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A Role for Social Workers in Improving Care Setting Transitions: A Case Study

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Abstract

High 30-day readmission rates are a major burden to the American medical system. Much attention is on transitional care to decrease financial costs and improve patient outcomes. Social workers may be uniquely qualified to improve care transitions and have not previously been used in this role. We present a case study of an older, dually eligible Latina woman who received a social work–driven transition intervention that included in-home and telephone contacts. The patient was not readmitted during the six-month study period, mitigated her high pain levels, and engaged in social outings once again. These findings suggest the value of a social worker in a transitional care role.

Keywords

case study; social work; care transitions; hospital readmissions; older adults

INTRODUCTION

High rates of readmissions among American hospitals have an enormous impact on quality of life and costs of care of the American health care system (Bjorvatn, 2013; Coleman, Parry, Chalmers, & Min, 2006; Hansen, Young, Hinami, Leung, & Williams, 2011; Hernandez et al., 2010; Williams, 2013). Thirty-day readmission rates are an accepted marker of discharge success and a reflection of quality of care (Allaudeen, Vidyarthi, Maselli, & Auerbach, 2011; Bjorvatn, 2013; Jha, Orav, & Epstein, 2009; Vashi et al., 2013). It appears that American hospitals are not performing as well as desired: it is estimated that 20–25% of Medicare beneficiaries are readmitted within 30 days of hospital discharge and that these readmissions cost \$26 billion annually (Allaudeen, Schnipper, Oray, Wachter, &

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Vidyarthi, 2011; Centers for Medicare and Medicaid Services, 2012; Graham, Leff, & Arbaje, 2013; Hansen et al., 2011; Hernandez et al., 2010; Jencks, Williams, & Coleman, 2009; Voss et al., 2011). This amount accounts for 17–24% of overall Medicare hospital expenditures, (Jencks et al., 2009), which is especially concerning considering that 75% of readmissions are thought to be avoidable (Hansen et al., 2011).

Poor transitions that lack care continuity have been found to lead to adverse outcomes and greater risk of readmission, especially for older adults (Arbaje et al., 2008; Coleman, Parry, Chalmers, & Min, 2006; Jencks et al., 2009). In fact, the Institute of Medicine has explicitly identified transitional care as a high-priority area for performance measurement (Institute of Medicine Staff, 2006). Recent studies have found that lack of primary care follow-up within seven days of discharge increases risk of 30-day readmission tenfold (Hernandez et al., 2010; Takahashi et al., 2013). Other issues at discharge include lack of communication with the primary care physician (PCP) at discharge, a decreasing number of available PCPs (Williams, 2013), inadequate or nonexistent medication reconciliation (Boling, 2009), incomplete or inaccurate information transfer to the next provider (Boling, 2009; Williams, 2013), and patient non-compliance with prescribed medications (Boling, 2009). These issues can lead to inadequate patient and caregiver preparation for quality care at the next health location (Coleman et al., 2004; Coleman, Parry, Chalmers, Chugh, & Mahoney, 2007) lack of preparation for self-management role, lack of access to a health care practitioner to address direct concerns, and minimal input in patient care plans (Institute of Medicine Staff, 2006). Additionally, multiple transitions that lead to readmissions are common. It is estimated that over 30% of patients undergo more than one post-hospital transfer after discharge (Coleman, Min, Chomiak, & Kramer, 2004) and one out of seven patients discharged from hospitals have four to six transitions within three months, increasing the potential for mismanagement (Boling, 2009; Coleman et al. 2006; Hernandez et al., 2010; Kocher & Adashi, 2011). These shortcomings ultimately lead to greater use of hospital and emergency services (Coleman et al. 2004, 2006). As a result, national attention has been given to streamlining and improving care coordination during the discharge process to reduce avoidable readmissions, especially since the mere documentation of providing discharge instructions to patients has failed to significantly reduce readmission (Allaudeen et al., 2011; Hernandez et al., 2010; Jha et al., 2009).

Prior to the Affordable Care Act (ACA) (Patient Protection and Affordable Care Act, 2010), the fee-for-service system provided hospitals incentive for a short hospital stay, without penalty for unfavorable outcomes, such as high readmission or mortality rates (Bueno et al., 2010; Johnson & McCarthy, 2013; Kamerow, 2013). For common diseases like chronic heart failure, readmission rates increased, yet mean length of stay in hospital decreased by 26% (Bjorvatn, 2013; Bueno et al., 2010). Discharge disposition also changed significantly in recent years, with a 53% relative increase in proportion of discharges to skilled nursing facilities (SNFs) and a 10% reduction in discharges to home (Bueno et al., 2010). Among those discharged to home, greater percentages of patients are unstable, making post-discharge home care an important target for improvement (Kosecoff et al., 1990).

Now, due to the ACA, incentives for reducing readmission have changed. Hospitals are being penalized for excessive readmissions, defined as the ratio of a hospital's readmission

performance compared with the national average for the set of patients with an applicable condition, among other criteria (Allaudeen et al., 2011; Fontanarosa & McNutt, 2013; Lacker, 2011). Penalties for readmissions are currently incurred among patients diagnosed with acute myocardial infarction, heart failure, and pneumonia, with more conditions to be added in 2015 (Kocher & Adashi, 2011). Penalties currently entail a 2% reduction in Medicare Inpatient Prospective Payment System reimbursements for all expenses during readmissions for pneumonia, acute myocardial infarction, and heart failure. This figure will increase to 3% in 2015 and is expected to also include chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous coronary interventions, and other vascular procedures. These penalties cost hospitals—and save Medicare—an estimated \$300 million per year (Fontanarosa & McNutt, 2013; Jencks et al., 2009; Kamerow, 2013).

The need to reduce hospital readmission among older adults has never been more pressing. The national population of adults over 65 years old is projected to rise from 14% to 20% by 2030, and then peak at 25% by 2050. Additionally, adults over 85 are expected to increase by 400% by 2050, and their cost of care has been found to be eight times that of the average adult (Allaudeen et al., 2011; Bjorvatn, 2013; Hackstaff, 2009). This puts quite a burden on an already indebted health care system, which is projected to cost 30% of Gross Domestic Product (GDP) by 2035 and 50% by 2085 (Hackstaff, 2009). In addition to reduced health care costs, improved transitions from hospital to home will result in better quality of life for patients and better health outcomes for the general public (Allaudeen et al., 2011). Low-cost interventions focused on education, medication management, and peer support have demonstrated reductions in 30-day hospitalizations (Boling, 2009; Brock et al., 2013; Coleman et al., 2004; Jack et al., 2009). Interventions, especially those that utilize “transition coaches” that guide patients toward activation and self-care, have a significant association to reductions in rehospitalizations and emergency department visits for at least six months following discharge (Brock et al., 2013; Coleman et al., 2004; Dharmarajan et al., 2013; Johnson & McCarthy, 2013; McCarthy et al., 2013). A recent review of 14 hospital-to-home transition interventions showed a mean reduction of 5.7% in rehospitalizations (Brock et al., 2013). Interdisciplinary interventions have also resulted in fewer emergency department visits and better health outcomes (Brock et al., 2013; Johnson & McCarthy, 2013). Interventions that provide home-visits also have shown significant positive effects on mortality, admission, readmission, and nursing home placements (Elkan et al., 2001). Discharge planners and home health services that focus on the home transition are now positioned to play a more active role in care transitions, due to their simplicity and relatively low cost of implementation (Coleman et al., 2004).

Social workers, in contrast to more medically focused nurses or advanced practice nurses, are potentially better suited to fill an intervention role within hospitals (Health Resources and Services Administration, 2004) since they are trained to link patients with community and home-based services, reduce fragmented health and social service systems, and address both the medical and psychosocial needs of the patient (Atkinson & Nelson, 1995; Coley, Williams, DaPos, Chen, & Smith, 2002; Geron, Andrews, & Kuhn, 2005; Rosen & Teeson, 2001; Scharlach, Simon, & Dal Santo, 2002; Vourlekis, Gelfand, & Greene, 1992). This is especially important considering that 40–50% of hospital readmissions are linked to psychosocial problems and lack of community resources and that 80% of older adults

experience unaddressed social needs post-discharge (Altfeld, Pavle, Rosenberg, & Shure, 2012–2013). Social workers focus on incorporating both the patients' and caregivers' needs along with the needs of institutions or social services to provide an optimal care plan, according to the ecological model (Fabbre, Buffington, Altfeld, Shier, & Golden, 2011). Also, the social worker's emphasis on both tangible support, like connecting patients with resources, and emotional support, like reflective listening or giving encouragement, is important for better health outcomes for older adults (Fabbre et al., 2011; Parry, Mahoney, Chalmers, & Coleman, 2008). Thus, social work–driven interventions—social workers facilitating access to multidisciplinary care and interventions—may potentially reduce readmission rates and medical service use, as well as facilitate linkage to community-based social services to increase the quality of transitional care. Yet little is known about the social work role in improving care transitions.

We present a case study of a social work–driven care transitions intervention. This case study provides insight into how a social worker can potentially improve the transition experience and health outcomes for at-risk older adults.

METHODS

A single-case, case study methodology was used to investigate the social work role in providing care transition support for an at-risk older adult. Case studies provide an opportunity for in-depth investigation of a phenomenon to develop a greater understanding within a real-world context (Yin, 1989). Case studies also represent the preliminary stage of research, spark interest, and suggest possibilities for deeper and more detailed investigation of novel concepts in the future (Rowley, 2002). This case provides insights into the specific social work tasks that may support older adults transitioning from hospital to home.

Subject Eligibility and Recruitment

The case was selected from a larger study of a social work intervention. Participants were recruited from a large, non-profit, urban community hospital in Los Angeles County. Eligibility criteria included adults aged 65 years or more, currently hospitalized, cognitively intact (five or more correct on Short Portable Mental Status Questionnaire), English-speaking, residing within a study-designated geographical area, and identified as at high risk for readmission. High risk was determined by meeting at least one of the following criteria: aged 75 or older, prescribed five or more medications, or having one or more hospitalization or emergency department visit in the previous six months. Patients were screened and consented at bedside.

Social Work Intervention Focused on Transitions (SWIFT) Intervention

Those assigned to the SWIFT intervention group received transition care that included a home safety review, psychosocial assessment, medication reconciliation, review of discharge orders, and assistance with scheduling follow-up appointments with the primary care physician and/or specialists, as needed. In addition, they received the following assessments: home safety, depression, and self-management of chronic conditions needs. The goals of the intervention were to ensure comprehension and adherence to discharge instructions, ensure

medication accuracy and compliance, ensure physician follow-up within 10 days of discharge, and assess the patient's ability to manage chronic conditions.

The intervention also employed problem-solving therapy (PST) (Nezu, 2004) to assist the patient with prioritizing needs and identifying possible solutions. The aim of PST is not to solve problems for the patient; rather, to teach patients to address their problems and challenges by breaking them down into smaller goals and identifying actions that can be taken to solve them, with the ultimate goal of providing long-term and sustainable self-sufficiency (Enguidanos, Coulourides Kogan, Keefe, Geron, & Katz, 2011; Malouff, Thorsteinsson, & Schutte, 2007; Nezu, 2004). The social worker worked with the patient to identify problems or issues and to develop a plan to address them.

Those assigned to the SWIFT group received an in-home assessment (at least one visit conducted within 48-hours of discharge and a maximum of two visits to address unresolved issues identified during the first home visit, as determined by the social worker) and telephone follow-up (up to a maximum of four phone contacts).

Data Measures

Social worker chart notes, baseline documents taken in-hospital by a clinical research assistant, and all assessments completed over the phone and during home visits were sources of data for this study.

Demographics—Patient demographics and other characteristics including age, gender, marital status, and presence of advance directive were collected from patient surveys conducted at bedside.

Medications—A complete medication review was completed based on the Medication Management Improvement System program that focuses on medication duplication and psychotropic effects associated with falls and confusion (Alkema, Wilber, Frey, Enguidanos, & Simmons, 2008). Current medications were entered into the Medications Management Improvement System database (Partners in Care Foundation, 2013) and electronically screened for errors and potential problems using the home health criteria developed by a panel of experts (Meredith et al., 2001). Any problems were reported to the primary care physician and discussed with the patient.

Social Service Needs—A Home Safety Evaluation developed by the University of Southern California's Falls Prevention Center was used to assess the risk of falls at home (Fall Prevention Center of Excellence, 2014) The Lorig Chronic Care Self Management scale (Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001) was used to assess the patient's ability to manage his chronic conditions by monitoring symptom control, physician communication, and role function.

Pain—Numeric rating scale (0–10), where zero indicates no pain and 10 corresponds to the worst pain imaginable.

Service Utilization—Self-reported health service use was measured at six months following study enrollment. These self-reports were confirmed via electronic medical records at the clinical study site.

Findings

Case Description—Mrs. S was a 90-year-old widowed Latina woman with a second-grade education level. She resided with her granddaughter, who was her primary caregiver, and had both Medicare and Medicaid health care insurance. At the time of her index hospitalization, she was taking seven prescription medications for six health conditions and had been admitted for nausea and gastrointestinal bleeding via the hospital emergency department. Her chronic conditions included hypertension, asthma, arthritis, anemia, diabetes, and heart disease. She also reported a high pain level (10/10), since her prescribed pain medication had limited effect. The patient reported minimal depression with a score of 3 on the PHQ-9 Depression Scale, and reported moderate physical limitations in lifting and carrying groceries and climbing stairs. The patient ambulated with a cane, had no fear of falling, and had transportation to medical appointments from her granddaughter.

First Home Visit: During the SWIFT home assessment (first study contact), the patient reported a continued high level of pain (8/10) and had partially filled prescriptions following her hospital visit, including Tramadol, Metoprolol Tartrate, and Q-pap for pain. As part of the intervention, the social worker conducted a medication reconciliation using the HomeMeds medication software program. She found the medication regimen was clear of duplication, interactions, and medications contraindicated for older adults. The social worker also conducted a home safety check resulting in recommendation for installation of grab bars in her bathroom. The patient's greatest concern was her intractable pain resulting from arthritis and other health conditions. Using a problem-solving approach, Mrs. S, her granddaughter (caregiver), and the social worker worked together to identify ways to better manage her pain. Mrs. S established goals including getting a heating pad to ease discomfort and making a follow-up appointment with her primary care physician to obtain improved pain management interventions.

Second Home Visit: Due to the extreme pain experienced by Mrs. S, the social worker made a second home visit four days later. During this visit, the social worker discovered that Mrs. S had not scheduled her follow-up physician appointment and continued to experience sustained high levels of pain. Additionally, her existing pain medication was running low and the doctor's office was closed, preventing Mrs. S from obtaining a refill. With the help of the social worker, Mrs. S set goals to immediately schedule a physician visit, request that her physician provide improved pain management, and coordinate with her physical therapist to get a hospital bed for increased comfort at home.

Telephone follow-up #1: The social worker conducted a follow-up by phone four days after her second home visit with Mrs. S. The patient reported that she had made and attended an appointment with her primary care physician; however, the visit had focused on her anemia diagnosis, and her pain issues were not discussed or addressed. As a result, Mrs. S continued to experience high levels of pain and only had a few pain pills remaining. The social worker

attempted to contact the physician's office directly; however, the physician's office was closed for a three-day holiday weekend. The patient agreed to call the physician after the holiday to request Tylenol 500 (Acetaminophen 500 mg), a pain medication that had previously proven effective in alleviating her pain, or another alternative prescription medication to control her pain.

Telephone follow-up #2: Twelve days following hospital discharge and three days following the previous telephone call, the social worker conducted a second follow-up telephone call (fourth contact overall). Mrs. S reported that she had received a prescription for Tylenol 500 to treat her pain. However, her pain level remained high at 7 on a scale from 0 (no pain) to 10 (worst pain possible). The social worker subsequently contacted Mrs. S's granddaughter, who expressed a desire to switch Mrs. S's physician to one more responsive to her pain management needs.

Telephone follow-up #3: Three days later, the social worker conducted a third follow-up call and discovered that Mrs. S felt continued high levels of pain, but had scheduled an appointment with a new physician. The social worker coached the granddaughter on how to strongly advocate on her grandmother's behalf and advised the family to contact both the previous and current physician regarding pain management to receive the most prompt pain management possible. Additionally, Mrs. S's eligibility for both Medicaid and Medicare along with her physical functioning challenges qualified her for a Medicaid-waiver program for ongoing case management. The social worker placed her on the wait list to ensure ongoing access to needed social services and case management.

Telephone follow-up #4: On the 26th day after her discharge from the hospital, Mrs. S received her fourth and final telephone contact from the SWIFT social worker (a summary of all contacts can be seen in Table 1). The social worker learned that the family successfully advocated with the original primary care physician to obtain stronger pain medications. Additionally, the hospital bed was delivered, and Mrs. S stated she was feeling more comfortable at home. Mrs. S also reported increased socialization, significant reduction in pain, and subsequent ability to resume basic functions and simple errands, such as grocery shopping. Significantly, the patient was not readmitted to either the emergency department or the hospital in the six months following her hospital discharge.

Case Analysis—Our case study highlights potential patient needs during transition from hospital to home and the role of a social worker in improving care and maximizing health outcomes. The social worker focused on traditional transition issues, such as ensuring follow-up with primary care physician and performing medication reconciliation, and also worked with Mrs. S to identify and address other health-related needs, such as improved pain management and increased access to supportive services.

The social worker provided important coaching that enabled Mrs. S's granddaughter to effectively negotiate improved pain management with the primary care physician. This coaching was perhaps one of the most essential aspects of this case study: coaching in negotiation skills can give patients self-control and self-efficacy and reduce feelings of helplessness or victimization, leading to better health outcomes (Choi, Marti, Bruce, &

Hegel, 2013). Interventions like SWIFT that encourage person-centered self-advocacy, self-management, and problem solving (Coleman et al. 2006; Naylor et al., 1999) leads to long-lasting benefits that have proven to reduce rehospitalization, reduce health costs, and improve patient and provider satisfaction (Arbaje et al., 2008; Boling, 2009; Enguidanos et al., 2011; Naylor et al., 1999; Voss et al., 2011). Mrs. S had numerous factors that placed her at high risk for readmission including her ethnicity (Joynt, Orav, & Jha, 2011; McHugh, Carthon, & Kang, 2010); advanced age (Bjorvatn, 2013; Goldfield et al., 2008; Krumholz et al., 1997; Silverstein, Qin, Mercer, Fong, & Haydar, 2008); limited education (Arbaje et al., 2008); Medicare and Medicaid status (Coleman et al., 2004; Hasan et al., 2009); single (widowed) marital status (Arbaje et al., 2008; Garrison, Mansukhani, & Bohn, 2013); and multiple chronic conditions including hypertension, diabetes, and arthritis that caused her to experience severe pain (Bjorvatn, 2013; Coleman et al., 2004; Silverstein et al., 2008). In particular, studies have suggested that pain may worsen executive functions that lead to decreased compliance in older adults (Karp et al., 2006). With coaching and an emphasis on social solutions to positively impact physical conditions, Mrs. S's pain was reduced, and she was not subsequently readmitted to the hospital during the six months following initial hospital discharge. The patient also received referrals to community-based resources, such as a Medicaid-waiver program.

IMPLICATIONS

This study provides a detailed case study of a patient enrolled in a social work-driven intervention to improve transition from hospital to home.

The National Association for Social Workers (Herman, 2009) identifies key social work values and practice standards that bring strength to their role in transitional care for older adults. These include their focus on person-centered care, the ecological framework that includes assessment of personal and environmental factors, and their practice approach that includes collaboration with informal and formal caregivers and providers. Additionally, social workers often have more experience in geriatrics and community-based practice and may better address social-service issues (e.g., lack of access to community services like transportation or social support services) than a medical-based intervention (Altfeld et al., 2012). Social workers are knowledgeable in successfully utilizing mechanisms to overcome disciplinary boundaries, such as the electronic medication system used in this study (Fabbre et al., 2011). They are also trained to relieve caregiver burden, to help patients cope with changes in health status, and to connect patients with services ordered at discharge, which is oftentimes a challenge (Altfeld et al., 2012).

Rush University developed and tested another social work driven transition intervention. The Bridge Model (Altfeld et al., 2012; Fabbre et al., 2011) provided social work transition care beginning at bedside in the hospital and arranged services prior to hospital discharge. Telephone follow-up was provided two days post-discharge to identify new problems, to determine patient understanding of discharge instructions and medication regimens, and to schedule follow-up medical appointments. Although not effective in reducing 30-day readmissions, perhaps due to the lack of intense intervention post-discharge and the reliance

on telephone follow-up, The Bridge Model was effective in increasing access to follow-up care and services (Altfeld et al., 2012).

A traditional nurse-driven transition intervention providing purely medical follow-up may fail to address psychosocial problems and thus does not fully empower patients and caregivers to improve their health. Moreover, it is crucial that interventions address both psychosocial and health issues, linking patients to community resources as well as collaborating with the health care team (Altfeld et al., 2012). Including social workers in transitional care interventions may provide improved linkages to health care and community-based services as well as greater psychosocial support that lead to sustainable positive health outcomes. Indeed, studies have shown increased social work support services are associated with lower total hospital costs and increased probability of physician follow-up after discharge (Altfeld et al., 2012–2013; Hine, Howell, & Yonkers, 2008; Rizzo, 2006). Our case study provides a concrete example of how social workers can empower patients to improve their health status and provide critical linkages to health providers, community-based resources, and services that will provide ongoing support for community-dwelling older adults.

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TABLE 1

Summary of all Home and Telephone Contacts

Contact Number	Day	Type	Medication management	Discharge Planning	Psychosocial Assessment	Patient Training	Follow-Up Referrals	Result	Action Items
1	1	Home Visit	X	X	X	X	X	Home assessment, medication reconciliation, problem-solving pain management	Schedule a physician visit for pain
2	5	Home Visit	X	X	X	X	X	Increased pain, Mrs. S had not scheduled physician appointment yet, low on pain meds	Schedule physician visit ASAP, ask for pain medication prescription, get hospital bed
3	9	Phone		X		X	X	Mrs. S had seen physician, but not received pain meds	Call physician to ask about alternative to prescription pain medication
4	12	Phone				X	X	Taking Tylenol, but high pain; wanted to switch physicians	Call new physician
5	15	Phone		X		X	X	Reported increased pain, but had scheduled appointment	Contact both physician re: pain management; put on wait-list for case manager
6	26	Phone				X		Received hospital bed, received pain medication	-