

The Triple Aim

1. Better Health
2. Better Health Care
3. Lower Costs

Oregon's Coordinated Care Model Principles and Attributes

1. Best practices to manage and coordinate care
 - Single point of accountability
 - Patient and family-centered care
 - Team-based care across appropriate disciplines
 - Plans for managing care for 20 percent of population driving 80 percent of costs
 - Plans for prevention and wellness, including addressing disparities among population served
 - Broad adoption and use of electronic health records
2. Sharing responsibility for health
 - Shared decision-making for care among patients and providers
 - Consumer / patient education and accountability strategies
 - Consumer / patient responsibility for personal health behaviors
3. Measuring performance
 - Demonstrated understanding of population served
 - Quality, cost and access metrics
 - Strategies for targets and improvement
4. Paying for outcomes and health
 - Payments aligned to outcomes not volume
 - Incentives for prevention and improved care of chronic illness
5. Providing information
 - Readily available, accurate, reliable and understandable cost and quality data
 - Price and value for payers, providers and patients
6. Sustainable rate of growth
 - Focused on preventing cost shift to employers, individuals and families
 - Reduced utilization and cost trend

Coordinated Care Model Drivers

Driver 1: *Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)*

Driver 2: *Implementing alternative payment methodologies to focus on value and pay for improved outcomes*

Driver 3: *Integrating physical, behavioral, and oral health care with community health improvement*

Driver 4: *Standards and accountability for safe, accessible, and effective care*

Driver 5: *Testing, acceleration, and spread of effective delivery system & payment innovations*