

APPENDIX D

PRINCIPLES FOR NEW MODELS OF CARE

1. **Person-Centered, Family, and Community Focus.** Individual patients and their families should be at the forefront of any health system. The health of individuals is also strongly influenced by the broader community in which they live. Thus, new models of care should focus on the broader community and should include a strong population health emphasis.

2. **Improve Access, Quality, Health Outcomes, and Population Health and Reduce Costs.** North Carolina will be best served by developing models that will:
 - a. Improve health care quality (including outcomes and population health)
 - b. Increase access
 - c. Reduce costs (ie, reduce absolute health care costs and/or moderate the levels of increase)

The availability of funding sources should not solely drive the development of new models. Rather, once the key elements have been identified, funding sources should be pursued that will support the new models.

3. **Aggressively Test New Models to Improve Health.** North Carolina has a strong history of innovations that have led to improved access, quality, and patient outcomes with reductions in unnecessary health expenditures. However, there is a clear need for further progress. We need to build on current initiatives, while continuing to explore other options with the goal of further improvements in health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.

4. **Patient-Centered Interdisciplinary Teams.** North Carolina should support testing patient-centered interdisciplinary teams that include primary care, dental health professionals, behavioral health professionals, nutritionists, allied health professionals, pharmacists, and lay health advisors. These patient-centered teams should be positioned to address the health needs of the whole person. North Carolina should also support testing models that incorporate additional approaches (eg, health extenders such as lay health advisors or the use of group health visits) to determine if these models improve access, improve quality and health outcomes, and reduce costs.

5. **Involving Consumers More Directly in their Own Care.** North Carolina would be well served to explore options that involve consumers more directly in their own health and empower them to assume a more active role in their own health. Accordingly, consumers should be given the information, training, and support to be active participants in managing their own health and being an informed consumer in a redesigned health system. Any model of care should ensure that consumers are given culturally and linguistically appropriate health education and that information is conveyed in a way that ensures that it is understandable to people with lower health literacy.

6. **Utilize Health Professionals and Paraprofessionals to their Fullest.** In order to improve the capacity of our health care system to be able to serve all the newly insured, we need to consider new models that will utilize health professionals and paraprofessionals to the fullest extent of their training.
7. **Protect Vulnerable Patients and Safety Net Providers Serving Large Proportions of Vulnerable Populations.** Models of care should be designed to improve quality, health care outcomes, and health care access for populations that have been traditionally underserved including, but not limited to, low-income populations, the chronically ill, racial and ethnic minorities, and people with disabilities. New models should be specifically evaluated to determine the impact of redesigned delivery or payment methodologies on these vulnerable populations as well as on safety net providers serving large proportions of vulnerable populations.
8. **Transparency and Data.** Data should be collected in a manner that allows for the ongoing redesign and improvement of our care delivery systems including data collected at the individual, provider, and community levels. The data collection tools, evaluation methods, and results should be available to consumers.
9. **Evaluation and Monitoring.** Models of care should be thoroughly evaluated to determine if these innovations are leading to the stated goals (increased access, better quality and health outcomes, improved population health, increased efficiencies, and/or reductions in health care costs). It is important to understand what models work best for different populations in different communities and with different configurations of providers.
10. **Use Existing Frameworks to Encourage and Enhance Dissemination of New Innovations.** Successful initiatives should be disseminated throughout the state using existing dissemination infrastructures. Any new model tested in the state should be transparent in terms of design, outcomes, and costs.
11. **Multi-payer, Multi-provider.** To the extent possible, the new models of care should involve other payers in addition to Medicaid and Medicare. Multi-payer, multi-provider initiatives that involve public and private providers and community-based organizations have a greater possibility of improving quality, access to care, health outcomes, and population health while reducing health care costs.
12. **Reinvest Savings.** If savings are realized from the changes in the health care delivery and financing systems, these savings should be reinvested to support additional improvements in access, quality, health care outcomes, and population health and/or shared with consumers, taxpayers, payers, and providers.