Office-Hours Telephone Triage Protocols
User's Guide 2019

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Schmitt-Thompson Clinical Content (STCC)

Introduction

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

Benefits of Telephone Triage Protocols

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

Provide standarized approach to telephone triage	•Improve consistency of the home care advice offered by telephone nurses •Provide a consensus tool for physicians across a healthcare system regarding how telephone care will be delivered
Reduce telephone errors and legal liabilty	•Prevent omission of important questions •Provide a focus for review of nurse performance •Allow physicians to safely delegate calls to nurses
Improve efficiency	•Keep the assessment process thorough and logical •Simplify training and education of staff •Allow documentation by exception

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Number of Protocols

- Currently there are 245 active pediatric Office-Hours protocols (see Appendix A), including 20 behavioral health protocols (see Appendix T).
- Currently there are a total of 200 active adult Office-Hours protocols (see Appendix B), including 40 adult women's health protocols (see Appendix C) and 11 behavioral health protocols (see Appendix U).
- This set of telephone triage protocols covers over 90% of medical calls.

Structure of Protocols

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

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

Title (Topic Name)

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

Table 1: Examples of Disease Based Protocols

Disease-Based Protocols	Examples
Chronic Disease previously diagnosed by a health care provider	• Asthma Attack
Common acute diseases that could reliably be diagnosed by most adults	• Athlete's Foot • Head Lice
Pregnancy and Postpartum Conditions (Adult)	• Pregnancy – Decreased Fetal Movement • Pregnancy – Morning Sickness • Postpartum – Vaginal Bleeding and Lochia
Follow-up Call protocols for managing calls regarding recently diagnosed acute diseases	• Ear Infection Follow-Up Call • Urinalysis Results Tract Follow-Up Call

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Search Words

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

Definition

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

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

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

SYMPTOMS OF ATHLETE'S FOOT INCLUDE:

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

Background Information (BI)

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

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First Aid

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

Disposition Categories or Levels of Care

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

Table 2: Office-Hours Disposition Categories

URGENCY

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

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- The protocols contain many other dispositions that are needed for less common clinical scenarios. Examples are referrals to dentists, other local agencies such as poison centers, suicide hotlines, and social services for possible abuse situations.
- The adult protocols are supported by 35 dispositions (see Appendix D).
- The pediatric protocols are supported by 31 dispositions (see Appendix D—excluding the 4 OB and L&D dispositions that support the adult population).

See More Appropriate Protocol (SMAP) Questions

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

Examples of Office-Hours SMAP Questions

Guideline: Fever - Pediatric

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

Fever onset within 24 hours of receiving an immunization
Go to Protocol: Immunization Reactions (Pediatric-Office Hours)

Confused talking or behavior (delirious) with fever
Go to Protocol: Confusion-Delirium (Pediatric – Office Hours)

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

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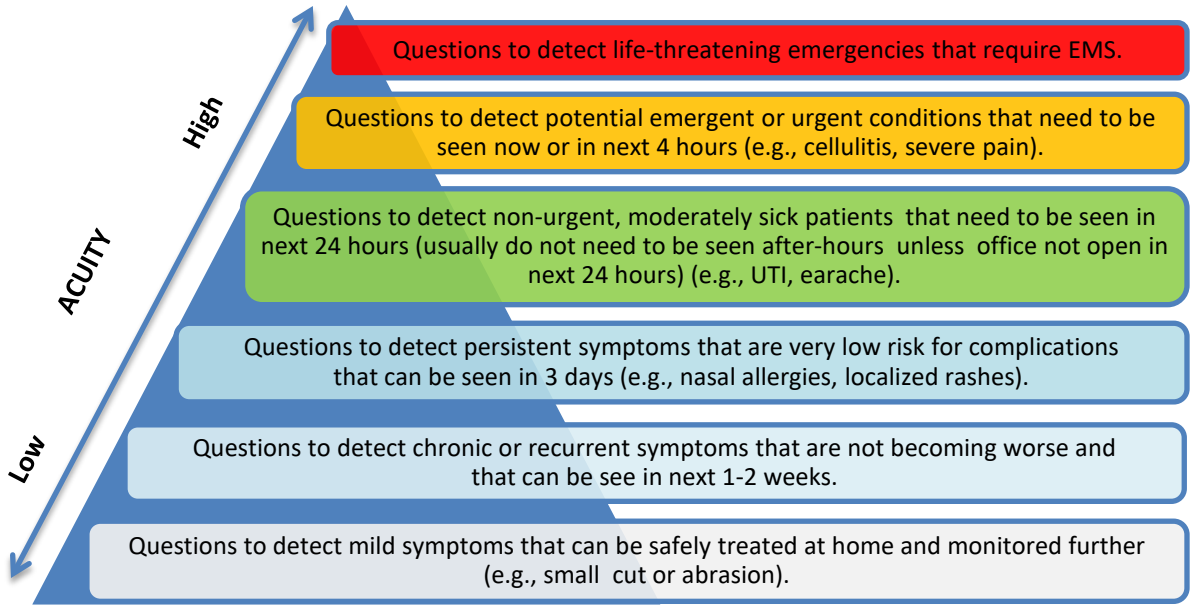
Triage Questions

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



Care Advice

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

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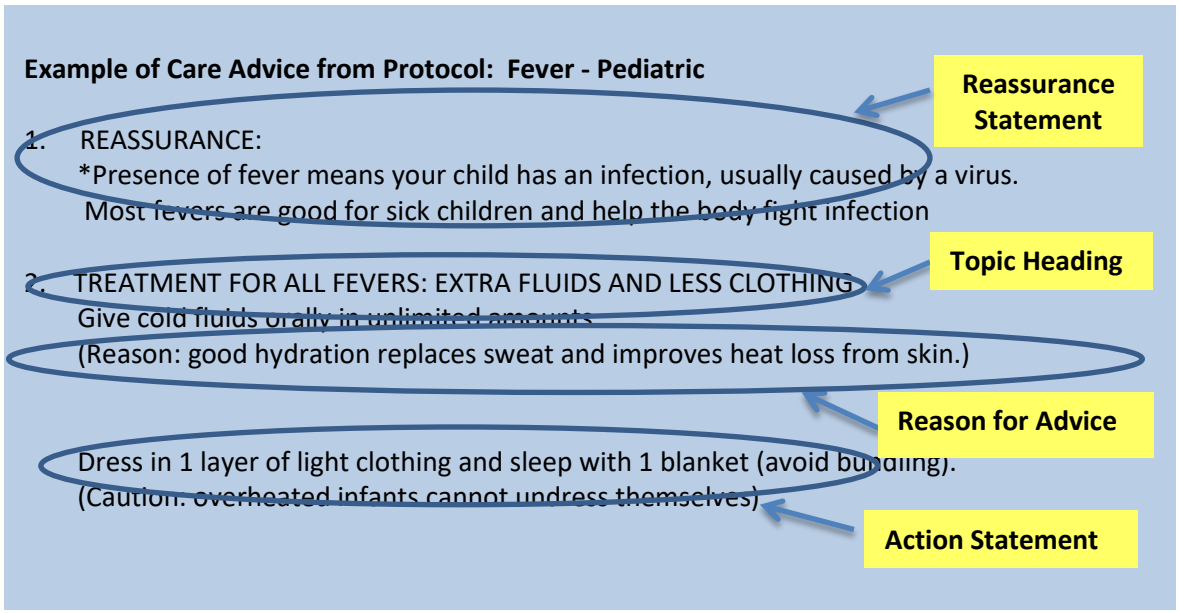

References

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

Citations

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

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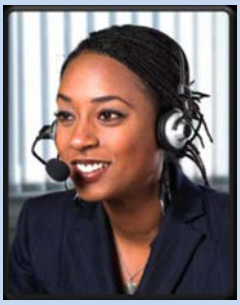
Structure of a Telephone Triage Encounter

Overview

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

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

Remember to Smile!



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

Introduce Self to Caller

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

Table 3: Triage Call Introduction

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

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Collect or Confirm Demographic Information

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

Obtain a Brief Health History

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

Document a Brief Description of the Patient's Illness

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

Identify the Chief Complaint or Main Symptom

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

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Assessing Physical Findings and Symptom Severity

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

Example: Triage Assessment of Breathing Difficulty in a Child

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

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

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

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

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

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

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

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Select the Correct Protocol

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

Tips for Improving Your Guideline Selection Skills

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

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

Triage – Ask the Triage Questions

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

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

Select an Appropriate Disposition

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

Upgrading the Disposition

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

Downgrading the Disposition

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

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Additional Factors that May Influence Disposition

Patient Expectations

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

Resources

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

Table 4: Office Resources

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

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Provide Care Advice (Telephone Advice)

Ask About Home Care Measures Already Tried at Home

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

Select Appropriate Care Advice (CA)

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

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

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

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Verify Understanding – Use Teach Back Method

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

Why Use Teach Back?

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

Example of Teach Back Method:

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

Give Call-Back Instructions

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

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

Call Back If:

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

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Practice Risk Management Strategies to Prevent Adverse Outcomes

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

Table 5: Key Strategies to Prevent Adverse Outcomes During a Telephone Triage Encounter		
1	**When in Doubt, Triage**	• Sometimes callers are seeking some brief health information and do not want to be triaged. When in doubt, perform a complete triage and document the call completely. • If the caller/patient has symptoms and declines triage, this should be documented.
2	**Recognize and Respond Quickly to Life-Threatening Symptoms**	• If the patient's condition sounds life-threatening or unstable, follow the 911 policy established by your call center. • This may involve transferring the call to 911, having the caller hang up and call 911, or calling 911 for the patient. • A good exercise to improve your ability to recognize life-threatening or serious disease is to read the EMS 911 section of each protocol.
3	**Recognize Weakness as a Serious Symptom in Adults and Children**	• If the patient sounds very sick or weak to you as the triager, have the patient come in immediately even if none of the other triage assessment questions are positive. • A patient who has become confused or too weak to stand needs immediate evaluation. The patient may require EMS 911 activation. • To recognize lethargic or toxic children, always ask about the child's current activity level. Ask, "What is he doing right now?" If not active now, ask "How does he look?" If sleeping at the time of the call, ask: "How was he acting before he went to sleep?"
4	**When in Doubt, See the Patient**	• 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.

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5	**Do NOT Diagnose**	• A nurse triager should not make a diagnosis over the phone. • It may be appropriate in certain circumstances for a physician to provide a possible/probable diagnosis over the phone.
6	**Use Caution When Assessing Patient's Self-Diagnosis**	• If a caller calls about a diagnosis (e.g., chickenpox or influenza), do not accept the caller's diagnosis unless it meets the criteria listed in the definition at the beginning of the protocol.
7	**Do Not Downgrade a Disposition**	• The triager should not override the protocol disposition to a lower disposition (called a downgrade). Instead, the triager should discuss with or refer such calls to the primary care physician. • The triager may override the protocol disposition to suggest the patient goes to a higher level disposition (called an upgrade).
8	**Strive for Alignment with Caller's Requests**	• After reviewing care advice, ask the caller, "Do you feel comfortable with the plan?" If the caller does not, schedule a call back in 1 hour or arrange for the patient to be seen. • Always strive for "alignment" with the caller. If the caller insists on being seen, always accommodate that request. From a risk management standpoint, it is challenging to defend a bad patient outcome when the caller and/or patient insisted on being seen and the triager adamantly disagreed. • Remember, telephone triage is a point of entry into the health care system. Do not use triage as a method of limiting access. Instead use it as a method of improving access to primary care.
9	**Give Call- Back Instructions**	• Encourage all callers to call back if the condition worsens. Callers should be given specific reasons to call back. • At the least, the triager should instruct the caller to call back if "the patient becomes worse."
10	**Three Calls = A Visit**	• Three calls equal a visit. If a patient calls seeking advice about the same problem 3 times, arrange for the patient to be seen. • In fact, if the caller phones in twice in 12 hours about the same or a worsening condition, the triager needs to be concerned and should consider referring patient in to be seen. • In these situations, usually the caller was not reassured by the information provided over the phone or the patient is actually sicker than described. • An exception to this rule is a patient calling in a second time to confirm a drug dosage.

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