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When high pressure, system constraints, and a social justice mission collide: a socio-structural analysis of emergency department social work services

Megan Moore^{1,2}, Margaret Cristofalo¹, Danae Dotolo¹, Nicole Torres, Alexandra Lahdya, Leyna Ho, Mia Vogel¹, Mollie Forrester³, Bonnie Conley³, and Susan Fouts³

¹School of Social Work, University of Washington

²Harborview Injury Prevention and Research Center, University of Washington

³University of Washington, Harborview Medical Center

Abstract

The emergency department (ED) can be a critical intervention point for many patients with multifaceted needs. Social workers have long been part of interdisciplinary ED teams. This study aimed to contribute to the limited understanding of social worker-patient interactions and factors influencing social work services in this setting. This paper reports a qualitative content analysis of social work medical record notes (N=1,509) of services provided to trauma patients in an urban, public, level 1 trauma center and an in-depth analysis of semi-structured interviews with ED social workers (N=10). Eight major social work roles were identified: investigator, gatekeeper, resource broker, care coordinator, problem solver, crisis manager, advocate, discharge planner. Analyses revealed a complex interplay between ED social work services and multi-layered contexts. Using a social-ecological framework, we identified the interactions between micro or individual level factors, mezzo or local system level factors and macro environmental and systemic factors that play a role in ED interactions and patient services. Macro-level contextual influences were socio-structural forces including socioeconomic barriers to health, social hierarchies that reflected power differentials between providers and patients, and distrust or bias. Mezzo-level forces were limited resources, lack of healthcare system coordination, a challenging hierarchy within the medical model and the pressure to discharge patients quickly. Micro-level factors included characteristics of patients and social workers, complexity of patient stressors, empathic strain, lack of closure and compassion. All of these forces were at play in patient-social worker interactions and impacted service provision. Social workers were at times able to successfully navigate these forces, yet at other times these challenges were insurmountable. A conceptual model of ED social work and the influences on the patient-social worker interactions was developed to assist in guiding innovative research and practice models to improve services and outcomes in the complex, fast-paced ED.

Correspondence to: Megan Moore.

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Keywords

United States; emergency department; social work; electronic medical records; ecological framework

1. Introduction

In 1913 Ida M. Cannon, one of the first hospital social workers in the US, wrote “The problems of many hospital patients are social as well as medical.” (pg 2). In her formative book on medical social work at the turn of the 20th century she outlined what are now called social determinants of health long before the term or its underlying concepts were widely used. She connected social factors like environmental conditions and poverty to human health outcomes. In addition, she outlined key mechanisms for addressing patient needs such as social worker skill, knowledge, and availability of community resources (Cannon, 1913). There now exists a substantial body of evidence to support what Cannon and other progressives of her time observed in their work: remediable social conditions impact health and are responsible for inequalities in health outcomes (World Health Organization, 2016). Cannon’s initial ideas about the components of medical social work practice necessary for successful intervention on social conditions provided a foundation in the field and have been expanded. Social workers now have access to evidence-based practices developed to address behavioral and psychosocial concerns in medical settings. They are integral members of interdisciplinary medical teams and provide many different services in a variety of settings (Beder, 2006). Medical social work has developed with a focus on enacting the social justice mission of the profession, specifically this focus includes working to “meet the basic human needs of all people, with a particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW, 2008). The present study focused on understanding social work services in the Emergency Department (ED), a critical setting for social justice oriented interventions for individuals who are medically vulnerable, disenfranchised, oppressed, or living in poverty.

1.1. Emergency departments and the healthcare system

ED utilization has been increasing and the nature of use has been changing (Hsia et al., 2015). Once envisioned as a place to treat and coordinate trauma care, the role of the ED in the healthcare system has expanded to include not only emergency medical services, but also comprehensive care for those who cannot access care elsewhere. This includes assessing medically complex patients, processing hospital admissions, and surveillance of injuries and infectious disease (Hsia et al., 2015). While the trend towards the expanding role of the ED in the healthcare system has been noted as far back as 1970 (Torrens & Yedvab, 1970), the passage of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 marked a turning point in the speed at which the trend was occurring. EMTALA guaranteed screening and stabilization for all persons, regardless of one’s ability to pay or other characteristics such as immigration status. The role of the ED as the healthcare system’s largest safety net has steadily and significantly increased after EMTALA (Pitts et al., 2008).

There are indications that with the increased number of insured individuals in the US due to the passage of the Affordable Care Act (ACA) ED use will continue to rise, at least initially, for certain populations at risk (Taubman et al., 2014; Smulowitz et al., 2011). The medical home model emphasized in the ACA may prove challenging for some patients who have psychosocial, economic and employment barriers to accessing care during regular hours or in a preventative manner, and it is unclear what changes will be made to the ACA in the coming years that may impact patient access to insurance and care. The ED is a safety net and will continue to be an important social work intervention point for many disenfranchised individuals.

1.2. Social work in the emergency department

Social workers' role in the ED has become increasingly important as ED use has increased and the role of the ED in the healthcare system has evolved (Moore et al., 2012). The 2010 Institute of Medicine report highlighted the importance of addressing social determinants of health (Institute of Medicine, 2010), and the ED, as part of the US medical safety net, is an important medical setting to address the social needs that impede health for vulnerable populations (Almgren & Lindhorst, 2012; Shankar, 2015). Social workers are the frontline providers of social services in the ED setting. They are crucial team members whose work supports the mission and everyday functioning of the ED (Gordon, 2001). Understanding and optimizing their roles and the context within which they practice is key to addressing the social factors that affect health and to improving the functioning of a critical safety net medical setting. Social workers in the ED provide care coordination services and mental health services, including chemical dependency counseling and crisis counseling; they provide thorough assessments and concrete services such as shelter and transportation that contribute to effective discharge plans for complex patients with multiple comorbidities and service needs (Moore et al., 2016). They can save medical providers' time (Gordon, 2001), enroll patients in insurance programs (Mahajan, et al., 2005), and assist with developing home care and discharge plans (Auerbach, et al., 2001). In the ED, social workers often receive referrals for patients with the most complex mental health and social needs (Auerbach, et al., 2001; Auerbach, et al., 2007; Auerbach and Mason, 2010). Much of the available research on ED social services has focused on types of services provided (see references above), a specific patient population (see for instance the many studies related to high users of the ED summarized in Moe, et al., 2016; Soril, et al., 2015), or specific interventions (see for instance the many studies testing SBIRT summarized in Babor, et al., 2007). There is an absence of research that explores the social meaning behind the human interaction that takes place when a patient meets with a social worker in the ED. This is particularly important because of the potential impact of social workers in this setting on addressing the social determinants of poor health such as social support, financial resources, and housing.

The ED environment is often characterized by high volumes of patients, limited physical space and pressure to discharge patients quickly. Examining the nature of the interactions between social workers and patients in this busy, high pressure, stressful ED environment is of crucial importance to contextualizing the impact of a social worker in such a fast-paced setting. Each interaction symbolizes the multi-level socio-structural influences which are

equally important to understanding ED social work services in the context of the healthcare system with a goal towards engagement at multiple levels to improve services and patient outcomes.

Social workers typically document their services and elements of the patient interaction in the electronic medical record (EMR). These records provide a glimpse into the work, the social workers' thought processes and the context of social work interventions in the ED. In the present study, we conducted an in-depth analysis of the ED social work EMR data coupled with social worker interviews exploring their interpretations of the EMR data and their experiences of interacting with patients to elucidate what it means to be a social worker in the ED and the nature of the social worker-patient interaction. We utilized Bronfenbrenner's (1977) social-ecological model as a guide for this analysis. This model places an emphasis on the macro or structural, mezzo or local system level and micro or individual level influences on a process (Bronfenbrenner, 1977). It allows for a multi-layered conceptualization of a particular process, in this case the ED social worker-patient interaction contextualized within mezzo and macro influences (e.g. the medical center and limited community resources). It was chosen as a guiding framework for this analysis because of its decades-long influence on social work training and practice models (Ungar, 2002). Ecology has been defined as "the interdisciplinary scientific study of the living conditions of organisms in interaction with each other and with their surroundings" (Naess, 1989, p.36). Social work has a long history, from Ida M. Cannon to Jane Addams and other founding mothers of the field, of focusing on "individual well-being in a social context and the well-being of society" (NASW, 2008). Ecological perspectives have been influential in the field of social work because of the natural alignment of ecology and the mission of social work to understand the person within their environment (Ungar, 2002). This paper presents a unique and layered socio-structural analysis of ED social work services. This analysis is critical at a time when attention to socioeconomic and environmental determinants have been deemed central to improving population health, with actionable targets identified at the individual and societal level (Institute of Medicine, 2010). Understanding ED social work services through a social ecological or socio-structural lens allows for identification of training, practice, and system targets to address socioeconomic and environmental determinants in the ED medical safety net.

2. Methods

2.1. Study location

The setting for the present study was an urban, public, level 1 trauma center ED. The payer mix for patients seen was diverse, including privately funded, publicly funded and unfunded patients. While social workers did not focus on serving patients with a particular medical diagnosis, they prioritized serving minors, homeless individuals, trauma patients, assault victims and those with substance abuse issues. There were at least two masters level social workers on duty 24 hours a day, seven days a week.

2.2. Sampling procedure

EMR data were extracted for patients (N=1,509) seen by social workers who were being treated for a traumatic brain injury and were not admitted to the hospital during their first visit to the ED in the study period January 1, 2012-March 31, 2013. The initial purpose of this study was to elucidate social work services to this group of patients. However, our questions evolved and new questions were generated as we conducted the analysis, a common process in qualitative research (Creswell, 2007). Specifically, the analytic focus shifted to social work services in the ED in general after analyses revealed that a distinction between patients by traumatic brain injury diagnosis was not relevant to the social work staff or to the provision of social work services. In part this is likely due to the fact that diagnoses in the EMR served as billing codes and each patient visit was generally associated with multiple diagnoses. These diagnoses were not typically the focus of social work treatment in the ED. This is discussed further in results section. Data were extracted using the Microsoft Amalga platform (Microsoft, 2016).

To recruit social work staff for interviews, researchers used a purposeful, homogeneous sampling strategy (Miles & Huberman, 1994). All ED social workers at the medical center were invited to participate in group interviews. They were informed about the opportunity to participate through flyers and word of mouth at monthly meetings. Participation was voluntary. Participants were compensated for their time with \$50 gift cards. N=10 social workers participated, which was 45% of all ED social workers (excluding supervisors) and 59% of all non-hourly, regular staff. All study procedures were approved by the University of Washington human subjects division.

2.3. Data sources and collection procedure

At the end of each patient interaction, social workers documented the encounter in the EMR with a note. Notes included patient symptoms, circumstances surrounding ED visit, biopsychosocial assessments, types of services provided, social worker perceptions of patients, descriptions of ED interactions and context.

A semi-structured interview was created addressing the general and specific roles and challenges of ED social work. We utilized a social-ecological framework to inform interview questions (Bronfenbrenner, 1977). This framework employs nested levels of the environment (Micro: individual; Mezzo: community/organizational; and Macro: societal/cultural) and captures the mutual interactions and influences of all entities within and between levels. We tailored the framework to include factors affecting social work practice in the ED on each level; the macro level includes socio-structural forces, the mezzo level includes forces in the local healthcare system and emergency department, and the micro level includes the social worker-patient interaction. The interview consisted of predominantly open-ended questions about social workers' experiences working in the ED and their impressions of the influences of micro, mezzo, and macro forces on their work, for example, non-social work professionals with whom they collaborate in the ED (micro), external organizations (mezzo), and state health policy (macro). Participants were also asked to interpret the meaning and context of a select set of EMR notes. Research interviews were conducted by a skilled qualitative research interviewer, accompanied by another researcher who took notes on the

interview content. All interviews were audio taped and transcribed verbatim with signed consent of all participants. Interviews were confidential and participant names were not linked with any specific comments made. Participants were allowed to speak freely and to raise their own topics during the process. Interviews ranged in duration from one to two hours.

2.4. Analysis

Researchers utilized inductive qualitative content analysis (Elo & Kyngas, 2008; Hsieh & Shannon, 2005). Data were read word for word to derive codes that captured key concepts or thoughts. Codes were then sorted into higher order concepts or categories based on how they were related or linked (Morse & Field, 1995). The aim was to describe a phenomenon, and the outcome of the analysis was the categories that described the phenomenon, which could then be used to build the conceptual model (Elo & Kyngas, 2008; Hsieh & Shannon, 2005).

Six coders read and analyzed the ED social work notes from the EMR. Coders identified categories and wrote reflective memos on their thought processes and analytic frames. The group met each week to discuss the coding process and emerging concepts and answer questions. Detailed notes were taken at these meetings. Next, coders analyzed all memos and meeting notes. Coders worked to come to consensus on primary concepts extracted from the combination of ED notes, memos, and meeting notes. A codebook was developed through the iterative process of coding, revising, refining, and defining codes. The analysis of the ED social work EMR notes introduced clarifications needed from the social workers, and informed development of the interview questions. In addition to generating questions, the results of the analysis of the EMR data ultimately corroborated results of the interview data. Finally, two coders who conducted the interviews of ED social workers, analyzed the interview transcripts using the same iterative process of coding, revising, refining, and defining concepts from the interviews to come to a consensus on the primary themes. These were incorporated into the original codebook. Dedoose qualitative analysis software was used for all analyses (Dedoose, 2015).

The results were used to develop an adapted ecological model (Figure 1) by interpreting the results within the basic framework of the ecological model. This framework includes micro, mezzo and macro level influences on a process, in this case the ED social worker and patient interaction. Through an iterative process of team discussion, we placed the themes within the ecological framework and then expanded the model to include the specific contextual factors relevant to this analysis such as the presenting medical complaint of the patient and barriers and facilitators to a safe ED discharge. The final model was agreed upon by all team members.

3. Results

3.1. EMR data and social worker participants

Our initial focus on services to patients with traumatic brain injury shifted as we analyzed the EMR data, which revealed virtually no specific traumatic brain injury services. This shift was further supported by the social worker interviews in which they reported this diagnostic

distinction was not highly relevant to their work. One social worker summed up what all reported.

“...I’m not going to see someone just because they had a TBI (traumatic brain injury) and just to acknowledge that. I’m going to see them if I’m helping them discharge, if I’m helping them go to a mental health facility, if I’m helping... redirect them to their primary care physician... There has to be specific reason [non-TBI related] we see a patient.” (Participant 1)

Social workers concentrated on the psychosocial needs of patients, which were sometimes related to their medical diagnosis and sometimes unrelated. Social workers provided information about traumatic brain injury only in the context of other priorities, which they viewed as largely unrelated to the diagnosis. They offered rich contextual information about the complexities of their roles, ED services and their work broadly in this setting with patients with varying diagnoses. Analysis of the EMR data and interviews together revealed a multi-layered, interrelated structure of influence on the patient-social worker interaction in the ED. It allowed for delineation of the various roles that social workers played in the ED and the nature of the emotional, cognitive, and professional demands of the job.

3.2. Boundary spanning roles of social workers

Social workers performed many different roles in the ED. Outlined in Table 1 are the eight major roles identified through the EMR coding process and confirmed in interviews. Social workers were boundary spanners, expected to perform a variety of roles and deliver varied services. Potentially all in the course of one shift, they might be required to quickly shift between each role. One social worker talked about the challenges of multiple roles in the context of providing bereavement services to families after sudden patient death in the ED:

“The pressure is to remain present with the family when you have all these other things still going on. You’re still an Emergency Department social worker...so you can get...pulled into other directions while trying to support this really devastating trauma. So that’s our biggest challenge: How can I continue to provide support to this family while doing my other multiple tasks that still have to be done? And it happens a lot.” (Participant 1)

Despite efforts to span many role boundaries, social workers reported often finding themselves at a loss to provide ideal services to patients. They were aware of some of the system and institutional forces that played a role in their (in)ability to meet the social justice mission of their work. Below we identified macro, mezzo, and micro level forces influencing social work practice in the ED. The next sections synthesize the impacts of these forces on ED social work services. See Figure 1 for the social-ecological conceptual model of ED social work.

3.3. Macro-level forces: socio-structural influences on ED social work

Macro-level influences included socioeconomic barriers to health such as poverty, homelessness, unemployment, racism, classism, labels and stigma, social hierarchies within the Western medical model, and the judgments and community level consequences of those influences. These factors were at play in subtle and overt ways as social workers, other

healthcare professionals and patients attempted to navigate the physical, cognitive and emotional demands of the ED.

In the EMR notes, social workers reflected or reported on power differentials, distrust and bias in understanding patients' presenting situations and needs. The hierarchical culture of the medical model sometimes placed social workers in a mediating role between medical providers, patients and families. Social workers were positioned to act as agents or challengers of socio-structural forces such as racism and classism that lead to dominant discourse about a particular patient or group. One social worker explained a racial stereotype found in an EMR note written about a difficult interaction with a patient's family member this way:

"I could also see staff not having a lot of patience and tolerance for this, and honestly ... some of that would be some racial profiling, too. I mean, I hate to say it...there's kind of..., oh, you know, drunk Native American woman. There's just going to be a lower tolerance than if it was some bubbly 22 year-old white girl. I hate to say it but it's true." (Participant 5)

Due to a combination of complexity and severity of physical and mental illness, and lack of socioeconomic and community resources, some patients presented frequently in the ED for problems staff judged would be more appropriate for another setting. Social workers frequently referenced this perceived high and inappropriate utilization of the ED by patients and the negative attitudes this engendered in all ED staff.

"She's supposed to be seeing her PCP (primary care provider). She's not supposed to be coming to the hospital, and they are assigned specific PCPs ... and she was ... really challenging because she came for no reason. She came for like a cut on her leg. She was, for lack of better words, kind of annoying and she really grated on staff and people were just like, ugh, roll their eyes when they see her coming. That type of thing...so I would get really challenged because...part of me would be mad that she was there and then the other part of me is wanting to be more patient and try to really direct her." (Participant 1)

Social workers demonstrated understanding of the impact of structural influences on their patients and effects on treatment in the ED and larger health system. The following quote demonstrates how social workers understood the complexity of their patients' situations and the resource limitations that resulted:

"The resources for these significant crises for patients, are so incredibly limited, especially for the patient population that we see, which are usually unfunded, low-income, Medicaid, medically complex ... patients. Their options are really limited, you know? ... The resources are limited and they also get excluded from a lot of things. So it's tough!" (Participant 2)

Despite the grave effects of these structural forces, social workers expressed efforts to challenge the limitations by navigation of larger systems. The following quote illustrates how social workers obtained needed services for their patients:

“We’re used to navigating difficult systems. And most people work with us and understand that our patients might be more challenging than the average patient. So we already work within the systems ... that accept and also work with challenging people. The shelters we work with, they work with all people who have mental health issues, traumatic brain injury, drug and alcohol. So those are the systems we’re going to anyway, you know? We’re not going to systems that take private insurance only.” (Participant 1)

The macro, structural forces manifested in attitudes and beliefs as well as in concrete exclusions at the healthcare system level. They were diffuse and interacted with the mezzo and micro level forces to impact social work encounters in the ED.

3.4. Mezzo-level forces: local health and mental health care

Mezzo level influences included limited resources, lack of coordination among health, mental health, and social service systems organizations, unrealistic expectations by ED staff, lack of time to adequately assess and intervene with patients, interdisciplinary culture and the role of social control.

3.4.1. Resources and system coordination—The healthcare system within which the ED functioned was important in shaping the context of social work services and capacity for influencing services. The system was described as complex and often uncoordinated with many strained resources. Social workers found it difficult to meet the needs of their complex, poorly resourced patients in an uncoordinated system, as illustrated in the following quote.

“And a lot of our patients...[have] other social problems or other issues going on, whether it be other medical issues or chemical dependency or mental health, and so [we are] trying to solve one, but it’s like Whack-A-Mole ... we can get them to see somebody else but then something else is going to pop up and so ... there’s no way to just cover the whole thing. You’re just constantly picking up problems when in crisis, when they pop up, and trying to put them into the right resources.” (Participant 2)

Despite these challenges, social workers reported building good relationships with existing extramural organizations and some, albeit limited, resources for patients. The relationships and connections with community resources were important.

“It’s a small, little ‘social worky’ world. It’s amazing how paths cross and people know each other and it’s nice how interconnected it can be.” (Participant 5)

3.5. Mezzo-level forces: The emergency department and hospital contexts

3.5.1. Expectations—The ED and hospital institutional forces that impacted social work services included the expectation and pressure on social workers to “fix” entrenched and multisystemic problems.

“I think that there’s this expectation that ... we will have the answer ... In the social setting when ... we have these patients that come in and they’re [the ED staff] like, ‘Are you gonna be able to *fix* it?’ and pull resources out ... that somehow we will

be able to find a [discharge plan] that everyone agrees with or that everyone is comfortable with. And when we don't, someone is left unhappy. You know, either the patient or the providers and then we're stuck in the middle of it and... sometimes you feel like you're expected to solve a larger, more institutional problem." (Participant 2)

3.5.2. Time—In addition, time constraints placed on ED staff to quickly discharge patients and the competing priorities of social work staff to serve a high volume of patients with high levels of need was a major theme in the social work interviews. One social worker stated:

"... there's that pressure for [short] length of stay ... Seems to be a major challenge...the medical providers feeling that pressure to ... either have [the patient] be admitted or discharge them and even if they are admitted...that clock is ticking on you ... [you're] trying to advocate for the families because ... that pressure of length of stay, the discharge plan may not be quite ready to go yet, but the physicians, the medical team is feeling that pressure to have a plan and move forward with it." (Participant 4)

3.5.3. Interdisciplinary culture—The interdisciplinary nature of the ED required collaboration and teamwork skills in addition to clinical social work skills. A positive team culture of respect for social work staff was described, which assisted with navigation of the complex environment. There were also problems with the interdisciplinary hierarchy in the ED and hospital context that left social workers sometimes feeling powerless. The following quote highlights both the positive aspects of teamwork and hierarchical challenges that lead to feelings of powerlessness:

"There's a lot [of] disposition questions [from doctors]... 'this patient could technically do this. How can we make that possible? Or could we make that possible?' ... There's been times where I've said, 'I don't think that's a safe discharge plan.' And they value that. And they just say, 'OK. Well, then I guess the person's going to be admitted' ... and I do feel that at times where you feel like you hold no power, there are times where you do feel like you have kind of that say ... they [the doctors] kind of do value that." (Participant 2)

3.5.4. Social control—Another major theme in the social work interviews revealed the challenging nature of the social worker role as gatekeeper. This role sometimes included identifying patients' family members, escorting family members through ED, and maintaining safety in the ED.

"...[the social worker] has to manage the whole social aspect of what's going on here...she's got drunk people in the waiting room who are really upset and some of whom are going back into the ED without social work escort...and that's a no-no ... You might have to get security involved, which could stress the patient out more...a lot of times, we have people show up to the ED who are not even really good friends with the [patient]...they maybe were out that night, everybody's drunk and everybody wants to go bedside and people are pissed and upset. So that's the

pressure. The pressure on the social worker is to take care of this, so that the nurses and doctors don't have to." (Participant 5)

The "crowd control" or gatekeeper role of social workers impacted their ability to conduct the important clinical interventions that patients needed. One social worker stated:

"A lot of what was done was crowd control. Appeasing the providers, appeasing the family, and you can do that, and then all of a sudden, boom! The patient's gone and you never got a chance to do anything clinical because you spent all your time trying to put out fire and then they're a pain and the family's a pain and the ER wants them out and so as soon as they're ready to go, out they go. And then you never get a chance to even have a discussion or find out about anything."
(Participant 6)

The local system constraints, ED culture and professional challenges reflected how the macro-level forces were at play at the local level. These in turn influenced the social worker-patient interaction directly.

3.6. Micro-level forces: The social worker-patient interaction

At the heart of ED social work practice was a human interaction, an interpersonal exchange between the social worker and the patient. The importance of that cannot be overstated. The weight of the socio-structural, systemic and institutional forces bore down on this exchange in the many and complex ways described above, yet the core of the ED social workers' day-to-day work involved talking with patients and families and performing interventions at the micro-practice level. During these interactions the macro and mezzo level factors were not often forefront in the minds of social workers. Micro-level influences included complexity and severity of patient medical and psychosocial stressors, empathic strain experienced by social workers and compassion.

The personal characteristics of the patient, including racial/ethnic and socio-economic identity, depth and complexity of psychosocial stressors and needs and immediate health status impacted the interaction. The following quote illustrates the complexity of the stressors and challenges that patients faced:

"Our target populations are vulnerable and frequently they're getting discharged to the street because they don't have a place to live and they've got substance abuse issues, mental health issues. And so you'll get a certain amount of people who are trauma patients who fall off a roof and they have a family and a support system and insurance and someone to watch them and see how they're gonna turn out. We get other people, as soon as they're able to walk around and they're breathing and talking, they're kinda discharged – like a Band-Aid, you know? So it's kind of the haves and the have-nots. We have limited things that we can do." (Participant 8)

Other influences on the interaction and outcome included characteristics of the social worker, including personal identity, social work skills and values, professional identity, level of compassion and level of burnout as evidenced by what we labeled empathic strain. Several social workers vividly remembered individual patients and families they worked with and described with empathy the impact those patients had on their work and on them

personally. The incredible compassion demonstrated in the following quote shows how ED social workers understood and resisted the socio-structural, system and institutional forces that influence interpersonal interactions, their patients, and their work. Despite the high-pressure environment and boundary spanning roles, ED social workers were able to carry out the social justice mission and empathy called for by the social work profession. One social worker became emotional as she recalled a case from years ago:

“That made me think of a case that still upsets me. There was an older woman who was knocked to the ground by an unknown person ... so her family was all here and deciding about taking her off life support, but then they caught the person and it turned into a homicide case, so then the legal system had to get involved. And I was just really remembering, they took her off life support and they were able to say good-bye. But that was very challenging. Her family was great ... They were all on the same page. They designated a spokesperson. It was just, when it turned into a homicide that was just very difficult. The really, really serious people, they do stick with you for a long time.” (Participant 3)

Social workers also reported times when it was difficult to feel compassion for patients or when other providers demonstrated lack of empathy for patients, a concept known as empathic strain. It is derived from psychology and psychotherapy literature and is evidenced when interpersonal interactions between patient and provider lead to lowered provider empathy (Wilson & Lindy, 1994). It is synonymous with vicarious traumatization, a state that results when providers’ ability to process and intervene with victims of trauma becomes “stressed and overwhelmed” due to the unpredictable and emotional nature of hearing stories of others’ traumatic experiences (Shubs, 2008). In the ED, social workers were constantly confronted with stories of traumatic injury and death, abuse, homelessness, medical crisis and other devastating biopsychosocial situations with varying levels of amenability to social work services and often they were not afforded opportunities for emotional closure with patients. This, at times, led to demonstrations of empathic strain, which the following quote demonstrates.

“We can try to address it and try to kind of alter our approach to these patients. But at the same time, a lot of times [the patients are] just kind of grouped into like the chronically homeless, the chronic alcoholics. Just like, lost cause ... Get them what they need and get them out the door.” (P5)

One social worker described the difficulty of the limited positive clinical experiences and the sometimes invisible nature of the crisis work they do that may result in empathic strain. In referring to the difference between the inpatient social worker experience and the ED social worker experience, the ED social worker stated:

“You maybe run into the inpatient social worker and you’re like, ‘Hey, how’s that [former ED patient] doing?’ And they’re like, ‘Oh, they’re great! They’re awake, they’re talking, this is what’s happening.’ And you’re like, ‘Oh, good, I’m glad you got to experience this wonderful experience.’ Or they say, ‘The family got there and they were all at bedside and they said good-bye and we withdrew care and it was such a warm and positive experience.’ And we’re like, ‘Great, we called them and told them their that son was hit by a car and they were screaming and crying on the

phone to us. And so you kind of feel like this crisis work that you do sometimes was overlooked and then you don't ever get to feel that closure. It kind of eats away...at you." (Participant 2)

Another theme noted in the social worker interviews was the fleeting nature of interactions with patients, another likely contributor to empathic strain. The lack of closure marking the ED social worker-patient interaction and intervention was a source of frustration and sadness.

"We see so many who do go out the door with their supportive family and they follow up in the clinic or something like that, but we never see them again. And so we never know how they're doing. Or they go [inpatient] and then the care is passed on to the inpatient social workers and we move on to the next day, to the next patient, to the next crisis and we never see what happens ever again. And, I mean, it is this feeling of kind of almost like an incomplete feeling of helping somebody but not seeing the results of your care or your resources or what you provide." (Participant 2).

Work in the ED was described as emotionally challenging with few opportunities to participate in or even learn about the final outcome of the patient care experience. This, coupled with the traumatic nature of the work sometimes contributed to empathic strain. Other times, social workers transcended the macro, mezzo and micro level factors described above and demonstrated compassion and empathy in devastating circumstances. One social worker summed up the unique challenges of the job and attitudes of ED social workers:

"I mean, really, our job is to do the hard stuff with people and have really tough conversations and educate and advocate for patients with families...I think all of us are very comfortable [with traumatic situations]. I think that's a great thing about ED social workers. We just dive right in." (Participant 5)

4. Discussion

The ACA has provided much needed access to insurance coverage and guidelines for coordinated care models to improve care quality (Obama, 2016). Although the future landscape of insurance coverage in the US remains unclear, some of the problems continuing to plague the healthcare system such as the shortage of primary care physicians, patient exclusions from insurance under the ACA, and economic or hassle related barriers to use of preventative care in office-based outpatient settings, are likely to contribute to continued use of the ED as a source of not only emergency medical care but also as a major safety net medical setting for underserved patients with multifaceted needs. Social workers are trained in the skills needed to serve these complicated patients and are often the frontline providers of psychosocial interventions in the setting (Moore et al, 2016). However, their contributions to patient care and the ongoing challenges faced by these important healthcare professionals has been understudied. Understanding the contributions and challenges has implications for training and practice standards and for system level changes, particularly in the context of the ACA, which in its current form incentivizes continuity of care between hospital and outpatient based health services requiring enhanced interprofessional team approaches to practice that may increasingly draw on the expertise of social workers.

In the present study we utilized a social ecological approach (Bronfenbrenner, 1977) to understand and explain social work services and interactions in the ED. This approach takes into account the environmental contexts and contributors at multiple levels to a particular condition or process. The ED social worker-patient interaction is a social exchange, a conversation between two individuals, both embedded in different ways in society and in the health and social service systems. The environmental contexts that contributed to their social positions and the outcome of the interaction itself are important to explore in order to first understand the ED social work service context and then to identify areas of strength as well as targets for improved practice, policy, training, and system change.

Social workers in the ED are “boundary spanners.” This term has been used to describe social work healthcare practice that encourages expanding knowledge and interventions, avoiding silos between health and mental health, and coordinating systems of care (Kerson, 2004). While a social worker’s ability to span such cognitive and social boundaries can be an asset to an organization, the multitude of roles performed by ED social workers begs questions about how these roles are perceived and deemed appropriate for social workers, how those decisions are made and in what ways social workers at different levels of practice comply with or reject these roles. A long-standing critique of social welfare and its social work agents has circled around the tension between functions of social control and social promotion. Social workers can be caught in the impossible dilemma of meeting the requirements of their job, following policy, and meeting individual patient needs (Lipsky, 1980). At the level of the ED social worker-patient interaction, this tension is best evidenced in the boundary-spanner, gatekeeping, and resource broker roles and in the unrealistic expectation that social workers at the micro practice level can “fix” or contain problems resulting from the intersection of macro, mezzo and micro forces. Social work’s code of ethics calls social workers to challenge social injustice, including ensuring access to needed resources (NASW, 2008), and the practice standards for social work healthcare professionals call for social workers to address health disparities, advocate for large system change and maintain their knowledge and skills in current interventions (NASW, 2005). ED social workers are being asked not only by their immediate work context to assist patients and healthcare systems to achieve a multitude of outcomes that are at odds with available resources and time, and they are also being charged with these expectations of their professional association. Social workers grapple with the stress of these tensions in their daily practice, and, along with regular exposure to traumatic content, it can take a toll. This is when the high pressure of the ED, system constraints and their social justice mission collide.

Social workers are essential for the ED to achieve its medical mission and critical for its day-to-day functioning. A recent study showed that social workers served nearly 40% of ED patients in the trauma center setting and that the majority of these services were mental health and care coordination services, services necessary for safe discharge plans (Moore et al., 2016). Social workers are the primary link to the psychosocial worlds and well-being of patients treated in the ED. In their boundary spanning roles they are tasked with meeting psychosocial needs to ensure safe discharges, yet also performing roles of social control, such as gatekeeping. Fulfilling the role of social control, combined with the challenge of practicing their profession with integrity in an environment of high expectations, sparse

resources, and other limitations, is a formula for poor patient outcomes, empathic strain, and moral distress, a phenomenon in which one knows the right action to take but is restrained from taking it (Jameton, 1984). Understanding this context has implications for social work practice, the ED, and the healthcare system. In terms of practice implications, social workers need to be aware of the potential consequences (e.g. empathic strain and moral distress) of taking on roles that span too far outside the scope of traditional medical social work practice and balance them with the impact and value these roles have on ED patient care. Problem solving with ED providers and administration to determine the most appropriate and effective ways to both meet the complex patient needs and better utilize social workers' skills and time is crucial. At the ED and healthcare system levels, utilizing multiple methods to improve patient flow through the system and innovative ways to meet the needs of patients with multi-level concerns is warranted. In particular, improving things like ED physical environment, patient flow, interprofessional care coordination, and enhancing resources to meet the needs of patients in other healthcare settings such as primary care or community clinics will likely decrease the need for gatekeeping, increase the efficacy of resource brokering in the ED, and align with the goals of the ACA.

In addition, this study revealed some of the challenging consequences of the fractured and siloed nature of health care systems on interdisciplinary and inter-organizational levels. At the practice level, increased interdisciplinary communication, collaboration, and training is needed to give other professions in the ED more exposure to the psychosocial domains of patients, and how ED social workers interface with them, as well as the focus of the social work profession to challenge social injustice and the ways in which they fit or conflict with current social work roles in the ED environment. Increased communication and collaboration can allow for a more holistic view of the patients referred to social workers, and their potential outcomes, as well as social work roles and expertise. It could also help to decrease the primary burden of the impact of inadequate psychosocial resources on patients that social workers are bearing, and give a forum to determine any overlap in empathic strain or moral distress among multiple ED professional groups, making it possible to collectively address these issues, ultimately resulting in better patient care. Collaboration to achieve these goals at a system level might include interdisciplinary and intra-system advocacy for policies that increase psychosocial resources for patients in multiple health and social service settings. It might also allow hospitals to better meet the ACA mandates for care coordination to decrease rapid readmissions for certain patients.

Social workers in the present study were cognitively agile and emotionally flexible in the high-pressure ED environment. They performed roles outside of the traditional scope of their professional identity, such as gatekeeping. These roles went unrecognized or were underappreciated, yet social workers acknowledged these roles were crucial to saving physician and nurse time to focus on providing medical care. The challenge facing the healthcare system, social workers and other healthcare professionals in the ED is to acknowledge the critical nature of the social work role and address the upstream macro and mezzo factors, some of which were identified in the present study, that require modification or ongoing training to improve patient outcomes.

4.1. Limitations

The socio-structural model and the social worker roles were developed using a convenience sample. Therefore, the factors attributed to each level of the model and the social worker roles might not be exhaustive. Data for the present study were collected at one urban, level 1 trauma center. Further research is needed to assess the applicability of the socio-structural model in other healthcare settings. In addition, our focus was on the social worker-patient interaction, which limited our ability to interpret how the socio-structural forces impact interactions between patients and other healthcare professionals in the ED.

5. Conclusion

Increasing knowledge of and attention to the social determinants of health compels the healthcare system to attend to broader societal, community and individual factors contributing to health. A commitment to the social justice mission of the social work profession requires not only reflective practice at the micro level that includes being attentive to internal responses to competing professional demands and stress, but also at the mezzo and macro levels that impact individual interactions. Macro-level targets for policy and training to improve patient outcomes in the ED identified in the present study include barriers to health and healthcare; mezzo-level targets include increasing healthcare coordination and interdisciplinary team collaboration; micro-level targets are methods for enhancing coping and role specification. This cannot be done by one or even a few practitioners, but requires interdisciplinary collaboration and advocacy. Future research could elaborate on this study in important ways. Investigation of other ED professionals' understanding of the social work role, patients' psychosocial situations, and how they interact, and exploration of patients' experiences of social work services in the ED will be important next steps to more holistically understanding and improving ED care and patient outcomes.

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Research Highlights

- Medical record notes and emergency department social work interviews were analyzed.
- Macro, mezzo and micro-level factors influence social worker-patient interactions.
- A socio-structural model of the social worker-patient interaction was developed.
- Multilevel targets for improved policy and training are identified.

Figure 1.
Socio-structural model of ED social work

Table 1

Social worker roles

Role	Description	Quotes from EMR data and Interviews
Investigator	Conducting patient assessments; triaging patient needs; understanding circumstances that lead to ED visit; locating family; identifying patients	EMR Note: "Pt. [patient] is unidentified male [brought in by] medics with CPR in progress...Pt. died in [emergency room] shortly after arrival. Per medics...initially the details of accident are unclear...After pt. expired, his wallet was found on the gurney and pt. was identified... EDSW [emergency department social worker] did various online searches in an attempt to locate LNOK [legal next of kin]...EDSW left a message at a number listed for pt. on White Pages but did not hear back. Pt. has multiple cards in his wallet with pictures of a girl, who appears to be pt.'s daughter. EDSW also made several calls to [police] over a period of hours, requesting any further information and requesting that [police] go to pt.'s residence to see if family are present...SW relays LNOK information to [medical examiner] and [organ donation center]."
Gatekeeper	Interfacing with family and friends of patients; coordinating and managing visits to patient	EMR Note: "SW [social worker] alerted that pt's [patient's] brother is in the ED and would like to visit pt. SW spoke with pt to confirm that he would like to have visitors, and he does. SW met brother, his son, and pt's wife. She had been contacted about the accident. Pt was in a bed at the end of the hall where there is more room, so SW took the 3 family members to bedside. Pt very glad to have family with him...SW checking in with family, who says they don't know what the plan will be, that the pt is in X-ray now. Family stayed through pt's evaluation.."
Resource Broker	Allocating resources such as shelter, transportation; referring to community agencies	EMR Note: "EDSW [emergency department social worker] consulted with the medical provider who states that patient requires a taxi to transport him home safely. EDSW requested a taxi to transport the patient...EDSW also offered patient printed resource materials on CD [chemical dependency] detox and treatment options..."
Care coordinator	Facilitating communication and family meetings between ED medical providers and families; linking ED medical providers and patients with community providers	Interview Participant 5: "...we meet with and coordinate all the sexual assaults that come in...coordinate that exam and the Attendings and get Pediatrics involved if the person is under the age of 18... contacting families, supporting families when they get bad news...kind of helping the doctors, you know, do a good job...in those conversations and making sure that families aren't being traumatized more than they need to be."
Problem solver	Identifying creative solutions to overcome barriers to gathering information from patients, or to a variety of immediate concerns for patients' health and well-being	EMR Note: "Complications include the fact that pt [patient] [requires bariatric transport] and lives [far]. No one in the family has a vehicle big enough to carry the pt...SW [social worker] agreed to investigate options. Called [one transport service] and found that pt cannot be accommodated... Called [second transport service] and found that they will take pt home, but may not be able to provide a bariatric ambulance tonight... Heard that they are calling in a crew and will know in 1-2 hrs if they can transport... SW let Attending know and let pt's [family] know...the ambulance arrived...earlier than expected. SW let pt know the plan...SW spoke with crew and reviewed the plan to take pt [home]...SW called [family] and let him know."
Mental health provider/crisis manager	Providing emotional support and crisis counseling to patients and families; exploring and motivating existing coping skills	EMR Note: "Pt [patient] was referred to SW [social worker] for assistance with his reaction to grief following the death of his mother...upon arrival bedside SW observed Pt weeping. SW spoke to Pt to help him process his trauma and his loss...SW comforted Pt by providing supportive counseling...SW also asked Pt if he would like to talk to Spiritual Care and he agreed, so SW contacted Spiritual Care and made the referral...Pt is having a reaction to the grief he is experiencing. Pt is in need of ongoing SW and Spiritual Care support while he remains in [hospital]...SW passed Pt to the next shift SW'r for continued support."
Advocate	Respecting and honoring patients' self-determination and assisting with communication of patients' and families' wishes to other providers; requesting resources for patients	Interview Participant 8: "If you're making the family happy and the doctor happy...you felt like you made some <i>gains</i> or progress – if everyone's got what they need there, then that's the best you can do, especially in the ED when you're busy and you don't have a lot of time and resources to work with."

Role	Description	Quotes from EMR data and Interviews
Safety planner/discharge planner	Ensuring patients have resources they need to be safe and meet basic needs for food and shelter; providing education on resources and follow-up to ensure recovery	EMR Note: "EDSW [emergency department social worker] repeatedly expressed deep concern for patient's safety noting that the level of violence appears to be escalating and this could result in tragic consequences... EDSW discussed with patient trauma counseling and DV resources and suggested to patient that [they] could benefit from engaging in counseling to address the above issues. EDSW additionally discussed safety planning with patient...EDSW expressed concern for patient's safety in returning to the residence...EDSW provided emotional support and counseling for the patient and gave printed resource materials on DV [domestic violence] resources and trauma counseling."