CHaSCI

Center for Health and Social Care Integration @ Rush

advancing practices & policies that break down barriers to health

The Center for Health and Social Care Integration (CHaSCI) promotes heath equity and helps transform complex healthcare system through training, technical assistance, the CHaSCI community, and policy advocacy. CHaSCI has been engaged in developing and researching practice models that advance these goals since 2005.

Our care models integrate social workers into interprofessional teams in order to address social risk factors and social needs, improve patient engagement, and improve quality of life for patients, families, and communities:

Bridge Model of transitional care

The Bridge Model uses social workers to provide care management to support adults with complex medical and social needs as they transition from the hospital or a skilled rehab stay. Bridge leverages care coordination and therapeutic techniques to increase patient activation and support medical stability after returning home.

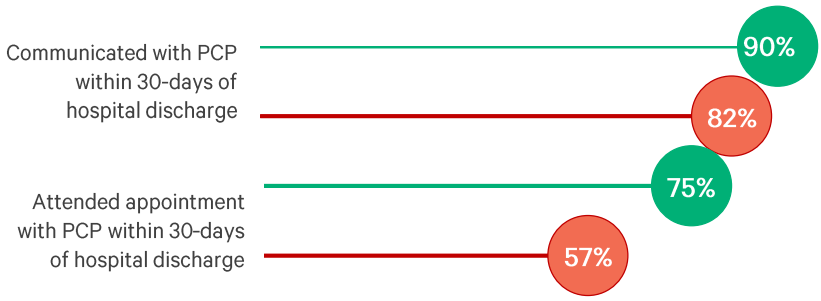
AIMS (Ambulatory Integration of the Medical & Social)

The AIMS model integrates social workers into primary and specialty care teams to support individuals and families with chronic care and social needs. AIMS social workers use CHaSCI's standardized protocol to assess and address complex issues impacting people's care plan adherence, health status, and quality of life.

Our research has demonstrated that introducing care management into traditional health care settings can improve physical and mental health and reduce utilization and cost of services. We have also demonstrated increased patient engagement and primary care follow up, as well as patient and provider satisfaction. The following reports are research findings comparing **intervention recipients (in green)** with various **comparison/control groups (in orange)**.

Utilization and Cost

Bridge recipients had increased primary care engagement within 30 days of hospital discharge



- n=720, 2009, randomized control trial

Altfeld SJ, Shier GE, Rooney M, et al. Effects of an enhanced discharge planning intervention for hospitalized older adults. A randomized trial. Gerontologist. 2013;53(3):430-440.

Bridge recipients had 20% fewer readmissions vs. hospital and state comparison populations

"A major strength of the model includes repeated assessments, customized interventions, and the ability to link individuals to existing community providers and services.

Providers, payers, and policy-makers may find the social work–based transitional care model of interest, particularly with regard to better addressing social and economic needs of urban, rural, dually eligible, and adult Medicaid populations"

- Boutwell, 2016

- n= 6,824, 2013-14, retrospective comparison

Boutwell AE, Johnson MB, Watkins R. Analysis of a Social Work-Based model of Transitional care to reduce hospital readmissions: Preliminary data. J Am Geriatr Soc. 2016;64(5):1104-1107.

Legend

Intervention

Comparison

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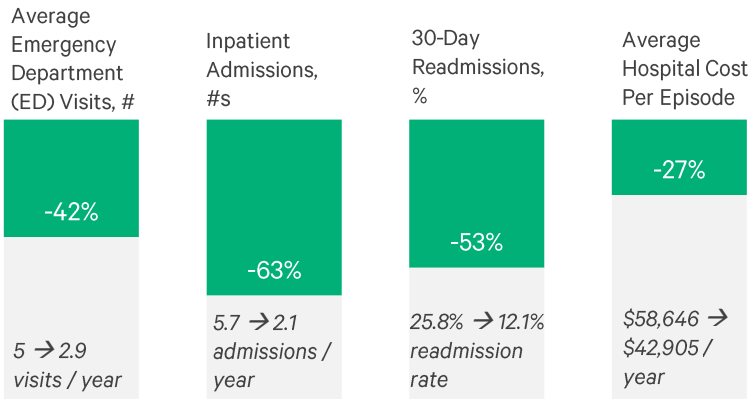
Utilization decreases significantly among high utilizers within 12-months of initiating Bridge intervention

Percent decrease, comparing 12 months before intervention vs. after



- n=586, 2015-16, pre-post comparison among individuals with 5+ admissions in previous year

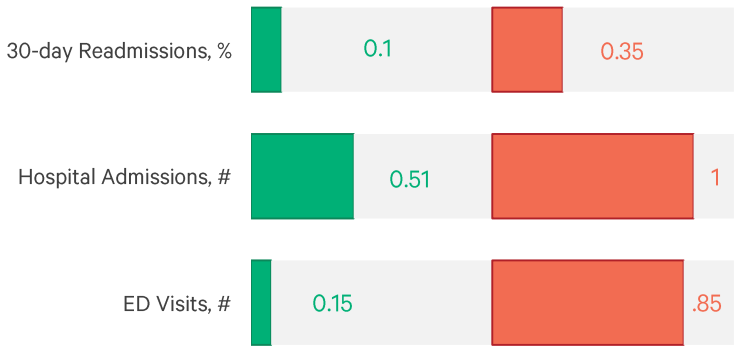
Xiang X, Zuverink A, Rosenberg W, Mahmoudi E. Social work-based transitional care intervention for super utilizers of medical care: a retrospective analysis of the bridge model for super utilizers. Social work in health care. 2019 Jan 2;58(1):126-41

Community-driven Bridge program also sees reductions in readmissions: COPD example

- Aging Care Connections, a community-based organization, partnered with a large hospital system to reduce 30-day readmissions for patients with COPD — an example of the CHaSCI care model being applied to a disease specific approach but also being driven by a community-based organization in collaboration with hospital.
- n=118, 2015-16, comparison of institution's COPD rates before and after Bridge offering

Telligen Squire Report.2017. https://www.telligenqinqio.com/news/quantifying-benefits-care-transitions/

Health service utilization across six months is lower for AIMS recipients vs. comparison group



- n=640,2010-2014, retrospective comparison vs Rush institution mean utilization rates

Rowe JM, Rizzo VM, Shier Kricke G, et al. The ambulatory integration of medical and social (AIMS) model: A retrospective evaluation. Soc Work Health Care. 2016;55(5)347-361

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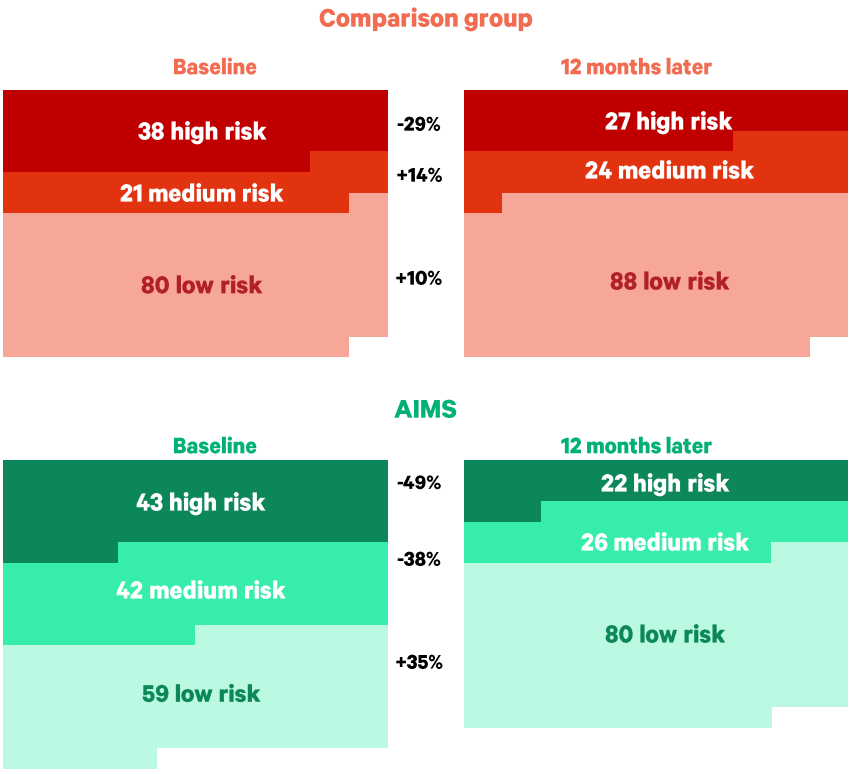
Patient-Centered Findings

AIMS recipients more likely to experience reduced health risk than comparison individuals

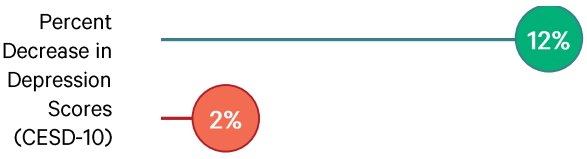


Number of participants in each health risk assessment score category, with percentage change in individuals scoring in given risk category, at baseline and 1 year after study enrollment

- Following a quasi-experimental study of the AIMS model, researchers identified that AIMS recipients experienced a significant reduction in their health risk assessment scores—a standardized instrument used to determine a patient's risk based on health status and habits. Participants were categorized as high risk, medium risk, or low risk, based on their assessment scores using a Medicaid managed care organization's standardized Health Risk Assessment tool.
- N=340, 2015-17, quasi-experimental

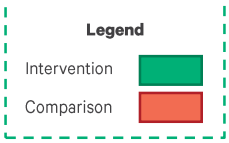
Manuscript in publication process. Study funded by The Commonwealth Fund.

AIMS Intervention contributes to drop in depression scores after 6 months



- The same two-year quasi-experimental study showed that patients who received care from an AIMS social worker experienced a larger decrease in their depression scores that those in usual care. n=340, 2015-17, quasi-experimental

ıwe, J, Rizzo, V, Kang, S.Y, Kukowski, R, Ewald, B, Newman, M, Golden, R. ıne Contribution of Social Workers in Care Management: Value for Older ılults. Wolters Kluwer Health, inc. 2019:24(6),306-216



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Providers' Perspectives on Addressing Social Needs

85% Agree "When unable to address my patients' social needs, they are at risk of negative outcomes"

79% Agree "Addressing unmet non-medical needs takes time from addressing patients' health care needs"

76% Agree "Unmet non-medical needs prevent from providing quality care"

70% Disagree "I am well informed about most of the resources available to address patients' unmet social needs"

88% Disagree "I am personally prepared to address my patients' social needs on my own"

- n=69, Survey of physicians, nurse practitioners, nurses, physician assistants, clinic coordinators, and medical assistants re: impacts on practice and job satisfaction

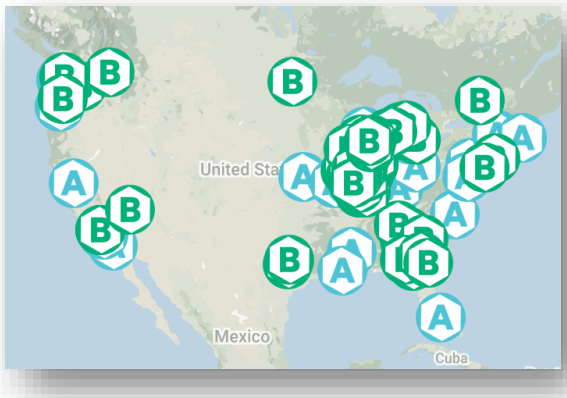
Internal study funded by The Commonwealth Fund.

Key Learnings from Replication Sites

Over 150 healthcare and community-based organizations (CBOs) have been trained in Bridge and AIMS since 2010.

To learn from their experience and strategies for success, we conducted semi-structured interviews with clinical supervisors from 13 CBOs were trained between 2012 and 2015. Key learnings included:

- **Identify champions from health care leadership**
- **Aim for contractual agreements w/ partners** (Helps to avoid obstacles due to staff turnover or acquisition)
- **Make sure program leaders understand changes in payment models**
- **Diversify funding**
- **Develop plan for evaluation and quality improvement from beginning – and invest in data platforms to enable it**
- **Nurture internal champions** (Helps to grow program and avoid staff turnover with innovative roles)
- **Clinical supervision helps strengthen social work therapeutic skills as part of intervention**



Xiang X, Robinson-Lane SG, Rosenberg W, Alvarez R. Implementing and sustaining evidence-based practice in health care: The bridge model experience.*Journal of gerontological social work.* 2018;61(3):280-294.