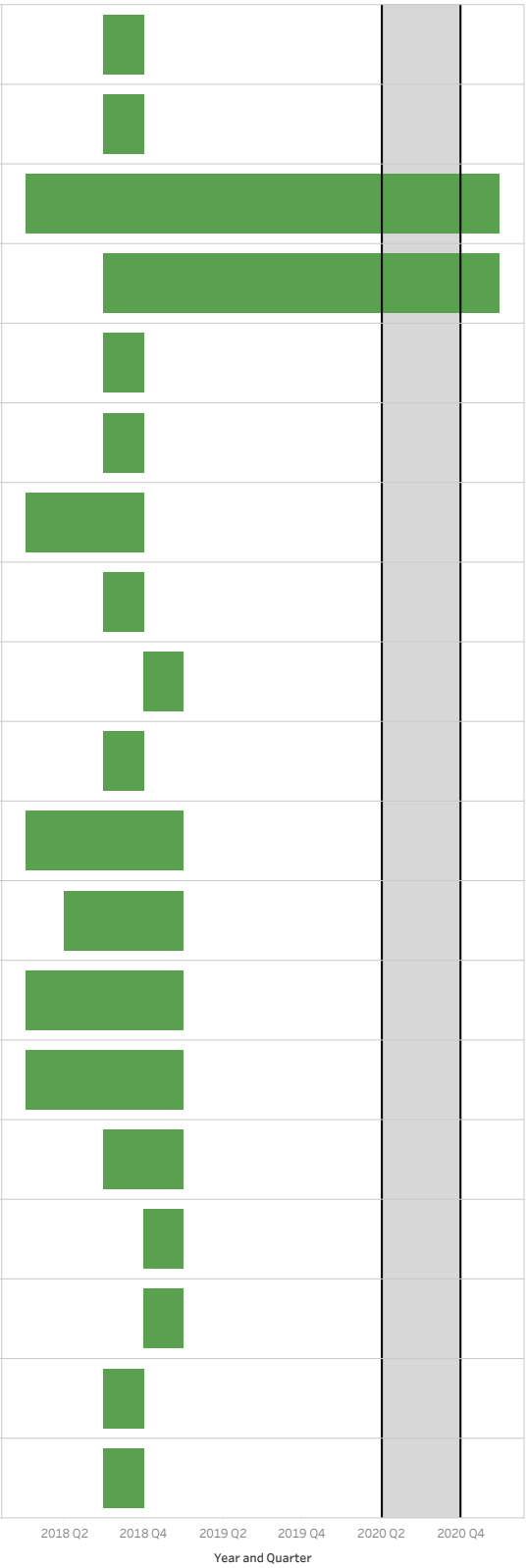
Implementation Plan Timeline: Stage 1

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (I..
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)		Director of Programs	List of selected trainings from Implementation Partners	None
	Review Outcomes and Tactics from submitted PHBH and CBOSS‡ Change Plans related to health systems capacity building and health equity		Director of Programs	Review notes	None
	Participate in cross ACH coordination with Artemis contract and state priorities workgroup collaboration with HCA and MCOs.		Executive Director	Plan that prioritizes health system capacity building strategies	None
	Identify shared training opportunities with other ACHs (including health equity training)		Executive Director	Work plan with Artemis consulting	None
	Identify preferred technical assistance vendors from Implementation Partners		Data Lead	OCH Current State Assessment results	None
	Identify interest in shared EHR, EBHR and/or population health management systems		None	PHBH Change Plan indicates preference, updated annually	PHBH* Implementation Partners
	Design PHBH and CBOSS‡ Change Plans to identify preferred activities to facilitate health systems and community capacity building and health equity		Director of Programs	PHBH and CBOSS‡ Change Plan templates	None
	Complete PHBH and CBOSS‡ Change Plans		None	Completed PHBH and CBOSS‡ Change Plans	PHBH* and CBOSS^ 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)	Select six BH Implementation Partners for in-depth IMC technical assistance from Qualis Health		Qualis Health Practice Coach Connector	Six BH Implementation Partners selected to receive technical assistance from Qualis Health on IMC	None
	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		Qualis Health Practice Coach Connector	Plan for trainings	None
	Participate in SBHO Provider Meetings		Program Coordinator	Meetings	None
	Participate in SBHO Pathway to 2020: IMC preparatory meetings inclusive of all SBHO-subcontracted agencies, HCA and MCOs		Director of Programs	Meetings	None
	Participate in SBHO Executive Board Meetings		Executive Director	Meetings	None
	Participate in SBHO Advisory Board Meetings		Program Coordinator	Meetings	None
	Meet monthly with the SBHO to develop an IMC transition plan for appropriate state and local agencies		Executive Director	IMC transition plan	None
	Host IMC and VBP trainings for behavioral health providers with CPAA, Qualis Health, and DOH		Qualis Health Practice Coach Connector	Trainings	None
	Assess behavioral health provider readiness for the transition to IMC		Qualis Health Practice Coach Connector	Coaching report from Qualis Health	None
Regional self-identified Milestone: Develop recommended Outcomes and Tactics in the PHBH Change Plan that are mutually supportive of the IMC transition	Report on value-based metrics that will be in MCO contracts (include as a Recommended Tactic in the PHBH Change Plan)		None	PHBH Implementation Partners select this Tactic in their PHBH Change Plan	Select PHBH* Implementation Partners
	Implement VBP arrangements with MCOs (include as a Recommended Tactic in the PHBH Change Plan)		None	PHBH Implementation Partners select this Tactic in their PHBH Change Plan	Select PHBH* Implementation Partners

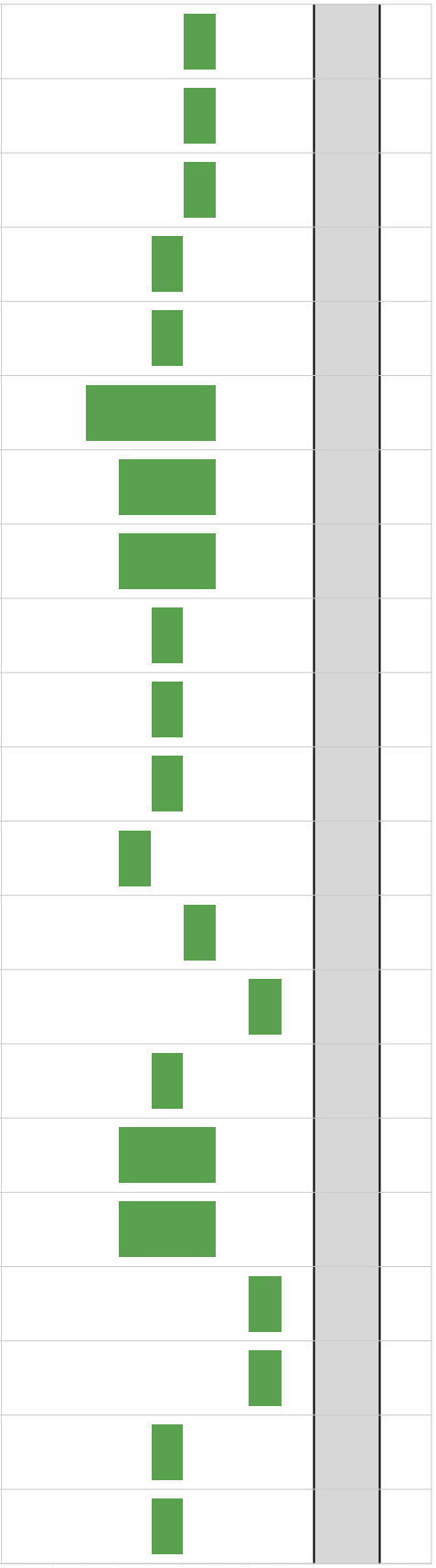


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (IP013121)
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		Director of Programs	Practice assessments (e.g., PAT, MeHAF, PCMH-A) and/or action plans	None
	Share recommendation for refinements of guidelines, policies, procedures, and protocols related to PHBH and CBOSS‡ Change Plans on OCH website		Program Manager	Partner Resource page on OCH website	None
	Review list of new promising guidelines, policies, procedures and protocols internally and/or with subject matter experts		Program Manager	Evaluation of gaps in guidelines, policies, procedures and protocols	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 s..		Director of Programs	List of new promising guidelines, policies, procedures and protocols related to PHBH and CBOSS‡ Change Plan activities	None
	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 transfo..		Qualis Health Practice Coach Connector	List of Outcomes and Tactics in PHBH and CBOSS‡ Change Plans	None
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways (Completion no later than DY 3, Q2)	Work with Performance, Measurement and Evaluation Committee (PMEC) to review QI approach and finalize measure set		Data Lead	Recommended measure set	PMEC ^^
	Provide QI technical assistance and training		P-TCPi Coach Facilitator	Training materials and/or technical assistance	None
			Qualis Health Practice Coach Connector	Training materials and/or technical assistance	None
	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)		None	PHBH and CBOSS‡ Change Plan progress to date and quantitative reporting are complete and timely	Select PHBH* and CBOSS^ Implementation Partners
	Form and maintain a diverse quality improvement (QI) team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, q..		None	PHBH Change Plan progress to date reporting indicates progression of QI implementation, updated biannually	Select PHBH* Implementation Partners
	Establish procedures for the QIP		Director of Programs	Site visits and QIP reporting	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 ..		Data Lead	Quality Improvement Plan (QIP) with measure set	None
	Convene PMEC to establish guidelines for ongoing review of reported data		Data Lead	PMEC materials	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)	Upload recordings, materials, webinars of trainings on OCH website		Communications and Development Coordinator	Partner Resource page on OCH website	None
	Review PHBH Implementation Partner readiness from Current State Assessment, completed coaching reports and practice assessments to create Implementation Partner readiness (for i..		Director of Programs	Implementation Partner readiness matrix	None
	Recommend available trainings and technical assistance		P-TCPi Coach Facilitator	Communications	None
			Director of Programs	Communications	None
	Participate in trainings		None	Training	PHBH* and CBOSS^ Implementation Partners and interested Shared Change Plan** Partners
	Make trainings available to partners		Community Program Coordinator	Training	None
	Identify trainings and technical assistance needs for integrated care activities associated with Outcomes and Tactics in Change Plans		P-TCPi Coach Facilitator	Training and technical assistance plan	None
			Director of Programs	Site visit report with recommendations	None

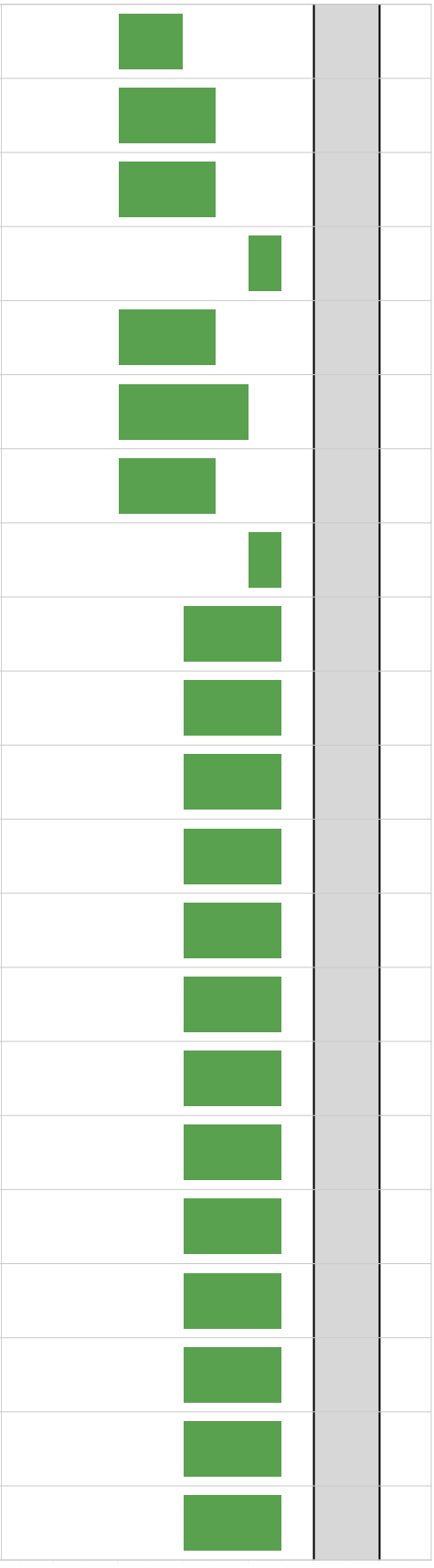


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (IP013121)
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		Executive Director	Contractual agreements	None
	Assist PHBH Implementation Partners in tracking QI projects		P-TCPi Coach Facilitator	QI technical assistance	None
			Qualis Health Practice Coach Connector	QI technical assistance	None
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)	Recommend or offer trainings in cultural competency and related areas to PHBH and CBOSS Implementation Partners and Shared Change Plan Partners		Community Program Coordinator	Cultural competency or related trainings	None
	Provide PHBH and CBOSS Implementation Partners with tools to assess cultural competence and facilitate action planning to address gaps that are identified		Director of Programs	Coaching report from Qualis Health, coaching report from P-TCPi, practice assessments, results from Current State Assess..	PHBH* and CBOSS^ Implementation Partners
	Offer QI check-ins to help evaluate progress		P-TCPi Coach Facilitator	QI meeting	None
			Qualis Health Practice Coach Connector	QI meeting	None
	Evaluate needs of PHBH and CBOSS Implementation Partners on cultural competency		Program Manager	Coaching report from Qualis Health, coaching report from P-TCPi, practice assessments, results from Current State Assess..	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)	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)		None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, partici..	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **
	Public is offered education and awareness around opioid epidemic (Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, partici..	Select 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 Cha..		None	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, partici..	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **
	Patients are engaged around prevention of OUD (Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, partici..	Select PHBH* Implementation Partners and interested Shared Change Plan Partners **
	Naloxone is accessible (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners; partici..	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)		None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, partici..	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **
	Educate clients on safe storage of opioids (Tactic in CBOSS‡ Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, partici..	Select CBOSS^ 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)		None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, partici..	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners **
	Capacity is built to prevent opioid use disorder (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, partici..	PHBH* Implementation Partners and interested Shared Change Plan Partners **
	Best practices for opioid prescribing are promoted and used (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, partici..	PHBH* Implementation Partners* and interested Shared Change Plan Partners **
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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select CBOSS^ Implementation Partners
	Screen clients for engagement with oral health provider and provide resources/referral as needed (Tactic in CBOSS‡ Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select CBOSS^ Implementation Partners
	Refer individuals needing oral health care to oral health care services (Tactic in CBOSS Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select CBOSS^ Implementation Partners

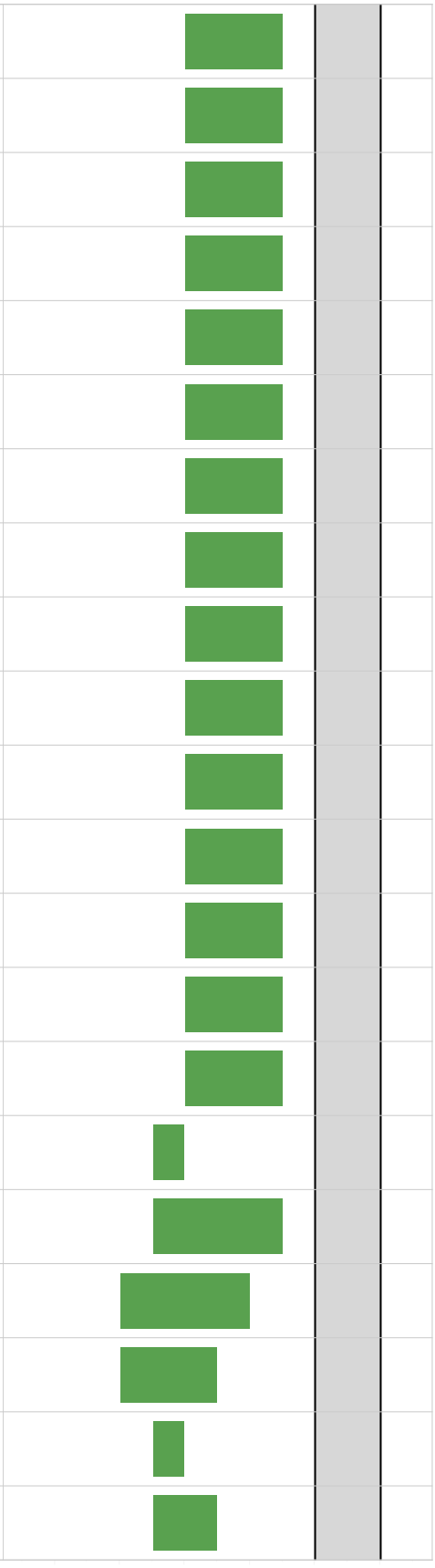


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (IP013121)
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)		None	Biannual report of progress on this work step and any associated intermediary measures	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 (Recommende..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
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)	Streamlined process is in place for information to be shared in a timely manner for shared patients/clients (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Providers are notified of patient/client ED visits (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	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 Pl..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	Implement PreManage (Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	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 (Recommende..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Establish and document a protocol for convening cross-sector care meetings (Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* 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: • 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)	Provide effective chronic care services to referred clients (Tactic in CBOSS‡ Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select CBOSS^ Implementation Partners
	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 C..		None	Biannual report of progress on this work step and any associated intermediary measures	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 depen..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	Facilitate culture shift across Implementation Partner organizations to prioritize chronic disease prevention and management (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* 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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select CBOSS^ Implementation Partners
	Screen clients for engagement with oral health provider and provide resources/referral as needed (Tactic in CBOSS‡ Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select CBOSS^ Implementation Partners
	Facilitate alignment with Arcora Foundation and available medical/dental integration practice coaching		Program Manager	Arcora Foundation representative participates in NCC convenings	None
	Develop strategies, emphasizing care coordination between new and existing dental providers and community-based services and supports (Tactic in CBOSS‡ Change Plan)		Executive Director	Biannual report of progress on this work step and any associated intermediary measures	None
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		P-TCPi Coach Facilitator	Coaching report from Qualis Health; coaching report from P-TCPi	None
			Qualis Health Practice Coach Connector	Coaching report from Qualis Health; coaching report from P-TCPi	None
	Review final PHBH Change Plans and crosscheck with Implementation Partner readiness matrix (for integrated care activities) to identify partner needs		Director of Programs	List of partner needs	None
	Provide examples of Releases of Information and best practices regarding compliance with 42 CFR Part II		Qualis Health Practice Coach Connector	Examples of Releases of Information	None

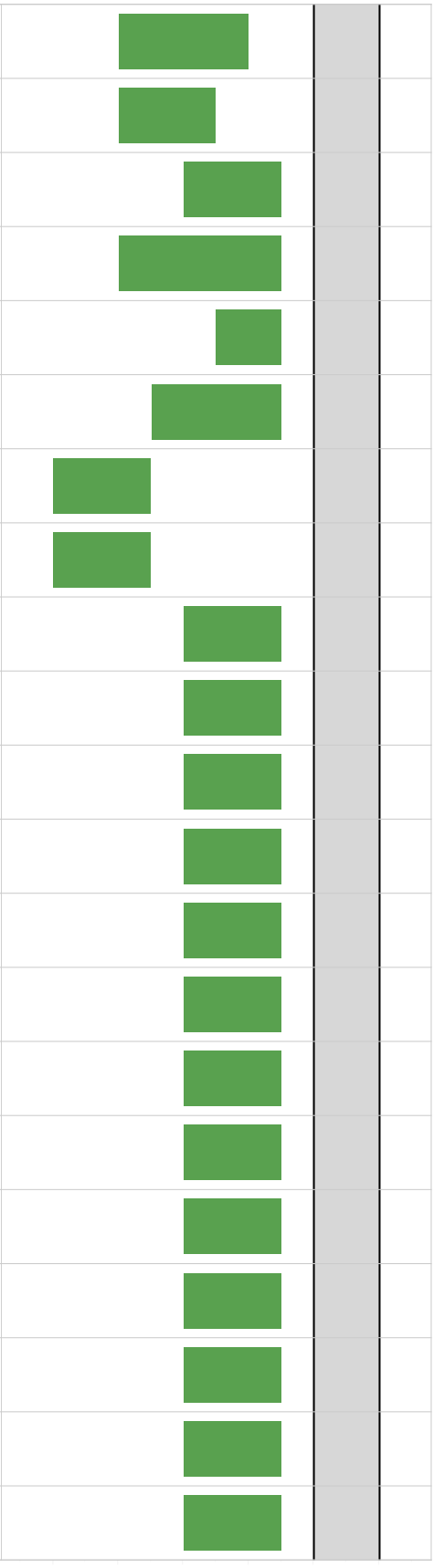


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (IP013121)
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)	Facilitate workflow mapping with Implementation Partners to assess care gaps in technology		P-TCPi Coach Facilitator	Workflow maps	None
			Qualis Health Practice Coach Connector	Workflow maps	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 (Recommende..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Distribute State consent management workgroup materials to BHA and SUD partners		Program Manager	Output from State consent management workgroup	None
	Distribute learnings and updates from PreManage learning collaborative		Program Manager	Tools from PreManage learning collaborative	None
	Convene learning sessions as needed to support partners to implement tools		Community Program Coordinator	Agendas, meeting minutes, and materials from learning sessions	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)	Share recommendations from Bree Collaborative Opioid Workgroup		Director of Community and Tribal Partnership	Materials	None
	Attend quarterly WA State Interagency Opioid Workgroup		Director of Community and Tribal Partnership	Workgroup meetings	None
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 (Recommende..		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* Select Implementation Partners
	SDOHs are assessed and integrated into standard practice (Required Outcome in PHBH and CBOSS‡ Change Plans)		None	Biannual report of progress on this work step and any associated intermediary measures	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)	Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to promote well-child visits and immunizations (Tactic in P..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	Provide evidence-based prenatal or early childhood interventions to promote optimal health outcomes (Tactic in CBOSS‡ Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	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 (Recommende..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ 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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners who have submitted a Primary Care Change Plan
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)		None	Biannual report of progress on this work step and any associated intermediary measures	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 Plans)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and 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 ensu..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Provide effective chronic care services (Tactic in CBOSS‡ Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select 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 an..		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Integrate social determinants of health (SDOH) assessments into standard practice (Required Outcome in PHBH and CBOSS‡ Change Plans)		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* and CBOSS^ 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)		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* Implementation Partners

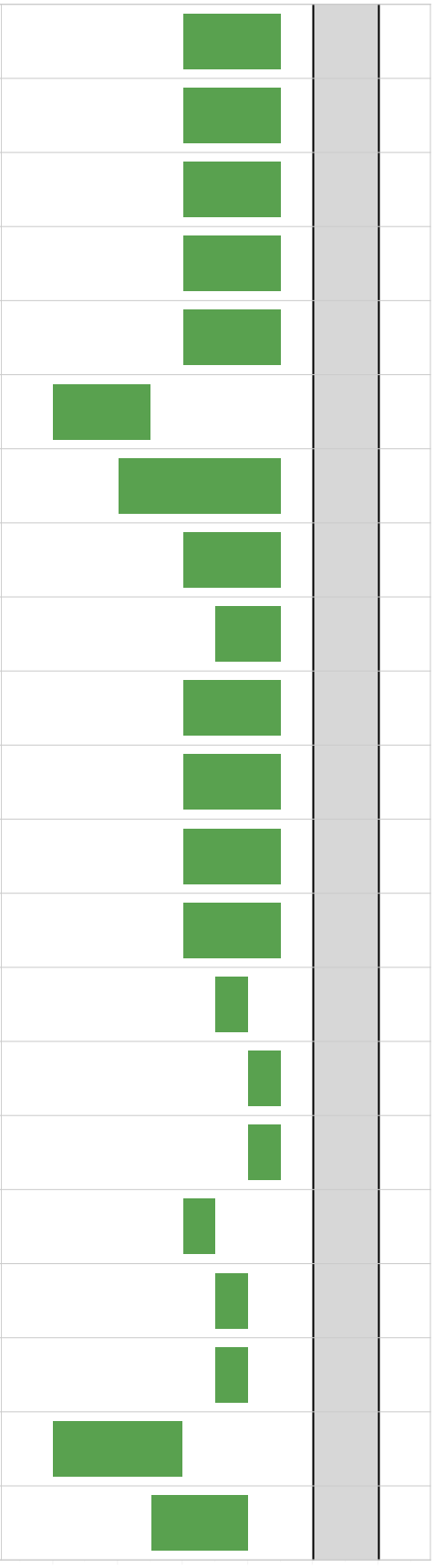


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (IP013121)
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 servic..		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* 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)	Report on value-based metrics that will be in MCO contracts (Recommended Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	QI methods are used to improve care and care delivery (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* Implementation Partners
	Incentivize value-based payment arrangements with MCOs (Tactic in PHBH and CBOSS‡ Change Plans)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ 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 (Recom..		None	Biannual report of progress on this work step and any associated intermediary measures	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, including ment..	Convene 3CCORP Steering Committee, Prevention Workgroup, Treatment Workgroup and Overdose Prevention Workgroup on a regular basis to guide the work of Project 3A		Director of Community and Tribal Partnership	Semi-annual to monthly 3CCORP meetings, agendas and meeting minutes, regional opioid response plan, completion and maintenanc..	None
	3CCORP members present accomplishments at Regional Opioid Summit(s)		None	Regional Opioid Summit(s)	3CCORP members***
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)	Train providers on screening for oral health needs and engagement with oral health provider (Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	Receive technical assistance from Arcora Foundation and/or Qualis Health to assist Implementation Partners in identifying care team members and integrating oral health scre..		Arcora Foundation	Standard operating procedure to screen and refer to an oral health provider identified at site visit	None
	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* Implementation Partners
	Assess progress on workflow integration at site visit		Program Manager	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	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		Director of Community and Tribal Partnership	Survey results	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		None	Documented QI strategies for referral process to recovery services	3CCORP Treatment Workgroup
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)	PHBH Implementation Partner bi-annual reporting on required QI Outcome in Change Plan		Program Manager	Bi-annual reporting	None
	Implement reporting policies and practices to ensure complete and timely Change Plan reporting		Director of Programs	PHBH Change Plan progress to date and quantitative reports	None
	Host OCH Performance, Measurement and Evaluation Committee (PMEC) meetings to review regional data		Data Lead	Quarterly PMEC materials and minutes	PMEC^^
	Establish procedures for and carry out QIP		Director of Programs	Scheduled biannual site visits by OCH staff biannual quantitative and qualitative data submitted by PHBH and CBOSS Implementation..	PHBH* and CBOSS^ Implementation Partners
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	Work with CSI (contracted vendor) to develop online platform for communication, resource sharing and reporting		Director of Programs	ORCA	None
	Solicit feedback on ORCA from PHBH, CBOSS and Shared Change Plan Partners		Program Manager	Site visit meeting minutes	None

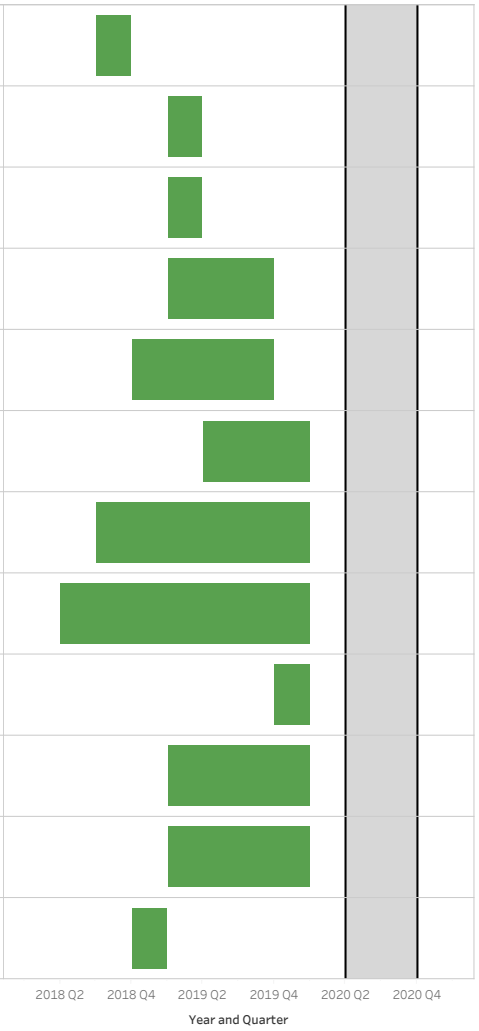


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization (IP013121)
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		Program Coordinator	Registered list of partners on ORCA	None
	Develop streamlined qualitative and quantitative reporting templates on ORCA for bi-annual reporting		Director of Programs	Online reporting templates	None
	Develop strategy to increase traffic and activity on ORCA		Communications and Development Coordinator	Communications plan	None
Regional self-identified milestone: Align monitoring of implementation progress of MTP with other ACHs	Review and potentially refine OCH intermediary metrics with members of the PMEC to identify opportunities for alignment with other ACHs		Data Lead	List of metrics and their specifications	None
	Contribute to cross-ACH repository of intermediary metrics to monitor implementation		Data Lead	List of metrics and their specifications	None
Regional self-identified milestone: Health equity considerations are incorporated in implementation of Outcomes and Tactics	Review patient/client data by subpopulations to identify and track inequities (Tactic in PHBH and CBOSS‡ Change Plans)		None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* and CBOSS^ Implementation Partners
	Regional health equity survey results are summarized and presented to the OCH Board, Committees, Natural Communities of Care convenings and staff meetings		Data Lead	Presentations	None
	PHBH and CBOSS Implementation Partners and Shared Change Plan Partners are surveyed regularly regarding health equity strengths and gaps; gaps are addressed		Data Lead	Regional health equity data	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	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		Executive Director	Reports recommendations	None
	Ensure every tribal nation within the three-county region has a designated seat on the OCH board of directors with opportunities to actively participate as they choose		Executive Director	OCH Board of Directors list	None
	Ensure a community-based organization representative has a designated seat on the OCH board of directors with opportunities to actively participate and represent sector		Executive Director	OCH Board of Directors list	None
	Determine appropriate sector representation and convene CTAC		Director of Community and Tribal Partnership	CTAC charter	None

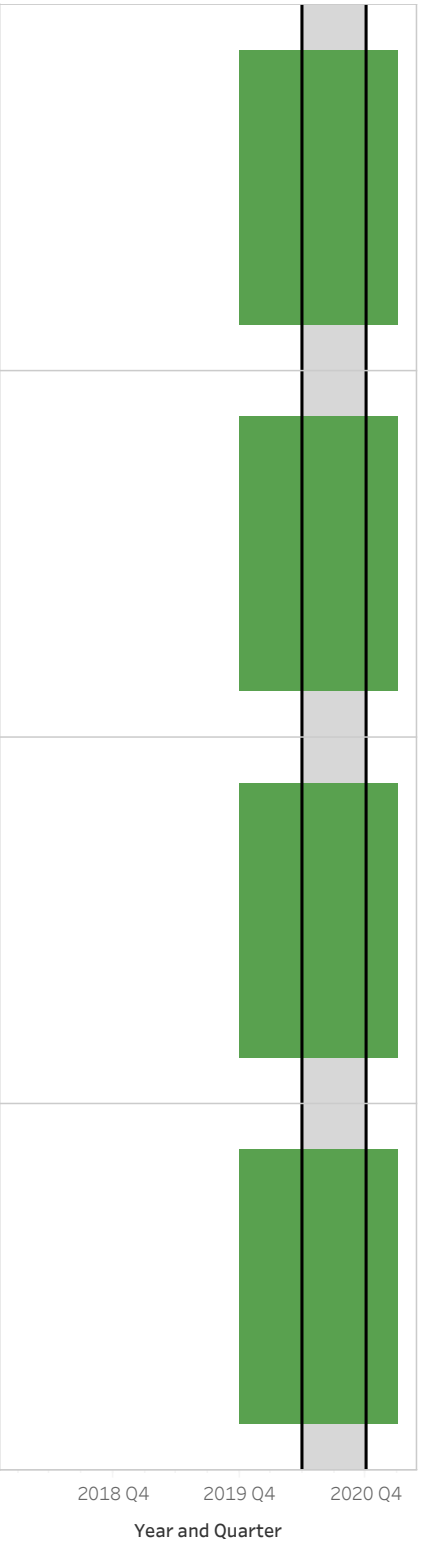


* Denotes change from previous Implementation Plan

Status Update
Completed, Deliverable Met

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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 a common or interoperable EHR or EBHR (Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
	Explore a shared population health management system within Natural Community of Care (Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners and interested Shared Change Plan 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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation 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		Program Coordinator	Communications and meetings	None

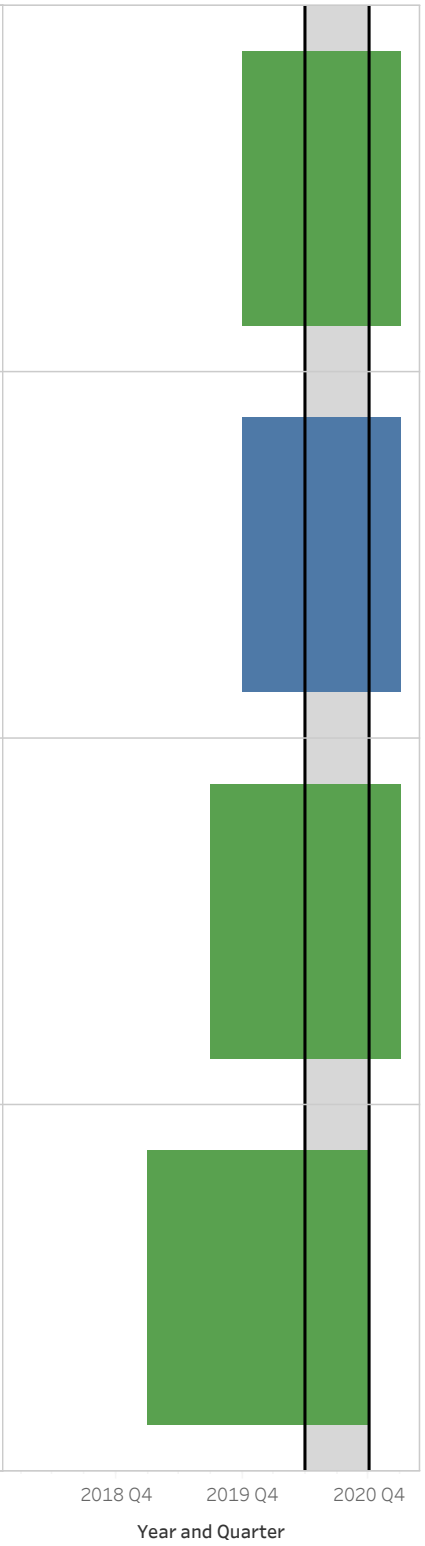


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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		None	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	Select PHBH* and CBOSS^ Implementation Partners
	Scale fully implemented Outcomes and Tactics in PHBH and CBOSS‡ Change Plans		None	PHBH and CBOSS‡ Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	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 partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges (Completion no later than DY 4, Q4)	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)		Executive Director	Participation of new partners in OCH-hosted events, committees and workgroups	None
	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		None	Identification of high-need areas	3CCORP Steering Committee

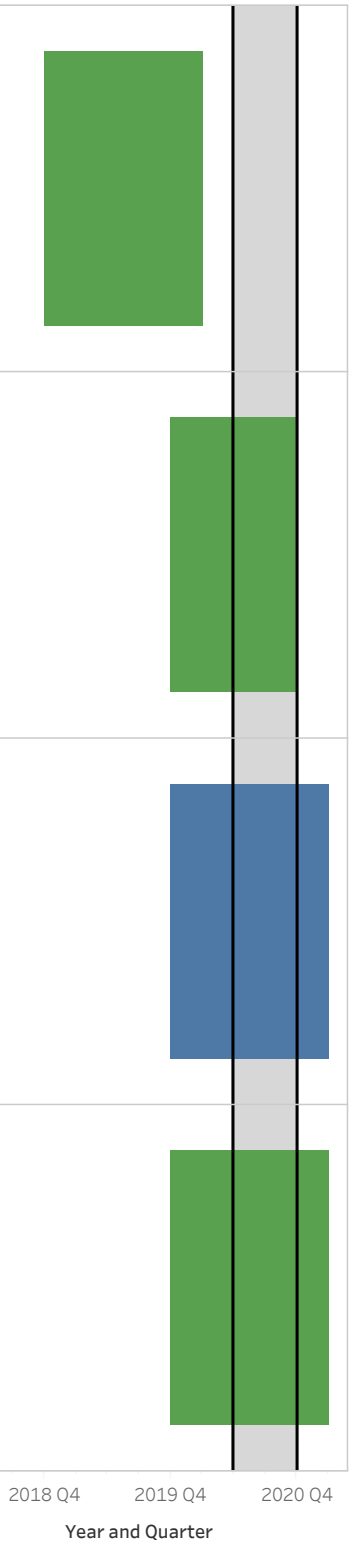


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Convene Regional Opioid Summit(s) for existing partners as well as new partners		Director of Community and Tribal Partnership	Regional Opioid Summit roster	None
	Identify new local efforts to address the opioid public health crisis to share expertise and resources		None	Roster of regional coalitions and efforts	3CCORP Steering Committee
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)	Coordinate with a mobile dental clinic (Tactic in PHBH and CBOSS‡ Change Plans)		None	PHBH and CBOSS‡ Change Plans indicate progress towards this work step, updated biannually	Select PHBH* and CBOSS^ Implementation Partners and interested Shared Change Plan Partners **
	Deepen partner engagement, continue outreach efforts to invite new partners to convenings and trainings		Executive Director	Convening/ training participant lists	None

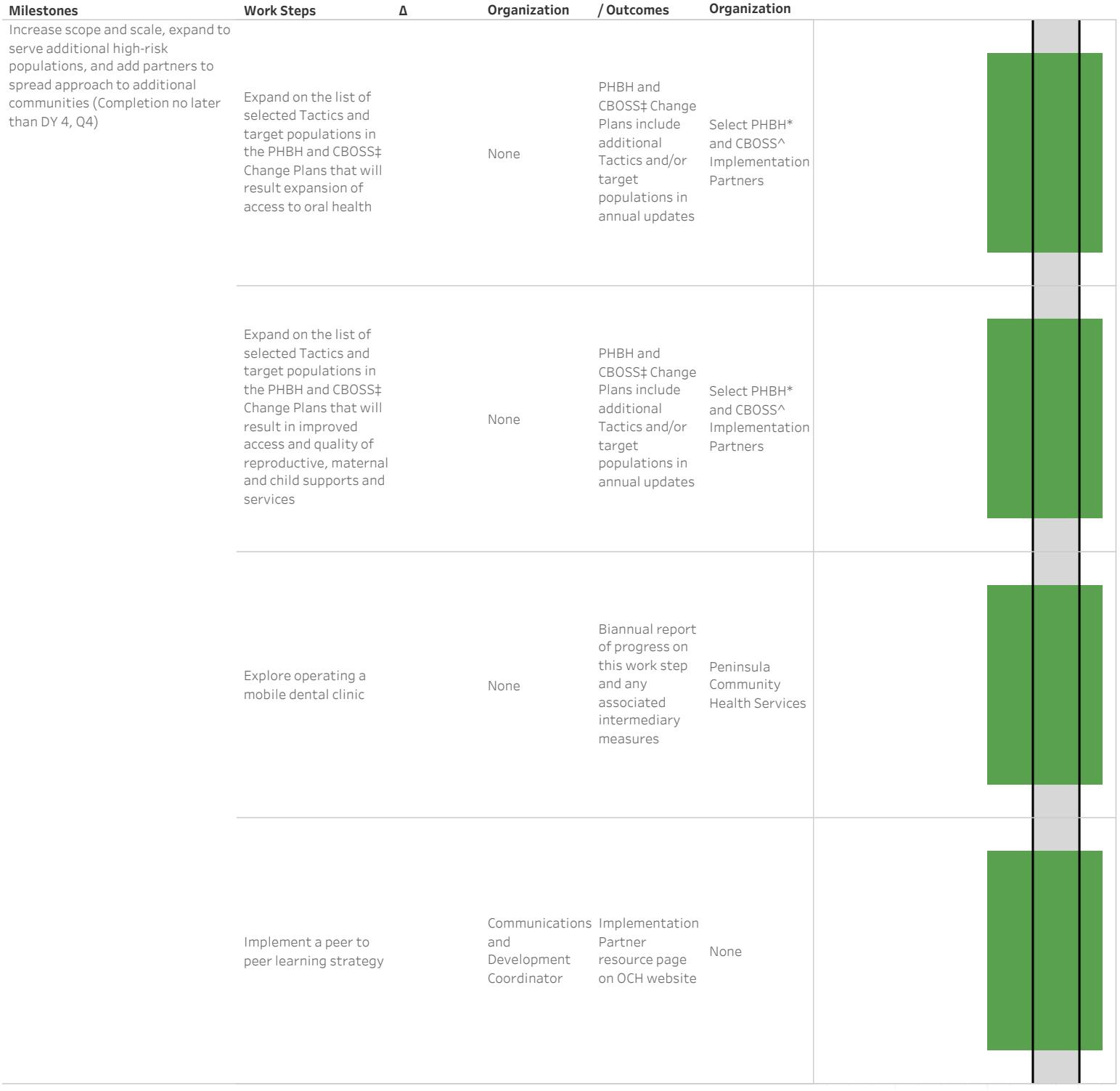


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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 expansion of access to oral health		None	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	Select PHBH* and CBOSS^ Implementation Partners
	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		None	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	Select PHBH* and CBOSS^ Implementation Partners
	Explore operating a mobile dental clinic		None	Biannual report of progress on this work step and any associated intermediary measures	Peninsula Community Health Services
	Implement a peer to peer learning strategy		Communications and Development Coordinator	Implementation Partner resource page on OCH website	None

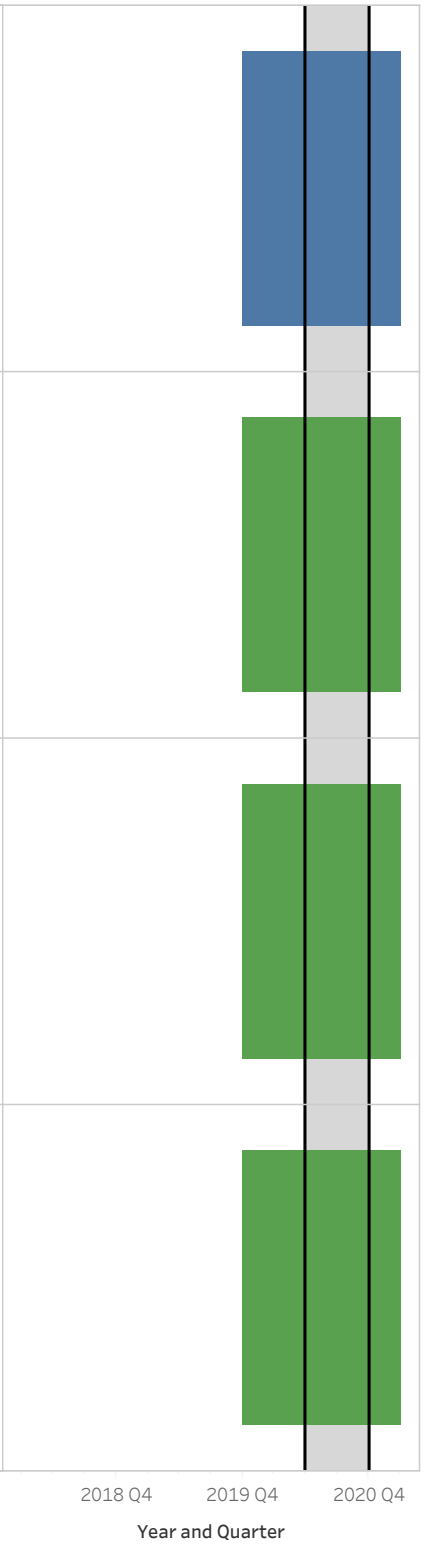


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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		None	PHBH and CBOSS‡ Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	Select PHBH* and CBOSS^ Implementation Partners
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)	Implement value-based payment arrangements with MCOs (Tactic in PHBH and CBOSS‡ Change Plans)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Report on value-based metrics that will be in MCO contracts (Recommended Tactic in PHBH Change Plan)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners
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	Build comprehensive partner resources page on OCH website		Communications and Development Coordinator	Partner Resources page	None

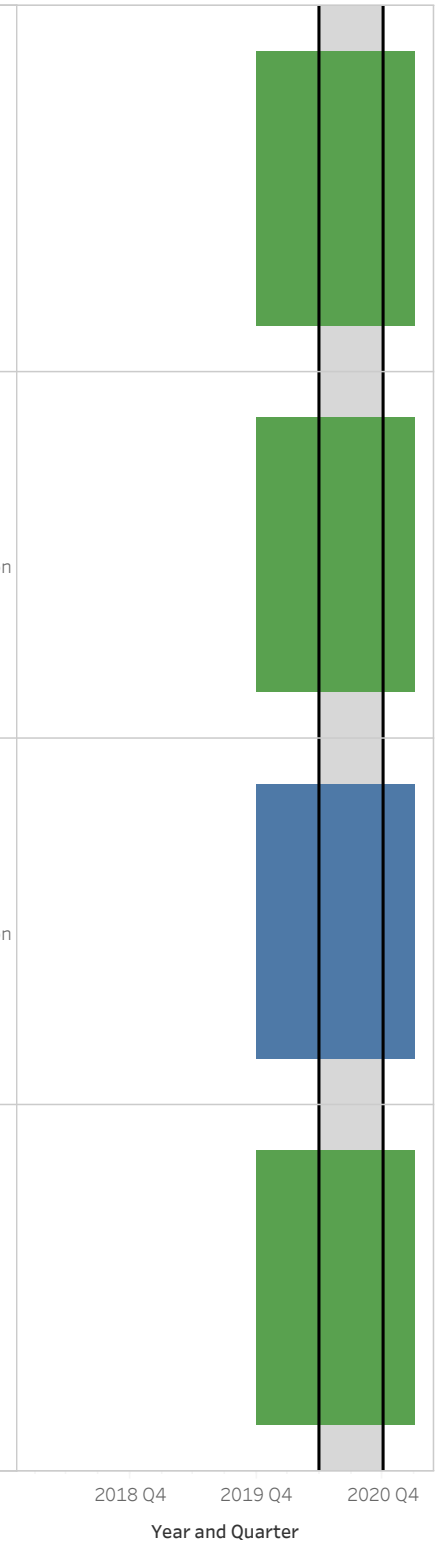


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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		Executive Director	Convening/ training participant lists	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		None	PHBH and CBOSS‡ Change Plans include additional Tactics and/or target populations in annual updates	Select PHBH* and CBOSS^ Implementation Partners
	Scale fully implemented Outcomes and Tactics in PHBH and CBOSS‡ Change Plans		None	PHBH and CBOSS‡ Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	Select PHBH* and CBOSS^ Implementation Partners
Identify new, additional target providers/organizations (Completion no later than DY 4, Q4)	Build comprehensive partner resources page on OCH website		Communications and Development Coordinator	Partner Resources page	None

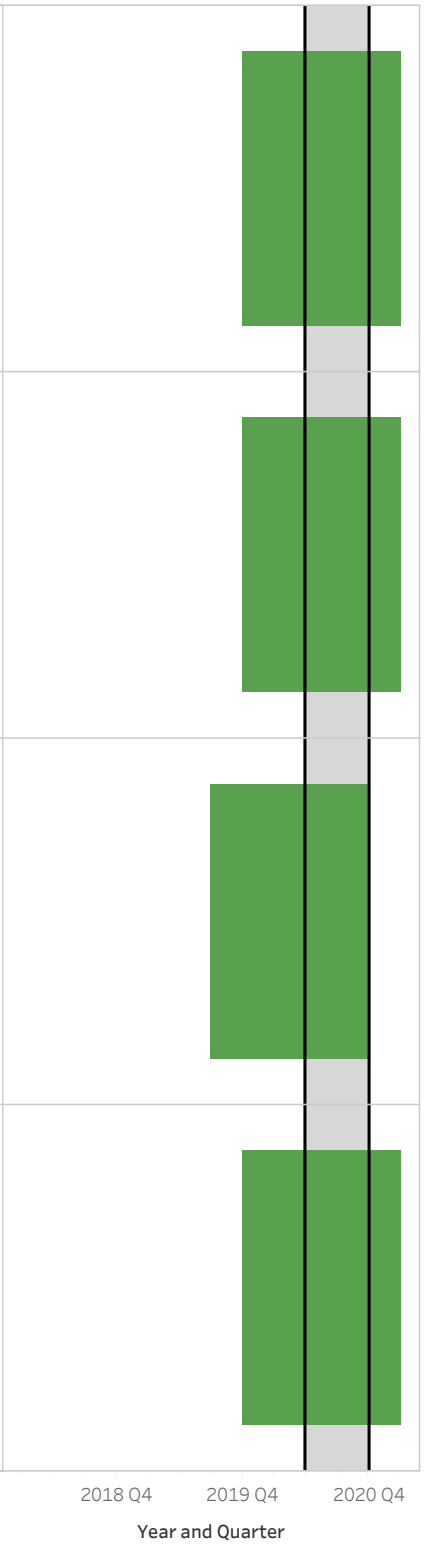


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization
Identify new, additional target providers/organizations (Completion no later than DY 4, Q4)	Deepen partner engagement, continue outreach efforts to invite new partners to convenings and trainings		Executive Director	Convening/ training participant lists	None
	Submit additional Change Plan types (e.g. Primary Care partner submitting Behavioral Health Change Plan once integration is implemented)		None	Additional Change Plans	Select PHBH* Implementation Partners
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)	Communicate performance to Implementation Partners		Program Manager	Performance reports/ dashboard, site visit materials	None
	Continuously employ QI approach to track progress on metrics and project implementation	*	Data Lead	Monitoring reports	OCH Board of Directors

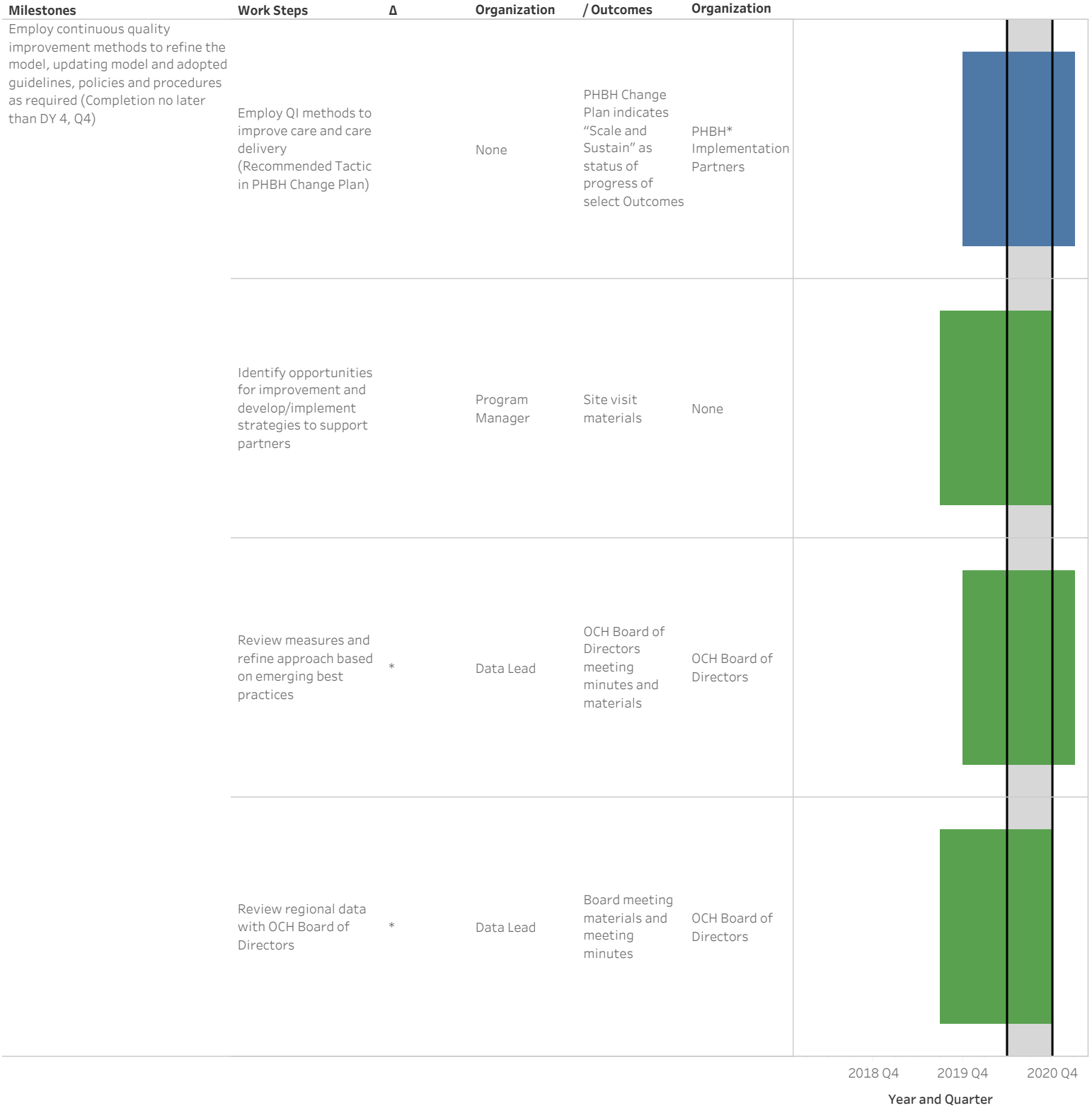


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)		None	PHBH Change Plan indicates "Scale and Sustain" as status of progress of select Outcomes	PHBH* Implementation Partners
	Identify opportunities for improvement and develop/implement strategies to support partners		Program Manager	Site visit materials	None
	Review measures and refine approach based on emerging best practices	*	Data Lead	OCH Board of Directors meeting minutes and materials	OCH Board of Directors
	Review regional data with OCH Board of Directors	*	Data Lead	Board meeting materials and meeting minutes	OCH Board of Directors

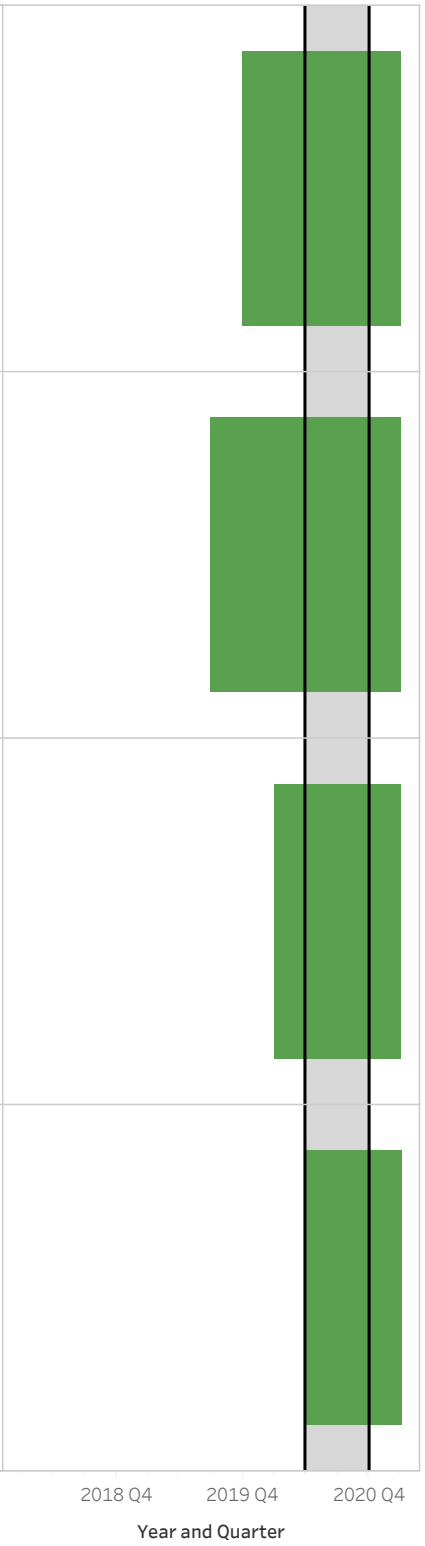


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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		None	PHBH and CBOSS‡ Change Plan progress to date and quantitative reporting are complete and timely	PHBH* and CBOSS^ 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)	Discuss data updates with 3CCORP		Data Lead	Meeting materials/ minutes	None
	Discuss data with PHBH and CBOSS Implementation Partners to inform decisions about strategies and/or spread		Program Manager	Meeting materials	None
	Discuss new data and possible strategy and/or spread opportunities with 3CCORP and PHBH and CBOSS Implementation Partners		Program Coordinator	Meeting materials/ minutes	3CCORP*** and PHBH* and CBOSS^ Implementation Partners

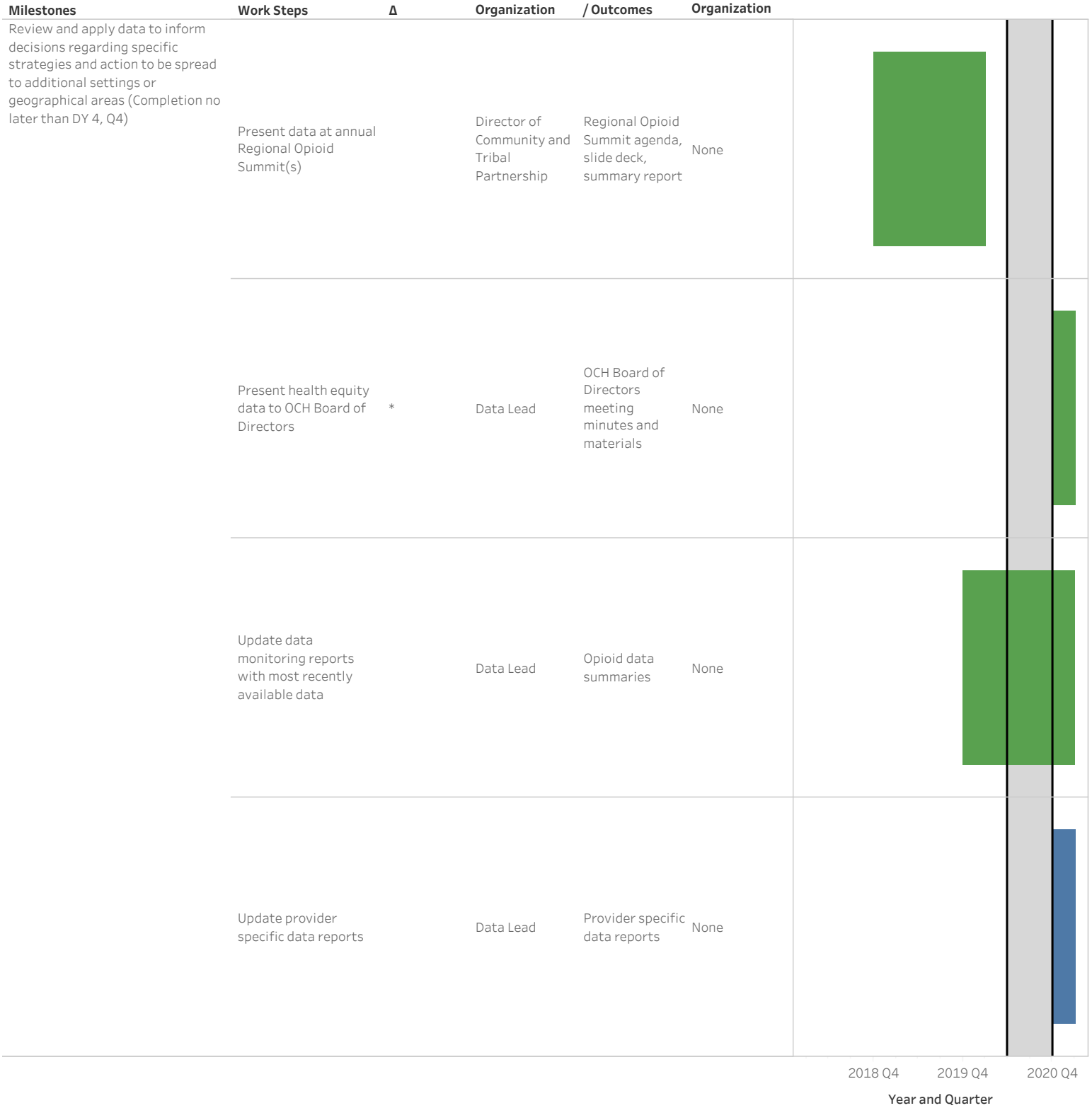


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Present data at annual Regional Opioid Summit(s)		Director of Community and Tribal Partnership	Regional Opioid Summit agenda, slide deck, summary report	None
	Present health equity data to OCH Board of Directors	*	Data Lead	OCH Board of Directors meeting minutes and materials	None
	Update data monitoring reports with most recently available data		Data Lead	Opioid data summaries	None
	Update provider specific data reports		Data Lead	Provider specific data reports	None

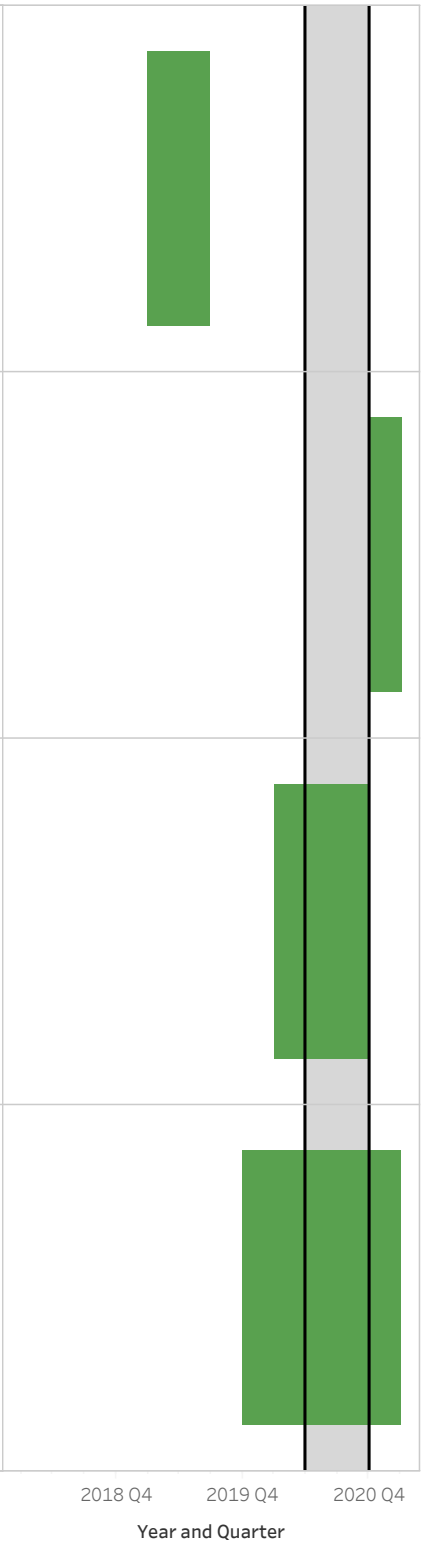


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Collaborate with Qualis Health to continue coach facilitator services		Director of Programs	Contract with Qualis	None
	Continue to support partners in advancement of health equity through QI activities, evaluation and the procurement of resources to assist progress	*	Program Manager	Training materials, assessments, and survey results	None
	Evaluate and update training plan based on feedback from QI process to respond to evolving partner needs		Program Manager	Training Plan	None
	Include topical breakout sessions and/or training at Natural Community of Care convenings		Program Manager	Convenings	None

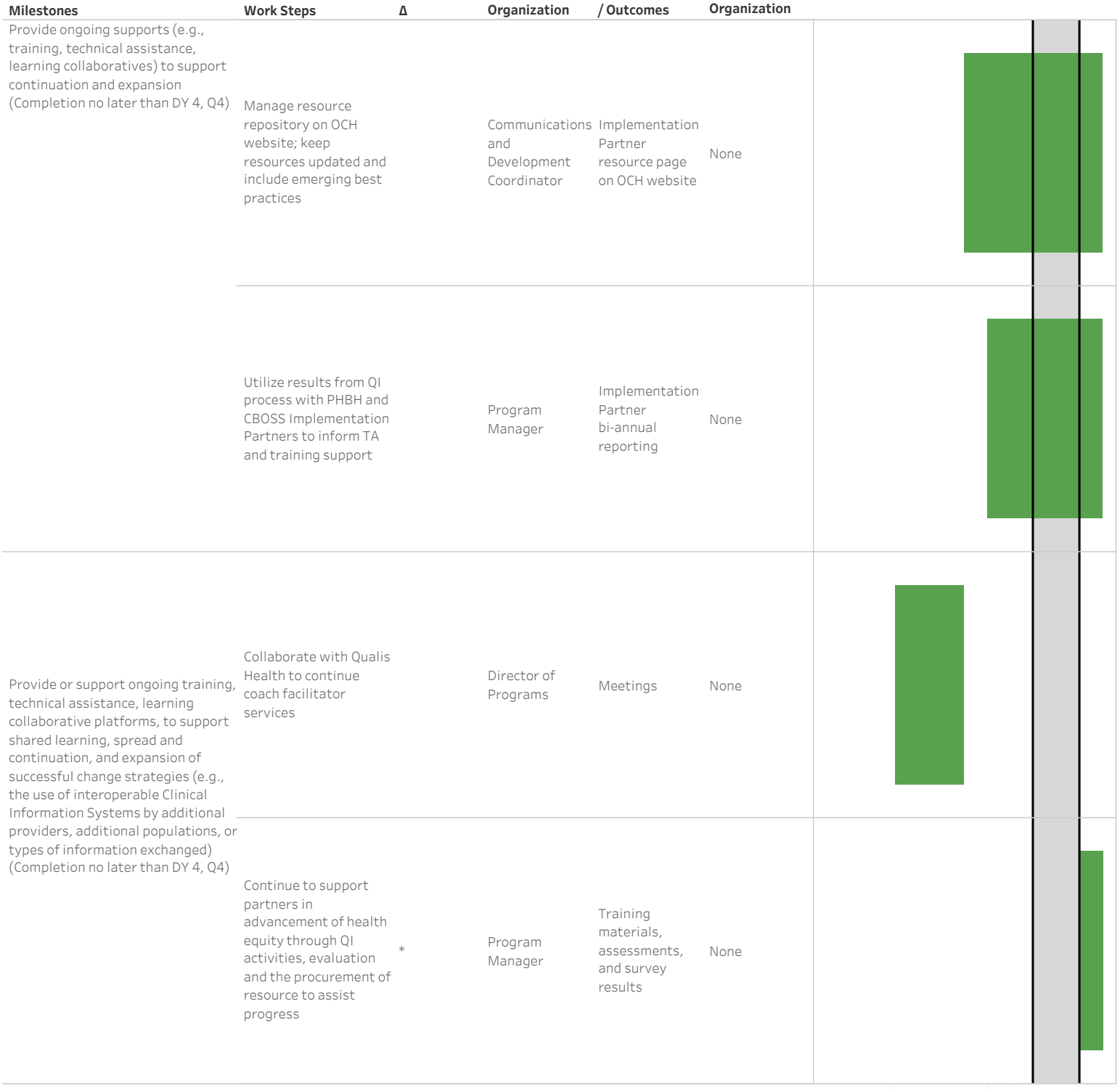


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Manage resource repository on OCH website; keep resources updated and include emerging best practices		Communications and Development Coordinator	Implementation Partner resource page on OCH website	None
	Utilize results from QI process with PHBH and CBOSS Implementation Partners to inform TA and training support		Program Manager	Implementation Partner bi-annual reporting	None
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		Director of Programs	Meetings	None
	Continue to support partners in advancement of health equity through QI activities, evaluation and the procurement of resource to assist progress	*	Program Manager	Training materials, assessments, and survey results	None

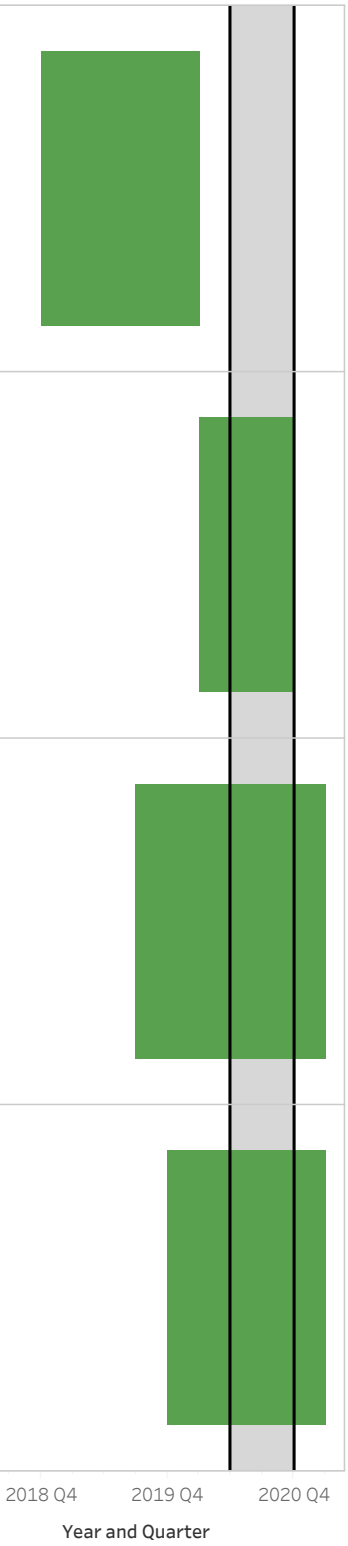


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Develop regional Behavioral Health Academy to train workforce in transitioning to integrated care		Qualis Health Practice Coach Connector	Training modules	None
	Evaluate and update training plan based on feedback from QI process to respond to evolving partner needs		Program Manager	Training Plan	None
	Maintain comprehensive Implementation Partner resource page on OCH wesbite; keep resources updated and include emerging best practices		Communications and Development Coordinator	Implementation Partner resource page on OCH website	None
	Provide space for partners to discuss shared learning, challenges, and best practices in chronic disease.	*	Program Manager	Convenings	None

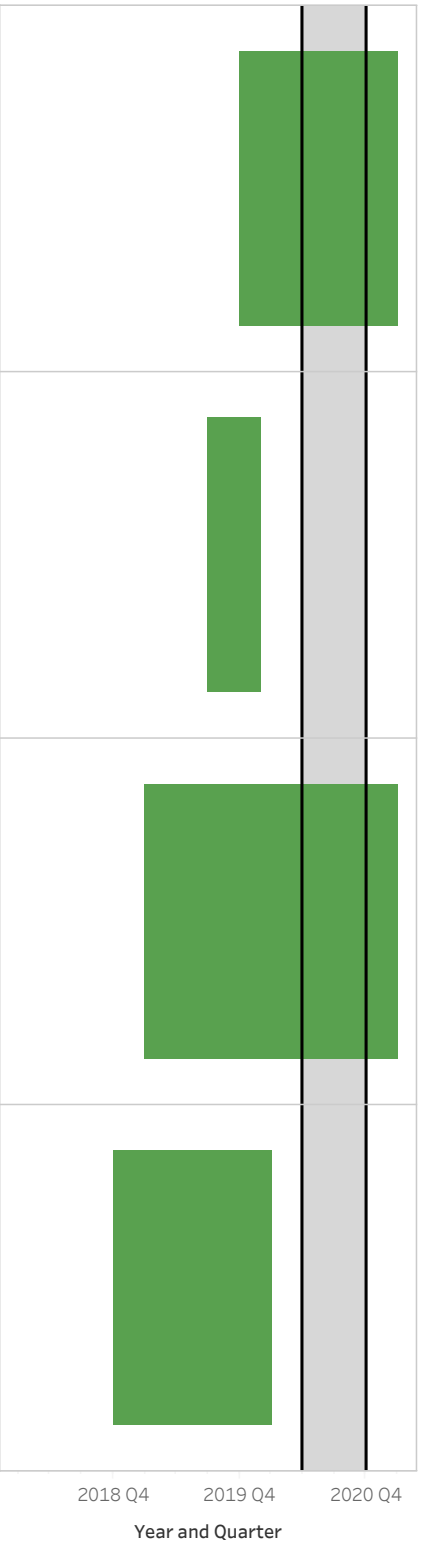


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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		Program Manager	Implementation Partner bi-annual reporting	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)	Collaborate with DOH to provide TA and training to recognize and appropriately respond to opioid related overdoses		Director of Community and Tribal Partnership	Overdose response training	None
	Collaborate with University of Washington to implement 6 Building Blocks for improved opioid prescribing in clinics in the region		Executive Director	Clinics participate in 6 Building Blocks	None
	Convene Regional Opioid Summit(s) to deliver training and identify technical assistance needs and new partnership opportunities		Director of Community and Tribal Partnership	Regional Opioid Summit(s)	None

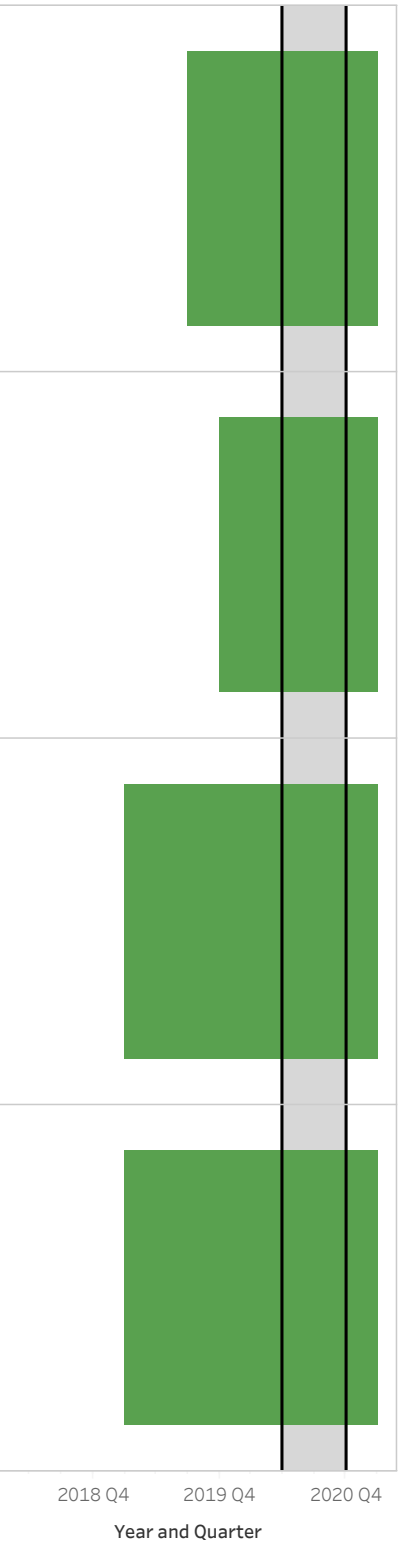


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Maintain comprehensive Implementation Partner resource page on OCH wesbite; keep resources updated and include emerging best practices		Communications and Development Coordinator	Implementation Partner resource page on OCH website	None
	Utilize results from QI process with PHBH and CBOSS Implementation Partners to inform TA and training supports		Program Manager	Implementation Partner bi-annual reporting	None
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		Program Manager	Presentations at Natural Community of Care Convenings	None
	Facilitate opportunities for regional champions to spread best practices		Communications and Development Coordinator	Presentations, resources on OCH website, newsletters	None

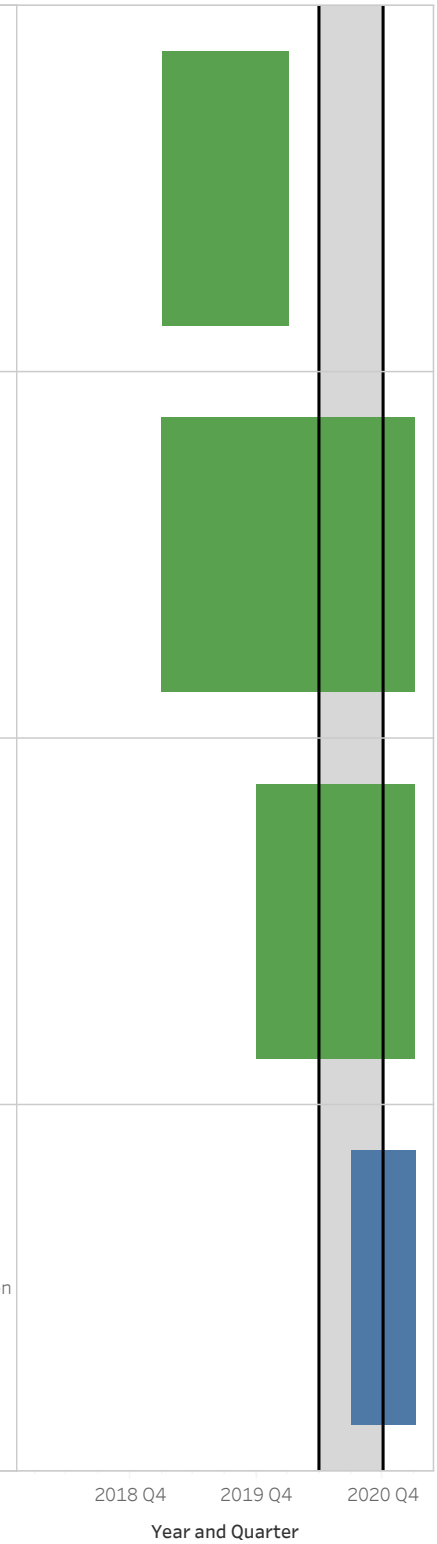


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Identify regional champions		Director of Programs	List of regional champions	None
	Interview regional champions to learn promising practices		Communications and Development Coordinator	Published partner spotlight success stories	None
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		Program Coordinator	Meeting materials	None
	Establish real-time exchange of health information between providers for bidirectional referral and care coordination for shared patient with OUD under the Olympic Digital HIT Commons or similar technology platform		None	E-referral technology platform	Select PHBH* Implementation Partners

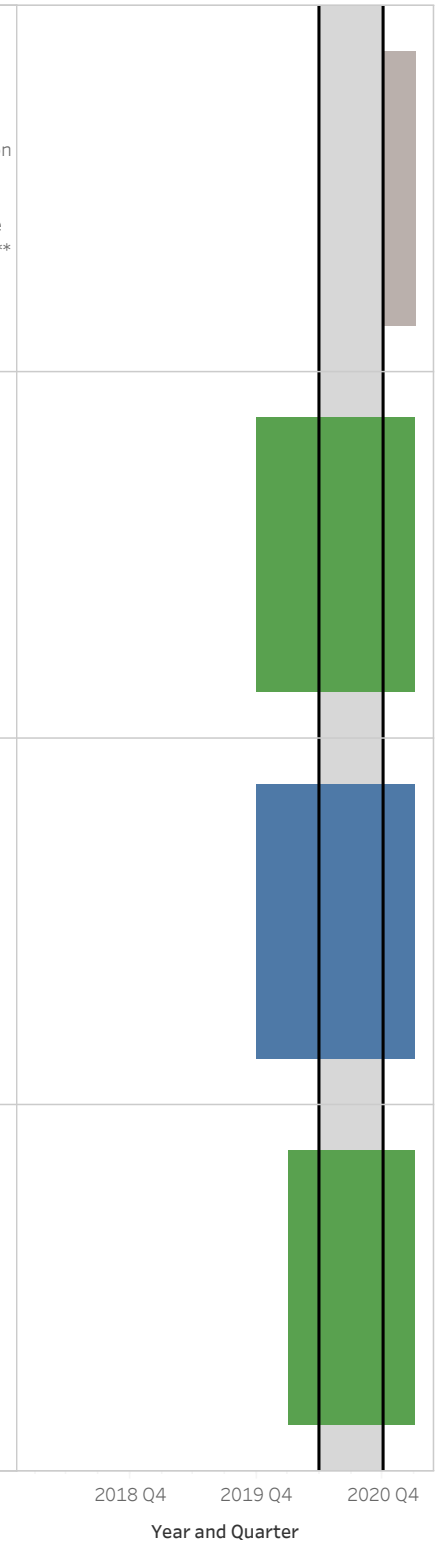


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Scale Olympic Digital HIT Commons or similar technology platform to new partners and use cases		None	E-referral technology platform participant list	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)	Advocate with other ACHs for Medicaid reimbursement codes that will directly support Change Plan Outcomes and Tactics		Executive Director	Meet with ACH EDs, legislators, MCOs and State partners	None
	Educate lawmakers, State partners, and payers on barriers to sustainability due to scope of practice, billing, coding and HIT constraints		Executive Director	Meet with ACH EDs, legislators, MCOs and State partners	None
	Explore rural global payment strategies		Executive Director	Meet with HCA and hospital partners	None

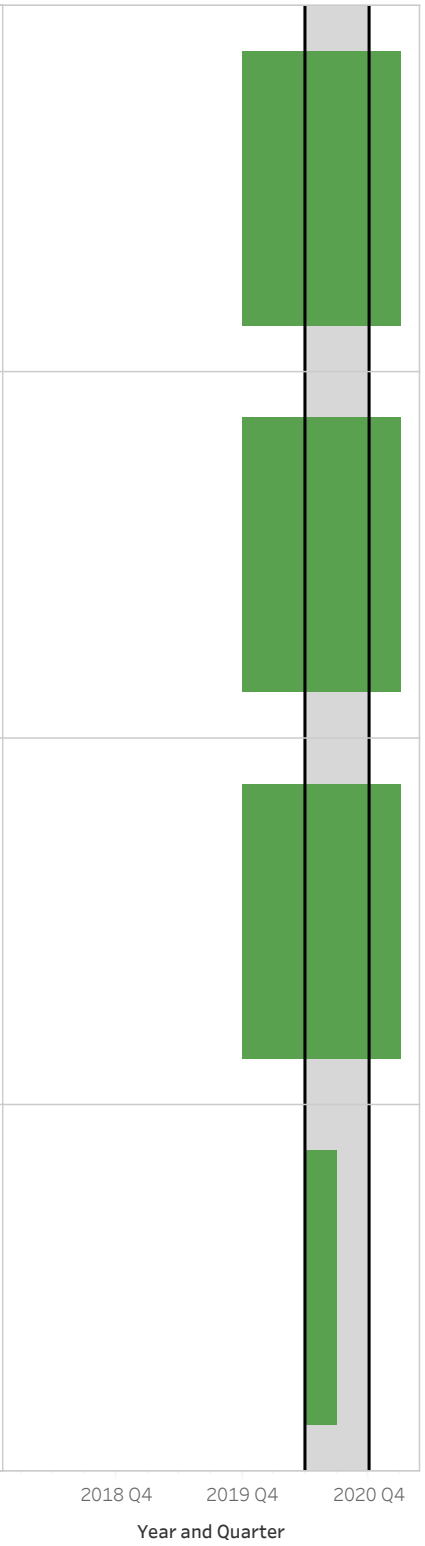


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization
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)		None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners
	Support statewide efforts to address rural workforce shortages		Executive Director	Information sharing with WSHA and WA Health Workforce Sentinel Network	None
Regional self-identified milestone: MAT Providers and SUD Providers are closely networked for referral and coordination of treatment for shared patients with opioid use disorder	Deepen engagement with MAT prescribers and SUD providers and convene together to facilitate coordination		None	Meeting materials	3CCORP Steering Committee
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		None	Regional standards of practice for treatment of OUD	3CCORP Treatment Workgroup

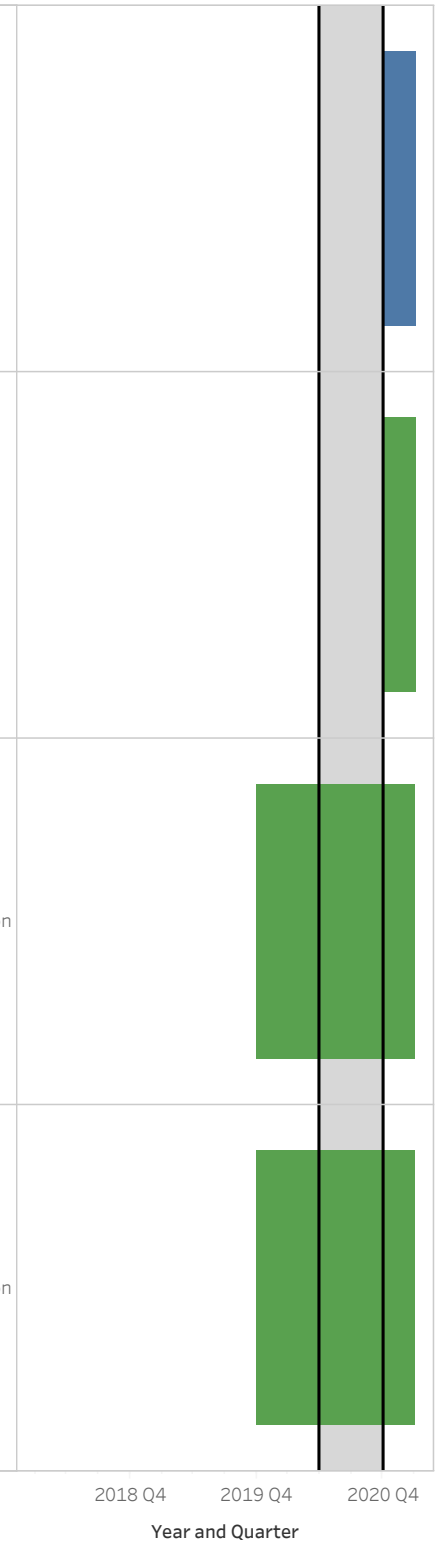


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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)	Disseminate regional standards of practice		None	Regional standards of practice for treatment of OUD are shared region-wide	3CCORP Steering Committee
	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		None	Annual review and update as needed based on current best practices	3CCORP Treatment Workgroup
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		None	PHBH Change Plan includes additional Tactics in annual updates	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		None	PHBH Change Plan includes additional target subpopulations in annual updates	Select PHBH* Implementation Partners

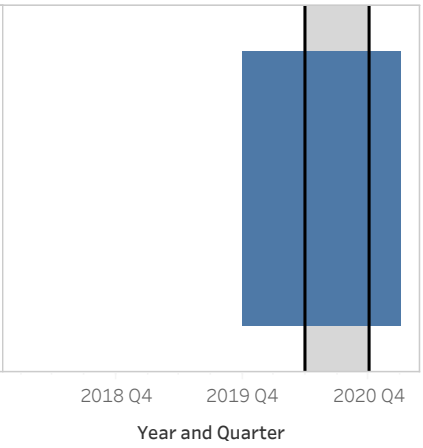


* Denotes change from previous Implementation Plan

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

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	Δ	ACH Organization	Key Deliverables / Outcomes	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		None	PHBH and CBOSS‡ Change Plans indicate "Scale and Sustain" as status of progress of select Outcomes	Select PHBH* and CBOSS^ Implementation Partners



* Denotes change from previous Implementation Plan

Status Update

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