The Bridge Model of Transitional Care

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An initiative of the Center for Health and Social Care Integration

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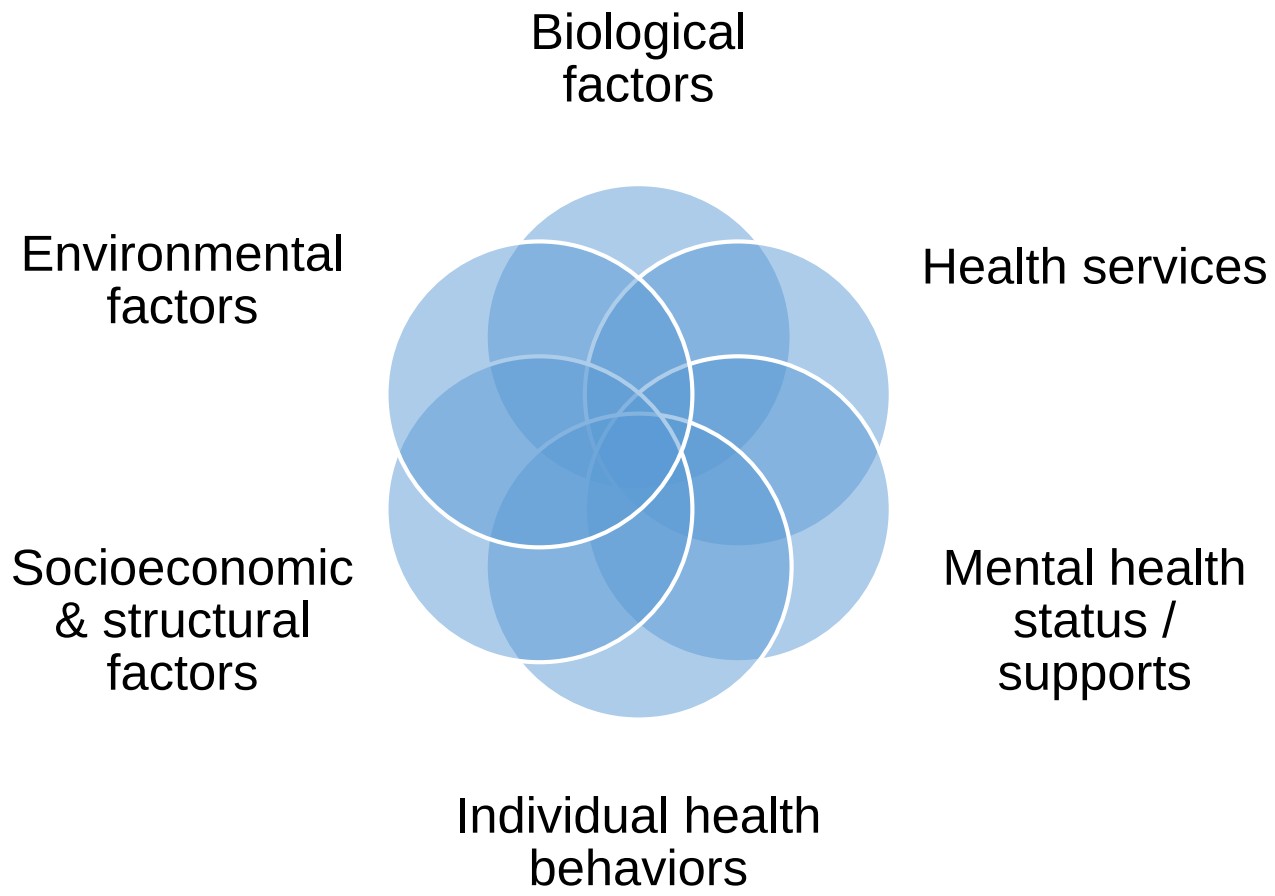
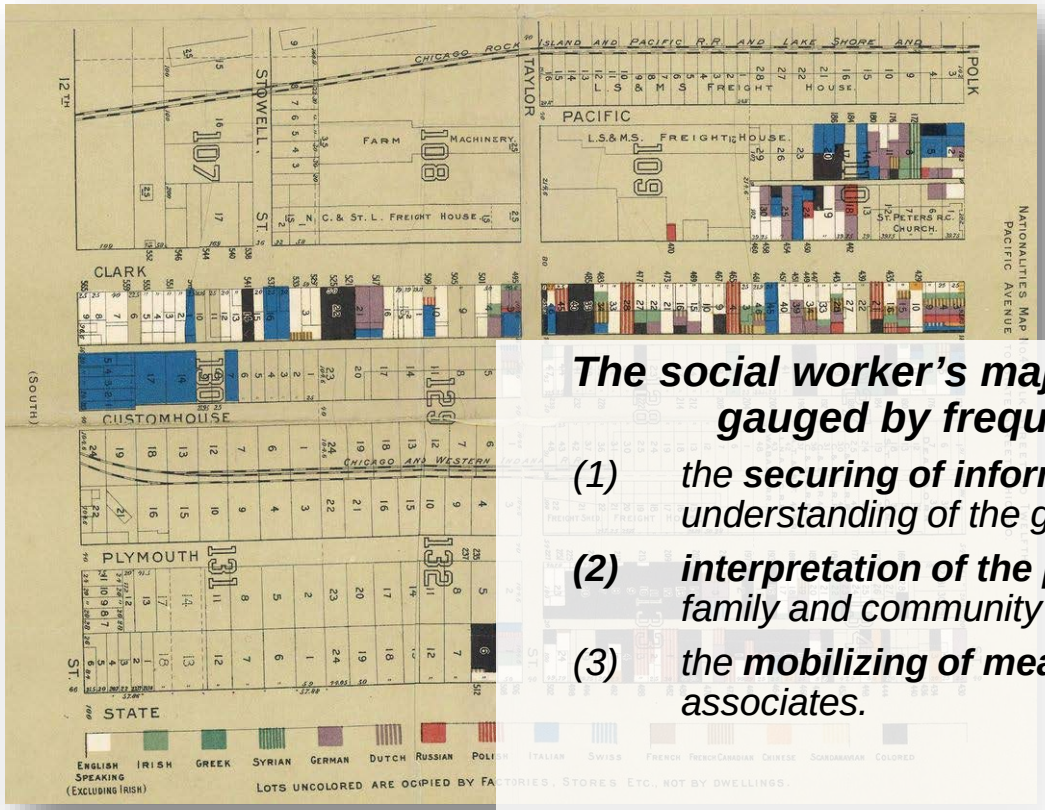
Context

What shapes our health?



Source: Flourish Index, 2018, University of Louisville
http://www.optimalaginginstitute.org/about-the-institute.

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;*

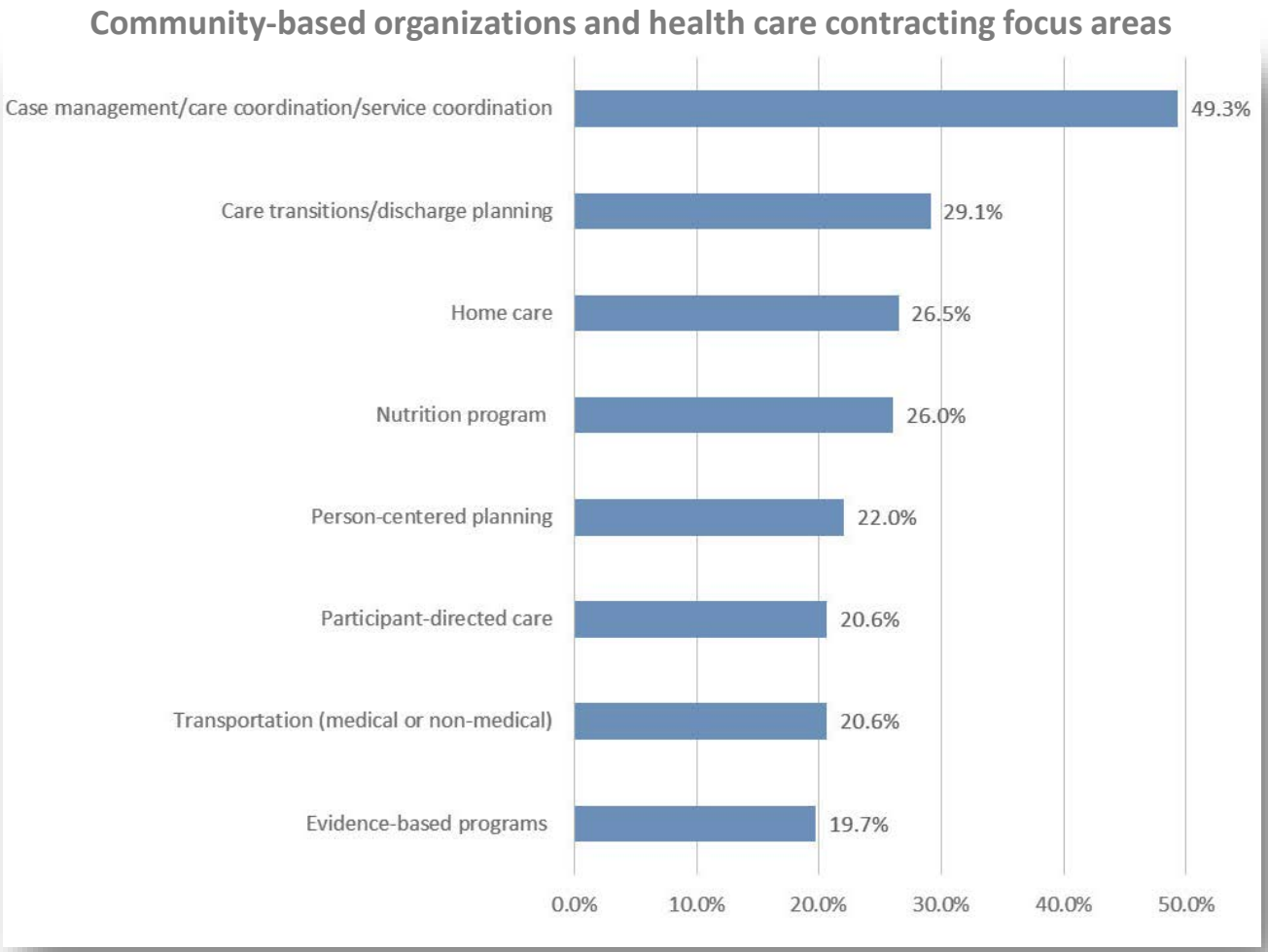
***(2) interpretation of the patient's health problem** to himself, his family and community welfare agencies; and*

*(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



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Kunkel SR, Straker JK, Kelly EM, Lackmeyer AE. Community-based organizations and health care contracting: research brief. Oxford (OH): Scripps Gerontology Center; 2017

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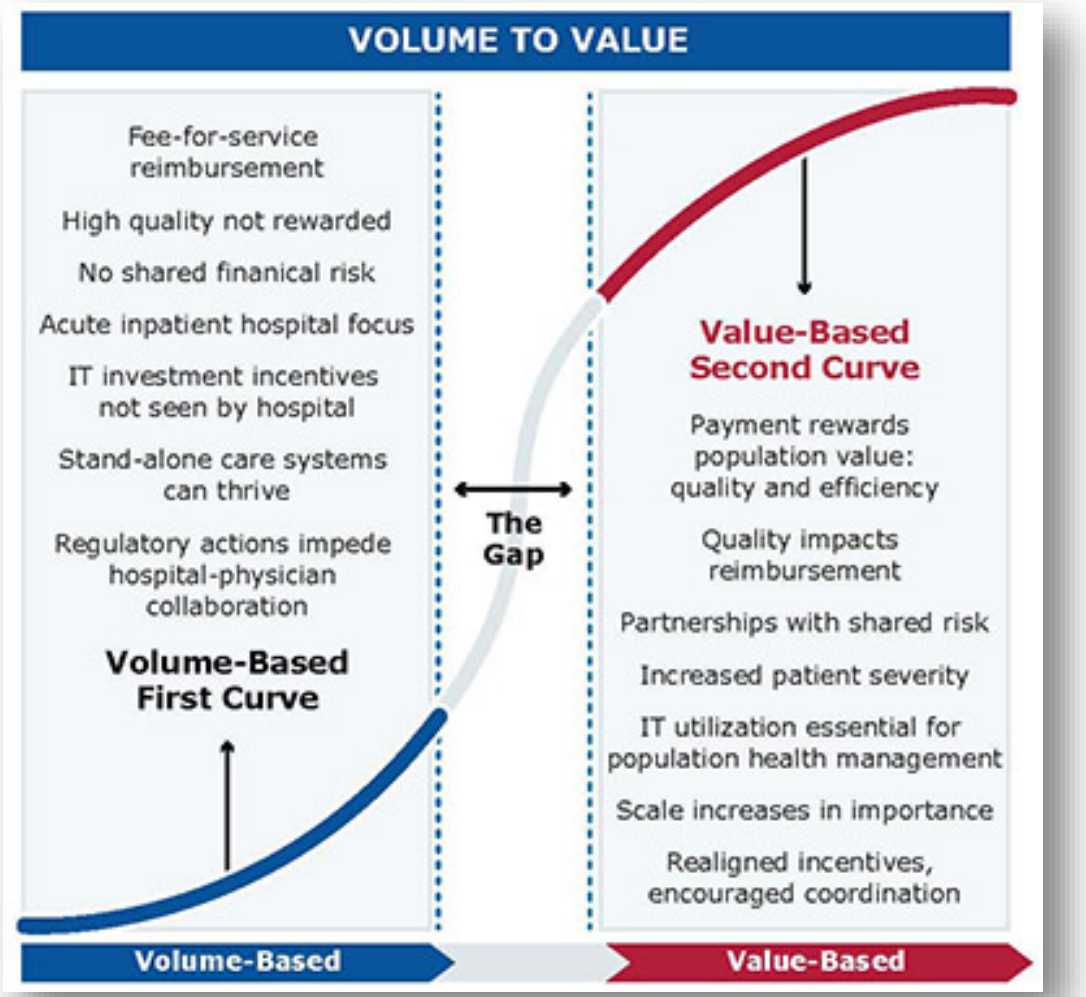
Volume vs. value



Characteristics of effective transitional care

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

Sources: 1. Mitchell, Suzanne E., et al. "Care transitions from patient and caregiver perspectives." *The Annals of Family Medicine* 16.3 (2018): 225-231.

2. Boutwell, Amy E., Marian B. Johnson, and Ralph Watkins. "Analysis of a social work–based model of transitional care to reduce hospital readmissions: Preliminary data." *Journal of the American Geriatrics Society* 64.5 (2016): 1104-1107

THE BRIDGE MODEL

Process and tools

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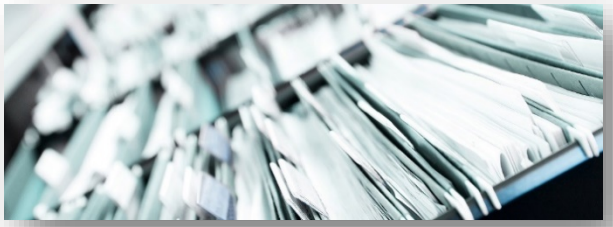
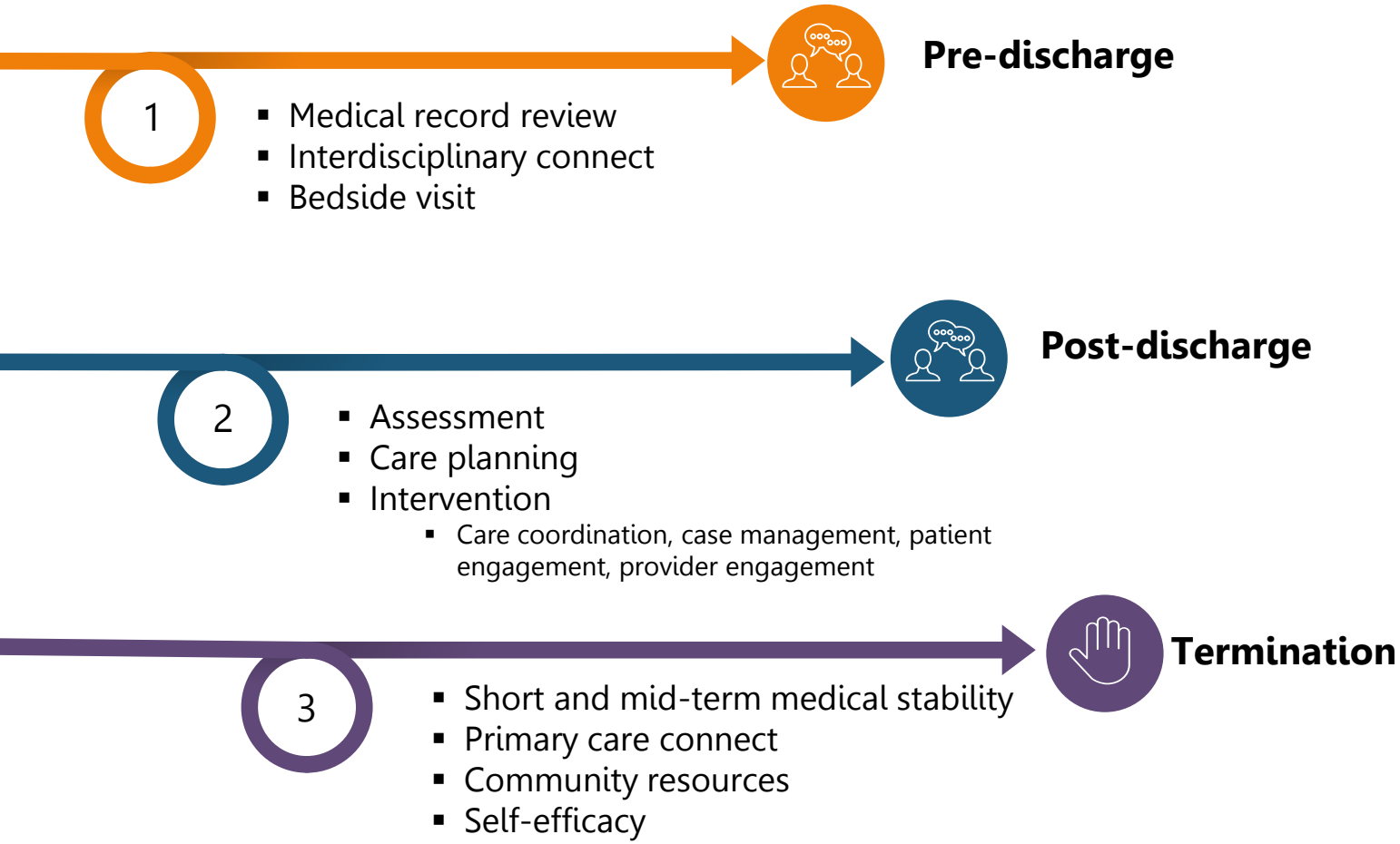
Bridge, at a glance

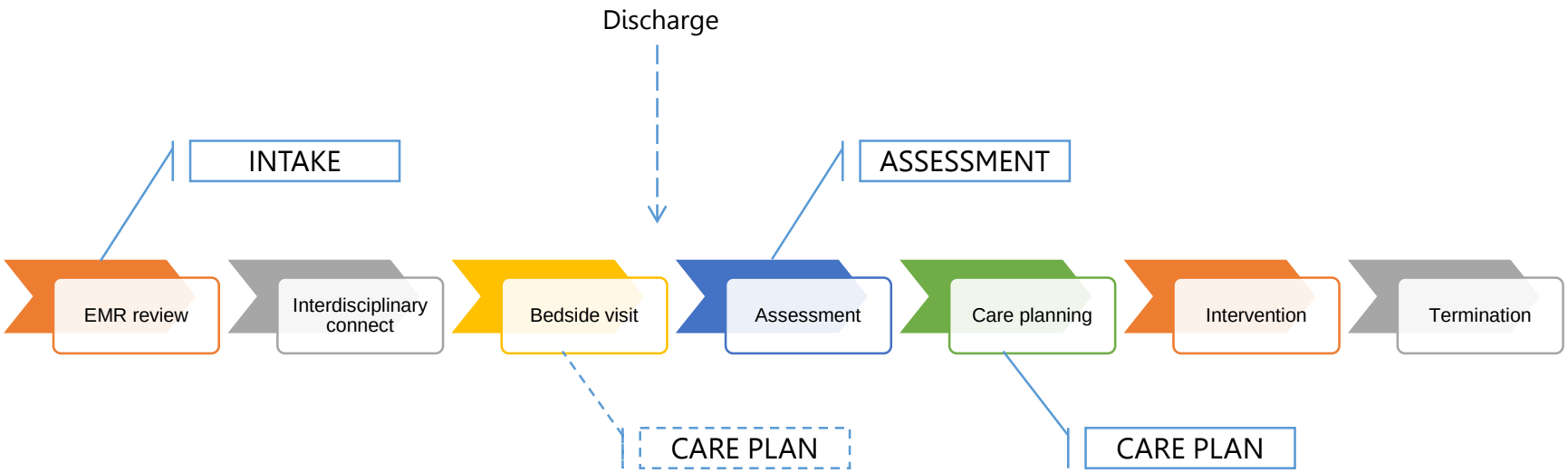


- **Delivery: in-person and/or telephonic**
  - Can be implemented by healthcare organization or community-based organization
- **Duration: 30 days**
- **Intensity: 20-25 telephonic and/or in-person contacts**
  - Patient, caregiver, family members
  - Medical providers
  - Community providers
  - Resources
- **Caseloads: 40-50 per month per social worker**
- **Peak activity: 3 to 5 days post-discharge**

The process


1
Pre-discharge
Medical record review
Interdisciplinary connect
Bedside visit
2
Post-discharge
Assessment
Care planning
Intervention
Care coordination, case management, patient engagement, provider engagement
3
Termination
Short and mid-term medical stability
Primary care connect
Community resources
Self-efficacy

The process – another look



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.”

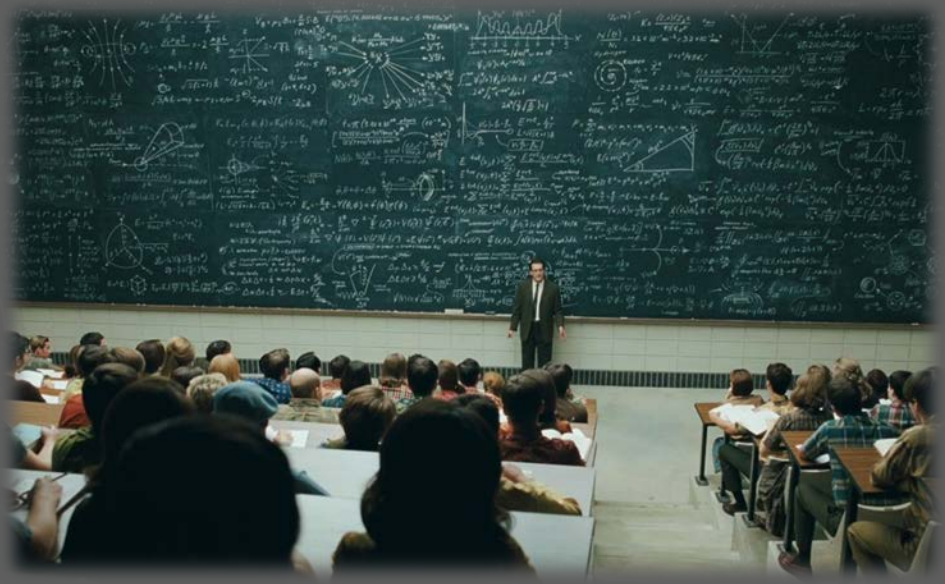
-Maya Angelou

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

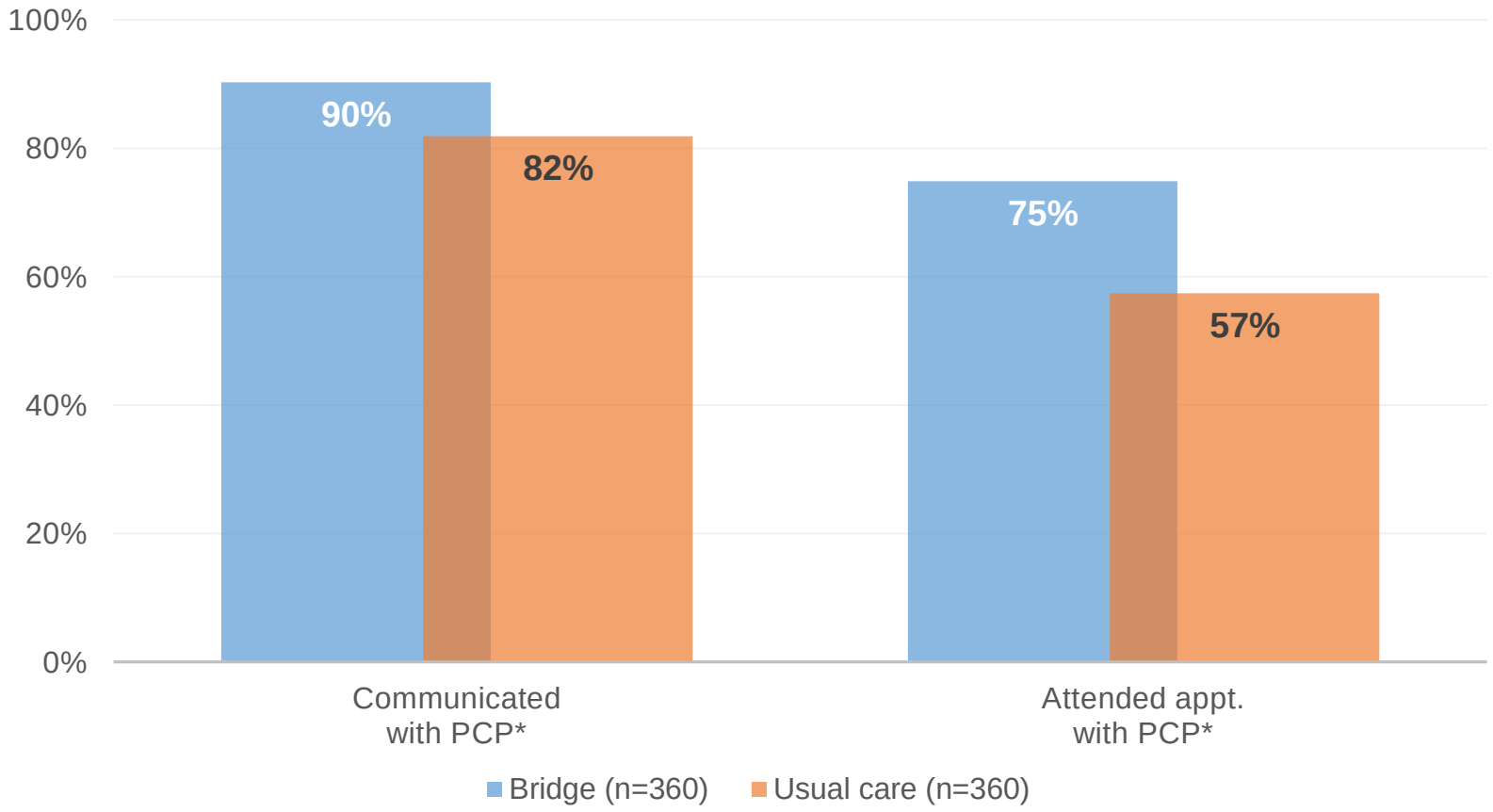
- Working with caregivers
- Home visits
- Patients with dementia and/or cognitive limitations
- Crisis intervention
- Interprofessional collaboration
- Burnout/ethics/demeanor
- Quality assurance and improvement



Key findings

Primary care engagement within 30 days of hospital discharge

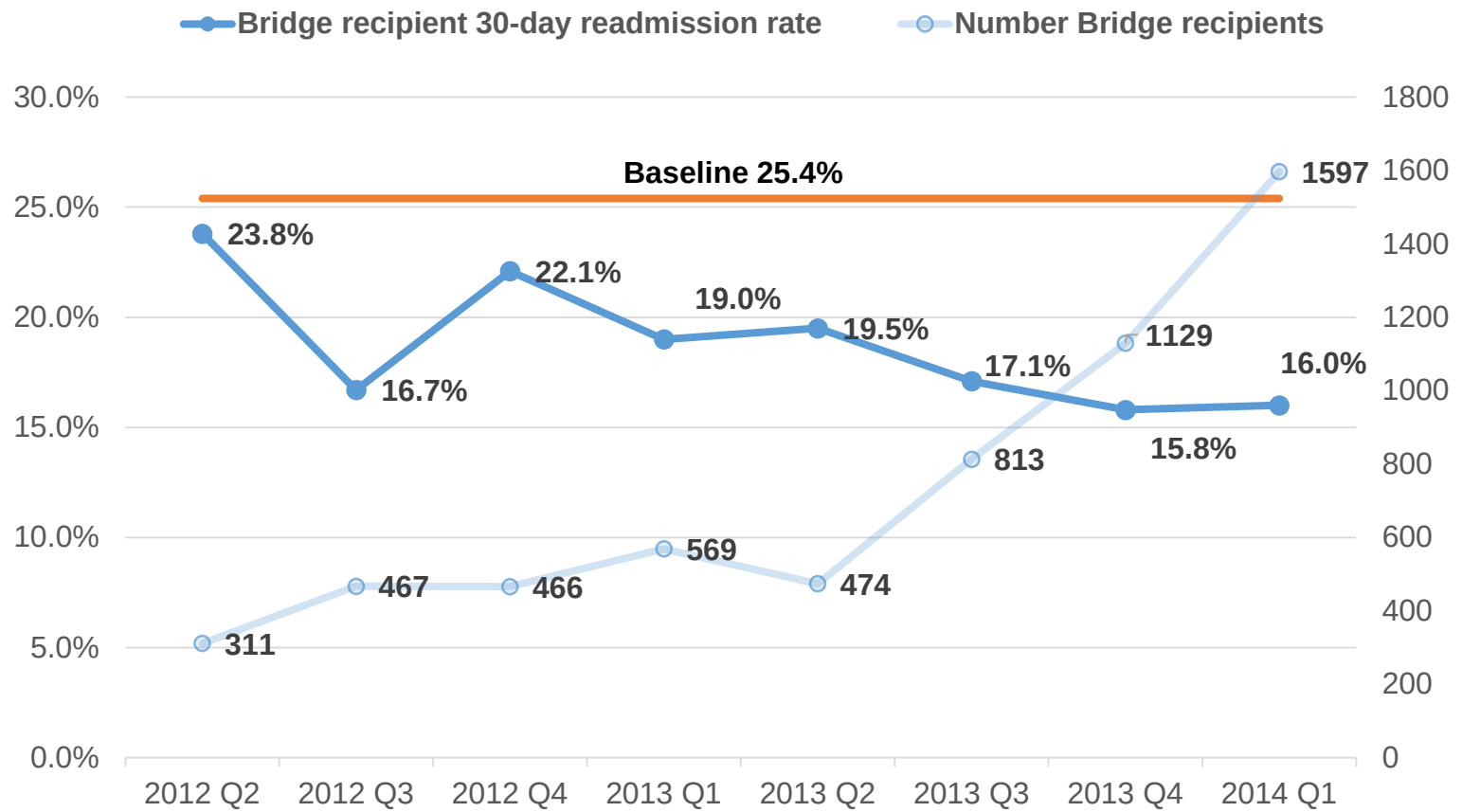
Increased communication and appointment attendance, p<.002



Altfeld SJ, Shier GE, Rooney M, et al. Effects of an enhanced discharge planning intervention for hospitalized older adults: A randomized trial. *Gerontologist*. 2013;53(3):430-440.

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

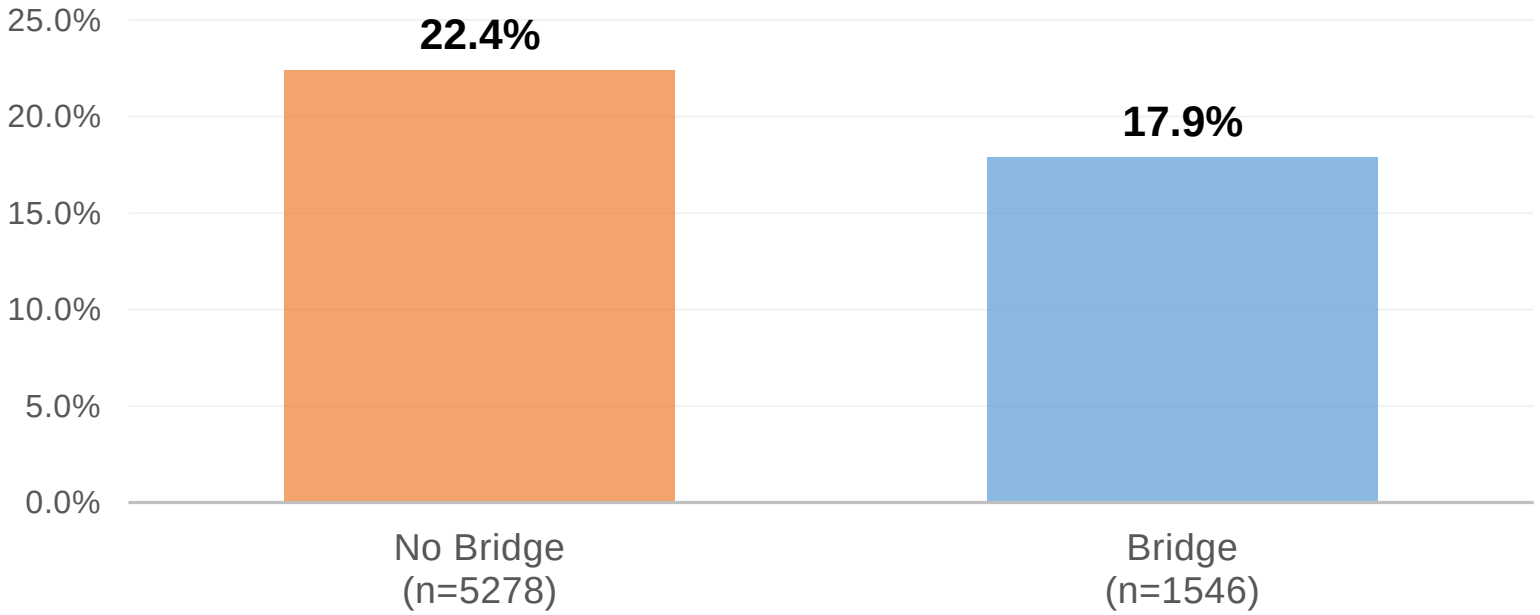
30.7% readmission reduction vs. baseline, n=5753 Medicare beneficiaries



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

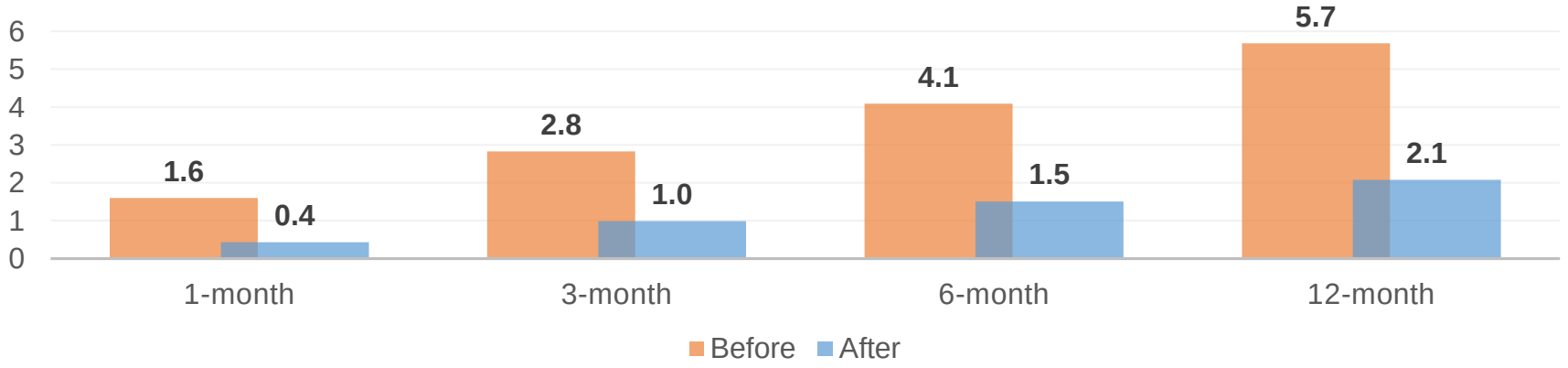
20% fewer readmissions, p < 0.05



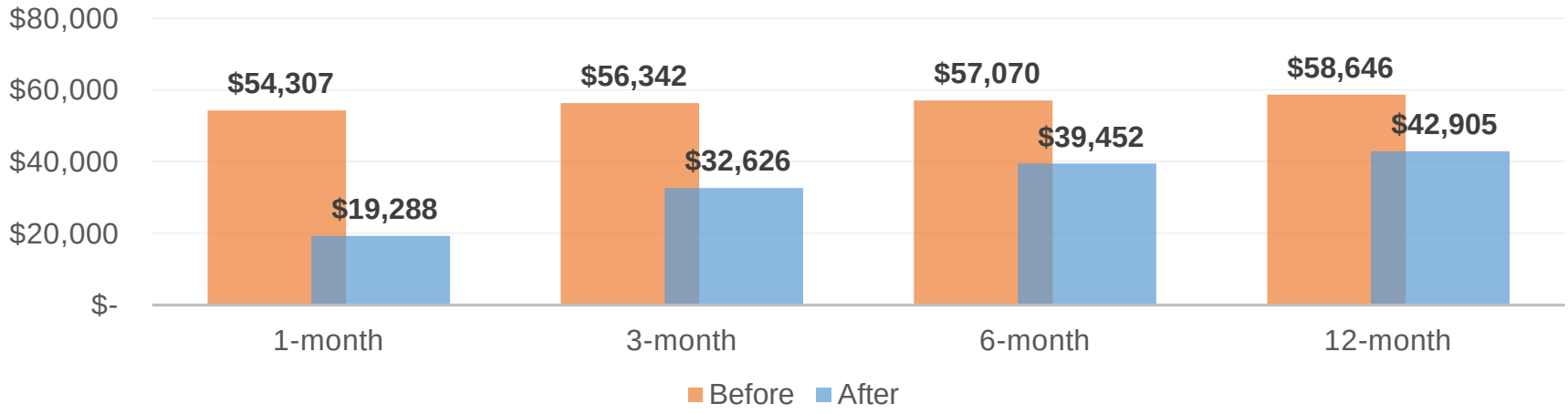
Boutwell AE, Johnson MB, Watkins R. Analysis of a social Work–Based model of transitional care to reduce hospital readmissions: Preliminary data. J Am Geriatr Soc. 2016;64(5):1104-1107.

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

Fewer hospitalizations, p<.001, n=423

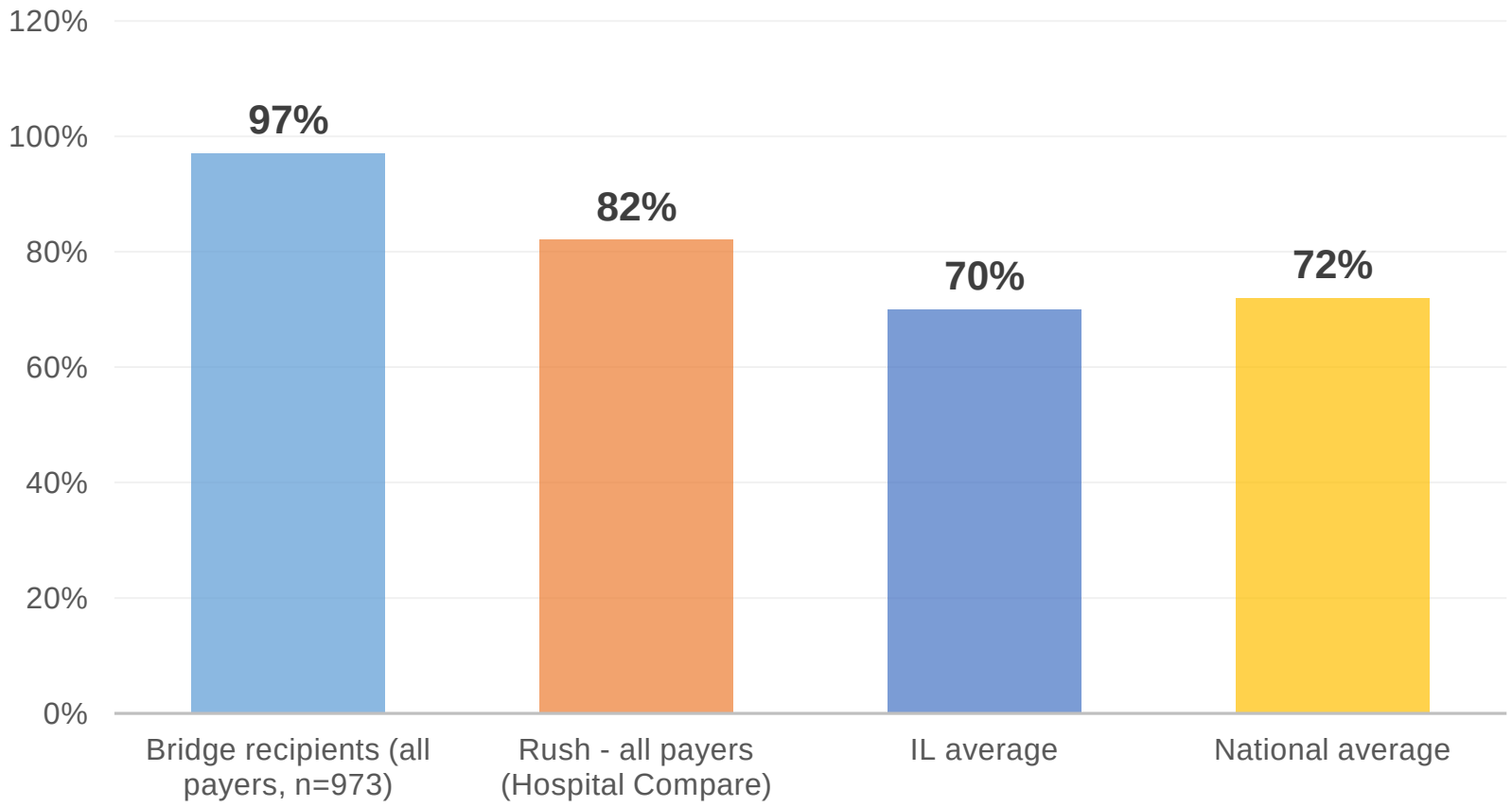


Average hospital cost per episode



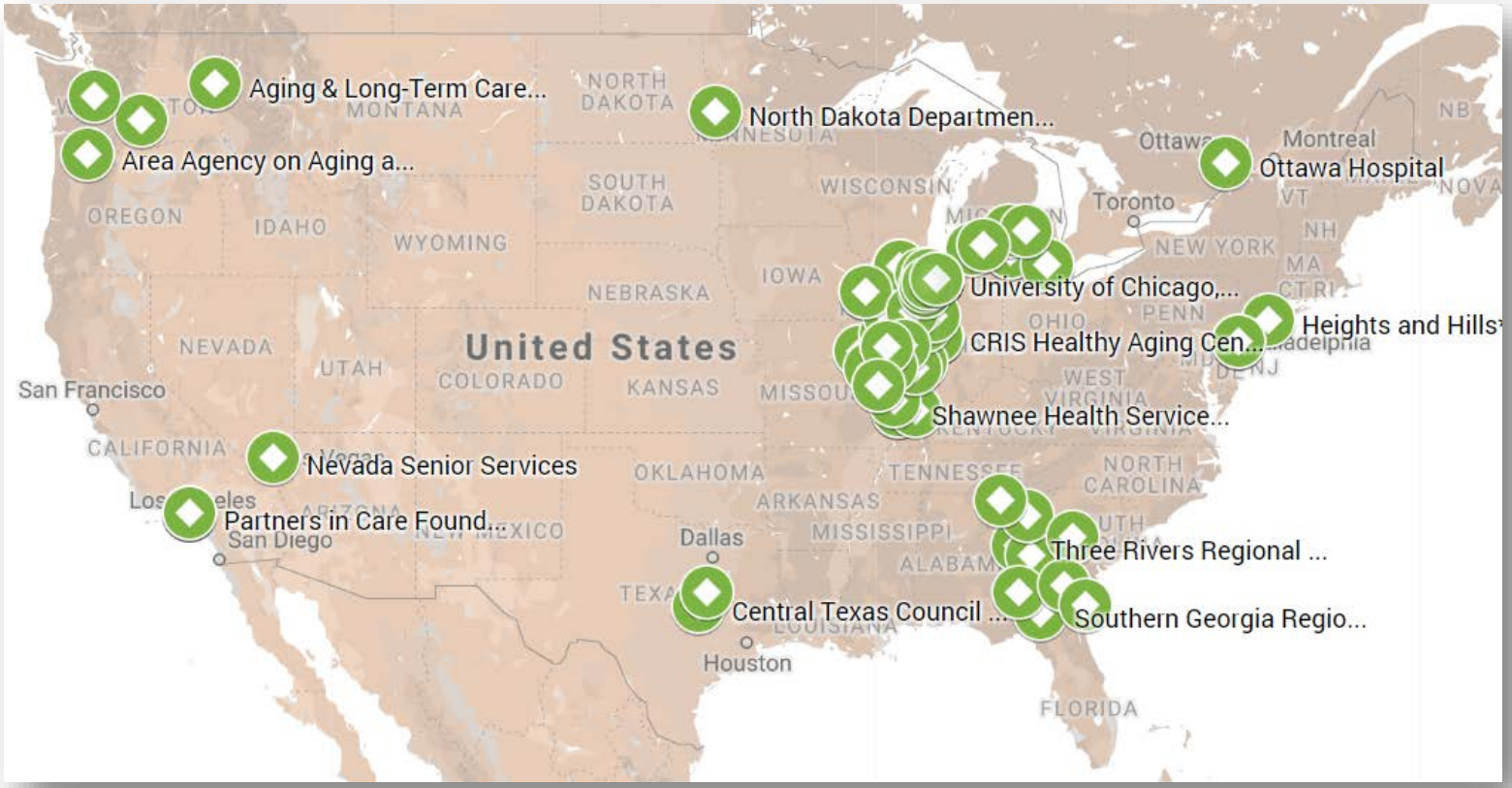
Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (accepted). Social work-based transitional care intervention for super utilizers of medical care: A retrospective analysis of the Bridge Model for Super Utilizers. Social Work and Health Care, "Social Workers in Integrated Healthcare: Improving Care throughout the Life Course" Special Issue.

% 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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