

# THE BRIDGE MODEL OF TRANSITIONAL CARE



The Bridge Model is a social work-based transitional care intervention designed for older adults discharged from an inpatient hospital stay. Bridge helps older adults to transition safely back to the community through intensive care coordination that starts in the hospital and continues after discharge to the community.

The model emphasizes six principles, including social determinants of health, community-specific focus, and hospital-community collaboration. Bridge Care Coordinators apply a thorough social work assessment to address the many biopsychosocial factors that may challenge clients and their caregivers in their transition home. Bridge emphasizes collaboration among hospitals, community-based providers, and the Aging Network in order to ensure a seamless continuum of health and community care across settings.

## NATIONAL BRIDGE REPLICATION SITES



More than forty partners in geographically-diverse areas around the nation have implemented Bridge, including six collaborations awarded funding from the Center for Medicare and Medicaid Services through the Affordable Care Act's Community-based Care Transition Program. The Bridge Model can be replicated by either hospitals, health systems, or community-based organizations, and is designed to be adapted to fit each site's unique client population and workflow.

Bridge replication sites are connected through the *Bridge Model Collaborative*, which provides a platform for administrators and clinicians to share best practices and resources with each other.

## EVIDENCE BASE

Results from a June 2009 – March 2010 randomized controlled trial (n=740) at Rush University Medical Center include: lower readmission rates, greater understanding of the discharge plan of care, increased understanding of the purpose of taking prescribed medications, increased attendance of post-discharge physician appointments, greater understanding of patient understanding of their responsibilities of managing their own health, decreased patient stress, and decreased caregiver stress. The Bridge Model has been recognized as evidence-based by the Administration for Community Living.

## RECENT FINDINGS

According to a monitoring report published by Mathematica on behalf of the Centers for Medicare and Medicaid Services (CMS), the Bridge Model reduced readmissions by 24.7% in 1,390 patients served at Rush University Medical Center from May 2012 through July 2013. This resulted in approximately \$245,000 in CMS savings per Bridge Care Coordinator per year.

*The Bridge Model National Office's mission is to develop a seamless continuum of health and community care through the implementation of Bridge, a person-centered, social work led, interdisciplinary model of transitional care.*



For additional information on Bridge, please visit [www.transitionalcare.org](http://www.transitionalcare.org)  
or contact [info@transitionalcare.org](mailto:info@transitionalcare.org).