Delivering “the right care at the right time”: Triage and Utilization in PACE

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Learning objectives

• Describe common triage issues
• Identify how triage impacts utilization in PACE
• Find one improvement goal to take home
Triage, a system

1. Resuscitation
2. Emergent
3. Urgent
4. Less Urgent
5. Non Urgent

Administrative Staff:
- Does caller report new fever, cough, body aches, and/or sore throat?
  - Yes: Refer caller to Clinical Staff
  - No: Follow office protocol

Life-threatening OR urgent health condition?
- Yes: Call 911/Go to ED now
- No: Flu-like symptoms??
  - No
  - Yes: High-risk patient** or patient with severe or progressive illness?
    - Yes: Antiviral treatment may be considered on the basis of clinical judgment for previously healthy, symptomatic outpatients.
    - No: Treatment should ideally be initiated within 48 hours of illness. One randomized placebo-controlled study suggested that treatment initiated 72 hours after illness onset among febrile children with uncomplicated influenza reduced symptoms by a day.

*Flu-like symptoms typically include:
- A 100°F or higher fever or feeling feverish/chills
- AND one or more:
  - Cough
  - Sore throat
  - Headaches and/or body aches
  - Difficulty breathing or shortness of breath
  - Fatigue
  - A runny or stuffy nose

Reminder: While there is an ongoing outbreak of Ebola in West Africa, ask caller about recent travel or residence in affected countries or contact with someone with Ebola Virus Disease within the last 21 days. For more information, see: http://www.cdc.gov/vhf/ebola/healthcare-providers/outpatient-settings/index.html.
“Triage” - non-PACE

• “Triage” in non-PACE settings
  ➔ Acute change in medical status
  ➔ Protocol-based delivery of care
  ➔ Goals to deliver quality care in briefest period of time
  ➔ Relies on quick assessment, stabilization, and transfer to a hospital
“Triage” in PACE

• PACE “Triage”
  ➔ Acute change in participant that destabilizes the function of the care plan
  ➔ Individual goals rather than protocol-based algorithms guide decision-making
  ➔ May or may not utilize ER or hospital
  ➔ Goal to deliver quality care as quickly as possible in way that meets the participant’s goals
Example of Triage in PACE

• Home care worker reports participant w/ dementia is weak -> same-day assessment by IDT:
  ➔ SW -> uncovers family is out of town
  ➔ RN -> bruising on skin (?falls)
  ➔ PT -> finds increasing knee pain
  ➔ MD -> UA + for UTI

• Plan: transfer prt to RCFE, start treatment for UTI, schedule family meeting to discuss supervision
Triage in PACE breaks down if

- Fragmentation of team work
  - “SW issue, PT issue or MD issue”, rather than team issue
- High-utilizer burnout
  - Team fatigue of triaging issues for same patient
- Lack of team-focused discussion
  - No organized retrospective review of triage success and failure
Triage metrics

How do you know if triage processes are effectively working on your PACE team?

• Utilization of ER / hospital services
• Strength of IDT communication after urgent / emergent events
• Use of participant care goals, and advance care planning to guide decisions

Every PACE team has different approach to triage
Our utilization history...in short

• IOA had 2 centers, historically one that had higher utilization, different population
• Centers came together in 2013...and began engaging in utilization (Basic ER Form, Data presentation, etc)
• Saw rise in utilization in late 2015, early 2016 with growth
• Need for smaller teams and re-engaging in utilization, team triage focus in May 2016
IOA ER Utilization

ER Visits per 1000/per year
Per Quarter, 2011-Current

Q1 2011, Q2 2011, Q3 2011, Q4 2011, Q1 2012, Q2 2012, Q3 2012, Q4 2012, Q1 2013, Q2 2013, Q3 2013, Q4 2013, Q1 2014, Q2 2014, Q3 2014, Q4 2014, Q1 2015, Q2 2015, Q3 2015, Q4 2015, Q1 2016, Q2 2016, Q3 2016

Legend:
- Per 1000/yr
- Linear (Per 1000/yr)
Re-engaging around utilization

• Share utilization philosophy and values
  ➔ We believe we know our clients best and that their best care comes from us and from feeling at home
  ➔ We believe no one really enjoys ER or hospitals
  ➔ We believe acute utilization events are major life events and can go in directions that don’t fit with client wishes
  ➔ We believe acute utilization that aligns with a good, thoughtful care plan and client’s wishes is important and required
Utilization Management Philosophy

• We look to data and outcomes, not “our gut feeling” or gross generalization to understand utilization. Feeling like you are “in trouble” does not help.
• Creative & thoughtful consideration and conversations helps. Got to think & talk about it.
• Utilization Management is a team sport.
• You can’t do it all at once. Focusing on a small group with high utilization or a pattern of types of utilization is better approach.
• Triage equals team support.
• Share and examine utilization trends. Data must guide the way. Our best guess is often wrong
   ➔ “It’s all these new clients”
   ➔ “It’s all these behavioral folks”

• Study team conversation / ER forms
   ➔ What is being talked about?
   ➔ What isn’t? Is it “just a form”
Improving Triage at IOA

- Start team to study triage at system level – “Complex care team”
- Review ER form data
- Identify patterns in service delivery
- Study data
- Develop utilization form to track IDT discussion
- IDT debrief of utilization event w/ new ER form
Planning – our data / center

• Team-based post-ER discussion
  ➔ Process – many iterations

• Goal of form: increase data surrounding sudden change in condition
  ➔ How was the prt seen / viewed leading into utilization event?
  ➔ What were gaps in communication or service delivery?
Do – our ER form

• Collecting data
  ➔ Team lead -> complete form with IDT after utilization event (within week)
  ➔ 90% completion rate for first 6 months

• System issues
  ➔ Became more about filling out the form than having a discussion
  ➔ Decline from 90% -> 67% completion rate
After a sudden change in condition, PACE IDT sees opportunity to treat in primary care

Source comparison: Truven Health Analytics Study – 2013 (www.truvenhealth.com)
Study – experience

• Primary care directed solutions proposed by IDT
  → Dementia education for families
  → Advance care planning updates
  → Behavioral health plans at RCFE
  → Increase surveillance of chronic conditions
  → Improved access, earlier contact w/ team

• Uncovered need to share solutions / struggles across system
“Complex Care Team”

- System level team to study all utilization patterns and triage process across 3 teams
- Team leads, Clinic staff, Managers, QI

Mission - to support care plans, improve service delivery, and engage management level review of difficult cases / triage

Case-based review of 2 utilization events with lens to improve service delivery and share solutions w/ across teams
Discussion

• What do triage systems look like in your PACE center?
• What do you wish you could improve in your system?
• How are utilization events discussed by your team or in your center?