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SOCIAL WORK AND TRANSITIONS OF CARE

Introduction

Adults experience multiple transitions as they age: family transitions, vocational transitions, transitions in health, and transitions in housing needs, to name a few. Within the health, behavioral health, and long-term care systems, older adults can face *transitions of care*, or *care transitions*, among care providers and across settings on an almost daily basis. During such transitions, older adults are at increased risk for medical and psychosocial complications (Coleman & Berenson, 2004; Tahan, 2007). Successful care transitions depend on the care and collaboration of every practitioner and organization involved in a client's care, and social workers play a key role in preventing and remediating problematic transitions.

The National Quality Forum (2006) has defined *care transition* as “a change or interruption of patient care, such as a discharge, a change in medications, a transfer among care units, a referral to services such as physical or occupational therapy, and the use of emergency services” (p. D-9). Put somewhat more broadly, “Care transitions take place when a patient requires a necessary change in care or services” (Tahan, 2007, p. 41). *Transitional care*, a related concept, is “a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location” (Coleman & Boulton, 2003, p. 1). In other words, smooth care transitions require high-quality transitional care.

Types of Care Transitions

Major care transitions, such as transitions between hospital and home or between home and a residential care community, present biopsychosocial challenges not only to older adults and family caregivers but also to practitioners. The sheer number of practitioners involved during such transitions can be overwhelming to older adults and family caregivers, and the role of each practitioner may not be clear. Crucial information affecting the plan of care frequently fails to be communicated among practitioners, or between practitioners and older adults and family caregivers, resulting in preventable complications.

Older adults also experience multiple transitions within care settings. Within a hospice agency, for example, numerous practitioners—such as a social worker, nurse, certified nursing assistant, spiritual caregiver, physician, and volunteer—are frequently involved in supporting each patient and family. An older adult living at home experiences a transition every time a practitioner enters and leaves the home, raising multiple questions: Is the visiting practitioner aware of changes in the patient's or family's status since admission or the practitioner's previous visit? Will the information discussed with the practitioner, and any changes to the plan of care, be conveyed to other members of the hospice team? Will the team coordinate care with the patient's physician or the hospice medical director? Have changes to the plan of care been approved by the payor? Consideration of these questions makes clear the

interdisciplinary effort needed to provide integrated care, even when that care is centered within one setting. Furthermore, if another organization, such as an Area Agency on Aging or a nursing home, is involved in caring for the older adult, the effort needed to ensure continuity of care increases.

Transitions of care also take place among individual practitioners, such as between a gerontological clinical social worker and a psychiatrist. The extent to which psychotherapy or medication is successful depends, in part, on the coordination between the two professionals. Similar transitions occur when a primary medical practitioner refers an older adult to a specialist or for diagnostic testing, and when the older adult returns to the referring practitioner. Failure to provide a necessary referral form, to communicate information in a manner that is understood by the patient, or to convey test results to the patient and primary care provider can impede care delivery and negatively affect the older adult's health.

Although transitions across health states often coincide with transitions within and between settings (Tahan, 2007), they may also take place in the absence of external transitions of care. For example, an older adult living at home falls and is no longer able to ambulate independently. The family locates a wheeled walker used by a deceased relative and offers it to the older adult, who begins to use it. Although the adult remains at home and does not undergo evaluation for appropriate mobility assistance—indeed, may not even visit a medical provider—after the fall, she or he has undergone a health transition, and one that may require, eventually, new care providers or a move to a residential care setting. Similarly, an older adult pursuing curative treatment for cancer may decide to forego such treatment but may not be ready to consult a palliative care specialist or elect hospice care. Nonetheless, a significant psychosocial transition has taken place, one that will likely lead to a physical transition—and, perhaps, a transition to palliative or hospice care providers—over time.

The Social Work Role in Transitions of Care

Social workers' values, knowledge, and skills are ideal for helping older adults successfully navigate transitions of care. Social workers' strengths

perspective (Blundo, 2008; Kim, 2008), emphasis on interpersonal relationships, affirmation of the dignity and worth of each person, and promotion of self-determination (National Association of Social Workers [NASW], 2008) facilitate client engagement and client-centered care, which in turn lead to better health care outcomes and lower health care costs (National Quality Forum, n.d.). Furthermore, social workers' collaborative practice extends beyond client engagement to other practitioners and organizations involved in caring for older adults and family caregivers; as Lawson (2008) noted, "An option for some professions, collaborative practice is an essential, defining feature of social work practice" (p. 342). Moreover, the profession's ecological framework guides social workers in assessing each client in the context of her or his environment and in intervening on both individual and systemic levels (Gitterman & Germain, 2008). Guided by both the person-in-environment perspective and NASW's standards (NASW, 2001) and indicators (NASW, 2007) addressing cultural competence, social workers can also lead their colleagues in striving for cultural competence in all aspects of service delivery.

Policymakers have highlighted the need for greater care coordination to improve the quality and continuity of care, but care coordination must address both medical and psychosocial aspects of care to be effective (Brown, 2009). Social workers have long been involved in coordinating care for clients; in fact, case management has its roots in the profession of social work, and research has demonstrated the value of social work in care coordination. A 2009 *Consumer Reports* article ("Patients, beware") describing results of a survey of hospital nurses recognized hospital social workers as one of the specialists who coordinate patient care. Nurses noted that working with social workers could help prevent problems, especially difficulties related to hospital discharge. More specifically, Kitchen and Brook's (2005) hospital-based study found that using master's-level social workers as coordinators of physician-led health care teams resulted in more comprehensive care; earlier identification of high-risk social and medical conditions; greater organization and efficiency in the discharge process; enhanced education of medical residents; increased quantity and quality of social information to physicians, which enhanced medical treatment planning; and more accurate and timely documentation, tracking, and billing, as

reported by interdisciplinary team members and administrative staff (pp. 9–10). In another teaching hospital, researchers are examining whether posthospitalization care coordination done by social workers can reduce rates of rehospitalization within 30 days of discharge (Brown, 2009; “Rush University,” 2009).

NASW Activities and Resources Related to Transitions of Care

Recognizing the social work profession’s integral role in transitional care, NASW has participated in multiple interdisciplinary initiatives to improve care transitions for older adults.

As a founding Advisory Task Force member of the National Transitions of Care Coalition (NTOCC), NASW has contributed to the development of multiple tools to help consumers, professionals, policymakers, and the media understand, navigate, and improve transitions of care. The *Transitions of Care Checklist* cues practitioners to consider and communicate biopsychosocial information essential to effective care transitions. *Taking Care of MY Health Care* cues consumers to discuss similar information with their health care providers and includes a personal medicine list; both documents are available in English, Spanish, and French. A concept paper describes policy changes needed to improve transitions of care. Forthcoming resources include a hospital guide for consumers and a tool for professionals that provides information, strategies, and resources regarding cultural competence as it relates to transitions of care. Visit www.ntocc.org to download these tools and other resources.

NASW also participated in an advisory group, led by Consumers Advancing Patient Safety, that developed a toolkit to guide consumers through hospital discharges and to support them in communicating with their health care providers before, during, and after discharge. The toolkit is available at <http://patientsafety.org/page/transtoolkit/>

Additionally, NASW participated in the development of another tool, *Planning for Your Discharge*, released by the Centers for Medicare and Medicaid Services (CMS).¹ The CMS checklist is available in both English (www.medicare.gov/Publications/Pubs/

[pdf/11376.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf)) and Spanish (www.medicare.gov/Publications/Pubs/pdf/11376_S.pdf).

Reducing avoidable hospitalizations of nursing home residents is the goal of a Commonwealth Fund–supported project to which NASW contributed. NASW helped refine tools designed to improve the interdisciplinary team’s identification and evaluation of, and communication about, changes in resident status.² The toolkit is being piloted in three states and is available to the public at <http://interact.geri.u.org/>

Collaborating with professionals from other disciplines is essential to NASW’s work on care transitions. Executive director Elizabeth Clark, PhD, ACSW, MPH, partnered with the executive director of the Case Management Society of America (CMSA), Cheri Lattimer, RN, BSN, to copresent on collaborative case management practice at CMSA’s 2007 Collaborative Practice Summit (Clark & Lattimer, 2007). Addressed to an audience of nurses and social workers, the presentation described case management roles shared by the two professions, the need for collaboration to improve transitions of care, and the two associations’ collaborative efforts. The social work profession was also represented at CMSA’s 2009 Collaborative Practice Summit (Simmons, 2009), and the NASW 2009 Aging Practice Conference included a social work- and nurse-led workshop on collaborative case management (Skinner & Herman, 2009).

Conclusion

Older adults and family caregivers experience transitions of care throughout the continuum of health and behavioral health care. Smooth transitions are critical to maintaining health and well-being and require coordination among all practitioners and organizations involved in the care of older adults and family caregivers. Social workers play an integral role in preventing and addressing problems related to care transitions. NASW, in collaboration with other organizations, is leading the way in creating resources to improve transitions of care.

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