

Screening Questions and Streamlining Triage
An Information Paper
Reviewed by the ACEP Board of Directors, November 2015

Background

The modern concept of triage began in France during the Napoleonic era as an attempt to distribute limited medical resources to the most appropriate patients. This concept was incorporated into the US Armed Services, and subsequently into our emergency departments (ED).

Up through the 1980s there were a variety of triage systems in the United States, primarily based on a three-tiered complexity system – emergent, urgent, and non-urgent. Due to a combination of various factors, including increased ED volumes, increased demands on ED triage requests (eg, regulatory and operational requests increasingly conducted at triage) and a focus on time-critical conditions (eg, trauma, cardiac care, and stroke care), in the 1990s there was a transition towards more elaborate triage processes designed to prioritize patients greatest in need of acute care.

In 2002, ENA and ACEP formed a Joint Triage Five-Level Task Force that resulted in the 2003 position statement from both organizations supporting the adoption of a 5-level triage scale. In 2010, the same two organizations put out a revised statement supporting the adoption of the 5-level Emergency Severity Index (ESI) that has now been adopted by most facilities across the country.

Counter to the goal of rapid, focused assessment and prioritization of patient acuity, some institutions use triage as a control mechanism for many “non-critical” demographic and regulatory requirements. Examples include asking detailed screening questions for fall risks, abuse, HIV testing, domestic violence, advance directives, etc. The emphasis on “doing more” at ED triage has created a bottleneck to efficient patient flow.

Regulatory Requirements

The Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) recommend that patients be assessed and screened for several non-acute social and environmental factors. However, they do not require that such screening be performed in any one location or during a particular time. In fact, CMS states that “Triage entails the clinical assessment of the individual’s presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel.”

The Joint Commission recommends that hospitals screen patients for risk of falls, abuse, neglect, suicidality, and pain, but there is no defined requirement that the screening must be performed as part of the initial intake or triage process.

Many state regulatory agencies are silent regarding the triage process and leave it up to the ED and hospital to develop their own policies. For example, New York State requires that “Every person arriving at the emergency service for care shall be promptly examined, diagnosed, and appropriately treated in accordance with triage policies and protocols adopted by the emergency service and approved by the hospital.”

Improving Triage Efficiencies and Throughput

In an effort to streamline and limit triage to what is crucial, a number of resources are provided describing best practices used by some facilities to improve triage efficiencies and throughput.

Immediate Bedding and Bedside Triage

Immediate bedding and bedside triage may decrease waiting times, decrease left-without-being-seen rates, and improve patient satisfaction by bypassing the traditional initial full registration and triage process. However, eliminating triage is only possible if empty beds are available.

Chan TC, Killeen JP, Kelly D, et al. [Impact of rapid entry and accelerated care at triage on reducing emergency department patient wait times, lengths of stay, and rate of left without being seen](#). *Ann Emerg Med*. 2005;46(6):491-7.

Morgan R. [Turning around the turn-arounds: improving ED throughput processes](#). *J Emerg Nurs*. 2007;33(6):530-6.

Spaite DW, Bartholomeaux F, Guisto J, et al. [Rapid process redesign in a university-based emergency department: decreasing waiting time intervals and improving patient satisfaction](#). *Ann Emerg Med*. 2002;39(2):168-77.

Provider in Triage

Some studies have shown that the practice of placing a provider in triage has decreased emergency department length of stay as well as the number of patients who leave without being seen by a provider.

Day TE, Al-Roubaie AR, Goldlust EJ. [Decreased length of stay after addition of healthcare provider in emergency department triage: a comparison between computer-simulated and real-world interventions](#). *Emerg Med J*. 2013;30(2):134-138.

Nestler DM, Fratzke AR, Church CJ, et al. [Effect of a physician assistant as triage liaison provider on patient throughput in an academic emergency department](#). *Acad Emerg Med*. 2012;19(11): 1235–1241.

Russ S, Jones I, Aronsky D, et al. [Placing physician orders at triage: the effect on length of stay](#). *Ann Emerg Med*. 2010;56(1):27-33.

Wiler JL, Gentle C, Halfpenny JM, et al. [Optimizing emergency department front-end operations](#). *Ann Emerg Med*. 2010;55(2):142-160.

Innovative Technology

Given the evolving nature of technology, EDs may want to consider innovative technologies to improve front-end operations and overall throughput. These include smart phone apps as well as self-check-in kiosks to assist in initial patient registration and history-taking.

Benaroya M, Elinson R, Zarnke K. [Patient-directed intelligent and interactive computer medical history-gathering systems: a utility and feasibility study in the emergency department](#). *Int J Med Inform*. 2007;76(4):283-8.

Ozdalga E, Ozdalga A, Ahuja N. [The smartphone in medicine: A review of current and potential use among physicians and students](#). *J Med Internet Res*. 2012; 14(5):22.

[Smartphone app speeds registration](#). *ED Manage*. 2011;23(3):28–9.

Wiler JL, Gentle C, Halfpenny JM, et al. [Optimizing emergency department front-end operations](#). *Ann Emerg Med*. 2010;55(2):142-160.

Additional Reading

1. Welch SJ, Davidson SJ. [The performance limits of traditional triage](#). *Ann Emerg Med*. 2011; 58(2):143-144.
2. Agency for Healthcare Research and Quality. [Emergency Severity Index \(ESI\): A Triage Tool for Emergency Department. Implementation Handbook](#), 2012 Edition. Publication #11(12)-P014
3. American College of Emergency Physicians. [A Uniform Triage Scale in Emergency Medicine](#) [information paper]. June 1999
4. Weber EJ, McAlpine I, Grimes B. [Mandatory triage does not identify high-acuity patients within recommended time frames](#). *Ann Emerg Med*. 2011; 58:137-142.
5. New York Codes, Rules & Regulations (NYCRR) Title 10; section 405-19 [Emergency services](#).

*Created by members of the ACEP Emergency Medicine Practice Committee
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