NCHF NORTH CAROLINA HEALTHCARE FOUNDATION

THE DUKE ENDOWMENT

BRIDGE TO HEALTH MODEL

The Bridge to Health Model is a collaborative population health approach designed to proactively engage the sickest patients with complex health conditions. These highest-risk patients often have multiple chronic medical conditions, suffer from substance abuse/mental health conditions rooted in trauma and have unmet social needs related to homelessness and poverty.

This model is designed to improve health outcomes for patients with complex health conditions and reduce unnecessary hospital utilization and related health care costs by stabilizing patients within a "bridge" clinic, where they are connected to community resources and primary care medical homes. By leveraging data, collaboration, and innovative care models, health systems can improve outcomes, support payment reform, and build sustainable value-based care.

IDENTIFY

Use data to identify vulnerable, high-risk patients with frequent ER visits and admissions related to advanced medical and mental health issuesand no connection to community healthcare providers.

INTERVENE

Stabilize immediate medical and mental health needs with trauma focused care delivered by integrated care teams, while also addressing social determinants of health by connecting patients to communityresources.

CONNECT

Utilize flexible engagement methods, such as shelter/street outreach, hospital and clinic visits, telemedicine and phone outreach, with patience and perseverance.

COORDINATE

Strengthen collaboration with community safety net partners and share care plans to treat medical conditions holistically.

The six health systems highlighted below are being funded to implement the model and participate in a learning community that will share best practices and evaluate impact.