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Introduction

As acute care hospitals address the ever-changing goals, mandates, and regulations for reimbursement, cost reductions, quality, and satisfaction with outcomes of their care, they have started to require and implement CM functions. CM has a long history, with roots in social service, and it is currently used as a strategy for helping both payer and provider organizations operate efficiently and effectively.

CM has been defined in various ways over several years, but the definition always includes certain principles such as access, connecting need with service, and monitoring of some kind. Other descriptions and metaphors vary to fit the politics of the times; CM has been defined as a process, a system, a role, and an intervention (Bower, 1990). Case managers can be professionals, laypeople, or family members. The best generic definition for CM is a function that "ensures a closed-loop of services at or near the client level, using data and information technology [representing] the biggest change in the way work is organized since the industrial revolution" (Davenport and Nohria, 1994) because it creates a virtual matrix organization around each client (i.e., patient). In other words, case managers bring resources from many sources to bear on patients’ and families’ needs across time and place.

Learning Objectives

1. List the seven main functions included in the evolving core of case management (CM)
2. Compare the roles of emergency department (ED) staff nurse, ED case manager, and ED clinical social worker
3. Describe why EDs increasingly involve RNs as case managers
4. Review a scenario of a futuristic ED
In healthcare, case managers combine high-level analysis and synthesis of patient situations with consultation and facilitation of decision-making. As part of the clinical team, case managers manage the “clinical contract” to ensure reimbursement and best-practice clinical outcomes within ethical, legal, and compliance parameters. Case managers are sometimes described as general contractors, team leaders, or expediters/facilitators.

**The role of CM**
CM is best described as a service (rather than as a department) that includes a combination of somewhat distinct but overlapping functions. When these functions are put into a relationship with each other, the key responsibilities represent an “evolving core of functions,” with the most basic being access. Access is exactly where EDs sit in our society.

There is some debate and confusion about the necessity of ED CM, as it obviously requires an investment in one or more additional FTEs. The rationale for the role will be thoroughly covered in this text. The roots of the confusion about having the position at all, however, seem to stem from lack of agreement with the following profound statement about the hospital’s role in society:

“The hospital ED is perhaps the only local institution where professional help is mandated by law, with guaranteed availability for all persons, all the time, regardless of problem. EDs provide treatment of illness, identification of basic social needs, and extension of existing community resources” (Gordon, 1999).

Is the ED for purely medical problems? Or is it also the major intersection between a residential community and a professional healthcare community? Should the ED be a fence to all non-medical situations, a gate that only allows a few through, a door with locks and keys, or a front porch on which people can feel welcome? A facility’s model of CM, including social work, will be a reflection of the hospital’s articulated mission and goals.

**Models of CM**
The term *model*, when used in healthcare, includes reporting structures, authority, responsibilities, and relationships. CM models define roles and relationships in CM services—that is, they define the number and type of personnel and how they are deployed to carry out an array of responsibilities. Models are extremely diverse and do not easily lend themselves to benchmarking or exact replication. Models depend on many factors, including:

- History and tradition
Ironically, no model can exactly prescribe how to respond to every situation that occurs. And it is precisely because of this need for individual judgment within the context of standards of care and conduct that professional nurses and social workers are used in CM services.

Generally, RNs and social workers fill the role of case manager in an ED. To best understand and ultimately position this crucial role in acute care, it is important to put it in the context of the entire set of functions within a framework called the "Evolving Core of Case Management." These core functions could be considered the key activities and responsibilities under the widening CM umbrella.

Each CM function is firmly based in corporate compliance and supports direct caregivers and the contracts between hospitals and payers. At times, the functions are carried out behind the scenes, invisible to patients, families, and sometimes even the direct caregivers. Other functions are much more visible and apparent to providers and patients in the acute care environment. Figure 1.1 illustrates the relationship of the functions to each other, which are described in detail below the figure.
Access: Facilitating the entry of patients into the appropriate level of care for initial treatment in the healthcare system. Examples include ED Case Management, coordinating direct admits, payer and Medicaid verification, bed placement, booking, and liaison evaluations.

UR/UM/Denial management: Identifying and negotiating reimbursement for services; matching payment with the day using criteria. This can include auditing QA indicators and documentation improvement.

Care coordination: Collaborative leadership of the healthcare team to determine and pace the treatment plan in accordance with quality and safety parameters, LOS, and reducing avoidable days.

Discharge planning: Matching specific needs for continued care and recovery with available resources acceptable to the patient or guardian.
**Recovery episode**: Period from crisis to recovery or stabilization; tracking across time and venue with the emphasis on highest level outcome. The emphasis should be on the avoidance of readmissions, patient education, PCP follow-up, and follow-up phone calls. Usual episodes defined as 48 hours post-ED, 7 days, 14 days, and 30 days.

**Continuum**: An infinite time frame, which includes a person’s health and lifestyle. This may include chronic but stable states such as well-maintained diabetes or handicaps. The continuum includes disease management and primary prevention.

**Disease Management**: A comprehensive, integrated approach to care and reimbursement based on the natural course of a disease. The ultimate goal is patient self-care by focusing on both clinical and non-clinical interventions when and where they are most likely to have the greatest positive impact. (Todd & Natsh, 1997).

**Health and Prevention**: Formal systems that ensure and promote healthy and preventative behaviors.

**Contracting**: Negotiation and procurement of agreements with internal and external services and agencies.

**Precursors to CM in the ED**

**Triage nurse**

It could be argued that the earliest form of CM in the ED was the triage nurse. Triage began in the military as “the sorting out and classification of casualties of war or other disaster, to determine priority of need and proper place of treatment” (Miller-Keane, 1992). Triage is a rapid version of the scientific method, which is analogous to the following nursing process: assess, plan, intervene, and evaluate. The triage nurse determines how ill or injured each patient is and then prioritizes/ranks them to determine the order in which patients should be seen. Trauma patients and patients with chest pain are always clear cases, but all other cases are left to the triage nurse’s initial judgment. The original triage function has expanded to more options with the development of fast tracks in EDs, designated rooms and areas for different populations, mandates for rapidly administering medications for pneumonia and stroke, and the initiation of care in the ambulance on the way to the ED. In addition, bedside registration and more diagnostic capability have moved into the ED, enabling patients to be placed quickly in an exam room.
Triage for the psychiatric behavioral health population has always involved an evaluation of altered mental status, disturbed behavior, suicidal ideation and attempts, and other difficulties, followed by appropriate placement for safety and treatment. These evaluations are provided by a range of behavioral health personnel, some internal to the hospital and some contracted by the hospital. There is more on this topic in Chapter 11.

Social work
From the earliest days of hospitals, social workers have been advocates for the under- and unserved by connecting people in need to resources. As part of a healthcare organization, social workers provide a “voice for the voiceless” (St. John Health System).

Except for planned admissions, the ED is the front door of the hospital. Social work has a presence and place on the multidisciplinary teams in many EDs for both a supportive and clinical function. “The pressure for immediate action in this setting is intense, and the social worker must remain in a constant state of readiness, prepared for what might come through the door next” (Dziegielewski and Duncklee, 2003). For the next person “through the door,” social workers must be prepared to provide crisis intervention, grief counseling and other psychosocial support, and arrangement of services directly from the ED to the community. Social workers with such responsibilities may be assigned full time to the EDs of large hospitals and may be on call to EDs of smaller hospitals. Some are on call evenings and weekends, and others come on-site to assist with severe and catastrophic situations in person.

Social workers fulfill many needed services in an ED. In an interesting survey of ED social workers, all had the same answer to the question “What do you see as the most significant need of the clients you serve?” Their answer was adjustment issues, regardless of whether they were related to a crisis situation or a long-term problem. The second most important need they noted was for linkages, referrals, and follow-ups with community resources. They also cited psychological and supportive counseling, advocacy, and helping clients or their families negotiate the hospital and posthospital healthcare system. They added that ED staff “often did not identify high-risk situations that required advocacy or appropriate emotional support. In addition, when referrals were made, it was often so late in the intervention process that issues that might have been simply addressed if presented earlier had magnified into much larger problems” (Dziegielewski and Duncklee, 2003).

These are important comments that ring true throughout acute care. Although social workers in the ED have more compressed time (and sometimes space) to do their work than others in the
hospital, social workers clearly have a skill set that should be used not only for the previously noted services but also to develop CM plans for frequent repeaters to the ED, as well as DM programs in partnership with RN case managers and other clinical experts, such as pharmacists.

**Case manager role as new expertise for the ED**

As described earlier, the clinical staff in the ED benefited for many years from the expertise of social workers and behavioral health evaluators. However, major changes in the industry have created a need for officially adding personnel with the title “case manager,” or restructuring the work currently completed by social workers and others to create a more comprehensive CM service.

As EDs began to deal with the need for improved flow and capacity, as well as the need to accurately place patients in observation status or inpatient status, hospitals tried to cope by teaching nursing staff how to evaluate patients. This new responsibility on top of staff members’ clinical responsibilities was understandably overwhelming and often perceived as inappropriate because, for example, staff nurses’ role was made even more difficult when physicians did not cooperate or when billing status became intermingled with bed placement problems. Separate clinical decision/observation units sometimes helped clarify the problem and provided somewhere to put patients whose condition was ambiguous and evolving, but they did not completely remove the need to assign a billing status. Although policies such as assigning observation status should be familiar to staff nurses and other personnel, hospitals have begun to see the need to assign one group—usually CM—accountability for accuracy in the ED.

CM in the ED has become more than classic social work or discharge planning. It has grown into the primary method used to address and divert patients who are not sick enough to need an acute care bed but are at too much risk (physically, psychosocially, or mentally) to be sent back to their homes immediately following the ED encounter. Case managers live and work in the gray area between these two extremes. They also do whatever they can to help staff members keep patients moving. Because of the plethora of needs that the community brings into the ED setting, it makes sense to have both sets of professional expertise available in some combination of coverage during ED “prime time.”

The inclusion of RNs as case managers for the ED has been gradual. However, it is becoming the predominant model, due to a variety of factors that will be addressed later in this text. The main factor is the need to deal with the ever-increasing volumes of patients coming to EDs—from patients who are near death to patients who may not require inpatient admission at all. It is our belief that if an ED has more than 35,000 visits per year, a full-time case manager is warranted.
In addition, the acuity of ED patients has increased over the past several years. In fact, a large healthcare database substantiates that the number of high-complexity Medicare patients nearly doubled between 2000 and 2004, while low-complexity visits declined in those years (Savafi, 2006). As a result, ED case managers are intervening at both the entry to and the exit from the ED, as well as during the ED stay. Thus, there are currently a variety of responsibilities and roles for the ED case manager, a few of which are described in the following sections.

**Case manager as expeditor**

One type of ED CM role is as an expeditor, such as the RN care facilitators at Brigham and Women’s Hospital in Boston. These RNs are armed with cell phones and respond to outside hospital EDs’ and physicians’ office calls to ascertain whether patient should be taken directly to cardiac catheterization or other services. The patient’s disposition is discussed with the ED medical director or the surgical specialty attending physician, and the patient is sent to the appropriate area upon arrival.1

**Access care manager**

Another role in ED CM is an RN access case manager who approves all direct admissions and admissions from the ED into the hospital based on criteria and, if needed, negotiation with the referring physician as well as the ED (see Appendix A for Direct Admission Process). Eventually, hospitals large and small will incorporate this kind of decision-making by ED case managers in collaboration with medical directors and hospital administrators for all comers, including acute-to-acute transfers.

**Case manager as clinical specialists**

To provide the kind of assessment that is aimed at decreasing the “demand” for inappropriate medical interventions/hospitalizations, ED CM professionals must be knowledgeable about disease states and trajectories, mental and physical functional abilities, and levels of nursing care available in the patient’s community. In addition to having a background in reimbursement and medical necessity criteria, RNs are being increasingly utilized as case managers because they can be more clinically connected with the staff RNs and technicians. RNs are also generally more comfortable than social workers with proactive dialogue with physicians before physicians have determined the final disposition. One nurse manager of an ED, commenting on these skills, said, “We [the nursing staff] are so relieved that we have a case manager, because otherwise we would feel guilty not admitting the patient.”
Clinical staff in EDs have benefited for many years from the expertise of social worker and psychiatric evaluators. However, as described earlier, major changes in the industry have created the need for officially adding case managers to fill these necessary roles or restructuring the work currently completed by social workers and others to create a more comprehensive CM service.

**Dovetailing with the hospital CM service**

ED CM is a specialty within acute care CM. CM employees should be on the same salary and benefit scale as the rest of the department. However, although the CM personnel assigned to the ED are part of the larger service, their positions should be protected to allow them to maintain concentrated coverage for the ED. Although it may be reasonable to combine ED coverage with intensive care unit coverage or coverage of a similar area in a small hospital, it would not be wise to spread coverage in a medium to large hospital with high ED volumes. These are just some of the considerations when dovetailing commitments to the ED with the needs of the larger hospital and CM service.

A typical CM department structure includes a range of roles, some combined and some distinct, including:

- Director or manager
- Physician advisor or medical director
- RN case managers
- Social workers
- Denials/appeals specialists
- Administrative assistant for the department
- Coverage for weekends, holidays, and PTO
- Case aides, documentation specialists, case managers in admitting (depending on the model)

Caseload numbers per FTE and assignment patterns vary within every organization. The most reasonable guide to compare and contrast FTEs is to use the overall case mix index (CMI) as a proxy for the complexity of the organization and patients’ conditions (see Figure 1.2). The amount and type of liaison staff, role and level of social workers (e.g., having bachelors or a
Chapter 1

Figure 1.2

CM—Integrated Role— and MSW Caseloads by CMI
Proposed Framework to Plan/Evaluate/Benchmark Staffing

Introduction: This framework represents ranges and direction rather than absolutes. Please use as a
guideline. There are many contingencies to be considered (type of technology available, use of case mgmt
assistants, onsite payers and liaisons, etc.). These numbers represent CM with a combined role of UR, Care
Coordination, and Discharge Planning and MSW in a risk-referral Clinical Social Work Role, not including DP.
These numbers do not include ED, weekend or PTO coverage, clinical documentation improvement
specialists, or denial and appeals specialists.

<table>
<thead>
<tr>
<th>CMI = .9-1.1</th>
<th>CMI = 1.2-1.3</th>
<th>CMI = 1.4-1.5</th>
<th>CMI = 1.6-2+</th>
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<tr>
<td>LOS, Medicare</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Case Mgrs(^1): Pts (If under 50% Medicare mix)(^2)</td>
<td>3-4 days</td>
<td>4-5 days</td>
<td>5.1-5.4 days</td>
</tr>
<tr>
<td>Case Mgrs(^1): Pts (If over 50% Medicare mix)(^1), (^5)</td>
<td>1: 20-25</td>
<td>1: 20</td>
<td>1: 15-20</td>
</tr>
<tr>
<td>Ratio to ADC, not beds</td>
<td></td>
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<td></td>
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<tr>
<td>Physician Advisor(^6)</td>
<td>Can be VPMA</td>
<td>.5 FTE</td>
<td>.5-1 FTE depending on hospital size</td>
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<tr>
<td>Social Work(MSW)(^2): Pts/Families (if over 50% total Medicaid and Medicaid mix OR if Trauma, Oncology, or Pediatric specialty hospital)</td>
<td>1: 50</td>
<td>1: 35- 50</td>
<td>1:35</td>
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\(^1\) With combined UR, Care Coordination, and Discharge planning functions. If assigned by service line, will need more FTEs
\(^2\) Not including ED coverage
\(^3\) With combined UR, Care Coordination, and Discharge Planning functions. If assigned by service line, will need more FTEs
\(^4\) Not including ED coverage
\(^5\) Must have SW as well if over 50% high Medicare plus Medicaid populations. If no SW, CM will need lower caseloads
\(^6\) In most cases, should not be VPMA

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Emergency Department Case Management
masters degrees), presence of on-site payers, structure of medical staff, and type of technology/software all have bearing on number of FTEs and how personnel are deployed.

Placing case managers in an ED usually comes several years into the development and transformation of a CM department or service. Appropriations for the position occur when two realities merge:

1. The hospital becomes concerned about flow and capacity issues
2. The hospital accepts its place as the center of the community for both medical and related social problems

As the organization realizes that “case managers connect the boardroom with the bedside,” it becomes willing to establish a full contingent of social work and RN staff in all care settings, including the ED. As a result, CM professionals have the opportunity to create a practice firmly based in authority, social power, and influence (Zander, 2000; French and Raven, 1959).

Being an active part of the entire department is essential for ED case managers and social workers. The work can be very isolating unless there are continuous connections with the director, peers, physician advisor, and others. What is most important is the handoff of vital information between the ED CM/social worker and the nurses, physicians, and others to whom he or she transfers the patient, whether internally or externally. ED case managers also should be assigned to quality improvement teams, throughput task forces, and DM programs.

**The future of ED CM**

To predict the future of ED CM, it helps to study the strongest current trends in meeting patient needs. It is also informative to understand the subtle examples of best practice that might be replicated and sustained if they are congruent with the values of the organization, some of which are highlighted in this text. The chapter on improving performance will give you ideas as to how to start rethinking your ED.

In addition, reviewing the trends and examples show that CM in the ED will be a way to expand services and connections. Recent trends show the following:

- The ED as the central access point for all patients from all sources (e.g., direct, ambulance, walk-ins), including expediting patient tests and treatments and patient placement throughout the health system
Emergency Department Case Management

- An increased presence of specialists for rapid assessment and intervention beyond purely medical conditions, including physical therapy, Medicaid registration, and other patient financial services
- The use of additional tools for disposition planning, including discharge-planning software
- An increased focus on prevention of hospitalizations and on DM through the use of CM plans for frequent visitors
- The provision of counseling for families in crisis and community life-care planning as hospitals accept their role at the social center of the community, with the ED as the front porch
- Mobile EDs that go on call to homes and offices

Scenario 1

Picture this as the future of CM: As you are driven to the ED in the family car or an ambulance, someone calls ahead to let the facility know you are coming and what is wrong. By the time you arrive, all of your past history and data have been reviewed by an advanced practice nurse. To update any information, you have your history, which includes your health history, immunizations, and results from the latest tests and x-rays, among other information, on a portable memory stick. As you walk through the door, a full-body MRI will be completed. If you need additional diagnostic studies, most will be available in the ED or at your bedside.

In addition, you would receive a CM plan if you have a chronic disease (or even something as nonlethal but problematic as a severe migraine headache), are a current patient receiving outpatient services such as chemotherapy, or are a frequent ED user. The plan would be developed collaboratively with you, ED case manager, social worker, and other key team members.

Scenario 2

Now envision this scenario: Your family is absolutely at wits’ end about your 97-year-old mother who lives with you and is suddenly saying mean, paranoid, and threatening things. You need someone to calm everybody down. What if there was someone ready to meet with you? This meeting would be possible because your ED believes that prevention is as important an intervention as surgery. Additionally, if your mother has also been falling, there will be a physical therapist on staff to evaluate her after the medical exam. If you don’t know what you and
your mother can afford as far as future care and living situations, a counselor will be available to walk you through a software questionnaire that will give you a written report to ponder and discuss (such as the product developed by J. Jackson for EquaCare).

**Scenario 3**
You are a patient admitted to the ED. If you do not have a PCP, an appointment is made with one the next day. If the ED has to ascertain your insurance to find a PCP for you, staff members will begin the process and follow up with you. Similarly, if you need a bed in a shelter, hospice, or nursing home, the ED case managers will use discharge-planning software to help match your needs to resources within minutes, 24 hours a day. For less complex situations, such as discussing living wills or medication interactions, you can e-mail your ED from home or come in person by appointment.

In addition to today’s fast tracks and slow tracks, there will be innumerable tracks. And maybe the ED will be mobile and come to you. Obviously, both RN case managers and social workers will be needed in any future ED. They will have expanded scope, expanded hours, and authority to truly make a difference in the lives of people and the life of the community.

**References**


Dutkiewicz, C. Nurse Manager, Department of Care Coordination, Brigham and Women’s Hospital, Boston, MA. Used with permission. Bower, K. (1992). *Case management by nurses*. ANA publication.


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