Mobile Integrated Healthcare Program – 911 Nurse Triage

Measurement Strategy Overview

Aim

A clearly articulated goal statement that describes how much improvement by when and links all the specific outcome measures; what are we trying to accomplish?

Develop a uniform set of measures which leads to the optimum sustainability and utilization of patient centered, mobile resources in the out-of hospital environment and achieves the Triple Aim® — improve the quality and experience of care; improve the health of populations; and reduce per capita cost.

Measures Definition:

1. **Core Measures {In-Brackets}**
    a. Measures that are considered ***essential*** for program integrity, patient safety and outcome demonstration.

2. **CMMI Big Three Measures (RED)**
    a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMMI) as the four primary outcome measures for healthcare utilization.

3. **MIH Big Four Measures (ORANGE)**
    a. Measures that are considered ***mandatory*** to be reported in order to classify the program as a bona-fide 911 Nurse Triage program.

4. **Top 10 Measures (highlighted)**
    a. The 10 measures identified by **operating 911 Nurse Triage** programs as essential, collectable and highest priority to healthcare partners.

Notes:

1. All financial calculations are based on the ***national average Medicare payment*** for the intervention described. Providers are encouraged to also determine the ***regional average Medicare payment*** for the interventions described.
2. Value may also be determined by local stakeholders in different ways such as reduced opportunity cost, enhanced availability of resources. Program sponsors should develop local measures to demonstrate this value as well.

Table of Contents

Measure Categories

Structure: Describes the acquisition of physical materials and development of system infrastructures needed to execute the service (Rand). For example:

- Community Health Needs Assessment
- Community Resource Capacity Assessment
- Executive Sponsorship, Strategic Plan & Program Launch Milestones
- Organizational Readiness Assessment – Health Information Technology Systems
- Organizational Readiness Assessment – Medical Oversight
- Plan for Integration with Healthcare, Social Services and Public Safety Systems

Outcomes: Describes how the system impacts the values of patients, their health and wellbeing (IHI). For example:

Quality of Care & Patient Safety Metrics

- 9-1-1 EMD Protocol Compliance
- Call Processing Safety
- Nurse Algorithm Compliance
- Locus of Care Compliance
- Patient Follow-up

Utilization Metrics

- Ambulance Transports
- Emergency Department Visits
- Alternative Treatment Settings

Cost of Care Metrics

- Expenditure Savings

Experience of Care Metrics

- Patient Satisfaction

Balancing: Describes how changes designed to improve one part of the system are impacting other parts of the system, such as, impacts on other stakeholders such as payers, employees, or community partners (IHI). For example:

- Partner (healthcare, behavior health, public safety, community) satisfaction
- Practitioner (Triage Nurse) satisfaction
- Public and stakeholder engagement
- PCP and other healthcare utilization

Process: Describes the status of fundamental activities associated with the service; describes how the components in the system are performing; describes progress towards improvement goals (Rand/IHI). For example:

- Clinical & Operational Metrics
- Referral & Enrollment Metrics
- Volume of Contacts, Visits, Transports, Readmissions

Definitions: Throughout the document, hyperlinks for certain defined terms are included.

Structure/Program Design Measures – Nurse Triage

Describes the development of system infrastructures and the acquisition of physical materials necessary to successfully execute the program

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Executive Sponsorship	**S1:** Program has Executive Level commitment and the program manager reports directly to the Executive leadership of the organization. ***{CORE MEASURE}***	The Nurse Triage program plan clearly identifies organizational executive level commitment for the human, financial, capital and equipment necessary to develop, implement, and manage the Nurse Triage program both clinically and administratively.	0. There is no evidence of organizational executive level commitment 1. There is some evidence of limited commitment for the program. 2. There is evidence of full commitment for the program.	Documents submitted by agency demonstrating this commitment such as approved budgets, organizational chart and job descriptions
Strategic Plan	**S2:** The program has an Executive Level approved strategic plan. ***{CORE MEASURE}***	The strategic plan should be based on the knowledge of improvement science and rapid cycle testing, and include the key components of a Driver Diagram, specific measurement strategies, implementation milestones and a Financial Sustainability Plan and the plan is updated periodically.	0. No evidence of a strategic plan. 1. A written strategic plan, but it lacks key components. 2. A written strategic plan that includes all key components.	Institute for Healthcare Improvement

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Community Resource Capacity Assessment	**S3:** Program is designed to address gaps in resource capacity.	The Nurse Triage program has completed a comprehensive inventory that identifies the availability and distribution of current capabilities and resources from a variety of partners and organizations throughout the community.	0. There is no community-wide resource assessment. 1. A resource assessment has been completed that documents the resources available to help meet the clinical needs of patients that may be enrolled in the Nurse Triage program. 2. A community-wide resource assessment has been completed that documents the resources available in the local community to help meet the clinical, behavioral and social needs of patients that may be enrolled in the Nurse Triage program.	Adapted from HRSA Community Paramedic Evaluation Tool
Integration/Program Integrity	**S4:** Program integrates with external regional healthcare system stakeholders	There has been an initial assessment (and periodic reassessment) of overall program effectiveness completed by an external agency (i.e.: CMS Quality Improvement Network or external stakeholder group comprised of healthcare, payer, social service and patient representatives).	0. No external examination of the Nurse Triage program overall or individual components has occurred. 1. An outside group of stakeholders has conducted a formal assessment and has made specific recommendations to the program. 2. Independent external reassessment occurs regularly, at least every two years.	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Organizational Readiness Assessment – Medical Oversight	**S5:** Organization is committed to strong medical oversight, effective clinical quality improvement, comprehensive education and continuing education program.	The Nurse Triage program medical director has the authority to adopt protocols, implement a performance improvement system, ensure appropriate practice of Nurse Triage providers, and generally ensure medical appropriateness of the program based on regulatory agency scope of practice and accepted standards of Nurse Triage care.	0. There is no Nurse Triage program medical director. 1. There is a Nurse Triage program medical director with a written job description; however, the individual has no specific authority or time allocated for those tasks. 2. There is a Nurse Triage program medical director with a written job description. The community program medical director has adopted protocols, implemented a performance improvement program, and is generally taking steps to improve the medical appropriateness of the community paramedicine program.	Adapted from HRSA Community Paramedic Evaluation Tool NAEMSP Position Paper on MIH/CP program development
Organizational Readiness Assessment - Health Information Technology (HIT)	**S6:** Organization has the ability to collect data electronically.	The Nurse Triage program collects and uses patient data as well as provider data to assess system performance and to improve quality of care.	0. Patient care data are not collected electronically by the program. 1. Patient care data are collected electronically but are not used to assess system performance or quality of care. 2. Patient care data are collected electronically and are used to assess both system performance and to improve quality of care across the program.	

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
HIT Integration with Local/Regional Healthcare System	**S7:** Organization has health information exchange technology systems infrastructure in place to protect the exchange of Protected Health Information.	The Nurse Triage HIT system is integrated with the local healthcare providers to facilitate access to patient records by healthcare system participants.	0. There is no database that captures patient/client contacts. 1. There is a simple log (electronic or paper based) that identifies demographic information about the patient/client contact, e.g. patient and provider identifier, date, time, etc. 2. There is an electronic medical record documentation of each patient/client contact that can be accessed by primary care physicians, case managers and/or payers.	
Public & Stakeholder Engagement	**S8:** Care Coordination Advisory Committee	Nurse Triage program, in concert with a multidisciplinary, multi-agency advisory committee meets regularly and advises the program on strategies for improving care coordination.	0. There is no care coordination advisory committee. 1. There is an established care coordination advisory committee, but it is missing key stakeholders. 2. There is an established care coordination advisory committee and all key stakeholders are represented.	

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Specialized Training & Education	**S9: Specialized initial and continuing education for RNs**	A formal program for telephone triage nursing initial training and Continuing Education is in place that is approved by the local medical control authority.	0. Not known 1. There is no specialized education offered. 2. There is specialized education offered, but it lacks key elements of instruction. 3. There is specialized education offered meeting or exceeding a nationally recognized or state approved curriculum.	IAED/AAACN or equivalent
Compliance with State and Federal Regulations	**S10:** Compliance Plan ***{CORE MEASURE}***	The Nurse Triage program has a plan in place which assures compliance with all applicable laws and regulations and which prevents waste, fraud, abuse.	0. No evidence of a compliance plan. 1. A written compliance plan, but it lacks key components. 2. A written compliance plan that includes all key components.	Centers for Medicare and Medicaid Services

Outcome Measures for Telephonic Nurse Triage Intervention

Describes how the system impacts the values of patients, their health and well-being

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Quality of Care & Patient Safety Metrics	**Q1:** 9-1-1 EMD Protocol Compliance – Over Triage ***{CORE MEASURE}***	Minimize number of calls that are inappropriately referred to the triage nurse.	Number of calls referred to triage nurse that the EMD program did not identify were nurse eligible.	Total number of calls referred to the triage nurse.	Value 1/Value 2.	
	Q2: 9-1-1 EMD Protocol Compliance – Under Triage ***{CORE MEASURE}***	Minimize number of calls that are not appropriately referred to the triage nurse.	Number of calls not referred to triage nurse that the EMD program identified were nurse eligible.	Total number of calls that the EMD program identified as nurse eligible.	Value 1/Value 2.	
	Q3: Call Processing Safety ***{CORE MEASURE}***	Reduce the number of calls dropped during hand-off to the triage nurse.	Number of calls dropped during transfer to the triage nurse.	Total number of calls referred to the triage nurse.	Value 1/Value 2.	
	Q4: Cold Call Transfers	Reduce the number of calls transferred to the triage nurse without warm introductory handoff.	Number of calls transferred to the triage nurse that did not have an introductory handoff.	Total number of calls referred to the triage nurse.	Value 1/Value 2.	
	Q5: Triage Nurse Algorithm Compliance	Reduce variation in use of algorithm and decision support tools.	Number of calls referred to triage nurse with an identified nurse triage algorithm deviation.	Total number of calls referred to the triage nurse.	Value 1/Value 2.	

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	Q6: Ambulance Kick-Backs	Reduce delay in appropriate emergency ambulance response.	Number of calls referred to the triage nurse that are referred back for an emergency ambulance response.	Total number of calls referred to the triage nurse.	Value 1/Value 2.	
	Q7: Recommended triage disposition compliance	Reduce under or over-triage by the Nurse over what was recommended by the approved Decision Support Tool.	Number of calls referred to the triage nurse that had a final disposition that is different than the disposition recommended by the approved Decision Support Tool.	Total number of calls referred to the triage nurse.	Value 1/Value 2.	
	Q8: Acute Care Use	Minimize occurrence of secondary 9-1-1 calls that result in an acute care referral for a medical symptom related to the symptoms initially handled by the triage nurse.	Number of calls with an alternate disposition in which an emergency ambulance response was generated within 24 {Footnote NQF} hours for a medical need related to the one referred to the triage nurse.	Total number of calls with an alternate disposition.	Value 1/Value 2.	

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	Q9: Adverse Outcome ***{CORE MEASURE}***	Minimize occurrence of adverse outcomes.	Number of calls with an alternate disposition in which the *Enrolled Patient* had an unexpected death, or had an Intensive care hospital admission within 24 hours for a medical condition related to the one referred to the triage nurse.	Total number of calls with an alternate disposition.	Value 1/Value 2.	
	Q10: Abandoned Calls	Reduce the number of calls dropped during call transfer process	Calls dropped during the call transfer process	Total calls transferred to the Nurse Triage program	Value 1/Value 2.	
	Q11: Uncompleted Calls by Caller	Reduce the number of Nurse Triage calls prematurely terminated by the caller after the call triage program was initiated	Calls prematurely terminated by callers referred to the Nurse Triage program	Total Calls answered by the Nurse Triage program	Value 1/Value 2.	

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Experience of Care Metrics	**E1:** Patient Satisfaction ***{CORE MEASURE}***	Optimize patient satisfaction scores by intervention.	To be determined based on tools developed	To be determined based on tools developed		Recommend an externally administered and nationally adopted tool.

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Notes
Utilization Metrics	**U1:** Number of calls answered by the Nurse Triage program ***{CORE MEASURE}***	Maximize the utilization of the Nurse Triage program	Number of calls answered by the nurses in the program			
	U2: Ambulance Transport Impact	Measure rate of ambulance transports to an ED by *enrolled patients*	Number of ambulance transports for enrolled patients.	Number of enrolled patients.	Value 1/Value 2	Monthly run chart reporting.
	U3: Hospital ED Visit Impacts	Measure rate of ED visits by *enrolled patients*	Number of ED visits for enrolled patients.	Number of enrolled patients.	Value 1/Value 2	Monthly run chart reporting.
	U4: Number and % of calls with Self-Care disposition	Measure of calls with disposition of Self-Care	# of calls resulting in a Self-Care disposition	Total number of Nurse Triage calls with completed to disposition	Value 1/Value 2	
	U5: Number and % of calls with an Established Care Provider appointment disposition	Reporting of calls with disposition of make an appointment with Established Care Provider	# of calls resulting in a appointment with Established Care Provider disposition	Total number of Nurse Triage calls with completed to disposition	Value 1/Value 2	
	U6: Number and % of calls with Urgent Care provider disposition	Reporting of calls with disposition of seek care from an Urgent Care provider	# of calls resulting in a disposition of seek care from an Urgent Care provider disposition	Total number of Nurse Triage calls with completed to disposition	Value 1/Value 2	

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Notes
	U7: Number and % of calls with Poison Control referral disposition	Reporting of calls with disposition of referral to Poison Control	# of calls resulting in a disposition of referral to poison control disposition	Total number of Nurse Triage calls with completed to disposition	Value 1/Value 2	
	U8: Number and % of calls with Behavioral Health referral disposition	Reporting of calls with disposition of referral to Behavioral Health	# of calls with disposition of referral to Behavioral Health	Total number of Nurse Triage calls with completed to disposition	Value 1/Value 2	
	U9: Number and % of calls with Obstetrics Center disposition	Reporting of calls with disposition of referral to an Obstetrics Center	# of calls with disposition of referral to an Obstetrics Center	Total number of Nurse Triage calls completed to disposition	Value 1/Value 2	
	U10: Number and % of calls that resulted in an immediate ambulance response	Measure the number of calls referred to the Nurse Triage Program that result in an immediate ambulance response	# of calls with disposition of an immediate ambulance response	Total number of calls referred to the Nurse Triage program	Value 1/Value 2	
	U11: Number and % of calls with Mobile Healthcare Provider Scene Response disposition	Measure the number of calls referred to the Nurse Triage Program that result in a Mobile Healthcare Provider Scene Response	# of calls with disposition of a Mobile Healthcare Provider Scene Response	Total number of Nurse Triage calls completed to disposition	Value 1/Value 2	

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Cost of Care Metrics -- Expenditure Savings	**C1: Ambulance Transport Savings**	Reduce Expenditures for ambulance transports to an ED.	Ambulance transports avoided for enrolled patients.	Average payment per transport MINUS Expenditure per nurse triage patient contact PLUS the expenditure related to the alternate disposition.	Value 1 X Value 2.	Monthly run chart reporting. CMS Public Use Files (PUF) for ambulance supplier expenditures or locally derived number.
	C2: Hospital ED Visit Savings	Reduce Expenditures for ED visits.	ED visits avoided in period for enrolled patients.	Average payment per ED visit MINUS Expenditure per nurse triage patient contact PLUS the expenditure related to the alternate disposition.	Value 1 X Value 2.	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C3: Total Expenditure Savings	Total expenditure savings for Nurse Triage interventions	Individual savings for each enrollee MINUS the Cost of Nurse Triage interventions for intervention per enrollee, including alternative sources of care expenditures		Sum of Value 1	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Balancing Metrics	**B1:** Practitioner (Triage Nurse) Satisfaction	Optimize practitioner satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B2: Partner Satisfaction	Optimize partner (healthcare, behavior health, public safety, community) satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B3: Emergency Department Capacity	Decrease number of hours of ED bed utilization by Nurse Triage patients during measurement period	Number of ED visits avoided as a result of the Nurse Triage intervention	Number of ED visits avoided * average Door to Disposition Time or all ED patients	Value 1-Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	B4: System Capacity - PCP	Number and percent of patients ***unable*** to receive PCP services that they would otherwise be eligible to receive as a result of lack of PCP system capacity	Number of patients referred to PCP services that were unable to receive PCP services due to lack of PCP capacity	Number of patients referred to PCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B5: System Capacity - SCP	Number and percent of patients ***unable*** to receive SCP services that they would otherwise be eligible to receive as a result of lack of SPC system capacity	Number of patients referred to SCP services that were unable to receive SPC services due to lack of SPC capacity	Number of patients referred to SCP services	Value 1 Value 1/Value 2	Network provider or patient reported

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	B6: System Capacity - BCP	Number and percent of patients ***unable*** to receive BCP services that they would otherwise be eligible to receive as a result of lack of BCP system capacity	Number of patients referred to BCP services that were unable to receive BCP services due to lack of BCP capacity	Number of patients referred to BCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B7: System Capacity - SSP	Number and percent of patients ***unable*** to receive SSP services that they would otherwise be eligible to receive as a result of lack of SSP system capacity	Number of patients referred to SSP services that were unable to receive SSP services due to lack of SSP capacity	Number of patients referred to SSP services	Value 1 Value 1/Value 2	Network provider or patient reported

Definitions

Specific Metric Definitions:

Expenditure: The amount ***PAID*** for the referenced service. Expenditures should generally be based on the national and regional amounts paid by Medicare for the covered services provided.

Examples:

Service	Cost to Provide the Service by the Provider	Amount Charged (*billed*) by the Provider	Average Amount Paid by Medicare
Ambulance Transport	$350	$1,500	**$420**
ED Visit	$500	$2,000	**$969**
PCP Office Visit	$85	$199	**$218**

National CMS Expenditure by Service Type:

Service	Average Expenditure	Source
Emergency Ambulance Transport	$419	Medicare Tables from CY 2012 as published
ED Visit	$969	http://www.cdc.gov/nchs/data/hus/hus12.pdf
PCP Office Visit	$218	http://meps.ahrq.gov/data_files/publications/st381/stat381.pdf
Hospital Admission	$10,500	http://www.hcup-us.ahrq.gov/reports/projections/2013-01.pdf

Triple Aim

- Improve the quality and experience of care
- Improve the health of populations
- Reduce per capita cost

Driver Diagram: A Driver Diagram is a strong one-page conceptual model which describes the projects' theory of change and action. It is a central organizing element of the operations/implementation plan and includes the aim of the project and its goals, measures, primary drivers and secondary drivers. The aim statement describes what is to be accomplished, by how much, by when and where?

- Aim – A clearly articulated goal statement that describes how much improvement by when and links all the specific measures. What are we trying to accomplish? CMMI/IHI.
- Primary Drivers – System components that contribute directly to achieving the aim; each primary driver is linked to clearly defined outcome measure(s). CMMI.
- Secondary Drivers – Actions necessary to achieve the primary driver; each secondary driver is linked to clearly defined process measure(s). CMMI.

General Definitions

- *Adverse Outcome*: Death, temporary and/or permanent disability requiring intervention
- *All Cause Hospital Admission:* Admission to an acute care hospital for any admission DRG
- *Average Length of Stay:* The average duration, measured in days, of an in-patient admission to an acute care, long term care, or skilled nursing facility.
- *Behavioral Health:* The scope of services that includes assessment and/or treatment of the behavioral or substance abuse needs of a patient.
- *Care Plan*: A written plan that addresses the medical and psychosocial needs of an enrolled patient that has been agreed to by the patient and the patient's primary care provider
- *Case Management Services*: Care coordination activities provided by another social service agency, health insurance payer, or other organization.
- *Compliance Plan: A Compliance Plan clearly articulates policies, procedures and processes to assure compliance with all applicable laws and regulations associated with the Nurse Triage Program, including; prevention, detection and correction; conflict of interest policies; and mechanisms for identifying and addressing noncompliance.*
- *Core Measure*: Required measurement for reporting on MIH-CP services
- *Critical Care Unit Admissions or Deaths*: Admission to critical care unit within 48 hours of CP intervention; unexpected (non-hospice) patient death within 48 hours of CP visit
- *Decision Support Tool*: A plan or guide for the assessment and management of a clinical problem to reduce the risk of omission and increase the predictability of desired clinical outcomes[1]
- *Desirable Metric*: Optional measurement
- *Door to Disposition Time*: "Door" time is defined according to the EMTALA and the AHA STEMI Guidelines: "The time at which the ambulance arrives at the hospital." Disposition time means the time at which the patient is admitted to the hospital as an inpatient or observation patient; or a patient is designated for observation within a Clinical Decision area of the ED, or is discharged from the ED.
- *Enrolled Patient*: A patient who is enrolled with the EMS/MIH program through either; 1) a 9-1-1 or 10-digit call; or 2) a formal referral and enrollment process.
- *Established Care Provider*: A medical care professional for which the patient already has a patient/provider relationship.
- *Evaluation*: determination of merit using standard criteria
- *Executive Level*: The most senior leadership of the organization. For governmental agencies, this should be the Chief of the Department, City/County Manager, City/County Commission, or other similar leadership. For private agencies, this would be the owner, CEO, President, Executive Director, or other similar leadership.

[1] Espensen, MBA, BSN, Maureen, Telehealth Nursing Practice Essentials; aaacn, 2012, p 247

- *Financial Sustainability Plan*: a document that describes the expected revenue and/or the economic model used to sustain the program.
- *Guideline*: a statement, policy or procedure to determine course of action
- *Hotspotter/ High Utilizers*: Any patient utilizing EMS or ED services 12 times in a 12 month period, or as defined by local program goals.
- *Measure*: dimension, quantity or capacity compared to a standard
- *Medication Inventory*: The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
- *Metric*: a standard of measurement.
- *Mobile Healthcare Provider*: A field provider with specialized training and expertise in managing patients in the out-of-hospital setting.
- *Obstetrics Center*: A facility that specializes in the provision of obstetrical services.
- *Payer Derived: measure that must be generated by a payer from their database of expenditures for a member patient*
- *Pre and Post Enrollment*: The beginning date and ending date of an enrolled patient.
- *Repatriation*: Returning a person to their original intended destination, such as an emergency department, following an intervention
- *Poison Control*: A free, confidential medical advice hotline offering services 24 hours a day, seven days a week through a designated poison control access number.
- *Self-Care*: The recommended care level that includes care administered by the patient or family member in the patient's home, without the need for any assessment or referral to a medical care provider.
- *Social & Environmental Hazards and Risks*: include trip/fall hazards, transportation, electricity, food, etc.
- *Standard*: criteria as basis for making a judgment.
- *Urgent Care*: The provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness and injury.
- *Unduplicated*: Unduplicated patients are the number of unduplicated people served in a given time period, in this case, a calendar year. This means each person who has been serviced by the Nurse Triage program in the calendar period is counted once regardless if that person had one or 20 calls referred to the nurse.
- *Unplanned*: Any service that is not part of a patient's plan of care.