



## Central Triage Introduction

The development of central triage (CT) represents an evolutionary move forward from previous systems of referral. CT creates a standardized referral process, creates a single point of entry to reduce the variation and allows a more equitable distribution of workloads over all the receiving units (load-leveling). At the same time, however, CT has formalized priority systems that will not work and has made measurement of the basic dynamic of matching demand to supply much more difficult.

I recognize the previous approach to referrals, based on popularity, customization and luck, failed to meet the needs of either primary care referring physicians, or, more importantly, patients. That old process simply had to change. I also understand that the change was not going to occur in the periphery and had to be done centrally at a higher oversight level. There has been a great deal of effort and personal investment devoted to this change. I suspect that what occurred was that the “goal” became the strategy, that is, the goal was to institute the change. In that view, then, the “goal” has been accomplished and there may be little incentive to re-think the change.

The goal for patients, though, is to be able to move through a system of care, a series of steps, with knowledge, without any unnecessary delay, and with optimum clinical and operational safety (less errors and mistakes in the process). CT does move us in this direction. In my perspective, then, the goal is to match the customer demand with the system capacity at each step along this process. CT is a strategy, not a goal, tested and implemented in order to achieve this goal of flow.

Due to the confusion of goal and strategy, the implementation of CT has had some unintended consequences. How do we know, for example, that this strategy has resulted in improvement? Has CT improved the flow of patients, has it improved system performance?

CT has achieved its own internal function goals - all patients are referred to a central area, more patients are appointed, and workloads are leveled. But this is similar to a self-fulfilling prophecy. CT may have actually guided and helped move patients from primary care to specialty care without delay and with greater clinical and operational safety, but we don't **know** that. The current process makes it extremely difficult to measure basic system performance metrics that would confirm if indeed patients are moving from one step to another with greater efficiency, without unnecessary delay, and with optimum safety. The basic measures we need are measures of delay, of demand, of capacity, of activity and of caseload. CT is a conduit, a mechanism and an enabler.

There has been reluctance on the part of CT to participate in any assessment of system performance. Attempts to work with CT around data have been met with “this is working” and “measuring is not our job” or “measuring is too difficult.” I am concerned. I see that the receiving



groups are hiding their supply (their capacity) in an attempt to protect themselves. I am concerned we are entering a cycle of antagonism and poor behaviors. I have seen this before.

There is a huge opportunity here to avoid this antagonism and self protectionism. It really is not a primary care, a specialty care or a CT staff issue, but an oversight leadership issue. I believe it is key to see CT as an enabler, a strategy, organized to achieve a greater patient-centered aim and that as such, the measures for system performance improvement within that perspective are critical to gauge success. Right now, despite the huge improvements we suspect have been accomplished with this change, we simply do not know for sure. This is basic: how can we tell that a change has resulted in improvement? We measure. We want to measure system performance from the customer perspective, not measure success as "we implemented, therefore we are successful."