

	<u>SIM Component/Project Area</u>	<u>Start date</u>	<u>Milestones</u>
A Establishing infrastructure	1 Program and grant management	Ongoing	<ul style="list-style-type: none"> Quarterly reports and annual operations plan
	2 Hold Cross Committee Meetings (approximately 1 per quarter)	Ongoing	<ul style="list-style-type: none"> Approx 3 cross committee meetings per year. Exact dates TBD. May taper to fewer meetings in later years as program shifts to more monitoring
	3 State evaluation contractor	Q1 2016	<ul style="list-style-type: none"> Annual reports
	4 Support full functioning of DCHI Board and committees	Q1 2016	<ul style="list-style-type: none"> Fill vacant Board seats by Q1 2016
	5 Support DCHI in staffing (Healthy Neighborhoods Program Director and Executive Assistant)	Q2 2016	<ul style="list-style-type: none"> Both positions filled and have started in Q2 2016
	6 Overall scorecard for program monitoring	Q2 2016	<ul style="list-style-type: none"> Dashboard running in Q2 2016. Individual measures updated on a rolling basis
B Health IT	1 Delivery system and payment model		
	<ul style="list-style-type: none"> Increase clinical data access <ul style="list-style-type: none"> Increase number of practices submitting CCDs Increase number of LTPAC facilities sending clinical data Provide funding for CCD import Generate Scorecard measures from clinical data 	<ul style="list-style-type: none"> Ongoing Ongoing Q2 2017 for CCD import funding Ongoing 	<ul style="list-style-type: none"> Increase automatic submission of CCDs from baseline of 14 eligible providers to 200 by Q3 2017 Recruit and train 80% of SNF and home health organizations on submission of C-CDA documents to the community health record by Q3 2017 Target 5-15% of DE providers that can automatically incorporate data from CCDs by Q2 2018 Implementation of clinical quality measures from CCDs for primary care practices submitting CCDs by Q2 2017

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<ul style="list-style-type: none"> ▪ Enable event notifications across healthcare system 	Ongoing	<ul style="list-style-type: none"> ▪ Increase number of eligible providers receiving alerts to 475 from baseline of 150 by Q3 2017 ▪ Enable alerting from 80% of SNF and home health organizations by Q3 2017
<ul style="list-style-type: none"> ▪ Increase direct secure messaging 	Ongoing	<ul style="list-style-type: none"> ▪ Complete database of direct addresses with functionality to add and remove entries by Q2 2016 ▪ Recruit, enroll, and train 75% LTPAC organizations on direct secure messaging by Q3 2017
<ul style="list-style-type: none"> ▪ Provide EMR adoption incentives for behavioral health 	Q1 2016	<ul style="list-style-type: none"> ▪ 50 behavioral health providers with EMRs by end of 2016 ▪ Another 30 BH providers by end of 2017 and 20 by end of 2018
<ul style="list-style-type: none"> ▪ Aggregate claims-based information 	Q3 2016	<ul style="list-style-type: none"> ▪ Implementation by Q1 2018 ▪ Data availability to stakeholders by Q2 2018
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<h2 data-bbox="390 799 928 834">2 Patient and consumer engagement</h2>		
<ul style="list-style-type: none"> ▪ Enable consumer transparency into cost and quality information: Ensure payer provision of consumer transparency into cost and quality information 	Q1 2016	<ul style="list-style-type: none"> ▪ Top procedures and services are made available by each of the major payers by Q1 2018
<ul style="list-style-type: none"> ▪ Enable consumer transparency into cost and quality information: Develop public tool for consumer transparency into cost and quality information 	Q1 2018	<ul style="list-style-type: none"> ▪ Public cost/quality tool implemented and available by Q3 2018

B Health IT (continued)

	SIM Component/Project Area	Start date	Milestones	
B	Health IT (continued)	3 Research, evaluation and planning		
	<ul style="list-style-type: none"> Conduct public health planning through multi-payer claims aggregation 	<ul style="list-style-type: none"> Q1 2018 	<ul style="list-style-type: none"> Tools available by Q3 2018 	
C	Population health Healthy Neighborhoods (HN)	1 Planning for HN pilot and Wave 1 implementation	Q1 2016	<ul style="list-style-type: none"> Preparations complete by Q2 2016
		2 Staggered launch of up to 3 Neighborhoods in Wave 1	Q2 2016	<ul style="list-style-type: none"> Have up to 3 HN launched by Q4 2016
		3 Monitoring and reporting	Q3 2016	<ul style="list-style-type: none"> HN Dashboard by Q3 2016
		4 Assessment of Wave 1 and planning for Wave 2	Q4 2016	<ul style="list-style-type: none"> Assessment of Wave 1 complete by Q4 2016
		5 Wave 2 and Wave 3 implementation	Q1 2017	<ul style="list-style-type: none"> 5 total HN launched by Q4 2017, 8 or more by Q4 2018
D	Workforce	1 Credentialing	Q1 2016	<ul style="list-style-type: none"> Consensus approach developed by Q2 2016
		2 Curriculum	Q1 2016	<ul style="list-style-type: none"> Curriculum available by Q4 2016 75% of relevant primary care workforce has participated in retraining programs by Q4 2018
		3 Capacity planning	Q1 2016	<ul style="list-style-type: none"> Planning analysis complete by Q4 2016
		4 Residency program	Q3 2016	<ul style="list-style-type: none"> 1 additional residency program by Q3 2018

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E Payment	1 Medicaid value-based payment	Q1 2016	<ul style="list-style-type: none"> Highmark Medicaid TCC pilot Q1 2016 and P4V pilot Q3 2016 United Medicaid rollout of TCC and P4V models on rolling basis during 2016
	2 Commercial value-based payment	Q1 2016	<ul style="list-style-type: none"> Highmark Commercial P4V program Q1 2017
F Clinical	1 Practice Transformation	Q1 2016	<ul style="list-style-type: none"> 25% practices in Q1 2016, 50% by Q4 2016, 75% by Q3 2017
	2 Care Coordination	Q1 2016	
	<ul style="list-style-type: none"> Define opportunities to standardize approaches to care coordination 	Q1 2016	<ul style="list-style-type: none"> Recommendations on standardization tools adopted by Board by Q2 2016
	<ul style="list-style-type: none"> Outreach to PCPs and ACOs to understand further areas for support 	Q2 2016	<ul style="list-style-type: none"> Recommendations for other areas of support by Q3 2016
	<ul style="list-style-type: none"> Care coordination funding through VBP models 	Q1 2017	<ul style="list-style-type: none"> Practices enrolled in VBP models receive care coordination funding in Q1 2017
	3 Behavioral health integration	Q1 2016	
	<ul style="list-style-type: none"> Detailed implementation planning 	Q1 2016	<ul style="list-style-type: none"> Implementation plan for review by DCHI Clinical Committee Q1 2016
	<ul style="list-style-type: none"> Required capabilities for support 	Q2 2016	<ul style="list-style-type: none"> Capabilities for support developed by Q3 2016
	<ul style="list-style-type: none"> Support for integration 	Q3 2016	<ul style="list-style-type: none"> Support for integration reaching practices by Q4 2016
	4 Effective diagnosis and treatment	Q3 2016	<ul style="list-style-type: none"> Strategy complete by Q4 2016

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F Clinical <i>(continued)</i>	5 Common Scorecard	Ongoing	<ul style="list-style-type: none"> Scorecard available statewide by Q3 2016
	<ul style="list-style-type: none"> Additional functionality for Common Scorecard 	Q2 2016	<ul style="list-style-type: none"> Quarterly releases with bug fixes and/or additional functionality
	<ul style="list-style-type: none"> Assess measures annually and make amendments where necessary 	Q2 2016	<ul style="list-style-type: none"> V3.0 Scorecard by Q3 2016
G Patient and consumer	1 Health literacy materials	Q1 2016	<ul style="list-style-type: none"> Launch web site with materials by Q4 2016
	2 Lab and clinical information	Q3 2016	<ul style="list-style-type: none"> Lab and clinical information from community health record available to consumers by Q4 2016