HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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AHC Media

Treat challenging patients with understanding, respect

Be aware of why they're acting that way

Every case manager encounters challenging patients and family members — those who are angry, provocative, depressed, or just plain ornery. That's because people in the hospital are sick, under stress, and often fearful about their situation.

"There is a huge difference between difficult people and people who are acting in difficult ways because of difficult circumstances. People don't wake up in the morning and say 'My job for today is to be a problem for my case manager,'" says **Tammy Lenski**, EdD, chief executive officer of Tammy Lenski LLC, a conflict resolution and negotiation consulting firm based in Peterborough, NH. *(For more about avoiding mistakes with patients, see related story, p. 84.)*

Most challenging patients are otherwise decent people who are having a bad day, week, or month, says **John Banja**, PhD, professor of rehabilitation medicine, medical ethicist at Emory University's Center for Ethics and director of the Section on Ethics in Research at Emory's Atlanta Clinical and Translational Science Institute. Their ways of coping with distressful events were shaped long ago. "Challenging patients don't think they are being difficult," he says. "They're feeling overwhelmed, helpless, and depressed because of their situation, and they project their feelings to those around them." *(For more information on difficult patients, see related story, p. 83.)*

EXECUTIVE SUMMARY

When case managers encounter challenging patients and family members, they shouldn't take it personally but should recognize that the hospital setting puts people under stress. They should try to defuse the situation.

- Present yourself as a supporter and resist the temptation to fight back or just leave the room.
- Keep your emotional health in good shape by educating yourself and getting trained on how to cope with difficult situations.
- Don't set yourself up for failure by making assumptions about patients and their viewpoints.

Case managers often deal with patients and family members who are under stress and might be difficult to deal with, Banja adds. It's important not to take it personally but to keep in mind that the patient or family member is simply trying to share his or her overall mood and the feeling that what happened is unfair, he says.

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Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Senior Vice President/Group Publisher: **Donald R. Johnston.**

Editorial Questions
For questions or comments, call Joy Dickinson at (229) 551-9195.

Case managers are in the unique position of being a link between the patient and the treatment team, says **Kathleen Miodonski**, RN, BSN, CMAC, manager for The Camden Group, a national healthcare consulting firm with headquarters in Los Angeles. "Case managers often can diffuse problems between the treatment team and the patient and family members. They aren't doing the hands-on care, so they have more objectivity," she says.

Be aware of which patients might become difficult, and make it a point to develop a rapport with them, Miodonski advises. For example, if you hear other staff talking about difficult patients, it might be a cue for you to talk to the patient and call in other people, such as a social worker, or a representative from the patient's religious or cultural organization. "Case managers may not be involved with every patient, but sometimes simple cases can be more difficult. It's the case manager's role as patient advocate to step in when there are problems," she says.

Banja suggests that when case managers work with sick people, they should present themselves as supporters and encourage the patients to share their frustrations, disappointments, and pain. "The biggest mistake we make is emotionally reacting to patients, instead of trying to understand why they are acting that way," he says.

The therapeutic approach to dealing with challenging patients is to try to understand the patient's behavior as a reaction to his or her circumstances and to discover what is making them difficult, he says. For example, if patients have had a bad experience with a healthcare professional in the past, they might not believe or trust you. Encourage patients to talk about their past. This talking might explain why the patient is being difficult, and once you understand it, it will be easier to cope with. "If you can get patients to start thinking about why they are feeling the way they are and expressing it, it might defuse the feelings and put you on the way to a better relationship," he says.

Begin by validating the patient's feelings by saying something such as "Mr. Jones, you seem to be very angry. Please tell me what is going on." Then, be a good listener. Don't talk, except to intersperse comments such as "I hear you," or "That sounds like an important point. Tell me more." Try to obtain insight into what it is like to be Mr. Jones right now.

Sometimes, the best you can do is to keep a difficult encounter from getting worse, he says. You might think at the end of the discussion that it went poorly; however, remember that you're likely to

have another conversation with the patient, and it probably will go better.

Lenski advises that healthcare professionals resist the temptation to run or to fight when they encounter grumpy or combative patients. "Leaving the room or arguing with patients tends to escalate the situation, and that will only make it worse in the future," she says.

When patients yell or snap at you, resist the temptation to push back. Instead, take a deep breath and remember that there is a huge difference between yelling at somebody and yelling toward somebody, she says. "Most people in the hospital setting are not combative because they don't like the person with whom they are dealing." Lenski points out. They're acting that way because they are on edge, frustrated with several things, and everything seems to be a major struggle.

"When people realize that the combative patient is yelling toward them and not at them, it helps them understand that the person yelling is actually expressing frustration and pain. Then the healthcare professional can have compassion for the patient's misery," she says.

If the situation escalates, Lenski advises taking a break. Tell the patient you feel like the conversation got off on the wrong foot and you're going to come back in 30 minutes and start over, she says. "If you stay in a hot conversation, it doesn't get any cooler. It's better to take a half hour break and do something to take your mind off the topic," she says.

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For more information contact:
- **John Banja**, PhD, Professor of Rehabilitation Medicine, and Medical Ethicist at Emory University's Center for Ethics, Atlanta. Email: jbanja@emory.edu.
- **Tammy Lenski**, EdD, Chief Executive Officer, Tammy Lenski, LLC, Peterborough, NH. Email: Tammy@lenski.com. Website: www.lenski.com.
- **Kathleen Miodonski**, RN, BSN, CMAC, Manager for The Camden Group, Los Angeles. Email: kmiodonski@thecamdengroup.com. ■

Don't let patients get you down

Don't fight back in tense situations

Dealing with difficult or challenging patients makes healthcare professional feel uncomfortable, whether the patients are angry, depressed, provocative, or just plain cranky, says **John Banja**, PhD, professor of rehabilitation medicine, medical ethicist at Emory University's Center for Ethics and director of the Section on Ethics in Research at Emory's Atlanta Clinical and Translational Science Institute

"The first human response when people feel uncomfortable is to defend themselves, rather than trying to understand what is going on with the patient. With difficult patients — and remember, we are the ones who call them 'difficult' — this is probably the wrong thing to do, and it's probably why relationships between these kinds of patients and healthcare professionals don't tend to improve very much," he says.

Case managers need to expect that they're frequently going to encounter difficult patients and should keep their emotional health in good shape, Banja advises. "Remember that you can get along fine with some patients, and others know how to provoke you. Patients are labeled 'difficult' because they assault healthcare providers' self-esteem and make them feel out of control, incompetent, and inadequate," he says.

Confront your own fears, anxieties, fantasies, and insecurities. The psychological baggage that you've been carrying around since childhood will come out when you are made anxious by difficult patients, Banja says. Acknowledge to yourself that your own insecurities might create a need to be appreciated, loved, and admired and that difficult patients might trigger these insecurities. "Healthcare professionals should acknowledge that difficult patients are a very real problem and that dealing with them can cause burnout," he says. Look for opportunities to educate yourself and develop a good skill set to cope with these patients.

Banja recommends that training programs for case managers include information on how to cope with difficult patients. "You can't know too much about how to empathically engage these patients," he says. *(See recommended reading list at end of this story.)*

Evaluating a case manager's ability to cope with difficult situations should be part of the hiring process, he says. "It's a huge mistake to hire a case manager based only on their intellectual ability. They need to be able to cope with all the difficulties they are going to encounter. Someone who understands clinical medicine very well may not be able to negotiate a difficult relationship," he adds. The person doing the hiring should have some experience in communication skills in order to evaluate the answers, Banja says. Ask prospective employees

to describe how they would deal with a difficult situation. Ask them if they have mental health experience, how they feel about working with difficult patients, and what they know about empathy. "If a case manager says 'I expect a client to work with me completely and respect my authority.' I wouldn't think his or her empathetic skills were very good," he adds.

RECOMMENDED READING:

- "Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes" by Mohammadreza Hojat, PhD, Springer, 2007.
- "Find Your Focus Zone: An Effective New Plan to Defeat Distraction and Overload" by Lucy Jo Palladino, PhD, Free Press, 2007.
- "From Detached Concern to Empathy: Humanizing Medical Practice" by Jodi Halpern, MD, PhD, Oxford University Press, 2001.
- "Making Mediation Your Day Job" by Tammy Lenski, PhD, iUniverse, 2008.
- "Medical Errors and Medical Narcissism" by John Banja, PhD, Jones and Bartlett, 2005.
- "Zen of Listening: Mindful Communication in the Age of Distraction" by Rebecca Z. Shafir, MA, CCC, Quest Books, 2003. ■

Avoid making mistakes when dealing with patients

Don't set yourself up for difficulties

When healthcare professionals try to get patients to be cooperative and go along with the discharge plan, they often make four mistakes, according to **Tammy Lenski**, EdD, chief executive officer of Tammy Lenski LLC, a conflict resolution and negotiation consulting firm based in Peterborough, NH.

"If case managers make these mistakes when dealing with patients, they're setting themselves up for problems," she says. The mistakes are:

1. Assuming if people are given logical information, they will automatically follow your recommendations.

"We tend to think that if we give patients more information, they will change," Lenski says. "Instead, we need to try to understand why they won't do what you want them to. Maybe they lead a different life from what you imagine and they know that the treatment plan won't work for them."

When patients won't cooperate, stop giving then more and more information, Lenski advises. Instead, try to understand why they aren't cooperating and why they think your plan won't work. Don't interrogate the patient. Instead, say, "The discharge plan calls for X, Y, and Z but you won't do Z. What about Z isn't working in your life? Help me understand."

2. Assuming that nodding and silence means agreement.

Silence can mean a lot of things from "I'm thinking about it," to "I don't agree, but I'm never going to admit it," Lenski says. Patients might nod agreement because they believe that their agreement is what will get them out of the hospital, she points out. In some cultures, nodding has nothing to do with agreement, she adds.

Remember that the goal of the conversation isn't to get agreement, but to come up with a plan the patient will act on. Don't ask patients and/or family members if they understand, because they can understand the plan perfectly and still not follow it. Instead, ask them how the plan will work for them and what could get in the way of their following it.

For example, sometimes people who are overweight might not weigh themselves daily because they hate to know their weight. With heart failure patients who need to weigh themselves every day, Lenski suggests broaching the subject by saying something such as, "One of the things we know from experience is that patients who aren't happy with their weight often avoid the daily weigh-in, and the consequences can be dire. I am wondering if this might happen to you, and how I can help you get around it."

3. Letting their diagnosis of someone's personality flaws lead them when they work with patients.

"In a healthcare organization, people make diagnoses all the time, but there is a huge difference in diagnosing a medical condition and diagnosing a personality flaw," Lenski points out. If you label patients as uncooperative or difficult, you will start treating them in a different way, and that treatment is likely to compound the problem.

Case managers need to be aware that they let their tendency to diagnose patients extend into diagnosing personalities. The minute you start to think of someone as uncooperative, stop and think that you could be wrong about the person. Remember that every person has family and friends who think he or she is just fine.

4. Trying to fix the person without understanding why they are being uncooperative.

Take time to talk with patients and understand

them, Lenski says. People in the hospital setting are asked to multi-task and to move quickly, and they might think they don't have time to sit down and talk to their patients. But taking time on the front end to understand the patient might save time on the back end when the patient won't cooperate with the treatment plan or the discharge plan, she adds. ■

Redesign standardizes care coordination

Unit staffers spend more time with patients

A far-reaching redesign of the care coordination process at Norfolk, VA-based Sentara Healthcare has standardized the process across hospitals, centralized the administrative and clerical tasks that care coordinators must perform, and freed the staff at the bedside to concentrate on working with patients.

The redesign, which took about a year, has resulted in enhanced staff satisfaction and anecdotal evidence that it has reduced length of stay, but it's too early to have any firm data, reports **Teresa Gonzalvo**, RN, BSN, MPA, CPHQ, ACM, vice president for care coordination. Gonzalvo is responsible for care coordination at Sentara hospitals, including Sentara Norfolk General Hospital, the system's flagship hospital, in Norfolk, VA.

"Our vision at Sentara is to be a leader in facilitating case management across the continuum and providing patient-centered, high-quality care, but to do so we need to make sure every care coordination department is doing the same thing consistently," Gonzalvo says. "There was a lot of variation in the care coordination process when we began."

Phase I of the redesign involves seven hospitals, all in southeastern Virginia, that have been using Sentara's electronic medical record for a few years. Three other hospitals, in northern Virginia and the Blue Ridge region, will be part of Phase II after they also implement the electronic medical record system. "We want to maximize technology as a way of creating efficiency," Gonzalvo says.

A key component of the redesign was to create a centralized Resource Management Center with staff to handle the administrative and clerical tasks involved in care management for all the hospitals, which freed the care managers on the unit to spend more time with patients. *(For details on the Resource Management Center and how it operates, see related article on p. 86.)*

The redesign created teams of unit-based RN case manager care coordinators and master's-prepared social workers who collaborate on care coordination and discharge planning. In some hospitals, LPNs were a part of the care coordination team and continue to work as associate care coordinators in those hospitals. "We wanted to incorporate all the expertise of our existing staff while developing a unified model for our individual hospitals to use," Gonzalvo says.

Depending on the size of the hospital and the size of the unit, some care coordinator/social worker teams cover more than one unit. "Now that we have removed all the administrative and clerical duties, the care coordinators and social workers are expected to be on the unit, talking to physicians, patients, and family members and facilitating communication," she says.

Frequent communication is a key component of the redesigned care coordination program. The RN care coordinator and social worker on each unit have a daily huddle to discuss priorities and what is needed for the patients who are slated for discharge. The multidisciplinary teams in each unit have regular rounds to talk about the patients and update the plan for the day and the plan for the stay, Gonzalvo says.

At least once a week, the entire care coordination staff, the director of finance, and the vice president for medical affairs at each hospital hold care progression rounds to discuss long-stay patients and those with complex needs. The manager of care coordination identifies cases to discuss and invites other

EXECUTIVE SUMMARY

By centralizing administrative and clerical tasks usually performed by clinical staff, the care coordination department at Sentara Healthcare, with headquarters in Norfolk, VA, has freed the bedside staff to concentrate on case management and discharge planning.

- RN care coordinators and master's prepared social workers collaborate to manage care on the unit, holding a daily huddle and participating in multidisciplinary rounds.
- Clerical staff set post-discharge appointments with primary care providers while the patient is still in the hospital.
- Staff members at a centralized Resource Management Center, created at a new location, are responsible for utilization management, including admissions reviews, continuing stay reviews, and retrospective reviews and facilitation of discharges for patients in all hospitals.

disciplines, such as wound care, hospice, or palliative care if appropriate. "Without everyone on the team rounding and being in constant communication, we couldn't be successful," Gonzalvo says.

Sentara Healthcare is rolling out a program in which care coordinators review patient records for medical necessity and admissions status when they come through the emergency department, the post-anesthesia care unit (PACU), the cardiac catheterization lab, and the obstetrics unit. "One thing we know really works is having care coordinators monitoring all points of entry for patients," Gonzalvo says.

In May, the clerical staff began setting up follow-up appointments with primary care providers, prior to patient discharge, to make sure there is a seamless hand-off between levels of care. "We are working to maximize the tools and workflows we have in place to meet our care coordination goals and to prevent unnecessary admissions and readmissions," Gonzalvo says

Before the redesign, each hospital's vice president of medical affairs assisted with the secondary reviews for admission criteria and patient status. Because of the sheer volume of reviews, some were not handled in a timely manner. Now the health system has contracted with an off-site physician advisor to perform the admission criteria reviews. The vice president of medical affairs continues to act as an advisor for continued stay reviews and commercial payer reviews.

The contracted physician advisor organization has conducted a comprehensive education program in documentation and admissions criteria for the medical staff, care coordination staff, and other appropriate staff. Sentara also has contracted with a consultant for an ongoing review of the effectiveness of the process.

The care coordination department is working with the information technology department to identify case management software that will interface with the hospital's system software as well as the technology being used by Medicare and Medicaid auditors. "We are working on a number of projects to meet the challenges of the future as well as the challenges of today," Gonzalvo says. "We need to be able to get patients the treatment in the right setting and move them through the care continuum in a timely manner. We believe that level of care coordination will ultimately improve patient outcomes."

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For more information contact:

• **Teresa Gonzalvo**, RN, BSN, MPA, CPHQ, ACM, Vice President for Care Coordination, Sentara Healthcare, Norfolk, VA. Email: tigonzal@sentara.com. ■

Resource center supports CMs at 7 hospitals

Unit staff free for patient care

Sentara Health's Resource Management Center is staffed by 26 RNs, LPNs, and clerical staff members who support the care coordinators at seven hospitals, all in the Norfolk, VA, area.

"The main purpose of redesigning the care coordination process is to provide patient-centered care," says **Teresa Gonzalvo**, RN, BSN, MPA, CPHQ, ACM, vice president for care coordination at the Norfolk-based healthcare system. "This has been fostered by removing the administrative and clerical work from the clinical staff at the bedside and centralizing it in a newly created location. The care coordinators are there to meet the needs of the patients and respond to whatever needs doing, rather than spending their time on the telephone or doing paperwork."

The Resource Management Center (RMC) staff handles all utilization management, including admissions reviews, continuing stay reviews, and retrospective reviews of patients in all hospitals. They also facilitate discharges by arranging for equipment and other post-acute services and managing referrals for post-acute care for all seven hospitals. "When patients make their choices of post-acute providers, the RMC staff receives the information along with other key patient information," Gonzalvo says. "The RMC uses an electronic discharge planning system to send inquiries to those post-acute providers. This process is designed to decrease length of stay and increase patient satisfaction."

A team of dedicated department auditors who monitor compliance issues and perform audits for all hospitals in the system perform quality reviews of the RMC on a regular basis.

The Resource Management Center also manages a centralized pool of part-time and temporary healthcare professionals who can fill in for the regular staff when they are taking vacation time or sick leave. The healthcare system has created an array of dedicated positions in four categories for resource pool staff. Categories include staff members who want to work

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CASE MANAGEMENT INSIDER
Case manager to case manager

The role of the social worker on the case management team

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

The role of the social worker in the acute care setting has been evolving for the last two decades. Once seen as the primary owners of discharge planning, social work roles and functions have changed and grown. During the 1990s, many hospitals eliminated social workers in an effort at cost containment, a strategy that proved to be non-beneficial over time. Today many hospitals are still struggling with determining the demarcation of the roles and responsibilities of the nurse case manager versus the social worker. In this issue we will take a look at how these roles are related and complimentary.

Social workers and nurse case managers have different, yet complimentary skill sets. Each discipline brings different knowledge to the interdisciplinary team. Case management departments have to consider the unique differences between the two disciplines when developing their case management models and when they are determining roles, functions, and caseloads. Some case management departments have combined the social workers and case managers and asked them to perform the same roles and functions. This kind of approach does not optimize the knowledge, education, and experiential differences between the two disciplines. It does not respect the talent and expertise that each contributes toward making the team stronger.

In the beginning of the transition toward acute care case management, most hospitals had what we now think of as the "traditional" model. These models evolved in a fee-for-service environment in which the fiscal incentives included more reimbursement for a longer length of stay. The reimbursement scheme was based on a per diem system in which few questions were asked in terms of medical necessity or appropriate length of stay. Lengths of stay were long, and hospitals were incentivized to keep patients in the inpatient setting.

Social workers in the acute care setting worked on a referral basis. Referrals were based on high-risk criteria that typically focused on social dysfunction and life-altering medical events with the option to also independently case find. The social worker performed mainly discharge planning combined with counseling. Discharge planning was, however, somewhat limited in comparison to today's healthcare environment. Home care services were much more limited in scope, and sub-acute care was not widespread. Social workers participated actively when patients needed to be placed in skilled nursing facilities and actively worked with the patient and family to make these kinds of transitions as smooth as possible.

Prior to prospective payment, utilization review consisted of determining whether the patient needed to be in the hospital. Even when patients appeared to no longer need acute care, little was done to move them out of the hospital in a pro-active manner. The philosophy was geared toward optimizing the length of stay by keeping the patient in the hospital as long as possible.

With the advent of prospective payment in the mid-1980s, the field began to shift. Prospective payment was developed to contain costs by prospectively determining the amount the hospital would be paid for specific patient types. The fiscal incentives changed from longer lengths of stay in a fee-for-service environment, to fixed payments that required tighter lengths of stay and resource management. The tighter fiscal

environment that came as a result of prospective payment required some immediate changes in terms of how hospitals did business. In such an environment, the role of the social worker began to change and evolve. Social workers became more involved with discharge planning as it became more and more of a focal point. As discharge planning rose in importance, psychosocial counseling became less of a focus and became something that social workers did "when time permitted." While social work roles were rapidly changing, utilization review was evolving into case management. The role of the social worker was becoming pulled beyond the social worker's scope of knowledge as discharge planning became more clinical and less psychosocial in nature.

Unfortunately, during this time, social workers performing discharge planning and nurses performing utilization review remained segregated. Usually reporting to different administrators, there was minimal emphasis on integration of the roles, although the field was moving in that direction. By the end of the 1980s, many hospitals began to recognize the need to consider the roles and functions of both disciplines in a different way. By the end of the 1980s and beginning of the 1990s, many hospitals had begun to evolve into some form of acute care case management. These new models began to redefine the role of the social worker to address the changing healthcare landscape. ■

Paradigm shift for social workers

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

During the transition to hospital case management, many hospitals shifted to nurse-driven discharge planning. It was also during this time that some hospitals significantly reduced and/or eliminated social workers from the acute care setting. This approach, which was extremely shortsighted, resulted in hospitals being unable to meet the psychosocial needs of their patients.

This deficiency resulted in the advent of a redefinition of the role of the social worker. In addition to the psychosocial patient needs, managed care required other changes in how the business side of healthcare was viewed. A greater emphasis on authorizations, third-party payer denials, and the changes in home care and subacute care required more emphasis on nurses as the drivers of these processes.

The paradigm shift for social workers was a redefinition of their roles and functions. Nurse case managers began to focus on the management of care processes and outcomes as a way of managing shorter and shorter expected lengths of stay. In this accelerated environment, it became more important that all patients be assessed for continuing care needs. In addition, case managers began to manage the clinical components of discharge planning, and social workers then were able to concentrate on the psychosocial components of the discharge planning process. ■

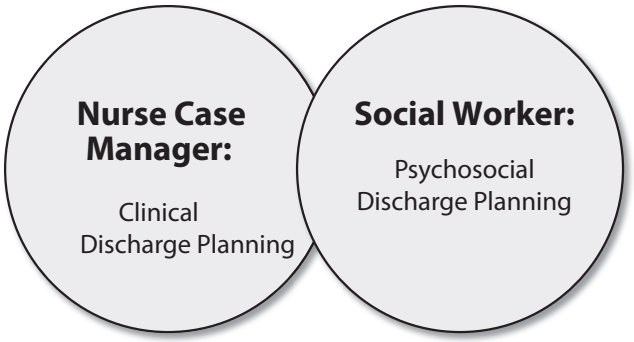
Acute care social work in today's environment

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

The challenge in any case management model or department is to ensure that the skill sets of the social work and nurse case management staff are optimized. Recognize that each discipline brings different, yet complimentary, skills sets to the case management team. Each hospital must evaluate its specific patient population and needs, and adapt the staffing accordingly.

The case management department should prospectively create a list of referral criteria. The list should be dependent on the patient population the hospital serves and the split of nurse case mangers versus social workers. For example, in some departments the social workers might strictly be doing psychosocial counseling and intervention. In others, they might be doing a combination of psychosocial counseling and discharge planning. To determine the appropriate referral criteria, the roles and functions of the social workers must be clearly defined.

One way to think of this is in the illustration on p. 89. This illustration describes the differences in skill sets that each discipline brings to the team. By aligning the clinical components of discharge planning with the nurse case manager, and the psychosocial components with the social



worker, the work associated with discharge planning can be deployed appropriately. In this way, the skill sets of each discipline can be most optimized.

In this model, the social worker works collaboratively with the nurse case manager on high-risk cases. Patients are assigned to the social worker based on the pre-determined criteria list. In most case management departments, and in the integrated model in particular, the social worker and nurse case manager share some of the elements of discharge planning. Because the social workers are focused on the psychosocial elements, they might take primary responsibility for nursing home placements, legal issues related to discharge planning, and difficult family issues or hospice placements, as examples. These are issues with a greater degree of psychosocial need associated with them.

Purely psychosocial skills that social workers have include:

- providing emotional support related to illness, trauma, violence, abuse, or family conflict;
- identifying barriers to effecting a safe and timely discharge plan;
- collaborating with the case manager in the discharge planning process on complex patients;
- ensuring access to continuing case services, particularly for nursing home placements.

With an understanding of the unique skill sets of the social worker, a prospective referral list can be created. Below is a list of potential referral criteria:

- adjustment to illness/difficulty coping;
- major illness causing lifestyle change;
- behavior management problems;
- new or poor prognosis;
- end-stage disease;
- family concerns and/or conflicts;
- cultural and/or language issues;
- inadequate social and/or financial supports;
- issues of non-adherence;
- abuse and/or neglect of elder, adult, or child;
- multi-system trauma patient;
- psychiatric and/or substance abuse or history;
- homelessness;
- patient and/or family considering long-term care placement;
- blood alcohol level > 1.0 on admission. ■

Collaborating on issues of non-compliance

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

The list in the previous article is intended to represent issues that are purely social work in nature. However, like any two related disciplines, there are patient issues that can overlap and may be shared between the two disciplines. In these cases, there will be issues that can be appropriately shared between the nurse case manager and the social worker.

The RN case manager can address patient education by assessing for knowledge deficits related to medications, follow-up, appointments, etc. The social worker can address patients refusing to accept needed services and leaving against medical advice. The social worker can handle crisis intervention: substance abuse, family dysfunction, and/or problems coping with illness.

Here are additional examples of collaborating in various areas:

- **Collaborating on issues of non-payment.**

RN case manager: Addresses questions about insurance/benefit coverage.

Social worker: Addresses entitlements (Medicaid, disability, HIV/AIDS services, and food stamps) and community services (housing and Red Cross).

- **Collaborating on obtaining medications.**

RN case manager: Asks physician to prescribe least costly drug, asks hospital pharmacy to supply drug, and facilitates use of voucher system with local pharmacy.

Social worker: Refers patient for entitlements. Helps patient negotiate payment plan with local pharmacy. Explores other options such as veteran's services. Facilitates use of voucher system with local pharmacy.

- **Collaborating on homeless patients.**

RN case manager: Handles shelter referrals.

Social worker: Obtains social history related to homelessness, performs financial assessment, and contacts family/friends and community agencies.

Once a referral has been made to the social worker, a social work assessment should be completed. Each social work department should have a standardized assessment tool to use for this purpose. The referrals to social work should take place on the day of admission, if appropriate, or later in the stay if circumstances change. For this reason, ongoing assessments and reassessments are critical to the roles of the case manager and the social worker.

If the social worker picks up the case on admission, that situation does not mean that he or she needs to keep the case until discharge. The intervention might be a one-time event, and they might be able to close the case after that time. Conversely, a particular patient might not need to be seen by social work on admission, but during the course of the hospital stay, the patient's situation and/or needs change. At that point, the social worker might need to get involved and pick up the case. Therefore the caseload of a social worker will change throughout the course of a patient's hospital stay. The same patient might be assigned and then unassigned to the social worker as circumstances change. This situation is in direct contrast to the role of the nurse case manager, who picks up the patients on admission and keeps them until discharge.

For these reasons, it is much more difficult to measure social worker caseloads. The volume of patients should be based on "open" cases, not beds, and should not generally exceed 18 patients.

Social workers and psychosocial counseling

Some social workers might need to have their counseling skills refreshed. It is not uncommon for a social worker to take a job as a discharge planner in a hospital without ever having done psychosocial counseling and support work. When this model transition takes place, a social worker who has not done counseling, or has not done counseling for a long time, might feel nervous about the new function. It is important that case management leaders understand this nervousness and provide refresher educational opportunities to these individuals.

The opportunity for a social worker to transition away from discharge planning and toward more purely social work functions such as counseling will require that the entire organization understand the evolving and emerging roles of social work in contemporary acute care case management. If the physicians in your hospital only know social workers as discharge planners, they might need to be informed of the shift of some discharge planning functions away from social work and to the nurse case managers. A good communication plan will be important, as well as constant reinforcement to the interdisciplinary care team as issues arise. For the perception of social work to change, communication and feedback will be required.

Consider each inappropriate social work referral as a "teachable moment." Explain the new social work role, and explain the rationale for it. The department of nursing will be just as important in this process, as too many might be accustomed to calling social work for issues that might now need to go to the RN case manager. In addition, they will need to understand that the social work staff is available for other issues under the umbrella of psychosocial counseling and support.

Of course the flip side to this is the situation in which a hospital might have social workers doing no discharge planning at all. In these circumstances, if the integrated model is being implemented, then social workers might need to pick up some discharge planning functions that they were not doing in the past. The social workers will need to be educated on everything related to discharge planning and will have to learn how to manage both functions, i.e. discharge planning and psychosocial counseling and support.

The role of social work is transitioning and new case management models are being implemented that optimize the skill sets of the nurses and the social workers. Even so, old perceptions and paradigms are sometimes hard to change. Be patient, but diligent, as these transitions take place.

The role of the social worker has evolved and grown as acute care case management has evolved and grown. Today's social workers have a renewed interest in psychosocial support to their patients and families. In addition, social workers play a vital role in helping to facilitate socially complex discharge planning issues and the transitions of patients from the acute to lower levels of care. Each case management department should take the time to assess their social worker's roles and functions to ensure that they are meeting the needs of the current and future healthcare environments. ■

Continued from p. 86.

only at a particular hospital, staff members who want to work in one of two geographic zones, and staff members who will work at any of the hospitals or the RMC location. Each option has a different salary range, correlating with the flexibility required of the staff to go where they are needed.

"Our aim is to attract seasoned professionals to our staff who want to work only a couple of days a week and to create a flexible system so they can work wherever they are most comfortable," Gonzalvo says.

The staff members at the Resource Management Center previously worked in case management at one of the seven hospitals participating in the redesign program. Gonzalvo established the RMC positions and pay categories with the help of the human resources department, then asked the staff members who were interested in working there to sign up.

"The staff at the RMC loves what they are doing, and we're seeing some really good results," she says. ■

Providers team up to cut HF readmissions

High-risk patients identified early on

A Hartford (CT) Physician Hospital Organization's program to reduce the rate of readmission for patients discharged with a primary diagnosis of heart failure has kept the readmission rate at between 11% and 13% for the last year, according to **Linda Conroy**, RN, BSN, clinical integration case manager for the Hartford Physician Hospital Organization, a partnership between Hartford Hospital and Hartford Physicians Association.

Conroy acts as a liaison between Hartford Hospital, the physician association, community home health agencies, and skilled nursing facilities to help patients with heart failure navigate the healthcare system and keep their conditions under control. To ensure continuity in care, the hospital, physician group, and post-acute providers have collaborated on the education process to ensure the patients receive the same education in all settings.

"We try to identify the high-risk patients early on so we can start to work with them," Conroy says. She attends heart failure physician rounds three days a week and discusses problem cases with the nurses and physicians. Most of her referrals come from the rounds, and most are being discharged to a skilled nursing facility or to home with home health services. Few are discharged to home with no services.

When she receives a referral, Conroy goes to the patient room, introduces herself, explains her role, and gives the patient or family member her card with her phone number in case they have questions. "I don't contact the patients again while they are in the hospital. Patients see so many people while they're hospitalized that it gets confusing. I want them to have a face to go with my voice, but I don't want them to confuse my role with the role of the discharge planner," she says.

When patients are being discharged, Conroy reviews the discharge summary and the physician orders to make sure they are in sync. If there is conflicting information, she obtains clarification and notifies the staff at the next level of care. She calls the patients' primary care physicians, finds out if they received the discharge summary and, if not, faxes it over to them.

"Communication between the hospital, the doctor, and the next level of care is critical to successfully keeping patients from being readmitted," she says.

If patients are discharged to home with home care services, Conroy calls them to check on them and follows up with the visiting nurse. She asks the home nurses to keep her updated whenever they see patients. Conroy calls the patients discharged to home at intervals that depend on their needs and the severity of their illness. She might call patients several times a week if their condition is not stable, or as infrequently as once a week if they are doing

EXECUTIVE SUMMARY

A clinical integration case manager acts as heart failure liaison at Hartford Physician Hospital Organization in Hartford, CT. She coordinates care between the hospital, Hartford Physicians Association, home health agencies, and skilled nursing facilities. The initiative has kept the readmission rate at 11% to 13%.

- The liaison attends heart failure physician rounds and receives most referrals during the rounds.
- She meets the patients in the hospital, then contacts them by phone as often as necessary for 30 days or more after discharge.
- She collaborates with staff at the home health agencies and skilled nursing facilities to ensure that patients are receiving the care and education they need.

well. Conroy asks how they feel, if the visiting nurse is coming regularly, if they have seen a doctor, and asks about their experiences with telemonitoring equipment if they are using it.

"I often talk to family members as well," she says. "Sometimes caregivers call me because they are frustrated and tired and need someone to talk to."

If the patient is stable at the end of 30 days, Conroy stops following them. In the case of patients who are having difficulty, she manages them beyond 30 days.

When patients are discharged to a skilled nursing facility, Conroy calls the facility, asks them to keep her informed about the patients' progress, and makes sure the patients see a cardiologist within 5-7 days after discharge. She calls the skilled nursing facility intermittently to check on the patients and to find out when they are going to be discharged. She receives the discharge paperwork and makes contact at the next level of care which, in most cases, is the home health agency.

The most successful cases are those when Conroy and the visiting nurse are in constant contact. When patients have an exacerbation after discharge, the home care nurse gets in touch and discusses the symptoms. "The home care nurses call me because I'm easy to reach on the telephone," Conroy says. "I have a close working relationship with the doctors and can reach the patient's physician and get orders to adjust the medication, many times when the home health nurse is still in the patient's home."

The close communication between Conroy and the home health nurse is particularly effective when uninsured or underinsured patients are being treated at the Hartford Hospital Clinic. "The physicians at the clinic are very busy, and they aren't there every day. Getting in touch with them can be frustrating to the visiting nurses. The doctors know me, and most of the time I can reach them and get them to adjust the medication," she says.

For example, one patient, who was on IV dobutamine and IV furosemide, historically had been hospitalized at least every two weeks because he had problems keeping his condition under control. Conroy was able to coordinate adjustments in the frequency of the infusions with the home health nurse and the doctor. As a result, the patient has been staying out of the hospital for much longer periods of time.

"Communication is the key to keeping high-risk patients out of the hospital," she says. "We give them a lot of support in the skilled nursing facilities and at home and keep providers at all levels of care informed."

SOURCE

For more information contact:
• **Linda Conroy**, RN, BSN, Clinical Integration Case Manager, Hartford (CT) Physician Hospital Organization. Email: lconroy@harthosp.org. ■

Multi-faceted program cuts HF readmissions

Components include education, follow-up

After Good Samaritan Hospital Medical Center in West Islip, NY, began a comprehensive process to reduce readmission rates for heart failure patients, readmission rates dropped from 21.1% to 15.3% in just a few months.

"When the project started, the hospital's readmission rate for heart failure was about above the national average. We knew there was an imperative to look at the current processes to see what was driving the readmissions," says **Rita Regan**, RN, BS, CPHQ, quality management coordinator for the 537-bed hospital.

As quality management coordinator, Regan was part of a multidisciplinary team, headed by care management, that analyzed heart failure readmissions to determine the reasons patients were coming back. Other disciplines on the team included nurse managers from the units where

EXECUTIVE SUMMARY

Good Samaritan Hospital Medical Center in West Islip, NY, reduced its heart failure readmission rates from 21.1% to 15.3% in just a few months with a readmission reduction initiative.
• A multidisciplinary team researched best practices in reducing readmissions and came up with an initiative that includes improving the educational process and facilitating smooth care transitions.
• Team members standardized educational materials, by working with other hospitals and home care agencies, and they educated the hospital staff and home care agencies on the teach-back method.
• Team members worked with skilled nursing facilities on ways to avoid sending heart failure patients back to the hospital. They worked with physician offices to ensure that patients obtain a timely follow-up appointment after discharge.

heart failure patients were admitted and representatives from nutrition, pharmacy, physical therapy, nursing performance improvement, and Good Samaritan's home care agency.

After researching best practices in reducing readmissions, the team decided to take two approaches: changing the behavior of staff and patients during the educational process, and providing an ideal transition between levels of care.

An early step in the process was to identify the patients' primary caregivers and involve them in all aspects of education and transition planning. "We wanted to determine the best person to receive the education, if it's not the patient," Regan says. "If the relative or caregiver isn't available for on-site education, we ask them the best time for a telephone conversation."

The team looked at ways to standardize patient education among units in the hospital and between levels of care. They collaborated with the Long Island Health Network, a group of 10 hospitals that work together to improve patient care and their home care departments, and chose a standardized booklet that all the hospitals and home health agencies use to educate patients. "This way, patients are getting the same instructions in the home after discharge as they got in the hospital," Regan says.

The booklet includes a weight log in which patients record their daily weight. As part of the behavior changes for staff and patients, the team recommended that the hospital staff have the patient write down their weight in the book to get them accustomed to doing it when they get home.

The care managers educate patients and family members on the importance of making the follow up visit and taking their educational materials, discharge instructions, and medication list with them. "Medical treatment is just part of the whole picture," Regan says. "We found that we needed to educate the patients on the risks of not following their treatment plan. We want to get patients to take ownership of their condition and to understand the risks of non-adherence."

The team educated the entire staff including nursing aides, nurses, care manager, and dieticians on using the teach-back method for patient education. "In order to implement our recommendations, we got our clinical council to take a stand and say that teach-back was the standard method for all clinicians to use to educate patients," she adds.

The team members monitored the hospital's video-on-demand system that provides patient education in the patient rooms, and they found that usage was very low. As a result, the team educated the staff on how to use the video-on-demand system and created an addendum to their identification badges with instructions on how to use the system. It's now a hospital standard for heart failure patients and their families to view the video "Heart Failure — Getting Ready to Go Home." The team put on a skit attended by 400 staff members that demonstrated the right way to conduct education including using teach-back method and using the educational video.

One key to the success of the project is developing close relationships with providers across the continuum, Regan says. The team presented their teach-back skit at the home care agencies in the community. "It was well-received and showed them what we were doing in the hospital to support them by providing patients information they needed after discharge," Regan says. The team collaborated with community skilled nursing facilities home on ways to keep heart failure patients out of the hospital. "It was a real eye opener for us to learn that patients in a skilled nursing facility get to choose their diets," Regan says. "We worked with the dieticians in the skilled nursing facilities on the importance of educating patients to make healthy choices."

Because patients typically are not weighed daily in skilled nursing facilities, the team developed a red-flag form that identifies heart failure patients and alerts the skilled nursing staff that the patients' weight should be monitored daily for two weeks, then twice a week. The team educated the staff to call a physician to adjust the medication if the patient gained weight.

Members of the care management team visited community physician offices and asked them to ensure that heart failure patients could obtain a post-discharge follow up appointment in a timely manner. They worked with the hospitalists to make sure the discharge summary gets to the patient's primary care physician or specialist in a timely manner.

The team continues to monitor readmissions and reviews the charts of readmitted patients every month determine if anything could have been done differently.

"This process has proven to provide a safer transition home, to discharge the patients with a lot more education, and to get them to the physician for an early follow-up visit," Regan says. ■

AMBULATORY CARE
Quarterly

Rapid intake energizes no-wait ED model

Staff's solutions equal high patient satisfaction

Getting an entire staff of physicians, nurses, and techs to do things differently is never easy, but you can clear away hurdles by giving them the ability to formulate some of their own solutions. That, at least, has been the experience of Swedish Medical Center in Issaquah, WA, in its quest to implement a more efficient, no-wait ED concept. The approach appears to be sitting well with patients, too. Administrators say that that the ED has been able to deliver on its no-wait promise in nearly every case, and patient satisfaction is greater than 95%, according to Press Ganey surveys.

Getting to this point involved a process of trial and experimentation that began with the opening of a freestanding ED back in 2005, explains **John Milne**, MD, MBA, the vice president of medical affairs at Swedish Medical Center, who oversees three of the organization's EDs, including the one at Issaquah. "That was the first step in a bridge strategy as we were building a new hospital in the community," says Milne, noting that he was one of the physicians who started the group that was staffing that ED, which has since closed. "The department we created there was in many ways a laboratory for a variety of things around efficiency, flow, and process," he says.

Given a blank slate to work with, staff members were empowered to tweak, tune, and manipulate the no-wait model. A group of nurses, in particular, were highly motivated to come up with solutions, says **Anne Neethling**, RN, who managed the initial freestanding ED, but is now the nurse manager of the ED on the Issaquah hospital campus. "They were really fed up with the way regular or normal EDs worked, especially the long wait process," says Neethling. "They were given the opportunity to try out some new ways of doing this."

Opt for a rapid intake approach

The result of all this experimentation is a process that begins with a burst of activity as soon as a patient presents for care.

"Any patients who come to the front registration desk provide three pieces of information: their name, their birth date, and another identifier. Then they get placed in a room right away, so nobody has to wait outside," says Neethling. "Then the process of triage, diagnostics, and treatment is started immediately, which has been a great satisfier for patients who are not used to this system."

Milne likens this phase of the process to the way pit crews service cars in the midst of a NASCAR race. "We refer to it as swarming," he says. "When a patient comes to a room, you've got the primary nurse who is taking care of him, but then a tech comes into the room, the charge nurse is there as another set of hands, and the physician is trying to get into the room as quickly as possible as well."

During the first 5-10 minutes, there may be as many as six people in the room tending to the patient during the initial intake event. "This ultimately frees up additional resources to move on to that next patient so that when a surge does happen, where you have one patient after another … you are moving faster, so on the back end it saves time in the sense that there is more capacity," says Milne. "The patient is out of the department sooner, so we have another room available."

There can be as many as three or four patient intakes going on at the same time, and by taking care of the diagnostics early on, patients move through the system swiftly, says Milne, who contrasts the process with a traditional triage approach. "The concept of triage is essentially a misnomer. You basically have created a bottleneck choke point — a triage nurse or a triage entry point — which, from my perspective, adds limited value," he observes. "The highest-risk person is the one who is waiting in the waiting room, and we all hear stories of facilities where patients die of a heart attack in the waiting room after they have been sitting there for four or five hours after they have been triaged. Triage is not a perfect system, so the better choice, from our perspective, is to get patients back and evaluated, and have a rapid intake process."

Listen to staff

Milne suggests that administrators are now grappling with the biggest challenge involved with implementing the new model: finding ways to sustain the initial vision, and to continue to empower staff to own their portion of the workflow. The burden of this task largely rests with managers,

adds Milne, who notes that it is not enough to hold a monthly staff meeting.

"Anne [Neethling] comes in early every morning and huddles with staff. She spends time trying to understand their issues while reinforcing the vision, and nipping in the bud any seeds of discontent," says Milne. "At the same time, the staff know she is an advocate for them with senior administration, even while she is continually challenging them to do better."

It's a balancing act, acknowledges Neethling, but staff members are responsive when they have a seat at the table. "This is not a top-down thing that has been mandated. There are obviously budget constraints that have to be followed, but the biggest success from this whole thing came from the fact that the front-line people who were actually doing the job were listened to and taken seriously," she says. "They felt they had some ownership, so that is a big part of what we are still trying to work on every day."

Processes don't always go smoothly, Neethling emphasizes. There might be a staffing issue on the floor, or a patient might not get moved along as quickly as he or she should. These issues come up on a daily basis, and you have to keep working at them, she says. "However, when you establish ownership, it makes a huge difference. You don't feel like you have to keep pushing people. You can actually work with them and walk with them in the right direction, and encourage others to follow in the same way."

Become accustomed to parallel processing

One of the challenges administrators at the Issaquah ED ran into when they began to implement the no-wait concept was the mentality among many of the ED nurses that it was a sign of weakness to have someone come in and help them with a patient, says Milne.

"They were used to doing everything themselves, but they were using serial processing," explains Milne. As a result, it would take 20 to 30 minutes to complete the intake process on a patient.

Conversely, with the "swarming" intake process, there are typically three or four people carrying out several tasks simultaneously, so getting over this mental hurdle took some time, explains Milne. "Once the nurses were able to embrace the concept, the department started humming and moving a lot more efficiently," he says.

There has to be ownership and understanding and teamwork for the model to work well, explains Neethling.

"There cannot be anyone, including the physicians, who is a solo flyer because then it doesn't work," she says. "Staff need to learn to respect and rely on other people, including people from other departments that service the ED." ■

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CNE OBJECTIVES

After reading each issue of Hospital Case Management, the nurse will be able to do the following:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- Why ED case management is so important
- How to develop a discharge plan that really works
- Creating an environment of patient-focused care
- Recruiting and retaining case management staff

CNE QUESTIONS

1. According to Tammy Lenski, EdD, chief executive officer of Tammy Lenski LLC, when you encounter grumpy or combative patients you should:
   A. Leave the room immediately.
   B. Try to convince them that you have their best interest in mind.
   C. Snap back at them and let them know you are annoyed by their behavior.
   D. Understand that the person is not combative because they don't like you but that they're acting that way because they are on edge and frustrated.

2. A redesign of the care coordination process at Sentara Healthcare has centralized clerical and administrative tasks in a Resource Management Center, freeing up unit-based RN care coordinators and social workers to concentrate on managing patients. What tasks does the Resource Management Center handle?
   A. Handles admissions reviews, continuing stay reviews, and retrospective reviews of patients in all hospitals.
   B. Facilitates discharges, arranging for equipment and other post-acute services for all hospitals.
   C. Manages referrals for post-acute care for all hospitals.
   D. All of the above.

3. True or False? Linda Conroy, RN, BSN, clinical integration case manager and heart failure liaison for the Hartford Physician Hospital Organization, introduces herself to the patient in the hospital but waits until discharge to begin working with the patients so they won't confuse her role with that of the discharge planner.
   A. True
   B. False

4. The heart failure team at Good Samaritan Hospital worked with local skilled nursing facilities to develop a protocol for monitoring the weight of heart failure patients. What frequency did they determine would work best?
   A. Every day for as long as the patient is in the skilled nursing facility.
   B. Every day for two weeks, then twice a week for the remainder of the stay.
   C. Every other day for the duration of the stay.
   D. Twice a week while the patient is in the facility.

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