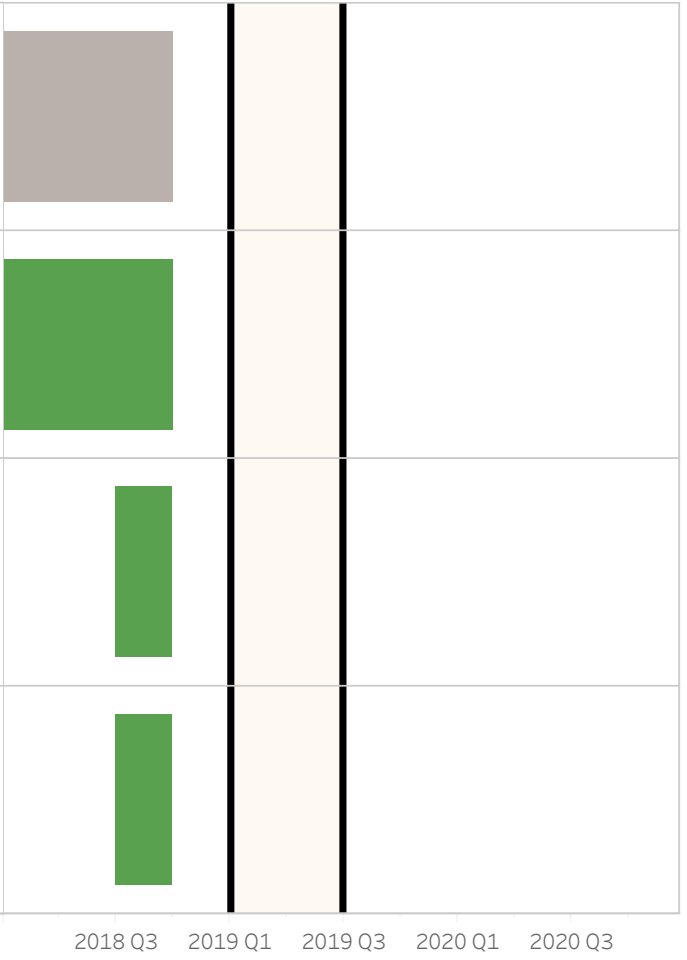
Implementation Plan Timeline: Stage 1

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Identify work steps and deliverables to implement the transformation 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)	Participate in the Health Systems Capacity Building Workgroup (AWPHD, UW, HCA, ACHs, DOH)		Plan that prioritizes health system capacity building strategies	Executive Director	None
	Design PHBH and CBOSS‡ Change Plans to identify preferred activities to facilitate health systems and community capacity building and health equity	*	PHBH and CBOSS‡ Change Plan templates	Director of Programs	None
	Complete PHBH and CBOSS‡ Change Plans		Completed PHBH and CBOSS‡ Change Plans	None	PHBH* and CBOSS^ Implementation Partners
	Review Outcomes and Tactics from submitted PHBH and CBOSS‡ Change Plans related to health systems capacity building and health equity	*	Review notes	Director of Programs	None



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Implementation Plan Timeline: Stage 1

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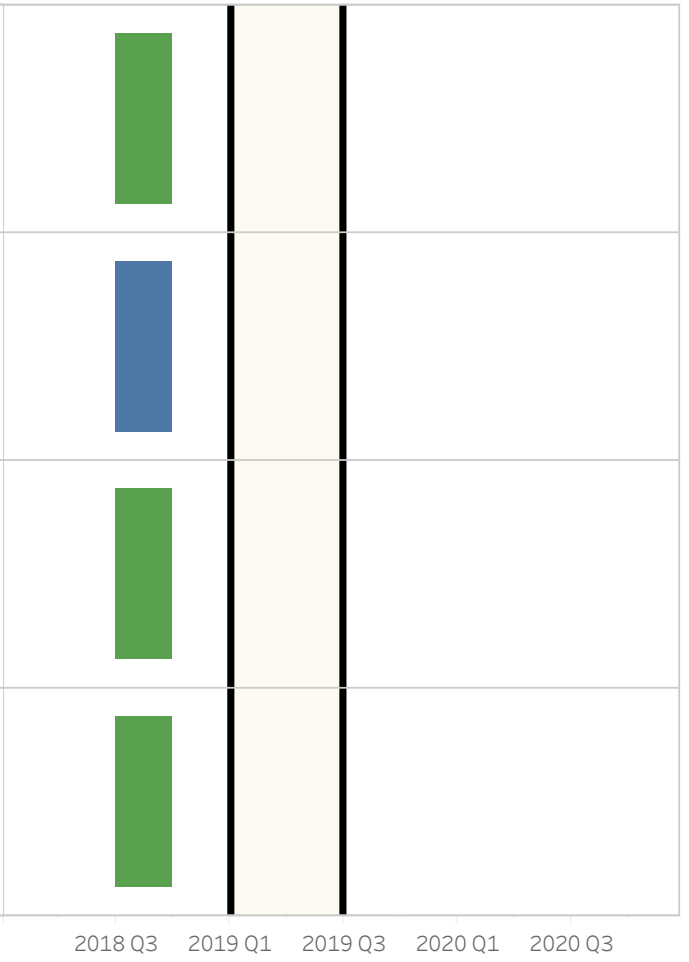
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3)	Review Outcomes and Tactics from submitted PHBH and CBOSS‡ Change Plans to identify selected trainings (including health equity training)	*	List of selected trainings from Implementation Partners	Director of Programs	None
	Identify shared training opportunities with other ACHs (including health equity training)	*	Work plan with Artemis consulting	Executive Director	None
	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



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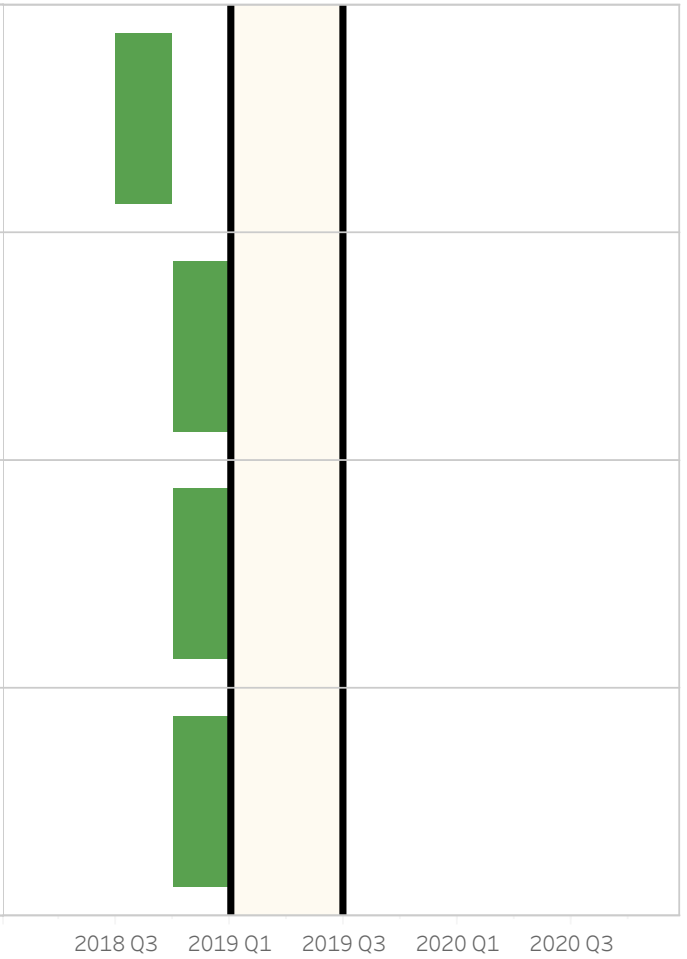
Implementation Plan Timeline: Stage 1

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
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	Qualis Health Practice Coach Connector	None
	Host IMC and VBP trainings for behavioral health providers with CPAA, Qualis Health, and DOH	*	Trainings	Qualis Health Practice Coach Connector	None
	Assess behavioral health provider readiness for the transition to IMC		Coaching report from Qualis Health	Qualis Health Practice Coach Connector	None
	Select six BH Implementation Partners for in-depth IMC technical assistance from Qualis Health		Six BH Implementation Partners selected to receive technical assistance from Qualis Health on I..	Qualis Health Practice Coach Connector	None



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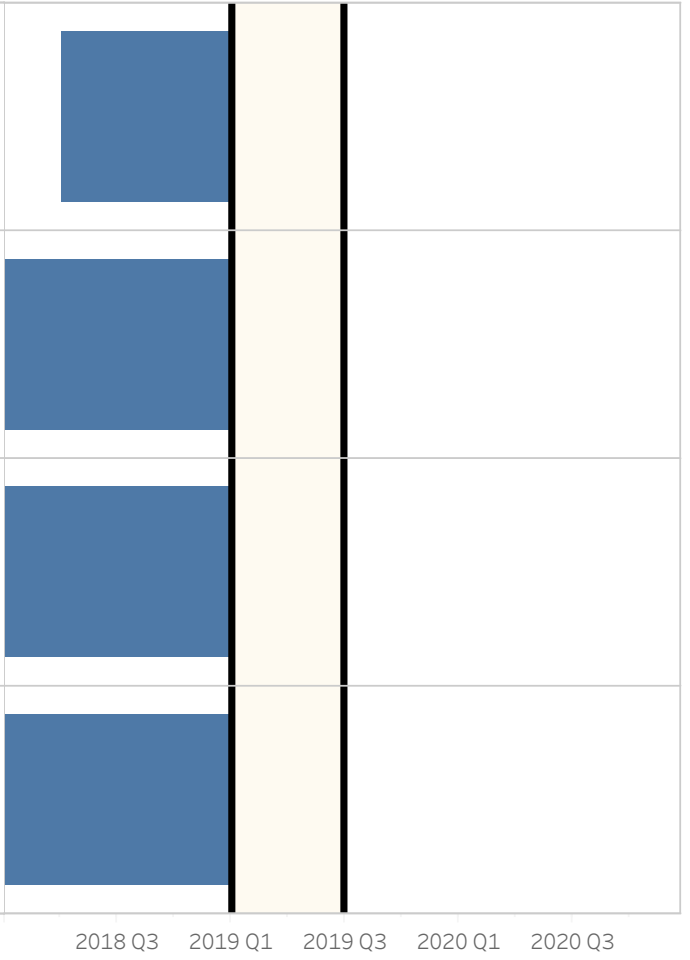
For 2020 adopters of integrated managed care: Ensure planning reflects timeline and process to transition to integration of physical and behavioral health including: engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners (Completion no later than DY 2, Q4)	Participate in SBHO Pathway to 2020: IMC preparatory meetings inclusive of all SBHO-subcontracted agencies, HCA and MCOs	*	Meetings	Director of Programs	None
	Participate in SBHO Executive Board Meetings		Meetings	Executive Director	None
	Participate in SBHO Advisory Board Meetings	*	Meetings	Program Coordinator	None
	Participate in SBHO Provider Meetings	*	Meetings	Program Coordinator	None



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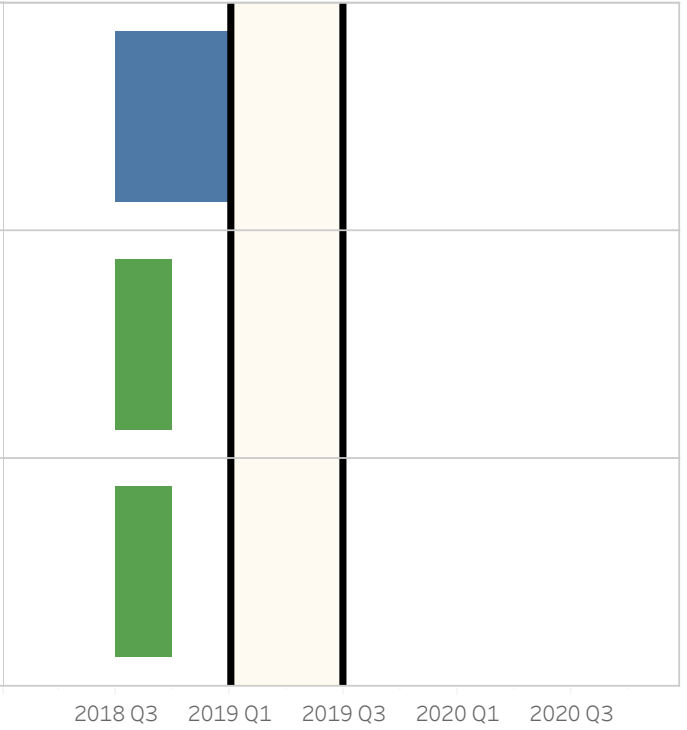
Organizations, Behavioral Health and Primary Care providers, and other critical partners (Completion no later than DY 2, Q4)	Meet monthly with the SBHO to develop an IMC transition plan for appropriate state and local agencies	IMC transition plan	Executive Director	None
Regional self-identified Milestone: Develop recommended Outcomes and Tactics in the PHBH Change Plan that are mutually supportive of the IMC transition	Implement VBP arrangements with MCOs (include as a Recommended Tactic in the PHBH Change Plan)	PHBH Implementation Partners select this Tactic in their PHBH Change Plan	None	Select PHBH* Implementation Partners
	Report on value-based metrics that will be in MCO contracts (include as a Recommended Tactic in the PHBH Change Plan)	PHBH Implementation Partners select this Tactic in their PHBH Change Plan	None	Select PHBH* Implementation Partners



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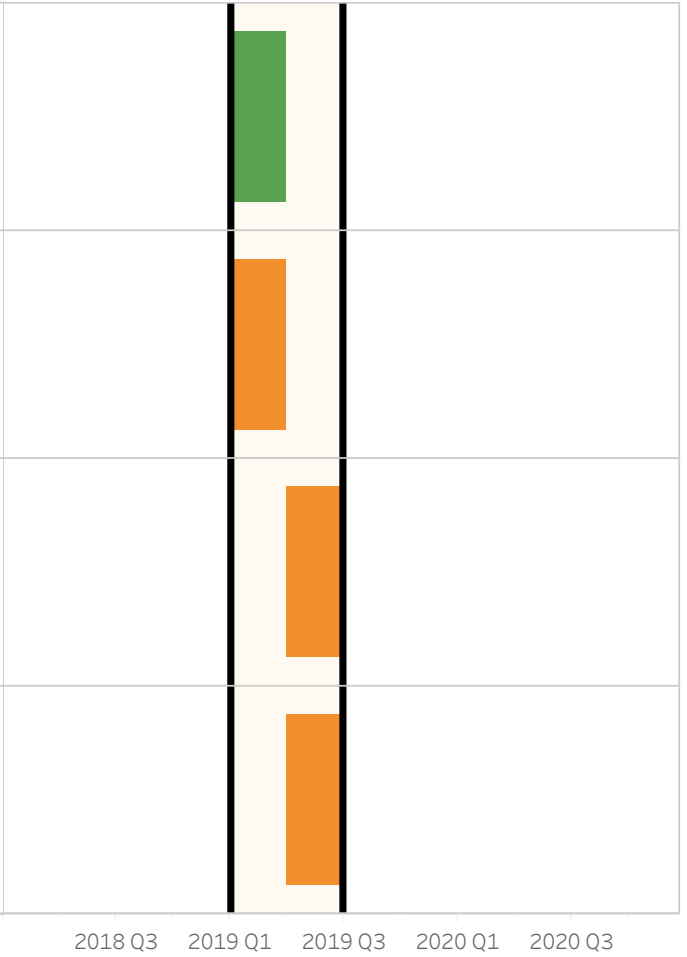
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2)	Identify Outcomes and Tactics in PHBH and CBOSS‡ Change Plans that may require partners to develop new or improved guidelines, policies, procedures and protocols to implement transformation work; share with PHBH and CBOSS Implementation Partners		List of Outcomes and Tactics in PHBH and CBOSS‡ Change Plans	Qualis Health Practice Coach Connector	None
	Review a sample of guidelines, policies, procedures and protocols associated with identified list of Outcomes and Tactics from PHBH and CBOSS Implementation Partners at site visits	*	List of new promising guidelines, policies, procedures and protocols related to PHBH and CBO..	Director of Programs	None
	Review list of new promising guidelines, policies, procedures and protocols internally and/or with subject matter experts	*	Evaluation of gaps in guidelines, policies, procedures and protocols	Director of Programs	None
	Share recommendation for refinements of guidelines, policies, procedures, and protocols related to PHBH and CBOSS‡ Change Plans on ORCA	*	Web links on ORCA	Director of Programs	None



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Implementation Plan Timeline: Stage 2

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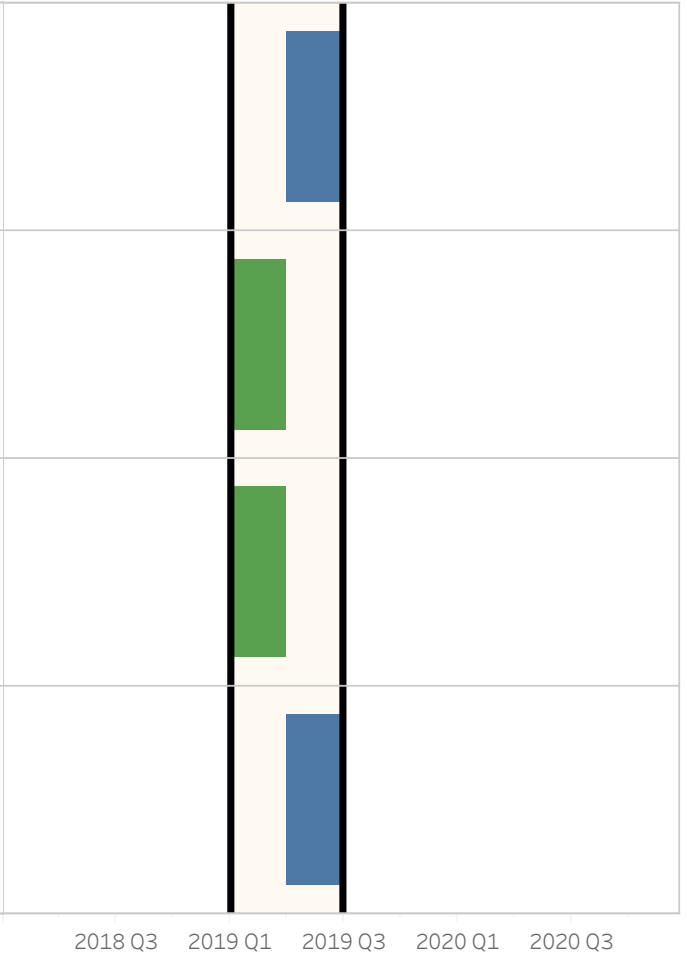
Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2)	Support PHBH and CBOSS Implementation Partners that request or require assistance in developing new guidelines, policies, procedures and protocols	*	Practice assessments (e.g., PAT, MeHAF, PCMH-A) and/or action plans	Director of Programs	None
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways (Completion no later than DY 3, Q2)	Form and maintain a diverse quality improvement (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)		PHBH Change Plan progress to date reporting indicates progression of QI implementation, updated biannual..	None	Select PHBH* Implementation Partners
	Implement reporting policies and practices to ensure complete and timely reporting of Change Plan activities to OCH (Recommended Tactic in PHBH and CBOSS‡ Change Plans)		PHBH and CBOSS‡ Change Plan progress to date and quantitative reporting are complete and timely	None	Select PHBH* and CBOSS^ Implementation Partners
	Provide QI technical assistance and training		Training materials and/or technical assistance	P-TCPi Coach Facilitator	None



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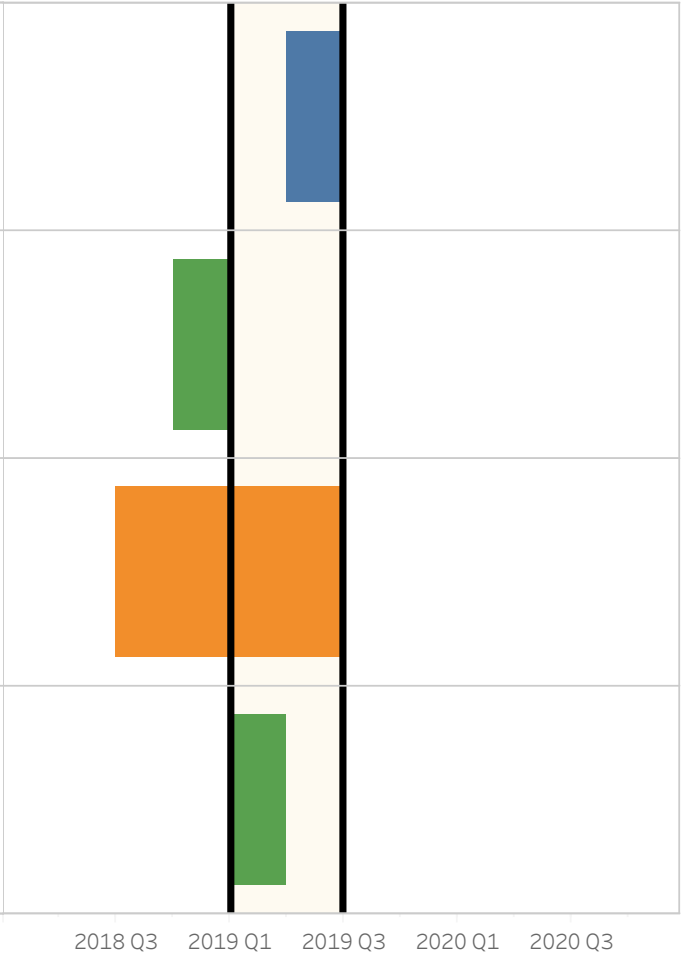
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways (Completion no later than DY 3, Q2)	Provide QI technical assistance and training		Training materials and/or technical assistance	Qualis Health Practice Coach Connector	None
	Develop QI approach (data collection, analysis, and continuous monitoring) to track progress on metrics and project implementation, detailing frequency of measure collection and reporting as well as reporting mechanism(s)		Quality Improvement Plan (QIP) with measure set	Data Lead	None
	Work with Performance, Measurement and Evaluation Committee (PMEC) to review QI approach and finalize measure set		Recommended measure set	Data Lead	PMEC ^^
	Establish procedures for the QIP	*	Site visits and QIP reporting	Director of Programs	None



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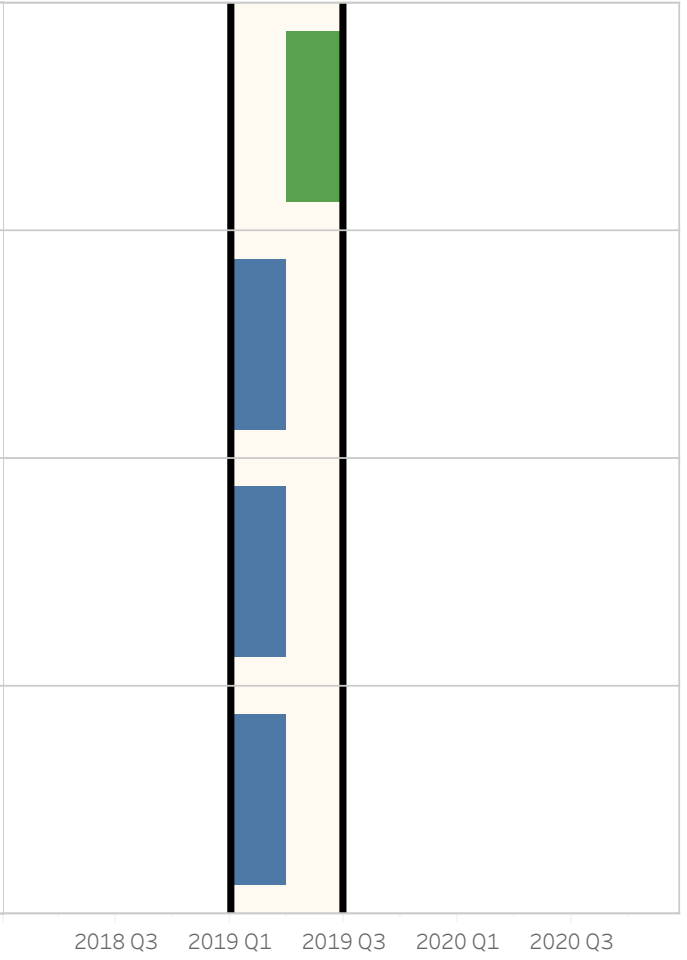
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways (Completion no later than DY 3, Q2)	Convene PMEC to establish guidelines for ongoing review of reported data		PMEC materials	Data Lead	PMEC^^
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Review PHBH Implementation Partner readiness from Current State Assessment, completed coaching reports and practice assessments to create Implementation Partner readiness (for integrated care activities) matrix	*	Implementation Partner readiness matrix	Director of Programs	None
	Identify trainings and technical assistance needs for integrated care activities associated with Outcomes and Tactics in Change Plans		Training and technical assistance plan	P-TCPi Coach Facilitator	None
		*	Training and technical assistance plan	Director of Programs	None



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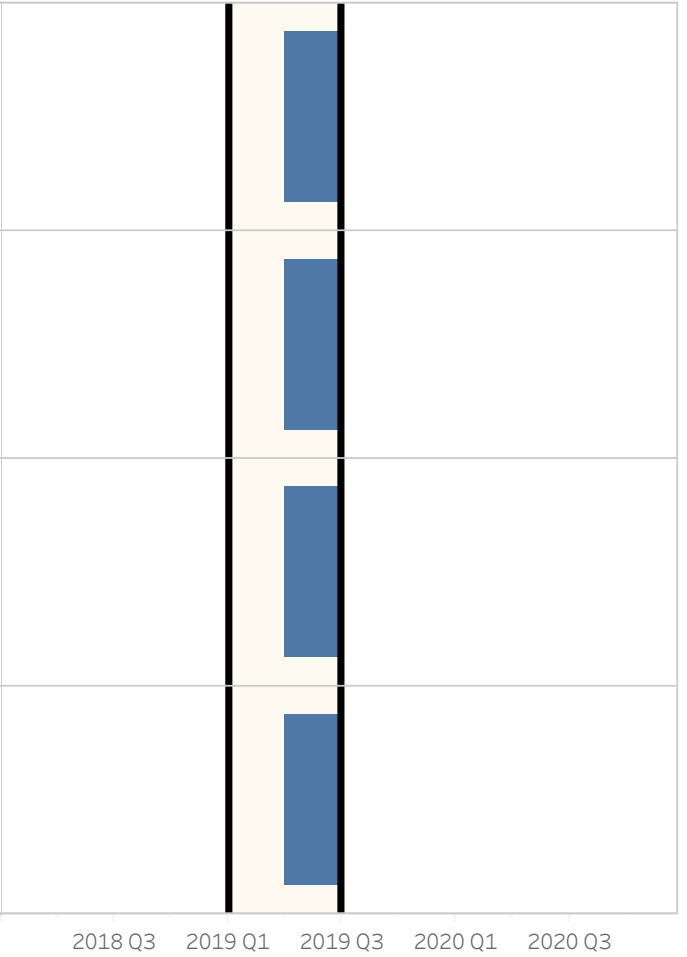
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Recommend available trainings and technical assistance		Communications	P-TCPi Coach Facilitator	None
		*	Communications	Director of Programs	None
	Assist PHBH Implementation Partners in tracking QI projects		QI technical assistance	P-TCPi Coach Facilitator	None
				Qualis Health Practice Coach Connector	None



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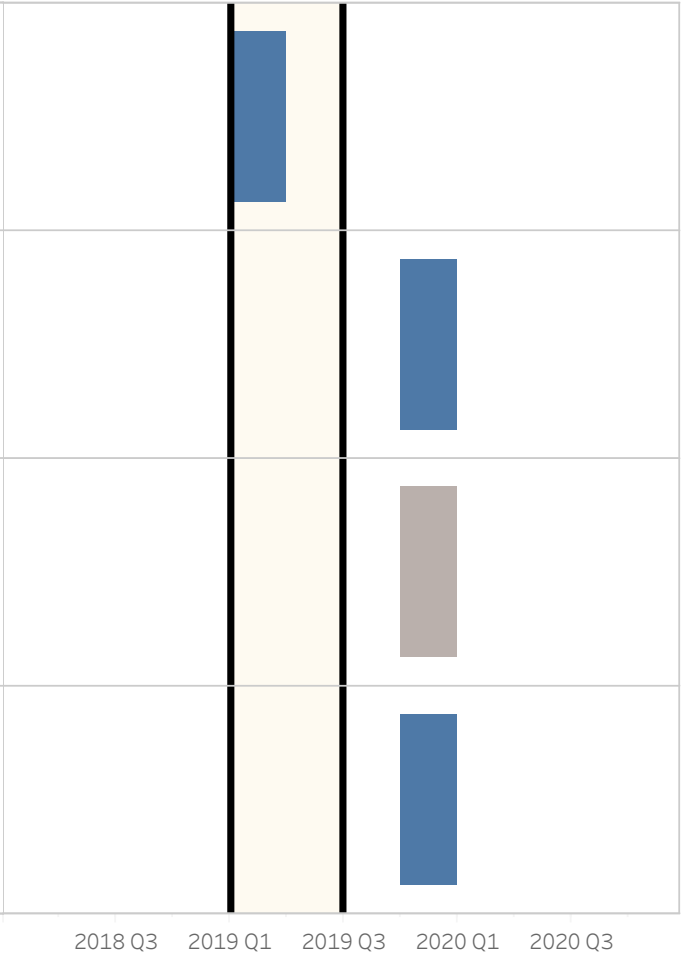
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Collaborate across-ACHs to contract with vendors for overlapping training needs		Contractual agreements	Executive Director	None
	Make trainings available to partners	*	Training	Director of Programs	None
	Participate in trainings		Training	None	PHBH* and CBOSS^ Implementation Partners and interested Shared Change Plan** Partners
	Upload recordings, materials, webinars of trainings on ORCA		Web links on ORCA	Program Coordinator	None



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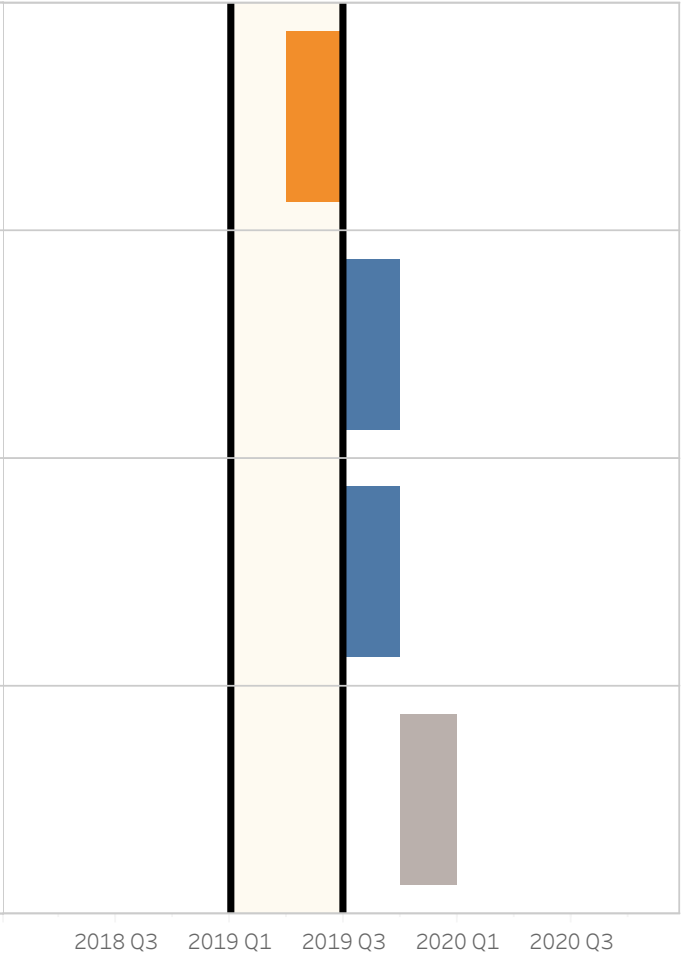
Ensure each member of the care team, participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner (Completion no later than DY 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 Curr..	Director of Programs	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 Curr..	Director of Programs	None



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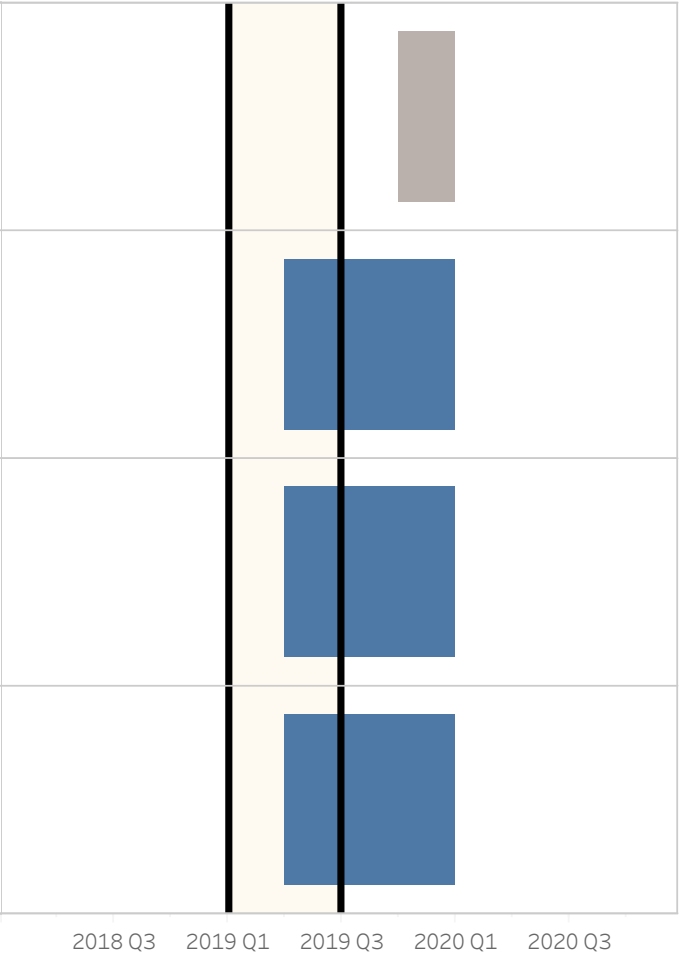
the guidelines and to perform their role in the approach in a culturally competent manner (Completion no later than DY 3, Q4)	Recommend or offer trainings in cultural competency and related areas to PHBH and CBOSS Implementation Partners and Shared Change Plan Partners	*	Cultural competency or related trainings	Director of Programs	None
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 ..	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 ..	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 ..	None	PHBH* Implementation Partners and interested Shared Change Plan Partners **



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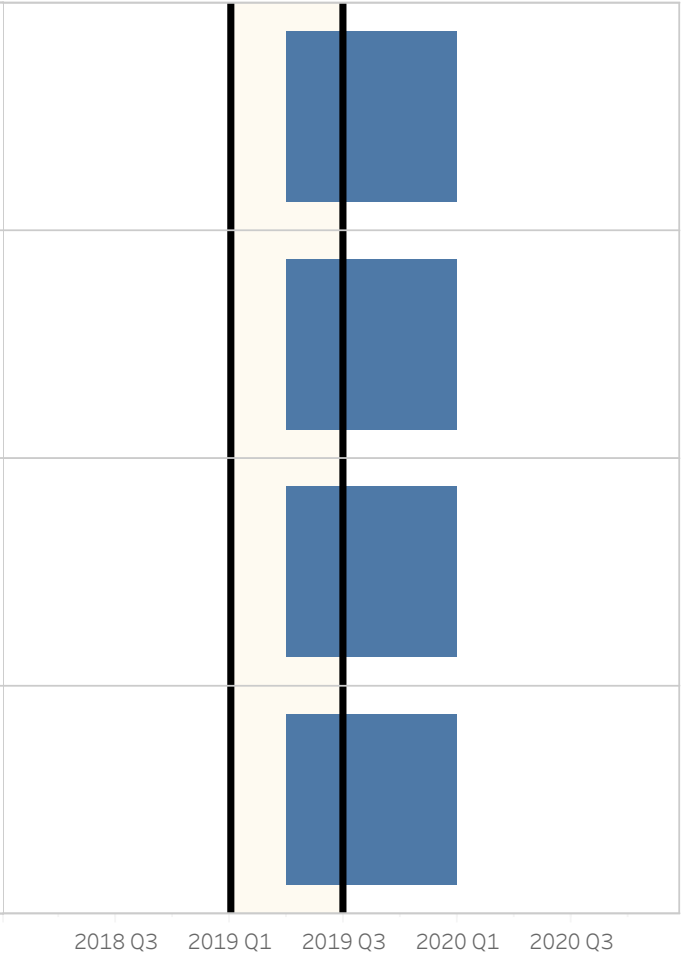
Implement selected strategies/ approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports (Completion no later than DY 3, Q4)	Patients are engaged around prevention of OUD (Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation ..	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 ..	None	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **
	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 Implemen..	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 Implemen..	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **



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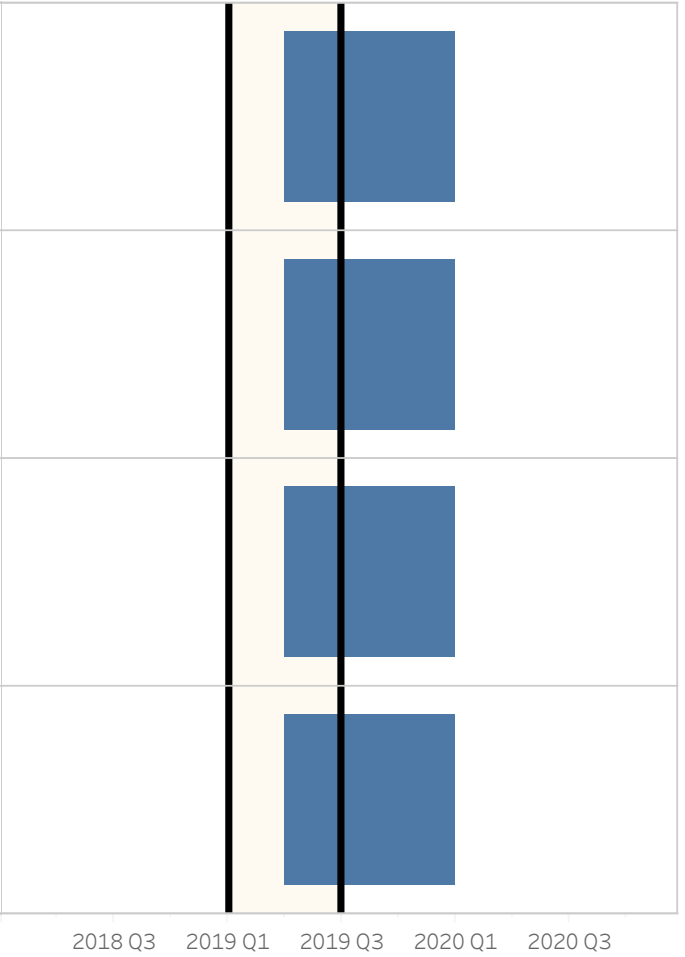
Implement selected strategies/ approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports (Completion no later than DY 3, Q4)	Educate clients on safe storage of opioids (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implemen..	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 Implemen..	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 Implemen..	None	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **
Implement bi-directional communications strategies/ interoperable HIE	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



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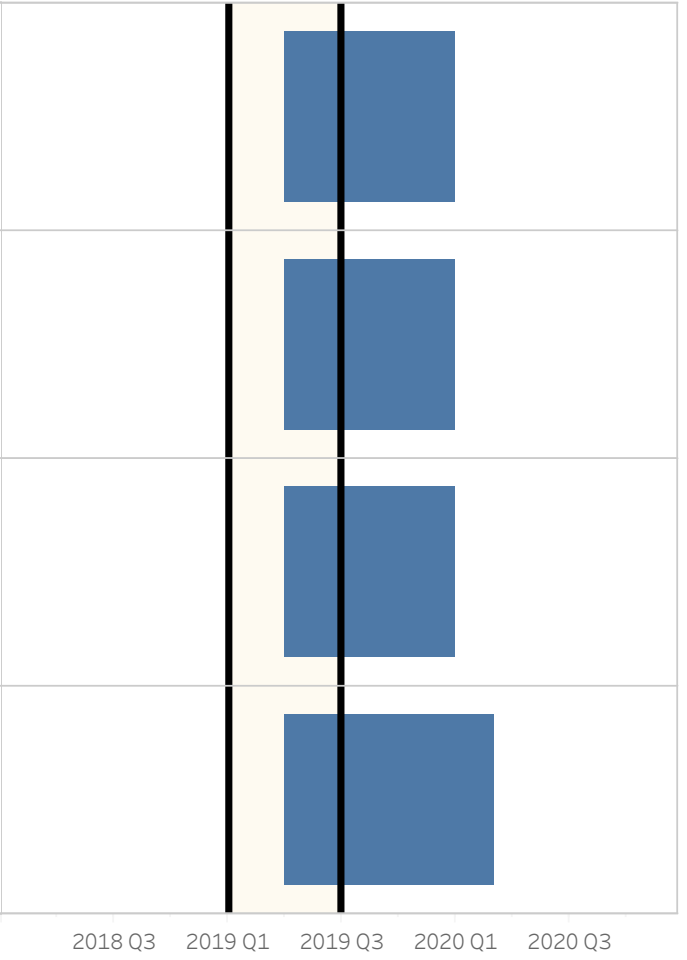
Implement bi-directional communications strategies/ interoperable HIE tools to support the care model (Completion no later than DY 3, Q4)	Utilize screening tools and protocols to identify client oral health needs and inform appropriate referrals (Tactic in CBOSS‡ Change Plan)	Biannual report of progress 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
	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



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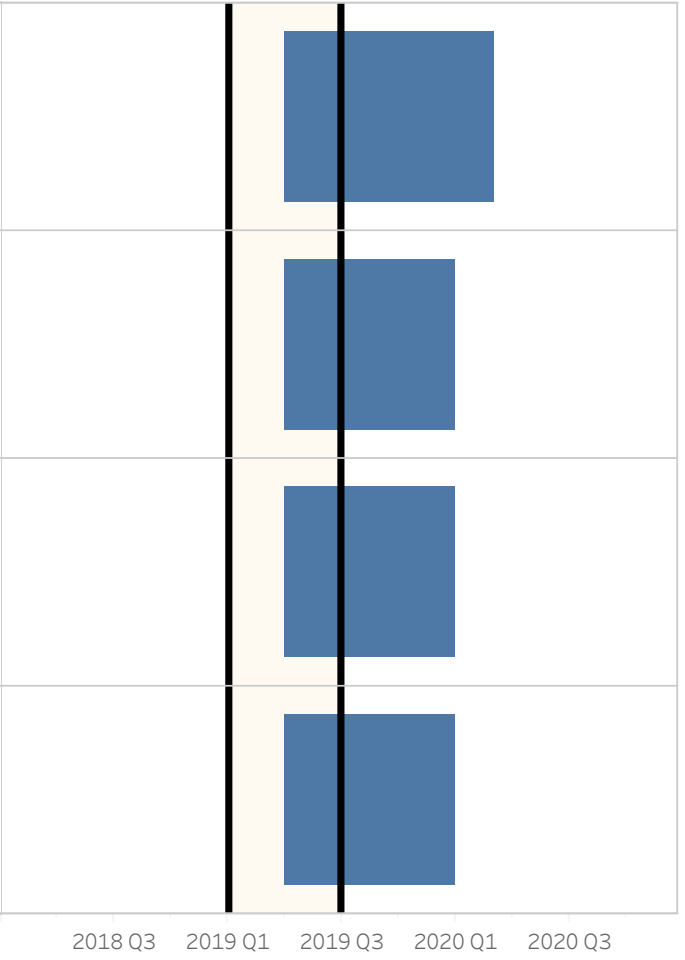
Implement bi-directional communication strategies/ interoperable HIE tools to support project priorities (e.g. , ensure team members, including client and family/ caregivers, have access to the information appropriate to their role in the team and the care plan) (Completion no later than DY 3, Q4)	Explore 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 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



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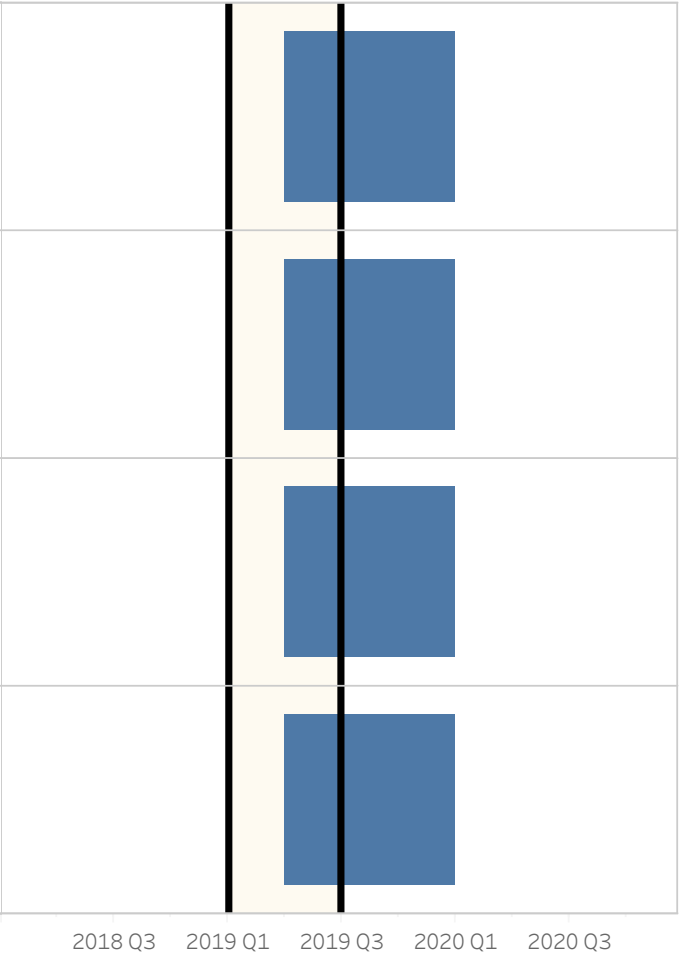
Implement bi-directional communication strategies/ interoperable HIE tools to support project priorities (e.g. , ensure team members, including client and family/ caregivers, have access to the information appropriate to their role in the team and the care plan) (Completion no later than DY 3, Q4)	Sign 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
	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
Implement disease/ population-specific Chronic Care Implementation Plan for identified	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



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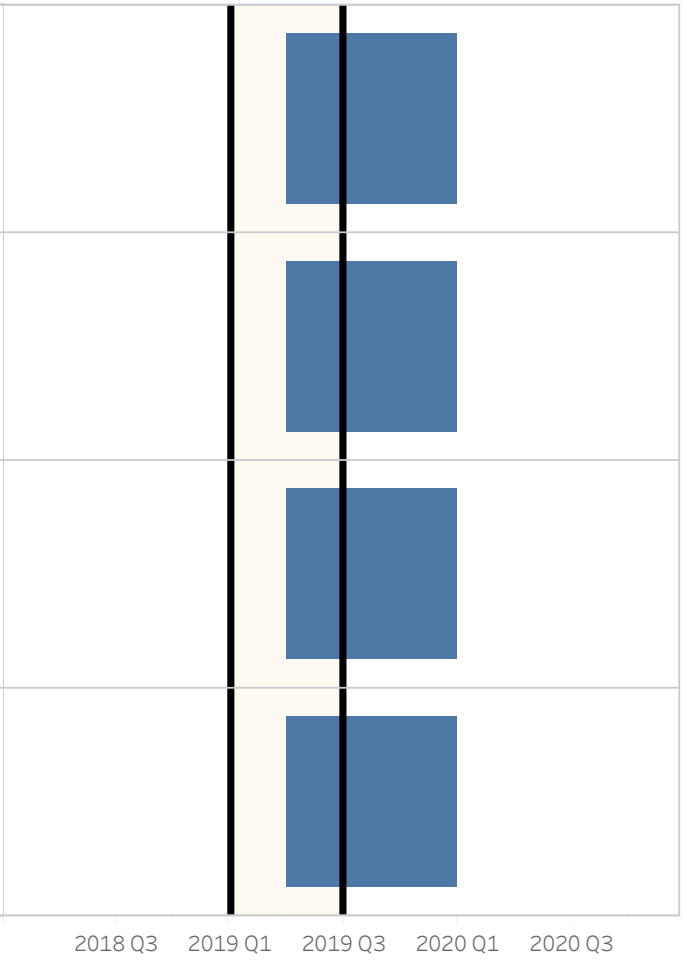
- Not Started

Implementation Plan Timeline: Stage 2

Milestones	Work Steps *	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve: • Self-Management Support • Delivery System Design • Decision Support • Clinical Information Systems (including interoperable systems) • Community-based Resources and Policy • Health Care Organization (Completion no later than DY 3, Q4)	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
	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 Ch..	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners
	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	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



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Implementation Plan Timeline: Stage 2

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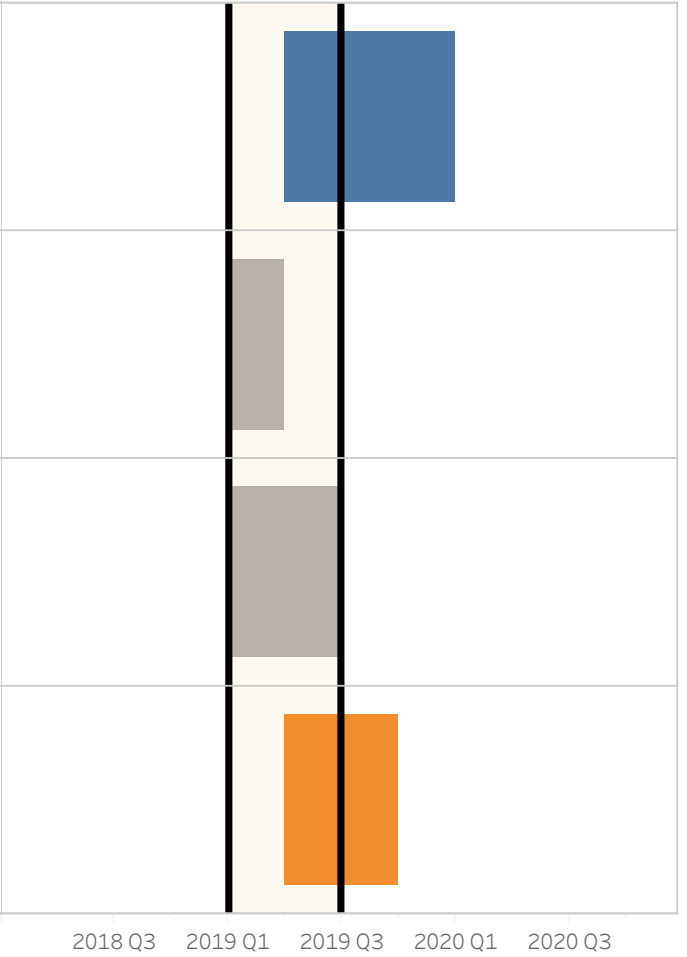
Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	Screen clients for engagement with oral health provider and provide resources/referral as needed (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step 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 of 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
	Select partner organizations for local oral health improvement network with Arcora Foundation	List of partner organizations for local health improvement network	Executive Director	None



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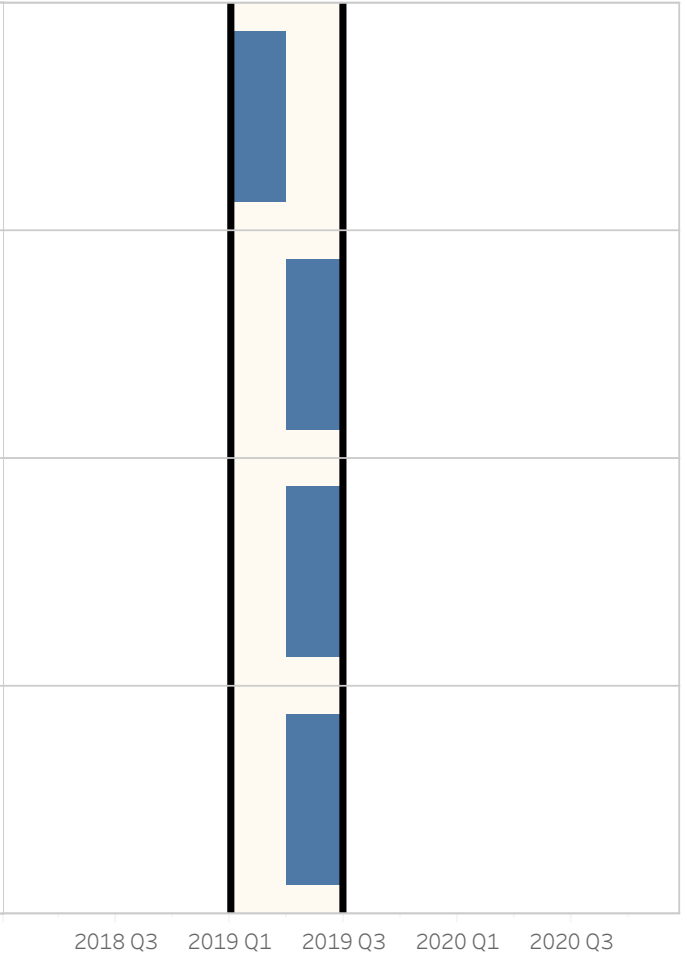
Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities (Completion no later than DY 3, Q4)	Review final PHBH Change Plans and crosscheck with Implementation Partner readiness matrix (for integrated care activities) to identify partner needs	*	List of partner needs	Director of Programs	None
	Facilitate workflow mapping with Implementation Partners to assess care gaps in technology		Workflow maps	P-TCPi Coach Facilitator	None
				Qualis Health Practice Coach Connector	None
	Teach and design PDSA (Plan, Do, Study, Act) to address identified care gaps		Coaching report from Qualis Health; coaching report from P-TCPi	P-TCPi Coach Facilitator	None



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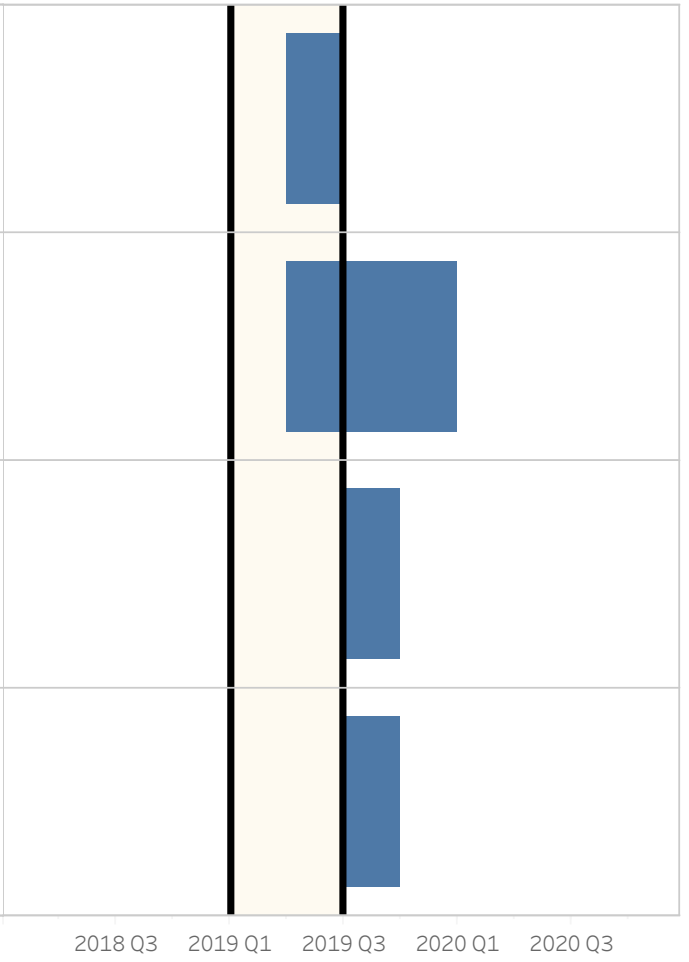
Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities (Completion no later than DY 3, Q4)	Teach and design PDSA (Plan, Do, Study, Act) to address identified care gaps		Coaching report from Qualis Health; 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



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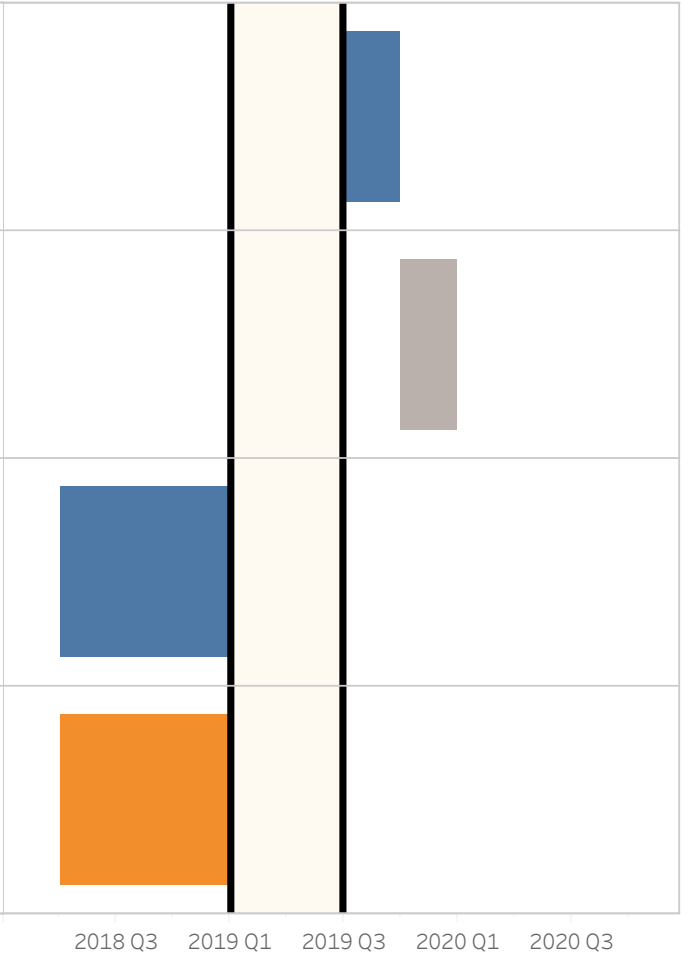
Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities (Completion no later than DY 3, Q4)	Distribute State consent management workgroup materials to BHA and SUD partners		Output from State consent management workgroup	Qualis Health Practice Coach Connector	None
	Convene trainings as needed to support partners to implement tools	*	Trainings	Director of Programs	None
Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan (Completion no later than DY 3, Q4)	Attend quarterly WA State Interagency Opioid Workgroup		Workgroup meetings	Director of Community and Tribal Partnership	None
	Share recommendations from Bree Collaborative Opioid Workgroup		Materials	Director of Community and Tribal Partnership	None



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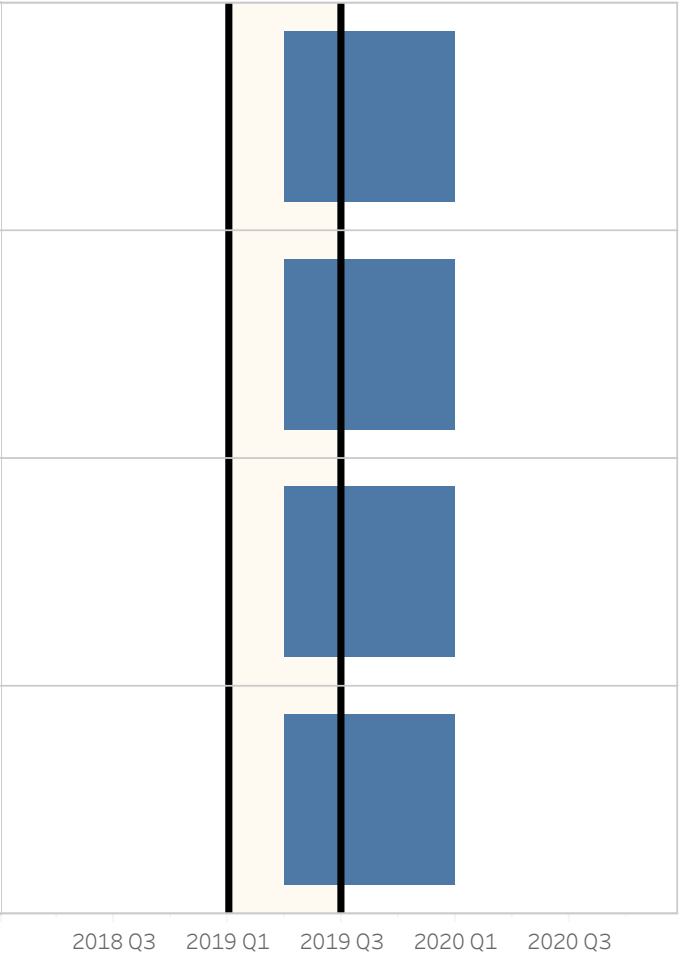
Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through suported housing programs (Completion no later than DY 3, Q4)	Standardize identification of and track individuals experiencing homelessness and/or food insecurity 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	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



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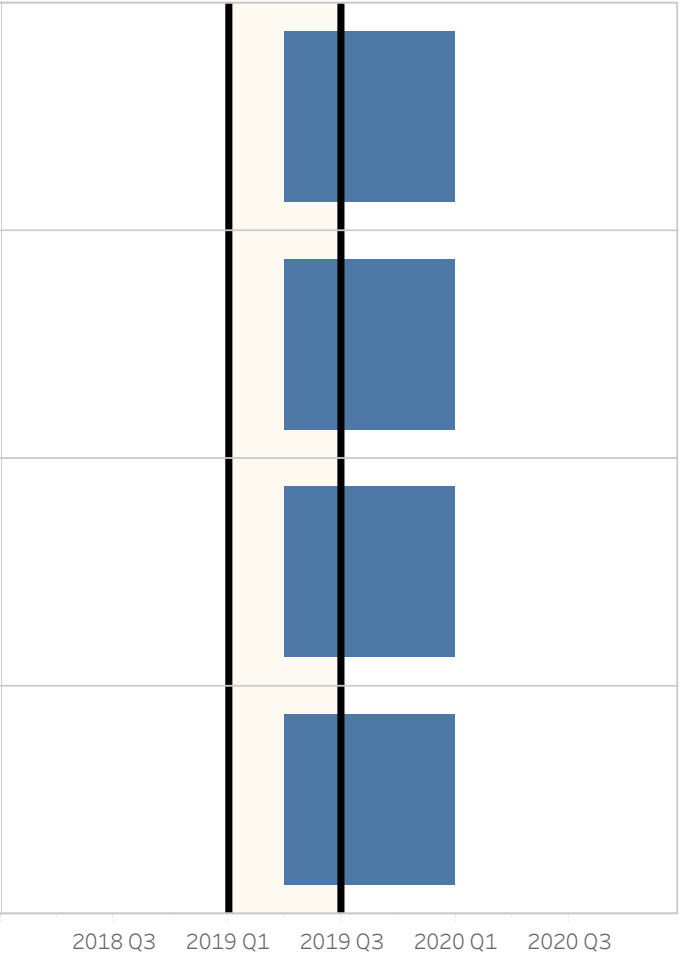
technology-enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	Conduct coordinated, targeted outreach 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
	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



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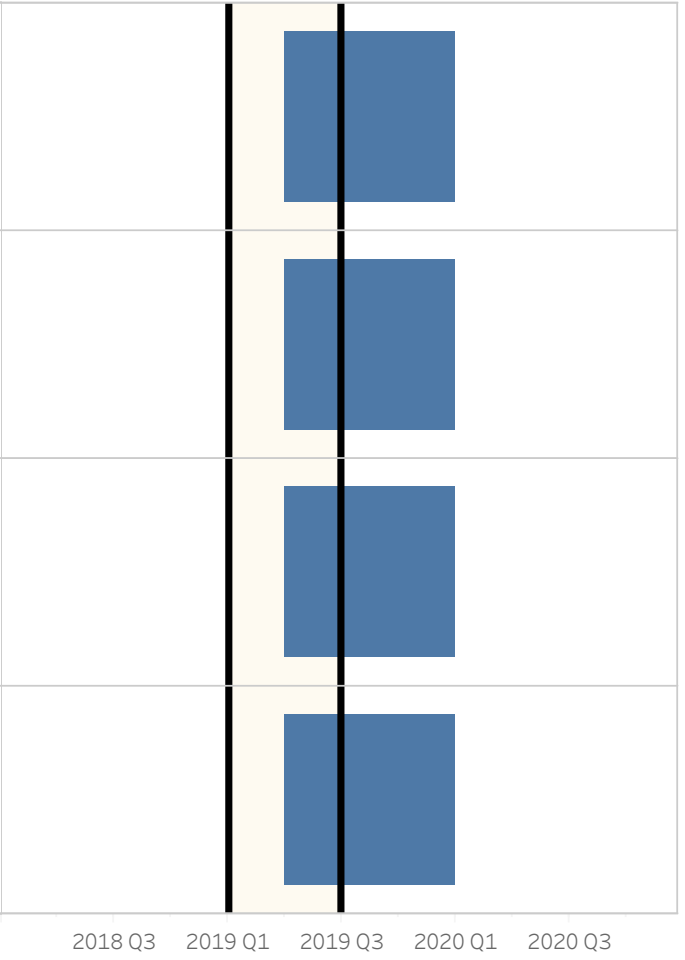
Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies (Completion no later than DY 3, Q4)	Streamline processes for information to be shared in a timely manner for shared patients/clients (Required Outcome in PHBH 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
	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 PHB..	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners



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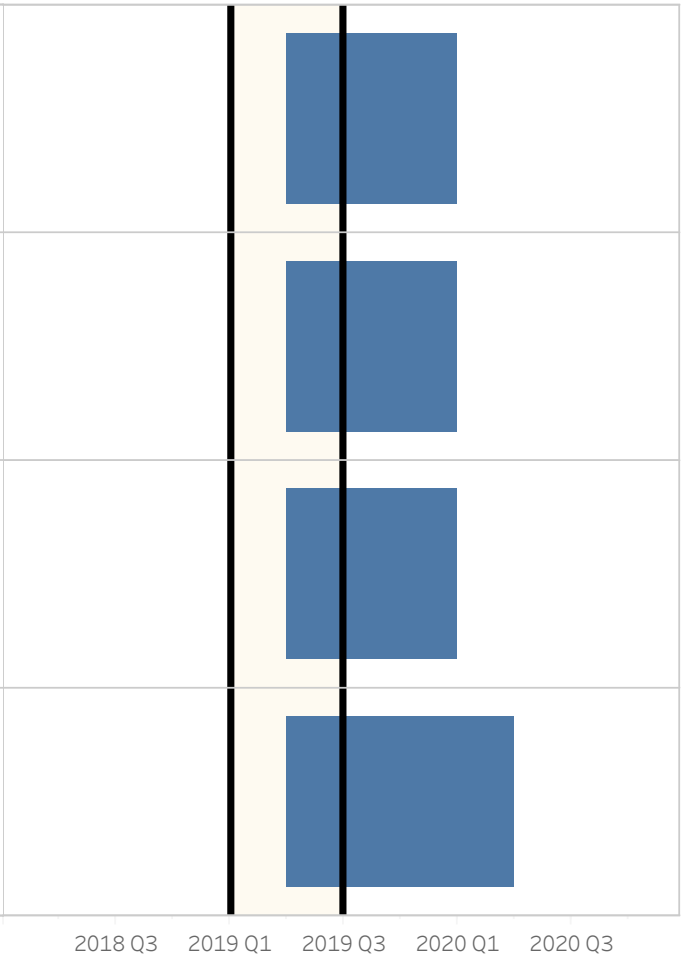
Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies (Completion no later than DY 3, Q4)	Sign inter-organizational agreements for access to records of referred and/or shared patients/clients (Recommended Tactic 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 infrastructure necessary to support integrated care activities. (Completion no later than DY 3, Q4)	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
	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



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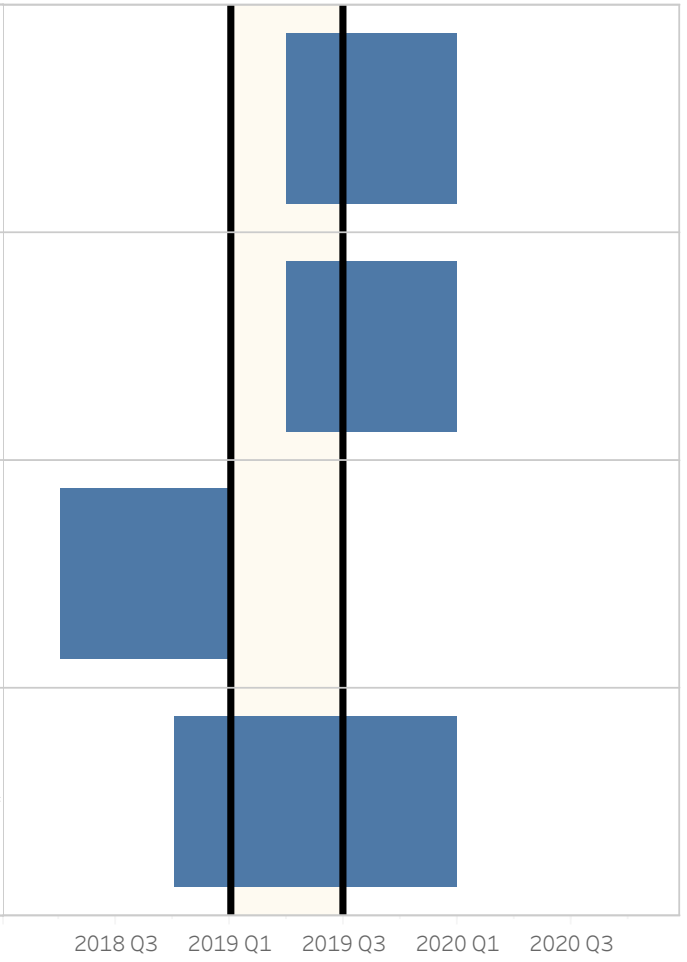
Implementation Plan Timeline: Stage 2

Milestones	Work Steps *	Key Deliverables / Outcomes	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)	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
	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
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, includin..	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 ..	Director of Community and Tribal Partnership	None
	3CCORP members present accomplishments at Regional Opioid Summit(s)	Regional Opioid Summit(s)	None	3CCORP members***



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Implementation Plan Timeline: Stage 2

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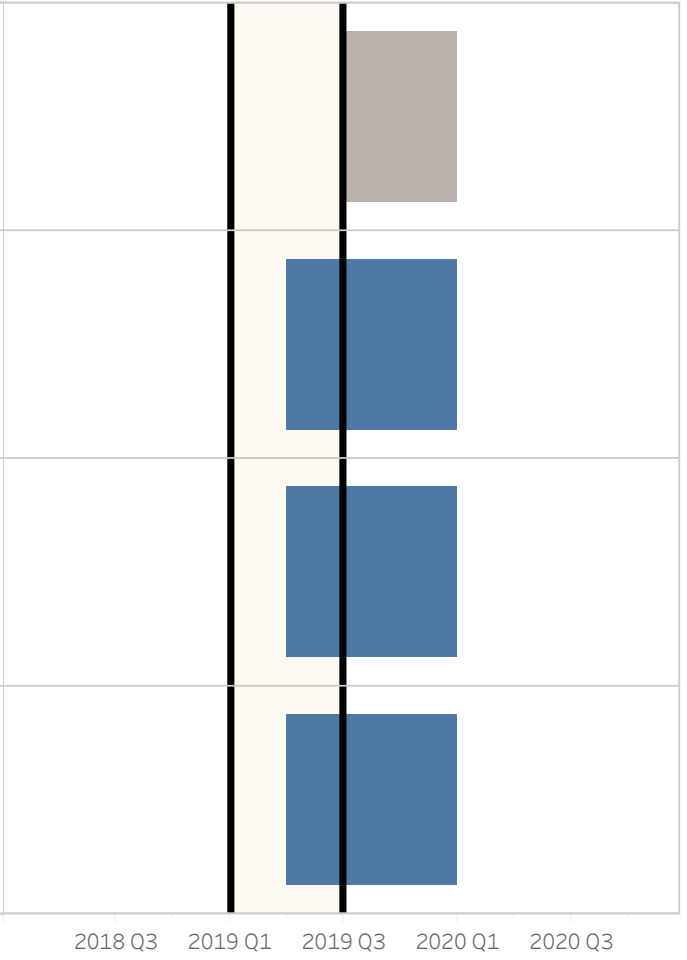
Develop workflows to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed (Completion no later than DY 3, Q4)	Receive technical assistance from Arcora Foundation and/or Qualis Health to assist Implementation 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
	Assess progress on workflow integration at site visit	*	Biannual report of progress on this work step and any associated intermediary measures	Director of Programs	Select PHBH* Implementation Partners
	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
	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



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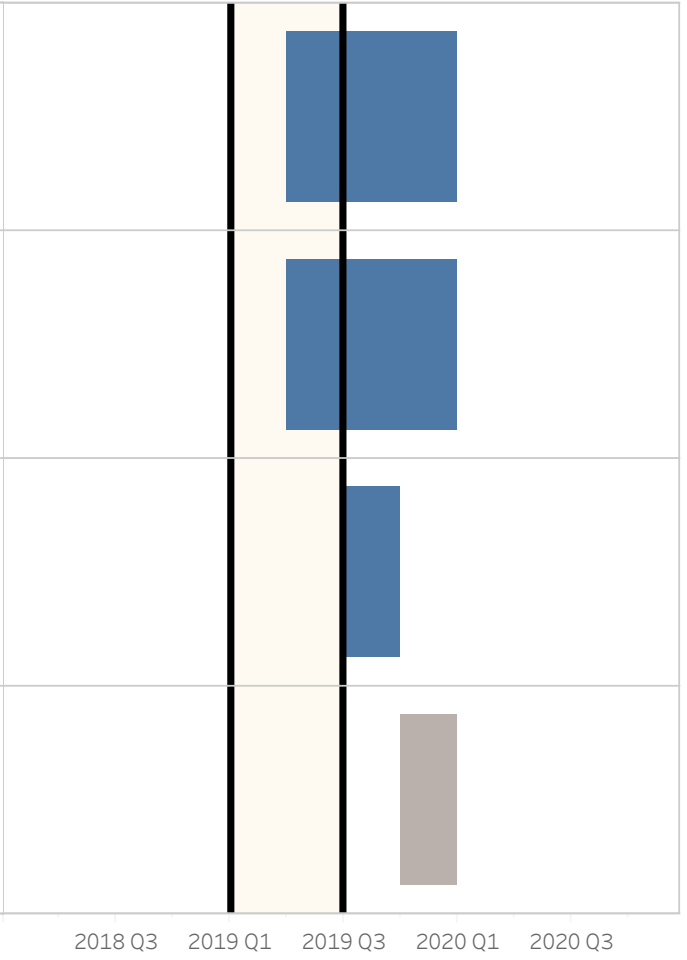
Establish referral relationships with dentists and other specialists, such as ENTs and periodontists (Completion no later than DY 3, Q4)	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)		Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners
	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		Documented QI strategies for referral process to recovery services	Qualis Health Practice Coach Connector	None



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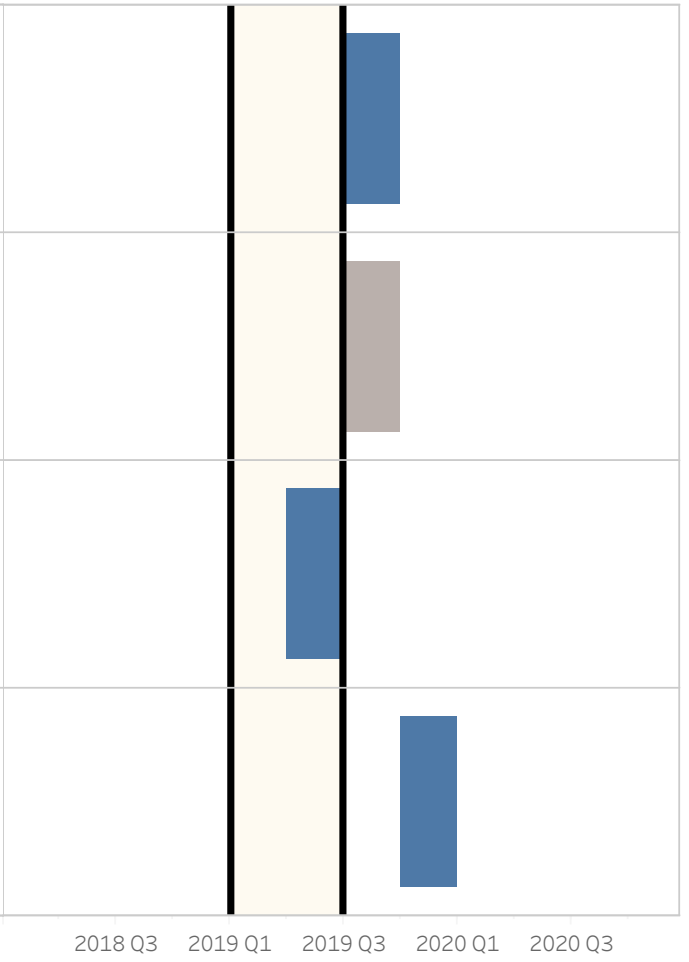
Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes (Completion no later than DY 3, Q4)	Establish procedures for and carry out QIP	*	Scheduled biannual site visits by OCH staff biannual quantitative and qualitative data submitted by PH..	Director of Programs	PHBH* and CBOSS^ Implementation Partners
	Host OCH Performance, Measurement and Evaluation Committee (PMEC) meetings to review PHBH and CBOSS Implementation Partner data		Quarterly PMEC materials and minutes	Data Lead	PMEC^^
	Implement reporting policies and practices to ensure complete and timely Change Plan reporting	*	PHBH Change Plan progress to date and quantitative reports	Director of Programs	None
	Assist PHBH Implementation Partners in tracking QI		QI technical assistance	P-TCPi Coach Facilitator	None



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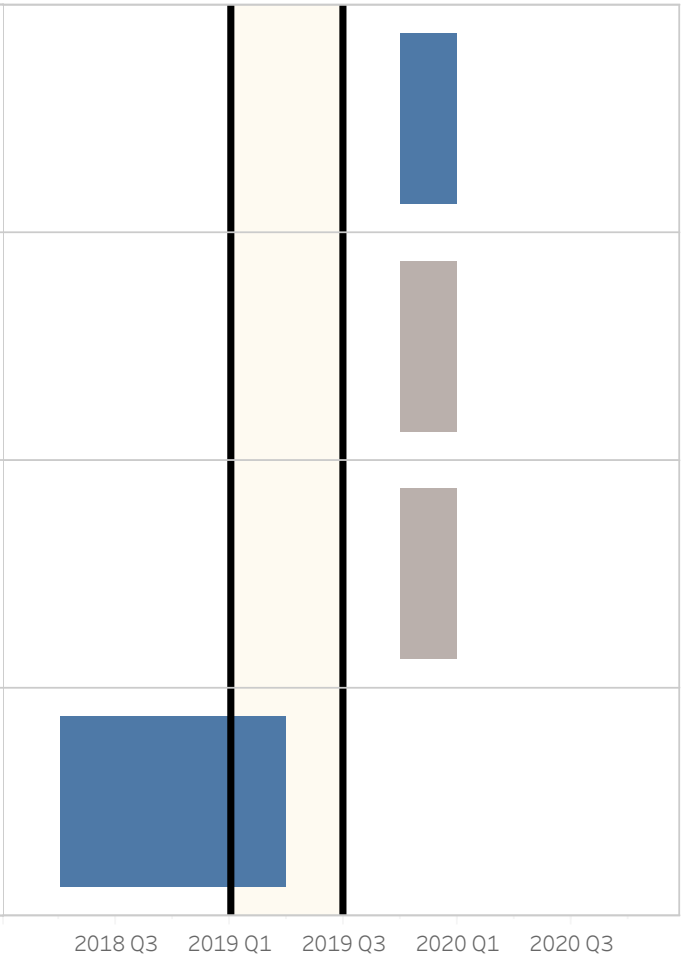
providing performance feedback, implementing changes and tracking outcomes (Completion no later than DY 3, Q4)	Assist PHBH Implementation Partners in tracking QI		QI technical assistance	Qualis Health Practice Coach Connector	None
Engage with payers in discussion of payment approaches to support access to oral health services (Completion no later than DY 3, Q4)	Facilitate Implementation Partners to establish connection with apparently successful bidders of dental managed care contracts		Communications	Executive Director	None
	Meet with future successful bidders of dental managed care contracts to discuss potential financial and technical support of oral health integration in primary care		Meetings	Executive Director	None
Regional self-identified milestone: Ensure communication with	Work with CSI (contracted vendor) to develop online platform for communication, resource sharing and reporting	*	ORCA	Director of Programs	None



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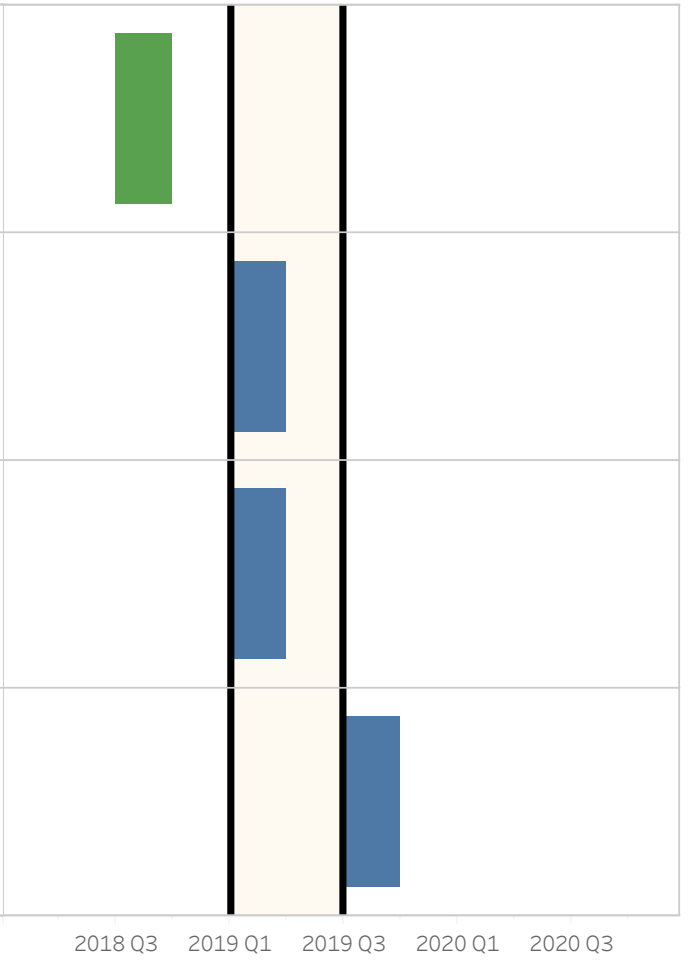
Regional self-identified milestone: Ensure communication with, resource sharing for, and reporting requirements of PHBH and CBOSS Implementation Partners are streamlined, transparent and minimally burdensome while holding them accountable to implementation	Ensure Shared Change Plan Partners are registered on ORCA		Registered list of partners on ORCA	Program Coordinator	None
	Develop strategy to increase traffic and activity on ORCA		Communications plan	Communications and Development Coordinator	None
	Develop streamlined qualitative and quantitative reporting templates on ORCA for bi-annual reporting	*	Online reporting templates	Director of Programs	None
	Solicit feedback on ORCA from PHBH, CBOSS and Shared Change Plan Partners		Feedback forms	Program Coordinator	None



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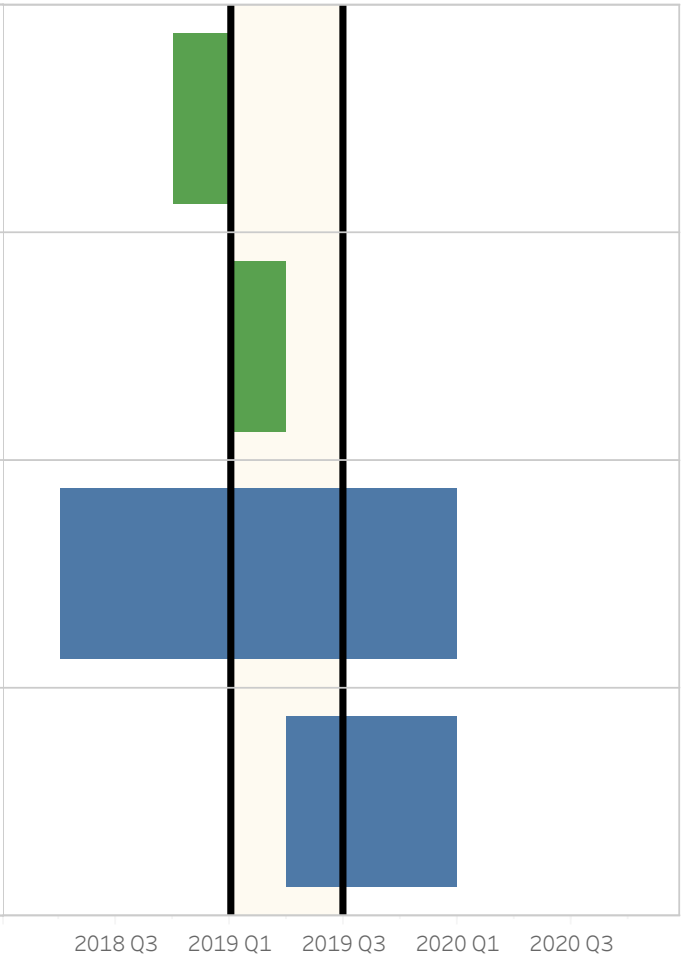
Regional self-identified milestone: Align monitoring of implementation progress of MTP with other ACHs	Contribute to cross-ACH repository of intermediary metrics to monitor implementation		List of metrics and their specifications	Data Lead	None
	Review and potentially refine OCH intermediary metrics with members of the PMEC to identify opportunities for alignment with other ACHs		List of metrics and their specifications	Data Lead	None
Regional self-identified milestone: Health equity considerations are incorporated in implementation of Outcomes and Tactics	PHBH and CBOSS Implementation Partners and Shared Change Plan Partners are surveyed regularly regarding health equity strengths and gaps; gaps are addressed	*	Regional health equity data	Data Lead	None
	Review patient/client data by subpopulations to identify and track inequities (Tactic 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



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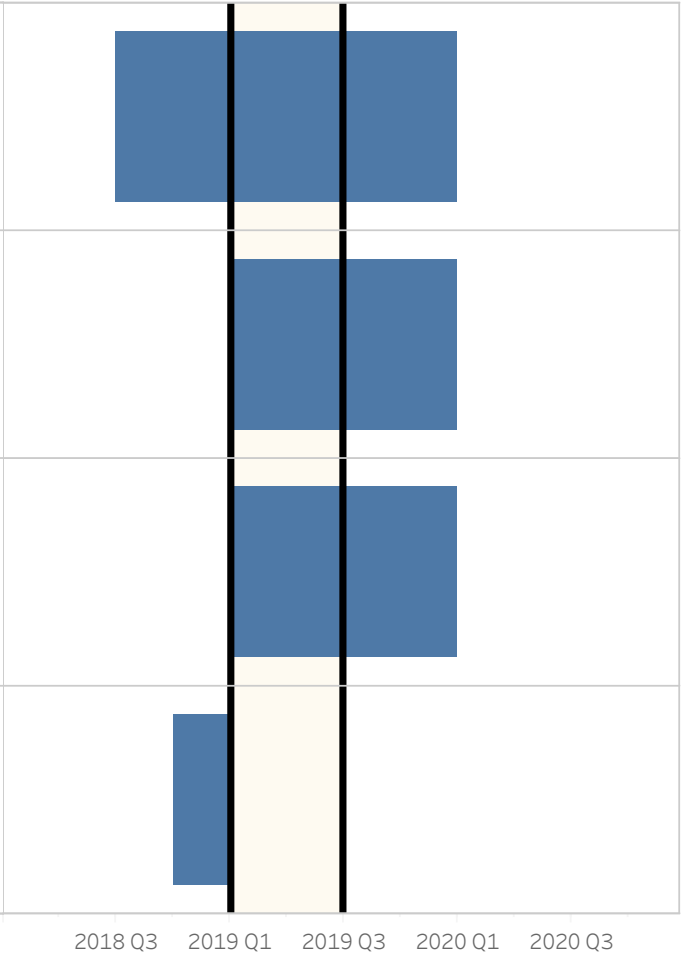
Regional self-identified milestone: Health equity considerations are incorporated in implementation of Outcomes and Tactics	Regional health equity survey results are summarized and presented to the OCH Board, Committees, Natural Communities of Care convenings and staff meetings	*	Presentations	Data Lead	None
Regional self-identified milestone: Proactively engage community-based organizations, Tribes, and the beneficiaries of services to ensure that their voice guides and informs the decision making of the Olympic Community of Health	Establish the Community and Tribal Advisory Committee (CTAC) and meet no less than semi-annually		CTAC meeting calendar	Director of Community and Tribal Partnership	None
				Communications and Development Coordinator	None
	Determine appropriate sector representation and convene CTAC		CTAC charter	Director of Community and Tribal Partnership	None



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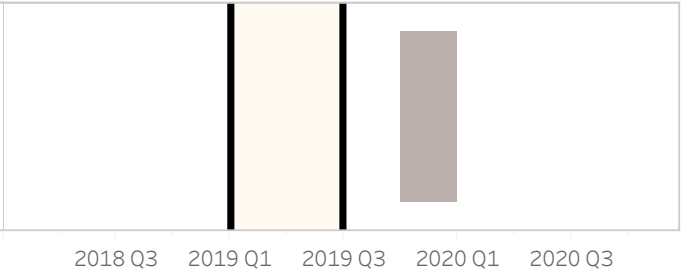
Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
organizations, Tribes, and the beneficiaries of services to ensure that their voice guides and informs the decision making of the Olympic Community of Health	Provide written reports and/or recommendations to the OCH Board and staff to summarize strengths and gaps in social justice and health equity in the work of the MTP	*	Reports recommendations	Director of Programs	CTAC



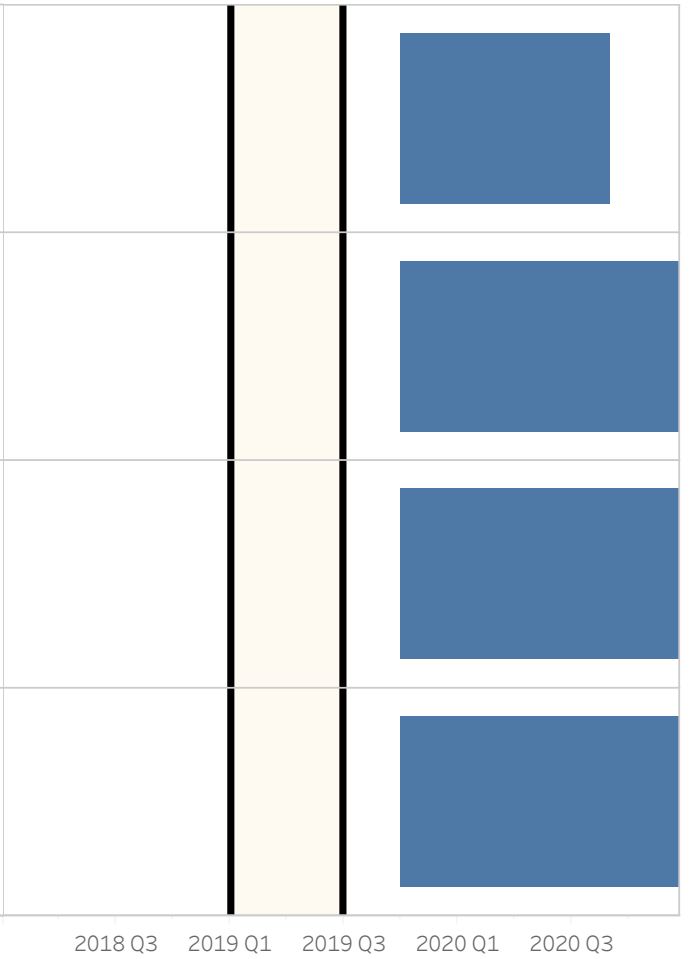
* Denotes change from previous Implementation Plan

Status Update

- Completed, Deliverable Met
- Delayed, Remains in Progress
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	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	Build relationships with stand-alone SUD providers who have not yet participated in practice transformation	*	Communications and meetings	Program Coordinator	None



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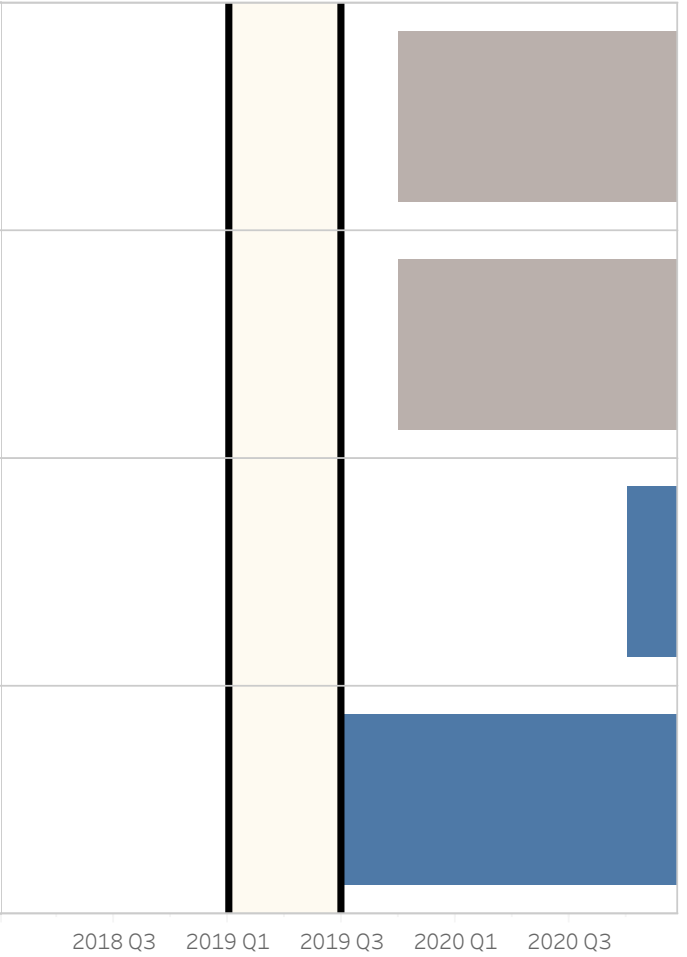
Status Update

- Delayed, Remains in Progress
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Expand the model to additional communities and/or partner organizations (Completion no later than DY 4, Q4)	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
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	Convene Regional Opioid Summit(s) for existing partners as well as new partners	Regional Opioid Summit roster	Director of Community and Tribal Partnership	None
	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/..	Participation of new partners in OCH-hosted events, committees and workgroups	Director of Community and Tribal Partnership	None



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Status Update

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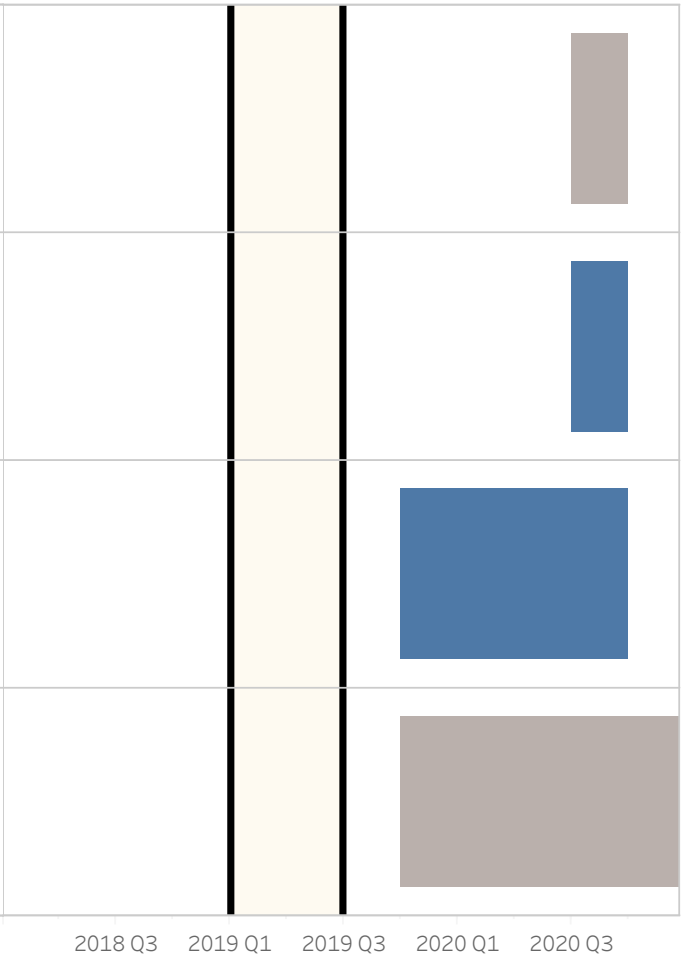
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
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
	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
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
	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



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Status Update

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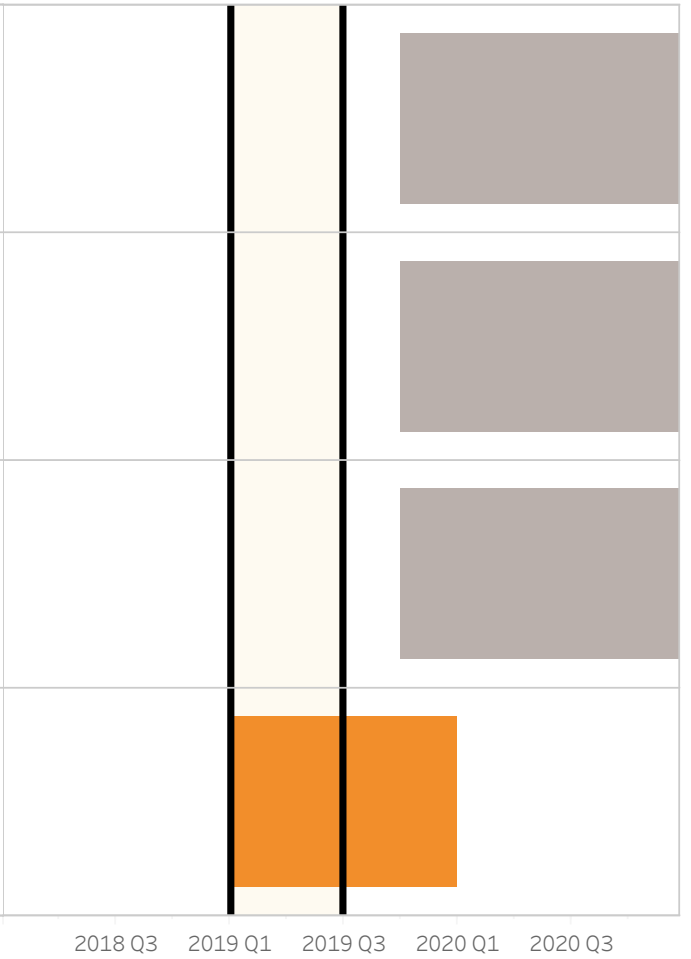
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	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)	Explore operating a mobile dental clinic		Biannual report of progress on this work step and any associated intermediary measures	None	Peninsula Community Health Services
	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 **
	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
	Form Local Improvement Networks to enhance oral health access in partnership with the Arcora Foundation	*	Oral health local impact network implementation plan	Executive Director	None



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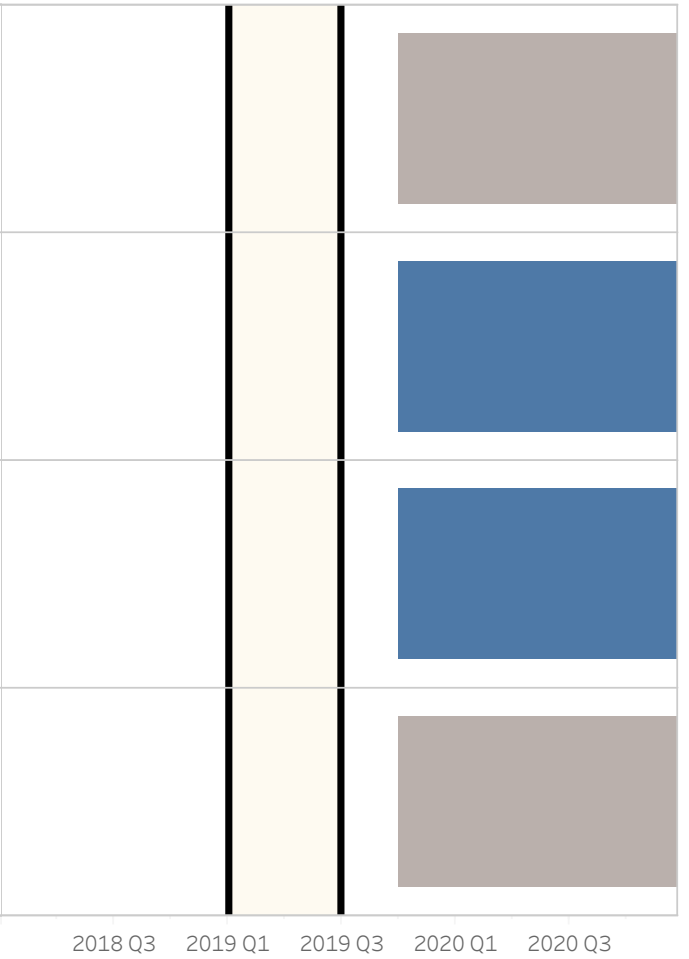
Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	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)	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
	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
	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



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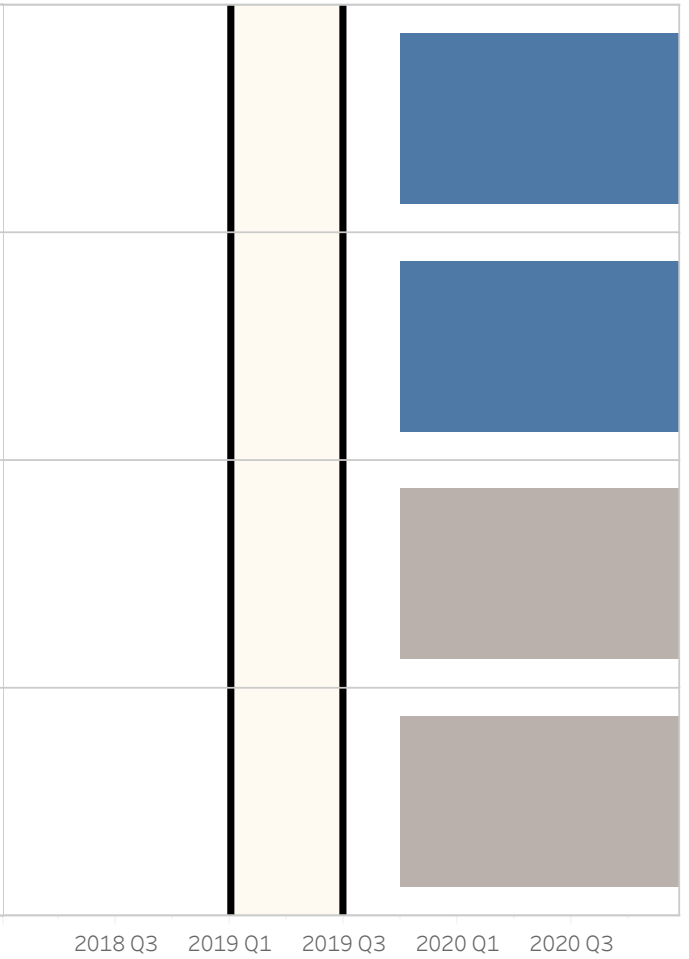
Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
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
Increase scale of approach, expand to serve additional high-risk populations, include additional	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



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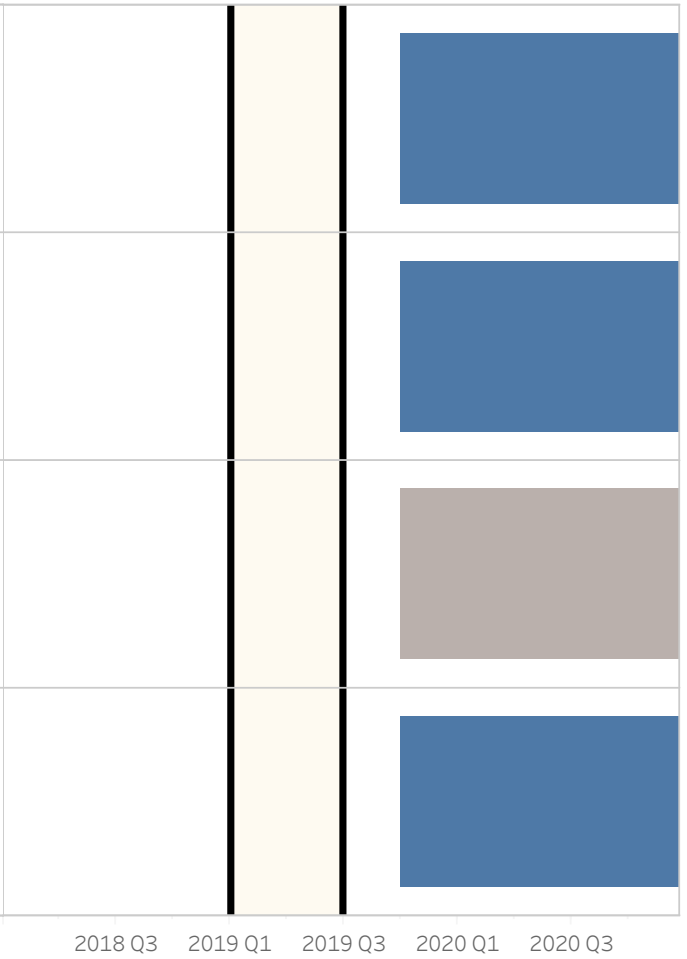
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	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)	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
	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
Employ continuous quality improvement methods to refine the model, updating	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



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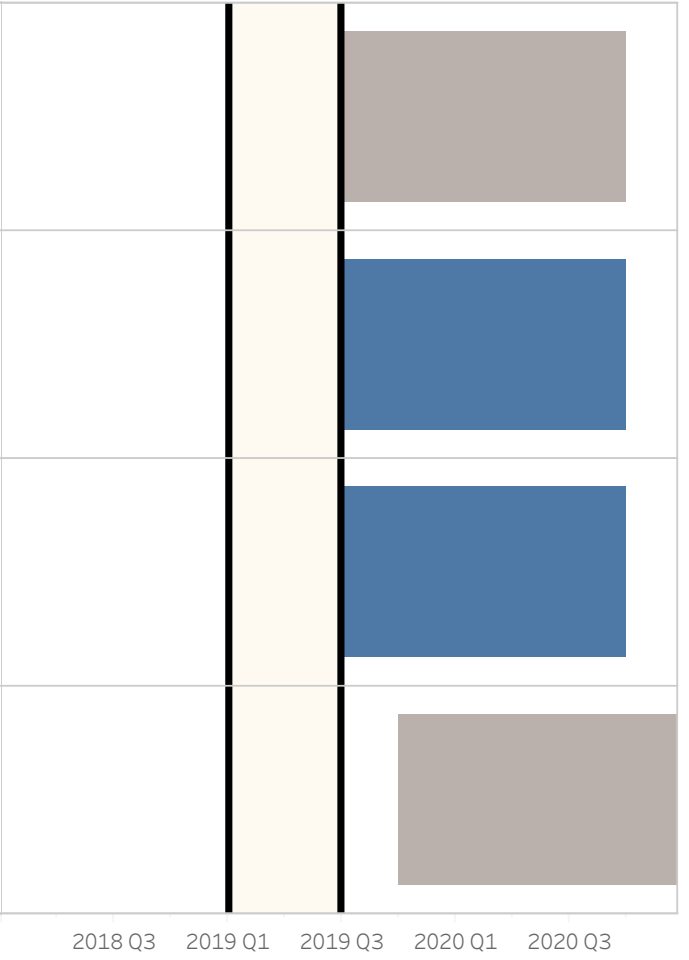
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	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)	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	Director of Programs	None
	Identify opportunities for improvement and develop/implement strategies to support partners	*	Site visit materials	Director of Programs	None
	Continuously employ QI approach to track progress on metrics and project implementation	*	Monitoring reports	Data Lead	PMEC^^



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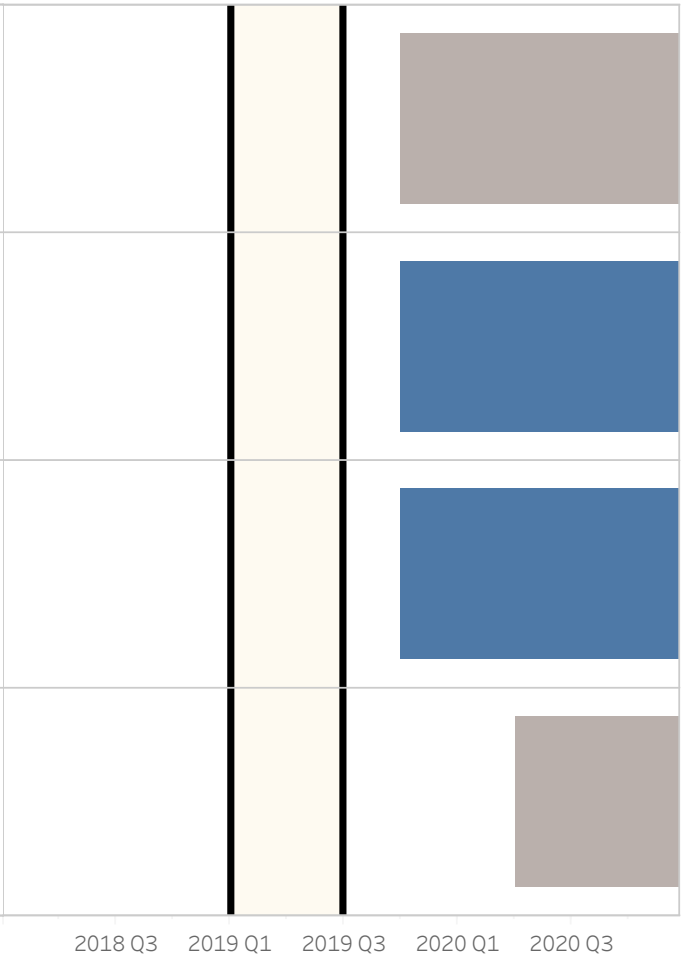
Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	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)	Convene PMEC to review measures and refine approach based on emerging best practices	PMEC materials and minutes	Data Lead	PMEC^^
	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
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
	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



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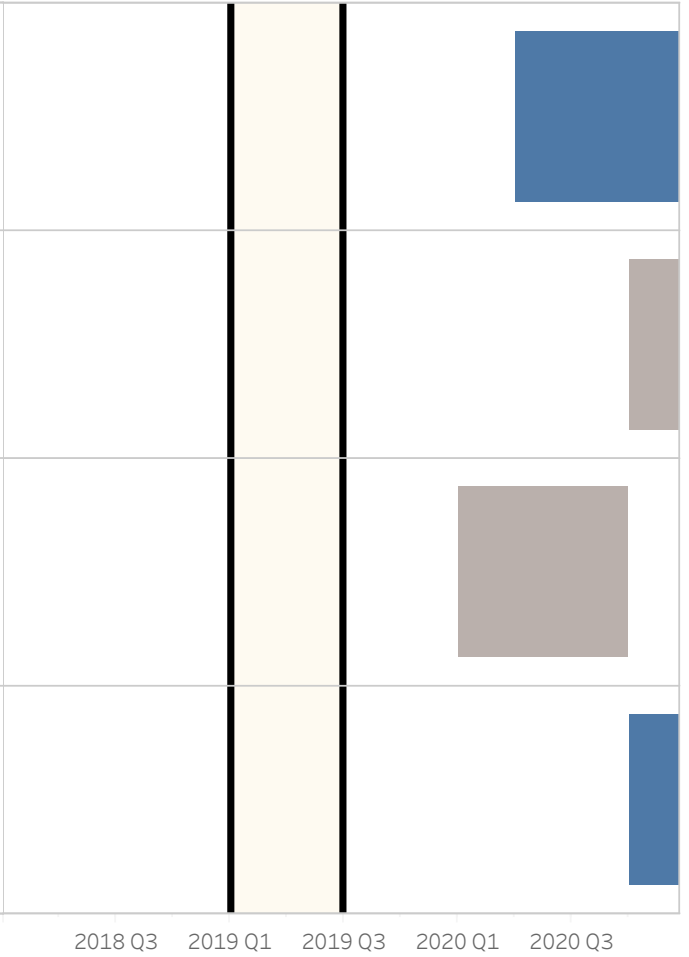
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
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)	Discuss data updates with 3CCORP	*	Meeting materials/minutes	Data Lead	None
	Update provider specific data reports		Provider specific data reports	Data Lead	None
	Discuss data with PHBH and CBOSS Implementation Partners to inform decisions about strategies and/or spread	*	Meeting materials	Director of Programs	None
	Present data at annual Regional Opioid Summit(s)		Regional Opioid Summit agenda, slide deck, summary report	Director of Community and Tribal Partnership	None



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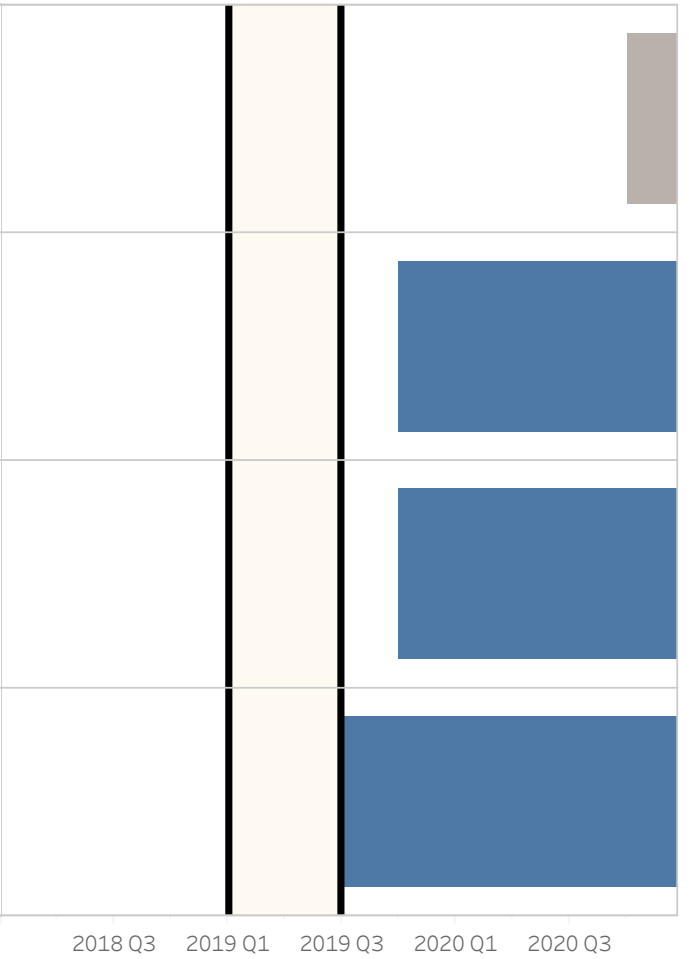
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
decisions regarding specific strategies and action to be spread to additional settings or geographical areas (Completion no later than DY 4, Q4)	Monitor data to track and address health equity in Outcomes	*	Equity tracking	Data Lead	None
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion (Completion no later than DY 4, Q4)	Include topical breakout sessions and/or training at Natural Community of Care convenings	*	Convenings	Director of Programs	None
	Provide progress reports to PHBH Implementation Partners related to Eight Change Concepts of the Patient Centered Medical Home Principles		Coaching report from Qualis Health	Qualis Health Practice Coach Connector	None
	Continue to utilize ORCA as a resource repository; keep resources updated and include emerging best practices		Timely posts on ORCA	Program Coordinator	None



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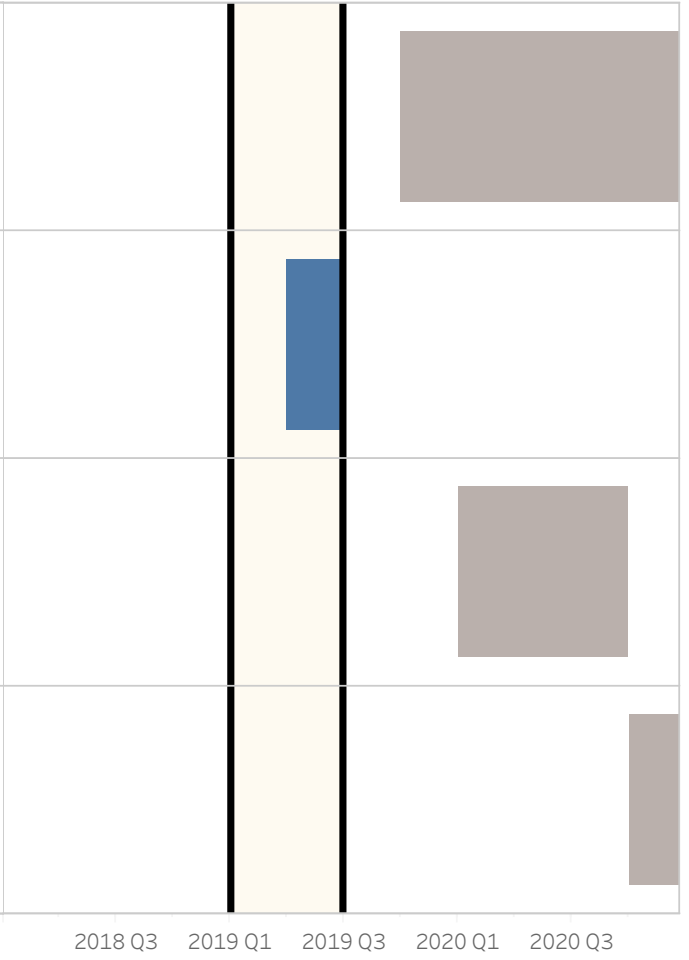
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion (Completion no later than DY 4, Q4)	Utilize results from QI process with PHBH and CBOSS Implementation Partners to inform TA and training support	*	Coaching report from Qualis Health	Director of Programs	None
	Collaborate with Qualis Health to continue coach facilitator services	*	Meetings	Director of Programs	None
	Evaluate and update training plan based on feedback from QI process to respond to evolving partner needs	*	Training Plan	Director of Programs	None
	Continue to support partners in advancement of health equity through QI activities, evaluation and the procurement of resources to assist progress	*	Equity tracking	Qualis Health Practice Coach Connector	None



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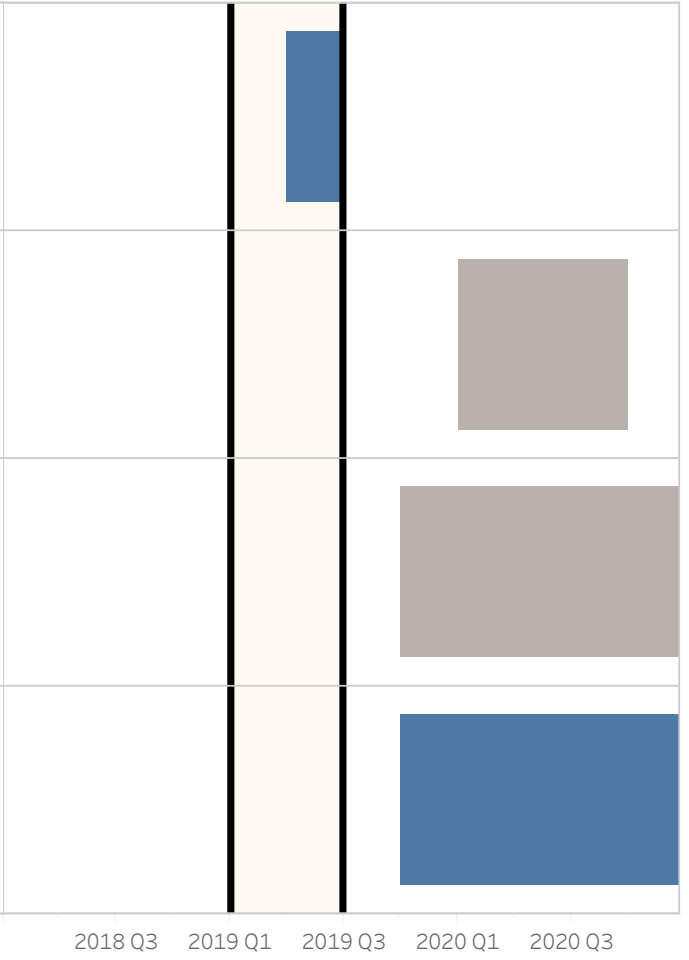
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	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)	Collaborate with Qualis Health to continue coach facilitator services	*	Meetings	Director of Programs	None
	Evaluate and update training plan based on feedback from QI process to respond to evolving partner needs	*	Coaching report from Qualis Health	Director of Programs	None
	Include breakout sessions and/or training in chronic disease prevention and control at Natural Community of Care convenings	*	Convenings	Director of Programs	None
	Provide progress reports to Implementation Partners related to Eight Change Concepts of the Patient Centered Medical Home Principles		Coaching report from Qualis Health	Qualis Health Practice Coach Connector	None



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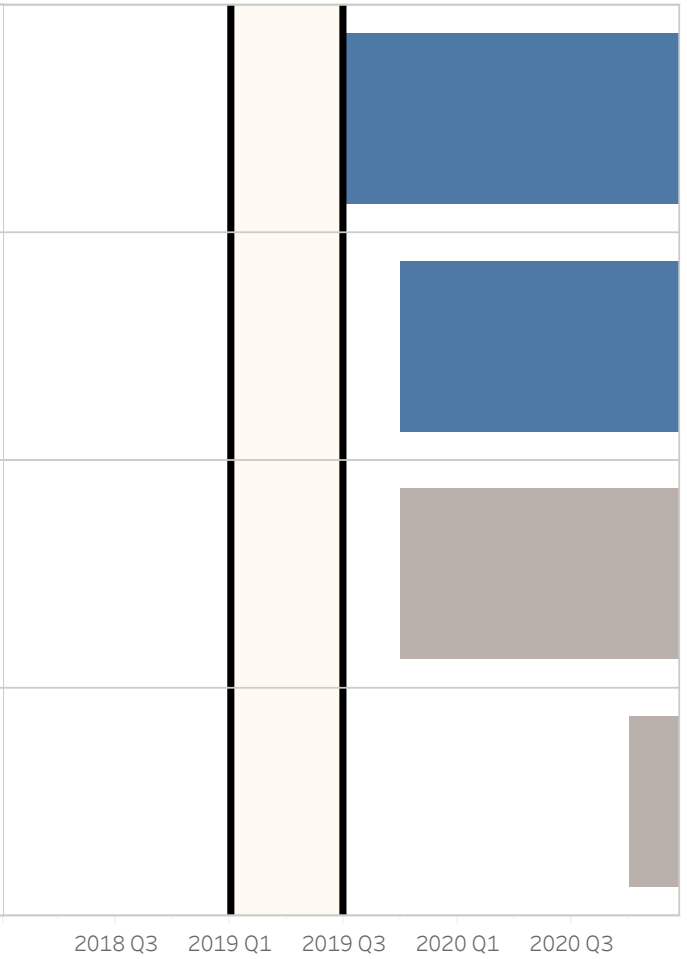
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	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)	Continue to utilize ORCA as a resource repository; keep resources updated and include emerging best practices		Timely posts on ORCA	Program Coordinator	None
	Utilize results from QI process with PHBH and CBOSS Implementation Partners to inform TA and training supports		Coaching report from Qualis Health	Qualis Health Practice Coach Connector	None
		*	Coaching report from Qualis Health	Director of Programs	None
	Continue to support partners in advancement of health equity through QI activities, evaluation and the procurement of resource to assist progress	*	Equity tracking	Director of Programs	None



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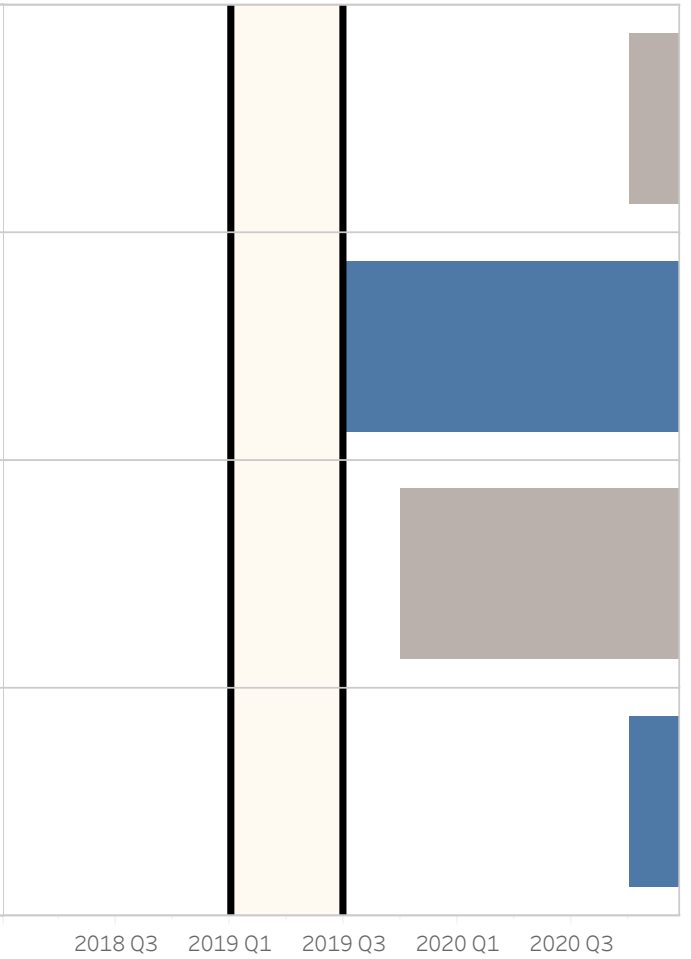
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Systems by additional providers, additional populations, or types of information exchanged) (Completion no later than DY 4, Q4)	Develop regional Behavioral Health Academy to train workforce in transitioning to integrated care		Training modules	Qualis Health Practice Coach Connector	None
Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/ approaches (Completion no later than DY 4, Q4)	Continue to utilize ORCA as a resource repository; keep resources updated and include emerging best practices		Timely posts on ORCA	Program Coordinator	None
	Utilize results from QI process with PHBH and CBOSS Implementation Partners to inform TA and training supports	*	Coaching report from Qualis Health	Director of Programs	None
	Convene Regional Opioid Summit(s) to deliver training and identify technical assistance needs and new partnership opportunities		Regional Opioid Summit(s)	Director of Community and Tribal Partnership	None



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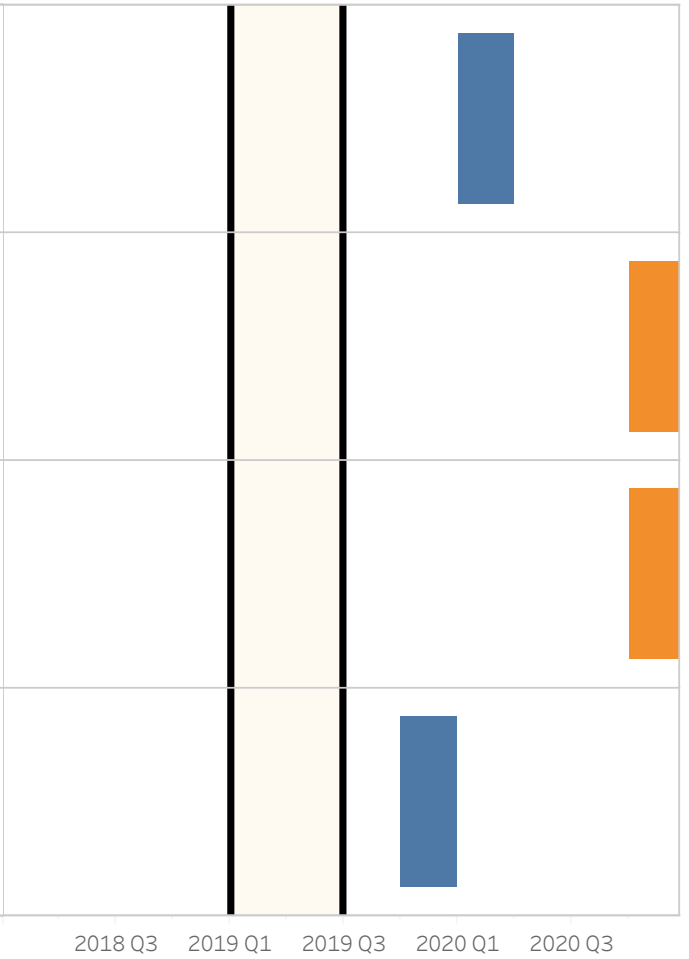
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/ approaches (Completion no later than DY 4, Q4)	Collaborate with University of Washington to implement 6 Building Blocks for improved opioid prescribing in clinics in the region		Clinics participate in 6 Building Blocks	Director of Community and Tribal Partnership	None
	Collaborate with DOH to coordinate training for providers to become waivered for MAT		MAT training	Director of Community and Tribal Partnership	None
	Collaborate with StopOverdose.org to provide TA and training to recognize and appropriately respond to opioid related overdoses		Overdose response training	Director of Community and Tribal Partnership	None
Leverage regional champions and implement a train-the-trainer	Identify regional champions	*	List of regional champions	Qualis Health Practice Coach Connector	None



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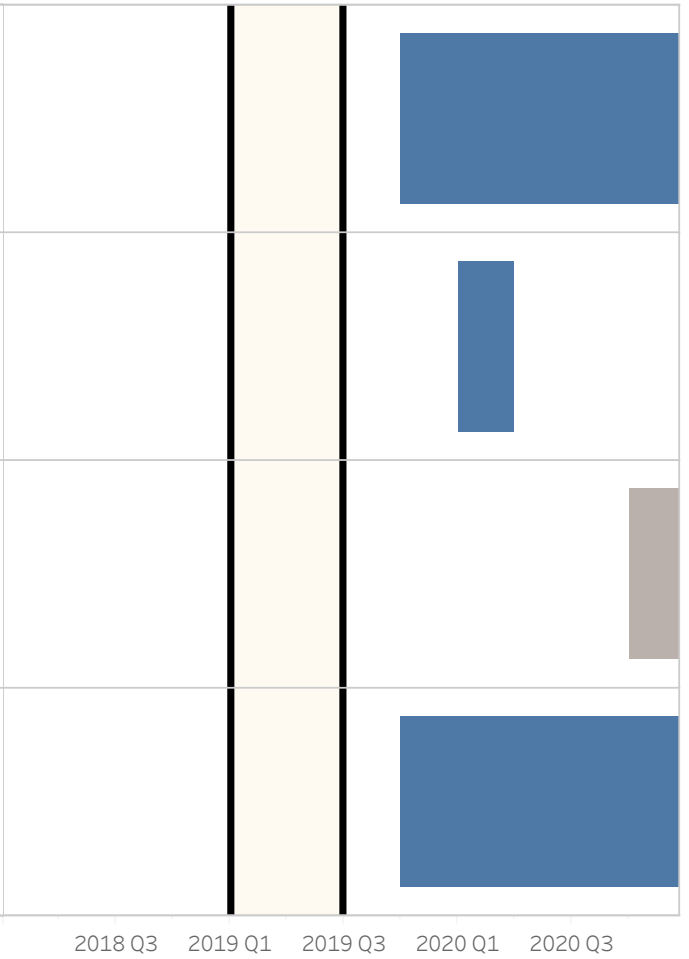
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices (Completion no later than DY 4, Q4)	Connect regional champions with Natural Communities of Care to share best practices with other providers	*	Presentations at Natural Community of Care Convenings	Director of Programs	None
	Interview regional champions to learn promising practices	*	Interview notes	Communications and Development Coordinator	None
	Facilitate opportunities for regional champions to spread best practices	*	Presentations, resources on ORCA, newsletters	Communications and Development Coordinator	None
Convene and support platforms to facilitate shared learning and exchange of best	Convene 3CCORP Steering Committee and Workgroups		Meeting materials	Director of Community and Tribal Partnership	None



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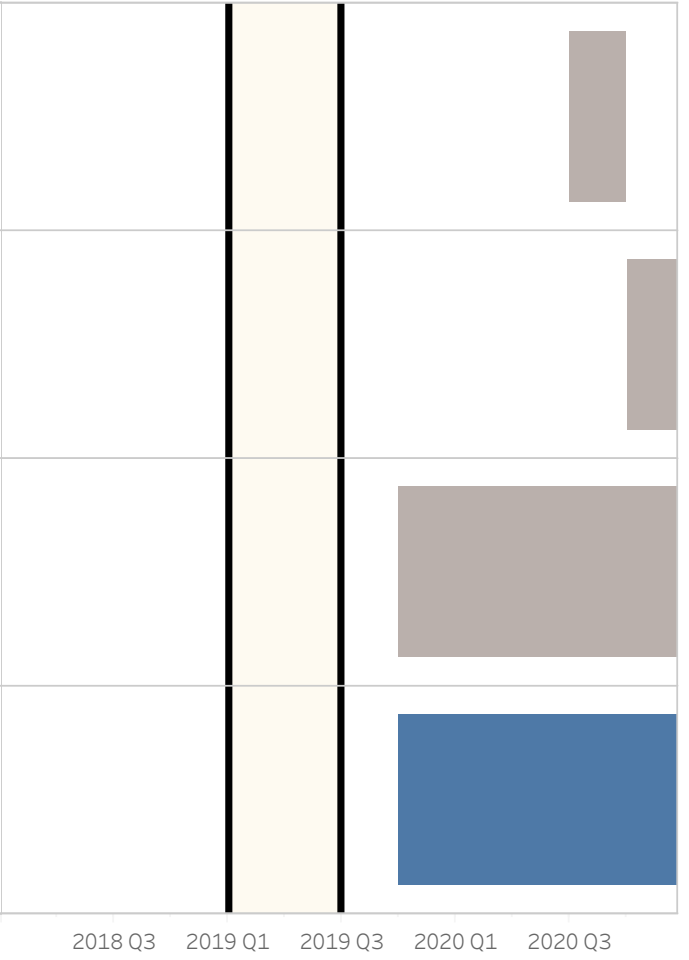
Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	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)	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



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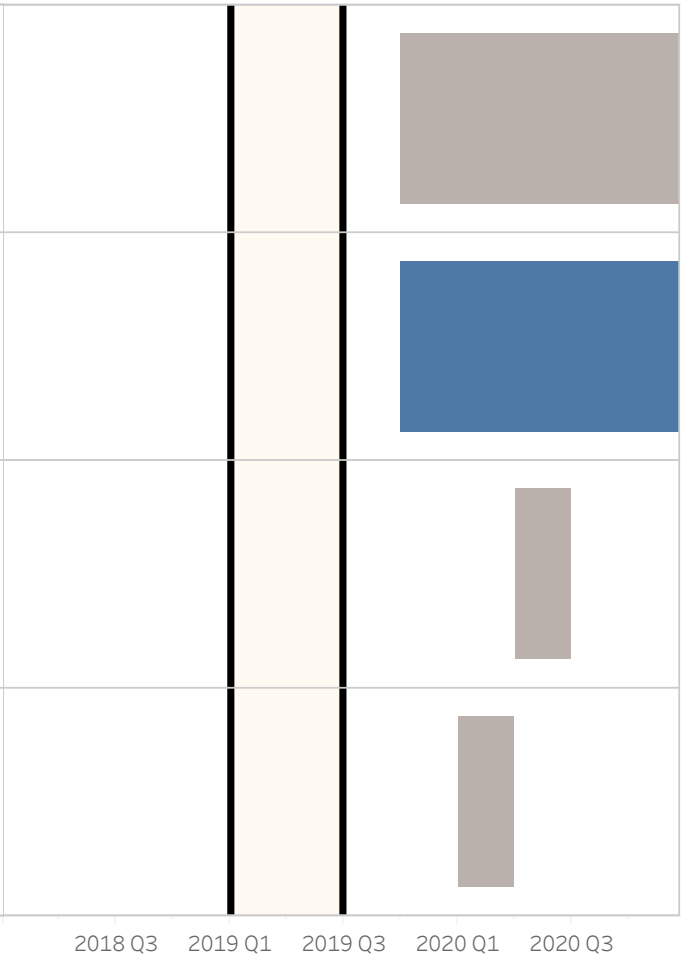
Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Identify and resolve barriers to financial sustainability of Project(s) activities post-DSRIP (Completion no later than DY 4, Q4)	Advocate with other ACHs for Medicaid reimbursement codes that will directly support Change Plan Outcomes and Tactics		Meet with ACH EDs, legislators, MCOs and State partners	Executive Director	None
	Support statewide efforts to address rural workforce shortages		Information sharing with WSHA and WA Health Workforce Sentinel Network	Executive Director	None
	Explore an all-payer collaborative		Meet with MCO and commercial payer partners	Executive Director	None
	Explore rural global payment strategies		Meet with HCA and hospital partners	Executive Director	None



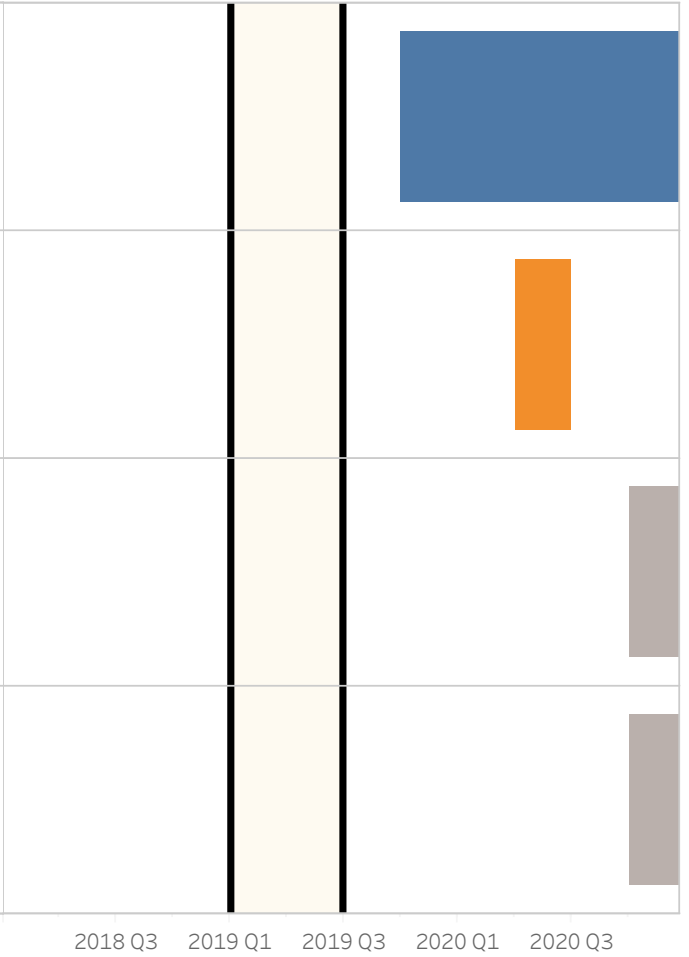
* Denotes change from previous Implementation Plan

Status Update

- Delayed, Remains in Progress
- Fulfilled for Quarter, Remains in Progress
- Not Started

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	*	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
Regional self-identified milestone: MAT Providers and SUD Providers are closely networked for referral and coordina..	Deepen engagement with MAT prescribers and SUD providers and convene together to facilitate coordination		Meeting materials	Director of Community and Tribal Partnership	None
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



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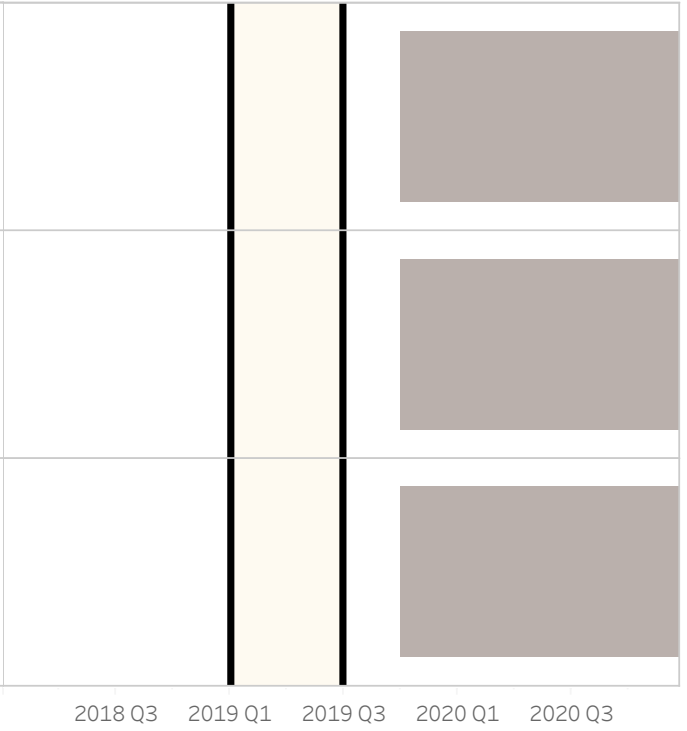
Implementation Plan Timeline: Stage 3

Milestones	Work Steps *	Key Deliverables / Outcomes	ACH Organization	Partnering Provider Organization
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
	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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