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Implementing the Bridge Model to Reduce Readmissions at a Major Medical Center

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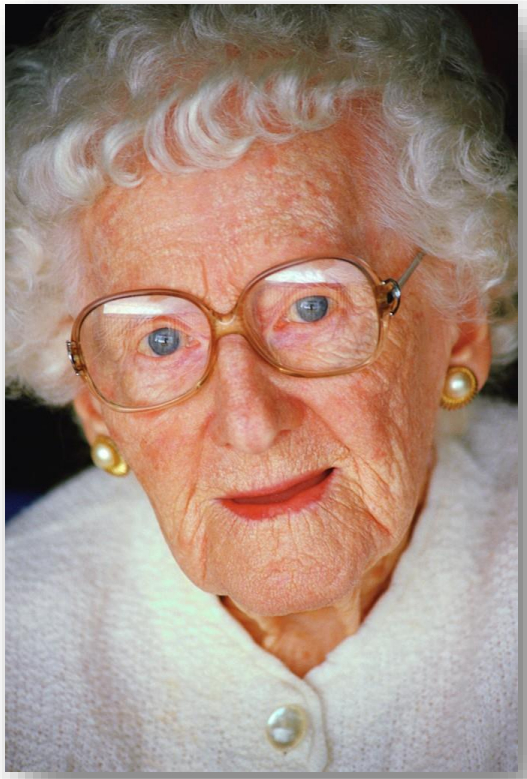
Program Coordinator

California Readmission Summit
October 10th, 2013

Agenda

- Introductions
- Case example
- Why are we here?
- Bridge model overview
- Model findings
- Case example

Case



- 74 years old
- CHF and Diabetes
- Widow
- Admitted through ER after a fall
- Home with HH and 10 medications

Mrs. Harrison at Home

Is this the worst case scenario, or is it a typical transition?

Community PCP doesn't know Mrs. Harrison was admitted to the hospital.

Mrs. Harrison is afraid she will fall again and have to return to the hospital.

Mrs. Harrison's primary caregiver is overwhelmed

turn to work.

on doesn't know which medications to resume and which to stop taking at home.

The Home Health Care agency doesn't arrive on time.

Mrs. Harrison's two children can't agree how to best manage their mother's medical needs.

Mrs. Harrison is having difficulty coping with her mobility changes.

Mrs. Harrison is feeling depressed because she can't get around anymore like she used to.

Mrs. Harrison has questions about her medical bill and doesn't know what her insurance will cover.

Mrs. Harrison can't afford her medications anyway

Mrs. Harrison is feeling isolated now that she's homebound.

Mrs. Harrison's Community Services are delayed

follow-up medical appointments.

Why are we here today?

- Change at the policy level
  - Value Based Purchasing
  - Patient Centered Medical Home
  - Accountable Care Organization
- "The Revolving Door: A Report on U.S. Hospital Readmissions" from the Robert Wood Johnson Foundation
  - *"One in eight Medicare patients were readmitted to the hospital within 30 days of being released after surgery in 2010, while one in six patients returned to the hospital within a month of leaving the hospital after receiving medical care. Patients were not significantly less likely to be readmitted in 2010 than in 2008."*

Accessed from http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178

The Second Curve

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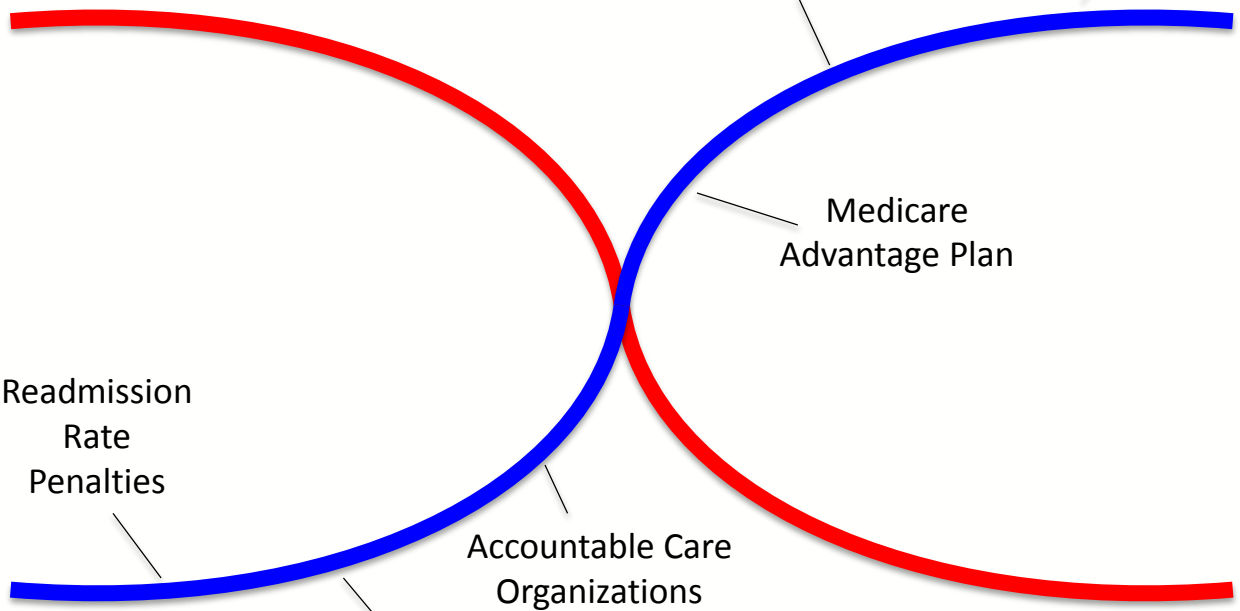
First Curve

Second Curve

Traditional Fee-for-Service Payment System



Population Health Per Capita Payment System

Adapted from Ian Morrison

Said another way

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VOLUME		VALUE
Watch reform and respond	**Reform**	**Shape** their own reform
Procedural driven	**Business Model**	Population **health** driven
Fill **beds**	**Growth**	Meet patient needs across the entire **care continuum**
Improve inpatient care **quality**	**Value**	Optimize patient **experience**
Inpatient services	**More…**	**Outpatient** services

Where and when to intervene?

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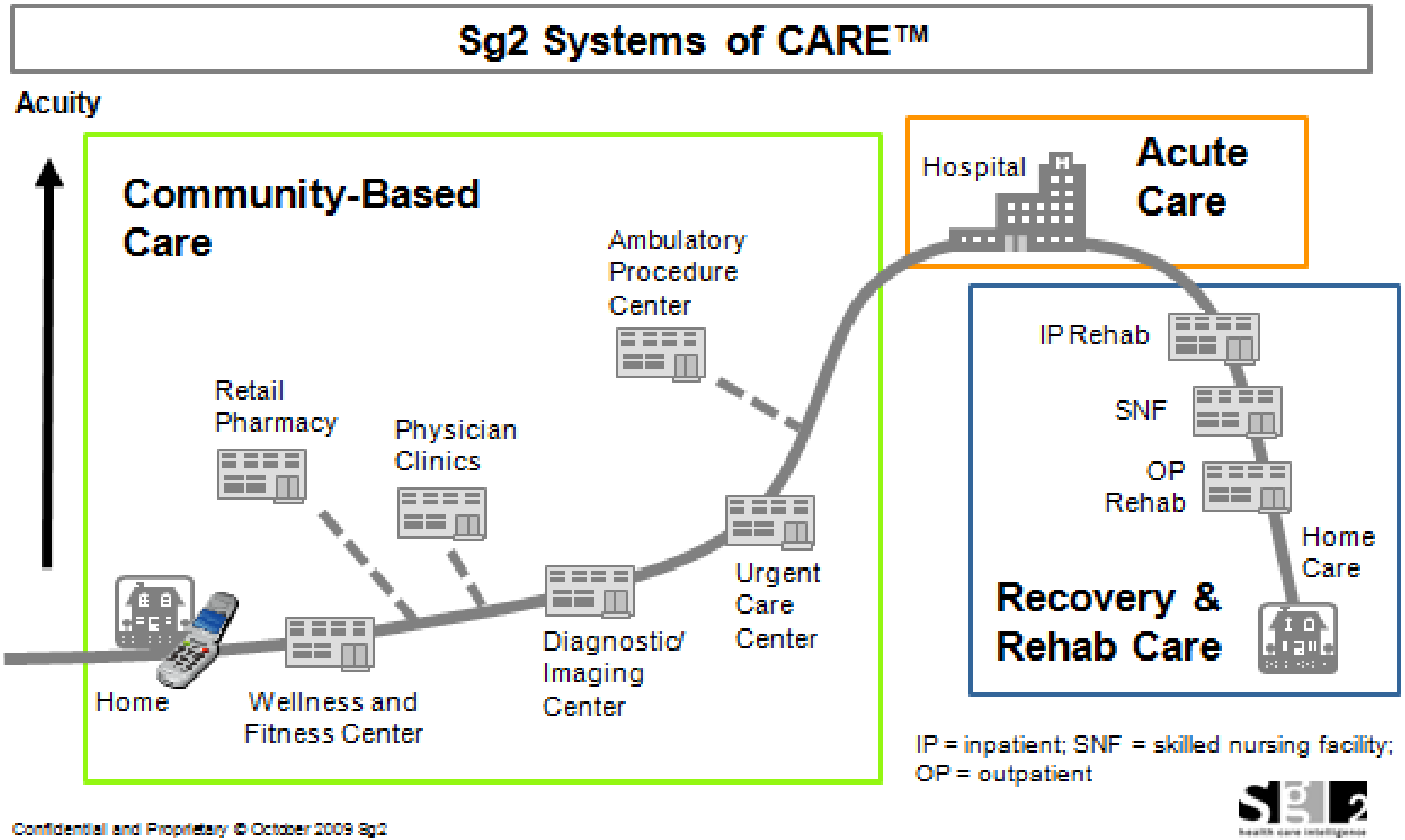

Social Factors and Health Outcomes

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Societal-level social determinants have individual-level impact

Issue	Outcome
Low education, lack of social support, and social exclusion	Poor self-management and reduced care plan adherence
Housing and transportation issues	Increased health care costs and utilization
Health disparities and psychosocial issues	Preventable hospitalizations and mortality

Shi L, Singh D. *The Nation's Health. 8th ed*. Sudbury, MA: Jones and Bartlett Learning, LLC; 2011.; Gallant MP. The influence of social support on chronic illness self-management: a review and directions for research. *Health Educ Behav*. 2003;30(2):170-95.; DiMatteo MR. Social support and patient adherence to medical treatment: a meta-analysis. *Health Psychol*. 2004;23(2):207-18.; Krieger J, Higgins DL. Housing and health: time again for public health action. *Am J Public Health*. 2002;92(5):758-68.; American Public Health Association. The hidden health costs of transportation. http://www.apha.org/NR/rdonlyres/A8FAB489-BE92-4F37-BD5D-5954935D55C9/0/APHAHiddenHealthCosts_Long.pdf. Published February 2010. Accessed January 10, 2012.; Centers for Disease Control and Prevention. CDC health disparities and inequalities report – U.S. 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.; Robert Wood Johnson Foundation. Overcoming obstacles to health care. www.commissiononhealth.org/PDF/ObstaclesToHealth-Highlights.pdf. Published February 2008. Accessed January 10, 2012.

Predicting Readmissions

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- New literature questioning the status quo
  - Cognitive decline while in hospital and post-discharge
    - *Journal of General Internal Medicine*
  - 40-50% of readmissions tied to psychosocial problems and lack of community resources
    - *Health and Social Work*
  - "Unplanned readmissions largely determined by broader social and environmental factors…"
    - *Journal of the American Medical Association, JAMA* (in *Readmission News*)
  - *"Unmet social needs .. are leading directly to worse health for all Americans."*
    - *Robert Wood Johnson Foundation Survey, 2011*

The Healthcare Neighborhood

- Integrated model with the medical and social components of equal value
- Team-based care with the person and family on the team
- Service connection, coordination, and communication
  - "Boundary spanning" and "spanners"
  - Partnerships across sites and settings
- Community engagement and activation
  - Where people live
  - Where service providers are located
  - Where social determinants of health begin and can be influenced

The Bridge History

2005: Enhanced Discharge Planning Program pilot begins; Aging Resource Center started

2009: Randomized controlled trial of EDPP model begins; Illinois Transitional Care Consortium formed

2011: ADRC Transitions Grant obtained by ITCC for Bridge Program

2012: Bridge awarded Community Based Care Transitions Program (Section 3026)

The Bridge Model: Replication

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Illinois Hospital Association partnership across the State →24 sites

Chicago & Suburbs, IL →6 Sites*

Danville, IL →Community-based organization (CBO), Aging Network

North Dakota State Unit on Aging

Brooklyn, NY* CBO

Philadelphia, PA* →Area Agency on Aging

East Lansing, MI* → Area Agency on Aging

San Fernando, CA* Health care organization

Brunswick, GA →Area Agency on Aging

Carbondale and Herrin, IL →2 sites, CBO, Aging Network

*Community-based Care Transition Program replication sites.

Building Blocks

- Social determinants of health
- Hospital-community collaboration
- Motivational interviewing
- Advocacy
- Provider engagement
- Community resource expertise
- Cultural competency
- Continuous quality improvement

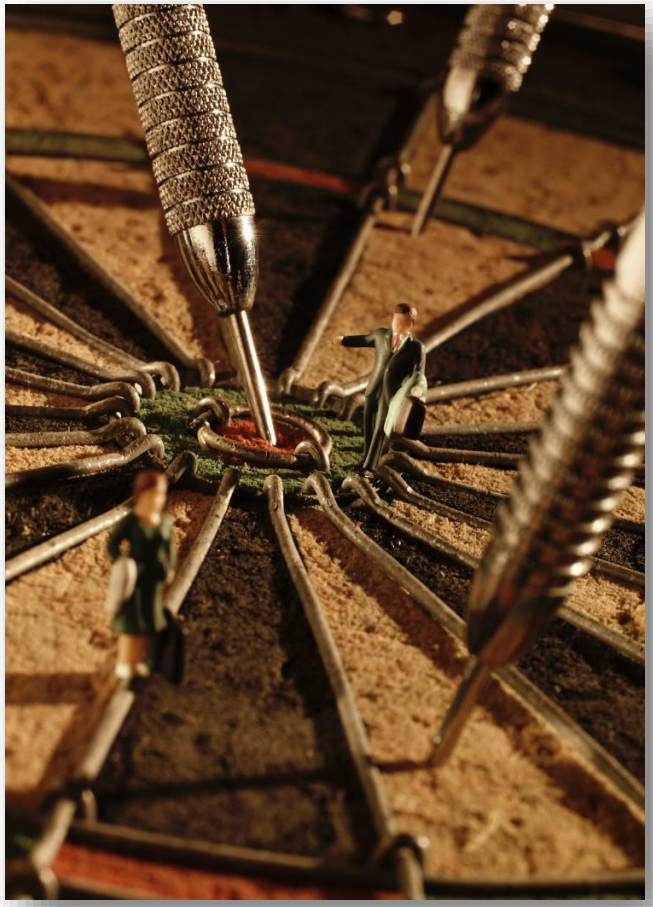
Quick information

- Telephonic
- Social worker led interdisciplinary team
- 5-6 calls over a period of 5-6 days
- Calls made to:
  - Client/caregiver
  - Primary care
  - Hospital of origin
  - Pharmacy
  - Community-based organizations

The post-discharge environment

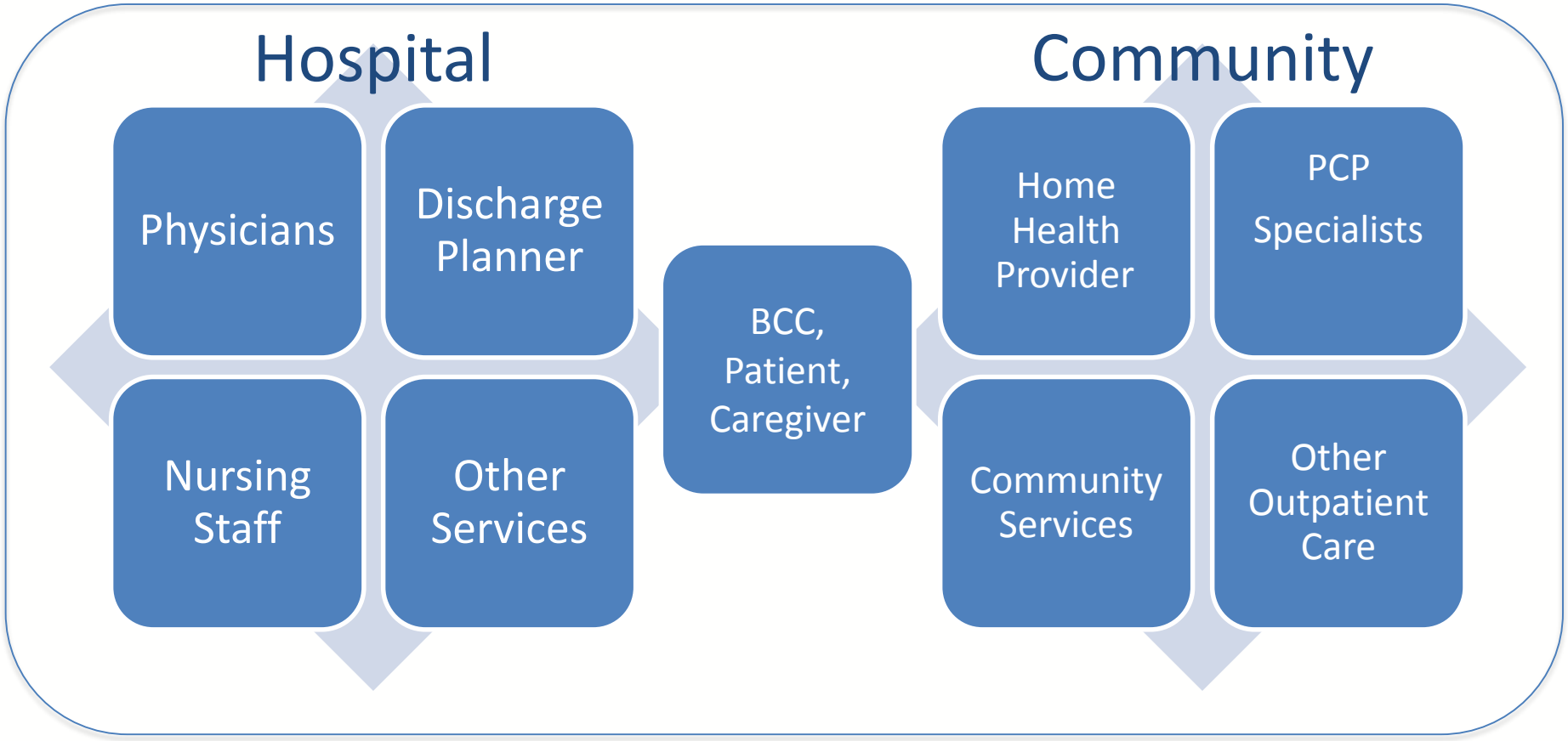
- Post-discharge issues:
  - 300 of 360 (83.3%) of patients had issues identified by social worker after discharge
  - For 219 of 300 (73%) of these individuals, problems did not emerge until post-discharge

Target Population



- Must have all of the below
  - 60+
  - Chronic condition
  - Previous hospitalization within 6 months
- Must have at least one of the below
  - Discharged with home health
  - Living alone
  - Discharged to a skilled nursing facility
- Current practice
  - Expanded demand and realistic pressures

The “Quarterback”



Hospital and Community providers communicate across disciplines and settings under the facilitation of a care coordinator

Pre-discharge

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The participant enters the hospital with more than an illness.	Referrals can originate from an electronic medical record, a discharge planner, the patient or a family member.	Preparation for discharge must include as broad a picture of the patient/consumer as possible
•Caregiver •Family •SES •Race •Gender •Ethnicity •Religion •Mental Health •Personal Values and Beliefs	•Risk screen built in to the EMR •If non-hospital staff, requires access to the EMR •Balance between consistency and flexibility	•Discharge plan of care •Community resources •Systemic challenges •Community physicians •Interdisciplinary team •Essential information

Post-discharge

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Walking through your house doors, one walks back into their real life	The map is not the territory. What changed? How can we help?	Longer term involvement to ensure the patient/consumer remains connected
•Caregiver •Family •SES •Race •Gender •Ethnicity •Religion •Mental Health •Personal Values and Beliefs	•Understanding of discharge plan of care •Understanding of medications •Follow-up on community resources •Ensure physician follow-up •Caregiver support •Emotional support •Building a community network	•Still connected to necessary resources? •Quality assurance •Emotional support (30% re-contacts post-intervention)

Motivational Interviewing

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- Semi-directive
- Explores intrinsic motivation
- Four tasks:
  - Express empathy
  - Develop discrepancy
  - Roll with resistance
  - Support self-efficacy
- Main goals:
  - Establish rapport
  - Elicit change talk
  - Establish commitment language

Cultural and Community Expertise

The client's treatment plan is influenced by culture. A client may consider a combination of remedies including:

- Medical
- Psychotherapy
- Religion
- Self-help groups
- Yoga
- Chiropractors
- Crystals
- Special foods
- Old family remedies

Data is key

- The link between agencies
  - Good data along with a solid RCA is the best way to start a new partnership or strengthen an existing one
- Funding
  - Funders need numbers
- Quality improvement
  - You can't fix what you can't measure

Supervision

- Weekly
  - Case reviews
    - Follow-up on partnership development (reference relationship map)
    - Role play own case
- Monthly
  - Readmission analysis
    - Root cause analysis
  - Quality improvement tracking
  - Data tracking

Bridge: Evidence

AHRQ HEALTH CARE
INNOVATIONS EXCHANGE

Innovation Profile:

Hospital-Based Social Workers Follow Up With Recently Discharged Older Adults to Resolve Transition Problems, Reducing Readmissions and Deaths

Snapshot

Summary

As part of its Enhanced Discharge Planning Program, Rush University Medical Center helps at-risk older adults transition back to their homes after hospital discharge. Hospital-based social workers call eligible patients or their caregivers within 48 hours to reinforce the discharge plan of care and to address anticipated and unanticipated needs by connecting patients to health and community-based services and providing other forms of support. The program enhanced patients' and caregivers' knowledge and ability to manage at home, improved attendance at followup appointments, and reduced readmissions and deaths.

Evidence Rating (What is t

Strong: The evidence consists participants and a control group

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PRACTICE FORUM

Social Work and Transitions of Care: Observations from an Intervention for Older Adults

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Making the transition from hospital to home can be challenging for many older adults. This article presents practice perspectives on these transitions, based on a social work intervention for older adults discharged from an acute care setting to home. An analysis of interviews with clinical social workers who managed 356 cases (n = 3) and a review of their clinical notes (n = 581) were used to

The Gerontologist
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Effects of an Enhanced Discharge Planning Intervention for Hospitalized Older Adults: A Randomized Trial

Susan J. Altfeld, PhD,[*,1] Gayle E. Shier, MSW,[2] Madeleine Rooney, LCSW,[2] Tricia J. Johnson, PhD,[3] Robyn L. Golden, LCSW,[2] Kelly Karavolos, MA,[3] Elizabeth Avery, MS,[3] Vijay Nandi, MPH,[4] and Anthony J. Perry, MD[5]

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Purpose of the Study: To identify needs encountered by older adult patients after hospital discharge and assess the impact of a telephone hospital readmission. ***Implications:*** At-risk older adults may benefit from transitional care programs to ensure delivery of care as ordered and address

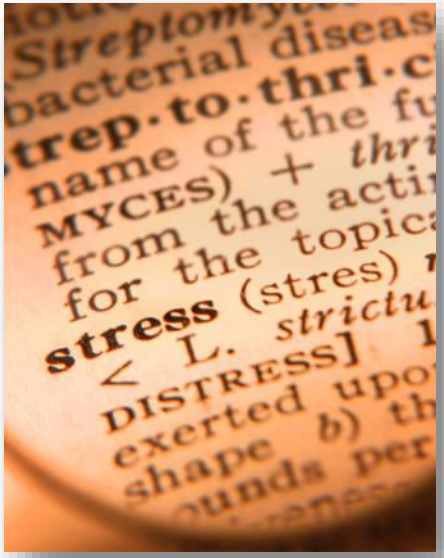
Readmissions and mortality

- Bridge clients (19.5%) were less likely to be readmitted than expected from institutional calculations for anticipated readmission (26%)
  - 25% decrease
- Mortality within one month
  - 3.1% of those randomized to the treatment group
  - 4.4% in the nonintervention group

Follow-up appointments

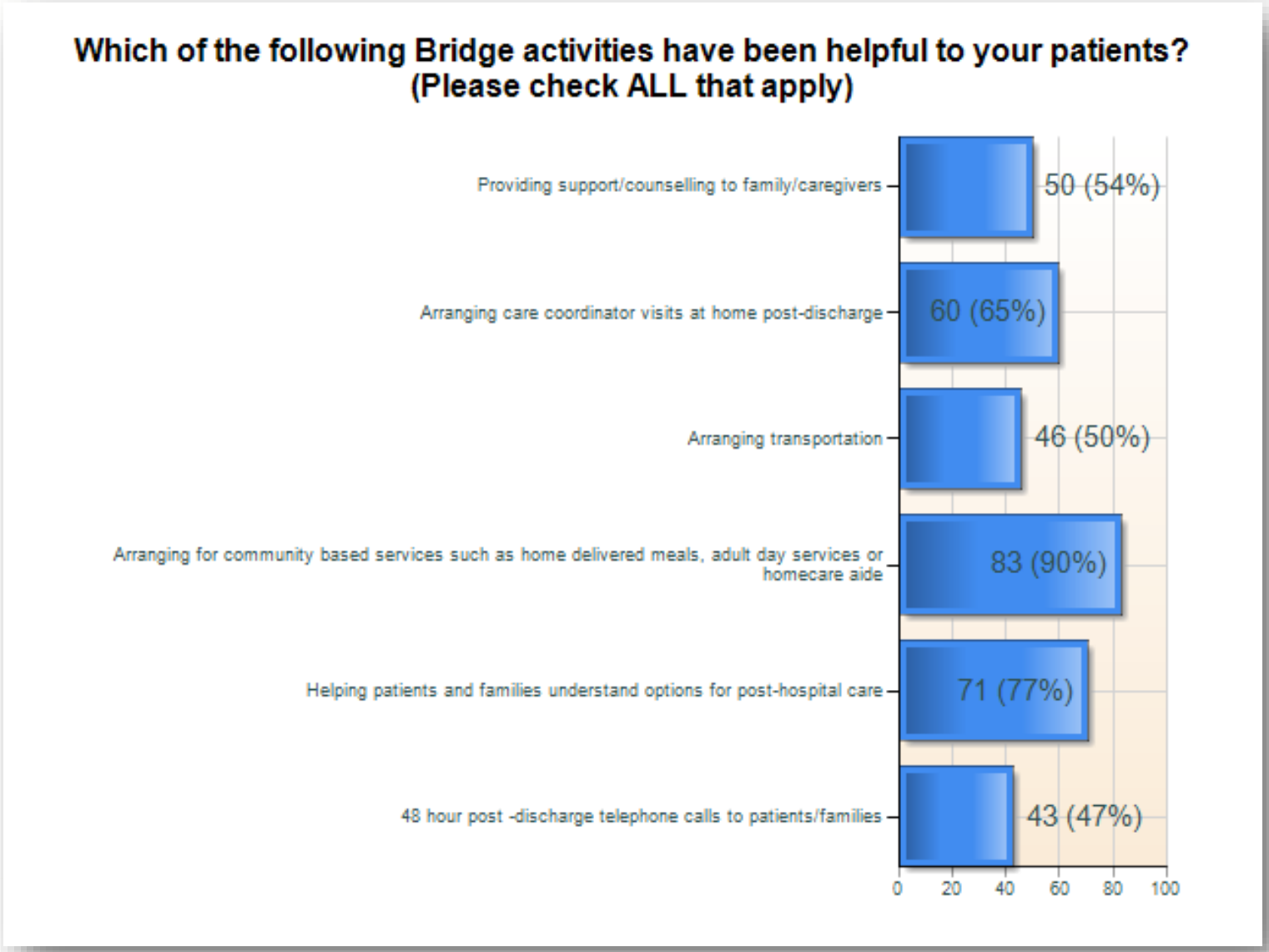
- Approximately 75% of participants scheduled and attended a follow-up appointment within one month of discharge compared with 57% of the usual care group.

Medication understanding and reduced stress



- Increased patient 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
  - Patients: from 36.8% to 30.9%
  - Caregivers: from 44.9% to 35.4%

Stakeholder Survey (n=97)

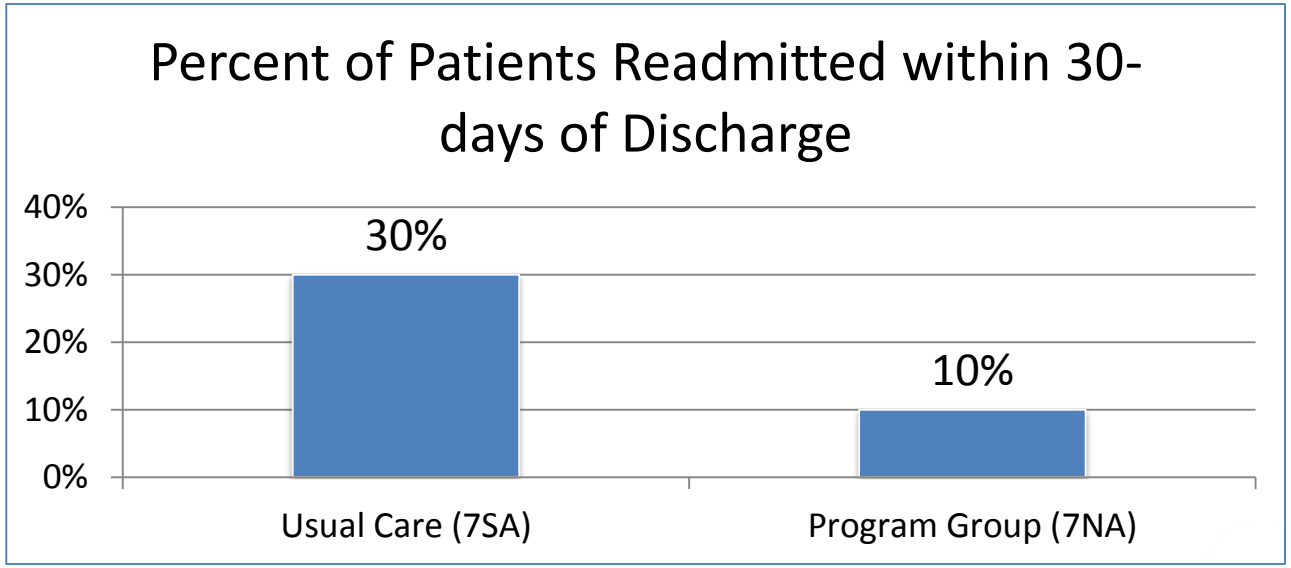


Bridge: Impact

Type of Problem	Cases With Problems, n (%)
Any problem identified	***300 (83.3)***
Self-Management (other than medication)	*165 (45.8)*
Caregiver burden	*126 (35.0)*
Coping with change	124 (34.4)
Home Health – provider issues/unmet needs	*92 (25.6)*
Difficulties obtaining community services	*85 (23.6)*
Issues with coordination between care providers	70 (19.4)
Difficulty understanding plan for follow-up care	60 (16.7)
Medication management	59 (16.4)
Communication with service and medical providers	53 (14.7)
Mental illness	39 (10.8)
Medication reconciliation needed	38 (10.6)
Issues with transportation resources	36 (10.0)
Inadequate social support	35 (9.7)

Bridge Model: Adding a Pharmacist

- In another study, addition of pharmacist protocol to Bridge
  - Adds protocol for standard involvement by a pharmacist
  - Studied through retrospective cross-sectional design
  - Results:

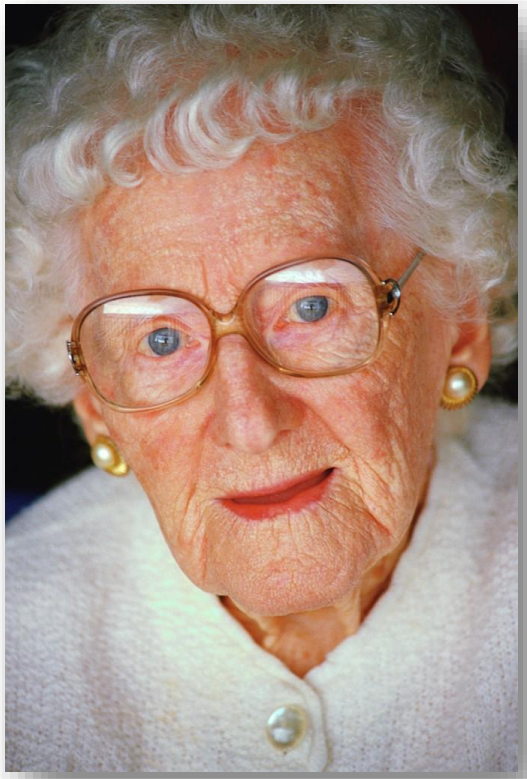


*Difference in 30-day readmissions between usual care and program group is significant at p = .012

Strengths and Opportunities

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

Mrs. Harrison and the Bridge Model



- Mrs. Harrison through the eyes of a Bridge Care Coordinator
- What is done to help?

Pre-discharge

Review EMR to research PCP. Contact PCP to alert of pending discharge.

Arrange or administer screen for services.

Evaluate impact on client. Note potential caregiver stress to address post-discharge.

Screen for transportation services. Research non-traditional sources if necessary.

Research agency. Contact to discuss their process and introduce the program.

Pre-discharge phase complete

Post-discharge phase

30-day complete

Thank You

Questions?

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Thank You to Our Funders & Partners

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