





Implementation Plan Timeline: Stage 1

Milestones	Work Steps	ACH Organization	Key Deliverables/ Outcomes	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)	Complete PHBH and CBOSS‡ Change Plans	None	Completed PHBH and CBOSS‡ Change Plans	PHBH* and CBOSS^ Implementation Partners	2019 Q1
	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	2019 Q1
	Identify interest in shared EHR, EBHR and/or population health management systems	None	PHBH Change Plan indicates preference, updated annually	PHBH Implementation Partners	2019 Q1
	Identify preferred technical assistance vendors from Implementation Partners	Data Lead	OCH Current State Assessment results	None	2019 Q1
	Identify shared training opportunities with other ACHs (including health equity training)	Executive Director	Work plan with Artemis consulting	None	2019 Q1 - 2020 Q1
	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	2019 Q1 - 2020 Q1
	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	2019 Q1
	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	2019 Q1

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Status Update
 Completed, Deliverable Met

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Milestones	Work Steps	ACH Organization	Key Deliverables/ Outcomes	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)	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	
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)	None	PHBH Implementation Partners select this Tactic in their PHBH Change Plan	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)	None	PHBH Implementation Partners select this Tactic in their PHBH Change Plan	Select PHBH* Implementation Partners	

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Status Update
 Completed, Deliverable Met

Implementation Plan Timeline: Stage 2









Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	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	Qualis Health Practice Coach Connector	List of Outcomes and Tactics in PHBH and CBOSS Change Plans	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	Director of Programs	List of new promising guidelines, policies, procedures and protocols related to PHBH and CBOSS Change Plan activities	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	
	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	
	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	
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	Data Lead	PMEC materials	PMEC^^	
	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)	Data Lead	Quality Improvement Plan (QIP) with measure set	None	
	Establish procedures for the QIP	Director of Programs	Site visits and QIP reporting	None	
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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
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)	None	PHBH Change Plan progress to date reporting indicates progression of QI implementation, updated biannually	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)	None	PHBH and CBOSS‡ Change Plan progress to date and quantitative reporting are complete and timely	Select PHBH* and CBOSS^ Implementation Partners	
	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	
	Work with Performance, Measurement and Evaluation Committee (PMEC) to review QI approach and finalize measure set	Data Lead	Recommended measure set	PMEC ^^	
	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 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)	Executive Director	Contractual agreements	None	

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
	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	2019 Q1
		Director of Programs	Site visit report with recommendations	None	2019 Q1
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)	Make trainings available to partners	Community Program Coordinator	Training	None	2020 Q1
	Participate in trainings	None	Training	PHBH* and CBOSS^ Implementation Partners and interested Shared Change Plan** Partners	2020 Q1
	Recommend available trainings and technical assistance	P-TCPI Coach Facilitator	Communications	None	2019 Q1
		Director of Programs	Communications	None	2019 Q1
	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	Director of Programs	Implementation Partner readiness matrix	None	2019 Q1
	Upload recordings, materials, webinars of trainings on OCH website	Communications and Development Coordinator	Partner Resource page on OCH website	None	2020 Q1
					2021 Q1

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
	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 Assessment, findings from site visits and QIP reporting	None	
	Offer QI check-ins to help evaluate progress	P-TCPI Coach Facilitator	QI meeting	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)	Qualis Health Practice Coach Connector	QI meeting	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 Assessment, findings from site visits and QIP reporting	PHBH* and CBOSS^ Implementation Partners	
	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	
	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, participation of Shared Change Plan Partners	PHBH* 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, participation of Shared Change Plan Partners	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)	None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, participation of Shared Change Plan Partners	Select CBOSS^ Implementation Partners and interested Shared Change Plan Partners**	
	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)				
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Implementation Plan Timeline: Stage 2









Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization			
Implement selected strategies/approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports (Completion no later than DY 3, Q4)	Educate clients on safe 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, participation of Shared Change Plan Partners	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, participation of Shared Change Plan Partners	Select CBOSS^ 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; participation of Shared Change Plan Partners	Select CBOSS^ 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, participation of Shared Change Plan Partners	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 Change Plan)	None	Biannual report of progress on this work step and any associated intermediary measures by PHBH Implementation Partners, participation of Shared Change Plan Partners	Select PHBH* 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, participation of Shared Change Plan Partners	Select PHBH* 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)	None	Biannual report of progress on this work step and any associated intermediary measures by CBOSS Implementation Partners, participation of Shared Change Plan Partners	Select CBOSS^ 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			
Implement bi-directional communications strategies/interoperable HIE tools to support the care model (Completion no later than DY 3, Q4)							
					2019 Q1	2020 Q1	2021 Q1
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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
Implement bi-directional communications strategies/interoperable HIE tools to support the care model (Completion no later than DY 3, Q4)	Integrate dental records into the medical EHR (Tactic in PHBH Change Plan)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* 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	
	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	
	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	
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)	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	
	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	
	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	
	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)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* Implementation Partners	
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Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client and family/caregivers, have access to the information appropriate to their role in the team and the care plan) (Completion no later than DY 3, Q4)	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			
	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			
	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			
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: <ul style="list-style-type: none"> • 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) 	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			
	Form bi-directional referral system within the Natural Community of Care between clinical and community partner for effective chronic care services; refer to appropriate programs depending on patient profile (Recommended Tactic in the PHBH Change Plan)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* 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 Change Plan)	None	Biannual report of progress on this work step and any associated intermediary measures	PHBH Implementation Partners			
	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			
Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	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			









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Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	Facilitate alignment with Arcora Foundation and available medical/dental integration practice coaching	Program Manager	Arcora Foundation representative participates in NCC convenings	None	
	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	
	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	
	Convene learning sessions as needed to support partners to implement tools	Community Program Coordinator	Agendas, meeting minutes, and materials from learning sessions	None	
	Distribute learnings and updates from PreManage learning collaborative	Program Manager	Tools from PreManage learning collaborative	None	
	Distribute State consent management workgroup materials to BHA and SUD partners	Program Manager	Output from State consent management workgroup	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)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners	
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	
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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)	Facilitate workflow mapping with Implementation Partners to assess care gaps in technology	Qualis Health Practice Coach Connector	Workflow maps	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	
Review final PHBH Change Plans and crosscheck with Implementation Partner readiness matrix (for integrated care activities) to identify partner needs	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	
	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	
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	Director of Community and Tribal Partnership	Workgroup meetings	None	
	Share recommendations from Bree Collaborative Opioid Workgroup	Director of Community and Tribal Partnership	Materials	None	
Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	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	









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Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	Standardize identification of and track individuals experiencing homelessness and/or food insecurity needing more efficient management and effective care (Recommended Tactic in PHBH Change Plan)	None	Biannual report of progress on this work step and any associated intermediary measures	PHBH* Select 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			
Establish mechanisms, including technology-enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs (Completion no later than DY 3, Q4)	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ 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			
	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)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* 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)	None	Biannual report of progress on this work step and any associated intermediary measures	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)	None	Biannual report of progress on this work step and any associated intermediary measures	PHBH 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			
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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)	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)	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			
	Sign Business Associate Agreements or equivalent with partners involved with the patient's care to support referrals OR sub-contract with community partners to ensure shared patients/clients receive appropriate services (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners			
	Sign inter-organizational agreements for access to records of referred and/or shared patients/clients (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	None	Biannual report of progress on this work step and any associated intermediary measures	Select PHBH* and CBOSS^ Implementation Partners			
	Streamline processes for information to be shared in a timely manner for shared patients/clients (Required Outcome in PHBH Change Plan)	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)	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)	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			
	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			
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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			
Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened (Completion no later than DY 3, Q4) -Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions. -Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges, and overall progress. -Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.	3CCORP members present accomplishments at Regional Opioid Summit(s)	None	Regional Opioid Summit(s)	3CCORP members***			
	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 maintenance of partnering provider roster	None			
	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			
	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 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	Arcora Foundation	Standard operating procedure to screen and refer to an oral health provider identified at site visit	None			
	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			
Establish referral relationships with dentists and other specialists, such as ENTs and periodontists (Completion no later than DY 3, Q4)							

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Implementation Plan Timeline: Stage 2

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
Establish referral relationships with dentists and other specialists, such as ENTs and periodontists (Completion no later than DY 3, Q4)	Train providers on screening for oral health needs and engagement with oral health provider (Tactic in PHBH Change Plan)	None	Biannual report of progress on this work step and any associated intermediary measures	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)	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	
	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	
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	Director of Programs	Scheduled biannual site visits by OCH staff biannual quantitative and qualitative data submitted by PHBH and CBOSS Implementation Partners	PHBH* and CBOSS^ Implementation Partners	
	Host OCH Performance, Measurement and Evaluation Committee (PMEC) meetings to review regional data	Data Lead	Quarterly PMEC materials and minutes	PMEC^^	
	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	
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	PHBH Implementation Partner bi-annual reporting on required QI Outcome in Change Plan	Program Manager	Bi-annual reporting	None	
	Develop strategy to increase traffic and activity on ORCA	Communications and Development Coordinator	Communications plan	None	









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 Completed, Deliverable Met

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
	Develop streamlined qualitative and quantitative reporting templates on ORCA for bi-annual reporting	Director of Programs	Online reporting templates	None	
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	
	Solicit feedback on ORCA from PHBH, CBOSS and Shared Change Plan Partners	Program Manager	Site visit meeting minutes	None	
	Work with CSI (contracted vendor) to develop online platform for communication, resource sharing and reporting	Director of Programs	ORCA	None	
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	Data Lead	List of metrics and their specifications	None	
	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	
	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: 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	Data Lead	Presentations	None	
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Status Update

 Completed, Deliverable Met

Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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	Completed, Deliverable Met
	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 **	Completed, Deliverable Met
	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	Completed, Deliverable Met
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	Completed, Deliverable Met
	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	Completed, Deliverable Met
	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	Fulfilled for Quarter, Remains in Progress
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	Completed, Deliverable Met

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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	
	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	
	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	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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			
	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			
	Build comprehensive partner resources page on OCH website	Communications and Development Coordinator	Partner Resources page	None			
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			

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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			Completed, Deliverable Met
	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			Fulfilled for Quarter, Remains in Progress
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			Completed, Deliverable Met
	Deepen partner engagement, continue outreach efforts to invite new partners to convenings and trainings	Executive Director	Convening/training participant lists	None			Completed, Deliverable Met
	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			Completed, Deliverable Met
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			Completed, Deliverable Met
	Continuously employ QI approach to track progress on metrics and project implementation	* Data Lead	Monitoring reports	OCH Board of Directors			Completed, Deliverable Met

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

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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	
	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	
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	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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	
	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	
	Develop regional Behavioral Health Academy to train workforce in transitioning to integrated care	Qualis Health Practice Coach Connector	Training modules	None	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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 website; 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	
	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	
	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	
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)	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	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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 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 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	
	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	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	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)	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	
	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	
	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	

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Implementation Plan Timeline: Stage 3

Milestones	Work Steps	ACH Organization	Key Deliverables / Outcomes	Partnering Provider Organization	
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	
	3CCORP Treatment Work Group to develop regional standards of practice	None	Regional standards of practice for treatment of OUD	3CCORP Treatment Workgroup	
	Disseminate regional standards of practice	None	Regional standards of practice for treatment of OUD are shared region-wide	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)	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	
	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	
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	

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