THE ACA AND CARE TRANSITIONS: IMPLICATIONS FOR SOCIAL WORK

Presented by
Paul Gould and Walter Rosenberg
July 16, 2014
Paul R. Gould, PhD, LCSW

Visiting Assistant Professor
Assistant Director, Institute for Intergenerational Studies, Southern Tier Center on Aging
Binghamton University
Background and Context

- Health condition or diagnosis is a significant determining factor in hospital readmission risk (Hasan et al., 2009).
- The presence of comorbid chronic illness and the need for assistance with activities of daily living place older adults at the greatest risk for 30-day rehospitalizations (Wolff, Starfield, & Anderson, 2002).
- Hernandez et al. (2010) determined patients of hospitals with higher rates of follow up care had the lowest rates of readmission.
- Health care utilization alone does not reduce readmissions (Grafft et al., 2010).

Cost of Hospital Readmissions

- From 2007–2011 the national average readmission rate within 30 days was **19%**.
- **2012** readmission rates were **18.4%** (Gerhardt et al., 2013).
- Approximately 1.9 million 30-day all cause readmissions cost Medicare **$17.5 billion in 2010**—the estimated average cost is **$9,200 per readmission** (Centers for Medicare & Medicaid Services, 2013).
- In **October 2012** Medicare began penalizing more than 2,000 hospitals for readmissions within 30 days (Rau, 2012).


Care Transition

- Occurs when patient transfers to new health care provider/setting
- Comprehensive plan of care
- Addresses multiple factors in patient health
- Interdisciplinary team
Community-Based Care Transition Program (CCTP)

- Pilot enhanced care transition models
  - Improve transitions
  - Enhance quality of care
  - Reduce readmissions
  - Document cost savings

- 102 community-based organizations (CBO)

- Learn more at http://innovation.cms.gov/initiatives/CCTP
Implementing a Social Work Empowerment-based Intervention to Reduce 30-Day Hospital Readmission Rates

Institute For Intergenerational Studies
Southern Tier Center on Aging
Binghamton University

Laura Bronstein, PhD, LCSWR, ACSW
Shawn Berkowitz. MD, CMD, CAQ Geriatrics, AAFP, AGS
Paul R. Gould, PhD, LCSW
Gary James, PhD
Kris Marks, LCSW-R, OSW-C
Study Goals

- Encourage patients to take greater ownership of their care using a social work strengths-based, patient-empowerment model.
- Demonstrate cost savings.
- Reinvent the learning process to engage students in real-world patient care as part of an interprofessional team.
Process

Participants in the study received typical care. Those in the intervention group also received the following case management services provided by master's-level social work (MSW) students through phone and home visits:

- Initial contact made with patient in hospital prior to discharge
- Follow-up phone call 3–7 days post-discharge
- Home visit 4–7 days post-discharge
- Follow-up phone call 7 days after home visit
- Some patients requested additional home visits
Intervention

MSW students providing the intervention addressed:

- Basic needs
- Adherence to the prescribed medication regimen
- Transportation problems
- Caregiver stress
- Home safety
- Other questions & concerns

Advocacy, empowerment, and emotional support from a strengths-based perspective are emphasized throughout the 30-day process.
Impact

- **63** patients WERE enrolled into the program (intervention group).
  - 4 patients **readmitted within 30 days** who were enrolled in the intervention group using Intention to Treat Analysis (ITT).
- **59** patients DID NOT readmit who were enrolled in the intervention.
- **44** patients WERE NOT enrolled into the program (control group).
  - 8 patients **readmitted within 30 days** who were enrolled in the control group.
- **36** patients DID NOT readmit who were enrolled in the control group.

6.3% vs. 18.1%
- A 65% reduction in readmission
Interpretation

• The pilot study conservatively saved the hospital about 5 readmissions.
  ➢ Presuming greater than 50% reduction of cases in the intervention group

• The hospital conservatively calculates the average cost of a “preventable” readmission within 30 days to be $7,500.
  ➢ National average cost is $9,200

• $7,500 x 5 patients =
  
  $37,500 potentially saved from our small pilot study
Extrapolation

• If extrapolated to the hospital readmission population as a whole, the savings would be about $7.5 million.
  ➢ Based on about 2,000 readmissions per year and a 50% reduction to only 1,000 readmissions.

• $7500 \times 1,000 \text{ patients} = \$7.5 \text{ million potential cost savings.}
Geriatric Consultation Clinic

An Interprofessional Learning Experience

Paul R. Gould, PhD, LCSW
Shawn Berkowitz, MD, CMD
Youjung Lee, PhD, LMSW
Laura Bronstein, PhD, LCSW-R, ACSW

Funding provided by the John A. Hartford Foundation
Geriatric Consultation Clinic

MSW and fourth-year medical students collaborated with interdisciplinary faculty to conduct a three-step Comprehensive Geriatric Assessment with rural older adults and caregivers:

• Step 1: In-Home Assessment
• Step 2: Clinic Assessment
• Step 3: Consultation
Geriatric Consultation Clinic

Three major themes relating to the effectiveness of the interprofessional education experience and implications for practice emerged:

1. Benefits of collaborative experiential learning environment
2. Recognition of complementary roles in developing a holistic intervention with complex geriatric patients
3. Challenges to interprofessional communication
Implications for Social Work Education

- Communication style that better integrates with current medical model
  - Health literacy
  - Concise & precise case presentation
  - Understanding diverse professional roles in health care settings
- Greater attention to cost effectiveness of social work practice models
- Expand interprofessional educational experiences in integrated health care settings
Implications for Social Work Field Education

- Expand interprofessional educational experiences in integrated health care settings
- Expand placements that provide care transition:
  - Patient Centered Medical Home
  - Primary Care
  - Hospitals
  - Home Health Agencies
- Include funding for interns in care transition research proposals
Walter Rosenberg, MSW, LCSW

Manager of Transitional Care
Rush University Medical Center

Program Manager
Bridge Model National Office
# Connecting Medical and Social

<table>
<thead>
<tr>
<th>Statement</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care in the US is too hospital-centric</td>
<td>1949</td>
</tr>
<tr>
<td>Medical services alone won’t be adequate</td>
<td>1954</td>
</tr>
<tr>
<td>We should integrate medical and social support</td>
<td>1956</td>
</tr>
<tr>
<td>Care patterns are local, and reflect capacity to deliver care</td>
<td>1973</td>
</tr>
<tr>
<td>Hospital costs are unsustainable</td>
<td>1980</td>
</tr>
<tr>
<td>Hospital readmissions are prevalent</td>
<td>1984</td>
</tr>
<tr>
<td>The Health Care Financing Administration (renamed CMS) could direct appropriate subcontractors to do things that would prevent readmissions</td>
<td>1984</td>
</tr>
</tbody>
</table>
Triple Aim of Health Reform

- Better Care for Individuals
- Lower per capita Costs
- Better Health for Populations
Volume vs. Value

First Curve

*Traditional Fee-for-Service Payment System*

Second Curve

*Option on the Health Exchange*

*Direct Contracts with Employers*

*Medicare Advantage Plan*

*Accountable Care Organizations*

*Readmission Rate Penalties*

*Bundled Payment Pilots*

*Population Health per capita Payment System*
Your New Health Care System
Accountable Care Organizations (ACO)

- Groups of providers coming together to treat a set population of patients

- Types
  - Medicare Shared Savings Program
  - Advance Payment ACO Model
  - Pioneer ACO Model

- Health care “neighborhood”
Is There Room for Social Work?
Rush Health and Aging

Inpatient
- Identify and understand patient and caregiver concerns
- Impact patient goals
- Make sense of confusing time
- Emotionally support and engage patients in their own care
- Advocate with providers
- Reduce 30-day readmissions

Community
- Health lectures
- Evidence-based workshops and classes
- Support groups
- Resource centers
- Community advisory board
- Rush Generations membership program

Outpatient
- Work closely with primary care and specialty clinics
- Emotionally support and engage patients in their own care
- Collaborate with healthcare and resource providers and advocate on behalf of patient
- Reinforce medical home
- Reduce unnecessary utilization
- Increase adherence

Policy, Education, and Research
- Advancing public policy
- Redesigning delivery systems
- Interprofessional education and practice
- Community integration
- Building evidence
- National innovation leadership
- Student development

Better health and emotional well-being
Why Transitional Care?

• Numerous “providers” in the medical and psychosocial community
• Insufficient and flawed interdisciplinary and inter-provider communication
• No single “owner” of a transition
We Still Don’t Know Why…

- Medical model emphasis
  - Care Transitions Intervention
  - Transitional Care Model
- New literature questioning the status quo
  - Cognitive decline while in hospital and post-discharge (Lindquist, Fleisher, Jain, & Baker, 2011)
  - 40–50% of readmissions tied to psychosocial problems and lack of community resources (Proctor, Morrow-Howell, Li, & Dore, 2000)
  - “Unplanned readmissions largely determined by broader social and environmental factors…” (Kansagara et al., 2011)


Building Blocks of Bridge Model

Continuous Quality Improvement

- Comprehensive Assessment
- Clinical Intervention
- Social Determinants of Health
- Community-specific Focus
- Hospital-Community Collaboration
Bridge Model Components

Model Findings \((n = 2,581)\)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission decrease</td>
<td>25+%</td>
</tr>
<tr>
<td>Mortality decrease</td>
<td>13+%</td>
</tr>
<tr>
<td>Physician follow-up</td>
<td>75%</td>
</tr>
</tbody>
</table>
Social Work Clinical Skills

• Bridge is led by master's-level social workers
  - Person-in-environment perspective
  - Client-centered interviewing
  - Motivational interviewing, acceptance and commitment therapy, cognitive behavioral therapy, etc.
  - Stages of change
  - Cultural humility
Person-in-Environment

- Uniquely defines social work
- An individual and his or her behavior cannot be adequately understood without considering the various aspects of that person’s environment
- More comprehensive overview of strengths and challenges
- Increases range of interventions:
  - Psychotherapy
  - Case management
Client-Centered Interviewing

• OARS
  ➢ Open-ended questions
  ➢ Affirmation
  ➢ Reflection
  ➢ Summary

• Motivational Interviewing
Motivational Interviewing

- Semi-directive
- Explores intrinsic motivation of client
- Main goals:
  - Establish rapport
  - Elicit change talk
  - Establish commitment language

YOU CAN
DO IT!!
Data Collection

**Process data**
- Identified needs and interventions utilized
  - Number per case
  - Top three (or four, or five…)
- Relationship status (Excel)
  - Most frequently utilized providers
  - Five best and worst
- Cases per month
- Length per case

**Outcome data** – where can you get this?
- Readmissions
- Physician follow-up
- ER utilization
- Mortality
Connecting Processes and Outcomes

• Limited by data availability but the gold standard
• Readmission example
  ➢ Identify cases readmitted within 30 days
  ➢ Identify process measures associated with those cases
  ➢ Compare with cases that did NOT readmit and note differences—does anything stand out?
    o Shorter duration of intervention
    o Unique subset of identified needs
    o Demographic differences
Supervision

- **Weekly**
  - Clinical case discussions
    - Open-ended, role plays, theory
  - Relationship updates
    - Has a provider stepped up their game?
    - New challenges on the horizon?
- **Monthly**
  - Data collection
    - Does everyone still define terms the same way?
  - Readmission review
  - Team cohesion
- **Quarterly**
  - Process data analysis and discussion
Bridge Model National Office (BMNO)

- Multiple viewpoints
  - Hospital, community, policy, evaluation
- National advisory board
  - Experts from a broad spectrum of backgrounds
    - Physicians, pharmacists, foundations, government, research
- Program management team
  - Maintain model fidelity
  - Update training materials
  - Conduct trainings
- Bridge Model Collaborative
  www.transitionalcare.org
Crafting a Plan

• Transitional care business cases are challenging and always in flux.
  ➢ Readmission reduction
    o Penalty avoidance
    o Payer perspective
  ➢ Post-discharge appointments
    o New appointments made
    o Missed appointments prevented
  ➢ Downstream revenue (i.e. marketing impact)
  ➢ Patient satisfaction
    o Hospital Consumer Assessment of Healthcare Providers and Systems
    o Clinician and Group Consumer Assessment of Healthcare Providers and Systems
  ➢ Grant funding
Implications: Curriculum and Field Education

- Greater emphasis on interface with health care
- Care delivery redesign and analysis
- Hands-on psychotherapy practice
- Interdisciplinary education
  - Example of Geriatric Interdisciplinary Team Training at Rush
  - Virtual teams and communication
- Data collection and analysis
Questions
Thank You

To access a recording of this webinar and other teaching resources, please visit:

www.cswe.org/CentersInitiatives/GeroEdCenter