# THE BRIDGE MODEL

## An interdisciplinary transitional care model focused on psychosocial and community-level factors

### MAIN GOALS

1. Patient engagement and self-efficacy
2. Primary care integration
3. Appropriate use of long-term community resources
4. Medical stability

**Pre Discharge**
- Chart Review
- Interdisciplinary collaboration

**Post Discharge**
- Core Intervention

| | |
|---|---|
| Engagement | Our relationship with the patient and caregiver is at the heart of the intervention |
| Assessment | A comprehensive assessment to identify strengths and barriers to health outcomes |
| Care Planning | A form and process to help focus intervention efficacy |
| Care Management | Care coordination, case management, patient engagement and provider engagement |
| Goal Attainment | A focus on the four main Bridge goals |

## A FLEXIBLE & ADAPTABLE PROCESS

Bridge has served the following populations:

- Older adults and caregivers
- Medicaid beneficiaries
- Super-utilizers
- Patients with dementia/ADRDs

Over 100 sites have been trained:

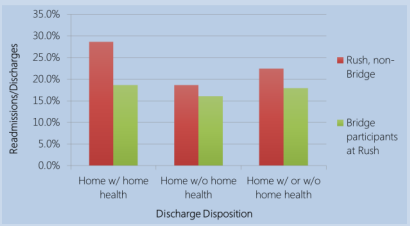
- Hospitals/hospital systems
- Community-based organizations
- Home Health agencies
- Skilled Nursing Facilities
- FQHCs

## AN EVIDENCE-BASED APPROACH WITH POSITIVE RESULTS

### Journal of the American Geriatrics Society Analysis by Boutwell et al. (2016)

*Largest site of implementation*
*n = 1,546*
*March 2013—Feb. 2014*

Compared to the IL average, a **20% reduction in all-cause 30-day readmissions,** regardless of diagnosis or comorbidities was found.




### Community-based Care Transitions Program (CCTP): A Medicare Demonstration

*6 hospitals in Chicagoland area*
*n = 5,753*
*May 2012—April 2014*

Recognized as an evidence-based by the **Administration for Community Living** and the **Agency for Healthcare Research and Quality**.

Readmission reduction per Medicare FFS analysis:
- 30-day: 30.7%
- 60-day: 9.4%
- 90-day: 13.9%

### "Super-utilizer" pilot of Medicare beneficiaries with 5+ hospitalizations

*Largest site of implementation*
*n = 456*
*June 2014—May 2015*

**Statistically significant** reductions in admissions, 30-day readmissions, Emergency Department visits and No-Shows.

| Variable | Pre-Intervention n or Mean % or ± SD n = 456 | Post-Intervention n or Mean % or ± SD n = 456 |
|---|---|---|
| # of Admissions | 2.52 ± 1.79 | 1.25 ± 1.67 |
| 30-day Readmission Rate | 29.1% ± 34.3% | 11.3% ± 24.0% |
| # of ED visits | 2.39 ± 2.64 | 1.52 ± 2.15 |
| # of no-shows | 4.05 ± 5.35 | 3.25 ± 5.11 |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