Philadelphia Bridge Care Transition Program
North Philadelphia Safety Net Partnership:

Philadelphia Corporation for Aging (PCA)
Einstein Medical Center Philadelphia (EMCP)
Temple University Hospital (TUH)

PCA
PHILADELPHIA CORPORATION FOR AGING
Enriching lives, preserving dignity.™

Einstein HEALTHCARE NETWORK

Temple University Hospital

OUR COLLABORATION

Partners include two safety net hospitals in North Philadelphia:

- Einstein Medical Center Philadelphia (EMCP) and Temple University Hospital (TUH).
- Although both hospitals are in the 4th quartile for readmissions, they have already met some success reducing readmissions using BOOST (EMCP) and RED (TUH), two evidenced-based models of CCTP.

OUR PREVIOUS EXPERIENCE

- PCA is the Area Agency on Aging for the County of Philadelphia
- PCA has 35 years experience in providing assessment and care management services to older adults and people with disabilities.
- PCA currently serves 15,000 consumers through Pennsylvania's Long Term Services and Supports (LTSS) programs.
- PCA works with hospitals throughout the region to transition consumers back to the community.
- PCA has provided Nursing Home Transition services for 8 years.

OUR COMMUNITY

OUR TARGET POPULATION

- Medicare FFS all-cause hospital discharges to home in 12 designated zip codes.
- Disproportionate prevalence of health problems: 24.4% have CVD, 35% have diabetes, 75.1% diagnosed with high blood pressure; these figures exceed the national average.
- 80% of TUH and Einstein patients are impoverished and beneficiaries of entitlement and social programs.
- Social determinants account for 40% to 50% of hospital readmissions nationally.

OUR IMPLEMENTATION STRATEGY

PCA will use the Bridge Model of CCTP, developed by the Illinois Transitional Care Consortium (ITCC).

- Bridge was selected because it is a Social Work model and it emphasizes a Strength-based approach to transitional care.
- Patients will be referred by the hospitals' Navigators, who will also introduce the Bridge Care Coordinator (BCC) during a pre-discharge, face-to-face visit.
- Prior to discharge, medications will be reconciled and appointments will be scheduled for follow-up medical care.
- Upon discharge, the BCC will conduct home visits and/or telephone calls to assure the discharge plan is carried out, including visits to the PCP, medication management, and other home care needs.
- The scope and intensity of the care plan will be determined by the patients' level of *Patient Activation Measurement* (PAM) and the BCC's needs assessment.
- The BCC will also assist patients with information and referral to community resources and / or entitlement programs.
- Approximately 10% of the participants, who have no other resources, will receive a "brief service" package, including home delivered meals and/or transportation vouchers.
- For those participants who may benefit from and/or are currently receiving LTSS, the BCC will either conduct the Level of Care Assessment for LTSS programs or coordinate with the participants' Care Manager or Service Coordinator.