Creating Cost-Efficient Initiatives in Social Work Practice in the Cardiac Program of an Acute Care Hospital

The dramatic changes in federal–provincial funding for health care outlined in the 1989 federal budget have had a profound effect on hospitals in Ontario province (Gilchrist James, 1997). By November 1995 it was clear that hospital funding would decrease by 1.3 billion over three years. This 18 percent reduction was staged in 5 percent, 6 percent, and 7 percent increments over the period 1995 to 1998 (Ministry of Health, Ontario, 1996). Combined with other environmental pressures and advancements in medical–surgical practices, this reduction in funding initiated a surge of restructuring, re-engineering, and reshaping of initiatives in health care organizations.

Many measures were implemented to cope with these fiscal pressures, ranging from layoffs, bed closures, decreased length of stays, increased ambulatory programs to multiskilling. And yet, along with these changes, continuous quality improvement remained a pivotal concern for staff and management (Jirsch, 1993).

As the Cardiac Program at Toronto General Hospital (TGH), part of the University Health Network (UHN) went through a re-engineering process, the Department of Social Work concurrently attempted to look for efficiencies. This article describes the three-fold results within the cardiovascular surgical division: (1) the creation of a one-page application form to streamline the cardiac rehabilitation application process, (2) the assignment of a specific role for the resource specialist of the Department of Social Work in assisting with applications for rehabilitation, and (3) the development and distribution of an information package on cardiac rehabilitation to patients and families. These three initiatives resulted in benefits for patients and families, for the social workers, and for the program.

THE CARDIOVASCULAR SURGICAL SERVICE AT TGH, UHN

The Cardiac Program of TGH is a quaternary care program in clinical service, research, and teaching. Its cardiovascular surgical division (CVS) serves a multi-ethnic patient population from the Greater Toronto Area and surrounding communities. CVS also accepts out-of-province and out-of-country referrals.

Currently, 28 intensive care beds and 55 ward beds accommodate cardiac surgical patients in a newly renovated area within the hospital. The number of cardiac surgeries performed during the past several years has increased steadily. In the fiscal year 1996–97, 2,342 cardiac surgeries were completed; in 1997–98, this number grew to 2,502 surgeries. In 1998–99, 2,726 surgeries were forecast.

Two full-time, master’s level–trained social workers are assigned by the Department of Social Work to the cardiac program. The CVS division accounts for approximately two-thirds of their workload. Cardiovascular surgical patients requiring social work services are referred by staff to the social workers. Social work services include:

- psychosocial assessments
- supportive, adjustment, and crisis counseling regarding hospitalization, and coping with heart disease
- assistance with planning for continuing care
- provision of information about and linkage with community resources
- patient–family education
- consultation to the treatment team.

In addition to clinical work, teaching and research account for approximately 20 percent of social work practice.
For cardiac patients who have little social support, planning for continuing care may include an application to one of the local rehabilitation hospitals that provide a cardiac rehabilitation program. Facilitating both applications and transfers to these rehabilitation hospitals has been a significant and necessary part of the social work role within the CVS.

**The Resource Specialist**

The Discharge Office, located in the Department of Social Work, created the position of resource specialist to allow social work staff to spend more time with patients and families. The office has one full-time resource specialist whose focus is resource finding and follow-up of patients waiting for alternate levels of care. The resource specialist

1. creates, monitors, and communicates information from “the resource bank” of community resources to facilitate timely discharge and appropriate post hospital care
2. reviews, monitors and follows up with alternate level of care applications and accepts bed calls from receiving facilities
3. provides direct assistance to patients and families locating resources and supports as requested by social workers.

The resource specialist has an undergraduate degree, plus a social service diploma from a community college. Additional skills include communication, time management, and client advocacy. These distinct qualifications ensure that there is a clear role distinction between the social workers, educated at the master’s level, and the resource specialist.

The advantages of this system include

- an increase in the amount of clinical time available to social workers for work with patients and families
- a tracking system for information on applications to ALC, including discharge data, e.g. length of hospital stay
- improved linkages to the community
- an extensive data base of resources for all staff.

**Initiative 1: One-Page Application Form**

The cardiac program performed 2,502 surgeries in fiscal year 1997–98. Of these 2,502 patients approximately 12 percent, or 300 patients, required a period of postoperative rehabilitation at one of two local rehabilitation centers. Each of these centers has a program of education, exercise, and monitoring that is designed to help the patient and family adjust to the recent surgery and achieve a level of activity that allows the patient to return home safely.

The process of admission to these facilities traditionally has required a four-page application form to be completed by the physician, nurse, and social worker, in consultation with the patient. With the permission of the patient, the application form is then faxed to both facilities by a discharge secretary. The rehabilitation facility contacts the discharge office when a bed becomes available, and the patient is transferred on the preappointed day.

The review of this process identified the application form as cumbersome and repetitive. Many patients requiring rehabilitation have a diagnosis of arterial coronary bypass (ACB) or valve surgery, are elderly, and have inadequate or unavailable social support. Initially in postoperative recovery, they typically require assistance with their activities of daily living, assistance or supervision with ambulation, and psychoeducation regarding recovery. These patients commonly follow predictable stages of progression in their recovery. Accordingly, staff found themselves rewriting the same information describing the patient’s medical and functional levels and outlining identified needs on the application for cardiac rehabilitation.

In 1995, in collaboration with one of the rehabilitation facilities, the Social Work Department arranged meetings of health care teams from both settings to exchange information and develop a better understanding of the goals of acute care and post-acute care for surgical cardiac patients. The results of these meetings included an application form that was reduced from four pages to one page for ACB and valve surgery patients and an education package for patients shared between the two facilities. By 1996 collaboration with the second rehabilitation facility resulted in the immediate acceptance of the shortened application form. Our acute care hospital guaranteed to take patients back who were not able to cope with the rehabilitation program or who became acutely ill and required readmission.

The shortened application form has increased efficiencies and allowed the social workers to spend more time with patients and less time doing repetitive paper work. Time-saving gains
were recognized also by nurses and physicians. The benefits to the cardiovascular surgical division and the hospital were two-fold: (1) maintenance of quality of service delivery and (2) cost reduction. It is estimated that the shortened application form has resulted in an annual cost savings of $9,900 through reduction in professional and support staff time and printing costs.

The ongoing collaborative efforts of the cardiac program social workers, the Social Work Department, and the rehabilitation hospitals ensured that quality of service delivery was maintained through streamlining the rehabilitation application process.

**Initiative 2: Use of the Resource Specialist**

Further efficiencies were realized when, in August 1998, the resource specialist took on the task of completing the one-page cardiac rehabilitation application. The cardiac social worker now triages all requests for social work post-cardiac surgery and refers those who do not have complex issues to the resource specialist. The resource specialist then meets with the patient and

- assesses the patient’s suitability for the rehab program
- explains the program
- ensures that the information pamphlet is given to the patient
- completes the one-page application form
- documents the intervention on the patient’s medical chart.

From the Rehabilitation Center’s perspective, ACB and valve surgery patients are identified easily because of the one-page form. Patients who are more complex in their rehabilitation needs still have a four-page application completed on their behalf by the cardiac social worker to communicate all the necessary information.

In summary, the introduction of the resource specialist created a staffing skill mix appropriate to the tasks involved in planning a continuum of care for patients and families.

**Initiative 3: Information Pamphlet**

In June 1997, with the streamlined rehabilitation application process in place, cardiac social workers and management focused on examining further opportunities for efficiencies. Patient orientation to cardiac rehabilitation was targeted for review, given the high number of patients requiring application to rehabilitation hospitals after their surgery.

Social work practice at that time involved an individual interview with each patient and family about the cardiac rehabilitation programs. This orientation usually took place on the first or second day following surgery to facilitate timely submission of the application and reduce waiting time for admission.

The central activity in the orientation interview was information provision; the information provided was essentially the same for the majority of patients. The repetitive nature of this orientation allowed us to consider the provision of this information in the form of an information package on cardiac rehabilitation for patients and families.

We reviewed the literature on adult education and reminded ourselves that adults learn best if they feel there is a need to learn and if there are opportunities for them to be participants (Gessner, 1989). We recognized that patients’ abilities to learn vary from one recovery phase to another and differ among individuals (Allan, 1998). With input from our nursing colleagues, we decided on an information pamphlet combined with a shortened interview with the social worker to deal with patients’ concerns and comments.

The pamphlet was both practical and cost-efficient. The patient could read the pamphlet at his or her leisure, could share the pamphlet with his or her family so that all were informed, and could keep it for review at any time. The interview, scheduled at the time that the application form was signed by the patient, provided the opportunity for the patient to participate directly, ask questions, identify concerns, and receive responses. It also allowed the social worker to adjust the intervention to the varying stages of a patient’s ability to learn.

For patients whose primary language is other than English, often there is a family member who can speak English and provide translation. A logical next step is to translate the pamphlet into other languages.

The information package, accompanied by a questionnaire on its usefulness was pilot tested over four months beginning at the end of August 1998. Of the patients that were handed the package and questionnaire, 77 percent actually read the material. The results (Table 1) indicated that the majority of patients and their families who...
had read the information found the information helpful in understanding the steps and issues involved, had no other questions or concerns about the information, and preferred to read the information rather than see a video. We concluded that the combined information package and shortened interview format met our goal of streamlining the process of providing information to patients and families about cardiac rehabilitation without compromising the quality of care.

Throughout the pilot, social workers monitored their time spent with patients in the shortened interviews. The results of this tracking identified that approximately five to 12 minutes of social work time per patient is saved by using the combined pamphlet and shortened interview. Over the four months, this amounted to a saving of from eight to 19.2 hours.

Summary and Conclusion

All three cost-saving initiatives—the creation of a one-page application form to streamline the rehabilitation application process, the use of the resource specialist to assist with applications, and the development of an information package on cardiac rehabilitation—reflect a process whereby a creative idea, generating planning, activities, and follow-up resulted in a measurable effective change in practice. This process truly translated strategy into action (Kaplan, 1996) and is vital to the current rethinking in health care of how best to do our work (Coan, 1994). Because of this process, social workers in the cardiovascular surgical division of the cardiac program are better equipped to respond to the psychosocial needs of a growing cardiac population in a fiscally restrained environment.

References


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