**Supplemental Table 1.** Themes describing considerations in selecting items for inclusion on a patient information form

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| **Sub-theme** | **Exemplar quotations from text explanations submitted as part of the Delphi deliberation process** |
| **Theme 1: Identifying multiple relevant factors** | |
| Support accurate prognostication. | Age is very important when considering disease process and mortality. I see no way to think about a patient's mortality and predicted resource utilization without it. |
| Gauge consistency & accuracy | I am wondering about the ability to predict that a patient needs a resource for 6 days vs 10 days. Are these predictions reliable? |
| [The] current level of respiratory support is dependent on available support devices, unit culture, and hospital location. |
| It is fairest either to just list comorbidities with no qualifiers or have agreed upon scoring systems (i.e. NYHA, HFSS, MELD). "Mild, moderate, severe" is too subjective and can be misinterpreted. |
| Maybe phrase [as] "Principal cause/reason for this hospitalization". There are some nuances in hospital principal diagnoses that sometimes result in the billed principal diagnosis not being the primary clinical reason they were in the hospital. |
| Frailty indices are well known and robust but not commonly employed in routine care, so it will be unclear to the triage team whether the "frail" patient they are trying to triage has been determined to be frail by a validated index or simply by an eyeball by the care team. |
| Minimize opportunities to introduce bias | I think it is very hard to predict [an] estimated length of stay and the team will want to advocate for the patient and so will err on yes to the second question |
| Comments [ie, a free text box] to clarify a comorbid condition seems like it leaves room for bias. For example, “patient is non-compliant, substance use, or patients comes in frequently, well known to staff, etc.” |
| Frailty too easily becomes synonymous w/ disability |
| I think comorbidities [vs age] will be a better gauge for candidacy to prevent age discrimination. |
| I understand fears regarding discrimination against the elderly….[age] should only be included if we are allowed to consider it in our ethical reasoning (there's no way to fully separate out ethical and medical reasoning, so although it might be useful medically, if we aren't supposed to consider it ethically, then it shouldn't be there.) |
| Accommodate other ethically relevant factors | Pregnancy status is important as this person represents 2 lives with intertwined survival odds. |
| I would like to see equity considerations included earlier in the process. Our long history of people of color being underserved calls out for some preference being given to this group. |
| **Theme 2: Approach to navigating conflicting values** | |
| Weigh conflicting values | I do agree that a text box for other comorbidities can lead to bias. However, knowing whether or not someone has severe/end-stage dementia is important and impacts prognosis and decision-making. |
| Distill information |  |
| We need to have brevity in what we are looking for and make sure the details we would like to know are the ones we \*need\* to know. |
| The [regional triage leadership] guidelines exclude considering age in our decisions, however, need to know whether adult or pediatric |
| Malnutrition is a chronic situation. It may have [a] predictive value related to [long-term] outcome, but more detailed information would not contribute to decision making in the short term. |
| Reporting albumin level is probably the most neutral way to report malnutrition. |
| Need for external validation | I also think we should reach out to our community on this very important question about whether to include age. I am also curious to know what other states are deciding. |
| I’d argue age is [relevant] but I understand fears regarding discrimination against the elderly…The state seems to have decided against this [age as triage criterion], however. |
| We should continue to work on this form as institutions build their CSC teams and run practice cases. We will not get it right the first time but with ongoing review, we will continue to improve. |
| Acknowledge imperfection | I think there is potential bias with each of these categories, but…the information is important for the teams to get a clinical picture |
| Capturing this someway is important, even if [the] wording is impossible to perfect. |
| There does need to be some way to identify patients for whom life will be short. Perhaps this subjective approach will work. There will need to be monitoring to ensure that discrimination does not occur against disabled/elderly/minorities. |
| **Theme 3: Fitting into the bigger picture** | |
| Operational considerations | I am concerned about the time it would take to meaningfully determine an accurate status of a person's underlying medical ailments. |
| I am not sure that the second sentence is necessary. It is likely to simply slow down [the]process of filling out the form. |
| It may be more burdensome to the person entering the information to try to convey nuance from a POLST or other preferences than it provides value to the triage team. |
| I think it is [of] utmost importance to have a consistent way to track throughout the triage process, including the person inputting the information, and also the attending physician as those people will likely have additional information to give if needed by the team. |
| Minimize clinicians’ moral distress | I think allowing patients in a given category to keep currently received resource[s] will cause much less stress on healthcare workers. |
| Public perception | Frailty is, in many ways, an ideal triage marker, as it gives an overall view of the patient's health status and resiliency. Unfortunately, the lay definition and the professional definition differ and this word will strongly imply that old people won't get care. We need a different term. |

\*Misspellings have been corrected and non-standard abbreviations have been expanded for clarity.

Abbreviations: New York Heart Association, NYHA; Heart Failure Survival Score, HFSS; Model for End-Stage Liver Disease, MELD, Crisis Standards of Care, CSC; Physician Orders for Life-Sustaining Treatment, POLST; Coronavirus Disease 2019, COVID.