

**SECOND EDITION**

# **EMERGENCY DEPARTMENT CASE MANAGEMENT**

**The Compendium of Best Practices**

**KATHLEEN WALSH RN, PHD  
KAREN ZANDER, RN, MS, CMAC, FAAN**

# Emergency Department Case Management

The Compendium of Best Practices

Second Edition

**HCP**ro  
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## Continuing Education

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# Foreword

The ED sits at the fulcrum of the most expensive decision in medicine, namely to admit a patient or not. In decades past, in a largely fee-for-service environment where cost containment was rarely part of the equation, this was not a decision that received much attention. However, in the present era of efforts to contain the rising costs of healthcare, this decision is in the spotlight. In part due to this change, EDs have evolved considerably from their roots as triage initial-treatment disposition centers. U.S. EDs are providing an increasingly broader scope of management of acute care episodes. Most EDs now routinely perform complex diagnostic evaluations that may involve algorithms of care and advanced imaging techniques—some even designate portions of their EDs as rapid diagnostic units in which these evaluations take place. In addition, many EDs now operate observation and short-stay units, where patients who need more than a few hours of care but less than a few days can remain in outpatient status and undergo treatment in a less resource-intense environment than an inpatient admission would provide. This ever-broadening scope of emergency practice is part of the larger effort to provide the right care at the right time in the right place for each patient with an acute healthcare problem. This evolution in the role of the ED within a healthcare system has, of necessity, led to an evolution in the type of care, providers, and resources that are required to ensure an effective and high-quality ED. One critical and relatively new member of the ED care team is the case manager.

The ED case manager is a valued and valuable member of the ED care team who enhances quality of care and safety for emergency patients by identifying at-risk patients and helping the clinical providers to disposition patients to the appropriate level of care. The ED case manager does this by using evidence-based practice, providing discharge options to physicians, identifying and creating options for high utilizers of ED services, improving patient flow and throughput, and improving outcomes of care by ensuring safe transitions to postacute care facilities or to home with needed services. ED case managers can also evaluate patients returning to the ED within 72 hours of an initial ED visit or presenting within 30 days of an inpatient stay. These are high-risk and high-cost situations where the expertise of the case manager can be critical to the safe assessment and ultimate disposition of the patient to the appropriate level of care.

There is no greater example of the importance of ED case management than in ED-based observation units. Case managers join multidisciplinary morning rounds in observation units and provide

valuable information related to the patient's medical story, such as the home situation or personalized insurance benefits that identify choices for safe and effective discharge plans. In facilitating the appropriate disposition of these patients, case managers are critical to maintaining rapid flow through these units while still ensuring high-quality and safe care.

Case managers can further help ED clinicians and patients navigate the healthcare system by accessing social resources, having knowledge of regulatory laws and insurance benefits, involving primary care physicians, and helping patients gain reentry back to the community.

Case managers are now a recognized, integral part of the care team in any high-functioning ED. It is highly appropriate that there be a textbook devoted to this important ED role and function.

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# Introduction

EDs have become the most rapidly evolving segment of healthcare. They demonstrate healthcare at its finest point of delivery, often when the community in which they are located and its residents are at their lowest and neediest. Supporting that reality is a steadily growing addition of ED case managers (RNs and social workers) joining with ED physicians and nurses committed to providing safe, quality care for all patients. In fact, a 2009 survey of more than 400 hospitals by the Case Management Society of America revealed that 81% of them had at least one case manager in their ED. The first edition of this text, written in 2007, was written to inform interested readers and potential case managers about the work. In 2014, a betting person would gamble that out of all hospitals in the United States, at least 90% would have case management services available to the ED in some form or another. This second edition rides on the waves of change by describing how case management services assist EDs in addressing the needs of diverse populations while simultaneously helping the hospital and health system/accountable care organization meet both their margin and mission.

The evolution in our nation's EDs, as well as case management services within EDs, has gone hand in hand with the changes in federal regulations, mandates for access, quality, and safety, and, finally, tight reimbursement for healthcare delivery. If anything, EDs are often ahead of the times, leading the way for the rest of the organization. This text documents all of those changes and how both ED and case management staffs have supported hospitals through the last five years. The material in the appendixes will provide some basic tools. Most chapters have a "Spotlight" section to highlight prime examples of ideas in action. In addition, some of the content asks you to stretch your thinking beyond your current experience to what case management will mean to EDs in the future.



# Chapter 1

## ED Case Management: The Heart of Access and Hub of the Community

*Karen Zander, RN, MS, CMAC, FAAN*

### Learning Objectives

1. Describe the current and evolving role of EDs in our society and healthcare systems
2. List the six main functions included under the larger umbrella of case management (CM)
3. Compare the roles of the ED staff nurse, ED case manager, and ED clinical social worker
4. Describe why EDs increasingly involve RNs as case managers
5. Review a scenario of a futuristic ED

### Introduction

Acute care hospitals must constantly address the challenges of potential reimbursement reductions, risk contracts, ever-increasing numbers of federal and state regulations, and quality/satisfaction mandates. As hospitals determine how to meet these and other challenges, they implement and/or shift case management services to the clinical areas that are most vulnerable. CM has a long history, with roots in social service, and is an extremely powerful strategy for helping both payer and clinical provider organizations operate efficiently and effectively. The presence of RN case managers and social workers in both pediatric and adult hospital EDs has become more the rule than the exception. In fact, a survey by the American Case Management Association<sup>1</sup> of more than 400 hospital case management departments revealed that 81 % had ED case managers (either social work or RN).

CM has been defined in various ways over many years. The definition generally includes principles such as access, connecting patient and family needs with resources and services, and monitoring the

results of interventions by both direct care teams and CM professionals. Other descriptions and metaphors vary to fit the politics of the times; CM has been defined as a process, a system, a role, a strategy, and an intervention.<sup>2</sup> Case managers may be professionals from a variety of traditional academic training and backgrounds, laypeople, or—in many cases, the patient’s family members/caregivers. The best generic definition for CM is that it 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”<sup>3</sup> because it creates a virtual matrix (team) organization around each client (i.e., patient and/or family). In other words, case managers bring resources from many sources to bear on patients’ and families’ needs across time and place (often referred to as a “continuum”).

In healthcare, case managers combine high-level analysis and synthesis of patient/family situations with information, education, 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 expeditors/facilitators and navigators/coaches.

## The Evolving Role of Hospital EDs

Hospitals cannot be “highly reliable”<sup>4</sup> in terms of safety and quality without highly reliable EDs. “High-reliability production decreases waste and risk exposure, while excellent service results in loyal patients and engaged physicians and nurses. Measurement is the most fundamental tool in the hospital leader’s toolkit to identify and mitigate variation.”<sup>5</sup> To go one step farther, a hospital’s ED cannot be highly reliable without the addition of either or both social work and RN CM.

Traditional ED goals have been the following:

- ❖ Urgent, life-saving care
- ❖ Safety net for uninsured patients
- ❖ Public health surveillance
- ❖ Disaster preparedness
- ❖ Main source of primary care for some populations
- ❖ Adjunct to community physicians

There is some debate and confusion about the necessity of ED CM, as it obviously requires an investment in one or more additional RN and/or social work FTEs. The expanding rationale for the CM role will be thoroughly covered in this text. The roots of the debate about having the position at all, however, seem to stem from lack of agreement with the following profound statement about the hospital ED’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.<sup>6</sup>*

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 analogous to a stonewall to all nonmedical situations, a gate that only allows a few through, a door with special locks and keys, or a front porch to the community on which people can both be *and* feel welcome and cared for relative to their immediate needs? Ultimately, a hospital and health system's model of CM will be a reflection of the organization's articulated mission, including its role in the community and its quality and financial goals.

## Functions and Models of CM

CM is best described as a service (rather than as a department) that includes a combination of somewhat distinct but overlapping functions, with the most basic being access to healthcare. Access is exactly where EDs sit in our society. 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 of the ED and hospital in the community it serves
- ❖ Personalities and politics
- ❖ Culture internal to the ED and between the hospital and ED
- ❖ Goals of the health system or hospital
- ❖ Perceived risks to patients and organizations

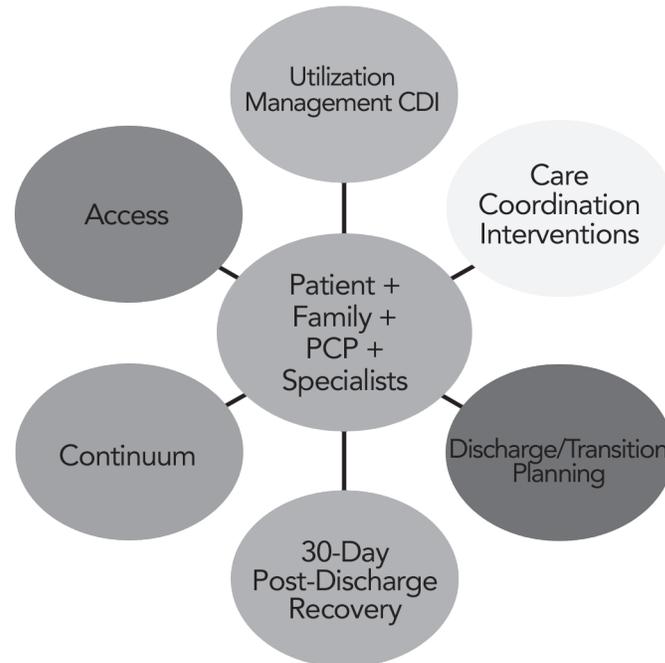
No model can exactly prescribe how to respond to every situation that occurs. And it is precisely because of this need for individual judgment within the context of standards of care and conduct that professional nurses and social workers are used as case managers in EDs.

Generally, RN case managers and social workers provide one or more of six key case management functions in an ED. ED CM services could be conceived as a subspecialty of acute care CM. To best understand and ultimately position this crucial role in hospitals of every size, shape, and character, ED CM services must be put in the context of the entire set of six basic CM functions. These core functions are the primary activities and responsibilities under the widening CM umbrella.

Every CM function is firmly based in corporate compliance with federal, state, and local regulations, and each function 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 to 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.

**Figure 1.1 | Six Core Functions of Case Management Services**



1. **Access:** Facilitating the entry of patients into the appropriate level of care for initial treatment in the healthcare system should be based on an assessment of their immediate situation. Examples include ED CM, coordinating direct admits, payer and Medicaid verification, bed placement, booking appointments, and evaluations by postacute liaison personnel.
2. **Revenue cycle:** Utilization review (UR)/utilization management/denial management: identifying and negotiating reimbursement for services and matching payment with the day using medical necessity criteria. This function can include clinical documentation improvement (CDI) activities as well.
3. **Care coordination:** Collaborative leadership of the healthcare team to determine and pace the treatment plan in accordance with quality and safety parameters, length of stay, and reducing avoidable days. Care coordination includes activities and interventions that progress patients from admission to the medical outcomes that constitute stability so patients can be transitioned to the next level of care, such as family meetings or substance abuse evaluations. Care coordination activities are also huddles and various types of rounds that seek to individualize information and clinical interventions to patient's and family's needs. Care coordination is not discharge planning.

4. **Transition/discharge planning:** Matching specific needs for continued care, recovery, or a comfortable death with available resources that are acceptable to the patient and/or family or guardian.
5. **Recovery episode:** The period from crisis to recovery or stabilization, tracking across time and venue with the emphasis on the highest level of functioning outcomes. The emphasis should be on the avoidance of readmissions, patient education, primary care physician (PCP) follow-up, and follow-up phone calls. Usual recovery episodes are often defined as 48 hours post-ED, seven days, 14 days, and 30 days.
6. **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 health, disease management, and primary prevention. Disease management, sometimes referred to as population health, is a comprehensive, integrated approach to care and reimbursement based on the natural course of a disease. The ultimate goal for case management is patient self-care by focusing on both clinical and nonclinical interventions when and where they are most likely to have the greatest positive impact.<sup>7</sup>

## ED Role Definitions Based on Hospital's Organizational Structure

There are basically three determining factors for role clarification of CM professionals in the ED. The three factors are 1) definition and scope of CM within the hospital as a whole, 2) functions of each discipline specific to the ED, and 3) coverage.

1. The definition and scope of CM services is first and foremost determined by the calculated and perceived risks of the hospital not providing CM services, and based on that judgment, the reporting structure of CM through a director to a vice president or chief operating officer. There are specific financial, quality, and satisfaction risks to hospitals that do not provide CM services of any kind in its ED. The risks are described throughout this text.
2. The way that a hospital organizes and staffs the core CM functions shown in Figure 1.1 is usually termed "model." Functions needed and expected in the ED by social workers or RNs may be numerous or extremely limited. The functions themselves, such as UR or discharge planning, may be discrete for a specific discipline or completely interchangeable between disciplines. The Center for Case Management (CCM) recommends that both social work and RN case managers be able to work "at the top of their licenses" as much as possible.
  - a. This would entail using the RN case manager for the following:
    - ◆ Determining level of care designation/transition to the correct level of care
    - ◆ Performing other UR functions
    - ◆ Providing care coordination with the ED team to pace the case
    - ◆ Educating patients as needed, especially about options for levels of care

- ♦ Providing explanations of the implications of observation status for traditional Medicare patients
  - ♦ Aggregating input from staff RNs, physicians, therapists, and others as to whether the patient may be able to be transitioned to another care setting or service without requiring a hospital bed
  - ♦ Potentially providing CDI consultation to physicians
- b. CCM recommends positioning social workers, especially those at the MSW level (if available), to provide the following services:
- ♦ Assessment of abuse and neglect
  - ♦ Procurement of community resources for the homeless and others
  - ♦ Identification of funding for the indigent
  - ♦ Crisis and grief counseling
  - ♦ Facilitation of family decision-making, etc.
  - ♦ Assistance with discharge/transition planning
  - ♦ Development of collaborative CM plans for high ED utilizers and patients within population health programs
3. Coverage is the third determinant of differentiating CM-related roles within an ED. For example, social workers and RNs may be assigned solely and exclusively to the ED, may be only on call to the ED for specific problems, may cover the ED by phone for some or all time periods, may overlap shifts, etc. Changes in coverage of CM professionals are irritating if not disruptive to EDs, create role confusion for the ED, and should always be discussed ahead of time.

Some examples of the wide variety of CM services by nurses and social workers are described below, although by no means is this a comprehensive list.

### Model A: Care/CM department includes both RNs and MSWs reporting to same director

**Example 1:** Both professions have title case managers (i.e., RN CM and SW CM) and both might be expected to perform UR, care coordination, and discharge planning (especially if they are both educated in the use of medical necessity criteria).

**Example 2:** Only RNs are titled as case managers; social workers are called social workers (sometimes not differentiated by MSW vs. BSW). The RNs would usually perform UR, care coordination, and discharge planning, and the social worker would intervene for psychosocial crises.

**Example 3:** Both social workers and RN CMs are referred to as “discharge/transition planners.”

## Model B: Care/CM department only includes RNs; social work reports to a different director and is separate from the care/CM department

**Example 1:** The RN case manager is used exclusively for UR and transition planning; social work coverage for the ED (not necessarily differentiated by MSW or BSW) are called social workers and are used only for the traditional tasks of assessment of abuse, neglect, grief, funding issues, and crisis counseling

**Example 2:** RN is used exclusively for UR; social work (MSW or BSW) is used for the traditional tasks in example 1, as well as discharge planning, and may be called discharge planners

## 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.”<sup>8</sup> 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 each one to determine the order in which patients should be seen. Trauma patients and patients with chest pain are always clear cases, but most 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 diagnostic 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 staff to quickly place patients in exam rooms.

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 information on this important topic in Chapter 6.

### 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.”<sup>9</sup>

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.”<sup>10</sup> 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 the issues 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 post-hospital 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.”<sup>10</sup>

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 can also help develop CM plans for frequent repeaters to the ED, as well as disease management (DM) programs in partnership with RN case managers and other clinical experts, such as pharmacists.

## **RN CM Role as Enhanced 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 adding RN personnel with the title case manager or restructuring the work currently completed by social workers and others to create a more comprehensive and strategic CM service. The expanded rationale and role of RN case managers in the ED can be summarized as follows:

1. Document present-on-admission findings
2. Consult with attending physicians about observation vs. inpatient determination
3. Provide discharge/transition arrangements directly from the ED for care needs outside of the hospital
4. Develop CM plans for ED high utilizers, sometimes referred to as “familiar faces”
5. Decrease revisits to the ED and readmissions to the hospital

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 began to acknowledge 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 (i.e., throughput). Because of the plethora of needs that the community brings into the ED setting, it makes sense to have both RN and social work CM 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 a bed at all. It is CCM's belief that if an ED has more than 25,000 visits per year, at least one full-time RN case manager and social worker is warranted during ED prime time for that community.

In addition, the acuity of ED patients has increased over the past several years. In fact, a large health-care database substantiates that the number of high-complexity Medicare patients nearly doubled between 2000 and 2004, while low-complexity visits declined in those years.<sup>10</sup> 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, Massachusetts. These RNs are armed with cell phones and respond to outside hospital EDs' and physicians' office calls to ascertain whether a patient should go 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.<sup>11</sup>

## 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, negotiates with the referring physician as well as the ED. 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 become 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."

## Dovetailing With the Hospital's CM Service

ED CM is a specialty within acute care CM. CM employees in the ED 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 or observation unit coverage in a small hospital, spreading coverage in a medium-to-large hospital with high ED volumes is unwise. 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 the following:

- ❖ 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 paid time off
- ❖ Case aides, documentation specialists, case managers in admitting (depending on the model)

Caseload numbers per full-time equivalent (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 as a proxy for the complexity of the organization and patients' conditions. The amount and type of liaison staff, role and level of social workers (e.g., having a bachelor's or a master's degree), presence of on-site payers, structure of medical staff, and type of technology/software all have bearing on the number of FTEs and how the organization deploys personnel. 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:

- ❖ The hospital becomes concerned about flow and capacity issues
- ❖ 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.<sup>12</sup>

Being an active part of the entire department is essential for ED case managers and social workers. The work can be isolating unless there are continuous connections with the director, peers, physician advisor, and others. 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 to population health programs.

## The Future of ED CM

The ED will soon no longer serve as the welcome mat for the community, because the role of the entire hospital in the continuum of healthcare services is going through rapid transformation. “Indeed, regardless of payer mix, bed size or ownership status, the business model of American hospitals is in a time of upheaval. As healthcare moves from a volume-based payment system to one that rewards value—cost divided by quality—inpatient hospital utilization is no longer the breadwinner it used to be. In fact, emerging payer models discourage hospital use as much as possible.”<sup>13</sup> One hospital in Cumberland, Maryland, has been part of a group of nine other hospitals that moved to an entirely value-based payment system. “That means that the traditional delivery model, with the hospital and the emergency department at the center, has been replaced with a continuum of care that elevates the importance of pre-acute services such as retail pharmacies and urgent care centers, and postacute services, including rehabilitation and skilled nursing facilities, hospice, and palliative care,” their hospital president and CEO, Barry Ronan, states. “We’re out there, constantly trying to explain to folks why they need to seek alternatives to the ED and why they may not be admitted to the hospital now, when a few years ago, they would have been admitted for the same medical situation.”<sup>13</sup>

To accomplish these goals, it will be crucial for CM RNs and social workers to have an accurate and detailed benefit profile for each patient upon entry to the ED and a rapidly determined diagnosis. To continue to be helpful to EDs as well as the increasing volume of dedicated short-stay/observation units, CM professionals will need new mindsets and methods.

New mindsets will include:

- ❖ Clinical knowledge to anticipate the condition or illness trajectory and create immediate, individualized pictorial plans of care in the patient's language
- ❖ Knowledge of the costs of various options for inpatient and outpatient follow-up and medications, with medications delivered if and when the patient is discharged directly from the ED
- ❖ Appreciation and support of the performance measurements for EDs established by The Centers for Medicare & Medicaid Services (CMS):

*“Previous CMS ED measures related primarily to clinical processes (median time to ECG). Pending measures continue to focus on clinical processes (time to pain management and troponin results). But CMS has signaled a willingness to look more globally at ED processes by including the throughput measures (arrival to departure for admitted and discharged patients, decision to admit, door-to-diagnostic evaluation, and left before being seen). CMS has fended off criticism of these ‘nonclinical’ measures by stating that despite their lack of focus on a specific clinical issue, they capture the totality of the ED experience, which frequently includes collaboration and coordination between many departments through the hospital.”<sup>5</sup>*

New methods of operating will include:

- ❖ Possibly merging clinical documentation and UR functions in the ED
- ❖ If the ED is in a hospital located on a border state, using international CM assistance
- ❖ Transition planning to narrow networks of postacute vendors for services

To predict the future of ED CM, 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.

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
- ❖ 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 technology and other tools for patient placement and disposition planning, including electronic bedboards and discharge-planning software
- ❖ An increased focus on prevention of hospitalizations 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 and hub
- ❖ Mobile EDs that go on call to homes and offices, such as described in Spotlight 6-1

## 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 non-lethal 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, your family, the ED case manager, social worker, and other key team members, including your PCP and specialists.

## Scenario 2

Now envision this scenario: Your family is absolutely at its 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.

## Scenario 3

You are a female paraplegic with an indwelling catheter and encounter about approximately two UTIs (urinary tract infections) a year. Today you also have red blood in your catheter bag. You go to your local ED because it is Sunday, close to your house, efficient, gives good care and—most importantly—it is connected by an electronic medical record to your PCP, your PCP's case manager (your medical home), and your several specialists (your medical neighborhood). The ED knows you are allergic to certain antibiotics, but quickly conducts a urinalysis, culture, and sensitivity, and other blood tests

and orders you Cipro®. After a day on Cipro, you get a call from the ED to say that the Cipro will be ineffective to resolve the cause of your UTI, and the ED sends an email to your PCP about the antibiotics that will work. Your PCP orders the new antibiotic and you pick it up within hours so you can be on your way to health.

## Scenario 4

You are a patient in 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 to give you a name and appointment. Similarly, if you need a bed in a shelter, hospice, or nursing home, the ED case managers may 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 email 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 a van with a nurse practitioner (NP) or EMT that will come to you. Obviously, future EDs will need both RN case managers and social workers. They will have expanded scope, expanded hours, and the necessary authority to truly make a difference in the lives of people and the life of the community.

### Spotlight 1-1: A Piece in the Puzzle—Development of a Health Systemwide Transfer Center

*Andrea Snyder, RN, CCRN*

A concept was developed in 2006 as a collaborative initiative between an extensive health system and a county emergency medical service (EMS). Lee Memorial Health System (LMHS) and Lee County EMS (LCEMS) in Ft. Meyers, Florida, went on a retreat to develop a plan that would lead to a unified approach with interfacility patient transfers. It was identified to proceed "as pieces of a puzzle."

LMHS is a six-hospital public health system located at four separate campuses. LMHS comprises four acute-care hospitals and two specialty hospitals, including a children's hospital and an acute rehabilitation center, for a total of 1,423 licensed beds. The Lee Memorial Hospital is a regional trauma center for the surrounding five counties with 2,000 injured patients seen per year, and annual total admissions to the system is 81,500. As healthcare is an ever-changing dynamic, the need to move patients to the appropriate healthcare center will remain if not increase. Service lines of care and specialty centers of care are continuing to develop and specialize to the needs of healthcare in the community.

The retreat started with recognizing the challenges and limitations that existed—a four-part puzzle that required solving it piece by piece. Immediate goals were established to meet the needs of patient safety and to optimally utilize their resources of both organizations (LMHS and LCEMS).

The first and most important lesson learned was to organize and control the number of transfers. Due to having no central clearing point, any member of the patient care team could initiate a transfer on a physician's order without regard for the necessity of the transfer, the level of care to be provided, or the financial impact to both organizations. It was easily recognized that a knowledge deficit existed and could be quickly repaired with staff education. This repair would enhance the communication needed between each provider (hospital and ambulance staff) for the proper safe handoff of patient care, ensure the continuity of care, and be fiscally responsible to both organizations.

### **The first piece of the puzzle**

The approach to the first piece of the puzzle was to establish a Transfer Center staffed with critical care/ED nurses who could assess the needs of the patient and the reason for the transfer. This approach was enhanced with the ED case management program already in place at each campus, and their role was crucial for assisting with the validity of the ED patient transfer and the assurance that an appropriate physician was in place to care for the patient. It was quickly realized that all the case management staff throughout the system was vital to the success of the Transfer Center.

With the large health system being in a seasonal community, ED visits fluctuated. There are 170,000 annual ED visits combined during peak months of the year, and resulting overcrowding would occur. It became necessary to communicate the ED flow and census to the 911 system to facilitate delivery of patients and thus avoid overloading of a particular campus. This, then, grew into the information sharing of specific service line coverage at an individual campus to assist in the delivery of the patient to the most appropriate site the first time.

The Transfer Center became the central control point, rapidly identifying the trends in patients requiring movement and the need to reevaluate the current process. Nonessential transfers, such as for physician convenience or patient preference, were quickly reduced, and the focus was then placed on the real needs of each organization. Each patient transfer that required an ambulance affected the EMS system and its core mission to meet the community needs for emergency services. Patient transfers were delayed as needed, which affected total system bed flow or possible delays in care.

The Transfer Center established a priority protocol for patient movement; this resulted in fewer patient care delays and allowed EMS to meet its mission. This protocol included providing education to all staff members in the health system to notify the Transfer Center as early as possible regarding a pending transfer. The early notification allowed the RN staff to evaluate each case and have the opportunity to intervene with the care management teams and physician staff for alternative solutions. The physical location of the Transfer Center was in a centralized location, and the need for access to each hospital was identified via electronic charting and information services. The center was set up with complete electronic record access to each site and visual references of large screen monitors on the wall to easily see the activity in each ED. This assisted the Transfer Center RN to predict transfers related to specialized service lines for trauma, stroke, tertiary cardiology, and pediatrics.

Figure 1.2 | Transfer Center, Lee Memorial Health System



### The second piece of the puzzle

The first piece of the puzzle to centralize information moved rapidly. The second piece included moving the Transfer Center into another location along with EMS personnel and access to information systems. A destination coordinator position was created by EMS to facilitate open communication between the two organizations in real-time mode. This enabled EMS to know where a service line was on call and to direct ambulances to the appropriate facility. It in turn assisted the Transfer Center coordinators with monitoring of the ambulances and heading off any delays that may impact patients. With this direct interactive collaboration of both roles, the overall relationships for both organizations grew toward the common goal and missions for each.

### The third piece of the puzzle

The third piece was to have centralized control of any patient entering into the health system from a surrounding county. Many of the areas outside the immediate county are considered rural with critical access hospitals only. Due to these limitations, patients need to be transferred to our system for tertiary care. As with many transfer centers, the transfer process consistently allows for a smooth transition into the system with 1) patient safety at the forefront, 2) appropriate physician acceptance, and 3) verification that the organization could deliver the appropriate level of care. In a multiple-site system, several campuses may have been simultaneously working on transferring the same patient with multiple physicians and beds being reserved. As the centralized point of contact, the Transfer Center resolved the issue of multiple efforts for a single patient transaction. In this public hospital system, the Transfer Center staff took on a key role verifying the financial obligations for each admission to the system with the admissions department leadership.

### The fourth piece of the puzzle

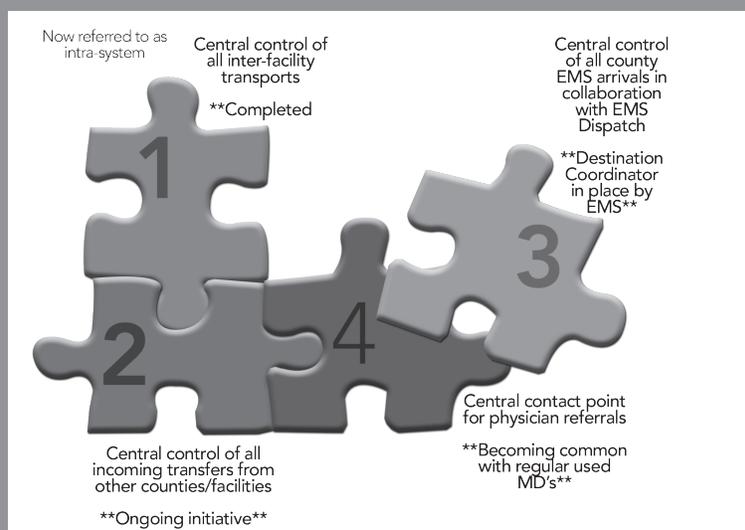
As the momentum developed with each additional piece of the puzzle solved, the department expanded quickly to 24 hours and took on additional responsibilities. Initially, the fourth piece, having a central contact point for physician referrals and admissions, was considered long-term; however, solving

the third piece made the last goal real and timely. Referrals became known as the “direct admission” from the primary care physician office. The Transfer Center handled coordination for each admission, verifying communication between the primary care physician and the accepting hospitalist for continuity of care. The Transfer Center staff followed their triage process to evaluate the stability of the patient and appropriate level of care that would be required.

The direct admission process was the most difficult piece to fit into place. It was a significant change in our culture for the primary care physicians who previously had admitted as needed via the administrative house supervisor. But campus administrative house supervisors weren’t always aware when another bed was being made available at another campus or whether the patient would need an ED evaluation first. With the key principles followed by the Transfer Center—patient safety and the appropriate level of care kept in the forefront—staff evaluated direct admission beds accordingly. Because of direct communication to the administrative supervisor and the ability to look at the total needs of the system, the patient was assigned to a bed or was admitted through the ED after initial stabilization. Previously, patients too often arrived for a bed and were found to be unstable due to the lack of communication between the physicians. With the screening process and evaluation done by the Transfer Center, staff members made the most optimal decision possible in conjunction with the administrative house supervisor to directly place a patient in a bed at the appropriate level the first time and avoid a subsequent transfer.

With the fourth piece of the puzzle solved and the ideas for collaboration within and between organizations realized, staff members recognized that other projects could also be accomplished. The health system developed a community health service center with a goal to reduce ED visits by patients without a primary care physician setting. To build trust with the community, these patients had round-the-clock ability to call the center. The Transfer Center became the answering point for the patient during the night and weekend hours. Simple triage could help avoid an ED visit and set the patient up for appointments in the center. The community health setting has since expanded to three locations, and the Transfer Center continues to maintain the after-hours lines along with taking on behavioral health center calls.

**Figure 1.3 | Pieces of the Puzzle in Controlling Cost of Transport/Transfers and Associated Costs**



The puzzle is now together with the original four critical pieces in place, but it is not yet completely finished. It must remain dynamic to keep in pace with process changes required due to insurance reimbursements, length-of-stay allowances, centers of excellence development, and discharge planning. The organization did accomplish the initial goal of reducing nonessential transfers by reducing the outpatient center transfers for PET scans, specialized MRIs, and physician convenience. The development and recognition of specialized service lines of care and centers of excellence have caused an increase in the need to transfer certain populations for stroke, trauma, and pediatrics. These transports come at a short-term cost to the system but will be a benefit to the patient and the system in the long-term. Each new development is monitored by an interdisciplinary team for the continued benefit or risk of the transfers.

All of the information collected by the Transfer Center is maintained in a central database used by many departments. The data collection begins with every patient encounter, and staff monitors trends closely for changes occurring through the health system. The data show areas to improve upon related to financial obligations/responsibilities and utilization of resources. Projections have been made for on-call physician coverage expansion needs, evaluation of various department hours, and relocation of services to specific campus sites. Outpatient procedures continue to prove to be a financial challenge as well as a potential patient safety concern. With the data collection, however, specific teams of caregivers evaluate the outpatient procedures for necessity before the transfer will occur. This has been successful and incorporates a multidisciplinary approach to approve the transfer with safety and fiscal responsibilities in mind.

New projects are underway for the center. The patient transfers have transitioned to a private ambulance company, which allows EMS to meet its primary commitment to the community and allows the hospital to schedule the transports appropriately and prevent delays. The pediatric transfers are now completed by the Golisano Children's Hospital of Southwest Florida team and have been successful in providing the appropriate level of care for that specialized population. The Transfer Center has also expanded to provide additional RN staffing to an Advanced Life Support ambulance when needed for the complex critically ill or injured patient.

Moving forward, the center will continue to grow and adapt for every need of the health system and community, as its advantages are numerous (see Figure 1.4). It will remain dynamic to meet the needs for any patient requiring a transfer and to meet the challenges that are on the horizon.

Figure 1.4 | Summary of Identified Transfer Center Benefits

	BENEFIT	CATEGORY	MEASURE
INTER-FACILITY	REDUCE ↓	Inappropriate Transfers	Denials of inappropriate transfers x transfer costs
	INCREASE ↑	Logistics / Coordination/ Prioritization between: EMS/LMHS/Physicians	
	ENABLE	System shift to increased specialization	Anticipated increase in inter-facility transfers
EXTERNAL	REDUCE ↓	No coverage and Inappropriate External Transfers	Denials of transfers x ave. DRG/LOS self pay cost = cost avoidance
	INCREASE ↑	Correct hospital location – initial EMS delivery	See below
	REDUCE ↓	Subsequent inter-facility transfers	Reduction of inter- facility transfers

### Spotlight 1-2: Connecting Case Management and Patient Placement: Strengthening Resources to Manage Hospital Entry

*Bonnie M. Geld, MSW*

The relationship between hospital case management (CM) departments and the function of bed management has often been vague, and a true partnership has rarely been realized. Additionally, bed management (i.e., patient placement) teams are often undeveloped as a clinical function to support patient progression. Yet, both case management and patient placement functions are integral to launching the patient into care. By synergizing the clinical work of these teams, hospital leadership can be more assured of getting the patient in the right location, level of care, and status. Doing so will provide improved outcomes in the following areas:

- ❖ Fewer bed turnovers (i.e., patients in the right bed will not need to move unless they have a clinical need to move to a higher or lower level of care), which in turn lowers the cost per case
- ❖ Reductions in high-cost boarder days
- ❖ Reductions in Code 44 status changes
- ❖ More immediate and appropriate care plans upon admission (i.e., no loss of time in directing appropriate care)
- ❖ Physician and nursing satisfaction
- ❖ Patient satisfaction

At Baystate Health in Springfield, Massachusetts, a synergy of these practices occurred in 2012. The director of case management, Bonnie M. Geld, MSW, advocated to lead the patient placement team (a clinically based bed-management team) to ensure integration of efforts at the front end. Both teams came under the organizational chart of CM leading up to the chief medical officer. Patient placement managers (who are RNs) completed medical necessity training (via InterQual™ light) to ensure that they

would understand level-of-care and status concepts as they identified the appropriate bed for patients being admitted from the following five portals:

- ❖ ED
- ❖ Direct admissions
- ❖ Scheduled surgical admissions
- ❖ Acute care transfers
- ❖ Interlevel transfers (i.e., patient's transferring between levels of care)

The central function used to pull everyone together was the development of the three-way call. Upon the request for a bed into the hospital, the patient placement manager evaluated the patient based on level-of-care and geographic needs (by disease entity). She or he determined who the attending physician would be and created a three-way conversation along with the physician requesting the bed and the physician accepting the patient. During this call, the patient placement manager listened and guided the decision on level of care. A great byproduct of this call was greater knowledge of medical necessity and admissions needs on the part of the ED physicians. Case managers in the ED reported that they experienced an improved partnership with the physicians when it came to making admission decisions. As a result, the organization realized significant improvements in reducing bed turnovers and Condition Code 44 changes. Additionally, staff and patients were pleased with the process.

As the patient placement managers became more adept in their function and knowledge of medical necessity, the CM team realized the fullness of the partnership. Patient placement managers began contacting the ED or inpatient case managers with avoidable admissions and discharge planning needs. Over the course of six months, the patient placement managers facilitated 45 ED discharge plans (all on the phone with support from RNs in the ED) and avoided 34 unnecessary admissions.

In 2013, Baystate opened a dedicated observation unit. The unit uses 12 different protocols. The patient placement manager was instrumental in ensuring that the unit remained exclusively for observation patients so expected outcomes could be realized. While on the three-way call, the patient placement managers and ED case manager identify which patients will go into the observation unit. The unit has been a success and continues to move forward in maintaining these patients with the expectation of decreasing the observation length of stay.

Both teams became increasingly information-rich and provided a more thorough start to patient care. Before integrating the two teams, both were siloed and did not see that, together, they are a mighty force in managing appropriate entry into the organization.

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# SECOND EDITION EMERGENCY DEPARTMENT CASE MANAGEMENT

The Compendium of Best Practices

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From defining goals, clarifying roles, and understanding the necessary knowledge and skills required, ***Emergency Department Case Management: The Compendium of Best Practices, 2nd Edition*** will ensure that ED case management staff have a solid and sustainable foundation in place.

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