MCI Triage[®]



©Lou Romig MD, 2002

APPENDIX 2

MODIFIED SEQUENTIAL ORGAN FAILURE ASSESSMENT (MSOFA)

The MSOFA requires only on lab value, which can be obtained using bedside point-of-care testing (creatinine obtained through (ISTAT)).

MSOFA scoring guidelines						
Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
SpO ₂ /FIO ₂ ratio* or nasal cannula or mask O ₂ required to keep SpO ₂ >90%	SpO ₂ /FIO ₂ >400 or room air SpO ₂ >90%	SpO ₂ /FIO ₂ 316-400 or SpO ₂ >90% at 1-3 L/min	SpO ₂ /FIO ₂ 231-315 or SpO ₂ >90% at 4-6 L/min	SpO ₂ /FIO ₂ 150-230 or SpO ₂ >90% at 7-10 L/min	SpO ₂ /FIO ₂ ≤150 or SpO ₂ >90% at >10L/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:						_____

* 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

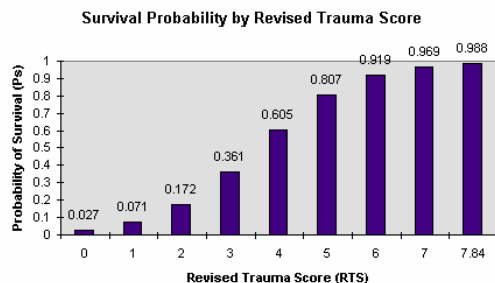
epi – epinephrine in micrograms/kg/min

norepi = norepinephrine in micrograms/kg/min

APPENDIX 3

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 influenza at triage Levels 2 and 3.



Revised Trauma Score Calculation				
Criteria	Score	Coded value	Weighting	Adjusted Score
Glasgow Coma Score	3	0	x0.9368	_____
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 16	4		
Systolic Blood Pressure (SBP)	0	0	x0.7326	_____
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
Respiratory Rate (RR) in breaths per minute (BPM)	>89	4	x0.2908	_____
	0	0		
	1 to 5	1		
	6 to 9	2		
	>29	3		
Revised Trauma Score (add 3 adjusted scores)				_____

APPENDIX 4

GLASGOW COMA SCORE

A Glasgow Coma Score (GCS) of < 6 is an **EXCLUSION CRITERION** for hospital admission in the case of pandemic influenza at triage Levels 2 and 3.

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 sub-scores; range 3 to 15)				_____

APPENDIX 5

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 influenza at triage Levels 2 and 3.

Age (years)	Burn Size (% TBSA)									
	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 \geq 90%) and with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission \geq 14-21days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50-90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission \geq 14-21 days, multiple surgeries and prolonged rehabilitation; **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant:** Predicted survival \leq 10% even with unlimited aggressive treatment.

APPENDIX 6

PUGH SCORE

A Total Pugh Score > 7 is an **EXCLUSION CRITERION** for hospital admission in the case of a pandemic influenza at triage Levels 2 and 3.

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

APPENDIX 7

New York Heart Association (NYHA) Stages of Heart Failure

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 influenza at triage Levels 2 and 3.

NYHA Classes	
Class	Patient Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, or dyspnea.
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitations, or dyspnea.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes fatigue, palpitations, or dyspnea.
Class IV (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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APPENDIX 8

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

EMTALA provisions may be waived by the Secretary of Health and Human Services during a declared public emergency and under the Stafford Act. The Secretary can issue a 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 with 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 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.

DRAFT

APPENDIX 9

SAMPLE GOVERNMENT EXECUTIVE ORDERS

(adapted from the Colorado Department of Health) (subject to revision by legal counsel)

Florida Governor Executive Orders will be needed for various purposes in a pandemic influenza event or other public health emergency. Sample Governor Executive Orders from the State of Colorado are shown below:

Executive Order 0.0 Declaring a State of Public Health Disaster. This executive order declares a disaster emergency of an epidemic type. The State Surgeon General would meet and advise the governor that an emergency exists. The governor would then issue this order, which is good for 30 days and sets the stage for other orders directing specific actions to meet the emergency.

Executive Order 1.1 Ordering Hospitals to Transfer or Cease the Admission of Patients to Respond to the Current Disaster Emergency. In directly authorizing hospitals to cease admissions and transfer patients, this order permits hospitals to determine on their own without central guidance whether they have reached their capacity to examine and treat patients. It further grants immunity from civil or criminal liability to those hospitals, physicians, and emergency service providers who act in good faith to comply with the executive order. The order takes the position that the Emergency Medical Treatment and Labor Act (EMTALA) requirements do not preempt this order.

Executive Order 2.0 Concerning the Procurement and Taking of Certain Medicines and Vaccines Required to Respond to the Current Disaster Emergency. This order authorizes the seizure of certain named drugs from public and private outlets listed in the State's pharmacy statutes, and embargoes the supply of those drugs. At the same time, it exempts from seizure those supplies that certain facilities are required to keep on hand for the chemoprophylaxis of their employees. It provides for keeping records of drugs embargoed and for compensating the outlets at the cessation of the emergency.

Executive Order 3.0 Concerning the Suspension of Certain Statutes and Regulations to Provide for the Rapid Distribution of Medication in Response to the Current Disaster Emergency. This order implements Florida's Strategic National Stockpile Plan and suspends certain pharmacy statutes to facilitate the rapid distribution of medicines and vaccines in response to an emergency epidemic. The order further authorizes named officials to direct listed health care providers to participate in this effort and explicitly permits the limited participation in that effort by nonmedical personnel. The order is not intended for application in response to a chemical event.

Executive Order 4.0 Concerning the Suspension of Physician and Nurse Licensure Statutes to Respond to the Current Disaster Emergency. This order permits physicians and nurses who hold a license in good standing in another State, or who hold an unrestricted but inactive Florida license, to practice under the supervision of a Florida-licensed physician during the emergency,

provided they do so without charge to the State or any individual patient or victim. This order would permit more physicians and nurses to be available to treat infected persons during the emergency.

Executive Order 5.0 Concerning the Suspension of Certain Licensure Statutes to Enable More Florida-Licensed Physician Assistants and Emergency Medical Technicians to Assist in Responding to the Current Disaster Emergency. Under normal conditions, physician assistants (PAs) and emergency medical technicians (EMTs) licensed in Florida can practice only in association with or under the supervision of physicians by prior agreement. This order permits PAs and EMTs to practice under the supervision of any licensed physicians in order to afford treatment to the greatest number of infected individuals. The PAs, EMTs, and physicians involved are granted immunity from civil or criminal liability if they act in good faith to meet the terms of the order.

Executive Order 6.0 Concerning the Isolation and Quarantining of Individuals and Property in Response to the Current Disaster Emergency Epidemic. This order empowers the Florida Department of Health to establish, maintain, and enforce isolation (of infected individuals) and quarantine of (exposed individuals) as needed to protect the public health in an epidemic situation. It further grants similar powers to local emergency management to combat infectious disease epidemics.

Executive Order 7.0 Ordering Facilities to Transfer or Receive Patients with Mental Illness and Suspending Certain Statutory Provisions to Respond to the Current Disaster Emergency. This order permits the transfer of mentally ill persons from a designated facility to some other facility as necessary to treat them for the infectious disease causing the epidemic. It further specifies requirements related to required services and use of identifying personal information, and provides for immunity from civil or criminal liability for any facility acting in good faith under the order.

Executive Order 8.0 Concerning Suspension of Certain Statutes Pertaining to Death Certificates and Burial Practices in Response to the Current Disaster Emergency. This order suspends the statutory timing requirements for filing death certificates and authorizes the State Surgeon General of the Florida Department of Health to direct the disposition of dead bodies in a manner that will protect the public health.

REFERENCES AND RESOURCES

Utah Pandemic Influenza Hospital and ICU Triage Guidelines, Utah Department of Health and the Utah Hospitals and Health Systems Association, Draft document, 8/12/08 - http://www.pandemicflu.utah.gov/plan/med_triage120707.pdf

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