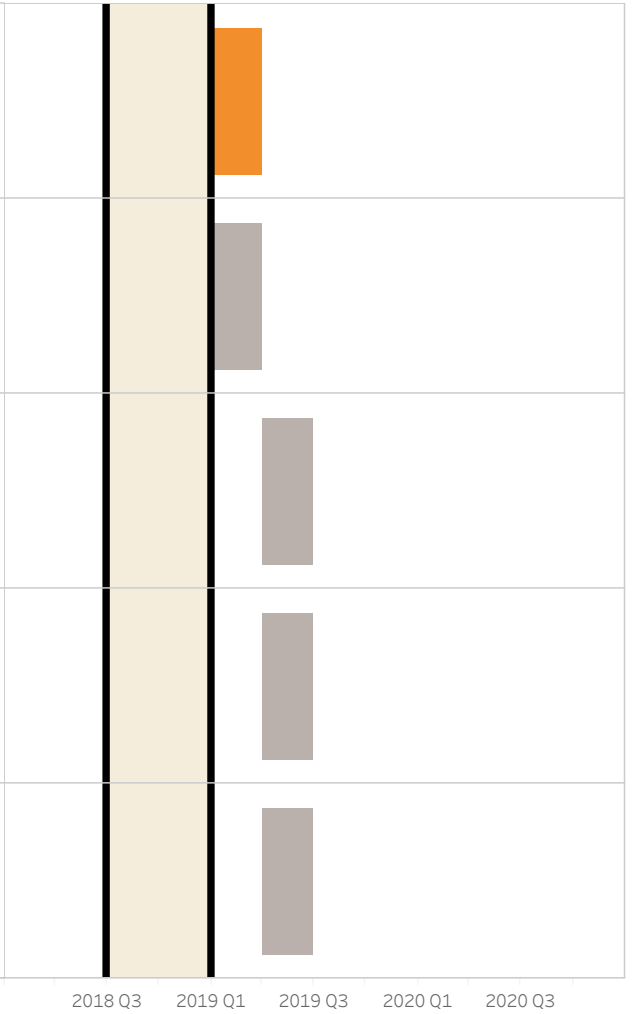
Implementation Plan Timeline: Stage 2

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



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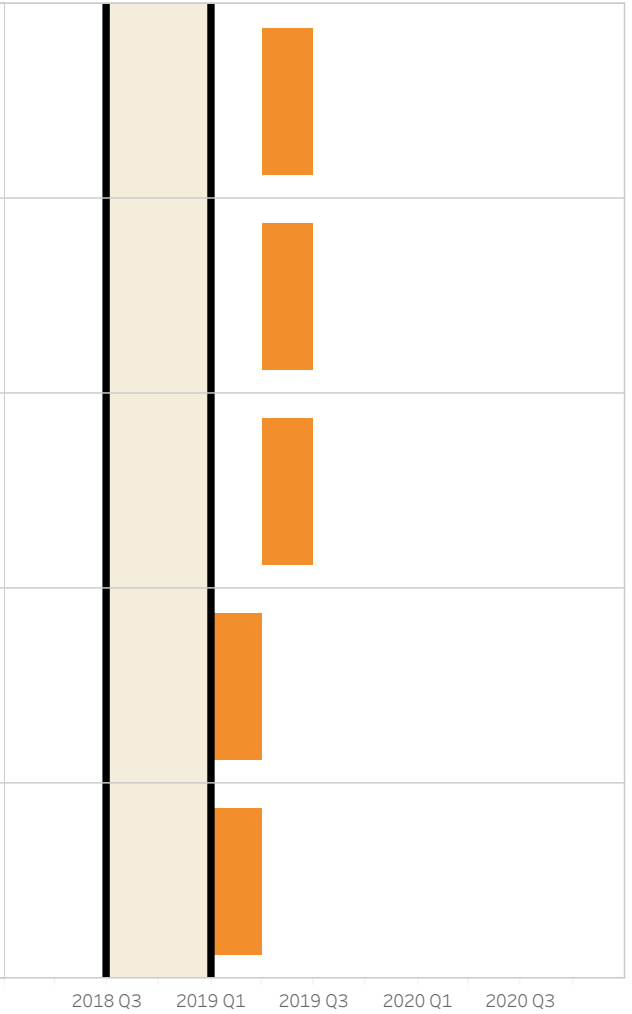
Status Update

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

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2)	Support PHBH and CBOSS Implementation Partners that request or require assistance in developing new guidelines, policies, procedures and protocols	Practice assessments (e.g., PAT, MeHAF, PCMH-A) and/or action plans	Qualis Health Practice Coach Connector	None
			Clinical Transformation Manager	None
			P-TCPi Practice Facilitator	None
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways (Completion no later than DY 3, Q2)	Form and maintain a diverse quality improvement (QI) team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care, and patient satisfaction (Recommended Tactic in PHBH Change Plan)	PHBH Change Plan progress to date reporting indicates progression of QI implementation, updated biannually	None	Select PHBH* Implementation Partners
	Implement reporting policies and practices to ensure complete and timely reporting of Change Plan activities to OCH (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	PHBH and CBOSS‡ Change Plan progress to date and quantitative reporting are complete and timely	None	Select PHBH* and CBOSS^ Implementation Partners



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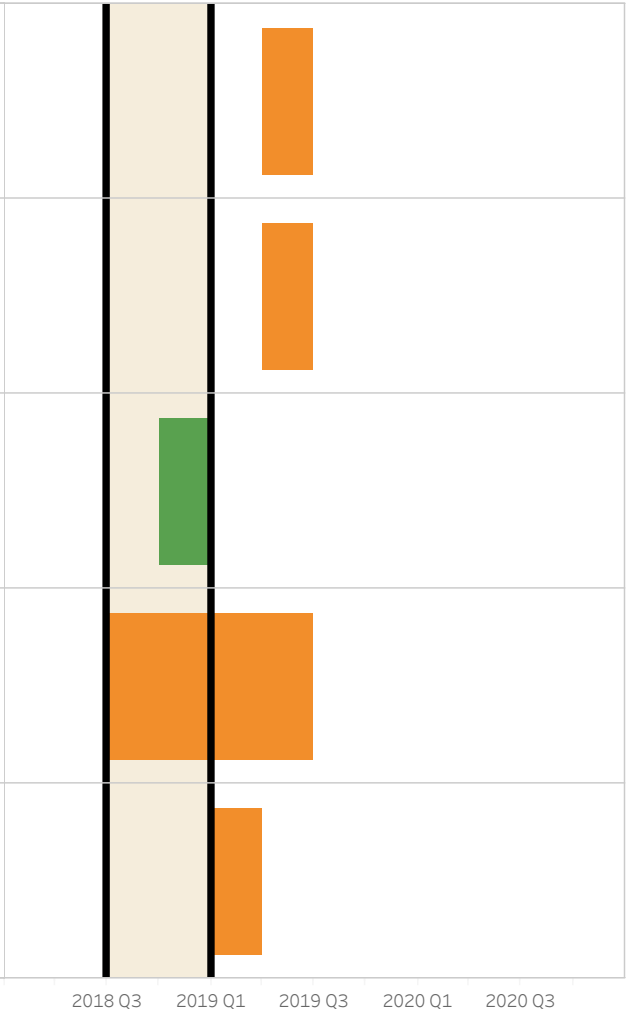
Implementation Plan Timeline: Stage 2

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



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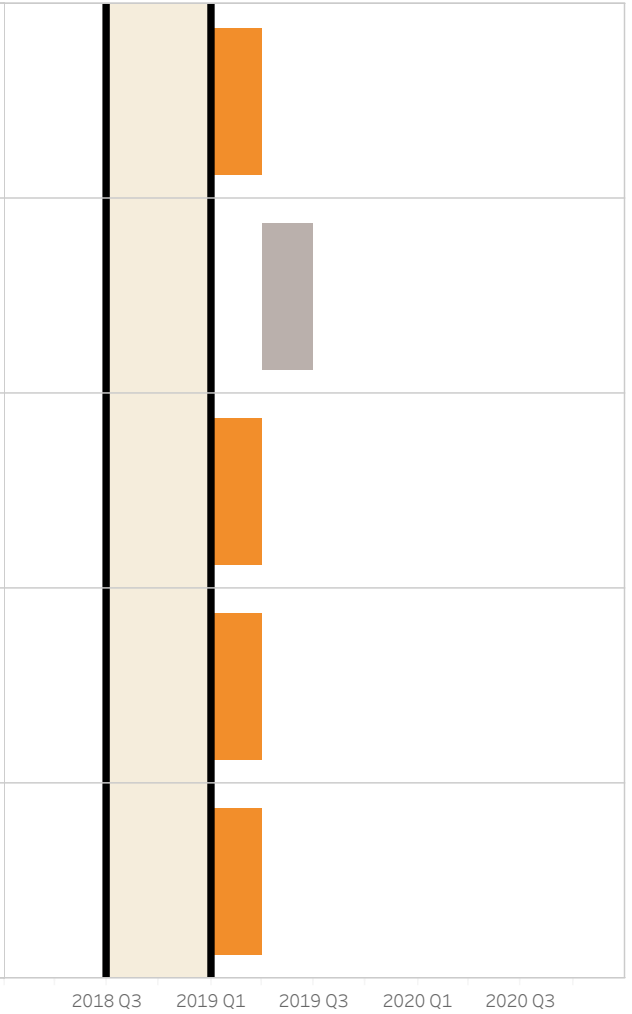
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways (Completion no later than DY 3, Q2)	Establish procedures for the QIP	Site visits and QIP reporting	Clinical Transformation Manager	None
	Convene PMEC to establish guidelines for ongoing review of reported data	PMEC materials	Data Lead	PMEC^^
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Review PHBH Implementation Partner readiness from Current State Assessment, completed coaching reports and practice assessments to create Implementation Partner readiness (for integrated care activities) matrix	Implementation Partner readiness matrix	P-TCPi Practice Facilitator	None
			Qualis Health Practice Coach Connector	None
			Clinical Transformation Manager	None



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Implementation Plan Timeline: Stage 2

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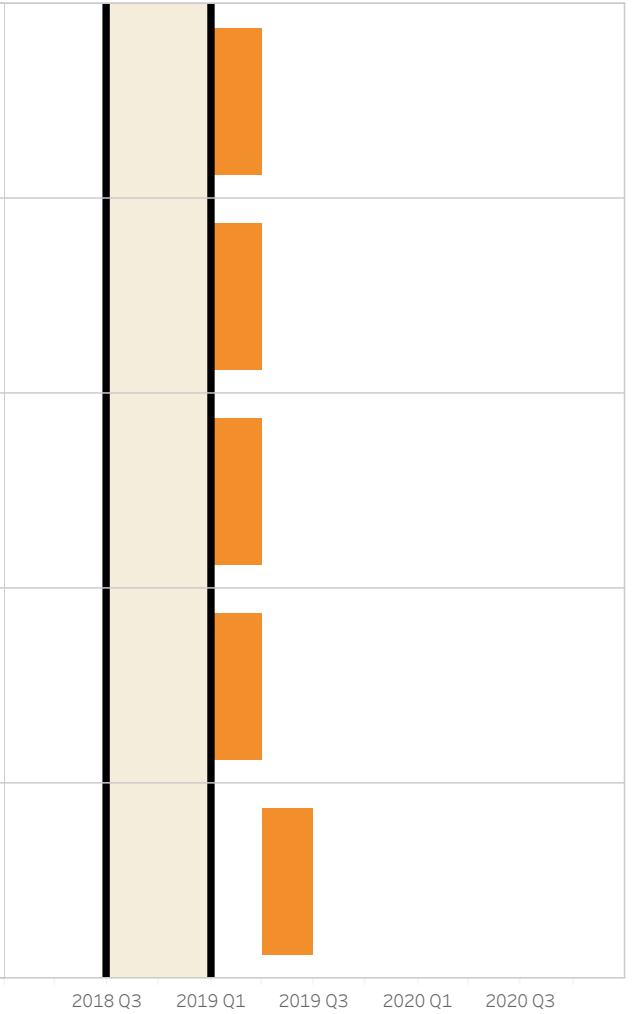
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Identify trainings and technical assistance needs for integrated care activities associated with Outcomes and Tactics in Change Plans	Training and technical assistance plan	Director of Community and Tribal Partnership	None
			P-TCPi Practice Facilitator	None
			Qualis Health Practice Coach Connector	None
			Clinical Transformation Manager	None
	Recommend available trainings and technical assistance	Communications	Director of Community and Tribal Partnership	None



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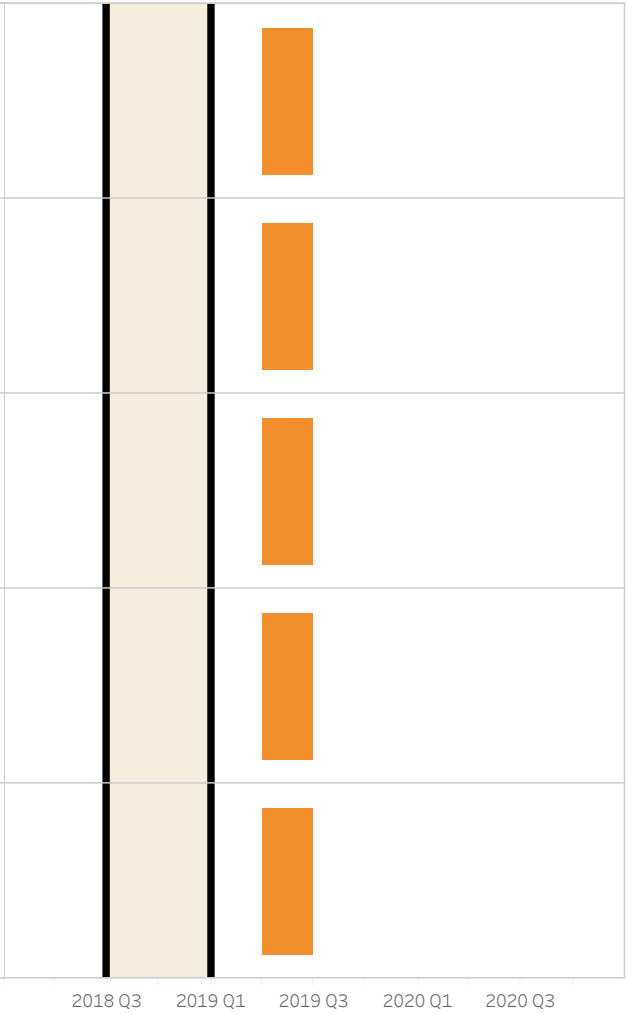
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Recommend available trainings and technical assistance	Communications	P-TCPi Practice Facilitator	None
			Qualis Health Practice Coach Connector	None
			Clinical Transformation Manager	None
	Assist PHBH Implementation Partners in tracking QI projects	QI technical assistance	P-TCPi Practice Facilitator	None
			Qualis Health Practice Coach Connector	None



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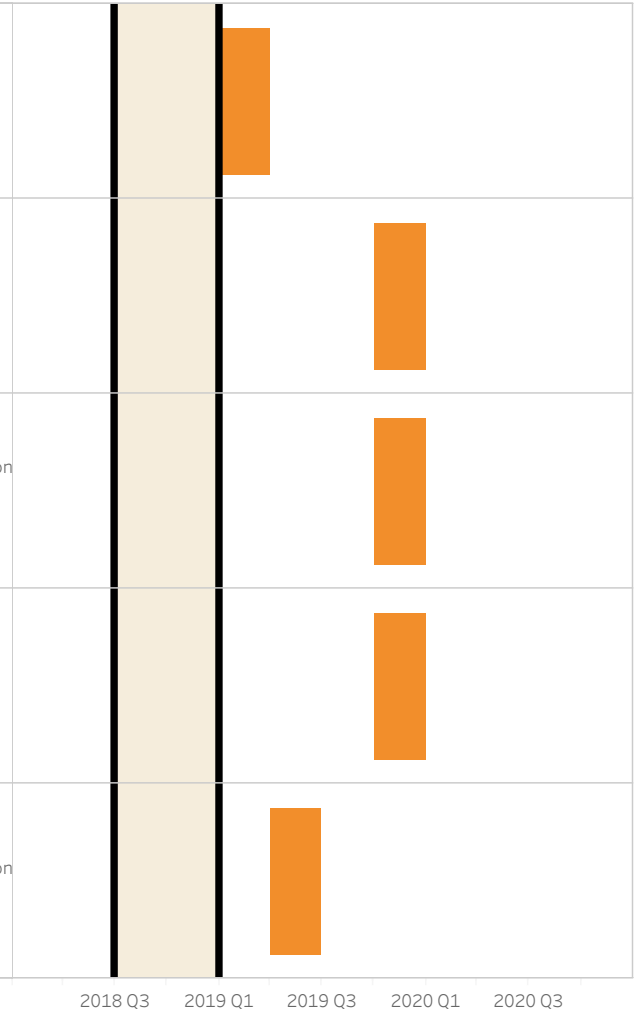
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities (Completion no later than DY 3, Q4)	Collaborate across-ACHs to contract with vendors for overlapping training needs	Contractual agreements	Executive Director	None
	Make trainings available to partners	Training	Clinical Transformation Manager	None
	Participate in trainings	Training	None	PHBH* and CBOSS^ Implementation Partners and interested Shared Change Plan** Partners
	Upload recordings, materials, webinars of trainings on ORCA	Web links on ORCA	Program Coordinator	None
Ensure each member of the care team, participating provider and/or organization is provided with, or has secured, the	Provide PHBH and CBOSS Implementation Partners with tools to assess cultural competence and facilitate action planning to address gaps that are identified	Coaching report from Qualis Health, coaching report from P-TCPi, practice assessments, results from Current State Assessment	Director of Community and Tribal Partnership	PHBH* and CBOSS^ Implementation Partners



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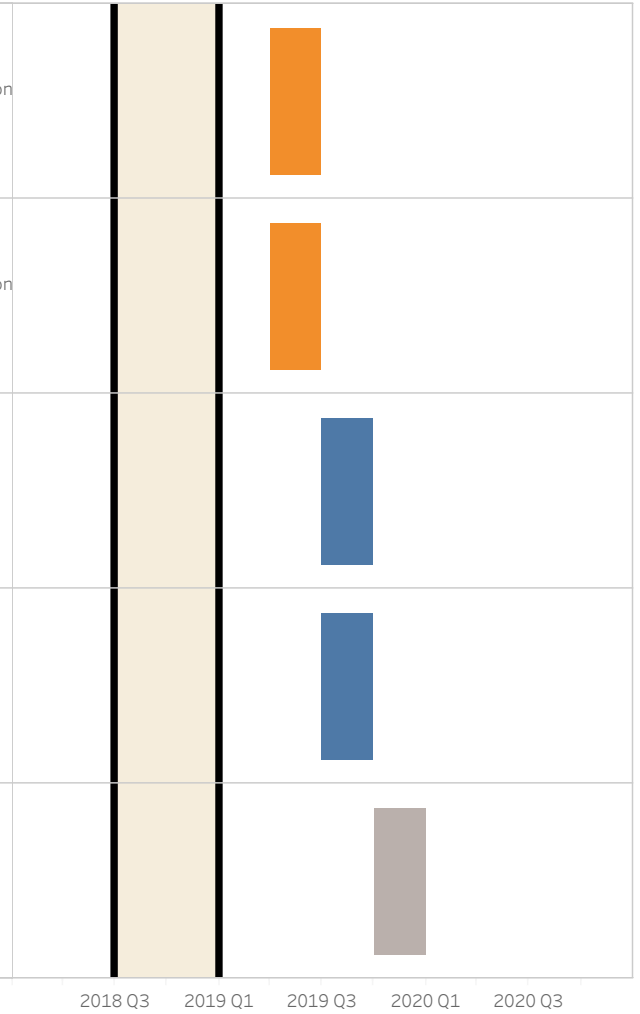
Implementation Plan Timeline: Stage 2

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



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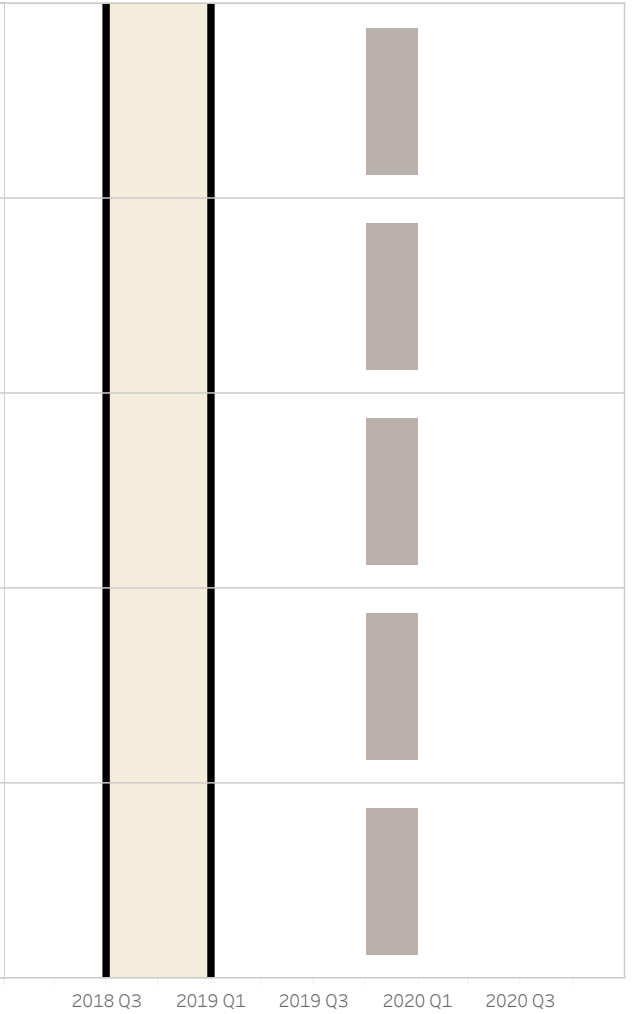
Ensure each member of the care team, participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner (Completion no later than DY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



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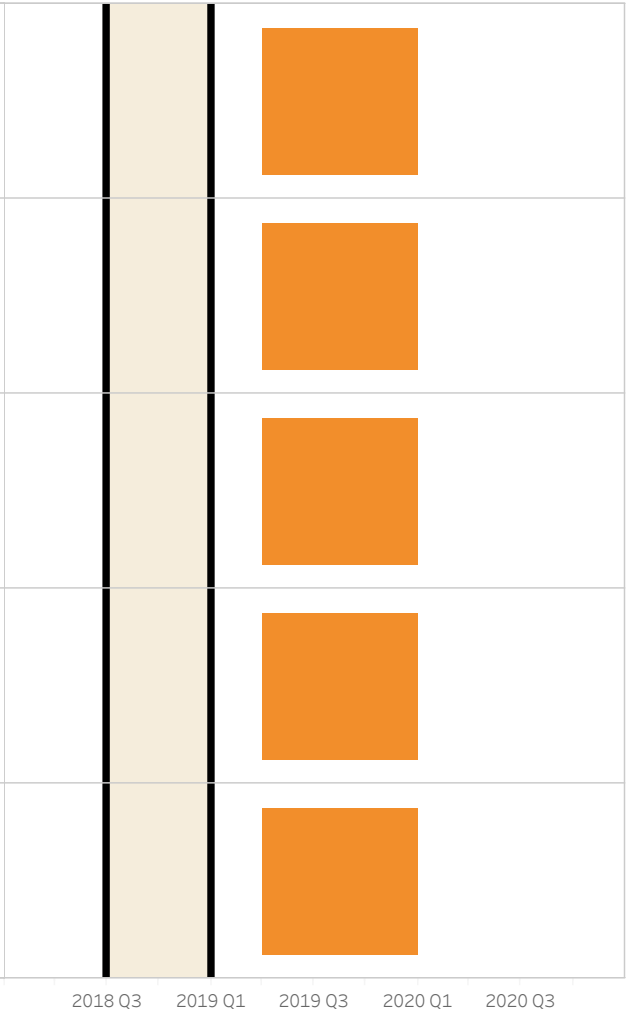
Implementation Plan Timeline: Stage 2

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



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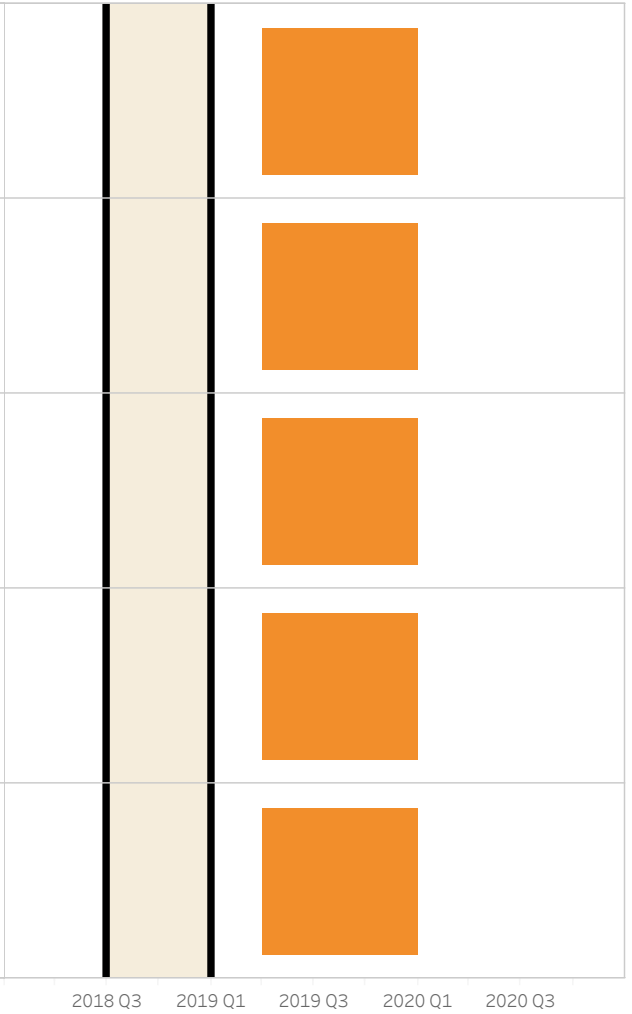
Implementation Plan Timeline: Stage 2

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



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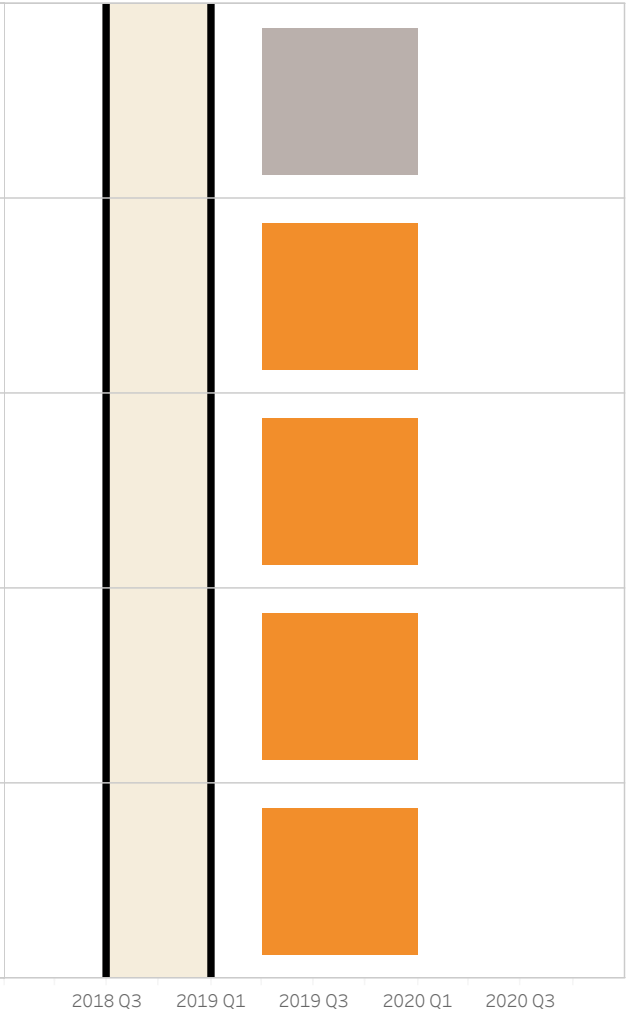
Implementation Plan Timeline: Stage 2

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



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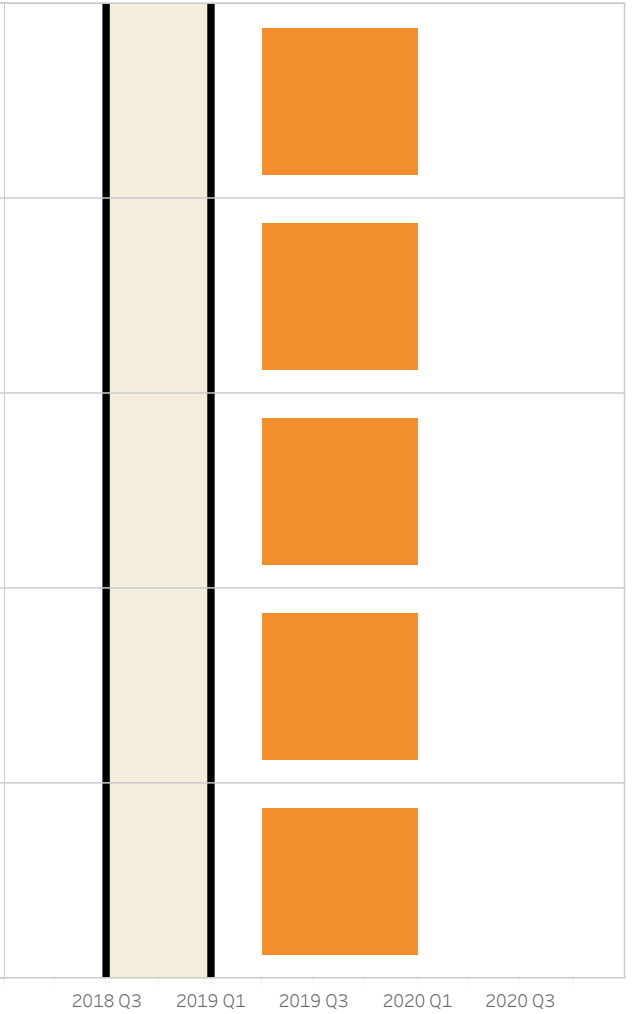
Implementation Plan Timeline: Stage 2

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



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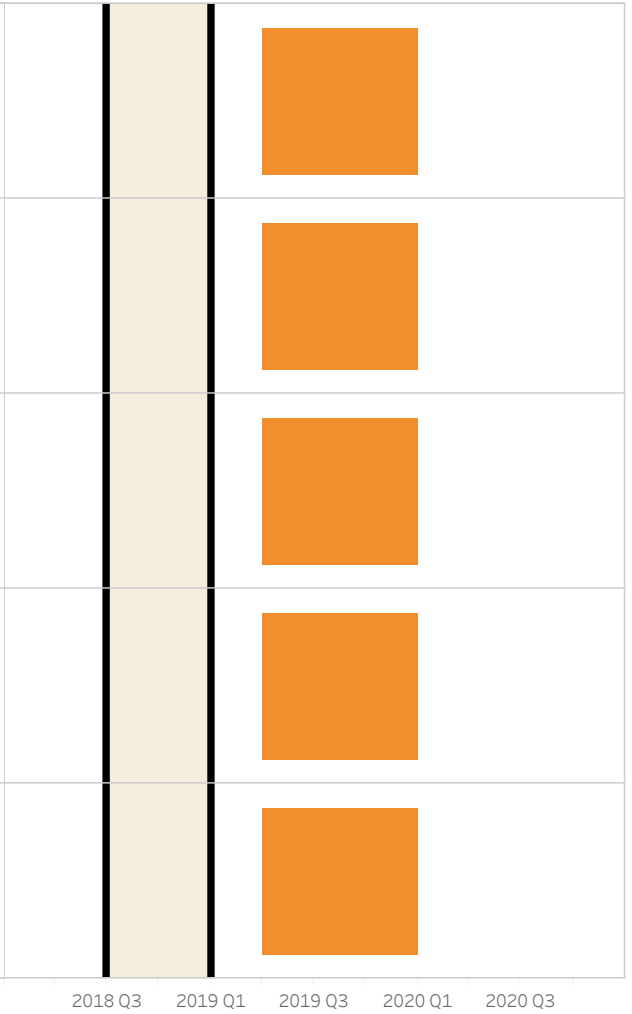
Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client and family/caregivers, have access to the information appropriate to their role in the team and the care plan) (Completion no later than DY 3, Q4)	Implement process to review the PRC (patient review and coordination) list and EDIE feeds, assess patient needs and link patients to community providers (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners
	Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share (Recommended Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* and CBOSS^ Implementation Partners
Implement disease/ population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/ or improve: • 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)	Biannual report of progress on this work step and any associated intermediary measures	None	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)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners
	Form bi-directional referral system within the Natural Community of Care between clinical and community partner for effective chronic care services; refer to appropriate programs depending on patient profile (Recommended Tactic in the PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners



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Status Update

- Completed
- Completed for DY2, In Progress for DY3
- Completed for DY2, Not Started for DY3
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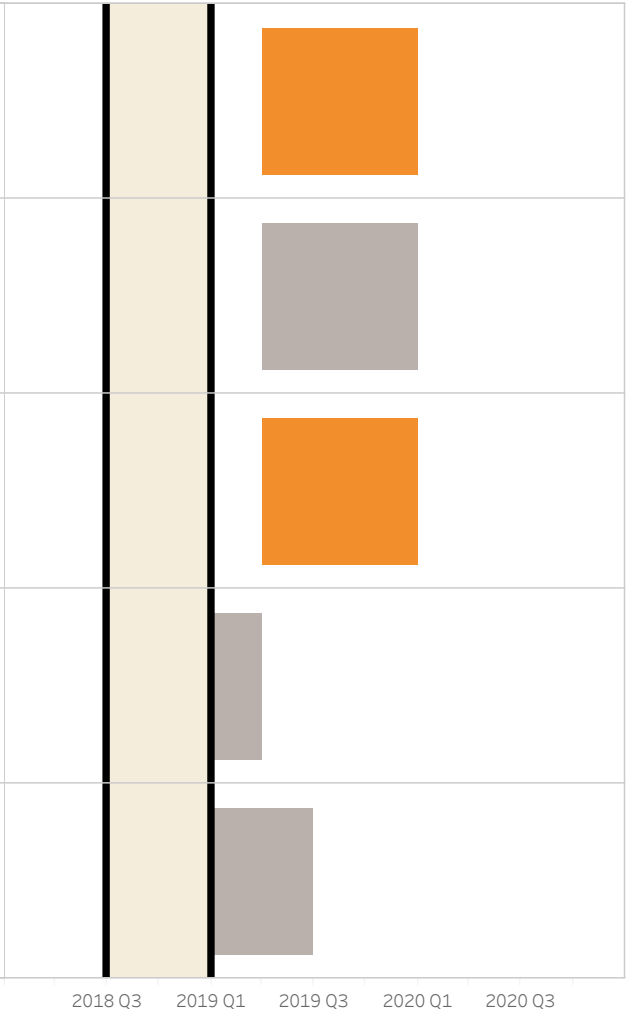
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
• 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)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners
Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	Utilize screening tools and protocols to identify client oral health needs and inform appropriate referrals (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners
	Screen clients for engagement with oral health provider and provide resources/referral as needed (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select CBOSS^ Implementation Partners
	Facilitate alignment with Access to Baby and Child Dentistry (ABCD)	ABCD coordinator participates in NCC convenings	Director Community and Tribal Partnership	None
	Develop strategies, emphasizing care coordination between new and existing dental providers and community-based services and supports (Tactic in CBOSS‡ Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	Executive Director	None



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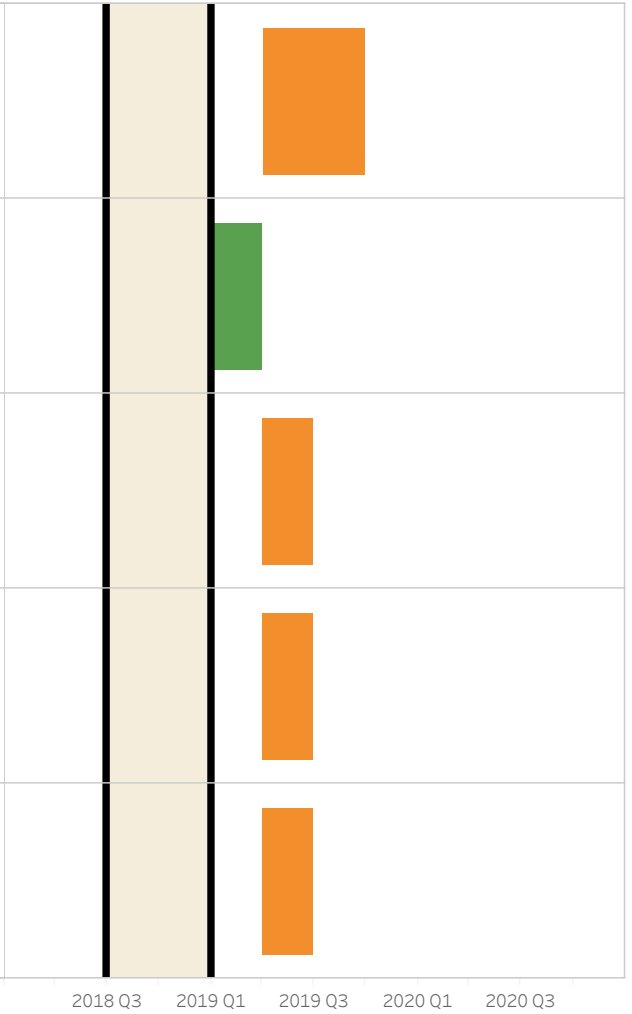
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	Select partner organizations for local oral health improvement network with Arcora Foundation	List of partner organizations for local health improvement network	Executive Director	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)	Review final PHBH Change Plans and crosscheck with Implementation Partner readiness matrix (for integrated care activities) to identify partner needs	List of partner needs	Clinical Transformation Manager	None
	Facilitate workflow mapping with Implementation Partners to assess care gaps in technology	Workflow maps	P-TCPi Practice Facilitator	None
			Qualis Health Practice Coach Connector	None
	Teach and design PDSA (Plan, Do, Study, Act) to address identified care gaps	Coaching report from Qualis Health; coaching report from P-TCPi	P-TCPi Practice Facilitator	None



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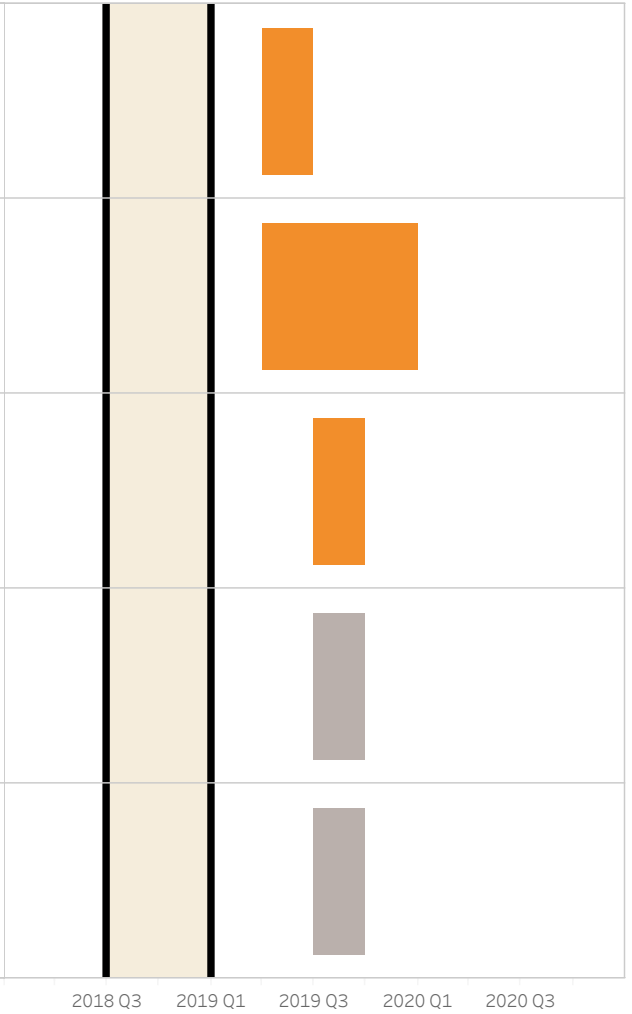
Implementation Plan Timeline: Stage 2

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



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Implementation Plan Timeline: Stage 2

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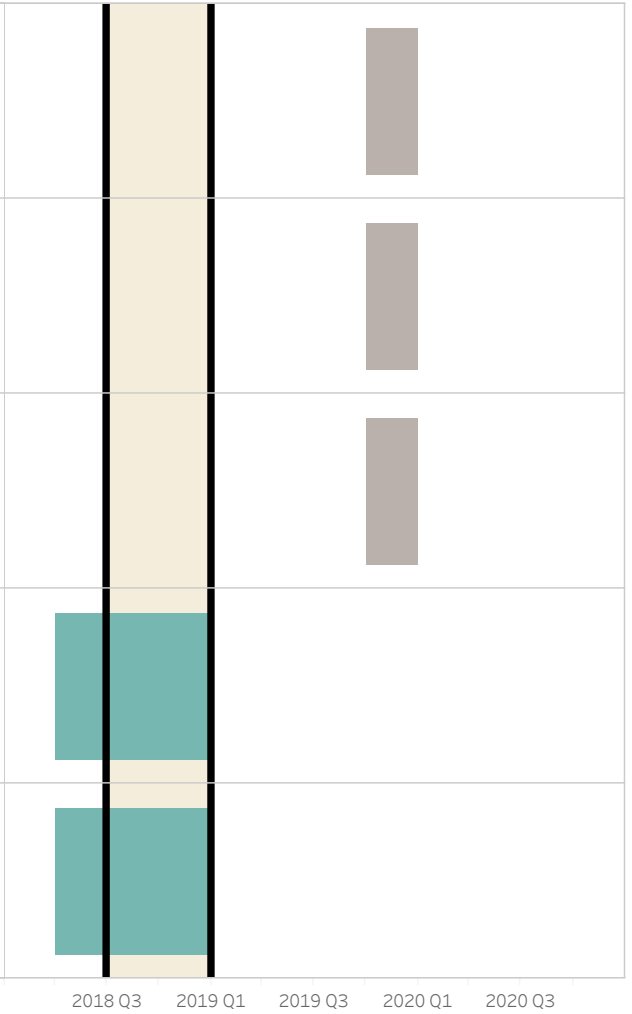
Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities (Completion no later than DY 3, Q4)	Convene trainings as needed to support partners to implement tools	Trainings	Clinical Transformation Manager	None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



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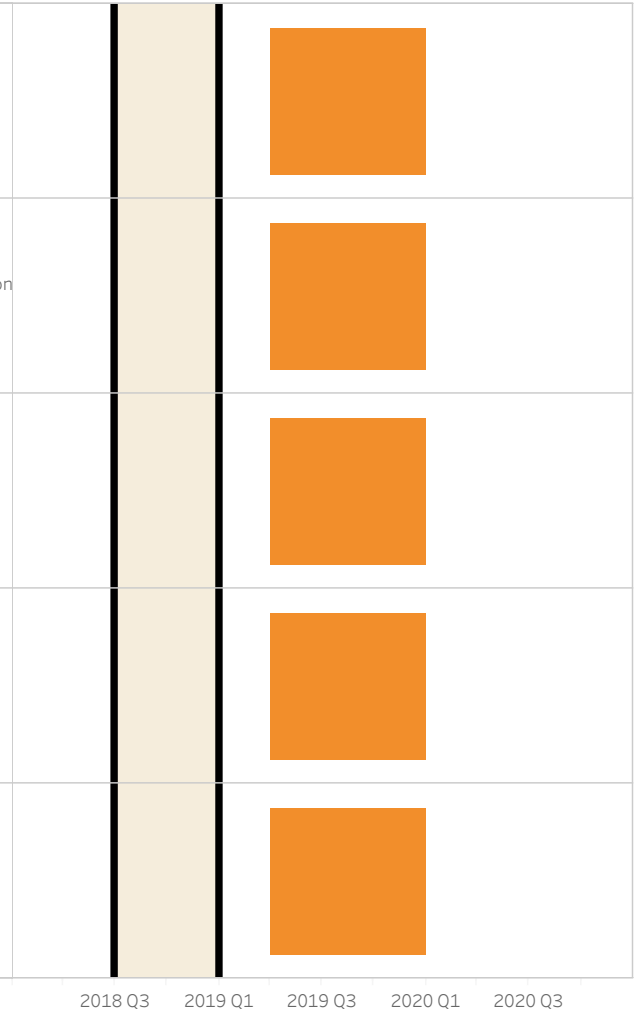
Implementation Plan Timeline: Stage 2

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



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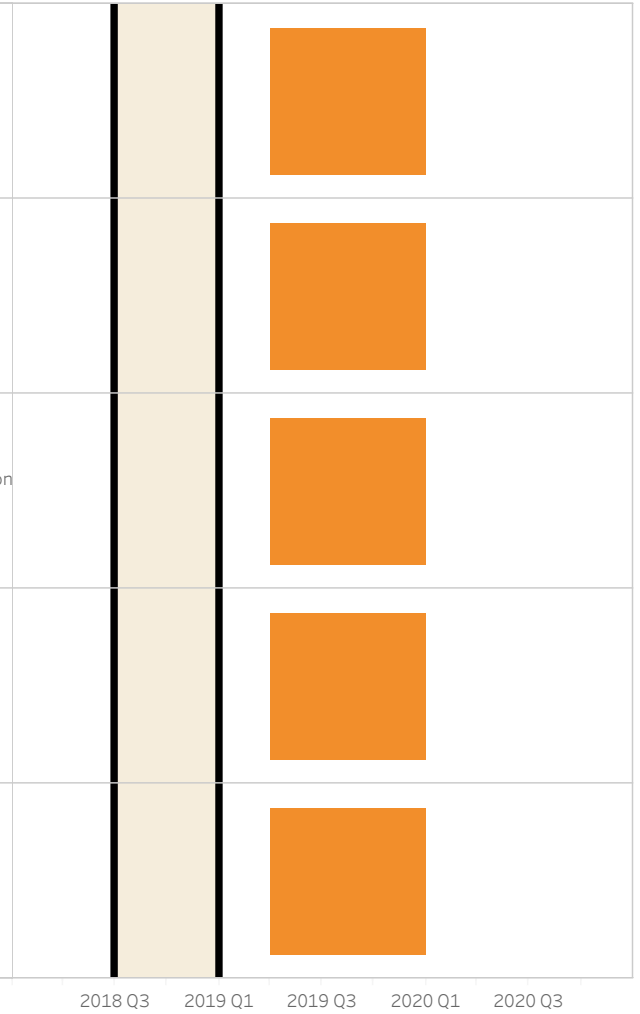
Implementation Plan Timeline: Stage 2

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



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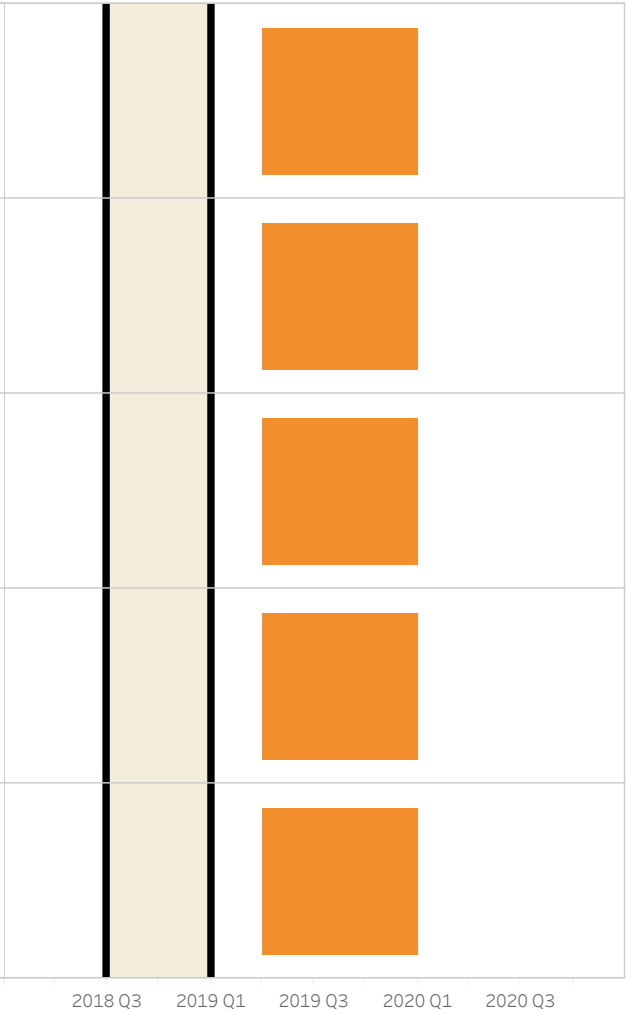
Implementation Plan Timeline: Stage 2

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



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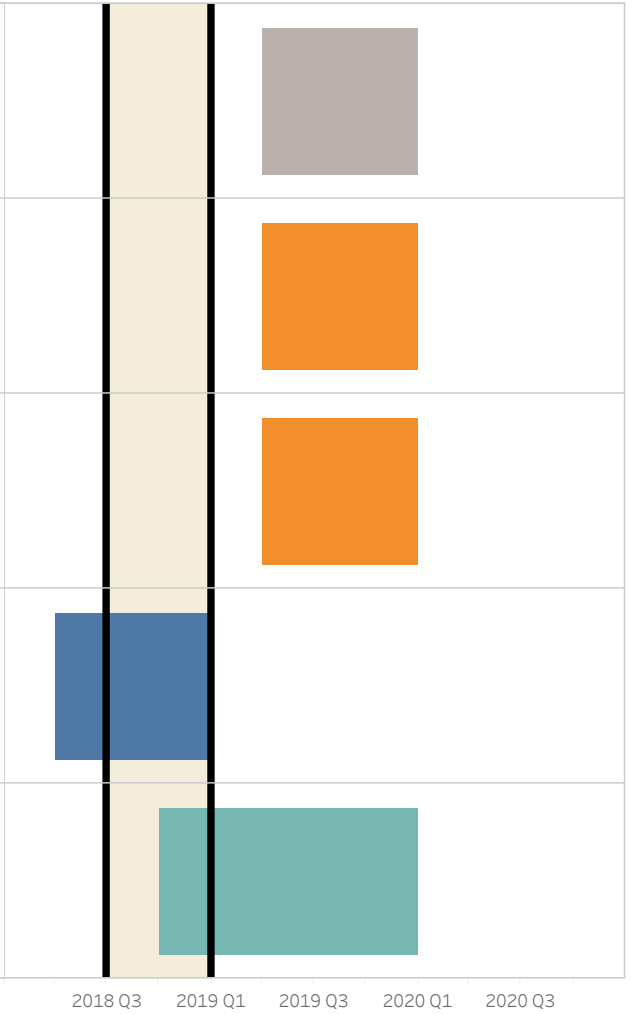
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities. (Completion no later than DY 3, Q4)	Report on value-based metrics that will be in MCO contracts (Recommended Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners
	QI methods are used to improve care and care delivery (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners
	Form and maintain a diverse QI team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care and patient satisfaction (Recommended Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners
Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened (Completion no later than DY 3, Q4) -Each partnership should include health care service, including mental health and SUD providers, community-based service ..	Convene 3CCORP Steering Committee, Prevention Workgroup, Treatment Workgroup and Overdose Prevention Workgroup on a regular basis to guide the work of Project 3A	Semi-annual to monthly 3CCORP meetings, agendas and meeting minutes, regional opioid response plan, completion and maintenance of partnering provider roster	Director of Community and Tribal Partnership	None
	3CCORP members present accomplishments at Regional Opioid Summit(s)	Regional Opioid Summit(s)	None	3CCORP members***



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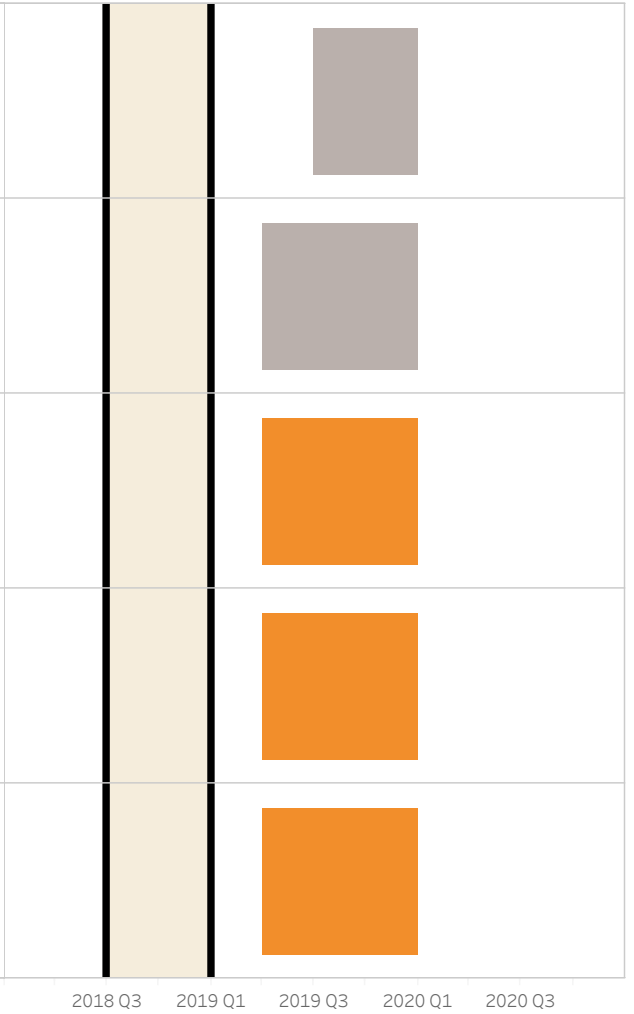
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Develop workflows to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed (Completion no later than DY 3, Q4)	Receive technical assistance from Arcora Foundation and/or Qualis Health to assist Implementation Partners in identifying care team members and integrating oral health screening and referral to dentist or periodontist into workflows	Standard operating procedure to screen and refer to an oral health provider identified at site visit	Arcora Foundation and Qualis Health	None
	Assess progress on workflow integration at site visit	Biannual report of progress on this work step and any associated intermediary measures	Clinical Transformation Manager	Select PHBH* Implementation Partners
	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners
	Train providers on screening for oral health needs and engagement with oral health provider (Tactic in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	Select PHBH* Implementation Partners
Establish referral relationships with dentists and other specialists, such as ENTs and periodontists (Completion no later than	Oral health education, screening and/or preventive procedures are integrated into care (Required Outcome in PHBH Change Plan)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* Implementation Partners



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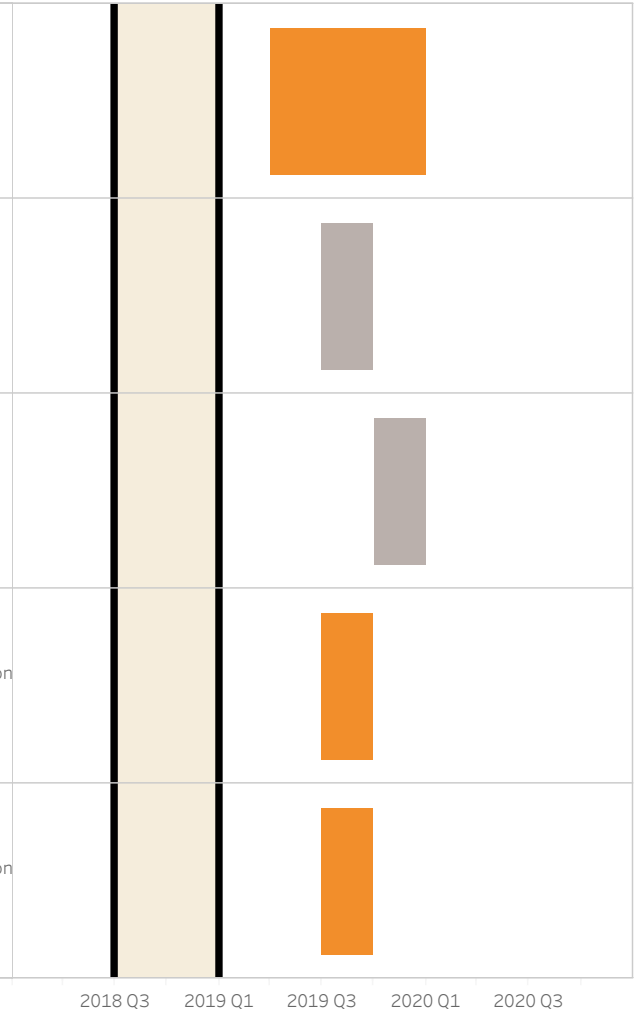
Implementation Plan Timeline: Stage 2

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



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Implementation Plan Timeline: Stage 2

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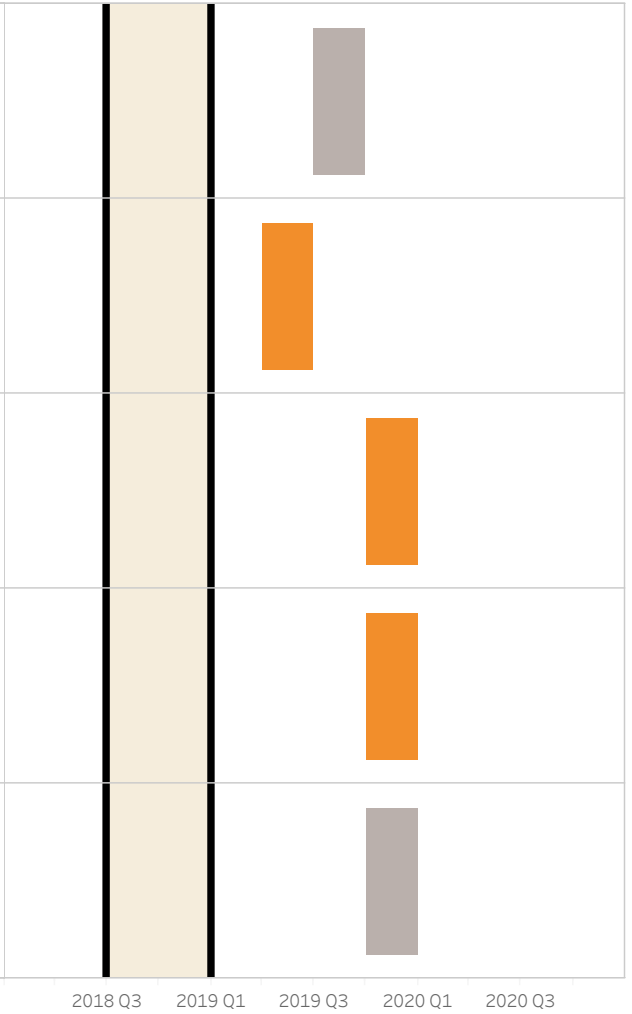
Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes (Completion no later than DY 3, Q4)	Host OCH Performance, Measurement and Evaluation Committee (PMEC) meetings to review PHBH and CBOSS Implementation Partner data	Quarterly PMEC materials and minutes	Data Lead	PMEC^^
	Implement reporting policies and practices to ensure complete and timely Change Plan reporting	PHBH Change Plan progress to date and quantitative reports	Clinical Transformation Manager	None
	Assist PHBH Implementation Partners in tracking QI	QI technical assistance	P-TCPi Coach Facilitator	None
			Qualis Health Practice Coach Connector	None
Engage with payers in discussion of payment approaches to support access to oral health services (Completion no	Facilitate Implementation Partners to establish connection with apparently successful bidders of dental managed care contracts	Communications	Executive Director	None



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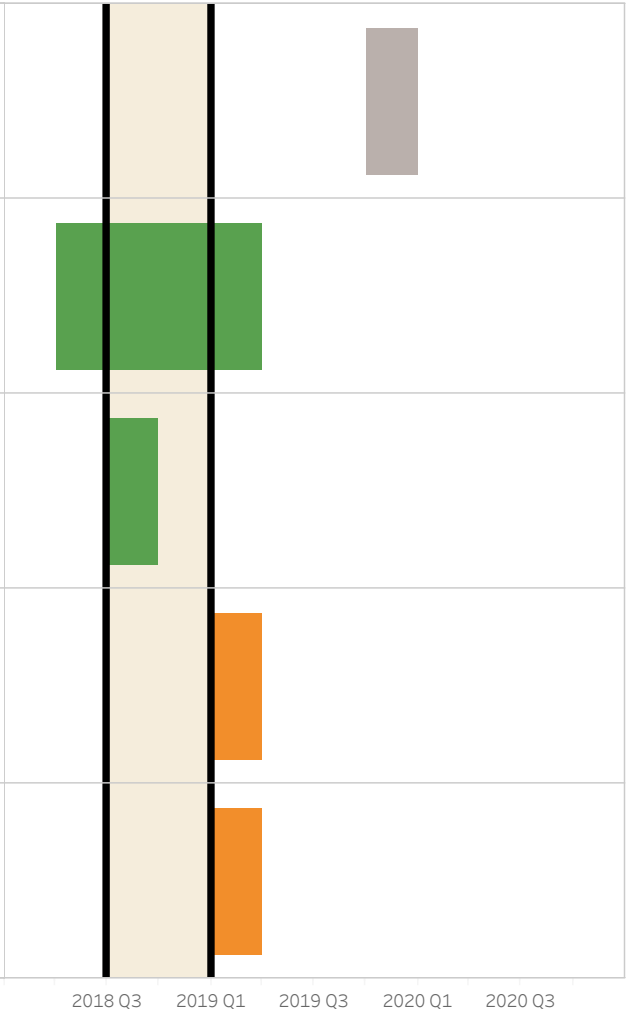
Engage with payers in discussion of payment approaches to support access to oral health services (Completion no later than DY 3, Q4)	Meet with future successful bidders of dental managed care contracts to discuss potential financial and technical support of oral health integration in primary care	Meetings	Executive Director	None
Regional self-identified milestone: Ensure communication with, resource sharing for, and reporting requirements of PHBH and CBOSS Implementation Partners are streamlined, transparent and minimally burdensome while holding them accountable to implementation	Work with CSI (contracted vendor) to develop online platform for communication, resource sharing and reporting	ORCA	Clinical Transformation Manager	None
	Ensure Shared Change Plan Partners are registered on ORCA	Registered list of partners on ORCA	Program Coordinator	None
	Develop strategy to increase traffic and activity on ORCA	Communications plan	Communications and Development Coordinator	None
	Develop streamlined qualitative and quantitative reporting templates on ORCA for bi-annual reporting	Online reporting templates	CSI	None



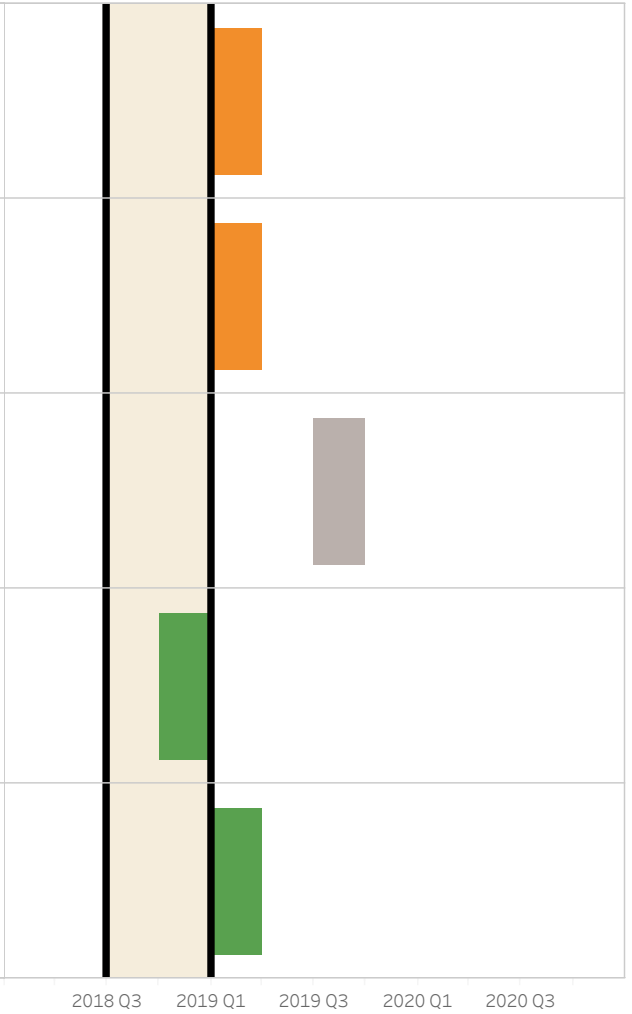
Start Date1 Day for each Partnering Provider Organization broken down by Milestones, Work Steps, Key Deliverables / Outcome and ACH Organization. Color shows details about Status Update. Size shows average of Days Duration. The data is filtered on Stage, Pivot Field Values Quarter and Start Date1 Quarter.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

Status Update

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

Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
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	Develop streamlined qualitative and quantitative reporting templates on ORCA for bi-annual reporting	Online reporting templates	Data Lead	None
			Clinical Transformation Manager	None
	Solicit feedback on ORCA from PHBH, CBOSS and Shared Change Plan Partners	Feedback forms	Program Coordinator	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	List of metrics and their specifications	Data Lead	None
	Review and potentially refine OCH intermediary metrics with members of the PMEC to identify opportunities for alignment with other ACHs	List of metrics and their specifications	Data Lead	None



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Status Update

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- Completed for DY2, In Progress for DY3
- Completed for DY2, Not Started for DY3
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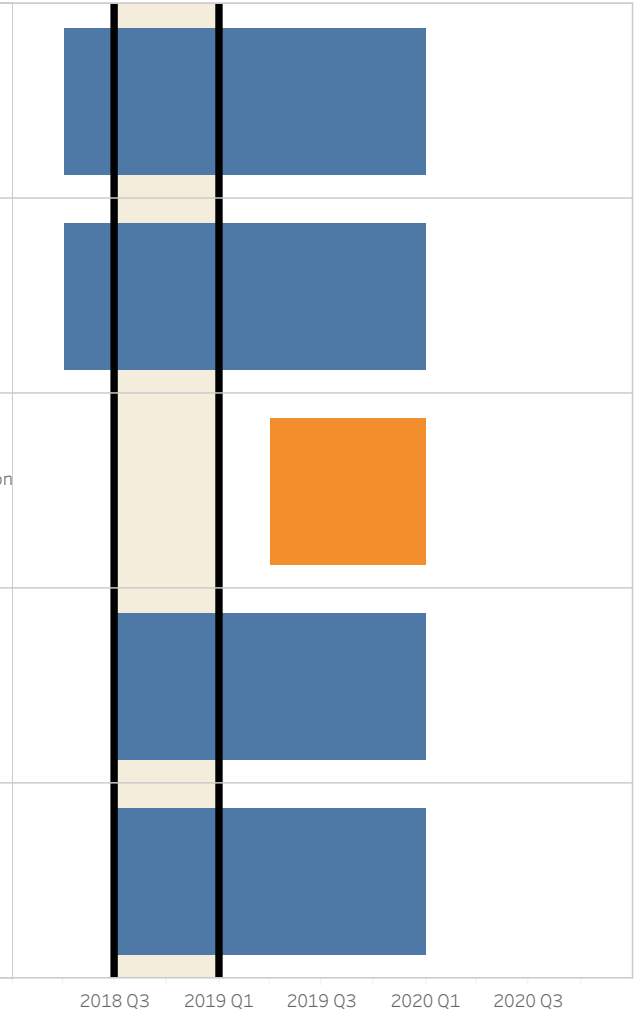
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Regional self-identified milestone: Health equity considerations are incorporated in implementation of Outcomes and Tactics	PHBH and CBOSS Implementation Partners and Shared Change Plan Partners are surveyed regularly regarding health equity strengths and gaps; gaps are addressed	Regional health equity data	Director of Community and Tribal Partnership	None
			Data Lead	None
	Review patient/client data by subpopulations to identify and track inequities (Tactic in PHBH and CBOSS‡ Change Plans)	Biannual report of progress on this work step and any associated intermediary measures	None	PHBH* and CBOSS^ Implementation Partners
	Regional health equity survey results are summarized and presented to the OCH Board, Committees, Natural Communities of Care convenings and staff meetings	Presentations	Director of Community and Tribal Partnership	None
			Data Lead	None



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Status Update

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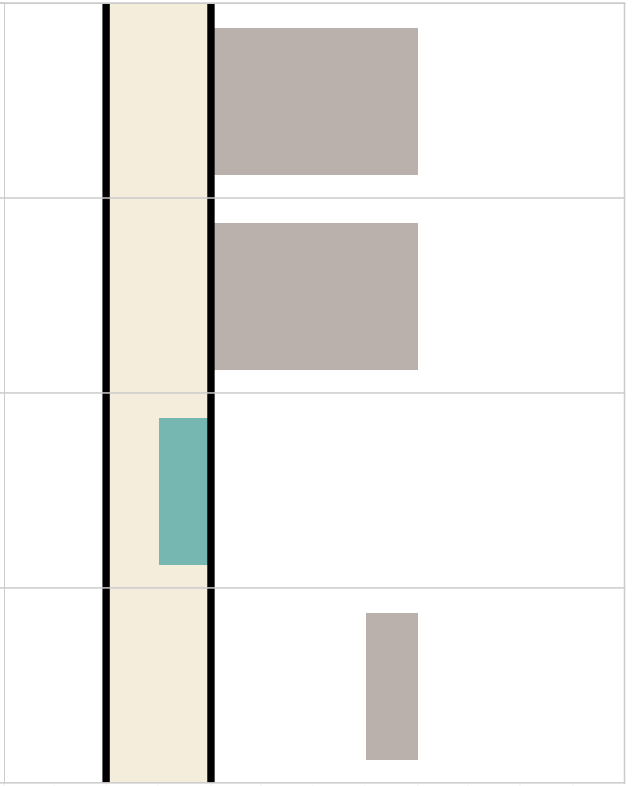
Implementation Plan Timeline: Stage 2

Milestones	Work Steps	Key Deliverables / Outcome	ACH Organization	Partnering Provider Organization
Regional self-identified milestone: Proactively engage community-based organizations, Tribes, and the beneficiaries of services to ensure that their voice guides and informs the decision making of the Olympic Community of Health	Establish the Community and Tribal Advisory Committee (CTAC) and meet no less than semi-annually	CTAC meeting calendar	Communications and Development Coordinator	None
			Director of Community and Tribal Partnership	None
	Determine appropriate sector representation and convene CTAC	CTAC charter	Director of Community and Tribal Partnership	None
	Provide written reports and/or recommendations to the OCH Board and staff to summarize strengths and gaps in social justice and health equity in the work of the MTP	Reports recommendations	Director of Community and Tribal Partnership	CTAC



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