Commentary on the “Bridges to Health” Model

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The complex U.S. health system is currently organized around the needs and interests of providers. The “Bridges to Health” model offers a way to think about developing programs for segments of the population that meet patients’ needs for coordinated, integrated care. When these programs are aggregated, they should improve the quality and efficiency of care for the entire population. Three examples are given to illustrate the possibility of conceptualizing integrated care and its advantages.

Keywords: Population segmentation, coordination of care, integration of care.

DESPITE THE BEST EFFORTS OF ITS HIGHLY TRAINED and industrious workforce, the U.S. health care system performs poorly: access is inequitable; care is expensive; resources are used inefficiently; and quality is uneven (Schoen et al. 2006). According to the Commonwealth Fund’s Commission on a High Performance Health System, the overarching purpose of a country’s health care system is to achieve, to the greatest extent possible, long, healthy, and productive lives for everyone. Doing so requires access for all, effective and efficient processes of care, and a workforce and health care system capable of and dedicated to innovation and improvement (2006). The key to getting there is delivering care through models that emphasize far more coordination and integration than we have now, increasing transparency, rewarding quality and efficiency, and expanding the use of information technology and exchange.

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The U.S. health system is complex. As Lynn and her colleagues note, it currently is organized around the needs and interests of institutional and individual providers: hospitals, long-term care facilities, ambulatory facilities, and physicians and their practices (2007). Payment policies generally favor this segmentation, with the result being progressively more fragmented and inefficient care. By developing the “Bridges to Health” model and thinking about a logical grouping of subpopulations, Lynn and colleagues offer a structure for conceptualizing the process of redesigning U.S. health delivery to serve the varying needs of population subgroups as well as those of the entire population. The model is simple, elegant, and powerful. Some health care providers whose thinking is consistent with the “Bridges to Health” model already are considering or actually redesigning care processes. Three examples are given next.

Michael Porter and Elizabeth Teisberg argue that health care competition is “at the wrong level” and needs to be redefined so that it is about providing “value for customers, or the quality of products or services relative to their price” and “leads to relentless improvements in efficiency” (2006). For example, for a patient with increasing hip pain who needs a hip replacement, the currently billable units such as physician visits and operating room charges do not fit the design of an effective, efficient, and coordinated care system that will enable the patient to achieve excellent and painless function in a few months. Instead, Porter and Teisberg want to establish a competition among care systems or programs to provide excellent outcomes at the lowest cost. Others health care providers are now defining episodes of care in order to devise reporting and payment systems that support the kind of competition just described.¹

For many years, through its Department of Aging and Disabilities, Vermont has been providing better, more effective, and more efficient services to the elderly (Wasserman 2004). To do so, for the past decade the state has been shifting resources from institutional long-term care facilities to community and home-based services, and in 2005, the state received a Section 1115 Medicaid waiver to continue this shift in services. The waiver allows the state to serve an expanded population who do not qualify for institutional care and who earlier would not have been eligible to receive Medicaid long-term care services (Kaiser Commission on Medicaid and the Uninsured 2006). Although the waiver has been helpful in removing some of the payment fragmentation, Lynn’s model might help Vermont and its providers continue to improve delivery to these frail elders.

David Bergman, a Stanford University pediatrician, and his colleagues have developed a plan for a high-performing system for well-child care in the United States (2006). They had to consider not only the “average” healthy young child but also those subpopulations who might live in urban or rural settings and children of different races and ethnicities. Elements of Bergman and his colleagues’ proposed system include same-day appointments, remote encounters, and home visitors; team-based care for a broad range of services; individualized developmental and behavioral screening; services providing better and culturally sensitive language access; coordination among providers to handle children with complex needs; information systems to facilitate knowledge and information; and a financing mechanism to support all these elements. Under a new grant from the Commonwealth Fund, Bergman is planning how to implement this innovative model in a health maintenance organization.²

Although these examples, and others not described here, predate the work of Lynn and her colleagues, most persons in the U.S. health system, and even the general public, have been conditioned to think in terms of the existing fragmented system. We hope that the “Bridges to Health” model will lead to more and broader thinking about developing integrated/coordinated care delivery programs and services that meet the needs of each of the populations outlined in the model. If we can then align our payment and reward systems accordingly, the U.S. health care system and our nation will be well served.

Endnotes

1. See A. Smyth, New Health Provider Compensation Method Unveiled, September 16, 2006. Available at http://www.theinsurancepolicy.com/insurance_news/evidencebased_case_rates_system/ (accessed March 10, 2007).
2. http://www.cmwf.org/grants/grants_show.htm?doc_id=422881 (accessed March 10, 2007).

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