**Clinical Protocol**

**RN ER Case Management**

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<th>Staff Role:</th>
<th>RN</th>
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**Protocol Summary:** Comprehensive, proactive case management for all patients who have had known recent ER visit.

**ER Transition Care**

1) ER record (get ER record if aware from pt or census) reviewed.

2) Looking for date and diagnosis.

3) Look into eCW for TE, documents or encounters to see what is already in place for this condition.

4) Triage diagnosis and assessing need for follow up.
   a. Low risk – no need for intervention. Ex. Condition handled completely by ER staff (sprain ankle, simple URI)
   b. Medium risk – infection, wound, trauma, pending labs, sutures, fracture, medication change, etc. potential follow up or tracking needed. Phone call or office visit should be established.
   c. High Risk - Elderly, pregnant, young children, multiple co-morbidities, HIV, serious infections, cardiac condition, serious pulmonary condition, vascular event (DVT, TIA), significant new diagnosis, significant medication concern. – Phone call to triage current status and appointment within 48hrs or earlier.
   d. Recurrent ER visits – consider referral to high risk case management team (Dave Murphy).

5) Communication with Care Team (to be determined by need) –
   a. By TE or in Document notes for FYI.
   b. Note in HPI for future Progress note.
   c. Care conference

6) Tracking
   a. Follow up on pending labs, DI or other care items initiated in ER visit.
   b. Update chart for items completed in ER visit (Immunizations, procedures, allergies, medications, tracked labs)

**Effective Date:** 9/1/2011

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<th>Supervisor Approval:</th>
<th>Medical Director Approval: JLC Initial</th>
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