CME: This peer-reviewed article is offered for AMA PRA Category 1 Credit.™
See CME Quiz Questions on page 11.

The 'Triage' Misnomer in Urgent Care

Urgent Message: While the term "triage" refers to one distinct step in emergency department throughput, in urgent care the concept encompasses a series of activities that span queuing, registering, intake, and the physical exam. Given the clinical and legal implications of the term, including who legally can triage, the term should be avoided in most urgent care settings.

ALAN A. AYERS, MBA, MAcc

According to modern dictionaries, *triage* refers to the "assignment of degrees of urgency to wounded or ill patients to decide the order of treatment." In urgent care, the term is frequently used to describe a patient intake and rooming process. But, according to participants in a "triage bootcamp" at the Fall 2023 convention of the Northeast Urgent Care Association, the term "triage" is a misnomer in urgent care.

In an emergency room, triage refers to a brief patient evaluation after signing in but prior to completing registration. **Table 1** offers an example of the process as it's explained to patients on the OhioHealth website. Consistent with the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), hospitals accepting government payment must provide all patients with a screening examination, stabilize patients with an emergency medical condition, and transfer or treat patients as appropriate for their condition.

Thus, in an emergency department, triage has legal as well as clinical implications. Due to the wider range of acuity seen in a hospital setting, there's a constant process of reprioritizing patients based on arrivals. By contrast, urgent care is generally limited to conditions that require same-day care, "immediate" within 24 hours, but not medical emergencies.

Per **Figure 1**, the patient "journey" in urgent care is diagrammed as a sequence of sequential steps. Whereas a triage in an emergency room is one distinct step, in urgent care triage encompasses multiple steps, from queuing and registration to clinical intake and physical exam.

Queuing and Registering

Treatment at urgent care is typically delivered on a first-come, first-served basis with obvious exceptions for

Author affiliations: Alan A. Ayers, MBA, MAcc is President of Experity Networks and is Practice Management Editor of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.

Table 1. Helping Patients Understand What to Expect in the ED vs Urgent Care

OhioHealth, a not-for-profit operator of 21 emergency care and trauma locations serving 47 counties, describes on its website what happens when patients arrive at the emergency department:

- When you first arrive, there may be security to make sure all our patients and families feel safe.
- At the check-in desk, you will be asked your name, date of birth, Social Security number, and the reason for your visit.
- You will also go through triage. The triage process determines who needs to be treated first. A triage nurse will determine the severity of a patient's condition based on symptoms. In addition, we'll ask about your personal and medical history, and take your vital signs, such as temperature, heart rate and blood pressure.

This process differs from urgent care in that emergency department registration does not occur until after triage. In urgent care, there is no dedicated "triage nurse," registration occurs before intake and treatment, and urgent care patients are generally seen on a first-come-first-served basis.

Source: https://www.ohiohealth.com/services/emergency-and-trauma.

medical emergencies. To join the "line," patients either sign in on a clipboard, provide their name to the front desk or, increasingly, use a queuing app that not only informs of expected wait times, but provides text message updates as expected wait times change.

"Triage" thus starts with "joining the line." If the patient joins online, verbiage should appear that patients experiencing a medical emergency—ie, threat of loss of life or limb—should call 911 or go to the nearest emergency room. Hopefully, most emergent patients would avoid urgent care.

Otherwise, arriving patients should be identified for the following symptoms:

- Bleeding that will not stop
- Fainting or loss of consciousness
- Chest pain or tightness
- Difficulty breathing or shortness of breath
- Changes in vision or difficulty speaking

This is accomplished at the front desk by staff visual observation, a paper intake questionnaire, and/or signage at registration asking patients to notify the front desk of these symptoms. If paperless registration is used, special attention should be paid to the presence of these symptoms. When these symptoms present, especially as a chief complaint registration should cease and a provider notified immediately. The provider can then determine whether to initiate emergency treatment, call 911, or return the patient to complete the registration process.

Under no conditions should nonclinical staff, such as medical receptionists, conduct any evaluation of a patient's condition. If there's any question as to whether a patient has potentially emergent symptoms, the provider should be involved.

One recommendation is a facility layout in which providers can see and hear front desk activity, such as positioning the medical station behind the front desk, thus strengthening communication between the front and the back office.

Intake and Rooming

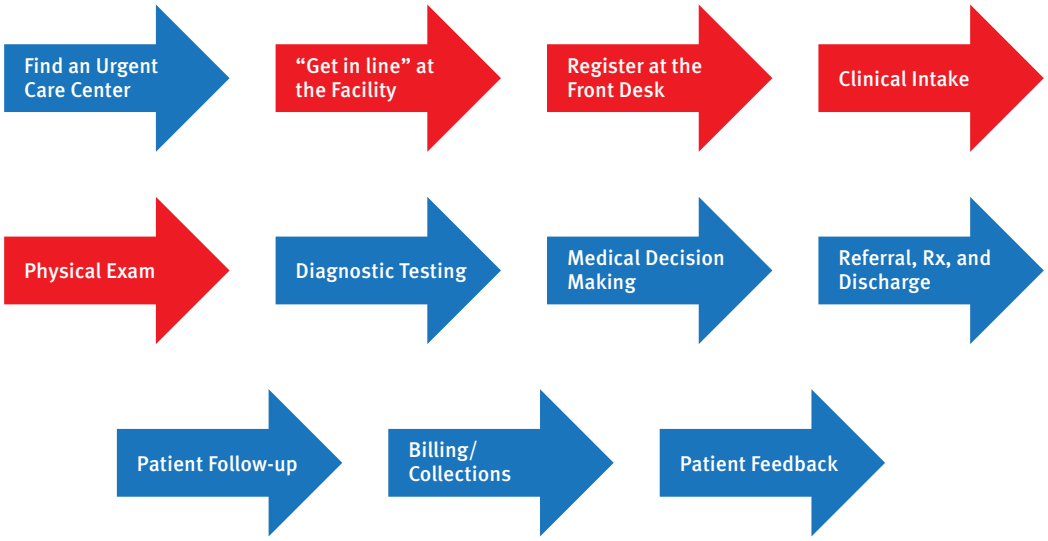
Clinical intake, also called rooming, typically entails a medical assistant retrieving the next patient from the waiting room; taking vitals such as height/weight, temperature, and blood pressure; and reviewing the patient's medical history and complaints to assure accurate documentation for the provider. In many cases, the intake process includes following "standing orders" like conducting a rapid COVID, strep, or influenza test on patients meeting clinical criteria.

Now…should intake occur in a distinct location or in the exam room? Feedback is that a dedicated intake room adds inefficiency by creating a bottleneck in patient flow. It's easy when retreating to a separate room to engage in conversation that can easily waste 5-10 minutes. Efficient centers typically have a weight scale in the hallway but then take other vitals in the exam room where the patient will remain for the physical exam.

As with the front desk, clinical support staff must be aware of symptoms that would warrant immediate notification of the provider. Essentially, anything *abnormal* requires provider notification. The provider may then give the staff verbal orders for care until able to examine the patient him/herself.

It's important to note that a medical assistant cannot legally interpret medical data, make independent medical decisions, or give any type of medical advice. Thus, a medical assistant cannot legally triage a patient. Triage is reserved for licensed personnel such as Registered Nurses. In urgent care, it's more like "identification" and "notification" of emergent symptoms.

Figure 1. Patient Touchpoints in Urgent Care



The term "triage" has significant implications for medical practices including:
- Legal/compliance
- Training/licensure
- Flow/throughput
- Wait times
- Patient experience
- Team experience
- Clinical outcomes

Physical Exam

The physical exam is a continuation of the intake process. Based on a review of the patient's history, symptoms, complaints, and a hands-on physical exam, the provider may provide medical assistants with additional orders such as labs or an ECG. The provider may also administer medications such as IV fluids or call an ambulance. Due to the human element, identifying potentially emergent patients can be more of an art than a science. But the responsibility can't fall entirely on the provider.

According to the bootcamp participants, teamwork is key to effective coordination between the front and back office. The front desk, medical assisting staff, and providers must all understand their respective roles and then communicate extensively.

Conclusion

Triage is a word that carries significant medical and legal implications while referring specifically to a process that occurs in emergency departments. Dealing with nonemergent presentations, urgent care tends to process patients according to their order of arrival. While triage, per se, is not a part of urgent care throughput, urgent care should have procedures to identify abnormal symptoms and complaints that could indicate an emergent condition warranting immediate provider attention. Key is awareness and communication by all team members—front office, medical assisting, and providers. ■

Take-Home Points

- The term "triage" is something of a misnomer in urgent care, as it actually encompasses sequential steps, from queuing and registration to clinical intake and physical exam, whereas in the ED it occurs in one distinct step.
- Urgent care front desk, medical assisting staff, and providers must all understand their respective roles and communicate extensively.
- Nonclinical staff should never conduct any evaluation of a patient's condition. If there is any question as to whether a patient has potentially emergent symptoms, notify a provider immediately.
- Registration should cease and a provider should be notified immediately when patients present with any of the following complaints or symptoms:
  - Bleeding that will not stop
  - Fainting or loss of consciousness
  - Chest pain or tightness
  - Difficulty breathing or shortness of breath
  - Changes in vision or difficulty speaking