The Social Work Role in Reducing 30-Day Readmissions: The Effectiveness of the Bridge Model of Transitional Care

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The hospital experience is taxing and confusing for patients and their families, particularly those with limited economic and social resources. This complexity often leads to disengagement, poor adherence to the plan of care, and high readmission rates. Novel approaches to addressing the complexities of transitional care are emerging as possible solutions. The Bridge Model is a person-centered, social work-led, interdisciplinary transitional care intervention that helps older adults safely transition from the hospital back to their homes and communities. The Bridge Model combines three key components, care coordination, case management, and patient engagement, which provide a seamless transition during this stressful time and improve the overall quality of transitional care for older adults, including reducing hospital readmissions. The post-ACA and managed care environment’s emphasis on value and quality support further development and expansion of transitional care strategies, such as the Bridge Model, which offer promising avenues to fulfill the Triple Aim by improving the quality of individual patient care while also impacting population health and controlling per capita costs.
Keywords

Chronic illness, Health Policy, Long-Term Care, Social Services, Curriculum and Training

Introduction

The hospital experience is taxing and confusing for patients and their families, particularly those with limited economic and social resources. This complexity often leads to disengagement, poor adherence to the plan of care, and high readmission rates. Novel approaches to addressing the complexities of transitional care are emerging as possible solutions. The Bridge Model is a person-centered, social work-led, interdisciplinary transitional care intervention that helps older adults safely transition from the hospital back to their homes and communities. The Bridge Model combines three key components, care coordination, case management, and patient engagement, which provide a seamless transition during this stressful time and improve the overall quality of transitional care for older adults, including reducing hospital readmissions. The post-ACA and managed care environment’s emphasis on value and quality support further development and expansion of transitional care strategies, such as the Bridge Model, which offer promising avenues to fulfill the Triple Aim by improving the quality of individual patient care while also impacting population health and controlling per capita costs. **The Bridge Model: A**
Social Work Intervention

Patients at high risk of readmission are increasingly referred to post-acute transitional care services. Although most well-described models of transitional care are adherent to the medical model and focus on patient health education and medication management (Arbaje, 2010; Coleman, 2006; Hansen, 2013; Jack, 2009; Naylor, 2003), the literature suggests that social or non-medical issues are frequently involved in readmission events (Altfeld et al., 2013). Rooted in the social determinants of health, psychosocial factors such as food security, housing stability, social support, transportation, or health literacy play a significant role with regards to readmission rates. Research among older adults has shown about 40-50% of readmission rates are due to psychosocial factors (Altfeld et al., 2013). The Bridge Model specifically addresses these psychosocial barriers with a social worker trained as a Bridge Care Coordinator (BCC).

The BCC works with each patient to ensure their immediate health needs as well as non-medical, psychosocial needs are identified and addressed through therapeutic techniques like cognitive behavioral therapy and motivational interviewing. Best practice demonstrates that effective transitional care includes an assessment of the patient and the entire spectrum or his or her post-discharge needs along with coordination of the care needed. Aside from care coordination, BCCs provide case management, which includes a process to plan, seek, advocate for, and monitor services from different social services or health care organizations on behalf of the patient or client (Barker, 2003). A meaningful assessment and successful linkage to follow-up care and wraparound services also depends on how engaged patients are with their care plan. The Bridge Model leverages psychotherapeutic techniques from several modalities in order to engage the
patient. Social work as a discipline serves a critical role in transitional care due to the comprehensive lens it brings to assessment, patient engagement, intervention, and coordination of social services that address identified needs. Social workers forge authentic relationships with their clients and leverage those relationships to affect real health care behavior change.

**Bridge Model Effectiveness**

The Bridge Model’s approach of addressing both medical and social issues has led to many positive outcomes, including significantly lower readmission rates and decreased stress for patients and family caregivers. Findings from the 2012-2014 Community-based Care Transitions Program (CCTP)—a Medicare demonstration project—for Medicare beneficiaries with multiple chronic conditions at six Chicago-area sites (n=5,753) indicated that Bridge participants had 30.7% fewer 30-day readmissions, 9.4% fewer 60-day readmissions, and 13.9% fewer 90-day readmissions. We also found an increased attendance of post-discharge physician appointments.

To date, more than sixty partners in geographically-diverse areas around the nation have been trained in the Bridge Model, including a number of sites that received funding for various health reform demonstration projects, including CCTP, the Balancing Incentive Program (BIP), and Delivery System Reform Incentive Payment (DSRIP) Waivers. The Bridge Model can be replicated by hospitals, health systems, or community-based organizations, and is designed to be adaptable and continuously improved to fit different client populations and workflows. For example, Rush University Medical Center adjusted the Bridge Model to specifically serve high utilizers, which are defined as Medicare beneficiaries with five or more hospitalizations in the
previous year. An assessment comparing patient utilization six months before and six months after the intervention (n=456) found a 61.1% 30-day readmission reduction, 50.3% admission reduction, 36.4% ED utilization reduction, and 19.8% outpatient no-show reduction.

The Bridge Model was designed to specifically address psychosocial issues and facilitate access to community services such as transportation, homemaker, and social support. Sites that are geographically dispersed may address their patient populations’ transportation needs by adapting the Bridge Model to be a primarily telephonic intervention. For example, Bridge Model replication site Partners in Care Foundation (PICF) in southern California is a nationally-recognized leader in geriatric care management and offers two methods of transitional care: the Bridge Model and the Care Transitions Intervention (CTI). PICF recognized that home visits were a barrier for some of their patients in accepting transitional care. Therefore, PICF utilized the flexibility of the Bridge Model to allow their patients to choose whether they will follow up via telephone post-discharge or in person. With this person-centered approach, the BCC completes a bedside visit while patients are in the hospital and continues to follow up and engage with them telephonically, allowing the intervention to reach patients that would typically be excluded from a model requiring home visits.

PICF endorsed the Bridge Model as their primary transitional care intervention because of its person-centered, post-discharge telephonic approach. In addition, PICF employed the Bridge Model when patients refused home visits for cultural reasons, personal discomfort levels, or cognitive dissonance about their post-discharge support needs. To date, PICF has served almost 5,000 patients at 11 hospitals using the Bridge Model. At a PICF site in 2014, 92 patients
received the Bridge intervention over a 6 month period and 9 of those patients were readmitted 30 days post-discharge; resulting in a readmission rate of 9.78%.

**Discussion**

Research on the social factors related to hospital readmissions support the need for a diverse coordinated team of health care and community professionals that support people beyond their medical needs (Calvillo-King, 2013; Hu, 2014; Kocher, 2011). The Bridge Model connects patients with complex health needs to community services and resources based on their identified needs as well as their goals and values. Bridge offers person-centered health care and the effectiveness of the Bridge Model in older adult Medicare populations can be expanded to other populations, including those on Medicaid or uninsured. Coordinating post-hospital care through the use of care managers or care coordinators, social workers, and an extended network of health care and social service professionals outside of the confines of a hospital, can also lower health care costs by reducing the probability that patients will readmit to the hospital. Social workers are thus perfectly set up to act as the "bridge" between the hospital and the community since they are skilled and competent in addressing social needs while still understanding the medical needs of patients.

Even as insurance coverage expands under the ACA, hospitals will continue to need new ways of providing efficient, quality care that meets new standards in value-based contracts with payers. The Bridge Model offers a promising model to shift hospital operations toward whole-person care that links medical and social services, thereby propelling the entire service delivery
system toward a more person-centered, outcomes-oriented approach. More time spent in the community in conjunction with less time spent in the hospital translates to less costly healthcare utilization.

The Bridge Model is constantly evolving its approach to evaluating the program itself, and recognizes that there are additional quality metrics beyond readmission rates. For instance, examining the length of stay in the community or home may be more compelling in demonstrating healthcare utilization and quality compared to readmission rates.

However, lowering hospital readmissions are a much more concrete, relatable goal for an individual patient and healthcare provider. Furthermore, readmission reduction compels hospitals and physicians to consider community and population health since the social determinants of health and psychosocial factors create the context for wellness or illness and injury. Readmissions as a quality measure can move us towards the goal of the Triple Aim to have the best care for the whole population at the lowest cost. In responding to readmissions, amidst many other challenges in transitional care, the social-work led Bridge Model produces tangible benefits for individuals and families, creates value for hospitals and payers, and also points toward a future of person-centered, population health management.
Finally, limitations of the Bridge Model include a lack of consistent capture of process, outcome and cost data, limiting programs' abilities to effectively describe impact and value. Hospital-community partnerships are still evolving and one ongoing barrier is the difficulty with sharing information between hospitals and community-based organizations. The readmission data presented here are calculated using raw, unadjusted Medicare claims for the specified periods of time. They do not indicate impact or take trends or other initiatives into consideration. These metrics are provided by CMS for performance monitoring purposes only and while they inform evaluative results, they do not constitute the entirety of the program evaluation, which is ongoing.
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