The triage process in rehabilitation centers

Sobre o processo de triagem em centros de reabilitação

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ABSTRACT

The triage process in rehabilitation centers consists of an evaluation of the conditions of a patient who might use the services of these units in the health system. In general it takes place at first contact with the clinical team. By schedule a patient is interviewed by a doctor, a social worker, and a psychologist at the same time whereby they verify the clinical conditions, relationship dynamics and psychopathological aspects, as well as the social requirements for regular supervised participation in the prescribed activities. The object of the triage process is not to obstruct access of anyone to the services available, but to guide the potential user either to the easiest form of treatment or to that most appropriate to his needs. At the end of the triage process the patient may be chosen for multi-professional intervention several days a week or other alternative interventions, either therapeutic or guiding, with the recruitment of any number of professionals or weekly contacts. Considering the reality of rehabilitation in Brazil, which does not include internment, one can expect full service of the rehabilitation program only under optimal conditions. Resources for rehabilitation are limited, therefore its optimization is necessary, and the triage process enables the best use of these resources with a fair and ethical distribution.

Keywords: Rehabilitation Centers, Health Administration, Triage, Disabled Persons/rehabilitation

RESUMO

O processo de triagem em centros de reabilitação consiste numa avaliação das condições do paciente potencial usuário dos serviços prestados nessas unidades do sistema de saúde. Em geral ela ocorre no primeiro contato com a equipe clínica. Por meio de agendamento, o paciente é submetido a entrevista com um médico, um assistente social e um psicólogo num só momento, onde são verificadas as condições clínicas, aspectos de dinâmica de relacionamento e psicopatológicos, bem como requisitos sociais para participação regular e supervisionada nas atividades propostas. O objetivo do processo de triagem não é obstruir o acesso de qualquer pessoa aos serviços disponíveis, mas sim direcionar o potencial usuário para a forma mais ágil de atendimento ou mais apropriada às suas necessidades. Ao final do processo de triagem o paciente pode ser eleito para intervenção multiprofissional em vários dias da semana, outras alternativas de intervenção, seja terapêuticas ou de orientação, com recrutamento de número diferente de profissionais ou contatos semanais. Considerando a realidade de reabilitação no Brasil, que não contempla a internação, pode-se esperar um aproveitamento integral do programa de reabilitação somente em condições otimizadas. Os recursos para reabilitação não são ilimitados, assim, a sua otimização é necessária e o processo de triagem viabiliza o melhor aproveitamento desses recursos, e uma distribuição mais justa e ética dos mesmos.

Palavras-chave: *Centros de Reabilitação, Administração em Saúde, Triagem, Pessoas com Deficiência/reabilitação*

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What is the triage process

The triage process described here corresponds to the practice developed and improved at *IMREA - Instituto de Medicina de Física e Reabilitação HC FMUSP* (Physical Medicine and Rehabilitation Institute HC – FMUSP) over the last 33 years. Triage is understood as the process of evaluating patients in relation to clinical, social, and affection pre-requisites, which make their participation viable in the therapeutic program. In general, triage is the first physical contact between the client and the health service and includes initial evaluation, selection, and forwarding of clients to the units or specialties appropriated to their assistance.[1]

As a routine, the triage process in our service presupposes three interviews: with the medical, social, and psychological services.

The medical interview concentrates its attention on defining the debilitating syndrome that the patient presents and the stability of his/her clinical symptoms, especially in relation to the corporeal systems that may interfere more clearly with the rehabilitation program, such as convulsions, diabetes, or cardiovascular and respiratory diseases. Another decisive aspect related to the medical intervention at that moment is the verification of any previous interventions for rehabilitation before this moment of triage. This investigation must observe the duration and suitability of the rehabilitation process already done, its reach and the areas not included. From this aspect it is convenient to specifically investigate the interventions that are necessary and were not done, for it is common that patients report having already done physiotherapy, but at a very poor weekly frequency, for short periods, or with insufficient or inadequate techniques. It is also necessary to verify whether the multidisciplinary aspects were approached, for patients are not uncommonly submitted only to physiotherapeutic intervention, and important aspects such as daily life activities, and emotional or communication issues were not discussed, characterizing the previous process as incomplete. For those patients who have already been submitted to complete rehabilitation programs, this moment can identify new demands that were not targeted in the previous treatment or that happened after their clean bill of health, such as spasticity control, the need for a new orthosis, or the replacement of components of auxiliary technology that are in bad condition, justifying a new cycle of rehabilitation.

The psychology service in the triage process is initiated by questioning the patient on his/her expectations for the rehabilitation process, characterizing them from the patient and his family's discourse to make them clear for the team in precise and technical terms. At this stage it is necessary to confirm to what point the expectation of the patient is realistic and in harmony with his/her clinical outlook. Identifying expectations that are not coherent with the patient's real possibilities or with the objectives of the service permits re-directing the patient in cognitive terms and initiating the definition of the therapeutic process defining possible objectives and reducing the frustration with the therapeutic program. Thus, the orientation given to the patient and his family at the moment of triage by any one of the participating professionals also has the therapeutic effect of bringing these new characters to a clearer understanding of the interventions and possible results.

It is still part of the psychological evaluation to check for signs and symptoms of psychiatric afflictions or emotional suffering. On the other hand, a brief evaluation of cognitive functions allows one to evaluate gross deficiencies that may interfere with the results of the rehabilitation program, such as memory or attention deficits These evaluations allow one to identify the need for specialized medical evaluations – psychological or neurological – to elucidate the diagnosis and therapeutic orientation. Finally, behavioral aspects that interfere with the treatment are evaluated. In relation to this, attention directed towards aggressiveness, lack of sexual inhibition, use of illicit drugs, or even previous involvement in illegal situations allows the identification of sources of possible problems of the patient with the therapeutic or administrative teams of the service.[2]

A third evaluation to which the patient is submitted is done by the social service worker. Its focus is directed towards the initial characterization of the support network available to the patient, the people who can accompany him/her in the treatment and in getting to the rehabilitation center. Rehabilitation in the clinic occurs at a frequency of 2 to 4 weekly sessions, which can be augmented with the training of their companions so that there can be continuity and repetition of training at home. The availability of transport resources to the rehabilitation center is also characterized, whether by the patient's own means, loans, or public transportation.

At this moment, patients or their companions can be oriented in obtaining free public transport, access to adapted transport or to other social benefits. After discussing the cases with the triage team, the social worker is also in charge of communicating their decision to the patient, explaining the rules of the service, and the steps to follow to make appointments for consultation or to search for other services.

The discussion of cases occurs in the presence of all the professionals involved. This is the moment to examine the information obtained by interviews and exams. Through this practice it is possible that aspects that were missed by one professional, because they were not pertinent to his/her scope of investigation, will be exposed to and pondered by the others as to their impact on the therapeutic process. The decisions by the triage team can be:

Eligible for treatment: this means that the patient and his family have appropriate expectations about the rehabilitation process, have no social or cognitive-emotional aspects that will impede his/her adhesion to the treatment, have a prognosis of functional gain, and are clinically stable.

Experimentally eligible for treatment: this corresponds to that patient which, despite having shown aspects that could be a barrier to the results and/or his/her adhesion to the program, the triage team still feels that, with specific interventions, he/she will be benefitted.

Then, in this case, for those patients with a history, for example, of alcoholism or active psychopathology, which are factors for ineligibility, but who are under specialized treatment, it is believed that these factors will not impede the behavioral adaptation or acceptance of the therapeutic orientations. In this category can also be those patients who, despite having completed rehabilitation program(s) in other rehabilitation centers, and who therefore have no recommendation to repeat it, can be admitted to the rehabilitation center for spasticity control, pain, or adaptation to a new orthosis, prosthesis, or auxiliary locomotion, or wheelchair. Finally, factors related to aging and the appearance of new demands can be addressed, as is the case with handicapped children who have already gotten a clean bill of health, but who need new monitoring for guidance in specific questions of growth or adolescence. In these last three examples, the patient is eligible for specific interventions, which are much more limited than a multi-professional and inter-disciplinary rehabilitation program.

Ineligible at the moment: it refers to patients who, due to the existence of any ineligibility factor cannot be included in the rehabilitation program or even in the physiatric monitoring; however, with the adaptation to these factors these conditions can be changed in the near future. In this category are those patients who present, for example, clinical instability or co-morbidities improperly diagnosed or controlled, but that after a specific medical consultation may come to be moni-

tored by the rehabilitation center. There were also cases in which the patients did not have means of transport to the rehabilitation center available to them at that moment, but through the cooperation of family and friends they may be available in the medium term, making the treatment viable.

Ineligible: this is the patient who does not have a rehabilitation prognosis because he/she has already completed the program on another occasion or in another service. The family has already been appropriately trained, but may have expectations (and the patient also) of additional gains with the carrying out of more interventions already performed. It can also be a patient whose clinical, social, or psychological conditions definitely do not allow his/her participation in the rehabilitation program or even in orientation activities or in specific therapeutic interventions. It may be necessary to forward him/her to a more suitable social, medical or rehabilitation resource. In these cases the triage process must end with a careful process of explaining about the impossibility of continuing the monitoring of the patient in this rehabilitation service.

The experience of our service is that up to 25 patients can go through triage in a period of the day, morning or afternoon, with a team composed of a physician, two psychologists, and two functional assistants. The patients are divided into two groups; in the first, all the patients are scheduled for the same time at the beginning of the period. After all these patients have been evaluated by the three professionals, the cases are discussed, with the presentation of the aspects decisive to defining the conclusion of the triage process, and preserving the aspects relative to professional confidentiality. The other patient group to be triaged is scheduled for the second half of the period, which allows the first group to be evaluated, discussed and to receive their decisions about whether or not they are eligible for the treatment, all this with a maximum wait of 2 hours, and the same with the second group.

Justifications for triage

One of the major problems in the administration of health services is, on the one hand, how to deal with the clients' absences to scheduled appointments, and on the other hand, how to organize the overload of services with unscheduled walk-ins, such as intercurrences and requests for extra care or care outside regular hours. Resources are not unlimited, therefore the best use of them is fundamental to a suitable balance between investment and social return, as well as to guarantee a fairer use of these resources.[3]

The reason for doing triage in rehabilitation services is to guarantee a better use of the therapeutic resource by the patient,[4] therefore, it leads to the first problem mentioned in the paragraph above. The expression "therapeutic resource" refers to all the equipment and service hours available to the handicapped patient at the rehabilitation center. From the administrative point of view, it is logical to understand that the most efficient use of these resources is that which optimizes them, guaranteeing that there are no time slots unused. The logic behind this thought is that the scheduled appointment or the use of equipment does not mean only the need for organization from the therapists, but also from the team supporting the care, such as administrative personnel, cleaning, and reception, among others.[5]

However, reducing absences does not only seek to reduce the waste of resources or optimize the use of equipment and time slots from the therapeutic team. It is also fundamental to understand that, from the point of view of social justice, the non-use of a public resource means the denial of care to needy people who are waiting in line. Thus, even though an isolated absence in the therapeutic program may seem to have no importance, the sum of those absences in the analysis of all the clients of the service could mean the exclusion of a significant number of people who would have been benefitted.

Figure 1 presents the results of the triage process, month by month at the *Unidade Clínicas do IMREA - Instituto de Medicina Física e Reabilitação do Hospital das Clínicas da Faculdade de Medicina da USP* (Clinics Unit from IMREA – Physical Medicine and Rehabilitation from the Clinics Hospital at the School of Medicine of University of São Paulo– USP) in the year 2009. There were 945 patients evaluated in triage during that year, with 837 (88.6%) considered *eligible*, and 108 considered *ineligible:* the *ineligible at the moment* (45) added to those *definitely not eligible* (63). For comparison at the Vila Mariana Unit of the IMREA, during the same year 184 patients were evaluated in triage, of those 169 (91.8%) were considered eligible and only 15 were classified as *ineligible*. Both results indicate a small percentage of patients who did not satisfy the criteria of eligibility for these services, indicating that the referrals by health professionals from other services and the spontaneous walk-ins from the patients has met the helpful objectives of the service. This data also indicates that the triage is not a cruel system of excluding patients, since the vast majority of them are included for care in the services available.

DISCUSSION

In major rehabilitation centers it is common to have specialized therapeutic groups, that is, patients receive care from teams with differentiated training for neurological, musculoskeletal afflictions, pain, amputees, etc. In this context, a patient who is sent equivocally

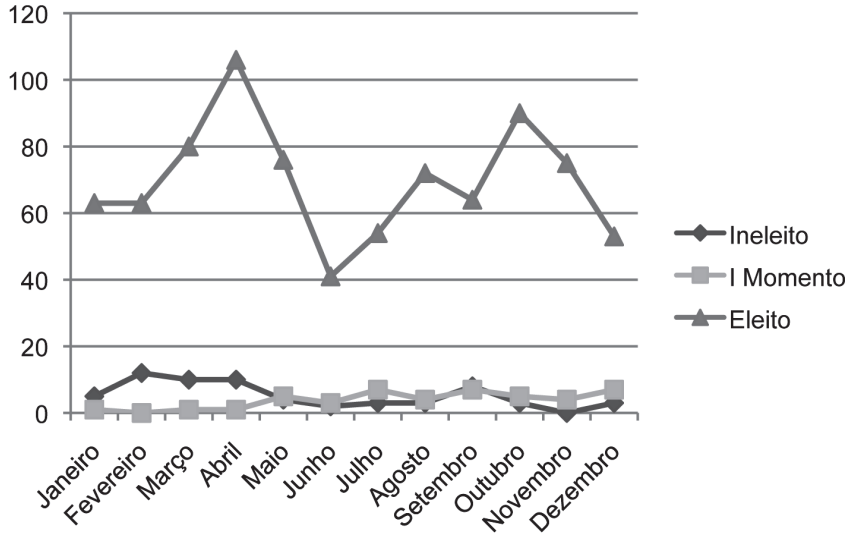

Figure 1 - Triage results at the Clinics Unit of the Physical Medicine and Rehabilitation Institute of the Clinics Hospital at the University of São Paulo School of Medicine in the year 2009.

to a team that does not correspond to his/her problem represents discomfort and a waste of time for the patient and for the evaluating physician. It is not uncommon for patients to be referred and not be able to describe their deficiencies at the scheduling of an appointment or to carry medical referrals with them that explain very little. In these situations the triage team can define precisely which group the patient should be sent to.

The triage in rehabilitation services does not seek to deny care to people, but to identify which type of care is most appropriate for the condition of the patient. Those who are admitted in the rehabilitation center, that is, classified as *eligible* or *eligible experimentally*, are necessarily sent to a medical consultation for initial evaluation with a trained specialist and, eventually, sub-specialized in the problems the patient presents.

The *rehabilitation program* is the set of integrated rehabilitation actions promoted by professionals with varied qualifications, with objectives shared and defined by the institutional work philosophy. We understand that this program is only effective if it occurs at a frequency of at least twice a week and if there is continuity at other moments of the week, such as, in repetitions at home. Thus, a condition necessary to guarantee this continuity is the presence of a companion during the therapeutic interventions that can repeat them later. A substantial part of the therapist's task therefore consists of training the care-giver/companion and verifying the difficulties that can impede the performance of this role.

At times the patient cannot have any more permission to participate in the multidisciplinary rehabilitation program of the rehabilitation center for the motives mentioned above. However, it may be necessary to adapt the treatment for spasticity, pain, depression, or convulsions. Alternatively, the wearing out of orthoses, prostheses, and wheel-chair components can occur. In children's groups the arrival of adolescence can bring new demands, associated with corporeal dimension changes, sexuality, and social roles expected.

As it was pointed out before, the patient can be eligible experimentally because, despite having good potential to achieve the functional objectives, he/she does not have means of transport or companions to come to the rehabilitation center at the right times or expected frequency. In these situations the patient may be directed to orientation groups after initial medical evaluation.

The *orientation groups* are attendance sessions carried out by a multiprofessional team, for groups of 4 to 8 patients with a determined debilitating syndrome, coordinated to repeat each month or every two months, whose main objective is the supply of instructions to the patients and care-givers about strategies that can be used in routine environments to deal with the limitations imposed by deficiency, as well as the training of interventions that could be done in therapy, but which must be followed at home because of the inability of the patient to attend the therapeutic program.

The efficiency of a triage team can be measured by the number of patients or care-givers and responsible people evaluated. This number reflects the capacity of initial care to the local and referred demand. Nevertheless, a better measure of the results of this routine is the number of patients who remained in treatment until the end of the program. This number indicates that the patients who could not stay with the rehabilitation program, whether due to badly controlled clinical problems, limitations in interpersonal relationships, or due to social determiners were identified early and directed to the care that best suited them, whether the lighter, more specific, or with a smaller team, reserving the more complex interventions for those with greater adherence.

CONCLUSION

The triage process is an efficient way to improve the viability of the fair distribution of resources, based on the particular conditions of each patient, for it identifies the most appropriate mechanism so that each potential client of the service can be considered. The triage care must be transdisciplinary and presupposes a discussion of each case for the decision-making process by a seasoned team. The efficiency of the triage process is defined by the number of people who, after being included in the transdisciplinary rehabilitation program, do not abandon it for identifiable motives in this initial period. Triage becomes necessary for a better utilization of rehabilitation resources, since they are not unlimited and, clinical rehabilitation – as it is performed in Brazil – depends on a series of favorable conditions.

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