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.
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 present 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 care instructions (Appendix C2 or C3).

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

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.

See pages 4 and 5 for triage algorithm and supporting tools.
ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE
Applies at Pandemic Triage Levels 2 and 3

Patient arrival and initial stabilization

1 or more

EXCLUSION CRITERIA (a)

none

MSOFA score (b)

MSOFA >11

LOW PRIORITY
- Lowest chance of survival even with treatment
- Manage medically
- Provide palliative care as needed
- Send home

DISCHARGE TO HOME OR FOR PALLIATIVE CARE

MSOFA 8 TO 11

INTERMEDIATE PRIORITY
- Intermediate priority for hospital admission
- For severe pandemic, highest priority for admission is given to patients triaged to RED

ADMIT to HOSPITAL

MSOFA 1 TO 8

HIGHEST PRIORITY
- Highest chance of survival with treatment
- Highest priority for hospital admission

ADMIT to ICU/VENTILATOR

MSOFA = 0

LOW PRIORITY
- Highest chance of survival without treatment
- Refer or discharge to home with instructions
- Reassess as needed

DISCHARGE OR DO NOT ADMIT

Reassess daily to determine continued priority for hospitalization

ADMIT to HOSPITAL

ICU INCLUSION CRITERIA (c)

yes

no

ADMIT to FLOOR

Reassess daily after 48-72 hrs ICU care to determine continued priority for ICU/VENTILATOR

Still meet ICU INCLUSION CRITERIA (c)

no

Discharge from critical care. Use hospital admission triage to determine continued need for hospitalization.*

EXCLUSION CRITERIA (a)

yes

no

Interpret MSOFA results along with physician judgment about patient condition

MSOFA >11

LOW PRIORITY
- Consider palliative care
- Discharge from critical care (and hospital)

DISCHARGE

MSOFA increasing or 8 to 11 unchanged

INTERMEDIATE PRIORITY
- Triage Level 2: Continue ICU/Ventilator
- Triage Level 3: Consider moving patients to floor bed on O₂ or CPAP

MSOFA <8 or <11 and decreasing

HIGHEST PRIORITY
- Triage Level 2: Continue ICU/Ventilator
- Triage Level 3: Consider moving patients who are still intubated and on CPAP to beds outside the ICU.
### 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.
- **(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 (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 (g), right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
  - **Liver**: PUGH SCORE >7 (h), when available. Includes bilirubin, 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 obtained using bedside point-of-care testing (creatinine obtained through ISTAT). MSOFA has not been validated in children, but is currently under study.

<table>
<thead>
<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 0 required to keep SpO2 &gt;90%</td>
<td>SpO2/FIO2 &gt;400 or room air SpO2 &gt;90%</td>
<td>SpO2/FIO2 316-400 or SpO2 &gt;90% at 1-3 L/min</td>
<td>SpO2/FIO2 231-315 or SpO2 &gt;90% at 4-6 L/min</td>
<td>SpO2/FIO2 151-230 or SpO2 &gt;90% at 7-10 L/min</td>
<td>SpO2/FIO2 ≤150 or SpO2 &gt;90% at &gt;10 L/min</td>
<td>______</td>
</tr>
</tbody>
</table>

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

---

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

- **(2)** Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.
  - *Hypotension = Systolic BP <90 mm Hg 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

See Appendix B for a Patient Worksheet based on the above Exclusion and Inclusion Criteria.
(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.

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

Total Score (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.

<table>
<thead>
<tr>
<th>Revised Trauma Score Calculation</th>
<th>Criteria</th>
<th>Score</th>
<th>Coded value</th>
<th>Weighting</th>
<th>Adjusted Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Coma Score</td>
<td>3</td>
<td>0</td>
<td>x 0.9368</td>
<td>3.1092</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 to 5</td>
<td>1</td>
<td></td>
<td>5.2858</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 to 8</td>
<td>2</td>
<td></td>
<td>12.5893</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 to 12</td>
<td>3</td>
<td></td>
<td>24.6147</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13 to 16</td>
<td>4</td>
<td></td>
<td>52.8721</td>
<td></td>
</tr>
<tr>
<td>Systolic Blood Pressure (SBP)</td>
<td>0</td>
<td>0</td>
<td>x 0.7326</td>
<td>0.0000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 49</td>
<td>1</td>
<td></td>
<td>0.7326</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50 to 75</td>
<td>2</td>
<td></td>
<td>2.4357</td>
<td></td>
</tr>
<tr>
<td></td>
<td>76 to 89</td>
<td>3</td>
<td></td>
<td>3.7021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;89</td>
<td>4</td>
<td></td>
<td>5.6018</td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate (RR) in breaths per minute (BPM)</td>
<td>0</td>
<td>0</td>
<td>x 0.2908</td>
<td>0.0000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 5</td>
<td>1</td>
<td></td>
<td>0.5948</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 to 9</td>
<td>2</td>
<td></td>
<td>2.1274</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;29</td>
<td>3</td>
<td></td>
<td>8.7654</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 to 29</td>
<td>4</td>
<td></td>
<td>17.2855</td>
<td></td>
</tr>
</tbody>
</table>

Revised Trauma Score (add 3 adjusted scores): __________

Survival Probability based on Revised Trauma Score

<table>
<thead>
<tr>
<th>Revised Trauma Score Value</th>
<th>Probability of Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>2.0</td>
<td>0.7</td>
</tr>
<tr>
<td>3.0</td>
<td>0.5</td>
</tr>
<tr>
<td>4.0</td>
<td>0.3</td>
</tr>
<tr>
<td>5.0</td>
<td>0.2</td>
</tr>
<tr>
<td>6.0</td>
<td>0.1</td>
</tr>
<tr>
<td>7.0</td>
<td>0.0</td>
</tr>
<tr>
<td>7.84</td>
<td>0.0</td>
</tr>
</tbody>
</table>
(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.

<table>
<thead>
<tr>
<th>Age (yrs)</th>
<th>Burn Size (% total body surface area)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1.9</td>
<td>Very high</td>
</tr>
<tr>
<td>2.0-4.9</td>
<td>Outpatient</td>
</tr>
<tr>
<td>5.0-19.9</td>
<td>Outpatient</td>
</tr>
<tr>
<td>20.0-29.9</td>
<td>Outpatient</td>
</tr>
<tr>
<td>30.0-39.9</td>
<td>Outpatient</td>
</tr>
<tr>
<td>40.0-49.9</td>
<td>Outpatient</td>
</tr>
<tr>
<td>50.0-59.9</td>
<td>Outpatient</td>
</tr>
<tr>
<td>60.0-69.9</td>
<td>Very high</td>
</tr>
<tr>
<td>70.0+</td>
<td>Very high</td>
</tr>
</tbody>
</table>

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.

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

(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.

<table>
<thead>
<tr>
<th>Scoring criteria</th>
<th>Value</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Serum Bilirubin</td>
<td>&lt;2 mg/dL</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2-3 mg/dL</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>&gt;3 mg/dL</td>
<td>3</td>
</tr>
<tr>
<td>Serum Albumin</td>
<td>≥3.5 g/dL</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2.8 - 3.5 g/dL</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>&lt;2.8 g/dL</td>
<td>3</td>
</tr>
<tr>
<td>INR</td>
<td>&lt;1.70</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1.71-2.20</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>&gt;2.20</td>
<td>3</td>
</tr>
<tr>
<td>Ascites</td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Controlled medically</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Poorly controlled</td>
<td>3</td>
</tr>
<tr>
<td>Encephalopathy</td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Controlled medically</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Poorly controlled</td>
<td>3</td>
</tr>
</tbody>
</table>

Total Pugh Score

<table>
<thead>
<tr>
<th>Score interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PUGH SCORE</td>
</tr>
<tr>
<td>5-6</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>7 to 9</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>10 to 15</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Used with permission from www.abouthf.org.
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:


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 Markowitz, 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. McGill, 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. Geibhart, 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

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 it is first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.

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