



How Social Workers Can Impact Readmissions: An Interview with SSWLHC Past President, June Simmons

SSWLHC: How would you describe what Partners in Care Foundation does? How is it different than other treatment settings working on readmission prevention?

June Simmons (JS): Partners in Care provides significant care transitions services to a range of health care payers and providers. We primarily target Medicare Fee for Service, Medicare Advantage and Medicaid (especially dually eligible for Medicare and Medicaid). Typically, we are looking to identify individuals at high risk of readmission, which usually includes those with prior ER within six months, prior hospitalization with six months, two or more medications changed during hospitalization, lack of caregiver at home or exhausted caregiver, those with multiple, chronic conditions. We work with a range of hospitals and did a lot of work with groups of hospitals under the CMS Community Care Transitions Program with great success – saw 32,000 patients and reduced readmissions by about 1/3 (more in some instances).

Partners brings a “non-clinical” alternative workforce to bear – social workers, community health workers, coaches and others who do not provide physical care – they deploy evidence based models that are proven as tools to empower patients and their families with resources, skills and information. These interventions include Eric Coleman’s Care Transitions Intervention (CTI) (a coaching intervention: <https://caretransitions.org/>), the Rush Bridge model developed by Robyn Golden (<http://www.transitionalcare.org/about-us/the-consortium/>), MSW – a social work hospital to home telephonic social work program (<http://www.transitionalcare.org/about-us/the-consortium/>). In addition, we deploy HomeMeds (<https://www.picf.org/homemedes/>), an evidence-based medications inventory and interview to identify possible adverse medication responses – developed by Partners in Care so an alternative workforce can identify key medication risks in the home and electronically get them to pharmacist/prescriber for review and resolution.

Many other solutions are clinical health care interventions – ours address social determinants of health and issues of self-management and timely access to follow up medical care and medications review.

SSWLHC: What factor (factors) was most important to the development of your program?

JS: Ready access to strong evidence-based programs that work well together. CTI is an in-home visit that helps equip the patient/family with skills to obtain timely follow up physician visits and pull together a medication record. Also, to track changes in the condition and seek help quickly rather than waiting for a crisis.

Bridge works well for those for whom a home visit is not possible or accepted. For example, an individual may be afraid to have someone come to their home. This could be a general sense of safety concerns or might reflect anxiety that if someone actually sees their situation they may interfere and have them placed. Some simply live too far away from the hospital to make a visit viable. Others may have family who object to an outside service – some cultures feel they must provide all care for their loved ones.

HomeMeds is a unique system for identifying possible adverse medication issues, the number one driver of readmissions.

SSWLHC: What are the key pieces of the model that focus on readmission prevention?

JS: As noted above, timely follow up visit with physician, medications review, interview for signs and symptoms of adverse medication responses, self-monitoring for changes in condition, key resources such as proper nutrition and transportation

SSWLHC: What role do social workers play in your care model? How are they uniquely valued on the team?

JS: Social workers have advanced training and can carry complex cases and train and supervise others.

A complex case would include such things as significant behavioral health issues, complex family dynamics, a need to understand cultural drivers, broader knowledge of special advance care planning dynamics and legislation impacting practice.

SSWLHC: Tell us about some of the outcomes of your program you're most proud of in your care transitions program.

JS: Significant reductions in readmissions. Ability to identify medications issues in the home generally missed through other tracking systems. Deploying community health workers and social workers to play a unique role – physicians, nurses and pharmacists and others are so valuable, but these social work experts are great solutions for social determinants of health and self-management issues that do not require clinical interventions in the home.

SSWLHC: Are there any lessons learned or best practices to share with others who want to develop similar programs or initiatives?

JS: The power of the alternative workforce and evidence-based interventions have achieved proof as a concept and can be scaled as best practices. Partners in Care collaboratives have achieved between 22-42% reduction in readmissions (in different settings) and a 13% reduction in ED visits within 30 days. (See the powerpoint presentation in the [Knowledge Database](#))