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 completed both her bachelor's and master's degrees in social work focusing on aging and mental health.

- 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
    - *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*)

The Bridge Model: A Social Work Approach to Transitional Care

- Operates systemically to best navigate and problem solve patient needs
- Strengths focus looks at patients holistically
- 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

Collaboration/Partnership: Concept and Action

- 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

Collaboration in Social Work Practice, edited by Jenny Weinstein, Colin Whittington, and Tony Leiba, Jessica Kinglsey Publishers Ltd, London, England, 2003

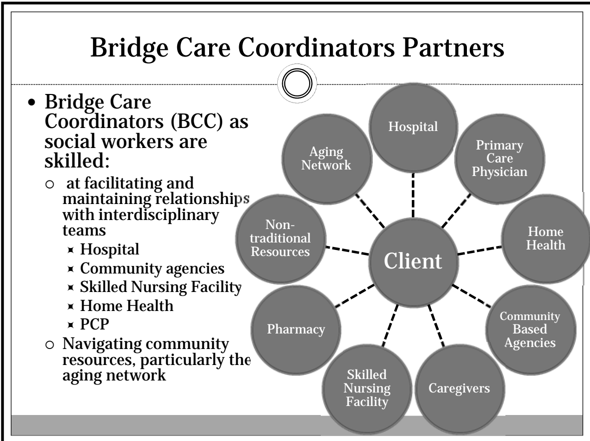
Continuum of Collaboration

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

Working with Older People, by Denise Tanner and John Harris, Routeledge, New York, NY, 2008.

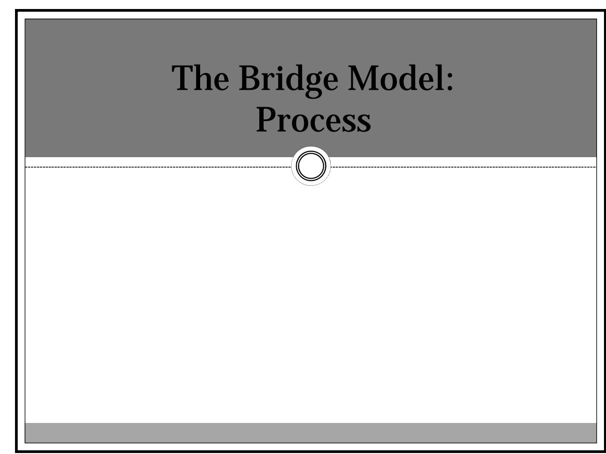
Bridge Program and Value of Partnerships

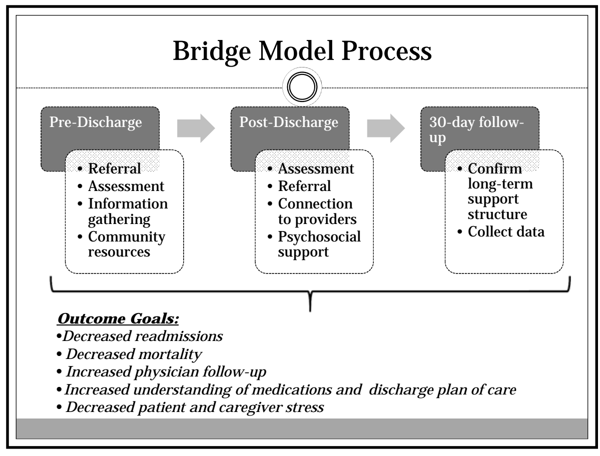
- Partnerships are a fundamental component of the Bridge Model
  - Patients do not live in the hospital or short-term rehabilitation facility
    - They live in homes, communities, long-term care SNF's
    - The plan of care is only as good as the receiver's ability to actualize it
    - How does one 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*

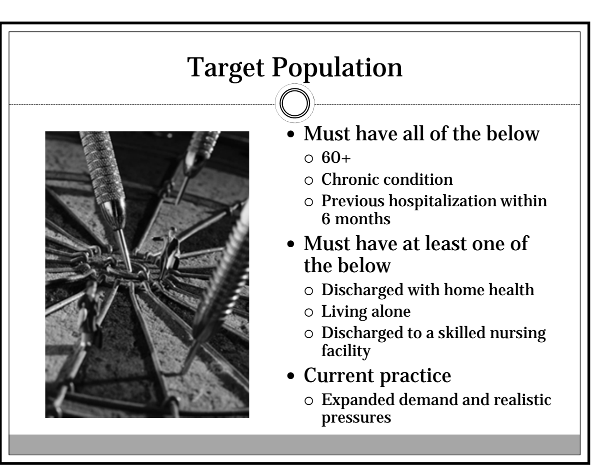


Partnership Development Tips

- 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







Intervention Focus

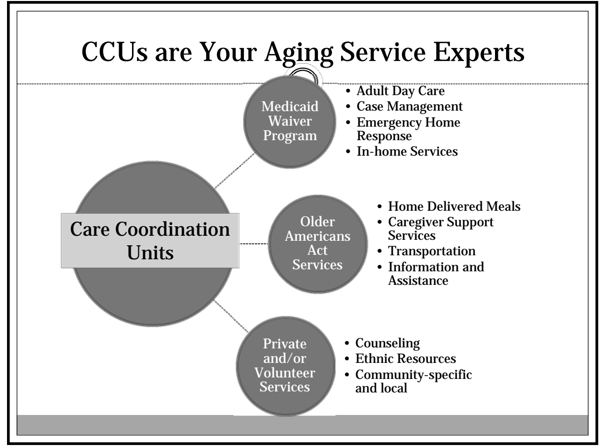
- Ensure patients/caregivers understand and can access the discharge plan of care
- Connect patients to their health care providers and community-based services and facilitate communication
- Provide support, information and resources to patients/caregivers
- Assess for safety and stability of home situation, 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

- AoA • Administration on Aging & Older Americans Act
- SUA • State Unit on Aging
- AAA • Area Agency on Aging
- CCU • Care Coordination Unit (Unique to Illinois)

CCUs are Your Aging Service Experts



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.

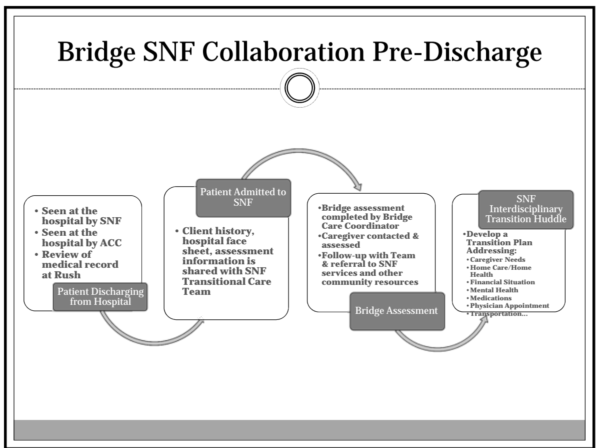
The Bridge Setting at Rush University Medical Center

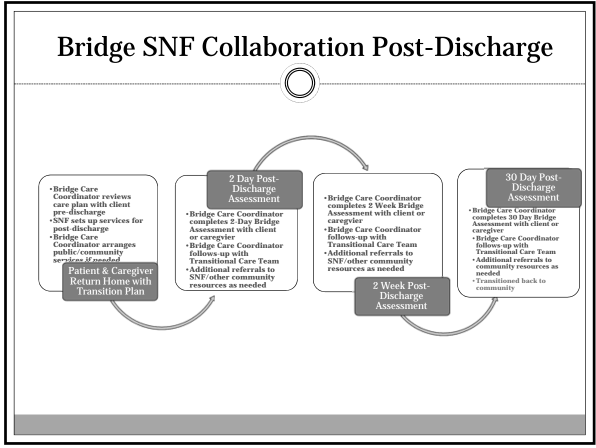
- Large urban hospital with 676 beds, 27 care units
- Hospital located in diverse neighborhood of Chicago
- Resource centers available to patients and family members: Anne Byron Waud Resource Center and the Tower Resource Center
- Diverse socioeconomic, cultural, racial and ethnic attitudes and educational 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





Case Example: Nursing Home

Case Example: Bridge SNF Collaboration Pre-Discharge

- Patient Discharging from Hospital
  - 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: falls, pain, non-ambulatory, blind, caregiver support
    - Pt Strengths: pt articulate, support of son, pt well connected to providers
- Patient Discharging to SNF
  - BCC communicates medical record review and assessment to SNF Transitional Care Team (SNF TCT)
    - 81 y/o African American woman, from west side of Chicago
    - Lives in a house with son; son primary caregiver and supportive
    - Reason for hospital admission: R eye globe rupture d/t fall and hyperkalemia
    - PMH: DM II, CAD, s/p CABG, renal insufficiency, hx MVA
    - ADL/IADL: s/p fall, total assistance, non-ambulatory, L knee pain, anxiety during tx noted, obese, blind
    - DME: walker
    - Strengths: well established with Rush PCP, pt articulate
    - No history of home health care or homemaker services
- Bridge Assessment
  - SNF TCT provide feedback to BCC about pt adjustment to SNF
    - Pt in their Cardiac Care Program d/t CAD
  - BCC calls son; he is visits pt daily, is very committed, anticipates her coming home, acknowledges care giving challenges, is open to assistance, pt w/ leg pain d/t MVA from years ago, blindness new

Case Example: Bridge SNF Collaboration Pre-Discharge

- SNF Interdisciplinary Transition Huddle: weekly phone conference call includes BCC, SNF Social Worker and Speech Therapist
  - **Therapy Updates**: reluctance , unable to ambulate, requires max to total assistance, barriers- pain, anxiety, fear of falls; coaxing and scheduled pain medications help
  - **Caregiver Needs**: SNF TCT feel son is not realistic, referral for homemaker services and meals on wheels placed
  - **Home Health Care**: patient agrees to use Bridge affiliated HHC agency, pt met w/ HHC liaison prior to SNF discharge; RN, 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 health situation and prognosis, home psychotherapy service recommended, pt ambivalent
  - **Financial Situation:** no needs identified

Case Example: Bridge SNF Collaboration Post Discharge

- 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

Case Example: 2 Day Post-Discharge Interventions

- 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

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: 2 Day Post-Discharge Interventions

- Patient's perspective
  - Angered by MD limitations
  - States she cannot sit up for long and cannot stand
  - Not open to visiting MD due to previous negative experience
  - Pushed her to reconsider visiting MD
- HHC PT's perspective and relationship!
  - Pt is maximal to total assistance, unable to walk, much pain
  - Requires 3-4 people to get off stretcher due to obesity
  - He has a genuinely good relationship with pt,
    - He will reinforce visiting MD instead of out-patient
- Outcome
  - HHC PT discussed visiting MD with patient who is now receptive
  - BCC makes referral, pt is seen!

Case Example: 2 Week Post-Discharge Intervention

- BCC and HHC SW continue to communicate and monitor
- BCC re-contacts son
  - Son would like homemaker, but she does not
    - Son honest, more reflective about his limitations
    - Encouraged limit setting with patient
  - He vacillates: "Pretend like my needs don't exist."
    - Patient with dominant power dynamic over son
    - Son not yet ready for change
      - He is contemplating change but is not yet determined
        - Unclear why: emotional, financial, neglect/abuse?
      - Son informed of caregiver support options, should he like
      - 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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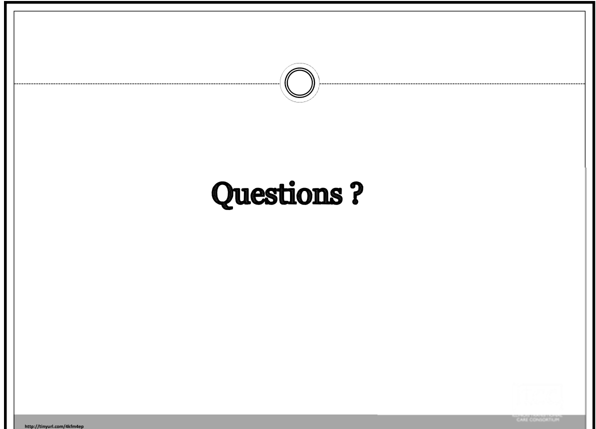

Questions ?