ED Telephone Triage: Gridlock or Access

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PROBLEM DESCRIPTION:

Timely and appropriate access to care in the emergency department (ED) setting is a problem which has reached crisis proportions. Overcrowding (too many clients) and overutilization (innapropriate and unnecessary ED visits) impede access to healthcare services, sometimes barring those who genuinely need emergency care. However, little attention has been paid to the fact that many initial attempts at ED access begin with a phone call for advice. Currently, this simple request actually exacerbates the access problem, by encouraging unnecessary ED visits which contribute to overcrowding and inappropriate utilization.

The purpose of this paper is to explore and describe the current role of telephone triage as gatekeeper and its potential to facilitate appropriate ED access while reducing cost. Telephone triage is the assessment, advice, treatment, counseling and crisis intervention for health related problems by telephone. Telephone triage should remain "symptom based" (relating on symptoms presented any the caller) and provides a provisional or "working diagnosis". Although it is practiced in settings such as medical offices and HMOs, no where are standards of practice more critical than in the emergency department. In the ED setting, the call volume may be high (30 - 80 calls per shift) and the acuity may range from low (informational) to high (crisis intervention), challenging the expertise and resourcefulness of the most experienced nurse. At worst, poorly performed telephone triage is costly and can result in injury, death or lawsuits; at best, it save lives and money. Current ED telephone triage practice is ineffective, creating a barrier to healthcare rather than facilitating access.

PROBLEM SIGNIFICANCE:

"Since emergency departments are often the front doors of hospitals, patients enter them in larger numbers on an unscheduled basis with a wide range of problems, from simple to complex. These facilities, designed and staffed to handle true emergencies in relatively small numbers, have great difficulty in adapting to the sheer weight of numbers and variety of demand." (Bryant,1975) This observation, made 16 years ago, seems to have had little impact. If anything, the situation has worsened. The use of emergency departments for primary care is well documented and most agree that the situation has reached crisis proportions (Gallagher& Lynn, 1990., Brunette et al., 1991., Derlet et al., 1990., Pachter et al., 1991). A 1990 study of emergency departments in large cities showed that in the largest cities, utilization increased 104% in the last 10 years. (American Hospital Association). In San Francisco, for example, utilization increased 56.7%. At the same time, increasing numbers of community and rural hospitals closed (Nurseweek, 1991). While the uninsured population grows, emergency departments--even as closures diminish their numbers-- are the place of last resort for the poor and uninsured who call or come in, many acutely ill.

There is considerable disagreement about who or what is responsible for creating gridlock. Gallagher and Lynn (1990) maintain that causes for overcrowding include poverty, psychiatric illness, substance abuse and AIDS epidemics. However, in their study of ED use for minor complaints, Shesser et al (1991) found no major difference in clients from different racial, educational and economic backgrounds. It is clear that ED gridlock threatens the community at large by lengthening EMS

response time, lengthening ED stays from hours to days, and eventually forcing closure of costly emergency departments. Derlet and Nishio (1990) found that 19% of the clients coming to ED were nonemergencies and able to be referred elsewhere (community clinics, county primary care center, off site university clinic and personal physician). These studies indicate that innapropriate ED visits are at the base of gridlock, a problem which can be at least partially remedied by telephone triage.

A review of the literature reveals that few studies have focused on the widespread inadequacy of ED telephone triage practice. It is the author's opinion that quality assurance (QA) is almost non-existent and most systems' and nurses' performances are substandard, failing to provide appropriate access, needed information; thereby fostering system abuse. Few hospitals provide training, staffing, protocols or authorization for telephone triage practice and most ED nurses are unprepared to perform crisis intervention (CPR, first aid) by phone (Wheeler, 1989).

Studies done by Verdile (1989) and Levy et al (1980) graphically illustrate the absence of QA or standards. In Verdile's study, a research assistant posing as a caller contacted 46 emergency departments and presented the following scenario: "her father was having bad indigestion and heartburn" -- symptoms that could reasonably be interpreted as myocardial ischemia. If nurses questioned her further, she described "her father" as a "56-year-old man who smoked cigarettes, did not drink alcohol, and had no previous cardiac history." In response to additional questions regarding the heartburn, the caller described it as "a squeezing sensation, in the chest, associated with nausea and sweating." Verdile's data showed:

1. 9% of the calls were managed by clerks.
2. Three nurses refused to give any advice or information over the phone, stating this was a hospital policy.
3. Four nurses advised the caller to call 911.
4. 56% of the nurses failed to elicit or explore histories of client or chief complaint.
5. 32% instructed callers to give the client antacids, even after eliciting myocardial ischemia symptoms.
6. One nurse advised the caller to give "sublingual nitroglycerin to the patient every five minutes." When the caller asked what nitroglycerin was and how to obtain it, the respondent told the caller to "ask any cardiac patient, they all have nitroglycerin." (Verdile, 1989)

Verdile concluded that ED nurses provided erratic and faulty advice, had poor interviewing skills, failed to use protocols or to collect adequate data and histories, or to document calls. He recommended that emergency departments adopt training programs modeled after the program for emergency medical dispatchers created by Jeff Clawson, MD. (1988). In his study of calls about children, Levy (1980) found that ED staff (1) failed to obtain basic information, and (2) failed to obtain the child's age in 46% of the calls. If these studies represent the current level of practice, it is not surprising that emergency departments are plagued with inappropriate visits.

There is another explanation for inappropriate ED visits. Perhaps the community is seeking access of a different kind -- home treatment advice, information or referral, rather than appointments. In fact, a

1984 study shows that the community has come to expect telephone triage as an expanded role of the emergency department (Knowles & Cummins). According to the authors 48% of the calls concerned minor problems; 44% sought advice; 17% were urgent; and 1% were true emergencies. They concluded that ED medical advice reflects a true community need. On the other hand: call volume increased during periods of high ED activity; staff spent about 90 minutes per day on calls, viewing the calls as an interruption of more important work and providing advice on the basis of informal, on-the-job training and experience only, without the use of protocols. Researchers recommended formal implementation of advice nurses and standardized protocols, and that at least five minutes be devoted to each call.

Two things are clear from the above examples:

1. Clients rely on and expect access to free, professional, instantaneous medical advice by telephone 24 hours a day.

2. Emergency departments have failed to meet this need in an effective and safe way.

Nurses maintain that they are forbidden by hospital administrators to dispense advice (a directive often ignored by nurses themselves). In fact, most are instructed to "have all callers come in" (regardless how minor the problem). However, Kaiser Permanente, one of the the oldest and largest HMOs, has used advice nurses to decrease unnecessary office and ED visits for over 20 years. Kaiser has provided this service with minimal liability, dispelling the myth that it is unsafe to assess and advise clients without first seeing them. If HMO's can perform telephone triage more effectively, then why not emergency departments?

ACCESS THEORY -- TELEPHONE TRIAGE AS GATEKEEPER:

Healthcare access can be improved through creation of more effective gatekeepers. Although everyone agrees that improved access to care is a basic health policy goal, no one seems to agree on how to define and operationalize the concept (Melnyk, 1988). Simply stated, access is "a way in, a means of approaching or entering, or the right or opportunity of reaching or using" and barrier is "something which prevents or controls advance, access or progress." (Oxford, 1980) Barriers may originate from the system or the client (Melnyk, 1988). System barriers include lack of primary provider, lack of transportation or time or expense, lost work, poor provider/client relationship and poor accessibility. Client barriers include culture, language and ethnicity. Taken collectively, these barriers would discourage anyone, but especially the indigent and uninsured.

Perhaps a more appropriate definition might be that "access assumes services are available whenever and wherever the patient needs them and the system point of entry is well defined" (Bodenheimer, 1970; Freeborn and Greenlick, 1973). Although clients seek and expect advice in increasing numbers, information and referral by telephone, most hospitals have failed to provide a formal service. To consumers, telephone triage is an inexpensive, instantly accessible and (hopefully) personable service. Barriers inherent in a visit on site -- (transportation, time and expense) are nonexistent if the problem is minor and treatable by phone. Such problems can be instantly and safely treated with standard advice, information or counseling. Granted, telephone triage cannot overcome cultural, language barriers or lack of phone availability; urgent problems must be assessed and brought in. However, for many callers, what could be more accessible and convenient than telephone advice from a responsive, knowledgeable and well trained nurse?

The access model (Figure 1) depicts health delivery system components (Andersen et al,1970). Telephone triage can enhance services at the level of consumer satisfaction and utilization (see Figure

1, lower boxes). For example, telephone triage influences when, where and how a client is seen (services, site, purpose and time interval) as illustrated below:

SITE AND TYPE OF SERVICE: Telephone triage nurses may direct clients to other sites or services such as physicians' offices, clinics, pharmacists, or community services, support groups, hotlines and/or health informational and referral systems, instead of serving as a dumping ground for every call which comes in.

PURPOSE: Telephone triage has several components (informational, home treatment, crisis intervention and counseling) which are multipurpose (preventive, illness related -- curative or stabilizing). Nurses can provide information, counseling or advice, or refer callers to informational AIDS hotlines or alcoholism support groups -- all low cost, accessible and timely alternatives to ED visits.

TIME INTERVAL: Finally, the telephone's indisputable capacity for immediacy enhances the time interval (how often and how quickly access is made). A six minute phone interaction which saves a trip to the ED in the middle of the night with a sick child is always preferable, if the problem can be safely managed at home.

CONSUMER SATISFACTION: Telephone triage has long been recognized as a public relations tool. In fact, some hospitals still lease and implement expensive "telemarketing" programs for the sole purpose of increasing revenue ! As gatekeeper, telephone triage provides the ultimate in convenience, coordination, courtesy, information and low cost, all of which makes it appealing to consumers.

Are formal telephone triage services costly? Several recent studies show that effective telephone triage pays for itself and actually saves money (Wall Street Journal, 1991., da Silva & Steinberg, 1991., Masunaga, 1991). For example, Henry Ford Health system, a Detroit-based HMO, implemented an advice nurse program. According to the project coordinator, Laura Napiewocki the program sounds like a win, win, win situation. In a recent Wall street Journal article, Ms. Napiewocki stated that, although some callers come in despite advice to the contrary, 53% of the callers followed home treatment advice at home. The program prevented 2,951 unnecessary emergency room and clinic visits. The program saved $48,000, after subtracting orating costs. Physicians concurred with nurses' decisions in 99% of the cases and patient satisfaction exceeded 92%.

An unpublished Kaiser Permanente study (Dhanoa & Masunaga, 1991) substituted a follow up telephone call for an office visit, the goal being to "improve overall access " to urgent care and minor trauma departments. Researchers concluded that telephone management successfully demonstrated a "new patient care delivery system," adding that "telephone follow up appointments performed by nurses can be substituted for office visits." Like the previous study, this program increased cost effectiveness and increased member, physician and nurse satisfaction.

Finally, Harvard Community Health Plan has implemented a pilot telephone triage program (Interpractice) to members. This program utilizes computerized protocols as well as accessing and

storing client records on computer. InterPractice CEO, Albert Martin, MD, believes that by eliminating unnecessary office visits, programs could cut operating costs by as much as 20%.

IMPLICATIONS FOR EMERGENCY DEPARTMENT NURSES:

Both the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) have addressed the problems of telephone advice and ED overcrowding. Both have issued policy statements about telephone advice emphasizing that QA be a primary prerequisite. ACEP recommends "quality of advice be assured though the use of policies, protocols, documentation and quality assurance programs to monitor outcomes?" (1990) ENA proposes "clearly defined protocols with medical direction and specialized education in triage, telephone assessment legal aspects and limits and capabilities of the served." In a joint statement on ED overcrowding, ACEP and ENA proposed a goal of "timely access to necessary emergency and inpatient hospital care" (ACEP,1990) They recommend measures such as "expanding the supply of nurses" and "supporting access to primary care services and encourage initiatives designed to prevent serious illnesses and injuries (1990)". One concrete way to operationalize this concept is to develop, formalize and expand gatekeeper role; hiring a nurse dedicated to the task of telephone triage and creating a program with formal training, protocols and standards.

In "Nursing's Agenda for Health Care Reform", the American Nurses Association (1991) identified major health issues as access, quality and cost. Effective telephone triage promotes these goals. It can serve as an integral component of healthcare, facilitating care in all settings (home health, public health, office, clinic, and emergency department). In short, some primary care services and many healthcare tasks can be performed more quickly and inexpensively by phone than in person.

The time has come for hospital administration to recognize the expanded role of the Emergency departments. Effective telephone triage does make a difference. ED nurses must demand that standards for training, protocols, formalized programs, an adequate staffing be implemented.

Improved telephone triage services accomplishes many of these goals. Within the current crisis are the seeds of opportunity. Diverse forces are synthesizing to produce new technologies, services, and care delivery methods. When effectively practiced and formally implemented, telephone triage has unlimited potential as a gatekeeper which enhances rather than impedes access to healthcare services.

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