



Office-Hours Telephone Triage Protocols User's Guide 2016

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Contents

Contents	2
Schmitt-Thompson Clinical Content (STCC)	3
Introduction	3
Benefits of Telephone Triage Protocols	3
Number of Protocols	4
Structure of Protocols.....	4
Structure of a Telephone Triage Encounter.....	10
Overview.....	10
Introduce Self to Caller	10
Collect or Confirm Demographic Information.....	11
Obtain a Brief Health History.....	11
Document a Brief Description of the Patient’s Illness.....	11
Select the Correct Protocol.....	13
Triage – Ask the Triage Questions	13
Select an Appropriate Disposition	14
Additional Factors that May Influence Disposition	15
Provide Care Advice (Telephone Advice).....	16
Give Call-Back Instructions	17
Practice Risk Management Strategies to Prevent Adverse Outcomes.....	18
Frequently Asked Questions (FAQ) about Using STCC in an Office or Medical Call Center	20
Call Center Employees and Training Questions.....	21
Call Center Operations Questions	23
Triage Protocols Questions.....	26
Triage Call Processing Questions	33
Triage Call Documentation Questions.....	36
Quality Improvement Questions	40
Appendices for STCC Office-Hours User’s Guide	44

Schmitt-Thompson Clinical Content (STCC)

Introduction

- The Schmitt (pediatric) and Thompson (adult) telephone protocols are decision-support tools for telephone care providers (TCPs).
- They assist the TCP through the data collection, triage, decision-making, disposition selection and advice-giving processes.
- Most telephone triagers are registered nurses with special advanced training.
- The use of protocols by nurses who work in medical call centers is recommended by the American Academy of Pediatrics, the American Accreditation Health Care Commission, and other risk management groups.
- In most states, the Nurse Practice Act requires that nurses use standardized protocols if they are providing telephone triage and giving advice. Reason: Giving any medical advice to callers is legally deemed as medical practice. The supervising physician is responsible for all medical advice given, no matter who gives it. Using protocols ensures the nurse is functioning within the nursing scope of practice.

Benefits of Telephone Triage Protocols

There are many benefits of using telephone triage protocols, including the following:

Provide standardized approach to telephone triage

- Improve consistency of the home care advice offered by telephone nurses
- Provide a consensus tool for physicians across a healthcare system regarding how telephone care will be delivered

Reduce telephone errors and legal liability

- Prevent omission of important questions
- Provide a focus for review of nurse performance
- Allow physicians to safely delegate calls to nurses

Improve efficiency

- Keep the assessment process thorough and logical
- Simplify training and education of staff
- Allow documentation by exception

Number of Protocols

- Currently there are 232 active pediatric Office-Hours protocols (see Appendix A), including 15 behavioral health protocols (see Appendix T).
- Currently there are a total of 173 active adult Office-Hours protocols (see Appendix B), including 28 adult women's health protocols (see Appendix C) and 11 behavioral health protocols (see Appendix U).
- This set of telephone triage protocols covers over 90% of medical calls.

Structure of Protocols

The pediatric and adult Office-Hours protocols have identical organization and structure. Each set of protocols include the following 10 components which are described further in the sections below:

1. Title (Topic Name)
2. Search Words
3. Definition
4. Background Information
5. First Aid
6. References
7. See More Appropriate Protocols (SMAP) Questions
8. Triage Questions
9. Care Advice
10. Citations

Title (Topic Name)

- The adult and pediatric protocols nearly always have identical titles. This makes it easier for the triager to transition between protocol sets.
- Most protocols are symptom-based (e.g., Cough, Vomiting).
- Exposure protocols are available for some illnesses (e.g., Influenza Exposure)
- Disease-based protocols are also included (Table 1).

Disease-Based Protocols	Examples
Chronic Disease previously diagnosed by a health care provider	<ul style="list-style-type: none"> • Asthma Attack
Common acute diseases that could reliably be diagnosed by most adults	<ul style="list-style-type: none"> • Athlete's Foot • Head Lice
Pregnancy and Postpartum Conditions (Adult)	<ul style="list-style-type: none"> • Pregnancy – Decreased Fetal Movement • Pregnancy – Morning Sickness • Postpartum – Vaginal Bleeding and Lochia
Follow-up Call protocols for managing calls regarding recently diagnosed acute diseases	<ul style="list-style-type: none"> • Ear Infection Follow-Up Call • Urinalysis Results Tract Follow-Up Call

Search Words

- Search words are carefully selected for each protocol.
- These search words help the nurse triager find the most appropriate protocol available to use for that specific symptom or concern.
- Based on the results of search word testing, new search words are added each year.
- Search words that bring up unrelated protocols are also deleted each year.

Definition

- This section defines the symptoms that need to be present before using this protocol.
- Some symptoms are straightforward (e.g., Headache).
- Other symptoms require clarification (e.g., Constipation).
- For disease-based topics, diagnostic criteria for that disease are listed. The disease-based protocols should only be used if the caller's description of symptoms matches the symptoms listed in the definition section for that disease.

Example of Diagnostic Criteria for Disease-based Guideline: Athlete's Foot - Pediatric

Use this guideline only if the patient has symptoms that match Athlete's Foot

SYMPTOMS OF ATHLETE'S FOOT INCLUDE:

- * Red, scaly, cracked rash between the toes
- * The rash itches and burns
- * With itching, the rash becomes raw and weepy
- * Often involves the insteps of the feet
- * Unpleasant foot odor
- * Mainly in adolescents. Prior to age 10, it's usually something else.

Background Information (BI)

- This section includes additional clinical information to help nurses improve their clinical reasoning (critical thinking skills) and fine tune their assessment skills.
- **Causes** are included for symptom-based protocols.
- **Complications** are included for disease-based protocols.
- **Reasons** behind any triage or treatments that are controversial are also discussed.
- When call centers ask the authors questions, we respond directly. If it is a frequent question, we also add the response to the background information.

First Aid

- This section allows the triager to quickly find first-aid instructions for any patient who has a life-threatening or serious emergency.
- First aid minimizes injury and damage before the patient is transported to the emergency department (ED) or office.
- Examples are giving an epinephrine injection for a probable anaphylactic reaction and applying cold water to a new burn.



Disposition Categories or Levels of Care

- The main objective of telephone triage is to sort patients into appropriate dispositions (triage categories) based on acuity or severity of the illness. The disposition categories are the keystone of a telephone triage and advice systems.
- They range from emergent care to home care. Table 2 includes the nine main Office-Hours Disposition Levels.

Table 2: Office-Hours Disposition Categories

	Disposition	Description
URGENCY ↑	Call Emergency Medical Services (911) Now	Patients with life-threatening emergencies
	Go to the ED Now (by car)	Patients with emergent symptoms that require emergency department resources
	Go to the ED Now (or to Office with PCP Approval):	Patients with emergent symptoms that can be evaluated and managed in some offices. Discuss the best site with the PCP.
	Go to Office Now	Patients with less emergent symptoms who can be evaluated in most office settings. See during office session (half day), preferably within 2 hours
	See Today in Office*	Patients with urgent symptoms and patients who are very uncomfortable. Includes many callers who request to be seen.
	See Today or Tomorrow in Office*	Patients with non-urgent symptoms
	See Within 3 Days in Office*	Patients with persistent symptoms that are not becoming worse
	See Within 2 Weeks in Office*	Patients with chronic or recurrent symptoms that are not becoming worse
	Home Care (Self-Care)	Patients with mild symptoms that can be managed at home with care advice and continued monitoring
*By Appointment		

- The protocols contain many other dispositions that are needed for less common clinical scenarios. Examples are referrals to dentists, other local agencies such as poison centers, suicide hotlines, and social services for possible abuse situations.
- The adult protocols are supported by 33 dispositions (see Appendix D).
- The pediatric protocols are supported by 29 dispositions (see Appendix D—excluding the 4 OB and L&D dispositions that support the adult population).

See More Appropriate Protocol (SMAP) Questions

- The purpose of a SMAP question is to prompt the triage nurse to consider a more appropriate protocol that best addresses the caller's chief complaint.
- For symptom-based protocols, the SMAP may redirect the triager to a more specific disease-based protocol. For example, the triager may initially select the Rash or Redness–Widespread protocol. If Swimmer's Itch is suspected (rash is consistent with the clinical presentation of Swimmer's Itch), a SMAP would prompt the triager go to the Swimmer's Itch protocol.
- For disease-based protocols, if the diagnostic criteria are not met, the triage nurse is redirected to the appropriate symptom protocol (e.g., from Ringworm to Rash or Redness–Localized).
- The SMAP questions are especially helpful to new nurses. Using the most appropriate protocol helps assure that the triager selects the most appropriate disposition and targeted care advice.
- The SMAP section is found towards the beginning of the triage protocol section, but always after the 911 triage questions.

Examples of Office-Hours SMAP Questions

Guideline: Fever - Pediatric

Seizure occurred

Go to Protocol: Seizure with Fever (Pediatric - Office Hours)

Fever onset within 24 hours of receiving an immunization

Go to Protocol: Immunization Reactions (Pediatric-Office Hours)

Confused talking or behavior (delirious) with fever

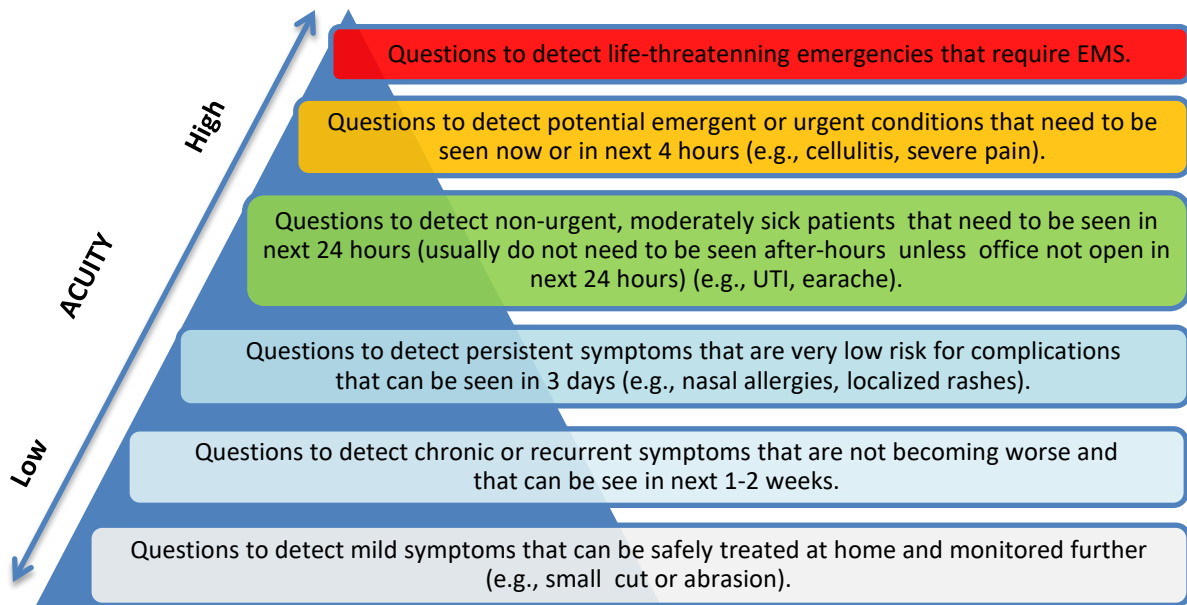
Go to Protocol: Confusion-Delirium (Pediatric – Office Hours)

Exposure to high environmental temperatures

Go to Protocol: Heat Exposure (Pediatric – Office Hours)

Triage Questions

- The triage questions are grouped within dispositions and are sequenced from highest to lowest acuity (from most serious to least serious diagnoses or complications) as outlined in diagram below.



Care Advice

- This section contains care advice for the delayed dispositions (See Today down to Home Care).
- Note: Unlike After-Hours protocols, the care advice in Office-Hours is not targeted towards specific triage questions. Generally, most Office-Hours advice is meant for “Home Care” patients or those patients that will be seen later by appointment.
- For patients who are referred in immediately, the nurse may only give first aid or pain control advice. These patients will get the rest of the care advice in the ED or office when seen.
- Limited interim care advice is offered for patients who will be seen by appointment the next day or later. The patients will receive the rest of the care advice after they are evaluated in a medical setting.
- All of the care advice is written in lay person’s language.
- The treatment advice is written in an **action statement** format. It’s also written directly for the caller. Therefore, the triager can use it as a script.
- The care advice often starts with a **reassurance statement**. Reassurance may be just as helpful to the caller as specific treatment advice.
- Each piece of care advice is preceded by a **topic heading** (e.g., Fever Medicine, Cleanse the Wound). These headings help you efficiently scan care advice items and jog your memory.
- The **reason** for giving that advice is also often included.

Example of Care Advice from Protocol: Fever - Pediatric

1. REASSURANCE:
*Presence of fever means your child has an infection, usually caused by a virus.
Most fevers are good for sick children and help the body fight infection
2. TREATMENT FOR ALL FEVERS: EXTRA FLUIDS AND LESS CLOTHING
Give cold fluids orally in unlimited amounts
(Reason: good hydration replaces sweat and improves heat loss from skin.)
Dress in 1 layer of light clothing and sleep with 1 blanket (avoid bundling).
(Caution: overheated infants cannot undress themselves)

Reassurance Statement

Topic Heading

Reason for Advice

Action Statement

References

- The clinical content in these protocols is as evidenced-based as possible.
- New medical research is reviewed, incorporated into the protocols, and added to the reference list on a yearly basis.
- New clinical practice protocols, regulations, or recommendations from national organizations are always included.

Citations

- This last section lists the following:
 - ✓ Author of the protocols
 - ✓ Latest revision date
 - ✓ Copyright notice

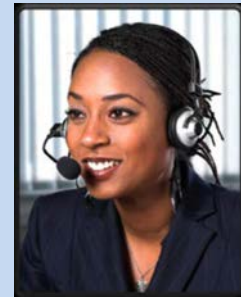
Structure of a Telephone Triage Encounter

Overview

When a call comes into a medical call center, the telephone triager typically goes through the following call process while managing the call. Each step in the call process will be discussed in further detail.

1. Introduce self to caller
2. Collect (or confirm) brief demographic information
3. Obtain brief health history
4. Document a brief description of the patient's illness
5. Identify the chief complaint and most serious symptom
6. Select the correct protocol
7. Triage – ask the triage questions
8. Select an appropriate disposition category
9. Provide care advice (telephone advice)
10. Verify understanding – use Teach-Back method
11. Give call-back instructions
12. Practice risk management in every step of call process

Remember to Smile!



**Callers easily can hear the smile
in your voice even when they
cannot see it.**

Introduce Self to Caller

- The call begins with a greeting, during which you introduce yourself.
- Apologize for any delays or excessive hold time if necessary.
- The greeting ends with an invitation to the caller to describe his/her problem or symptoms.
- Many call centers have a specific scripted approach to this first part of the encounter. Your greeting might contain the following scripted elements (see Table 3):

Introduction Element	Examples of Scripted Responses
Greeting	<i>"Good Morning." "Thank you for calling ..."</i>
Introduction	<i>"This is Donna."</i>
Title	<i>"I am a nurse at the __ Call Center." "I am the nurse working with Dr. __."</i>
Apology if indicated	<i>"I apologize for the wait."</i>
Query	<i>"How can I help you this morning?"</i>

Collect or Confirm Demographic Information

- Collect minimal demographic information such as name, age, gender, and phone number.
- In pediatrics, the name and relationship of the caller is also obtained.
- In some call centers and offices, support staff (or non-clinical personnel) elicit and enter this information before the call is transferred to the telephone triage nurses. In others, the triage nurse takes calls directly.
- If the call is about an emergency, the call should be taken by the first available nurse. For these calls, triage and first aid should be completed before collecting demographic information.
- Demographics can quickly be confirmed or edited for previous (repeat) callers when using an electronic system.

Obtain a Brief Health History

- Briefly ask about chronic health problems, medications, and recent visits/hospitalizations.
- This part of the assessment should be focused primarily on issues that will likely affect the call outcome (disposition).
- When the symptoms presented are very serious or life-threatening, this step is eliminated or very brief.
- Document these within the patient's health history.

Document a Brief Description of the Patient's Illness

- The description of the patient should give the reader of the call report an accurate mental picture of the patient's illness or injury.
- The description should also justify the use of the specific triage protocol.

Identify the Chief Complaint or Main Symptom

- Encourage the caller to describe the patient's main symptom. Use an open-ended question such as, *"Tell me more about your sore throat."* Follow-up with more direct questions as needed to clarify and to elicit specific information (e.g., pain rating).
- Prompt the caller to describe other symptoms that are present today.
- Practice active listening.
- Briefly assess the severity of all symptoms before honing in on the most serious symptom. (Exception: an emergent or life-threatening symptom is present).
- Set a goal of learning the patient's most serious symptom by 1 minute or sooner.
- The initial assessment of the caller's concerns can be a time-consuming part of the call process. Therefore, it is beneficial to choose a protocol as soon as possible. Once in a specific protocol, the triager can control call flow and become more focused and efficient.

Assessing Physical Findings and Symptom Severity

- One of the challenges of telephone triage is the inability to examine the patient. However, you can still listen for clues and “look through the caller’s eyes” and “feel using the caller’s hands.”

Example: Triage Assessment of Breathing Difficulty in a Child

To determine the severity of breathing difficulty in a child, the triage nurse can:

- ✓ Ask about presence of cyanosis and retractions.
- ✓ Ask the parent to bring the child to the phone and then listen for wheezing, stridor, grunting, and tachypnea.
- ✓ Ask the parent to count respirations per minute if needed.
- ✓ Ask about the child’s level of activity and ability to talk and converse.
- ✓ If the child has asthma, ask about Peak Flow results.



The triage nurse can then better determine the degree of respiratory distress:

MILD: No SOB at rest, mild SOB with walking, speaks normally in sentences, can lay down, no retractions, wheezing audible with stethoscope (**Green Zone:** PEFr 80-100%)

MODERATE: SOB at rest, speaks in phrases, prefers to sit (can't lay down flat), mild retractions, audible wheezing (**Yellow Zone:** PEFr 50-80%)

SEVERE: severe SOB at rest, speaks in single words (struggling to breathe), severe retractions, usually loud wheezing or sometimes minimal wheezing because of decreased air movement (**Red Zone:** PEFr < 50%)

- You always need to be cautious when interpreting physical findings obtained over the phone. Callers are not always accurate or reliable with their description of symptoms (e.g., rashes, swelling). The caller’s ability to obtain accurate vital signs is also variable.
- However, by asking the right questions you can usually collect enough information from the caller to obtain an overall assessment that helps you determine severity of the patient’s illness or injury.
- In addition, a number of protocols contain severity scales that help the triager identify physical findings associated with varying levels of symptom severity (e.g. pain, dehydration, vomiting and diarrhea).

Select the Correct Protocol

- Once you have identified the main problem or symptom, enter a search word describing the caller's chief complaint to bring up appropriate protocols. The search may bring up several protocols for you to consider. The keyword search system has become very selective and should meet your needs.
- Many of the protocols start with a section called "See More Appropriate Protocol." These SMAP statements prompt you to rethink the patient's needs. The SMAP statements might direct you to a better protocol that provides more specific triage advice than the protocol you are currently using. You don't need to ask all the SMAP's. Quickly scan them and ask only if you think the SMAP might apply to your patient.
- If the patient has multiple symptoms, always select the most serious symptom. If none of the symptoms are serious, select the one with the highest likelihood of needing to be seen (e.g., earache instead of cough, cold or fever).
- If uncertain where to start, ask the caller, "Which symptom are you most concerned about?"
- EXCEPTION: If the caller's answer is "fever" and this fever is present with other symptoms, go to their second concern. Fever is covered in all protocols where fever could be an accompanying symptom.
- For 5 to 10% of calls, you will need to use 2 protocols (e.g., Rash and Diarrhea)

Tips for Improving Your Guideline Selection Skills

TIP 1: To improve your efficiency, periodically review the Anatomical Table of Contents (Appendix H and I) to better understand all of the topic options available within each body area.

TIP 2: If selecting the appropriate guideline is difficult for you, ask your supervisor or mentor for help. Using the wrong guideline can cause serious triage errors.

Triage – Ask the Triage Questions

- Triage is sorting patients into levels of severity of their medical symptoms and then into appropriate levels of referral and care (i.e., dispositions).
- Ask the triage assessment questions in the sequence presented in the protocol. You will be asking the highest acuity questions first. This prevents a potential delay of care to a patient who needs to be seen immediately.
- If an answer is negative, proceed to the next question.
- Since the triage assessment questions in the protocol are organized under disposition categories, a positive response will give you the appropriate disposition (level of care) for your patient.

- Once in the call, you do NOT need to ask the triage questions you've already determined the answer to in the assessment. You just need to ask the questions you don't know or aren't sure about.
- Within a disposition level, it is acceptable for the nurse to select any of the triage questions and mark it YES. The nurse may “scan” the list of triage questions for the one that seems most appropriate to the caller’s presenting complaint. The nurse does not need to ask the questions within any single disposition category sequentially. However, the nurse **does** need to know the answers to all the questions in that disposition category before moving onto the next disposition level.
- We arrange higher-volume or higher-acuity triage questions at the top of each disposition level grouping.

Select an Appropriate Disposition

- Stop asking questions as soon as you elicit a positive answer (presence of an indicator for being seen). The remaining questions (the complete history) can be asked in the office or ED by the examining physician. Avoid duplication of effort.
- Select the disposition associated with that level of question (e.g., ED Now, See Today).
- When using two unrelated protocols for a patient, you may end up with two different dispositions. Give the caller the higher acuity disposition of the two.
- These protocols attempt to place patients who can be safely treated at home into the Home Care/Self Care category. This helps prevent unnecessary visits.

Upgrading the Disposition

- The telephone nurse or caller can elect to move patients to a more urgent disposition if warranted.
- This is known as “upgrading” the disposition and is medically “safe care.”
- This may be done by the nurse when she is concerned about a patient but that patient doesn’t necessarily meet criteria to be seen.
- Callers may also want to be seen even when the nurse doesn’t think they need to be seen.

Downgrading the Disposition

- “Downgrading” a patient to home care or a less urgent disposition than recommended in the protocol should not be done.
- Doing so may have medical-legal consequences.
- Instead, the nurse should discuss such cases with or refer these calls to the primary care physician.
- Make sure you know and follow your organization’s policy regarding downgrading dispositions.

Additional Factors that May Influence Disposition

Patient Expectations

- For calls to a medical practice, a caller starts off with an expectation about whether or not they need to be seen.
- From a customer service standpoint, the way to achieve patient satisfaction is to meet or exceed these expectations.
- If you are unable to meet the patient's expectations, to achieve patient satisfaction you will need to "manage" this expectation by:
 - ✓ successfully convincing the patient that an office visit is not urgently needed OR
 - ✓ that an appointment can be safely postponed
- If the patient wants to be seen, the office should attempt to accommodate this request at the patient's convenience.
- What do you do if there are no office appointments available right now, today, or tomorrow? If you have no appropriate open appointments, your options include:
 - ✓ Overbook the patient into the office schedule according to your scheduling policy.
 - ✓ Discuss the situation with the physician.
 - ✓ Recommend that the patient be seen in the local urgent care or emergency department.

Resources

- The resource needs of the patient's problem also impact your triage decision-making.
- "Resources" is a broad term describing the equipment, medications, supplies, and personnel skills needed for a specific patient problem.
- You will need to consider what resources are needed to care for this patient? For example, a large laceration needing sutures will require a provider skilled in suturing and the necessary supplies. If your office does not provide this service, the patient needs to be sent to an ED or UCC instead.
- It is very helpful in advance of the call to know what resources and services your office provides.
- You can tabulate the resources you have available in your office by using a resource form (see Appendix E). There are 3 basic categories of resources (see Table 4 below).

Type	Examples
Procedures	Foreign body removal, laceration repair, fracture casting, pelvic examination, IV fluids
Tests	X-rays, urine pregnancy test, STI cultures, EKG
Medications	Immunizations, nebulizer treatments

Provide Care Advice (Telephone Advice)

Ask About Home Care Measures Already Tried at Home

- Before giving advice, ask the caller, “What treatment have you tried so far?” “How is that working?” (You may already know this if patient offered this information earlier in call.)
- If the caller’s treatment is appropriate and effective, compliment the caller and do not change it.
- If the treatment is incomplete or not working, supplement it from the protocol.
- Your goal is to help callers feel competent in their ability to handle common conditions and problems on their own.

Select Appropriate Care Advice (CA)

- Give care advice for those patients who don’t need to be seen or who will be seen later by appointment. See rationale, “When Less is Better”, below.
- Make sure the caller has a pen and paper handy to write down instructions. This is especially important if detailed care advice or medication dosages are given.
- The nurse should select the most appropriate 2-3 pieces of care advice for the caller. The nurse should not feel compelled to give all the care advice.
- Complete care advice is displayed for patients that can be seen by appointment or can be cared for at home. However, consider it a “menu” from which the nurse delivers “a la carte.”
- Some callers may benefit from 3-6 pieces of information; others may only need 1 or 2 pieces. The triage nurse should select care advice as determined by the caller’s needs.
- Try to limit your advice to 3 instructions and try to keep your comments brief (2 or 3 sentences per instruction). Reason: to improve caller’s memory of imparted information.

When LESS is Better: Limit Care Advice for Patients Referred In for Evaluation

- The sooner a patient is referred in (higher dispositions), the less care advice that is needed.
- Brief care advice can be offered for patients who are referred in now. However, it should only include first aid or pain control. This is purposefully done for two reasons:
 - ✓ Doing so helps avoid any delays to accessing care.
 - ✓ Patient will get the complete care advice in the ER, UCC, or office.
- Limited interim care advice can be given for patients who will be seen by appointment the next day or later.

Verify Understanding – Use Teach Back Method

- After providing your care advice, allow patient an opportunity to fill in any missing pieces by asking, “What other questions do you have about what we just discussed?”
- Teach Back Method: Use the “Teach-Back” method to verify patient understanding, especially if more detailed care advice is given. Also, consider emailing detailed care advice or if the call is lengthy.
- When using the Teach Back method, the triager asks the patient to repeat back the care advice instructions using their own words.
- This allows the triager to verify if the patient understands the instructions correctly, and to correct any misunderstandings.
- Chunk and Check: If the care advice is lengthy, you can break up the information in “chunks.” Use the Teach Back method after each chunk of information to check patient understanding.

Why Use Teach Back?

Studies have shown that approximately 40 to 80% of information given to patients during medical visits is forgotten immediately.

Example of Teach Back Method:

“I just covered a lot of information. Let’s review what I just went over with you. I want to make sure I explained everything clearly. Can you tell me in your own words the 3 things you should do to treat your child’s diaper rash?”

Give Call-Back Instructions

- End each telephone encounter with call-back instructions.
- “Call Back If” statements are included at the bottom of each Care Advice section.
- Covering every worst case scenario is impossible and will unduly alarm the caller.
- At the very least, the triager should instruct the caller to call back “if the patient becomes worse.” Make sure the caller knows how to recognize a worsening condition.
- General indications for calling back should also include “if the symptom persists for more than ___ days.”

Example of Call-Back Instructions from Guideline: Sore Throat – Pediatric

Call Back If:

- Sore throat is the main symptom and lasts over 48 hours
- Sore throat with a cold lasts over 5 days
- Fever lasts over 3 days
- Your child becomes worse

Practice Risk Management Strategies to Prevent Adverse Outcomes

- During the call, the triager should always adhere to the risk management strategies outlined in Table 5 below. These strategies will help prevent adverse outcomes.
- The patient's safety and well-being should always be the highest priority.
- Refer to Appendix S (Risk Management Checklist) for a checklist to use preventively to help protect your office from substandard care and adverse outcomes.

Table 5: Key Strategies to Prevent Adverse Outcomes During a Telephone Triage Encounter

1	When in Doubt, Triage	<ul style="list-style-type: none"> • Sometimes callers are seeking some brief health information and do not want to be triaged. When in doubt, perform a complete triage and document the call completely. • If the caller/patient has symptoms and declines triage, this should be documented.
2	Recognize and Respond Quickly to Life-Threatening Symptoms	<ul style="list-style-type: none"> • If the patient's condition sounds life-threatening or unstable, follow the 911 policy established by your call center. • This may involve transferring the call to 911, having the caller hang up and call 911, or calling 911 for the patient. • A good exercise to improve your ability to recognize life-threatening or serious disease is to read the EMS 911 section of each protocol.
3	Recognize Weakness as a Serious Symptom in Adults and Children	<ul style="list-style-type: none"> • If the patient sounds very sick or weak to you as the triager, have the patient come in immediately even if none of the other triage assessment questions are positive. • A patient who has become confused or too weak to stand needs immediate evaluation. The patient may require EMS 911 activation. • To recognize lethargic or toxic children, always ask about the child's current activity level. Ask, "What is he doing right now?" If not active now, ask "How does he look?" If sleeping at the time of the call, ask: "How was he acting before he went to sleep?"
4	When in Doubt, See the Patient	<ul style="list-style-type: none"> • Prevent delayed visits of seriously ill patients by taking a proactive and cautious triage stance. • When in doubt, see the patient or make arrangements for the patient to be seen. • If the problem could be serious, see the patient immediately.

5	Do NOT Diagnose	<ul style="list-style-type: none"> • A nurse triager should not make a diagnosis over the phone. • It may be appropriate in certain circumstances for a physician to provide a possible/probable diagnosis over the phone.
6	Use Caution When Assessing Patient's Self-Diagnosis	<ul style="list-style-type: none"> • If a caller calls about a diagnosis (e.g., chickenpox or influenza), do not accept the caller's diagnosis unless it meets the criteria listed in the definition at the beginning of the protocol.
7	Do Not Downgrade a Disposition	<ul style="list-style-type: none"> • The triager should not override the protocol disposition to a lower disposition (called a downgrade). Instead, the triager should discuss with or refer such calls to the primary care physician. • The triager may override the protocol disposition to suggest the patient goes to a higher level disposition (called an upgrade).
8	Strive for Alignment with Caller's Requests	<ul style="list-style-type: none"> • After reviewing care advice, ask the caller, "Do you feel comfortable with the plan?" If the caller does not, schedule a call back in 1 hour or arrange for the patient to be seen. • Always strive for "alignment" with the caller. If the caller insists on being seen, always accommodate that request. From a risk management standpoint, it is challenging to defend a bad patient outcome when the caller and/or patient insisted on being seen and the triager adamantly disagreed. • Remember, telephone triage is a point of entry into the health care system. Do not use triage as a method of limiting access. Instead use it as a method of improving access to primary care.
9	Give Call- Back Instructions	<ul style="list-style-type: none"> • Encourage all callers to call back if the condition worsens. Callers should be given specific reasons to call back. • At the least, the triager should instruct the caller to call back if "the patient becomes worse."
10	Three Calls = A Visit	<ul style="list-style-type: none"> • Three calls equal a visit. If a patient calls seeking advice about the same problem 3 times, arrange for the patient to be seen. • In fact, if the caller phones in twice in 12 hours about the same or a worsening condition, the triager needs to be concerned and should consider referring patient in to be seen. • In these situations, usually the caller was not reassured by the information provided over the phone or the patient is actually sicker than described. • An exception to this rule is a patient calling in a second time to confirm a drug dosage.

Frequently Asked Questions (FAQ) about Using STCC in an Office or Medical Call Center

- This section includes questions the protocol authors frequently receive from medical call centers or office practices.
- The questions are organized into six main categories (see Table 6 below).

Table 6: Frequently Asked Questions Received from Call Centers		
Question Category	Questions Related to These Topics Are Covered	Page
Call Center Employees and Training	Roles of Staff Members (Clinical/Non-Clinical)	21
	Telephone Provider (TCP) Training	21-22
Call Center Operations	Prioritizing Calls	23
	Handling Life-Threatening Emergencies	24
	Providing OTC and Prescription Medication Advice	24-26
Triage Protocols	STCC - Type of Decision-Making Tool	26-27
	STCC - Supporting Evidence	28
	STCC - Review Process	28
	STCC - Supporting Research	28
	STCC - Review/Implementation of Annual Updates	29
	Customization of Protocols	29-31
	Safety of Disease-Based Protocols	31
	Authors' Rationale for Splitting Protocols	32
	Purpose of Reason/Rule Out Statements	32-33
Triage Call Processing	Selection of Protocols Based on Age	33
	How to Address Transient Symptoms	34-35
	Other Options for Providing Care Advice	35-36
Triage Call Documentation	Generic Nursing Assessment Questions	36-37
	Documenting Pertinent Negatives	37
	Chronic Illness, Current Meds, Allergies, & Social History	37-39
	Call Documentation Reports for Providers	39
	Patient Refusal of a 911 or Go to ED Now Disposition	40
Quality Improvement	Quality of Telephone Triage Care – Overview	41
	ED Over-Referrals and Under-Referrals	41-42
	Determining Appropriate Dispositions on Call Audits	42-43

Call Center Employees and Training Questions

Roles of Staff Members (Clinical/Non-Clinical)

Q: Telephone Care Providers (TCPs): Who is qualified to provide telephone triage?

- Physicians, physician assistants, and nurse practitioners usually have the skills necessary for providing telephone assessments.
- Registered nurses usually require additional specialized training to become TCPs.
- The standard of care for registered nurses is that they follow written protocols when providing telephone care.
- It is the author's opinion that medical assistants and LPNs do not have the skills to provide telephone care, even when using protocols. Some offices may use MAs and LPNs to manage calls after special training and under the direct supervision of a HCP.

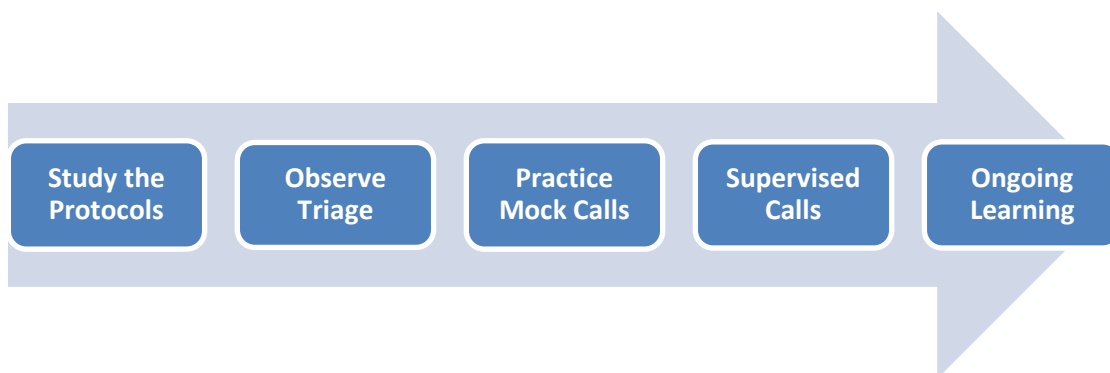
Q: Non-Clinical Staff: Is there a role for non-nurses in a triage call center?

- It is more cost-effective to use non-clinical staff to front-end incoming calls.
- Clerical staff can collect demographics from callers.
- Calls can then be placed in a call queue and returned (or answered if placed on hold) as telephone care providers (TCPs) become available.

Telephone Provider (TCP) Training

Q: What are the basics of telephone care provider (TCP) training?

- We recommend a structured orientation to telephone triage that includes the following five main steps or stages of training:



- In each step, there are specific activities that help promote learning (see Table 7).

Table 7: Telephone Triage Training Basics

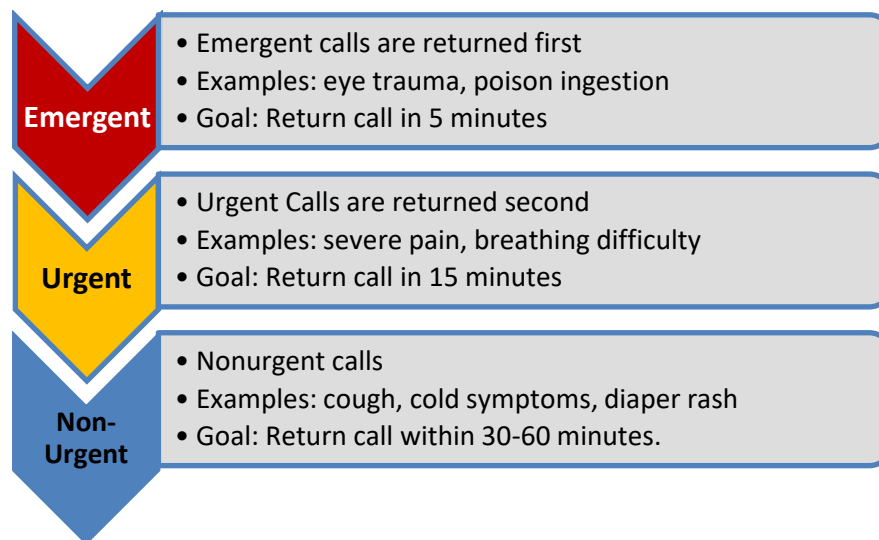
Step	Description
<p>Step 1: Study the Protocols</p>	<ul style="list-style-type: none"> • A good place to start is to study this STCC User's Guide. • Next, study one protocol in depth (e.g., Colds). Read through and become acquainted with the different parts of the protocol. • Study the top 20 pediatric and top 20 adult protocols (see Appendix F and G). Knowledge of these protocols will prepare you for the most common telephone triage complaints. These top 20 protocols account for > 70% of all calls. • Finally, review the anatomical version of the table of contents (see Appendix H and I). This review will help you appreciate the topics available within each body part (e.g., respiratory or abdomen).
<p>Step 2: Observe Calls</p>	<ul style="list-style-type: none"> • After studying the above protocols, observe an experienced nurse or physician managing phone calls for a minimum of 16 hours. While observing, you should learn how to: <ul style="list-style-type: none"> ✓ Select the correct protocol. ✓ Recognize serious symptoms (e.g., stridor in a child or an acute neurological deficit in an adult). ✓ Use the triage assessment questions and reach a disposition that is appropriate. ✓ Give reassurance for high-frequency, safe symptoms (e.g., yellow sputum).
<p>Step 3: Mock Calls</p>	<ul style="list-style-type: none"> • Before taking calls from patients, it is a good idea for you to practice doing some "mock" triage calls with your mentor. Your mentor can pretend to be the patient. • This allows you to become familiar with the triage steps and to receive feedback on your performance. • It also allows you to practice communication strategies such as active listening and use of open-ended and non-leading questions.
<p>Step 4: Supervised Calls</p>	<ul style="list-style-type: none"> • Finally, you should take calls with an experienced nurse or physician observing. • This should be done for a minimum of 24 hours.
<p>Step 5: Ongoing Learning</p>	<ul style="list-style-type: none"> • Learning about telephone triage and advice is an ongoing process. Whenever you have an unusual call, ask your mentor or supervisor for assistance. Your goal is to provide safe and effective medical advice to your callers. • The protocols are designed to be a catalyst for continuing self-education. <ul style="list-style-type: none"> ✓ Pay attention to the reason given for each triage question. The reason indicates the most common diseases that can cause that indicator/symptom. Understanding the reasoning behind the triage questions helps you become a better triager and increases your job satisfaction. ✓ The Background Information in the protocols also contains information that can enhance your knowledge and triage skills. • Take time to review all new protocols and annual updates.

Call Center or Office Operations Questions

Prioritizing Calls

Q: How should a call center or office prioritize incoming calls?

- Offices or triage call centers can either take calls directly and place callers on hold OR operate in a call-back mode.
- Many medical call centers or offices operate in a call-back mode. Reasons include:
 - ✓ Incoming call volume can fluctuate greatly and is not always predictable.
 - ✓ Answering all calls “live” is expensive.
- To avoid a delayed response to an emergent call, calls should be screened and prioritized before being placed in a call queue.
- Potential life-threatening symptoms should be addressed immediately (e.g., transferred to triage nurse immediately without delay). Examples are severe breathing difficulty, unresponsiveness, and possible anaphylaxis.
- Other symptom-based calls generally fall into three urgency categories:



- A triage nurse should scan incoming messages for unusual symptoms that need a higher priority. These types of calls require an expedited return call or transfer to the next available nurse.
- Prioritizing calls checklists are available for pediatric calls (see Appendix J and K) and adult calls (see Appendix L and M).

Office-Hours Telephone Triage Protocols

User's Guide

Handling Life-Threatening Emergencies

Q: How should a call center manage 911 (EMS) calls?

- For life-threatening emergencies, follow the 911 policy established by your call center or office. This may involve one or more of the following:



- **Transfer the call to 911**
 - **Have the caller hang up and call 911**
 - **Call 911 yourself for ambulance dispatch to patient's home.**
-
- Do not delay care by giving lengthy care advice. Tell the caller to immediately call Emergency Medical Services (EMS) or 911 (or as directed by your 911 policy). EXCEPTION: If brief advice could be lifesaving (e.g., abdominal thrusts for choking), take 15 seconds to instruct the caller before contacting EMS.
 - Reason to involve 911 quickly: EMS can dispatch a rescue squad while a dispatcher helps the caller with pre-arrival instructions (first aid) by telephone, pending arrival of the rescue squad.
 - Indications for EMS (911): The patient has a life-threatening condition that may require resuscitation during transport. Examples are severe choking, anaphylaxis, severe respiratory distress, and coma.
 - If patient is calling 911 and is alone, call the caller back in 5 minutes to be certain they have called 911.
 - EXCEPTIONS: For a suicidal or drug-intoxicated patient, stay on the line with the caller. Have someone else in your call center call 911 to dispatch a rescue squad. Provide support to the caller until help arrives.

Providing OTC and Prescription Medication Advice

Q: How should a call center manage the various nurse practice act restrictions related to medication advice when taking calls from multiple states?

Legal Ramifications:

- Many call centers cover calls from different states.
- What nurses can and can't do in a state is governed by each state's nurse practice act.
- State Nurse Practice acts vary widely from state to state with regards to medications. Nurses' role in refilling medications, using medication protocols/standing orders, and recommending OTC medications is restricted to various degrees.

- In some states, the practice acts haven't quite caught up to how telehealth nursing is being practiced.
- This is a legal issue that depends on the interpretations (which can vary) of:
 - ✓ the state nursing practice act by nursing board members
 - ✓ your own call center or office management, and
 - ✓ your legal department's recommendation.
- Since this is a risk management issue, you should seek the advice of whoever provides legal counsel for your program.
- It does depend on interpretation and what level of risk you/they are willing to take.
- Currently, we are not aware of any legal precedent being set in this manner or the law being challenged with a legal case in regards to a nurse recommending OTC medications.

Authors' Stance - MD Standing Orders for OTC Meds:

- Our own stance on this is because nurse telephone triage falls under the medical scope of practice, the medical director in the call center (or supervising physician in an office setting) is responsible for all triage and advice given.
- That means the Medical Director signs off and reviews all protocols by which that care is provided.
- This includes protocol advice about OTC meds and dosing information per the drug dosing tables.
- Therefore, the argument could be made that the nurses are functioning with a standing order from the MD by recommending OTC meds/doses already pre-approved and ordered by the physician.
- Also, the individual PCPs should have signed a contract with your call center that should (or can) include prior authorization for approval for recommending those medications as a standing order within the protocols.



Authors' Stance - OTC Medicines:

- A lay person can buy a medication, guess at dosage and/or follow the package for dosing with **no** medical advice at all.
- A lay person can also give the drug independently without consulting anyone in the medical profession.
- Therefore, we believe a nurse (who has been educated about healthcare and medication) should certainly be able to provide a safe recommendation based upon MD pre-approved dosage tables and protocols.
- This seems like a very safe practice and prevents harm.

Authors' Recommendations - Prescription Medicines:

- As far as prescriptions go, this is more stringently governed. This does depend on the state's Nurse Practice Act as to whether or not the nurses can call in prescription refills, new prescriptions, etc.
- You may want to consult with your legal department about this if you take calls for a number of states. You could theoretically make the argument that the nurses are following MD pre-approved standard orders for new prescription medication as above by following protocol.
- PCP's should have signed a contract with your call center that also can include prior authorization for those new prescriptions by protocol (standing orders).
- However, the states are more rigid in terms of prescriptions than OTC meds. The state practice acts vary greatly in what the nurses can and can't do.

Option for Prescription Medicines versus Patient Call or See PCP:

- There is also an option within the protocols to just have the patient be seen if you don't have standing orders for prescription medicines pre-approved.
- This may be an easy/safe alternative if your program covers multiple states where this is an issue.
- During office hours, you also have the option of discussing or referring these requests to the PCP.

Triage Protocols Questions

STCC - Type of Decision-Making Tool

Q: Are the triage decision-making tools guidelines, protocols, or algorithms?

Guideline/Protocol:

- The terms **guideline and protocol** are often used interchangeably. For example, one online definition defines a clinical guideline as a *"best practices protocol for managing a particular condition, which includes a treatment plan founded on evidence-based strategies and consensus statements by peers in the field."*
- Another definition of a clinical practice **guideline** that still stands the test of time (IOM, 1990) includes: *"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."*
- The Schmitt-Thompson clinical content conforms to these definitions of a clinical guideline/protocol.

The Schmitt-Thompson clinical content is a decision-support tool that:

- ✓ Was developed systematically through a survey of the relevant medical literature.
- ✓ Incorporates evidenced-based information when available.
- ✓ Is reviewed by an expert panel of nurses and physicians.
- ✓ Is updated annually based upon changes in the medical literature, feedback from triage nurses, physicians and call center medical directors, input from the Schmitt-Thompson expert reviewer panels, and results from ongoing analysis of outcome and quality assurance information.

Algorithm:

- One can define an **algorithm** as a logical sequence of steps for solving a problem that can be translated and loaded into a computer software program.
- The Schmitt-Thompson clinical content also meets this definition of an algorithm. The Schmitt-Thompson clinical content is stored in a highly structured relational database and organized algorithmically.

PURPOSE: Regardless of whether one describes the Schmitt-Thompson clinical content (STCC) as telephone triage guidelines, protocols, or as algorithms, their purpose is to:

- **Facilitate a safe telephone triage process** and sort patients to the most appropriate level of medical care (disposition) based upon the acuity and severity of their symptoms (triaging the right patient to the right place at the right time).
- **Provide decision-support** to telephone triage nurses. The purpose of the protocols is to guide the triage nurse's decision-making process. The triage nurse uses the triage protocols, along with critical thinking and clinical judgment, to determine the best recommendation for the patient.
- **Deliver best practice care** and advice based on expert consensus and evidence-based research.
- **Reduce variability in triage practice** and provide a standardized basis for referral and patient education.
- **Promote efficient use of resources.**
- **Serve as a framework for quality assurance** audits and quality improvement.
- **Provide a reference for ongoing nurse education** both during and after triage calls.

STCC - Supporting Evidence

Q: Are the STCC protocols evidenced-based?

Yearly changes in the protocols are based upon the following resources and evidence:

- American Academy of Pediatrics (AAP) new clinical practice guidelines and policy statements (including the AAP Red Book)
- American College of Emergency Physicians (ACEP) new clinical policies and guidelines
- American College of Obstetricians and Gynecologists (ACOG) new clinical policies and guidelines
- American Academy of Family Physicians (AAFP) new clinical policies and guidelines
- Centers for Disease Control and Prevention (CDC) new guidelines or recommendations
- Food and Drug Administration (FDA) new regulations and advisories
- Cochrane Library of evidence-based medicine: new and updated reviews
- National Protocol Clearinghouse (NGC) new evidence-based guidelines
- New Clinical Guidelines from other national organizations (e.g., AHA, ADA)
- Research findings reported in medical literature over the year
- Expert reviews of and recommendations for all specialty protocols by specialists in that field
- Consensus-based recommendations from expert panels (medical advisory boards, etc.) of practicing physicians

STCC - Review Process

Q: How are the STCC protocols reviewed?

- These protocols have been reviewed by numerous experts in this field.
- See the list of pediatric protocol reviewers (Appendix O) and adult protocol reviewers (Appendix P).

STCC - Protocol Research

Q: Have the STCC protocols been researched?

- These protocols have over 10 published research studies in peer-reviewed journals. See the attached annotated bibliography (Appendix N).
- These studies have documented:
 - ✓ High caller compliance with recommendations for ED and Home Care dispositions
 - ✓ High caller satisfaction of over 95%
 - ✓ High efficacy with 90% appropriate ED referral rates
 - ✓ High PCP satisfaction
 - ✓ Substantial cost-savings in recent study of caller prior intent (70% of ED self-referrals were unnecessary following nurse triage).
 - ✓ Very safe care (rare under-referrals of 1: 600 calls).

STCC - Review/Implementation of Annual Updates

Q: What is the best way to review and implement the updated protocols each year?

- The protocols are updated each year.
- Most call centers have their medical director review the yearly changes before approval. Offices may have their lead physician review.
- The review process can be labor-intensive if one reviews every single change.
- To expedite this process, it's recommended that medical directors only review the **MAJOR** changes in existing protocols and the **new protocols**.
- Reviewing all the **MINOR** changes is a time-consuming process and doesn't serve much purpose.
- Another briefer way to do this review is to target the protocols that the author mentions in the annual "letter to the users" explaining the major changes.
- Some call centers install the updated protocols and use them while the internal review is ongoing. They trust that the updates have already been cross-checked by both authors and other experts in the field.
- Examples of **MAJOR** and **MINOR** protocol revisions are outlined in the diagram below.

New Protocols	<ul style="list-style-type: none">• Newly released triage guideline
Major Redline Revisions	<ul style="list-style-type: none">• Addition or deletion of triage assessment question• Any movement of a triage question to a different disposition level• Substantive care advice changes• Substantive background information changes• Substantive definition changes
Minor Revisions	<ul style="list-style-type: none">• Addition/deletion of references• Re-ordering of triage assessment questions within same disposition level• Minor wording changes throughout• Spelling, grammar, punctuation• Any Search Word change

Customization of Protocols

Q: What are the Pros and Cons of customizing triage protocols for a call center?

- Some call centers or offices make custom changes to the standard triage protocols.
- The pros and cons of making custom changes should be carefully considered when making these changes (see Table 8 below).

Table 8: Customizing Protocols - Pros and Cons

Pros – Reasons to Customize	Cons – Reasons Not to Customize
<ul style="list-style-type: none"> • Health care practice standards and health care resources can vary by location. Respecting this variation, local call centers have the right to make minor modifications to the Schmitt-Thompson Clinical Content (STCC) to reflect local healthcare practices and resources. • Local Practice Standards. Clinicians in a healthcare network may have developed a consensus standard and identified certain fever thresholds for pregnancy or neonatal fever that require immediate physician evaluation. The drug of choice for treating eye infections has no national consensus and some offices may select a different one for their use. • Local Resources. Variation in the availability of health care resources may be a more significant factor than healthcare practice standards. For example, in some rural areas, urgent care centers are rare. In other areas, urgent cares are open 7 days a week with some providing diagnostic testing that rivals small emergency departments (ultrasound). • Approximately 10-20% of medical call centers make modifications to the Schmitt-Thompson Telephone Triage protocols. At the majority of call centers these modifications are modest, limited to a few protocols, and approved by the Medical Director or a Medical Advisory Board. 	<ul style="list-style-type: none"> • Increasingly, national standards should be the guiding factor in clinical decision-making and medical care. • The STCC telephone triage protocols are internally consistent. It is important for clinical care and nursing ease of use to maintain this consistency. A change in one protocol can often make that protocol inconsistent with other protocols. It also may make the pediatric and adult triage or care advice different when they don't need to be. • The STCC telephone triage protocols have been extensively reviewed by experts from the STCC Pediatric and Adult Review Panels. • The content of the STCC telephone triage protocols reflects years of feedback from call centers across the United States and Canada. This feedback process is ongoing and input from medical call center managers and medical directors is actively welcomed by Dr. Schmitt and Dr. Thompson. • New telephone triage protocols are reviewed and tested before release. Updates of existing protocols reflect important and at times critical changes in the medical literature. Updates incorporate the results of call reviews and quality improvement projects. • The Schmitt-Thompson Telephone Triage Protocols are updated annually. The logistics of synchronizing your customizations with the annual updates increases exponentially with the number of customizations you have made. Mistakes can be made in the process. Call centers also report that this manual synchronization process delays implementation of the annual update.

Here are our recommendations if your program decides to make modifications to the Schmitt-Thompson telephone triage protocols:

- For call centers, avoid making customizations for individual physicians or individual physician practices. Instead, research, discuss, and implement customizations so that they are applied to all calls at your call center. This approach to customizations will require active and involved leadership from your call center Medical Director or Medical Advisory Board.
- Utilize policies and procedures. Look for ways to handle changes through your organization's policies and procedures rather than through changes to the protocols.
- Limit minor changes. Minor changes suggest low clinical significance. The ratio of the benefit of such changes to the challenges of annual protocol synchronization is low.
- Submit your ideas for major changes to the authors. Drs. Schmitt and Thompson welcome input from their triage partners. Managers and physicians can submit recommendations and rationale for content improvement via email. Drs. Schmitt and Thompson will review the recommendation, research best practice, obtain input from the STCC Review Panel members if needed, and then respond to you. If they agree with your recommendation, they will add your changes to the clinical content. This time-tested approach leads to ongoing-yearly improvements in the content that benefits all call centers and office practices.

For *office practices*, individual modifications can be made to the Schmitt-Thompson telephone triage protocols based on your group's physicians' practices.

Safety of Disease-Based Protocols

Q: Is it safe to use disease-based protocols?

- A premise of disease-based protocols is that if a lay person can reliably make a diagnosis (e.g., an ingrown toenail), then the TCP is more than qualified to make that same diagnosis.
- As a general rule, most of the protocols are symptom-based and neither the caller nor the triage nurse makes diagnoses. However, there are exceptions such as diseases that the average lay person can easily recognize (athlete's foot, head lice, or the common cold).
- Callers may have had other family members diagnosed with the same disease (e.g., chickenpox or influenza) or have friends or neighbors who suggest the diagnosis to them. For these, a disease-based protocol may be indicated.
- The safeguard in all the disease-based (diagnosis-based) protocols is that they start with a section called Disease Definition. The caller's description of the patient's symptoms must match the listed diagnostic criteria before this protocol's triage and advice are implemented. The TCP should rigorously adhere to the definition.
- There are several advantages of using a disease-based protocol including:
 - ✓ The triage questions and care advice are more specific and targeted.
 - ✓ The call encounter is faster and more productive.
- The See More Appropriate Protocol section prevents nurses from overusing disease-based protocols, and these should be carefully considered by the TCP. If the diagnostic criteria are not met, the triage nurse is redirected to the appropriate symptom protocol (e.g., from Hives to Rash or Redness - Widespread).

Authors' Rationale for Splitting Protocols

Q: Why are there so many protocols?

- “Splitting” refers to a protocol development philosophy of splitting topic areas into discrete triage protocols that address specific patient complaints rather than having longer all-purpose protocols.
- Complaint-specific protocols are shorter, allowing the nurse to triage a patient with fewer questions and in less time. This is important because the cost per call is directly related to the length of the call.
- Splitting also permits more targeted and relevant care advice. Using eye symptoms as an example, rather than having one general eye symptom protocol, there are multiple eye symptom protocols available (e.g., Eye - Allergy, Eye Injury, Vision Loss or Change and other eye topics).

Purpose of Rule Out/Reason Statements

Q: Why are “Rule-Out” and “Reason” statements provided?

- The **Rule-Out (R/O)** statements adjacent to a triage assessment question list the most likely conditions or diagnoses that could cause this symptom.
- The **Reason** statements provide the specific indications for a disposition.

Examples of R/O & Reason Statements

Guideline: Chest Pain - Adult

Major surgery in the past month

R/O: *pulmonary embolus*

Guideline: Cold Sores - Adult

Weak immune system (e.g. HIV positive, cancer chemo, splenectomy, organ transplant, chronic steroids)

Reason: *anti-viral treatment indicated*

- Rule-outs and Reasons are intended for the triager, **not** for the caller. The rationale statements allow the triager to:
 - ✓ Understand the medical thinking and reasons behind each question.
 - ✓ If unsure of patient's status, more easily create other questions to pursue relevant diagnoses.
 - ✓ More easily memorize the questions (understanding increases recall).
 - ✓ Increase triager job satisfaction and improve judgment.
- These rationale statements also allow physician reviewers to more easily critique the indications for seeing patients.

CAUTION to Triage Nurses:

Do Not Share Possible Diagnoses with Callers

- Be careful not to overstep your practice boundaries. Nurse triage aims to sort the symptoms by acuity and assign the appropriate level of care. Generally, diagnoses should not be made without seeing the patient and performing a physical examination.
- It is fine for you to think diagnostically or consider differential diagnosis. However, you shouldn't share these provisional diagnosis (e.g., suspected appendicitis) with the caller.
- **What if the caller asks you what he or she might have?**
Tell the caller, *"It's impossible to diagnose most conditions over the telephone. However, from what you've told me, you (or your child) need to be seen for a complete evaluation today."*
- **What if the patient raises a diagnostic possibility such as appendicitis and you agree with it?**
Tell the patient, *"It is one possibility. That's why you (or your child) need to be evaluated now."*
- Only as a last resort should you use scare tactics (i.e., telling potential diagnoses) to motivate a patient to comply with a 911 or ED Now recommendation.



Triage Call Processing Questions

Selection of Protocols Based on Patient's Age

Q: When should the triager use the pediatric versus adult protocols for different age groups?

Use the following guide (Table 9) for selecting the correct set of protocols to use.

Use the Pediatric Protocols for:	Use the Adult Protocols for:
<ul style="list-style-type: none"> • Newborn: First month of life • Infant: Birth to 12 months • Child: 1-5 years • Older child: 5-12 years (school age) • Teen: 12-18 years 	<ul style="list-style-type: none"> • Young-Adults: 18-21 years • Adults: 21-120 years • College Students: 16-21 years • Pregnancy: 12-60 years • Postpartum: 12-60 years
	<p>Adult-Only Call Center (No Pediatric Calls)</p> <ul style="list-style-type: none"> • Adults: 16-120 years • Pregnancy: 12-60 years • Postpartum: 12-60 years

How to Address Transient Symptoms (Symptoms Now Gone)

Q: How should the triager handle triaging transient symptoms that have resolved at the time of the call? Does it matter how long in the past (minutes or hours verses days) the symptom last occurred?

- Generally, the protocols are written in the present tense, for symptoms that are occurring now.
- Nursing judgment is required for symptoms that have occurred in the past and are now resolved (or nearly so).
- It would be very difficult to write logic into the protocols that would handle every variation of symptom and onset.
- The triage nurse should take into consideration several factors (see Table 10) when triaging symptoms that occurred but are no longer present at the time of the call.



Table 10: Triaging Transient Symptoms (Now Gone) – Factors to Consider

<p>Symptom Acuity</p>	<ul style="list-style-type: none"> • An earache that happened 3 days ago, lasted 30 minutes, and is now completely resolved is really more of a health information call (e.g., what are the causes of earache). This patient would not need to be seen. • Whereas, a 30 minute episode 3 days ago of paralysis of the left arm in a 60 year old patient with hypertension, still deserves some type of semi-urgent follow-up care and good Call Back If instructions.
<p>When Symptom Occurred</p>	<ul style="list-style-type: none"> • The longer ago the symptom occurred the less urgent the follow-up disposition. For example: <ul style="list-style-type: none"> ✓ a fever of 104 in an adult occurring right now is moderately concerning. ✓ the same fever having last occurred yesterday is mildly concerning. ✓ the same fever having occurred 3 weeks ago is just a health information call.

<p>Symptom Recurrence</p>	<ul style="list-style-type: none"> • In most cases, low acuity symptoms that happened only once and completely resolved merit a home care disposition. Examples of this would be an earache, toothache, knee pain, or brief abdominal pain. • The nurse also needs to consider the pattern of recurrences and how frequently they are occurring. For example, a frequent pattern of recurring transient crying in children can also indicate more serious conditions (e.g., intussusception). • If symptoms have been recurring or chronic (over weeks), then a follow-up (usually non-urgent for low-acuity symptoms) is indicated.
<p>Other Clinical Factors</p>	<ul style="list-style-type: none"> • The triager needs to also consider clinical factors. Examples include the patient's age, co-morbidities, immune status (e.g., HIV, diabetes, cancer chemotherapy), recent hospitalizations/procedures/PCP visits, pregnancy and prior calls.
<p>Social Factors</p>	<ul style="list-style-type: none"> • Social factors that should be considered are: <ul style="list-style-type: none"> ✓ Reliability ✓ Abuse ✓ Travel distance (and access to care) ✓ Emotional. • The triage nurse can RATE the patient by assessing these factors (see Page 39).

EXAMPLE: Transient Chest Pain

- In the particular case of chest pain, if a day had passed and the patient was completely asymptomatic, it would not make much sense to Call 911. Instead, an ED visit might be a reasonable and conservative disposition.
- If several days had passed and the patient was completely asymptomatic, a SEE IN 24 hour disposition would probably be appropriate. When in doubt, a conservative disposition stance for adult chest pain is warranted.

Other Options for Providing Care Advice

Q: What are other options for providing care advice?

- Providing complete care advice can be time-consuming. The length of the call relates directly to the cost of the call.

- Instead of providing all care advice live, the TCP can use the following strategies to expand care advice or to provide backup for forgotten care advice:
 - ✓ Care advice can be transmitted by fax, email, or smart phone applications.
 - ✓ Care advice may also be made available as pre-recorded messages.
- When using any of the above methods, it is important to check and comply with the HIPAA requirements of your organization's policies and be sure your software can support these safeguards.
- Internet Access: Medically-sound information to supplement advice given may also be available to the caller if they have access to the internet (e.g., CDC website or office/hospital website).
- Self-triage products (e.g., symptom checkers) may also be available on hospital or outpatient clinic websites to provide additional care advice and information on when to call the physician.
- Self-triage: Pediatrics and adult self-triage/self-care information is also available for consumers who have iPhones or Android phones (Symptom MD application).

Triage Call Documentation Questions

Generic Nursing Assessment Questions

Q: Is there a list of generic assessment questions the triage nurse should ask before choosing the correct protocol?

The assessment piece of the triage call should drive protocol selection and should also support the positive triage question selected (disposition). In general, this is what you need to know on every call:

- The patient's main symptoms
- Onset of the symptoms
- Severity of the symptoms
- Activity level/behavior
 - ✓ In pediatrics—*How is the child is acting?*
 - ✓ In adults—*Is the patient able to perform ADLs and function normally?*
- Assessment of pain where appropriate and applicable with the symptom
 - ✓ For level of pain, adults can use the 1/10 scale.
 - ✓ For children, we generally assess behavior to interpret their level of pain.
 - ✓ In some protocols, (e.g., abdominal pain), the pattern of pain may be clinically relevant.
- Any chronic illness/medical issue and current routine medication (i.e. the health history of the patient)

The following may also be important to assess where applicable, but these clinical parameters are generally included in triage protocol questions when relevant:

- Presence of fever when clinically pertinent to decision-making
- Hydration when clinically pertinent to the symptom (e.g., vomiting and/or diarrhea)

- For females of child-bearing age--possibility of pregnancy where clinically pertinent to decision making (e.g., LMP, sexually active, etc.)
- What have they tried already to treat the symptoms? Examples include pain meds, home care remedies, first aid, etc.
- If they've tried appropriate home care treatment and it's not working, this may result in higher disposition for the call.

The generic templates (see Appendix T) may also aid in developing appropriate generic assessment questions for given clinical situations.

Documenting Pertinent Negatives

Q: Don't we also need to document negative triage questions?

- Sometimes a concern is raised that only the "Yes" statement is documented, but that all the preceding "No" statements (pertinent negatives) are not charted. This is called charting by exception.
- Documenting by pertinent positives is safe and permissible because the nurse is following and adhering to a protocol.
- The protocol is key. Without it, the nurse would need to record pertinent negatives as well.
- Charting by exception has become the standard of care in medical call centers and offices.
- It keeps call processing and documentation simple and brief.

Chronic Illness, Current Medications, Allergies, and Social History

Q: How much does the triager need to document about patients medical and social history?

Active Chronic Medical Conditions:

- *Active* chronic medical conditions are important to know in most calls. Documentation of pertinent chronic illness is indicated in most calls.
- Documentation should not be a comprehensive listing of every medical and surgical problem that the patient has ever had. Instead, documentation should reflect current ongoing medical problems (the active problem list).
- The higher the acuity of the disposition, the less documentation of chronic illness will be needed. A patient who obviously requires an EMS 911 or GO TO ED NOW disposition needs a very abbreviated or no documentation of chronic illness.
- The protocols contain **Triage Questions** that prompt the triage nurse to inquire about key chronic illnesses for certain complaints, and then the protocols recommend a disposition.

Example: Guideline Puncture Wound – Adult:

Triage Statement:

Diabetic and puncture wound of foot

Reason: diabetic neuropathy and decreased resistance to infection

Example: Guideline Headache – Pediatric:

Triage Statement:

High-risk child (e.g. bleeding disorder, V-P shunt, CNS disease) and new headache

- When documentation of chronic illness is indicated, the recorded information can often be very brief (e.g., *PMH – diabetes, PSH – coronary bypass surgery*).

Medications:

- It is reasonable and appropriate to document medications to the extent that they are pertinent to the presenting complaint and they affect the disposition.
- Sometimes inquiring about current medications reveals a **Chronic Illness** that the caller had forgotten or denied.
- Documenting every medicine that a patient takes on every call is time-consuming and not necessary.
- The higher the acuity of the disposition, the less that the medications will need to be documented. A patient who requires an EMS 911 disposition rarely needs any documentation of medications. Such rare circumstances would include a life-threatening reaction to the medication (e.g., anaphylaxis) or severe hypoglycemia. In such a circumstance, documentation should not delay completion of the call.
- A patient who requires a GO TO ED NOW disposition usually doesn't need to have medications documented.
- The protocols contain **Triage Questions** that prompt the nurse to inquire about key medications for certain complaints, and then suggest a disposition.
- When medication documentation is appropriate, the recorded information can often be very brief (e.g., *MEDS – amoxicillin, started yesterday*). Documenting the exact dosage of a medication or dosing interval is not necessary unless:
 - ✓ The patient has a specific medication question, or
 - ✓ An adverse drug reaction (dose-related side effect or overdose) is suspected by the triage nurse or caller, or
 - ✓ The triage nurse is calling in a prescription (by physician standing order and per protocol) for a medication (e.g., antibiotic eye drops for purulent conjunctivitis, nystatin for oral thrush).

Medication Allergies:

- Medication allergies are only rarely pertinent to the presenting complaint and the triage decision-making process.
- Medication allergies should be documented in the following two circumstances:

- ✓ Presenting complaint is rash or other suspected drug reaction.
- ✓ Triage nurse is calling in a new prescription (by physician standing order and per protocol), calling in a refill (per office policy and per physician standing order), or recommending an Over-the-Counter medication (per office policy and protocol).

Social History:

- There are a number of social factors that may influence triage decision-making.
- Social history only needs to be documented if it affects the triage disposition.
- The triage nurse can use the acronym RATE to remember important social factors (see Table 11).

Table 11: Social Factors RATE the Patient	
R eliability	Language barriers Confusion Intoxication Limited education Second-party callers Truthfulness
A buse	Partner, child and elder abuse Drug and alcohol abuse
T ravel Distance and Access	Distance from hospital and office Access to car or other transportation Ambulatory or bedridden
E mootional	Anxiety, fear, hysteria

Call Documentation Reports for Providers

Q: What type of information are the providers looking for in our call center or office triage call reports?

- Computerized triage systems capture all the data that the TCP records. Also, many offices now have access to EMR software where they can add their triage call documentation.
- In addition, many medical call centers record all calls, so the recording stores every detail of the telephone encounter.
- The patient's PCP usually wants a brief report of what happened. The following are the essential documentation needed beyond patient identifying information:
 - ✓ Protocol used
 - ✓ Positive triage question that led to disposition
 - ✓ Disposition reached and recommended
 - ✓ Statement that standard care advice given for that protocol
 - ✓ For any OTC drugs recommended, record dosage

Patient Refusal of a 911 or ED Now Disposition

Q: What should the triage nurse do if patient refuses to follow a 911 or ED Now recommendation?

- It is important for every call center or office to have a procedure/policy that covers the nurses in case of caller disagreement and caller downgrades.
- This is a risk-management issue and may have legal consequences. Therefore, it's important to have some organizational legal counsel and approval in developing these policies. Each organization's policies and procedures should give guidance for the triage nurse to follow in case of patient disagreement with the recommended disposition. This is especially important for 911 and Go to ED Now Dispositions.
- There are many reasons why a caller might disagree with a 911 or ED recommendation. The triage nurse must diligently attempt to identify the barriers to compliance and work with the caller to remove those barriers.
- For 911 Dispositions, the triage nurse must make sure the patient understands the rationale for ambulance transport versus going to ED by car and the possible consequences (e.g., death). Explaining what can happen, and what EMS can do to save the patient's life en route to ED should be emphasized. In addition, the person may place others at risk if the patient drives by causing a serious accident (e.g., if patient loses consciousness). Additional factors such as weather, road conditions, road detours and traffic delays can make transport by car even more dangerous.
- Similarly, for ED Now dispositions, the triage nurse must make sure the patient understands the rationale for going to the ED versus an urgent care or office and consequences of delayed emergency care. In an office setting, the PCP may talk with the family or agree to see them in the office.
- If all of the above attempts fail and the patient still refuses, the nurse should not change the recommended disposition. In these cases, the nurse should document: a) the 911 or ED recommendation; b) attempts to remove barriers to compliance; c) patient's understanding of potential consequences; and d) patient's plan to choose an alternative option.
- Each call center or office may choose to handle these calls a bit differently. For example, some call centers or office settings may offer a rapid consult with a PCP if the patient adamantly refuses. Rationale: some patients will comply when they have been instructed to do so by a medical provider they know and trust.
- It is important to keep in mind that a caller/patient does have a right to disagree with the triage nurse's recommendations. Demonstrating respect for the caller/patient and keeping the lines of communication open are important. Instead, the triage nurse should emphasize concern for the person and person's safety. Even when patients disagree, the goal is to have a collaborative relationship. This increases the likelihood that the patient may change his/her mind or call back if needed.
- The key is to document thoroughly and clearly exactly what was recommended and patient's decision to do something else.

Quality Improvement Questions

Quality of Telephone Triage Care - Overview

Q: How is quality of telephone triage care protected?

- The primary goal of telephone triage is to provide safe, high-quality care.
- Key quality improvement measures will help assure your call center nurses are achieving this goal (see Table 12).

Table 12: Components of Quality Improvement System for Telephone Triage	
Monitor New Nurses Closely	<ul style="list-style-type: none"> • New triage nurses need regular review of call documentation reports until they become competent.
Call Audio Recording and Review	<ul style="list-style-type: none"> • The call audio recording should be listened to if the generated call report raises concerns.
Periodic Call Documentation Review	<ul style="list-style-type: none"> • Periodic review of call documentation on triage calls is the best way to check ongoing triager performance. Choose protocols with high risk symptoms (e.g., Vomiting, Chest Pain). • Review the call for selection of the appropriate protocol, proper disposition, and accurate documentation. A more formal review can utilize a Quality Assurance (QA) checklist (see Appendix Q). • The main goals of call review are to prevent under-referrals and over-referrals. • All errors or omissions should be discussed in a constructive way with the triage nurse to facilitate their ongoing education. • Utilize the Good Call checklist (see Appendix R) to assess whether a specific call met the standard of care.

ED Under-Referrals and Over-Referrals

Q: What are the risks of under-referrals to the ED?

- **Definition:** Not referring a patient to the ED who needs medical care now.
- **Goal:** A call center should have goal of zero under-referrals.

- **Risks:** The risks of under-referrals to the ED include:
 - ✓ Delayed diagnosis and delayed treatment of serious conditions
 - ✓ Increased medical complications and adverse outcomes
 - ✓ Increased malpractice liability for triage nurses, PCP and hospital and/or organization

Q: What are the risks of over-referral to the ED?

- **Definition:** Referring a patient to ED now who can safely be seen tomorrow (during office hours).
- **Goal:** Over-referral is a given. The protocols are written to be somewhat conservative and safe. The goal should be 10% or less of total calls.
- **Risks:** Over-referrals can lead to:
 - ✓ Unnecessary ED visits
 - ✓ Stress for the patient
 - ✓ Longer wait times-inconvenience
 - ✓ Sense of medical vulnerability to the patient and caregiver
 - ✓ Unnecessary exposure to infectious disease
 - ✓ More expensive for consumer
 - ✓ Loss of time and money for the parent
 - ✓ Misuse of ED physician's expertise
 - ✓ Increased costs for medical care system

Determining Appropriate Dispositions on Call Audits

Q: When doing call audits, if the nurse chooses the "wrong" triage indicator, but ends up with the correct disposition level for the call, should this be tracked as an error by the triage nurse?

- We favor separating out the disposition from the triage question selection for QI. Selecting the appropriate disposition should always receive credit, and getting the correct disposition (minimizing over-referral, avoiding under-referral) is central to what we do from a patient safety standpoint.
- Drs. Thompson and Schmitt teach residents that it is more important to get the disposition (911 versus Go to ED by car versus See in office tomorrow morning) right than to have an exact diagnosis.
- For certain clinical presentations (e.g., "Chest Pain"), diagnostic-certainty is initially elusive and only becomes apparent over hours (or longer) and after diagnostic testing (e.g., angiogram). This also applies to telephone triage.
- The only sure way to prove the triage question selected is not appropriate for the call is to listen to the call (this can be time consuming). Occasionally, you will find documentation does not accurately reflect the call on audio. The nurse may give the right disposition on the audio based on clinical judgment (e.g., she knows what should happen), but selects a clinical indicator that doesn't fit with the patient's history to get the patient to the appropriate disposition.
- The correct thing from a documentation perspective is to override the protocol if "nothing fits."

However, newer nurses can feel uncomfortable doing that. It's also a learning process to become comfortable interpreting the protocols and using the triage questions as they were intended.

- If the nurse gets the right disposition on audio, but selects the wrong triage indicator, make a note of it on your call audits (or track both the appropriate triage question and correct disposition). It's not a disposition error. The most important thing from patient safety standpoint is did the nurse give the right disposition.....and a little less important on how they got there.
- If documentation errors are happening frequently (using wrong indicator, wrong protocol, any under-referrals, chronic over-referrals, etc.), it would be important for the nurse to get further call review.
- Call centers can see these results (and notes) by running reports for individual staff.
- There can be many reasons at the root of this performance issue if it is happening consistently (using wrong protocols, inadequate knowledge base, nurse uncomfortable, etc.).

Appendices for STCC Office-Hours User's Guide

- Appendix A: Alphabetical Table of Contents for Pediatric Protocols
- Appendix B: Alphabetical Table of Contents for Adult Protocols
- Appendix C: Alphabetical Table of Contents for Women's Health Adult Protocols
- Appendix D: Office Hours Dispositions - Adult and Pediatric
- Appendix E: Office Resources
- Appendix F: Pediatric Top 20 Protocols Rank-Ordered
- Appendix G: Adult Top 20 Protocols Rank-Ordered
- Appendix H: Anatomical Table of Contents for Pediatric Protocols
- Appendix I: Anatomical Table of Contents for Adult Protocols
- Appendix J: Pediatric Prioritizing Calls Checklist
- Appendix K: Pediatric Prioritizing 911 Calls Checklist for Answering Services
- Appendix L: Adult Prioritizing 911 Calls Checklist
- Appendix M: Adult Prioritizing Calls Checklist (ED or Office Now)
- Appendix N: List of Published Research Articles on STCC
- Appendix O: Pediatric Protocol Reviewers
- Appendix P: Adult Protocol Reviewers
- Appendix Q: Quality Assurance (QI) Call Checklist
- Appendix R: Good Call Checklist
- Appendix S: Risk Management Checklist
- Appendix T: Pediatric Behavioral Health Protocols
- Appendix U: Adult Behavioral Health Protocols