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Why Not the Best? A High Performance Health System in Oregon

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Commonwealth Fund's Commission on a High Performance Health System

Objective:

- Move the U.S. toward a higher-performing health care system that achieves better access, improved quality, and greater efficiency, with particular focus on the most vulnerable due to income, gaps in insurance coverage, race/ethnicity, health, or age



State Scorecard: Purpose and Methods

- Aims to stimulate discussion, collaboration, and policy action
- Modeled on National Scorecard
 - 5 dimensions: access, quality, avoidable hospital use and costs, equity, and healthy lives
 - Contrasts to highest performers
- Ranks states on indicators and dimensions
 - 32 indicators
 - Dimension rank based on average of indicator ranks
 - Overall rank based on average of dimension ranks
- Equity
 - Gaps for vulnerable group (income, insurance, race/ethnicity) on subset of 11 indicators



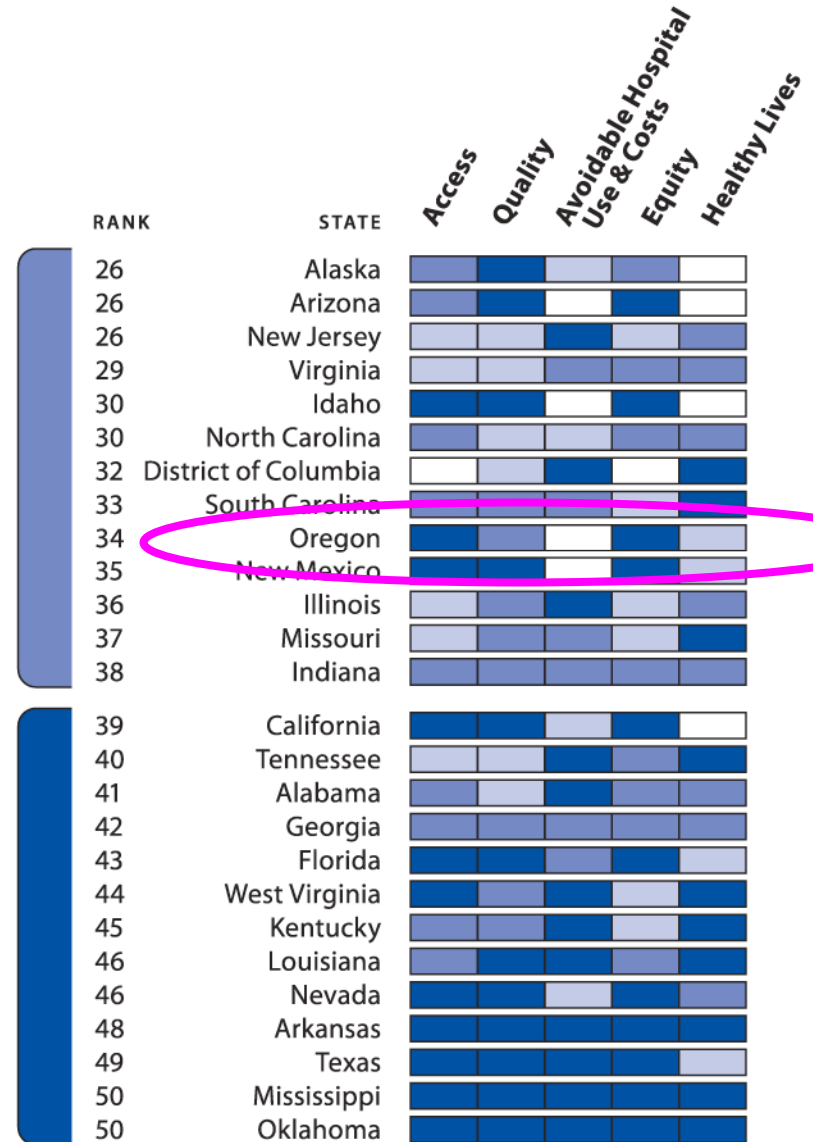
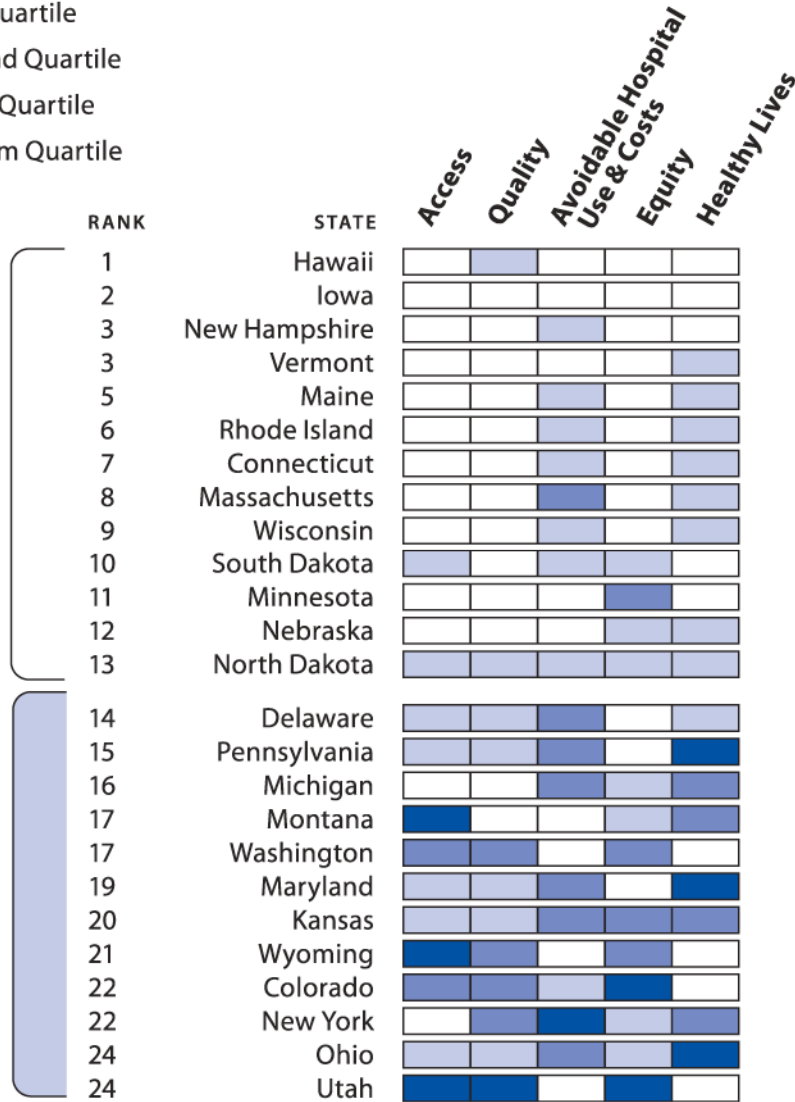
Key Findings

- **Wide variation among states, huge potential to improve**
 - Two- to three-fold differences in many indicators
 - Leaders offer benchmarks
- **Leading states consistently out-perform lagging states**
 - Suggests policies and systems linked to better performance
 - Distinct regional patterns, but also exceptions
- **Access and quality highly correlated across states**
- **Significant opportunities to address cost, quality, access**
 - Quality not associated with higher cost across states
- **All states have room to improve**
 - Even best states perform poorly on some indicators

State Scorecard Summary of Health System Performance Across Dimensions

State Rank

- Top Quartile
- Second Quartile
- Third Quartile
- Bottom Quartile



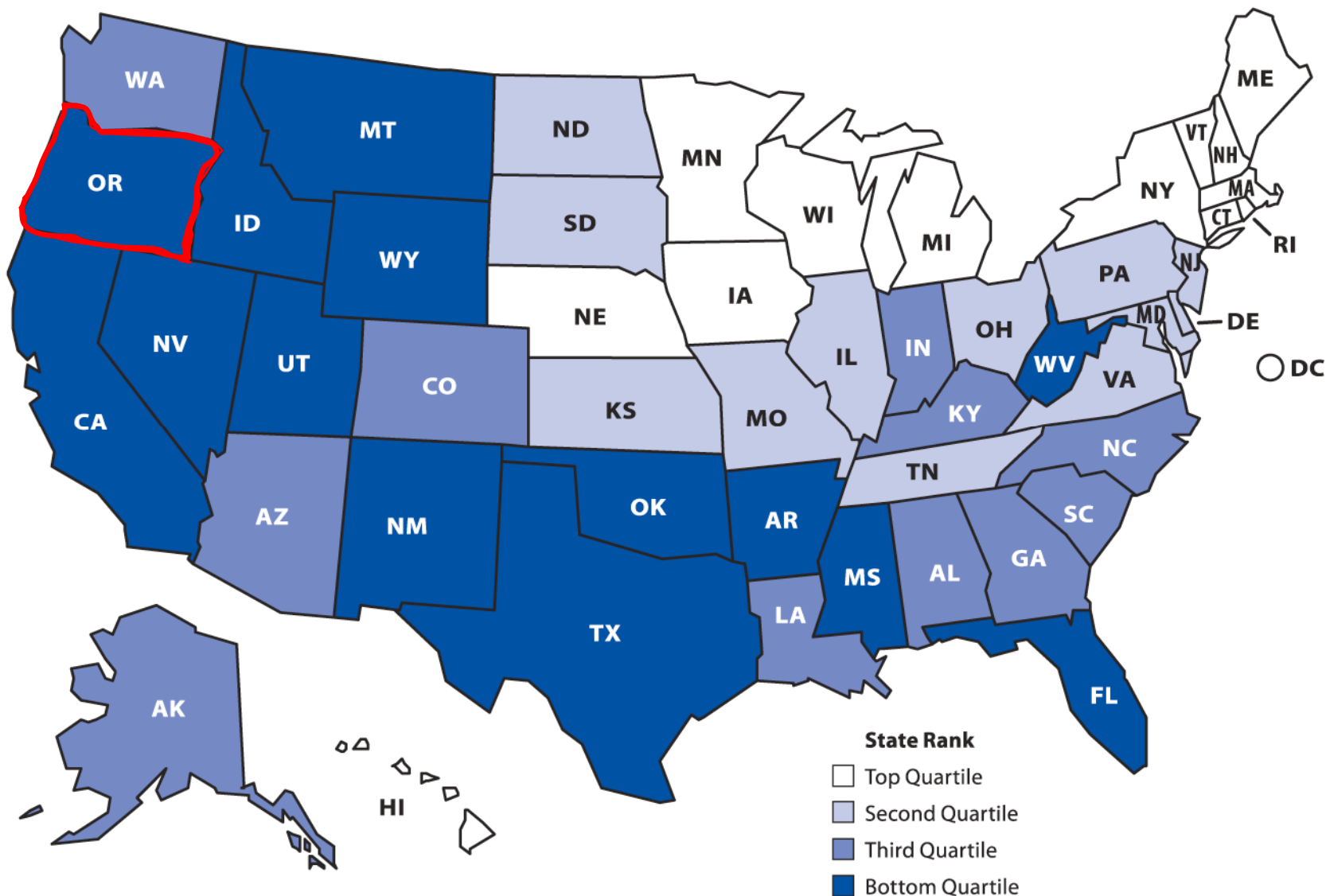
Gains if Oregon Achieved Top State Performance

- **More People Covered**
 - Nearly 300,000 additional adults and children insured
- **More Getting the Right Care**
 - More than 110,000 additional adults (age 50+) would receive recommended care
 - 14,000 children immunized
- **More Getting Primary Care**
 - Over 375,000 adults and 150,000 children with primary care
- **Less Avoidable Hospital Utilization**
 - Almost 3,000 fewer Medicare hospital admissions and readmissions per year (Savings of \$17 million+ per year)
- **Healthy Lives**
 - 448 fewer premature deaths

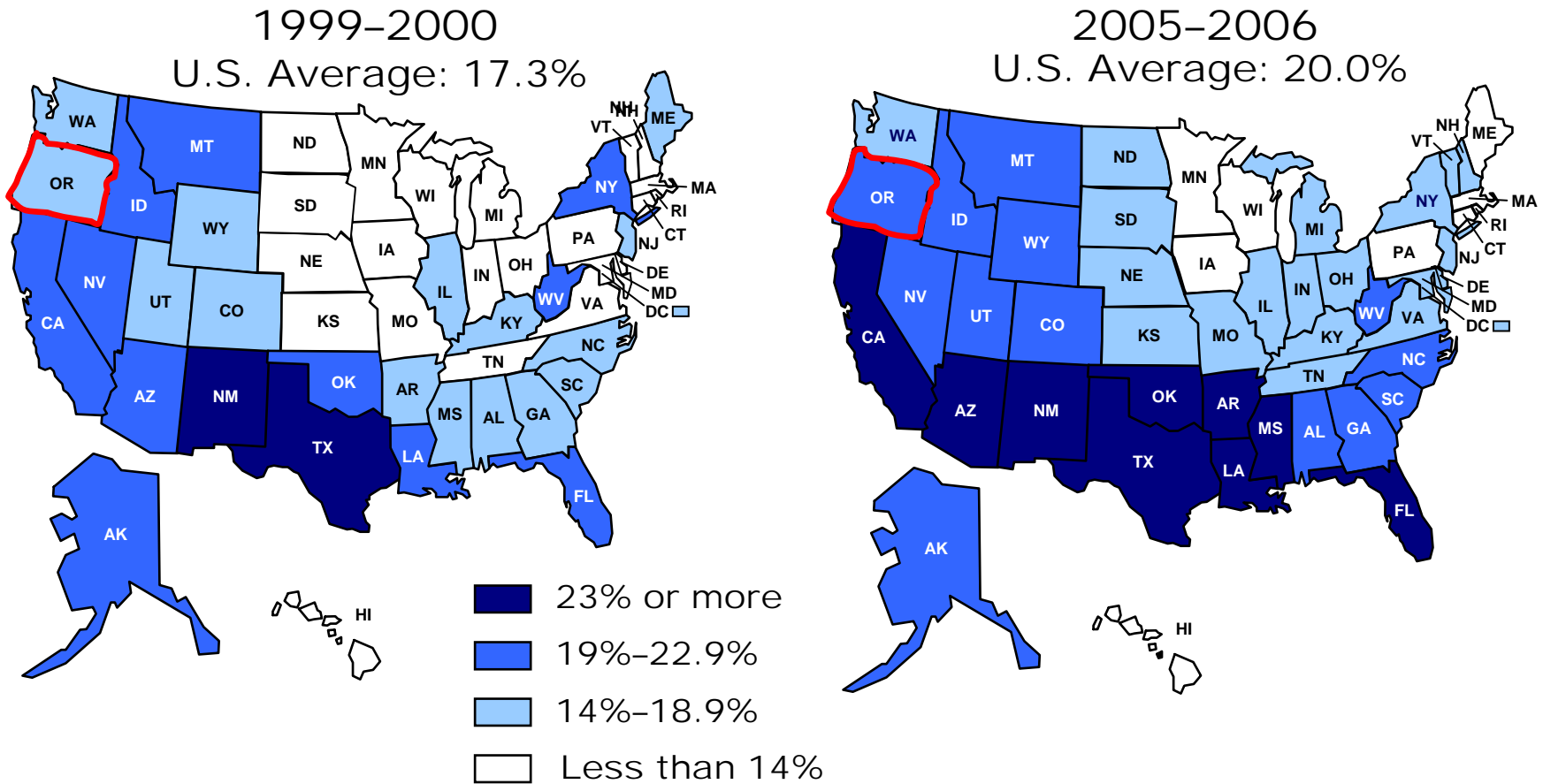
Summary of Indicator Rankings for Oregon

DOMAIN (# indicators):	Top Quartile	Second Quartile	Third Quartile	Bottom Quartile
ACCESS (4)	0	0	2	2
QUALITY (13)	2	3	3	5
AVOIDABLE USE/COSTS (8)	7	1	0	0
HEALTHY LIVES (5)	3	1	0	1
TOTAL (30)	12	5	5	8

State Ranking on Access Dimension



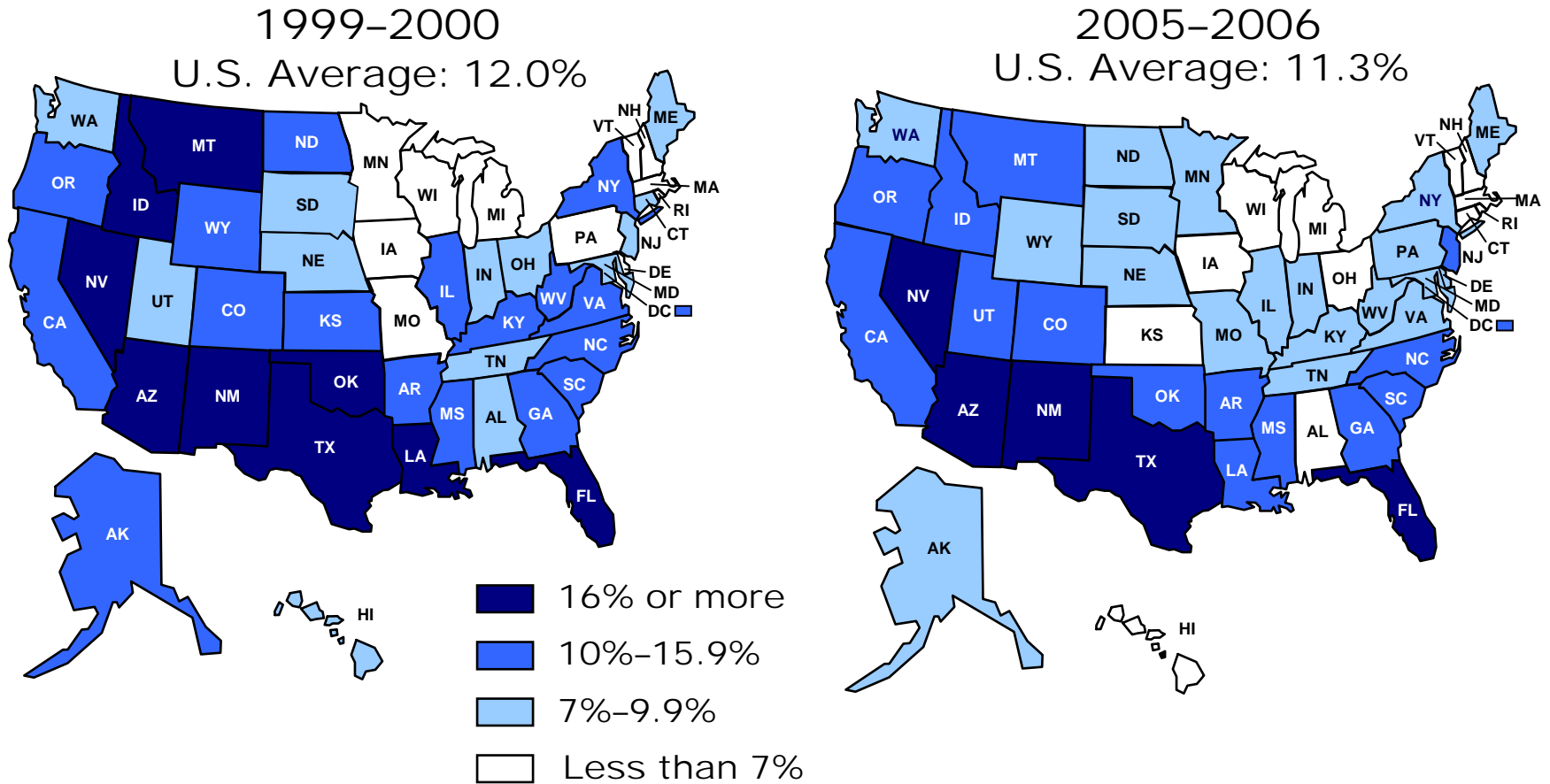
Number of States with 23% or More of Adults Under Age 65 Uninsured Rose from 2 to 9 Last Six Years



Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).

Updated Data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau’s March 2000, 2001 and 2006, 2007 Current Population Surveys.

Percent of Uninsured Children Declined Since Implementation of SCHIP, But Gaps Remain



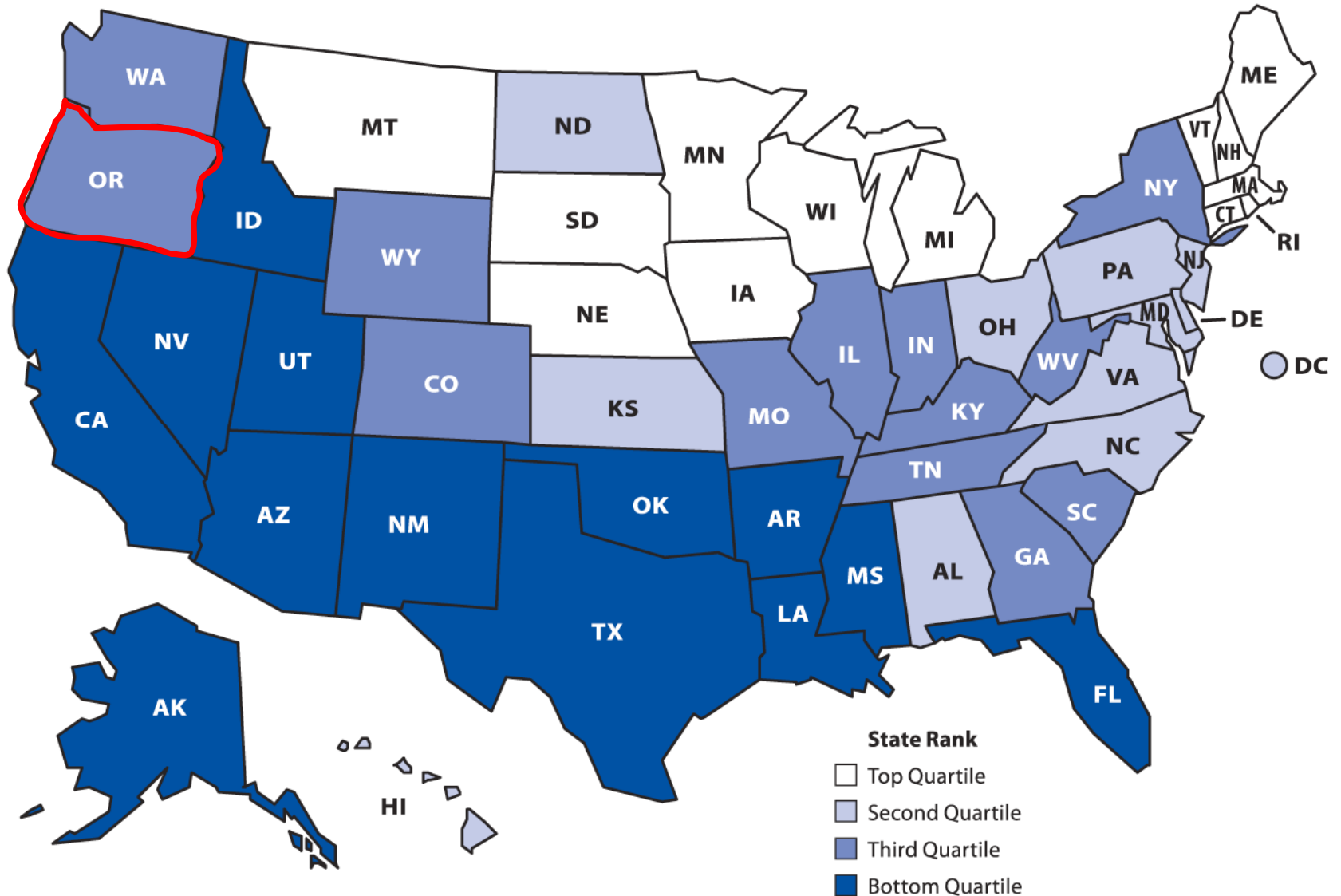
Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).

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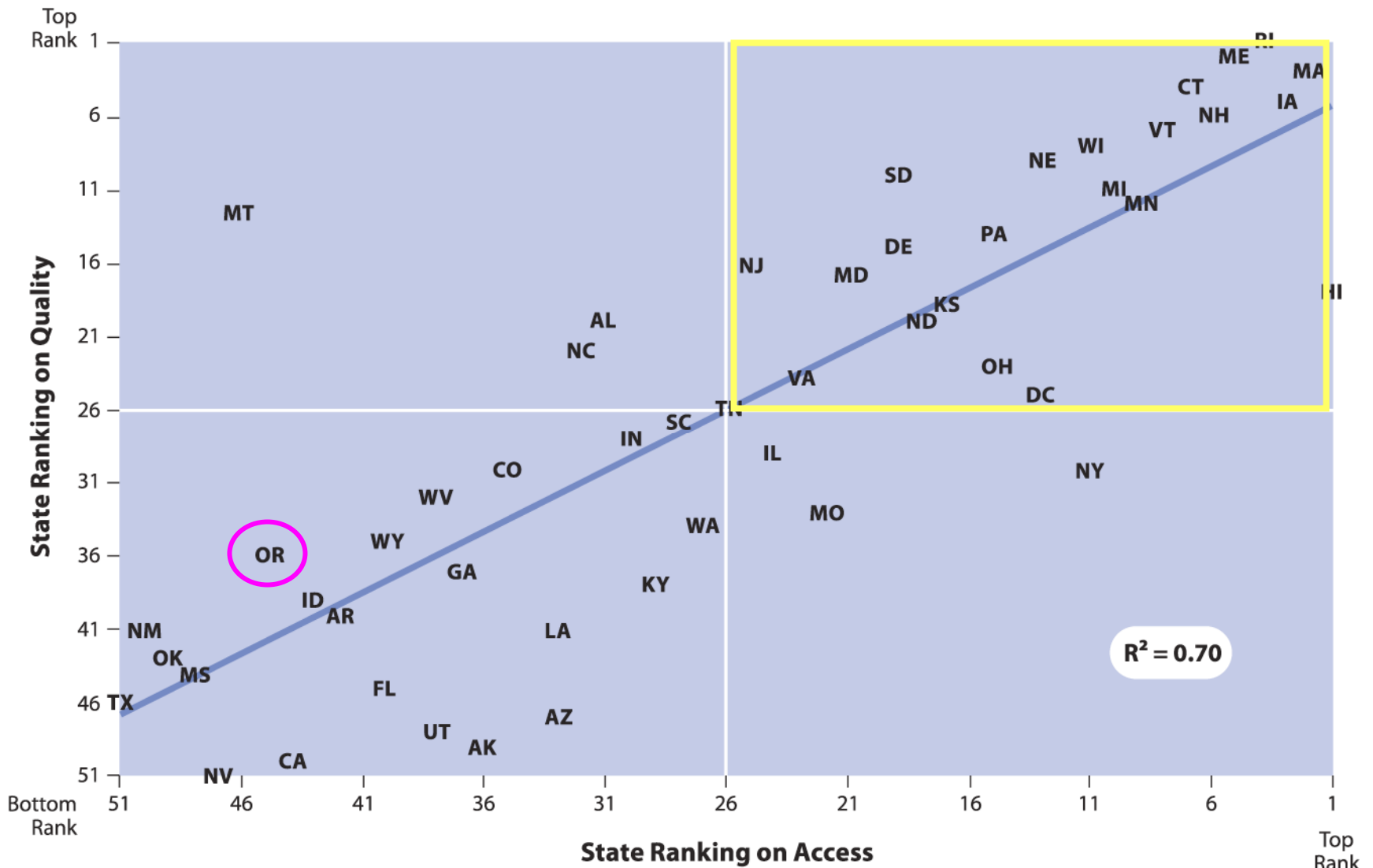
QUALITY

- **Getting the Right Care**
- **Coordinated Care**
- **Patient-Centered Care**

State Ranking on Quality Dimension



State Ranking on Access and Quality Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

State Variation: Ambulatory Care Quality Indicators

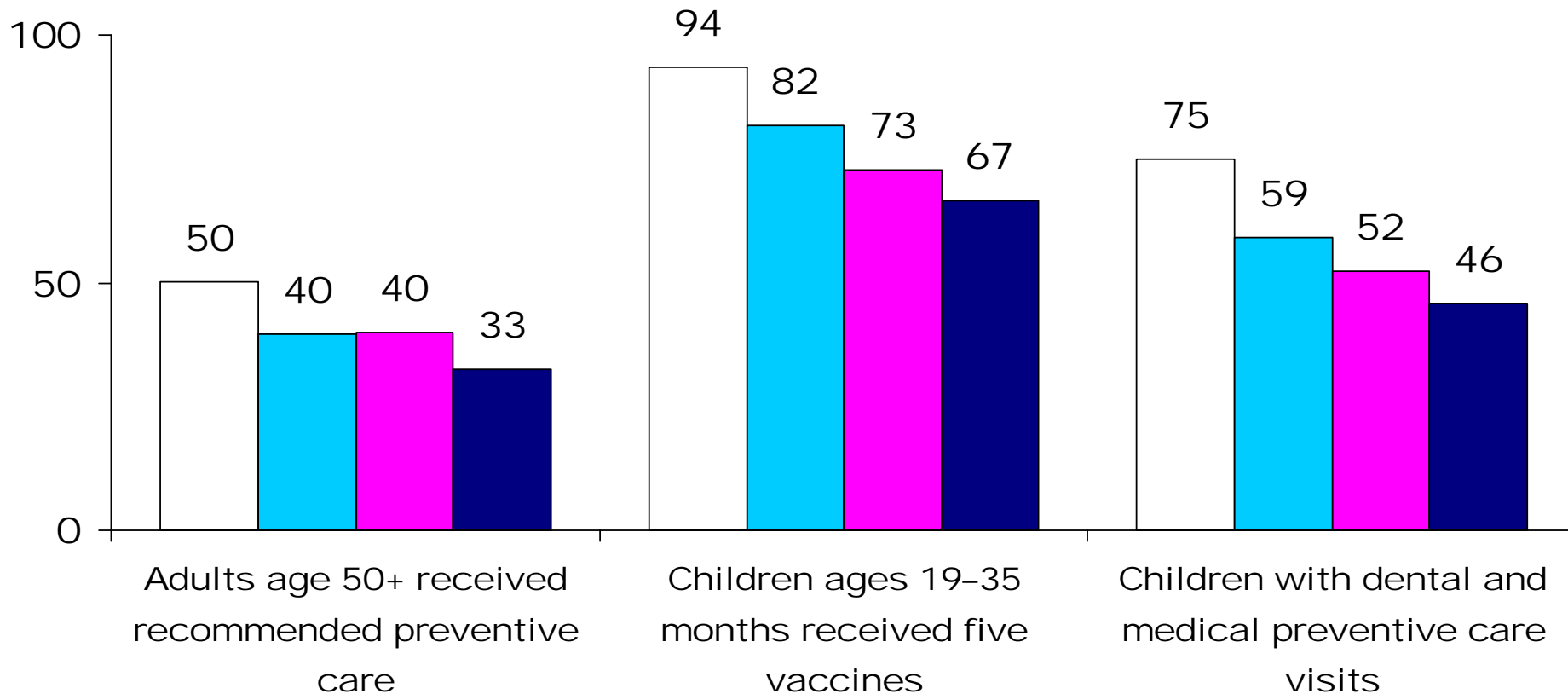
Percent

□ Best State

■ All States Median

■ Oregon

■ Worst State



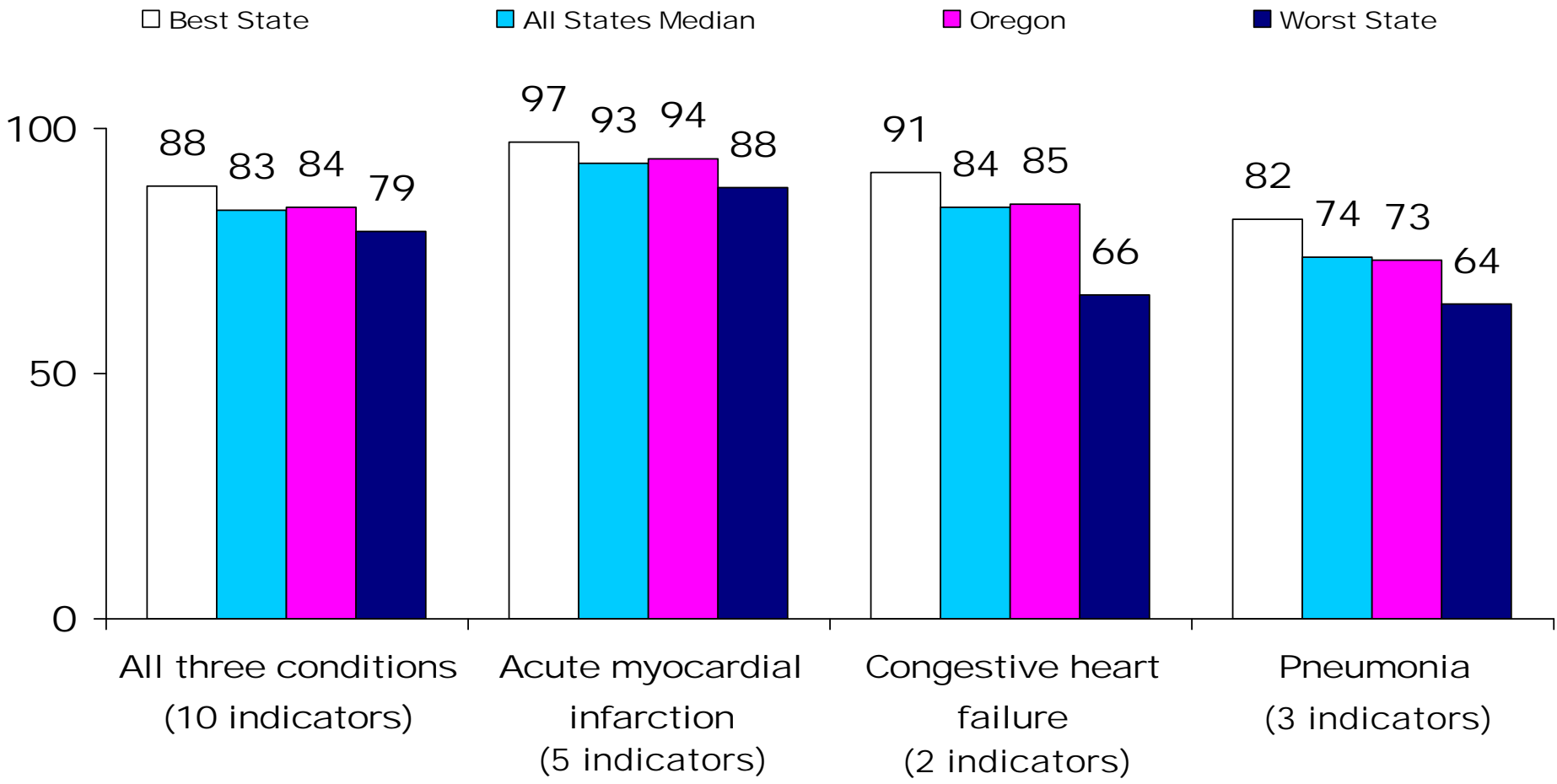
DATA: Adult preventive care – 2002/2004 BRFSS; Child vaccines – 2005 National Immunization Survey; Child medical and dental visits – 2003 National Survey of Children’s Health

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

QUALITY: THE RIGHT CARE

State Variation: Hospital Care Quality Indicators, 2004

Percent of patients who received recommended care



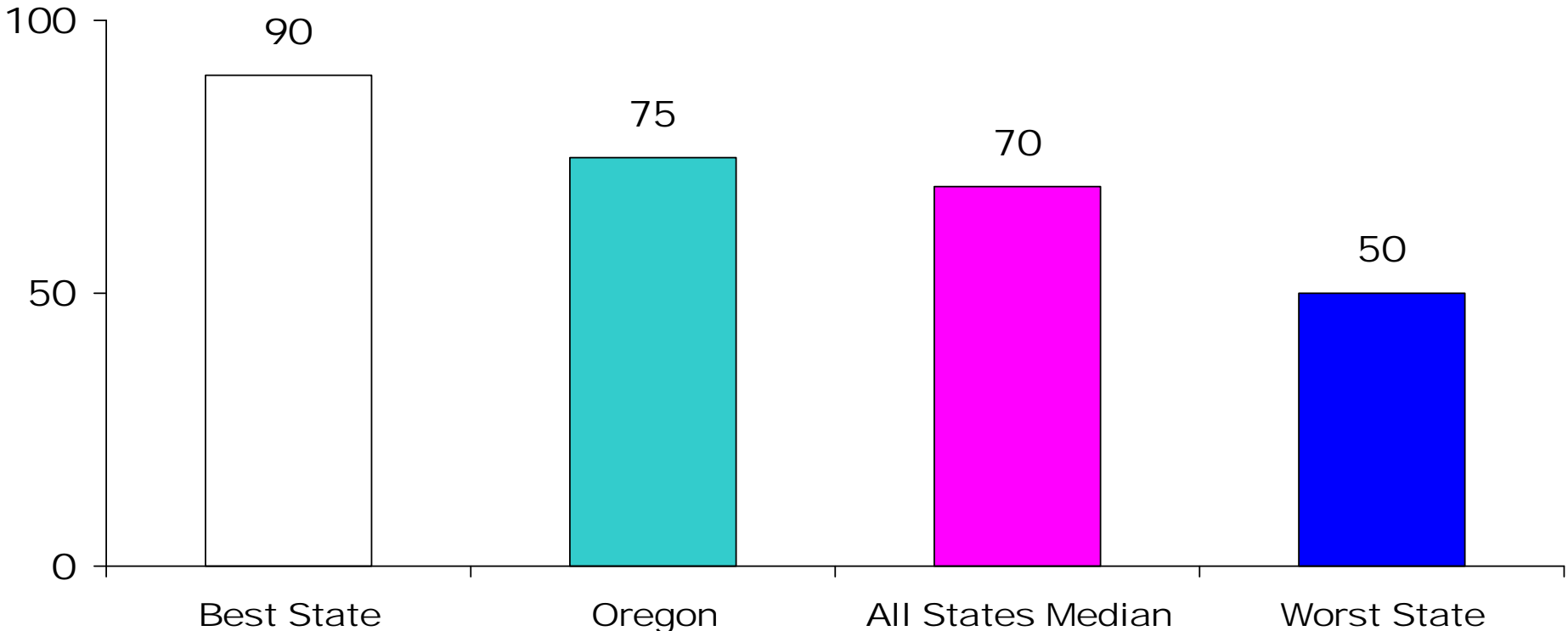
DATA: 2004 CMS Hospital Compare

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

QUALITY: THE RIGHT CARE

State Variation: Surgical Infection Prevention, 2005

Percent of adult surgical patients who received appropriate timing of antibiotics to prevent infections*



* Comprised of two indicators: before and after surgery.

DATA: 2005 CMS Hospital Compare

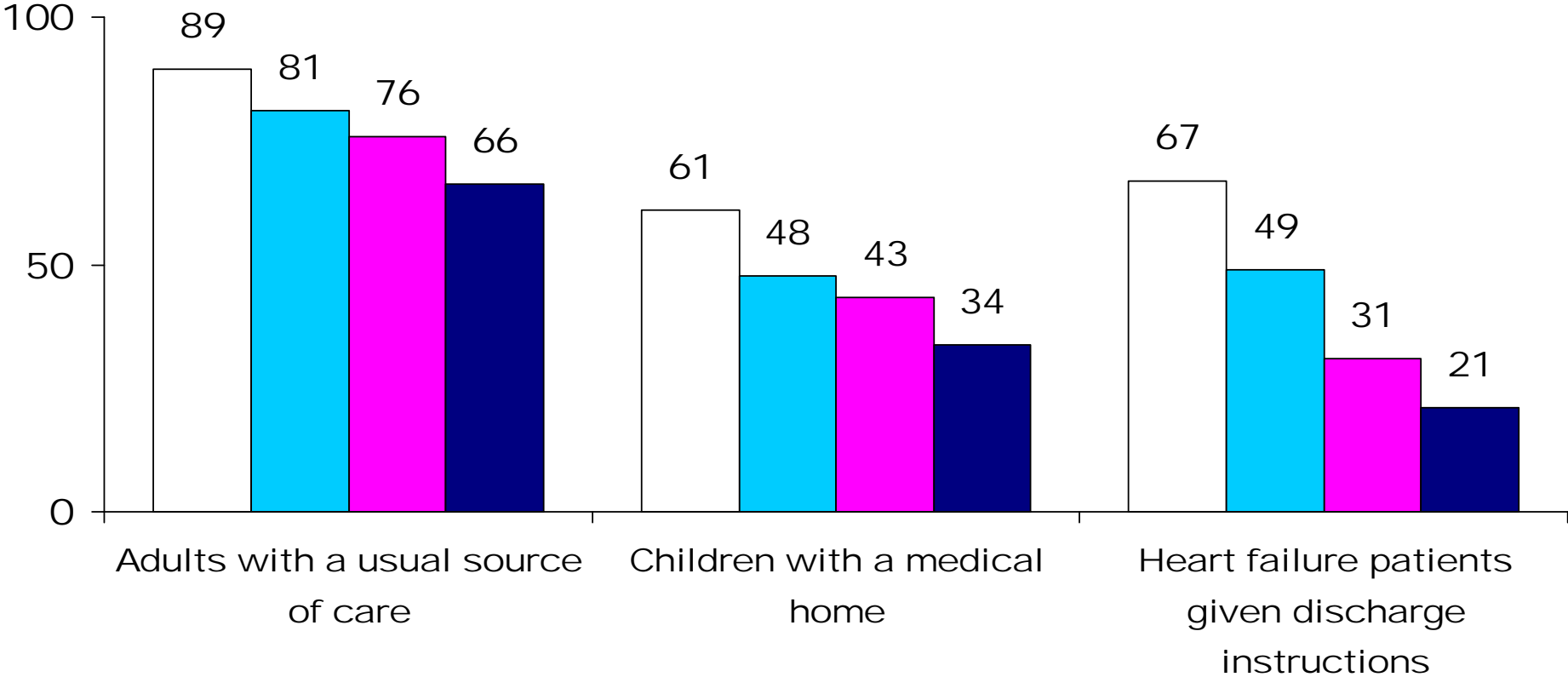
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

QUALITY: COORDINATED CARE

State Variation: Coordination of Care Indicators

Percent

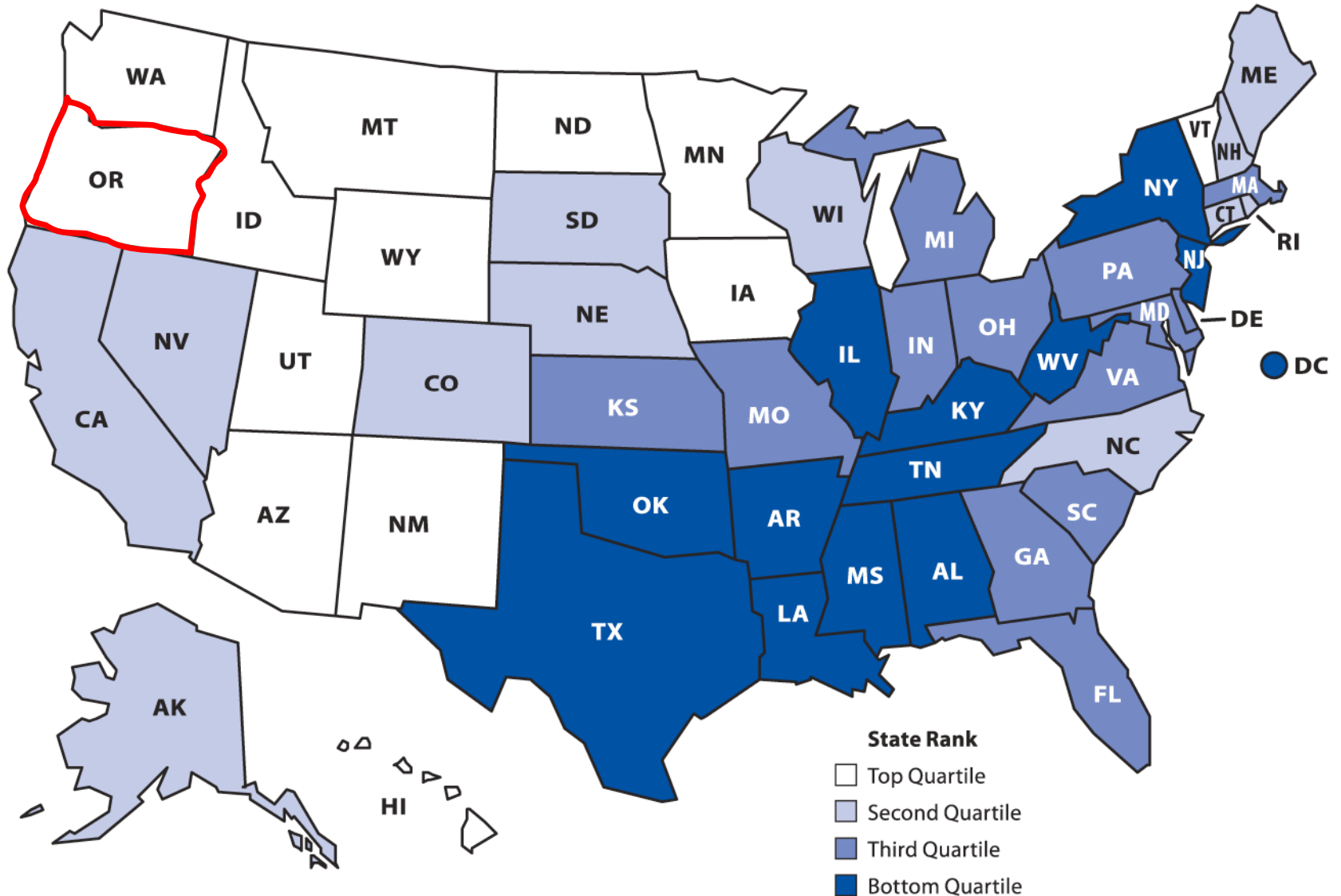
□ Best State ■ All States Median ■ Oregon ■ Worst State



DATA: Adult usual source of care – 2002/2004 BRFSS; Child medical home – 2003 National Survey of Children’s Health; Heart failure discharge instructions – 2004-2005 CMS Hospital Compare

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

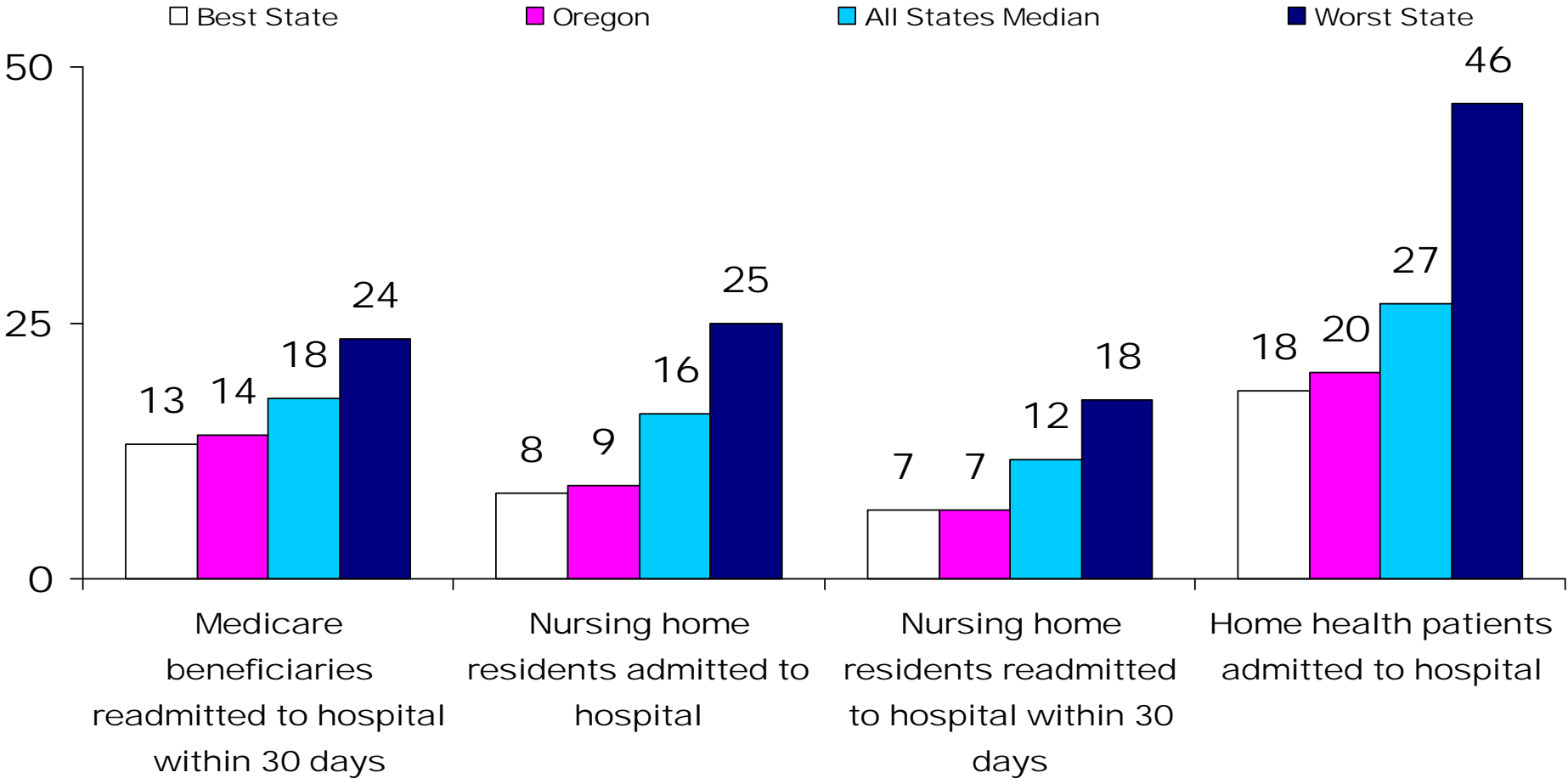
State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension



AVOIDABLE HOSPITAL USE AND COSTS

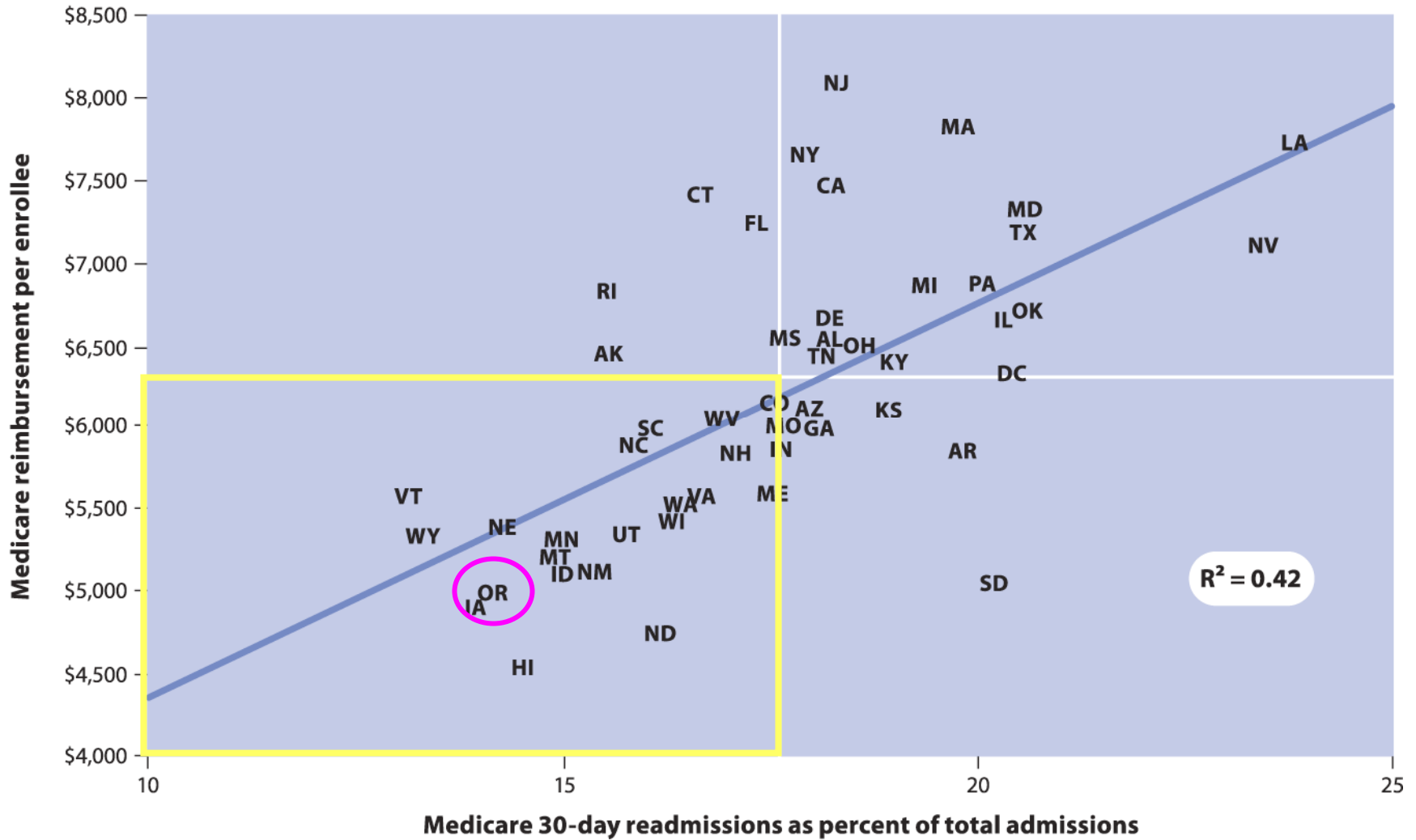
State Variation: Hospital Admissions Indicators

Percent



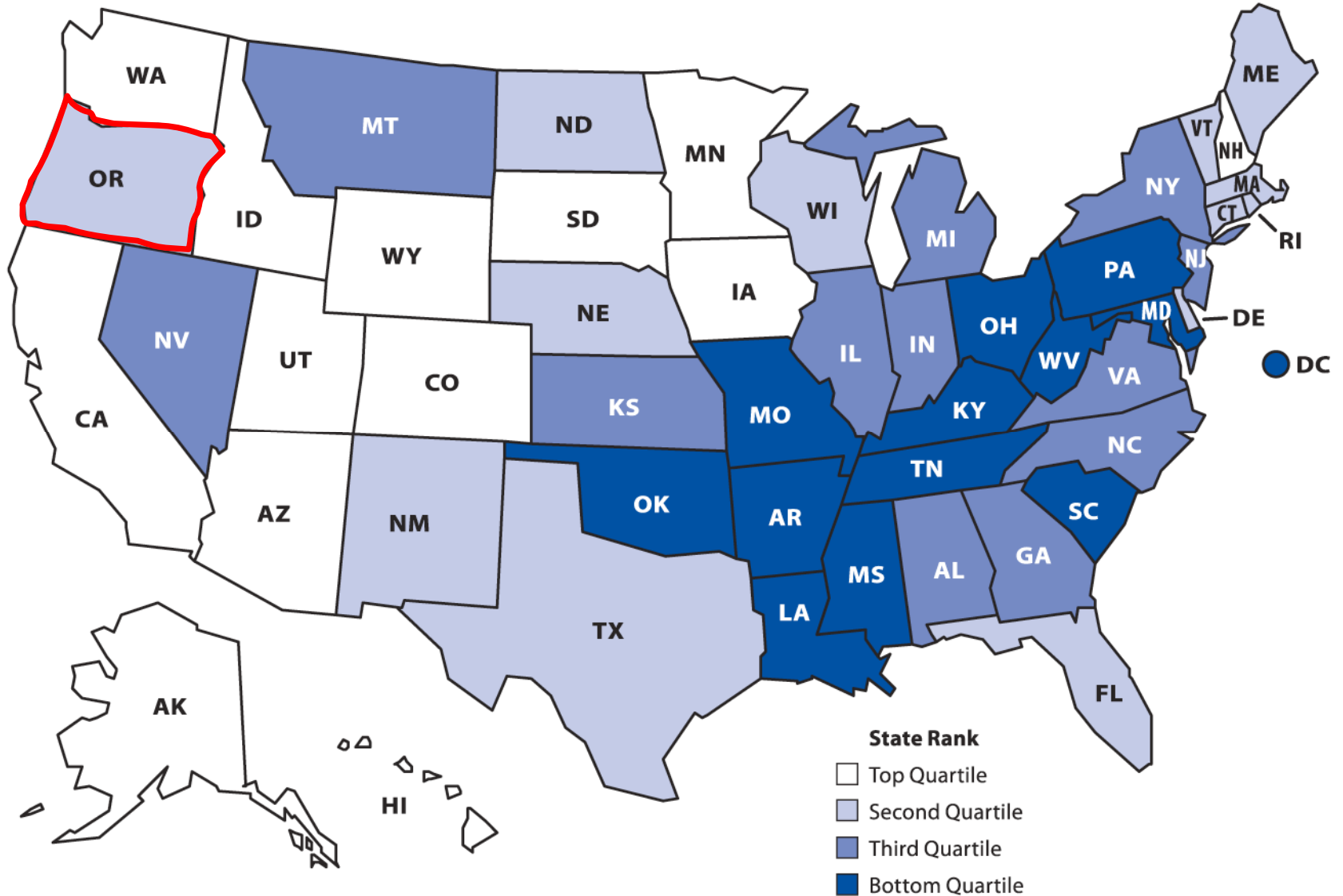
DATA: Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data; Nursing home admission and readmissions – 2000 Medicare enrollment records and MedPAR file; Home health admissions – 2004 Outcome and Assessment Information Set
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Medicare Reimbursement and 30-Day Readmissions by State, 2003



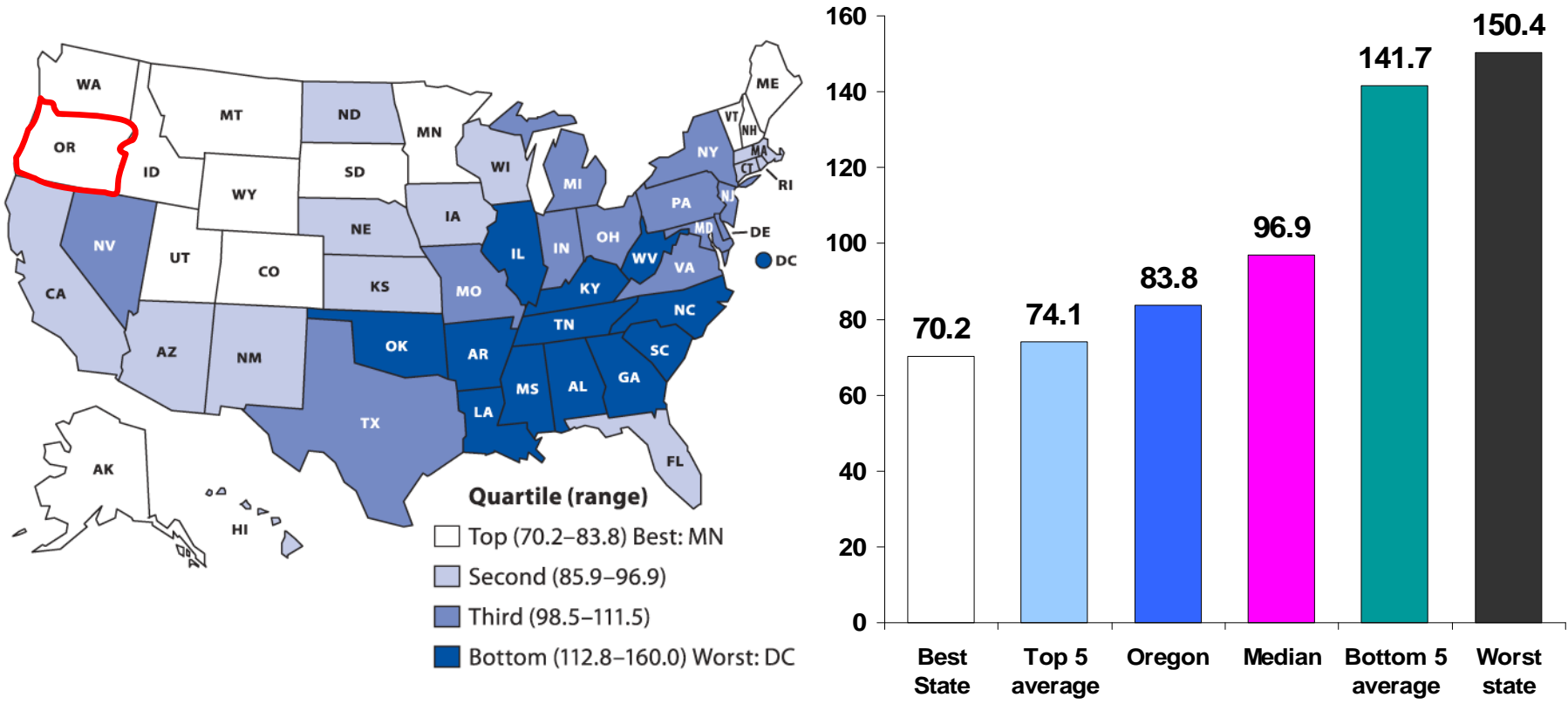
DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

State Ranking on Healthy Lives Dimension



Mortality Amenable to Health Care by State, 2002

Deaths* per 100,000 Population
U.S. Average = 103.3 deaths per 100,000



*Age standardized deaths before age 75 from select causes; includes ischemic heart disease
DATA: Analysis of 2002 CDC Mortality Cause-of-Death data files using Nolte and McKee methodology, BMJ 2003.
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

EQUITY

- **Based on gaps between most vulnerable to national average**
 - **Low-income (below 100% or 200% of poverty)**
 - **Uninsured**
 - **Racial, ethnic minority**

EQUITY

Lack of Recommended Preventive Care by Income and Insurance

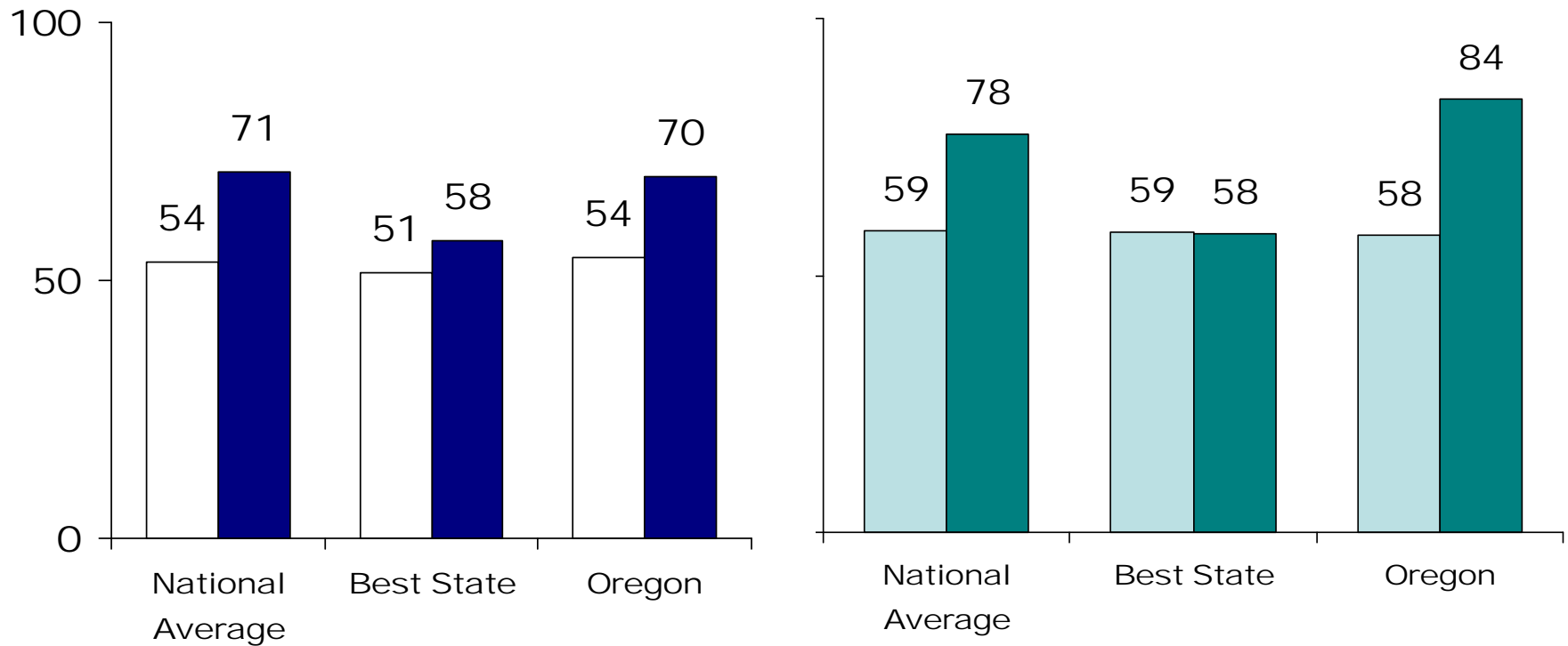
Percent of adults age 50+ who *did not* receive recommended preventive care

By income

By insurance

□ >200% of poverty ■ 200% of poverty or less

□ Insured ■ Uninsured



Note: Best state refers to state with smallest gap between national average and low income/uninsured.

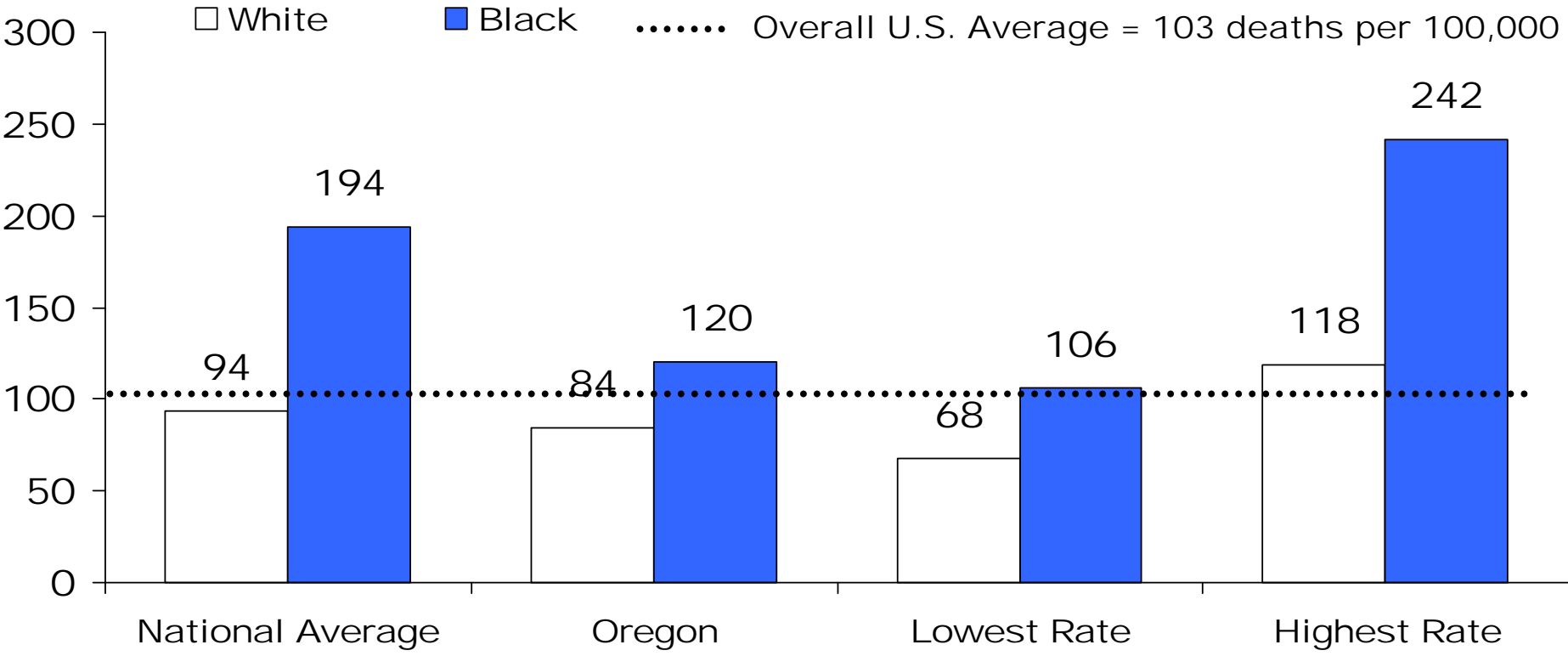
DATA: 2002/2004 BRFSS

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

HEALTHY LIVES

Mortality Amenable to Health Care by Race, National Average and State Variation

Deaths* per 100,000 Population



*Age-standardized deaths before age 75 from select causes; includes ischemic heart disease

DATA: Analysis of 2002 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, *BMJ* 2003.

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Lessons From The Scorecard

- Care far from “perfect”
- Tremendous variation within the U.S.
- Possible to have higher quality and lower cost
- We need to address multiple issues simultaneously – e.g., coverage, efficiency, quality

Toward a High Value Health System: Core Strategies for Change

- **Affordable coverage for all**
- **Aligned incentives and effective cost control**
- **Accountable coordinated care**
- **Aim higher for quality and efficiency**
- **Accountable leadership**



Commonwealth Fund Commission
on a High Performance
Health System

The Healthy Oregon Act: What Will Health Care Reform in Oregon Look Like?

Goal: create a sustainable high-value, affordable health care system that includes all Oregonians

Oregon's priorities:

Cover the uninsured

Maximize public resources

Give all Oregonians timely access to high quality, high value care

Develop method to finance coverage of essential health services for Oregonians

Allow options for participation

Encourage creation of public-private partnerships

Build on proven models of delivery and payment, with focus on prevention and disease management

Provide dignified end-of-life services

Offer fair and proportionate payments

Create high quality and transparent system

Ensure equitable and affordable financing

Minimize annual inflation

Commission Report:

A Roadmap to Health Insurance for All

Design Matters: Key Principles to Consider in Developing and Evaluating Health Reform Proposals

- **Access to Care**
 - Provides equitable and comprehensive insurance for all
 - Full and equitable participation
 - Minimum, standard benefit floor for essential coverage with financial protection
 - Costs are all affordable relative to family income
 - Coverage is automatic and stable with seamless transitions
- **Quality, Efficiency, and Cost Control**
 - Health risks are pooled, and insurance practices designed to avoid poor health risks are eliminated
 - Fosters efficiency by reducing complexity and administrative costs
 - Improves health care quality and efficiency
 - Minimizes dislocation
 - Simple to administer
 - Has the potential to lower overall health care cost growth
- **Financing**
 - Financial commitment to achieving these principles
 - Adequate and fair, based on ability to pay and shared responsibility



What States Can Do to Promote a High Performance Health System: *Strategies to Expand Coverage*

- **Design shared responsibility strategy to include state, employers and individuals**
 - Expand public programs
 - Require “pay-or-play” for employers; and encourage offering Section 125 benefit plans
 - Mandate individuals to purchase coverage
 - Provide financial assistance to low income workers and employers to afford coverage
- **Pool purchasing power and promote new benefit designs to make coverage more affordable**
- **Develop reinsurance programs to make coverage more affordable in the small group and individual markets**
- **Require insurers to raise age limit for dependents**
- **Improve efficiency: reduce complexity, administrative costs, and churning**



Massachusetts Health Plan

- **MassHealth expansion for children up to 300% FPL; adults up to 100% poverty**
- **Individual mandate, with affordability provision; subsidies between 100% and 300% of poverty**
- **Employer mandatory offer, employee mandatory take-up**
- **Employer assessment (\$295 if employer doesn't provide health insurance)**
- **Connector to organize affordable insurance offerings through a group pool**



Massachusetts' Accomplishments

- **Commonwealth Choice Health Plans launched May 1, 2007**
 - 42 plan offerings
 - Innovative website allows consumers and employers to shop, compare, and enroll
 - Aggressive advertising campaigns conducted by Health Connector and Massachusetts Health Care Reform Coalition
- **Reasonable success since implementation:**
 - Approximately 200,000 newly covered individuals in just over a year
 - 67% of MA voters view reform favorably
 - Costs in free care pool showed a 15% decline in FY 2007



Massachusetts' Challenges

- **Implementing Commonwealth Care – impact on safety net?**
- **Transferring Uncompensated Care Pool (safety net) dollars to subsidies for coverage – will free care usage decline?**
- **Affordability of the product, exemptions – will costs moderate?**
- **Individual mandate – outreach/education, enforcement, will public accept consequences of mandate and MCC?**
- **Insurance market changes, insurance connector (critical mass?)**
- **Employer Assessment & Free Rider Surcharge, Section 125 plans**
- **Benefit designs – will deductibles and higher cost sharing be accepted in Massachusetts market?**



California Governor's Proposal: Health Care Security and Cost Reduction Act

- Individual mandate
- Shared responsibility
- Medi-Cal expansion
 - All children below 300% poverty
 - Parents, caregivers, and young adults below 250% poverty
 - Childless adults below 100% poverty
- Premium subsidies for adults below 250% poverty
- Tax credit for families between 250 and 350% of poverty
- Employers provide health insurance or pay a fee of up to 4% of wages
- Hospital fee assessment: 4% of revenues
- Insurance exchange
 - Guaranteed issue; community rating with age and geography bands
 - 85% minimum medical loss ratio
- Health and Human Services Agency to establish minimum benefit level for coverage



Pennsylvania Governor's Proposal

- Prescription for Pennsylvania

- Three part proposal:

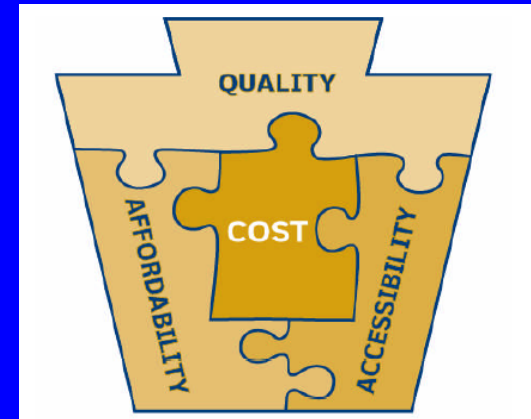
1. a public-private coverage partnership called Cover All Pennsylvanians (CAP)
1. a cost-containment agenda
2. a quality improvement platform

- First elements passed July 2007

- Increase access to primary care by expanding scope of practice for mid-level practitioners
- Reducing hospital-acquired infections through surveillance and reporting

- Cover all Pennsylvanians

- Would subsidize comprehensive coverage for uninsured individuals below 300% FPL and small businesses
- Employer mandate, no individual mandate
- Funding would come from an employer assessment, increased tobacco tax, and federal matching funds



Illinois All Kids



- Effective July 1, 2006
- Available to any child uninsured for 12 months or more
- Cost to family determined on a sliding scale
- Linked to other public programs - FamilyCare & KidCare
- Funded by federal and state funds
 - Children <200% of the federal poverty level funded by federal funds
 - Children 200%+ of the federal poverty level funded by state savings from the Medicaid Primary Care Case Management Program
- All-Kids Training Tour
 - Public outreach program to highlight new and expanded healthcare programs
- More than 160,000 additional children gained coverage as of September 2007

Illinois Covered



- **Illinois Covered *Rebate*:**
 - Premium assistance for working families (between 100 and 400% FPL) with employer-based insurance
- **Illinois Covered *Assist*:**
 - Comprehensive coverage for adults below FPL who do not qualify for Medicaid
 - Low co-pays, no premium
- ***Family Care Expansion***
 - Access to insurance for uninsured parents up to 400% FPL
 - Sliding scale premium assistance
- **Coverage for Young Adults**
 - Bridge for young adults ages 19 to 21 with pre-existing conditions who have no access to insurance
 - Subsidized premiums up to age 21





Vermont Health Care Affordability Act Enacted May 2006

- Coverage expansion
 - Catamount Health Plan
 - Targets individuals w/o access to work-based coverage
 - Premium subsidies based on sliding scale up to 300% FPL
 - Comprehensive benefit package including primary care, chronic care, acute care & other services
 - No patient cost-sharing for preventive or chronic care services
- Financing
 - Employer assessment
 - Increase in tobacco taxes
 - Federal matching funds from Medicaid waiver
- Enrollment
 - Began October 1, 2007





Maine's Dirigo Health

2003 Act aimed to make affordable health care coverage available to every Maine citizen by 2009, slow the growth of health care costs, and improve the quality of care

- Estimated savings of \$32.8 million in third year of operation
- Enrollment 27,677 as of August 2007
- Governor's proposed reforms (April 2007)
 - State reinsurance plan
 - Insurers required to provide discounts for nonsmokers and worksite wellness programs
 - Employer "pay or play" to begin July 2008
 - Individual mandate to begin January 2009
 - Dirigo able to self-insure and will grow moderately (legislation passed August 2007)
- Blue Ribbon Commission endorsements (January 2007)
 - Increasing the tax on tobacco products
 - Establishing a snack tax and a tax on soft drinks and syrups
 - Beer and wine tax
 - Continued capture and redirection of bad debt and charity care funding



Insure New Mexico!



State Coverage Expansion Targeting Employees of Small Businesses

- **State Coverage Insurance (SCI)** (<50 employees)
- Public/private partnership
- Working adults <200% FPL
- 4,400 enrollees, Fall 2006
- **The Small Employer Insurance Program (SEIP)**
- Comprehensive benefit package with an annual benefit limit of \$100,000 per member available to employees and dependents
- Available for previously uninsured employees of small businesses



Oklahoma “ALL-KIDS” INSURANCE EXPANSION

- Increased eligibility level for children from Medicaid level of 185% FPL to 300%
 - *SoonerCare (Medicaid) already added some 100,000 children between 2003 and 2007*
- Creates eligibility for an estimated 40,000+ children to buy private insurance. Parents pay 26% of premium and state/federal governments pay the balance
- State funds provided by the OK Tobacco Tax (2004)
 - Voters approved Governor Henry’s proposal to increase tobacco excise taxes to \$1.03/pack – an increase of \$.80 (net increase was \$.55/pack because sales taxes were eliminated)



Maryland: Proposal to Expand Medicaid Coverage

Special session of Maryland General Assembly to convene October 29th to consider expansion of Medicaid coverage to 100,000 uninsured residents

- **Governor O'Malley's Proposal:**
 - Extend Medicaid from 40% up to 116% FPL for adults
 - Subsidies for small businesses
 - Incentives for wellness plans
 - \$500 million mostly financed by tax reforms



What States Can Do to Promote a High Performance Health System: *Strategies to Improve Quality and Efficiency*

- **Provide incentives for improved performance**
 - **Promote/practice value-based purchasing (P)**
 - Includes pay-for-performance, selective purchasing/tiering, value-based benefit designs
- **Promote better organization/integration**
 - **Encourage development and selection of a medical home**
 - improved access to primary care/preventive services (P)
 - Non-emergency settings for non-emergency care (P)
 - **Promote transitional care post-hospital discharge (T, P)**
 - **Promote the use of health information technology (L, T, P, R)**
 - Includes information exchange, ambulatory & hospital systems

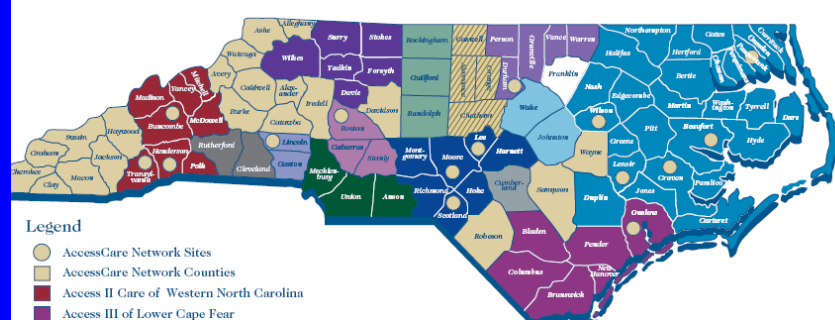


Puget Sound Health Alliance



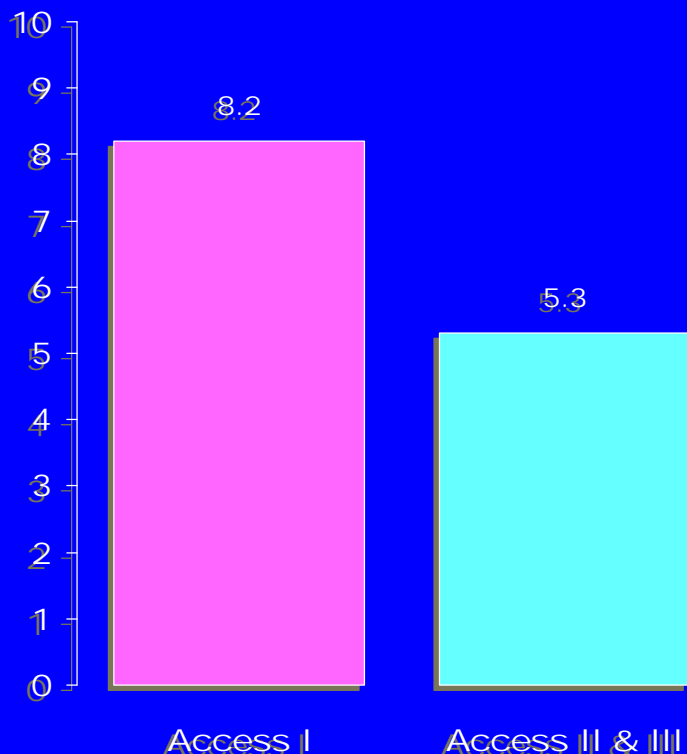
- **Regional partnership involving more than 150 participating organizations, including employers, health plans, physicians, hospitals, community groups, and individual consumers**
- **Participants agree to use evidence to identify and measure quality health care, then produce publicly-available comparison reports designed to help improve health care decision-making**
 - **Region's first public report on quality expected fall 2007 including data from 15 health plans, self-insured employers, union trusts; 16 clinic systems**
 - **Rx Clinical Improvement Team Phase 2 Final Report provides recommendations for increasing affordable prescriptions**
 - **Clinical Improvement Team report on Prevention to come out fall 2007 with recommendations for preventable diseases with cost-effective clinical preventive services**

Community Care of North Carolina



Asthma Initiative: Pediatric Asthma Hospitalization Rates (April 2000 – December 2002)

In patient admission rate per 1000 member months

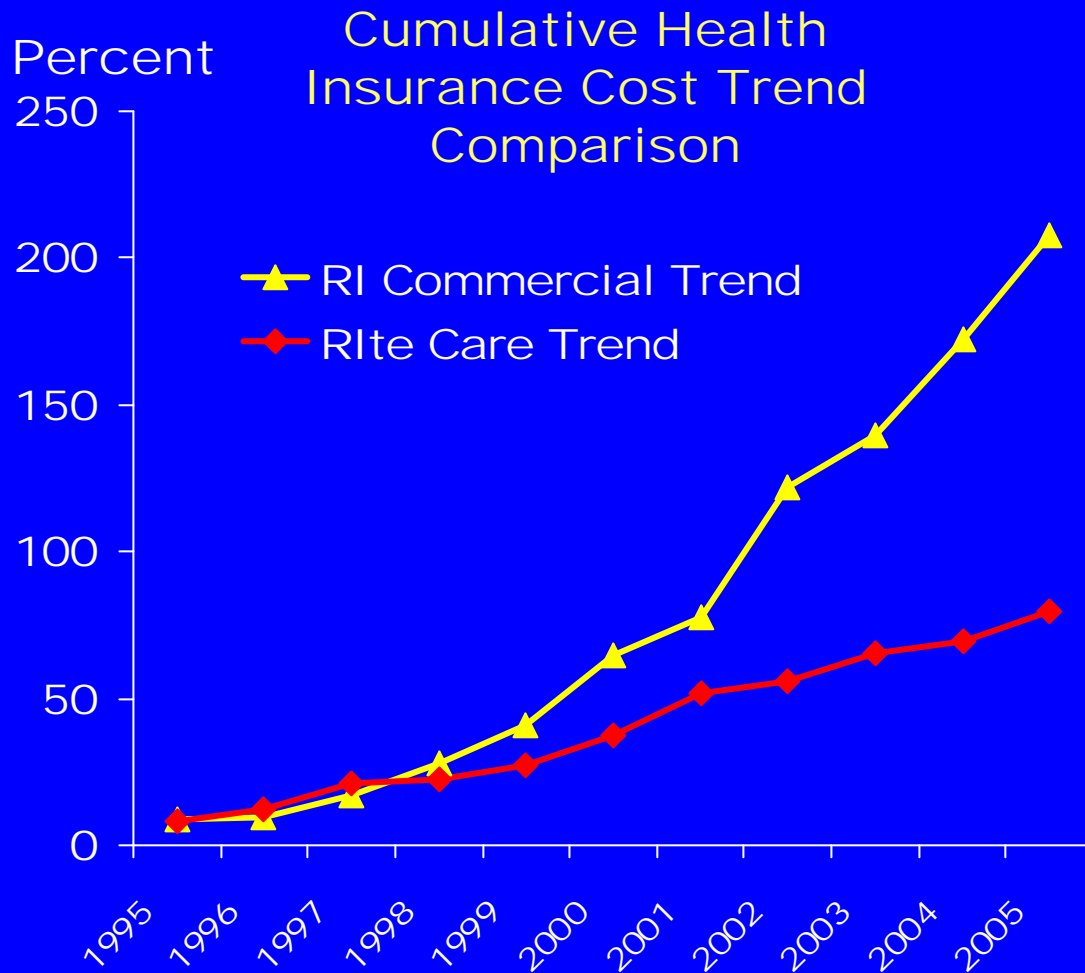


- 15 networks, 3,500 MDs, >750,000 patients
- Receive \$2.50 PM/PM from the state
- Hire care managers/medical management staff
- PCP also get \$2.50 PMPM to serve as medical home and to participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost (FY2003) – \$8.1 million; Savings (per Mercer analysis) \$60M compared to FY2002



Building Quality Into Rlte Care

Higher Quality and Improved Cost Trends



- Quality targets and \$ incentives
- Improved access, medical home
 - One third reduction in hospital and ER
 - Tripled primary care doctors
 - Doubled clinic visits
- Significant improvements in prenatal care, birth spacing, lead paint, infant mortality, preventive care

Source: Silow-Carroll, *Building Quality into Rlte Care*, Commonwealth Fund, 2003. Tricia Leddy, *Outcome Update*, Presentation at Princeton Conference, May 20, 2005; updated.





Information Exchange: States Leading the Way



New York State Health Information Technology (HIT) initiative

- Health Care Efficiency and Affordability Law for New Yorkers capital grant program
 - NY state budget fiscal year 2005–06
- \$52.9 million awarded to 26 regional health networks to expand technology in NY health care system and support clinical data exchange
- Commonwealth Fund-supported evaluation underway

Delaware Health Information Network/Information Exchange

- Public-private partnership (1997)
- Functions under the direction of the Delaware Health Care Commission
- In 2006 signed an extendable 6-year contract to create the first statewide health information exchange (Start-up costs = \$4 to 5 million)
 - Access to secure, fast, and reliable electronic patient information at the time and place of care
 - Funded by participating health care organizations, the State of Delaware, AHRQ and HHS





Florida's Health Information Network

Health Information Infrastructure Advisory Board called for Florida Health Information Network (FHIN) in 2005, to promote the development and implementation of Florida health information infrastructure

- **Strategy:**

- Empower local stakeholder collaborations focused on health information exchange
- Build out health information networks using a grants program to leverage the development of local RHIOs
- Integrate RHIOs with a state-level server to manage data exchange among RHIOs, other state/federal databases
- Create a non-profit organization to maintain FHIN and set standards of interoperability for the RHIOs

- **Steps taken toward sustainability:**

- Use of eHealth Initiative Roadmap and Value & Sustainability model
- FHIN White Paper core functions and services
- BCBS Blueprint for Building a Sustainable Health Information Exchange Organization



Arizona Health Care Cost Containment System (AHCCCS)



- **Goals:**
 - use interoperable health transformation systems and clinical decision support tools to improve the healthcare system
 - implement statewide adoption of HIT that supports the exchange of electronic records
- **Building blocks:**
 - Web-based health information and decision support tools act as common reference for providers, payers, and consumers—increase transparency
 - System-wide access to web-based electronic health records to maximize value and reduce variations in cost and quality
 - New generation of consumer, provider, and payer care management decision support and analytical tools integrated with EHR, EMR, and PHR systems



What States Can Do to Promote a High Performance Health System: *Strategies to Improve Quality and Efficiency*

- **Use better information to guide and drive improvement**
 - Promote evidence-based medicine and shared-decision making (P, L, T)
 - Encourage data transparency and reporting on performance (P, L, T, R)
 - Identify/spread best practices (T)
- **“Continuous Improvement”**
 - Convening around data (T,P)
 - Convening around techniques/processes – e.g., teamwork, improvement of patient flow (T,P)





Minnesota: Quality Care and Rewarding Excellence (QCare)

- Created by governor executive order in July 2006
- Objective: accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting
- All contracts for MinnesotaCare, Medicaid, and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining greater overall accountability
- Initial focus on four areas:
 - Diabetes
 - Hospital stays
 - Preventive care
 - Cardiac care
- Private sector health care purchasers and providers will be encouraged to adopt QCare through the Smart Buy Alliance



Maryland Healthcare Commission

- Established in 1999, the Maryland Healthcare Commission (MHCC) is a public regulatory commission and the 13 members are appointed by the Governor
- Releases annual state sponsored HMO performance guides on how state commercial HMOS perform in terms of access and service, keeping people healthy and caring for the sick, with a focus on patients with chronic conditions



Pennsylvania Health Care Cost Containment Council (PHC4)

- Publicly reports patient outcomes on almost 80 treatment categories for physicians, hospitals and managed care plans
- Recognized as a leader in addressing medical errors and hospital acquired infections
- The Council is funded through the Pennsylvania state budget. In addition, the Council receives revenue through the sale of its data to health care stakeholders in PA and worldwide

Institute for Clinical Systems Improvement

- **Formed in 1993**
- **56 members are comprised of hospitals, medical groups, and health plans**
- **Produces evidence-based best practice guidelines, protocols, and order sets**
- **Guidelines are recognized as the standard of care in Minnesota**
- **Facilitates “action group” collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work**



- **Wisconsin Collaborative for Healthcare Quality**
 - Voluntary consortium formed in 2003 – physician groups, hospitals, health plans, employers & labor
 - Develops & publicly reports comparative performance information on physician practices, hospitals & health plans
 - Includes measures assessing ambulatory care, IT capacity, patient satisfaction & access
- **Wisconsin Health Information Organization**
 - Coalition formed in 2005 to create a centralized health data repository based on voluntary sharing of private health insurance claims, including pharmacy & laboratory data
 - Wisconsin Dept of Health & Family Services and Dept of Employee Trust Funds will add data on costs of publicly paid health care through Medicaid



What States Can Do to Promote a High Performance Health System: *Strategies to Improve Quality and Efficiency*

- **Promote health**
 - Effective chronic care management (P, T)
 - Promote wellness and healthy living (P, T, L)
- **Workforce Improvement**
 - Use licensure authority creatively to ensure access and promote health (R,L,T)





Health Pact RI



2006 legislation required creation of “wellness health benefit plan” by major insurers in Rhode Island.

Goal: Create an affordable health insurance product for small business and individuals

- Platform to begin to address the underlying cost of care in Rhode Island by creating appropriate incentives for all key stakeholders to appropriately control costs
 - Better premium rates for:
 - Selection of primary care doctor
 - Completion of health risk appraisal
 - Weight management
 - Smoke free or smoking cessation
 - Disease management
- Plans offered beginning October 1, 2007



Wellness and Preventive Health Initiatives: Vermont Blueprint for Health



- Information, tools and support that patients and providers need to successfully manage chronic conditions
- Developing a web-based chronic care patient information system, free to providers requiring only Internet access; First site will install and test system in 2007



Missouri HealthNet:

Shifting the Focus to Prevention and Early Detection

New focus on preventive care

- \$6 billion budget intended to direct state-funded health care to prevention and early detection
- Cover uninsured women making up to 185% FPL for cancer screenings and family planning services
- Raise payments to medical providers up to federal maximum
- New services designed to help patients create personalized long-term health plans and facilities to act as central point of contact



Restore services previously cut from Medicaid:

- Dental and vision care
- Coverage for necessary adult medical equipment
- Coverage for almost 14,000 children with limited premiums
- Coverage for over 3,000 disabled workers

Oregon: Why Not the Best?



Acknowledgements and Related Commission Reports

- ***Aiming Higher: Results from a State Scorecard on Health System Performance (June 2007).*** The Commonwealth Fund Commission on a High Performance Health System. Authors:
 - Joel C. Cantor and Dina Belloff, Rutgers University Center for State Health Policy
 - Cathy Schoen, Sabrina K.H. How, and Douglas McCarthy, The Commonwealth Fund
- **Related Commonwealth Fund Commission Reports**
 - ***Why Not the Best? Results from a National Scorecard on U.S. Health System Performance (Sept. 2006).*** The Commonwealth Fund Commission on a High Performance Health System.
 - ***Framework for a High Performance Health System for the United States (Aug. 2006).*** The Commonwealth Fund Commission on a High Performance Health System.



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State Scorecard

This interactive U.S. map draws from the Commission on a High Performance Health System's report, [Aiming Higher: Results from a State Scorecard on Health System Performance](#). Use the map to view state-specific rankings and results compared to benchmarks, and to view the number of lives and dollars each state could save by achieving benchmark levels of performance.



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Thank You!



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