After-Hours Telephone Triage Guidelines
User’s Guide 2013
# Table of Contents

**Schmitt-Thompson Clinical Content**  
Benefits of Telephone Triage Guidelines  
Number of Guidelines  

**Structure of Schmitt-Thompson Guidelines**  
Title (Topic Name)  
Definition  
Initial Assessment Questions (IAQ)  
Background Information (BI)  
First Aid  
References  
Search Words  
See More Appropriate Guideline (SMAG) Questions  
Disposition Categories or Levels of Care  
Triage Questions  
Care Advice  
Citations  

**Structure of a Telephone Triage Encounter**  
Overview  
Introduce Self to Caller  
Collect or Confirm Demographic Information  
Obtain a Brief Health History  
Document a Brief Description of the Patient's Illness  
Identify the Chief Complaint or Main Symptom  
Select the Correct Guideline  
Triage the Patient Into an Appropriate Disposition Category Using the Triage Questions  
Provide Care Advice (Telephone Advice)  
Give Call – Back Instructions  
Practice Risk Management: Prevent Adverse Outcomes  

**Frequently Asked Questions (FAQ) - Using STCC in a Medical Call Center**  
Call Center Employees/Training Questions  
Call Center Operations Questions  
Guideline Questions  
Call Processing and Documentation Questions  
Quality Improvement Questions  

**Appendix for STCC After Hours User's Guide**  

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Schmitt-Thompson Clinical Content

The Schmitt (pediatric) and Thompson (adult) telephone triage guidelines are a decision support tool 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 guidelines 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 guidelines if their role crosses over into medical practice, which can occur in providing telephone care.

Benefits of Telephone Triage Guidelines

• Provide a standardized approach to telephone triage (reduce variance)
• Reduce telephone triage errors and medical-legal liability
• Improve consistency of the home care advice offered by various telephone nurses
• Keep the assessment process thorough and logical
• Prevent omission of important questions
• Improve nurse productivity when dealing with unfamiliar symptoms
• Simplify nurse training and education
• Allow documentation by exception
• Provide a focus for review of nurse performance
• Allow physicians to safely delegate calls to nurses
• Provide consensus tool for physicians across a healthcare system regarding how telephone care will be delivered

Number of Guidelines

• Currently there are 296 pediatric guidelines (See Appendix A).
• Currently there are a total of 312 adult guidelines (See Appendix B), including 64 adult women’s health guidelines. (See Appendix C)
• This set of telephone triage and advice guidelines covers over 99.9% of medical calls.
Structure of Schmitt-Thompson Guidelines

The pediatric and adult guidelines have identical organization and structure. The guidelines have the following components and each will be discussed in detail:

- Title (Topic Name)
- Definition
- Initial Assessment Questions (IAQs)
- Background Information
- First Aid
- References
- Search Words
- See More Appropriate Guidelines (SMAG) Questions
- Triage Questions
- Care Advice
- Citations

**Title (Topic Name)**

- The adult and pediatric guidelines nearly always have identical titles for easy transitions, thereby, helping the TCP
- Most topics are Symptom-based guidelines (e.g., Cough, Vomiting)
- Disease-based topics are also available for:
  - Chronic diseases that have been previously diagnosed by a physician (e.g., Asthma or Diabetes)
  - Pregnancy or Postpartum conditions in the adult content
  - Common acute diseases that could reliably be diagnosed by most adults (e.g., Athlete's Foot or Head Lice)
  - Follow-up call guidelines for managing calls regarding recently diagnosed acute diseases (e.g., Sinus Infection Follow-Up Call)
  - Exposure guidelines for some conditions (e.g., Chickenpox or Shingles Exposure, Whooping Cough Exposure)

**Definition**

- Defines the symptoms that need to be present before using this topic
- Some symptoms are straightforward (e.g., Headache)
- Some symptoms require clarification (e.g., Constipation)
- For disease-based topics, diagnostic criteria for that disease are listed. The disease-based guidelines can only be used if the caller’s description of symptoms matches the symptoms listed in the definition section for that disease.
Initial Assessment Questions (IAQ)

- A list of questions that help the triager elicit an accurate picture of the illness or injury
- Questions about severity and duration of the symptoms are always included
- All the IAQs are specific and relevant to the topic
- Mainly used as memory prompts during the call (Asking all the IAQs, however, is not required)
- Helpful in training new staff

Background Information (BI)

- Additional clinical information to help nurses improve their clinical reasoning (critical thinking skills) and fine tune their assessment skills
- For symptom-based guidelines, causes are included
- For disease-based guidelines, complications are included
- Contains the reasons behind any triage or treatments that are controversial
- When call centers ask the authors questions, we respond directly and commonly also add the response to the background information

First Aid

- A section for quickly finding 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 range from giving an epinephrine injection for a probable anaphylactic reaction to applying cold water to a new burn

References

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

Search Words

- Search words are carefully selected for each guideline
- Based on the results of search word testing, new search words are added each year
- Search words that bring up unrelated guidelines are also deleted each year
See More Appropriate Guideline (SMAG) Questions

• These are questions that help the triage nurse select the most appropriate guideline.
• The nurse can use these prompts to rethink the caller’s main concern.
• For symptom-based guidelines, they may redirect the triager to a more specific disease-based guideline (e.g., from Rash or Redness–Widespread to Swimmer’s Itch).
  If Swimmer’s Itch is suspected and the patient’s rash is consistent with the clinical presentation of Swimmer’s Itch, more targeted triage and advice is found in this disease-based guideline.
• For disease-based guidelines, if the diagnostic criteria are not met, the triage nurse is redirected to the appropriate symptom guideline (e.g., from Ringworm to Rash or Redness–Localized).
• The SMAG section is found at the beginning of the triage question section after the 911 triage questions.

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.
• They range from emergent care to home care.
• The disposition categories are the keystone of a telephone triage and advice system.
• The 5 main disposition options are:
  - Call Emergency Medical Services (911) Now
  - Go to the Emergency Department Now (by car)
  - See Physician Within 4 Hours
  - See Physician Within 24 Hours (majority of time in office or clinic)
  - Home Care (Self-Care)
• The guidelines contain many other dispositions that are needed for less common clinical scenarios (e.g., referrals to dentists, other local agencies such as poison centers, suicide hotlines, social services for possible abuse situations).
• The adult guidelines are supported by 27 dispositions (Appendix D) that are usually numbered as care advice 40-67 (see Appendix E).
• The pediatric guidelines are supported by 23 dispositions (Appendix D—excluding the 2 Labor and Delivery dispositions that support the adult population) and are usually numbered as care advice 50-72 (see Appendix E).

Triage Questions

• The triage questions are grouped within dispositions, thereby determining the disposition for each patient.
• The triage questions are sequenced from highest to lowest acuity (from most serious to least serious diagnoses or complications).
• First, questions to detect life-threatening emergencies are listed.
• Second, questions to detect patients with potential emergent or urgent conditions who need to be seen now or within 4 hours are listed (e.g., severe pain or cellulitis).
• Third, questions to detect non-urgent, moderately sick patients are listed (e.g., earaches or UTIs). They should be seen within 24 hours, and usually do not need to be seen during after hours (Exception: office not open the next day).
• Fourth, questions to detect persistent symptoms that are not at risk for any complications (e.g., nasal allergies, localized rashes) are listed. They can be seen by appointment within 3 days and don’t need to be seen on weekends.
• Fifth, questions to detect chronic or recurrent symptoms that are not becoming worse are listed. They can be seen by appointment within 1 or 2 weeks.

Care Advice

• This section contains specific (“targeted”) care advice for each triage question
• This ensures that the care advice is relevant to the precise set of symptoms and disposition of the caller
• It reduces triage nurses’ need to scan lists and to select appropriate care advice
• Lack of targeted care advice causes nurses to waste time selecting from generic lists and sometimes even creating care advice for callers. It also leads to inaccurate documentation of what care advice was actually given.
• All the care advice is written in lay person’s language
• Even with targeted care advice, 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 targeted care advice.
• Care advice is purposefully abbreviated for patients who are referred in now and may only include first aid or pain control. 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.

Citations

• This last section lists the following:
  - Author of the guidelines
  - Latest revision date
  - Copyright notice
Structure of a Telephone Triage Encounter

Overview

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

- Introduce self to caller
- Collect (or confirm) brief demographic information
- Obtain brief health history
- Document a brief description of the patient's illness
- Identify the chief complaint and most serious symptom
- Select the correct guideline
- Triage the patient into an appropriate disposition category
- Provide care advice (telephone advice)
- Give call-back instructions
- Practice risk management in every step of call process

Introduce Self to Caller

The call begins with a greeting, during which you introduce yourself and apologize for any delays or excessive hold time. The greeting ends with an invitation to the caller to describe their 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:

- Greeting (“Good morning”)
- Introduction (“This is Donna”)
- Title (“I am a nurse at the ( ) call center” “covering for Dr. ________”)  
- Apology if indicated (“I’m so sorry for the wait”)  
- Query (“How can I help you this morning?”)

Remember to smile. Callers easily can hear the smile in your voice even when they cannot see it.
Collect or Confirm Demographic Information

- Minimal demographic information includes name, age, gender, phone number
- In pediatrics, the name and relationship of the caller is also obtained
- In some call centers, support staff (or non-clinical personnel) elicit and enter this information before the call is transferred to the telephone triage nurses (Other call centers take 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 a computerized system

Obtain a Brief Health History

- Briefly ask about chronic health problems, medications, etc. that may influence the call outcome
- 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 guideline
- Use the Initial Assessment Questions (IAQs) to help elicit this picture
- The IAQs will help you better define the severity and duration of the patient’s condition
- Asking the IAQs is optional (in contrast to asking triage questions, which is mandatory)

Identify the Chief Complaint or Main Symptom

- Encourage the caller to describe the patient’s main symptom
- Prompt the caller to describe symptoms that are present today
- Practice active listening
- Briefly assess the severity of all symptoms before honing in on the most serious symptom (Exception: emergent or life-threatening symptom 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, the benefit of choosing a guideline as soon as possible is that once in a specific guideline, the nurse can control call flow and become more focused and efficient.
Select the Correct Guideline

• Once you have identified the main problem or symptom, go to that guideline.
• You will become faster at this if you periodically review the Anatomical Table of Contents to better understand all of your topic options within each body area.
• Many of the guidelines start with a section called “See More Appropriate Guideline”. Use these prompts to rethink the patient’s needs. These are usually more specific topics and provide more specific triage than the topic you are currently in.
• 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 is present with other symptoms, go to their second concern.) Fever is covered in all guidelines where fever could be an accompanying symptom.
• Several guidelines are designed to help you locate the most appropriate guideline. For example:
  - Trauma - Multiple Sites - Guideline Selection
  - STDs - Guideline Selection
• For 5 to 10% of calls, you will need to use 2 guidelines (e.g., Rash and Diarrhea)
• If selecting the appropriate guideline is difficult for you, ask your supervisor for help. Using the wrong guideline can cause serious errors.

Triage the Patient Into an Appropriate Disposition Category Using 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 guideline. 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 guideline are organized under disposition categories, a positive response will give you the appropriate disposition (level of care) for your patient.
• 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.
• When using 2 unrelated guidelines for a patient, you may end up with 2 different dispositions. Give the caller the higher acuity disposition of the 2.
These guidelines attempt to place patients who can be safely treated at home into the Home Care/Self Care category (i.e., to prevent unnecessary visits).

The telephone nurse or caller can elect to move patients to a more urgent disposition if warranted. 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. This is known as “upgrading” the disposition and is medically “safe care”.

“Downgrading” a patient to home care or a less urgent disposition than recommended in the guideline, however, should not be done and may have medical-legal consequences. Instead, the nurse should discuss such cases with or refer these calls to the primary care physician.

Provide Care Advice (Telephone Advice)

- Targeted care advice (CA) for your positive triage question will appear on your computer screen.
- Make sure the caller has a pen and paper handy to write down instructions or medication dosages.
- Before giving advice, ask the caller, “What treatment have you tried so far?” “How is that working?” (You may already know this.)
- 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 guideline. (Goal: help callers feel competent in their ability to handle common conditions and problems on their own.)
- The Care Advice section often starts with a reassurance statement. Reassurance may be as helpful to the caller as specific treatment advice.
- All the treatment advice is written in an action statement format. It’s also written directly for the caller, so you can use it as a script and not need to transpose it. The reason for giving that advice is also included.
- Each piece of care advice is preceded by a topic word (e.g., Fever Medicine) or phrase (e.g., Cleanse the Wound). Use these to help you efficiently scan CA items and as a memory jog.
After-Hours Telephone Triage Guidelines
User’s Guide 2013

• The sooner a patient is referred in (higher dispositions), the less care advice that is needed.
• Brief care advice is offered for patients who are referred in now. However, it may only include first aid or pain control. This is purposefully done for several reasons: 1) not to delay care AND 2) the patient will get the rest of the care advice in the ER, UCC, or office.
• Limited interim care advice is offered for patients who will be seen by appointment the next day or later
• Complete care advice is displayed for patients with a Home Care disposition, but 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. 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.
• After finishing your care advice, allow an opportunity to fill in any missing pieces by asking the caller, “Do you have any further questions about what we’ve discussed?”

Give Call – Back Instructions

• End each telephone encounter with call-back instructions
• Suggested “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”

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: Prevent Adverse Outcomes

• The patient’s safety and well-being are always the highest priority
• 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.
• 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.
After-Hours Telephone Triage Guidelines
User’s Guide 2013

• 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.

• Any patient who has become confused or too weak to stand needs immediate evaluation. Usually, this patient will require EMS 911 activation.

• 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 yourself for ambulance dispatch.

• To recognize lethargic or toxic children, always ask about the child’s current activity level. A helpful question is, “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?”

• A good exercise to improve your ability to recognize life-threatening or serious disease is to read the EMS 911 section of each guideline.

• After reviewing home care advice, ask the caller, “Do you feel comfortable with the plan?” Most will. If the caller does not, perform a call back in 1 hour or, even better, 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.

• The triager may override the guideline to suggest the patient goes to a higher level disposition. The triager should not override the guideline to a lower disposition, but instead should discuss with or refer such calls to the primary care physician.

• A nurse triager should not make a diagnosis over the phone. It may be appropriate in certain circumstances for a physician triager to provide a possible/probable diagnosis over the phone.

• 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”.

• Sometimes callers telephone 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.

• 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 2 times in 12 hours about the same or a worsening condition, the triager needs to be concerned and should generally arrange for the patient to be looked at. The reason you should see the patient is that either 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.

• 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 guideline.

• The triage guidelines should be reviewed and amended as needed by the medical director or physician advisory panel in your call center.

• Refer to Appendix S (Risk Management Checklist for Call Centers) for a checklist to use preventively to help protect your call center from substandard care and adverse outcomes.
Frequently Asked Questions (FAQ) about Using STCC in a Medical Call Center

The following topics are addressed:

Call Center Employees/Training Questions (See Page 16):
- Telephone Care Providers (TCPs): Who is qualified to provide telephone triage and advice?
- Training: What are the basics of Telephone Care Provider (TCP) training?
- Non-Clinical Staff: Is there a role for non-nurses in a triage call center?

Call Center Operations Questions (See Page 18):
- Prioritizing Calls: How are incoming calls prioritized?
- Life-Threatening Emergencies: How to manage 911 Calls?
- Office Hours Calls: Can the After Hours Guidelines be used for Office Hours calls?
- PCP Triage or Second Level Triage: Should we offer it?
- Medicine Recommendations, State Nurse Practice Acts and the Guidelines: How do we handle differences when taking calls for multiple states?

Guideline Questions (See Page 22):
- Evidenced-Based Practice: Are these guidelines evidenced-based?
- Annual Updates: How to best review and implement the guidelines each year?
- Reviewers: Are these guidelines reviewed?
- Research: Have the guidelines been researched?
- Customization: What are the pros and cons to customizing the guidelines?
- Splitting Guidelines: Why do you have so many guidelines?
- Disease-Based Guidelines: Are they safe?
- Triage Questions: Why are Rule-Outs and Reason statements provided?
- Multiple Home Care Statements: Why are there multiple home care statements? Why don’t you combine all home care advice into one all-inclusive home care statement?
- ALSO statements within Home Care: Why are there “ALSO” questions within the HOME CARE Disposition that don’t include the main symptom care advice?
- Urgent Home Treatment with Follow-Up Call: What is the ideal process in using the “Urgent Home Treatment with Follow-Up Call” disposition that is found in a small percentage of guidelines? How do other call centers handle these follow-up calls and what are other options if we don’t do call backs?
- Go to ED Now (or PCP triage) Disposition: How do we use this disposition? Does this mean the patients need to go to an ED only or can they go to an Urgent Care Center?
- Call Process During Triage: Do the nurses need to ask all disposition statements sequentially in the guideline until the first positive disposition is reached?

Call Processing and Documentation Questions (See Page 31):
- Patient’s Age: When to use Pediatric versus Adult guidelines?

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After-Hours Telephone Triage Guidelines
User’s Guide 2013

• Pediatric Telephone Physical Exam: Can pediatric physical findings be assessed by telephone?
• Adult Telephone Physical Exam: Can adult physical findings be assessed by telephone?
• Care Advice: What are the options on how to provide care advice?
• Call Documentation Reports: What feedback do PCPs want about their patients?
• Initial Assessment Questions: How are the Initial Assessment Questions intended to be used by the authors? Should we use these to document the nurse’s assessment?
• Generic Nursing Assessment Questions: Is there a list of generic assessment questions you have developed that would be applicable to ask on the front end of the calls before choosing the correct guideline?
• Documenting the Positive Triage Question: Don’t we also need to document negative triage questions?

Quality Improvement Questions (See Page 40):
• Quality Improvement System: How is quality of care protected?
• Under-referral to ED: What are the risks?
• Over-Referral to ED: What are the risks?
• Over-referrals and Under-referrals: What are possible ways to look for and track over-referrals and under-referrals?
• Appropriate Dispositions on Call Audits: 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 nurse?
• After-Hours Triage Dispositions: What are Pediatric benchmarks?
• After-Hours Triage Dispositions: What are Adult benchmarks?
• Over-Referral Reduction: How can call centers act to reduce nurse ED referral rates if they are high?
Call Center Employees/Training Questions:

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

• 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 guidelines when providing telephone care
• Medical assistants and LPNs do not have the skills to provide telephone care, even when using guidelines

Training: What are the basics of Telephone Care Provider (TCP) Training?

1. The first step in training is to study this User’s Guide.
2. Make certain that you understand the structure of the typical telephone triage encounter.
3. Study one guideline in depth (e.g., Colds). Read through and become acquainted with the different parts of the guideline.
4. Study the top 20 pediatric and top 20 adult guidelines (see Appendix F and G). Knowledge of these guidelines will prepare you for the most common telephone triage complaints. They account for over 70% of all calls.
5. Study the anatomical version of the table of contents. It will help you appreciate the topics available within each body part (e.g., respiratory or abdomen). (see Appendix H and I)
6. After studying the above guidelines, observe an experienced nurse or physician managing phone calls for a minimum of 16 hours.
   • Learn how to select the correct guideline.
   • Learn how to recognize serious symptoms (e.g., stridor in a child or an acute neurological deficit in an adult)
   • Learn how to use the triage assessment questions and reach a disposition that is appropriate.
   • Learn how to give reassurance for high-frequency, safe symptoms (e.g., yellow sputum)
7. Lastly, triage calls yourself for a minimum of 24 hours with an experienced nurse or physician observing.
8. 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.
9. The guidelines are also designed to be a catalyst for continuing self-education. Whenever you ask a question, the reason for that question is provided (i.e., the most common diseases that could cause each indicator are listed). The Background Information in the guidelines also contains information that will help you become a better triager and increase your job satisfaction.
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 or answering services and enter them for the nurses
- Calls can then be placed in a call queue and returned (or answered if placed on hold) as telephone care providers (TCPs) become available
Call Center Operations Questions:

Prioritizing Calls: How are incoming calls prioritized?

- Triage call centers can either take calls directly and place callers on hold OR operate in a call-back mode. Many medical call centers operate in a call-back mode because incoming call volume can fluctuate and 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.
- Prioritizing calls checklists are available for pediatric calls (see Appendix J and K) and adult calls (see Appendix L and M).
- Emergent calls are returned first.
- Urgent calls are returned second (e.g., severe pain or difficulty breathing).
- Finally, nonurgent calls are returned in the order received (e.g., cough and cold symptoms).

Life-Threatening Emergencies: How to Manage 911 Calls?

- For life-threatening emergencies, 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 yourself for ambulance dispatch.
- Do not delay care by giving lengthy care advice; tell the caller to immediately call Emergency Medical Services (EMS) (911). (or as directed by your call center 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 en route (e.g., severe choking, anaphylaxis, severe respiratory distress, coma, etc).
- 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.
- The call center charge nurse should scan incoming messages for unusual symptoms that need a higher priority. These kind of calls require an expedited return call or transfer to the next available nurse.
After-Hours Telephone Triage Guidelines
User’s Guide 2013

Office Hours Calls: Can The After Hours Guidelines Be Used For Office Hours Calls?

• The main change that needs to be made is to the triage section.
• The after-hours dispositions need to be converted to office-hours dispositions.
• The following template should help you do that. It can be posted at work stations.
• Many physicians and nurses can transpose the dispositions in their head.
• Here is the conversion template:
  - 911- same
  - Go to ED Now – same
  - Go to ED Now (or PCP triage) – Go to ED Now (or to Office with PCP approval)
  - See Physician Within 4 hours – Go to Office Now
  - See Within 24 Hours – See in Office Today
  - See Within 3 Days – same
  - See Within 2 weeks - same
  - Home Care – same

PCP Triage or Second Level Triage: Should We Offer It?

• Definition: the PCP or medical group elects to re-triage any patient who will be sent to the ED within 1 to 4 hours based upon nurse triage using the guidelines. The triage nurse transfers these calls to the on-call physician.
• Exception: The Go to ED Now (without PCP triage) disposition. These calls should not be transferred to the on-call physician. These calls are about conditions where there is a PCP consensus (unpublished research) that re-triage is unnecessary (e.g., obvious lacerations that need sutures).
• Value: second level triage has been studied and found to reduce ED referrals from 20% to 10% (study done in a pediatric call center)
• Reasons that second level triage is effective: the physician has better knowledge of the patient’s medical problems and the family’s ability to care for the patient. Also, the PCP is better able to reassure the caller, call in a prescription or promise to see the patient the next morning.
• How to set up second level triage: Ideally, all groups provide second level triage until 10 pm at night. It's good for patients and for preventing unnecessary ED visits.
• The following are the 2 dispositions where second level triage can be implemented. (Note that it is optional). Hence, there are 2 scripts for each of these dispositions.
• GO TO ED NOW (or PCP triage)
  IF NO PCP TRIAGE: The patient needs to be seen within the next hour. Go to the ER/UCC at___________Hospital. Leave as soon as you can.
  IF PCP TRIAGE REQUIRED: The patient may need to be seen. Your doctor will want to talk with you to decide what’s best. I’ll page him now. If you haven’t heard from the on-call doctor within 30 minutes, or the patient becomes worse, go directly to the ER/UCC) at___________Hospital.
After-Hours Telephone Triage Guidelines
User’s Guide 2013

• SEE PHYSICIAN WITHIN 4 HOURS (or PCP triage)
  IF NO PCP TRIAGE: The patient needs to be seen. Go to ________________
  (ED/UCC or office if it will be open) within the next 3 or 4 hours. Go sooner if the patient be-
  comes worse.
  IF PCP TRIAGE REQUIRED: The patient may need to be seen. Your doctor will want
to talk with you to decide what’s best. I’ll page him now. If you haven’t heard from
the on-call doctor within 30 minutes, call again. (Note: If PCP can’t be reached,
send to ED/UCC or office.)

Medicine Recommendations, State Nurse Practice Acts and the Guidelines: Our call center covers
calls for different states. In looking at nurse practice acts for different states, new prescription
medications, refill prescription medications, and even recommending OTC meds and/or a dosage
are questioned as far as the nurse role. The states seem to vary widely on this. When these
restrictions are in place, how can call centers continue to effectively triage and provide care advice
across state lines?

• Nurse Practice Acts. What nurses can and can’t do in a state is governed by each state’s nurse
practice act. In some states, the 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 management and your legal
department’s recommendation.

• Legal Advice. 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.

• MD Standing Orders for OTC meds. Our own stance on this is since 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/guidelines by which that care is provided. This
includes guideline 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 PCP’s should have signed a contract with your call center that should (or can)
include prior authorization for approval for recommending those meds as a standing order within
the protocols or guidelines.

• OTC Medicines. We think that if a lay person can go grab a package, guess at dosage or follow
the package for dosing, and administer the drug independently with no advice at all, 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.

• 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 a protocol/guideline. PCP’s should have signed a contract with your call center that also can include prior authorization for those new prescriptions by guideline (standing orders). However, the states are more rigid in terms of prescriptions than OTC meds and really vary in what the nurses can and can’t do.

• **Option for Prescription Medicines.** There is also an option within the guidelines to just have the patient seen or call the office during office hours 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.
After-Hours Telephone Triage Guidelines
User’s Guide 2013

Guideline Questions:

Evidenced-based Practice: Are these guidelines evidenced-based?

Yearly changes in the guidelines 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 Guideline 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 guidelines by specialists in that field
- Consensus-based recommendations from expert panels (medical advisory boards, etc) of practicing physicians

Annual Updates: How to best review and implement the guidelines each year?

- The guidelines are updated each year
- Most call centers have their medical director review the yearly changes before approval.
- 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 redline changes in existing guidelines and the new guidelines.

- MAJOR changes cover the following:
  - Addition or deletion of triage assessment questions
  - Any movement of a triage question to a different disposition level
  - Substantive care advice changes
  - Substantive background information changes
  - Substantive definition changes

- All other changes are MINOR and include:
  - 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
  - Any Initial Assessment Question change
Annual Updates: How to best to review and implement the guidelines each year?

• Trying to review all the MINOR changes is a time-consuming process and doesn’t serve much purpose.
• Another briefer way to do the pediatric review is to target the guidelines that Dr. Schmitt mentions in his annual “letter to the users” explaining the major changes.
• Some call centers install the updated guidelines 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. (see the following FAQ)

Reviewers: Are these guidelines reviewed?

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

Research: Have the guidelines been researched?

These guidelines have over 10 published research studies in peer-reviewed journals. See the attached annotated bibliography (Appendix N). These studies have documented high caller satisfaction of over 95%, high PCP satisfaction, high efficacy with 90% appropriate ED referral rates, high caller compliance with recommendations for ED referral and Home care dispositions and finally very safe care (rare under-referrals of 1: 600 calls). The most recent study compared caller prior intent to the triage nurse recommended disposition, and it found substantial cost-savings (70% of ED self-referrals were unnecessary following nurse triage).
Customization: What are the pros and cons of customizing the guidelines?

**Reasons to Customize the Guidelines**

- Health care practice standards and health care resources can vary by locale. 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 call center advisory boards may select a different one for the clients they serve.
- **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 guidelines. 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.

**Reasons Not to Customize the Guidelines**

- There are a number of valid reasons to not make local changes to the Schmitt Thompson clinical content:
  - Increasingly, national standards should be the guiding factor in clinical decision-making and medical care.
  - The STCC telephone triage guidelines are internally consistent. It is important for clinical care and nursing ease of use to maintain this consistency. A change in one guideline can often make that guideline inconsistent with other guidelines. It also may make the pediatric and adult triage or care advice different when they don’t need to be.
- The STCC telephone triage guidelines have been extensively reviewed by experts from the STCC Pediatric and Adult Review Panels.
- The content of the STCC telephone triage guidelines 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 Drs. Schmitt and Thompson.
- New telephone triage guidelines are reviewed and tested before release.
- Updates of existing guidelines 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 results in delayed implementation of the annual update.

**Recommendations**

- Here are some recommendations if your call center decides to make modifications to the Schmitt-Thompson telephone triage guidelines:
  - 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 call center’s policies and procedures rather than through changes to the guidelines.
- Limit minor changes. Minor changes suggest low clinical significance — the ratio of the benefit of such changes to the challenges of annual guideline synchronization is low.
- Submit your ideas for major changes to the Authors. Drs. Schmitt and Thompson welcome input from their call center partners. Managers and Medical Directors 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.

Splitting Guidelines: Why do you have so many guidelines?

- “Splitting” refers to a guideline development philosophy of splitting topic areas into discrete triage guidelines that address specific patient complaints rather than having longer all-purpose guidelines
- Complaint-specific guidelines 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 guideline, there are multiple Eye guidelines (e.g., Eye-Allergy, Trauma - Eye, Vision Loss or Change and 8 other eye topics)

Multiple Home Care Statements: Why are there multiple home care statements?

- The guidelines are written so that the nurse will have targeted care advice for a specific clinical question. In this way, only specific care advice directly related to the clinical situation is displayed. This aids in a more efficient and faster triage call process.

Multiple Home Care Advice Statements: Why don’t you combine all home care advice into one all-inclusive home care statement?

- Call centers who think they want this option may not realize the total ramifications of incorporating all the care advice into one long home care statement. Namely, these are:
- Call times are longer if the triager gives all the care advice. This results in more call center inefficiency and less productivity.
- Caller tunes out from advice overload resulting in caller dissatisfaction and inability to retain the most important information.
- Nurse dissatisfaction from having to sort through and select from all the care advice on the screen— they can’t find what they need quickly.
- Care advice present on the screen that may not be applicable to the majority of calls.
ALSO statements within HOME CARE: Why are there “ALSO” questions within the HOME CARE Disposition that don’t include the main symptom care advice?

• The "ALSO" questions in the guidelines were meant to be additional care advice to the primary home care statement. For example in the pediatric Cold guideline, there is a primary statement: "Colds with no complications". This is followed by several ALSO statements:
  • ALSO, blood-tinged nasal discharge is present
  • ALSO, mild cough is present
  • ALSO, air travel with colds, questions about

• We intended the nurses to check 2 questions in the home care disposition if they need the “ALSO” additional care advice. This does NOT imply they do triage for a second time to get to the additional statement. We assume the nurse is looking at all the home care statements grouped together. We are aware that not all software platforms support checking 2 statements nor viewing the whole guideline at one time (instead relying on one question at a time).
• However, we encourage software platforms to allow the nurse to check more than one statement (in home care only). This allows the nurse to view only the applicable care advice for the call.

We have separated these homecare statements out for a couple reasons:
• To include all the care advice for all the conditions is unnecessary. For example, in the pediatric Colds protocol, getting on a plane or having blood-tinged nasal discharge will not apply to the majority of calls. The additional care advice only applies for a small percentage of children with colds and those callers who call with those specific conditions. The majority of children with colds do not need this extra advice.
• To put all the care advice for example #1 under Home Care for all colds, would make the care advice extremely long and difficult to weed through for nurses. Plus, the more care advice on the screen, the more the nurses feel obligated to give it all. This results in longer call times and less call center efficiency and productivity.
• Software vendors hopefully will support looking at the whole guideline (or all questions within a disposition level) as well as checking 2 statements in the Home Care disposition for reasons above.

Urgent Home Treatment with Follow-Up Call: How do the authors ideally envision using the disposition, “Urgent Home Treatment with Follow-Up Call”, that is found in a small percentage of guidelines?

We ideally envision this particular disposition statement being used this way:
1) The nurse originally triages thru the guideline and comes up with a disposition, "Urgent Home Treatment with Follow-Up Call". The reason for this disposition is that the patient might qualify for a more delayed disposition if you can effectively manage the patient at home— but you need more information or need the caller to try some things at home right now.
2) The call is stored depending on software options. (such as stored within a follow-up queue, nurse schedules a follow-up call, or nurse notes manually to call the patient back)
3) The call is kept open—this allows for documentation to be added, the call re- triaged on the call back, and a final disposition to be added.
4) The nurse calls the patient back and completes triage. Note: The Urgent Home Treatment is NOT a final legal recommended disposition--so does require some kind of follow-up--either by patient or nurse (preferably by nurse).

Software considerations and features that can support this process:
1) Can the nurses place a call into a follow-up queue to call them back later? The record remains open in this case to adjust documentation.
2) The ability to be flexible when a call closes. Can a 1 hour time frame be picked? Or can closing be triggered by another function other than ending the call? This allows the nurse to be able to re-triage and change dispositions on the follow-up call.
3) The ability to re-triage with the same guideline on a follow-up call and pick another disposition on an open call.

Urgent Home Treatment with Follow-Up Calls: How do other call centers handle these follow-up calls?

The call process for these follow-up calls that are recommended within the guidelines are generally determined by call center policy and supported with software functionality.

Call centers can do all of the following aspects of these calls a little differently:
1) Follow-up Call initiator: Does the nurse call the patient back or do you have the patient call back?
2) Call process: Do you do a new second call or do you keep the first call open and readjust the disposition on the call back?
3) Documentation: Do you completely reassess or do you just add an addendum to the original assessment about what's changed? In general, these calls do require re-assessment and re-triage, but how the nurse does that and what is documented in the second call is covered by a policy. (Some call centers have the nurses completely re-assess, some have them only chart what's changed, some have nurses refer to the first call for the assessment that hasn't changed, and some have the nurse add an addendum. So, documentation of the follow-up call can be done several different ways.)
4) Call centers can also opt to send these patients in and remove this disposition entirely. The above items are decided at the call center level.

Urgent Home Treatment with Follow-Up Calls: Our call center doesn't want the nurses to do call backs with the Urgent Home Treatment with Follow-Up Call Disposition. What are other options?

Options for call centers that do not approve call backs or want calls 100% closed after ending:
1) The patient becomes worse within the specified time frame; they are previously instructed to go to ED (as stated in the care advice).
2) Patient calls back within specified time frame. These calls are moved up in priority and hopefully routed to same nurse who took the first call. The nurse completes a new 2nd call from knowledge of first encounter.
3) Nurse calls back and creates a 2nd call. Can copy and paste documentation from 1st call into 2nd call. Re-triages and ends up with final disposition.
4) Nurse calls back with a call in follow-up queue or just noted manually. She adds a note to the original closed call (first call) as to final disposition and what she told the caller to do (although, this
is not ideal in triage medico-legal world).

5) Call centers can customize and take out Urgent Home Treatment Disposition statements from triage and replace with Go to ED Now.

Go to ED Now (or PCP triage) Disposition: When the patient triages to the disposition, “Go to ED Now (or PCP triage)”, does this mean that the patient can be seen in a PCP office or does it mean go to ED at a hospital?

• For after hours, the “Go to ED Now (or PCP triage)” disposition means either sending patients into the ED or UCC within the next hour OR putting the call back to the on-call physician for 2nd level triage (See page 18.) Some of your physicians want to do second level triage for their patients who would otherwise be sent to an ED based on nurse triage. The nurse puts the call back to involve the MD. The MD then contacts and re-triages the patient and decides on the final disposition.

• If your program doesn’t have any physicians that do second level triage, the nurse sends the patient in with instructions to be in the ED or UCC within the next hour (or at least have left for the ED/UCC).

• For daytime triage during office hours, the after hours disposition equates to “Go to ED Now (or to Office with PCP approval)”. They could be seen at the office if the MD gives prior approval and wants to see the patient in the office. Otherwise, they go to ED or UCC.

Using EDs Versus Urgent Care Centers: When the patient triages to the disposition, “Go to ED Now” or “Go to ED Now (or PCP triage)” does this mean that the patient needs to only go to an ED or can they be seen in an Urgent Care Center (UCC)?

• The decision whether a patient can go to UCC versus an ED depends on the seriousness or acuity of the patients main problem, differential diagnosis the nurse is concerned about, presence of complex chronic illness and the knowledge of local resources (what the UCC’s are capable and comfortable dealing with). This requires some nurse judgment as to where the appropriate place is. It also depends on what is the closest facility that’s appropriate for the patient acuity. For instance, a possible surgical case (e.g., appendicitis) should go to an ED and not to UCC. Serious illness/trauma, those with chronic unstable disease and patients who sound really sick should go to an ED. Patients that possibly need ultrasounds, CTs, specialty care (e.g., ophthalmology) usually need to go to an ED that have those resources. A simple laceration that needs sutures or Dermabond can certainly go to a UCC as well as patients that sound stable that just need an exam/possible lab work/x-ray, etc.

• The term UCC incorporates both free-standing and those near/within a hospital. Those that are within a hospital may be able to deal with a little higher acuity.

• If there’s any question about the most appropriate place to have patients seen, have the nurse call ahead. They can speak to the MD or charge nurse to decide whether the UCC is comfortable with a specific type of patient.
Disease-Based guidelines: Are They Safe?

• A premise of disease-based guidelines 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 guidelines 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., chicken pox or influenza) or have friends or neighbors who suggest the diagnosis to them. For these, a disease-based guideline may be indicated.
• The safeguard in all the disease-based (diagnosis-based) guidelines 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 guideline’s triage and advice are implemented. The TCP would rigorously adhere to the definition.
• The advantages of using a disease-based guideline are several. The triage questions and care advice are more specific and targeted. The call encounter is faster and more productive.
• The See More Appropriate Guideline section prevents nurses from overusing disease-based guidelines, 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 guideline (e.g., from Hives to Rash-Widespread and Cause Unknown).

Triage Questions: Why are Rule-Outs 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.
• Rule-outs and Reasons are intended for the triager, not for the caller. The rationale statements also allow physician reviewers to more easily critique the indications for seeing patients. Furthermore, 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.
• Caution: do not share these possible diagnoses with the caller. This should not be done for the following reasons:
• Triage nurses may overstep their practice boundaries if they attempt to make a diagnosis over the phone. Therefore, although it is fine for triage nurses to think diagnostically, they shouldn’t share their provisional diagnosis (e.g., suspected appendicitis) with the caller.
• While it is acceptable to have nurses consider possible differential diagnosis, they should not attempt to diagnose the patient. Nurse triage aims to sort the symptoms by acuity and assigning the appropriate level of care. Generally, diagnoses should not be made without seeing the patient and performing a physical examination.
• If the caller asks you what he or she might have, tell the caller, “It’s impossible to diagnose most conditions over the telephone, but from what you’ve told me, you (or your child) need to be seen for a complete evaluation today”.
• If the patient raises a diagnostic possibility such as appendicitis, and you agree with it, tell the patient, “It is a possibility and that’s why you (or your child) need to be evaluated today”.
• Only as a last resort should you use scare tactics (i.e., telling potential diagnoses) to motivate a patient to comply with your recommendation to call an ambulance or go to the ED now for an evaluation.

Call Process During Triage: Do the nurses need to ask all disposition statements sequentially in the guideline until the first positive disposition is reached?
• 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 or the triage question that the nurse already has the answer to because of the initial open-ended conversation at the beginning of the call. The nurses do not need to ask the questions within any single disposition category sequentially, but do need to know the answers to all the questions in that disposition category before moving on to the next disposition level.
• Our telephone protocols provide “targeted” care advice, that is, care advice specifically-associated with each triage question. Thus, selecting the most appropriate triage question is preferable.
• We try to arrange higher-volume or higher-acuity triage questions at the top of a disposition level grouping.
Call Processing and Documentation Questions:

Patient’s Age: When to use Pediatric versus Adult guidelines?

Pediatric Guidelines

- 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
- Young-Adult: 18-21 years

Adult Guidelines

- Adult: 21-120 years
- College Students: 16-21 years
- Pregnancy: 12-60 years
- Postpartum: 12-60 years

In Adult Only Call Centers (No Pediatric Calls)

- Adult: 16-120 years
- Pregnancy: 12-60 years
- Postpartum: 12-60 years

Pediatric Telephone Physical Exam: Can pediatric physical findings be assessed by telephone?

One of the challenges of telephone triage is the inability to examine the patient. However, you can still try to look to “look through the caller’s eyes”. You need to be cautious in interpreting physical findings obtained over the phone. However, there is some information that you can gain that can help you in your overall assessment of the severity of the patient’s illness or injury.

- Hydration status
  - 4 factors best predict dehydration:
    - dry mucous membranes
    - absent tears
    - ill appearance
    - cap refill > 2 seconds
  - 2 factors correlate with 5% fluid deficit
  - 3 factors correlate with 10% fluid deficit
Respiratory Status: Assessing Breathing in Young Children
- Parents have difficulty describing respiratory distress or “wheezing” and need prompting by the nurse in order to determine if the child is in distress or not
- Many parents say that their children are having difficulty breathing because of nasal congestion which is easily treated at home
- Usually, it is faster and easier to listen to the child directly to confirm wheezing, stridor, or congestion than to have the parent try to tell the nurse
- This also helps target appropriate care advice (treatment is different for stridor, wheezing or upper airway congestion)

Mental status
Meningeal signs
Peritoneal signs
Range of motion
Exception: description of rashes over the telephone are often unreliable.

Adult Telephone Physical Exam: Can adult physical findings be assessed by telephone?

One of the challenges of telephone triage is the inability to examine the patient. However, you can still try to look to “look through the caller’s eyes” and “feel using the caller’s hands”. You need to be cautious in interpreting physical findings obtained over the phone. However, there is some information that you can gain that can help you in your overall assessment of the severity of the patient’s illness or injury.

- Overall Appearance (e.g., vital signs, general appearance)
- The overall patient appearance is important. Does the person look well? Is the person fully alert?
- Vital Signs. The reliability of vital signs obtained from lay persons is variable. However, some callers have been trained to take vital signs. Some individuals have automated blood pressure and pulse monitoring.
  - Pulse Rate
  - Respiratory Rate
  - Blood Pressure
  - Temperature
• Dehydration
  • Hydration status is difficult to exactly determine based upon physical exam. The following signs and symptoms of dehydration should be considered together in estimating whether a person is dehydrated:
    - Thirst: In normally health adults, the symptom of thirst occurs with even mild dehydration.
    - Dizziness: The presence of dizziness or lightheadedness when standing is suggestive of moderate dehydration.
    - Weakness: If a person is too weak to stand (and normally is able to stand/walk), moderate to severe dehydration should be suspected.
    - Pale skin
    - Dry mucous membranes
    - Cap refill > 2 seconds
    - Decreased urine output

• Eyes
  • Visual acuity is the vital sign of the eye. New onset of true loss of vision is a concerning finding. Vision can be assessed by simply asking if the vision is blurred or asking patient to read something one eye at a time (with glasses on if person uses glasses).
  • Jaundice: white of the eyes have turned yellow

• Respiratory
  • Cyanosis: Bluish lips, tongue or face. Cyanosis is always serious and generally requires a 911 disposition.
  • Stridor: Heard on inspiration. Stridor is always serious and generally requires a 911 disposition.
  • Wheezes: Whistling sound heard on expiration, suggestive of bronchospasm (from asthma, COPD, bronchitis).
  • Determining the degree of respiratory distress
    - MILD: No SOB at rest, mild SOB with walking, speaks normally in sentences, can lay down, no retractions, pulse < 100. (GREEN Zone: PEFR 80-100%)
    - MODERATE: SOB at rest, SOB with minimal exertion and prefers to sit, cannot lie down flat, speaks in phrases, mild retractions, audible wheezing, pulse 100-120. (YELLOW Zone: PEFR 50-80%)
    - SEVERE: Very SOB at rest, speaks in single words, agitated, sitting hunched forward, cannot lie down flat, retractions, usually loud wheezing, sometimes minimal wheezing because of decreased air movement
• **Musculoskeletal (fingers/toes, hands/feet, arms/legs, joints)**
  - Visible deformity is strongly suggestive of fracture dislocation.
  - Inability to bear weight is suggestive of a more serious injury.
  - Adults can usually tell you the point of maximal tenderness (PMT). This helps locate the exact site of a problem.
  - Loss of range of motion of a joint means that a person cannot fully extend (straighten) or flex (bend) a joint. True loss of range of motion is concerning. In a patient with trauma, it suggests a dislocation, a fracture involving the joint, or a severe traumatic effusion (blood or fluid in the joint). In a non-trauma patient with joint pain, complete inability to bend a joint suggests the possibility of severe inflammatory arthritis (e.g., gout) or a joint infection (i.e., septic arthritis).

• **Skin**
  - Change in skin color: cyanosis, pallor
  - Rashes: Callers are not very reliable in their description of rashes over the phone.
    - Is rash in one area (localized) or present in more than one body area?
    - If there is a localized area of redness or rash, how large is it? (Caller can compare it to common objects: coins, their palm, their entire hand)
    - Is the rash tender to touch? Tenderness is suggestive of infection.

• **Neurologic**
  - Level of consciousness can be defined:
    - Alert: Normal state; oriented to person, place, and time
    - Delirious (Confused): Awake but confused talking, thinking, behavior
    - Lethargic: Very sleepy but can be awakened with verbal or tactile stimuli. When awakened, not alert.
    - Stuporous: Very difficult to awaken and only responds to painful stimuli
    - Comatose: Persistent loss of consciousness. Doesn’t awaken to painful stimuli
  - Level of consciousness can also be defined using the AVPU acronym:
    - A: Awake
    - V: Responding to verbal stimuli
    - P: Responding to painful stimuli
    - U: Unresponsive
• Neurologic
  • All adults with any decrease in their level of consciousness require urgent or emergent evaluation.
    • Sudden loss of a neurological function is very concerning
    • Weakness or paralysis of the face, arm or leg
    • Numbness of the face, arm or leg
    • Loss of speech, garbled or confused speech

• Meningeal signs and “stiff neck”
  • The stiff neck that accompanies meningitis is the result of inflammation of the spinal cord membranes. Patients with meningitis are typically unable to touch the chin to their chest because of pain.
  • Patients with muscle strain or myalgia may also describe some neck stiffness. However, such patients are usually able to touch their chin to their chest, but have difficulty putting the chin to each shoulder (can’t rotate the neck). In addition, the neck muscles are often painful to the touch.

Care Advice: What are the options on how to provide 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, smart phone applications. It 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). Self-triage products (e.g., Schmitt-Thompson Symptom Checkers) may also be available on hospital 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)
Call Documentation Reports: What feedback do PCPs want about their patients?

Computerized triage systems capture all the data that the TCP records. 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:

- Guideline used
- Positive triage question that led to disposition
- Disposition reached and recommended
- Statement that standard care advice given for that guideline
- For any OTC drugs recommended, record dosage

Initial Assessment Questions: How are the Initial Assessment Questions intended to be used by the authors?

Each after hours telephone triage guideline has its own set of Initial Assessment Questions (IAQs) as illustrated below.

<table>
<thead>
<tr>
<th>Initial Assessment Questions</th>
<th>Bed Bug Bite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult After Hours Telephone Triage Guideline</td>
<td></td>
</tr>
</tbody>
</table>

1. LOCATION: "Where are the bites located?"
2. ONSET: "When did you get bitten?"
3. CAUSE: Why do you suspect bed bugs?" (e.g., recent travel, recent purchase of used clothing)
4. REDNESS: "Is the area red or pink?" If so, ask "What size is area of redness?" (inches or cm). "When did the redness start?"
5. ITCHING: "Does it itch?" If so, ask: "How bad is the itch?"
   a. MILDE: doesn't interfere with normal activities
   b. MODERATE-SEVERE: interferes with work, school, sleep, or other activities
6. SWELLING: "How big is the swelling?" (inches, cm, or compare to coins)
7. OTHER SYMPTOMS: "Do you have any other symptoms?" (e.g., difficulty breathing, hives)

*The primary purpose of the IAQ’s is for training and reference. New call center nurses can benefit from the IAQs by using them during each call for both training and as a reference. Many call centers have new nurses study the top 20 calls. Reviewing and using the IAQs during mock calls is an effective way for the new nurse to begin to incorporate this important information into his or her telephone interactions.

*The IAQs can also be helpful to nurses who have completed training, even those who have been
After-Hours Telephone Triage Guidelines
User’s Guide 2013

working in a call center for years. Nurses who are struggling with long call times or call efficiency can use these as a reference to organize their nursing assessment.
• Some types of calls are so rare that the IAQs are beneficial to experienced call center nurses to use as a reference on an as needed basis. They can serve as an educational tool to discuss rare calls at staff meetings or use in scripting mock calls for training purposes.

<table>
<thead>
<tr>
<th>Purpose of the IAQs</th>
<th>Training</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>New staff</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Staff with long call times and/or efficiency issues due to lack of an organized assessment or inability to control the call</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Staff who are using a guideline for the first time or have a lack of clinical experience in dealing with a certain symptom</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Initial Assessment Questions: Should we use them to document our assessments on every call?

Some medical call centers require their triage nurses to use the IAQs on every call and document answers to each question. This was not our original intent, and we do not think this should be a standard for all call centers.

There are number of disadvantages and inefficiencies to requiring nurses to use the IAQs on every call. These disadvantages and inefficiencies impact the call process and potentially increase call times and the cost per call.

• The guideline Definition and the See More Appropriate Guideline prompts both help the nurse quickly select and enter the correct guideline after a general nursing assessment. The IAQ’s are not a necessary step in selecting the correct guideline.
• The nursing assessment should precede and drive guideline selection. If the nurse is doing the majority of the assessment with the IAQ’s after guideline selection, this may lead to errors in selecting the correct guideline. Selecting the right guideline for the set of symptoms is crucial to reaching the correct disposition.
• If the nurse discovers she is in the wrong guideline while answering the IAQ’s and/or scanning the See More Appropriate Guideline prompts, the nurse will then need to select the correct guideline and go through another set of IAQ’s. The original set of IAQ’s may or may not be relevant. The result can be longer call times and an inefficient call process.
• Not all of the IAQ’s are relevant to an urgent or emergent disposition (e.g., tetanus status of the patient for significant trauma; this becomes unimportant since the tetanus status will be covered in the ED.) Documentation of these facts is irrelevant to the correct disposition and is another example of inefficiency. A general principal of telephone triage call documentation is that the higher the level of disposition, the less documentation is needed.
• Requiring the nurses to ask all the IAQ’s adds time to the call. The essential questions are covered in triage, but may also be cross-covered within the IAQ’s. If call centers require answers to be documented in both IAQ’s and triage questions, this leads to duplication of data collection and documentation.

• Nurses are required to be able to complete a basic nursing assessment independently at the bedside. Phone triage is no exception and nurses should develop this important skill. This is a critical thinking skill that is essential to effective nurse telephone triage decision-making. Required and consistent use of IAQ’s may hinder the nurses’ ability to think “outside the box” and encourage very concrete thinkers. (e.g., “If it’s not on the screen, I don’t need to think about this.”)

• Summary: Medical call centers may choose to use the IAQs on every call to augment the nursing assessment. However, the authors do not think this should be a standard policy for all medical call centers. The primary purpose of the IAQ’s is for training, education and reference.

Generic Nursing Assessment Questions: Is there a list of generic assessment questions you have developed that would be applicable to ask on the front end of the calls before choosing the correct guideline?

The assessment piece of the triage call should drive guideline selection and should also support the positive triage question selected (disposition).

In general, this is what you need to know on every call:

1) The patient's main symptoms
2) Onset of the symptoms
3) Severity of the symptoms
4) Activity level/behavior. In pediatrics—how is the child is acting? In adults, are they able to perform ADLs and function normally?
5) Assessment of pain where appropriate and applicable with the symptom. For level of pain, adults can use the 1/10 scale or in kids we generally assess behavior to interpret their level of pain. In some guidelines, (e.g., abdominal pain), the pattern of pain may be clinically relevant.
6) Any chronic illness/medical issue and current routine medication—e.g., 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 guideline questions when relevant:

1) Presence of fever when clinically pertinent to decision making
2) Hydration when clinically pertinent to the symptom (e.g., vomiting and/or diarrhea)
3) For females of child-bearing age--possibility of pregnancy where clinically pertinent to decision making. (LMP, sexually active, etc)
4) What have they tried already to treat the symptoms? (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 (Appendix T) may also aid in developing appropriate generic assessment questions for given clinical situations.
Documenting the Positive Triage Question: 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 guideline.
- The guideline 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.
Quality Improvement Questions:

Quality Improvement System: How is quality of care protected?

- The goal of telephone triage is to provide safe, high-quality care
- New triage nurses need regular review of call documentation reports until they become competent
- The call audio recording should be listened to if the generated call report raises concerns
- Periodic review of call documentation on sick patient calls is the best way to check ongoing triage nurse performance
- Choose guidelines with high risk symptoms (e.g., Vomiting)
- Review the call for selection of the appropriate guideline, 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 prove that a specific call met the standard of care

Under-referral to ED: What are the risks?

- Definition: not referring a patient to the ED who needs medical care now
- 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
- Goal: zero under-referrals

Over-Referral to ED: What are the risks?

- Definition: seeing a patient now who could safely be seen tomorrow (during office hours)
- 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
- Goals: keep over-referrals to 10% or less of ED referrals
Over-referrals and Under-referrals: What are possible ways to look for and track over-referrals and under-referrals?

1. If you have access to outcome data or hospital utilization data, you can look at all hospital admissions to see if there was a triage call within the last 24 hours. This process looks for possible under-referrals. Review any cases that meet the 24 hour criteria. Listen to the call, review documentation and the admitting note from the ED. Determine if the call is related to the primary diagnosis in the hospital. Compare the information in the ED to the information given at the time of the call to determine if possible under-referral or if disposition was correct for the time of the call. Of note, natural progression of the disease causes many hospitalizations within 24 hours, rather than the triage nurse missing something that was present at the time of the call. Track and monitor under-referrals for individuals as well as the call center.

2. Routine QI audits can be done also to look for under-referral. Focus efforts on high-risk symptoms or frequently-utilized guidelines.

3. Over-referral is a given. The guidelines are written to be somewhat conservative and safe. The goal should be 10% or less of total calls. QI projects should mainly look for under-referral, unless over-referral is a concerning issue. Over-referral is easy to track simply by looking at the ED/UCC referral rates month by month for your call center or for individual nurses. (See page 47 for more).

Appropriate Dispositions on Call Audits: 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 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 (and that is time consuming).

Occasionally, you will find calls where the documentation does not accurately reflect the call on audio. The nurse may get 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 guideline if "nothing fits". However, newer nurses can feel uncomfortable doing that. It's also a learning process to become comfortable interpreting the guidelines 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 get the right disposition......and a little less important on how they got there. Obviously, if documentation errors start happening frequently (using wrong indicator, wrong guideline, 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 guidelines, inadequate knowledge base, nurse uncomfortable, etc).
After-Hours Triage Dispositions: What are Pediatric Benchmarks?

- Call 911 Now < 1%
- Go to ED Now 14%
- See Within 4 Hours 6%
- See Within 24 Hours or Later Appt 30%
- Home Care 50%

After-Hours Triage Dispositions: What are Adult Benchmarks?

- Call 911 Now 3%
- Go to ED Now 23%
- See Within 4 Hours 14%
- See Within 24 Hours or Later Appt 25%
- Home Care 25%

Reducing Over-Referral: How can call centers act to reduce nurse ED referral rates if they are high?

In general, appropriate dispositions are reflected in the nurses’ correct interpretation of the triage questions, collecting and clarifying the caller’s data accurately, comfort with the patients’ symptoms, and knowledge base. Your call center QI program should be auditing calls for “appropriate” dispositions. Therefore, you can determine whether this is an individual or group issue by comparing each nurse’s results to the aggregate data for the call center.

Over-referrals are determined by:

1. Reviewing the call documentation
2. Listening to the call (if call center records calls)
3. Getting the patient outcome data—call the patient/family back, can call the private MD back for patient outcome data, ED data if available, etc. Have a way to electronically track this data for QI purposes.
4. Make a determination whether the referral is appropriate based on the information available at the time of the call OR is an over-referral.

For ED over-referral, you have to determine whether this is an individual or group issue. The root of the problem will drive the solutions.

1. Monitor referral rates for individual nurses. Is this a program problem or an individual nurse problem? Track it quarterly for both. Work with the nurses who are way outside the established benchmark.
2. Look at referral rates for the top utilized guidelines. Are there referral rates that seem high for the particular symptom? Do call audits on those topics with those specific triage indicators.
3. Provide group or individual education about specific triage parameters. For example: What objective signs and symptoms to you have to have to click on “Dehydration suspected” or “Sounds sick or weak to triager”?
4. Provide education about commonly over-referred symptoms, ones that callers are concerned about but that don’t need to be seen in an ED. (Note: Always balance education about over-referral with under-referral. Focus on the “appropriate disposition”.)
After-Hours Telephone Triage Guidelines
User’s Guide 2013

Reducing ED Referral with Second Level Triage

The guidelines are designed to be somewhat conservative and we expect and tolerate about 10% over-referral. Certainly, physicians can cut the ED referral rate in half by doing 2nd level triage (see page 18). They are able to manage patients medically by calling in scripts or approving more frequent treatment at home (e.g., q 3 hour albuterol treatments for asthmatics). They also have the advantage of being familiar with their patients and disease history.

e) If the nurses aren’t sure initially, can they give some care advice and call the patient back? Or tell the patient to call back in the next 30-60 minutes (if call center doesn’t allow call backs)?
Appendix for STCC After Hours User’s Guide

- Appendix A: Alphabetical Table of Contents for Pediatric Guidelines
- Appendix B: Alphabetical Table of Contents for Adult Guidelines
- Appendix C: Alphabetical Table of Contents for Women’s Health Adult Guidelines
- Appendix D: After Hours Dispositions - Adult and Pediatric
- Appendix E: After Hours Triage Disposition Care Advice – Adult and Pediatric
- Appendix F: Pediatric Top 25 Guidelines – Rank–Ordered
- Appendix G: Adult Top 25 Guidelines – Rank-Ordered
- Appendix H: Anatomical Table of Contents for Pediatric Guidelines
- Appendix I: Anatomical Table of Contents for Adult Guidelines
- 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 Guideline Reviewers
- Appendix P: Adult Guideline Reviewers
- Appendix Q: Quality Assurance (QI) Call Checklist
- Appendix R: Good Call Checklist
- Appendix S: Risk Management Checklist
- Appendix T: Templates for Generic Assessment and Documenting the Chief Complaint