

STATE INNOVATION MODEL (SIM) DESIGN

PROJECT UPDATE



Completed since March meeting of Collaborative

Formation and meetings of Steering Committee

Identification of Consultants

Participation in CMS-sponsored webinars and national SIM meeting

Items Delivered to CMS

- Stakeholder Engagement Plan (3/30)
- First Quarterly Report (6/1)
- Draft Driver Diagram (6/1)

Steering Committee Update - Membership

- Secretary Bowling (Chair)
- Cindy Beane: Commissioner BMS
- Sharon Carte: Director, CHIP
- Ted Cheatham: Director, PEIA
- Fred Early: President, Highmark BCBS WV
- Rahul Gupta: Commissioner BPH
- Mike Riley: WV Insurance Commissioner
- Terri Giles: WV Affordable Healthcare
- Sue Johnson-Phillippe: CEO, St. Joseph's Hospital
- James Becker: Medicaid Medical Director
- Joe Letnaunchyn: WV Hospital Association
- Adam Breinig: WV State Medical Association

Steering Committee Update - Meetings

April 15th

- Project introduction
- Discussion of SIM initiative goals, committee role, operating procedures, information needs

May 13th

- Review of SIM activity in other states
- Review of goals and objectives within original application
- Agreed-upon approach to goal setting
- Subsequent Project Aim Statement

Consultant services

Workgroup and Public Outreach Expertise

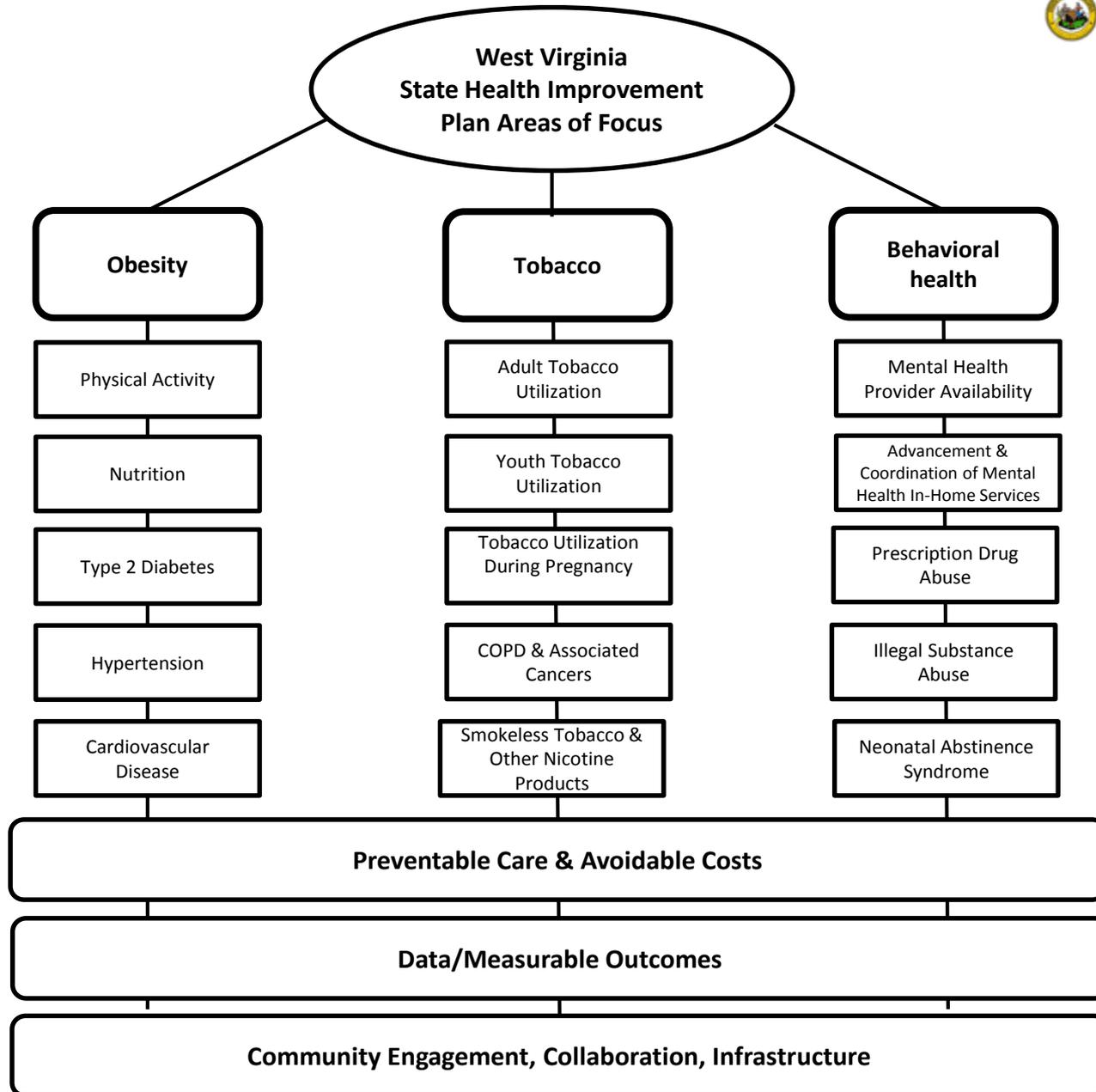
- Collective Impact, LLC
 - Facilitate workgroup meetings
 - Record workgroup activities
 - Lead Public Outreach activities
- Advisory Board Consulting and Management
 - Subject Matter Expertise
 - Steering Committee guidance
 - Assist with developing charge and providing background information for workgroups

Project Aim Statement (draft 5/29/15)

West Virginia will improve the health of our population, enhance quality and access to health care, and moderate health care spending. Over the next 5 years, the state will:

- Establish a highly coordinated care delivery system built upon a comprehensive primary care model;
- Implement payment systems developed to enhance value for consumers;
- Adopt population health improvement strategies that address existing health disparities, modifiable risk factors, and preventable conditions; and
- Expand the use of information technologies to provide better intelligence to providers and other stakeholders.

State Health Improvement Plan



Driver Diagram (draft 6/1/15)

AIM

West Virginia will improve the health of our population, enhance quality and access to care, and moderate health care spending.

Over the next five years, the state will:

- Reduce unnecessary ED usage.
- Reduce preventable hospital admissions.
- Reduce preventable hospital readmission.
- Increase follow-up care after hospitalization for mental illness.
- Decrease substance use, including tobacco, during pregnancy.
- Increase appropriate cancer screenings.
- Increase patient initiation and engagement of alcohol and other drug dependence treatment.

PRIMARY DRIVER

Establish a highly coordinated care delivery system built upon a comprehensive primary care model.

Implement payment systems developed to enhance value for customers.

Adopt population health improvement strategies that address existing health disparities, modifiable risk factors, and preventable conditions.

Expand the use of information technologies to provide better intelligence to providers and other stakeholders.

SECONDARY DRIVER

- Develop state and regional support network for transformation.
- Expand the primary care work forces.
- Train appropriate ancillary support providers.
- Develop payment model for practice care coordination.
- Establish regional care teams to support physicians' efforts to provide patient centered, physician driven, community-based care.
- Develop community and virtual support network for physician practices.
- Integrate behavioral health and support services.

- Develop sustainable reimbursement model.
- Engage physicians.
- Create consistent quality indicators.

- Identify and implement evidence-based practices to improve population health.
- Engage and educate patients through assessments, wellness activities, and technology.

- Track patient activity through Shared Care Management System.
- Share best practices.
- Track statewide and regional measures.

AIM

PRIMARY DRIVERS

SECONDARY DRIVERS

Better health

Achieve 75th percentile* or 10% improvement in key modifiable risk factors for chronic disease related to physical activity, healthy eating, and tobacco use by 12-31-19

Achieve 75th percentile or 10% improvement on key clinical quality measures related to weight and tobacco use assessment and counseling by 12-31-19

*75th percentile of HEDIS National Commercial (ALOB excluding PPO) 2013 rate

Better health care

Significantly improve performance on selected Clinical Quality Measures and other quality measures related to prevention and management of Pennsylvania's most prevalent and deadly chronic diseases by 12-31-19.

Lower cost

By 12-31-19 reduce:

- the total cost of care so that it aligns with forecast
- all-cause readmission rates by 10%
- potentially avoidable ED visit rates/1000 by 10%
- potentially avoidable hospitalization rates/1000 by 10%

Support spread of value-based payment models that reward quality, improved health and efficiency instead of volume

Support delivery system transformation through a new Healthcare Transformation Support Center

Improve care across the continuum of care, and reduce utilization of avoidable high intensity services with special focus on high-risk patients

Strengthen the Health Information Technology infrastructure to support population management, patient engagement, and performance measurement

Support recruitment, retention, and development of the health care workforce

Leverage the Community Health Improvement Planning process to improve community-clinical linkages, particularly in the areas of physical activity, healthy eating, and tobacco use

Align public and private payer payment models to spread adoption of APOs, PCMHs, and episodes of care

Develop statewide learning communities to support provider transition of population-based delivery models

Spread best practices in implementing APOs, PCMHs, and episodes of care

Provide onsite practice facilitation support for implementation of APOs, PCMHs, and episodes of care

Promote inclusion of training on inter-professional team-based care, leadership development, quality improvement, and patient-centeredness across health professions education programs

Develop Community-based Care Management teams to support high-risk patients

Develop regional health information exchanges across PA and the statewide highway to connect the regional HIEs

Enhance the collection, analysis, and reporting of provider performance measures

Expand telemedicine services in rural and underserved areas

Expand loan forgiveness for primary care, dental and behavioral clinicians with extra incentives for those working in PCMHs or safety net clinics

Create a learning network, using a case-based learning method built on PA's telestroke HIT to enhance primary care capacity in managing chronic and complex diseases.

Develop community resource database to facilitate knowledge of and access to community-based supports and services

State Innovation Model (SIM) – Next Steps

- Collaborative engagement to determine more specific objectives, targets and measures
- Consider and propose strategies to accomplish goals and objectives
- Project management team & consultants to provide suggested framework and approach at upcoming workgroup meetings in June
- Document preparation for use to include: baseline population health status assessment, baseline healthcare environment assessment, gap analysis, and identification of potential regulatory and policy levers

SIM update

Discussion