Bridge Transitional Care Partnership

AgeOptions, Aging Care Connections, Health and Medicine Policy Research Group, Kenneth Young Center, North Shore Senior Center, PLOWS Council on Aging, Rush University Older Adult Programs and Solutions for Care in partnership with Adventist LaGrange Memorial Hospital, Advocate Lutheran General, MacNeal Hospital, Palos Hospital, Rush University Medical Center and St. Alexius Medical Center

OUR COLLABORATION

AgeOptions has partnered with the following six Bridge Coordinating Agencies to serve six hospitals in the Chicagoland area.

Bridge Coordinating Agency	Hospital
Aging Care Connections	Adventist La Grange Memorial Hospital
Kenneth Young Center	St. Alexius Medical Center
North Shore Senior Center	Advocate Lutheran General
PLOWS Council on Aging	Palos Hospital
Rush University Older Adult Programs	Rush University Medical Center
Solutions for Care	MacNeal Hospital

Additional technical assistance will be provided by Health and Medicine Policy Research Group.

OUR TARGET POPULATION

The Bridge Transitional Care Partnership will target Medicare beneficiaries 60+ years old with multiple chronic conditions and at least one of the following:

- Discharged with home health
- Living alone
- Discharged to a partnering skilled nursing facility

OUR PREVIOUS EXPERIENCE

AgeOptions and the Bridge Coordinating Agencies have extensive experience with transitional care coordination. Most Bridge Coordinating Agencies provide care transition services and conduct hospital-based nursing home pre-screening in their role as Illinois Care Coordination Units.

AgeOptions, with our disability partner Progress Center for Independent Living, is the Aging and Disability Resource Center (ADRC) for suburban Cook County, Illinois. Through our ongoing ADRC Care Transitions grant, Aging Care Connections, Rush University Older Adult Programs and Solutions for Care have provided care transitions assistance to over 1,500 people.

OUR COMMUNITY

The Bridge Transitional Care Partnership is providing care transitions services in portions of Chicago, and the Southwest, North and Northwest suburbs of Cook County.

Partner hospitals are located in:

- Berwyn
- Chicago
- Hoffman Estates
- LaGrange
- Palos Heights
- Park Ridge

OUR IMPLEMENTATION STRATEGY

The Bridge Transitional Care Partnership will utilize the Bridge Model (Bridge), an evidence-based transitional care model. Bridge was developed and refined by two agencies in this partnership: Rush University Medical Center Older Adult Programs and Aging Care Connections.

Bridge primarily focuses on addressing barriers to successful discharge plan implementation; these barriers can result in hospital readmissions. Bridge provides transitional care through intensive care coordination that starts in the hospital and continues after discharge. Each Bridge Coordinating Agency employs Master's prepared social workers.

Bridge consists of three intervention phases:

1. **Pre-discharge:** An in-hospital assessment to identify unmet needs and to set up community-based services (including medical provider linkages) prior to discharge.
2. **Post-discharge:** Secondary assessment made via phone call two days after discharge to identify and intervene on additional identified needs.
3. **Follow-up:** Conducted thirty days post-discharge to track participant's progress, address any emerging needs and provide final linkages to community resources.

Additional services will be available to select beneficiaries including:

- Transportation to follow-up medical appointments
- In-home medication reconciliation conducted by a home health nurse