



State Innovation Model (SIM) Grant Phase I Recap

The five SIM design workgroups (Better Care, Health, Value; Health Information Technology and Workforce Development) have met three times each for three hours—a total of 15 meetings and more than 45 hours of meetings. An *ad hoc* meeting concerning the integration of behavioral health with primary care was also held. As the SIM grant enters Phase II of its design process, it is important to take stock and summarize the valuable output of these five workgroups, especially since this output frames the discussion of the Phase II design.

Better Care Workgroup

- To transition to a value-based health care system that is aligned with SIM goals, the workgroup comments reflect the view that payors should compensate providers for care coordination, the education of patients on how to appropriately access care and for meeting measures / benchmarks developed in consultation with providers that are aligned among all payors.
- Ideally this value-based health care system would be designed by leveraging the advanced primary care model(s), such as the patient-centered medical home, that currently exist in West Virginia. However, it would also include more holistic (e.g., social determinants of health) and integrated care (e.g., behavioral health with primary care).

Better Health Workgroup

- Workgroup comments reflect the view that core public health challenges faced by West Virginians are generally a consequence of unhealthy behaviors, such as substance abuse, tobacco use and poor nutritional habits coupled with a sedentary lifestyle.
- Furthermore, workgroup comments reflect the view that West Virginia must employ three types of approaches to address chronic disease, particularly obesity and tobacco usage, in the state. These approaches are: 1. traditional clinical approaches (e.g., measuring BMI and waist circumference); 2. innovative patient-centered care and / or community linkages (e.g., community-based preventative services, health education to promote health literacy and patient self-management) and 3. community-wide strategies (e.g., policy or legislative changes such as requiring caloric counts in menu labeling).

Better Value Workgroup

- Workgroup comments reflect the view that care coordination / care coordinators is / are essential and fundamental to developing a value-based health care system that is aligned with SIM goals. The workgroup comments further recognize West Virginia varies widely in culture and socio-economic status by geographic areas; this makes flexibility imperative in how care coordination should occur and who should perform it.
- To achieve administrative simplification and work toward attaining the same and better quality outcomes, the workgroup comments reflect the view that measures need to be aligned among payors to the extent possible.

Health Information Technology (HIT) Workgroup

- The workgroup spent considerable time creating a SWOT analysis of West Virginia's current HIT landscape. The key strength, weakness, opportunity and threat from this analysis are provided below:

Strengths: Existing technology and a governance structure is in place to leverage data, including West Virginia Health Information Network (WVHIN), the Medicaid Data Warehouse and the hospital system infrastructure

Weaknesses: There is lacking interoperability among current HIT infrastructure—a problem that is not unique to West Virginia

Opportunities: Identify the value and return on investment of HIT to both patients and providers

Threats: A sustainability model for WVHIN is not in place.

Workforce Development Workgroup

- Not yet knowing the value-based health care system West Virginia envisions under the SIM grant, the workgroup discussed short-term (1 to 2 years) and long-term strategies (3 to 5 years) to fill headcount gaps (i.e., gaps in the number of providers) and skills gaps that exist in the current health care delivery system. A sample strategy developed by the workgroup is provided below.

Headcount Gap Short-Term – Gather accurate data that reflects “true need” – reconsider medically underserved areas / populations (which are based on outdated measures); consider geography (e.g., miles to provider; days to appointment)