TELEPHONE TRIAGE
Program Design Supporting Best Practices

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Abstract

- Although we all learned to talk on the phone as children and don't generally regard it as a complex process, the provision of care over the telephone represents an actual patient encounter when it involves telephone triage.
- When errors occur in the provision of care, it is often due to poor program design.
- *This session will focus on the program elements that support the delivery of safe care.*

Objectives

1. Identify elements of program design that place patients at risk.
2. Discuss organizational processes to increase safety in the delivery of care over the phone.
3. List strategies to improve program design in your telehealth setting.

Telehealth Nursing

Telephone Nursing

Disease Management
Care Coordination / Transition Management
Behavioral Modification
Basic Communication eg Labs, Messages, Rx Renewals, etc ("Junk" ☺)
Telephone Management of Symptom Based Calls

Two Types of "Nurse" Calls

- **TRIAGE**
  - Time sensitive
  - Symptom based
  - Nature & urgency
  - Access to care and other immediate needs
- **NON-TRIAGE**
  - Usually not time sensitive
  - Patient management
  - Compliance with plan of care

Telephone Triage

- Description:
  - A component of telephone nursing practice that focuses on assessment, prioritization, and referral to the appropriate level of care.
- Definition:
  - An interactive process between nurse and client that occurs over the telephone and involves identifying the nature and urgency of client health care needs and determining appropriate disposition.

Greenberg, et al., 2003 AAACN

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Telephone Triage

- "…telephone triage is one of the most sophisticated and potentially high-risk forms of nursing practiced today." (p IX)

Rutenberg, Greenberg, 2012

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Appropriate means…

Safe

What Does Telephone Triage Mean to Nursing Practice?

- Integral part of ambulatory care nursing
- New specialty vs new skill set
- *Either way, we have a new area of accountability*
  (…and if we're going to undertake to do it, we better be doing it right!)

The Perfect Storm for care by phone

- Information Age
  - Evolving dependence on technology
- Disasters (911, Katrina, Haiti)
  - Need for care over distance
- Financial Crisis
  - Limited financial resources
- Looming Staffing Shortage
  - Baby Boomer exodus
- Growing Chronic Illnesses
  - Sicker patients outside hospital
- Changing Healthcare Landscape
  - Emphasis on accountable care and medical homes
- Pandemic Flu (CDC involvement)
  - Phone assessment and antiviral treatment by RNs
- EBOLA
  - Isolation and quarantine

Telephone Triage is Here to Stay!

NOT doing triage is no longer an option!

(You can do it WRONG, but you can't NOT do it)

Telephone Triage INCLUDES Education & Advice (& vice versa)

1. Is poison ivy contagious?
2. What are the symptoms of Ebola?

Patient assessment is key!
(regardless of what you call it!)

Formalized Telephone Triage Program

Why Formalize Phone Triage?

- Study of 35 adolescent care clinics
- Simulated triage calls
  - Adolescent actress
  - R/O ectopic
- > 1/3 gave inappropriate advice
- < 1/3 of advice given by RN
- No difference in the quality of advice given by an RN and a secretary!!!

Rupp, Ramsey & Foley (1994)

Standards

- Basic Nursing
- Regulatory
- Professional
- Accreditation
- Legal
- ORGANIZATIONAL POLICY

Rules of Engagement for Successful Telephone Triage

1. Dedicated RN staff
2. Systematic Assessment
3. Decision Support Tools
4. Medical Record Template

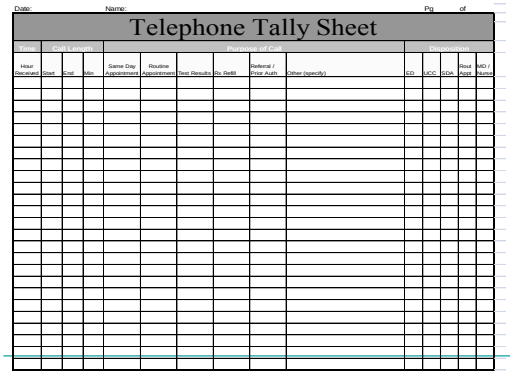



Organizational Elements: Staffing, Access & Call Flow



Start with workload analysis

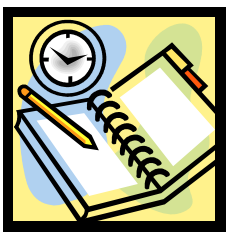
- Track ALL incoming calls
  - Determine how to tally transfer calls
  - Advertise to upper management cautiously
    - (bad data is worse than no data at all)
  - Place tally sheet at each phone
  - Collect 1 week of solid data
    - Avoid unusual weeks (e.g. holidays, bad weather, etc)
    - Don't start on Monday
    - Schedule for extra days (and hope to terminate early)
  - Quarterly tallies will help you identify trends


Date: Name: Pg of

Telephone Tally Sheet

Time	Call Length			Purpose of Call						Disposition				
Hour Received	Start	End	Min	Same Day Appointment	Routine Appointment	Test Results	Rx Refill	Referral / Prior Auth	Other (specify)	ED	UCC	SDA	Rout Appt	MD / Nurse

Access



Access

- Develop organizational strategy for availability of adequate acute appointments
  - Determine average number of acutes needed per day and assure they're available early AM each day
    - Team huddle to identify scheduled patients who might appropriately be managed by phone
    - "Create" necessary acute slots on a daily basis (work-in slots)
  - Assign "Dr. Acute" of the day
  - Hire mid-levels to manage acute appointments
  - Consider nurse-run clinics for routine follow-ups

Example Policy Empowering RN Booking of Acute Appointments

- If provider has no open slots
  - overbook 2 in AM & 2 in PM
  - schedule to another provider
- If all providers have no open slots
  - schedule to another appropriate practice
  - send to urgent care only if no other options (or they require that level of care)

Scheduling Support

- Adequate same day acute slots
- Nurse empowerment to schedule per policy (without "permission")
- Avoid "second guessing" the triage nurse
- Chain of command for clinical disagreements

FACTS:

Mom called with persistently sick child
Nurse documented "Mom not sure whether to bring him in…"
Physician gave order for home care (Ceclor)
Child was admitted with "necrotizing, putrifying pneumonia"
OUTCOME: Sepsis & autonomic dysreflexia

NURSE'S DEPOSITION: ☹

Nurse *says* she argued with mom to bring child in.
Nurse says she wasn't convinced home care was appropriate
"If it had been MY child, I would have gotten him seen!"
The nurse said "I knew he had pneumonia"

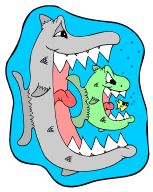
PLAINTIFF'S STRATEGY:

Failure to follow chain of command
The nurse has "deep pocket"

Practice Perils & Pearls

- How well are you communicating with your providers?
- Does your documentation support your actions? Will it stand up in court?
- Are you empowered to act in your patient's best interest?
- Do you have a chain of command policy in the event of clinical disputes?

Telephone Triage is NURSING practice:
NURSES define nursing practice

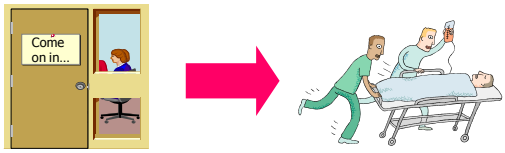


If physicians want to "overrule" your decision, policy and common sense should dictate that they talk to the patient first

ALL Same Day Appointment Requests Should Be Triaged

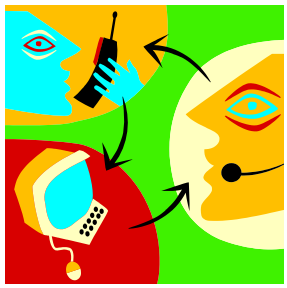
- The purpose of triage is to get the patient to the right place at the right time (not to serve as a barrier to care)
  - Some high acuity patients should not come to office
  - Some low acuity patients, who could benefit from home care, might prefer home care
- How many patients are transported to the ER from the clinic? Why does that happen?

Appointment scheduling without triage is anarchy!



Telephone triage nurses get patients to the *right place* at the *right time* for the *right level of care*.

Call Flow to Minimize Risk



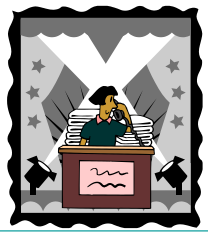
Application of Standards

- Triage Calls should be managed by RNs

- Methods of Call Intake and Routing
  - Clerk
  - Answering service
  - Electronic menu directly to appropriate person/place
  - Voice mail

Call Intake / Routing

- Through appointment clerks



Call Intake Challenges

- Decision making about call routing
  - All medical management calls involving assessment should be taken (promptly) by an RN
  - Identify causes of delays and remedy them
- Don't overestimate the value of "hot lists" - "red flag lists" - "cheat sheets"
- Patients THINK they've talked to a nurse!
- It's preferable for RNs to take calls live
  - Patient's are often no longer focused on problem
  - Returning calls is a (HUGE) time waster
  - It's not always necessary to "review chart" before talking to patient

Call Intake by Clerical Personnel

- 12% of the time (35/292), discrepancies were observed in chief complaints identified by clerks and RNs
- 32% of those (11) were considered to be significant
- 82% (3% [9] of the total calls) were underestimated by clerks and thought to be a potential problem
- 7 of those (2.4% of total calls) were triaged by the RN to "seek immediate care", ultimately representing a delay in care
- Generalizing these numbers to your population, you have at least 600 patients at risk per year (N x 2.4%)

(assuming 100 calls per day)

Klasner et al. (2006)

Message Taking includes INTERPRETATION (critical thinking)

- 82 y/o female, Gladys
- "I'm very upset... I was in to see my doctor and they put me on medicine for my urine infection. I didn't even know I had an infection, but now I'm sick from the medicine. My stomach's upset, and I just don't feel well…"
- MA wrote a note to the doctor stating, "Pt wants to know if she can change to another antibiotic because this one is upsetting her stomach."
- Pitfall: Accepting patient self-diagnosis
- Could this have been an MI or sepsis?

Fallacy of Message Taking by Non-RNs

- Husband called complaining that his wife's "Dramamine" was making her sleep all the time and she had just slept through a deposition.
- Clerk noted that patient was taking meclizine, assumed that was the "Dramamine" the husband was referring to and said "All calls about current meds have to be handled by the pharmacy". Patient was transferred to pharmacy.
- No assessment & no documentation patient with possible altered LOC.

Fallacy of Message Taking by Non-RNs

- Patient complaining of "bump on leg" accompanied by nausea and not feeling well…
- What little history was given could have been consistent with cellulitis, spider bite or DVT.
- Patient was given an appointment for later in the week. No documentation.

If You Must *Return* Calls…

- Develop a policy regarding when you're going to return calls
  - Safe
  - Achievable
- Have the secretary tell the patient when to expect the return call
- "Can it wait that long?"

Front Office Training

- Customer Service
  - The customer is *always* right!
  - Golden Rule
- Call Routing
  - If they say they're sick, they're sick
  - If they say it's an emergency, it is
  - Concerned patients and families should always be taken seriously
  - Even "frequent fliers" will eventually get sick
  - DO NOT TRIAGE (or determine urgency & give advice)

Call Intake / Routing

- Through answering service

Call Intake / Routing

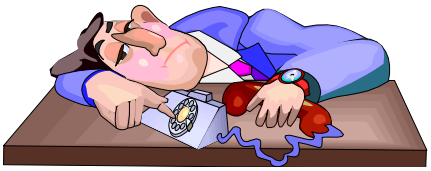
- Directly to triage nurse (via menu)
  - Buy technology to
    - advise of anticipated wait time
    - allow patients to leave a message for a call-back (without losing their place in line)
  - Utilize prerecord educational messages

Call Intake / Routing

- Directly to triage nurse (via menu)

ONE NUMBER ACCESS
(change/restrict "back-door" numbers)

Live Calls or Messages?

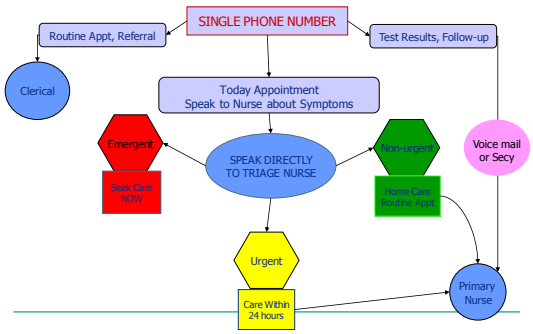


Call back within REASONABLE length of time

OR

Allow patient to hold to speak directly to a nurse
(in this case, perhaps an option to leave a message is reasonable)

Care Delivery Model (Call Flow)



Telephone Tally Sheet

Determine reason for calls

Menu Development (One number access)

If emergency hang up and dial 911 or other reliable option

1 -- Healthcare professional or patient returning our call
Secretary

2 -- Routine appointment (make / cancel / change)
Appointment Clerk (screen for acute symptoms)

3 -- Test results, prescription refills (may have short sub-menu)
VM, Secretary, LPN/Techs (screen for acute problems)

4 -- Referral; Business questions (may have short sub-menu)
Referral Management, Business Office (may have short sub-menu)

5 -- Today appointment or talk to a nurse about symptoms
to Triage Nurse

6 -- (Maybe) Hours of operation and directions to the clinic
0 -- Option to speak to a live person (receptionist)

In Summary…

- Route all *symptom based* calls directly to RN
- If patient holds until RN can pick up call
  - Option to hang up and dial 911
  - Option to trigger immediate RN response/access
  - Option to leave a message
- Where is the greater risk?
  - A chest pain "on hold" for a few minutes
  - A "tooth ache" (MI) waiting hours for call back

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Call Intake / Routing

- Into voice mail
  - "Do NOT leave an emergency on this line as it is only checked periodically"
  - We will call you back (when) AND DO IT!
  - Call US if you don't hear from us by that time (this is a shared responsibility)
  - If it can't wait, you may speak to someone now by… (not all "emergencies" are life-threatening)

Staffing

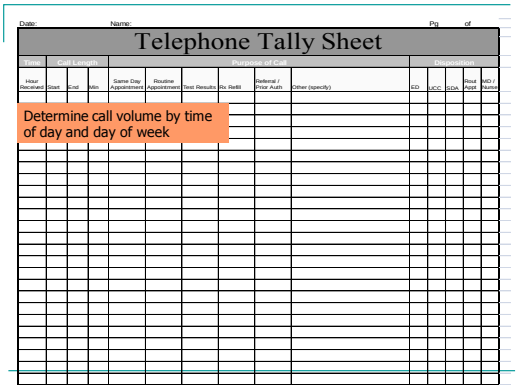
Skills & Traits of Triage Nurse

- Excellent assessment skills
- Respect for patient
- Excellent communicator
- Strong critical thinking skills & clinical judgment
- Respect for intuition (her/his own & the patient's)
- Huge and diverse knowledge base
- Able to collaborate (not a control freak)
  - (If not plan A, then plan B)

Characteristics of Effective Telephone Triage Nurses

- Self-Directed
  - Good work ethic
  - Flexible
  - Although authority limited, realizes importance of own role
- Focused on Short-Term Results
  - Good with time management
  - Enjoys and measures effectiveness with measurable outcomes. Likes checklists and bite-sized tasks
- Strong Patient Advocate
  - Empathetic leading to trust and effectiveness
- Practical Intelligence
  - Quick learner
  - Relates new information to previous knowledge
  - Enjoys learning

Suzi Wells / St. Louis Childrens's Hospital Telephone Triage Nurse Technical Report, 2005 with HR Chally Group

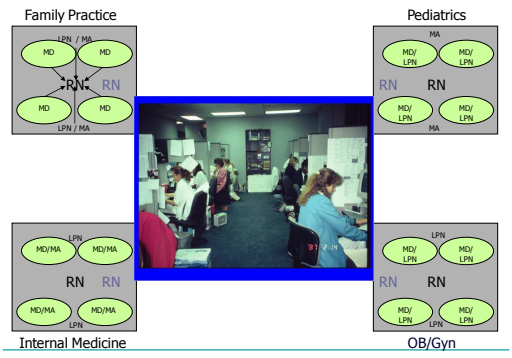


Basic Staffing Model

- Are you utilizing your personnel optimally?
- Where do you get dedicated staff?
  - You're already taking the calls (but are you doing it properly?)
    - Who's doing telephone triage *nursing*?
    - Meanwhile, what are the nurses doing?
- Avoid multitasking including:
  - Mixing clinical & phone responsibilities
    (Should not include walk-in triage)
  - Mixing telephone responsibilities
    (Should not include all phone activities)

Staffing Challenges

- Rotating vs permanent
  - Rationale for rotating staff
    - Insufficient staff ("Robbing Peter to pay Paul")
    - Everyone will quit! (☺)
    - Helps nurses "maintain their skills"
  - Rationale for permanent staff
    - Strong telephone triage nurse identity and investment
    - Practice makes perfect
  - Develop strategies for peak call times
    - Part timers (retired / stay at home parents)
    - Rotation to other staff by automated call distribution
    - Educate patients about best time to call



Advantages of Centralization

- Cost effectiveness (reduces duplication)
- Coverage (breaks, other responsibilities)
- Collaboration
- Practice makes perfect
  - Recognize telephone triage as a specialty
  - Discipline / familiarity with processes

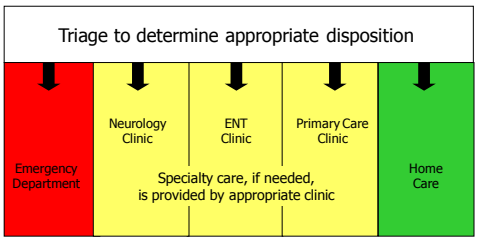
You can know them too well!

- "In a study to investigate the decision-making strategies of 'knowing the patient', Radwin (1995) also found that the decision-making process of nurses was largely influenced by how well they knew their patients.
- Marriner (1983) pointed out that prejudicial perceptions such as stereotyping, labeling and preoccupation often decreased nurses' perceptiveness which, in turn, weakened the accuracy of cue interpretation and diagnosis formulation."

Lee, Chan, Phillips (2006). Diagnostic practise in nursing: A critical review of the literature. *Nursing and Health Sciences 8*, 57-65.

Centralized Telephone Triage

(Patient doesn't know which clinic to call)



Telephone Triage Nurses: Zebra Hunters Extrordinare!

- Triage nurses deal with episodic care (often the unexpected), anticipating worst possible, looking for the zebras that live "outside the box"

- Primary nurses deal with continuity of care, considering the patient's existing plan of care, focusing on what's "inside the box"

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