

## **Appendix C: Pediatric Patient Application for the STRAC HOSPITAL AND ICU PANDEMIC CRISIS GUIDELINES Version 4, May 12<sup>th</sup> 2022**

The “Southwest Texas Regional Advisory Council’s Hospital and ICU Pandemic Crisis Guidelines Version 1.5 - January 2021” (STRAC Guidelines) are applicable for all age patients but require adaptation for pediatric patients. The following supplemental reference is designed complement the principles, considerations, and tools of the STRAC Guidelines and to offer adaptations for the unique needs of neonatal and pediatric patients. The Basic Principles on Page 1 of the STRAC Guidelines are critical and applicable to all patients.

### **SCOPE OF THIS DOCUMENT**

- The pediatric population is defined as persons age 17 or younger.

### **OVERVIEW**

Pediatric patients are unique, with needs and resource requirements different from adults. The level of crisis for the adult and pediatric populations may vary depending on the type of pandemic, which populations are more greatly affected, and the available pediatric and adult resources within a facility or system. It is possible that available resources may differ within a particular facility if pediatric care is overwhelmed while adult care is not, or vice versa. While facilities and systems should refrain from having separate pediatric and adult crisis levels, it should be recognized that the population with the higher level may define the response.

Principles of pediatric triage include the generally higher probability of survival on a physiologic basis—and therefore greater difficulty in predicting a low likelihood of survival from an episode of care—in pediatric patients. Pre-hospital and hospital administrative roles related to pediatric care should adjust for the unique needs of children for whom some procedures are only available or effective at specific phases of growth and development.

### **TRIAGE REVIEW COMMITTEE**

- The Triage Review Committee referenced on page 1 of the STRAC Guidelines serves as a resource which is likely comprised of mostly providers trained in the care of adult patients. A specific Pediatric Review Committee (PRC) with providers trained in pediatric care is suggested for supporting the care and decision-making related to pediatric patients.
- The Chair of the PRC should serve on the Triage Review Committee and will be the initial point of contact for consultation pertaining to the triage and management decisions of pediatric patients.
- The PRC will serve as a resource for the Triage Review Committee.

- Whether or not a health system has the resources to form a PRC, all pediatric cases reviewed by the Triage Review Committee require the participation of a provider trained in Pediatrics.

### **ADDENDUM TO HOSPITAL ADMINISTRATIVE ROLES – GENERAL (page 3)**

#### **Crisis Level 1 Pediatric Note:**

CMS tiers are not applicable to the pediatric population, but the principles underlying them are relevant. Crisis Level 1 will require initiation of a PRC (see above) to review the need to postpone and reschedule non-emergency procedures on an individual basis. This group must take into consideration that many non-emergency pediatric procedures are still essential to preserve growth and development and therefore cannot be delayed. Consider transfer of pediatric patients to a designated pediatric facility in the event a pediatric unit is transitioned to accommodate adult patient care during a crisis.

#### **Crisis Level 2 Pediatric Note:**

Use the PRC to evaluate capacity for non-emergency pediatric care in the context of the crisis. Consider transfer of pediatric care to facilities with greater pediatric resources (if available) to preserve adult crisis capacity and/or allow for pediatric care to continue without detrimental delay

#### **Crisis Level 3 Pediatric Note:**

Use the PRC to evaluate what pediatric care is needed to address life-threatening conditions. Transfer appropriate pediatric care to facilities with greater pediatric resources (if available) to preserve adult crisis capacity and/or allow for pediatric care to continue without detrimental delay

### **ADDENDUM TO HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE (page 4):**

The Hospital and ICU/Ventilator Admission Triage algorithm applies to pediatric patients with the following adaptations:

- Survival Score: Survival scoring in the STRAC Guidelines is intended for assessing adult patients. Reference Appendix C: Pediatric Patient Application Document for assigning appropriate pediatric priority for higher level of care.
- ICU Inclusion Criteria (also on page 8): Reference Appendix C: Pediatric Patient Application Document for appropriate pediatric ICU inclusion criteria.

### **ADDENDUM TO CRISIS TRIAGE TOOLS (page 5 and 6)**

The following Pediatric Crisis Triage and ICU/Ventilator Inclusion Criteria (see below) will apply for pediatric patients and will replace the adult-focused Crisis Triage Tools. The basic principles of equal opportunity, short-term survival, clinical judgment, and individualized assessment still apply. Assessment severity of acute illness or injury, as well as chronic organ system dysfunction or failure, must be performed by providers with pediatric training who understand

the unique physiology and prognostic challenges of pediatric populations. For pediatric patients do not use the triage tools included in Box 1 and Box 2 (page 5) and Table 1 and Table 2 (page 6). Instead, use the Pediatric Crisis Triage tool (see below).

**ADDENDUM TO APPENDIX B: ADDITIONAL RESOURCES (page 8)**

The prognostic scoring tools in Appendix B: Additional Resources do not apply to pediatric patients and prognostic scoring tools are not reliable for the unique physiology of and variety of diagnoses among pediatric patients. The Revised Trauma Score and Triage Decision Table for Burn Victims can provide useful information, but still must be reviewed by a trauma surgeon with pediatric training to ensure applicability.

**PEDIATRIC CRISIS TRIAGE**

	<b>TRIAGE CATEGORIES FOR PATIENTS AGE 17 AND YOUNGER</b> See supporting text for descriptions of levels
<b>GREEN</b>	<b>DOES NOT REQUIRE INPATIENT CARE TO SURVIVE.</b>
<b>RED</b>	<b>HIGHEST PRIORITY. LIKELY SURVIVAL WITH AND ONLY WITH ADMISSION/INTERVENTION.</b>
<b>ORANGE</b>	<b>INTERMEDIATE PRIORITY. HIGH RISK OF DEATH EVEN WITH ADMISSION/INTERVENTION.</b>
<b>BLUE</b>	<b>LOWEST PRIORITY. UNLIKELY TO SURVIVE HOSPITALIZATION.</b>

**GREEN: Does not require hospital care to survive**

These patients have been successfully stabilized, evaluated, or treated and do not require hospital admission. They will require usual pre-discharge care such as prescriptions, a safety plan, follow-up plan, wound care supplies, etc.

**RED: HIGHEST PRIORITY for hospital admission/transfer**

Under crisis standards of care, resources should be allocated to patients most likely to survive hospitalization. Because children overall have a lower death rate from both acute and chronic conditions compared to adults, **most children—even children with underlying health conditions—will fall into the highest priority status.**

This is not a reflection of the relative value of children’s lives compared to the lives of others. Rather, this is an assessment of clinical effectiveness and the patient’s likelihood to survive hospitalization.

Disability and functional status are NOT determinants of triage status. Children with disabilities will be evaluated on an individual basis based on clinical judgment, and only triaged to INTERMEDIATE or LOWEST priority based on assessment of near-term survival from the

episode of care that directly resulted from the illness or injury that required hospitalization.

**ORANGE: INTERMEDIATE PRIORITY for hospital admission/transfer**

The Orange Priority is included in this Pediatric specific document in order to be consistent with the overall STRAC Crisis Guidelines document. As it is more difficult to predict survival in the 10-50% probability of survival range in children, the model predicting survivability in the adult population does not fit in the pediatric and perinatal groups. Few pediatric patients would be expected to be classified in the Orange Priority. The determination of Orange Priority, if used, should be supported by the most appropriate prognosis scale such as pSOFA or PIM3 (see below), when such a scale is applicable.

**BLUE: LOWEST PRIORITY for Hospital Admission/transfer**

Children assigned this status are unlikely to survive hospital admission and should be triaged into the best available palliative care.

In broad terms, children who meet pediatric criteria for brain death fall into this group. Children who have severe organ dysfunction who have developed progressive signs and symptoms of multiple organ system failure, refractory to treatment, and are progressing towards cessation of all bodily functions fall into this group. This should be supported by the most appropriate prognosis scale such as pSOFA or PIM3, when such a scale is applicable

**For reference:**

PIM3: <https://www.cpccrn.org/calculators/prismiicalculator/>

pSOFA: <https://medicalcriteria.com/web/psofa/>