The Bridge Model of Transitional Care

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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

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

<table>
<thead>
<tr>
<th>Duration of Intervention (Days)</th>
<th>Mean</th>
<th>Std Dev</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.8</td>
<td>11.3</td>
<td>1 to 72</td>
</tr>
<tr>
<td>Total Calls</td>
<td>5.4</td>
<td>6.3</td>
<td>0 to 44</td>
</tr>
</tbody>
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- 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; 79% 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

- Illinois Hospital Association partnership across the State
  - Chicago & Suburbs, IL
  - San Fernando, CA
  - Carson and Hermi, IL
  - Detroit, MI
  - Danville, IL
  - Oklahoma, OK
  - Baltimore, MD
  - Philadelphia, PA
  - Washington, DC

- Indiana Hospital Association
  - North Dakota
  - Chicago & Suburbs, IL
  - San Fernando, CA
  - Carson and Hermi, IL

- Hospital in Brooklyn
  - Hospital in Detroit
  - Hospital in Lansing

- Hospital in Ottawa
  - Hospital in Chicago & Suburbs, IL
  - Hospital in San Fernando, CA

- Hospital in Carson and Hermi, IL
  - Hospital in Detroit, MI

- Hospital in Danville, IL
  - Hospital in Oklahoma, OK

- Hospital in Baltimore, MD
  - Hospital in Philadelphia, PA

- Hospital in Washington, DC

Building Blocks of Bridge

- Continuous Quality Improvement
- Comprehensive Assessment
- Clinical Intervention
- Social Determinants of Health
- Community-specific Focus
- Hospital-Community Collaboration
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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