

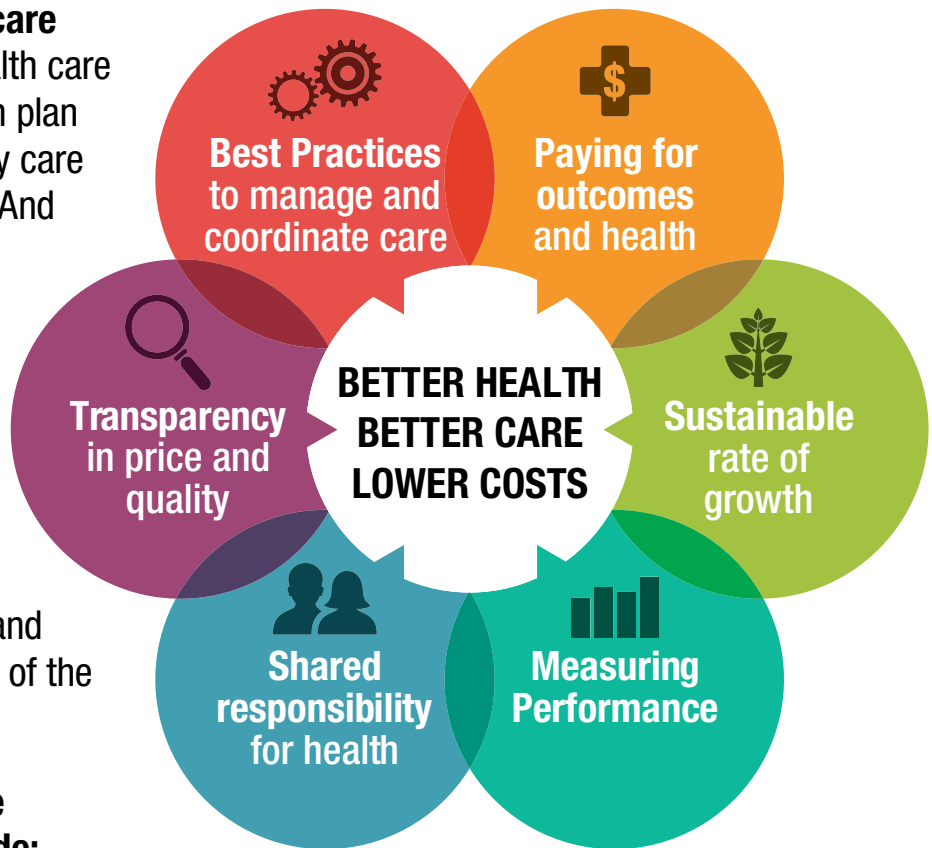
Oregon's coordinated care model

Better health, better care, lower costs: The Oregon Way

Through the coordinated care model, those paying for health care get a better value and health plan consumers get higher quality care at a price we can all afford. And Oregonians are experiencing improved, more integrated care. With a focus on primary care and prevention, health plans and their providers using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.

Oregon's coordinated care model key elements include:

-  **Best practices to manage and coordinate care**
-  **Shared responsibility for health**
-  **Transparency in price and quality**
-  **Measuring performance**
-  **Paying for outcomes and health**
-  **A sustainable rate of growth**



Separately, these elements all assist in producing better health outcomes at lower prices. When all elements are used together, they are the most effective in achieving better health, better care and lower costs.



Using best practices to manage and coordinate care

The model is built on the use of evidence-based best practices to manage and coordinate care. This produces better care, improved outcomes (including a positive patient experience) and lower costs.

Best practices include:

- Value-based benefit design that create incentives for consumers to use evidence-based services.
- These services are the most effective for cost and quality, so they cost less for consumers, their employers or purchasers, and health plans.
- Identification of a primary care clinician as the individual's regular source of care.
- Patient-centered primary care homes that provide team-based care. Care coordination through primary care homes is essential for patients with chronic health conditions.
- Behavioral, physical and dental health care integrated through evidence-based best practices. Evidence-based practices such as shared treatment plans and co-location of services are designed to maximize outcomes and efficiency, and eliminate waste.
- Providers and health systems use electronic health records and information exchange across care settings. These systems improve data accuracy, allowing for better patient care, while reducing costs associated with duplicate or unnecessary services.
- Culturally and linguistically appropriate care.

What it means for

The purchaser of health benefits

- ✓ Lower costs as the result of better quality care and better health outcomes
- ✓ A central point of contact for navigation of services

Your employees

- ✓ Higher quality care and better health outcomes
- ✓ Streamlined information sharing, due to electronic health records and care coordination
- ✓ Improved patient experience
- ✓ Prevention-focused health strategies
- ✓ Improved care coordination, especially for those with chronic health conditions

The health plan

- ✓ Providers are using evidence-based best practices
- ✓ More robust picture of members
- ✓ Information from more care delivery points is available (dental, physical, mental)
- ✓ Case management efficiencies developed



Shared responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and consumers can share responsibility and decision-making for care, while coming to joint agreements on how the individual wants to improve or maintain positive health behaviors.

Shared responsibility for health results from:

- Shared decision-making. Providers use shared decision-making as a standard of care with patients and their family members, as appropriate, as well as strategies that activate patients to take charge of their health and any chronic condition needing management.
- Health plan members taking a health risk assessment. This is one of the first key steps in becoming involved in one's own health outcomes.
- Benefits that provide incentives for preventive care and healthy behavior, and support the use of evidence based services. This can include low- and no-cost services for evidence-based screenings, well-child visits and other preventive services. Incentives can be used for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, smoking and medication use. Services that are not evidence-based would be more expensive, while evidence-based services would cost less.
- Consumer and community engagement and collaboration. Involving consumers and community members in advising health plans and practices through consumer advisory councils, and regular opportunities for feedback from consumers improves opportunities for shared responsibility for health. Additionally, collaboration with other entities such as public health, non-profits, and local government improves opportunities for shared responsibility for the health of the community.

What it means for

The purchaser of health benefits

- ✓ Cost savings achieved through healthier members and use of higher quality, evidence-based services and preventive services.
- ✓ Healthier employees who are more engaged in their health.

Your employees

- ✓ Better health through incentives, awareness and ownership of one's own health.
- ✓ Individual savings and improved health by using preventive care and evidence-based services.

The health plan

- ✓ Healthier, more involved health members.
- ✓ Cost savings achieved through healthier members and providers' use of higher quality, evidence-based services.
- ✓ Better knowledge of members' health through assessments; allow the plan to focus on interventions when and where needed.



Transparency in price and quality

Cost and quality data that is readily available, reliable and clear helps patients understand their health plan and provider choices and it helps purchasers make decisions about choosing health plans. With access to data, patients can share responsibility in their health care decisions. Increased transparency on price and quality can also lead to increased accountability.

Transparency in price and quality means:

- Transparency of prices to allow for comparisons of providers.
- Clear information about the price of specific services. This includes information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans.
- Transparency of provider performance on quality. Information on quality, patient experience, and volume is readily and clearly available to plan participants when the nationally recognized or endorsed measures of hospital and physician performance are used.

What it means for

The purchaser of health benefits

- ✓ Allows you and your employees to make decisions based on price and quality.
- ✓ Provides improved understanding of the costs of health care decisions.

Your employees

- ✓ Better health through incentives, awareness and ownership of one's own health.
- ✓ Individual savings and improved health by using preventive care and evidence-based services.

The health plan

- ✓ Allows for a more transparent view of provider performance. This information allows health plans to provide incentives for quality over quantity.
- ✓ Strategic insight into contracting.



Measure performance

Performance measurement that's consistent across health systems improves opportunities, performance, and accountability, while easing providers' reporting burden. It may also help improve the quality of care in the health system as a whole.

Successful performance measurement comes through:

- An aligned, consistent measure set. Measures are consistent across major public and private payers, including commonly defined measures in each of the following areas: access, quality, patient satisfaction, patient activation, service utilization, and cost.
- Regular analysis of information.
- Provider-level and administrator-level measurement. Performance is measured at the clinician, practice team or practice site, and organizational levels. Also, measure performance across all provider types and providers with meaningful volume for the health plan.

What it means for

The purchaser of health benefits

- ✓ Allows you and your employees to make decisions based on price and quality.

Your employees

- ✓ Informed decision-making when choosing provider and health plan.

The health plan

- ✓ Allows for a more transparent view of provider performance and with this information, allows health plans to provide incentives for quality over quantity.



Pay for outcomes and health

Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Innovative payment methods such as population and episode-based payments, and offering incentives for quality outcomes instead of volume-based fees support better care and lower costs.

Innovative ways of paying include:

- Pay providers according to performance. Providers who perform better can be paid more.
- Design payment and coverage approaches that cut waste while not diminishing quality. This includes reducing unjustified variation in payments, not paying for avoidable complications and hospital-acquired infections, or lower payments for unnecessary services.
- Support primary care. A robust primary care system is at the heart of the model; primary care payments should support both an effective primary care infrastructure and the provision of high-quality primary and preventive services.
- Increasing the proportion of total payments based on performance over time, or implementing a population-based model where the plan and providers share financial risk.

What it means for

The purchaser of health benefits

- ✓ Healthier employees. All members receive high-quality preventive health care and for those with chronic health conditions, care will be better managed.

Your employees

- ✓ High-quality preventive care.
- ✓ Team-based care helps those with chronic health conditions better manage their condition and keeps them in their best health.

The health plan

- ✓ Cost savings achieved through healthier members, use of higher quality, evidence-based services by providers, and cutting waste.
- ✓ Ability to support different payment structures for higher performing providers.



Sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Preventing a cost shift to employers, individuals, and families, and reducing inappropriate use and costs through a fixed-rate-of-growth approach is the foundation to health care transformation.

Achieving a sustainable rate of growth results from:

- Population-based contracts that include risk-adjusted annual increases in the total cost of care for services reimbursed.
- Provider contracts that include provisions that agree on rates and quality incentive payments for each contract year.

What it means for

The purchaser of health benefits

- ✓ A better understanding of health plan costs, how they'll grow over time, and the ability to budget over long periods of time.

Your employees

- ✓ Costs savings, and more affordable premiums, co-pays and co-insurance.

The health plan

- ✓ A better understanding of costs and how they'll grow over time.

