1. **Comprehensive Clinical Content**
   a. The Clinical Content should be comprehensive and cover 99+% of symptom calls.
   b. There are 269 Pediatric Triage guidelines that have been written by Dr. Barton Schmitt. There are 293 Adult Triage guidelines that have been written by Dr. David Thompson. Approximately 10 new guidelines are added each year.

2. **Dispositions**
   a. Disposition headings should be succinct and easy to understand.
   b. A statement clarifying the disposition should be provided in the targeted care advice. This improves caller compliance with urgent referrals. Studies by Dr. Kempe have shown that the most common cause of non-compliance is that the caller misinterprets what the triage nurse tells them to do.  

3. **Research**
   a. Clinical Content should be backed by research. Schmitt and Thompson content offers the advantage of being backed by research and statistical analysis.
   b. Dr. Schmitt is a pediatrician and Professor of Pediatrics; he is the author of over 100 articles and chapters on pediatric health care including the well-known book *Your Child’s Health*. He is the author of the telephone triage book *Pediatric Telephone Protocols – Office Version*; the most recent edition of this book was made available in October 2010. Dr. Schmitt’s pediatric telephone triage Clinical Content has been the subject of 20 years of research, including nurse and primary care physician concordance studies.

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c. Dr. Thompson is board certified in internal medicine and emergency medicine. He is the author of the telephone triage book *Adult Telephone Protocols – Office Version*; this book recently received a 4-star review from Doody Enterprises. A third edition of this book was made available in October 2010. Dr. Thompson has worked with Dr. Schmitt and leveraged the 20 years of Schmitt research in developing the adult triage guidelines. Furthermore, Dr. Thompson has performed chief complaint and telephone triage research using statistical analysis of large data sets from Medical Call Center, Emergency Department, and the Centers for Disease Control. Dr. Thompson has also published research in the area of patient satisfaction.

4. **Targeted Care Advice (After Hours – Standard version)**

   a. Clinical Content should contain specific (“targeted”) care advice for each triage question. This ensures that 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.

   b. Lack of targeted care advice wastes nursing time; causing nurses to spend time selecting and sometimes even creating care advice for callers. It also leads to inaccurate documentation of what care advice was actually given.

5. **Topic Splitting.**
   a. “Splitting” refers to a guideline development philosophy of splitting topic areas into discrete triage guidelines that address specific patient complaints. Shorter and complaint-specific guidelines allow 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.
   b. Using eye symptoms as an example, the Pediatric Clinical Content splits these symptoms into: Eye - Allergy; Eye - Chemical in; Eye - Foreign Body; Eye - Pus or Discharge; Eye - Red without Pus; Eye - Swelling; Eyes - Dark Circles Under; Stye; Tear Duct, Blocked; Trauma, Eye; and Vision, Loss or Change.
   c. Splitting also permits more targeted and relevant care advice.

6. **Annual Updates and New Guidelines**
   a. The Clinical Content should be reviewed and updated each year. The review/update process should consider call center input (triage nurses, call center medical directors) as well as statistical evidence (call center quality improvement projects and research) and medical evidence (literature review).
   b. The Schmitt-Thompson Clinical Content is reviewed and updated annually. “Red-line” documents showing changes are provided to call center clients.
   c. The Schmitt-Thompson Clinical Content has an ongoing quality assurance program that results in continual improvement. For example, in preparing recent annual updates, the following sources of data were utilized:
      i. Formal tabular/graphical reports/spreadsheet data from call centers
      ii. Formal tabulated “clinical concern forms” and “guideline clarification” documents (narrative suggestions from call centers nurses; to which Schmitt-Thompson provide written point-by-point responses)
      iii. Informal email input from many call center managers and medical directors
      iv. Quantitative analysis of a sample of 3.1 million calls from 10 Medical Call Centers
      v. Quantitative analysis of call volume at Denver Children's Hospital
      vi. 'Chart Reviews' of samples of calls with the same presenting chief complaint (e.g., dizziness, ear-trauma guidelines)
      viii. Literature review (new references are added to content; outdated references are eliminated)

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ix. Emergency Department research data on chief complaints/outcomes and pain scores/outcomes
d. The process for writing new guidelines should be systematic, evidence-based, and referenced; guidelines should be reviewed and tested before release. Schmitt-Thompson new guidelines meet these rigorous criteria (description available upon request).

7. **Review Panel and Review Process**
   a. The clinical review process should be rigorous. The guideline review process should include physicians and nurses with experience and knowledge in the topic area.
   b. Each of the Schmitt-Thompson telephone triage guidelines have been reviewed by members of the Pediatric or Adult Review Panels. The Review Panels are comprised of triage nurses, specialty nurses, medical call center directors, and actively practicing primary care physicians, emergency physicians, and physician specialists (list available upon request).

8. **Clinical Rigor and Referral Rates**
   a. The Clinical Content should be clinically rigorous. It should provide safe, effective, and efficient triage that directs patients to the most appropriate level of care.
   b. Each guideline should accurately reflect the spectrum of relevant diagnoses for that chief complaint.
   c. There is a dynamic and important balance between under-referral and over-referral.
   d. The term under-referral describes referring the patient to a disposition level lower than ideal. Delays in diagnosis and treatment can lead to adverse outcomes. Under-referral rates to the Emergency Department should approach zero.
   e. Over-referral is the term used to describe when a patient is directed to a level of care more urgent than needed. Over-referral leads to unnecessary ambulance runs (EMS 911), excessive emergency department visits, and increased cost to the patient and health care system. Over-referral rates should be tracked and kept to a minimum; quality audits of patients sent to the emergency department should show less than 10% over-referral.

9. **Rationale Statements (Reasons and Rule-Outs)**
   a. The Schmitt-Thompson Clinical Content contains rationale statements for most triage questions. These rationale statements contain “reasons” explaining why the question is important or “rule-outs” listing potential diagnoses. The rationale statements are solely for the nurses benefit and are not to be shared with the callers.

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b. The rationale statements allow the nurse triager to
   i. Understand the reasons behind each question
   ii. More easily memorize the questions (understanding increases recall)
   iii. More quickly assimilate the clinical thinking skills used in triage.
   iv. Increase triage nurse job satisfaction and improve nursing judgment

c. Rationale statements also add to nurse compliance in asking questions sequentially. When nurses skip protocol questions, it is often because they do not understand their relevance.

d. Call centers that have used Clinical Content that does not contain rationale statements and then switched to content with rationale statements, usually comment on the positive change in nurse adherence to guidelines as documented by call audits.

10. Cross-Protocol Compatibility
   a. Adult and pediatric content should have identical organization and structure. Triage question phrasing should be consistent from protocol to protocol.
   b. The format should be user-friendly, easy to learn, and supportive of nurse decision-making.
   c. If similar concepts/conditions are phrased differently from protocol to protocol, then the nurses have to mentally shift gears between protocols. Inconsistencies are frustrating and time-consuming for triage nurses.

11. Cross-Content Set Compatibility
   a. Drs. Schmitt and Thompson have developed a compatible set of telephone triage guidelines for use by call centers and office practices when the doctor’s office is open. Updated annually.
   b. Drs Schmitt and Thompson have developed compatible sets of self-triage, self-care guidelines for use by consumers on the internet: Symptom Checker. Updated annually.
   c. The Symptom Checker content is now available as an iPhone, iPad and Android application. SymptomMD is the full age-range content; Pediatric SymptomMD is the pediatric-only version and KidsDoc is the rebranded version distributed by the American Academy of Pediatrics.

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25 Thompson DA. Adult Office Hours Guidelines. 102 topics. Copyright 2006-2010.
12. **Second-Level Triage** *(After Hours – Standard version)*
   a. There is an emerging trend to offer a second-level triage by a primary care physician. This can reduce emergent and urgent referrals significantly.  
   b. Protocol dispositions should support effective “second level triage” of selected callers by the PCP, if the PCP requests this as part of his/her provider profile.
   c. The Schmitt-Thompson Clinical Content has this optional capability built-in to the disposition structure.

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**Comparing Clinical Content – 10 Priorities**

1. Have an expert panel of physicians and triage nurses compare similar guidelines.
2. Talk with existing clients regarding content completeness, ease of use, call handle times.
3. Is the clinical content accurate?
4. Is the clinical content researched, referenced, and reviewed?
5. Is the clinical content logical and user-friendly?
6. Do the dispositions fit with your healthcare system?
7. Is the call process consistent and easy to use?
8. Do the adult and pediatric content sets have same structure and format?
9. Emergent–urgent referral rate: is there no under-referral and reasonable over-referral?
10. Are yearly updates provided and substantive?

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