The Bridge Model of Transitional Care

Robyn Golden, LCSW
Director of Health and Aging
Rush University Medical Center

Robyn_L_Golden@rush.edu

The Opportunities of ACA

- Opportunities to address social needs in health care through the ACA
  - Enhanced primary care/Patient Centered Medical Homes
  - Accountable care organizations
  - Transitional care and hospital readmission reduction
  - Medicare and Medicaid dual eligible demonstrations
  - Medicaid Health Homes
  - ADRC funding
  - Independence at Home demonstration
  - Bundled payment

Meeting the Imperative

- Social work's potential and possibilities
  - Master's-prepared social workers with community, healthcare, and gerontology experience
    - Advanced psychosocial assessment skills
    - Able to perform sophisticated assessments and interventions
- Focusing on psychosocial factors that contribute to readmission and adverse events
  - Through assessment, linkage to community resources, and effective partnerships
  - Assessment and intervention focusing on patients, their caregivers, and their families

The Bridge Model

- Short-term telephonic transitional care coordination
- For older adults at risk for adverse events after an inpatient hospitalization
- Provided by Master's-prepared social workers
- From a biopsychosocial perspective

Bridge Model: Primary Goals

- Three guiding tasks:
  - Ensuring clients receive appropriate services in their home post-discharge
  - Connecting clients to their physicians for follow-up appointments
  - Supporting caregivers to reduce stress and burden
- Bridge MSW serves as primary care coordinator
  - Manages care coordination tasks
  - Facilitating inclusion of other team members

Bridge Model Overview

Pre-Discharge	Post-Discharge	30-day follow-up
• EHR Review • Bedside visit	• Assessment • Clinical intervention • Provider collaboration • Advocacy	• Ensure long-term supports in place

Bridge's impact:

- *Decreased readmissions (30, 60, 90 days)*
- *Decreased mortality*
- *Increased physician follow-up*
- *Increased understanding of medications and discharge plan of care*
- *Decreased client and caregiver stress, caregiver burden*

Impact

- Bridge's impact measured in a randomized controlled trial
  - June 2009 to March 2010
  - N=740
  - Referrals generated through EMR at point of discharge
  - Established formalized referral process and intervention protocol
  - At this point, was called "Enhanced Discharge Planning Program" (EDPP)

Level of Intensity

	Mean	Std Dev	Range
Duration of Intervention (Days)	5.8	11.3	1 to 72
Total Calls	5.4	6.3	0 to 44

- More than one call was needed for 254 of the 360 (70.6%) individuals in the study
  - These clients had issues that needed intervention and could not be resolved in the initial contact

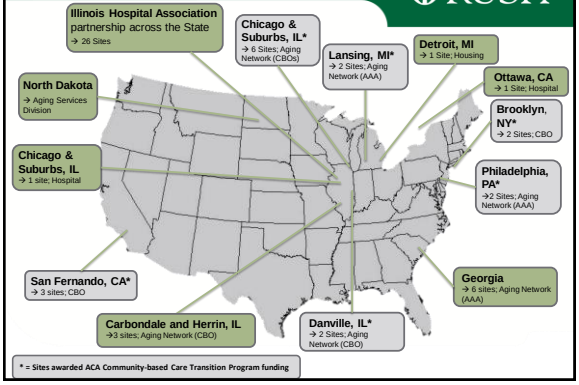
Evidence snapshot: RCT

- Post-discharge issues
  - 83% of clients reported post-discharge complications; 73% of those complications did not emerge until after discharge
- Readmissions
  - Bridge clients were less likely to be readmitted than expected from institutional calculations for anticipated readmission (19.5% vs. 26%)
    - 25% decrease
- Mortality (30 day)
  - Lower mortality rate in Bridge intervention group (3.1% vs. 4.4%)
- Follow-up appointments
  - Higher one-month follow-up appointment attendance in Bridge intervention group (75% vs. 57%)
- Additions
  - Adding a pharmacist yielded a 10% 30-day readmission rate (vs. 30% comparison group)

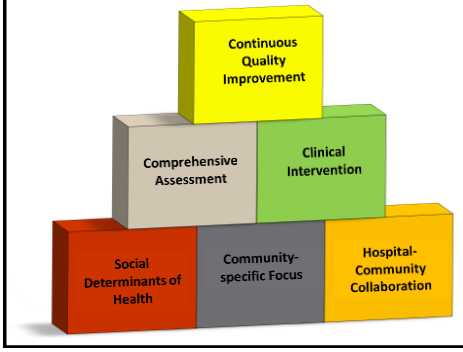
Evidence snapshot, continued

- Increased client understanding of the purpose of their medication
  - From 88.5% at baseline to 94.9% after intervention
- Reduced levels of stress related to managing health care needs
  - Clients: from 36.8% to 30.9%
  - Caregivers: from 44.9% to 35.4%
- $2,600 savings per client from avoided readmissions

The Bridge Model: Replication Sites



Building Blocks of Bridge



Strengths and Opportunities

- Flexible and adaptable
  - Compatible with existing models, diverse geographic settings and populations
- "Hospital out" or "community in"
- Project with healthcare actuaries on predictive model incorporating community and psychosocial factors
- Reinforces a team-based approach to transitions
- Scalable

Chicago CCTP Site

- AgeOptions partnership, in Chicago and suburbs
- 1 lead organization, 6 implementing agencies, 6 hospitals, 1 support organization
  - AAA as lead organization
  - 5 Care Coordination Units (IL Aging Network CBOs), Rush Health and Aging as implementing agencies
  - Bridge Model National Office support
- Cohort 2; 2-year agreement May 2012 – April 2014
  - Saw over 2,500 individuals, similar results as RCT
- Not refunded

Challenges

- Challenges with CCTP
  - Hospital-community relationships take time to develop
    - Focus on footprint/numbers
  - Focus on declines in overall all-cause FFS rate, not just in clients touched
- Important to think beyond 30-day readmissions
  - Days at home
  - Caregiver stress/burden
  - Patient satisfaction
  - Cost utilization

Future of Social Work

- We must prove the value of social work
  - Make clear business case
  - Show return on investment from social work involvement
- Clarify how social work helps to meet the Triple Aim of better care, better health, lower cost
- Frame within social determinant of health language and not just make it a guild issue
  - Not "social workers can do it better"
  - "Social workers can do it, too"
- Comparative effectiveness research to show outcomes of not having social worker involved

Thank You

- **For more information, please visit:**

  www.rush.edu/olderadults

  www.transitionalcare.org

- **Or, contact:**

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The BridgeModel