Designing a Transitions Social Worker Role in Population Health to Support Patients Post-Discharge

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Care Transitions Outreach Program

Office of Population Health

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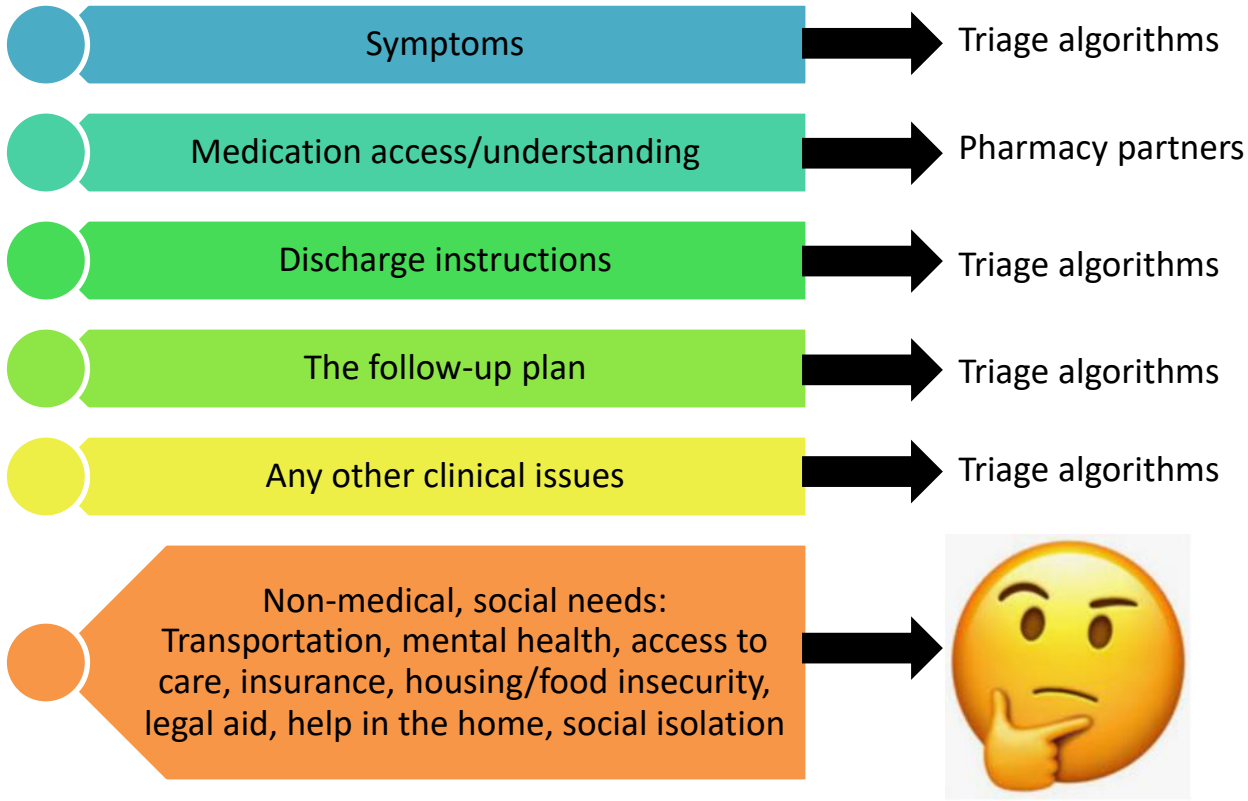
Background

The Care Transitions Outreach Program (CTOP) provides a safety net for patients discharged home from UCSF through discharge follow-up phone calls. The goals of CTOP include supporting patients/caregivers post-discharge to improve their experience, follow-up on the plan of care outlined by the inpatient care team, as well as reduce unnecessary utilization.

Negative social determinants of health can adversely affect patients' ability to follow-up on the plan of care outlined by the inpatient care team which could potentially impact outcomes and unnecessary utilization (Bernazzani 2016).
Unnecessary utilization such as preventable ED visits and readmissions affects the Quality & Safety, Financial Strength, and Patient Satisfaction pillars.

Prior to October 2020, the Care Transitions Outreach Program was comprised of nurses and pharmacists, who can address clinical concerns around symptoms, medications, and Rx issues, but lack expertise in assisting patients with non-medical, social needs that can also impact patients' health outcomes.

Post-Discharge Issues



Project Goals

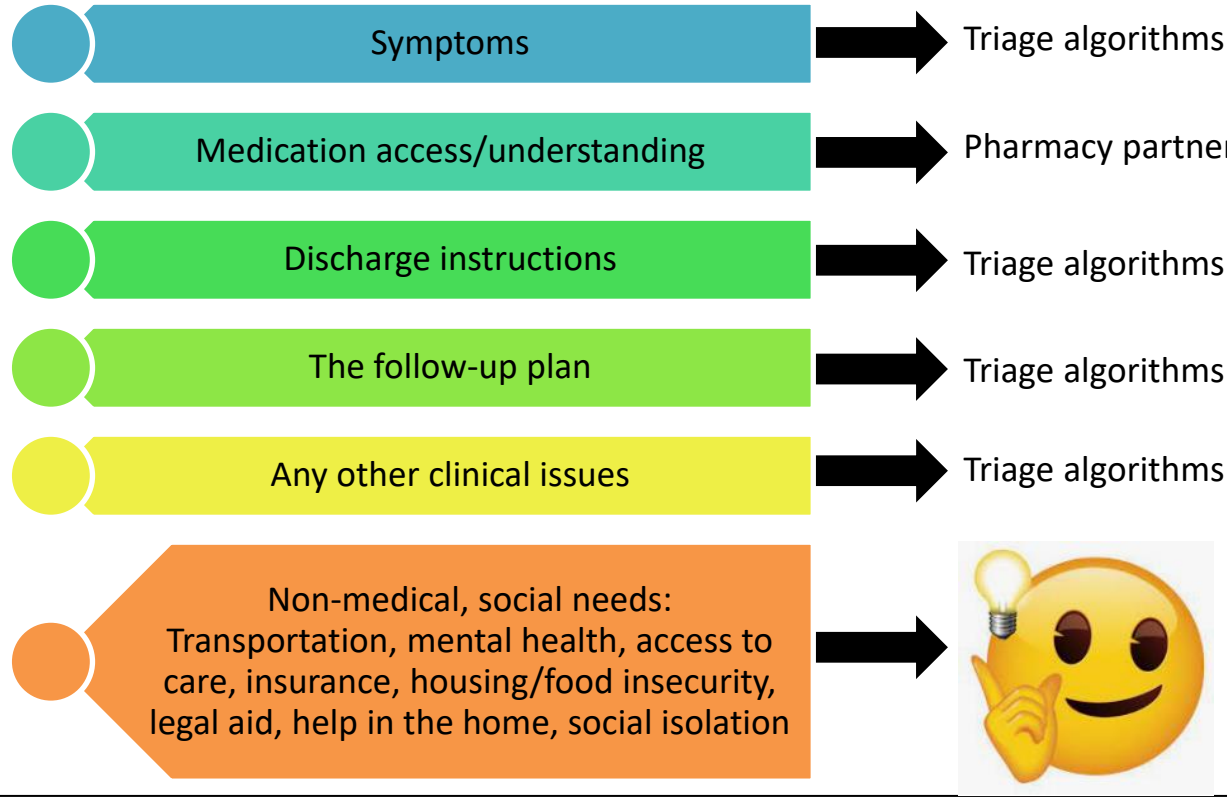
Our goal was to provide the opportunity for patients to receive social work support during the transition of care from hospital discharge to home, **regardless of where they get their primary or specialty care and their insurance status**.

As of October, 2020, the current state was:

- When psychosocial needs arose on the discharge follow-up call, the RNs and pharmacists would not always know how to address, resolve, or escalate these issues.
- The Care Transitions Outreach Team could escalate to social workers at some UCSF clinics (e.g. primary care, the OB clinic, transplant clinics).
- However, not all patients discharged from UCSF hospitals receive discharge follow-up care at UCSF; therefore, not all patients have equal access to social work assistance during the vulnerable transition from hospital to home.

The target state is that all patients discharged home from UCSF hospitals have equal access to a transitions social worker.

Post-Discharge Issues



Gap Analysis

All UCSF Discharges to Home	Post-DC Care Team	Embedded Social Work?
	UCSF Primary Care	*Yes*
	UCSF Specialty Care	*Variable*
	Non-UCSF Primary Care	*Variable*
	Home Hospice	*Yes*
	No Primary Care	*No*
	Uninsured	*No*

Project Plan & Interventions

- Due to an department restructure, one social worker FTE became available and we leveraged this opportunity to close the gap and create a new social work role in the Office of Population Health's Care Transitions Programs to support patients post-discharge.

- We determined the following root causes of the gap in social work support of all patients post-discharge:
  - Inpatient social work interventions are limited to the timeframe of the inpatient hospital stay.
  - Oftentimes, social work interventions need further follow-up beyond the hospital stay.
  - Sometimes patients'/caregivers' social work needs are not identified/anticipated prior to discharge, but become apparent post-discharge.
  - Not all patients have access to a social worker through their primary care or specialty clinic(s).

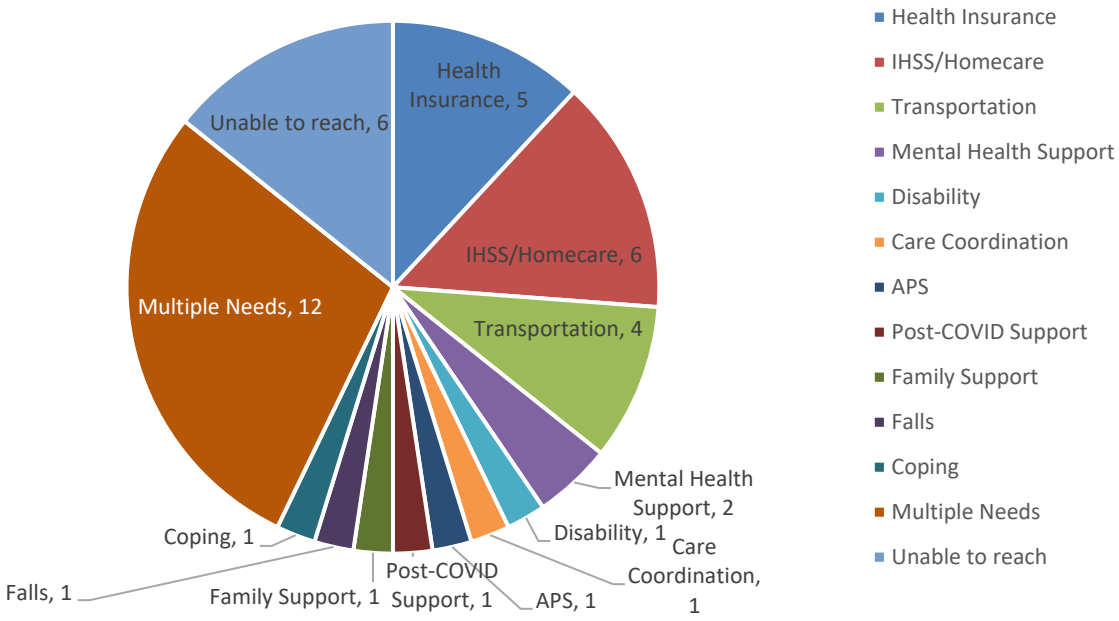
- We hypothesized that having a social worker embedded in the Care Transitions Outreach Program would facilitate timely access to bridging psychosocial gaps or other social work needs and provide support and linkages to services/resources.

- We worked towards the target state by creating referral processes from Care Transitions Program to the Transitions Social Worker:
  - Care Transitions Outreach Program
  - Transitional Care Model
  - Gastrointestinal Bundle Payment Program (GIBP)

- We also created a referral process with the inpatient social work team to streamline the patient care experience by providing continuity of care with warm handoffs directly from inpatient to transitions social worker. Patients therefore don't have to answer the discharge follow-up call in order to gain access to social work support.

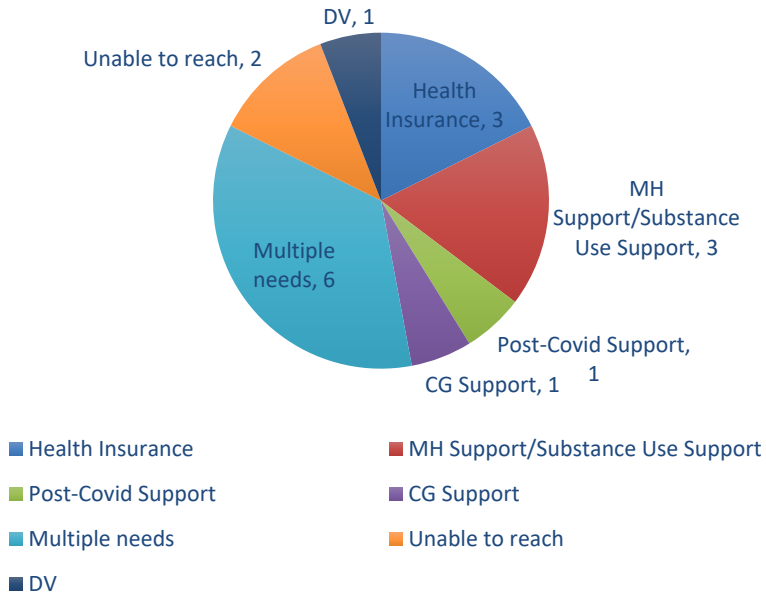
Project Evaluation & Impact

Types of SW Referrals from CTOP - 42



October, 2020 – April, 2021

Types of SW Referrals from Inpatient SW Team - 17



January, 2021 – April, 2021

Next Steps & Lessons Learned

Next Steps:

- Continue to track the types of referrals and social work issues addressed
- Continue to build the partnership with the inpatient social work team, encouraging referrals from more discharging services
- Pilot RNs proactively screening for social work needs
- This model and approach could be applied to future longitudinal post-discharge outreach, including additional Bundled Payment for Care Improvement or High Risk Care Transitions Programs.

Lessons Learned:

- We anticipated that it would be hard to define the post-discharge transition period, and worried that patients' needs would require numerous outreach attempts and encounters to resolve. We learned that half of the referrals can be addressed with one call and a follow-up MyChart message or email, if resources are needed.
- The Transitions Social Worker role in Population Health is a vital element of comprehensive Care Transitions Outreach work. This role is needed to provide patients with equal access to social work assistance during the vulnerable transition from hospital to home.