



Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-annual report Template
Reporting Period: July 1, 2018 - December 31, 2018

January 25, 2019

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• Semi-annual report workbook	
• Organizational self-assessment of internal controls and risks	

Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports to report on project implementation and progress milestones. ACHs will complete a standardized semi-annual report template and workbook developed by HCA. The template will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each Demonstration Year (DY):

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved Project Plans and corresponding Implementation Plans. HCA and the IA will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted at any subsequent time for purposes of monitoring and auditing, or general follow-up and learning discussions with the state (HCA), the Independent Assessor (IA) and/or the Independent External Evaluator (IEE).

Reporting requirements

The semi-annual report template for this reporting period includes four sections as outlined in the table below. With one exception, the reporting period for this semi-annual report covers July 1, 2018 to December 31, 2018.¹ Sections 1 and 2 instruct ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 4 per the Medicaid Transformation Toolkit. Sections 3 and 4 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

Note: Each section in the semi-annual report contains questions regarding the regional transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional transformation work completed by either:

- The ACH as an organization
- The ACH's partnering providers
- The ACH and its partnering providers

Please read each prompt carefully for instructions as to how the ACH should respond.

¹ The reporting period for Value-based Payment (VBP) milestones covers the full calendar year, January 1 through December 31, 2018.

ACH semi-annual report 2		
Section	Reporting period	Sub-section description
Section 1. Required milestone reporting (VBP Incentives)	DY 2, Q1-Q4	Milestone: Inform providers of value-based payment (VBP) readiness tools to assist their move toward value-based care
		Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH
		Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey
		Milestone: Support providers to develop strategies to move toward value-based care
Section 2. Required milestone reporting (Project Incentives)	DY 2, Q3-Q4	Milestone: Support regional transition to integrated managed care (2020 regions only)
		Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)
		Milestone: Engagement/support of Independent External Evaluator (IEE) activities
Section 3. Standard reporting requirements (Project Incentives)	DY 2, Q3-Q4	ACH organizational updates
		Tribal engagement and collaboration
		Integrated managed care status update (early- and mid-adopters only)
		Project implementation status update
		Partnering provider engagement
		Community engagement and health equity
		Budget and funds flow
Section 4. Provider roster (Project Incentives)	DY 2, Q3-Q4	Completion/maintenance of partnering provider roster
Section 5. Integrated managed care implementation (Integration Incentives)	N/A	Milestone: Implementation of integrated managed care (mid-adopters only)

Key terms

The terms below are used in the semi-annual report and should be referenced by the ACH when developing responses.

1. **Community engagement:** Outreach to and collaboration with organizations or

individuals, including Medicaid beneficiaries, that are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

2. **Health equity:** Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.²
3. **Integrated managed care:**
 - a. **Early-adopter:** Refers to ACH regions implementing integrated managed care prior to January 1, 2019.
 - b. **2020 adopter:** Refers to ACH regions implementing integrated managed care by January 1, 2020.
 - c. **Mid-adopter:** Refers to ACH regions implementing integrated managed care on January 1, 2019.
4. **Key staff position:** Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, and Program Management and Strategy Development.
5. **Partnering provider:** Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.
6. **Project areas:** The eight Medicaid Transformation projects that ACHs can implement.
7. **Project Portfolio:** The full set of project areas an ACH has chosen to implement.

Achievement Values

Throughout the transformation, each ACH can earn Achievement Values (AVs), which are point values assigned to the following:

1. Reporting on project implementation progress (Pay-for-Reporting, or P4R).
2. Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).

ACHs can earn AVs by providing evidence of completion of reporting requirements and demonstrating performance on outcome metrics. The amount of incentive funding paid to an ACH will be based on the number of earned AVs out of total possible AVs for a given payment period.

² Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.

All possible earned incentives for the second semi-annual report are associated with P4R. The required P4R deliverables and milestones for the second semi-annual reporting period are identified in the table below.

Deliverable/Milestone	One-time / Recurrent	Reporting Period	AVs
Section 1. Required milestone reporting (VBP Incentives)			
<i>Milestone:</i> Inform providers of VBP readiness tools to assist their move toward value-based care	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Support providers to develop strategies to move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Section 2. Required milestone reporting (Project Incentives)			
<i>Milestone:</i> Support regional transition to integrated managed care (2020 regions only)	One-time	DY 2, Q3-Q4	1.0
<i>Milestone:</i> Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)	One-time	DY 2, Q3-Q4	1.0
<i>Milestone:</i> Engagement/support of Independent External Evaluator (IEE) activities	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 3. Standard reporting requirements (Project Incentives)			
<i>Deliverable:</i> Complete and timely submission of SAR. <i>Note: All non-milestone, standard reporting requirements are a part of the SAR 1.0 AV.</i>	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 4. Provider roster (Project Incentives)			
<i>Deliverable:</i> Completion/maintenance of partnering provider roster	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 5. Integrated managed care implementation (Integration Incentives)			
<i>Milestone:</i> Implementation of integrated managed care (mid-adopters only)	One-time	N/A	N/A

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the Independent Assessor **no later than January 31, 2019 at 3:00p.m. PST.**

Washington Collaboration, Performance, and Analytics System (WA CPAS)

ACHs must submit their semi-annual reports through the WA CPAS, which can be found at <https://cpaswa.mslc.com/>.

ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled “Semi-Annual Report 2 – January 31, 2019.”

The folder path in the ACH’s directory is:

Semi-Annual Reports → Semi-Annual Report 2 – January 31, 2019.

Please see the WA CPAS User Guide provided in fall 2017, and available on the CPAS website, for further detail on document submission.

File format

ACHs must respond to all items in the Microsoft Word semi-annual report template and the Microsoft Excel semi-annual report workbook based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

ACHs must include all required attachments, and label and make reference to the attachments in their responses where applicable. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word and Microsoft Excel or a searchable PDF format. Below are examples of the file naming conventions that ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR2 Report. 1.31.19
- *Excel Workbook:* ACH Name. SAR2 Workbook. 1.31.19
- *Attachments:* ACH Name.SAR2 Attachment X. 1.31.19

Note that all submitted materials will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).³

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2018 – December 31, 2018.

³ <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>

ACH semi-annual Report 2 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report template and workbook for reporting period 2 to ACHs	HCA	August 2018
2.	Submit semi-annual reports	ACHs	Jan 31, 2019
3.	Conduct assessment of reports	IA	Feb 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2019
7.	Issue findings to HCA for approval	IA	End of Q2

Contact information

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

ACH contact information

Provide contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's semi-annual report. If secondary contacts should be included in communications, please also include their information.

ACH name:	Olympic Community of Health
Primary contact name	Margaret Moore
Phone number	(360) 689-2345
E-mail address	margaret@olympicch.org
Secondary contact name	JooRi Jun
Phone number	(360) 900-3539
E-mail address	joori@olympicch.org

Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

- If the ACH checked “No” in item A.1, provide the ACH’s rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response:

Not applicable.

- In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
<i>Providers with low Value-Based Payment (VBP) knowledge:</i> 1) Primary care, behavioral health and hospital Implementation Partners with low	Change Plan site visits and resource sharing on Olympic Reporting and Community Activities (ORCA) platform	August 2018-December 2018	All Implementation Partners were offered a site visit to assist in completing the Change Plans. Change Plans include required targeted Outcomes and Tactics, co-designed by providers, with the purpose

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
<p>levels of VBP knowledge</p>			<p>of preparing for value-based contracting</p> <p>Value Based Payment (VBP) resource shared by the Practice Transformation Support Hub (PTSH) were uploaded on ORCA.</p> <p>Title: Defining a Strategy for Value-Based Contracting</p> <p>Link: https://waportal.org/resources/defining-strategy-value-based-contracting</p>
<p><i>Small providers: 2)</i> Eleven local behavioral health agencies, including four community mental health centers and seven stand-alone substance use disorder treatment providers, six of whom would qualify as small providers, defined as ≤ 25 FTE.</p>	<p>On-site customized integrated billing support site visits</p>	<p>October 2018-December 2018</p>	<p>On-site, intensive clinic support from the PTSH and Outlook Associates with use of the BHA Billing Toolkit developed by Outlook Associates. The Salish Behavioral Health Organization attended three of these site visits. The sites completed a self-assessment for Integrated Managed Care (IMC) readiness, on-site intensive interview with operational staff and a gap analysis and readiness score card for IMC, with listed recommendations to prepare for success in a new billing environment.</p>
<p><i>Behavioral health providers: 3)</i> All behavioral health agencies in the Olympic region were invited to participate</p>	<p>Olympic Community of Health co-hosted with Cascade Pacific Action Alliance a two-part VBP and billing learning event in Shelton, WA</p>	<p>November 1 and 14, 2018</p>	<p>Behavioral Health providers attended two days of intensive training by the PTSH and Washington Council on Behavioral Health. They</p>

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
			were required to complete the BHA Billing Toolkit survey prior to attendance and learned strategies for implementing quality improvement to prepare for VBP, and billing. Each team developed a project to practice quality improvement in a PDSA (plan-do-study-act) format.

Acronyms used in this table:

IMC – Integrated managed care, ORCA – Olympic Reporting and Community Activities, PDSA – Plan-do-study-act, PTSH – Practice Transformation Support Hub, VBP – Value-based payment

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not applicable.”

ACH response:

Not applicable.

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
NW WA Family Residency Medical Clinic and Kitsap Mental Health Services (KMHS), Bremerton	Integration plan for KMHS Behavioral Health Provider within NW Family Residency Medical Clinic to improve care coordination and close care gaps	Olympic Community of Health (OCH) Natural Community of Care Convenings Site visits by OCH staff Collaborative Care Model/Aims Center Resource Practice Transformation Support Hub (PTSH)/Qualis Health Practice Coach
Sophie Trettevick Indian Health Center (Neah Bay)	Assessment of current state to plan for integration of care Empanelment Project to 1) design system to confirm assignments, review and update panel assignments 2) Pilot use of panel data and registries to proactively contact, educate and track patients by disease and risk status	Coaching services from Pediatric Transforming Clinical Practices Initiative (P-TCPI) Practice Facilitator and PTSH/Qualis Health Practice Coach On-site assessment, action planning, quality improvement training and on-going technical assistance
Reflections Counseling Services Group	Linkages with Primary Care, Behavioral Health and Community-Based Organizations in Clallam county in preparation for Integrated Managed Care (IMC) Integrated Billing Support Project to asses gaps and plan for success in IMC billing environment Implement PreManage through P-TCPI sponsorship to decrease avoidable Emergency Department visits	P-TCPI Practice Facilitator and PTSH/Qualis Health Practice Coach assessments, action planning and PDSA (plan-do-study-act) projects since 2017 BHA Billing Toolkit completion, gap analysis and readiness report for IMC from Outlook Associates. Workflow mapping to close care gaps with no-show clients On-going technical assistance from Collective Medical and P-TCPI Practice Facilitator/Department of Health

Acronyms used in this table:

IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, OCH – Olympic Community of Health, PDSA – Plan-do-study-act, P-TCPI – Pediatric Transforming Clinical Practices Initiative, PTSH – Practice Transformation Support Hub

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH's efforts to support completion of the state's 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
<i>Contractual expectation of provider: Copied the state provider survey into Olympic Community of Health's assessment and made completing the assessment a requirement for becoming an Implementation Partner</i>	Yes	Yes
<i>Post survey link to ACH website; email communication to broad distribution list: Email communication to broad distribution list</i>	No	No
<i>Individual communication with providers: Individual, targeted communication with providers that had not completed the survey</i>	No	No

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities

Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
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Note: Providers in all three categories are invited to engage in the Olympic Community of Health (OCH) Medicaid Transformation Project (MTP) Natural Community of Care (NCC) and Change Plan process. Action steps and milestones required for these three categories are shared in order to meet the Tactics and Outcomes of Change Plans.

<p><i>Provider with low VBP knowledge:</i> Beacon of Hope/Safe Harbor Recovery, Port Townsend</p>	<p>Understanding of clinical reporting requirements under Value-based payment (VBP)</p> <p>Assessment of current billing practices and plan for transition to managed care</p> <p>Assessment of Electronic Health Record (EHR) capabilities for direct contracting with Managed Care Organizations (MCOs)</p> <p>Identification of Integrated Managed Care (IMC) workforce training needs and current skill gaps</p> <p>Building linkages for integration activities with primary care, community mental health and community-based organizations (CBOs)</p>	<p>Inclusion in MTP and commitment to NCC and Change Plan process</p> <p>OCH staff site visits, technical assistance to maximize engagement as OCH NCC Change Plan Partner</p> <p>Coaching services to provide quality improvement (QI) culture training</p> <p>Current state assessment with the Practice Assessment Tool, The Maine Health Access Foundation Assessment or Patient-Centered Medical Home Assessment (PCMH-A)</p> <p>Pediatric Transforming Clinical Practices Initiative and Qualis Health action plan and on-going system of QI introduced to teams</p>	<p>Participation in OCH MTP NCC convenings and site visit by OCH staff</p> <p>Submission of Change Plan</p> <p>Participation in the Qualis Health On-site Integrated Billing Support Project and use of BHA Billing Toolkit</p>	<p>Engagement in OCH NCC and signed Change Plan completed</p> <p>Integrated billing readiness assessment completed, and gap analysis report received</p>
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ACH provider support activities

Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
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Note: Providers in all three categories are invited to engage in the Olympic Community of Health (OCH) Medicaid Transformation Project (MTP) Natural Community of Care (NCC) and Change Plan process. Action steps and milestones required for these three categories are shared in order to meet the Tactics and Outcomes of Change Plans.

<p><i>Small provider:</i> Kitsap Medical Group, Bremerton</p>	<p>Linkages with primary care, behavioral health and CBOs in the region to develop integration strategies</p> <p>Technical assistance to prepare and sustain Collaborative Care Model staffing, documentation and billing to improve clinical care</p>	<p>Inclusion in MTP and commitment to NCC and Change Plan</p> <p>OCH staff site visits, technical assistance to maximize engagement as OCH NCC Change Plan Partner</p> <p>Request for contacts in rural and remote area primary care clinics who have implemented telepsychiatry and Collaborative Care</p>	<p>QI team formed and protected time for QI activities</p> <p>Three completed PCMH-A and action plans</p> <p>Participation in OCH Kitsap NCC convenings and submission of Change Plan</p> <p>Multiple convenings with Kitsap Mental Health Services (KMHS) and developing pilot plan for KMHS integrated behavioral health provider</p>	<p>Engagement in OCH NCC and signed Change Plan completed</p> <p>Pilot project launched with KMHS for integrated behavioral health provider and use of collaborative care codes</p> <p>Alignment with NCC partners to network and advance integration within the Kitsap NCC</p>
<p><i>Behavioral health providers:</i> Peninsula Behavioral Health, Port Angeles</p>	<p>Understanding of clinical reporting requirements under VBP</p> <p>Assessment of current billing practices and plan for transition to IMC</p> <p>Assessment of EHR capabilities for direct contracting with MCOs</p>	<p>Inclusion in MTP and commitment to NCC and Change Plan</p> <p>OCH staff site visits, technical assistance to maximize engagement as OCH NCC Change Plan Partner</p>	<p>Participation in VBP Academy</p> <p>QI team formed and pilot of PDSA (plan-do-study-act) and PHQ-9 (a standardized depression screening tool) tracking treatment to target</p> <p>Submission of Change Plan</p>	<p>Engagement in OCH NCC and signed Change Plan completed</p> <p>Procurement of new EHR to meet capacity of IMC, planning to implement in early 2019</p> <p>Attendance to Southwest Accountable Community of Health behavioral health</p>

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
<p><i>Note: Providers in all three categories are invited to engage in the Olympic Community of Health (OCH) Medicaid Transformation Project (MTP) Natural Community of Care (NCC) and Change Plan process. Action steps and milestones required for these three categories are shared in order to meet the Tactics and Outcomes of Change Plans.</i></p>				
	Identification of IMC Workforce training needs and current skill gaps		Participation in the Qualis Health On-site Integrated Billing Support Project and use of BHA Billing Toolkit	agency site visit for lessons learned during IMC transition and best practices for IMC success

Acronyms used in this table:

CBO – Community-based organization, EHR – Electronic medical record, IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, MCO – Managed care organization, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, PCMH-A – Patient-Centered Medical Home, PDSA – Plan-do-study-act, QI – Quality improvement, VBP – Value-based payment

Acronyms used in Section 1:

CBO – Community-based organization, EHR – Electronic medical record, IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, MCO – Managed care organization, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PCMH-A – Patient-Centered Medical Home, PDSA – Plan-do-study-act, P-TCPi – Pediatric Transforming Clinical Practices Initiative, PTSH – Practice Transformation Support Hub, QI – Quality improvement, TA – Technical Assistance, VBP – Value-based payment

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

- a. If the ACH checked “No” in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response:

During this reporting period, the Olympic Community of Health (OCH) did not formally engage or convene partners to discuss a process and timeline for regional transition to integrated managed care (IMC). The reason for this is that until November 2018, the Salish Behavioral Health Organization (SBHO) executive board was actively pursuing a legislative alternative to IMC. Additionally, the previous SBHO administrator informed the OCH Board of Directors that the SBHO would assume sole responsibility for planning, convening, engaging and preparing partners for either pathway: (1) the proposed alternative model to IMC and, if that failed to move forward, (2) IMC. At a subsequent SBHO executive board meeting the OCH was encouraged and agreed to participate in this process where invited.

OCH staff and Board of Directors took many opportunities during this reporting period to offer support, assistance and resources to the SBHO in order to collaborate in the engagement and convening of providers, Managed Care Organizations (MCOs) and other regional partners. The OCH Board had challenging and important conversations during board meetings regarding how to leverage support for providers in the three-county region and how to support health care reform efforts.

During this reporting period OCH coordinated a technical assistance training opportunity for Behavioral Health Agencies (BHA) providers in the form of on-site intensives and 2-day value-based payment (VBP) readiness trainings, in conjunction with the Cascade Pacific Action Alliance Accountable Community of Health (ACH). OCH worked with the SBHO to recruit and secure participation of BHA providers in our region.

In December of 2018, OCH and SBHO began discussions to explore a joint effort to convene and engage providers in preparation of the IMC transition. These meetings began in December and will continue into the next semi-annual report (SAR) reporting period, 2019.

Finally, it is important to note that the OCH executive director sits on the SBHO executive board and OCH staff attend multiple monthly meetings to strengthen collaboration between the SBHO, providers, and the OCH.

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

- a. If the ACH checked “No” in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response:

During this reporting period, OCH did not formally work with county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to develop a plan for regional transition to IMC. The rationale for this, as described in A.1 above, is because the SBHO maintained it would assume responsibility for this role should the proposed alternative to IMC not be pursued. To better understand the SBHO’s intent and plan, members of the OCH executive leadership and the OCH executive director called for a meeting with the SBHO administrator and the Kitsap County Human Services director (who oversees the SBHO) in June 2018. At this meeting, the SBHO shared its work plan and timeline for regional transition to IMC that would begin in 2019 if the alternative model was not pursued.

Beginning in December of 2018, OCH and SBHO began exploratory discussions on a joint effort to prepare the IMC transition, including an interlocal leadership structure. These meetings began in December of 2018 and will continue into the next SAR reporting period, 2019.

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?
- a. If yes, describe the region’s plan to establish an EWS Workgroup, including:
- i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup

- iii. An estimate of the number and type workgroup participants
- b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

ACH response:

The region has not established an early warning system during the current reporting period. Beginning in December of 2018, OCH and SBHO began discussions to explore a joint effort to prepare for IMC transition, including an early warning system. These meetings began in December and will continue into the next SAR reporting period, 2019. OCH plans to continue discussion with the SBHO regarding the establishment of an early warning system in the next reporting period.

- 4. Describe the region's efforts to establish a communications workgroup, including:
 - i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type of workgroup participants

ACH response:

The SBHO assumed responsibility for formal communications to contracted BHA providers specific to IMC during this reporting period. The SBHO began convening and coordinating meetings of their subcontracted behavioral health providers, the OCH, the Washington State Health Care Authority (HCA) and the MCOs. These meetings were held in June and July of 2018. These meetings communicated an overview of House Bill 6312 (Fully Integrated Managed Care) and the SBHO-proposed pathways to get to IMC. They also included an orientation to the five MCOs.

The SBHO convened monthly provider meetings with contracted providers. At these meetings, the SBHO provided updates to BHA providers about progress towards securing an alternative model to IMC. OCH attended these meetings and, when called on, answered questions based on available facts. This was an opportunity for OCH, which wanted to both support and inform the BHA providers. The OCH Board directed staff to remain neutral about the viability of a legislative alternative to IMC while providing information and support to the SBHO and providers as appropriate.

During this reporting period, the OCH is not aware if the SBHO convened a formal communications workgroup for IMC. However, in December of 2018, the OCH and SBHO began exploratory discussions on a joint effort to prepare for IMC transition, including the exploring the establishment of a communications workgroup.

- 5. Describe the region's efforts to establish a provider readiness/technical assistance (TA) workgroup, including:
 - i. Which organization will lead the workgroup

- ii. Estimated date for establishing the workgroup
- iii. An estimate of the number and type of workgroup participants

ACH response:

The SBHO assumed responsibility for technical assistance to contracted BHA providers during this reporting period. The SBHO contracted with Adam Falcone to provide technical assistance to subcontracted behavioral health providers in the area of MCO contracting and arranged for MCOs to attend a number of the monthly BHA providers meetings.

During this reporting period, the OCH is not aware if the SBHO convened a formal technical assistance workgroup to establish provider readiness/technical assistance for IMC. However, in December of 2018, OCH and SBHO began exploratory discussions on a joint effort to prepare for the IMC transition, including identifying the necessary provider readiness/technical assistance needed.

6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response:

Two individuals, a practice coach and practice facilitator, have been working in the OCH region since 2017 through Qualis Health and the Department of Health as well as through Practice Transformation Support Hub and Pediatric Transforming Clinical Practices (P-TCPi), respectively. OCH integrated the practice coach and practice facilitator into the OCH Medicaid Transformation Project (MTP) team. This team meets regularly to work together to decide goals, activities, engagement and partnership strategies, as well as messaging and relationship-building in the region. The coach and facilitator have worked with over 40 providers across primary care, behavioral health and substance use disorder (SUD) clinics/agencies and tribal partners in order to teach basic quality improvement models, the goals of integrated care and assist these providers in developing a culture of quality improvement in preparation for a different billing model with MCOs and/or incentive funding received as Change Plan partners. It has been a priority to deploy the Qualis Health practice coach and P-TCPi practice facilitator to new partners in the region who would like to participate, may not have completed a Change Plan with OCH for MTP, and intend to work toward transformation within their Natural Community of Care. Remote and rural clinics that began participating during this reporting period include the Sophie Trettevick Indian Health Center (Neah Bay), Kitsap Recovery Center (Port Orchard), Beacon of Hope/Safe Harbor Recovery SUD (Port Townsend), True Star Behavioral Health (Port Angeles), Peninsula Behavioral Health (Port Angeles) and Catholic Community Family Services (Bremerton).

The technical needs requested have included comprehensive training around the transition to IMC, electronic health record assessment for success in a direct billing environment, clinical and operational documentation requirements, transition planning from SBHO model to IMC billing, PreManage communication systems and care

coordination strategies, MCO contracting strategies and best practices in regions of our state that have already transitioned to direct billing.

OCH is identifying additional steps to build bridges between direct care providers of Medicaid consumers and partners in our three-county region. We have addressed these technical needs and leveraged resources to share best practices. These activities include:

- Convening of Natural Communities of Care
- Convening of SUD providers for Electronic Health Record (EHR) training and interoperability
- Webinars and follow up visits, emails and phone calls to address questions, concerns and/or provide resources
- Ongoing attendance at regional provider, coalition, and mental health/substance use disorder committee meetings
- On-site visits to orient and field questions regarding the Change Plan model
- Continued building of assessments and action planning with engaged providers across the three-county region.

Qualis Health, through the Healthier Washington Practice Transformation Support Hub, was asked to provide technical assistance to a select group of behavioral health agencies (BHA) in the Olympic region in order to determine readiness to transition to IMC. The consultants evaluated each participating site's information systems, processes, and reporting capability and provided an assessment and gap analysis of current billing operations and systems. Eleven sites in the OCH region participated, including four BHAs and seven SUD providers.

As a result of the integrated billing site-visits, a Q&A document was developed between OCH BHA teams and Columbia River Mental Health Services staff. Information is collected regarding IMC billing and issues to consider when transitioning to Care Logic, an EHR for BHAs.

The Practice Transformation Support Hub, in partnership with the Washington Council for Behavioral Health, provided a two-part learning event for BHAs in order to prepare for VBP and IMC. The days were structured for team participation and group work. The OCH and SBHO assisted in outreach to agencies to broaden participation.

The OCH BHA partners visited the Southwest Washington region on December 4, 2019. This visit was organized by the Practice Transformation Coach and the Southwest Washington ACH at the request of a BHA in the OCH region. Five SUD and BHA agencies in the Southwest region took the time to meet with OCH BHA teams with 28 participants total. The team spent the afternoon with Vanessa Gaston, the lead administrator during the Regional Support Network transition to IMC in 2016.

7. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

ACH response:

Below is a list of non-financial technical assistance OCH has identified to help address provider readiness needs:

- An assigned lead or team at the HCA with experience in working with early or mid-adopter IMC in other regions, that regularly attends local meetings, offers resources developed in other regions, and provides general staff support to workgroups or committees
- Access to consultants contracted with HCA to assist in the transition to IMC

8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response:

The OCH has not formally engaged MCOs, regional behavioral health organizations, tribal health clinics, or other affected stakeholders in planning for the transition to IMC. The rationale for this, as described in A.1 above, is because the SBHO maintained it would assume responsibility for this role should the alternative model not be pursued.

In November 2018 the SBHO executive board determined that the alternative model to IMC was no longer viable and affirmed moving forward toward an IMC launch date of 1/1/2020.

On December 4, 2018 OCH encouraged BHAs to travel to Vancouver for an IMC learning session hosted by Southwest Washington ACH. The SBHO, OCH and BHAs from the Olympic region spent the day learning from their IMC experience.

On December 7, 2018, OCH hosted a meeting between the SBHO executive board chair/county commissioner, SBHO administrator, OCH staff and representatives from all five MCOs to begin exploratory discussions on a joint effort to convene and engage providers in preparation of the IMC transition. The meeting was chaired by the SBHO executive board chair/county commissioner.

Also, on December 7, 2018, the SBHO hosted its Advisory Board meeting which includes consumers and stakeholders to discuss planning for IMC.

On December 10, 2018, the SBHO executive board chair/ county commissioner and SBHO administrator spoke directly to the OCH Board of Directors about a potential collaboration between the SBHO and OCH to prepare providers for IMC.

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond “Not applicable.”

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity, and describe the entity's qualifications. Include a description of the HUB lead entity's organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

ACH response:

Not applicable.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response:

Not applicable.

3. Describe the Project 2B HUB lead entity's role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

ACH response:

Not applicable.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

Place an "X" in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item C.1, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked “Yes,” to item C.1 respond “Not applicable.”

ACH response:

Not applicable.

Acronyms used in Section 2:

BHA – Behavioral health agency, EHR – Electronic health record, HCA – Washington State Health Care Authority, IMC – Integrated managed care, MCO – Managed care organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, P-TCPI – Pediatric Transforming Clinical Practice Initiative, SAR – Semi-annual report, SBHO – Salish Behavioral Health Organization, SUD – Substance use disorder, VBP – Value-based payment,

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

1. **Attestations:** In accordance with the Medicaid Transformation’s Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	

	Yes	No
e. Meetings of the ACH's decision-making body are open to the public.	X	

2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked "Yes," to all items respond "Not applicable."

ACH response:

Not applicable.

3. **Attestation:** The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an "X" in the appropriate box.

Yes	No
X	

- a. If the ACH checked "No" in item A.3, describe the ACH's process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked "Yes," to item A.3 respond "Not applicable."

ACH response:

Not applicable.

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an "X" in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period		X

If the ACH checked "Yes" in item A.4 above:

Insert or include as an attachment a current organizational chart. Use **bold italicized font** to highlight changes, if any, to key staff positions during the reporting period.

B. Tribal engagement and collaboration

1. **Attestation:**

The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).⁴

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

2. If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked “Yes,” to item B.1 respond “Not applicable.”

ACH response:

Not applicable.

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not applicable.”

ACH response:

Not applicable. Please note that the Olympic Community of Health (OCH) Tribal Collaboration and Communication Policy as approved by the OCH Board is significantly stronger than the Model ACH Tribal Collaboration and Communication Policy. It is OCH.SAR2 Attachment 1. 1.31.19.

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

ACH response:

Not applicable.

2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response:

Not applicable.

⁴ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

Not applicable.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues **after** the transition to integrated managed care?

ACH response:

Not applicable.

5. **Complete the items outlined in tab 3.C of the semi-annual report workbook.**

Not applicable.

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH’s Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH’s activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.⁵

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
- If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.

1. Provide the ACH’s current implementation plan that documents the following information:
 - a. Work steps and their status (in progress, completed, or not started).
 - b. Identification of work steps that apply to required milestones for the reporting

⁵ Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

period.

Required attachment: Current implementation plan that reflects progress made during reporting period.

The current updated implementation plan is included in PDF format. There are 3 attachments, one for each stage (1, 2, and 3). They are the following attachments respectively:

OCH.SAR2 Attachment 2. 1.31.19

OCH.SAR2 Attachment 3. 1.31.19

OCH.SAR2 Attachment 4. 1.31.19

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

ACH response:

Achievements:

1. Contracted Implementation Partners

A total of 33 partners submitted a Change Plan and signed a contract with Olympic Community of Health (OCH), agreeing to participate in the Medicaid Transformation Project (MTP). In total, these partners submitted 38 Change Plans: 12 Primary Care, 14 Behavioral Health, 4 Hospital, and 8 Community Based Organizations and Social Services.

Partner	NCC	Primary Care	Behavioral Health	Hospital	CBOSS
1 Bogachiel and Clallam Bay Primary Care Clinics	Clallam	x			
2 Olympic Personal Growth	Clallam		x		
3 Reflections Counseling Services Group	Clallam		x		
4 Peninsula Behavioral Health	Clallam		x		
5 West End Outreach Services	Clallam		x		
6 Jamestown Family Health Clinic	Clallam	x	x		
7 North Olympic Healthcare Network	Clallam	x	x		
8 Sophie Trettevick Indian Health Center	Clallam	x	x		
9 Forks Community Hospital	Clallam			x	
10 Olympic Medical Center, Hospital	Clallam			x	
11 Olympic Medical Center (OMP)	Clallam	x			
12 First Step Family Support Center	Clallam				x
13 Olympic Peninsula Health Communities Coalition	Clallam				x
14 OlyCAP	Clallam/Jefferson				x
15 Olympic Area Agency on Aging	Clallam/Jefferson				x
16 Beacon of Hope, Safe Harbor Recovery	Jefferson		x		
17 Discovery Behavioral Health	Jefferson		x		
18 Jefferson Healthcare	Jefferson			x	
19 Jefferson Healthcare Primary Care	Jefferson	x			
20 Northwest WA Family Medical Residency	Kitsap	x			
21 Harrison Health Partners Primary Care Clinics	Kitsap	x			
22 Kitsap Children's Clinic	Kitsap	x			
23 Kitsap Medical Group	Kitsap	x			
24 Peninsula Community Health Services	Kitsap	x	x		
25 Port Gamble S'Klallam Wellness Center	Kitsap	x	x		
26 Kitsap Mental Health Services	Kitsap		x		
27 Kitsap Recovery Center	Kitsap		x		
28 West Sound Treatment Center	Kitsap		x		
29 Harrison Medical Center	Kitsap			x	
30 Answers Counseling	Kitsap				x
31 Kitsap Division of Aging and Long-Term Care	Kitsap				x
32 Kitsap Public Health District	Kitsap				x
33 YMCA (Pierce & Kitsap Counties)	Kitsap				x

Combined, these 33 partners signed up for a total of 2,556 Tactics (values summed in the column labeled “Count” in the table below) across the four Domains (green shaded rows) and forty-four Outcomes (white shaded rows) that comprise the OCH Change Plan. This scope reflects a wide-range of transformation activities.

Domain and Outcome	Count
- Care Coordination	775
At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat mental health, substance use disorders and/or co-occurring disorders	13
Care coordination protocols that include screening, appropriate referral, and closing the loop on referrals are developed to connect specific subpopulations to clinical or community services	196
Individuals utilizing the criminal justice system are linked to a patient-centered medical home and appropriate services to treat mental health, substance use disorders and/or co-occurring	3
Organization develops or enhances services to help keep patients/clients out of ED	15
Patients/clients are assisted to understand appropriate settings for receiving health care	62
Population-based platform is systematically utilized to follow subpopulations for more efficient	236
Providers are notified of patient/client ED visits	46
Services are provided to individuals to keep them out of jail	10
Social determinants of health (SDOH) are assessed and integrated into standard practice	116
Streamlined process is in place for information to be shared in a timely manner for shared	78
- Care Integration	489
Access to behavioral health services is convenient and timely	58
Access to physical health services is convenient and timely	33
Oral health education and screening are integrated into care	28
Oral health education, screening and/or preventive procedures are integrated into care	40
Organization chooses and implements an evidence-based program for care integration	16
Patients are screened for behavioral health conditions and patient tracking is initiated (BC 6,	114
Patients are screened for physical health conditions and patient tracking is initiated	63
Staff work together regularly across behavioral and physical health to coordinate care	57
Staff work together regularly across physical and behavioral health to coordinate care	54
Organization chooses and implements an evidence-based program for care integration (BH)	26

- Care Transformation	924
⊕ All patients are offered the full spectrum of contraceptive options and are able to make	22
⊕ Best practices for opioid prescribing are promoted and used	137
⊕ Capacity is built to prevent OUD	12
Community-clinical linkages are enhanced to ensure patients are supported and active	
⊕ participants in their disease management	47
⊕ Coordinated, targeted outreach and engagement to increase well-child visits and immunizations	43
⊕ Culture shift across organization to prioritize chronic disease prevention and management is	46
⊕ Full spectrum of evidence-based care for OUD is available	181
⊕ Health information technology is used efficiently to facilitate effective care	110
Hospitals and primary care clinics partner with mental health and substance use disorder	
⊕ providers to deliver acute care and recovery services to patients with OUD	35
⊕ Manage OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome	29
⊕ Naloxone is accessible	79
⊕ Patient reproductive health planning and management is promoted and offered across the life	35
⊕ Patients are empowered and prepared to manage their own health care	36
⊕ Patients are engaged around prevention of OUD	37
Providers are trained to recognize potential for opioid use disorder (OUD) and utilize a	
⊕ standardized protocol for screening and referring these patients	26
⊕ Public is offered education and awareness around opioid epidemic	16
⊕ Team members are trained in preconception health and have access to evidence-based	11
⊕ Treatment is expanded to those with OUD in the criminal justice system	22
- Care Infrastructure	368
⊕ Access to care is increased	67
⊕ All staff understand the impact of trauma and health inequities on health	44
⊕ Health information is exchanged securely, appropriately, timely, and efficiently	49
Organization can exercise effective leadership, management, transparency and accountability of	
⊕ MTP activities throughout the duration of its Change Plan	49
⊕ Quality improvement methods are used to improve care and care delivery	25
⊕ Transformation is sustained beyond the Medicaid Transformation Project	66
Count	2556

2. [Six Building Blocks](#)

OCH successfully launched the Six Building Blocks evidence-based model in our region. The Six Building Blocks is a program for improving opioid management in primary care, directly tied to several required Outcomes under the Care Transformation Domain in the OCH Change Plan and specifically related to MTP Toolkit Project 3A. The first site to launch the program was one of the region's tribal Implementation Partners, Jamestown Family Health Clinic. The second site was Northwest Washington Family Medical Residency.

3. [Intermediary Measures](#)

OCH formed and convened its Performance, Measurement and Evaluation Committee. The first task of this committee was to complete development of a slate of reporting metrics for Implementation Partners. A total of 66 metrics were developed for five partner types: Hospital, Primary Care, Mental Health, Substance Use Disorder and Community-Based Organization/Social Service Organization. These metrics are

designed to track implementation of the Change Plan and are one of four reporting requirements associated with the Change Plan. Reporting on these metrics will occur bi-annually in Olympic Reporting and Community Activities (ORCA), the OCH online reporting and community activities platform. The metrics were designed to help OCH and Implementation Partners track individual progress as well as track regional performance associated with MTP pay-for-performance metrics close to real-time. They will help OCH make data-driven decisions to support Implementation Partners with investments and technical assistance.

Risks:

1. IMC Transition

Behavioral Health (BH) providers are challenged to work on achieving *clinical* and *financial* integration (IMC) simultaneously. There is a risk that one or both initiatives might lack focus, funding and infrastructure. BH providers may need more support with financial integration before working toward clinical integration. OCH is considering a mitigation strategy for BH Implementation Partners to delay certain deliverables and reporting requirements related to Outcomes in their Change Plans tied to clinical integration for 2019, so they may focus on IMC during 2019. A tailored timeline for certain deliverables for BH Implementation Partners will be finalized by DY3Q1. OCH is also working closely with the Salish Behavioral Health Organization (SBHO) and county commissioners to explore OCH's role in supporting providers and avenues of support for IMC.

2. Financial Stability of Implementation Partners

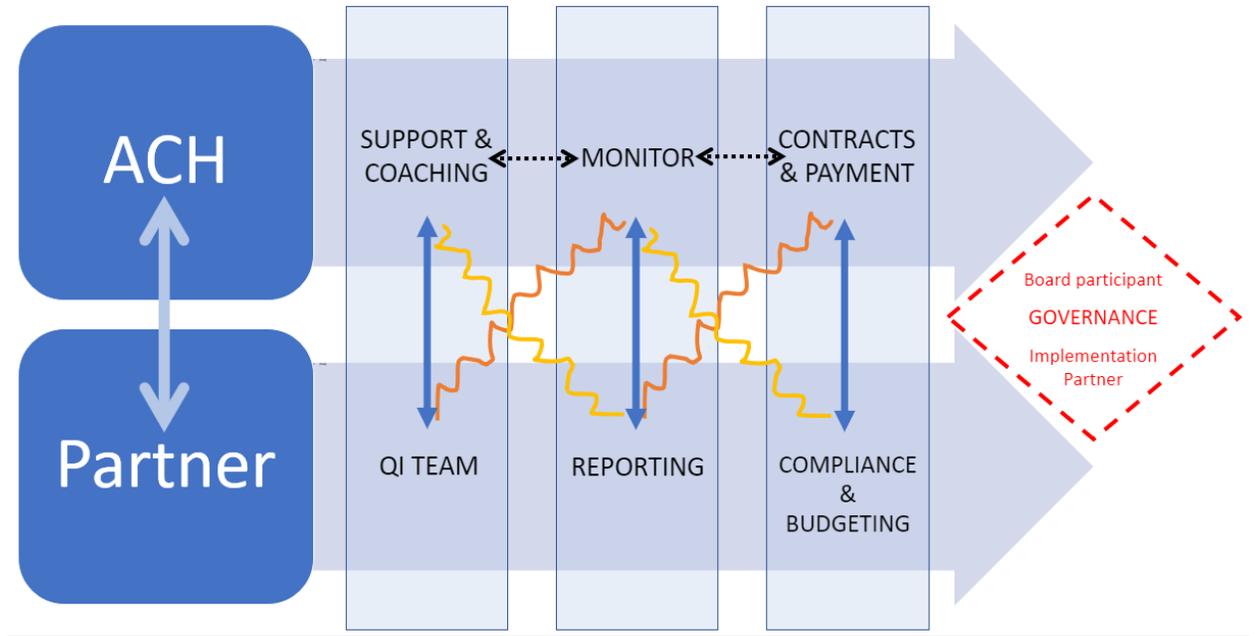
Several Implementation Partners might be at risk for not being able to carry out their MTP work due to organizational financial instability and lack of funds to cover costs associated with MTP work. Understanding the precarious financial situation, particularly of the smaller BH providers in the region, was an important first step in mitigating this risk. OCH is in the process of amending its contracts with Implementation Partners to include an attestation of financial solvency, which Implementation Partners will be asked to sign in DY3 Q1.

3. Tension of Roles

OCH has multiple roles as the Accountable Community of Health (ACH) contracted to implement MTP in the region (see graphic below). It has roles in supporting and coaching Implementation Partners and monitoring partner performance. In addition, it has a role in holding partners accountable through a contract. OCH is finding a need to balance these roles carefully in order to fulfill each successfully without causing conflict between them or damaging relationships with Implementation Partners. To mitigate this tension, OCH has decided to separate site visits designed for monitoring and coaching visits designed for quality improvement; OCH will deploy different staff members for each. OCH will also be crafting policies on performance and compliance that outline expectations and deliverables with consequences for not meeting these in DY3 Q1.

Figure 1:

ACH-Partner Relationship Roles and Tensions, DRAFT 12-12-18



3. **Did the ACH** make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

Place an “X” in the appropriate box.

Yes	No
	X

4. If the ACH checked “Yes” in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not applicable.”

ACH response:

Not applicable.

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid

duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
OCH is actively participating with other Accountable Communities of Health (ACHs) to identify joint contracting opportunities	Enhance efficiencies in the Medicaid Transformation Project (MTP) expenditures and increase opportunities for partners across ACHs	<ol style="list-style-type: none"> 1. Cross-ACH training grid 2. Agreement across multiple ACHs to jointly contract for health equity training: <ol style="list-style-type: none"> a. John A. Powell, Director of the Haas Institute for a Fair and Inclusive Society to conduct health equity trainings b. Kitsap Strong to train Practice Partners on program-level change related to the impact of Adverse Childhood Experiences (ACEs) and resilience
OCH is aligning reporting metrics for Implementation Partners with current reporting requirements to Managed Care Organizations (MCOs)	<ol style="list-style-type: none"> 1. Reduce duplicative reporting for Implementation Partners 2. Align MTP performance with MCO contracts 	A subset of the intermediary measures required for reporting by Implementation Partners will overlap with MCOs, reducing reporting burden
Qualis Health Value-based payment and Integrated Managed Care (IMC) Billing	Prepare partners for IMC	Partnering providers from both ACHs attended and participated in joint trainings to increase alignment across ACHs

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
Support training with Cascade Pacific Action Alliance		

Acronyms used in this table:

ACH – Accountable Community of Health, IMC – Integrated managed care, MCO – Managed care organization, MTP – Medicaid Transformation Project

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not applicable.”

ACH response:

OCH staff and leadership continue to prioritize community engagement and partnership beyond that with partners who are formally participating in MTP. We accomplish this by:

- Regularly and consistently attending standing tribal, committee, workgroup, coalition, association, and partner meetings across the region including those with Medicaid beneficiaries in their membership. For example, the Director of Community and Tribal Partnership attends the monthly SBHO Providers meeting, which includes those substance use disorder providers not formally participating in the MTP. Their work is critical to the success of the region and successful transformation of the healthcare delivery system. A more complete list of engagement activities is in the monthly OCH Board packets which are posted on our website.
- It has been a priority to deploy a Qualis Health coach and a Pediatric-Transforming Clinical Practices Initiative facilitator to partners in the region who would like to participate, may not be formally participating in MTP, and intend to work toward transformation within their Natural Community of Care/community. Remote and rural partners that began participating during this reporting period include the Sophie Trettevick Indian Health Center (Neah Bay), Kitsap Recovery Center, Beacon of Hope/Safe Harbor Recovery (substance use disorder provider), True Star Behavioral Health, Peninsula Behavioral Health and Catholic Community Family Services.
- OCH hired a Communications and Development Coordinator in July of 2018. We prioritized strong communication and collaboration skills to coordinate activities related to Olympic Community of Health’s mission and MTP and maintain clear, consistent, culturally appropriate messaging about the mission, vision and work that the OCH is doing. Strategies include a new website that is much easier to access and navigate; up to date and relevant social media; collaboration with other ACH communication leads to align messaging; revamping the OCH newsletter for clarity

and consistency; tracking information relevant to serving Medicaid beneficiaries and providers.

- OCH staff and leadership attended the American Indian Health Commission Tribal and State Leaders Health Summit. This biannual summit provides an opportunity to engage American Indian/Alaska Natives, tribal leaders, tribal providers across the state. OCH is committed to supporting and learning from tribal leaders and partners to address equity in the region.
- OCH hosted the 2nd Annual Olympic Regional Opioid Summit on October 17, 2018. There were approximately 300 attendees from the region, neighboring regions, and the state. Attendees included primary care providers, mental health providers, substance use disorder providers, dental providers, American Indian/Alaska Native and tribal partners, tribal leaders, public health and local government officials, law enforcement, fire/emergency medical services, emergency department providers, educators, students, school district staff, and community members. Individuals struggling with opioid use disorder are some of the most marginalized members of the community and this reflects our commitment to serving them and their families. In addition, OCH implemented a pre-summit survey that included questions about equity: “How often would you say your organization has discussed equity in the past year” and “Is equity a strategic priority in your organization?”. When appropriate, OCH’s surveys will include questions focused on equity.
- The Director of Community and Tribal Partnership at OCH tracks work/partners/organizations in the community that can support the work and success of the MTP to stay networked and connected to OCH and to each other. The Director of Programs and Program Coordinator are very responsive to requests throughout the region to learn more about OCH and MTP. They all regularly attend meetings by invitation to provide information and learn about current efforts by organizations not formally participating with MTP.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

ACH response:

- OCH met with Managed Care Organizations (MCOs) and the SBHO, the payer for behavioral health organizations, to determine the types of metrics that are currently collected by MCOs from regional providers. The purpose of this meeting was to align OCH MTP metrics with existing metrics in MCO contracts. Additionally, during the meeting the MCOs agreed to share aggregate-level data with the OCH on certain measures to assist in tracking progress towards shared benchmarks. A follow-up meeting is scheduled in Q1 of 2019.
- OCH convened the Performance Measurement and Evaluation Committee with an MCO-sector representative on the committee to recommend reporting measures for

providers. Wherever possible, these measures aligned with measures providers are currently reporting to MCOs.

- OCH arranged for MCO support and participation for two learning sessions for behavioral health providers to provide technical assistance in Value-based payment (VBP) readiness, billing and IT readiness support for IMC. MCOs presented valuable information to behavioral health providers on IMC and VBP during these learning sessions.
- OCH collaborated with Qualis Health and the SBHO to offer on-site intensive site visits to assess readiness for IT, billing and VBP, and provide technical assistance to reach provider-specific goals.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

2. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not applicable.”

ACH response:

Not applicable.

3. Provide three examples of the ACH’s community engagement⁶ and health equity⁷ activities that occurred during the reporting period that reflect the ACH’s priorities for health equity and community engagement.

ACH response:

- OCH staff and leadership attended the American Indian Health Commission Tribal and State Leaders Health Summit. OCH is committed to supporting and learning from tribal leaders and partners to address equity in the region.

⁶ Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH’s projects.

⁷ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

- OCH hosted the 2nd Annual Olympic Regional Opioid Summit on October 17, 2018. There were approximately 300 attendees from the region, neighboring regions, and the state. Attendees included primary care providers, mental health providers, substance use disorder providers, dental providers, American Indian/Alaska Native and tribal partners, tribal leaders, public health and local government officials, law enforcement, fire/emergency medical services, emergency department providers, educators, students, school district staff, and community members. Individuals struggling with opioid use disorder are some of the most marginalized members of the community and this reflects our commitment to serving them and their families. In addition, OCH implemented a pre-summit survey that included questions about equity: “How often would you say your organization has discussed equity in the past year” and “Is equity a strategic priority in your organization?”. When appropriate, future OCH surveys will include questions focused on equity.
- OCH staff and leadership continue to prioritize community engagement and partnership beyond that with partners who are formally participating in MTP. We accomplish this by:
 - Regularly and consistently attending existing tribal, committee, workgroup, coalition, association, and partner meetings across the region including those with Medicaid beneficiaries in their membership. This allows OCH to keep community members and partners updated, and to stay informed about the efforts underway.
 - OCH hired a Communications and Development Coordinator in July of 2018. We prioritized strong communication and collaboration skills to coordinate activities related to Olympic Community of Health’s mission and our Medicaid Transformation Project, and maintain clear, consistent, culturally appropriate messaging about the mission, vision and work that the OCH is doing.

G. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. Design Funds

Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. Earned Project Incentives

Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH’s Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health

providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

OCH issues MTP investments based on progress reported by Implementation Partners in their Change Plans. Specific to health systems capacity building, OCH incentivizes broad transformation goals of value-based contracting and population health management capability. To track progress towards these goals, Change Plans track and incentivize progress towards short term outcomes such as:

1. Common or interoperable electronic health records or electronic behavioral health records.
2. Adoptions of population health management tools.
3. Implementation of value-based payment arrangements with MCOs.

Implementation Partners benefit from these investments because it allows them to deploy MTP payments in the most efficient manner possible for their organization.

In addition to the above investments, OCH continues to sit at the table with the other eight ACHs, the University of Washington and the Association of Washington Public Hospital Districts to align and plan Health Systems and Capacity Building investments from Domain 1 activities to achieve shared short-term goals and broader transformation goals.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

Not applicable. OCH has not elected to establish a community health fund or wellness fund. This topic may be revisited in 2020 if OCH's performance in MTP exceeds budgeted expectations.

Acronyms used in Section 3:

ACH – Accountable Community of Health, BH – Behavioral health, IMC – Integrated Managed Care, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, SBHO – Salish Behavioral Health Organization, VBP – Value-based payment

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation

efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).⁸

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
 - a. All active partnering providers participating in project activities.
 - b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
 - c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Complete item 4.A in the semi-annual report workbook.

[Please see item 4.A in the attached SAR Workbook, it is OCH.SAR2 Workbook. 1.31.19.](#)

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response:

[All Olympic Community of Health \(OCH\) Implementation Partners are participating on an organizational level versus a site level. There are no organizations participating that are excluding certain sites from the transformation activities outlined in their Change Plan. This means that reporting will occur on an organizational level.](#)

[As outlined in the Implementation Plan, the OCH Quality Improvement Plan \(QIP\) model \(Figure 2\) involves a continuous plan-do-study-act cycle informed by multiple quarterly and biannual inputs from partnering providers and other sources. OCH's](#)

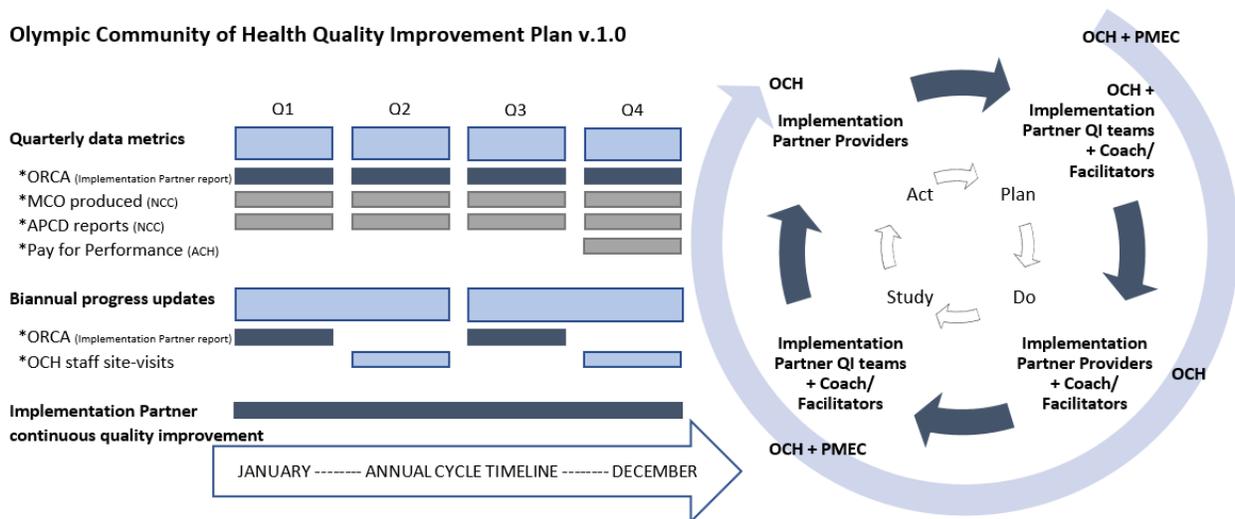
⁸ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

approach to partnering provider management is embedded within this model. The approach will be the same for both traditional and non-traditional Medicaid providers.

In Figure 2, the two concentric circles depict two quality/rapid improvement cycle layers based on a plan-do-study-act methodology. The two concentric circles show the division of responsibilities between OCH (outer light blue circle) and the partnering providers (darker blue inner circular arrows). The partnering providers will be responsible for managing their internal quality improvement (QI) cycle (darker blue inner cycle). OCH will support partnering providers by offering technical assistance through Qualis Health and Pediatric Transforming Clinical Practices Initiative (P-TCPi) coach/facilitators. OCH will not oversee this internal process. OCH will ensure that partnering providers are engaging in their internal process and utilizing the key skills learned at the personalized Jedi Mind Control training with Master Yoda; this is a requirement in the Change Plan.

Some of our Implementation Partners have internal QI teams, defined as an established process for QI and protected time for staff to participate in this process. Other partners have accessed the free services available in our region through the Department of Health’s Practice Transformation Support Hub Qualis Health Practice Coach Connector and P-TCPi Practice Facilitator. These coaches provide on-site assistance for clinics and agencies to facilitate assessments that measure readiness for integrated care, Collaborative Care Model, Chronic Care Model and Value Based Purchasing, identify healthcare and community-based support/social support partners with whom to build collaborative relationships and develop QI projects to close care gaps and improve care coordination. OCH has chosen to directly contract with Qualis Health to continue to provide Practice Coach Connector resources to Implementation Partners in 2019.

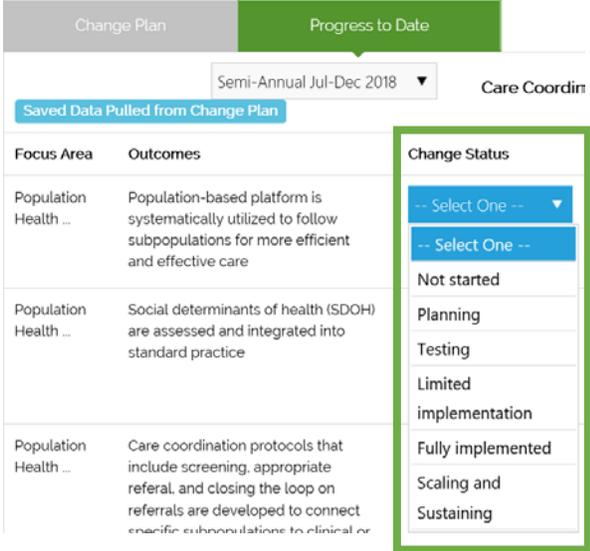
Figure 2:



Acronyms used in Figure 2:

APCD – All Payer Claims Database, MCO – Managed Care Organization, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PMEC – Performance Measurement and Evaluation Committee, QI – Quality Improvement

OCH will use what is included in the table below to do a quality/rapid improvement cycle to assess partnering providers' transformation. The table includes expectations, key indicators to measure implementation progress by providers and the processes and tools OCH will use to do rapid cycle quality improvement.

Expectations	Key Indicators	Processes and Tools
<p>Implement Change Plan Outcomes and Tactics for both traditional and non-traditional Medicaid providers</p>	<p>Bi-annual status updates on progress to date on Outcomes measured in 6-stages: not started, planning, testing, limited implementation, fully implemented, scaling and sustaining (Figure 3, outlined in green).</p> <p>Figure 3. Snapshot of Progress to Date Change Status</p>  <p>The screenshot shows a web interface for tracking change status. At the top, there are tabs for 'Change Plan' and 'Progress to Date', with 'Progress to Date' selected. Below this, there's a date selector for 'Semi-Annual Jul-Dec 2018' and a user name 'Care Coordin...'. A blue button indicates 'Saved Data Pulled from Change Plan'. The main content is a table with columns for 'Focus Area', 'Outcomes', and 'Change Status'. The 'Change Status' column has a dropdown menu with the following options: '-- Select One --', '-- Select One --', 'Not started', 'Planning', 'Testing', 'Limited implementation', 'Fully implemented', 'Scaling and Sustaining'. The dropdown menu is highlighted with a green border.</p>	<p>Progress to date status updates on Outcomes selected in each providers' Change Plan will be entered directly by the provider biannually in the OCH online platform, Olympic Reporting and Community Activities (ORCA).</p>
	<p>Bi-annual narrative updates in 6 open-ended questions asked by Olympic Community of Health (OCH). Questions 1–3 are answered for each Outcome, questions 4–6 are answered for the whole Change Plan (Figure 4).</p> <ol style="list-style-type: none"> 1) Please describe the top priority Tactics you worked on during the previous 6 months. What are you most proud of? 2) What are your top priority Tactics for the next 6 months? 3) Thinking about the Outcomes/Tactics in your Change Plan, during the previous 6 months, what were your 3 biggest barriers to progress? What kinds of assistance (from OCH and/or outside OCH) would help you to overcome those identified barriers (for example: IT support, training, workforce, resources...)? 4) Please list any new partnerships (informal/formal) your organization has formed with other partners in your Natural Community of Care in the previous six months (for example: signed agreement, etc.). 5) What steps has your organization taken to address health equity in your approach to the Outcomes/Tactics in your Change Plan during the previous 6 months? 6) What percentage of your current Medicaid contracts are value-based payment (VBP) contracts? How do you anticipate your participation in VBP will change in the next 6 	<p>Progress-to date-narrative updates will be entered directly by Implementation Partners biannually in ORCA.</p>

months – increase, stay the same, decrease? What are your greatest barriers for engaging in VBP?

Figure 4. Snapshot of Progress to Date Narrative Updates

1) Please describe the top priority Tactics you worked on during the previous 6 months in this domain. What are you most proud of?

2) What are your top priority Tactics for the next 6 months in this domain?

3) Thinking about the Outcomes/Tactics in your Change Plan for this domain, during the previous 6 months, what were your 3 biggest barriers to progress? What kinds of assistance (from OCH and/or outside OCH) would help you to overcome those identified barriers (for example: IT support, training, workforce, resources,)?

4) Please list any new partnerships (informal/formal) your organization has formed with other partners in your NCC in the previous six months (for example: signed agreements, etc.).

5) What steps has your organization taken to address health equity in your approach to the Outcomes/Tactics in your Change Plan during the previous 6 months?

6) What percentage of your current Medicaid contracts are value-based payment (VBP) contracts? How do you anticipate your participation in VBP will change in the next 6 months - increase, stay the same, decrease? What are your greatest barriers for engaging in VBP?

Provide data for quarterly quantitative performance measures associated with Outcomes, Tactics and milestones. Performance measures will be developed in a collaborative process by the members of the OCH Performance Monitoring and Evaluation Committee from August to November 2018 and may include population served, intermediary process measures and measures of health care access/utilization, health status or health outcomes, number of new procedures and protocols implemented, number of new partnerships. These measures will serve as timely indicators and provide opportunities for quality improvement or other course corrections.

Quantitative performance measures will be tracked and entered directly by the provider quarterly in ORCA.

Acronyms used in this table:

OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, VBP – Value-based payment

After provider reports containing the above key indicators are collected and assessed, the OCH Director of Programs and Program Coordinator will conduct, at a minimum, bi-annual on-site visits with all Implementation Partners to assess organizations’ progress on chosen Change Plan Outcomes/Tactics and associated milestones. OCH staff will use this time to address organization concerns and connect organizations with appropriate technical assistance resources. The site visit will also be used to evaluate the Implementation Partner’s areas of focus, within the Change Plan, for the next six-month

reporting period, as well as evaluate progress made on the previous six month's reporting period identified activities. In the OCH QIP model, through the plan-do-study-act cycle, OCH may reach out to Implementation Partners if data review suggests delays or issues with project implementation.

Acronyms used in Section 4:

APCD – All Payer Claims Database, MCO – Managed Care Organization, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PMEC – Performance Measurement and Evaluation Committee, QI – Quality improvement, QIP – Quality improvement plan, P-TCPi – Pediatric Transforming Clinical Practice Initiative, VBP – Value-based payment

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response:

Not applicable.

Master acronym list:

ACH – Accountable Community of Health, APCD – All Payer Claims Database, BH – Behavioral health, BHA – Behavioral health agency, CBO – Community-based organization, EHR – Electronic medical record, HCA – Washington State Health Care Authority, IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PCMH-A – Patient-Centered Medical Home, PMEC – Performance Measurement and Evaluation Committee, QI – Quality, PDSA – Plan-do-study-act, P-TCPi – Pediatric Transforming Clinical Practice Initiative, PTSH – Practice Transformation Support Hub, SAR – Semi-annual report, SBHO – Salish Behavioral Health Organization, TA – Technical Assistance, VBP – Value-based payment

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Olympic Community of Health (OCH)

Tribal Collaboration and Communication Policy with the

Hoh, Jamestown S’Klallam, Lower Elwha Klallam, Makah, Port Gamble S’Klallam, Quileute and Suquamish Tribes

I. Purpose

The Olympic Community of Health (OCH) is committed to active engagement with the tribal nations and Indian Health Service (IHS) facilities within our three-county region. All tribes are offered a seat on the Board of Directors. Recognizing that all tribes may not want to be active on the Board, this policy will guide our communications. All tribes/IHS facilities will receive the same level, type, and frequency of communications outlined in this policy.

The purpose of this policy is to establish a clear and concise collaboration policy and communication procedure between the Olympic Community of Health (OCH) and tribal governments in the development of all OCH policies or actions.

II. Governance

The OCH will hold one seat on the Board of Directors for each tribe.

III. Collaboration

The OCH will collaborate and communicate with tribal governments in a manner that respects the tribes’ status as sovereign nations and meets the federal trust responsibility and U.S. treaty obligations to American Indians/Alaska Natives (AI/ANs).

- The OCH will not refer to tribes as stakeholders but as partners.
- Because each Tribe has a seat on the Board of Directors, the OCH and Tribes will collaborate from the beginning of and throughout the planning and development process and engage in inclusive decision-making with tribes for all OCH actions, including actions that may have an impact on AI/Ans or tribes (as determined in accordance with Section IV) and not just solicit feedback from tribes.
- The OCH will respect and support the need for Tribal representatives or IHS facility representatives to inform their tribal councils and receive directives from their tribal councils or agency leadership on whether and how the tribe or IHS facility would like to proceed with respect to any OCH action.
- If a tribe declines an invitation to collaborate, the OCH will maintain a standing invitation for the tribe to collaborate with the OCH.

IV. OCH Actions Having Impacts on AI/ANs or Tribes

- **Determining Tribal Impacts.** The OCH will rely on the tribal representatives on the Board of Directors to notify the Board or staff whether an action may have an impact on AI/ANs or Tribes. If authorized by the tribal representatives on the Board, the OCH staff will convene an *ad hoc* Tribal Implications Subcommittee that will include at least one OCH staff member, at least two Tribal OCH Board Members, and one OCH Board member who is not a representative of a tribe. The committee will meet until it determines whether any OCH actions being contemplated, including the development of policies, programs, or agreements, will have an impact on

AI/ANs or Tribes. The OCH lead staff person will ensure that sufficient information about OCH actions is communicated during the meeting, and prior to implementation, to enable the committee to determine whether those actions will have an impact on AI/ANs or Tribes. If no Tribe designates an individual to serve on this committee and until such time when a tribe does designate an individual to serve on this committee, the Board of Directors will make determinations of whether any OCH actions being contemplated will have an impact on AI/ANs or Tribes and inform the tribe(s).

- **Addressing Tribal Impacts.** If the Tribal Implications Subcommittee determines an OCH action has or will have an impact(s) upon a tribe(s) or IHS facility(ies), the Subcommittee will report their findings and any recommendations for addressing those impacts to the Board of Directors. The Board of Directors will determine a plan of action in response to the Subcommittee’s findings and recommendations.

V. Communication

- A. The OCH will dedicate resources to support the function of tribal liaison when resources permit.
- B. The OCH will work with each of the individual tribes to ensure that all contact information is up-to-date and the correct representatives are notified and regularly receive information.
- C. The OCH will provide written information to tribes concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other OCH participants for participant or other meetings. Any tribe that wishes to receive mailed hard copies of meeting materials may do so upon request. The tribal liaison will work with each tribe to develop a specific communication strategy as requested.

VI. Sovereignty and Disclaimer

The OCH respects the sovereignty of each tribe located in the State of Washington and that the tribes have the right to request consultation with the State of Washington and/or the United States government in the event the OCH fails to address the impacts on AI/ANs or Tribes. In executing this policy, no party waives any rights, privileges, or immunities, including treaty rights, sovereign immunities and jurisdiction. This policy does not diminish any rights or protections afforded AI/AN persons or tribal governments or entities under state or federal law. The OCH acknowledges the right of each tribe to consult with state and federal agencies, including, where appropriate, the Health Care Authority, the Governor of the State of Washington, the Region X Administrator of the U.S. Department of Health and Human Services, or the President of the United States.

VII. Effective Date

This policy will be effective on _____, and will be reviewed and evaluated annually or at the request of any tribe or a majority of the OCH Board Members.

APPROVED BY:

OCH Board President
Roy Walker

DATE: _____

Implementation Plan Timeline: Stage 1



Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter. The Stage filter keeps 1. The Pivot Field Values Quarter filter ranges from 2018 Q1 to 2020 Q4 and keeps Null values. The Start Date1 Quarter filter keeps non-Null values only. The view is filtered on Milestones, which keeps 46 of 46 members.

- Status Update**
- Completed
 - Completed for DY2, In Progress for DY3
 - Completed for DY2, Not Started for DY3

Implementation Plan Timeline: Stage 1

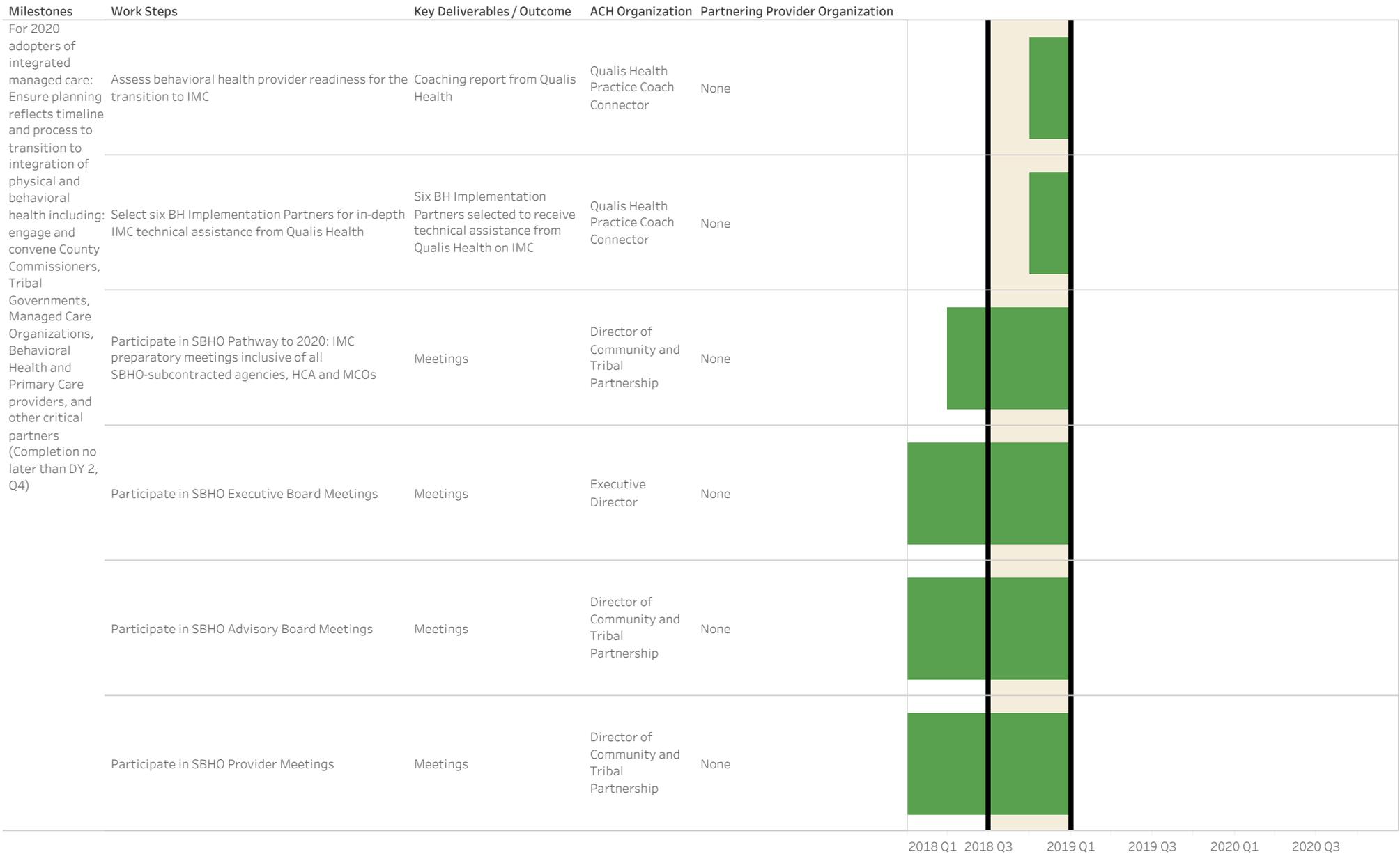
Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3)	Identify preferred technical assistance vendors from Implementation Partners	OCH Current State Assessment results	Data Lead	None	
	Identify interest in shared EHR, EBHR and/or population health management systems	PHBH Change Plan indicates preference, updated annually	None	PHBH* Implementation Partners	
For 2020 adopters of integrated managed care: Ensure planning reflects timeline and process to transition to integration of physical and behavioral health including: engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners (Completion no later than DY 2, Q4)	Plan Integrated Managed Care (IMC) and Value-Based Payment (VBP) trainings for behavioral health providers with Cascade Pacific Action Alliance (CPAA), Qualis Health and DOH	Plan for trainings	Director of Community and Tribal Partnership	None	
			Qualis Health Practice Coach Connector	None	
	Host IMC and VBP trainings for behavioral health providers with CPAA, Qualis Health, and DOH	Trainings	Director of Community and Tribal Partnership	None	
			Qualis Health Practice Coach Connector	None	

Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter. The Stage filter keeps 1. The Pivot Field Values Quarter filter ranges from 2018 Q1 to 2020 Q4 and keeps Null values. The Start Date1 Quarter filter keeps non-Null values only. The view is filtered on Milestones, which keeps 46 of 46 members.

Status Update

- Completed
- Completed for DY2, In Progress for DY3
- Completed for DY2, Not Started for DY3

Implementation Plan Timeline: Stage 1



Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter. The Stage filter keeps 1. The Pivot Field Values Quarter filter ranges from 2018 Q1 to 2020 Q4 and keeps Null values. The Start Date1 Quarter filter keeps non-Null values only. The view is filtered on Milestones, which keeps 46 of 46 members.

Status Update

- Completed
- Completed for DY2, In Progress for DY3
- Completed for DY2, Not Started for DY3

Implementation Plan Timeline: Stage 1

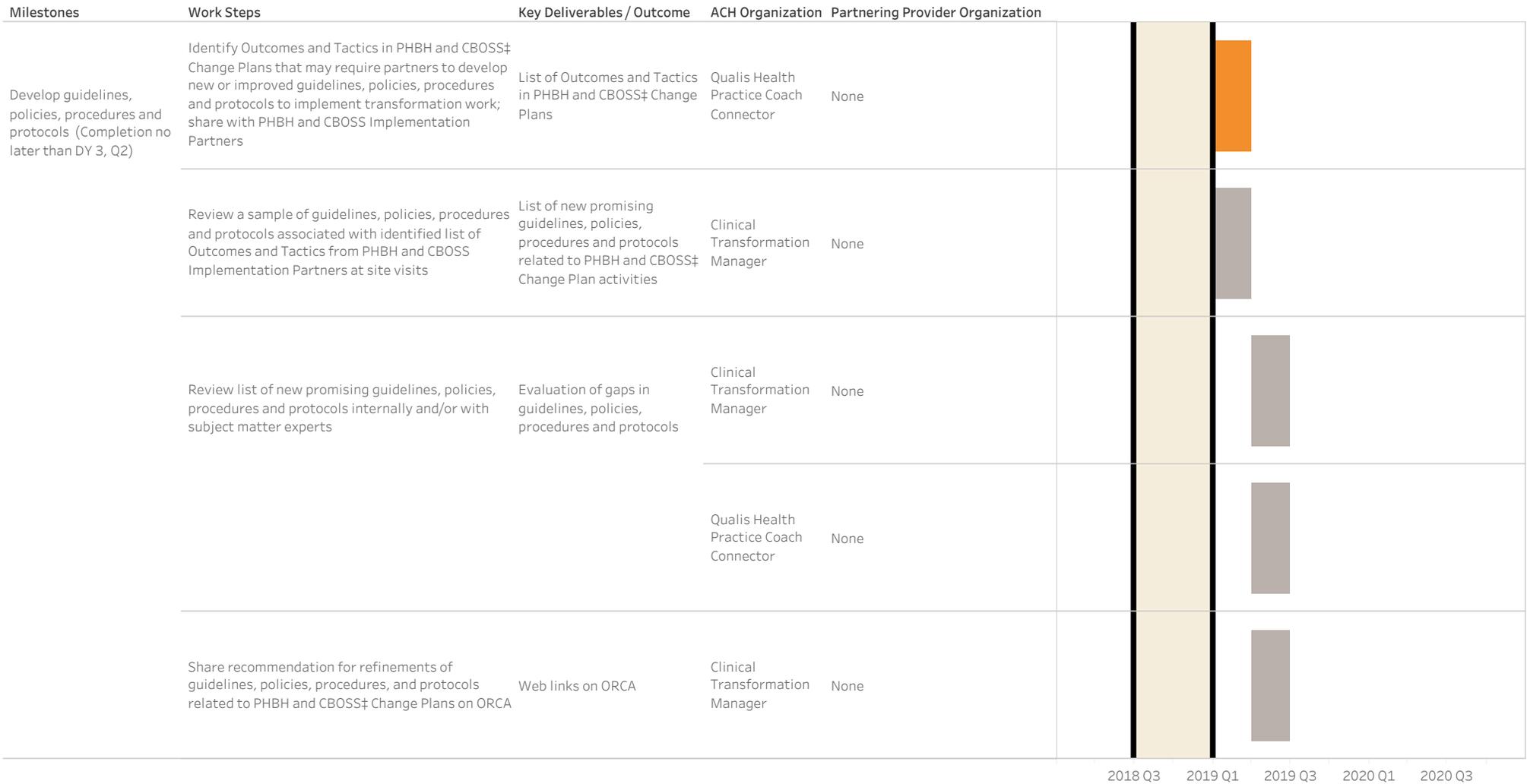


Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter. The Stage filter keeps 1. The Pivot Field Values Quarter filter ranges from 2018 Q1 to 2020 Q4 and keeps Null values. The Start Date1 Quarter filter keeps non-Null values only. The view is filtered on Milestones, which keeps 46 of 46 members.

Status Update

- Completed
- Completed for DY2, In Progress for DY3
- Completed for DY2, Not Started for DY3

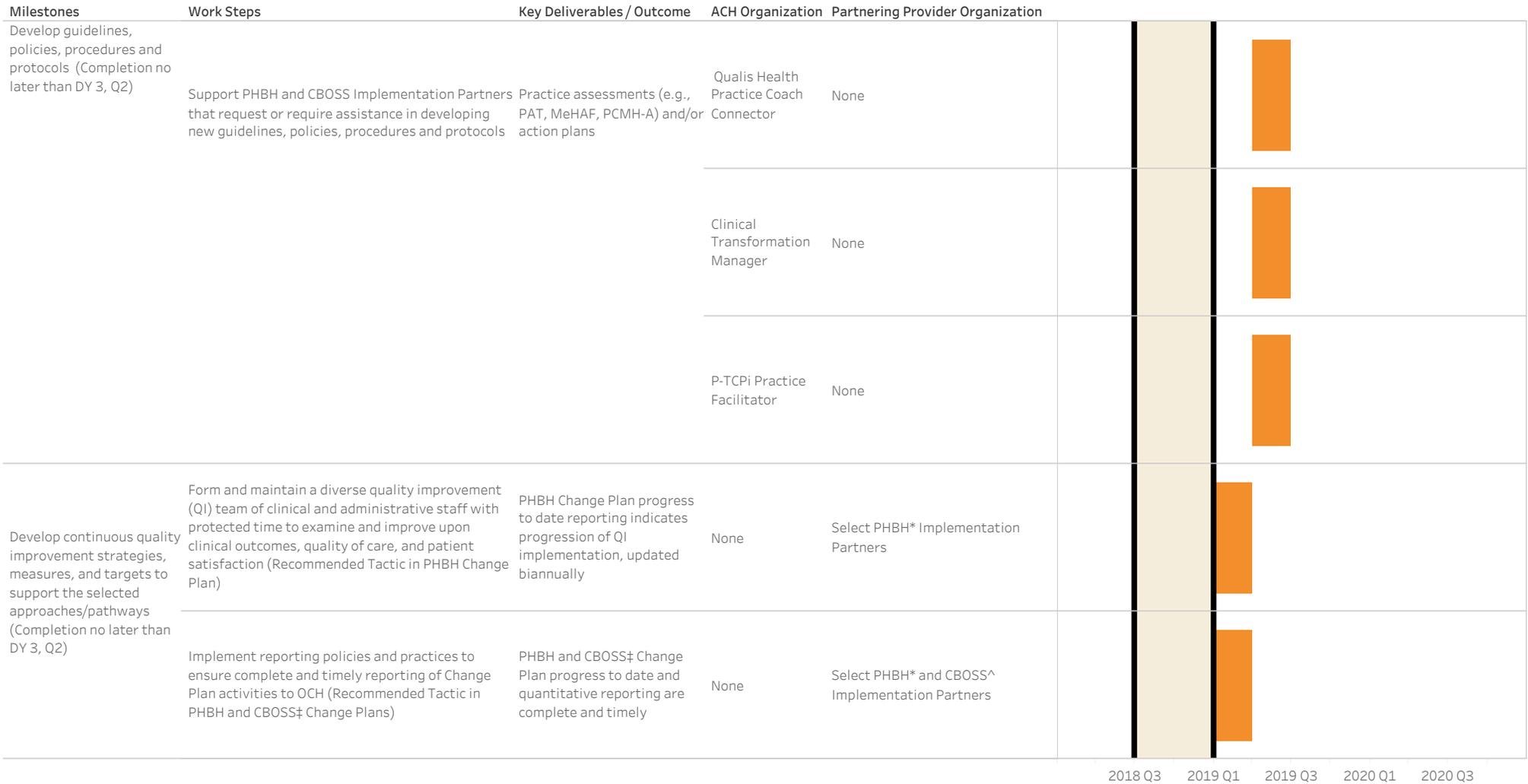
Implementation Plan Timeline: Stage 2



Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter. The Stage filter excludes 1 and 3. The Pivot Field Values Quarter filter ranges from 2018 Q1 to 2020 Q4 and keeps Null values. The Start Date1 Quarter filter keeps non-Null values only. The view is filtered on Milestones, which keeps 46 of 46 members.

- Status Update**
- Completed
 - Completed for DY2, In Progress for DY3
 - Completed for DY2, Not Started for DY3
 - In Progress
 - Not Started

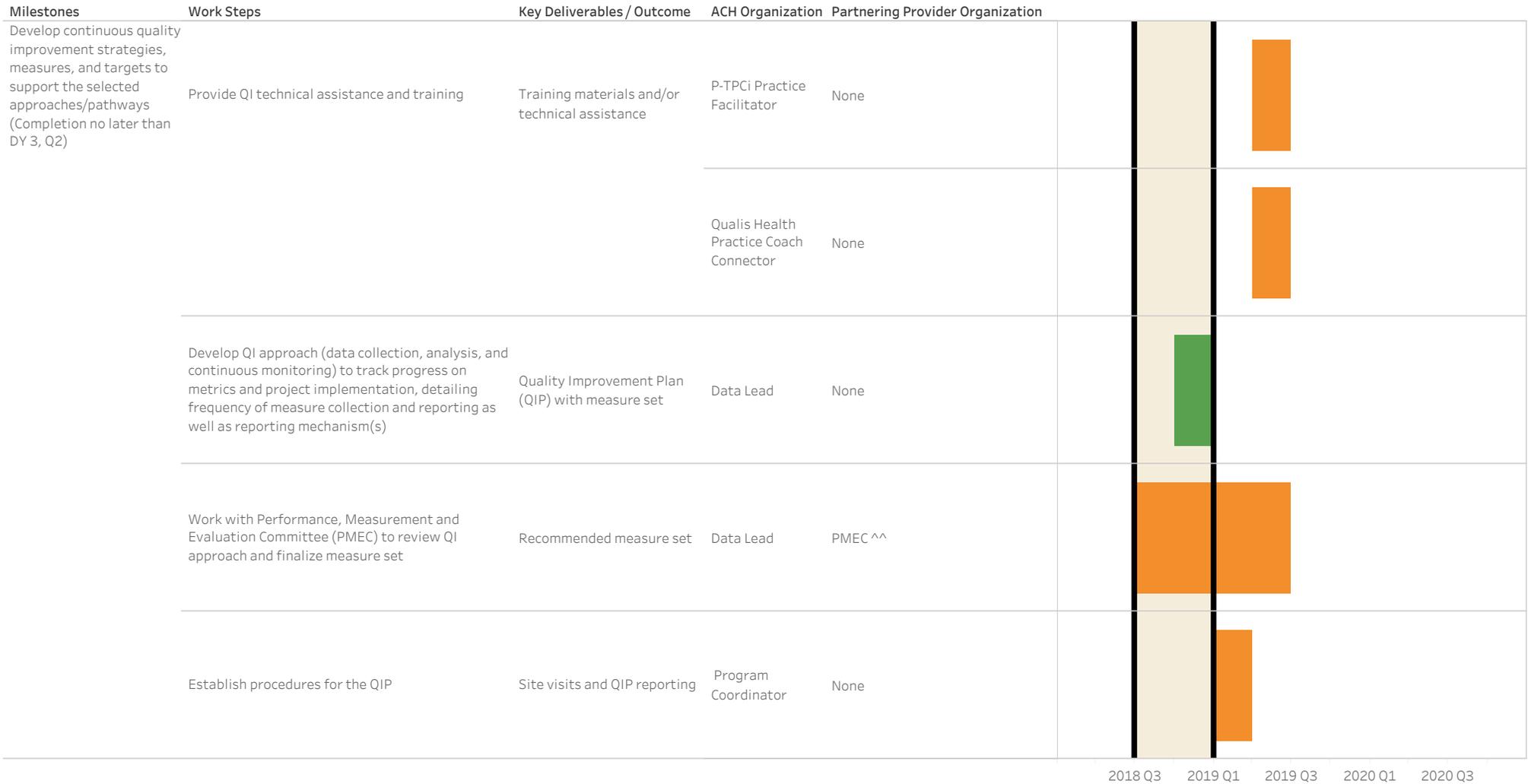
Implementation Plan Timeline: Stage 2



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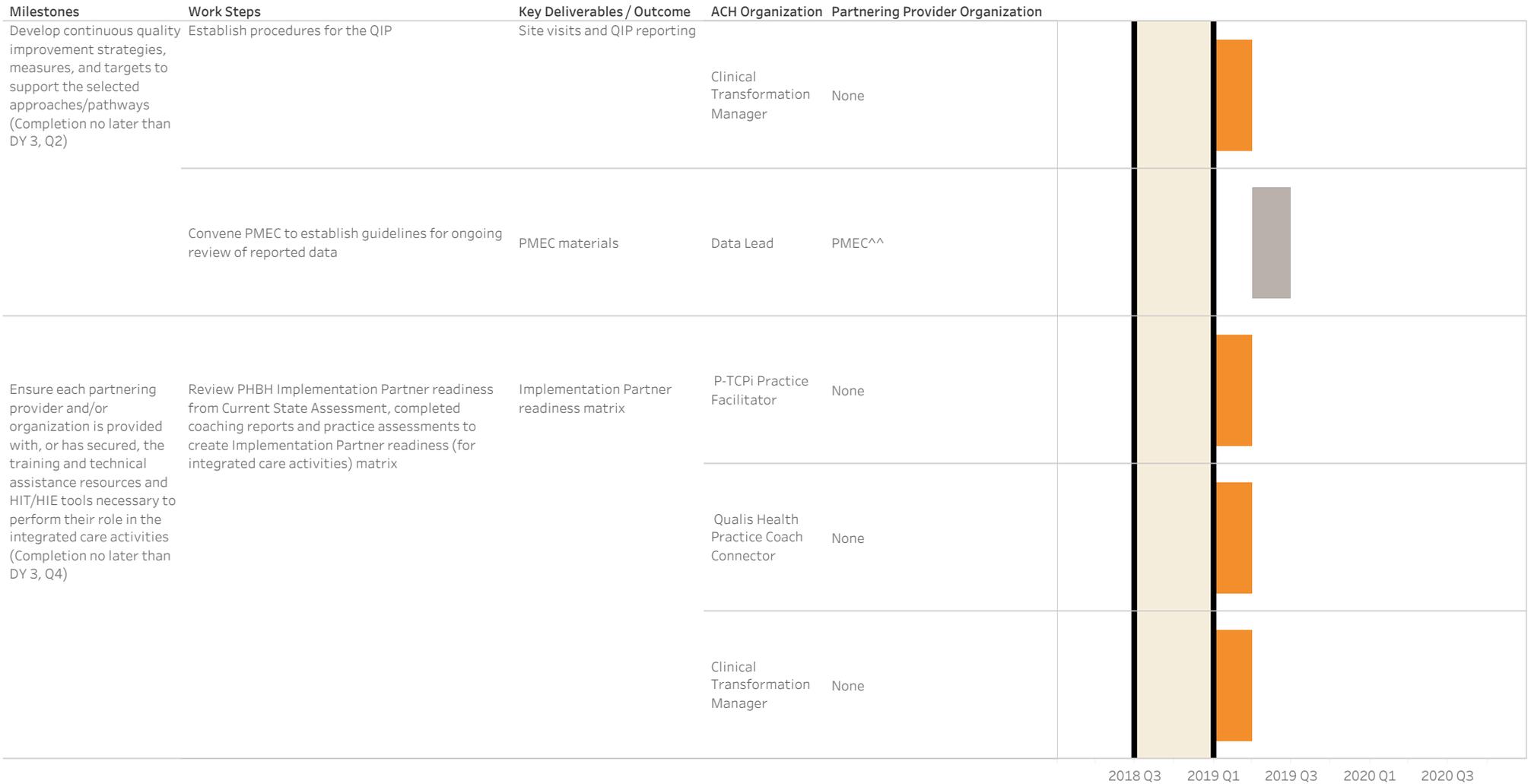
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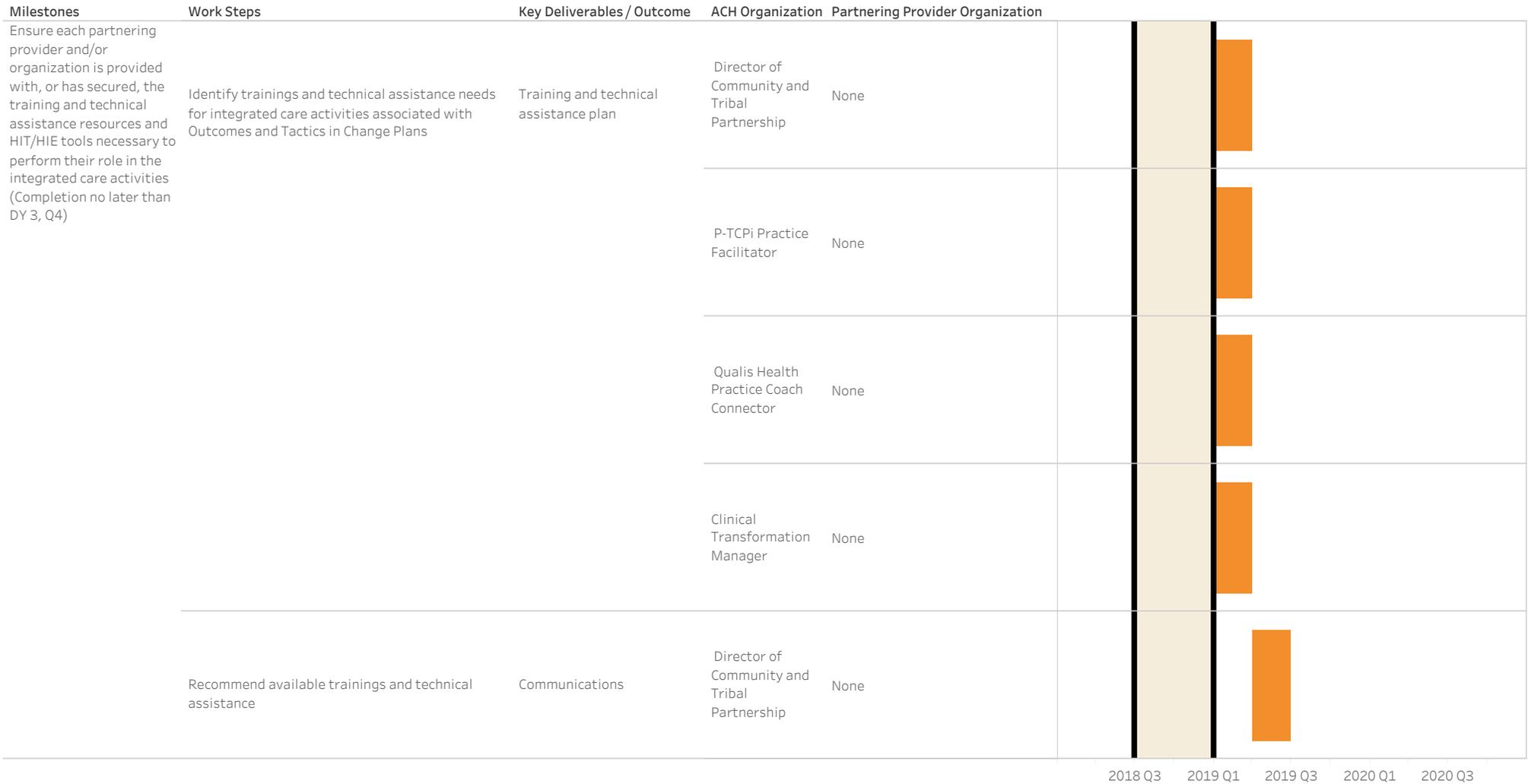
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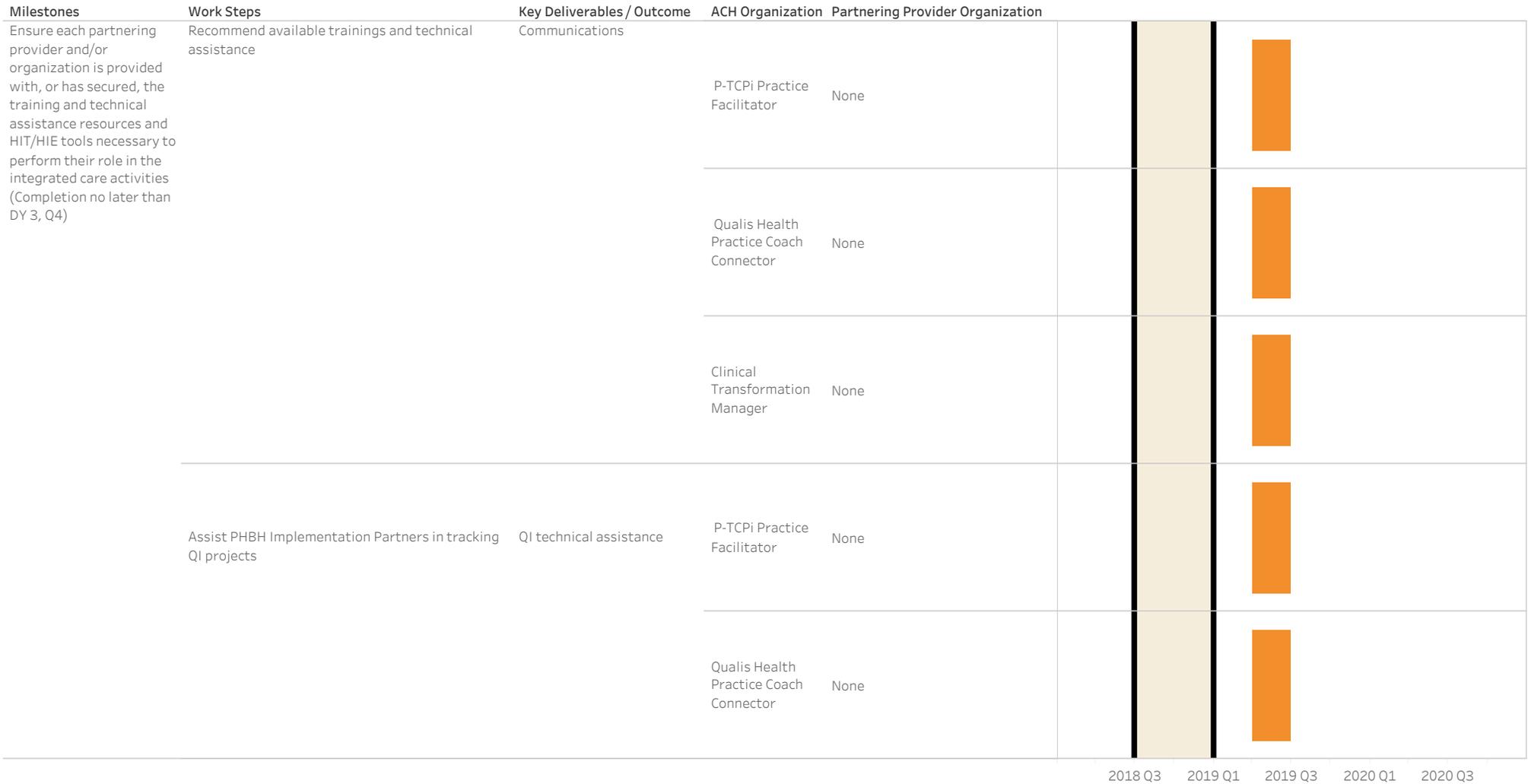
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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Ensure each member of the care team, participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner (Completion no later than DY 3, Q4)	Provide PHBH and CBOSS Implementation Partners with tools to assess cultural competence and facilitate action planning to address gaps that are identified	Coaching report from Qualis Health, coaching report from P-TCPI, practice assessments, results from Current State Assessment, findings from site visits and QIP reporting	P-TCPI Practice Facilitator	PHBH* and CBOSS^ Implementation Partners	
			Qualis Health Practice Coach Connector	PHBH* and CBOSS^ Implementation Partners	
	Offer QI check-ins to help evaluate progress	QI meeting	P-TCPI Coach Facilitator	None	
			Qualis Health Practice Coach Connector	None	
	Evaluate needs of PHBH and CBOSS Implementation Partners on cultural competency	Coaching report from Qualis Health, coaching report from P-TCPI, practice assessments, results from Current State Assessment	Director of Community and Tribal Partnership	None	

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Ensure each member of the care team, participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner (Completion no later than DY 3, Q4)	Evaluate needs of PHBH and CBOSS Implementation Partners on cultural competency	Coaching report from Qualis Health, coaching report from P-TCPI, practice assessments, results from Current State Assessment, findings from site visits and QIP reporting	P-TCPI Coach Facilitator	None	
			Qualis Health Practice Coach Connector	None	
	Recommend or offer trainings in cultural competency and related areas to PHBH and CBOSS Implementation Partners and Shared Change Plan Partners	Cultural competency or related trainings	Director of Community and Tribal Partnership	None	
			P-TCPI Coach Facilitator	None	
			Qualis Health Practice Coach Connector	None	

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Implement selected strategies/approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports (Completion no later than DY 3, Q4)	Best practices for opioid prescribing are promoted and used (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, participation of Shared Change Plan Partners	None	PHBH* Implementation Partners* and interested Shared Change Plan Partners **	
	Providers are trained to recognize potential for opioid use disorder (OUD) and utilize a standardized protocol for screening and referring these patients (Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, participation of Shared Change Plan Partners	None	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **	
	Capacity is built to prevent opioid use disorder (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, participation of Shared Change Plan Partners	None	PHBH* Implementation Partners and interested Shared Change Plan Partners **	
	Patients are engaged around prevention of OUD (Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, participation of Shared Change Plan Partners	None	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **	
	Public is offered education and awareness around opioid epidemic (Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, participation of Shared Change Plan Partners	None	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **	

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Implement selected strategies/approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports (Completion no later than DY 3, Q4)	Educate clients on safe medication return and disposal programs (also called "drug take back") (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, participation of Shared Change Plan Partners	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **	
	Raise public awareness programs about opioid misuse and abuse prevention through data and programs such as It Starts with One (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, participation of Shared Change Plan Partners	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **	
	Educate clients on safe storage of opioids (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, participation of Shared Change Plan Partners	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **	
	Naloxone is accessible (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners; participation of Shared Change Plan Partners	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **	
	Full spectrum of best practices for evidence-based care for opioid use disorder is available (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, participation of Shared Change Plan Partners	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **	

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Implement bi-directional communications strategies/interoperable HIE tools to support the care model (Completion no later than DY 3, Q4)	Integrate dental records into the medical EHR (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	
	Utilize screening tools and protocols to identify client oral health needs and inform appropriate referrals (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
	Screen clients for engagement with oral health provider and provide resources/referral as needed (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
	Refer individuals needing oral health care to oral health care services (Tactic in CBOSS Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	

2018 Q3 2019 Q1 2019 Q3 2020 Q1 2020 Q3

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client and family/caregivers, have access to the information appropriate to their role in the team and the care plan) (Completion no later than DY 3, Q4)	Implement PreManage (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	
	Providers are notified of patient/client ED visits (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	
	Streamlined process is in place for information to be shared in a timely manner for shared patients/clients (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	
	Sign inter-organizational agreements for access to records of referred and/or shared patients/clients (Recommended Tactic in PHBH and CBOSS^ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Establish and document a protocol for convening cross-sector care meetings (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	

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Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client and family/caregivers, have access to the information appropriate to their role in the team and the care plan) (Completion no later than DY 3, Q4)	Implement process to review the PRC (patient review and coordination) list and EDIE feeds, assess patient needs and link patients to community providers (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	
	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve:	Facilitate culture shift across Implementation Partner organizations to prioritize chronic disease prevention and management (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	
<ul style="list-style-type: none"> Self-Management Support Delivery System Design Decision Support Clinical Information Systems (including interoperable systems) 	Foster and enhance community clinical linkages in each NCC to ensure patients are supported and active participants in their disease management (Required Outcome in the PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	
<ul style="list-style-type: none"> Community-based Resources and Policy Health Care Organization (Completion no later than DY 3, Q4) 	Form bi-directional referral system within the Natural Community of Care between clinical and community partner for effective chronic care services; refer to appropriate programs depending on patient profile (Recommended Tactic in the PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	

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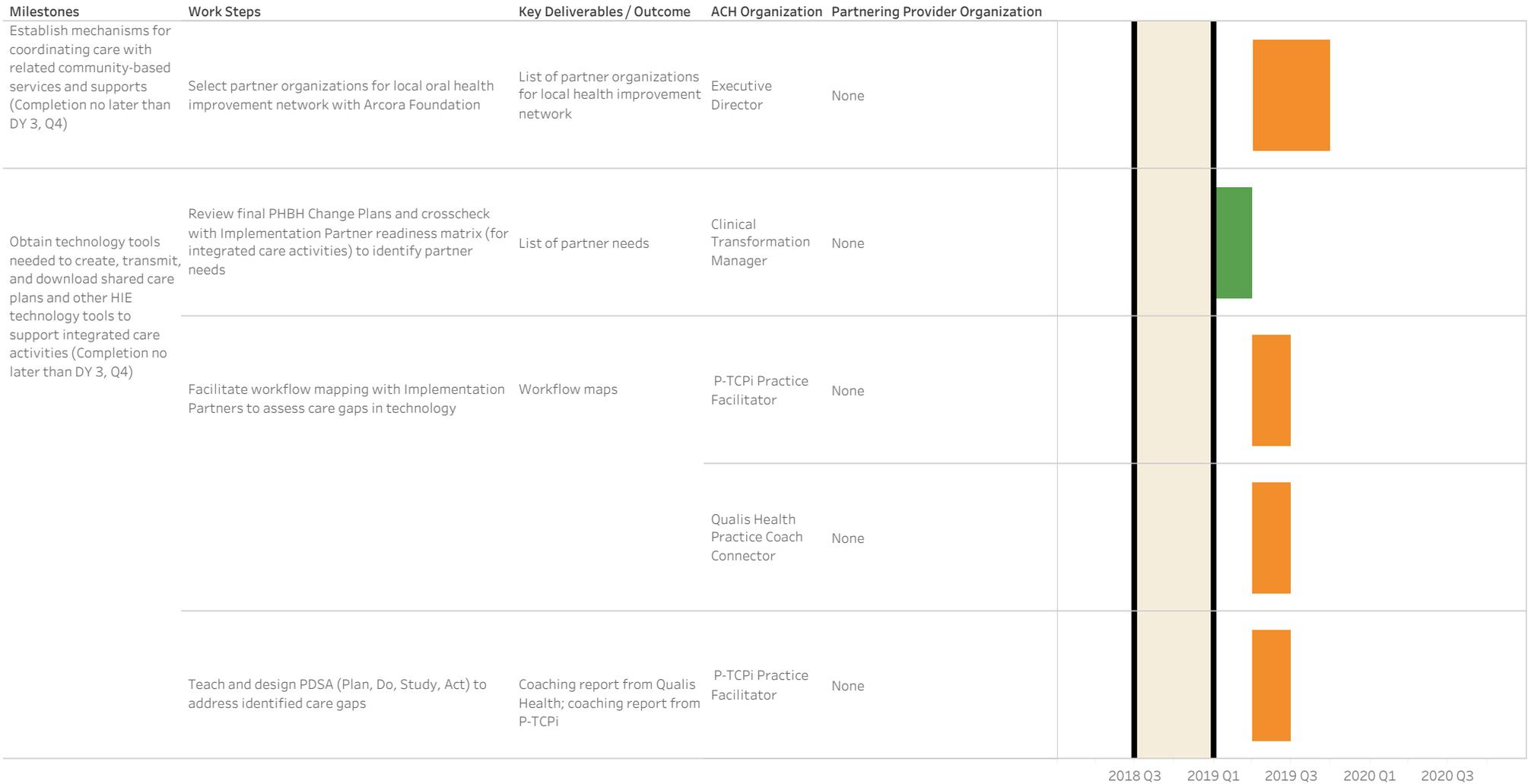
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Systems (including interoperable systems) <ul style="list-style-type: none"> Community-based Resources and Policy Health Care Organization (Completion no later than DY 3, Q4) 	Provide effective chronic care services to referred clients (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	Utilize screening tools and protocols to identify client oral health needs and inform appropriate referrals (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
	Screen clients for engagement with oral health provider and provide resources/referral as needed (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
	Facilitate alignment with Access to Baby and Child Dentistry (ABCD)	ABCD coordinator participates in NCC convenings	Director Community and Tribal Partnership	None	
	Develop strategies, emphasizing care coordination between new and existing dental providers and community-based services and supports (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	Executive Director	None	

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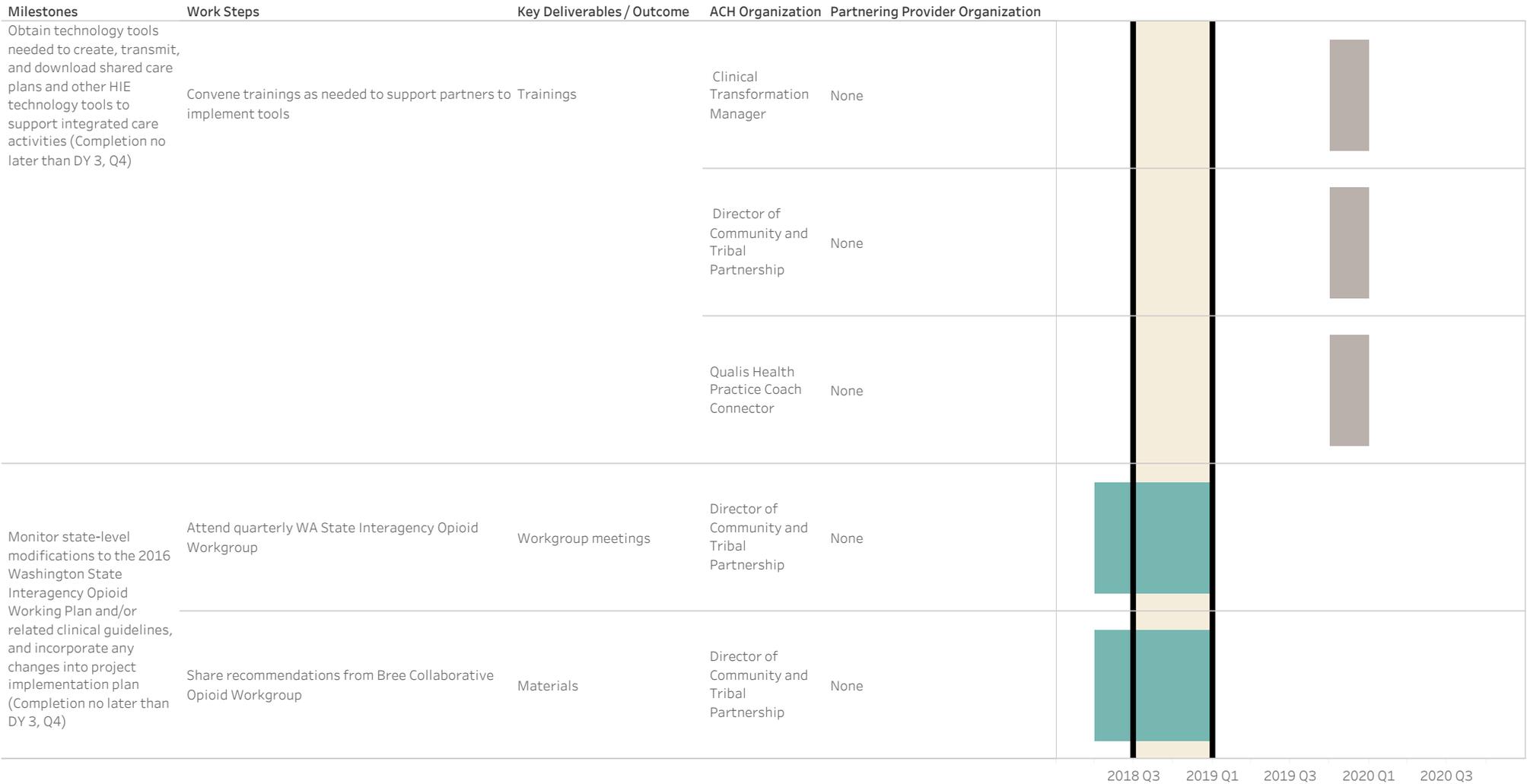
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Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities (Completion no later than DY 3, Q4)	Teach and design PDSA (Plan, Do, Study, Act) to address identified care gaps	Coaching report from Qualis Health; coaching report from P-TCPI	Qualis Health Practice Coach Connector	None	
	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Distribute learnings and updates from PreManage learning collaborative	Tools from PreManage learning collaborative	Qualis Health Practice Coach Connector	None	
	Provide examples of Releases of Information and best practices regarding compliance with 42 CFR Part II	Examples of Releases of Information	Qualis Health Practice Coach Connector	None	
	Distribute State consent management workgroup materials to BHA and SUD partners	Output from State consent management workgroup	Qualis Health Practice Coach Connector	None	

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	Standardize identification of and track individuals experiencing homelessness and/or food insecurity needing more efficient management and effective care (Recommended Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Select Implementation Partners	
	SDOHs are assessed and integrated into standard practice (Required Outcome in PHBH and CBOSS Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* and CBOSS^ Implementation Partners	
Establish mechanisms, including technology-enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to promote well-child visits and immunizations (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	
	Conduct coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates (Required Outcome in PHBH Change Plan for primary care)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners who have submitted a Primary Care Change Plan	

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transitional care plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	Provide evidence-based prenatal or early childhood interventions to promote optimal health outcomes (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies (Completion no later than DY 3, Q4)	Develop care coordination protocols that include screening, appropriate referral, and closing the loop on referrals to connect specific subpopulations to clinical or community services (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	
	Integrate social determinants of health (SDOH) assessments into standard practice (Required Outcome in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* and CBOSS^ Implementation Partners	
	Streamline processes for information to be shared in a timely manner for shared patients/clients (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	
	Ensure community-clinical linkages so that patients are supported and are active participants in their disease management (Required Outcome in PHBH Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	

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Status Update

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- Completed for DY2, In Progress for DY3
- Completed for DY2, Not Started for DY3
- In Progress
- Not Started

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies (Completion no later than DY 3, Q4)	Provide effective chronic care services (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners	
	Sign Business Associate Agreements or equivalent with partners involved with the patient's care to support referrals OR sub-contract with community partners to ensure shared patients/clients receive appropriate services (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Sign inter-organizational agreements for access to records of referred and/or shared patients/clients (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Participate in a technology platform that allows necessary patient/client information to be exchanged between the referee and referral organization (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Provide participating providers and organizations with financial resources to offset the costs of	Incentivize value-based payment arrangements with MCOs (Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners

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Status Update

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities. (Completion no later than DY 3, Q4)	Report on value-based metrics that will be in MCO contracts (Recommended Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	Not Started
	QI methods are used to improve care and care delivery (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	In Progress
	Form and maintain a diverse QI team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care and patient satisfaction (Recommended Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	In Progress
Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened (Completion no later than DY 3, Q4) -Each partnership should include health care service, including mental health and SUD providers, community-based service..	Convene 3CCORP Steering Committee, Prevention Workgroup, Treatment Workgroup and Overdose Prevention Workgroup on a regular basis to guide the work of Project 3A	Semi-annual to monthly 3CCORP meetings, agendas and meeting minutes, regional opioid response plan, completion and maintenance of partnering provider roster	Director of Community and Tribal Partnership	None	Completed for DY2, In Progress for DY3
	3CCORP members present accomplishments at Regional Opioid Summit(s)	Regional Opioid Summit(s)	None	3CCORP members***	Completed for DY2, Not Started for DY3

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Develop workflows to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed (Completion no later than DY 3, Q4)	Receive technical assistance from Arcora Foundation and/or Qualis Health to assist Implementation Partners in identifying care team members and integrating oral health screening and referral to dentist or periodontist into workflows	Standard operating procedure to screen and refer to an oral health provider identified at site visit	Arcora Foundation and Qualis Health	None	Not Started
	Assess progress on workflow integration at site visit	Biannual report of progress on this work step and any associated intermediary measures	Clinical Transformation Manager	Select PHBH* Implementation Partners	Not Started
	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	In Progress
	Train providers on screening for oral health needs and engagement with oral health provider (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	In Progress
Establish referral relationships with dentists and other specialists, such as ENTs and periodontists (Completion no later than)	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners	In Progress

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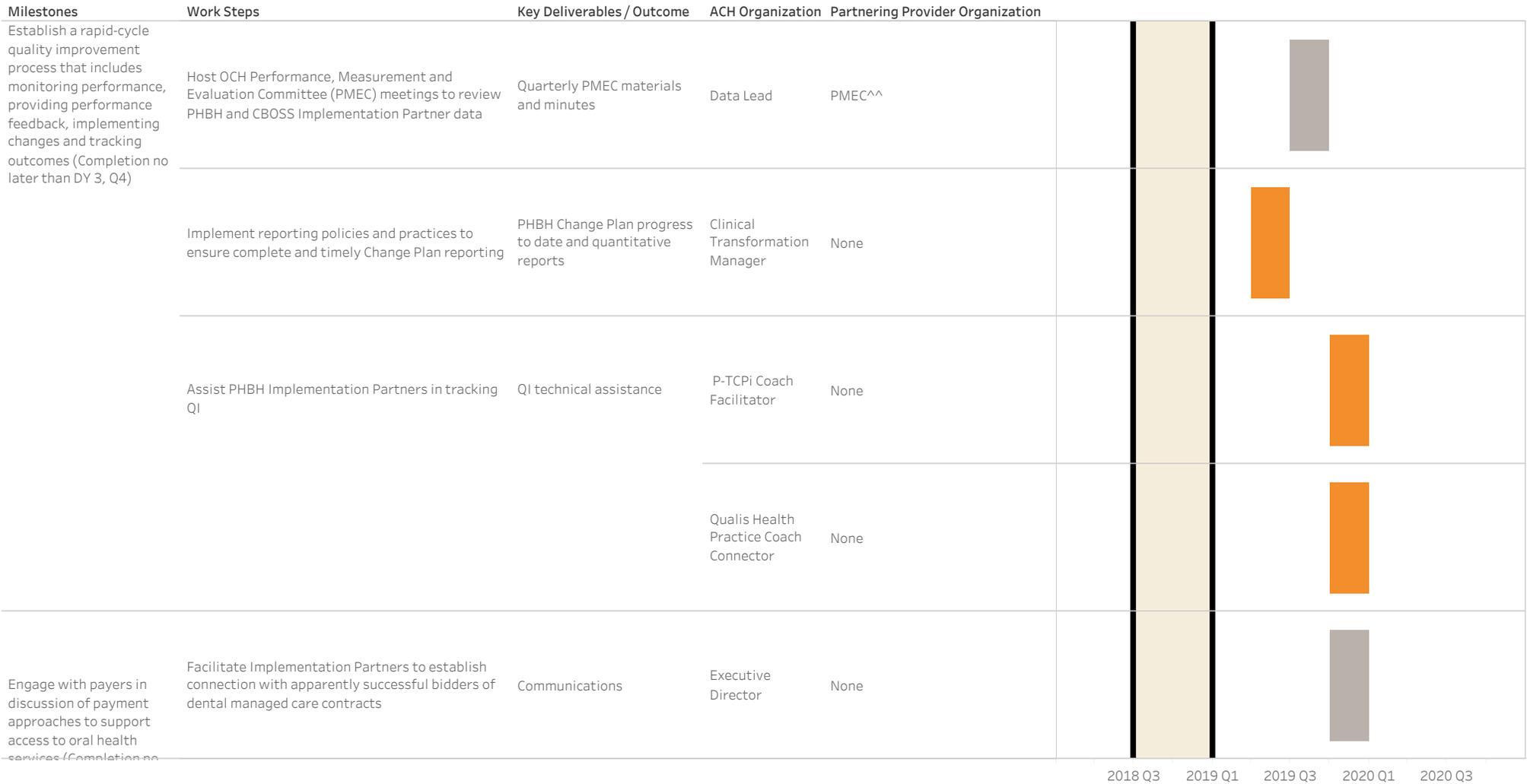
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Establish referral relationships with dentists and other specialists, such as ENTs and periodontists (Completion no later than DY 3, Q4)	Train providers on screening for oral health needs and engagement with oral health provider (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	
Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers) (Completion no later than DY 3, Q4)	Implement regional survey to identify gaps in the number or locations of providers offering recovery support services	Survey results	Director of Community and Tribal Partnership	None	
Identify regional care gaps for referred clients to recovery support services within the planning framework of QI team in PC, SUD and BH clinics to address these gaps	Identify regional care gaps for referred clients to recovery support services within the planning framework of QI team in PC, SUD and BH clinics to address these gaps	Documented QI strategies for referral process to recovery services	Qualis Health Practice Coach Connector	None	
Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes (Completion no later than DY 3, Q4)	Establish procedures for and carry out QIP	Scheduled biannual site visits by OCH staff biannual quantitative and qualitative data submitted by PHBH and CBOSS Implementation Partners	Data Lead	PHBH* and CBOSS^ Implementation Partners	
			Clinical Transformation Manager	PHBH* and CBOSS^ Implementation Partners	

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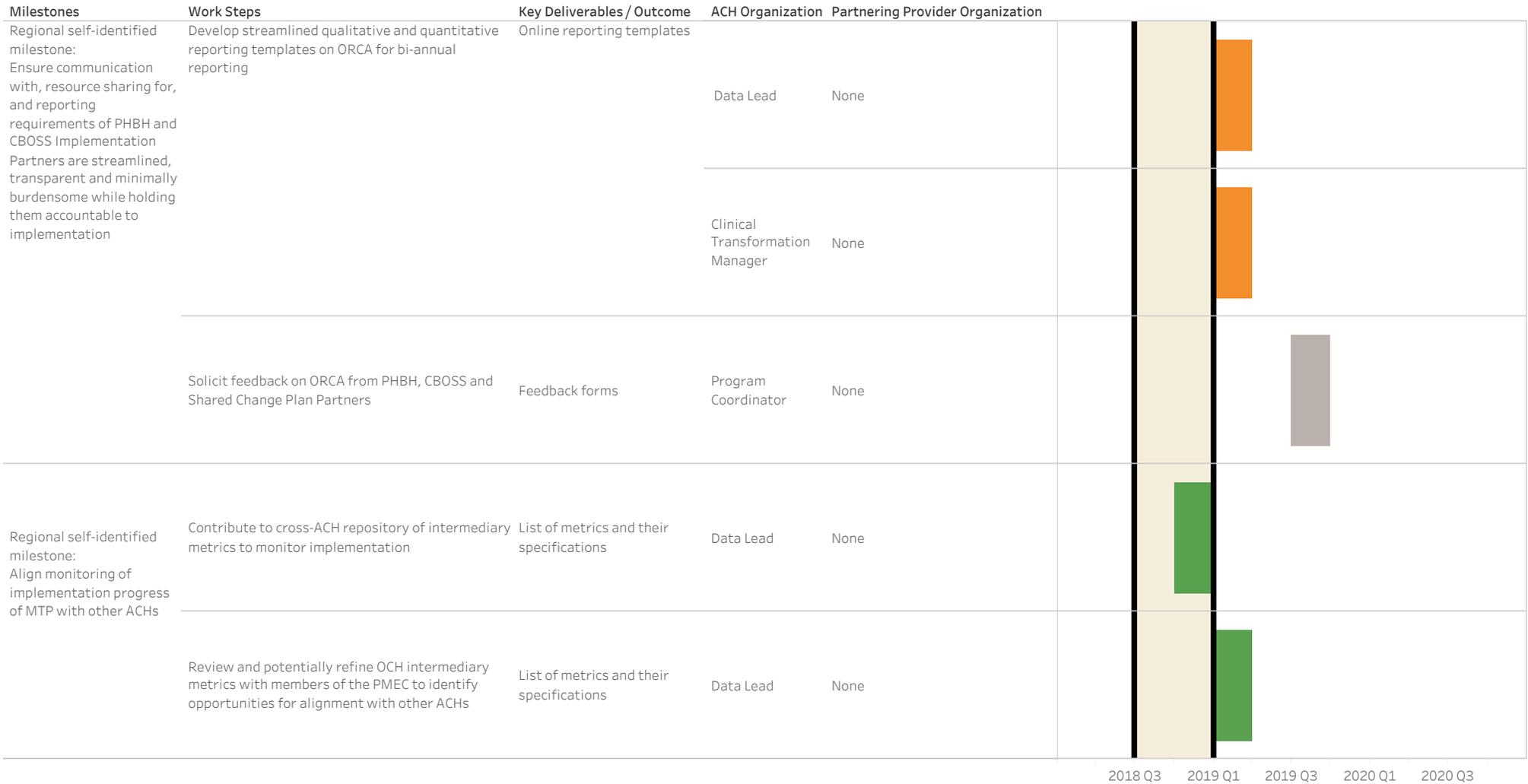
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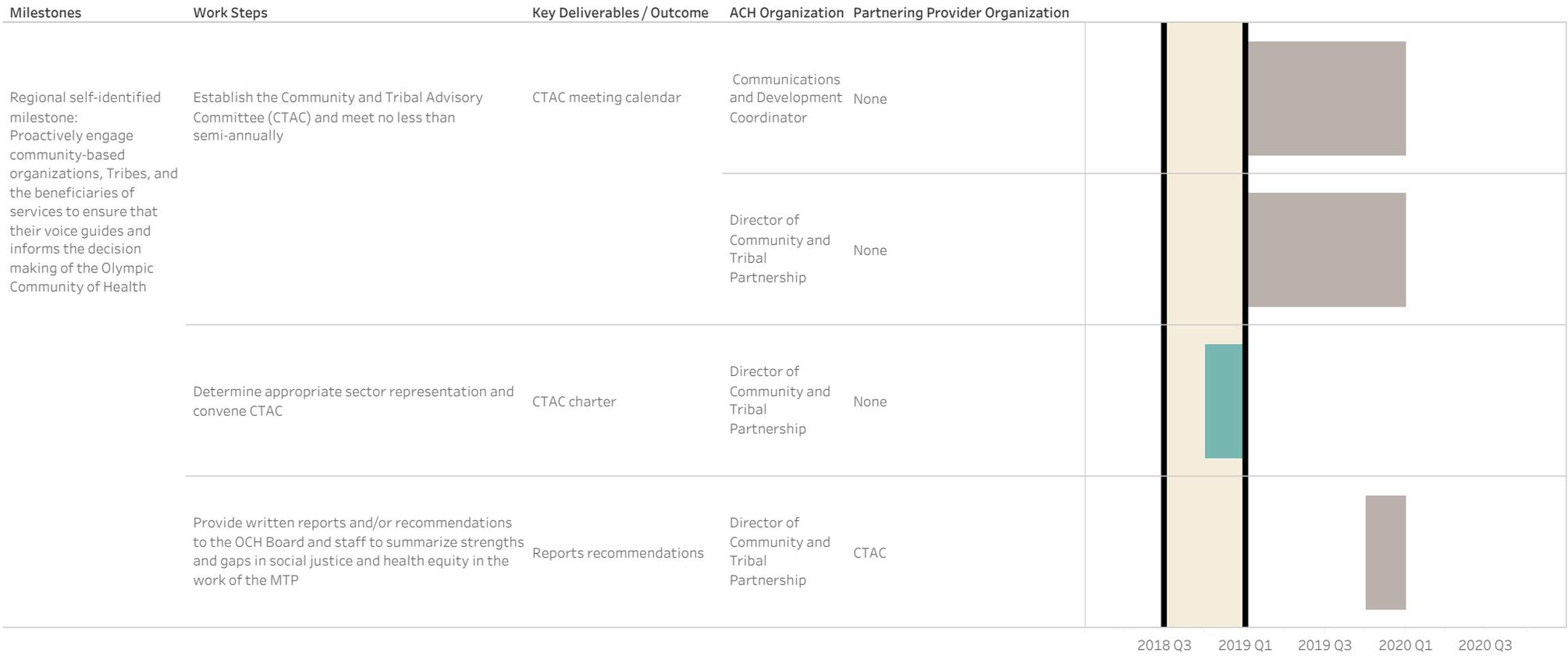
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Implementation Plan Timeline: Stage 2



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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Increase use of technology tools to support integrated care activities by additional providers/organizations (Completion no later than DY 4, Q4)	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Explore a common or interoperable EHR or EBHR (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	
	Explore a shared population health management system within Natural Community of Care (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **	
Expand the model to additional communities and/or partner organizations (Completion no later than DY 4, Q4)	Build relationships with stand-alone SUD providers who have not yet participated in practice transformation	Communications and meetings	Director of Community and Tribal Partnership	None	
			P-TCPI Practice Facilitator	None	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Expand the model to additional communities and/or partner organizations (Completion no later than DY 4, Q4)	Build relationships with stand-alone SUD providers who have not yet participated in practice transformation	Communications and meetings	Qualis Health Practice Coach Connector	None	
	Encourage Implementation Partners to expand on the list of selected Tactics and target populations in the PHBH and CBOSS Change Plans that will result in reduced unnecessary ED utilization	PHBH and CBOSS Change Plans include additional Tactics and/or target populations in annual updates	None	Select PHBH* and CBOSS^ Implementation Partners	
	Scale fully implemented Outcomes and Tactics in PHBH and CBOSS Change Plans	PHBH and CBOSS Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	None	Select PHBH* and CBOSS^ Implementation Partners	
	Convene Regional Opioid Summit(s) for existing partners as well as new partners	Regional Opioid Summit roster	Director of Community and Tribal Partnership	None	
Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges	Continue efforts to attend and present at local meetings, coalitions and councils to identify new partners that have not yet engaged and offer targeted invitations to bi-annual Natural Community of Care Convenings, 3CCORP workgroups and/or Opioid Summit(s)	Participation of new partners in OCH-hosted events, committees and workgroups	Director of Community and Tribal Partnership	None	

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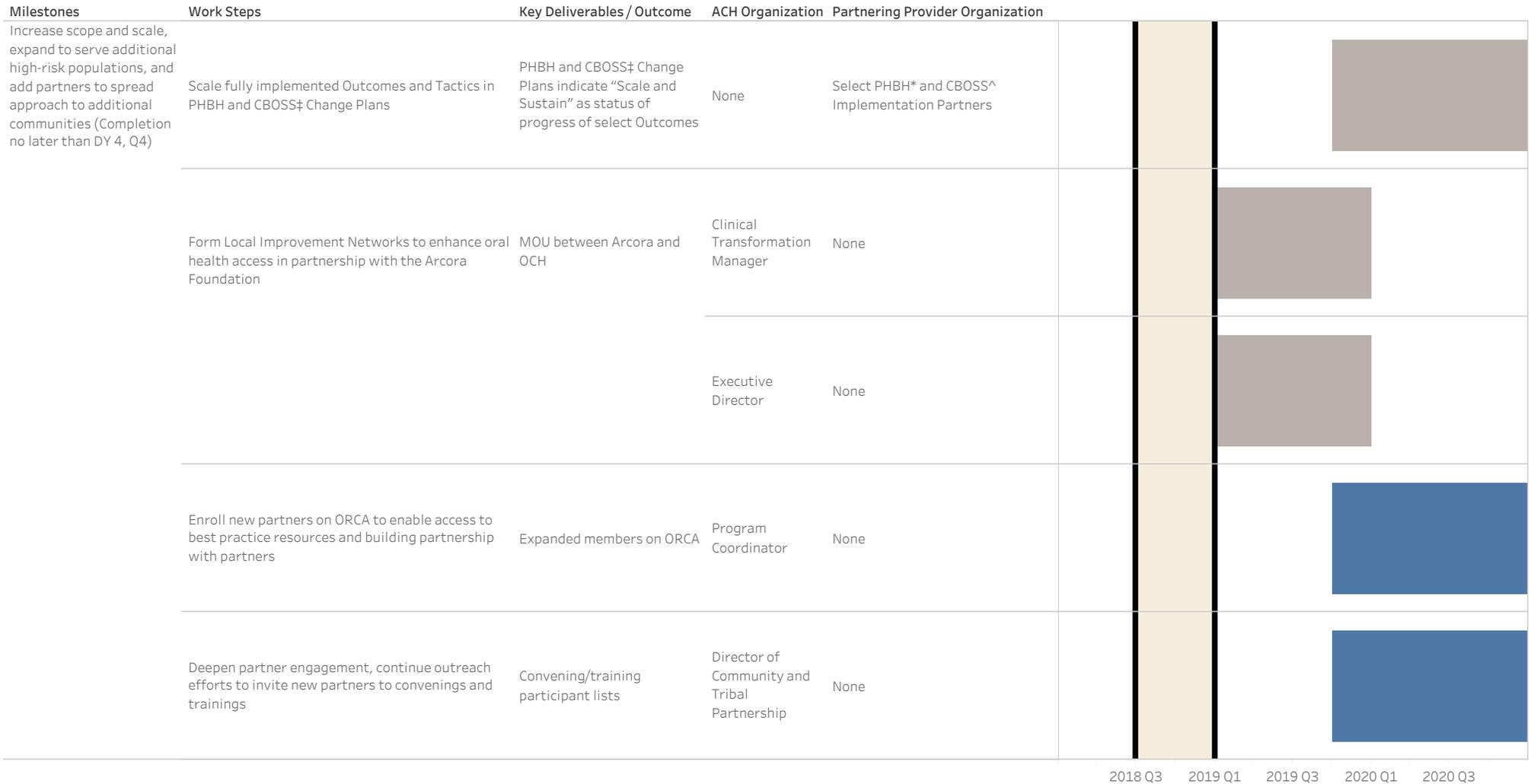
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges (Completion no later than DY 4, Q4)	Continue to monitor regional data to identify high needs geographic areas for prevention, treatment, and overdose prevention to address potential inequities in access to care and outcomes	Identification of high-need areas	Data Lead	None	Not Started
	Identify new local efforts to address the opioid public health crisis to share expertise and resources	Roster of regional coalitions and efforts	Director of Community and Tribal Partnership	None	In Progress
Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities (Completion no later than DY 4, Q4)	Explore operating a mobile dental clinic	Biannual report of progress on this work step and any associated intermediary measures	None	Peninsula Community Health Services	Not Started
	Coordinate with a mobile dental clinic (Tactic in PHBH and CBOSS‡ Change Plans)	PHBH and CBOSS‡ Change Plans indicate progress towards this work step, updated biannually	None	Select PHBH* and CBOSS^ Implementation Partners and interested Shared Change Plan Partners **	Not Started
	Expand on the list of selected Tactics and target populations in the PHBH and CBOSS‡ Change Plans that will result expansion of access to oral health	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	None	Select PHBH* and CBOSS^ Implementation Partners	Not Started

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Implementation Plan Timeline: Stage 3



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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities (Completion no later than DY 4, Q4)	Expand on the list of selected Tactics and target populations in the PHBH and CBOSS‡ Change Plans that will result in improved access and quality of reproductive, maternal and child supports and services	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	None	Select PHBH* and CBOSS^ Implementation Partners	Not Started
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project(s) beyond DY5 (Completion no later than DY 4, Q4)	Report on value-based metrics that will be in MCO contracts (Recommended Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners	In Progress
	Implement value-based payment arrangements with MCOs (Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	In Progress
Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes (Completion no later than)	Scale fully implemented Outcomes and Tactics in PHBH and CBOSS‡ Change Plans	PHBH and CBOSS‡ Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	None	Select PHBH* and CBOSS^ Implementation Partners	Not Started
	Enroll new partners on ORCA to enable access to best practice resources and building partnership with partners	Expanded members on ORCA	Program Coordinator	None	In Progress

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes (Completion no later than DY 4, Q4)	Deepen partner engagement, continue outreach efforts to invite new partners to convenings and trainings	Convening/training participant lists	Director of Community and Tribal Partnership	None	
	Expand on the list of selected Tactics and target populations in the PHBH and CBOSS‡ Change Plans that will result in better chronic disease prevention and management	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	None	Select PHBH* and CBOSS^ Implementation Partners	
Identify new, additional target providers/organizations (Completion no later than DY 4, Q4)	Enroll new partners on ORCA to enable access to best practice resources and building partnership with partners	Expanded members on ORCA	Program Coordinator	None	
	Deepen partner engagement, continue outreach efforts to invite new partners to convenings and trainings	Convening/training participant lists	Director of Community and Tribal Partnership	None	
	Submit additional Change Plan types (e.g. Primary Care partner submitting Behavioral Health Change Plan once integration is implemented)	Additional Change Plans	None	Select PHBH* Implementation Partners	

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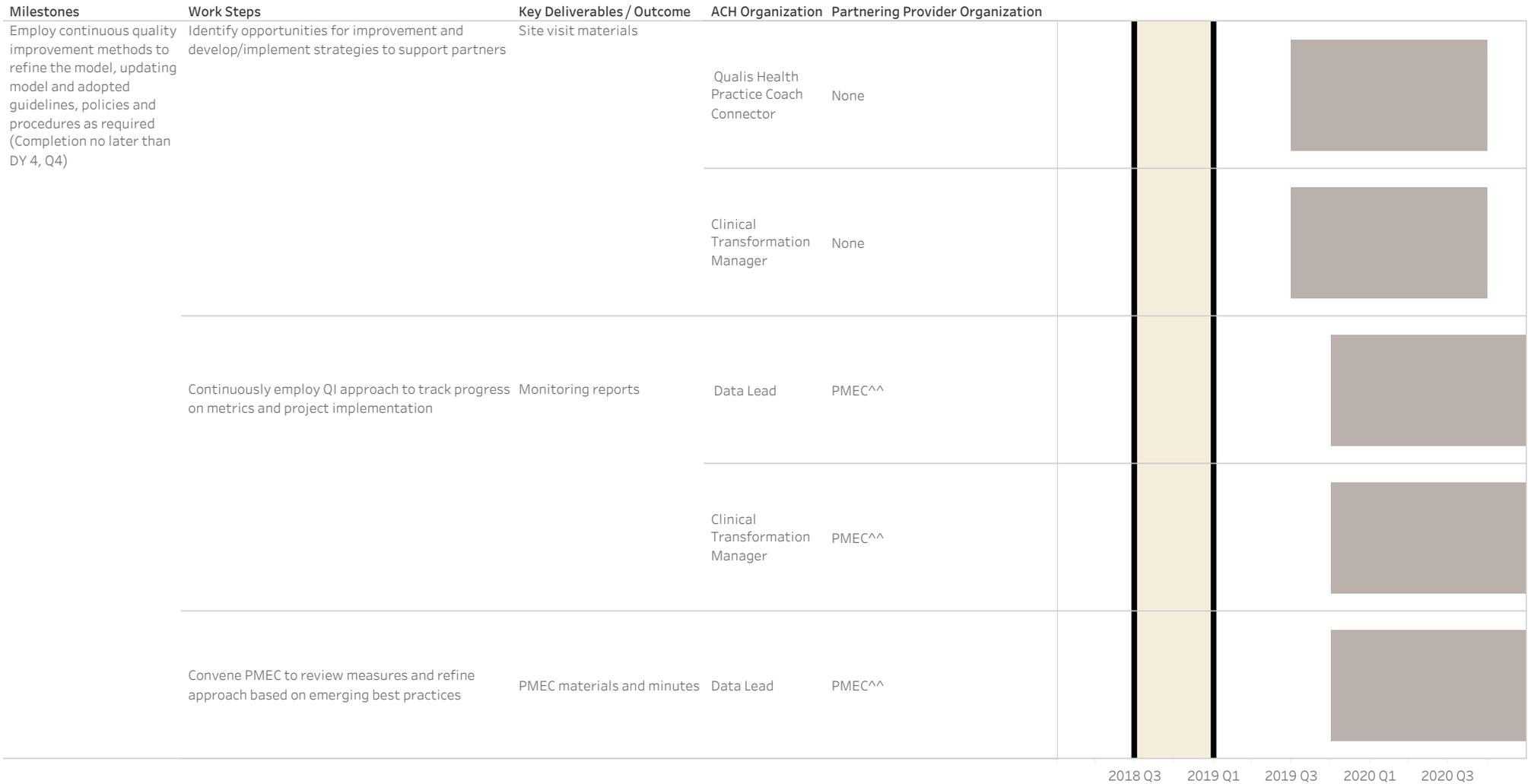
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required (Completion no later than DY 4, Q4)	Submit data to OCH	PHBH and CBOSS‡ Change Plan progress to date and quantitative reporting are complete and timely	None	PHBH* and CBOSS^ Implementation Partners	
	Convene OCH Performance, Measurement and Evaluation Committee (PMEC) meetings to review Implementation Partner data	PMEC materials and minutes	Data Lead	PMEC^^	
	Communicate performance to Implementation Partners	Performance reports/dashboard, site visit materials	Data Lead	None	
			Clinical Transformation Manager	None	
	Identify opportunities for improvement and develop/implement strategies to support partners	Site visit materials	P-TCPI Practice Facilitator	None	

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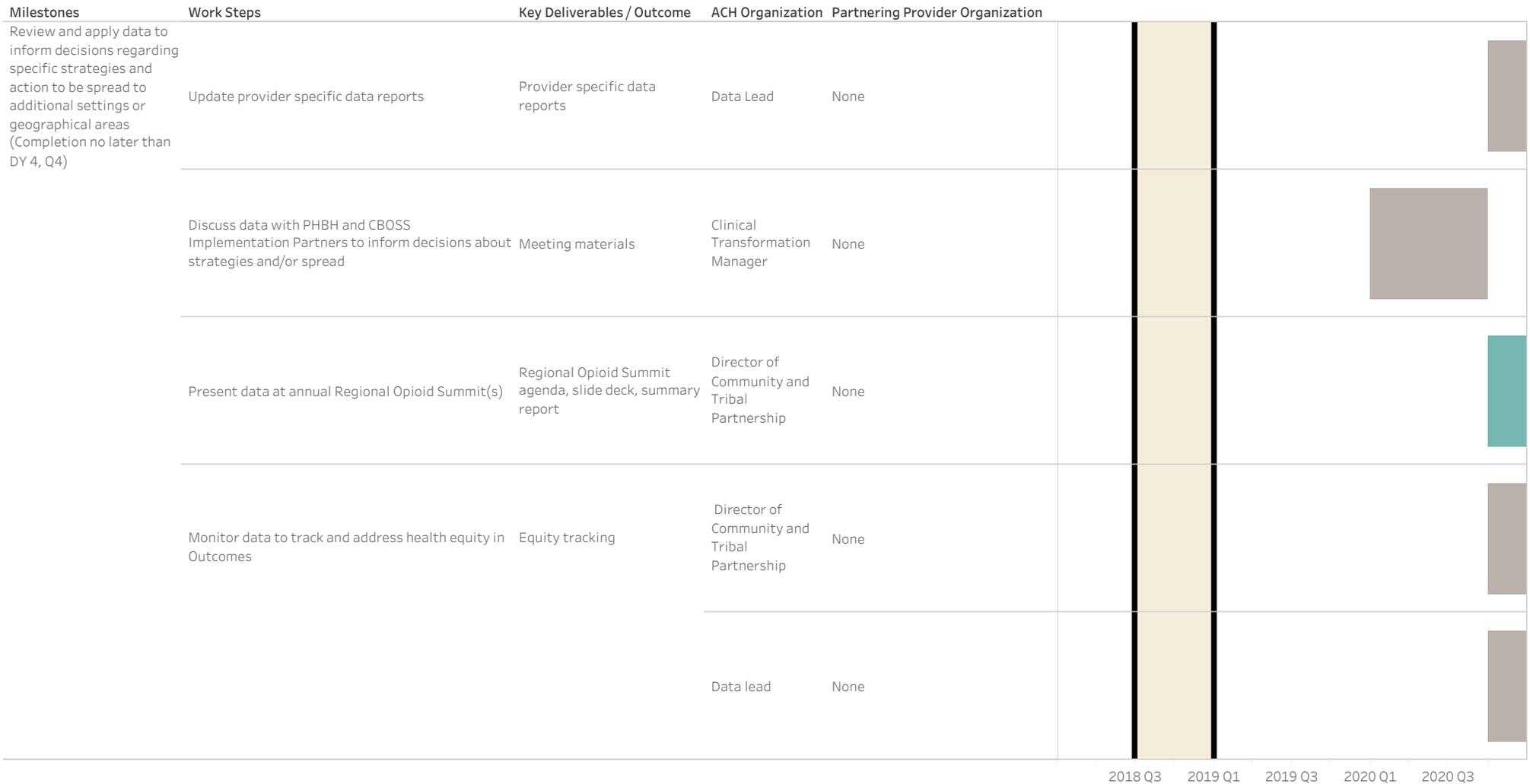
Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required (Completion no later than DY 4, Q4)	Employ QI methods to improve care and care delivery (Recommended Tactic in PHBH Change Plan)	PHBH Change Plan indicates "Scale and Sustain" as status of progress of select Outcomes	None	PHBH* Implementation Partners	Not Started
Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas (Completion no later than DY 4, Q4)	Update data monitoring reports with most recently available data	Opioid data summaries	Data Lead	None	In Progress
	Discuss new data and possible strategy and/or spread opportunities and with 3CCORP and PHBH and CBOSS Implementation Partners	Meeting materials/minutes	Director of Community and Tribal Partnership	3CCORP*** and PHBH* and CBOSS^ Implementation Partners	Not Started
	Discuss data updates with 3CCORP	Meeting materials/minutes	Director of Community and Tribal Partnership	None	Completed for DY2, In Progress for DY3
			Data Lead	None	Completed for DY2, In Progress for DY3

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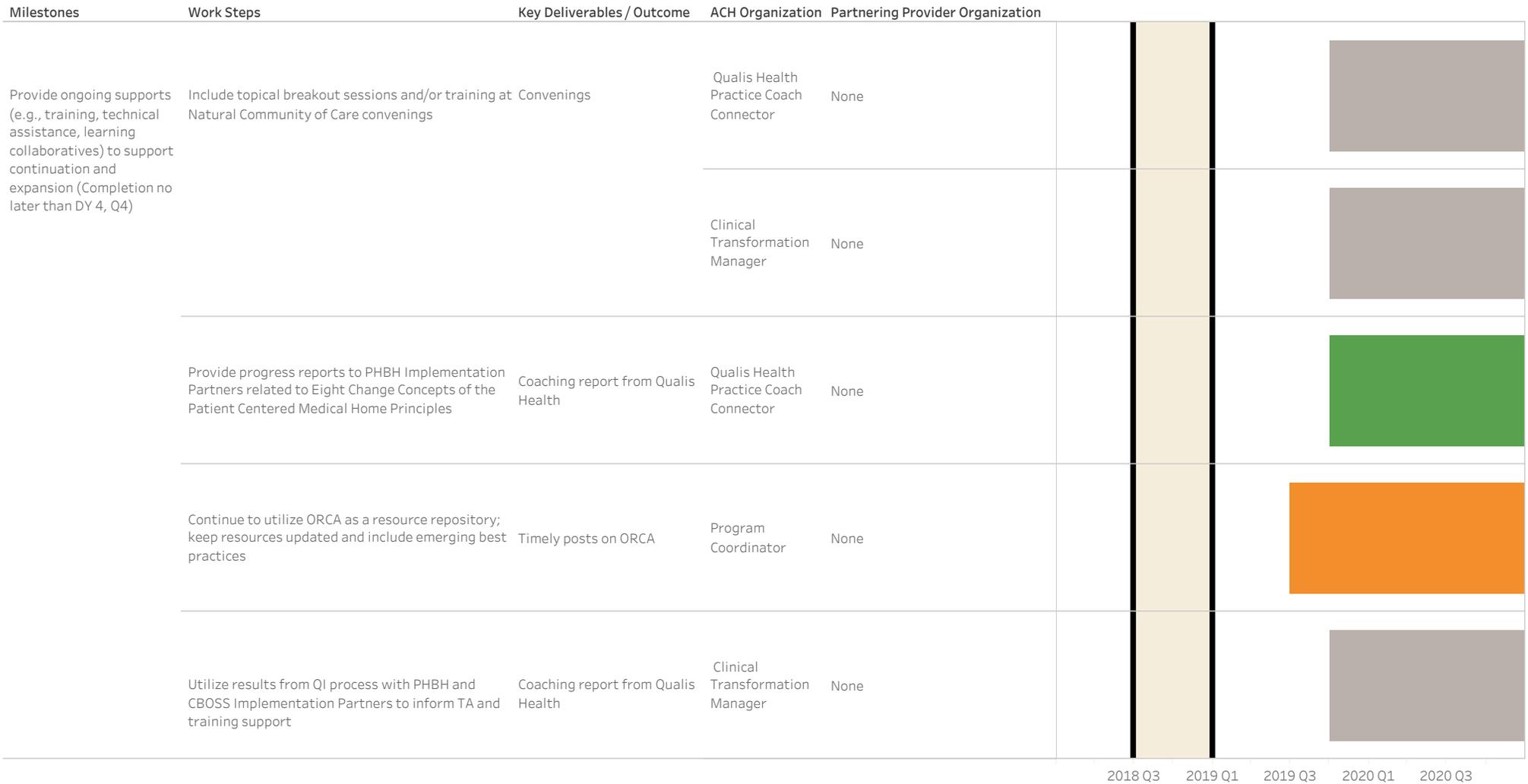
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Implementation Plan Timeline: Stage 3

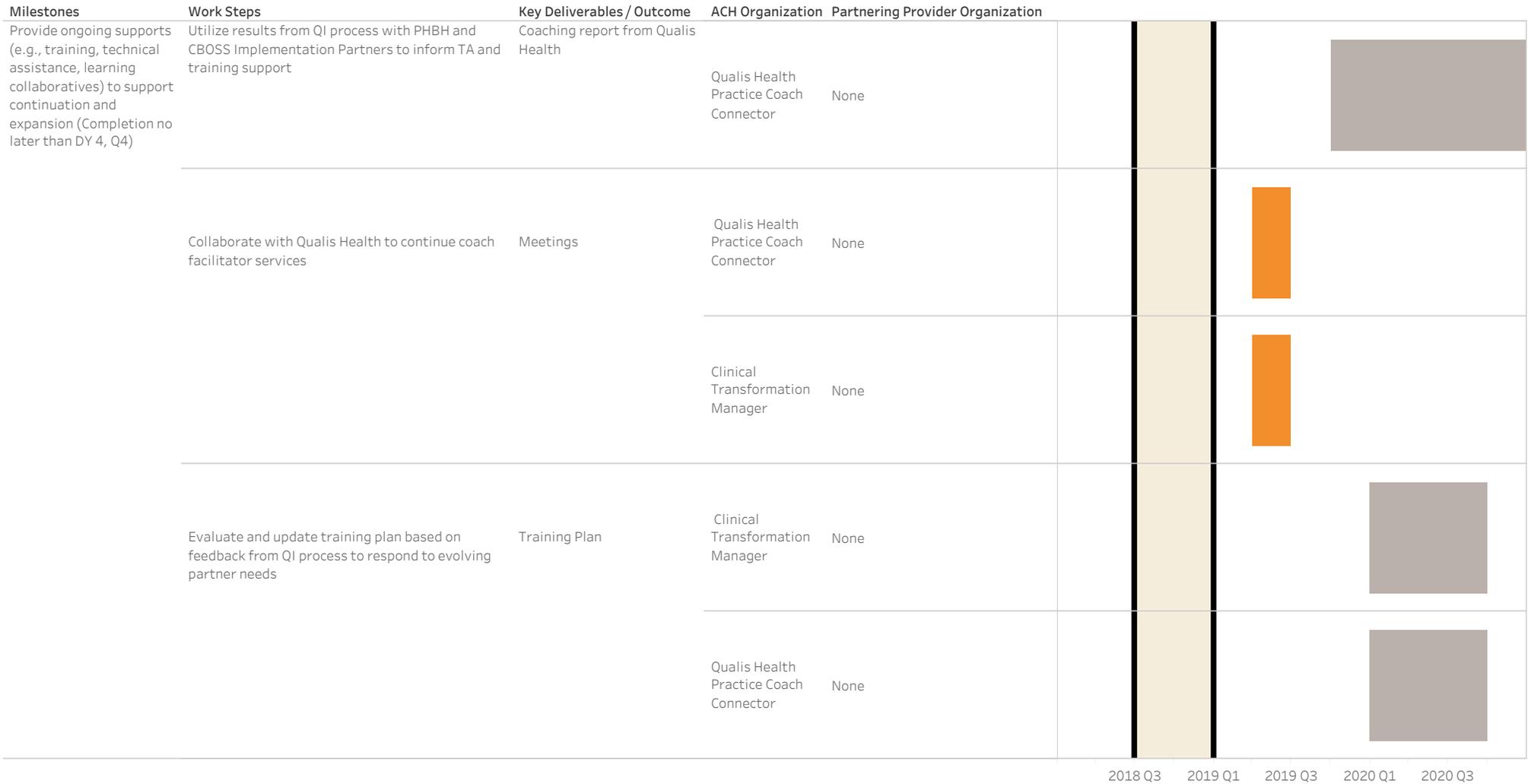


Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter. The Stage filter keeps 3. The Pivot Field Values Quarter filter ranges from 2018 Q1 to 2020 Q4 and keeps Null values. The Start Date1 Quarter filter keeps non-Null values only. The view is filtered on Milestones, which keeps 46 of 46 members.

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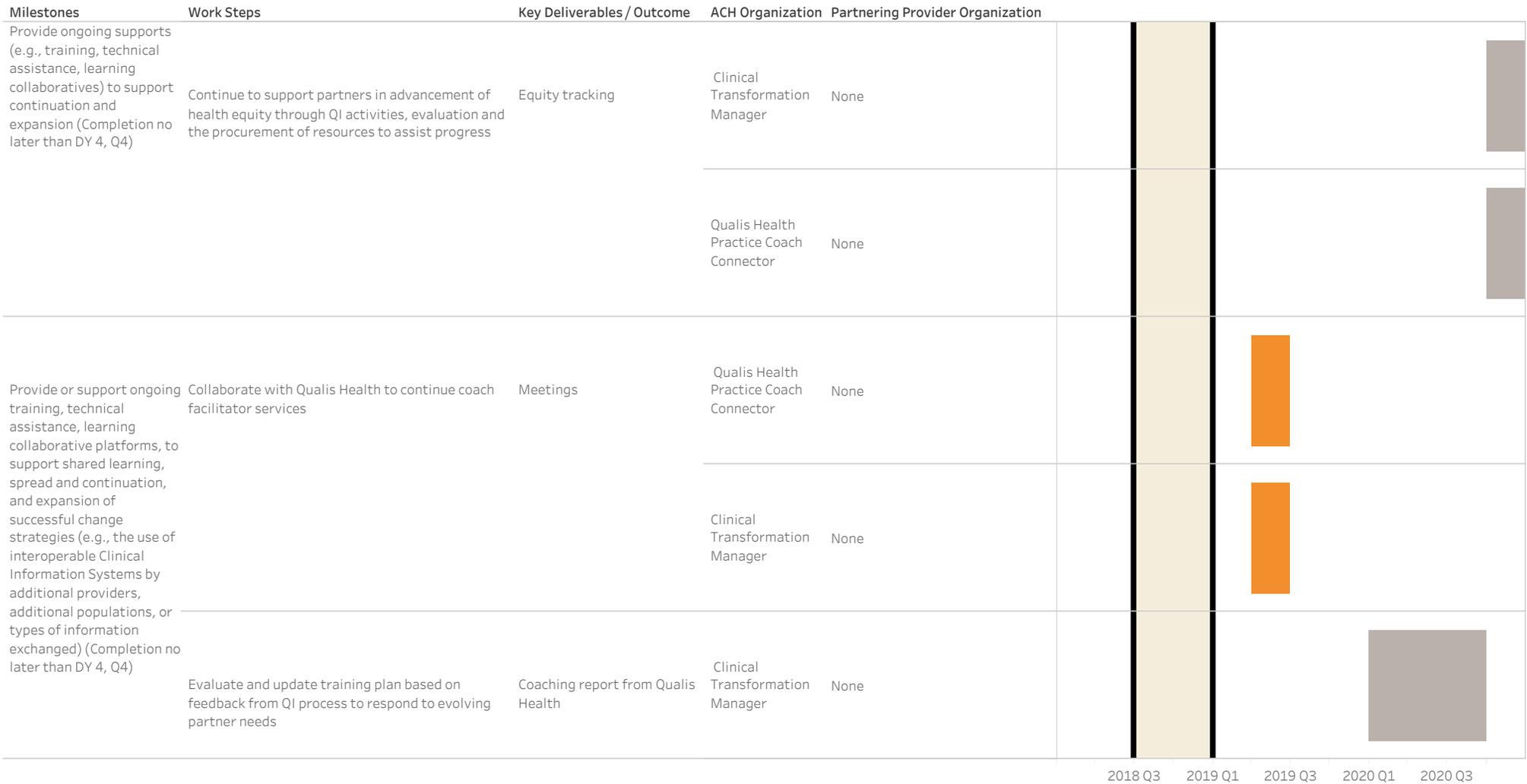
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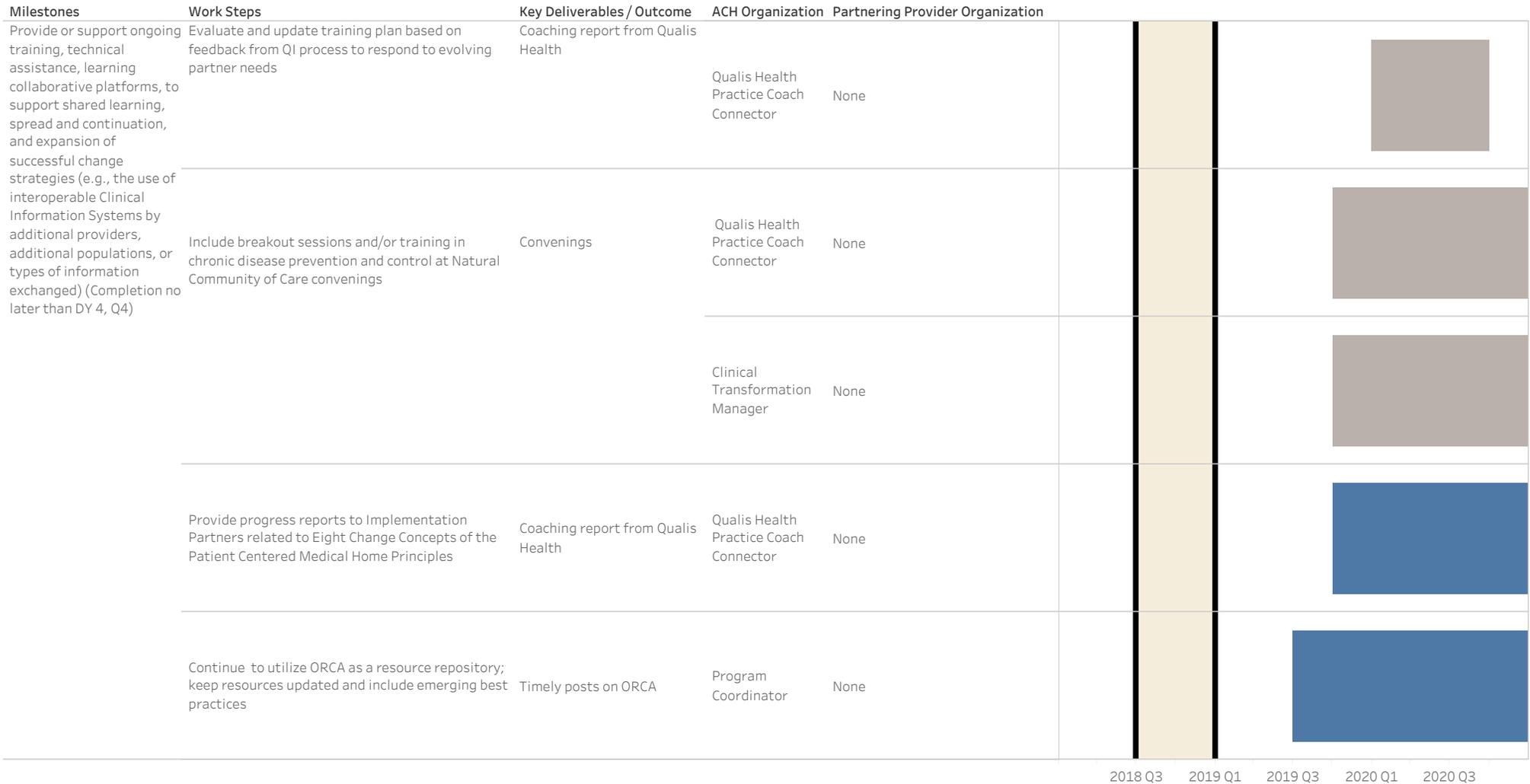
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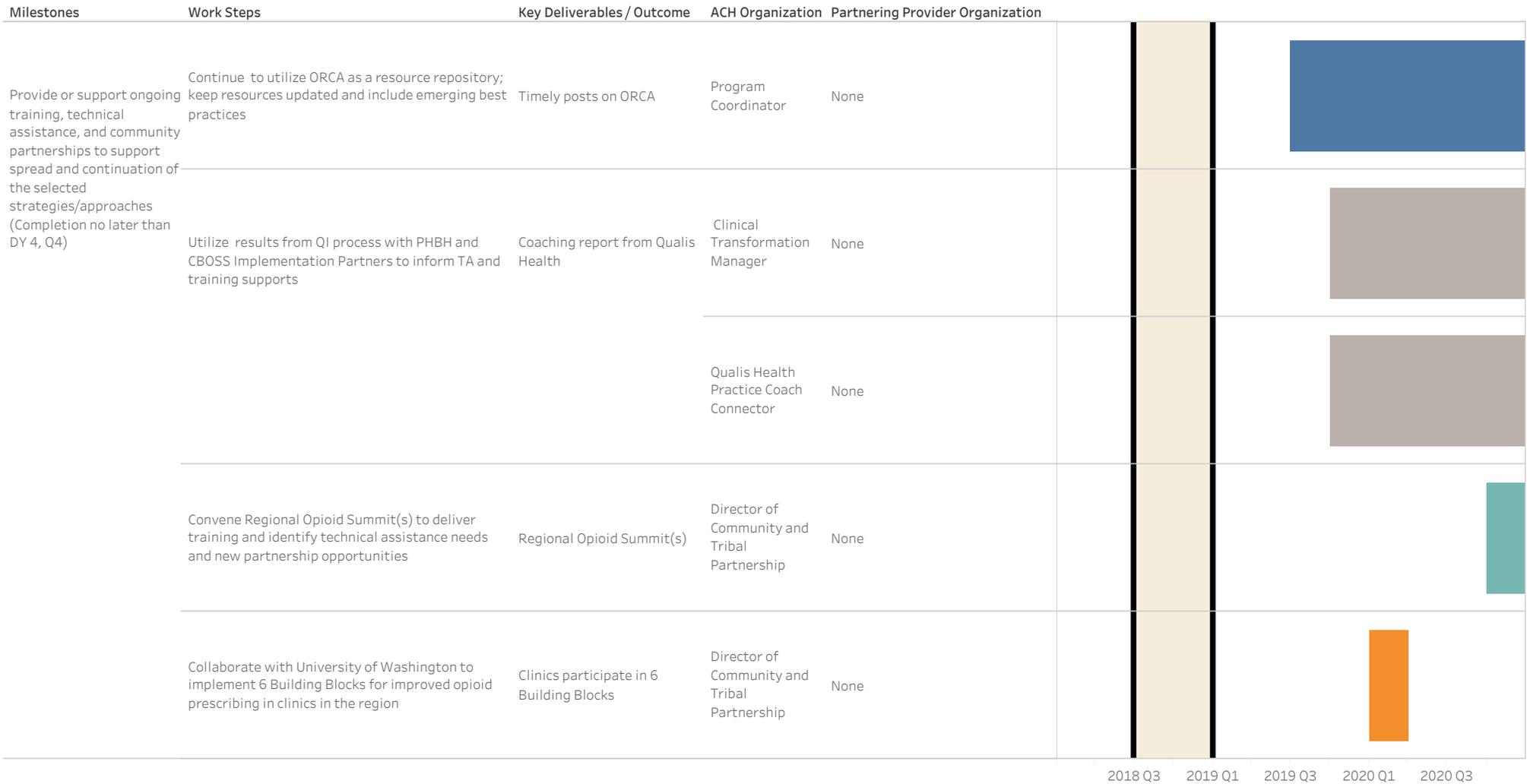
Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable Clinical Information Systems by additional providers, additional populations, or types of information exchanged) (Completion no later than DY 4, Q4)	Utilize results from QI process with PHBH and CBOSS Implementation Partners to inform TA and training supports	Coaching report from Qualis Health	Clinical Transformation Manager	None	
			Qualis Health Practice Coach Connector	None	
Continue to support partners in advancement of health equity through QI activities, evaluation and the procurement of resource to assist progress		Equity tracking	Clinical Transformation Manager	None	
			Qualis Health Practice Coach Connector	None	
Develop regional Behavioral Health Academy to train workforce in transitioning to integrated care		Training modules	Qualis Health Practice Coach Connector	None	

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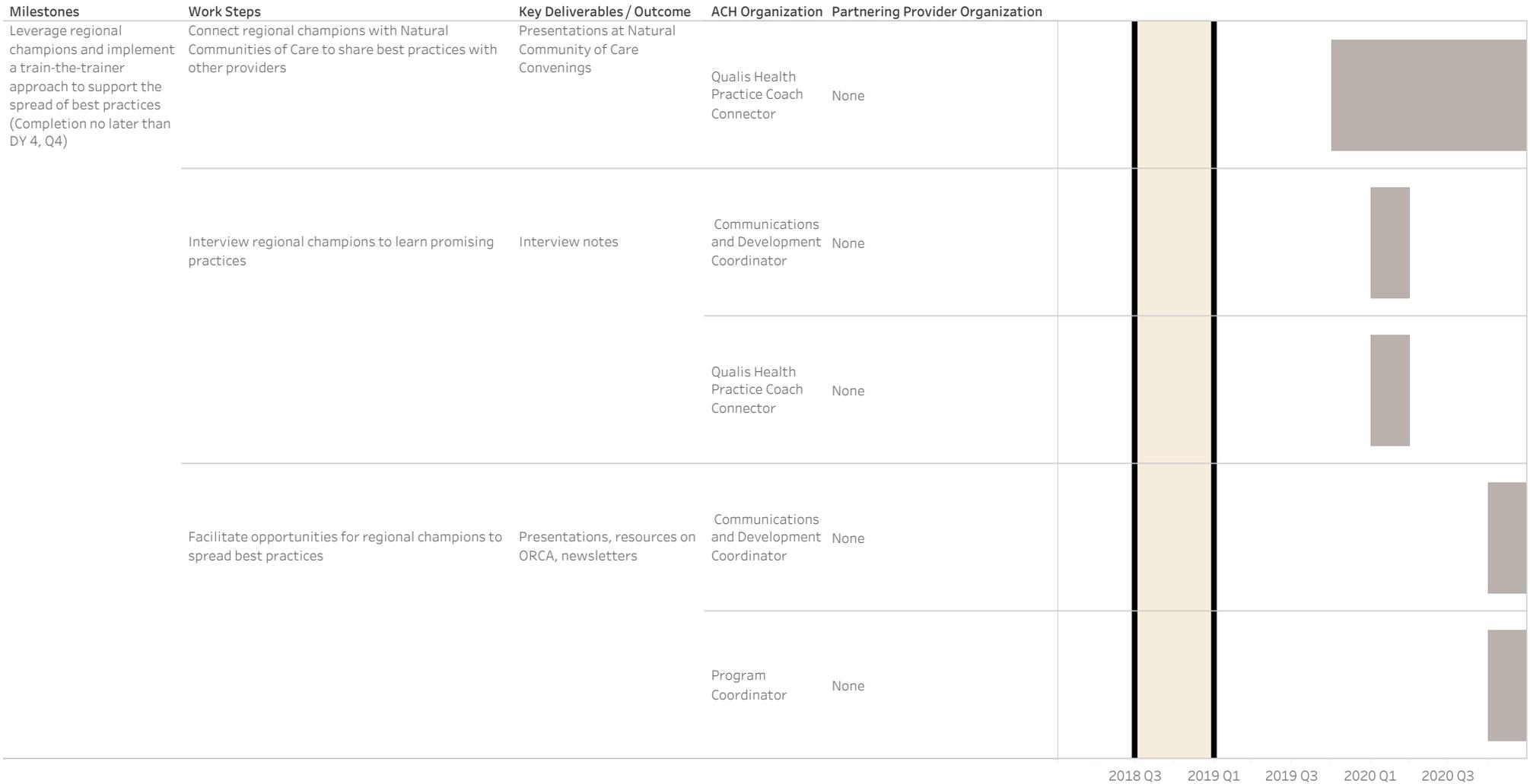
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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Convene and support platforms to facilitate shared learning and exchange of best practices and results to date (e.g., the use of interoperable HIE by additional providers providing treatment of persons with OUD) (Completion no later than DY 4, Q4)	Convene 3CCORP Steering Committee and Workgroups	Meeting materials	Director of Community and Tribal Partnership	None	
	Establish real-time exchange of health information between MAT prescriber and SUD provider for bidirectional referral and care coordination for shared patient with OUD under the Olympic Digital HIT Commons or similar technology platform	E-referral technology platform	None	Select PHBH* Implementation Partners	
	Scale Olympic Digital HIT Commons or similar technology platform to new partners and use cases	E-referral technology platform participant list	None	Select PHBH* Implementation Partners and interested Shared Change Plan Partners**	
Identify and resolve barriers to financial sustainability of Project(s) activities post-DSRIP (Completion no later than DY 4, Q4)	Implement value-based payment arrangements with MCOs (Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners	
	Educate lawmakers, State partners, and payers on barriers to sustainability due to scope of practice, billing, coding and HIT constraints	Meet with ACH EDs, legislators, MCOs and State partners	Executive Director	None	

2018 Q3 2019 Q1 2019 Q3 2020 Q1 2020 Q3

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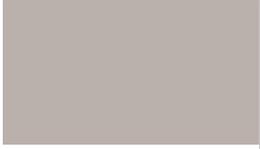
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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Regional self-identified milestone: Develop and share regional standards of practice for referral and treatment of opioid use disorder (use Bree Collaborative Opioid Use Disorder Treatment Report and Recommendations)	3CCORP Treatment Work Group to develop regional standards of practice	Regional standards of practice for treatment of OUD	Director of Community and Tribal Partnership	None	
	Disseminate regional standards of practice	Regional standards of practice for treatment of OUD are shared region-wide	Director of Community and Tribal Partnership	None	
	Regional standards of practice for referral and treatment of opioid use disorder are reviewed annually by the 3CCORP Treatment Workgroup to update to current best practices	Annual review and update as needed based on current best practices	Director of Community and Tribal Partnership	None	
Regional self-identified milestone: Expand integration of SDOHs and health equity into physical health and behavioral health practice	Encourage Implementation Partners to expand on the list of selected Tactics in the PHBH Change Plan that integrate SDOH screening and appropriate referral into practice	PHBH Change Plan includes additional Tactics in annual updates	None	Select PHBH* Implementation Partners	
	Encourage Implementation Partners to expand on the list of target subpopulations in the PHBH Change Plan to include populations experiencing the greatest health disparities	PHBH Change Plan includes additional target subpopulations in annual updates	None	Select PHBH* Implementation Partners	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization	
Regional self-identified milestone: Expand integration of SDOHs and health equity into physical health and behavioral health practice	Scale fully implemented Outcomes and Tactics in PHBH and CBOSS Change Plans related to SDOH and health equity	PHBH and CBOSS Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	None	Select PHBH* and CBOSS Implementation Partners	

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Olympic Community of Health

ACH Earned Incentives and Expenditures

July 1, 2018 - December 31, 2018

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period ²	
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$2,168,852
2B: Community-Based Care Coordination	
2C: Transitional Care	
2D: Diversion Interventions	\$881,096
3A: Addressing the Opioid Use Public Health Crisis	\$271,106
3B: Reproductive and Maternal/Child Health	\$338,883
3C: Access to Oral Health Services	\$203,330
3D: Chronic Disease Prevention and Control	\$542,213
Behavioral Health Integration Incentives	
Value-Based Payment (VBP) Incentives	
IHCP-Specific Projects	
High Performance Pool	
Total Funds Earned	\$4,405,480

Funds Distributed by ACH During Reporting Period, by Use Category ³	
Administration	\$11,081
Community Health Fund	
Health Systems and Community Capacity Building	
Integration Incentives	
Project Management	
Provider Engagement, Participation and Implementation	\$3,775,460
Provider Performance and Quality Incentives	
Reserve / Contingency Fund	
Shared Domain 1 Incentives	\$1,111,125
Total	\$4,897,666

Funds Distributed by ACH During Reporting Period, by Use Category ³	
ACH	\$11,081
Non-Traditional Provider	\$25,000
Traditional Medicaid Provider	\$3,457,180
Tribal Provider (Tribe)	\$293,280
Tribal Provider (UIHP)	
Shared Domain 1 Provider	\$1,111,125
Total Funds Distributed During Reporting Period	\$4,897,666

Total Funds Earned During Reporting Period	\$4,405,480
Total Funds Distributed During Reporting Period	\$4,897,666
Total Funds Left Available for Distribution During Reporting Period	-\$492,186

¹ Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 4, 2019 to accompany the second Semi-Annual Report submission for the reporting period July 1 to December 31, 2018.

² For detailed information on projects and earned incentives please refer to the below links.

- The [Medicaid Transformation Toolkit](#) contains the final projects, evidence-based approaches/strategies for pay-for-performance metrics for the ACHs.
- The [Measurement Guide](#) describes how the ACH selected projects are measured and the requirements to earn incentives.

³ Definitions for [Use Categories and Provider Types](#)



February 18, 2019

Dear Ms. Moore:

Thank you for the submission of Olympic Community of Health's Semi-Annual Report Assessment 2. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project, Myers and Stauffer LC (Myers and Stauffer) has assessed the Semi-Annual Review 2 submission requirements.

Upon review of the documentation submitted, we have identified the below areas within your submission where we have requests for additional information.

Please feel free to contact Myers and Stauffer at WADSRIP@mssl.com for additional information should you need clarification about the request. In your email, please specify your questions, or request a conference call if a discussion would be preferred. If requesting a conference call, please provide two or three available timeframes.

Please post your response in PDF, Excel or Word format following the resubmission instructions below to WA CPAS (<https://cpaswa.mssl.com/>) within the Request for Information folder (pathway is Semi-Annual Report > Semi-Annual Report 2 – January 31, 2019 > Request for Information). **We ask for your response no later than 5:00 p.m. PST, March 12, 2019.** Information received after this date will not be considered.

Thank you,
Myers and Stauffer LC



**Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-Annual Report 2 Assessment
*Reporting Period: January 1 to December 31, 2018***

Request for Supplemental Information

Upon review of the ACH's Semi-Annual Report Assessment, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification.

- If the question applies to the project narrative, please provide a response within this document. The naming convention should be as follows: "RESPONSE ACH name.SAR2.RFI.Date"
- If the question applies to the workbook, please respond with an **updated** workbook. The naming convention should be as follows: "REVISED ACH Name.SAR2 Workbook.Date"

Section 2: Required Milestone Reporting (Project Incentives)

Milestone 1, Question 4: Describe the region's plan to establish a **communications workgroup**, including: i) Which organization will lead the workgroup ii) Estimated date for establishing the workgroup iii) An estimate of the number of workgroup participants iv) Which stakeholders the ACH plans to include in the workgroup.

1. **Independent Assessor Question:** Please describe preliminary discussions between OCH and SBHO to establish a communications workgroup moving forward.

OCH and SBHO began exploratory discussions in December 2018 regarding partnering for IMC efforts. Part of these discussions included the possibility of OCH staffing and providing project management for establishing workgroups and getting providers ready for IMC. This decision will be made no later than DY3 Q1. If OCH were to become the project managing entity working with SBHO to facilitate these workgroups, OCH will work closely with MCOs and HCA in planning sessions in DY3 Q1 to gather input on how to structure multiple workgroups given providers' limited time and resources already available from early and mid-adopter regions (e.g. products from their communications workgroups). A communications workgroup is one of the possible workgroups that might be formed, or it might be combined with another workgroup and named differently. All behavioral health providers in the OCH region will be included in all IMC efforts.



2. **Independent Assessor Question:** Will SBHO lead the communications workgroup moving forward? If not, who does the ACH anticipate will lead the workgroup moving forward?

If OCH were to become the project managing entity working with SBHO to facilitate IMC, and if a communication workgroup is formed, OCH will lead the workgroup. If not, the SBHO will likely do so.

3. **Independent Assessor Question:** When does SBHO plan to establish the workgroup (estimated date)?

If OCH were to become the project managing entity working with SBHO to facilitate IMC, OCH will establish the workgroup(s) no later than DY3 Q2.

4. **Independent Assessor Question:** What is the estimated number and type of workgroup participants for the communications workgroup?

If a communications workgroup is formed, all behavioral health providers in the region (Mental Health and Substance Use Disorder) will be invited to participate. This number is estimated at 13-15 provider agencies. HCA and MCOs will also be a part of the workgroup.

Milestone 1, Question 5: Describe the region's plan to establish a provider readiness/technical assistance (TA) workgroup, including: i) Which organization will lead the workgroup ii) Estimated date for establishing the workgroup iii) An estimate of the number of workgroup participants iv) Which stakeholders the ACH plans to include in the workgroup.

5. **Independent Assessor Question:** Will SBHO lead the readiness/technical assistance workgroup moving forward? If not, who does the ACH anticipate will lead the workgroup moving forward?

If OCH were to become the project managing entity working with SBHO to facilitate IMC, OCH will staff and facilitate the workgroup. If not, the SBHO will likely do so.

6. **Independent Assessor Question:** When does SBHO plan to establish the workgroup (estimated date)?

Either OCH or SBHO will establish the workgroup no later than DY3 Q2.



7. **Independent Assessor Question:** What is the estimated number and type of workgroup participants for the readiness/technical assistance workgroup?

All behavioral health providers in the region (Mental Health and Substance Use Disorder) will be invited to participate in the readiness/technical assistance workgroup. This number is estimated at 13-15 provider agencies. HCA and MCOs will also be a part of the workgroup.

Section 4: Provider Roster (Project Incentives)

Part A, Question 2: Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

8. **Independent Assessor Question:** The ACH states, “OCH will ensure that partnering providers are engaging in their internal process and utilizing the key skills learned at the personalized Jedi Mind Control training with Master Yoda; this is a requirement in the Change Plan.” Please describe in more detail the Jedi Mind Control training with Master Yoda.

Due to the ongoing conflict with the Trade Federation, at this time it will not be possible for our partners to safely travel to Dagobah to attend Jedi Mind control training. OCH still feels this training will be incredibly valuable and will encourage its partners to complete their training if an opportunity arises in the future. The informational video “The Science Behind Jedi Mind Tricks” (<https://youtu.be/KU-F9pWdfLO>) outlines some of the valuable skills presented at the training with Master Yoda.