Schmitt-Thompson
Clinical Content

Office-Hours Telehealth Triage Protocols User's Guide 2025

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If you are a paid ClearTriage customer, we would be happy to send you the complete version of this User's Guide which includes an additional 25 pages of FAQs and more than twenty appendixes. There is also a separate version of the User's Guide for users of the After-Hours protocols. Paid customers can request the appropriate User's Guide by contacting us at support@cleartriage.com or 800-755-3545.

Contents

Schmitt-Thompson Clinical Content (STCC)

Introduction

- The Schmitt (pediatric) and Thompson (adult) telehealth triage protocols are decision-support tools for telehealth triage nurses.
- They assist with data collection, triage, decision-making, disposition selection and advice-giving processes.
- Most telehealth 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 telehealth triage and giving advice. Reason: Giving any medical advice to callers is legally deemed as medical practice. The supervising doctor is responsible for all medical advice given, no matter who gives it. Using protocols ensures the triage nurse is functioning within the nursing scope of practice.

Benefits of Telehealth Triage Protocols

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

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

Number of Protocols

- Currently there are 262 active pediatric Office-Hours protocols including 29 behavioral health protocols.
- Currently there are a total of 264 active adult Office-Hours protocols including 54 adult women's health protocols and 24 behavioral health protocols.
- This set of telehealth triage protocols covers over 95% of medical calls.
- New protocols are added each year to address emerging infectious diseases and call center needs.

Structure of Protocols

The pediatric and adult Office-Hours protocols have identical organization and structure. Each set of protocols includes the following 11 components which are described further in the sections below:

1. Title (Topic Name)
2. Search Words
3. Definition
4. Initial Assessment Questions (IAQ)
5. Background Information (BI)
6. First Aid
7. Disposition Levels
8. See More Appropriate Protocols (SMAP) Questions
9. Triage Assessment Questions (TAQ)
10. Care Advice (CA)
11. 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 • Diabetes - High Blood Sugar
Common acute diseases that could reliably be diagnosed by most adults	• Athlete's Foot • Head Lice
Pregnancy and Postpartum Conditions (Adult)	• 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 Follow - up Call

Search Words

Search words are carefully selected for each protocol.

- These search words help the triage nurse 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 Protocol: Athlete's Foot - Pediatric

Use this protocol 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.

Initial Assessment Questions (IAQ)

Initial assessment questions (IAQs) are questions that help the triage nurse elicit an accurate picture of the illness or injury.

- Questions about severity and duration of the symptoms are always included.
- The IAQs are specific and relevant to the topic covered in the protocol.
- These questions are mainly used as memory prompts during the call. Asking all the IAQs, however, is not required.
- The IAQs are especially helpful when training new staff. They are also helpful for the experienced triage nurse when an unfamiliar, less frequently accessed protocol is used.

Background Information (BI)

This section includes additional clinical information to help triage 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** are listed to support triage questions or treatments based on universal guidelines, or to highlight a lack of study consensus.
- A frequently asked question may be incorporated into the background information.

First Aid

This section allows the triage nurse 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 cool water to a new burn.

Disposition Levels

The main objective of telehealth triage is to sort patients into appropriate disposition levels based on acuity or severity of the illness.

- The dispositions range from Call EMS 911 to Home Care (Self-Care).
- The disposition categories are the keystone of telehealth triage and advice systems.
- The diagram below (Table 2) depicts the disposition options in order of urgency.

Table 2: Office-Hours Disposition Categories

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 ED/UCC Now (or to Office Now per Practice Policy)	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 in Office Today*	Patients with urgent symptoms and patients who are very uncomfortable. Includes many callers who request to be seen.
See in Office Today or Tomorrow*	Patients with non-urgent symptoms
See in Office Within 3 Days *	Patients with persistent symptoms that are not becoming worse.
See in Office Within 2 Weeks*	Patients with chronic or recurrent symptoms that are not becoming worse.
Home Care (Self-Care)	Patients with mild symptoms that can be managed at home with care advice and continued monitoring.
*By Appointment	

The protocols contain many other dispositions that are needed for less common clinical scenarios. Examples are referrals to dentists, other local agencies such as poison centers, suicide hotlines, and social services for possible abuse situations.

- The adult protocols are supported by 36 dispositions.
- The pediatric protocols are supported by 31 dispositions.
- Telemedicine alternate dispositions and care advice have been added to the content to support telemedicine video visit encounters for those offices that wish to use them.

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 to go to the Swimmer's Itch - Lakes and Oceans 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 nurses new to triage. Using the most appropriate protocol helps ensure that the triager selects the most appropriate disposition and care advice.
- The SMAP section is found towards the beginning of the triage question section, but always after the 911 triage assessment questions.

Examples of See More Appropriate Protocol (SMAP) Questions: Fever - Pediatric

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

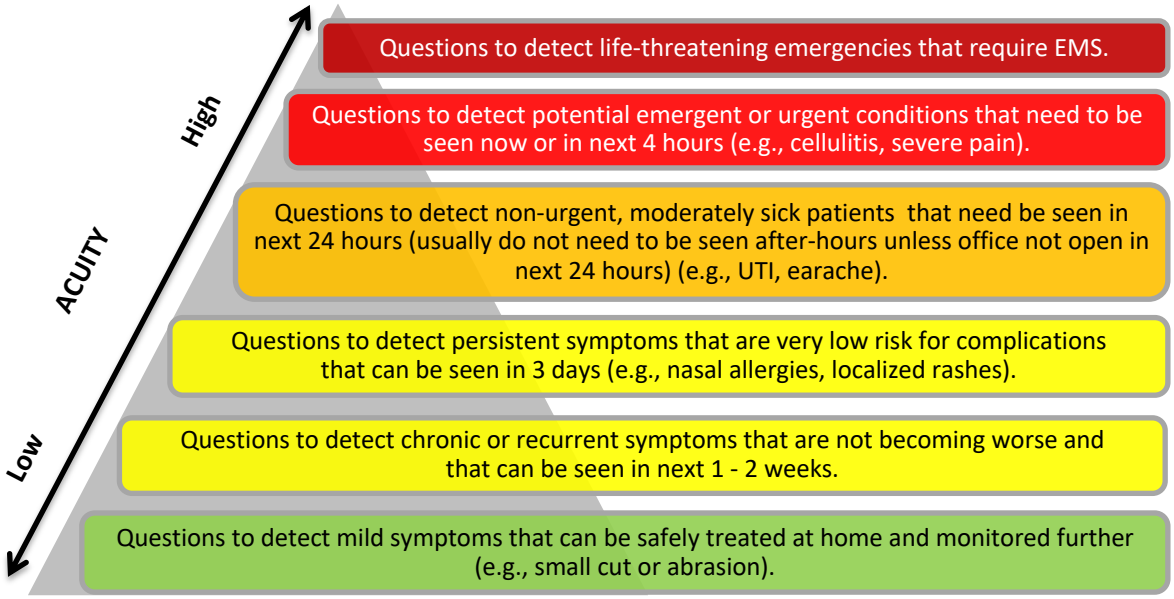
Fever onset within 24 hours of receiving an immunization
Go to Protocol: Immunization Reactions (Pediatric - Office Hours)

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 (Heat Exhaustion and Heat Stroke) (Pediatric - Office Hours)

Triage Assessment Questions (TAQs)

- The triage questions are grouped within dispositions and are sequenced from highest to lowest acuity (from most serious to least serious diagnoses or complication) as outlined in diagram below.
- Triage questions are also marked as "Yes" or "No" for telemedicine video visit eligibility.

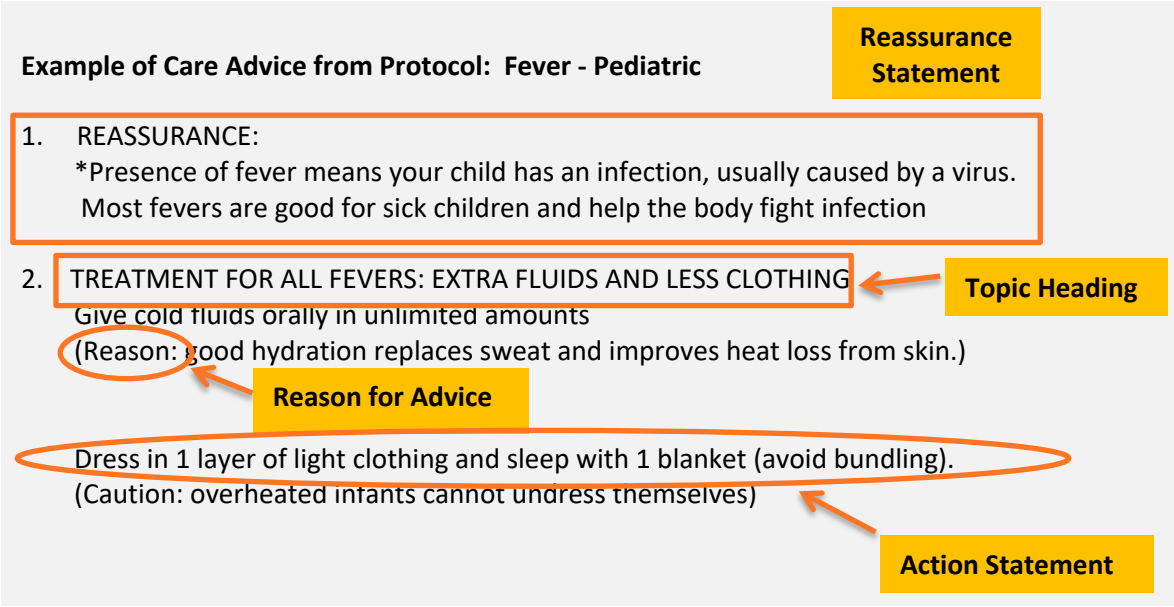


Care Advice (CA)

This section contains care advice for the delayed dispositions (See Today down to Home Care).

- Note: Unlike After-Hours guidelines, the care advice in Office-Hours protocols is not assigned to specific triage questions. Generally, most Office-Hours advice is meant for *Home Care* patients or those patients that will be seen later by appointment.
- Care advice is intentionally minimal for patients who are referred in immediately and may only include first aid or pain control. These patients will receive remaining 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 remaining care advice after they are evaluated in a medical setting.
- All care advice is written in layperson's language (at a 5th – 6th grade reading level).
- The treatment advice is written in an **action statement** format. Treatment advice is 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 the triager efficiently scan care advice (CA) items and serve as a memory prompt.
- The **reason** supporting the advice is also sometimes included.



References

The clinical content in these protocols is as evidenced-based as possible.

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

Citations

This last section lists the following:

- Author of the protocols
- Latest revision date
- Copyright notice

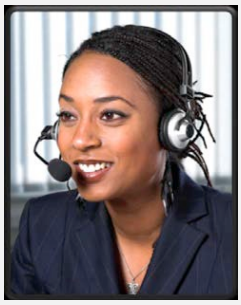
Structure of a Telehealth Triage Encounter

Overview

When a call comes into a medical call center or office, the telehealth triager typically goes through the following call process while managing the call.

1. Introduce self to caller
2. Collect (or confirm) brief demographic information
3. Identify the chief complaint
4. Document a brief description of the patient's illness
5. Obtain brief health history
6. Assess physical findings and symptom severity
7. Select the correct protocol
8. Ask the triage assessment questions (TAQs)
9. Select an appropriate disposition level
10. Provide care advice (Telehealth Advice)
11. Verify understanding – use Teach-Back method
12. Give call-back instructions
13. Practice risk management to prevent adverse outcomes

Remember to Smile!



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

Each step in the call process will be discussed in further detail below.

Introduce Self to Caller

The call begins with a greeting, during which the triage nurse introduces themself.

- Apologize for any delays or excessive hold time if necessary.
- 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 (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?"*

Collect or Confirm Demographic Information

- Collect (or confirm) 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 unlicensed staff) elicit and enter this information before the call is transferred to the telehealth triage nurses. In others, the triage nurse takes calls directly.
- If the call is about a suspected emergency, the call should be taken by the first available triage 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.

Identify the Chief Complaint

- Encourage the caller to describe their (or 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 focusing 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 one 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.

Document a Brief Description of the Patient's Illness

- The description of the patient's symptoms should give the reader of the call documentation an accurate mental picture of the patient's illness or injury. This is also known as the *Reason for Call* (chief complaint).
- The call documentation should also justify the use of the selected triage protocol(s).

Obtain a Brief Health History

- Briefly ask about chronic health problems, medications, and recent visits and 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.

Assessing Physical Findings and Symptom Severity

One of the challenges of telehealth 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 Readings.

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%)

The triage nurse always needs 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, a triager can usually collect enough information from the caller to obtain an overall assessment that helps determine the severity of the patient's illness or injury.
- In addition, some protocols contain severity scales that help the triager identify physical findings associated with varying levels of symptom severity (e.g., pain, vomiting, diarrhea).

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Select the Correct Protocol

- Once the main problem or symptom has been identified, enter a search word describing the caller's chief complaint to bring up appropriate protocols. The search may bring up several protocols to consider. The keyword search system has become very selective and should meet the needs of the triage nurse.
- Disease-based protocols are available for certain conditions (e.g., chronic disease, follow-up for some acute diagnoses, pregnancy, etc.). See page 4 for more information.
- There are protocol *sets* that focus on a specific patient population (e.g., newborns, pregnant or postpartum patients). If the triager has a caller in one of these populations, start with the specific population protocol set first, then proceed to a symptom or disease-based protocol if needed. Use search words to get into the right protocol.

Example

Pregnant and back injury from a fall. Use the search word *pregnant*. First, check if there is an appropriate pregnancy protocol (e.g., **Pregnancy - Fall**). Then, if needed, use the **Back Injury** protocol. Select the highest of the two dispositions if two protocols are used.

- Many of the protocols start with a section called *See More Appropriate Protocol (SMAP)*. These SMAP statements prompt the triager to consider other available protocols. The SMAP statements might direct the triage nurse to a better protocol that provides more specific triage advice. The triager doesn't need to ask all the SMAP's. Quickly scan them.
- 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 triage questions and care advice is covered in all protocols where fever could be an accompanying symptom.
- For 5 to 10% of calls, the triager will need to use two protocols. This is mainly needed when symptoms are present from two unrelated body systems. Examples are rash (skin) with diarrhea (GI) OR cough (respiratory) with a toothache (dental).

Tips for Improving Protocol Selection Skills

TIP 1: To improve your efficiency, periodically review the Anatomical Table of Contents to better understand the topic options available within each body area.

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

Ask the Triage Assessment Questions (TAQs)

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 (TAQs) in the sequence presented in the protocol. The triager 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 TAQs in the protocol are organized under disposition categories, a positive response will give the triager the appropriate disposition (level of care) for the patient.
- Once in the call, the triage nurse does NOT need to ask the TAQs they have already determined the answer to in their previous assessment. Ask the triage assessment questions only when the answer is unknown or unclear.
- Within a disposition level, it is acceptable for the triager to select any of the triage questions and mark it YES. The nurse may *scan* the list of triage questions for what seems most appropriate to the caller's reason for call. The triager 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 level before moving to the next disposition level.
- STCC has arranged higher-volume or higher-acuity triage questions at the top of each disposition level grouping.

Select an Appropriate Disposition Level

The triage nurse can stop asking questions as soon as a positive answer is reached (presence of an indicator for being seen). The remaining questions (the complete history) can be asked in the office or ED by the examining doctor. 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, a triager 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 telehealth triage nurse can elect to move patients to a more urgent disposition if warranted. This is known as *upgrading* the disposition and is medically *safe care*.

- This may be done by the triage nurse when they are concerned about a patient that has additional factors that increase their risk (e.g., complex medical history, concerning comorbidities, multiple moderate to high acuity symptoms or distance from care).
- Callers may elect to be seen sooner than recommended. The nurse triager can document the patient's plan of action and reason (if given).

Downgrading the Disposition

In general, downgrading a disposition is discouraged and should be done cautiously. Doing so may have medical-legal consequences.

- Follow call center or office policy regarding downgrading dispositions.

Additional Factors that May Influence Disposition

Patient Expectations

When calling into a medical office, a caller may have 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 the triage nurse is unable to meet the patient's expectations, to achieve patient satisfaction the triager will need to "manage" this expectation by:
  - ✓ successfully convincing the patient that an office visit is not urgently needed, after a thorough triage 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.
- There are several options for the scenario in which there are no timely appointments available. Follow your office scheduling policy.
  - ✓ Overbook the patient into the office schedule.
  - ✓ Discuss the situation with the doctor.
  - ✓ Recommend that the patient be seen in the local urgent care center (UCC) or emergency department.

Resources

The resource needs of the patient's problem also impact triage decision-making.

- *Resources* is a broad term describing the equipment, medications, supplies, and personnel skills needed for a specific patient problem.
- The triage nurse will need to consider what resources are needed to care for a 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.
- Local available resources in your office can be tabulated by using a resource form. There are three 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

Provide Care Advice (Telehealth Advice)

Ask About Home Care Measures Already Tried

Before giving advice, ask the caller, "What treatment have you tried so far?" "How is that working?" The patient may have offered this information earlier in call.

- If the caller's treatment is appropriate and effective, affirm the caller's actions and have them continue with their current self-care.
- If the treatment is incomplete or not working, supplement the care advice from the protocol.
- The triage nurse's 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.

- Prompt the caller to have something available to take notes for care instructions. This is especially important if detailed care advice or medication dosages are given.
- The triage nurse should select the most appropriate two to three pieces of care advice for the caller. The triager 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 this a menu from which the nurse delivers *a la carte*.
- Some callers may benefit from three to six pieces of information; others may only need one or two pieces. The triager should select care advice as determined by the caller's needs.
- In general, try to limit care advice to three instructions and try to keep comments brief (two or three 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 complete care advice in the ED, UCC, or office.
- Limited interim care advice can be given for patients who will be seen by appointment the next day or later.

Verify Understanding – Use Teach-Back Method

After providing care advice, allow the 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 sending detailed care advice via email, patient portal or if the care advice 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 triage nurse to verify if the patient understands the instructions correctly, and to correct any misunderstandings.
- *Chunk and Check:* If the care advice is lengthy, 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.

Nearly 50% of what is retained is incorrect.

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 three things you should do to treat your child's diaper rash?"

Email Care Advice Handout(s)

- Adult Care Advice Topics (ACATs) and pediatric care advice (PCA) handouts are available to email to callers for
  the most common topics, to help reinforce or shorten telephone home care instructions.
- Ask your software vendor for more information about accessing these handouts.

Give Call-Back Instructions

End each telehealth 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 triage nurse 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 lasts for more than ___ days.*

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

Call Back If:

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

Practice Risk Management Strategies to Prevent Adverse Outcomes

During the call, the triage nurse 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.

Table 5: Key Strategies to Prevent Adverse Outcomes During a Telehealth Triage Encounter		
1	**When in Doubt, Triage**	• Sometimes callers are seeking 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 are they doing right now?" If not active now, ask "How does your child look?" If sleeping at the time of the call, ask: "How was your child acting before they 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.
5	**Do NOT Diagnose**	• A nurse triager should not make a diagnosis over the phone. • It may be appropriate in certain circumstances for a doctor 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.

Table 5: Key Strategies to Prevent Adverse Outcomes During a Telehealth Triage Encounter		
7	**Do Not Downgrade a Disposition**	• The triager may use their clinical judgment and override the protocol disposition and recommend a HIGHER level disposition. This is called an **upgrade.** • In general, the triager should NOT override the protocol disposition and recommend a lower disposition independently. This is called a **downgrade.** See page 47 for more discussion.
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, telehealth 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 three 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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