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BIOPSYCHOSOCIAL CHALLENGES RELATED TO TRANSITIONS OF CARE

Introduction

Barriers to successful transitions of care exist within health care delivery systems, among health care practitioners, and among health care consumers (Coleman, 2003). Older adults' medical risks associated with care transitions, and the financial impact of transition-related complications, have gained increasing attention within the medical community. For example, the Institute of Medicine (IOM, 2007) has estimated that every hospital patient is likely to experience at least one medication error daily (p. 1), and approximately 7,000 people die from medication errors each year (U.S. Department of Health and Human Services, 2000). The risk of health care–associated infection (HAI) also increases with hospitalization. Almost 2 million hospital patients experience an HAI each year, and almost 100,000 deaths annually are attributable to HAIs (Klevens et al., 2007, p. 163).

One transition, such as a hospitalization, can lead to additional transitions of care, creating a chain reaction. A recent study of Medicare claims data for 2003–2004 (Jencks, Williams, & Coleman, 2009) found that almost 20% of Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days. This study also found that about half the beneficiaries who were discharged following treatment for medical conditions, and who were rehospitalized within 30 days of discharge, did not visit a physician between hospitalizations,

indicating gaps in postdischarge medical care. On the basis of their examination of the 2003–2004 data, Jencks et al. (2009) estimated that 90 percent of all rehospitalizations within 30 days were unplanned, costing Medicare more than \$17 billion in 2004—about 17 percent of total Medicare spending on hospitalizations for that year (Jencks et al., 2009, Results section, para. 1, and Discussion section, para. 8).

Psychosocial Issues Underlying Transitions of Care

Although psychosocial factors associated with transitions of care have garnered less attention than medical costs, they often contribute to problematic care transitions—highlighting the need for social work intervention.

- One hospital-based study (Keefler, Duder, & Lechman, 2001) found that increased length of stay was associated more with the severity of psychosocial problems—such as struggles with loss, dependency, isolation in social roles, and environmental challenges—than with the severity of medical problems.
- Arbaje et al. (2008) found an association between postdischarge environmental and socioeconomic factors—such as living alone, having unmet functional needs, having limited formal education, and lacking self-management skills—and hospital readmission within 60 days (p. 502).

- An earlier review of the literature related to hospital discharges (Proctor, Morrow-Howell, Li, & Dore, 2000) concluded that “studies show that 40 percent to 50 percent of readmissions are linked to social problems and lack of community services” (p. 88). Proctor et al.’s (2000) own study of Medicare beneficiaries discharged from the hospital to home found that home care significantly reduced the risk of hospital readmission among older adults, concluding that “a key social work activity—the careful assessment of day-to-day needs post-discharge and arrangements to meet those needs—may help prevent hospital readmission” (p. 93).
- Hou, Hollenberg, and Charlson (2001) found that old age (age 65 or older), severe illness, and lower functional status (as assessed by physicians) were correlated with increased need for hospital social work intervention, noting that “by age 85, more than 50% of hospitalized patients require some form of social services at discharge” (pp. 24–25).
- A study of hospital social work interventions (Auerbach, Rock, Goldstein, Kaminsky, & Heft-Laporte, 2000) found that patient care (especially need for placement) was the most frequently addressed problem, followed by patient and family adjustment to changes associated with illness or placement. Auerbach et al. (2000) also found that social work intervention in the emergency department diverted 85 percent of patients from inpatient admission (p. 18).

Another psychosocial factor that affects transitions of care is health literacy. According to the 2003 National Assessment of Adult Literacy, adults age 65 and older tend to have lower levels of health literacy than their 16- to 64-year-old counterparts, being almost three times less likely to possess basic health literacy—that is, the “skills necessary to perform simple and everyday literacy activities” related to health (Kutner, Greenberg, Jin, & Paulsen, 2006, p. 5). Although other factors—such as level of education, language spoken before starting school, income, gender, race, and ethnicity—can also affect health literacy (Kutner et al., 2006), lower than average health literacy increases older adults’ risk for nonadherence to medications and other treatments.

Financial constraints also increase older adults’ risk during transitions of care. A 2008 study by Madden et al. found that cost-related medication nonadherence among community-dwelling Medicare beneficiaries (85 percent of whom were older adults) with good to excellent health has decreased slightly since the advent of the Medicare prescription drug benefit (Part D). Yet, cost-related medication nonadherence persists among beneficiaries with fair to poor health, probably in part because those beneficiaries’ medication use and cost is higher than that of beneficiaries with good to excellent health (Madden et al., 2008, p. 1926).

Inadequate preparation of, and support for, family caregivers also leads to problematic care transitions. Family caregivers constitute the backbone of the U.S. health and long-term care system, providing emotional support, medication administration, personal care, health care monitoring, advocacy, coordination of care, medical decision making, household tasks, transportation, help with insurance and other paperwork, financial assistance, and other tasks (Wolff, as cited in IOM, 2009, p. 252). Their involvement has been shown to improve transitions of care (Coleman, 2003) and reduce the risk of both nursing home admission (Muramatsu et al., 2007) and early hospital readmission (Arbaje et al., 2008). Family caregiving services are not provided without significant cost, however. AARP (2008) estimated that family caregivers provided an estimated \$750 billion in uncompensated care for loved ones in 2007, resulting in decreases in caregivers’ wages, health insurance and other employer-sponsored benefits, and retirement savings (including Social Security benefits). Moreover, the cost of family caregiving far exceeds these indirect financial losses and the \$5,000 out-of-pocket direct caregiving costs accrued to each family caregiver (AARP, 2008). Family caregivers report experiencing decreases in energy and sleep; increases in stress, pain, depression, and headaches; and changes in weight as a result of their caregiving responsibilities (Evercare, 2006). Levine and Kuerbis (2002) asserted that of “the many professionals family caregivers encounter on their odysseys through the health care system, social workers are ideally the ones who have the broadest view and the greatest opportunities to provide essential information, support, and advocacy” (p. 5).

Conclusion

Transitions of care present multiple biopsychosocial challenges to older adults and family caregivers. Psychosocial factors—such as adjustment to illness, the need for home care or residential placement, low health literacy, limited financial or community resources, and caregiving stresses—contribute to problems during transitions of care and increase clients' risk of medical complications. These factors highlight the importance of social work in preventing and addressing problems related to care transitions.

Resources Related to Transitions of Care

NASW

- *Questions and Answers About Case Management*
<http://helpstartshere.org/WhatIsaCaseManager/tabid/965/language/en-US/Default.aspx>.
This article, written for NASW's consumer website, describes the role of case management, care management, and care coordination in transitions of care.
- *Social Work and Care Coordination*
www.socialworkers.org/advocacy/briefingpapers.asp
This policy briefing paper, written in conjunction with the National Coalition for Care Coordination (which is sponsored by the Social Work Leadership Institute at the New York Academy of Medicine), describes the unique skills social workers bring to care coordination.

Centers for Medicare and Medicaid Services (CMS)

- **Care Transitions Project**
www.cfmc.org/caretransitions/
A partnership with 14 state-based Quality Improvement Organizations, this pilot project aims to improve care transitions between hospitals and other settings and to reduce preventable hospital readmissions.
- **Postacute Care Payment Reform Demonstration (PAC-PRD)**
www.cms.hhs.gov/DemoProjectsEvalRpts/
Closely related to the Care Transitions Project, PAC-PRD develops the CARE (Continuity Assessment Record and Evaluation) instrument, an Internet-based, standardized assessment designed for use across hospitals and four postacute settings.

- **Medicare Medical Home Demonstration**
www.cms.hhs.gov/DemoProjectsEvalRpts/
Based in primary medical care settings, this demonstration promotes continuity of care. The model includes allied health professionals in patient care management (National Committee for Quality Assurance, 2008, p. 21).

The Joint Commission

www.jointcommission.org

This independent, not-for-profit accreditation organization addresses transitions of care in several accreditation standards and National Patient Safety Goals. Additionally, the Joint Commission's recently launched Center for Transforming Healthcare is planning an initiative to improve communications during transitions of care.

National Transitions of Care Coalitions (NTOCC)

www.ntocc.org

NASW serves on the Advisory Task Force of this coalition, which has developed multiple tools to help consumers, professionals, policy makers, and the media understand, navigate, and improve transitions of care.

References

- AARP. (2008). *Valuing the invaluable: The economic value of family caregiving, 2008 update*. Retrieved August 28, 2009, from http://assets.aarp.org/rgcenter/il/i13_caregiving.pdf.
- Arbaje, A. I., Wolff, J. L., Yu, Q., Powe, N. R., Anderson, G. F., & Boulton, C. (2008). Postdischarge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries. *The Gerontologist, 48*, 495–504.
- Auerbach, C., Rock, B. D., Goldstein, M., Kaminsky, P., & Heft-Laporte, H. (2000). A department of social work uses data to prove its case (88-99B). *Social Work in Health Care, 32*(1), 9-23.
- Coleman, E. A. (2003). Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society, 51*, 549–555. Retrieved August 11, 2009, from www.caretransitions.org/documents/Falling%20through%20the%20cracks%20-%20JAGS.pdf.
- Evercare (with National Alliance for Caregiving). (2006). *Evercare® study of caregivers in decline: A close-up look at the health risks of caring for a loved one*. Retrieved August 28, 2009, from www.caregiving.org/data/Caregivers%20in%20Decline%20Study-FINAL-lowres.pdf.

- Hou, J. W., Hollenberg, J., & Charlson, M. E. (2001). Can physicians' admission evaluation of patients' status help to identify patients requiring social work interventions? *Social Work in Health Care*, 33(2), 17–29.
- Institute of Medicine. (2007). *Preventing medication errors: Quality chasm series*. Washington, DC: National Academies Press. Retrieved August 7, 2009, from www.nap.edu/catalog.php?record_id=11623#toc.
- Institute of Medicine. (2009). *Retooling for an aging America: Building the health care workforce*. Washington, DC: National Academies Press. Retrieved August 6, 2009, from www.nap.edu/catalog.php?record_id=12089#toc.
- Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, 360, 1418–1428. Retrieved August 7, 2009, from <http://content.nejm.org/cgi/content/full/360/14/1418?ijkey=3CQjS3yxXjOtY&keytype=ref&siteid=nejm>.
- Keebler, J., Duder, S., & Lechman, C. (2001). Predicting length of stay in an acute care hospital: The role of psychosocial problems. *Social Work in Health Care*, 33(2), 1–16.
- Klevens, R. M., Edwards, J. R., Richards, C. L., Horan, T. C., Gaynes, R. P., Pollock, D. A., & Cardo, D. M. (2007, March–April). Estimating health care-associated infections and deaths in U.S. hospitals, 2002. *Public Health Reports*, 122, 160–166. Retrieved August 6, 2009, from www.cdc.gov/ncidod/dhqp/pdf/hicpac/infections_deaths.pdf.
- Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy* (NCES 2006-483). Washington, DC: U.S. Department of Education, National Center for Education Statistics. Retrieved August 31, 2009, from <http://nces.ed.gov/pubst2006/2006483.pdf>.
- Levine, C., & Kuerbis, A. (2002). Building alliances between social workers and family caregivers. *Journal of Social Work in Long-Term Care*, 1(4), 3–17.
- Madden, J. M., Graves, A. J., Zhang, F., Adams, A. S., Briesacher, B. A., Ross-Degnan, D., et al. (2008). Cost-related medication nonadherence and spending on basic needs following implementation of Medicare Part D. *JAMA*, 299, 1922–1928. doi:10.1001/jama.299.16.1922.
- Muramatsu, N., Yin, H., Campbell, R. T., Hoyem, R. L., Jacob, M. A., & Ross, C. O. (2007). Risk of nursing home admission among older Americans: Does states' spending on home- and community-based services matter? *Journal of Gerontology: Social Sciences*, 62B, S169–S178.
- National Committee for Quality Assurance. (2008). *Standards and guidelines for Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™): CMS version*. Retrieved September 1, 2009, from www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_PPC.pdf.
- Proctor, E. K., Morrow-Howell, N., Li, H., & Dore, P. (2000). Adequacy of home care and hospital readmission for elderly congestive heart failure patients. *Health & Social Work*, 25, 87–96.
- U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2000). *Medical errors: The scope of the problem* [Fact sheet] (Pub. No. AHRQ 00-P037). Retrieved August 7, 2009, from www.ahrq.gov/qual/errback.htm.