WellSpan Bridges to Health

Over 50% of health care spending in the United States is for the treatment of just 5% of patients[1]. Within Pennsylvania's Medicaid program, this would equate to the care for 90,000 individuals costing over $5.5 billion annually. WellSpan's Bridges to Health program has successfully improved the quality of care for this vulnerable patient population while drastically reducing the cost of that care.

The program, which began in 2012, now has more 80 alumni, the majority of whom are Medicaid enrollees, whose utilization of inpatient and emergency department services has decreased by 32%. This has resulted in a savings of over $30,000 per year, per patient.

Program Description

Bridges to Health (BTH) is an intensive primary care program that breaks down traditional barriers and siloes to create holistic patient-centered care that matches each patient's unique set of medical needs with an interdisciplinary medical team. Patients who have chronic conditions and other medical and psychological diagnoses often rely heavily on expensive inpatient and emergency department services. Their physical health and mental health problems are often interrelated, yet their care has historically not been managed by a single, synchronized team. Although the emergency department or an inpatient stay may be able to address their health needs during a particular episode, these patients require ongoing care management in order to restore their health.

BTH is interactive with all facets of the Patient-centered Medical Neighborhood. The BTH team includes a physician, nurse practitioner, nurse case manager, health coach, social worker, counselor, and embedded county behavioral health navigator. The team has access to a dietitian, pharmacist, and financial case worker. BTH also has ongoing collaboration with WellSpan's therapeutic rehabilitation services, nursing, and complementary medicine services (massage, acupuncture, etc.). Each of these team members works collectively to identify the unique needs of each patient, develop a care management plan to address those needs, and seamlessly implement that plan.

The BTH team puts the patient first. They recruit each patient at their Patient-centered Medical Home with a "warm hand-off" by the patient's primary care physician and then an initial roundtable discussion with the patient to develop patient-generated goals. Following enrollment,

---

[1] http://www.nationaljournal.com/healthcare/report-5-percent-of-people-account-for-half-of-u-s-health-care-spending-20110627

the BTH team meets with the patient in their home to complete a psycho-social and medical home assessment. The findings and goals are established within a Shared Care Plan.

When a patient is enrolled in BTH, he or she has routine scheduled appointments on about a monthly basis with the physician. BTH team members navigate key specialist appointments with the patient to ensure coordination of care. Transition of care appointments occur within seven days of being discharged from the hospital and ongoing communication occurs with hospital staff. BTH team members have daily interdisciplinary team huddles to discuss the patients' plans of care.

The BTH goal is to transition the patient to a more traditional primary care practice once a functional and sustainable care plan has been implemented. In most cases, the patient returns to their previous practice while being accompanied by a BTH team member to give a warm hand off back to the primary care physician.

Since the program began in 2012, the program has cared for more than 80 patients, the majority of whom are Medicaid enrollees, whose utilization of inpatient and emergency department services has decreased by 32%. This has resulted in a savings of over $30,000 per year, per patient.

Bridges has the goal of obtaining the Triple Aim:

- Better Health for patients enrolled in the program
- Better health for the population though learning how to better engage patients – sharing this knowledge across more than 90 sites of care in WellSpan
- Lower costs for society by avoiding unnecessary care in the emergency department and hospital and improving the patient's ability to navigate the healthcare system to get the right care at the right time in the right setting

WellSpan along with four other regional health systems published a nationally acclaimed White Paper on our SuperUtilizer work that combined data on more than 400 patients confirming WellSpan's experience of decreased cost of care – while improving patient's experiences. **The programs estimate that more than 4,000 days of hospital admissions and $3 million in avoided costs have resulted from our work with patients.** At the same time we have learned, and are now sharing nationwide, the importance of building trusting relationships with patients – particularly through home visits and the role that early childhood emotional trauma can play on medical utilization and heath later in life.

A copy of our SuperUtilizer white paper showing over a million dollars in cost savings for the care of just 138 patients can be found here:
http://www.aligning4healthpa.org/news.aspx?pageid=14933

For more information on WellSpan's Bridges to Health, please contact Chris Echterling, M.D., medical director for vulnerable populations, WellSpan Medical Group, at 717-851-5459.