



Oregon Interim Crisis Care Tool

1-06-2022

Principles

In the event of a public health crisis, healthcare demands may overwhelm available capacity to offer potentially life-saving care to all who need it. With an expected Omicron surge ahead which will further overwhelm hospital capacity, OHA is issuing this interim crisis care tool that hospitals can use to equitably prioritize care in the face of limited intensive care beds, ventilators and other life-saving resources should it be needed.

OHA developed this interim crisis care tool based on several existing triage tools, such as those published by Arizona, Massachusetts and Washington, and made adaptations according to Oregon's [Principles in Promoting Health Equity in Resource Constrained Events](#). These principles include non-discrimination, health equity, patient-led decision making and transparent communications.

Oregon hospitals may activate crisis standards of care if their critical care resources are severely limited, the number of patients presenting for critical care exceeds capacity, and there is no option to transfer patients to other critical care facilities.

For hospitals with an existing crisis care tool relating to scarce critical care resources, they may continue to use the existing tool so long as it is consistent with the principles outlined in [Principles in Promoting Health Equity in Resource Constrained Events](#) and does not violate state or federal anti-discrimination laws, or any other applicable laws.

The Omicron surge does not allow time for the robust, comprehensive and fully inclusive community and clinician engagement needed to establish a more permanent triage tool for Oregon hospitals. OHA remains committed to urgently continuing our parallel work to co-create new tools for the allocation of scarce resource with our community partners and healthcare providers in Oregon, and will convene the new Oregon Resource Allocation Advisory Committee this winter. This committee will inform revisions to OHA's 2020 published principles and this interim crisis care tool and guide the development of any additional necessary resources that help to center health equity in processes and decisions when healthcare system resources are constrained.

This interim tool remains imperfect and inadequately addresses health inequity, even as it better incorporates Oregon's non-discrimination, health equity principles into difficult triage decisions.

Barriers in the health system for communities of color, tribal communities and people with disabilities, along with the disproportionate experience of underlying or chronic health conditions, are linked to critical inequities in access to needed and unbiased health care, safe and supportive housing, adequate food and nutrition, and more. The work ahead of the Oregon Resource Allocation Advisory Committee must give specific attention to how we improve on the equitable allocation of scarce resources, while acknowledging the foundational inequities that begin before the process of triage and prioritization at the time of a crisis.

Concepts: Care continuum

As described by the Institute of Medicine in 2013¹, the need for healthcare surge capacity in a disaster occurs along a continuum based on demand for health care services and available resources. These concepts include:

- **Conventional Capacity.** The spaces, staff, and supplies used to deliver care are consistent with daily practices within hospitals. The clinical care spaces and practices that are used in response to the pandemic are adequate to support clinical care that is equivalent to usual patient care.
- **Contingency Capacity.** The spaces, staff, and supplies used are not consistent with daily practices, but support care that is functionally equivalent to usual patient care practices. Alterations in the use of clinical care spaces or practices may be used temporarily or on a more sustained basis during the pandemic (when the demands of the incident exceed community resources).
- **Crisis Capacity.** Crisis capacity activation constitutes a significant adjustment to standards of care. A crisis situation exists when critical care resources are severely limited, the number of patients presenting for critical care exceeds capacity, and there is no option to transfer to other critical care facilities.

Assumptions

In the event of impending scarcity, OHA will work with Oregon's hospitals to make every effort to maximize the capacity of the entire healthcare system to provide needed care to as many patients as possible. This will be achieved through coordination efforts to load balance patients across institutions and directing critical resources to the areas that are hardest hit.

Coordination among response partners at all levels (facility, local, regional, state, and federal) is expected in order to best meet medical surge needs.

¹ Institute of Medicine 2013. *Crisis Standards of Care: A Toolkit for Indicators and Triggers*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/18338>.

Oregon hospitals may activate crisis standards of care if their critical care resources are severely limited, the number of patients presenting for critical care exceeds capacity, and there is no option to transfer patients to other critical care facilities.

Prior to the implementation of the triage recommendations included in this document, the following assumptions will be met:

- Each hospital will take all possible steps to extend capacity to deliver critical care resources, including by (a) accumulating supplies; (b) delaying non-urgent care; (c) preparing to use space, staff and other resources that are not typically used for critical care delivery to deliver critical care.
- Each hospital will have coordinated with OHA, regional resource hospitals and other local and state response partners and alerted them to the current situation.
- Crisis standards of care (CSC) are only activated in extraordinary circumstances when critical care resources are severely limited, the number of patients presenting for critical care exceeds capacity, and there is no option to transfer to other critical care facilities.

When a hospital has met all of the assumptions above regarding the need for CSC and all other options have been exhausted, hospitals can and should activate a crisis care tool to triage critical care resources. Hospitals must let OHA know that CSC have been triggered and should publicly post that crisis tools are being used and make the tool they are using available upon request.

The public will need access to up-to-date, accurate, and transparent information about the use of CSC, and access to any relevant instructions as to how they may best seek access to care during the disaster.

The need for ongoing utilization of a crisis care tool should be continuously evaluated, and triage should be suspended immediately once critical resources are no longer scarce.

Crisis care guidance: introduction

If resources are sufficient, all patients who can potentially benefit from therapies will be offered therapies. If resources are insufficient, all patients will be individually assessed according to the best available objective medical evidence.

- Care decisions should be based upon the likelihood of survival to hospital discharge.
- No one will be denied care based on stereotypes, assumptions about any individual's quality of life, or judgement about an individual's "worth" based on the presence or absence of disabilities.

An individual's use of past or future medical or social resources may not be a factor in care decisions. Reasonable modifications must be applied where appropriate to any triage scoring criteria to account for individuals with underlying disabilities. Other reasonable modifications needed to ensure equal access to treatment for patients with disabilities may also be required.

All patients, regardless of resource availability, will be treated with respect, care, and compassion. Triage decisions will be made without regard to morally or scientifically irrelevant considerations such as socio-economic status, race, ethnicity, gender identity, sexual orientation, national origin, immigration status, faith orientation, parental status, ability to pay, insurance coverage, disability, veteran status, genetic information, perceived quality of life, resource- intensity/duration, perceived social worth, or solely on the basis of age.

Triage decisions may not use categorical exclusion criteria based on any of the factors listed above. Rather, decisions should be determined using an individual assessment based on the best objective medical evidence. As part of any assessment, reasonable modifications, auxiliary aids and services, and language interpretation services must be provided where necessary to ensure access to medical care.

If time permits, hospitals that have reached contingency or crisis capacity levels and face shortages of resources (hospital beds, ICU beds, ventilators, dialysis machines, etc.) should work with other facilities to see if these resources are available elsewhere. If time does not permit and/or other facilities are short on critical resources, triage protocols such as outlined in this document should be utilized.

Patient care preferences

Prior to, as well as during implementation of CSC, all efforts must be made to determine a patient's goals of care and treatment preferences. It is imperative to know whether aggressive interventions such as hospitalization, ICU admission or mechanical ventilation are consistent with a patient's preferences.

For a patient with decision-making capacity, the individual's informed refusals and informed wishes for life-sustaining treatment should be respected to the extent possible given the triage decisions that must be made. Patients and their families must not be steered or pressured into agreeing to the withdrawal from, withholding of, or advocating for life-sustaining care. All hospitalized patients should be asked whether they have advance directives for health care documents, portable orders for life-sustaining treatment (POLST)², what are their goals of care, and should be strongly encouraged to appoint a proxy decision-maker (e.g., health care representative or durable power of attorney for healthcare) if not previously in place.

Supported decision making will be used for patients with limited or low capacity to make decisions about their health. This will allow patients with disabilities to identify support people to help the person with a disability understand, consider, and communicate decisions, giving the patient with a disability the tools to make their own, informed, decisions.³

Providers must be careful not to pressure patients or their families to make advanced care planning decisions due to perceptions of quality of life or relative worth nor require patients to

² <https://oregonpolst.org/>

³ SB 1606/OAR 333-505-0033.

consent to a particular advanced care planning decision to continue to receive services from the facility. If advanced care planning documents are in place and available, the healthcare provider should verify the patient's goals of care and treatment preferences remain the same. Medical orders and advanced care planning documents should be updated if the patient's treatment wishes have changed.

CSC triage team

A CSC triage team should be designated by the hospital for implementing critical care resource allocation determinations. Those serving as representatives of the triage team should not be caring for the patient being triaged, unless that is impossible given the staffing capabilities of the hospital. Triage staff must recuse themselves from triage determinations for patients they are personally treating unless no other option exists. When possible, it is recommended that a hospital's CSC triage team consist of:

- Two to three senior clinicians with experience in triage (e.g., critical care, emergency medicine, trauma surgery, etc.). This should include at least one physician and one nurse. These clinicians should be licensed and actively participating in their field.
- A medical ethicist with experience and training as a healthcare ethics consultant.
- An expert in diversity, equity and inclusion.
- An administrative assistant to record all triage team decisions and maintain necessary records and documents.

In order to best mitigate implicit bias, to the greatest extent possible each hospital should have a group of triage officers and a triage team that adequately reflects the diversity of the patient population served by the hospital in terms of demographics such as race, ethnicity, disability, preferred language, sexual orientation and gender identity. Every attempt should be made to assemble a team that reflects the diversity of the community and population served by the hospital. Diversity among triage officers is intended to promote health equity and to mitigate against the perpetuation of health disparities in resource allocation.

Members of a hospital's triage team with the responsibility to determine allocation of scarce resources should also have training in implicit bias and anti-racism. If staff with this training are not immediately available, such training for triage team members should be attained as soon as possible.

Triage process for critical care resource allocation

When CSC are implemented, providers will assign triage priority scores for all patients that require ICU level of care (e.g., patients with hypotension, requiring ventilatory support, other ICU-level needs). These triage protocols should be applied to all individuals, including both COVID-19 and non-COVID-19 patients, regardless of age, disability status, or other extraneous factors. All individuals should be included and evaluated in the same triage pool of individuals requiring treatment in critical care settings.

- Assessments must be individualized for each patient based on the best available, relevant, and objective medical evidence. When considering prognosis, the relevant consideration concerns the acute episode and restoration to the patient's baseline and should not include considerations of the patient's long-term survival or resource intensity/duration of need.
- In the rare instance in which the reference tables provided may not capture an element important in determining prognosis, providers may consider extra elements in cases where triage (scores) are equal or are unable to be determined due to a lack of clinical data.
- After presenting relevant clinical information pertinent to triage criteria only, treating providers will be recused and the triage officer(s) will make a triage decision regarding the allocation of scarce resources; for example, the initiation, continuation, or withdrawal of a particular scarce resource. Treating providers will not make decisions to withhold or withdraw life-sustaining interventions in CSC situations as long as an independent triage officer or ethics consultant is available or unless allowed under Oregon Revised Statute (ORS) 127.635.
- Treating providers may make decisions to withhold or withdraw life-support based on goals of care conversations through shared decision-making with patient/family. This is consistent with conventional practice.

Triage priority scores

Triage priority scores are calculated for adults using a point system based on the SOFA or mSOFA score to assess survival to hospital discharge as determined based on the best available objective medical evidence. Modifications must be made for individuals with chronic kidney disease as outlined below.

For pediatric patients, an age appropriate prognostic tool (e.g., PELOD-2 for children, SNAPPE-II for full term neonates, and NICHD-OT for preterm neonates) should be used. See pediatric considerations section below.

Reasonable modifications must also be made to any assessment instrument when necessary to ensure that the final triage priority score is accurate for use with patients with underlying disabilities, and that disability-related characteristics unrelated to short-term mortality risk do not worsen the patient's score. Use of a pediatric specific scoring rubric, such as the PELOD-2, may be a reasonable modification for patients with a disability (e.g., deafness, cognitive or mobility limitations).

All patients will be eligible to receive critical care beds and services regardless of their triage priority score, but available critical care resources will be allocated according to priority score, such that the availability of these services will determine how many patients will receive critical care.

Steps for calculating triage priority scores

Step 1: Determine prognosis for hospital survival:

- a. Assess degree of organ dysfunction as measured or informed by the SOFA (Table A), mSOFA (Table B) or age appropriate prognostic tool (e.g., PELOD-2 for children, SNAPPE-II for full term neonates, and NICHD-OT for preterm neonates). May also consider other validated tools for special circumstances as appropriate e.g., MGAP for trauma patients.
- b. Adjust the mSOFA or SOFA score for patients with chronic kidney disease (see below).
- c. Assess need for reasonable modifications for individuals with underlying disabilities (see below).

Step 2: Assign triage priority score based on prognosis for hospital survival:

- a. Apply triage priority score according to Table C and best available objective medical evidence.
- b. **PAUSE** and review scoring for clinical consistency and potential biases; encourage participation of the multidisciplinary triage team during this review.
- c. If some of the information normally used to determine the prognosis for hospital survival is not immediately available, clinical judgment will be required and/or reasonable modifications made to assessment tools.
- d. Consider clinical signs indicating patient is imminently dying
- e. If the triage priority score based on prognostic tools such as mSOFA/SOFA is not clinically consistent, adjust score as needed, with input from multidisciplinary triage team, while being mindful of potential biases.

Step 3: Confirm and communicate triage priority score. Patients with the lowest points will be given highest priority to receive critical care resources

Step 4: If a patient meets ICU admission criteria but receives lower priority for scarce critical care resources, the patient will be placed on an ICU waiting list and admitted to the floor for ongoing care. As resources become available, their clinical situation will be re-assessed, and they will be re-triaged based on criteria outlined in Step 1–3.

See Diagram 1 for illustration of CSC algorithm.

Table A: Sequential organ failure assessment tool (SOFA)

Sequential Organ Failure Assessment (SOFA) Score ¹⁻²

Organ System	0	1	2	3	4
Respiratory PaO ₂ /FiO ₂ , mmHg	>400	≤400	≤300	≤200	≤100
Coagulation Platelets x10 ³ /μL	>150	≤150	≤100	≤50	≤20
Liver Bilirubin, mg/dL	<1.2	1.2-1.9	2.0-5.9	6.0-11.9	>12.0
Cardiovascular, hypotension	No hypo- tension	MAP <70 mm Hg	dopamine ≤5 or dobutamine any dose	dopamine >5 epinephrine ≤0.1 norepinephrine ≤0.1	dopamine >15 epinephrine >0.1 norepinephrine >0.1
CNS, Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal, Creatinine mg/dL urine output mL/d	<1.2	1.2-1.9	2.0-3.4	3.5-4.9 or urine <500 mL/d	>5.0 or urine <200 mL/d

Table B: Modified sequential organ failure assessment tool (mSOFA)

Organ System	0	1	2	3	4
Respiratory SpO ₂ /FiO ₂	>400	≤400	≤315	≤235	≤150
Liver	No scleral icterus or jaundice			Scleral icterus or jaundice	
Cardiovascular, hypotension	No hypo- tension	MAP <70 mm Hg	dopamine ≤5 or dobutamine any dose	dopamine >5 epinephrine ≤0.1 norepinephrine ≤0.1	dopamine >15 epinephrine >0.1 norepinephrine >0.1
CNS, Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal, Creatinine mg/dL	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5.0

Table C. Prognosis for hospital survival using mSOFA scores

Points				
1	2	3	4	5
mSOFA <6 or >80% predicted survival	mSOFA 6-9 or 60-80% predicted survival	mSOFA 10-12 or 40-60% predicted survival	mSOFA >12 or 20-40% predicted survival	actively dying or <20% predicted survival

Patients with the lowest points will be given highest priority to receive critical care resources

Adjustment to SOFA/mSOFA for patients with chronic kidney disease.

Use of SOFA/mSOFA scoring has the potential to compound existing structural health inequities. For example, use of SOFA/mSOFA scoring will have a disproportionately negative impact on patients with chronic kidney disease, who are disproportionately persons of color, who have in turn been disproportionately impacted by COVID-19. In an effort to mitigate this effect, ***any patient who is known to have chronic kidney disease will be assigned no more than 2 points in the SOFA or mSOFA score for elevated creatinine.***

Reasonable accommodations with use of SOFA/mSOFA in patients with disabilities.

The Glasgow Coma Scale, a tool for measuring acute brain injury severity in the SOFA/mSOFA, adds points to the SOFA/mSOFA score when a patient cannot articulate intelligible words, even if this condition is due to a pre-existing speech disability or chronic ventilation. Persons with disabilities who experience baseline levels of impairment prior to the acute care episode should be afforded reasonable accommodations in the scoring process so as not to increase SOFA/mSOFA scores for purposes of this protocol unless those conditions are believed to directly and substantially impact an individual’s likelihood of survival of the acute illness with treatment.

Additionally, patients with communication disabilities and/or limited English proficiency must be offered full access to qualified and certified health care interpreter services and, if indicated, assistive technology or other reasonable accommodations in order to appropriately and objectively complete the assessment. For some patients with significant communication disabilities, a hospital must ensure that their identified support person(s) or other members of the patient’s care team (e.g. a family member or personal PCA) are present at the bedside with appropriate safety training and PPE, as required by Oregon law.

Individualized assessments

While physiologic scoring systems like SOFA and mSOFA are designed to predict outcomes for certain groups, each scoring decision should be based on an individualized assessment of

the nature and severity of acute illness or injury including a careful history, physical exam, and appropriate use of ancillary studies and clinical consultation that doesn't include automatic exclusion of patients with chronic but stable health conditions.

Before proceeding with this triage process, it is important to be aware there are some persons who are likely to experience immediate or near-immediate death despite aggressive therapy, such that during conventional care clinicians do not provide critical care services (e.g., massive intracranial bleeds not amenable to surgical intervention, intractable shock despite treatment). During a public health emergency, clinicians must still make those same judgments about the medical appropriateness of critical care services using the criteria they use during conventional care.

Note on chronically ventilated patients

When a chronically ventilated patient with their own (non-hospital) ventilator is admitted, they will continue to be ventilated using that ventilator which is considered to be their personal property. While ventilated by their personal ventilator, patients will be exempt from the triage process when ventilators are the scarce resource requiring triage. Under no circumstances will a patient's personal ventilator be "reallocated" to another patient. This is likewise true of other durable medical equipment that the patient is using that does not belong to the hospital.

However, if a chronically ventilated patient's respiratory status changes and they need to be ventilated with a new ventilator provided by the hospital, the patient will be included for assessment and resource allocation if a triage protocol is in place for CSC. If this occurs, that patient's personal ventilator remains personal property and will not be subject to involuntary reallocation.

Diagram 1. Critical care triage algorithm

<insert algorithm in development here>

Equal priority resolution process (tie breaker)

Once patients have been classified according to their triage priority score, a situation could still arise where limited resources are needed by two or more patients with the same triage priority scores.

If one of the patients with an equal triage priority score is already receiving the resource, the resource should remain with the patient as long as the patient is not clinically worsening.

In other cases of a final priority tie for the same scarce resource, allocation should proceed randomly using a valid, blinded tool.

Note: OHA is aware that other states and some Oregon hospitals consider additional factors during triage or tie breaker situations, including but not limited to pregnancy status and a patient's Area Deprivation Index. OHA has chosen not to specifically recommend these factors until they can be further discussed in a more inclusive process as part of the Oregon Resource Allocation Advisory Committee deliberations.

Treatment decisions should not include consideration of long-term survival, quality-of-life judgments, past or future use of medical or social resources, resource intensity, or duration of resource need.

Ongoing triage

Triage priority scores should be recalculated at regular intervals (i.e., at least every 48-72 hours). This does not mean patient care will necessarily change; this is to allow treating physicians and triage officers to remain aware of each patient's status and for the awareness of the hospital's Incident Command regarding local resources in relationship to demand.

1. If an individual patient receiving scarce resources develops a condition that would drastically affect their triage priority score, that individual patient may have their triage priority redetermined.
2. A patient will not be reassigned a lower triage priority score simply because they continue to require a scarce resource such as a ventilator. As long as the clinical course is not dramatically worse (e.g., the development of a devastating complication) and the attending physician feels continued use of the scarce resource is medically indicated, the resource will not be reassigned. The attending physician cannot overrule the triage officer. Emerging clinical information on COVID-19 infections indicates some patients require prolonged ventilation; new information might change treatments or current therapies for this new and incompletely characterized infection. This document is not meant to interfere with that need or with clinical judgment concerning ongoing treatment.
3. At regular intervals, cases should be systematically reviewed by a triage officer or team other than those making the original decision to ensure consistency, fairness, and adherence to the process.

Request to re-evaluate patient cases

Any clinician, on their own or at the request of the patient, family or patient advocate, may bring a request for patient re-evaluation of CSC triage prioritization determination. Requests should be limited to concerns regarding whether an individual patient's triage priority score is accurate. The request for re-evaluation should be submitted in writing.

One or more appointed triage officers not involved in the original decision or a separate appeals team should be designated to review the case. Depending on the urgency of the medical event (i.e., no notice or prolonged) it is understood that this process may be retrospective. However, if the event is more prolonged and the potential outcomes of the patient may be affected, then processes should be in place to allow a sufficiently rapid decision.

Final decisions for any request for re-evaluation of a specific patient case should be in writing, dated, and timed, and include all supporting documentation.

Data collection

In order to retrospectively assess for the potential that this triage prioritization process may exacerbate health inequities and in order to inform future updates, the following data must be collected by the hospital for any patient undergoing consideration and triage for scarce resource allocation. Of note, demographic data should not be shared with the triage team in order to avoid any potential bias in resource allocation decision making. This data should be collected separately through administrative processes.

Data collection to be included:

- Patient's medical record number
- Hospital name and location
- Date of birth
- Patient's sexual orientation and gender identity, if known
- Patient's race, ethnicity, language and disability data (in accordance with REALD requirements⁴)
- Whether, at the time of presentation at the hospital, the patient was using a personal ventilator or other personal medical treatment equipment or resources.
- Home address, unhoused or unknown
- The patient's care preferences, as documented in an advanced directive, portable orders for life-sustaining treatment (POLST), or as communicated by a health care representative, support person, or a family member.
- Triage prioritization and clinical outcome

Transparent Communication

Transparency and clear and effective communication for the public and patients is always important but especially so during a public health crisis. Having access to needed health care information is life saving and people must not be disadvantaged in receiving timely and understandable health information because of their language, culture, or access to technology and other supports.

Transparency demands that the public be informed when crisis standards of care have been triggered. The public should have up-to-date and transparent information about health system

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<https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/COMMUNICABLEDISEASE/REPORTINGCOMMUNICABLEDISEASE/Pages/REAL-D-Collection-Toolkit.aspx>

crisis care plans, including how resources will be allocated differently than conventional standards of care, and when CSC have been activated.

Within a health care system, transparent and timely communication with all patients or their authorized decision-maker should occur when the hospital is facing resource constraints, including the nature of the constraints and how resource allocation decisions will be made. Any decision regarding resource allocation (i.e., eligibility for a ventilator or intensive care unit level of care) should be clearly communicated with patients or their authorized-decision maker and documented. Hospitals should provide all patients with information about how to contact the hospital's Americans with Disability Act (ADA) coordinator or patient advocate.

All communication during a public health emergency should be provided in a culturally responsive and linguistically accessible manner and meet the needs of individuals with intellectual, developmental or other disabilities.¹² This may include, but is not limited to: providing effective communication using qualified interpreters, making emergency messaging available in plain language and in prevalent languages, using multiple formats such as audio, large print, and captioning, providing access to support persons chosen by the patient who can help ensure effective communication, and ensuring websites providing emergency information are disability-accessible as required under federal civil rights laws.

Pediatric Considerations

Prioritization of scarce resources for pediatric patients is a similar process to prioritization for adults. The triage team should include clinicians with expertise in pediatric care in concert with clinical ethics.

A reasonable modification of the PELOD-2 or similar pediatric clinical instruments may be a necessary accommodation for pediatric patients with a disability. For patients with pre-existing speech disabilities or disabilities that effect motor movement, this may result in a higher PELOD-2 score even in instances where the patient's disability is not relevant to short-term mortality risk. Under such circumstances, reasonable modifications to the PELOD-2 or similar clinical instruments must be made to such tools to ensure that disability-related characteristics unrelated to short-term mortality risk do not worsen the patient's score.

The triage process, ongoing triage, review and appeals are similar to adults. Once a patient is in the ICU, they should be regularly reassessed (like adults) for continued need for ICU care and/or any condition that develops that would drastically affect their triage priority score.

If pediatric patients require the same resource and have the same triage priority score, allocation should proceed randomly using a valid, blinded tool.

Acronyms

COVID-19: Coronavirus disease of 2019

CSC: Crisis standards of care

ICU: Intensive care unit

MGAP: Mechanism, Glasgow Coma Scale, age, and arterial pressure triage score to predict mortality in trauma patients

mSOFA: Modified Sequential Organ Failure Assessment Tool

NICHD-OT: National Institute of Child Health and Development Outcomes Tool for extremely preterm births

OHA: Oregon Health Authority

PCA: Patient care assistant

PELOD-2: Pediatric Logistic Organ Dysfunction, version 2

POLST: Physician order for life-sustaining treatment

PPE: Personal protective equipment

REALD: Race, Ethnicity, Language, Disability data collection

SNAPPE-II: Score for Neonatal Acute Physiology and SNAP Perinatal Extension

SOFA: Sequential Organ Failure Assessment Tool

References

*needs to be added

**recognize state CSC that we adapted

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the COVID-19 Communications Unit at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us