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DEVELOPMENT AND IMPLEMENTATION OF A NURSE MANAGED WALK-IN/TELEPHONE TRIAGE PROGRAM

by

Theresa J. White

A Master's Thesis
Submitted to the Faculty of the
Allan & Donna Lansing School of Nursing
in partial fulfillment of the requirements
for the degree of

Master of Science in Nursing

Program of Graduate Nursing
Bellarmine College
Louisville, Kentucky

December, 1996

The thesis entitled, "Development and implementation of a nurse managed walk-in/telephone triage program," is accepted by the faculty of the Allan & Donna Lansing School of Nursing, Bellarmine College, in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

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Date December 12, 1996

Dedication

To Doug, my husband and best friend, for always encouraging and believing in me and for doing all the extra things that helped to make this possible. You are truly the "wind beneath my wings".

To Doug Jr. and Rick who may not always have understood my reasons but who always supported and respected those reasons. You are sons to be proud of.

To Beth, a daughter who was worth waiting for. You have set your own goals high so reach for the stars. You can do it!

To Dottie and Wendy, the other daughters brought to this family through marriage. I am proud to love you both.

To Dad, who has always been one of my biggest supporters.

To Mom who didn't live to see it happen but who, I know, cheered me on from heaven.

And last, but certainly not least, to Brian, Kayla, and Alexandra who prove to me daily that life is a beautiful thing.

Acknowledgement

I wish to acknowledge Dr.Sherill Cronin and Marjorie Walker for their honest feedback and encouragement that motivated one to strive for the highest level of quality.

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Abstract

The purpose of this project thesis was to develop a walk-in/telephone triage program. The thesis examines the process which was followed in program development. First, the need for the program was assessed and documented. The research literature was then reviewed in order to identify essential components of a walk-in/telephone triage program as well as patient and facility outcomes which could be anticipated. In addition, other existing programs were examined. The resulting program plan is included in its entirety

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Chapter I

DIMENSIONS OF THE PROBLEM

Introduction

The provision of health care in this country has been one of the most controversial topics of this presidential administration. According to Richmond and Fein (1995), "while there is consensus on the need for change, there is destined to be considerable debate on the nature of that change". Private sector providers are facing the challenge of the debate focusing in "patient, community, and health care systems needs and in the medical and health care resources required to meet those needs in a responsible, effective and efficient manner" (Richmond & Fein, 1995). One of the most criticized health care providers in this country is the Veteran's Administration (VA) Health Care System. The VA has been described as a "sacred cow".

The past three years have been a time of drastic change for the VA. Under the direction of the Under Secretary for Health, Dr. Kenneth W. Kizer, the VA is undertaking the challenge to restructure the VA health care system. The Prescription for Change, written by

Kizer and submitted to Congress in 1996, outlines the strategic objective and principles to guide this transformation.

All of the VA Medical Centers, in an attempt to meet Kizer's challenge, have been launching full scale initiatives to offer quality care in a more efficient, cost effective manner. The Louis A. Johnson VAMC is no exception. Since the trend in health care has been to switch from a primarily in-patient to out-patient mode, the goal of this facility has been to decrease the average daily in-patient census and increase and improve out-patient care.

Statement of the Purpose

The purpose of this thesis project was to develop an out-patient triage system consisting of two components: (a) a nursing triage system to address unscheduled walk-in patients in Primary Care, and (b) a nursing telephone liaison care system.

Background

Kizer's Prescription for Change (1996) emphasizes the impact of budget cuts on the resources available for providing patient care. The document also

emphasizes that as a result of decreasing health care benefits in general, veterans who previously did not utilize the system are now requesting screening required to establish eligibility status. This has provided two major challenges for the system: (1) providing more care to more veterans with fewer resources, and (2) remaining competitive with other models of health care delivery.

Another goal emphasized by Kizer is the initiation of patient-focused, rather than hospital-focused models of care. In 1992, the Louis A. Johnson VAMC initiated three Primary Care Teams for the purpose of providing increased continuity in providing care. Previous surveys had identified that patients were unhappy with always seeing different providers and Primary Care provided a solution for this.

However, since Primary Care providers now cared for the patients assigned to their respective teams as both in-patients and out-patients, this meant that these providers also had to make in-patient rounds as well as seeing patients in scheduled out-patient clinics. Primary Care now placed additional demands on

these providers as they attempted to juggle clinic schedules, in-patient rounds, and emergency room care.

Approximately, 18 months into Primary Care, out-patient department statistics demonstrated an increase in both unkept scheduled appointments and unscheduled walk-in patients. Each primary care team maintained four open slots, or 12 total between the three teams, for unscheduled walk-in patients. A patient survey conducted at the time identified long waiting times as the primary reason for unkept appointments. Patients noted that patients who "walked-in" with various complaints were often treated quicker than those with "routine" scheduled appointments. Patients also stated that often it was more convenient to be seen as a "walk-in" rather than wait for a scheduled appointment, especially if a patient was at or near the hospital for another reason.

This shift toward walk-in status created other problems, as well. Patients often did not get needed labs and other diagnostic tests which had been slated for a scheduled appointment, but not identified when the patient was seen as a "walk-in". Also, all

patients appearing in the out-patient department for services had to be triaged by the respective Primary Care Nurse, whether the problem was acute or not. Then a physician saw all of these patients. Overtime hours increased, waiting time for scheduled appointments increased, and staff frustration increased with what was described as a lower standard of care. Available time with scheduled patients decreased, and therefore opportunities for good patient education, etc. also decreased.

To explore the magnitude of the problem, the statistics for unscheduled out-patient visits were tabulated. The time span examined was from January 1995 to May 1996. The numbers included those patients seen as unscheduled appointments in the primary Care Clinics as well as the Emergency Department (ED). The ED was included because after clinics close at 5:30pm, unseen patients are sent to the Emergency Room to be seen by the on call physician. in the time period designated, a total of 13,168 patients were seen. This is an average of 877.8 patients/month. Of these, 8,004 or 60.7% were seen in the ED and 5164 were seen in

Primary Care Clinics. Of the 8,004 seen in the ED, 245 or 3% were classified as emergent(life threatening), 4049 or 51% were classified as urgent (needing same day care, but not life threatening), and 3710 or 46% were classified as routine (could have been scheduled for a later appointment). The data suggested that the process for treating walk-in patients in the outpatient department needed to be more cost effective, more efficient, and most importantly, more patient-focused.

In a survey conducted by the facility's Quality Management Department during the same time span, patients quoted these reasons for walk-in visits:

(1) decreased waiting time to be seen,

(2) accomplish more than one objective i.e., medication refills, eligibility (for services) upgrades, exam by physician for new problem or follow-up for existing problem, etc. per single visit, and

(3) personal convenience.

Chapter II

REVIEW OF LITERATURE

The VA Health System has closed 34,934 or 42% of in-patient beds and has increased out-patient visits by 10,735,000 or 60% (18,294,000 to 28,939,000) per year since 1980 (Kizer, 1996). This is consistent with the VA mission to increase out-patient care while reserving in-patient care for the most seriously ill. Kizer emphasizes that this must be accomplished in a cost effective, efficient, and patient-focused manner. The Louis A. Johnson VAMC was a forerunner (as one of the first VA hospitals) to initiate Primary Care in this geographical area. However, to meet the goal of increasing numbers of individual patients seen, instead of increasing numbers of visits per patient, the numbers of unscheduled walk-in patients must decrease.

This review of literature will examine the problem of unscheduled walk-in patients and approaches to resolving this problem.

Existence and Importance of Problem

Kelly (1994) notes that as many as 30% of patients seen in overcrowded emergency departments (EDs) have non-emergency conditions. In a study conducted at one community hospital in Marysville, California in 1992, patient volumes were peaking at 3000 patients per month in a department designed to see 1500 patients per month. 80% of these patients were uninsured or indigent without any source of Primary Care. Staffing was stretched and both nurses and physicians complained of burnout. Shifts were described as chaotic and unmanageable. Staff felt that patients with non-emergent problems demanded more from staff than did those patients with emergent problems because they became inpatient with the extended waiting times and constantly required explanations for the wait. At times, there were incidents of anger and belligerence causing staff concern that the potential for violence was high. Staff also worried that some patients' conditions would worsen significantly while they waited.

Pensker, Philips, Davis, and Iezzoni (1995) describe conditions of the ED at Boston's Beth Israel Hospital. Emergency room visits had risen 55% over the last three decades. Many of the patients utilizing the ED were seeking care for non-emergent problems. In addition, quality sometimes suffered for patients who encountered long waits behind more urgent cases. There was inadequate time for patient teaching and lack of mechanisms for follow-up.

The effort to improve health care access and cost containment sees patients enrolled in publicly assisted health care programs often moved into managed care plans. The state of Washington was a pioneer in implementing health care reform. Martin and Fruin (1995) describe the Healthy Options Managed Care Program for patients receiving Aid to Families with Dependent Children implemented in King County (Seattle area) in October, 1993. There were more than 300 patients enrolled in this program. These patients, by tradition, were frequent users of ED services. The ED triage nurses were expected to record and answer medical advice questions of patients who phoned the ED

as well as perform triage duties on as many 200 patients per day. The nurses were also expected to keep family members updated on patients' conditions. These telephone requests for medical advice were always answered but not as quickly or concisely as preferred. Additionally, the ED telephone system was not programmed to record such calls. Therefore, information regarding these calls was not documented in the medical record.

Possible Approaches

In this era of health care reform, it is imperative that hospitals explore different models for delivering care in order to be competitive and remain viable. The emergency department is an expensive department to operate, therefore the efficient use of emergency department resources is a priority. Treating unscheduled walk-in patients with non-emergent problems in the ER is expensive and does not represent an efficient appropriation of resources. The development of nurse managed walk-in and telephone triage programs addresses this issue.

The key to success for such programs is the concept of the nurse as the patient's personal health counselor. Kelly (1994) outlined a program that consisted of these steps: (1) development of a comprehensive triage program; (2) efforts to convince clients that the change was for their benefit; and (3) maximizing of patient teaching opportunities used in the triage process. The outcomes of the program included an average decrease in overall waiting times of 30 minutes, a decrease of staff burnout, and better management of security in the department due to less traffic.

Pinsker, Phillips, Davis, and Iezzoni (1995) describe the development of a walk-in unit to decrease the number of non-emergent ED visits at Boston's Beth Israel Hospital. Prior to the initiation of the program, care was provided to approximately 1200 walk-in clients per month. In this system, the ED nurse triaged all patients presenting for treatment. Those with non-emergent problems were referred to a walk-in unit for treatment. From the walk-in unit, referrals were made for regular follow-ups. The program was

found to decrease the numbers of non-emergent ED visits by 92% within a six month period. However, only approximately 50% of the 696 patients referred to follow-up care were compliant with medical recommendations. Most noncompliance was associated with long waiting times (greater than two weeks) between the walk-in visit and the scheduled follow-up appointment.

Selected Approach

Description. The approach selected to address the problem of unscheduled walk-in clients was to develop a nurse-managed triage program to provide both physical triage and telephone consultation. The move in health care today is toward managed care programs. Several of these programs have initiated triage programs to decrease the numbers of unscheduled visits by plan members.

Geraci and Geraci (1994) report on a study conducted in a managed care facility that reduced the average walk-in registration time from 25 minutes to 8 minutes. The results were the product of an effective triage system that reduced congestion in the out-

patient and emergency departments by directing non-emergent cases elsewhere. Triage also improved patient satisfaction. Waiting times were further reduced by differentiating primary or physical assessment from secondary or clerical triage. Appropriate and succinct telephone triage criteria were used to quickly, yet accurately, determine the urgency of health care problems and assure timely, appropriate treatment or advice.

Janowski (1995) describes a program that decreased walk-in visits by 63% and increased patient satisfaction by making clients feel that the Health Maintenance Organization (HMO) was "reaching" past its walls and into the client's home. The program utilized the concept of directing care over the phone. Resource nurses staffing such lines used well-researched guidelines for triage and symptom management, and databases of referral sources and health care information.

One of the biggest rewards for the health care facility was the improved image in the community. Callers reported feeling "cared for" when triage nurses

responded to their concerns and inquiries with sound advice and a sympathetic ear. The system was also financially sound since many managed or Primary Care programs require clients to call a triage network before presenting for services. This appropriately delayed provider contact until the next day, or longer, when the Primary Care physician was available. The system effectively, but safely, kept the patient from using costly hospital or urgent care services.

Leprohon and Patel (1995) examined decision making strategies for telephone triage. This study sample included 50 nurses actively working in an Emergency Medical Services (EMS) system. The study analyzed interactions with clients for the following data: (1) accuracy evaluation of triage decisions; (2) discourse analysis of verbal dialogues, focusing on the negotiations between the nurse and the client in triage situations; and (3) propositional analysis of the summaries and written explanations obtained from the nurses, representing propositions in the form of semantic networks to relate decision-making aspects to the organization of knowledge and to the use of

decision-making strategies. The results showed that 54% of nurse triage decisions were accurate, 38% resulted in false positives and only 8% resulted in false negatives. All nurses in the sample had at least two years' nursing experience.

The nurses' training focused initially on the knowledge, abilities, and attitudes required for the task. The methods for treating the calls, including ABCC (airway, breathing, circulatory, level of consciousness) assessment, and the most frequent symptoms and problems encountered represented important elements of this program. More than half of the three week orientation was devoted to apprenticeship, where the orientee was paired with another nurse (preceptor), first listening to the preceptor and then progressively treating the calls with decreasing supervision. All calls were recorded and the follow-up consisted of reviewing calls with the preceptor.

The system's performance was further evaluated by Champagne and colleagues (1991) in a larger study involving more than 1000 calls. It was found that

sensitivity was maximized (96%) on triage decisions on whether or not to send resources and that the remaining 4% could be explained by refusal by the patient among other reasons. The maximized sensitivity was related to nurses becoming more confident in the role and more adept at making decisions based on the assessment done. The specificity was 55% and it increased as the decisions became more "costly" in terms of risk or the availability of scarce resources for vital emergencies. The study also found that the time spent in making decisions was adjusted by the professional according to the emergency of the situation. Minimal time was required for vital emergencies, while more time was needed as the situation became less urgent and a decision was needed regarding dispatching resources.

Skipwith (1994) described a further extension of telephone triage. The described program used telephone counseling as an intervention with caregivers of the elderly. Telephone counseling sessions were conducted to: (1) assist caregivers in coping with the demands and burdens of caregiving; 2) increase caregivers' confidence in managing problems presented

by the elders; (3) help caregivers' identify and more effectively use support systems and resources; and (4) guide caregivers in the use of the problem solving approach.

Factors considered in designing the program included establishing a relationship, confidentiality, and communication dynamics. Strategies used to promote the establishment of a relationship included meeting of the caregiver face-to-face to discuss the purpose of the telephone counseling program. Then the nurse and the caregiver scheduled triweekly 15-minute telephone counseling sessions. Sessions focused on a variety of topics including crucial issues such as conflicts with siblings, loss of personal time, and management of personal care tasks. Other sessions were superficial and addressed topics such as weather and social comments. Caregivers were expected to set goals for the sessions and these goals usually reflected needs for enhancing coping capacity and for managing problems presented by the care recipient. The established goals were used during the telephone sessions as a guide for problem solving, referral and structures for topics.

Written logs of problems, solutions, and actions were maintained by the nurse.

Problems/limitations identified included brevity of calls, length of nurse-caregiver relationship and use of self reports as indicators of program effectiveness. Also the needs of the care recipients were sources of distractions and interruptions.

Positive outcomes of the program included elimination of problems related to travel barriers, homeboundness, and geographic isolation. Information could be exchanged quickly and decisions could be made in a timely manner. Caregivers reported some decrease in personal stress.

Martin and Fruin (1995) described a nurse managed telephone consultation system for managed care plans. This system provided the following services: (1) administrative information, (b) resources for level of care needed, (c) consistent protocol-directed medical advice, and (d) follow-up information on calls received after regular business hours, with referrals to the respective clinics for further management, as needed. Initial costs for implementation included 3.8 full-time

equivalent nursing positions, education and training for the nurses, and equipment, such as personal computers and telephones. Marketing consisted of a flyer sent only to those patients enrolled in the managed care programs. The monthly number of calls has progressively increased from 400 to 1400. Patient satisfaction surveys have depicted increased satisfaction in the specific areas of timeliness of access to needed education and referral to appropriate care providers of other resources.

A telephone triage system has also been used to respond to calls from surgical patients recovering at home (Telephone Triage Program: Nurses Respond to Calls from Patients Recovering at Home, 1995). This program was implemented at City of Hope National Medical Center in Duarte, California to close the potential gap in communication between surgical patients recovering at home and the health care provider in the hospital.

Prior to the implementation of the program, phone calls from patients recovering at home were answered by the hospital switchboard and routed to physicians' secretaries or to the clinics. The patient's concern

was taken down in the form of a message but it was often difficult for the physician to respond in a timely manner due to busy schedules.

The program was staffed by one Registered Nurse (RN) from 8:30am to 5pm, Monday through Friday and one of two available RNs during off-hours. The program utilized 40 detailed protocols designed by an RN, approved by the physicians, and reviewed by a program committee. The nurses' responsibilities were two-fold: to answer questions that were within the expertise of a nurse; and secondly, to decisively ascertain which questions need to be referred to a physician, nurse practitioner or physician assistant, either immediately or as soon as possible. In assessing the urgency of each call, the nurse first tried to answer three questions. What is the cause of the patient's problem? What is the patient doing to address it? What other options exist to deal with it? The program has increased patient satisfaction by providing patients with a personalized and efficient flow through the system therefore decreasing the need for walk-in clinic or emergency room visits.

Rationale

Williams, Crouch, and Dale (1995) state that in the United States, approximately 12% to 28% of primary medical care is conducted over the phone. Results of an audit of telephone advice programs showed that medical advice hot lines operated in all regions of the U.S. U.S. households were found to make more than one million calls per month to such services.

Poole (1995) notes that there is a growing interest in nursing triage programs that use standardized guidelines. In this era of health care reform, capitated reimbursement provides strong financial incentives to provide lower cost, quality care. It also requires effective demand management. As the field of nurse managed triage grows, more sophisticated triage algorithms will be needed. These will be expected to balance safety with cost-effective care. These new algorithms will require greater specificity and complexity in clinical decision-making than previously available, and clinical outcomes research will be required to refine the clinical algorithms.

VA Walk-In/Telephone Triage Programs. The Veteran's Administration (VA), like all other health care provider organizations, has been examining models for providing care with great scrutiny. With the focus of VA care shifting from in-patient to out-patient, several VA Medical Centers have developed nurse managed walk-in and/or telephone triage programs to decrease the numbers of unscheduled walk-in patients seen in outpatient Primary Care clinics. Models of Care: Samples for Primary Care and Telephone Liaison Care (1995) was issued by the National Center for Cost Containment to be used as a guide for VA facilities attempting to initiate such programs. The report highlighted five facilities that have initiated nurse managed Urgent Care Clinics and/or telephone triage programs.

The VA at Ann Arbor implemented a telephone triage program in September 1992 in order to improve the customer focused environment and to improve access to care. Patients and staff were informed about the new service and a direct extension number was added to the hospital automated answering service. The telephone

triage nurse coordinator collaborated with clinical staff regarding test results and medical inquiries.

In November, 1992, there were 35 calls. By June, 1994, there were over 1600 calls. In February, 1995, an 800 number was installed. Since that time the average number of calls rose to 1800 per month.

Patients reported that they had been transferred less often from department to department and were very satisfied with the timely response to their inquiries. By centralizing patient calls, system problems have been more readily identified and improvements have been noted in patient scheduling, medication renewals, and communication with the veteran population. The program has improved access to care and was one of the reasons for the over 20% reduction in number of visits to the Urgent Care Clinic during the past year.

In October, 1994, the Knoxville, Iowa VA Medical Center implemented a Telephone Liaison Care Program to help improve customer satisfaction to their aging psychiatric veterans. Prior to the initiation of the program, veterans had to travel great distances and present as walk-ins when they had questions or

concerns. The telephone program allowed patients and their families to contact the facility by phone to discuss access to care, eligibility, scheduling issues, medical concerns (treatment and follow-up), and questions regarding medications. This service was provided 24 hours a day, 365 days a year. An 800 number was installed. Protocols were developed for depression, suicide, and acute alcohol intoxication. Announcement letters were composed and mailed out with the regular appointment letters. Wallet cards were printed and given to staff and patients. A facility-wide education program was presented.

Presently, over 500 calls are processed each month. The telephone assistant answers the call and solicits basic information including the reason for the call. Calls are directed according to predetermined protocols. All medical calls are referred to the triage nurse. Emergencies are directed to the nearest Emergency Rooms and 911 number. Urgent and non-urgent calls are directed to the proper disposition sites by the triage nurse. The veteran's call is documented in the electronic record. Comparative analyses between

the number of calls and the number of walk-in visits indicated that as the number of calls increased, the number of walk-in visits decreased along with increased patient satisfaction.

Telephone triage began at the Memphis VA Medical Center in September, 1989, when the facility was dealing with large numbers (200 per day) of walk-in patients. Many visits were for non-urgent care, but patients had no other method of getting their needs met. A prescheduled, admission screening clinic was established. Appointments could be scheduled by telephone no more than two weeks in advance and some were available on the same day, if needed. The phone number was advertised to the veteran population served by the facility. This phone line was answered by health benefit advisors (Medical Administration Service). Eligibility was determined over the phone and routine appointments in screening clinics were scheduled. If the veteran stated that urgent or emergent care was needed, the phone call was transferred to a triage nurse who used protocols to

determine the medical urgency, then made referrals as needed.

This program cut the walk-in traffic in half, to an average of 70 per day. In addition to increased patient satisfaction, the workload in the admissions area has been spread over the entire day as opposed to everyone "walking-in" early in the morning.

In January, 1994, the facility began a telephone triage program for patients followed in the general internal medicine primary care clinics. This program provided easy access for the patients to have questions answered between appointments and to schedule follow-up appointments as necessary. There is a different 800 number and dedicated phone line for this program. Each patient is provided a "Patient Information Card" with the name and telephone number of the Telephone Care Nurse Coordinator. Patients are instructed to call if they have questions about their medications, appointments, laboratory results, or an urgent medical problem.

The telephone care nurse coordinator has been able to directly answer 80-90% of the patients' questions.

Currently, 8,941 patients are enrolled in the facility's Primary Care Teams. When the program was initiated, it averaged 700 calls per month. The average is now 2,000 calls per month.

In 1986, the Portland, Oregon VA Medical Center recognized the need to develop mechanisms for reorganizing the Emergency Care Unit (ECU), to improve access to care, and to improve the continuity of care. Staff estimated that 50% of the patients visiting the ECU were not in need of either urgent or emergent care. Many patient needs could be met without even an official patient-clinician visit. As a part of preliminary planning, there was unanimous agreement that the patients and staff needed both a clinically oriented telephone program and an intake clinic to provide interim care for patients with non-emergent and non-urgent needs and problems. In March, 1988, the Telephone Linked Care (TLC) Program and a Primary Evaluation Clinic (PEC) were initiated. Since 1988, three advice nurses, one advice pharmacist and four Medical Administration Service (MAS) assistants have been shifted to the program.

ECU visits decreased from approximately 27,000 visits in Fiscal Year (FY) 1992 to 14,000 visits in FY 1994. In FY 1994, there were 4,556 visits to the PEC. Many patients gained access via the telephone program, with a total of 31,923 in FY 1994. In mid-1994, the inpatient nursing staff joined the telephone care program to assist patients recently discharged from the wards. In September 1995, telephone care was expanded to 24 hours per day, 7 days per week.

Protocols were developed to assist the nurses with patient assessment, management of cases, and patient education. Currently, activities are centered on measuring agreement and disagreement on telephone management among telephone providers and to conducting discussions that are focused. Training seminars have been conducted at Portland VA Medical Center, other Veteran Health Administration (VHA) facilities, and at VHA national meetings.

The Tucson VA Medical Center recognized the need for change in the delivery of health care from a fragmented, episodic, acute illness model to a model of Primary Care, the cornerstone for managed care.

Telephone Linked Care (TLC) was identified as the critical link if this mission was to become reality. Telephone triage was considered the most appropriate way to provide a prompt response to less complex issues such as eligibility questions and medication refills. It was hypothesized that elimination of hours of patient waiting time and increased efficiency of providers would result in more effective care of patients.

The goals of the program were to: (1) improve patient satisfaction; (2) improve efficient use of resources; and (3) provide continuity of care. Implementation of TLC required: (1) establishment of a design team responsible for identification of equipment, supplies, personnel, competencies,marketing and training required prior to implementation; and (2) development of a three tier education plan. Level I involved mandatory education for personnel about Primary Care and TLC, as well as marketing to and educating their patients. Level II involved the process of using TLC, targeting nursing staff, medical administration, social service, psychology, psychiatry,

surgery, and medicine. Level III (the most comprehensive) targeted TLC staff. The two week team training included goals of the program, roles, telephone skills, and computer training, including the Portland VA software package.

TLC started November 16, 1994. Since its inception, unscheduled visits in the Urgent Care Clinic have decreased from 100-130 to 60-80 per day. Approximately 125 telephone encounters are logged daily.

Finally, the San Diego VA Medical Center implemented a program in November, 1992, that included both a telephone triage program and a nurse practitioner managed Primary Evaluation Clinic (PEC). The PEC provided 15 minute appointments where patient complaints were prioritized, appropriate referrals made and limited care provided. From the clinic, the decision was made to: (a) send patient to the Emergency Room; (b) make a same day appointment in the appropriate clinic; or (c) schedule an appropriate clinic appointment at a later date. Protocols were developed and approved by clinical service chiefs to

guide the disposition of patients. After patients became familiar with this program, the Telephone Advice System (TAS) was introduced and patients were encouraged to call and discuss concerns with the nurse before "walking-in" for services.

Educational sessions regarding the programs were conducted for staff. Letters were sent to all patients describing the program. At the onset of the programs, the number of walk-in patients was approximately 100 per day. This number has since been reduced by approximately 40%, to 60 patients per day.

Theoretical Basis

The patient population served by the Louis A. Johnson VAMC is not accustomed to having a "gatekeeper" to access primary care physicians. The implementation of a nurse managed triaged system will constitute a major change for these patients. Change theory and creative education will have to be utilized when planning marketing strategies for the program. The implementation of this program will also necessitate a change in the perception of the nurse's role in providing care for these unscheduled patients. This

change in the nurse role dictates certain considerations for the nurse(s) chosen for the role. The nurse must have a certain degree of competence and experience.

With these considerations in mind, change theory has been chosen to guide this project. The CLER model for change theory is the particular model selected.

The CLER acronym stands for Configurations of social relationships within and between systems in the planner and adopter roles; Linkages to carry communications within and between the planner and adopter systems; Environment(s) inside and around the systems involved in the change transaction; and Resources dedicated by the planner system for enabling implementation and to the adopter system for incorporating the change (Bhola, 1994). This model has a 25-year history of development and expansion, but is new to nursing professionals. The model is appropriate for, but not limited by or exclusive to, the area of nursing.

Bhola (1988) states that change can be accomplished in two major ways: (1) *Change in*

transmission, which occurs through social, institutional, and cultural processes: or (2) *Change by transformation*, which occurs when a participant undertakes the change agent role to transform a present situation into a future situation in terms of sufficiently articulated change objectives.

The CLER model depicts change in the later way. To utilize the CLER model effectively, its components and their relationships to the project objectives will be explored in more detail.

1. *Configuration of change*: A configurational perspective is at the core of the CLER model. It asserts that change is not one, standard, homogeneous phenomenon. Rather, change occurs in many different, often overlapping, configurations (Bhola, 1988).

The change agent must begin by defining the primary relationship between the configurations involved in a change episode. It is important to define the essential overall configurational relationship of the change in question, remembering that large-scope configurational relationships always

are mediated by, and through, smallscope configurational relationships (Bhola, 1986).

The project coordinator will be the change agent or planner in this project. Care providers (doctors, nurses, social workers, pharmacists,etc.) and patients will be the adopter systems. The planner will examine the process for providing care to unscheduled walk-in patients as it exists and will consider the role that each adopter system sees itself as holding. The relationship between the systems, at present, is a familial one. Patients expect to have all of their needs met at their convenience. Care givers have been accustomed to meeting these needs in this way. With the focus of health care changing, the new process must remain patient-focused, but must be more efficient as well. The process, as it is, has little consideration for the overall consequences to the system. Therefore, the process has become unmanageable at times.

2. *Linkages*: The CLER model calls attention to linkages to carry communications between and within the planner and adopter systems. It also calls attention to formal and informal linkages-both horizontal and

vertical- between and among the adopter systems (Bhola, 1986).

Communication and marketing will be major keys to the success of this project. Data will be used to explain the problem and need for change to the caregiver adopter system. Input from this group will be solicited to assure that major considerations regarding quality of care and proper disposition of patients are addressed. Criteria will be developed by the planner and presented for approval. Training and informational sessions will be presented by the planner to provide caregivers the opportunity to become familiar with the changed triage process.

Likewise, information regarding the system will be provided to the patient population in advance of initiation of the program. Patients must understand the reason for the change and the desired outcomes so that they do not feel services are being withheld.

3. *Environment*: Environment can be seen as the "most outlying" configuration within which all the change transactions are taking place. Environments can be inhibitive, neutral, or supportive. They are seldom

static and sometimes may be deliberately manipulated. Planner and adopter systems engaged in a change transaction will not necessarily be responding to the same environment (Bhola, 1988).

Environment, as it relates to this project, can be addressed in two dimensions: (a) the actual physical environment to be allotted to the project ; and (b) the atmosphere in which the project will be implemented.

Due to budget constraints and increased competition for viability, a very stressful atmosphere abounds throughout the Veteran's Administration Health Care System. This has filtered to the individual medical centers where many departments and programs are facing the potential of closure or incorporation into other departments or programs. While the Outpatient Department (OPD) Primary Care Clinics are stressed by the increased workload generated by unscheduled walk-in patients, there is still fear associated with the relinquishment of the process. The fear is that this relinquishment will justify decreases in Full Time Equivalent (FTE) staffing or space. The planner must help this adapter system to identify other areas where

resources can be shifted; i.e. patient education and wellness teaching.

The actual physical space selected must be conducive to the objective of decreasing walk-in patients. For example, the space should not be part of the area used for scheduled OPD clinic waiting areas. Because scheduled patients have to sometimes wait for lab work and other diagnostic results before being seen by the physician, it may appear that walk-in patients are being seen more quickly than are scheduled patients. In choosing space, consideration for patient confidentiality and privacy must also be addressed. There should be a space where walk-in patients can be interviewed and assessed outside of hearing distance of other patients awaiting triage.

4. *Resources*: The CLER model elaborates six types of resources: cognitive; influence; material; personnel; institutional; and time (Bhola, 1988). The cognitive resources associated with the project will be the tools used to communicate the change. These will include informational sessions for staff, pamphlets designed to explain the program to patients

and multi media displays throughout the OPD explaining the new process.

Influence will be derived from the support given to the program by medical center administration. A memo from the Chief of Staff will go to all employees explaining and lending support for the program. A letter from the Medical Center Director will be sent to all patients, explaining the program and how it will improve the care presently provided.

Materials needed will be actual space for the program, computer terminals, and phones with direct lines. Also needed will be assessment equipment; i.e. thermometers, blood pressure monitors, stethoscopes, etc. Triage guidelines must be developed and approved.

Personnel will be an important resource. At the present time, each department is attempting to maintain current staffing levels. No hiring is presently being done. This program must be staffed with existing resources, thus requiring a shift in personnel.

Institutional resources will involve the facility's dedication to the program. These resources

will also include administration's consistency in handling patient complaints regarding services.

Time will be a major resource. The program must be well planned before being implemented. Time must be devoted to marketing and explaining the program to staff and patients alike, in order to guarantee success.

Summary

The Veterans' Administration Health Care System is being challenged to restructure for greater efficiency. (Kizer, 1996). One of the biggest problems facing the Louis A. Johnson VAMC has been the numbers of unscheduled patients presenting for treatment with non acute problems. Many of these patients present in the ED. Kelly (1994) notes that as many as 30% of patients seen in overcrowded EDs have non emergency conditions.

The literature reports several approaches to dealing with this problem. One effective approach has been the development of walk-in and/or telephone triage programs. Many investigators report the success of these programs in decreasing numbers of non-emergent

visits and average visit waiting times. They have also been found to enhance patient satisfaction.

A variety of VA facilities have developed models that can guide the development of a walk-in and/or telephone triage system. Additionally, change theory provides a way of conceptualizing the aspects of development that will be needed.

As the challenge for facilities to remain viable becomes more pronounced and the move continues to outpatient care, nurse managed walk-in and telephone triage programs will be expanded to help in caring for the increased outpatient population. This project will result in the development of such a program for this facility.

Chapter III

METHOD

Various methods were used in the development of the walk-in/ telephone triage program. The first step was the compilation of data to examine the extent of the problem. Walk-in visit statistics compiled for a time period from January, 1995 to May, 1996 were further analyzed to determine: (a) what numbers of these walk-in patients were seen in the Emergency Department (ED) after regular clinic hours, (b) how many of these were seen for actual emergent problems, and (c) and how many could have been scheduled for later appointments.

Results from a study conducted by the Quality Management Department to determine the reasons for patients "walking-in" for services were reviewed. In addition, representatives from Primary Care and ED nurses, Social Work Service, Medical Service, Surgical Service, Mental Health Clinic, Psychiatry Service, Pharmacy Service, Medical Administration Service (MAS), and Engineering Service (for space needs) were consulted. Based on input from these different

services, appropriate program components were developed.

Structure

Several structural components were considered in developing the program. These included physical location of the walk-in triage area. This area was strategically chosen. One of the prime reasons patients indicated for "walking-in" for services is long waiting periods. Since the triage process should move quickly, the area should be separated from the scheduled clinic patients' waiting area. This will prevent scheduled patients from assuming that walk-in patients are being treated quicker, which would reinforce walk-in behavior.

Spacee will be needed for the triage clerk to be able to collect demographic data. Space must also be allotted to the triage nurse for doing assessment on the patients. These areas must provide privacy so that patient confidentiality can be respected. The project coordinator consulted with engineering to choose the best possible location for the triage areas.

Equipment

Equipment needed included telephones, computer terminals, and assessment equipment (i.e. blood pressure monitors, thermometers, stethoscopes, etc.). The project coordinator consulted with Information Management Service to obtain the electronic equipment. This included the computers, telephones and direct lines and electronic record access for recording the patient/nurse encounters.

Staffing

Minimum staffing for the initiation of the program will be one Registered Nurse and one MAS clerk. The coordinator met with the Chiefs of Nursing and MAS to gain commitment to these staffing requirements.

Job Descriptions

The coordinator worked with the Chiefs of nursing and MAS to determine job qualifications and requirements for the triage nurse and clerk positions. Once these have been determined, the job postings were developed and each of the involved services utilized its routine interview and selection process to choose the most appropriate candidate.

Education

The education component was three fold. It included education and training of the Registered Nurse and the clerk chosen for the triage positions. They were educated according to chosen criteria for triage and established policies and procedures. It also included informational sessions provided by the coordinator to inform staff about the purpose and function of the new program.

The project coordinator developed media (pamphlets, informational posters located in the Outpatient area, speaking at Service organization meetings,etc) to be utilized to educate patients regarding this change in delivering care.

Policies and Procedures

The coordinator developed policies and procedures that outlined the objectives and purpose of the program. These were then presented to a task force composed of representatives of different services for review. Then these were presented to the Administrative and Clinical Administrative Boards for final approval.

Triage Guidelines

The coordinator consulted with other programs and Quality Management to develop guidelines to be used by the triage nurse in determining the disposition of patients. Several resources were reviewed and then the most appropriate was forwarded to the Chiefs of Medicine, Surgery, Psychiatry, Psychology and Ambulatory Care for review and approval.

Documentation

A documentation tool for recording the patient/nurse encounter (whether in person or by phone) was developed by the coordinator. After the form is finalized, the coordinator will work with IRM to have it included in the electronic record package. Data for evaluation of the program can also be retrieved from this tool.

Marketing

Marketing was vital to the success of the program. A memo was sent, under the signature of the Chief of Staff, to all staff introducing and supporting the program. A letter was sent from the Medical Center Director to all current patients on the enrollment

roles explaining the program and how it is projected to improve the care they are receiving. The coordinator arranged to speak at Veteran Service Organization Meetings to acquaint the veterans with the program and answer questions. A brochure with concise facts will be available for all patients. It included the direct phone line number to make access easy.

Evaluation

Outcome indicators have been initiated from the beginning of the program to measure the effectiveness of the program. These included numbers of walk in patients after this program initiated and proper disposition of the patients.

Chapter IV

RESULTS/DISCUSSIONS

This chapter will describe the results of the thesis project. A brief summary of the program proposal, policies, job descriptions, and marketing tools are included. Also mentioned is the significance of developing the program and its benefits to patients. Lastly, the implications of the project and suggestions for evaluation and future research are considered.

Description of the Project

The result of this project was the development of a proposal for the initiation of a nurse managed telephone/walk-in triage program. The proposal is an in-depth guide to developing and initiating such a program. An attempt has been made to identify each factor that affects the success of such a program. These factors include program location, staffing requirements, assessment guidelines, and equipment needs. Position descriptions, communication tools describing the program to patients and staff, informational brochure and program policy are also included.

Significance

From January, 1995 to June, 1996, there were 13,168 unscheduled walk-in patient visits at the Louis A. Johnson VAMC. Of these, 8,004 were seen in the Emergency Department (ED) and 5,164 were seen in the Primary Care Clinics. Of the 8,004 seen in the ED, 245, or 3%, were classified as emergent (life-threatening), 4,049 were classified as urgent (needs seen same day but not life-threatening), and 3,710 were classified as routine (could have been rescheduled at a later time). These visits have resulted in increased use of overtime hours and decreased patient/staff satisfaction.

With the institution of a nurse managed walk-in/telephone triage program, unscheduled walk-in patients will be able to be seen without going through the Primary Care Clinic process. This process involves assessment by the clinic nurse and the doctor at the time the patient presents, whether or not the problem needs addressed at that time. With the proposed triage program, the patient can be seen by his/her Primary Care physician if the problem is emergent or urgent or,

the patient can be scheduled for a later appointment if the problem is routine. Such a program can reinforce the renewed mission of the Veterans' Health Administration (VHA) to deliver care in the most efficient, effective manner possible (Kizer, 1995).

Limitations

Since patients and staff at this facility are accustomed to every patient being seen at the time of presentation, the nurse-managed walk-in/telephone triage program will be a new concept. Gaining support of all constituents is essential. Administration will have to assist in reaching this goal. The project coordinator will conduct informal, educational meetings with all levels of staff. The Chief of Staff will send a memo to all staff endorsing the program. A letter will be sent to all patients from the Director's Office explaining the concept. In addition, informational brochures will be available in the Outpatient Department (OPD).

A major limitation will be financial constraint. At the present time, the VHA is experiencing budget reductions. Financial constraints will affect space

renovation, equipment, and staff dedicated for the program. It also will limit operational hours to the administrative tours of duty (8:00am to 4:30pm) at the time of initiation. During non administrative hours, these patients continue to be seen in the ED, but the ED nurses will use the walk-in/telephone triage guidelines for assessment of urgency of need for services.

Relevance to Nursing

Development of a walk-in/telephone triage program will benefit patients, staff, and the facility. It will introduce a new role for the nurse as a more autonomous practitioner in this facility. The program will also provide the opportunity for the nurse and Primary Care physician to work as collaborators. The nurse will use management and assessment skills in areas not previously considered within the realm of nursing, i.e., deciding the patient's urgency for the patient's need to have physician contact and scheduling the contact. The patient will start to view the nurse as his/her personal health counsellor (Janowski, 1995).

As this program expands, the project coordinator envisions the opportunity for it to become a nurse practitioner-managed urgent care clinic. Since the concept of the nurse practitioner is just beginning to be explored in this facility, such a role could elevate nursing to yet another level.

The role of the nurse-practioner was initiated approximately 25 years ago. The recent changes in health care have dictated the need to utilize the many skills of the Advance Practice Nurse. In recent years, the contributions of these nurses have been recognized as assets to providing quality care for greater numbers of patients.

Methods of Evaluation

Two primary outcomes have been projected. These are: (1) decreased numbers of unscheduled, walk-in patients seen in the Primary Care Clinics; and (2) correct triage assessment and disposition of the patient. The project coordinator and the Information Resource Management Department are collaborating to develop computer spreadsheets to monitor the patients assessed in the triage program. The spreadsheets will

allow the data to be entered and then will be able to analyze the data. The computer system will allow trending to be done; i.e., identifying the most common errors in disposition of patients, peak days and times for patients walking-in for treatment, kinds of telephone advice requested, etc. Other outcomes to consider would be increased patient and staff satisfaction and decreased overtime hours.

Recommendations for Future Research

Future research should examine the further development of such programs. This would include physician perceptions of the programs, continued analysis of the data related to errors in triage assessment, and trending of anticipated savings to EDs in time, staff, and financial resources. It would also be important to survey nurses in such roles to identify the needed changes in education and training for these nurses.

Summary

The need for a walk-in/telephone triage program in this facility has been demonstrated. Although finances remain an issue, the hope for program funding

continues. By helping to develop and manage such a program, nursing can improve the standard of care for patients and help the facility to refine care delivery to be more effective and efficient. In addition, such a nursing role will help to enhance the nurse as a physician collaborator and, therefore, advance the professionalism of nursing.

References

Bass, D.M. and Noelker, L.S. (1987). The influence of family caregivers on elders' use of in home services: An expanded conceptual framework. Journal of Health Society Behavior 28, 184-196.

Bhola, H.S. (1986). Pathways to effective dissemination: Configuration-mapping and linkage-typing as tools. Columbus, OH: National Center for Research in Vocational Education. (ERIC Document No. ED 253728).

Bhola, H.S. (1988,). The CLER model of innovation diffusion, planned change, and development: A conceptual update and applications. Knowledge in Society: The International Journal of Knowledge Transfer,1(4), 56-66.

Bhola, H.S. (1994). The CLER model: Thinking through change. Nursing Management, 25(4), 59-63.

Champagne, F., Contandriopoulos,A.P., & Eeckhoudt,L. (1991). Evaluation du traitment des appels a urgences sante. (r91-10). Montreal, Quebec, Canada: GRIS, Universite de Montreal.

Geraci, E.B., & Geraci, T.A. (1994). An observational study of the emergency triage nursing

role in a managed care facility. Journal of Emergency Nursing, 20, 189-193.

Janowski, M.J. (1995). Is telephone triage calling you? American Journal of Nursing, 95(9), 59-62.

Kelly, K.A. (1994). Referring patients from triage out of the emergency department to primary care settings: One successful emergency department experience. Journal of Emergency Nursing, 20, 458-463.

Kizer, K.W. (1996). Prescription for change. (Availabe from Department of Veterans Affairs, Veterans Health Adminstration, Washington, DC 20420)

Leprohon, J. & Patel, V. (1995). Decision-making strategies for telephone triage in emergency medical services. Medical Decision-Making, 15, 240-253.

Martin, C. & Fruin, M. (1995). Telephone consultation for a "managed care population". Journal of Emergency Nursing, 21, 155-156.

Pinsker, J., Phillips, R.S., Davis, R.B. & Iezzoni, L.I. (1995). Use of follow-up services by patients referred from a walk-in unit: How can patient compliance be improved? American Journal of Medical Quality, 10(2), 81-87.

Poole, S.R. (1995). Are you interested in telephone triage research? Pediatrics, 95, 802.

Richmond, J.B. & Fein, R. (1995). The health care mess. Journal of the American Medical Association, 273(2), 69-71.

Select Committee on Aging, house of Representatives (1988). Exploding the myths: Caregiving in America (Committee Publication No. 100-665). Washington, DC: U.S. Government Printing Office.

Skipwith, D.H. (1994). Telephone counseling interventions with caregivers of elders. Journal of Psychosocial Nursing, 32(3), 7-12.

Telephone triage program: Nurses respond to calls from patients recovering at home. (1995, July/August). Today's OR Nurse, 17(4), 38-39.

Veterans Adminsitration Health Care System. (1995). Models of care: Samples for primary care and telephone liaison care. (Available from Department of Veterans' Affairs, Veteerans Health Administration, Washington, DC 20420)

Williams, S., Crouch, R. & Dale, J. (1995). Providing health care advice by telephone. Professional

Nurse, 10, 750-752.

PROPOSAL AND POLICIES

for a

NURSE MANAGED WALK-IN/TELEPHONE

TRIAGE PROGRAM

CONTENTS

SECTION

WALK-IN/TELEPHONE LIAISON CARE TRIAGE PROPOSAL

For some time, the Louis A. Johnson VAMC has been attempting to deal effectively with an increasing number of walk-in patients in the Outpatient Department. Presently, there is no real way to control or manage the workload, and timeliness and continuity are lacking. Most importantly, there is no mechanism to defer the large, non-emergent workload to a more appropriate setting. It is clear that some system changes need to be developed and implemented.

This proposal addresses the possibility of a nurse triage system for walk-in patients and a nurse telephone triage system for patients seeking health care advice.

WALK-IN PATIENT TRIAGE

This triage system would enable a triage clerk to appropriately refer the patient to the appropriate service to answer the patient's questions or address the patient's health care needs. The triage nurse would have the capability of assessing the patient's needs and determining if the patient needs to be seen on the same day or if a later appointment would appropriately address the patient's need. The triage nurse would also have the ability of scheduling the patient into the appropriate clinic either with or without physician consultation as guided by specific triage protocols developed by the work group.

TELEPHONE TRIAGE

The concept of providing health and illness advice and information to patients by telephone is not unique. It is used in many settings(ERs, physician offices, community clinics, etc.). Many VAMCs are beginning to examine and incorporate **"TELEPHONE TRIAGE"** in the systems used to manage outpatient workload. Using available telephone and computer resources, maximizing staff skills and much "patient behavior modification", the Louis A. Johnson VAMC can better

manage the outpatient workload. The Louis A. Johnson VAMC now sees an average of 35 walk-in patients/day in the Ambulatory Care area. Many of these patients do not require same day or emergency care and would most likely accept a later appointment within 7-14 days. For many patients already enrolled in a Primary Care or Specialty Clinic, a timely phone call from the nurse could prevent unnecessary trips to the Ambulatory Care Department.

PROBLEMS WITH PRESENT SITUATIONS

1. Patients have no way of accessing VA services without appearing in person and experiencing lengthy waiting times.
2. Workload is difficult to manage.
3. The system does not provide for coordinated care.

PROPOSED SOLUTIONS

The work group proposes that this facility develop and implement a system for the nursing triage of patients who either "walk-in" for treatment or who phone in for advice before "walking-in" for treatment. The workgroup proposes the following steps for each type of triage. The systems would operate from 8:00am to 4:00pm Monday through Friday, excluding holidays.

Walk-In Triage

1. The patient would check in with the triage clerk who would obtain information pertinent to the patient's need based on established protocol and then direct the patient to the appropriate resource: triage nurse, pharmacy, eligibility clerk, benefits counsellor, outpatient social worker.
2. The triage clerk would document disposition on the appropriate progress note.

Telephone Triage

1. Initial call would be received by the triage clerk. The clerk will then obtain information pertinent to the patient's need based on established protocol and then direct the patient's call to the appropriate resource: triage nurse, pharmacy, eligibility clerk, benefits counsellor, outpatient social worker.
2. The triage clerk will document the call on the appropriate progress note and include the disposition.

REQUIRED RESOURCES

Staffing

1. Medical Administration Service (MAS)-- one(1) clerk

The person selected needs to possess excellent interpersonal skills, a medical terminology background, ability to remain calm in crisis situations and make a commitment to the program. The ACMAS has committed to the dedication of one(1) MAS FTE to the program.

2. Nursing--one(1) Registered Nurse

This nurse would report to the Outpatient Department Nurse Manager. This nurse should possess excellent interpersonal skills, a strong medical/surgical background, and ability to remain calm in crisis situations. This nurse should be at the level of Nurse II or higher. The Acting Chief, Nursing Service has committed to the dedication of one(1) Registered Nurse FTE to the program.

Space

The program would require a designated space which would accommodate two(2) work stations and provide for patient confidentiality. It would also require space for the nurse to do the physical assessment to determine the disposition of patients. The group strongly feels that this space should be separate from the Primary Care/Specialty Clinics waiting area.

Equipment

a. Telephones--one(1) at each work station. The phone system should include "800 number" service.

b. Computer terminals-- one(1) CRT at each workstation and one (1) printer to be shared by both workstations.

c. Typewriter-- one(1) located at the clerk's workstation.

d. Vital sign equipment including thermometer, blood pressure apparatus, and stethoscope.

STRATEGY FOR IMPLEMENTATION

Hospital memoranda delineating policy, responsibilities and procedures need to be implemented for the operation of the program. Training for all staff in the program, development of protocols/criteria for the triage team and scheduling privileges for the team need to be established.

Communication, especially between the triage team and Primary/Specialty Clinic physicians and nurses is crucial to the success of the program. The availability of the program must be communicated throughout the Medical Center and most importantly, to the patients. The fact that the program will indeed improve the quality of care for patients must be stressed. Veterans' Service Organizations could be instrumental in this area as well as in direct support of the program. This program should become the primary interface between patients and the Medical Center, showcasing ease of access of care and improved quality of care.

VA MEDICAL CENTER
MEMORANDUM
CLARKSBURG, WV March 16, 1996

SUBJECT: Walk-In and Telephone Triage

1. Policy-Purpose:

To delineate the policy concerning the triage of walk-in, unscheduled patients and those patients utilizing the telephone triage system for accessing care.

2. Definitions:

a. Walk-In Triage System: a program consisting of a Registered Nurse and an administrative clerk who triage patients who arrive for services without a scheduled appointment.

b. Telephone Triage System: A program consisting of health care providers and administrative staff who provide information, referral to other health care providers and problem-solving assistance for veterans by telephone.

c. Triage Clerk: A Medical Administration Service employee who is the first line contact for walk-in patients or those patients utilizing the telephone triage system and who directs the patient to the appropriate resource (Registered Nurse,Pharmacist, Eligibility Clerk, Social Worker).

d. Triage Nurse: A Registered Nurse who interviews and assesses walk-in patients and who interviews patients who utilize the telephone system to have health concerns addressed and makes appropriate recommendations for intervention.

e. Emergent Care: Care that requires immediate attention to prevent serious impairment, dysfunction, or threat to health and safety (COBRA, 1985). Generally, this care is provided in the Emergency Room.

f. Non-emergent care: Care that does not require immediate attention to prevent serious impairment, dysfunction, or threat to health and safety (COBRA, 1985). The care required can be deferred to a more appropriate time and place; ie.. within one-two weeks.

g. Same-Day Care: Care that does not require treatment in the ER.

h. Triage: The process of interviewing, assessing. and "sorting" of patients to determine the type and timeliness of care. This will be done by the triage nurse.

3. Responsibilities:

a. The Triage Clerk will be the first contact for walk-in patients and will receive all calls coming to the telephone triage line. The clerk will decide to which resource the patient or call should be directed. The clerk will document the patient's(whether walk-in or telephone call) name (if telephone call, caller's name if different from patient's), patient's social security number, time of call or walk-in arrival, reason for call or walk in appearance and disposition of patient or call(who dealt with patient's concern).

b. The Triage Nurse will assess walk-in patient's or caller's need and make appropriate recommendations based on established criteria and document all details of the encounter. The Triage Nurse will consult with the Primary Care Team as necessary.

c. A Registered Pharmacist will respond to calls that relate to medications. The Pharmacist will assess the patient's needs, make appropriate recommendations and document the encounter. The Pharmacist will consult with the Primary Care Physician as needed.

d. The Eligibility Clerk will respond to questions concerning VA eligibility, benefits, etc. Pertinent forms can be initiated over the phone. The advisor will document all details of the encounter.

e. The Primary Care Team Nurses will review printers in the out-patient clinic areas at least hourly to check for messages from the Triage Clerk or Nurse concerning patients enrolled in their clinics. They will use appropriate records, interview the patient, and consult with the Primary Care Physician as necessary to make appropriate recommendations.

f. ER Staff(nurse, physician, MAS staff) will assess walk-in patients during non-administrative hours for the type of care required: emergency, same-day or non-emergent. Patients assessed as non emergent and who can utilize the Telephone Triage System will be instructed to call the Telephone Triage System during its regular hours of operation(8:00am-4:00pm Monday through Friday, excluding holidays).

4. Procedure:

a. Walk in patients will be directed to the walk-in triage area where the Triage Clerk will take pertinent information as to patient identification and nature of need. The clerk will then direct the patient to the proper resource and document the encounter on the appropriate progress note.

b. The Telephone Triage Line will be answered by the Triage Clerk and proceed as above.

c. The Triage Nurse will assess the walk-in patient with a health complaint and according to the established criteria, will send the patient to the ER, arrange a same day appointment or schedule a later appointment. All details of the encounter will be documented.

d. The Triage Nurse will interview the patients whose telephone calls are directed to her according to the established criteria and then proceed as above.

5. References:

Congressional Omnibus Budget Reconciliation Act (COBRA) of 1985.

6. Rescission:

None

7. Review Date: March 1997

8. Republication Date: March 1999

MICHAEL W. NEUSCH
Medical Center Director

Distribution:

Pharmacy Guidelines for Walk-In Triage or Telephone Triage

Questions regarding:

1. Outpatient pharmacy prescription information(i.e. availability or number of refills remaining on a prescription).

* Have the patient call _____

2. Pharmacy mailout prescription information(i.e. the date a patient's prescriptions were last mailed out)

* Have the patient call _____

After review of the checklist for referral of patients to the clinical pharmacist, if patients are appropriate for referral, one of the following selections may be chosen:

1. Patients have the option of checking with the pharmacist to see if they may be interviewed over the phone regarding their medication problem. The Triage Clerk or Nurse will send for the patient's chart and instruct the patient to call back in two (2) hours regarding their evaluation. Upon receipt of the second call, the Triage Nurse or Clerk will contact the pharmacy and transfer the call. The pharmacist will either: (a) interview the patient over the phone and document the interaction and actions taken, or (b) instruct the patient to come in for "physical" evaluation (i.e. vital signs, lab tests,etc.).

2. Walk-in patients have the option of waiting to see the pharmacists. The wait may vary from 15 minutes to 2-3 hours depending on workload and staffing.

PHARMACY REFERRAL CHECKLIST

Questions for patients:

1. Is the patient sure they are out of refills?
   - if NO- Refer patient to speak with the pharmacist in the Outpatient Pharmacy for clarification
   - if YES- ask the following question:

2. What happened to cause them to run out of refills?

   -if the patient is unsure what caused them to run out of refills, they may be unsure of their refill status
   -in the following situations refer them to the pharmacy for clarification

   a) they do not have refill slips
   b) they appear unsure of their refill status

   - if the patient reports any of the following situations, refer them to the pharmacy:

   a) their clinic appointment was postponed-out of refills
   b) they missed their scheduled clinic appointment-out of refills
   c) they are visiting Clarksburg or have moved here and are out of refills
   d) they lost their medications
   e) they indicate on a refill slip or medication label that they are on their last refill
   f) they indicate that they are on their last refill by presenting a letter from the VA that states that they are on their last refill

WHEN A PATIENT CALLS THREATENING SUICIDE

1. Clerk receives all incoming calls

2. If a caller is threatening suicide or harm to himself, the clerk holds up a large card that reads **SUICIDE CALL** to the Triage Nurse.

3. The RN immediately calls X3538, alerting Psychiatry staff to the suicide call.

4. Meanwhile, the clerk is holding the caller on the line and asking short direct questions (What's your name?, What's happening with you right now?, Are you alone?, Where are you?, etc.)

5. The Triage Nurse joins the clerk on the line with the caller and tells the caller that the call is being transferred to the Psychiatry staff who will help him/her. The Psychiatry staff member is awaiting the call. Because 2 Triage staff are on the line with the caller, the call cannot be lost in transferring it and the staff will remain on the line until Psychiatry has received the call.

RESOURCE

The following text has been reviewed by the Chiefs of Medicine, Surgery, Psychiatry and the ACOS for Ambulatory Care. All have signed indicating agreement for this reference to be used as criteria for triage as to urgency of patient being seen.

Guidelines for Practice by Sandra M. Simonsen, RN, published by Mosby Co. Approximate Cost: $35.00 plus shipping and handling. Two(2) copies, one (1) for the Triage area and one (1) for the ER would be needed.

WALK-IN/TELEPHONE TRIAGE NURSE GUIDELINES

Purpose: To outline the nursing management of patients calling the Telephone Triage System or walk-in patients requesting treatment.

Level: Independent

Content:

a. Patients calling or walking in with health concerns/problems will be referred to the Triage Nurse by the Triage Clerk. Using the established criteria, the nurse will determine the acuity and severity of the patient's health care problem.

(1). Information will be elicited from the patient when possible. If information is obtained from the significant other or other family member, the individual's name and relationship to the patient will be documented. If information is solely from a second party, document reason why(i.e, patient is aphasic, etc.)

(2). Patient information, including chief complaint, pertinent history, subjective and objective data and allergies will be documented.

b. The Triage Nurse will recommend appropriate health care follow-up:

(1). Urgent-- the patient will be referred to the VAMC Emergency Room, the Emergency Room nearest to the patient(by distance), or the suicide protocol will be followed. If the patient is advised to call the Emergency Medical System, the nurse will call back for follow-up.

(2). Same-day-- the patient will be referred to the appropriate clinic. The Nurse will provide documentation to the clinic.

(3). Non urgent patients will be scheduled an appointment with the appropriate clinic at a later date and will be given instructions regarding what symptoms would require them to seek additional treatment prior to that date and to obtain such care.

(4). Interventions will be discussed with the patient/significant other,etc. and documented.

(5). The Triage Nurse will consult the attending physician if the appropriate intervention cannot be determined.

(6). If the patient/significant other,etc. disagrees with the recommended intervention and/or requests a different type of intervention, the attending physician will be notified.

Date:

From: Chief of Staff

Re: Walk-in Triage/Telephone Advice System

To: All Physicians, Nurses, Pharmacists, Physicians' Assistants

1. The Walk-In Triage/ Telephone Advice System is here. What does it mean? Patients can call the Triage Clerk/Nurse (phone #) for answers to questions concerning their health, medications or eligibility. Also unscheduled walk-in patients will be triaged by the triage nurse instead of being sent directly to the Primary Care Clinics.
The systems will be in operation from 8:00am to 4:00pm, Monday through Friday, excluding holidays.

2. The triage nurse will determine the urgency of the patient's health care needs as guided by established criteria which have been approved by the clinical service chiefs. The nurse will then make the appropriate referral or schedule the appropriate appointment for the patient.
The Triage area will be located in_____

3. You are encouraged to urge patients and help to educate them about the Triage System to decrease the number of unscheduled walk-in patients.

4. If a patient telephones and describes an emergent problem, he/she will be instructed to come to the medical
center for evaluation.

5. If you have any questions, please refer them to the your appropriate service chief or the triage nurse at (phone #) .

It is hoped that these arrangements will facilitate patient care and support the effort to provide quality care to our veteran patients while increasing the efficiency of the Ambulatory Care Department.

6. Thank you for your cooperation.

_____
ERLINDA DE LE PENA, MD
Chief of Staff

Date:

Dear Veteran:

I am writing to tell you about a new program which has recently been implemented at the Clarksburg VA Medical Center-- the ***Walk-In*** and ***Telephone Triage Systems***. This program was implemented to better meet your needs when you require our services.

We have developed these systems to help keep you from making an unnecessary trip to the medical center and to enable you to obtain advice and help by phone.

The ***Walk-In Triage System*** would help those patients who do make an unscheduled visit to the Medical Center. The triage nurse would see you and assess your needs and then arrange for you to be seen that day, if necessary or arrange a later scheduled appointment for you.

The ***Telephone Triage System*** can help you in avoiding unnecessary trips to the Medical Center. By utilizing this system, you can eliminate a long wait and have your concerns addressed. We are especially hopeful that you will utilize the **telephone system** as the first means of contact with the Medical Center when you have a problem or question. We know that sometimes you have a health care or other concern or question, that if addressed quickly, can put your mind at ease. This system will allow you to quickly connect with staff who can be of assistance.

If you need to talk with a health care professional, call (phone #) between the hours of 8:00pm and 4:00pm, Monday through Friday, except holidays. The receptionist will ask you several brief questions and then transfer your call to a nurse, a pharmacist or a health benefits advisor, depending on the reason for your call.

The ***Telephone Triage System*** can assist you in avoiding unnecessary trips to the Medical Center, eliminate a wait to have a simple concern addressed, improve communication with those providing your care and help

you to receive care when the need is urgent. The enclosed brochure will provide you with information but feel free to call the direct phone line (phone #) with any questions. The receptionist or nurse will be happy to help you.

The ***Telephone Triage*** and ***Walk-In Triage Systems*** are just two ways we hope to better meet your needs. This is one more step in making the Clarksburg VA Medical Center one of the best and most caring medical centers in the nation.

Sincerely,

_____

MICHAEL W. NEUSCH
Medical Center Director

Telephone

Triage

System

"Your VA Connection"
Phone Number

VA Medical Center
Clarksburg, WV

WHAT IS THE TELEPHONE TRIAGE SYSTEM (TTS)? ☎

Quite simply, it's our way to serve you better! It will allow you to receive personalized, timely attention to your health concerns by telephone. We know that most unscheduled visits to the Ambulatory Care Department are for health problems that don't need "same-day" attention. We also know that it can be inconvenient to have to come to the Medical Center for minor problems, as the waiting time can be long. The **TTS** lets you talk to specially trained staff who will review your needs and either deal with them immediately (by phone) or help you to receive care at the Medical Center.

WHEN SHOULD I USE THE TTS? ☎

Call the **TTS 8:00am to 4:00pm, Monday through Friday, except holidays,** when you have a question about your health, medications, or eligibility to receive VA health care. Some typical questions are: "What should I do if I run out of medicine before my next clinic appointment?" "I've had a cough and a fever for 3 days...what should I do?" "I'm not scheduled for an appointment till next week, but I've got a concern about.....?"

WHAT HAPPENS WHEN I CALL THE TTS PHONE NUMBER? ☎

A specially trained clerk will take your call and ask you some basic questions: what is your name, social security number, address, phone number, reason for the call,etc. This will help determine which TTS staff member is best able to help you with your concern

WHO ARE THE TTS STAFF? ☎

•ADVICE NURSE (RN):
The advice nurse can provide information about and/or determine the seriousness of your health problem and help you to decide how best to handle that problem. In most cases, the nurse will call you back to discuss your concern. Usually, the nurse must speak directly to the patient.

•PHARMACIST
The pharmacist can handle questions or problems about medication, such as prescriptions, dosages, side effects, or renewals..

•Health Benefits(Eligibility) Advisor:
This advisor can answer your questions about VA eligibility, travel, insurance,etc. and can begin the process to determine your eligibility to receive care at the Medical Center.

WHAT IF I'M NOT ENROLLED IN A CLINIC AND I NEED TO BE SEEN? ☎

Just call the **Triage Line (TTS)**! Once you describe the problem you are having we can make an evaluation and advise you on what to do. The nurse will determine if you need "Same-day" treatment or can be given an appointment in the appropriate clinic at a later date.

CAN I STILL WALK-IN TO THE AMBULATORY CARE DEPARTMENT AND BE SEEN? ☎

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We want to encourage you to call the **TTS** first and talk about your problem with the RN, pharmacist,or eligibility clerk; however, if you choose to walk-in to the Ambulatory Care Department without an appointment , the triage nurse will interview you and determine if your problem is a medical emergency or requires "same-day" attention. If the problem is not an emergency or "same-day" treatment is not required, you will be given an appointment to the appropriate clinic and information on how to use the **TTS** in thefutue. We thank you for your cooperation in this

WE ARE DEDICATED TO SERVING YOU BETTER.

TRIAGE CLERK

MAJOR DUTIES

The clerk is assigned to the Ambulatory Care Department and is assigned to the Triage Program. The clerk would be the initial contact person in the program. The clerk must make decisions to insure that the patient is referred to the appropriate health care professional. These decisions are critical and affect the overall functioning of the program as well as the health and well-being of the patient. The decisions would be based on the information obtained from the patient by means of an interview protocol, knowledge of the overall functions of the program and the ability of the clerk to determine medical need. The clerk must be able to identify situations of an emergent nature so that the patient's health and well-being are not jeopardized.

The clerk would determine if the patient is a new or a current patient to our system. In the case of a new patient, the clerk would refer the patient to the Eligibility Clerk for eligibility determination. For current patients, the clerk must screen the patient's eligibility based on the correct application of laws and regulations governing the entitlement of veterans to medical and dental benefits including inpatient, outpatient treatment, prosthetic and indigent services. In every case, the determination requires meticulous judgement of facts and conclusive application of the law. Certifies the decision regarding the application for care, thereby assuming responsibility in committing the United States Government to provide or deny the care being requested.

The clerk personally works with veterans in determining the nature of the patient's needs, questions or complaints and answers questions, provides information, gives guidance and initiates action as appropriate.

The clerk is responsible for all administrative functions of the program. He/she must be actively involved in identifying problem areas and in the

development of methods to improve the functions of the process.

In the performance of official duties, the employee has regular access to the printed and electronic files containing sensitive data which must be protected under the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, VA statutes and policy. The employee is responsible for protecting the data from unauthorized release or from loss, alteration, or unauthorized deletion and following applicable regulations and instructions regarding access to computerized files, release of access codes, etc.

FACTOR 1, KNOWLEDGE REQUIRES BY THE POSITION

Must have a complete knowledge of pertinent laws, rules, regulations, policies and procedures to determine eligibility.

Thorough knowledge is required regarding the Agent Orange, Nuclear Exposure and Persian Gulf Screening Programs.

Employee must possess a wide knowledge of medical terminology, especially for diagnoses to determine eligibility for benefits.

Thorough knowledge is required regarding relevant functions of the Medical Center.

Highly developed communication skills and the ability to interact with veterans and staff is necessary. Communication both verbally and in writing is necessary.

The ability to function during times of high stress is necessary. Knowledge of medical records and file procedures to maintain orderly records is required.

Technical knowledge of local decentralized hospital computer program is necessary. Various options/menus are required in daily work requirements. Technical understanding of computer equipment to determine when

specialized support is required when equipment does not function is necessary.

Clerk must be a qualified typist in order to type letters/forms, etc. and to enter/retrieve data in a computer.

FACTOR 2, SUPERVISORY CONTROLS

General supervision is received from the supervisor who provides instructions concerning new and/or changes in Medical Center procedures. The clerk must work independently and decisive action is mandatory. The Supervisor is available for guidance in emergency or unusual situations.

FACTOR 3, GUIDELINES

Guidelines are VA manuals, pertinent laws, regulations, VISN and VAMC directives and instructions issued by the Supervisor. Written guidelinesc are available when needed for specific situations. A certain amount of independent judgement is required in dealing with day-to-day problems involving individual veteran patients.

FACTOR 4, COMPLEXITY

The clerk reviews, interprets and extracts information from veteran's discharge documents, computer systems and, when necessary, from documents returned from a Regional Office to determine eligibility for requested benefits. Must be able to comprehend complex medical terms and make proper application of laws and regulations to provide information advice or take decisive action on correcting previous improper determination. Various cases may involve extensive research along with multiple administrative and professional contacts to present a precise report before committing the VA to responsibility.

FACTOR 5, SCOPE AND EFFECT

The purpose of the position is to meticulously make application of laws and regulations to determine entitlement to VA benefits. This work contributes to

the continual effort to process veterans deserving of care in a prompt manner and of committing the VA to responsibility.

Determination must be related to the concerned party in a helpful and caring method in promotion of the VA's goal and it's veterans. Special attention and advice will be extended to those persons having no entitlement to provide proper contacts at various community services.

Recommendations to the professional staff on applicable VA regulations and laws assist in providing continued medical care.

FACTOR 6, PERSONAL CONTACTS

Personal contacts are with veterans, their families and representatives and private agencies. Other contacts are with Medical Center, VISN Office and various service organization employees and the professional staff.

FACTOR 7, PURPOSE OF CONTACTS

The purpose of these contacts is to interview, counsel and process veterans concerning eligibility to VA benefits.

Other VA offices and organizations act as complimentary services and advisory sources in more difficult cases in obtaining agreeable solution to the parties.

With the incumbent's assistance, the professional staff members can provide medical recommendations that are in keeping with VA laws and regulations to provide continuation of medical care.

FACTOR 8, PHYSICAL DEMANDS

Required to stand or sit for prolonged periods of time, depending on the nature and assignment on a given day. Also required to stoop or kneel to obtain information and records from file cabinets.

FACTOR 9, WORK ENVIRONMENT

Work is performed in a Medical Center responsible for treating patients with a wide variety of medical problems, including psychiatric patients. The clerk is frequently exposed to communicable diseases. Safety precautions are sometimes necessary.

WALK-IN/TELEPHONE TRIAGE NURSE POSITION DESCRIPTION

Purpose: The Walk-In/Telephone Triage Nurse provides triage both physical and telephone assessment of the urgency and severity of patient health problems and makes care recommendations or referrals based on established criteria and guidelines. The nurse works collaboratively with the Triage Clerk in managing the Triage System.

Qualifications:

See qualifications for Nurse II and III grades(MP-5 Part II, Chapter 2, Section C, Change I, Appendix F, 8/15/90. In addition, the following will be expected of the Triage nurse:

A. Three (3) years of recent ICU, Emergency, Medical-Surgical, or Outpatient nursing experience at this Medical Center.

B. Evidence of excellent assessment, judgement, and crisis management skills.

C. Knowledge of VA services, eligibility criteria, and community resources.

D. Current licensure in any state or territory.

Key Job Responsibilities:

A. Elicits health information from patients using interviewing skills, a sound knowledge base, guidelines/criteria, and other resources.

B. Assesses the urgency and severity of the patient's problem and makes appropriate care recommendations to the patient.

C. Collaborates with the patient in prioritizing and planning treatment.

D. Consults with physicians, nurses, other departments, and community resources to meet patient care needs.

E. Provides timely response to patients having potentially emergent or urgent care needs.

F. Uses effective communication skills to establish an optimal patient-provider relationship.

G. Serves as a patient advocate.

H. Provides telephonic health maintenance/disease prevention information to patients through direct education or referral to Medical Center/community resources.

I. Assesses patients' safety needs and communicates relevant information to patients/caregivers.

J. Promotes continuity of care through communication and documentation of patient interactions.

K. Assists with pre-care preparation by ordering diagnostic, laboratory or X-ray tests per criteria/guidelines, or in collaboration with the care provider.

L. Schedules patients for appropriate appointments.

M. Identifies and monitors quality indicators and participates in quality improvement activities.

TRIAGE CONSULTATION FORM

Veteran _____ Age _____ SS# _____ Date _____

Time: ____a ____p Health Care Provider _____

Person providing information _____ Relation to Veteran _____ Phone _____

1. Chief Complaint or Concern _____

Onset _____

2. Nursing Assessment (as per protocol) _____

Health History _____

Medications(not prescribed by VA) _____

Allergies _____

3. Nursing Interventions/Advice _____

Dispositions

_____ 911 _____ Appointment
_____ Advice _____ ER
_____ Referral(s) _____

Instructions Accepted _____ Yes _____ No
Noncompliance warning _____ Yes _____

If s/s increase (or No Improvement) Call Back for : _____

RN Signature _____