The Bridge Model of Transitional Care

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An initiative of the Center for Health and Social Care Integration
www.chasci.org
What shapes our health?

- Biological factors
- Environmental factors
- Socioeconomic & structural factors
- Individual health behaviors
- Health services
- Mental health status / supports

Source: Flourish Index, 2018, University of Louisville
Social work’s roots in community – and in health care

The social worker’s major contributions to medical care, gauged by frequency of performance, are:

1. **the securing of information** to enable an adequate understanding of the general health problem of the patient;

2. **interpretation of the patient’s health problem** to himself, his family and community welfare agencies; and

3. **the mobilizing of measures for the relief** of the patient and his associates.

-- American Association of Hospital Social Workers, 1928

Study of 1,000 client cases from 60 social work departments
Community-based organizations – key partners for supporting health in the community

Community-based organizations and health care contracting focus areas

- Case management/care coordination/service coordination: 49.3%
- Care transitions/discharge planning: 29.1%
- Home care: 26.5%
- Nutrition program: 26.0%
- Person-centered planning: 22.0%
- Participant-directed care: 20.6%
- Transportation (medical or non-medical): 20.6%
- Evidence-based programs: 19.7%
Volume vs. value

Volume-Based First Curve:
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

Value-Based Second Curve:
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

The Gap

VOLUME TO VALUE
Characteristics of effective transitional care

- Using empathic language and gestures<sup>1</sup>
- Anticipating the patient’s needs to support self-care<sup>1</sup>
- Providing actionable information<sup>1</sup>
- Minimal handoffs<sup>1</sup>
- Frequent touch points<sup>2</sup>
- Person-specific, tailored interventions<sup>2</sup>
- Ability to effectively link individuals to services<sup>2</sup>

Sources:
Process and tools
Bridge, at a glance

- **Delivery:** in-person and/or telephonic
  - Can be implemented by healthcare organization or community-based organization

- **Duration:** 30 days

- **Intensity:** 20-25 telephonic and/or in-person contacts
  - Patient, caregiver, family members
  - Medical providers
  - Community providers
  - Resources

- **Caseloads:** 40-50 per month per social worker

- **Peak activity:** 3 to 5 days post-discharge
The process

Pre-discharge

1. Medical record review
   - Interdisciplinary connect
   - Bedside visit

Post-discharge

2. Assessment
   - Care planning
   - Intervention
     - Care coordination, case management, patient engagement, provider engagement

Termination

3. Short and mid-term medical stability
   - Primary care connect
   - Community resources
   - Self-efficacy
The process – another look

INTAKE

EMR review
Interdisciplinary connect
Bedside visit

ASSESSMENT

Assessment
Care planning

Intervention
Termination

CARE PLAN

Discharge

CARE PLAN

CHaSCy
Center for Health and Social Care Integration

RUSH UNIVERSITY MEDICAL CENTER
Twenty tools

Core
• Checklist
• Intake
• Assessment
• Care plan

Reference
• Scripting
• Diagnosis-specific questions
• Psychotherapy cheat sheets (3)
• Evidence-based screens (8)

Clinical and Quality
• Readmission review
• Case conceptualization
• Care continuity form
• Fidelity check

Administrative
• Running list template
• Dashboard template
• Access database
• Relationship tracking form
The clinical in clinical social work
Relationship-centered care

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

-Maya Angelou
Core skills and frameworks

- Person in environment
  - Systems theory
- Stages of change
- Cultural humility
- Trauma-informed care
- Strengths-based approach
- Psychotherapeutic techniques
  - Motivational Interviewing and OARS
  - Relational psychodynamics
  - Acceptance and Commitment Therapy
  - Cognitive Behavioral Therapy
Special topics

- Working with caregivers
- Home visits
- Patients with dementia and/or cognitive limitations
- Crisis intervention
- Interprofessional collaboration
- Burnout/ethics/demeanor
- Quality assurance and improvement
Key findings
Primary care engagement within 30 days of hospital discharge

*Increased communication and appointment attendance, p<.002*

Communicated with PCP*
- Bridge (n=360): 90%
- Usual care (n=360): 82%

Attended appt. with PCP*
- Bridge (n=360): 75%
- Usual care (n=360): 57%

30-day readmissions at 6 Bridge sites in Chicago area, 2012-2014

30.7% readmission reduction vs. baseline, n=5753 Medicare beneficiaries

Unpublished. Rush was one of six sites under the AgeOptions CBO participating in CMS’s Community-based Care Transitions program, 2012-2014.
30-day readmission rate, Medicare beneficiaries hospitalized at Rush, 2013-2014

*20% fewer readmissions, p < 0.05*

Average number of inpatient admissions per patient, before and after start of Bridge

*Fewer hospitalizations, p<.001, n=423*

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<td>12-month</td>
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Average hospital cost per episode

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% respondents who agreed that they would definitely recommend the hospital, 2013-2017

Unpublished analysis of Rush HCAHPS results, compared with results posted at https://www.medicare.gov/hospitalcompare/.
Nearly 100 sites trained
Questions

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