North Sound ACH

October 2019 Reporting Data Report

Revised February 2020

Background

All partners committed to Medicaid Transformation Projects (MTP) with the North Sound Accountable Community of Health (North Sound ACH) are required to complete reporting twice a year. In October 2019, partners reported on activities during the reporting period of April 2019 to September 2019. Reporting requirements vary depending on the strategies and tactics committed to in a partner's Change Plan. Partners must complete reporting on implementation of their Change Plans and, if applicable, submit additional statewide surveys/assessments on bi-directional integration and opioid work.

This Reporting Data Report provides a summary of partner reporting with a focus on the Change Plan reporting. Individual data briefs are available for the bi-directional integration and opioid survey reporting. An additional document outlines all reporting for each milestone by strategy. These documents are available on the partner portal.

Summary of Reporting

Of the 49 North Sound ACH partners, 100.0% completed this round of reporting of their Change Plan implementation via the reporting portal on time with no extensions or delays in reporting.

MeHAF Reporting Survey

A total of 18 (36.7%) North Sound ACH partners have committed to bi-directional integration strategies. Of these 18 partners, 18 (100.0%) completed the Maine Health Access Foundation Site Self-Assessment (MeHAF SSA) Survey and submitted them to the North Sound ACH. A total of 105 MeHAF SSA Surveys were submitted during October 2019 reporting, with the number per organization ranging from one to 30 and the average submitted being 5.8. This was an increase of 29.6% from April 2019 reporting. A complete MeHAF SSA Survey Data Brief is available in Appendix A and on the partner portal.

Opioid Reporting Survey

Thirty (61.2%) partners have committed to opioid strategies. All of the 30 (100.0%) partners committed to opioid strategies completed the relevant Opioid Surveys and submitted them to the North Sound ACH. A total of 135 Opioid Surveys were submitted during October 2019 reporting, with the number per organization ranging from one to 31 and the average submitted being 5.6. Of the 135 surveys submitted, 56 (41.5%) completed the Community-Based Organization survey and 79 (58.5%) completed the Clinical survey. The average number for the Clinical Surveys submitted per organization was 5.6 and the average number of Community-Based Organization Surveys submitted per organization was 3.3. A complete Opioid Survey Data Brief is available in Appendix B and on the partner portal.

Change Plan Implementation Reporting

Partners were asked to report on the implementation of their Change Plans. Each partner reporting on six milestones for each strategy committed to in the Care Coordination, Care Transformation, and Care Integration initiatives, and four to five milestones for the Capacity Building Initiative.

The milestones for the Care Coordination, Care Transformation, and Care Integration are:

1. Implementation of committed tactics,
2. Evidence-based models and/or promising practices,
3. Populations of focus,
4. Trainings and technical assistance,
5. Quality improvement, and
6. Guidelines, policies, procedures, and protocols.

The milestones for the Capacity Building initiative are:

1. Leadership, management, transparency, and accountability,
2. Accessibility,
3. Equity and health disparities,
4. Population health management, and
5. Value-based payments (optional milestone).

For each milestone, partners were asked to select a change status (Table 1) and select all tactics worked on during that period. In this brief we will provide a detailed analysis of portal change status reporting and discuss the results of the open-ended narrative questions.

Many partners also indicated working on tactics that they had not committed to in their Change Plans. Organizations that indicated work on tactics they had not committed to are listed when appropriate in Appendix C. This indicates that work in the region is progressing even further than many partners may have expected when completing their Change Plans in early 2019 and may be an area to add Change Plan commitments in 2020 contracting.

Table 1. Change Status Reporting[1]

Change Status	Definitions
Not Started	Have not begun efforts on any committed tactics related to this milestone. All tactics should be unselected for milestones that have not yet been started.

[1] For the purpose of this analysis, in progress and fully implemented have been combined into "implemented" or "reported implementation". For a more in-depth view of change status reporting see attached documents.

In Progress	Work is moving along as expected for committed tactics related to this milestone. Only tactics that you are currently working on for this milestone should be selected.
Delayed	Achievement of milestone is delayed; unexpected events or barriers have stalled implementation progress. ACH assistance is required. Select any tactics where you are encountering barriers for ACH follow-up.
Fully Implemented	All committed tactics related to this milestone are fully implemented. All tactics that were committed to should be selected.

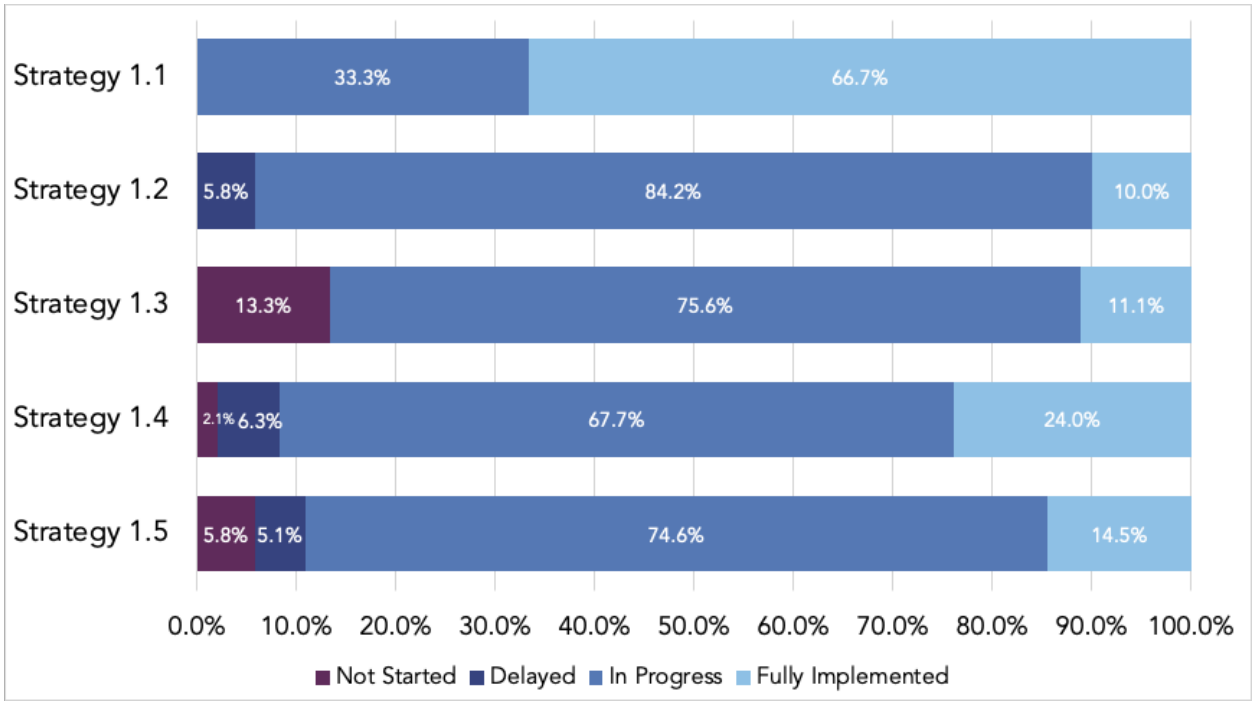
Care Coordination Strategies

There are five Care Coordination strategies:

- Strategy 1.1 - North Sound Community HUB
- Strategy 1.2 - Acute Care Transitions
- Strategy 1.3 - Transitional Care after Incarceration
- Strategy 1.4 - Emergency Department Diversion
- Strategy 1.5 - Cross-Sector Care Coordination and Diversion Collaboratives

Figure 1 outlines details the Change Status reporting of each Care Coordination strategy.

Figure 1. Care Coordination Strategies Change Status Reporting, April-September 2019 Partner Reporting, North Sound ACH.



Because of the unique nature of Strategy 1.1 all three committed partners have already begun implementation of all milestones and we will not expand on reporting results here. For more information on this reporting for this strategy please review the additional reporting documents.

Milestone 1 - Implementation of Committed Tactics

Strategies 1.3 and 1.5 have the are the only Care Coordination strategies with partners who have not yet started implementing their committed Care Coordination tactics (6.7% and 8.7% respectively). Strategy 1.2 has two (10.0%) partners that indicated delays for committed tactics and Strategy 1.4 has one (6.3%) partner that indicated delays for committed tactics. Strategy 1.4 has the most progress being made on implementation tactics, with two of the four tactics having over 90.0% of committed partners reporting implementation:

- Strategy 1.4 Tactics:
    - Collaborate with North Sound ACH implementation partners (93.8%).
    - Community paramedics or EMTs have partnerships with hospitals and social services (91.7%).

Other Care Coordination tactics that have high percentages of committed partners reporting implementation include:

- Strategy 1.2 Tactics
    - Implement Acute Care Transitions strategy for identified Medicaid eligible and/or enrolled populations of focus (90.0%).
- Strategy 1.5 Tactics
    - Participate in regularly scheduled cross-sector care meetings (91.3%).

Tactics with the lowest percentages of implementation for Care Coordination strategies include:

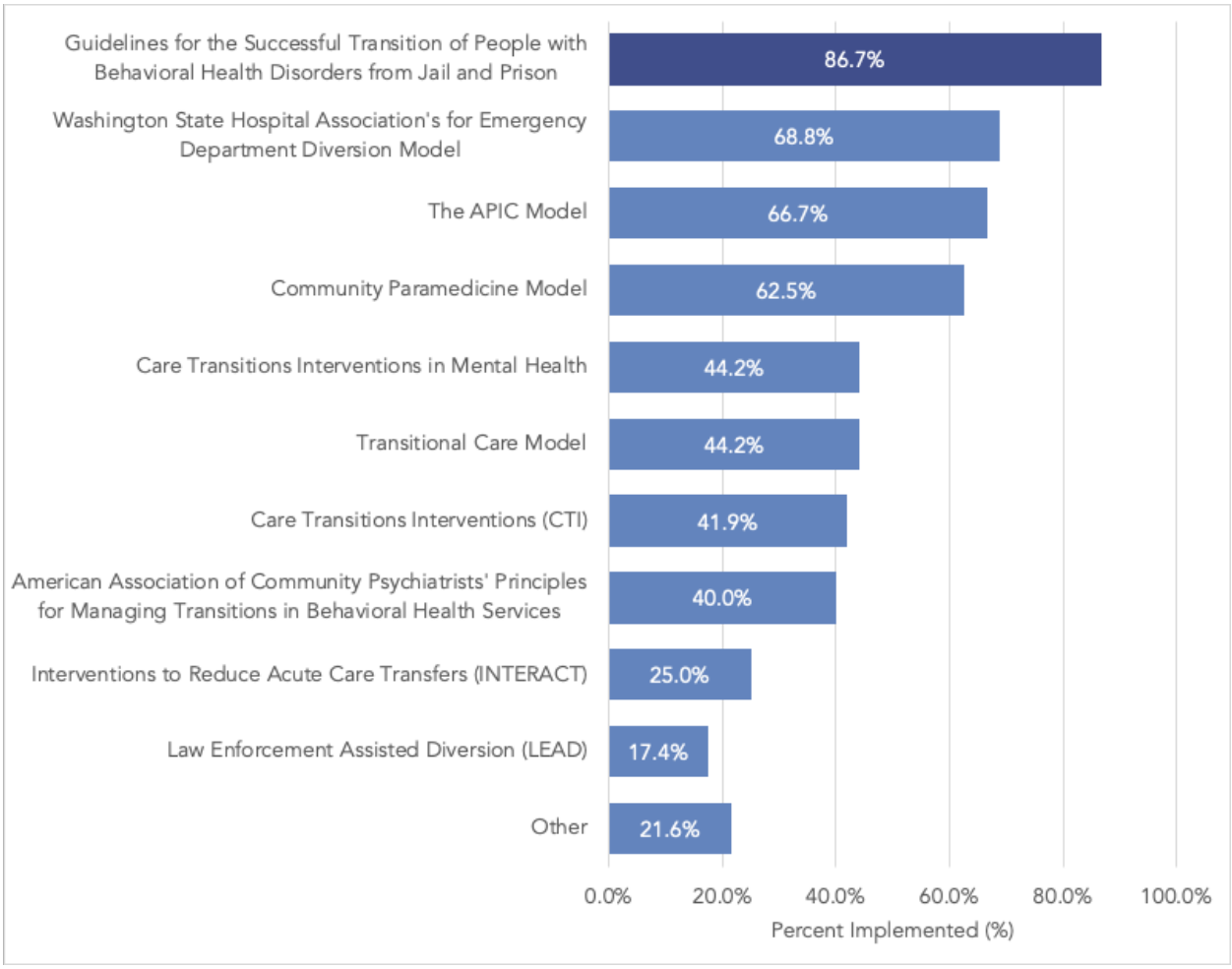
- Strategy 1.3 Tactics
    - Embed community health workers (CHWs) in criminal justice settings (40.0%).
- Strategy 1.4 Tactics
    - Embed community health workers (CHWs) in emergency room settings (60.0%).

Milestone 2 - Evidence-Based Models and Promising Practices

Four partners reported delays in implementation of Care Coordination evidence-based models and four partners reported not have started selecting models. There are ten evidence-based models for Care Coordination strategies. The most commonly implemented model is Guidelines for the Successful Transitions of People with Behavioral Health Disorders from Jail and Prison (86.7%), which is implemented for Strategy 1.3 - Transitional Care after Incarceration. Several partners also noted using models or practices other than those listed, including the Community Resource Paramedical, Person Centered Options Counseling (PC-OC) based on the Essential Lifestyle Planning (ELP) Model, CTI "like" models, Care Coordination Measurement Tool (CMMT), Pediatric Care Coordination

Curriculum, SMART Teams, Child and Adolescent Needs and Strengths - Family (CANS-F), CHART, Supportive Housing, ED and Up from IHI, Help Me Grow Mid-Level Developmental Assessment (MLDA) Model, Recovery Care Coordination, GRACE, and CCS ED Diversion. See Figure 2 below for a full report of implemented models.

Figure 2. Care Coordination Evidence-Based Models, April-September 2019 Partner Reporting, North Sound ACH.



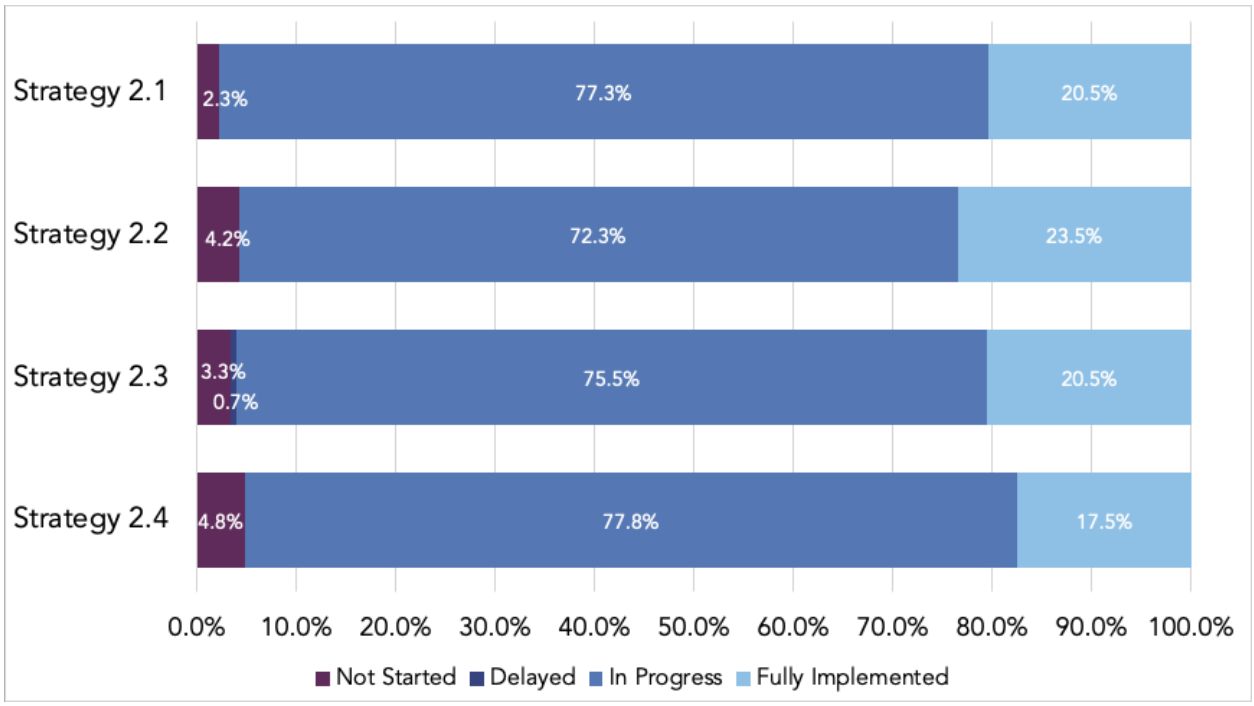
Addressing the Opioid Crisis Strategies

There are four opioid strategies that include:

- Strategy 2.1 - Prevent Opioid Use and Misuse
- Strategy 2.2 - Link Individuals with Opioid Use Disorder with Treatment
- Strategy 2.3 - Intervene in Opioid Overdoses to Prevent Death
- Strategy 2.4 - Community Recovery Services and Networks for Opioid Use Disorder

Figure 3 outlines details the Change Status reporting of each opioid strategy.

Figure 3. Opioid Strategies Change Status Reporting, April-September 2019 Partner Reporting, North Sound ACH.



Milestone 1 - Implementation of Committed Tactics

All partners committed to opioid strategies reported having started working on their committed tactics and no delays were reported. Strategy 2.1 - Prevent Opioid Use and Misuse has the most progress being made on implementation tactics, with 100.0% of committed partners reporting implementation on the following tactics:

- Promote use of best practices for prescribing opioids for managing acute and chronic pain.
- Together with the Center for Opioid Safety Education and other partners, such as statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid-users.
- Providers and staff are trained on guidelines for prescribing opioids for pain.

Other opioid tactics that have 100.0% of committed partners reporting implementation include:

- Strategy 2.2 Tactics
    - Expand access to, and utilization of, Opioid Use Disorder medication in the criminal justice system.
- Strategy 2.3 Tactics
    - Make system-level improvements to increase the availability and use of naloxone.

Tactics with the lowest percentages of implementation for opioid strategies include:

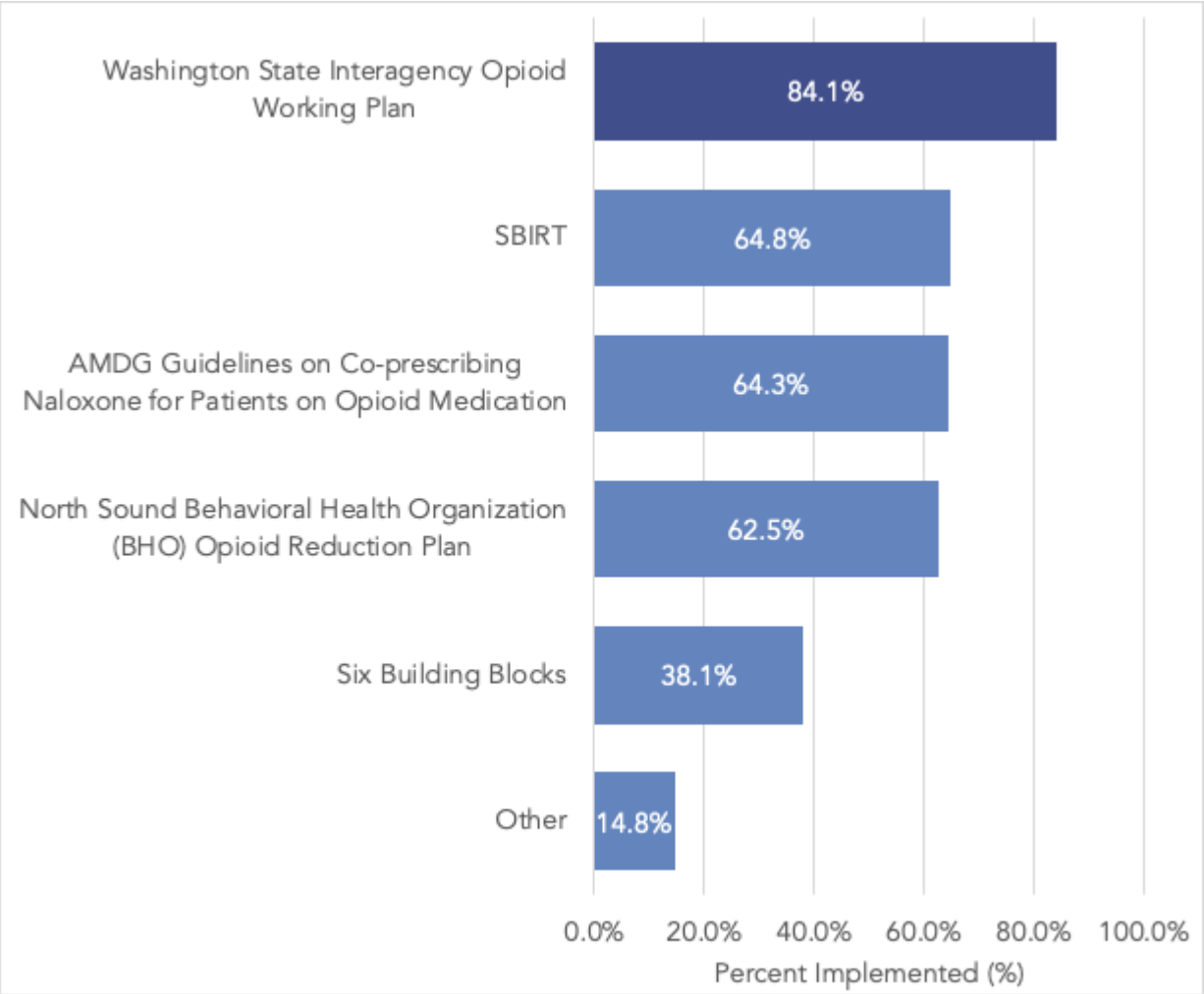
- Strategy 2.1 Tactics
    - Implement the Six Building Blocks model (28.6%).

- Strategy 2.2 Tactics
    - Implement the Six Building Blocks model (40.0%).
- Strategy 2.4 Tactics
    - Use Telehealth resources to expand capacity to support opioid use disorder prevention and treatment (62.5%).
    - Utilize technical assistance to organize or expand syringe exchange programs (66.7%).

Milestone 2 - Evidence-Based Models and Promising Practices

One partner reported delays in implementation of opioid strategy evidence-based models and three (3.4%) reported not have started selecting models. There are five evidence-based models for opioid strategies. The most commonly implemented model is the Washington State Interagency Opioid Working Plan (84.1%), which is implemented across all four strategies. Several partners also noted using models or practices other than those listed, including the Recovery Coach Model, providing Naloxone to patients at risk for overdose, Starts with One, Recovery Cafe Model, integrating PMP into EPIC, Bree Collaborative, CDC Guidelines for Prescribing Opioid for Chronic Pain, Whatcom has HOPE Campaign, SURGE Grants, and linking patients with Ideal Options. See Figure 4 below for a full report of implemented models.

Figure 4. Addressing the Opioid Crisis Evidence-Based Models, April-September 2019 Partner Reporting, North Sound ACH.



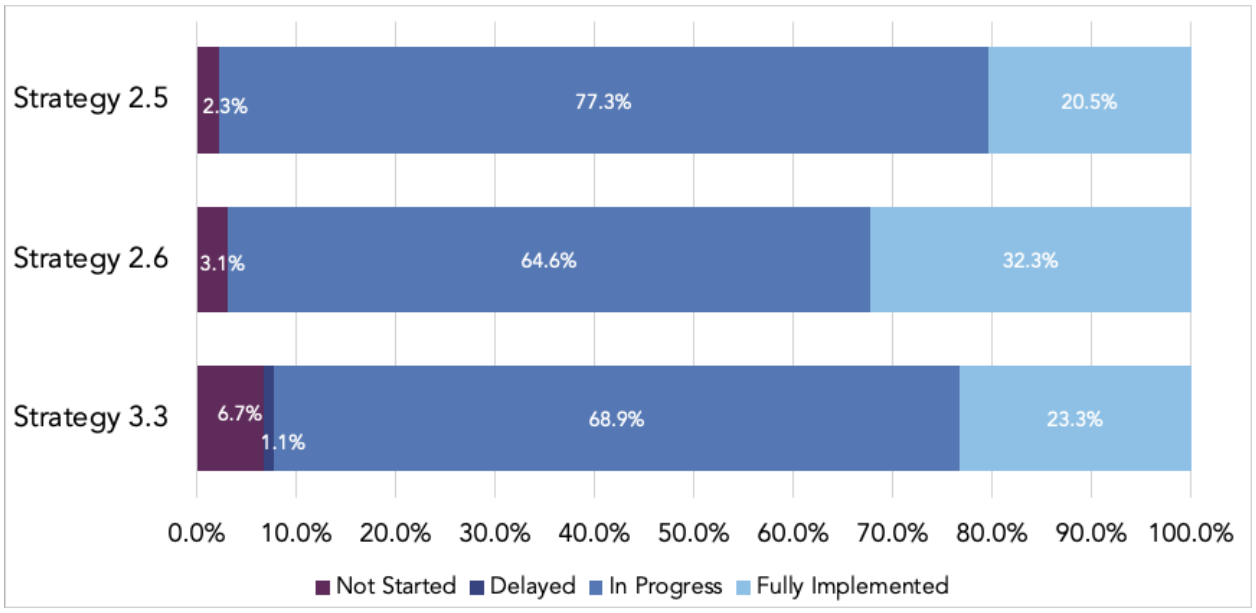
Reproductive Health and Pediatric Practices Strategies

There are three reproductive health and pediatric practice strategies, including:

- Strategy 2.5 - Fully Spectrum of Reproductive Health Services (including Long-Acting Reversible Contraception (LARC))
- Strategy 2.6 - Pediatric Practices to Promote Child Health, Well-Child Visits, and Childhood Immunizations
- Strategy 3.3 - Integrate Reproductive Health Services in Clinical and Community Settings

Figure 5 outlines details the Change Status reporting of each reproductive health and pediatric practice strategy.

Figure 5. Reproductive Health and Pediatric Practice Strategies Change Status Reporting, April-September 2019 Partner Reporting, North Sound ACH.



Milestone 1 - Implementation of Committed Tactics

Strategy 3.3 - Integration of Reproductive Health Services in Clinical and Community Settings is the only strategy in this area that has partners who reported delays in implementing their committed tactics (12.5%). Strategy 2.5 - Full Spectrum of Reproductive Health Services and Strategy 2.6 - Pediatric Practices to Promote Child Health, Well-Child Visits, and Childhood Immunizations have the most progress being made on implementation tactics, with two-thirds of their tactics having 100.0% of committed partners reporting implementation:

- Strategy 2.5 Tactics
    - Facilitate referral of all individual in first trimester of pregnancy to appropriate prenatal care.
    - Facilitate referral of all pregnant individuals with high risk behaviors to evidence-based community support programs and specialty care.
    - Staff are trained to offer education and information resources to all patients on the full spectrum of contraceptive options (including LARC) and their relative effectiveness.
    - Facilitate referral of all individuals with a history of adverse pregnancy outcomes to evidence-based community support programs.
- Strategy 2.6 Tactics
    - Embed Healthy Steps specialist or a trained staff member in pediatric practice to increase well-child visits, support early child behavioral health integration.
    - Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

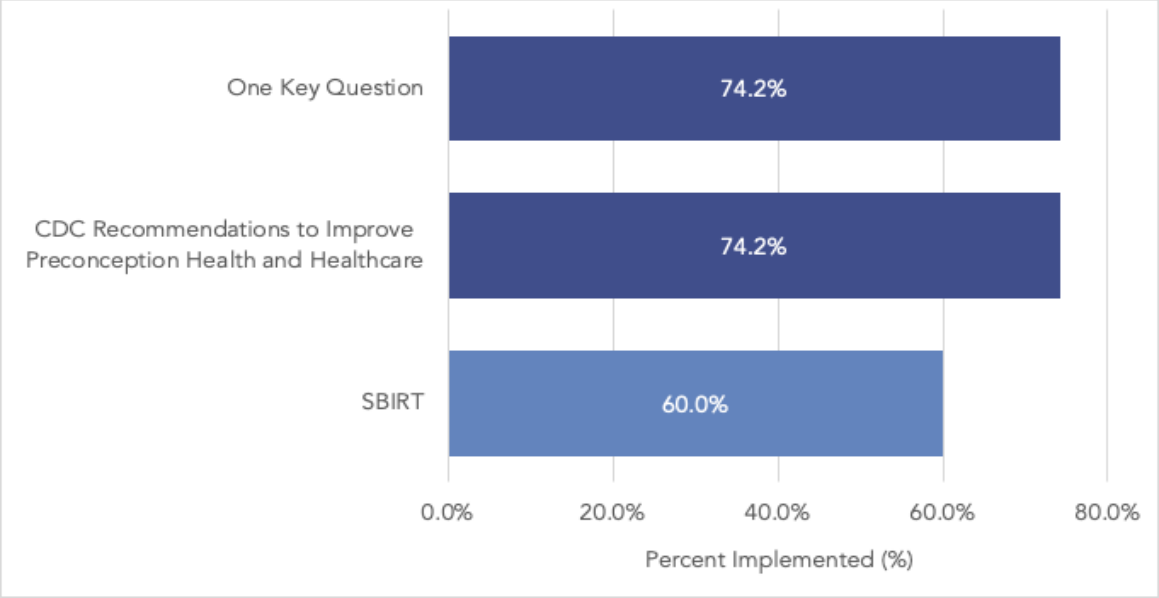
Tactics with the lowest percentages of implementation for reproductive health and pediatric practices strategies include:

- Strategy 2.5 Tactics
    - Offer a full range of effective contraceptive methods, including Long-acting Reversible Contraception (LARC) (80.0%).
    - Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs (75.0%).
- Strategy 3.3 Tactics
    - Incorporate One Key Question into patient/client assessments (68.8%).

Milestone 2 - Evidence-Based Models and Promising Practices

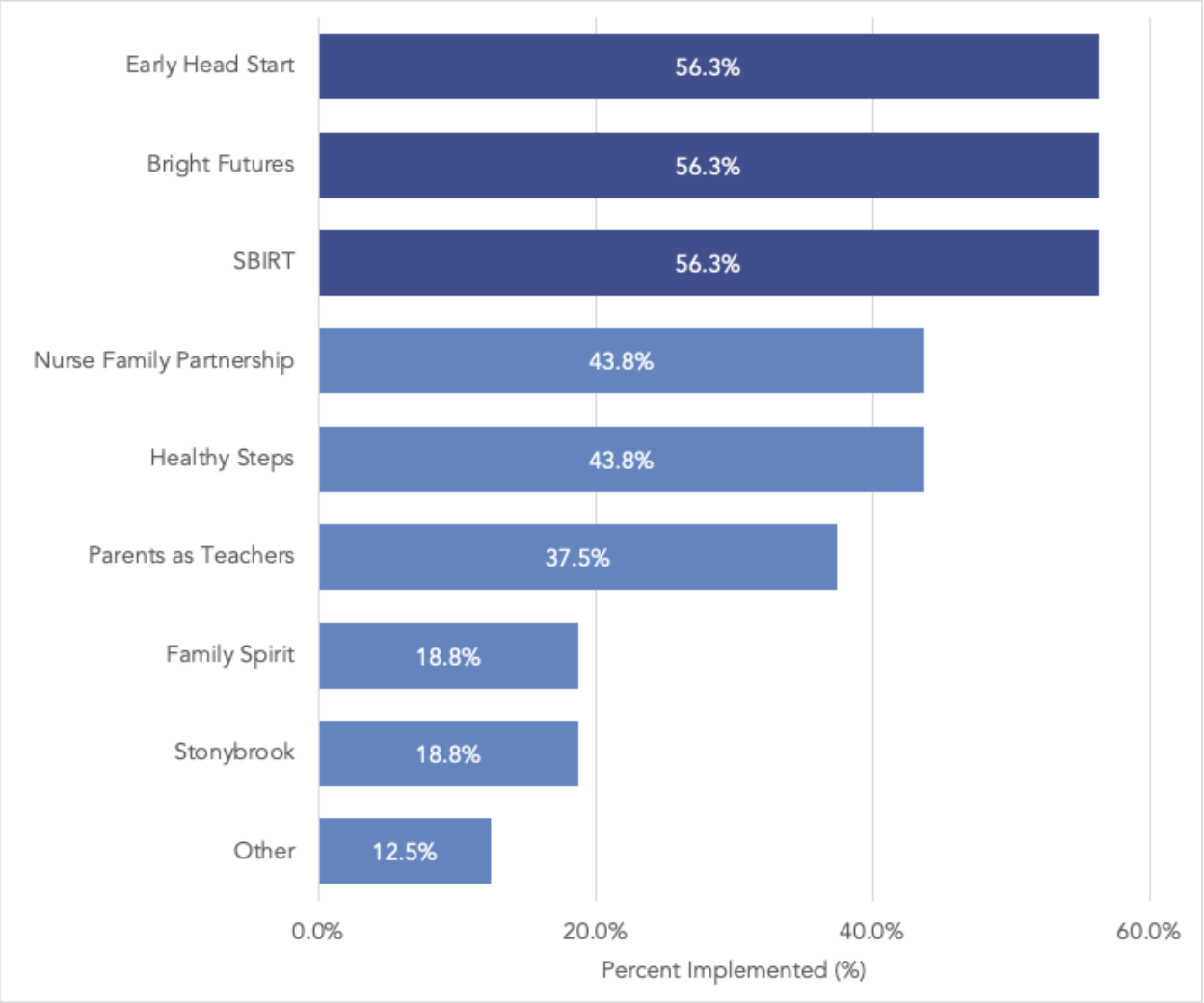
One partner reported delays in implementation of reproductive health evidence-based models and 4.3% reported not have started selecting models. There are three evidence-based models for reproductive health strategies. One Key Question and the CDC's Recommendations to Improve Preconception Health and Health Care were implemented across both strategies evenly (74.2%). See Figure 6 below for a full report of implemented models.

Figure 6. Reproductive Health Evidence-Based Models, April-September 2019 Partner Reporting, North Sound ACH.



For the Strategy 2.6 - Pediatric Practices, one partner (6.3%) reporting not having started selecting models. The most commonly implemented models were Early Head Start, Bright Futures, and SBIRT, all at 56.3%. Additional model that partners indicated using for pediatric strategies include Medical Home, SMART Teams, Help Me Grow, and Children with Special Health Care Needs. See Figure 7 below for a full report of implemented models.

Figure 7. Pediatric Practice Evidence-Based Models, April-September 2019 Partner Reporting, North Sound ACH.



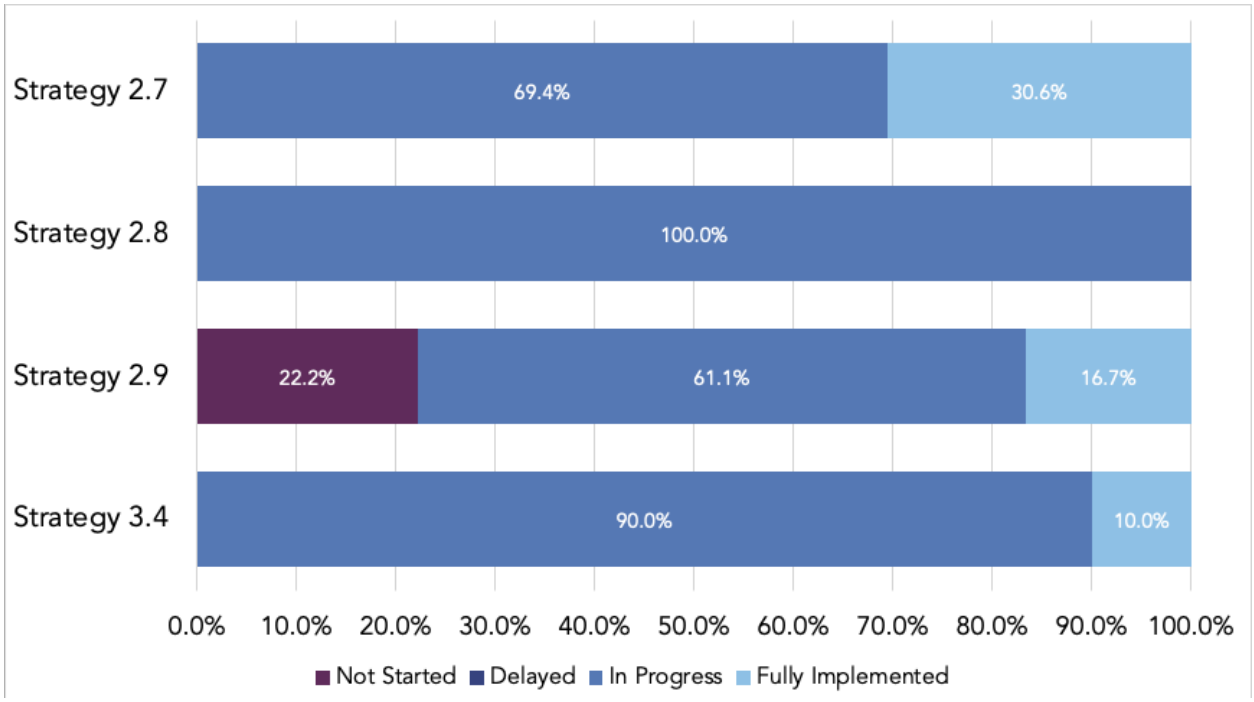
Oral Health Strategies

There are four oral health strategies, including:

- Strategy 2.7 - Population Management in Oral Health Settings
- Strategy 2.8 - Dental Health Aide Therapists (DHATs) in Tribal Clinics
- Strategy 2.9 - Mobile Dental Care in Community Settings
- Strategy 3.4 - Integrate Oral Health Care into Physical Health or Behavioral Health Settings

Figure 8 outlines details the Change Status reporting of each oral health strategy.

Figure 8. Oral Health Strategies Change Status Reporting, April-September 2019 Partner Reporting, North Sound ACH.



Milestone 1 - Implementation of Committed Tactics

No partners reported experiencing delays or not having started tactics related to Oral Health strategies. Oral health strategies are much further along than many of the other areas, however, this area has very few partners compared to other strategies with six partners for Strategy 2.7, one for Strategy 2.8, three for Strategy 2.9, and four for Strategy 3.4. It is possible that many of the committed partners were doing much of this work prior to ACH implementation, resulting in high rates of implementation. Tactics with 100.0% implementation are as follows:

- Strategy 2.7 Tactics
    - Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.
    - Use International Statistical Classification of Diseases (ICD-10) coding in oral health settings.
    - Increase or expand use of silver diamine fluoride.
    - Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- Strategy 2.8 Tactics
    - Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.
- Strategy 2.9 Tactics
    - Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.
- Strategy 3.4 Tactics
    - Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.

    - Physical health providers are trained on screening for oral health needs and engagement with oral health provider.
    - Physical health providers are trained to apply fluoride varnish.
    - Physical health providers perform oral health screening when appropriate.

Two tactics had less than 100.0% implementation:

- Strategy 3.4 Tactics
    - Facilitate referral of all patients/clients needing dental care to community dental providers, and/or mobile dental services (75.0%).
    - Follow-up with oral health referral partner after referral is made (75.0%).

Milestone 2 - Evidence-Based Models and Promising Practices

One partner indicated not starting implementation of models or promising practices for oral health strategies, for Strategy 2.9. Unlike other areas, oral health models and promising practices are not implemented across multiple strategies. Model and promising practice implementation by strategy is as follows:

- Strategy 2. 7 Evidence-Based Models and Promising Practices
    - Guidelines to improve access to oral health services, especially among children and pregnant individuals (100.0%).
    - Screening, Brief Intervention, Referral to Treatment (SBIRT) (66.7%).
- Strategy 2.8 Evidence-Based Models and Promising Practices
    - Requirements and standards of Dental Health Aide Therapists (DHATs) in Tribal Clinics (100.0%).
- Strategy 2.9 Evidence-Based Models and Promising Practices
    - Requirements and standards for mobile dental units and portable dental care equipment (66.7%).
- Strategy 3.4 Evidence-Based Models and Promising Practices
    - Guidelines to improve integration of oral health screening, assessment, intervention, and referral into primary care and/or behavioral health settings (100.0%).

Chronic Disease Management and Prevention Strategies

There are two chronic disease management and prevention strategies, including:

- Strategy 2.10 - Clinical Transformation for Prevention and Management of Chronic Disease
- Strategy 2.11 - Community Linkages for Chronic Disease Prevention and Management Programs

Milestone 1 - Implementation of Committed Tactics

Nearly one-third of partners (29.4%) for Strategy 2.10 indicated not having yet started implementing their committed tactics. One partners (3.7%) for Strategy 2.11 had not started implementing their

tactics and one indicated delays. Strategy 2.11 has the most progress being made on implementation tactics, with 82.6% of committed partners reporting implementation on the following tactic:

- Patients/clients are referred to chronic disease education and support services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), and exercise programs based on patient/client diagnosis and profile.

Partners committed to 2.11 indicated progress was made on other tactics related to the strategy not listed (14.8%).

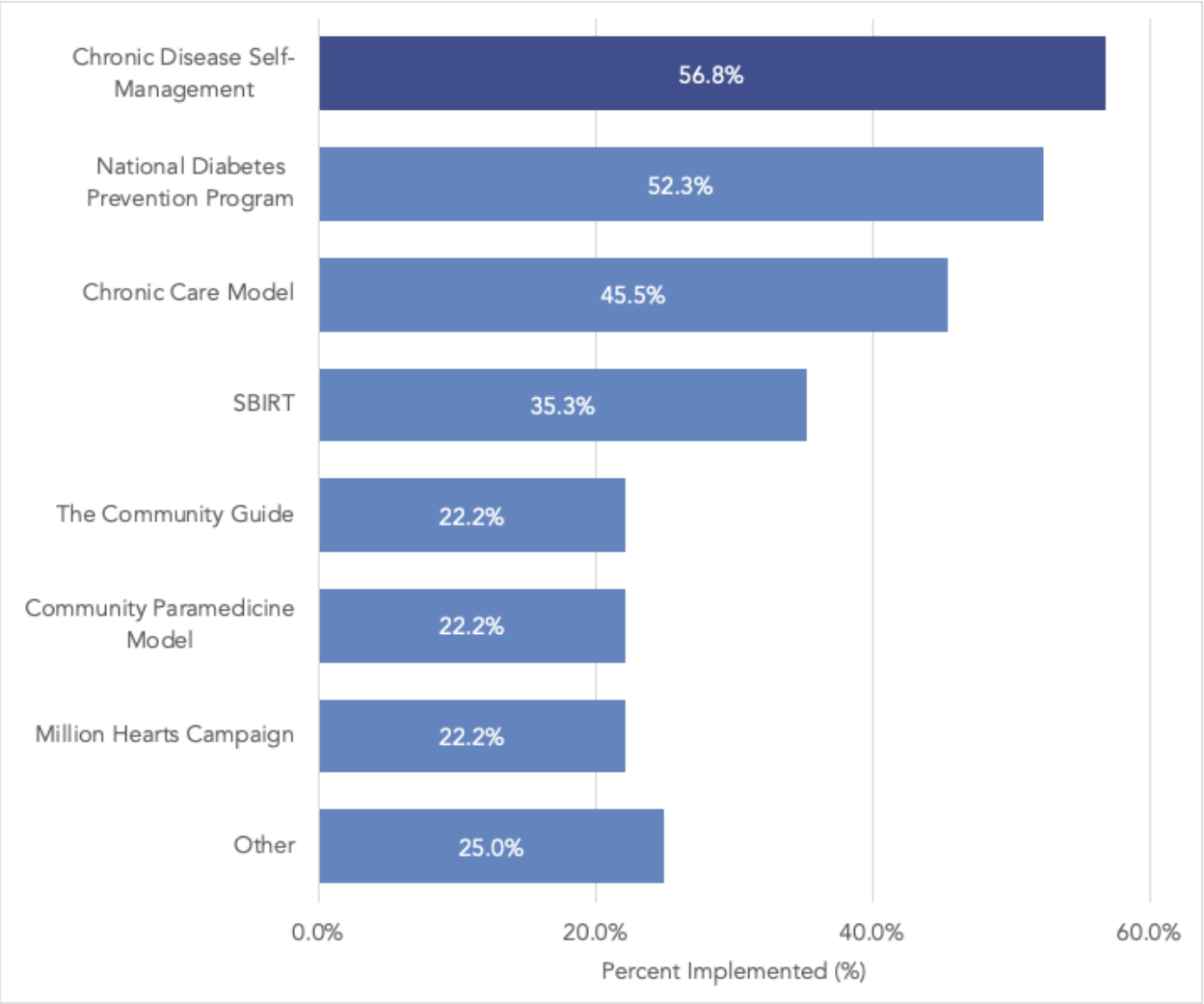
Implementation for Strategy 2.10 tactics are as follows:

- Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs (50.0%).
- Other tactics related to the strategy not listed (41.2%).

Milestone 2 - Evidence-Based Models and Promising Practices

Four partners reported not having started implementation of chronic disease strategy models. There are seven evidence-based models for chronic disease management strategies. The most commonly implemented model is Chronic Disease Self-Management (CDSM) (56.8%), which is implemented across both strategies. Several partners also noted using other models including Fruit and Vegetable Prescription Programs, Actively Changing Together (ACT!), CDC DPP Program, LiveSTRONG, Enhance Fitness, LOCUS, ANSA, IMR, DBT, HealthMeet, Teen Heart Screening, and Native American prevention projects including fitness challenges and nutrition education classes. See Figure 9 below for a full report of implemented models.

Figure 9. Chronic Disease Management Evidence-Based Models, April-September 2019 Partner Reporting, North Sound ACH.



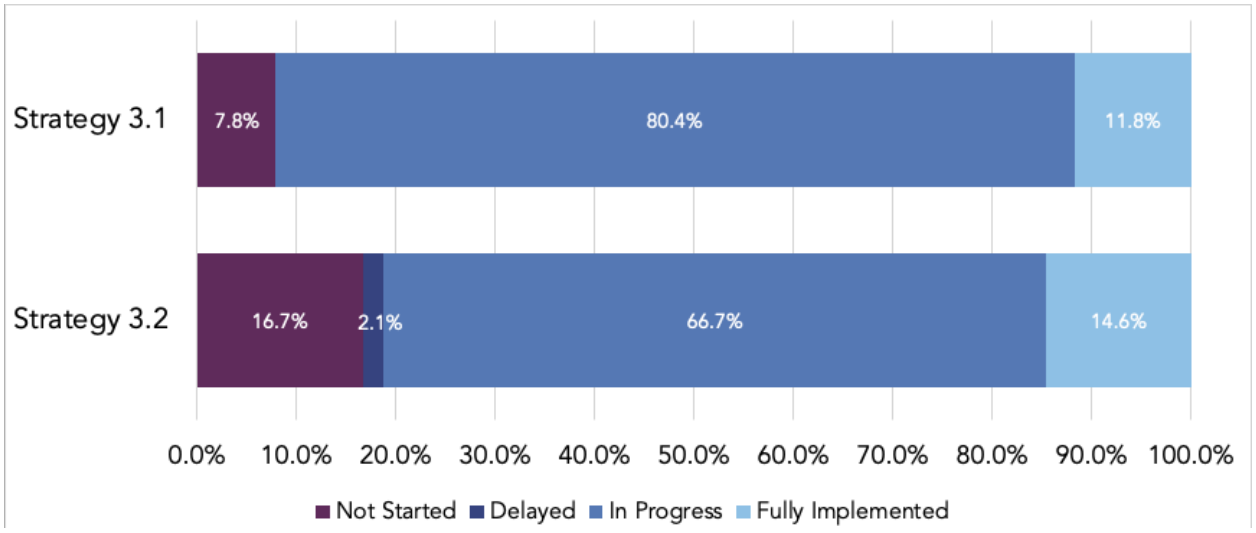
Bi-Directional Integration Strategies

There are two bi-directional integration strategies, including:

- Strategy 3.1 - Integrate Behavioral Health Services in Primary Care Settings
- Strategy 3.2 - Integrate Physical Health Services in Behavioral Health Settings

Figure 10 outlines details the Change Status reporting of each reproductive health and pediatric practice strategy.

Figure 10. Bi-Directional Integration Strategies Change Status Reporting, April-September 2019 Partner Reporting, North Sound ACH.



Milestone 1 - Implementation of Committed Tactics

Two partners, one for Strategy 3.1 and one for Strategy 3.2, indicated not having yet started implementing their committed tactics. Strategy 3.2 has the most progress being made on implementation tactics:

- Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s) (75.0%).
- Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool (87.5%).
- Enhance collaboration of primary care and behavioral health providers (87.5%).

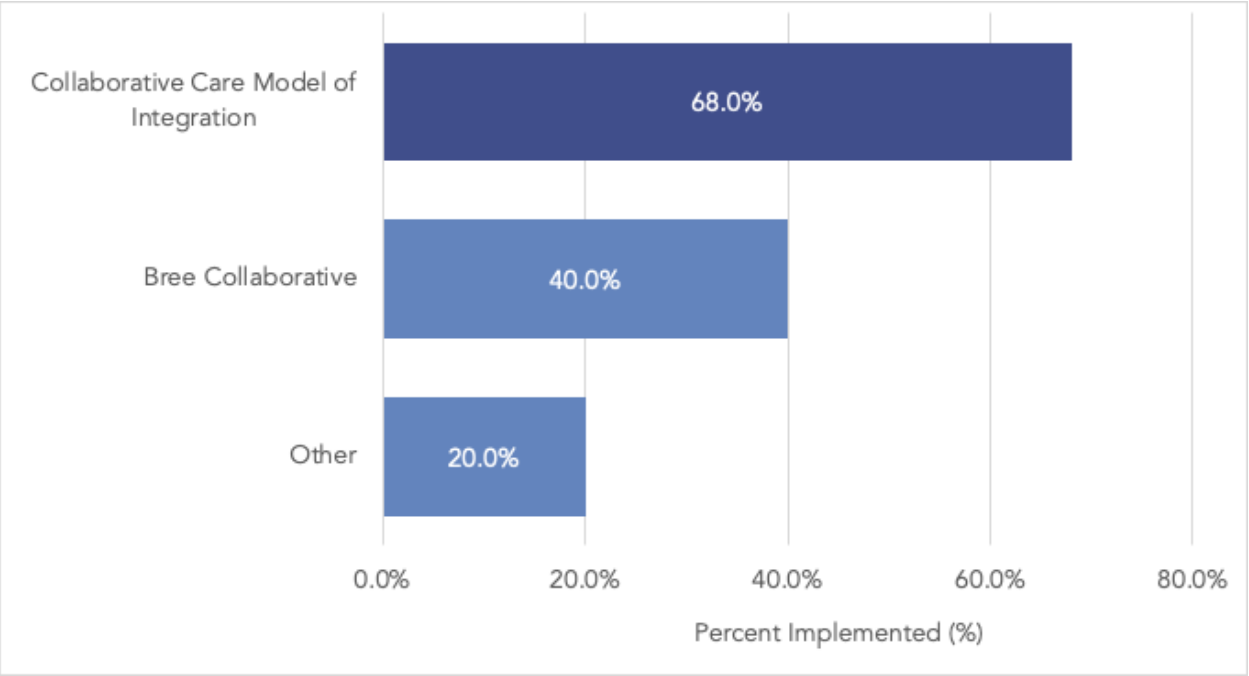
Implementation for Strategy 3.1 tactics are as follows:

- Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s) (52.9%).
- Providers are trained on the Collaborative Care Model of Integration (64.7%).
- Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool (94.1%).

Milestone 2 - Evidence-Based Models and Promising Practices

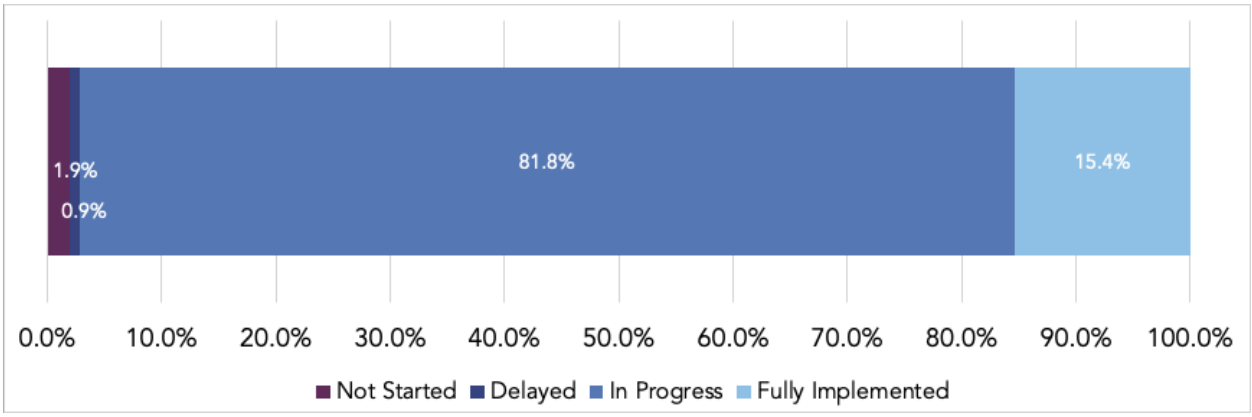
Two partners indicated not having yet started selecting models for Strategy 3.1 and two indicated not have yet started for Strategy 3.2. There are two evidence-based models for bi-directional integration strategies. The most commonly implemented model is Collaborative Care Model of Integration (68.0%), which is implemented across both strategies. Other models that partners indicated using for bi-directional integration strategies include University of Washington AIMS Model and ANSA. See Figure 11 below for a full report of implemented models.

Figure 11. Bi-directional Integration Evidence-Based Models, April-September 2019 Partner Reporting, North Sound ACH.



Capacity Building Strategies

Figure 12. Capacity Building Change Status Reporting, April-September 2019 Partner Reporting, North Sound ACH.



Milestone 1 - Leadership, Management, Transparency, and Accountability

Four of the six tactics under Milestone 4.1.1 were required for all partners. All partners reported participation in North Sound ACH partner convenings and collaboration with North Sound ACH partners. While 45 partners (91.8%) reporting participating in the North Sound Equity and Tribal Learning Series, this, however, is most likely an error as 100.0% of partners sent representatives to our May 22 Tribal and Equity Learning Series Launch and the August Partner Retreat. Forty-six partners (93.9%) reported participating in trainings on topics critical to implementation, such as Trauma-Informed Care, Adverse Childhood Experiences, and LGBTQ+ communities.

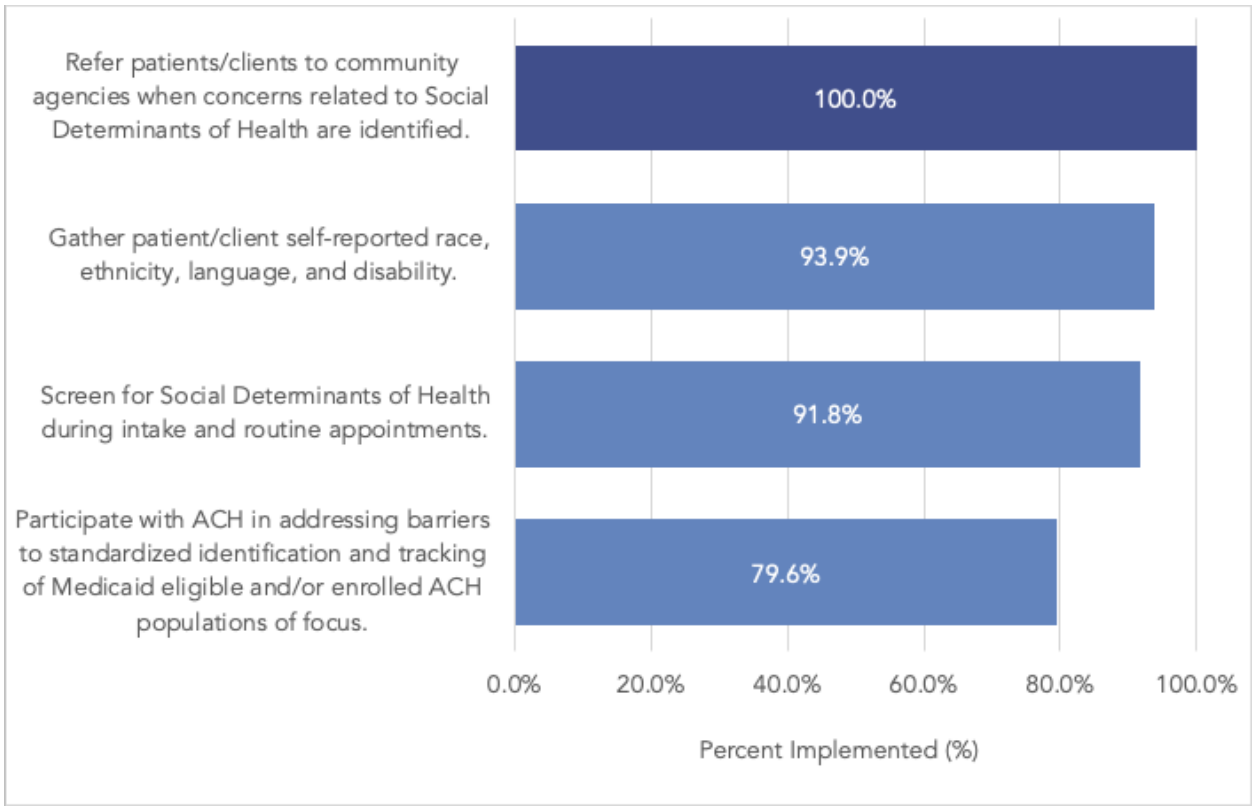
Milestone 2 - Accessibility

Milestone 4.1.2 included eight tactics related to patient accessibility. Implementation of the four required tactics is well under way for most organizations; these include maintaining a public-facing website (100.0%), maintaining a toll-free number (85.7%), and offering language translation (87.8%) and interpreter services (87.8%). The remaining four tactics ranged in implementation from 37.5% (Participate in Choosing Wisely initiative) to 93.3% (Offer health insurance enrollment onsite).

Milestone 3 - Equity and Health Disparities

Milestone 4.1.3 included four tactics related to advancing equity and reducing health disparities that all partners were required to commit to. The tactic with the highest reporting of implementation was for referral of clients to community agencies when Social Determinants of Health (SDOH) concerns were identified (100.0%). The lowest reported implementation was for participation in conversations to address barriers to standardized identification and training of Medicaid populations of focus (79.6%). This is still an area that the North Sound ACH has plans to expand capacity building work (see Figure 13).

Figure 13. Capacity Building Milestone 3 Tactics, April-September 2019 Partner Reporting, North Sound ACH.



Milestone 4 - Population Health Management

Milestone 4.1.4 included seven tactics related to population health management (Table 2). All partners were required to "participate in regional discussions of shared health information and health information exchange gaps and opportunities" and to "respond to periodic North Sound ACH requests for information on gaps and subject matter expertise." Commitments to the remaining tactics ranged from 10 partners (Washington Syndromic Surveillance Program/Rapid Health Information Network) to 29 partners (Premanger/EDie). The Prescription Drug Monitoring Program (PMP) tactic had the most partners reporting implementation (94.7%) and the Washington Syndromic Surveillance Program/Rapid Health Information Network (RHINO) reported the lowest implementation (60.0%).

Table 2. Milestone 4.1.4 - Leverage and expand systems for population health management, April-September 2019 Partner Reporting, North Sound ACH, n=49.

	In Progress or Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N

Participate in regional discussions of shared health information and a health information exchange (HIE) gaps and opportunities.	37	75.5	1	2.0	49
Respond to periodic North Sound ACH requests for information on gaps and subject matter expertise.	41	83.7	1	2.0	49
Increase use of Prescription Drug Monitoring Program (PMP).	18	94.7	0	0.0	19
Increase use of Washington Syndromic Surveillance Program/Rapid Health Information Network (RHINO).	6	60.0	0	0.0	10
Increase use of Washington State Immunization Information Systems (WA IIS).	15	93.8	0	0.0	16
Increase use of Washington State EMS system (WEMSIS).	10	66.7	1	6.7	15
Report on feasibility of integrating tools like PreManage or EDie.	25	86.2	1	3.4	29

Number Not Started = 3 (1.6%)

Milestone 5 - Value-Based Payments

Of the 49 North Sound ACH partners, 20 (40.8%) have committed to implementing "strategies to increase readiness of providers to enter into advanced value-based payment contracts." One partner (5.0%) reporting not have started work on value-based payments and the remaining 19 (95.0%) reporting that work on implementing value-based payments was currently in progress.

Aggregated Strategy Data

Milestone 3 - Populations of Focus

During reporting, partners were asked to identify which populations they were focusing on for each of the strategies they had committed to. Figure 14 below outlines the total number of partners that have identified working with each population for at least one of their committed strategies. The most commonly identified populations of focus were for people experiencing access, care, and utilization disparities, and for people experiencing co-occurring disorders and conditions, with 93.9% of partners identifying these populations for at least one strategy. The next most reported populations were for people with chronic conditions at 91.8%.

Figure 14. Populations of Focus, April-September 2019 Partner Reporting, North Sound ACH.

Population	Partners	
People experiencing access, care, and utilization disparities	46 (93.9%)	
People experiencing co-occurring disorders/conditions	45 (91.8%)	
People experiencing homelessness	43 (87.8%)	
People experiencing pregnancy	37 (75.5%)	
People experiencing serious mental illness	42 (85.7%)	
People experiencing substance use disorder (SUD), include opioid use disorder (OUD)	43 (87.8%)	
People who are high utilizers of systems	44 (89.8%)	
People who have been arrested	36 (73.5%)	
People who have experienced abuse, trauma, and ACES	40 (81.6%)	
People with chronic conditions = 5 partners	43 (87.8%)	

Opportunities for expanding populations of focus includes people who have been arrested, which 73.5% of partners identified as a population of focus, people experiencing pregnancy, which 75.5% of partners identified, and people who have experienced abuse, trauma, and adverse childhood experiences, which 81.6% of partners identified as a population of focus.

Milestone 4 - Trainings and Technical Assistance

For each strategy under Care Coordination, Care Transformation, and Care Integration, all partners were required to commit to Milestone 4 - Participate in trainings and utilize technical assistance resources necessary to perform role in committed strategies. The tactics for Strategy 1.1 - Pathways Community HUB are slightly different than the rest of the strategies and therefore are not included here. For a full analysis of Strategy 1.1, please see attached tables.

For Milestone 4, 5.8% of commitments to this milestone had not yet been implemented by partners, and 1.5% were reported as delayed. The tactic with the highest implementation was "Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach." (79.9%) and the lowest was "Utilize trainings and/or technical assistance offered by ACH to address areas identified as needing improvement." (67.9%).
See Table 3 below for the full analysis of Milestone 4.

Table 3. Milestone 4 - Participate in trainings and utilize technical assistance resources necessary to perform role in committed strategies, April-September 2019 Partner Reporting, North Sound ACH, n=293.

	In Progress or Fully Implemented	
Tactic	N	%
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	234	79.9
Utilize trainings and/or technical assistance offered by ACH to address areas identified as needing improvement.	199	67.9
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	208	71.0

Milestone 5 - Quality Improvement

For each strategy under Care Coordination, Care Transformation, and Care Integration, all partners were required to commit to Milestone 5 - Use continuous quality improvement strategies, measures, and targets to support implementation of committed strategies. The tactics for Strategy 1.1 - Pathways Community HUB is slightly different than the rest of the strategies and therefore are not included here. For a full analysis of Strategy 1.1, please see attached tables.

For Milestone 5, 7.8% of commitments to this milestone had not yet been implemented by partners, and 3.0% were reported as delayed. The tactic with the highest implementation was "Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, QI specific policies and procedures." (84.0%) and the lowest was "Utilize direct transformation coaching when appropriate and/or available." (60.4%). See Table 4 below for the full analysis of Milestone 5.

Table 4. Milestone 5 - Use continuous quality improvement strategies, measures, and targets to support implementation of committed strategies, April-September 2019 Partner Reporting, North Sound ACH, n=293.

	In Progress or Fully Implemented	
Tactic	N	%
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools	246	84.0

and methodologies in use, quality improvement (QI) specific policies and procedures.		
Staff are trained in quality improvement methodologies.	210	71.8
Utilize direct transformation coaching when appropriate and/or available.	177	60.4

Milestone 6 - Guidelines, Policies, Procedures, and Protocols

For each strategy under Care Coordination, Care Transformation, and Care Integration, all partners were required to commit to Milestone 6 - Develop guidelines, policies, procedures and protocols to support committed strategies. The tactics for Strategy 1.1 - Pathways Community HUB are slightly different than the rest of the strategies and therefore are not included here. For a full analysis of Strategy 1.1, please see attached tables.

For Milestone 6, 3.8% of commitments to this milestone had not yet been implemented by partners, and 1.3% were reported as delayed. The tactic with the highest implementation was "Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy." (91.5%) and the lowest was "Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed." (72.4%). See Table 5 below for the full analysis of Milestone 6.

Table 5. Milestone 6 - Develop guidelines, policies, procedures and protocols to support committed strategies, April-September 2019 Partner Reporting, North Sound ACH, n=293.

	In Progress or Fully Implemented	
Tactic	N	%
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	268	91.5
As needed integrate new guidelines, policies, and procedures for selected strategy.	243	82.9
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	212	72.4

Narrative Responses

Partners were asked to respond to open-ended narrative questions for each of the initiatives they were committed to and the Capacity Building initiative. Questions for the three Care Initiatives included:

1. What has changed for your organization since implementation? Please include any changes in scope of work and/or populations being served.
2. What was challenging, and why? What held you back?
3. Describe how you are using quality improvement to support implementation. Please identify any specific QI methods, approaches, or models you are using. What resources/assistance are needed to support these efforts?
4. How are you applying requirements and standards of evidence-based models and/or promising practices to your selected strategies within this initiative? Include the names of the model/promising practice and a description of how you are implementing them in your scope of work.
5. Tell us about your collaboration efforts with both ACH and non-ACH partners. Which partners are you working with for this initiative, and how are you collaborating with them? Which, if any, of these are new partners for your organization?
6. Tell us what policies, procedures, or protocols you have adopted for this initiative and describe your process for implementing them. Describe any challenges you've had in adopting them.
7. What do you see as the next steps for your work in this initiative? What assistance/resources could help you move the work forward?

The Capacity Building initiative narrative questions included questions 1, 2, and 7 above. Responses to the open-ended narrative questions coded to identify the following themes: facilitators, barriers, change in capacity, and impact of initiative strategies. To code narrative responses, each response was read through by North Sound ACH staff and quotes that met the definition for the codes (outlined in Table 6 below) were highlighted and entered into a thematic analysis spreadsheet in Excel. Further subthemes from these highlighted quotes, called "response excerpts" were then identified. The total number of quotes under each theme and subtheme were then quantified. Significant quotes were pulled to highlight the information provided.

Table 6. Codebook for Qualitative Analysis of Narrative Responses, April-September 2019 Partner Reporting, North Sound ACH.

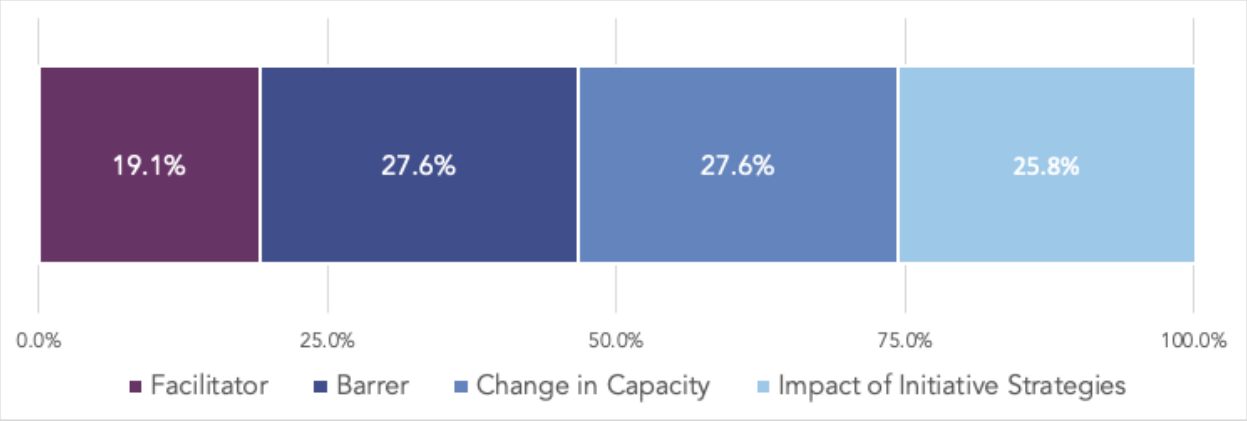
Primary Code/Theme	Definition
Facilitator	Facilitators experienced by North Sound ACH partners and stakeholders in achieving successful implementation of their scope of work.

Barrier	Barriers experienced by North Sound ACH partners and stakeholders in achieving successful implementation of their scope of work.
Change in Capacity	Any changes noted for organizational capacity building. Subthemes may include: quality improvement, access (ex. toll-free numbers, etc), evidence-based practices/models, data sharing agreements, value-based payment, workforce, capacity to address disparities.
Impact of Initiative Strategies	Examples of implementation progress and impact. Examples that would fall under this theme include: effectiveness of evidence-based practices/models, cross-partner coalition building, increased community-clinic linkages, key changes in utilization and access (ex. Emergency department visits), scope and spread of common health information technology platforms.

Summary of Qualitative Findings

The qualitative analysis included a total count of 1,165 response excerpts from the open-ended narrative questions. Of these excerpts, two themes, Barrier and Change in Capacity, had the most excerpts at 27.6%, and the theme Facilitator had the least at 19.1% (Figure 15).

Figure 15. Qualitative Coding Themes, April-September 2019 Partner Reporting, North Sound ACH, n=1,165.



When looking across the four North Sound ACH initiatives, differences can be seen by theme. For the theme Facilitator, the initiative Care Integration has the highest percentage of excerpts (21.1%), indicating that more partners have reported on facilitators to help them achieve implementation of their work on Care Integration strategies. Capacity building has the highest percentage of barriers reported (32.9%), which indicates that North Sound ACH staff should be focusing on barriers partners may be experiencing for their Capacity Build work. The highest percentage for Impact of Initiative Strategies was for Care Transformation (31.3%), indicating that partners are seeing the impacts of these strategies and are providing examples that may be useful for sustainability and future funding. See Table 7 below for all counts and percentages by initiative and theme.

Table 7. Qualitative Coding by Theme and Initiative, April-September 2019 Partner Reporting, North Sound ACH, n=1,165.

Initiative	Care Coordination		Care Transformation		Care Integration		Capacity Building		
Theme	N	%	N	%	N	%	N	%	Total
Facilitator	73	19.9	72	17.6	31	21.1	47	19.3	223
Barrier	99	27.0	95	23.2	47	32.0	80	32.9	321
Change in Capacity	97	26.5	114	27.9	28	19.0	82	33.7	321
Impact of Initiative Strategies	97	26.5	128	31.3	41	27.9	34	14.0	300
Total	366	100.0	409	100.0	147	100.0	243	100.0	1,165

Qualitative Conclusions

Findings from the qualitative coding were reviewed to identify sub themes within the previously analyzed themes. Several sub themes emerged that are important for better understanding the work that has been done during the first year of implementation and for identifying needs from the North Sound ACH to partners. See Appendix D for a full list of sub themes that emerged from qualitative analysis.

For the theme "Facilitator" one notable sub theme that emerged was partners indicating collaboration with other ACH partners as well as non-ACH organizations as a facilitator to successful implementation of their work (43.5%). Examples include working with "*community partners to provide targeted intensive case management and care coordination services to clients who are dealing with substance abuse/opioid addiction.*" Partners have also indicated that collaborations created through North Sound ACH convenings act as facilitators by allowing partners to "*learn more about [their] local resources and create new relationships with others in the ACH that are doing similar work.*" Collaboration acts as a large facilitator to this work, with partners participating "*in campaigns to raise awareness of the possible adverse effects of opioid use,*" "*providing evidence-based parenting support for low-income families...at risk of experiencing Adverse Childhood Experiences*," and referring "*pregnant and parenting mothers to the Parent-Child Assistance Program...where they can receive the support that they need … to provide a safe and nurturing environment for their children.*" Partners also noted trainings (21.1%), such as the "*North Sound ACH's Equity Training… [which] prompted an agency-wide discussion of internal policies and procedures regarding diversity, equity, and inclusion*" and training "*clinical staff on the use of Narcan*" as a facilitator to their work. Workforce expansion (12.1%) was noted as a facilitator, such

hiring "*a Co-occurring Mental Health and Substance Use Disorder Clinical… [with] extensive training and experience as a Chemical Dependency Profession*", hiring a "*recruiter and HR Generalist to help recruit good staff, fill vacancies, and ensure good onboarding and training*" and hiring a "*Director of Accountable Care Operations that will lead efforts on all or our Value Based Payment contracts.*"

Alternatively, when looking at the theme "Barrier", workforce shortages and challenges emerged as the number one sub theme (24.6%). This included the "*loss of staff at clinical partner sites*" which lead to a narrowed population of focus for the organization, "*competition for MAs… [leading to a need] to add incentives for new hires,*" and demands "*often greater than staffing allows.*" The lack of collaboration was also a barrier to implementing work (13.7%), this includes the lack of collaboration from other partners, such as organizations expressing the desire for involvement from larger organization who they "*continue to invite to collaborate but few attend community meetings,*" organizations also felt they were being left out of collaboration opportunities stating that "*people don't often know the extent of what we do and they assume we are a small agency that serves a very small population.*" Other barriers related to collaboration included "*connect[ing] with the appropriate staff,*" "*geographical challenges*", and "f*inding time to coordinate with other partners.*" Issues obtaining the necessary trainings (12.1%) and technical assistance (9.0%) were also noted. Partners noted that they have a "*difficult time prioritizing trainings*" and that finding time "*both in terms of having adequate staffing to keep our agency doors open and also the time needed for off-island travel*" and "*busy provider schedules in all departments.*" Financial barriers to training were also noted, including "*staff and providers who needed to be compensated for their time.*" Partners noted many areas that they were lacking technical assistance where the North Sound ACH may be helpful, including "*a meeting to create connections between those medical providers who want to refer to CDSM and those community organizations which provide CDSM classes*", "*support in connection with other frequent utilizers initiatives*", "*time to connect with other providers using [Results Based Accountability] to see how it works in their clinics*", and "*continued convening by ACH and education around QI and equity.*"

Under the theme "Change in Capacity", which identified changes in organizational capacity building, several sub themes emerged, including data, policy, and capacity to address disparities. The most commonly identified sub theme was collaboration (26.5%), indicating the collaboration played a significant role in organizational capacity to implement their work. This included working with tribal partners such as "*attending Swinomish Days... and a training on the history of the Coast Salish people.*" Other collaborations supported "*QI efforts around equity, diversity, systemic oppression, and structural inequities*" and "*working with local community partners… to develop a screening tool to help clinic providers and support staff to determine appropriate referrals.*" Quality improvement (23.1%) was another major sub theme, including expanding "*staffing to free up time for data system development and quality improvement activities*", "*administrative support team and Executive Director… working on a continuous quality improvement project using PDSA involving refining and*

streamlining our data collection procedures", and development of a "*QI platform that will be used to track performance of building our capacity to deliver One Key Question and track key performance indicators.*" General capacity building (22.1%) to better serve clients and patients included examples such as "*adding a 1-800 [number and] language translation information and interpreter services*", offering "*walk in assessments or 'open access' to our clients so they can be seen same day*", and hiring "*a fourth General Dentist and have opened up the dental clinic for 10 hours on Saturdays.*" Equity (18.1%) emerged as the next most commonly identified sub theme. Partners indicated equity capacity building steps such as "f*ormally adopted a Health Equity statement and are now requiring training for all staff including implicit bias training*", building the "*electronic health record to include demographics including race, ethnicity, disability, and language...in order to develop reports to pull and understand our populations*", hosting trainings for all staff that includes "*identifying our own internal biases, correcting behavior, and working through scenarios where racial anxiety may impact our patients or providers*", and working "*to analyze our website for those who have low-vision.*"

Similar to the previous three themes, collaboration came in as a major sub theme for the theme "Impact of Initiative Strategies" (42.3%) indicating that collaboration was often identified as an outcome of participation in the Medication Transformation Project work. Examples include collaborating with tribal partners to "*propose a joint homeless housing program to focus on the disproportionality of Native American homelessness*", reducing "*hospital readmissions by partnering with our local Skilled Nursing Facilities to make sure information flow and communication are seamless*", and working with the Oral Health Local Impact Network "*to increase oral health screening and mobile dental van access in the county… [including] over 270 children receiv[ing] an oral health screening.*"

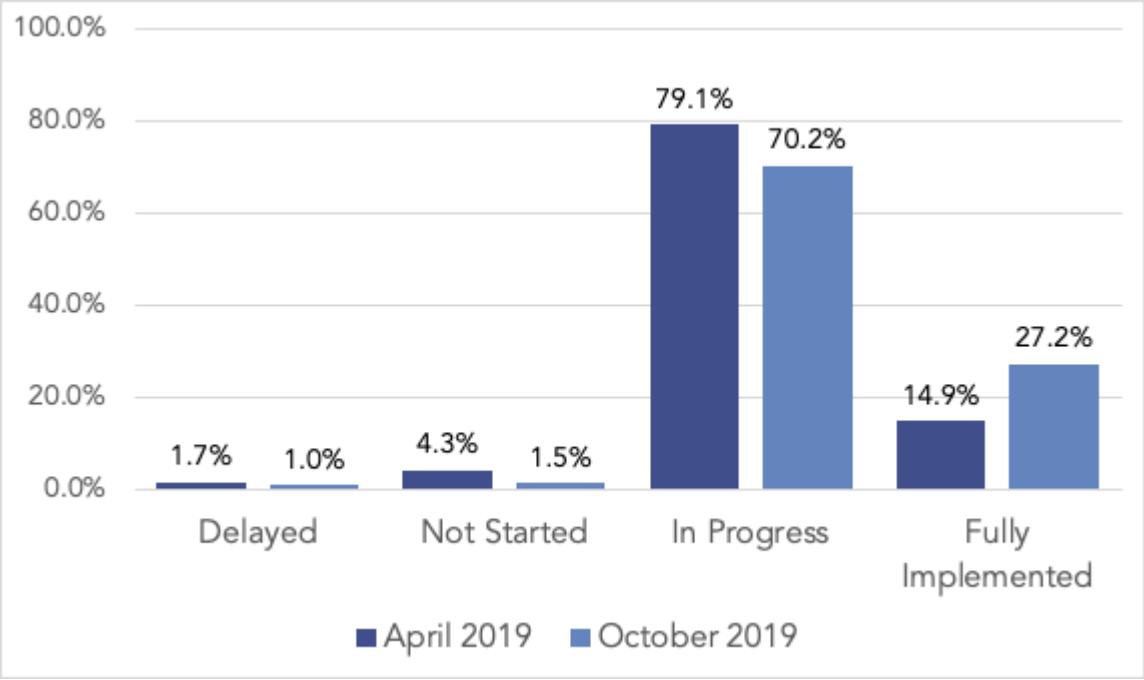
The next most identified sub themes were evidence-based models/promising practices (20.0) which many partners expressed positive impacts of their work incorporating these. Examples include training staff on "*One Key Question and contraceptive methods… [which they] have woven… into their visits with families*", using Stepping Up to "*bring community stakeholders together to reduce and shorten incarceration of persons with serious mental illness and/or substance use disorder through a systemic approach*", and using Pathways to "*provide care coordination services to a more diverse population… [resulting in] clients identified as a 'rising risk' benefit[ing] from earlier intervention.*" Access (13.3%), community-clinic linkages (11.3%), and training (11.3%) where the next most identified sub themes. Examples of access include "*recruitment including interviews on Spanish language radio stations, announcements at the Latino/a Advisory Committee meetings, Farm workers center and… announcement translated to Spanish*", "*updating our website and resources around LGBTQ+ services and access*".

Examples of linkages between community and clinical partners include partnerships to "b*ring an autism center of excellence training to our region*", "*referrals from SUD providers who have identified that an individual needs support services to be effective in recovery*", and partnerships with "*MAT treatment provider*" focusing on "*harm reduction, low barrier to services approach, and use of peer counselors.*" Finally, training examples include one organization which "*had 40 providers trained and waivered to provide MAT-assisted therapy throughout all… medical clinics*", trauma-informed care trainings, with "*nearly 90% of ED physicians hav[ing] received Trauma Informed Care Training this year alone*" at another organization, and training IMHTs in "CBT for pain management to better address the needs of those suffering with pain management issues" at a third organization.

Summary

This analysis of the first reporting period shows us that much of the Medicaid Transformation work among North Sound ACH partners is already underway. Partners are working hard to implement their strategies, including the use of evidence-based models and promising practices, quality improvement methods, and capacity building work. In nine months since implementation, over 70% of strategies change status indicate work in progress, with 27.2% indicating a status of fully implemented. A small minority, 1.5%, reported work not started, a decrease of 65.1% from reporting in April. An even smaller number (1.0%) indicated a delay in implementation, a 41.2% decrease from reporting in April. The decrease in tactics listed as delayed and not started, and the increase in those listed as fully implemented (82.6% increase) indicates that North Sound ACH partners have made significant progress in the past six months towards their implementation. (Figure 16)

Figure 16. Change Plan Implementation Trends, 2019 Partner Reporting, North Sound ACH.



There are several strategies that appear to have the greatest opportunities to improve on Implementation:

- Strategy 2.9 - Mobile Dental Care in Community Settings has the highest percentage of milestones "Not Started" (22.2%) and the lowest percentage "In Progress" (61.1%).
- Strategy 3.2 - Integrate Physical Health Services in Behavioral Health Settings has the second highest percentage of milestones "Not Started" (16.7%).

Several strategies, after Strategy 1.1 and Strategy 2.8, also arise as strengths within the region.

- Strategy 2.7 - Population Management in Oral Health Settings has the highest percentage of milestones "Fully Implemented" (30.6%) and an additional 69.4% of milestones are "In Progress".
- Strategy 3.4 - Integrate Oral Health Care into Physical Health or Behavioral Health Settings has the highest percentage of milestones "In Progress" (90.0%) and an additional 10.0% "Fully Implemented".

Strategies with lower percentages of implementation or high percentages of delays should be further looked at by the North Sound ACH to understand what barriers are delaying implementation and where technical assistance can be offered. See Table 7 for milestone implementation by strategy.

Table 7. Percent Milestone Implementation by Strategy, April-September 2019 Partner Reporting, North Sound ACH.

Strategy	Not Started	Delayed	In Progress	Fully Implemented
1.1 - North Sound Community HUB	-	-	31.6%	68.4%
1.2 - Acute Care Transitions	-	5.8%	84.2%	10.0%
1.3 - Transitional Care after Incarceration	13.3%	-	75.6%	11.1%
1.4 - Emergency Department Diversion	2.1%	6.3%	67.7%	23.9%
1.5 - Cross-sector Care Coordination and Diversion Collaboratives	5.8%	5.1%	74.6%	14.5%
2.1 - Prevent Opioid Use and Misuse	2.3%	-	77.3%	20.5%
2.2 - Link Individuals with Opioid Use Disorder with Treatment	-	4.1%	72.7%	23.1%
2.3 - Intervene in Opioid Overdose to Prevent Death	3.3%	0.7%	75.3%	20.7%
2.4 - Community Recovery Services and Networks for Opioid Use Disorder	4.8%	-	77.8%	17.5%

2.5 - Full Spectrum of Reproductive Health Services	6.7%	1.1%	68.9%	23.3%
2.6 - Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations	3.1%	-	64.9%	32.0%
2.7 - Population Management in Oral Health Settings	-	-	69.4%	30.6%
2.8 - Dental Health Aide Therapists in Tribal Clinics	-	-	100.0%	-
2.9 - Mobile Dental Care in Community Settings	22.2%	-	61.1%	16.7%
2.10 - Clinical Transformation for Prevention and Management of Chronic Disease	10.8%	-	72.5%	16.7%
2.11 - Community Linkages for Chronic Disease Prevention and Management Programs	8.6%	1.9%	74.7%	14.8%
3.1 - Integrate Behavioral Health Services in Primary Care Settings	13.0%	-	75.9%	11.1%
3.2 - Integrate Physical Health Services in Behavioral Health Settings	16.7%	2.1%	66.7%	14.6%
3.3 - Integrate Reproductive Health Services in Clinical and Community Settings	4.1%	3.1%	69.1%	23.7%
3.4 - Integrate Oral Health Care into Physical Health and Behavioral Health Settings	-	-	90.0%	10.0%
4.1 - Capacity Building	1.9%	0.9%	81.9%	15.3%

Findings from the qualitative analysis demonstrated that collaboration is playing a significant role in the implementation of Medicaid Transformation work by the North Sound ACH partners. The sub theme collaboration arose as the number one sub theme for three of the four qualitative themes. This indicates that working with other partners has been instrumental in our partners work, both for initiative strategies as well as organizational capacity building. This finding supports the North Sound ACH's continuous focus on collaboration as a method for building regional capacity and sustainability of the Medicaid Transformation work. Continuing to host retreats, trainings, convenings, and opportunities for technical assistance is an important scope of work for the ACH staff. With workforce

emerging as a large barrier to implementation for partners, the ACH may also want to continue to expand focus on workforce capacity building, such as strengthening partnerships with regional workforce organizations and training programs, such as community colleges and the Area Health Education Center for Western Washington (AHEC).

Appendix A. MeHAF SSA Survey Report, April-September 2019 Reporting Period.

Background

The Maine Health Access Foundation (MeHAF) developed the Site Self-Assessment (SSA) survey, known as the MeHAF SSA Survey, to assess levels of primary and behavioral care integration and focuses on two domains: 1) integrated services and patient and family-centeredness, and 2) practice/organization characteristics. The MeHAF SSA Survey asks physical health and behavioral health sites to rate 12 characteristics from domain one and nine characteristics from domain two based on the site's level of bi-directional integration. Characteristics are rated on a scale of 1 to 10, with 10 being complete integration and 1 being no integration. See Appendix A for the complete MeHAF SSA Survey.

The Washington State Health Care Authority required that all Medication Transformation Project (MTP) partnering practices participating in Project 2A: Bi-Directional Integration to complete both domains of the MeHAF SSA Survey twice a year for each site participating in the project area. The North Sound Accountable Community of Health (North Sound ACH) divided Project 2A into two strategies: Strategy 3.1 – Integrate Behavioral Health Services in Primary Care Setting, and Strategy 3.2 – Integrate Physical Health Services in Behavioral Health Settings. All partners committed to either strategy were required to complete, at the site level, the MeHAF SSA Survey for the second reporting period of DSRIP Year 3 (2019) and return it to the North Sound ACH by October 31, 2019. Partners were asked to report for the second and third quarters of the year, April 1, 2019 to September 30, 2019. See Appendix B for a complete list of North Sound ACH partners committed to bi-directional integration Strategies.

Purpose

Bi-directional integration intends to address physical and behavioral health needs in one system through an integrated network of providers. This whole-person care approach offers better coordination of care for patients and more seamless access to the services needed.

The MeHAF SSA Survey was designed to show the current status of a practice's bi-directional integration to encourage conversations among integrated care team members about their current status and where they would like to be in the future. The purpose of having Medicaid Transformation Partners complete the MeHAF SSA is to understand the current extent of integration and help show changes made over time.

Of North Sound ACH's 49 MTP partners, a total of 18 (36.7%) have committed to bi-directional integration strategies. Of these 18 partners, 10 (55.9%) have committed to Strategy 3.1 – Integrate Behavioral Health Services in Primary Care Settings, one (38.9%) has committed to Strategy 3.2 – Integrate Physical Health Services in Behavioral Health Settings, and seven (5.6%) are committed to both strategies. (Figure 1)

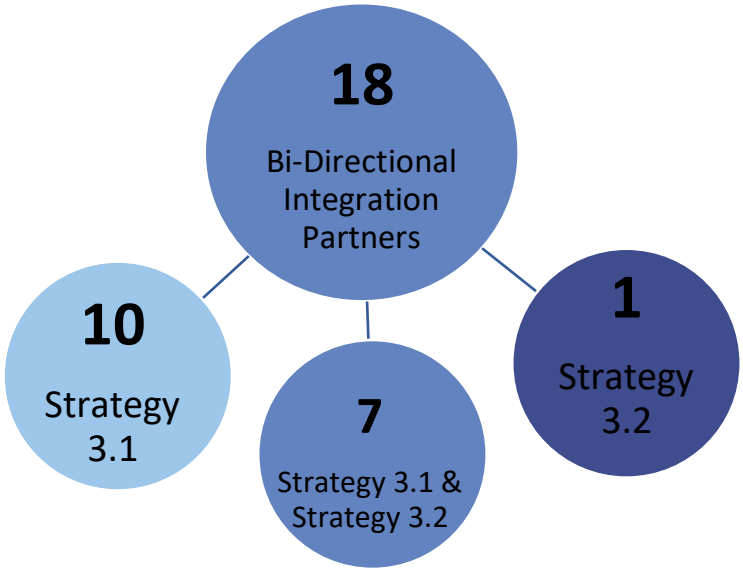


Figure 1. North Sound ACH Bi-Directional Integration Partners by Strategy

Results

Of the 18 partners committed to bi-directional integration strategies, 18 (100.0%) completed a total of 105 MeHAF SSA surveys and submitted them to the North Sound ACH, a 29.6% increase from April 2019 reporting. The number of surveys submitted per organization ranged from one to 30, with the average number submitted per organization being 5.8. (See Appendix C)

Nearly two-thirds (62.9%) of the MeHAF SSA surveys submitted indicated that the survey had been completed by a team, ten of the surveys (9.5%) did not indicate whether or not the survey was filled out by a team or by one individual. Ninety-eight sites (93.3%) indicated the role of the individual completing the survey with the most common being directors (40.8%), such as clinical and department directors, and managers (40.8%), such as program and clinic

managers. The remaining roles of those completing the surveys included supervisors (5), chief executive officers (4), clinicians (3), coordinators (3), administrators (2), and chief operating officers (1).

When reviewing the data for the completed MeHAF SSA Surveys, several areas where organizations were excelling in bi-directional integration were apparent, and several opportunities for improvement also arose.

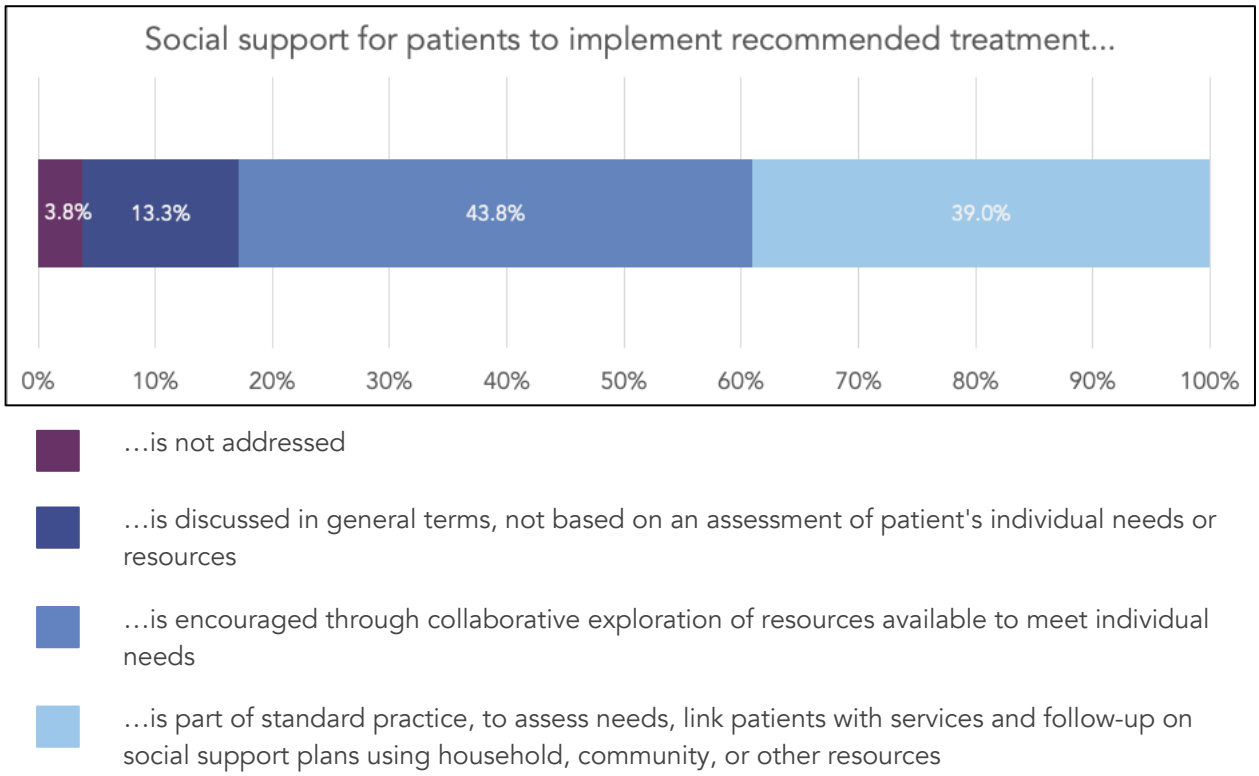
Strengths

Characteristic 1 from Section II: Practice/Organization, organizational leadership for integrated care, received the highest average score of 6.7, with 49 sites (47.1%) scoring an 8 or above (Section II, Question 1). A score of 8, 9, or 10 indicates that leadership "*strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models.*" Nine of the sites (8.7%) reported the maximum score of 10. (Figure 2)

Figure 2. Organizational Leadership for Integrated Care, n=104.

The second highest average score was for Characteristic 8 from Section I: Integrated Services and Patient and Family-Centeredness. This characteristic was for social support for patients to implement recommended treatments (Section I, Question 8). The average score for this question was 6.6, with 41 sites (39.0%) scoring 8 or above. A site that scored an 8, 9, or 10 indicated that it is "*part of standard practice to assess needs, link patients with services, and follow up on social support plans using household, community, or other resources.*" Five of the sites (4.8%) scored at the highest score of 10. (Figure 3)

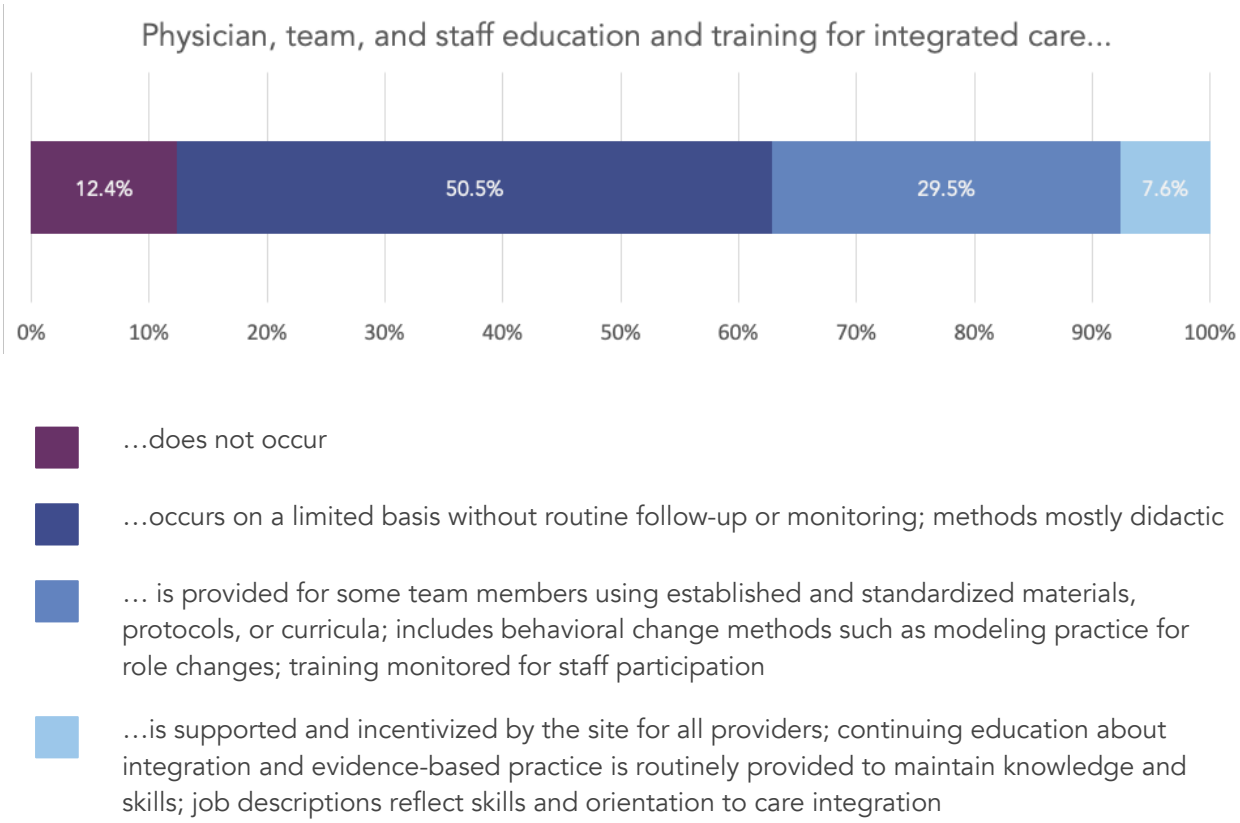
Figure 3. Social Support for Patients to Implement Recommended Treatment, n=105.



Opportunities

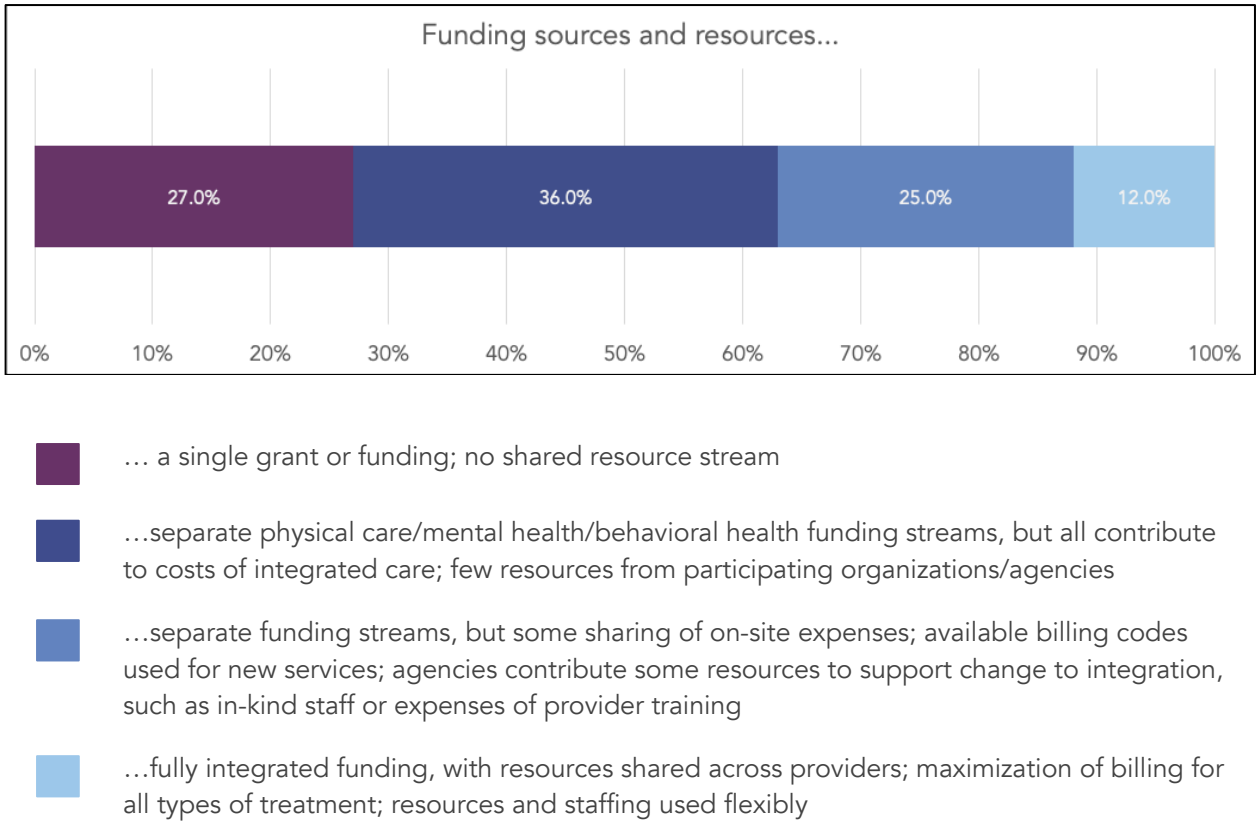
Characteristic 8 from Section II: Practice/Organization, physician, team, and staff education and training for integrated care, received the lowest average score of 3.9, with 66 sites (62.9%) scoring a 4 or below (Section II, Question 8). A site with a score of 1, 2, 3, or 4 indicated that staff education and training either did not occur at all (score of 1) or "*occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic*" (score of 2, 3, or 4). Thirteen of the sites (12.4%) scored at the lowest score of 1. (Figure 4) While this was also the lowest scoring characteristic from April 2019 reporting, it did increase 5.4% from 3.7 to 3.9, indicating a positive change.

Figure 4. Physician, Team, and Staff Education and Training for Integrated Care, n=105.



Characteristic 9 from Section II: Practice/Organization, funding source and resources, received the second lowest average score of 4.0, with 63 sites (63.0%) scoring a 4 or below (Section II, Question 9). A site with a score of 1 indicated that "*a single grant or funding source* [was used for integrated care]; *no shared resource streams* [were in use]." A site with a score of 2, 3, or 4 indicated that "*separate physical care/mental health/behavioral health funding streams* [were in use*], but all contribute to costs of integrated care; few resources from participating organizations/agencies.*" Twenty-seven of the sites (27.0%) scored at the lowest score of 1. (Figure 5) This was also the second lowest scoring characteristic in April 2019, but the score did increase 5.3% from 3.8 to 4.0.

Figure 5. Funding Sources and Resources, n=100.



Conclusions

Although the level of integration varies greatly among the 18 committed North Sound ACH partners, a few themes emerged from the October 2019 reporting. Many of the sites reported strong levels of organizational leadership support of integrated care with nearly half reporting strong levels of support and resources. The organizations reporting high levels of leadership support may serve as useful case studies to provide sites that are struggling to get leadership buy-in to learn about successful best practices.

Given that staff education and training fell on the lowest end of the scale for integration for the second reporting period in a row, it is obvious that this is an area of need across the North Sound region. Peer learnings, case studies, and other forms of collaboration, as well as hosted training and technical assistance from the North Sound ACH or their partners, will be valuable to assist partnering sites in increasing the knowledge and abilities of staff to integrate care.

The majority of the other integration characteristics evaluated in the MeHAF SSA Survey fall in the middle of the integration scale. This indicates that significant work has already been done in the region to work towards truly integrated care, but also highlights a need for

continued education, support, and assistance to the North Sound ACH partners. However, we have seen some areas where significant progress has been made since April 2019 reporting. The largest increase was seen for Characteristic 11 of Section 11, tracking of vulnerable patient groups that require additional monitoring and intervention, with a 25.6% increase from 3.9 to 4.9. Characteristic 10 of Section 1, patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications, also had a significant increase of 15.7% from 5.1 to 5.9. Three characteristics showed a decrease in the average score. Characteristic 2 of Section 1, screening and assessment for emotional/behavioral health needs, decreased by 7.7%, Characteristic 5 of Section 1, patient/family involvement in care plan, decreased by 4.8%, and Characteristic 6 of Section 1, communication with patients about integrated care, decreased 2.0%. Figures 6 and 7 outline the average scores for both sections from April 2019 and October 2019 reporting. While there appears to be some significant changes in scores, it is difficult to know whether these are artificial due to the increase in MeHAF SSA surveys submitted or whether it accurately depicts changes in bi-directional integration. Future reporting will allow us to better understand changes in scores as we have finalized the sites participating in bi-directional integration.

Appendix A: MeHAF SSA Survey Report, April - September 2019 Reporting Period

Background

The Maine Health Access Foundation (MeHAF) developed the Site Self-Assessment (SSA) survey, known as the MeHAF SSA Survey, to assess levels of primary and behavioral care integration focused on two domains: 1) integrated services and patient and family-centeredness, and 2) practice/organization characteristics. The MeHAF SSA Survey asks physical health and behavioral health sites to rate 12 characteristics from domain one and nine characteristics from domain two based on the site's level of bi-directional integration. Characteristics are rated on a scale of 1 to 10, with 10 being complete integration and 1 being no integration. See Appendix A for the complete MeHAF SSA Survey.

The Washington State Health Care Authority required that all Medication Transformation Project (MTP) partnering practices participating in Project 2A (Bi-Directional Integration) complete both domains of the MeHAF SSA Survey twice a year for each site participating in the project area.

The North Sound Accountable Community of Health (North Sound ACH) divided Project 2A into two strategies: Strategy 3.1: Integrate Behavioral Health Services in Primary Care Setting, and Strategy 3.2: Integrate Physical Health Services in Behavioral Health Settings. All partners committed to either strategy were required to complete, at the site level, the MeHAF SSA Survey for the second reporting period of DSRIP Year 3 (2019) and return it to the North Sound ACH by October 31, 2019. Partners were asked to report for the second and third quarters of the year, April 1, 2019 to September 30, 2019. See Appendix B for a complete list of North Sound ACH partners committed to bi-directional integration Strategies.

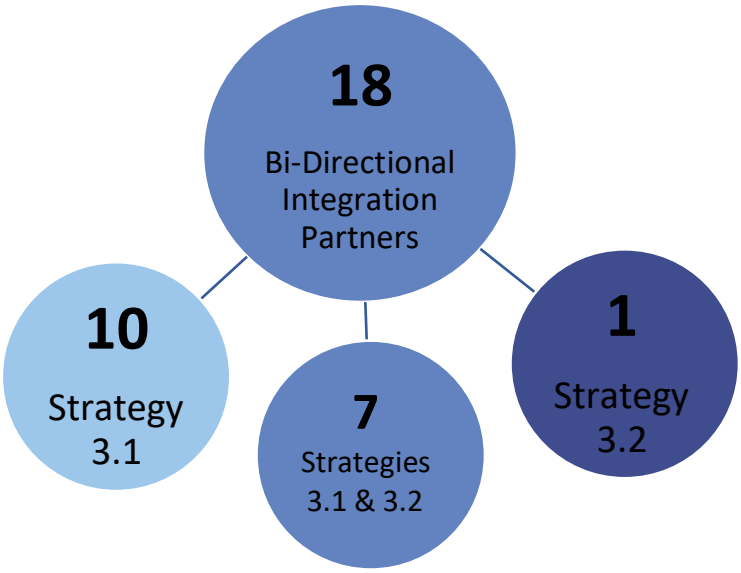
Purpose

Bi-directional integration addresses physical and behavioral health needs in one system through an integrated network of providers. This whole-person care approach offers better coordination of care for patients and more seamless access to the services needed.

The MeHAF SSA Survey is designed to show the current status of a practice's bi-directional integration to encourage conversations among integrated care team members about their current status and where they would like to be in the future. The purpose of having Medicaid Transformation Partners complete the MeHAF SSA is to understand the current extent of integration and help show changes made over time.

Of North Sound ACH's 49 MTP partners, 18 (36.7%) have committed to bi-directional integration strategies. Of these 18 partners, 10 (55.9%) have committed to Strategy 3.1: Integrate Behavioral Health Services in Primary Care Settings, one (38.9%) has committed to Strategy 3.2: Integrate Physical Health Services in Behavioral Health Settings, and seven (5.6%) are committed to both strategies. (Figure 1)

Figure 1. North Sound ACH Bi-Directional Integration Partners by Strategy



Results

Of the 18 partners committed to bi-directional integration strategies, 18 (100.0%) completed a total of 105 MeHAF SSA surveys and submitted them to the North Sound ACH, a 29.6% increase from April 2019 reporting. The number of surveys submitted per organization ranged from one to 30, with the average number submitted per organization being 5.8. (See Appendix C)

Nearly two-thirds (62.9%) of the MeHAF SSA surveys submitted indicated that the survey had been completed by a team, ten of the surveys (9.5%) did not indicate whether or not the survey was filled out by a team or by one individual. Ninety-eight sites (93.3%) indicated the role of the individual completing the survey with the most common being directors (40.8%), such as clinical and department directors, and managers (40.8%), such as program and clinic managers. The remaining roles of those completing the surveys

included supervisors (5), chief executive officers (4), clinicians (3), coordinators (3), administrators (2), and chief operating officers (1).

When reviewing the data for the completed MeHAF SSA Surveys, several areas where organizations were excelling in bi-directional integration were apparent, and several opportunities for improvement also arose.

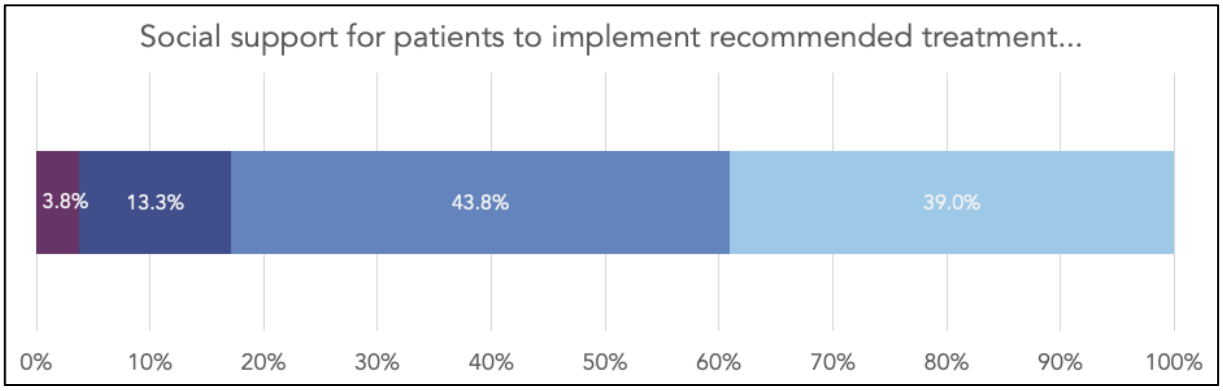
Strengths

Characteristic 1 from Section II: Practice/Organization, organizational leadership for integrated care, received the highest average score of 6.7, with 49 sites (47.1%) scoring an 8 or above (Section II, Question 1). A score of 8, 9, or 10 indicates that leadership "*strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models.*" Nine of the sites (8.7%) reported the maximum score of 10. (Figure 2)

Figure 2. Organizational Leadership for Integrated Care, n=104.

The second highest average score was for Characteristic 8 from Section I: Integrated Services and Patient and Family-Centeredness. This characteristic was for social support for patients to implement recommended treatments (Section I, Question 8). The average score for this question was 6.6, with 41 sites (39.0%) scoring 8 or above. A site that scored an 8, 9, or 10 indicated that it is "*part of standard practice to assess needs, link patients with services, and follow up on social support plans using household, community, or other resources.*" Five of the sites (4.8%) scored at the highest score of 10. (Figure 3)

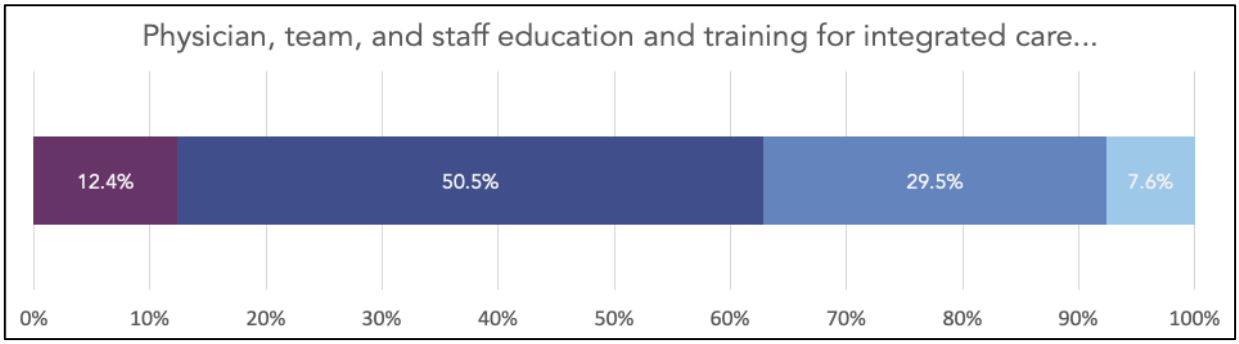
Figure 3. Social Support for Patients to Implement Recommended Treatment, n=105.



Opportunities

Characteristic 8 from Section II: Practice/Organization, physician, team, and staff education and training for integrated care, received the lowest average score of 3.9, with 66 sites (62.9%) scoring a 4 or below (Section II, Question 8). A site with a score of 1, 2, 3, or 4 indicated that staff education and training either did not occur at all (score of 1) or "*occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic*" (score of 2, 3, or 4). Thirteen of the sites (12.4%) scored at the lowest score of 1. (Figure 4) While this was also the lowest scoring characteristic from April 2019 reporting, it did increase 5.4% from 3.7 to 3.9, indicating a positive change.

Figure 4. Physician, Team, and Staff Education and Training for Integrated Care, n=105.



…does not occur

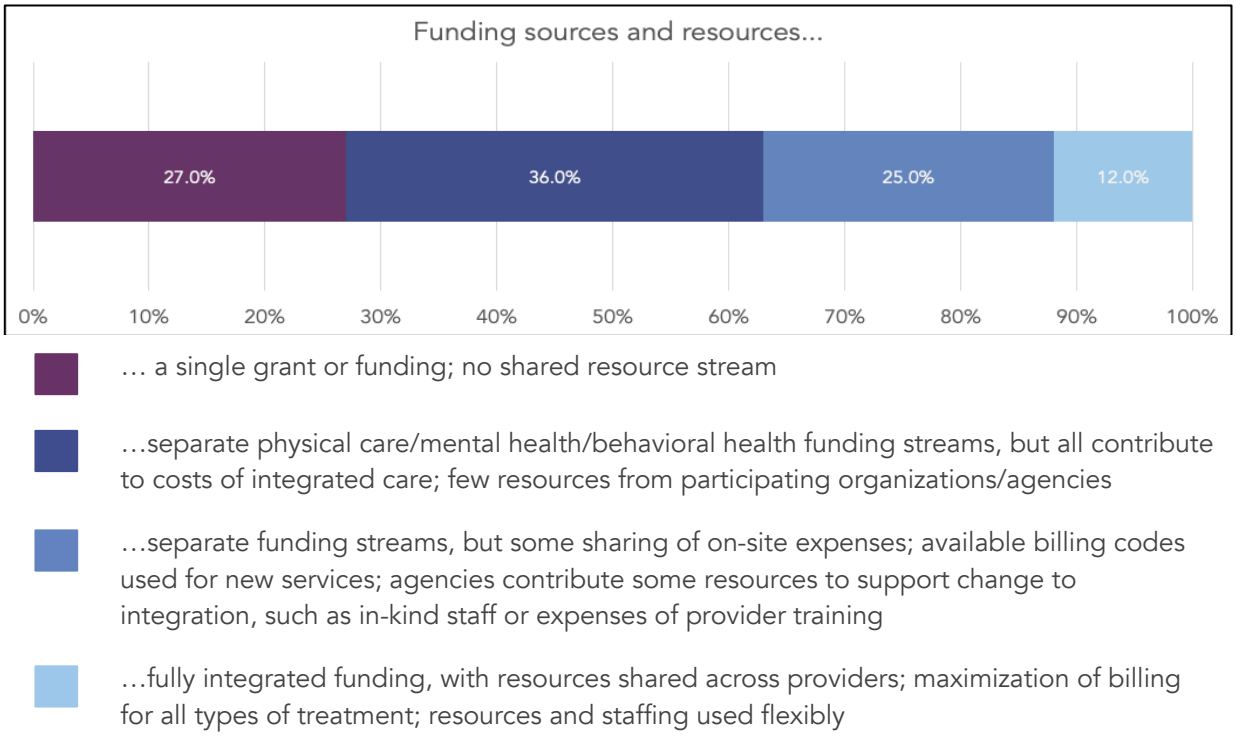
…occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic

… is provided for some team members using established and standardized materials, protocols, or curricula; includes behavioral change methods such as modeling practice for role changes; training monitored for staff participation

…is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration

Characteristic 9 from Section II: Practice/Organization, funding source and resources, received the second lowest average score of 4.0, with 63 sites (63.0%) scoring a 4 or below (Section II, Question 9). A site with a score of 1 indicated that "*a single grant or funding source* [was used for integrated care]; *no shared resource streams* [were in use]." A site with a score of 2, 3, or 4 indicated that "*separate physical care/mental health/behavioral health funding streams* [were in use*], but all contribute to costs of integrated care; few resources from participating organizations/agencies.*" Twenty-seven of the sites (27.0%) scored at the lowest score of 1. (Figure 5) This was also the second lowest scoring characteristic in April 2019, but the score did increase 5.3% from 3.8 to 4.0.

Figure 5. Funding Sources and Resources, n=100.



Conclusions

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The majority of the other integration characteristics evaluated in the MeHAF SSA Survey fall in the middle of the integration scale. This indicates that significant work has already been done in the region to work towards truly integrated care, but also highlights a need for continued education, support, and assistance to the North Sound ACH partners. However, we have seen some areas where significant progress has been made since April 2019 reporting. The largest increase was seen for Characteristic 11 of Section 11, tracking of vulnerable patient groups that require additional monitoring and intervention, with a 25.6% increase from 3.9 to 4.9. Characteristic 10 of Section 1, patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications, also had a significant increase of 15.7% from 5.1 to 5.9.

Three characteristics showed a decrease in the average score. Characteristic 2 of Section 1 (screening and assessment for emotional/behavioral health needs) decreased by 7.7%, Characteristic 5 of Section 1 (patient/family involvement in care plan) decreased by 4.8%, and Characteristic 6 of Section 1 (communication with patients about integrated care) decreased 2.0%. Figures 6 and 7 outline the average scores for both sections from April 2019 and October 2019 reporting. While there appears to be some significant changes in scores, it is difficult to know whether these are artificial due to the increase in MeHAF SSA surveys submitted or whether it accurately depicts changes in bi-directional integration. Future reporting will allow us to better understand changes in scores, as we have finalized the sites participating in bi-directional integration.

Figure 6. Trends in Section I Average Scores from 2019 Reporting.

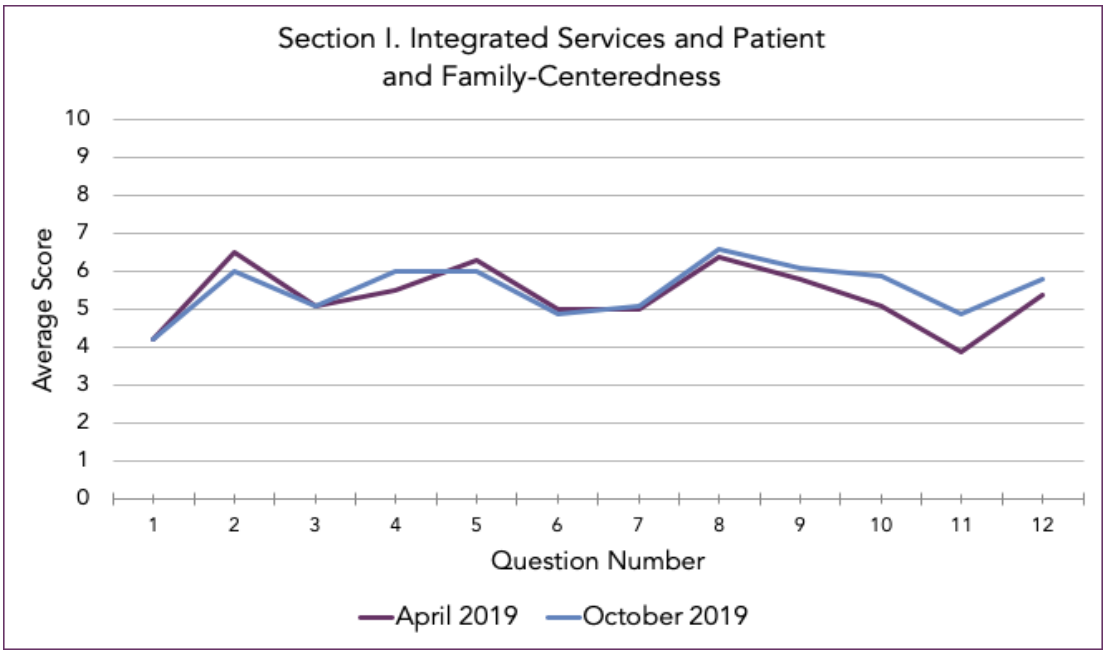
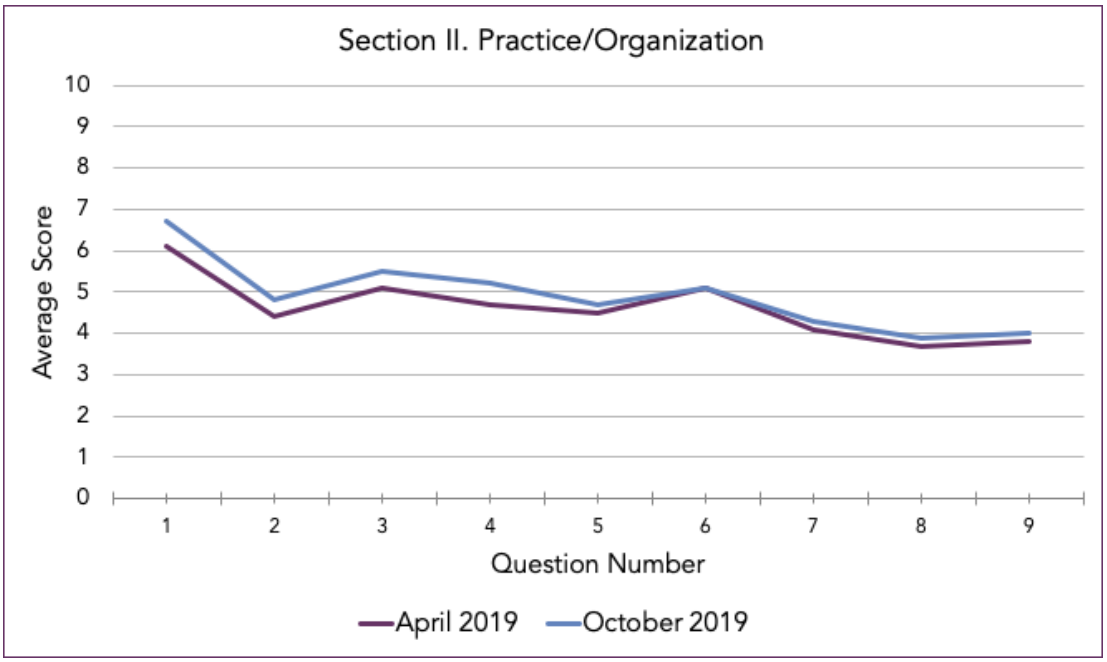


Figure 7. Trends in Section II Average Scores from 2019 Reporting.



Next, the North Sound ACH will complete a review of the findings from the MeHAF SSA Surveys to identify areas of need/technical assistance as well as potential areas for partner collaboration and shared learnings. This information will be gained through staff reviews of individual partners surveys and during site visits. MeHAF SSA Surveys will continue to be collected from North Sound ACH partners every six months. Analysis of future MeHAF SSA reporting will allow for ongoing monitoring of partner progress towards bi-directional integration and will allow staff and partners to identify strengths and opportunities for growth.

Appendix B: Opioid Survey Report, April-September 2019 Reporting Period

Background

The Washington State Health Care Authority requires that all Medication Transformation Project (MTP) partners participating in Project 3A: Addressing the Opioid Use Public Health Crisis to complete an opioid survey twice a year. The statewide surveys are split into two:

- Clinics and practices committed to Addressing the Opioid Crisis strategies
- Community-based organizations committed to Addressing the Opioid Crisis strategies

The North Sound ACH divided Project 3A into four strategies:

- Strategy 2.1 – Prevent Opioid Use an
- Misuse
- Strategy 2.2 – Link Individuals with Opioid Use Disorder with Treatment
- Strategy 2.3 – Intervene in Opioid Overdoses to Prevent Death
- Strategy 2.4 – Community Recovery Services and Networks for Opioid Use Disorder

Partners committed to any of these strategies were required to complete an opioid survey for each site participating in opioid strategies for the second reporting period of DSRIP Year 3 (2019) Quarters 2 and 3, April 1, 2019 to September 30, 2019. Surveys were due by October 31, 2019 at 5:00 pm. See Appendices A and B for the complete Opioid Surveys. See Appendix C, D, and E for a complete list of North Sound ACH partners and sites committed to opioid strategies.

Purpose

The work of the transformation project area "Addressing the opioid use public health crisis" supports the state's goals of reduced opioid-related morbidity and mortality. The HCA designed the opioid surveys to assess the current scope of MTP partners' work, and to monitor and demonstrate changes made over time. In the North Sound region, respondents to this survey are those partners committed to strategies 2.1, 2.2, 2.3, and/or 2.4.

The practice/clinic version of the opioid survey assesses the status of four metrics:

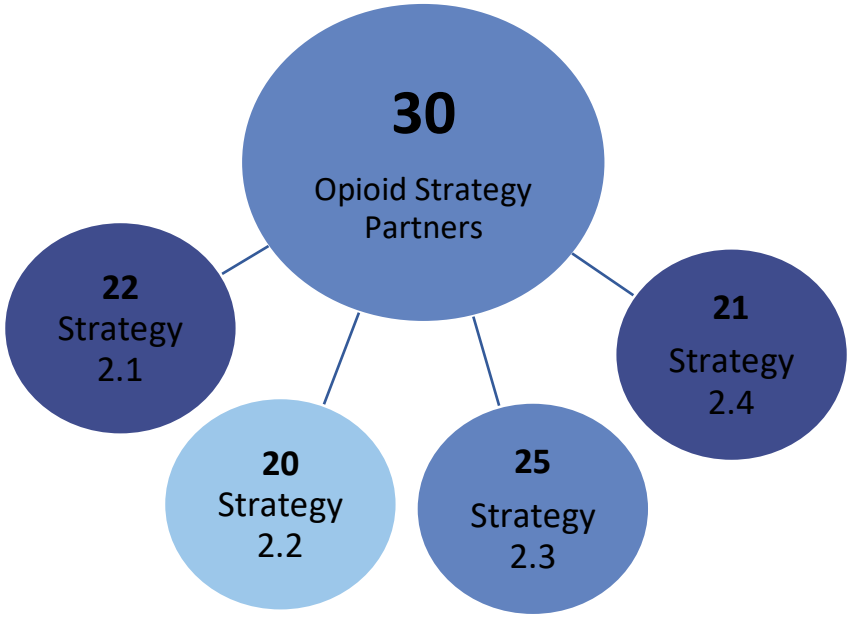
- Provider use of guidelines for prescribing opioids for pain.
- Availability and use of key clinical decision support features for opioid prescribing guidelines.
- Linkage to behavioral care and medication-assisted treatment (MAT) for people with opioid use disorders.
- Emergency department has protocols in place to initiate MAT or offer take home naloxone.

The community-based organization (CBO) version assesses the status of two metrics:

- CBO site is an access point where persons can be referred for MAT.
- CBO site provides services aimed at reducing transmission of infectious diseases to persons who use injection drugs.

Of North Sound ACH's 49 contracted MTP partners, 30 (61.2%) have committed to opioid strategies. Of these 30 partners, 22 (73.3%) have committed to Strategy 2.1 – Prevent Opioid Use and Misuse, 20 (66.7%) have committed to Strategy 2.2 – Link Individuals with Opioid Use Disorder with Treatment, 25 (83.3%) have committed to Strategy 2.3 – Intervene in Opioid Overdoses to Prevent Death, and 21 (70.0%) have committed to Strategy 2.4 – Community Recovery Services and Networks for Opioid Use Disorder. (Figure 1)

Figure 1. North Sound ACH Opioid Partners by Strategy



Results

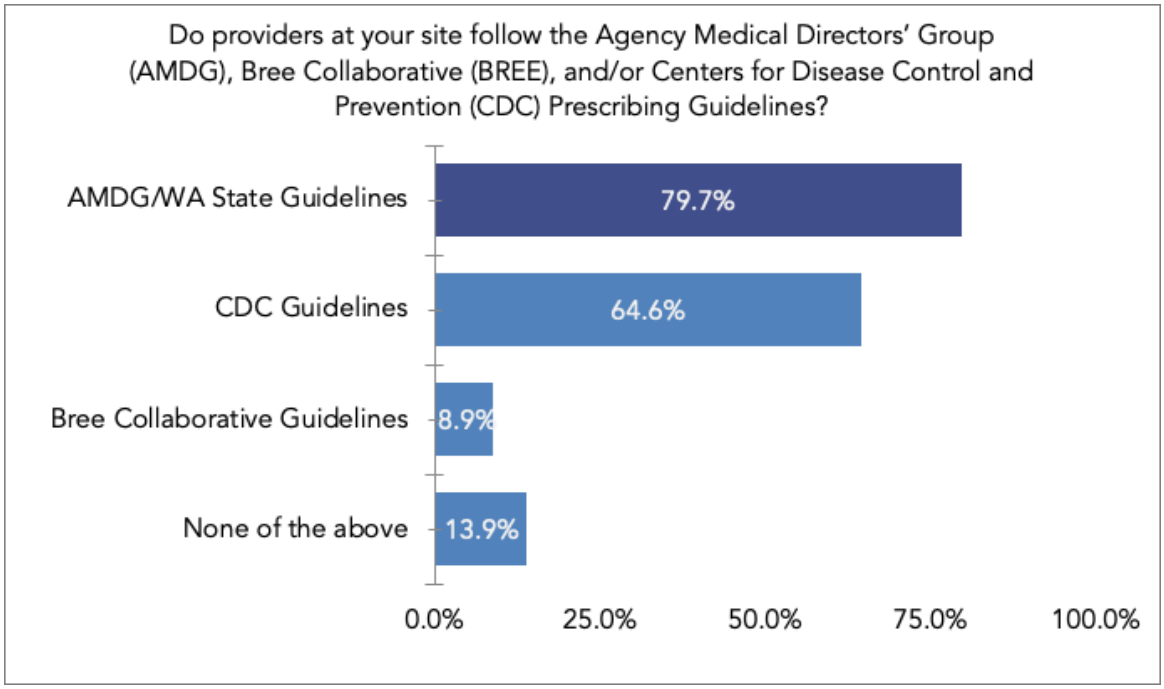
All 30 partners committed to opioid strategies completed the relevant Opioid Surveys for all sites participating in opioid work and submitted a total of 135 surveys to the North Sound ACH, with an average of 4.5 surveys per organization. Fifty-six (41.5%) of the surveys were the Community-Based Organization survey and 79 (58.5%) were the Clinical survey. The number of surveys per organization ranged from one to 31. The average number for the clinical surveys submitted was 5.6 and the average number of community-based surveys submitted was 3.3. See full results of both surveys in the tables at the end of this document.

When reviewing the responses submitted to the Opioid Surveys, several areas where organizations were excelling in their work to address the opioid crisis were apparent while opportunities for improvement also arose.

Clinical Strengths

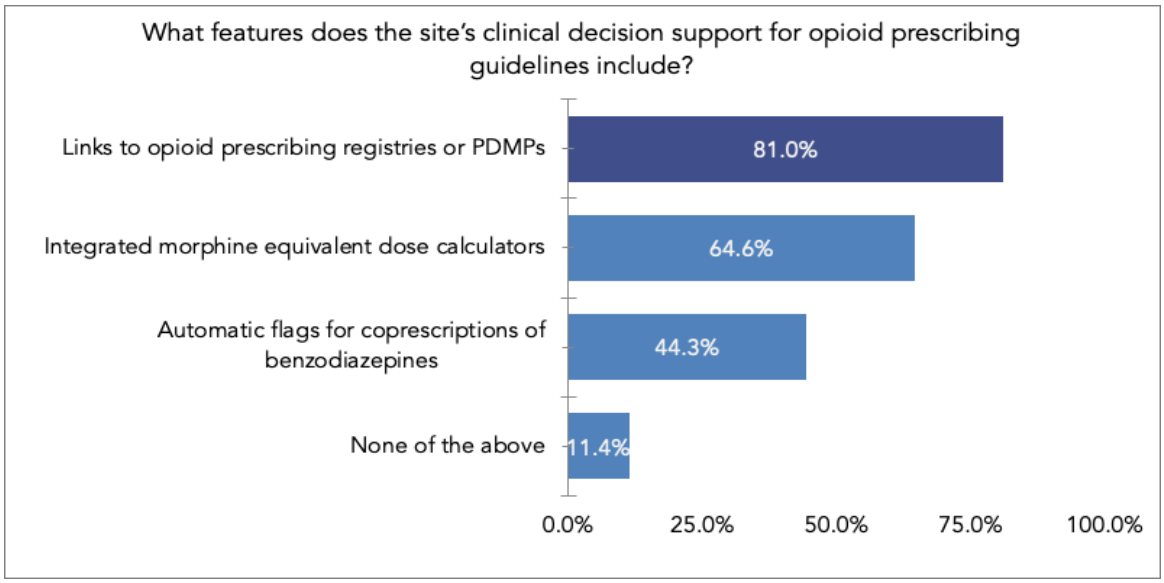
Results from the analysis of the surveys submitted by the clinical practices participating in the North Sound ACH opioid strategies indicate that they are excelling in several areas of their opioid work. Of the 79 sites that submitted information on opioid prescribing guidelines, 68 (86.1%) are using evidence-based practices, such as the Bree Collaborative Guidelines (8.9%) or the Agency Medical Directors' Group (AMDG) Guidelines (79.7%). 70 of the 79 sites (88.6%) also have some sort of clinical decision support in place to assist physicians with prescribing guidelines. (Figures 2 and 3)

Figure 2. Protocols for Behavioral Health Intervention for Patients with Opioid Use Disorder, N=79.



North Sound ACH Reporting, October 2019.

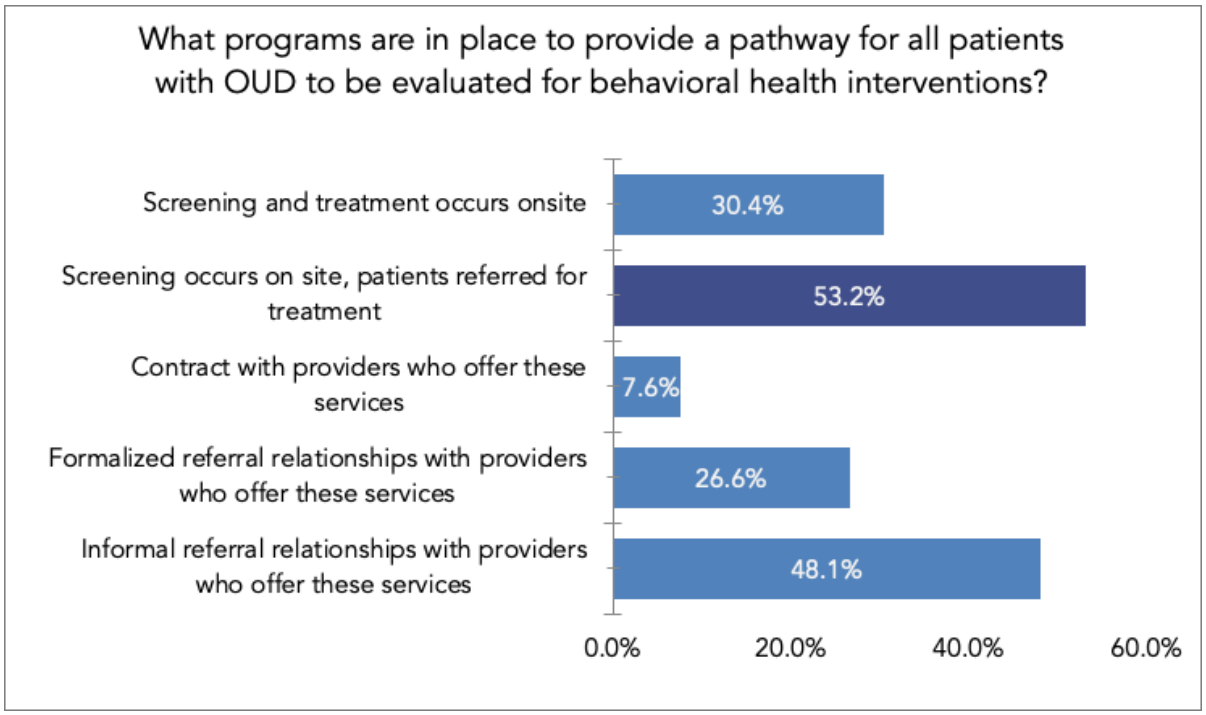
Figure 3. Clinical Decision Support for Opioid Prescribing Guidelines, N=79.



North Sound ACH Reporting, October 2019.

Clinical practice strengths were also evident in their integration of behavioral health care. Of the 79 reporting sites, 24 (30.4%) offer screening and treatment for depression and anxiety on-site and 42 (53.2%) offer screening on site and refer out for treatment. All 79 sites have a protocol in place for behavioral health interventions. (Figure 4)

Figure 4. Integration of Behavioral Health Care, N=79.



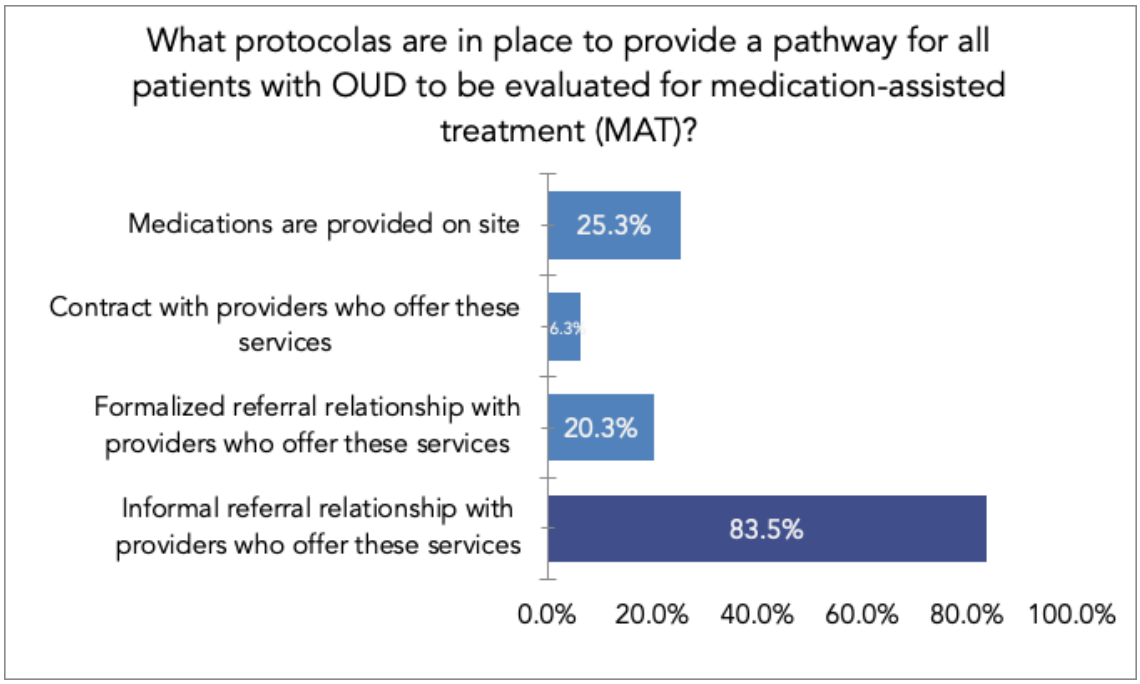
North Sound ACH Reporting, October 2019.

Thirty-six of the clinical sites self-identified as having an emergency department. Of these, 14 (38.9%) offered medication-assisted treatment (MAT) initiation or take-home naloxone to patients seen for an opioid overdose while 21 (58.3%) offered both services. Only one site (2.8%) indicated that it did not provide either service.

Clinical Opportunities

One area of growth for clinical practices is the offering of MAT to patients with opioid use disorder (OUD). Of the 79 sites, only 20 (25.3%) provided MAT on-site, over half (62.0%) had an informal referral relationship with MAT providers only. (Figure 5)

Figure 5. Medication-Assisted Treatment Evaluation Protocols, N=79.



North Sound ACH Reporting, October 2019.

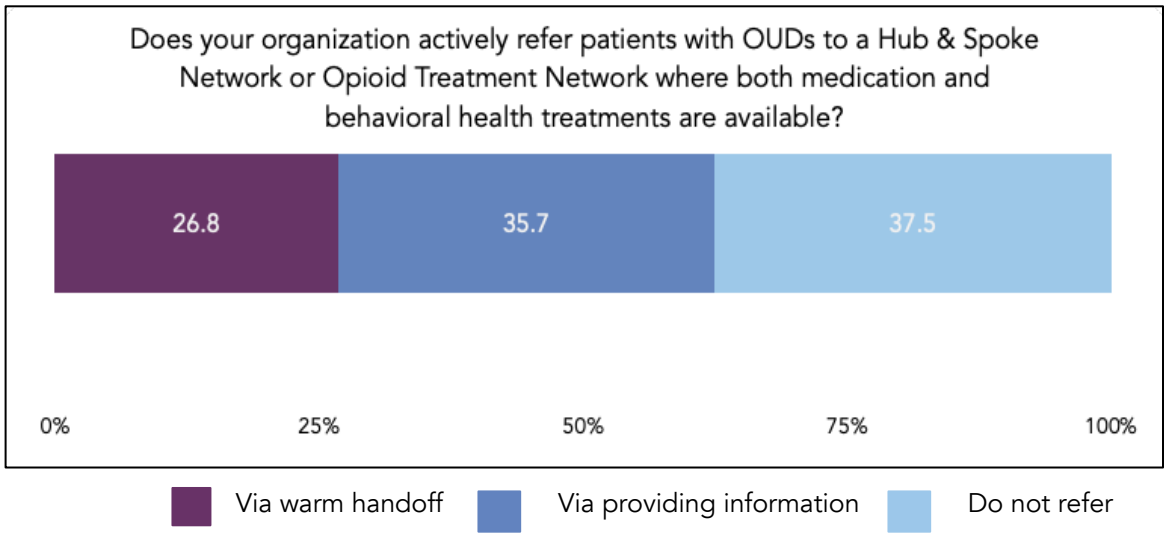
Community-Based Organization Strengths

Results from the analysis of the surveys submitted by the community-based organizations participating in the North Sound ACH opioid strategies indicate that they are excelling in several areas of their opioid work. Their greatest strength was around the referral of individuals with opioid use disorder to psychosocial care. Forty-eight of the 56 sites (85.7%) refer patients with OUD to psychosocial care. Referrals to MAT providers for people with OUDs was also a strength, with 46 sites (82.1%) indicating that they had protocols in place for MAT referrals.

Community-Based Organization Opportunities

One opportunity for growth for community-based organizations is in their referrals of patients with OUD to treatment networks where both medication and behavioral health treatments are available. While over half of the sites (62.5%) offer some sort of referral system, only 57.1% of those do so via a warm hand off. The remaining 42.9% solely provide information to patients. Fourteen of the sites (25.0%) do not refer for reasons not listed in the survey, including a lack of awareness about these networks, a lack of networks in rural areas, and a lack of training. (Figure 6)

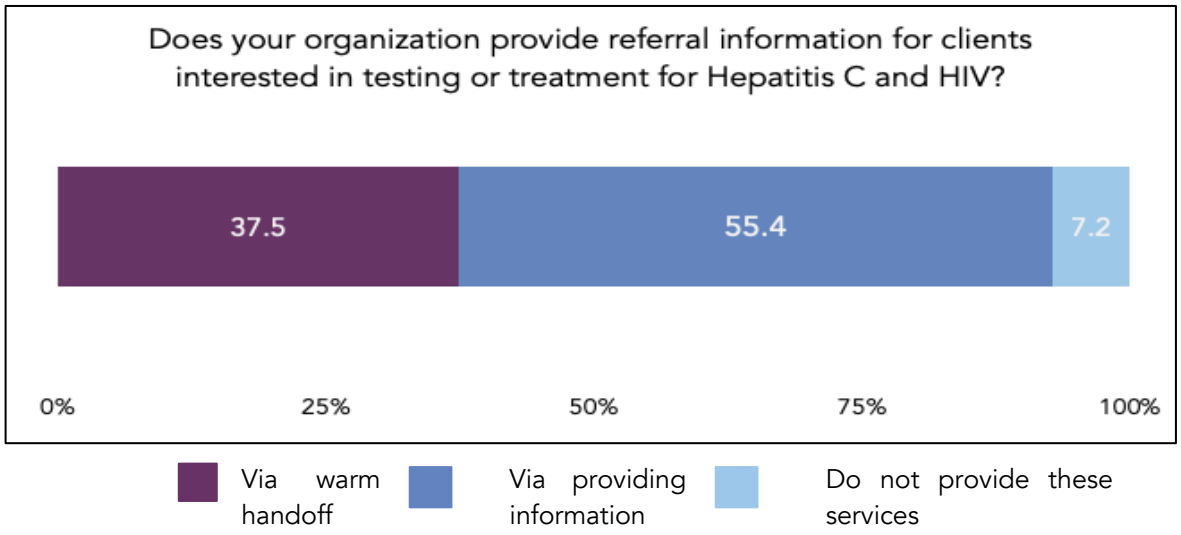
Figure 6. Opioid Treatment Network Referrals, N=56.



North Sound ACH Reporting, October 2019.

Another opportunity for growth in the North Sound region is for increased referrals for testing and treatment for Hepatitis C and HIV. While the majority of sites (92.9%) offered referrals, more than half (59.6%) did so through providing information alone. The remaining 40.4% did so via warm handoff. (Figure 7)

Figure 7. Hepatitis C and HIV Testing and Treatment Referrals, N=56.



North Sound ACH Reporting, October 2019.

Narrative Responses

At the end of each survey, an open-ended question was provided for organizations to expand on their work related to addressing the opioid crisis. Thirty-five [(44.3%) clinical sites

and 22 (39.3%) community-based organization sites offered additional information in the surveys. To analyze qualitative narrative responses each response was read through and coded under five main codes: clarification or more information on opioid work, collaboration, future directions for opioid work, grants and funding, and training and education. These responses were then quantified for each code and representative quotes were selected for reporting.

The most common response was to provide additional information about opioid strategy tactics (66.7%). Examples include "*prescribing Naloxone…for patients to take home*, having "*100% of...primary care providers who see adults (40 in total) waived for MAT*, and "r*eceiving fentanyl [testing] strips and distributing for overdose prevention.*"

Eleven (19.3%) sites provided information about future directions for their opioid work, such as EMS referring to "*a diversion center as opposed to the ED*" for MAT. Nine (15.8%) sites provided additional information about collaborations with other organizations in the region, for example on site noted *"actively working with other Snohomish County agencies to collect and share data to determine gaps and possible needs for intervention."* Two (3.5%) sites offered information about training or education with staff and in the community, including "*distributing 2,500 English and 500 Spanish [Opioid Resource] guides to hundreds of partners."* Finally, two (3.5%) sites offered information on grants specific to opioid funding that had been received during the reporting period.

Conclusions

The North Sound ACH partners committed to opioid strategies are well on their way to addressing the opioid crisis. Clinics and practices with the ability to prescribe opioids are taking precautions to prevent opioid misuse and abuse, such as using evidence-based prescribing guidelines, offering clinical support for the implementation of opioid prescribing guidelines, and screening for and offering services for mental health and behavioral health conditions.

However, there are still areas for growth in the region. While most of the community-based organizations are routinely referring OUD patients for psychosocial care, there is room for increasing referrals to treatment networks and Hepatitis C and HIV testing and treatment. Further, many of these organizations are not offering warm handoffs when doing referrals, often considered a best practice, and can help build relationships and engage patients and families.

During October 2019 reporting opioid surveys were collected on the site level instead of the organizational level as was done in April 2019. This led to an increase from 29 surveys

to 135 surveys (362.1%). Due to such a large increase and the wide range of surveys submitted by each organization, we are unable to compare the results of April and October reporting. However, the results from October 2019 can be used as a baseline for future reporting to let us better understand progress towards addressing the opioid crisis in the North Sound region.

Clinical Opioid Survey Results

Table 1. Clinic Question 2: Do providers at your organization follow any opioid prescribing guidelines? N=79

	Number	Percent
Agency Medical Directors' Group (AMDG) guidelines/Washington State prescribing guidelines	63	79.7
Bree Collaborative (BREE) guidelines	7	8.9
CDC guidelines	51	64.6
None	11	13.9

Table 2. Clinic Question 3: What features does your organization's clinical decision support for opioid prescribing guidelines include? N=79

	Number	Percent
Integrated morphine equivalent dose calculators	51	64.6
Links to opioid prescribing registries or Prescription Drug Monitoring Programs (PDMPs)	64	81.0
Automatic flags for co-prescriptions of benzodiazepines	35	44.3
None of the above	9	11.4

Table 3. Clinic Question 4: What protocols are in place to provide a pathway for patients with opioid use disorder to be evaluated for behavioral health interventions? N=79

	Number	Percent
Screening and treatment for depression and anxiety occurs on site	24	30.4
Screening for depression and anxiety occur on site, patients are referred for treatment	42	53.2
Contracting with providers who offer these services	6	7.6
Formalized referral relationship (through MOU or similar arrangement) with providers who offer these services	21	26.6
Informal referral relationships with providers who offer these services	38	48.1

Table 4. Clinic Question 5: What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for medication-assisted treatment? N=79

	Number	Percent
Medications are provided on site	20	25.3
Contracting with providers who offer these services	5	6.3
Formalized referral relationship (through MOU or similar arrangement) with providers who offer these services	16	20.3

Informal referral relationships with providers who offer these services	66	83.5

Table 5. Clinic Question 6: Does your emergency department (ED) have protocols in place to initiate MAT and offer take home naloxone for individuals seen for opioid overdose? N=36*

	Number	Percent
MAT initiation	34	94.4
Take-home naloxone	22	61.1
Our ED site does not offer these services	1	2.8

*Forty-three of the organizations who completed the Clinical Opioid Survey noted that their organization did not include an emergency department and therefore did not respond to this question.

Community-Based Organization (CBO) Opioid Survey Results

Table 6. CBO Question 2: Does your organization have protocols in place to refer people with opioid use disorders (OUDs) to medication-assisted treatment (MAT) providers? N=56

	Number	Percent
Yes	46	82.1
No	10	17.9

Table 7. CBO Question 3: Does your organization refer people with OUDs for psychosocial care? N=56

	Number	Percent
Yes	48	85.7
No	8	14.3

Table 8. CBO Question 4: Does your organization actively refer patients with OUDs to a Hub & Spoke Network or Opioid Treatment Network (OTN), where both medication and behavioral health treatments are available? N=56

	Number	Percent
Yes, via warm handoff	15	26.8
Yes, via providing information	20	35.7
No, we provide these services onsite	7	12.5
No, we do not refer for another reason	14	25.0

Of the 14 organizations who responded that they did not refer patients with OUD for another reason, 6 (42.9%) noted that this was due to geographic barriers to accessing these services, notably in San Juan and Island County. Other reason noted were that there were few, if any, clients with OUD (3), they were unaware about the existence of these services or unsure if they utilized them (3), there was a lack of training (1), and that referrals for OUD happened in another department (1).

Table 9. CBO Question 5: Did your organization receive technical assistance (TA) to organize or expand a syringe exchange program (SEP), or to learn about locally available access to clean syringes? N=56

	Number	Percent
Yes, to organize and expand	1	1.8
Yes, to learn about access	5	8.9
No, we asked for TA about organizing/expanding but did not receive any	1	1.8
No, we asked for TA about access but did not receive any	0	0.0
No, we did not ask for TA around SEPs	49	87.5

Table 10. CBO Question 6: Does your organization provide referral information for client interested in testing or treatment for Hepatitis C and HIV? N=56

	Number	Percent
Yes, via warm handoff	21	37.5
Yes, via providing information	31	55.4
No, we provide these services onsite	1	1.8
No, we did not refer for another reason	3	5.4

Of the three organizations who responded that they did not refer patients with OUD for another reason, one responded that referrals happened in another department, another noted that more training was needed, and the last stated this fell outside the scope of services for their agency.

Appendix A: Clinical Opioid Survey

1. Please provide the following information about your organization:
   Name:
   Site reporting on:
   Name of staff person completing survey:
   Name(s) of other staff assisting with completing survey:

2. Do providers at your organization follow any opioid prescribing guidelines? Select all that apply.
   a. Agency Medical Directors' Group (AMDG) guidelines/Washington State prescribing guidelines
   b. Bree Collaborative (BREE) guidelines
   c. CDC guidelines
   d. None

e. Other (please specify):

3. What features does your organization's clinical decision support for opioid prescribing guidelines include? Select all that apply.
    a. Integrated morphine equivalent dose calculators
    b. Links to opioid prescribing registries or Prescription Drug Monitoring Programs (PDMPs)
    c. Automatic flags for co-prescriptions of benzodiazepines
    d. None of the above
    e. Our organization does not offer clinical decision support for prescribing guidelines
    f. Other (please specify):

4. What protocols are in place to provide a pathway for patients with opioid use disorder to be evaluated for behavioral health interventions? Select all that apply.
    a. Screening and treatment for depression and anxiety occurs on site
    b. Screening for depression and anxiety occur on site, patients are referred for treatment
    c. Contracting with providers who offer these services
    d. Formalized referral relationship (through MOU or a similar arrangement) with providers who offer these services
    e. Informal referral relationships with providers who offer these services
    f. No protocols are in place
    g. Other (please specify):

5. What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for medication-assisted treatment? Select all that apply.
    a. Medications are provided on site
    b. Contracting with providers who offer these services
    c. Formalized referral relationship (through MOU or a similar arrangement) with providers who offer these services
    d. Informal referral relationships with providers who offer these services
    e. No protocols are in place
    f. Other (please specify):

6. Does your emergency department (ED) have protocols in place to initiate MAT and offer take home naloxone for individuals seen for opioid overdose? Select all that apply.
    a. MAT initiation
    b. Take-home naloxone

c. Our ED site does not offer these services
d. N/A – Oure site is not an ED

7. Is there anything else you would like to add about your organization's work on "Addressing the Opioid Crisis" strategies?

Appendix B: Community-Based Organization Opioid Survey

1. Please provide the following information about your organization:
   Name:
   Site reporting on:
   Name of staff person completing survey:
   Name(s) of other staff assisting with completing survey:
2. Do your organization have protocols in place to refer people with opioid use disorders (OUDs) to medication-assisted treatment (MAT) providers?
   a. Yes
   b. No
3. Does your organization refer people with OUDs for psychosocial care?
   a. Yes
   b. No
4. Does your organization actively refer patients with OUDs to a Hub & Spoke Network or Opioid Treatment Network (OTN), where both medication and behavioral health treatments are available? Select one answer.
   a. Yes, via warm handoff
   b. Yes, via providing information
   c. No, we provide these services onsite
   d. No, we do not refer for another reason (please specify):
5. Did your organization receive technical assistance (TA) to organization or expand a syringe exchange program (SEP), or to learn about locally available access to clean syringes? Select one answer.
   a. Yes, to organize and expand
   b. Yes, to learn about access
   c. No, we asked for TA about organizing/expanding and did not receive any
   d. No, we asked for TA about access but did not receive any
   e. We did not ask for TA around SEPs
6. Does your organization provide referral information for clients interested in testing or treatment for Hepatitis C and HIV? Select one answer.
   a. Yes, via warm handoff
   b. Yes, via providing information
   c. No, we provide these services onsite

d. No, we do not refer for another reason (please specify):

7. Is there anything else you would like to add about your organization's work on "Addressing the Opioid Crisis" strategies?

Appendix C: North Sound ACH Partners Committed to Opioid Strategies

Organization	Strategy 2.1	Strategy 2.2	Strategy 2.3	Strategy 2.4
Brigid Collins House				X
Center for Human Services	X		X	X
Community Action of Skagit County		X	X	X
Community Health Center of Snohomish County	X	X	X	X
Compass Health			X	
Consistent Care Services	X	X	X	X
Island County		X		
Island Hospital	X	X	X	
Lifeline Connections	X	X	X	X
Lydia Place		X	X	X
Opportunity Council		X	X	X
Orcas Family Connections	X	X	X	X
PeaceHealth	X	X	X	
Pioneer Human Services			X	X
Planned Parenthood of the Great Northwest and the Hawaiian Islands	X			
Providence Health	X	X	X	X
San Juan County Fire District #2	X		X	X
San Juan Island Family Resource Center	X			X
Senior Services of Snohomish County	X			
United General Hospital 304	X	X	X	X
Skagit County Public Health	X	X	X	X
Skagit Regional	X	X	X	X
Snohomish County Fire Protection District #15			X	

Snohomish Health District	X		X	
Sunrise Services	X	X	X	X
Swedish Edmonds	X	X	X	X
Tulalip Health System	X	X	X	X
Unity Care NW	X	X	X	X
Whatcom County	X	X	X	X
Whidbey General Hospital	X	X	X	

Appendix D: North Sound ACH Partner Sites - Community-based Organization Survey

Organization	Site
Brigid Collins House	Brigid Collins Family Support Center - Bellingham
Brigid Collins House	Brigid Collins Family Support Center - Mount Vernon
Community Action of Skagit County	Skagit Project Homeless Connect
Compass Health	Aurora House (RTF)
Compass Health	Bailey Center - Adults Services
Compass Health	Bailey Center - IOP
Compass Health	Bailey Center - PACT
Compass Health	Coupeville OP
Compass Health	Dawson Place
Compass Health	Everett - Child & Family Clinic
Compass Health	Everett - Children's Intensive Services
Compass Health	Greenhouse (RTF)
Compass Health	Harbor Station (Island Children's Intensive)
Compass Health	Haven House (RTF)
Compass Health	Lynnwood Adult Services
Compass Health	Lynnwood Child & Family Clinic
Compass Health	Marysville Adult Services

Compass Health	Monroe Children & Family Clinic - 1016
Compass Health	Monroe Children & Family Clinic - 1022
Compass Health	Monroe WISe (Children's Intensive)
Compass Health	Mount Vernon - Adult Services
Compass Health	Mount Vernon - Child & Family Clinic
Compass Health	Mount Vernon - PACT Services
Compass Health	Mukilteo E&T
Compass Health	San Juan Island Outpatient
Compass Health	San Juan Island WISe
Compass Health	Smokey Point Child & Family Clinic
Compass Health	Snohomish Adult Services
Compass Health	Snohomish Triage Center
Compass Health	Whatcom - Cordata (WISe & CPIT)
Compass Health	Whatcom - McLeod
Compass Health	Whatcom Triage Center
Consistent Care Services	Consistent Care Services
Island County of Washington	Camano Island Health Office
Island County of Washington	Island County Human Services
Island County of Washington	Nursing Admin/Main Office
Island County of Washington	Oak Harbor Health Office: North Whidbey Family Resource Center
Island County of Washington	Sheriff Office
Island County of Washington	Sheriff Office - Camano
Island County of Washington	Sheriff Office - Freeland
Island County of Washington	South Whidbey Health Office: South Whidbey Parks and Recreation Bldg

Lydia Place	Lydia Place
Opportunity Council	1111 Cornwall Avenue
Orcas Community Resource Center	Orcas Community Resource Center
Orcas Island Fire & Rescue	Orcas Island Fire & Rescue
Providence Health and Services - Washington	Providence Regional Medical Center Colby Campus
San Juan Island Family Resource Center	San Juan Island Family Resource Center
Senior Services of Snohomish County	Homage Senior Services
Skagit County Public Health	Skagit County Public Health
Skagit County PHD (United General 304)	United General District 304
Snohomish County Fire Protection District #15 (Tulalip Bay Fire)	Snohomish County Fire Protection District #15 (Tulalip Bay Fire)
Snohomish Health District	Snohomish Health District
Whatcom County	Whatcom County Emergency Medical Services
Whatcom County	Whatcom County Health Department

Appendix E: North Sound ACH Partner Sites - Clinic/Practice Survey

Organization	Site
Center for Human Services	CHS Edmonds - Pacific Commons
Center for Human Services	CHS Everett - Silver Lake
Center for Human Services	CHS South Everett
Community Health Center of Snohomish County	Arlington Clinic - Medical, Dental, Pharmacy
Community Health Center of Snohomish County	Everett Central Clinic - Medical
Community Health Center of Snohomish County	Everett College Clinic
Community Health Center of Snohomish County	Edmonds Clinic - Medical, Dental, Pharmacy
Community Health Center of Snohomish County	Everett North Clinic - Medical, Dental, Pharmacy
Community Health Center of Snohomish County	Everett South Clinic - Medical, Dental, Pharmacy

Community Health Center of Snohomish County	Lynnwood Clinic - Medical, Dental, Pharmacy, Behavioral Health
Island Hospital	Anacortes Family Medicine
Island Hospital	Fidalgo Medical Associates
Island Hospital	Island Hospital
Lifeline Connections	Lifeline Connections - Bellingham
Lifeline Connections	Lifeline Connections - Mount Vernon
PeaceHealth	Center for Senior Health
PeaceHealth	Childbirth Center
PeaceHealth	Family Medicine
PeaceHealth	Medical Group Cordata South
PeaceHealth	Medical Group Burlington Family Medicine
PeaceHealth	Medical Group Cordata Main
PeaceHealth	Medical Group Cordata South
PeaceHealth	Medical Group Friday Harbor
PeaceHealth	Peace Island Medical Center
PeaceHealth	Specialty Care Clinic
PeaceHealth	St. Joseph Medical Center
PeaceHealth	United General Medical Center
Pioneer Human Services	Phoenix Recovery Services
Pioneer Human Services	Pioneer Center North
Pioneer Human Services	Skagit County Crisis Center
Pioneer Human Services	Whatcom Community Detox
Planned Parenthood of the Great Northwest and the Hawaiian Islands	Everett Health Center
Planned Parenthood of the Great Northwest and the Hawaiian Islands	Lynnwood Health Center
Planned Parenthood of the Great Northwest and the Hawaiian Islands	Marysville Health Center
Providence Health and Services-Washington	Providence Harbor Pointe Clinic - Mukilteo
Providence Health and Services-Washington	Providence Family Medicine - Lynnwood
Providence Health and Services-Washington	Providence Family Medicine - Snohomish Clinic
Providence Health and Services-Washington	Providence Medical Group Marysville Clinic
Providence Health and Services-Washington	Providence Medical Group Mill Creek Clinic
Providence Health and Services-Washington	Providence Mill Creek Commons
Providence Health and Services-	Providence Medical Group Monroe Clinic

Washington	
Providence Health and Services-Washington	Providence Medical Group North Everett Clinic
Providence Health and Services-Washington	Providence Pavilion for Women & Children - Everett
PHD 1 dba Skagit Valley Hospital	Arlington Family Medicine
PHD 1 dba Skagit Valley Hospital	Benson Family Medicine
PHD 1 dba Skagit Valley Hospital	Cascade Valley Hospital
PHD 1 dba Skagit Valley Hospital	Family Medicine Residency Clinic
PHD 1 dba Skagit Valley Hospital	Skagit Regional Clinic - Camano Island Clinic
PHD 1 dba Skagit Valley Hospital	Skagit Regional Clinic - Darrington Clinic
PHD 1 dba Skagit Valley Hospital	Skagit Regional Clinic - Mount Vernon Clinic
PHD 1 dba Skagit Valley Hospital	Skagit Regional Clinic - Riverbend
PHD 1 dba Skagit Valley Hospital	Skagit Regional Health - Arlington Pediatrics
PHD 1 dba Skagit Valley Hospital	Skagit Regional Health - Arlington Women's Health
PHD 1 dba Skagit Valley Hospital	Skagit Regional Health - Granite Falls Family Medicine
PHD 1 dba Skagit Valley Hospital	Skagit Regional Health - Stanwood Clinic
PHD 1 dba Skagit Valley Hospital	Stanley Internal Medicine Residency Clinic
Sunrise Services	Sunrise Community Mental Health - 1520
Sunrise Services	Sunrise Community Mental Health - Coupeville
Sunrise Services	Sunrise Community Mental Health - Mount Vernon
Swedish Edmonds	Mill Creek Primary Care
Swedish Edmonds	Swedish Birth & Family Clinic
Swedish Edmonds	Swedish Edmonds Campus
Swedish Edmonds	Swedish Edmonds Primary Care
Swedish Edmonds	Swedish OB/GYN Specialists
Swedish Edmonds	Swedish Richmond Beach Primary Care
Tulalip Tribes of Washington	Tulalip Family Services (Behavioral Health & Recovery)
Unity Care NW	UCNW 1616 Cornwall #205
Unity Care NW	UCNW 220 Unity
Unity Care NW	UCNW Ferndale
Unity Care NW	UCNW Ferndale Pioneer
Unity Care NW	UCNW North Whatcom
WhidbeyHealth	WhidbeyHealth Medical Center
WhidbeyHealth	WhidbeyHealth Orthopedic Care
WhidbeyHealth	WhidbeyHealth Primary Care Coupeville
WhidbeyHealth	WhidbeyHealth Primary Care Freeland
WhidbeyHealth	WhidbeyHealth Primary Care Goldie St
WhidbeyHealth	WhidbeyHealth Primary Care Oak Harbor, Cabot
WhidbeyHealth	WhidbeyHealth Surgical Care

WhidbeyHealth	WhidbeyHealth Women's Care CPVL
WhidbeyHealth	WhidbeyHealth Women's Care OH

Table 1. Section I - Integration Services and Patient and Family-Centeredness, Number (Percent), n=105

Characteristic	1	2	3	4	5	6	7	8	9	10	Avg
1. Level of integration; primary care and mental/behavioral health care	15 (14.3)	11 (10.5)	19 (18.1)	29 (27.6)	4 (3.8)	3 (2.9)	8 (7.6)	9 (8.6)	3 (2.9)	4 (3.8)	4.2
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse) ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs	8 (7.6)	8 (7.6)	11 (10.5)	14 (13.3)	5 (4.8)	4 (3.8)	6 (5.7)	28 (26.7)	10 (9.5)	11 (10.5)	6.0
3. Treatment plan(s) for primary care and behavioral/mental health care	7 (6.7)	8 (7.6)	17 (16.2)	13 (12.4)	16 (15.2)	9 (8.6)	20 (19.0)	7 (6.7)	4 (3.8)	4 (3.8)	5.1
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care*	7 (6.7)	0 (0.0)	16 (15.4)	8 (7.7)	11 (10.6)	9 (8.7)	14 (13.5)	20 (19.0)	11 (10.5)	6 (5.7)	6.0
5. Patient/family involvement in care plan	4 (3.8)	4 (3.8)	5 (4.8)	17 (16.2)	19 (18.1)	8 (7.6)	11 (10.5)	20 (19.0)	11 (10.5)	6 (5.7)	6.0
6. Communication with patients about integrated care	17 (16.2)	8 (7.6)	9 (8.6)	4 (3.8)	21 (20.0)	15 (14.3)	16 (15.2)	9 (8.6)	2 (1.9)	4 (3.8)	4.9
7. Follow-up of assessments, tests, treatment, referrals, and other services*	5 (4.8)	9 (8.7)	21 (20.2)	12 (11.5)	11 (10.6)	10 (9.6)	19 (18.3)	9 (8.7)	7 (6.7)	1 (1.0)	5.1
8. Social support (for patients to implement recommended treatment)	4 (3.8)	1 (1.0)	7 (6.7)	6 (5.7)	14 (13.3)	13 (12.4)	19 (18.1)	18 (17.1)	18 (17.1)	5 (4.8)	6.6
9. Linking to Community Resources*	0 (0.0)	5 (4.8)	5 (4.8)	5 (4.8)	22 (21.2)	14 (13.5)	38 (36.5)	9 (8.7)	5 (4.8)	1 (1.0)	6.1
10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications**	10 (10.1)	7 (7.1)	6 (6.1)	9 (9.1)	8 (8.1)	7 (7.1)	12 (12.1)	24 (24.2)	9 (9.1)	7 (7.1)	5.9
11. Tracking of vulnerable patient groups that require additional monitoring and intervention*	10 (9.6)	13 (12.5)	5 (4.8)	9 (8.7)	25 (24.0)	18 (17.3)	13 (12.5)	6 (5.8)	3 (2.9)	2 (1.9)	4.9
12. Accessibility and efficiency of behavioral health practitioners*	17 (16.3)	2 (1.9)	7 (6.7)	4 (3.8)	10 (9.6)	11 (10.6)	22 (21.2)	15 (14.4)	10 (9.6)	6 (5.8)	5.8

*n=104

**n=99

Table 2. Section II – Practice/Organization, Number (Percent), n=105

Characteristic	1	2	3	4	5	6	7	8	9	10	Avg
1. Organizational leadership for integrated care*	1 (1.9)	1 (1.0)	5 (4.8)	9 (8.7)	15 (14.4)	12 (11.5)	11 (10.6)	28 (26.9)	12 (11.5)	9 (8.7)	6.7
2. Patient care team for implementing integrated care*	12 (11.5)	11 (10.6)	8 (7.7)	23 (22.1)	13 (12.5)	10 (9.6)	8 (7.7)	11 (10.6)	3 (2.9)	5 (4.8)	4.8
3. Providers' engagement with integrated care ("buy-in")*	7 (6.7)	4 (3.8)	8 (7.7)	8 (7.7)	23 (22.1)	22 (21.2)	13 (12.5)	12 (11.5)	2 (1.9)	5 (4.8)	5.5
4. Continuity of care between primary care and behavioral/mental health	5 (4.8)	7 (6.7)	9 (8.6)	14 (13.3)	27 (25.7)	15 (14.3)	11 (10.5)	13 (12.4)	3 (2.9)	1 (1.0)	5.2
5. Coordination of referrals and specialists	3 (2.9)	15 (14.3)	13 (12.4)	22 (21.0)	10 (9.5)	18 (17.1)	16 (15.2)	6 (5.7)	2 (1.9)	0 (0.0)	4.7
6. Data systems/patient records*	3 (2.9)	14 (13.5)	10 (9.6)	27 (26.0)	13 (12.5)	9 (8.7)	5 (4.8)	7 (6.7)	7 (6.7)	9 (8.7)	5.1
7. Patient/family input to integration management	3 (2.9)	14 (13.3)	29 (27.6)	20 (19.0)	9 (8.6)	11 (10.5)	12 (11.4)	6 (5.7)	0 (0.0)	1 (1.0)	4.3
8. Physician, team, and staff education and training for integrated care	13 (12.4)	24 (22.9)	22 (21.0)	7 (6.7)	16 (15.2)	4 (3.8)	11 (10.5)	4 (3.8)	3 (2.9)	1 (1.0)	3.9
9. Funding sources/resources**	27 (27.0)	9 (9.0)	17 (17.0)	10 (10.0)	9 (9.0)	8 (8.0)	8 (8.0)	3 (3.0)	3 (3.0)	6 (6.0)	4.0

*n=104

**n=100

The MeHAF Site Self-Assessment (SSA) Survey can be found on page 61 of the Partner Reporting Guide.

Appendix A: North Sound ACH Partners Committed to Bi-Directional Integration

Organization	Strategy 3.1	Strategy 3.2
Center for Human Services	X	
Compass Health	X	X
Family Care Network	X	
Island County	X	
Island Hospital	X	X
Lake Whatcom Center	X	X
Mt. Baker Planned Parenthood	X	X
PeaceHealth	X	
Pioneer Human Services		X
Planned Parenthood of the Great Northwest and the Hawaiian Islands	X	
Providence Health	X	
Sea Mar Community Health Centers	X	X
Skagit Pediatrics	X	
Sunrise Services	X	X
Swedish Edmonds	X	
Tulalip Health Systems	X	
Unity Care NW	X	X
Whidbey General Hospital	X	

Appendix B: North Sound ACH Sites Implementing Bi-directional Integration

Organization Name	Site Name
Center for Human Services	CHS Edmonds - Pacific Commons
Center for Human Services	CHS Everett - Silver Lake
Compass Health	Aurora House (RTF)
Compass Health	Bailey Center - Adult Services
Compass Health	Bailey Center - Intensive Outpatient
Compass Health	Bailey Center - PACT
Compass Health	Coupeville Outpatient
Compass Health	Dawson Place
Compass Health	Everett - Child & Family Clinic
Compass Health	Everett - Children's Intensive Services
Compass Health	Greenhouse (RTF)
Compass Health	Harbor Station (Island Children's Intensive)
Compass Health	Haven House (RTF)
Compass Health	Lynnwood - Adult Services
Compass Health	Lynnwood - Child & Family Clinic
Compass Health	Marysville - Adult Services
Compass Health	Monroe - Child & Family Clinic
Compass Health	Monroe WISe (Children's Intensive)
Compass Health	Mount Vernon - Adult Services
Compass Health	Mount Vernon - Children & Family Clinic
Compass Health	Mount Vernon - E Fir St - WISe Children's Intensive
Compass Health	Mount Vernon - PACT Services
Compass Health	Mukilteo E & T

Compass Health	San Juan Island Outpatient
Compass Health	San Juan Island WISe Children's Intensive
Compass Health	Smokey Point - Child & Family Clinic
Compass Health	Snohomish - Adult Services
Compass Health	Snohomish Triage Center
Compass Health	Whatcom - Cordata (WISe & CPIT)
Compass Health	Whatcom - McLeod
Compass Health	Whatcom Triage Center
Family Care Network	North Sound Family Medicine
Island County of Washington	Island County Human Services
Island County of Washington	Island County Nursing Admin/Main Office
Island County of Washington	Pediatric Associates of Whidbey Island - Cabot
Island County of Washington	Pediatric Associates of Whidbey Island - Layton
Island Hospital	Anacortes Family Medicine
Island Hospital	Fidalgo Medical Associates
Lake Whatcom Center	Agage Heights ALF
Lake Whatcom Center	Alabama ALF
Lake Whatcom Center	Baker Creek ALF
Lake Whatcom Center	Lake Whatcom Residential & Treatment Center
Mt Baker Planned Parenthood	Bellingham Health Center
Mt Baker Planned Parenthood	Friday Harbor Health Center
Mt Baker Planned Parenthood	Mt Vernon Health Center
PeaceHealth	Cancer Center
PeaceHealth	Center for Senior Health

PeaceHealth	Childbirth Center
PeaceHealth	Family Medicine
PeaceHealth	Medical Group Cordata Main
PeaceHealth	Medical Group Friday Harbor
PeaceHealth	PeaceIsland Medical Center
PeaceHealth	United General Medical Center
Pioneer Human Services	Pioneer Center North
Pioneer Human Services	Phoenix Recovery Services
Pioneer Human Services	Skagit County Crisis Center
Pioneer Human Services	Whatcom Community Detox
Planned Parenthood of the Great Northwest and Hawaiian Islands	Everett Health Center
Planned Parenthood of the Great Northwest and Hawaiian Islands	Lynnwood Health Center
Planned Parenthood of the Great Northwest and Hawaiian Islands	Marysville Health Center
Providence Health and Services	Providence Family Medicine - Lynnwood
Providence Health and Services	Providence Family Medicine - Snohomish Clinic
Providence Health and Services	Providence Gynecologic Oncology - Everett
Providence Health and Services	Providence Harbour Point Clinic - Mukilteo
Providence Health and Services	Providence Medical Group Marysville Clinic
Providence Health and Services	Providence Medical Group Mill Creek Clinic
Providence Health and Services	Providence Medical Group Monroe Clinic
Providence Health and Services	Providence Medical Group North Everett Clinic
Providence Health and Services	Providence Mill Creek Commons
Providence Health and Services	Providence Pavilion for Women & Children - Everett

Sea Mar Community Health Center	Sea Mar Bellingham Medical Center
Sea Mar Community Health Center	Sea Mar Concrete Medical Clinic
Sea Mar Community Health Center	Sea Mar Everett
Sea Mar Community Health Center	Sea Mar Everett Behavioral Health
Sea Mar Community Health Center	Sea Mar Marysville Medical Clinic
Sea Mar Community Health Center	Sea Mar Mt. Vernon Behavioral Health Clinic - College Way
Sea Mar Community Health Center	Sea Mar Mt. Vernon Behavioral Health Clinic - Old Highway 99
Skagit Pediatrics	Skagit Pediatrics
Sunrise Services	Community Behavioral Health - Bellingham
Sunrise Services	Community Behavioral Health - Concrete
Sunrise Services	Community Behavioral Health - Coupeville
Sunrise Services	Community Behavioral Health - Everett
Sunrise Services	Community Behavioral Health - Mountlake Terrace
Sunrise Services	Community Behavioral Health - Mt Vernon - E College Way
Sunrise Services	Community Behavioral Health - Mt Vernon - S 2nd St
Sunrise Services	Community Behavioral Health - Oak Harbor
Sunrise Services	Community Behavioral Health - Sedro Woolley
Sunrise Services	Community Behavioral Health - Stanwood
Sunrise Services	Sunrise Community Mental Health - 1021
Swedish Edmonds	Swedish Edmonds Primary Care
Swedish Edmonds	Swedish Pediatrics - Edmonds
Tulalip Tribes of Washington	Tulalip Child Youth and Family
Tulalip Tribes of Washington	Tulalip Family Services (Behavioral Health & Recovery)

Tulalip Tribes of Washington	Tulalip Health Clinic
Unity Care NW	UCNW 1616 Cornwall
Unity Care NW	UCNW 220 Unity
Unity Care NW	UCNW Ferndale
Unity Care NW	UCNW Ferndale Pioneer
Unity Care NW	UCNW North Whatcom
WhidbeyHealth	WhidbeyHealth Primary Care Coupeville
WhidbeyHealth	WhidbeyHealth Primary Care Freeland
WhidbeyHealth	WhidbeyHealth Primary Care Goldie St
WhidbeyHealth	WhidbeyHealth Primary Care Oak Harbor, Cabot
WhidbeyHealth	WhidbeyHealth Women's Care CPVL

Appendix C. Reporting Quantitative Analysis Tables - April - September 2019

Strategy 1.1 - North Sound Community HUB

Milestone 1.1.1 - Implement North Sound Community HUB strategy for identified Medicaid eligible and/or enrolled populations of focus, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report process gaps and alignment opportunities between selected Pathways.	0	0.0	2	66.7	0	0.0	3
Participate in development and integration of HUB policies, procedures, and protocols for Care Coordination Agencies (CCAs) and care coordination staff.	1	33.3	2	66.7	0	0.0	3
Participate in HUB Advisory Committee meetings.	1	33.3	2	66.7	0	0.0	3

Number Not Started = 0 (0.0%)

Milestone 1.1.2 - Apply requirements and standards of evidence-based models and/or promising practices to support North Sound Community HUB strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Pathways HUB	0	0.0	3	100.0	0	0.0	3
Other	0	0.0	0	0.0	0	0.0	3

Number Not Started = 0 (0.0%)

Milestone 1.1.3 - Select North Sound ACH populations of focus for the North Sound Community HUB strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	0	0.0	2	66.7	0	0.0	3
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	0	0.0	3	100.0	0	0.0	3
People experiencing pregnancy	0	0.0	1	33.3	0	0.0	3
People experiencing serious mental illness	0	0.0	3	100.0	0	0.0	3
People experiencing substance use disorder, including opioid use disorder	0	0.0	3	100.0	0	0.0	3
People who have experienced abuse, trauma, adverse childhood experiences	0	0.0	2	66.7	0	0.0	3
People who have been arrested	0	0.0	2	66.7	0	0.0	3
People with chronic conditions	0	0.0	2	66.7	0	0.0	3
People who are high utilizers of systems	0	0.0	2	66.7	0	0.0	3
People experiencing homelessness	0	0.0	2	66.7	0	0.0	3

Number Not Started = 0 (0.0%)

Milestone 1.1.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in North Sound Community HUB strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	1	33.3	2	66.7	0	0.0	3

Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	1	33.3	2	66.7	0	0.0	3
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	1	33.3	2	66.7	0	0.0	3

Number Not Started = 0 (0.0%)

Milestone 1.1.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of North Sound Community HUB strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	3	100.0	0	0.0	0	0.0	3
Staff are trained in quality improvement methodologies.	2	66.7	0	0.0	0	0.0	3
Participate in review of HUB outcomes performance evaluation.	3	100.0	0	0.0	0	0.0	3
Utilize Care Coordination Systems (CCS) Platform to track HUB referrals and clients.	2	66.7	0	0.0	0	0.0	3

Number Not Started = 0 (0.0%)

Milestone 1.1.6 - Develop guidelines, policies, procedures, and protocols to support North Sound Community HUB strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that	1	33.3	2	66.7	0	0.0	3

serve as best practices for selected strategy.							
As needed integrate new guidelines, policies, and procedures for selected strategy.	1	33.3	2	66.7	0	0.0	3
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	1	33.3	2	66.7	0	0.0	3

Number Not Started = 0 (0.0%)

Strategy 1.2 - Acute Care Transitions

Milestone 1.2.1 - Implement Acute Care Transitions strategy for identified Medicaid eligible and/or enrolled populations of focus, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Implement Acute Care Transitions strategy for identified Medicaid eligible and/or enrolled populations of focus.	16	80.0	2	10.0	2	10.0	20

Number Not Started = 0 (0.0%)

Milestone 1.2.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Acute Care Transitions strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Interventions to Reduce Acute Care Transfers (INTERACT)	4	20.0	1	5.0	0	0.0	20
Transitional Care Model (TCM)	8	40.0	1	5.0	0	0.0	20
The Care Transitions Intervention (CTI)	7	35.0	3	15.0	0	0.0	20
Care Transitions Interventions in Mental Health	7	35.0	2	10.0	0	0.0	20
Other	5	25.0	0	0.0	0	0.0	20

No Tactics Selected	0	0.0	0	0.0	1	5.0	20

Number Not Started = 0 (0.0%)

Models listed under "Other" in progress include: Community Resource Paramedical, Person Centered Options Counseling (PC-OC) based on the Essential Lifestyle Planning (ELP) Model, CTI "like" model, and one organization that is "Researching Pediatric Models e.g., Care Coordination Measurement Tool (CCMT) and the Pediatric Care Coordination Curriculum, SMART Teams." The "Other" model indicated in delayed was the Child and Adolescent Needs and Strengths-Family (CANS-F).

Milestone 1.2.3 - Select North Sound ACH populations of focus for the Acute Care Transitions strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	10	50.0	7	35.0	0	0.0	20
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	9	45.0	6	30.0	0	0.0	20
People experiencing pregnancy	5	25.0	2	10.0	0	0.0	20
People experiencing serious mental illness	8	40.0	5	25.0	0	0.0	20
People experiencing substance use disorder, including opioid use disorder	6	30.0	4	20.0	0	0.0	20
People who have experienced abuse, trauma, adverse childhood experiences	6	30.0	4	20.0	0	0.0	20
People who have been arrested	4	20.0	4	20.0	0	0.0	20
People with chronic conditions	9	45.0	5	25.0	0	0.0	20
People who are high utilizers of systems	11	55.0	6	30.0	0	0.0	20
People experiencing homelessness	6	30.0	5	25.0	0	0.0	20

Number Not Started = 0 (0.0%)

Milestone 1.2.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Acute Care Transitions strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	17	85.0	0	0.0	1	5.0	20
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	12	60.0	0	0.0	1	5.0	20
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	14	70.0	0	0.0	1	5.0	20

Number Not Started = 0 (0.0%)

Milestone 1.2.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Acute Care Transitions strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	16	80.0	0	0.0	0	0.0	20
Staff are trained in quality improvement methodologies.	15	75.0	0	0.0	0	0.0	20
Utilize direct transformation coaching when appropriate and/or available.	10	50.0	0	0.0	0	0.0	20
No tactics selected	1	5.0	0	0.0	1	5.0	20

Number Not Started = 0 (0.0%)

Milestone 1.2.6 - Develop guidelines, policies, procedures, and protocols to support Acute Care Transitions strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	19	95.0	0	0.0	1	5.0	20
As needed integrate new guidelines, policies, and procedures for selected strategy.	14	70.0	1	5.0	0	0.0	20
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	11	55.0	1	5.0	0	0.0	20

Number Not Started = 0 (0.0%)

Strategy 1.3 - Transitional Care after Incarceration

Milestone 1.3.1 - Implement Transitional Care after Incarceration strategy for identified Medicaid eligible and/or enrolled populations of focus, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Collaborate with North Sound ACH implementation partners for selected strategy.	11	73.3	2	13.3	0	0.0	15
Embed community health workers (CHWs) in criminal justice settings.*	1	20.0	1	20.0	0	0.0	5
No Tactics Selected	1	0	0.0	0.0	0	0.0	15

Number Not Started = 1 (6.7%)

*One additional partner not committed to tactic reported implementation "In Progress": Whatcom County.

Milestone 1.3.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Transitional Care after Incarceration strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison	8	53.3	1	6.7	0	0.0	15
A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model	9	60.0	1	6.7	0	0.0	15
American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services	5	33.3	1	6.7	0	0.0	15
Other	1	6.7	2	13.3	0	0.0	15

Number Not Started = 3 (20.0%)
Models listed under "Other" include: CANS-F (in progress), and CHART and supportive housing (fully implemented).

Milestone 1.3.3 - Select North Sound ACH populations of focus for the Transitional Care after Incarceration strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	4	26.7	5	33.3	0	0.0	15
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	7	46.7	5	33.3	0	0.0	15
People experiencing pregnancy	4	26.7	4	26.7	0	0.0	15
People experiencing serious mental illness	6	40.0	5	33.3	0	0.0	15
People experiencing substance use disorder, including opioid use disorder	6	40.0	5	33.3	0	0.0	15

People who have experienced abuse, trauma, adverse childhood experiences	4	26.7	4	26.7	0	0.0	15
People who have been arrested	5	33.3	5	33.3	0	0.0	15
People with chronic conditions	3	20.0	5	33.3	0	0.0	15
People who are high utilizers of systems	3	20.0	5	33.3	0	0.0	15
People experiencing homelessness	3	20.0	6	40.0	0	0.0	15

Number Not Started = 2 (13.3%)

Milestone 1.3.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Transitional Care after Incarceration strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	12	80.0	0	0.0	0	0.0	15
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	8	53.3	0	0.0	0	0.0	15
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	7	46.7	0	0.0	0	0.0	15
Not tactics selected	1	6.7	0	0.0	0	0.0	15

Number Not Started = 2 (13.3%)

Milestone 1.3.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Transitional Care after Incarceration strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement	12	80.0	0	0.0	0	0.0	15

capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.							
Staff are trained in quality improvement methodologies.	8	53.3	0	0.0	0	0.0	15
Utilize direct transformation coaching when appropriate and/or available.	7	46.7	0	0.0	0	0.0	15

Number Not Started = 3 (20.0%)

Milestone 1.3.6 - Develop guidelines, policies, procedures, and protocols to support Transitional Care after Incarceration strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	14	93.3	0	0.0	0	0.0	15
As needed integrate new guidelines, policies, and procedures for selected strategy.	10	66.7	0	0.0	0	0.0	15
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	8	53.3	0	0.0	0	0.0	15

Number Not Started = 1 (6.7%)

Strategy 1.4 - Emergency Department Diversion

Milestone 1.4.1 - Implement Emergency Department Diversion strategy for identified Medicaid eligible and/or enrolled populations of focus, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Collaborate with North Sound ACH implementation partners for selected strategy.	9	56.3	6	37.5	0	0.0	16
Embed community health workers (CHWs) in emergency room setting. *	2	40.0	1	20.0	0	0.0	5
Community paramedics or EMTs have partnership with hospitals and social services. **	7	58.3	4	33.3	0	0.0	12
Emergency department has open access, same-day walk-in capacity.***	3	50.0	2	33.3	1	16.7	6

Number Not Started = 0 (0.0%)
*One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
**One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems. One additional partner not committed to tactic reported implementation "Fully Implemented": Consistent Care Services.
***One additional partner not committed to tactic reported implementation "Fully Implemented": Consistent Care Services.

Milestone 1.4.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Emergency Department Diversion strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Washington State Hospital Association's for emergency department diversion model	9	56.3	2	12.5	0	0.0	16
Community Paramedicine Model	6	37.5	4	25.0	0	0.0	16

Other	1	6.3	0	0.0	0	0.0	16
No Tactics Selected	1	6.3	0	0.0	1	6.3	16

Number Not Started = 0 (0.0%)
Models listed under "Other" include: ED and Up from IHI.

Milestone 1.4.3 - Select North Sound ACH populations of focus for the Emergency Department Diversion strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	6	37.5	9	56.3	0	0.0	16
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	6	37.5	8	50.0	0	0.0	16
People experiencing pregnancy	4	25.0	6	37.5	0	0.0	16
People experiencing serious mental illness	6	37.5	7	43.8	0	0.0	16
People experiencing substance use disorder, including opioid use disorder	6	37.5	7	43.8	0	0.0	16
People who have experienced abuse, trauma, adverse childhood experiences	4	25.0	6	37.5	0	0.0	16
People who have been arrested	4	25.0	6	37.5	0	0.0	16
People with chronic conditions	5	31.3	7	43.8	0	0.0	16
People who are high utilizers of systems	6	37.5	9	56.3	0	0.0	16
People experiencing homelessness	5	31.3	8	50.0	0	0.0	16

Number Not Started = 0 (0.0%)

Milestone 1.4.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Emergency Department Diversion strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	12	75.0	1	6.3	0	0.0	16
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	9	56.3	1	6.3	0	0.0	16
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	9	56.3	1	6.3	0	0.0	16
No Tactics Selected	0	0.0	0	0.0	1	6.3	16

Number Not Started = 0 (0.0%)

Milestone 1.4.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Emergency Department Diversion strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	13	81.3	1	6.3	0	0.0	16
Staff are trained in quality improvement methodologies.	13	81.3	1	6.3	0	0.0	16
Utilize direct transformation coaching when appropriate and/or available.	13	81.3	1	6.3	0	0.0	16
No Tactics Selected	1	6.3	1	6.3	0	0.0	16

Number Not Started = 0 (0.0%)

Milestone 1.4.6 - Develop guidelines, policies, procedures, and protocols to support Emergency Department Diversion strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	14	87.5	1	6.3	0	0.0	16
As needed integrate new guidelines, policies, and procedures for selected strategy.	14	87.5	1	6.3	0	0.0	16
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	13	81.3	1	6.3	0	0.0	16
No Tactics Selected	0	0.0	0	0.0	1	6.3	16

Number Not Started = 0 (0.0%)

Strategy 1.5 - Cross-sector Care Coordination and Diversion Collaboratives

Milestone 1.5.1 - Implement Cross-sector Care Coordination and Diversion Collaboratives strategy for identified Medicaid eligible and/or enrolled populations of focus, n=23.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in regularly scheduled cross-sector care meetings.	17	73.9	4	17.4	0	0.0	23

Number Not Started = 2 (8.7%)

Milestone 1.5.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Cross-sector Care Coordination and Diversion Collaboratives strategy, n=23.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Interventions to Law Enforcement Assisted Diversion (LEAD)	3	13.0	1	4.3	0	0.0	23
Transitional Care Model (TCM)	9	39.1	1	4.3	0	0.0	23
The Care Transitions Intervention (CTI)	5	21.7	3	13.0	1	4.3	23
Care Transitions Interventions in Mental Health	8	34.8	2	8.7	1	4.3	23
Other	3	13.0	4	17.4	0	0.0	23

Number Not Started = 1 (4.3%)

Models listed under "Other" include: Help Me Grow Mid-Level Developmental Assessment (MLDA) Model, Pediatric Care Coordination Curriculum, SMART Teams, Recovery Care Coordination - Skagit, and Person-Centered Options Counseling (PC-OC) based on the Essential Lifestyle Planning (ELP) Model. These models were listed as "In Progress." GRACE, CHART, CCS ED Diversion, and Supportive Housing were listed as "Fully Implemented." CANS-F was listed as "Not Started."

Milestone 1.5.3 - Select North Sound ACH populations of focus for the Cross-sector Care Coordination and Diversion Collaboratives strategy, n=23.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	7	30.4	9	39.1	0	0.0	23
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	10	43.5	8	34.8	0	0.0	23
People experiencing pregnancy	6	26.1	6	26.1	0	0.0	23
People experiencing serious mental illness	9	39,1	8	34.8	0	0.0	23
People experiencing substance use disorder, including opioid use disorder	10	43.5	7	30.4	0	0.0	23
People who have experienced abuse, trauma, adverse childhood experiences	7	30.4	6	26.1	0	0.0	23
People who have been arrested	6	26.1	6	26.1	0	0.0	23
People with chronic conditions	9	39.1	8	34.8	0	0.0	23
People who are high utilizers of systems	11	47.8	9	39.1	0	0.0	23
People experiencing homelessness	8	34.8	8	34.8	0	0.0	23

Number Not Started = 1 (4.3%)

Milestone 1.5.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Cross-sector Care Coordination and Diversion Collaboratives strategy, n=23.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	18	78.3	0	0.0	0	0.0	23

Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	13	56.5	0	0.0	0	0.0	23
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	10	43.5	0	0.0	0	0.0	23
No Tactics Selected	1	4.3	0	0.0	1	4.3	23

Number Not Started = 1 (4.3)

Milestone 1.5.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Cross-sector Care Coordination and Diversion Collaboratives strategy, n=23.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	18	78.3	0	0.0	0	0.0	23
Staff are trained in quality improvement methodologies.	15	65.2	0	0.0	0	0.0	23
Utilize direct transformation coaching when appropriate and/or available.	11	47.8	0	0.0	0	0.0	23
No tactics selected	0	0.0	0	0.0	3	13.0	23

Number Not Started = 1 (4.3%)

Milestone 1.5.6 - Develop guidelines, policies, procedures, and protocols to support Cross-sector Care Coordination and Diversion Collaboratives strategy, n=23.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that	18	78.3	2	8.7	0	0.0	23

serve as best practices for selected strategy.							
As needed integrate new guidelines, policies, and procedures for selected strategy.	15	65.2	2	8.7	1	4.3	23
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	11	47.8	2	8.7	0	0.0	23
No tactics selected	0	0.0	0	0.0	1	4.3	23

Number Not Started = 1 (4.3%)

Strategy 2.1 - Prevent Opioid Use and Misuse

Milestone 2.1.1 - Implement Prevent Opioid Use and Misuse strategy for identified Medicaid eligible and/or enrolled populations of focus, n=22.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Use or expand the use of the Prescription Monitoring Program (PMP) into workflow. *	9	69.2	3	23.1	0	0.0	13
Promote use of best practices for prescribing opioids for managing acute and chronic pain. **	9	69.2	4	30.8	0	0.0	13
Together with the Center for Opioid Safety Education and other partners, such as statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users. ***	13	72.2	5	27.8	0	0.0	18
Prevent opioid initiation and misuse in communities, particularly among youth. ****	10	66.7	3	20.0	0	0.0	15
Promote safe home storage and appropriate disposal of prescription pain	14	73.7	4	21.1	0	0.0	19

medication to prevent misuse (i.e., "drug take back"). *****							
Providers and staff are trained on guidelines for prescribing opioids for pain. ******	10	76.9	3	23.1	0	0.0	13
Practice/clinic sites has electronic health records (EHRs) or other systems that provide clinical decision support for the opioid prescribing guidelines.*******	6	66.7	1	11.1	0	0.0	9
Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. ********	11	78.6	2	14.3	0	0.0	14
Implement the Six Building blocks model for improving opioid management in primary care.	2	28.6	0	0.0	0	0.0	7
Use AMDG guidelines on co-prescribing naloxone for patients on opioid medication. *********	7	58.3	1	8.3	0	0.0	12

Number Not Started = 0 (0.0%)

*Two additional partners not committed to tactic reported implementation "In Progress": Sunrise Services and Tulalip Health Systems. One additional partner not committed to tactic reported implementation "Fully Implemented": Public Hospital District No. 1 Skagit County, WA (Skagit Regional).

**Two additional partners not committed to tactic reported implementation "In Progress": Skagit Co PHD Skagit County (United General) and Tulalip Health Systems.

***Three additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional), Tulalip Health Systems, and Unity Care NW.

****One additional partner not committed to tactic reporting implementation "In Progress": Tulalip Health Systems.

*****Three additional partners not committed to tactic reported implementation "In Progress": Island Hospital, Orcas Family Connections, and Tulalip Health Systems. One additional partner not committed to tactic reported implementation "Fully Implemented": Public Hospital District No. 1 Skagit County, WA (Skagit Regional).

******One additional partner not committed to tactic reporting implementation "In Progress": Tulalip Health Systems.

*******One additional partner not committed to tactic reporting implementation "In Progress": Tulalip Health Systems.

********Two additional partners not committed to tactic reporting implementation "In Progress": San Juan Island Family Resource Center and Tulalip Health Systems.
*********One additional partner not committed to tactic reported implementation "Fully Implemented": Public Hospital District No. 1 Skagit County, WA (Skagit Regional).

Milestone 2.1.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Prevent Opioid Use and Misuse strategy, n=22.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Washington State Interagency Opioid Working Plan	16	72.7	4	18.2	0	0.0	22
North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan	12	54.5	2	9.1	0	0.0	22
Screening, Brief Intervention, Referral to Treatment (SBIRT)	15	68.2	1	4.5	0	0.0	22
Six Building Blocks	10	45.5	1	4.5	0	0.0	22
AMDG guidelines on co-prescribing naloxone for patients on opioid medication	12	54.5	3	13.6	0	0.0	22
Other	3	13.6	0	0.0	0	0.0	22

Number Not Started = 1 (4.5%)
Models listed under "Other" include: Prescription Monitoring Program in EPIC, Bree Collaborative and CDC Guidelines for Prescribing Opioids for Chronic Pain.

Milestone 2.1.3 - Select North Sound ACH populations of focus for Prevent Opioid Use and Misuse strategy, n=22.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	11	50.0	9	40.9	0	0.0	22

People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	12	54.5	9	40.9	0	0.0	22
People experiencing pregnancy	10	45.5	9	40.9	0	0.0	22
People experiencing serious mental illness	11	50.0	9	40.9	0	0.0	22
People experiencing substance use disorder, including opioid use disorder	12	54.5	9	40.9	0	0.0	22
People who have experienced abuse, trauma, adverse childhood experiences	12	54.5	9	40.9	0	0.0	22
People who have been arrested	9	40.9	9	40.9	0	0.0	22
People with chronic conditions	13	59.1	9	40.9	0	0.0	22
People who are high utilizers of systems	13	59.1	9	40.9	0	0.0	22
People experiencing homelessness	10	45.5	9	40.9	0	0.0	22

Number Not Started = 0 (0.0%)

Milestone 2.1.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Prevent Opioid Use and Misuse strategy, n=22.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	16	72.7	4	18.2	0	0.0	22
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	11	50.0	2	9.1	0	0.0	22
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	15	68.2	4	18.2	0	0.0	22

Number Not Started = 0 (0.0%)

Milestone 2.1.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Prevent Opioid Use and Misuse strategy.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	19	86.4	1	4.5	0	0.0	22
Staff are trained in quality improvement methodologies.	15	68.2	1	4.5	0	0.0	22
Utilize direct transformation coaching when appropriate and/or available.	13	59.1	1	4.5	0	0.0	22

Number Not Started = 2 (9.1%)

Milestone 2.1.6 - Develop guidelines, policies, procedures and protocols to support Prevent Opioid Use and Misuse strategy, n=22.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	17	77.3	4	18.2	0	0.0	22
As needed integrate new guidelines, policies, and procedures for selected strategy.	16	72.7	4	18.2	0	0.0	22
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	16	72.7	4	18.2	0	0.0	22
No tactics selected	1	4.5	0	0.0	0	0.0	22

Number Not Started = 0 (0.0%)

Strategy 2.2 - Link Individuals with Opioid Use Disorder with Treatment

Milestone 2.2.1 - Implement Link Individuals with Opioid Use Disorder with Treatment strategy for identified Medicaid eligible and/or enrolled populations of focus, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Build organization's capacity to recognize signs of possible opioid misuse, effectively identify Opioid Use Disorder, and link patients/clients to appropriate treatment resources. *	11	73.3	3	20.0	1	6.7	15
Expand access to, and utilization of, clinically-appropriate evidence-based practices for Opioid Use Disorder treatment in communities, particularly MAT. **	10	66.7	3	20.0	1	6.7	15
Expand access to, and utilization of, Opioid Use Disorder medications in the criminal justice system. ***	4	66.7	2	33.3	0	0.0	6
Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing.	4	66.7	1	16.7	0	0.0	6
Identify and treat OUD among pregnant and parenting individuals and Neonatal Abstinence Syndrome (NAS) among newborns. ****	5	62.5	1	12.5	1	12.5	8
Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. *****	10	76.9	2	15.4	1	7.7	13
Implement the Six Building blocks model for improving opioid management in primary care.	2	40.0	0	0.0	0	0.0	5

Healthcare providers use Opioid Guidelines from Washington Agency Medical Directors' Group (AMDG) guidelines. ******	6	60.0	2	20.0	1	10.0	10
Organization site connects persons to MAT providers. *******	11	73.3	3	20.0	1	6.7	15
Utilize patient agreements for chronic opioid therapy (COT) and review them with patients annually. ********	6	75.0	1	12.5	0	0.0	8

Number Not Started = 0 (0.0%)

**Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.
**Two additional partners not committed to tactic reported implementation "In Progress": Skagit Co PH Skagit County (United General) and Tulalip Health Systems.
***One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems. One additional partner not committed to tactic reported implementation "Fully Implemented": Opportunity Council.
****One additional partner not committed to tactic reported implementation "In Progress": Skagit County Public Health.
*****One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
******Two additional partners not committed to tactic reported implementation "In Progress": Community Action of Skagit County and Tulalip Health Systems.
*******Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.
********Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.

Milestone 2.2.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Link Individuals with Opioid Use Disorder with Treatment strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Washington State Interagency Opioid Working Plan	11	55.0	5	25.0	1	5.0	20
North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan	8	40.0	3	15.0	0	0.0	20

Screening, Brief Intervention, Referral to Treatment (SBIRT)	10	50.0	2	10.0	1	5.0	20
Six Building Blocks	3	15.0	2	10.0	0	0.0	20
Opioid Guideline from Washington Agency Medical Directors' Group (AMDG) guidelines	8	40.0	4	20.0	1	5.0	20
Other	2	10.0	0	0.0	0	0.0	20

Number Not Started = 0 (0.0%)
Models listed under "Other" include: CDC Guideline for Prescribing Opioids for Chronic Pain and the Recovery Coach Model.

Milestone 2.2.3 - Select North Sound ACH populations of focus for the Link Individuals with Opioid Use Disorder with Treatment strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	6	30.0	11	55.0	0	0.0	20
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	8	40.0	10	50.0	1	5.0	20
People experiencing pregnancy	5	25.0	10	50.0	1	5.0	20
People experiencing serious mental illness	4	20.0	10	50.0	1	5.0	20
People experiencing substance use disorder, including opioid use disorder	8	40.0	10	50.0	1	5.0	20
People who have experienced abuse, trauma, adverse childhood experiences	6	30.0	10	50.0	1	5.0	20
People who have been arrested	4	20.0	9	45.0	0	0.0	20
People with chronic conditions	7	35.0	10	50.0	1	5.0	20
People who are high utilizers of systems	8	40.0	10	50.0	1	5.0	20
People experiencing homelessness	7	35.0	11	55.0	0	0.0	20

Number Not Started = 0 (0.0%)

Milestone 2.2.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Link Individuals with Opioid Use Disorder with Treatment strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	14	70.0	3	15.0	1	5.0	20
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	9	45.0	3	15.0	0	0.0	20
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	12	60.0	3	15.0	1	5.0	20

Number Not Started = 0 (0.0%)

Milestone 2.2.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Link Individuals with Opioid Use Disorder with Treatment strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	17	85.0	2	10.0	1	5.0	20
Staff are trained in quality improvement methodologies.	14	70.0	2	10.0	0	0.0	20
Utilize direct transformation coaching when appropriate and/or available.	12	60.0	2	10.0	1	5.0	20

Number Not Started = 0 (0.0%)

Milestone 2.2.6 - Develop guidelines, policies, procedures, and protocols to support Link Individuals with Opioid Use Disorder with Treatment strategy, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	16	80.0	4	20.0	0	0.0	20
As needed integrate new guidelines, policies, and procedures for selected strategy.	14	70.0	4	20.0	0	0.0	20
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	12	60.0	4	20.0	0	0.0	20

Number Not Started = 0 (0.0%)

Strategy 2.3 - Intervene in Opioid Overdoses to Prevent Death

Milestone 2.3.1 - Implement Intervene in Opioid Overdoses to Prevent Death strategy for identified Medicaid eligible and/or enrolled populations of focus, n=25.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose. *	16	69.6	5	21.7	0	0.0	23
Make system-level improvements to increase the availability and use of naloxone. **	17	77.3	5	22.7	0	0.0	22
Promote awareness and understanding of Washington State's Good Samaritan Law with the Center for Opioid Safety Education. ***	14	70.0	5	25.0	0	0.0	20

Emergency department has protocols in place for providing overdose education, peer support, and take-home naloxone to individuals seen for opioid overdose.	4	80.0	0	0.0	0	0.0	5
Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. ****	12	75.0	2	12.5	0	0.0	16
Staff are trained to recognize and appropriately respond to an overdose. *****	17	77.3	5	22.7	0	0.0	22
Providers co-prescribe Naloxone with medication-assisted treatment (MAT). ******	6	66.7	2	22.2	0	0.0	9
No tactics selected	1	4.0	0	0.0	0	0.0	25

Number Not Started = 0 (0.0%)

*Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.
**Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.
***One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
****One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
Number Not Started = 0 (0.0%)
*****Two additional partners not committed to tactic reported implementation "In Progress": Compass Health and Tulalip Health Systems.
******Two additional partners not committed to tactic reported implementation "In Progress": Skagit County Public Health and Tulalip Health Systems.

Milestone 2.3.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Intervene in Opioid Overdoses to Prevent Death strategy, n=25.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Washington State Interagency Opioid Working Plan	16	64.0	4	16.0	0	0.0	25
North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan	14	56.0	2	8.0	0	0.0	25
Screening, Brief Intervention, Referral to Treatment (SBIRT)	13	52.0	2	8.0	0	0.0	25
Other	3	12.0	1	4.0	0	0.0	25

Number Not Started = 2 (8.0%)
Models listed under "Other" include: Starts with One, providing Naloxone to patients at risk for overdose, and linking ED patients to Ideal Options (in progress). Fully implemented models listed under "Other" include training all staff on use of Naloxone.

Milestone 2.3.3 - Select North Sound ACH populations of focus for the Intervene in Opioid Overdoses to Prevent Death strategy, n=25.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	9	36.0	11	44.0	0	0.0	25
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	12	48.0	11	44.0	0	0.0	25
People experiencing pregnancy	8	32.0	11	44.0	0	0.0	25
People experiencing serious mental illness	11	44.0	11	44.0	0	0.0	25

People experiencing substance use disorder, including opioid use disorder	12	48.0	11	44.0	0	0.0	25
People who have experienced abuse, trauma, adverse childhood experiences	9	36.0	11	44.0	0	0.0	25
People who have been arrested	6	24.0	11	44.0	0	0.0	25
People with chronic conditions	9	36.0	11	44.0	0	0.0	25
People who are high utilizers of systems	11	44.0	11	44.0	0	0.0	25
People experiencing homelessness	7	28.0	12	48.0	0	0.0	25

Number Not Started = 1 (4.0%)

Milestone 2.3.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Intervene in Opioid Overdoses to Prevent Death strategy, n=25.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	18	72.0	3	12.0	0	0.0	25
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	16	64.0	3	12.0	0	0.0	25
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	18	72.0	3	12.0	0	0.0	25
No tactics selected	1	4.0	0	0.0	0	0.0	25

Number Not Started = 1 (4.0%)

Milestone 2.3.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Intervene in Opioid Overdoses to Prevent Death strategy, n=25.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N

Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	19	76.0	2	8.0	1	4.0	25
Staff are trained in quality improvement methodologies.	15	60.0	2	8.0	1	4.0	25
Utilize direct transformation coaching when appropriate and/or available.	14	56.0	2	8.0	1	4.0	25
No tactics selected	1	4.0	0	0.0	0	0.0	25

Number Not Started = 1 (4.0%)

Milestone 2.3.6 - Develop guidelines, policies, procedures, and protocols to support Intervene in Opioid Overdoses to Prevent Death strategy, n=25.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	20	80.0	4	16.0	0	0.0	25
As needed integrate new guidelines, policies, and procedures for selected strategy.	19	76.0	4	16.0	0	0.0	25
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	14	56.0	4	16.0	0	0.0	25
No tactics selected	1	4.0	0	0.0	0	0.0	25

Number Not Started = 0 (0.0%)

Strategy 2.4 - Community Recovery Services and Networks for Opioid Use Disorder

Milestone 2.4.1 - Implement Community Recovery Services and Networks for Opioid Use Disorder strategy for identified Medicaid eligible and/or enrolled populations of focus, n=21.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Use Telehealth resources to expand capacity to support opioid use disorder prevention and treatment.	5	62.5	0	0.0	0	0.0	8
Link to public awareness programs such as "It Starts with One".	12	70.6	2	11.8	0	0.0	17
Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery. *	8	72.7	1	9.1	0	0.0	11
Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care. **	9	75.0	2	16.7	0	0.0	12
Connect Substance Use Disorder providers with primary care, behavioral health, social service, and peer recovery support providers to address access, referral, and follow up for services. ***	10	83.3	0	0.0	0	0.0	12
Utilize technical assistance to organize or expand syringe exchange programs.	3	50.0	1	16.7	0	0.0	6
Mental health and substance use disorder (SUD) providers deliver acute care and recovery services for people with opioid use disorder (OUD). ****	5	62.5	0	0.0	0	0.0	8

Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. *****	10	83.3	1	8.3	0	0.0	12
Give patients/clients information about syringe exchange program. ******	12	70.6	2	11.8	0	0.0	17
Support linkages between syringe exchange programs and physical or behavioral health providers. *******	10	71.4	2	14.3	0	0.0	14

Number Not Started = 0 (0.0%)

*Three additional partners not committed to tactic reported implementation "In Progress": Community Action of Skagit County, San Juan Island Family Resource Center, and Tulalip Health Systems.
**Two additional partners not committed to tactic reported implementation "In Progress": San Juan Island Family Resource Center and Tulalip Health Systems.
***Two additional partners not committed to tactic reported implementation "In Progress": Opportunity Council and Tulalip Health Systems. One additional partner not committed to tactic reported implementation "Fully Implemented": Consistent Care Services.
****Two additional partners not committed to tactic reported implementation "In Progress": Providence Health and Services and Tulalip Health Systems.
*****Two additional partners not committed to tactic reported implementation "In Progress": San Juan Island Family Resource Center and Tulalip Health Systems.
******Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.
*******Two additional partners not committed to tactic reported implementation "In Progress": Public Hospital District No. 1 Skagit County, WA (Skagit Regional) and Tulalip Health Systems.

Milestone 2.4.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Community Recovery Services and Networks for Opioid Use Disorder strategy, n=21.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Washington State Interagency Opioid Working Plan	16	76.2	2	9.5	0	0.0	21
North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan	14	66.7	0	0.0	0	0.0	21
Screening, Brief Intervention, Referral to Treatment (SBIRT)	13	61.9	1	4.8	0	0.0	21
Other	4	19.0	0	0.0	0	0.0	21

Number Not Started = 1 (4.8%)
Models listed under "Other" include: Recovery Coach Model, Recovery Cafe Model, Whatcom HOPE Campaign, and SURGE.

Milestone 2.4.3 - Select North Sound ACH populations of focus for the Community Recovery Services and Networks for Opioid Use Disorder strategy, n=21.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	7	33.3	11	52.4	0	0.0	21
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	7	33.3	11	52.4	0	0.0	21
People experiencing pregnancy	5	23.8	11	52.4	0	0.0	21
People experiencing serious mental illness	5	23.8	11	52.4	0	0.0	21
People experiencing substance use disorder, including opioid use disorder	7	33.3	11	52.4	0	0.0	21

People who have experienced abuse, trauma, adverse childhood experiences	7	33.3	11	52.4	0	0.0	21
People who have been arrested	5	23.8	11	52.4	0	0.0	21
People with chronic conditions	5	23.8	11	52.4	0	0.0	21
People who are high utilizers of systems	6	28.6	11	52.4	0	0.0	21
People experiencing homelessness	6	28.6	12	57.1	0	0.0	21

Number Not Started = 1 (4.8%)

Milestone 2.4.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Community Recovery Services and Networks for Opioid Use Disorder strategy, n=21.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	16	76.2	2	9.5	0	0.0	21
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	11	52.4	2	9.5	0	0.0	21
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	13	61.9	2	9.5	0	0.0	21

Number Not Started = 2 (9.5%)

Milestone 2.4.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Community Recovery Services and Networks for Opioid Use Disorder strategy, n=21.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement	16	76.2	1	4.8	0	0.0	21

capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.							
Staff are trained in quality improvement methodologies.	12	57.1	1	4.8	0	0.0	21
Utilize direct transformation coaching when appropriate and/or available.	11	52.4	1	4.8	0	0.0	21

Number Not Started = 2 (9.5%)

Milestone 2.4.6 - Develop guidelines, policies, procedures, and protocols to support Community Recovery Services and Networks for Opioid Use Disorder strategy, n=21.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	16	76.2	3	14.3	0	0.0	21
As needed integrate new guidelines, policies, and procedures for selected strategy.	16	76.2	3	14.3	0	0.0	21
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	14	66.7	3	14.3	0	0.0	21
No tactics selected	1	4.8	0	0.0	0	0.0	21

Number Not Started = 0 (0.0%)

Strategy 2.5 - Full Spectrum of Reproductive Health Services (including Long-Acting Reversible Contraception (LARC))

Milestone 2.5.1 - Implement Full Spectrum of Reproductive Health Services strategy for identified Medicaid eligible and/or enrolled populations of focus, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N

Offer a full range of effective contraceptive methods, including Long-Acting Reversible Contraception (LARC).	9	60.0	3	20.0	0	0.0	15
Facilitate referral of all individuals in first trimester of pregnancy to appropriate prenatal care.*	9	69.2	4	30.8	0	0.0	13
Facilitate referral of all pregnant individuals with high risk behaviors (alcohol or drug use, etc.) to evidence-based community support programs and specialty care. **	8	66.7	4	33.3	0	0.0	12
Staff are trained to offer education and information resources to all patients on the full spectrum of contraceptive options (including LARC) and their relative effectiveness. ***	6	60.0	4	40.0	0	0.0	10
Incorporate 'One Key Question' into patient/client assessments.	8	53.3	4	26.7	0	0.0	15
Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. ****	2	25.0	4	50.0	0	0.0	8
Facilitate referral of individuals with a history of adverse pregnancy outcomes to evidence-based community support programs. *****	8	66.7	4	33.3	0	0.0	12

Number Not Started = 0 (0.0%)

*One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
**One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
***One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
****One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
*****One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.

Milestone 2.5.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Full Spectrum of Reproductive Health Services strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
CDC's Recommendations to Improve Preconception Health and Health Care	8	53.3	3	20.0	0	0.0	15
One Key Question	9	60.0	3	20.0	0	0.0	15
Screening, Brief Intervention, Referral to Treatment (SBIRT)	6	40.0	3	20.0	0	0.0	15
Other	0	0.0	0	0.0	0	0.0	15

Number Not Started = 1 (6.7%)

Milestone 2.5.3 - Select North Sound ACH populations of focus for the Fully Spectrum of Reproductive Health Services strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	7	46.7	6	40.0	0	0.0	15
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	5	33.3	7	46.7	0	0.0	15
People experiencing pregnancy	7	46.7	7	46.7	0	0.0	15
People experiencing serious mental illness	5	33.3	7	46.7	0	0.0	15
People experiencing substance use disorder, including opioid use disorder	5	33.3	7	46.7	0	0.0	15
People who have experienced abuse, trauma, adverse childhood experiences	6	40.0	7	46.7	0	0.0	15
People who have been arrested	3	20.0	6	40.0	0	0.0	15

People with chronic conditions	5	33.3	7	46.7	0	0.0	15
People who are high utilizers of systems	5	33.3	7	46.7	0	0.0	15
People experiencing homelessness	5	33.3	6	40.0	0	0.0	15

Number Not Started = 1 (6.7%)

Milestone 2.5.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Full Spectrum of Reproductive Health Services strategy.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	10	66.7	2	13.3	0	0.0	15
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	8	53.3	10	66.7	0	0.0	15
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	10	66.7	2	13.3	0	0.0	15

Number Not Started = 1 (6.7%)

Milestone 2.5.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Full Spectrum of Reproductive Health Services strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	10	66.7	1	6.7	1	6.7	15

Staff are trained in quality improvement methodologies.	9	60.0	1	6.7	1	6.7	15
Utilize direct transformation coaching when appropriate and/or available.	9	60.0	1	6.7	1	6.7	15
No tactics selected	1	6.7	0	0.0	0	0.0	15

Number Not Started = 2 (13.3%)

Milestone 2.5.6 - Develop guidelines, policies, procedures, and protocols to support Full Spectrum of Reproductive Health Services strategy, n=15.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	10	66.7	3	20.0	0	0.0	15
As needed integrate new guidelines, policies, and procedures for selected strategy.	9	60.0	3	20.0	0	0.0	15
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	7	46.7	3	20.0	0	0.0	15
No tactics selected	1	6.7	0	0.0	0	0.0	15

Number Not Started = 1 (6.7%)

Strategy 2.6 - Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations

Milestone 1.2.1 - Implement Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations strategy for identified Medicaid eligible and/or enrolled populations of focus, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Embed Healthy Steps specialist or a trained staff member in pediatric practice to increase well-child visits, support early child behavioral health integration. *	4	80.0	1	20.0	0	0.0	5
Integrate SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. **	6	66.7	3	33.3	0	0.0	9
Facilitate clinical-community linkages with schools and early intervention programs (i.e., child care, preschools, home visiting) to promote well-child visits and immunizations. ***	9	64.3	4	28.6	0	0.0	14
No Tactics Selected	1	6.3	0	0.0	0	0.0	16

Number Not Started = 0 (0.0%)

*One additional partner not committed to tactic reported implementation "Fully Implemented": Tulalip Health Systems.
**One additional partner not committed to tactic reported implementation "Fully Implemented": Tulalip Health Systems.
**One additional partner not committed to tactic reported implementation "In Progress": Whidbey General Health.

Milestone 2.6.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Nurse Family Partnership	6	37.5	1	6.3	0	0.0	16
Early Head Start	8	50.0	1	6.3	0	0.0	16
Parents as Teachers	5	31.3	1	6.3	0	0.0	16
Family Spirit	3	18.8	0	0.0	0	0.0	16
Bright Futures	7	43.8	2	12.5	0	0.0	16
Stonybrook	3	18.8	0	0.0	0	0.0	16
Healthy Steps	7	43.8	0	0.0	0	0.0	16
Screening, Brief Intervention, Referral to Treatment (SBIRT)	8	50.0	1	6.3	0	0.0	16
Other	2	12.5	0	0.0	0	0.0	16

Number Not Started = 1 (6.3%)
Models listed under "Other" include: Help Me Grow, Medical Home, SMART Teams, and Children with Special Health Care Needs.

Milestone 2.6.3 - Select North Sound ACH populations of focus for the Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	6	37.5	8	50.0	0	0.0	16
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	5	31.3	6	37.5	0	0.0	16
People experiencing pregnancy	4	25.0	7	43.8	0	0.0	16

People experiencing serious mental illness	4	25.0	5	31.3	0	0.0	16
People experiencing substance use disorder, including opioid use disorder	5	31.3	7	43.8	0	0.0	16
People who have experienced abuse, trauma, adverse childhood experiences	5	31.3	7	43.8	0	0.0	16
People who have been arrested	2	12.5	4	25.0	0	0.0	16
People with chronic conditions	4	25.0	8	50.0	0	0.0	16
People who are high utilizers of systems	4	25.0	7	43.8	0	0.0	16
People experiencing homelessness	5	31.3	8	50.0	0	0.0	16

Number Not Started = 0 (0.0%)

Milestone 2.6.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	10	62.5	4	25.0	0	0.0	16
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	6	37.5	4	25.0	0	0.0	16
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	9	56.3	4	25.0	0	0.0	16

Number Not Started = 0 (0.0%)

Milestone 2.6.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations strategy.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	10	62.5	4	25.0	0	0.0	16
Staff are trained in quality improvement methodologies.	10	62.5	4	25.0	0	0.0	16
Utilize direct transformation coaching when appropriate and/or available.	7	43.8	4	25.0	0	0.0	16

Number Not Started = 1 (6.3%)

Milestone 2.6.6 - Develop guidelines, policies, procedures, and protocols to support Pediatric Practices to Promote Child Health, Well-child Visits, and Childhood Immunizations strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	8	50.0	6	37.5	0	0.0	16
As needed integrate new guidelines, policies, and procedures for selected strategy.	8	50.0	6	37.5	0	0.0	16
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	8	50.0	6	37.5	0	0.0	16

Number Not Started = 1 (6.3%)

Strategy 2.7 - Population Management in Oral Health Settings

Milestone 2.7.1 - Implement Population Management in Oral Health Settings strategy for identified Medicaid eligible and/or enrolled populations of focus, n=6.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound ACH's Oral Health Local Impact Network (LIN).	4	66.7	2	33.3	0	0.0	6
Use International Statistical Classification of Diseases (ICD-10) coding in oral health settings.*	2	100.0	0	0.0	0	0.0	2
Increase or expand use of silver diamine fluoride.**	3	75.0	1	25.0	0	0.0	4
Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.***	1	100.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

*One additional partner not committed to tactic reported implementation "Fully Implemented": Tulalip Health Systems.
**One additional partner not committed to tactic reported implementation "Fully Implemented": Tulalip Health Systems.
***One additional partner not committed to tactic reported implementation "Fully Implemented": Tulalip Health Systems.

Milestone 2.7.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Population Management in Oral Health Settings strategy, n=6.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Guidelines to improve access to oral health services, especially among children and pregnant individuals	5	83.3	1	16.7	0	0.0	6

Screening, Brief Intervention, Referral to Treatment (SBIRT)	3	50.0	1	16.7	0	0.0	6
Other	0	0.0	0	0.0	0	0.0	6

Number Not Started = 0 (0.0%)
Models listed under "Other" include: Head Start/Early Head Start EBPs.

Milestone 2.7.3 - Select North Sound ACH populations of focus for the Population Management in Oral Health Settings strategy, n=6.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	3	50.0	3	50.0	0	0.0	6
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	3	50.0	2	33.3	0	0.0	6
People experiencing pregnancy	3	50.0	3	50.0	0	0.0	6
People experiencing serious mental illness	3	50.0	1	16.7	0	0.0	6
People experiencing substance use disorder, including opioid use disorder	2	33.3	3	50.0	0	0.0	6
People who have experienced abuse, trauma, adverse childhood experiences	2	33.3	3	50.0	0	0.0	6
People who have been arrested	2	33.3	2	33.3	0	0.0	6
People with chronic conditions	3	50.0	2	33.3	0	0.0	6
People who are high utilizers of systems	3	50.0	2	33.3	0	0.0	6
People experiencing homelessness	3	50.0	3	50.0	0	0.0	6

Number Not Started = 0 (0.0%)

Milestone 2.7.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Population Management in Oral Health Settings strategy, n=6.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	3	50.0	2	33.3	0	0.0	6
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	4	66.7	2	33.3	0	0.0	6
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	3	50.0	2	33.3	0	0.0	6

Number Not Started = 0 (0.0%)

Milestone 2.6.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Population Management in Oral Health Settings strategy, n=6.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	5	83.3	1	16.7	0	0.0	6
Staff are trained in quality improvement methodologies.	4	66.7	1	16.7	0	0.0	6
Utilize direct transformation coaching when appropriate and/or available.	3	50.0	1	16.7	0	0.0	6

Number Not Started = 0 (0.0%)

Milestone 2.7.6 - Develop guidelines, policies, procedures, and protocols to support Population Management in Oral Health Settings strategy, n=6.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	4	66.7	2	33.3	0	0.0	6
As needed integrate new guidelines, policies, and procedures for selected strategy.	4	66.7	2	33.3	0	0.0	6
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	3	50.0	2	33.3	0	0.0	6

Number Not Started = 0 (0.0%)

Strategy 2.8 - Dental Health Aide Therapists (DHATs) in Tribal Clinics

Milestone 2.8.1 - Implement Dental Health Aide Therapists (DHATs) in Tribal Clinics strategy for identified Medicaid eligible and/or enrolled populations of focus, n=1.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound ACH's Oral Health Local Impact Network (LIN).	1	100.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

Milestone 2.8.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Dental Health Aide Therapists (DHATs) in Tribal Clinics strategy, n=1.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Requirements and standards of Dental Health Aide Therapists (DHATs) in Tribal Clinics	1	100.0	0	0.0	0	0.0	1
Other	0	0.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

Milestone 2.8.3 - Select North Sound ACH populations of focus for the Dental Health Aide Therapists (DHATs) in Tribal Clinics strategy, n=1.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	1	100.0	0	0.0	0	0.0	1
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	1	100.0	0	0.0	0	0.0	1
People experiencing pregnancy	1	100.0	0	0.0	0	0.0	1

People experiencing serious mental illness	1	100.0	0	0.0	0	0.0	1
People experiencing substance use disorder, including opioid use disorder	1	100.0	0	0.0	0	0.0	1
People who have experienced abuse, trauma, adverse childhood experiences	1	100.0	0	0.0	0	0.0	1
People who have been arrested	1	100.0	0	0.0	0	0.0	1
People with chronic conditions	1	100.0	0	0.0	0	0.0	1
People who are high utilizers of systems	1	100.0	0	0.0	0	0.0	1
People experiencing homelessness	1	100.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

Milestone 2.8.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Dental Health Aide Therapists (DHATs) in Tribal Clinics strategy, n=1.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	1	100.0	0	0.0	0	0.0	1
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	1	100.0	0	0.0	0	0.0	1
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	1	100.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

Milestone 2.8.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Dental Health Aide Therapists (DHATs) in Tribal Clinics strategy, n=1.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	1	100.0	0	0.0	0	0.0	1
Staff are trained in quality improvement methodologies.	1	100.0	0	0.0	0	0.0	1
Utilize direct transformation coaching when appropriate and/or available.	1	100.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

Milestone 2.8.6 - Develop guidelines, policies, procedures, and protocols to support Dental Health Aide Therapists (DHATs) in Tribal Clinics strategy, n=1.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	1	100.0	0	0.0	0	0.0	1
As needed integrate new guidelines, policies, and procedures for selected strategy.	1	100.0	0	0.0	0	0.0	1
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	1	100.0	0	0.0	0	0.0	1

Number Not Started = 0 (0.0%)

Strategy 2.9 - Mobile Dental Care in Community Settings

Milestone 2.9.1 - Implement Mobile Dental Care in Community Settings strategy for identified Medicaid eligible and/or enrolled populations of focus, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound ACH's Oral Health Local Impact Network (LIN).	2	66.7	1	33.3	0	0.0	3

Number Not Started = 0 (0.0%)

Milestone 2.9.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Mobile Dental Care in Community Settings strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Requirements and standards for mobile dental units and portable dental care equipment	1	33.3	1	33.3	0	0.0	3
Other	0	0.0	0	0.0	0	0.0	3

Number Not Started = 1 (33.3%)

Milestone 2.9.3 - Select North Sound ACH populations of focus for the Mobile Dental Care in Community Settings strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	1	33.3	1	33.3	0	0.0	3
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	1	33.3	0	0.0	0	0.0	3

People experiencing pregnancy	1	33.3	0	0.0	0	0.0	3
People experiencing serious mental illness	1	33.3	0	0.0	0	0.0	3
People experiencing substance use disorder, including opioid use disorder	1	33.3	0	0.0	0	0.0	3
People who have experienced abuse, trauma, adverse childhood experiences	1	33.3	0	0.0	0	0.0	3
People who have been arrested	1	33.3	0	0.0	0	0.0	3
People with chronic conditions	1	33.3	0	0.0	0	0.0	3
People who are high utilizers of systems	1	33.3	0	0.0	0	0.0	3
People experiencing homelessness	1	33.3	0	0.0	0	0.0	3

Number Not Started = 1 (33.3%)

Milestone 2.9.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Mobile Dental Care in Community Settings strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	1	33.3	0	0.0	0	0.0	3
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	2	66.7	0	0.0	0	0.0	3
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	1	33.3	0	0.0	0	0.0	3

Number Not Started = 1 (33.3%)

Milestone 2.9.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Mobile Dental Care in Community Settings strategy, n=3.

	In Progress	Fully Implemented	Delayed	Total Number Committed

Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	2	66.7	0	0.0	0	0.0	3
Staff are trained in quality improvement methodologies.	1	33.3	0	0.0	0	0.0	3
Utilize direct transformation coaching when appropriate and/or available.	1	33.3	0	0.0	0	0.0	3

Number Not Started = 1 (33.3%)

Milestone 2.9.6 - Develop guidelines, policies, procedures, and protocols to support Mobile Dental Care in Community Settings strategy, n=3.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	3	100.0	0	0.0	0	0.0	3
As needed integrate new guidelines, policies, and procedures for selected strategy.	3	100.0	0	0.0	0	0.0	3
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	3	100.0	0	0.0	0	0.0	3

Number Not Started = 0 (0.0%)

Strategy 2.10 - Clinical Transformation for Prevention and Management of Chronic Disease

Milestone 2.10.1 - Implement Clinical Transformation for Prevention and Management of Chronic Disease strategy for identified Medicaid eligible and/or enrolled populations of focus, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	3	37.5	1	12.5	0	0.0	8
No Tactics Selected	4	23.5	3	17.6	0	0.0	17

Number Not Started = 5 (29.4%)
*One additional partner not committed to tactic reported implementation "In Progress": Skagit Co PHD Skagit County (United General).

Milestone 2.10.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Clinical Transformation for Prevention and Management of Chronic Disease strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Chronic Care Model	7	41.2	2	11.8	0	0.0	17
National Diabetes Prevention Program (NDPP)	7	41.2	3	17.6	0	0.0	17
Chronic Disease Self-Management (CDSM)	7	41.2	3	17.6	0	0.0	17
Screening, Brief Intervention, Referral to Treatment (SBIRT)	5	29.4	1	5.9	0	0.0	17
Other	5	29.4	0	0.0	0	0.0	17

Number Not Started = 2 (11.8%)
Models listed under "Other" include: Fruit and Vegetable Prescription, Actively Changing Together (ACT!), CDC DPP program, LiveSTRONG, Enhance Fitness, LOCUS, ANSA, IMR, and DBT.

Milestone 2.10.3 - Select North Sound ACH populations of focus for the Clinical Transformation for Prevention and Management of Chronic Disease strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	9	52.9	6	35.3	0	0.0	17
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	7	41.2	5	29.4	0	0.0	17
People experiencing pregnancy	2	11.8	3	17.6	0	0.0	17
People experiencing serious mental illness	3	17.6	4	23.5	0	0.0	17
People experiencing substance use disorder, including opioid use disorder	5	29.4	4	23.5	0	0.0	17
People who have experienced abuse, trauma, adverse childhood experiences	4	23.5	3	17.6	0	0.0	17
People who have been arrested	0	0.0	4	23.5	0	0.0	17
People with chronic conditions	11	64.7	5	29.4	0	0.0	17
People who are high utilizers of systems	9	52.9	6	35.3	0	0.0	17
People experiencing homelessness	4	23.5	4	23.5	0	0.0	17

Number Not Started = 0 (0.0%)

Milestone 2.10.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Clinical Transformation for Prevention and Management of Chronic Disease strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	9	52.9	2	11.8	0	0.0	17

Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	11	64.7	2	11.8	0	0.0	17
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	9	52.9	2	11.8	0	0.0	17

Number Not Started = 1 (5.9%)

Milestone 2.10.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Clinical Transformation for Prevention and Management of Chronic Disease strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	13	76.5	1	5.9	0	0.0	17
Staff are trained in quality improvement methodologies.	13	76.5	1	5.9	0	0.0	17
Utilize direct transformation coaching when appropriate and/or available.	10	58.8	1	5.9	0	0.0	17
No tactics selected	1	5.9	0	0.0	0	0.0	17

Number Not Started = 1 (5.9%)

Milestone 2.10.6 - Develop guidelines, policies, procedures, and protocols to support Clinical Transformation for Prevention and Management of Chronic Disease strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that	14	82.4	0	0.0	0	0.0	17

serve as best practices for selected strategy.							
As needed integrate new guidelines, policies, and procedures for selected strategy.	13	76.5	0	0.0	0	0.0	17
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	12	70.6	0	0.0	0	0.0	17

Number Not Started = 2 (11.8%)

Strategy 2.11 - Community Linkages for Chronic Disease Prevention and Management Programs

Milestone 2.11.1 - Implement Community Linkages for Chronic Disease Prevention and Management Programs strategy for identified Medicaid eligible and/or enrolled populations of focus, n=27.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Patients/clients are referred to Chronic disease education and support services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), and exercise programs based on patient/client diagnosis and profile.*	17	73.9	2	8.7	1	4.3	23
No Tactics Selected	3	11.1	1	3.7	0	0.0	27

Number Not Started = 1 (3.7%)

*One additional partner not committed to tactic reported implementation "In Progress": Senior Services of Island County. One additional partner not committed to tactic reported implementation "Fully Implemented": Public Hospital District No. 1, Skagit County, WA (Skagit Regional).

Milestone 2.11.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Community Linkages for Chronic Disease Prevention and Management Programs strategy, n=27.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Chronic Care Model	8	29.6	3	11.1	0	0.0	27
The Community Guide	4	14.8	2	7.4	0	0.0	27
Community Paramedicine Model	7	25.9	2	7.4	0	0.0	27
Million Hearts Campaign	4	14.8	2	7.4	0	0.0	27
National Diabetes Prevention Program (NDPP)	9	33.3	4	14.8	0	0.0	27
Chronic Disease Self-Management (CDSM)	10	37.0	5	18.5	0	0.0	27
Other	5	18.5	1	3.7	0	0.0	27
No tactics selected	1	3.7	0	0.0	0	0.0	27

Number Not Started = 2 (7.4%)
Models listed under "Other" include: HealthMeet, Teen Heart Screening, Fruit and Vegetable Prescription, ANSA, LOCUS, and Native American prevention projects including fitness challenges and nutrition education classes (in progress). The one model listed as "Fully Implemented" under "Other" was Weatherization Plus Health Standards.

Milestone 2.11.3 - Select North Sound ACH populations of focus for the Community Linkages for Chronic Disease Prevention and Management Programs strategy, n=27.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	11	40.7	8	29.6	0	0.0	27
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	11	40.7	7	25.9	0	0.0	27

People experiencing pregnancy	6	22.2	4	14.8	0	0.0	27
People experiencing serious mental illness	6	22.2	6	22.2	0	0.0	27
People experiencing substance use disorder, including opioid use disorder	8	29.6	5	18.5	0	0.0	27
People who have experienced abuse, trauma, adverse childhood experiences	8	29.6	5	18.5	0	0.0	27
People who have been arrested	5	18.5	5	18.5	0	0.0	27
People with chronic conditions	15	55.6	9	33.3	0	0.0	27
People who are high utilizers of systems	9	33.3	9	33.3	0	0.0	27
People experiencing homelessness	8	29.6	5	18.5	0	0.0	27

Number Not Started = 2 (7.4%)

Milestone 2.11.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Community Linkages for Chronic Disease Prevention and Management Programs strategy, n=27.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	17	63.0	2	7.4	0	0.0	27
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	17	63.0	2	7.4	0	0.0	27
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	19	70.4	2	7.4	1	3.7	27

Number Not Started = 1 (11.1%)

Milestone 2.11.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Community Linkages for Chronic Disease Prevention and Management Programs strategy, n=27.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	20	74.1	1	3.7	0	0.0	27
Staff are trained in quality improvement methodologies.	18	66.7	1	3.7	0	0.0	27
Utilize direct transformation coaching when appropriate and/or available.	14	51.9	1	3.7	0	0.0	27
No tactics selected	1	3.7	0	0.0	0	0.0	27

Number Not Started = 4 (14.8%)

Milestone 2.11.6 - Develop guidelines, policies, procedures, and protocols to support Community Linkages for Chronic Disease Prevention and Management Programs strategy, n=27.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	23	85.2	0	0.0	1	3.7	27
As needed integrate new guidelines, policies, and procedures for selected strategy.	23	85.2	0	0.0	0	0.0	27
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	19	70.4	0	0.0	0	0.0	27

Number Not Started = 2 (7.4%)

Strategy 3.1 - Integrate Behavioral Health Services in Primary Care Settings

Milestone 3.1.1 - Implement Integrate Behavioral Health Services in Primary Care Settings strategy for identified Medicaid eligible and/or enrolled populations of focus, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s).	8	47.1	1	5.9	0	0.0	17
Providers are trained on the Collaborative Care Model of Integration.	10	58.8	1	5.9	0	0.0	17
Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool.	15	88.2	1	5.9	0	0.0	17

Number Not Started = 1 (5.6%)

Milestone 3.1.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Integrate Behavioral Health Services in Primary Care Settings strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Collaborative Care Model of Integration	10	58.8	2	11.8	0	0.0	17
Bree Collaborative in the Behavioral Health Integration Report Recommendations	7	41.2	0	0.0	0	0.0	17
Other	1	5.9	2	11.8	0	0.0	17

Number Not Started = 2 (11.8%)

Models listed under "Other" include: University of Washington AIMS Model and ANSA.

Milestone 3.1.3 - Select North Sound ACH populations of focus for the Integrate Behavioral Health Services in Primary Care Settings strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	8	47.1	6	35.3	0	0.0	17
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	8	47.1	6	35.3	0	0.0	17
People experiencing pregnancy	7	41.2	5	29.4	0	0.0	17
People experiencing serious mental illness	9	52.9	6	35.3	0	0.0	17
People experiencing substance use disorder, including opioid use disorder	8	47.1	5	29.4	0	0.0	17
People who have experienced abuse, trauma, adverse childhood experiences	8	47.1	5	29.4	0	0.0	17
People who have been arrested	5	29.4	4	23.5	0	0.0	17
People with chronic conditions	6	35.3	5	29.4	0	0.0	17
People who are high utilizers of systems	7	41.2	6	35.3	0	0.0	17
People experiencing homelessness	7	41.2	5	29.4	0	0.0	17

Number Not Started = 2 (11.8%)

Milestone 3.1.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Integrate Behavioral Health Services in Primary Care Settings strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	12	70.6	1	5.9	0	0.0	17

Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	12	70.6	1	5.9	0	0.0	17
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	10	58.8	1	5.9	0	0.0	17

Number Not Started = 2 (11.9%)

Milestone 3.1.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Integrate Behavioral Health Services in Primary Care Settings strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	14	82.4	2	11.9	0	0.0	17
Staff are trained in quality improvement methodologies.	10	58.8	2	11.9	0	0.0	17
Utilize direct transformation coaching when appropriate and/or available.	7	23.5	2	11.9	0	0.0	17

Number Not Started = 1 (5.6%)

Milestone 3.1.6 - Develop guidelines, policies, procedures, and protocols to support Integrate Behavioral Health Services in Primary Care Settings strategy, n=17.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	17	100.0	0	0.0	0	0.0	17

As needed integrate new guidelines, policies, and procedures for selected strategy.	14	82.4	0	0.0	0	0.0	17
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	12	70.6	0	0.0	0	0.0	17

Number Not Started = 0 (0.0%)

Strategy 3.2 - Integrate Physical Health Services in Behavioral Health Settings

Milestone 3.2.1 - Implement Integrate Physical Health Services in Behavioral Health Settings strategy for identified Medicaid eligible and/or enrolled populations of focus, n=8.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s).	4	50.0	2	25.0	0	0.0	8
Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool.	5	62.5	2	25.0	0	0.0	8
Enhance collaboration of primary care and behavioral health providers.	5	62.5	2	25.0	0	0.0	8

Number Not Started = 1 (12.5%)

Milestone 3.2.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Integrate Physical Health Services in Behavioral Health Settings strategy, n=8.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Collaborative Care Model of Integration	4	50.0	1	12.5	0	0.0	8
Bree Collaborative in the Behavioral Health Integration Report Recommendations	3	37.5	0	0.0	0	0.0	8

Other	1	12.5	1	12.5	0	0.0	8

Number Not Started = 2 (25.0%)
Models listed under "Other" include: University of Washington AIMS Model and ANSA.

Milestone 3.2.3 - Select North Sound ACH populations of focus for the Integrate Physical Health Services in Behavioral Health Settings strategy, n=8.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	2	25.0	2	25.0	0	0.0	8
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	3	37.5	3	37.5	0	0.0	8
People experiencing pregnancy	2	25.0	2	25.0	0	0.0	8
People experiencing serious mental illness	4	50.0	3	37.5	0	0.0	8
People experiencing substance use disorder, including opioid use disorder	3	37.5	2	25.0	0	0.0	8
People who have experienced abuse, trauma, adverse childhood experiences	3	37.5	2	25.0	0	0.0	8
People who have been arrested	2	25.0	2	25.0	0	0.0	8
People with chronic conditions	2	25.0	2	25.0	0	0.0	8
People who are high utilizers of systems	2	25.0	3	37.5	0	0.0	8
People experiencing homelessness	2	25.0	2	25.0	0	0.0	8

Number Not Started = 1 (12.5%)

Milestone 3.2.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Integrate Physical Health Services in Behavioral Health Settings strategy, n=8.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	4	50.0	1	12.5	0	0.0	8
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	5	62.5	1	12.5	0	0.0	8
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	3	37.5	1	12.5	0	0.0	8

Number Not Started = 1 (12.5%)

Milestone 3.2.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Integrate Physical Health Services in Behavioral Health Settings strategy, n=8.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	5	62.5	0	0.0	0	0.0	8
Staff are trained in quality improvement methodologies.	5	62.5	0	0.0	0	0.0	8
Utilize direct transformation coaching when appropriate and/or available.	3	37.5	0	0.0	0	0.0	8
No Tactics Selected	0	0.0	0	0.0	1	12.5	8

Number Not Started = 2 (25.0%)

Milestone 3.2.6 - Develop guidelines, policies, procedures, and protocols to support Integrate Physical Health Services in Behavioral Health Settings strategy, n=8.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	7	87.5	0	0.0	0	0.0	8
As needed integrate new guidelines, policies, and procedures for selected strategy.	5	62.5	0	0.0	0	0.0	8
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	4	50.0	0	0.0	0	0.0	8

Number Not Started = 1 (12.5%)

Strategy 3.3 - Integrate Reproductive Health Services in Clinical and Community Settings

Milestone 3.3.1 - Implement Integrate Reproductive Health Services in Clinical and Community Settings strategy for identified Medicaid eligible and/or enrolled populations of focus, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Incorporate One Key Question into patient/client assessments.	5	31.3	6	37.5	2	12.5	16
Train providers on the use of most effective contraception options. *	2	22.2	6	66.7	1	11.1	9
No tactics selected	1	6.3	0	0.0	0	0.0	16

Number Not Started = 0 (0.0%)
*One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.

Milestone 3.3.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Integrate Reproductive Health Services in Clinical and Community Settings strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
One Key Question	7	43.8	4	25.0	1	6.3	16
The CDC's Recommendations to Improve Preconception Health and Health Care	8	50.0	4	25.0	1	6.3	16
Other	0	0.0	0	0.0	0	0.0	16

Number Not Started = 0 (0.0%)
Model listed under "Other" include: Referral partner for Island Reproductive Health Initiative.

Milestone 3.3.3 - Select North Sound ACH populations of focus for the Integrate Reproductive Health Services in Clinical and Community Settings strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	7	43.8	6	37.5	0	0.0	16
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	7	43.8	7	43.8	0	0.0	16
People experiencing pregnancy	8	50.0	6	37.5	0	0.0	16
People experiencing serious mental illness	6	37.5	7	43.8	0	0.0	16
People experiencing substance use disorder, including opioid use disorder	7	43.8	6	37.5	0	0.0	16
People who have experienced abuse, trauma, adverse childhood experiences	6	37.5	6	37.5	0	0.0	16
People who have been arrested	5	31.3	6	37.5	0	0.0	16
People with chronic conditions	7	43.8	6	37.5	0	0.0	16
People who are high utilizers of systems	7	43.8	7	43.8	0	0.0	16

People experiencing homelessness	8	50.0	6	37.5	0	0.0	16

Number Not Started = 0 (0.0%)

Milestone 3.3.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Integrate Reproductive Health Services in Clinical and Community Settings strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	11	68.8	3	18.8	0	0.0	16
Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	10	62.5	3	18.8	0	0.0	16
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	10	62.5	3	18.8	0	0.0	16
No Tactics Selected	1	6.3	0	0.0	0	0.0	16

Number Not Started = 0 (0.0%)

Milestone 3.3.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Integrate Reproductive Health Services in Clinical and Community Settings strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	13	81.3	1	6.3	0	0.0	16

Staff are trained in quality improvement methodologies.	9	56.3	1	6.3	0	0.0	16
Utilize direct transformation coaching when appropriate and/or available.	8	50.0	1	6.3	0	0.0	16

Number Not Started = 2 (12.5%)

Milestone 3.3.6 - Develop guidelines, policies, procedures, and protocols to support Integrate Reproductive Health Services in Clinical and Community Settings strategy, n=16.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	12	75.0	1	6.3	0	0.0	16
As needed integrate new guidelines, policies, and procedures for selected strategy.	10	62.5	1	6.3	0	0.0	16
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	9	56.3	1	6.3	0	0.0	16
No tactics selected	1	6.3	0	0.0	0	0.0	16

Number Not Started = 2 (12.5%)

Strategy 3.4 - Integrate Oral Health Care into Physical Health or Behavioral Health Settings

Milestone 3.4.1 - Implement Integrate Oral Health Care into Physical Health or Behavioral Health Settings strategy for identified Medicaid eligible and/or enrolled populations of focus, n=5.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound ACH's Oral Health Local Impact Network (LIN).	4	80.0	1	20.0	0	0.0	5

Physical health providers are trained on screening for oral health needs and engagement with oral health provider.*	3	75.0	1	25.0	0	0.0	4
Physical health providers are trained to apply fluoride varnish.	2	50.0	1	25.0	0	0.0	4
Physical health providers perform oral health screening when appropriate.**	3	75.0	1	25.0	0	0.0	4
Facilitate referral of all patients/clients needing dental care to community dental providers, and/or mobile dental services.	2	50.0	1	25.0	0	0.0	4
Follow-up with oral health referral partner after referral is made.	2	50.0	1	25.0	0	0.0	4

Number Not Started = 0 (0.0%)
*One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
**One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
***One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.
****One additional partner not committed to tactic reported implementation "In Progress": Tulalip Health Systems.

Milestone 3.4.2 - Apply requirements and standards of evidence-based models and/or promising practices to support Integrate Oral Health Care into Physical Health or Behavioral Health Settings strategy, n=5.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Guidelines to improve integration of oral health screening, assessment, intervention, and referral into primary care and/or behavioral health settings.	4	80.0	1	20.0	0	0.0	5
Other	0	0.0	0	0.0	0	0.0	5

Number Not Started = 0 (0.0%)

Milestone 3.4.3 - Select North Sound ACH populations of focus for the Integrate Oral Health Care into Physical Health or Behavioral Health Settings strategy, n=5.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
People experiencing access, care, and utilization disparities	4	80.0	1	20.0	0	0.0	5
People experiencing co-occurring disorders/conditions (behavioral health/substance use disorder/physical health)	4	80.0	1	20.0	0	0.0	5
People experiencing pregnancy	4	80.0	1	20.0	0	0.0	5
People experiencing serious mental illness	4	80.0	1	20.0	0	0.0	5
People experiencing substance use disorder, including opioid use disorder	4	80.0	1	20.0	0	0.0	5
People who have experienced abuse, trauma, adverse childhood experiences	4	80.0	1	20.0	0	0.0	5
People who have been arrested	3	60.0	1	20.0	0	0.0	5
People with chronic conditions	4	80.0	1	20.0	0	0.0	5
People who are high utilizers of systems	4	80.0	1	20.0	0	0.0	5
People experiencing homelessness	4	80.0	1	20.0	0	0.0	5

Number Not Started = 0 (0.0%)

Milestone 3.4.4 - Participate in trainings and utilize technical assistance resources necessary to perform role in Integrate Oral Health Care into Physical Health or Behavioral Health Settings strategy, n=5.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	5	100.0	0	0.0	0	0.0	5

Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	5	100.0	0	0.0	0	0.0	5
Track and report the number and names of staff trained in the best-practice or evidence-based approach(es).	4	80.0	0	0.0	0	0.0	5

Number Not Started = 0 (0.0%)

Milestone 3.4.5 - Use continuous quality improvement strategies, measures, and targets to support implementation of Integrate Oral Health Care into Physical Health or Behavioral Health Settings strategy, n=5.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Assess and report the state of the organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	5	100.0	0	0.0	0	0.0	5
Staff are trained in quality improvement methodologies.	5	100.0	0	0.0	0	0.0	5
Utilize direct transformation coaching when appropriate and/or available.	5	100.0	0	0.0	0	0.0	5

Number Not Started = 0 (0.0%)

Milestone 3.4.6 - Develop guidelines, policies, procedures, and protocols to support Integrate Oral Health Care into Physical Health or Behavioral Health Settings strategy, n=5.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy.	5	100.0	0	0.0	0	0.0	5

As needed integrate new guidelines, policies, and procedures for selected strategy.	5	100.0	0	0.0	0	0.0	5
Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	5	100.0	0	0.0	0	0.0	5

Number Not Started = 0 (0.0%)

Strategy 4.1 - Capacity Building

Milestone 4.1.1 - Exercise effective leadership, management, transparency, and accountability of the Medicaid Transformation Project activities, n=49.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in North Sound ACH partner convenings.	43	87.8	7	14.3	0	0.0	49
Collaborate with North Sound ACH implementation partners.	42	85.7	7	14.3	0	0.0	49
Participate in training and technical assistance sessions from the Equity and Tribal Learning Series.	38	77.6	7	14.3	0	0.0	49
Participate in trainings on topics critical to successful implementation (i.e. Trauma-informed Care, Adverse Childhood Experiences, supporting LGBTQ+ communities, etc.).	39	79.6	7	14.3	0	0.0	49
Establish a data sharing agreement with North Sound ACH.	27	60.0	6	13.3	0	0.0	45
Establish data sharing agreements with ACH partners working on the same or similar strategies.	25	59.5	6	13.3	0	0.0	42

Number Not Started = 0 (0.0%)

Milestone 4.1.2 - Ensure all patients/clients are able to connect with your organization, n=49.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N

Maintain a public-facing website with contact information on the home page.	35	71.4	12	24.5	1	2.0	49
Maintain a toll-free number and display on the homepage of your website and on printed materials.	30	61.2	12	24.5	1	2.0	49
Offer language translation options on your website and print materials, and when offering care and service options.	31	63.3	12	24.5	1	2.0	49
Offer interpreter services when responding to callers, and when offering care and service options.	31	63.3	12	24.5	1	2.0	49
Offer health insurance enrollment assistance onsite during office operating hours.*	20	66.7	8	26.7	0	0.0	30
Participate in the Choosing Wisely initiative (as supported by ABIM Foundation and WSMA).**	2	25.0	1	12.5	0	0.0	8
Adopt and support a patient/client facing portal for patient/review of visit histories.	13	65.0	5	25.0	0	0.0	20
Adopt and support a patient/client facing portal allowing review of narrative notes written by providers (i.e., Open Notes).	8	53.3	4	26.7	0	0.0	15

Number Not Started = 1 (2.0%)

*One additional partner not committed to tactic reported implementation "In Progress": South Snohomish County Fire.

**Two additional partners not committed to tactic reported implementation "In Progress": The Arc of Whatcom County and PeaceHealth. One additional partner not committed to tactic reported implementation "Fully Implemented": Mount Baker Planned Parenthood.

Milestone 4.1.3 - Support regional goals to advance equity and reduce health disparities, n=49.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Gather patient/client self-reported race, ethnicity, language, and disability.	37	75.5	9	18.4	0	0.0	49

Screen for Social Determinants of Health during intake and routine appointments.	36	73.5	9	18.4	0	0.0	49
Refer patients/clients to community agencies when concerns related to Social Determinants of Health are identified.	40	81.6	9	18.4	0	0.0	49
Participate with ACH in addressing barriers to standardized identification and tracking of Medicaid eligible and/or enrolled ACH populations of focus.	30	61.2	9	18.4	0	0.0	49

Number Not Started = 1 (2.0%)

Milestone 4.1.4 - Leverage and expand systems for population health management, n=49.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
Participate in regional discussions of shared health information and a health information exchange (HIE) gaps and opportunities.	32	65.3	5	10.2	1	2.0	49
Respond to periodic North Sound ACH requests for information on gaps and subject matter expertise.	36	73.5	5	10.2	1	2.0	49
Increase use of Prescription Drug Monitoring Program (PMP).	17	89.5	1	5.3	0	0.0	19
Increase use of Washington Syndromic Surveillance Program/Rapid Health Information Network (RHINO).	6	60.0	0	0.0	0	0.0	10
Increase use of Washington State Immunization Information Systems (WA IIS).	14	87.5	1	6.3	0	0.0	16
Increase use of Washington State EMS system (WEMSIS).*	9	60.0	1	6.7	1	6.7	15
Report on feasibility of integrating tools like PreManage or EDie.**	23	79.3	2	6.9	1	3.4	29

Number Not Started = 4 (8.2%)

*One additional partner not committed to tactic reported implementation "In Progress": Public Health District No. 1, Skagit County, WA (Skagit Regional).
**One additional partner not committed to tactic reported implementation "In Progress": The Arc of Whatcom County.

Milestone 4.1.5 - Implement strategies to increase readiness of providers to enter into advanced Value Based Payment contracts, n=20.

	In Progress		Fully Implemented		Delayed		Total Number Committed
Tactic	N	%	N	%	N	%	N
	19	95.0	0	0.0	0	0.0	20

Number Not Started = 1 (5.0%)

Appendix D. Reporting Qualitative Analysis Tables - April-September 2019 Reporting Period.

Qualitative Analysis Sub Themes, April-September 2019 Partner Reporting, North Sound ACH, n=1,165. *

Theme 1: Facilitator		
Subtheme	N	%
Collaboration	97	43.5
Training	47	21.1
Workforce	27	12.1
Equity	25	11.2
Evidence-based models/promising practices	19	8.5
Funding	10	4.5
Quality improvement	8	3.6
Technical assistance	7	3.1
Trauma-informed care	7	3.1
Housing	6	2.7
Capacity Building	5	2.2
Access	4	1.8
Policy	4	1.8
Policies, procedures, and protocols	4	1.8
Populations of focus	4	1.8
Total	223	
Theme 2: Barrier		
Workforce	79	24.6
Collaboration	44	13.7
Training	39	12.1

Technical Assistance	29	9.0
Funding	27	8.4
Equity	24	7.5
Access	22	6.9
Evidence-based models/promising practices	22	6.9
Quality improvement	19	5.9
Data	18	5.6
Capacity Building	16	5.0
Electronic health records	15	4.7
Health information exchange	14	4.4
Billing	13	4.0
Policy	12	3.7
Tribal	8	2.5
Value-based payment	8	2.5
Facility	4	1.2
Managed care organizations	4	1.2
Poverty	4	1.2
Total	321	
Theme 3: Change in Capacity		
Collaboration	85	26.5
Quality improvement	74	23.1
Capacity building	71	22.1
Equity	58	18.1
Training	54	16.8
Workforce	40	12.5
Access	34	10.6

Evidence-based models/promising practices	31	9.7
Capacity to address disparities	19	5.9
Data	15	4.7
Tribal	15	4.7
Community-clinic linkages	13	4.0
Housing	13	4.0
Health information exchange	12	3.7
Policies, procedures, and protocols	12	3.7
Electronic health records	9	2.8
Social determinants of health	6	1.9
Technical assistance	6	1.9
Trauma-informed care	6	1.9
Funding	5	1.6
Population health management	5	1.6
Adverse childhood experiences	4	1.2
Total	321	
Theme 4: Impact of Initiative Strategies		
Collaboration	127	42.3
Evidence-based models/promising practices	60	20.0
Access	40	13.3
Community-clinic linkages	34	11.3
Training	34	11.3
Capacity building	21	7.0
Equity	21	7.0
Quality improvement	19	6.3
Workforce	16	5.3

Housing	15	5.0
Policies, procedures, and protocols	12	4.0
Tribal	12	4.0
Policy	9	3.0
Technical assistance	9	3.0
Capacity to address disparities	8	2.7
Funding	6	2.0
Data	5	1.7
Health information exchange	5	1.7
Trauma-informed care	5	1.7
Total	300	

*Includes sub themes that occurred four or more times in each theme. Does not include themes related to specific strategies (i.e. reproductive health, opioid, oral health, etc.).