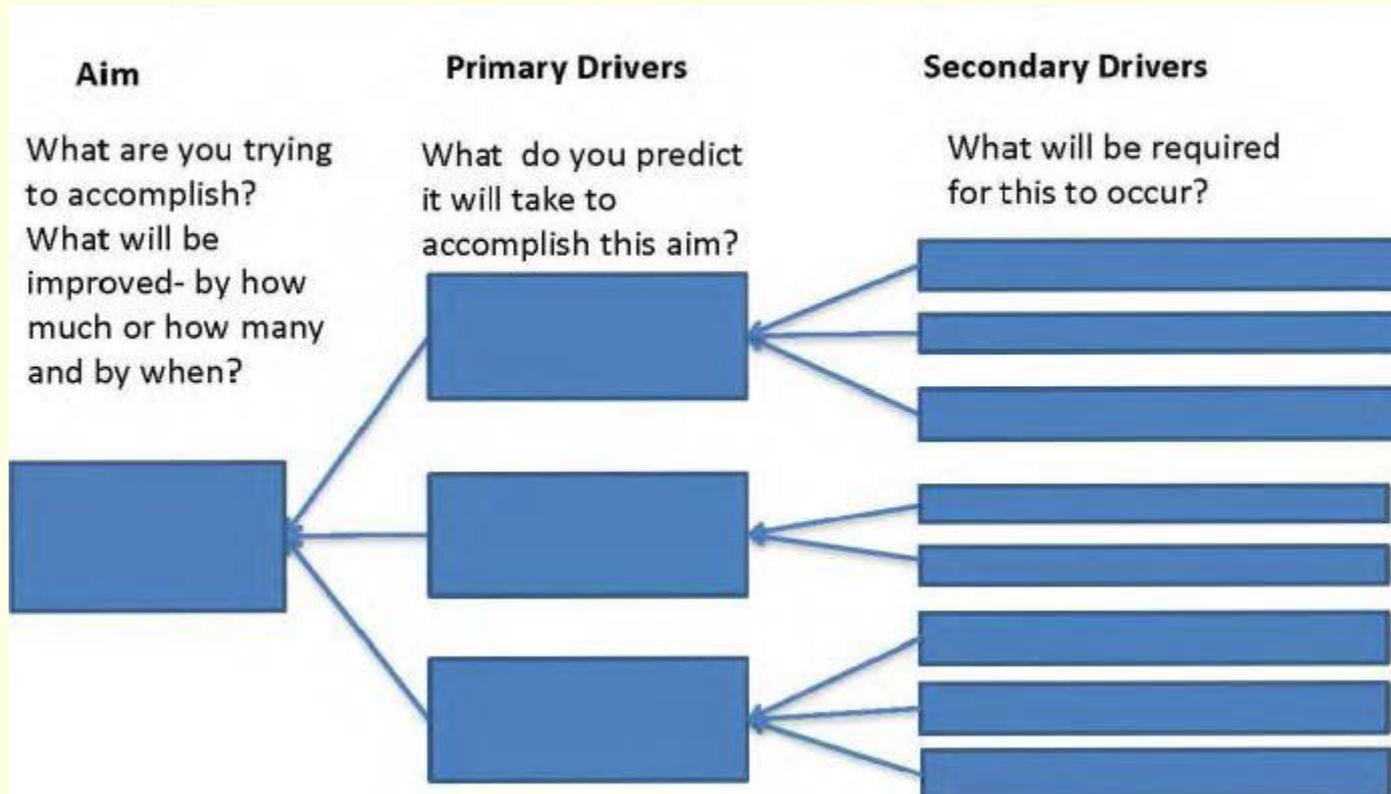


# SIM Project

Steering Committee  
May 13, 2015



# Required Driver Diagram



# West Virginia SIM Application Goals

**Goal 1: Comprehensive Primary Care & Primary Care Medical Homes (PCMHs): Increase number of PCMHs that are accountable for meeting large majority of patients needs including prevention, wellness, acute care, and chronic care**

**Objectives: Promote team-based, patient-centered care; Emphasize full array of medical, social, behavioral, and oral health as well as cultural, environmental, and socioeconomic factors**

## Intervention(s)

- Provide professional training on team-based, patient-centered care. Provide expertise (if not available) on other aspects of health, cultural, environmental, and socioeconomic factors
- Provide access to telehealth system to provide training, additional expertise, and other communication. Educate patients on comprehensive health in the workplace and refer to effective programs/services in the area.

## Targeted Outcomes

95% of all targeted citizens will be associated with a medical home in next five years.

**Goal 2: Coordinated Care: Increase number of PCMHs that will coordinate care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services.**

**Objectives: Focus coordinated care particularly in transitional periods of care; Support coordination efforts among providers**

## Intervention(s)

- **Facilitate stakeholder engagement in PCMH formation and planning. Provide access to national guidance and experts on PCMHs**
- **Utilize telehealth infrastructure to provide additional services. Use existing health information technology examples to increase awareness and use of HIT to improve care coordination within and across provider groups to build efficient PCMHs**

## Targeted Outcomes

**80% of all care utilizes the coordinated care model within next five years**

**Goal 3: Accessible Services: Increase patient accessibility to services (i.e., shorter waiting times, enhanced in-person hours, 24-hour access to care team member, alternative communication methods); Decreased ER visits for chronic care.**

**Objectives: Encourage accessible services; Support expanded primary care access**

## **Intervention(s)**

- **Reinforce accessible services through reimbursement and other means. Provide education related to inappropriate use of ER visits through PCMHs. Provide e-consult access to specialists through existing telehealth. Provide access to additional public health and programmatic information using non-visit methods.**

## **Targeted Outcomes**

**95% of patients (Tier 1 and 2) will have a PCMH and personal health management plan within next five years**

## **Goal 4: Quality and Safety: Improve consistency of defined care quality and specific quality outcomes within PCMHs**

**Objectives: Promote quality improvement among individual providers and larger PCMHs; Identify best practices for improving care quality**

Intervention(s)	Targeted Outcomes
<ul style="list-style-type: none"><li>• Continue to engage providers, payers, and other stakeholders to establish consistent quality measures, reimbursement for quality care. Provide on-going training and access to evidence-based medicine and clinical decision-support tools</li><li>• Utilize HIT to identify performance measures, modify improvement goals, measure and respond to patient experiences and satisfaction</li></ul>	Finalize quality measures identified by the Collaborative; Outline a process for expanding these measures to align with population health improvement plan

# West Virginia SIM Application Goals

**Goal 5: Integrated Care and Use of HIT: Advance evidence-informed clinical decision making using electronic health record (EHR) decision support, shared decision making tools, and provider quality and cost data at the point-of-care; Improve consumer-directed care decisions.** Objectives: Encourage care coordination across settings using health information exchange tools and data availability to care teams (claims and clinical data) to assist in measuring utilization, outcomes, cost and effectiveness of clinical interventions; Promote use of population-based data to understand practice sub-populations, panel, and individual risk, and to inform care coordination

Intervention(s)	Targeted Outcomes
<ul style="list-style-type: none"><li>Engage the Collaborative and other stakeholders to outline a standardized approach to clinical information exchange to accelerate providers' use of direct messaging and secure communication. Provide regular trainings and other educational means to increase awareness of existing HIT methods and frameworks.</li><li>Utilize case examples to increase familiarity with practice models using HIT. Provide direct assistance to providers to establish and use information.</li></ul>	<p>Promote effective adoption and use of HIT by 90% of health care providers within five years</p> <p>Use patient portals and personal health records by 50% of high risk patients within five years</p>

**Goal 6: Use of Data to Drive Improvement: Establish coordinated care among providers, patients, and payers to create common data measurements and scorecards that reflects the provider's ability to meet measures of health status, quality of care, and consumer experience.** Objectives: Encourage use of data to track performance for quality, care experience, equity, and cost measures.

## Intervention(s)

- Facilitate the use of data across payers in order to be able to track a provider's true performance for entire patient panel. Provide regular training opportunities on data-driven process.

## Targeted Outcomes

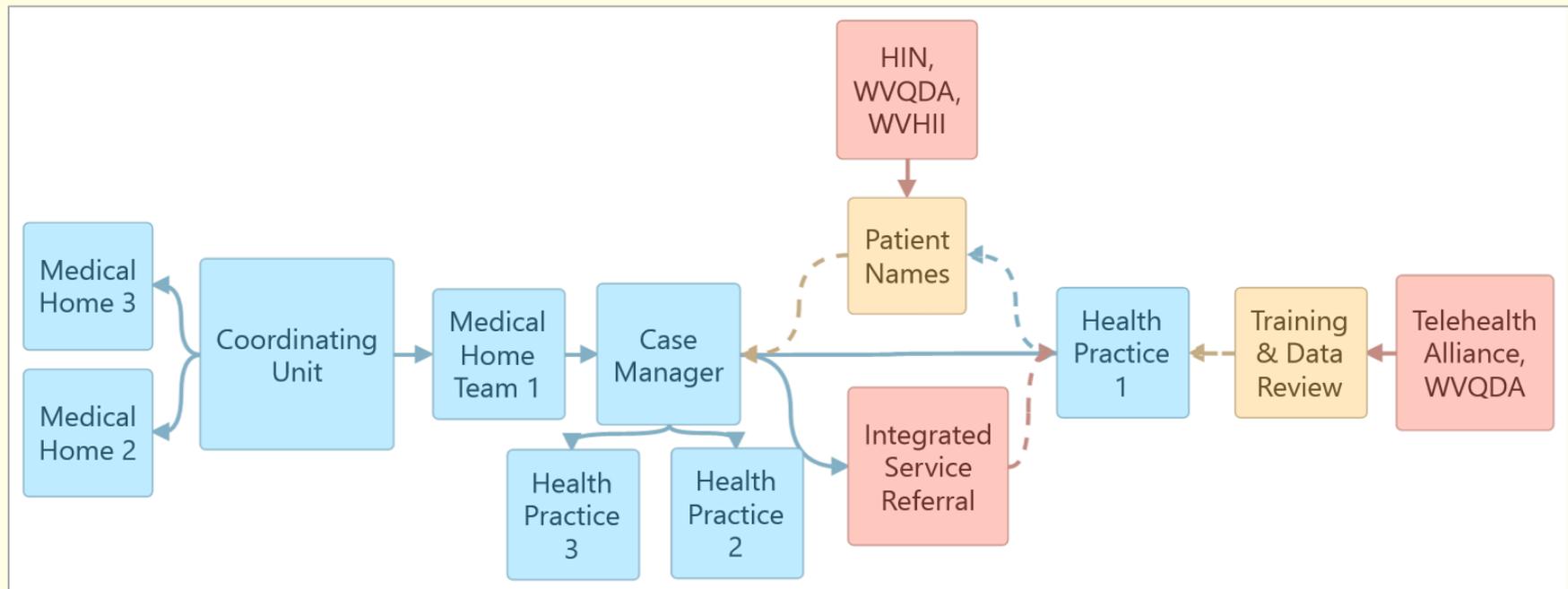
Identify and outline process and outcome data widely available for use within five years

# Vulnerable Populations Focus

Tier 1 targets the highest cost beneficiaries;  
Tier 2 is comprised of the larger segment of the respective coverage groups with chronic conditions or other “modifiable” conditions that result in avoidable costs or utilization of health care services.

Coverage Groups	# WV	Tier 1 (N)	Tier 2 (N)
Medicare	220,750	61,737	98,714
Dual Eligible	59,906	19,812	32,728
Medicaid	313,301	15,665	136,817
CHIP	25,136	1,256	3,254
PEIA/Com.	927,640	38,336	278,292
Uninsured	280,417	10,284	84,125
<b>Total</b>	<b>1,827,150</b>	<b>147,090</b>	<b>633,930</b>

# Concept of Regionally Coordinated PCMHs



# Operational Plan - Tasks and Milestones

<b>Task/Deliverable</b>	<b>Deadline(s)</b>	<b>Task Leader</b>
Operational Plan	2/28/15	Coben
Stakeholder Engagement Plan	3/30/15	Cottrell
Population Health Assessment & Gap Analysis	5/30/15	McCarty
Population Health Plan	8/30/15	McCarty
Driver Diagram	5/30/15	Sullivan
Identify Regulatory and Policy Levers	5/30/15	Campbell
Description of the Baseline Health Care Environment	5/30/15	Project Manager
Value-based Health Delivery and Payment Methodology Transformation Plan	8/30/15	Campbell
Health Information Technology Plan	11/30/15	Dolly
Workforce Development Strategy	11/30/15	King
Financial Analysis	11/30/15	Ruseski
Future Monitoring and Evaluation Plan	11/30/15	Cottrell
Future Operational & Sustainability Plan	11/30/15	Samples
Draft Innovation Plan	12/30/15	Project Manager
Final Innovation Plan	1/31/16	Project Manager
Quarterly Reports	5/30/15; 8/30/15; 11/30/15	Coben
Final Report	4/30/16	Coben