The Bridge Model & Transitional Care from Nursing Homes, Communities, and Hospitals: A Social Work Approach

NURSING HOME SOCIAL WORK WEBINAR SERIES
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- Debra Markovitz, LCSW is a social worker at the Rush Health and Aging at Rush University Medical Center in Chicago.
- She provides transitional care services as a Bridge Care Coordinator to older adults and caregivers.
- Her clinical expertise focuses on older adults, care giving, care coordination, mental health and the effects of chronic illness and disabilities on patients and caregivers.
- She also coordinates the Social Work Age Training Program which is a geriatrics focused educational program for professionals.

Ilana Shure, MSW
- Ilana Shure is the Program Manager of the Aging Resource Center, a transitional care program based on-site at Adventist La Grange Memorial Hospital in La Grange, Illinois.
- Ilana supervises master’s-level social workers assisting older adults and their families experiencing care transitions from hospitals and skilled nursing facilities utilizing the Bridge Model.
- She provides training to community-based organizations and hospital staff on the Bridge Model, the aging network, aging issues, and community-based services for older adults. As a representative for Aging Care Connections to the Illinois Transitional Care Consortium, Ilana serves on the Program Management Team and assists with the development, implementation, and replication of the Bridge Model.

Learning Objectives: By the end of this presentation, individuals will be able to:
- Explain the principles that underpin the Bridge Program.
- Learn about the processes and skill sets needed for the Bridge Program.
- Describe the role of Social Work in transitional care.
- Understand how processes and collaborations are actualized through case examples.

Agenda
- Social Work Approach to Transitional Care
- Partnerships and Collaborations
- Bridge Model: Process
- The Bridge Model: Context
- SNF Partnerships and Process
- SNF Case Example
- Questions/Discussion

The Bridge Model: A Social Work Approach
The Bridge Model: A Social Work Approach to Transitional Care

- Why transitional care?
  - Care is fragmented
  - Communication between providers limited
  - Older adults particularly vulnerable at times of transitions

- Biopsychosocial perspective places equal importance on the social determinants

- New literature highlights importance of social determinants in successful transitions
  - Cognitive decline while in hospital and post-discharge
  - 40-50% of readmissions tied to psychosocial problems and lack of community resources
  - "Unplanned readmissions largely determined by broader social and environmental factors..."
  - *Journal of General Internal Medicine*

- Person-centered: capitalizes on the "servable moment" - the time in the transition whereby the individual feels empowered to accept assistance and make a change

- Partnerships and collaborations are imperative to transitional care work
  - Social Workers adept at developing and managing partnerships
  - Collaboration is a core activity and competency in Social Work as we are trained to think systemically

The Bridge Program: Partnerships and Collaboration

- Partnership and Collaboration
  - Partnership: the state of the relationship or arrangement
  - Collaboration: the active process of the partnership in action
  - Collaboration in action...
    - "Discussion may be focused on the nature of a social care problem, to determine a course of action, to secure a service for someone in need or to re-establish help that has broken down. A kaleidoscope of factors enter the exchange: the views of service users and carers, service policies and structures, inter-agency agreements, professional cultures and methodologies, power and status, budgets and care resources, time priorities and personal styles. This is collaboration with other professionals and agencies, in action."
    - Colin Whittington, 2003

Continuum of Collaboration

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<thead>
<tr>
<th>Level</th>
<th>Feature</th>
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<tr>
<td>Isolation</td>
<td>No contact or communication between agencies, inter-professional rivalry and stereotyping; goals and interests perceived differently.</td>
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<tr>
<td>Encounter</td>
<td>Some contact between agencies but no meaningful action.</td>
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<tr>
<td>Communication</td>
<td>More frequent contact between agencies results in the exchange of information; some formal arrangement for liaison and some commitment to joint training.</td>
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<td>Collaboration</td>
<td>Information exchanged between agencies is acted on; there is engagement in joint working; general objectives are shared.</td>
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<td>Integration</td>
<td>Collaboration throughout the organization, at strategic and operational levels; very high level of trust and respect.</td>
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Bridge Program and Value of Partnerships

- Partnerships are a fundamental component of the Bridge Model
  - Patients do not live in the hospital or short-term rehabilitation facility
    - They live in homes, communities, long-term care SNF's
    - The plan of care is only as good as the receiver's ability to actualize it
    - How does one setting support the other, or not?
  - Partnerships and pre-established collaborative processes have a great impact on patient outcomes
    - **Meaningful partnerships allow for timely data transfer, expedited community service provision, and quicker problem solving**
Bridge Care Coordinators Partners

- Bridge Care Coordinators (BCC) as social workers are skilled:
  o at facilitating and maintaining relationships with interdisciplinary teams
  - Hospital
  - Community agencies
  - Skilled Nursing Facility
  - Home Health
  - PCP
  o Navigating community resources, particularly the aging network

The Call for Partnerships

- MANY different disciplines are trying to prevent readmissions

Partnership Development Tips

- Recognize the differences between cultures
- We come from different perspectives and have different languages
  - What does MI mean to you?
- Address concerns early and troubleshoot problems together
- Requires skills, effort and clear intentions
- Share both successes and challenges

The Bridge Model: Process

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<tr>
<th>Pre-Discharge</th>
<th>Post-Discharge</th>
<th>30-day follow-up</th>
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<td>Referral</td>
<td>Assessment</td>
<td>Confirm support</td>
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<tr>
<td>Information gathering</td>
<td>Referral</td>
<td>structure</td>
</tr>
<tr>
<td>Community resources</td>
<td>Connection to providers</td>
<td>Collect data</td>
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Outcomes Goals:
- Decreased readmissions
- Decreased mortality
- Increased physician follow-up
- Increased understanding of medications and discharge plan of care
- Decreased patient and caregiver stress

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
**Intervention Focus**
- Ensure patients/caregivers understand and can access the discharge plan of care
- Connect patients to their health care providers and community-based services and facilitate communication
- Provide support, information and resources to patients/caregivers
- Assess for safety and stability of home situation, crisis management
- Track systemic problems for corrective action or change
- Feed information back into the hospital, SNF and community-based organization system to help guide future care

**The Bridge Model:**

**Context**

**Aging Network**
- Administration on Aging & Older Americans Act
- State Unit on Aging
- Area Agency on Aging
- Care Coordination Unit (Unique to Illinois)

**CCUs are Your Aging Service Experts**
- Medicaid Waiver Program
  - Adult Day Care
  - Case Management
  - Emergency Home Response
  - In-Home Services
- Older Americans Act Services
  - Home-Delivered Meals
  - Caregiver Support Services
  - Transportation
  - Information and Assistance
- Private and/or Volunteer Services
  - Counseling
  - Ethnic Resources
  - Community-specific and local

**The Aging Resource Center (ARC)**
- Physical office space for BCCs to receive referrals, access hospital and community records
- A library of resources
- Space for the BCCs to collaborate with the interdisciplinary team
- A location for the BCC to meet with Bridge clients and their families to discuss community-based resources available

*The ARC is an on-site location for the Bridge Program. The establishment of an ARC symbolizes the commitment of both partners to sustaining Bridge.*

**The Bridge Setting at Rush University Medical Center**
- Large urban hospital with 676 beds, 27 care units
- Hospital located in diverse neighborhood of Chicago
- Resource centers available to patients and family members: Anne Byron Waud Resource Center and the Tower Resource Center
- Diverse socioeconomic, cultural, racial and ethnic attitudes and educational background of patients
Bridge SNF Partnerships at Rush University Medical Center and Aging Care Connections

RUMC's SNF Facility Partnership
- Currently with Warren Barr Pavilion in Chicago
- Started since Bridge Program began in 2012
- 34 SNF/Bridge admissions since May, 2012

Aging Care Connections Skilled Nursing Facility Partnerships

PARTNERSHIPS SINCE 2008

Bridge SNF Collaboration Pre-Discharge
- Seen at the hospital by SNF
- Discharge of medical record at Rush
- Patient Discharging from Hospital
  - Client history, hospital face sheet, assessment information is shared with SNF Transitional Care Team
- Patient Admitted to SNF
  - Bridge assessment completed by Bridge Care Coordinator
  - Caregiver contacted & assessed
  - Follow-up with Team & referral to SNF services and other community resources

Bridge Assessment
- Develop a Transition Plan
  - Addressing:
    - Caregiver Needs
    - Home Care/Home Health
    - Financial Situation
    - Mental Health
    - Medications
    - Physician Appointment
    - Transportation...

SNF Interdisciplinary Transition Huddle

Bridge SNF Collaboration Post-Discharge
- Bridge Care Coordinator reviews care plan with client pre-discharge
- SNF sets up services for post-discharge
- Bridge Care Coordinator arranges public/community services if needed

Patient & Caregiver Return Home with Transition Plan
- Bridge Care Coordinator completes 2-Day Bridge Assessment with client or caregiver
- Bridge Care Coordinator follows-up with Transitional Care Team
- Additional referrals to SNF/other community resources as needed

2 Day Post-Discharge Assessment
- Bridge Care Coordinator completes 2 Week Bridge Assessment with client or caregiver
- Bridge Care Coordinator follows-up with Transitional Care Team
- Additional referrals to SNF/other community resources as needed

2 Week Post-Discharge Assessment
- Bridge Care Coordinator completes 30 Day Bridge Assessment with client or caregiver
- Bridge Care Coordinator follows-up with Transitional Care Team
- Additional referrals to community resources as needed
- Transitioned back to community

30 Day Post-Discharge Assessment

Case Example: Nursing Home
Bridge SNF Collaboration Pre-Discharge

- **Patient Discharging from Hospital**
  - Ophthalmology’s perspective
    - PCP’s perspective
  - BCC Task: Coordinate transportation and logistics for 2 day post-discharge assessment with son
    - Patient & caregiver return home with transitional plan
      - 2 day post-discharge assessment with son
        - BCC confirms start of HHC, DME received
          - Son comfortable with medication management, delivery service in place
          - Transportation and follow up appointments remain problematic
          - Homemaker services and Meals on Wheels undecided
          - Discussed caregiver stress
            - Overwhelmed, but dedicated to care giving
              - Has limited support
                - Ambivalent about accepting support
                - Son and pt enmeshed
                  - Pt has dominant power dynamic over son
            - Encouraged self-care, support of friends and family
          - CCU has referral, but pt declined services
        - BCC contacts CCU to check status of homemaker services
      - Bridge Assessment
        - SNF TCT provides feedback to BCC about pt adjustment to SNF
          - Pt is in their Cardiac Care Program d/t CAD
          - No history of home health care or homemaker services
          - Strengths: well established with Rush PCP, pt articulate
          - DME: walker
          - ADL/IADL: s/p fall, total assistance, non-ambulatory, L knee pain, anxiety during tx noted, obese, blind
          - PMH: DM II, CAD, s/p CABG, renal insufficiency, hx MVA
          - Reason for hospital admission: R eye globe rupture d/t fall and hyperkalemia
            - Lives in a house with son; son primary caregiver and supportive
          - SNF liaison assesses pt, alerts BCC of eventual SNF admission
            - BCC reviews medical record for relevant medical and social determinants that may impact care or safety
            - BCC notes: ADL, pain, non-ambulatory, lack caregiver support
              - Pt strengthens pt’s support of son, pt well connected to provider

Bridge SNF Collaboration Post Discharge

- **Patient & caregiver return home with transitional plan**
  - 2 day post-discharge assessment with son
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HHC SW assessment

- No CDOA contact yet or SOC for homemaker, Meals on Wheels
- Discuss caregiver situation
- Limited mobility remains barrier to medical appointment
- Son managing pt’s care needs well
- BCC contacts CCU to check status of homemaker referral
  - CCU has referral, but pt declined services
  - BCC discusses with son and pt, they decline
    - She doesn’t want, he insists he’ll manage
  - Transportation: concerning due to immobility
  - Mental Health: anxiety with therapy, frustration with health situation and prognosis, home psychotherapy service recommended, pt ambivalent
  - Financial Situation: no needs identified

Case Example:

**2 Day Post-Discharge Interventions**

- BCC Task: Coordinate transportation and logistics for two follow-up appointments
  - Son states pt needs transportation via a stretcher
  - Can she tolerate movement and long duration of appointments?
  - Can the out-patient office spaces accommodate stretcher?
- PCP’s perspective
  - Cannot assist in moving patient off stretcher
  - PCP recommends visiting MD
- Ophthalmology’s perspective
  - Office space cannot accommodate stretcher
  - Ophthalmologist states appointment can wait, is not urgent

**Case Example:**

**HHC PT’s perspective and relationship!**

- Therapy Updates: reluctant, unable to ambulate, requires man to total assistance, services pain, anxiety, fear of falls, cramping and scheduled pain medications help
- Caregiver Needs: SNF TCT is not realistic, referral for homemaker services and Meals on Wheels needed
- Home Health Care: patient agrees to use Bridge affiliated HHC agency, pt met w/ HHC liaison prior to SNF discharge; RO, PT, OT, SW, home health aid ordered
- DME Ordered: Hoyer lift, hospital bed, commode, and wheel chair
- Medications: 20+ meds which son manages, agrees to home delivery service
- Physician Appointments: home physician recommended for PCP, however pt declines as she has long time relationship with PCP
  - Needs ophthalmologist follow up as well
  - Transportation: concerning due to immobility
  - Mental Health: anxiety with therapy, frustration with heath situation and prognosis, home psychotherapy service recommended, pt ambivalent
  - Financial Situation: no needs identified

**Case Example:**

**SNF Interdisciplinary Transition Huddle: weekly phone conference call includes BCC, SNF Social Worker and Speech Therapist**

- 8/19/2013
Case Example: 2 Week Post-Discharge Intervention
• BCC and HHC SW continue to communicate and monitor
  • BCC re-contacts son
    o Son would like homemaker, but she does not
    • Son honest, more reflective about his limitations
    • Encouraged limit setting with patient
    o He vacillates: "Pretend like my needs don’t exist."
    • Patient with dominant power dynamic over son
    • Son not yet ready for change
      o He is contemplating change but is not yet determined
      • Unclear why: emotional, financial, neglect/abuse?
      o Son informed of caregiver support options, should he like
      o He is welcome to re-contact BCC in the future
  • BCC updates SNF TCT

Case Example: 30 Day Post-Discharge Assessment
• Telephonic call made by colleague who spoke with son
  • Situation stable, HHC still following although less frequently
  • Son has no further requests or concerns

Thank You!
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Questions?