Addendum to
PROJECT-SPECIFIC AGREEMENT

Amendment to Exhibit A: Scope of Work

THIS AMENDMENT ADDENDUM amends Exhibit "A" (the "Scope of Work") as attached within the Project-Specific Agreement ("PSA"), an addendum to the Master Services Agreement ("MSA"), executed between North Sound Accountable Community of Health ("North Sound ACH"), a Washington nonprofit corporation, and Snohomish Health District ("Participant"). North Sound ACH and Participant (collectively referred to as "Parties") agree to this addendum to amend Exhibit A, attached to the PSA signed and executed between both Parties on July 2, 2018.

This amendment addendum modifies terms of the PSA agreed upon by the Participant only in reference to, and as fully described in Exhibit A, attached to this addendum. Modifications are permitted after both Parties have reviewed changes to the attached Exhibit A and this addendum is fully executed by both Parties. This addendum and the modified Scope of Work are incorporated by this reference and are binding as detailed by the requirements outlined in the PSA.

NOW, THEREFORE, in consideration of the mutual promises contained in this PSA and the promises contained in the MSA, the Parties agree as follows:

1. **Term and Effective Date.** This amendment addendum is intended to supplement the PSA. The term shall be referenced as agreed upon in the PSA. The effective date of this addendum begins on the date in which all Parties have signed and fully executed.

2. **Contract Compliance.** Participant acknowledges receipt of the PSA, MSA, and this amendment addendum to modify Exhibit A, collectively, and understand the terms and requirements therein.

Participant Signature	Printed Name and Title	Date Signed

North Sound ACH Signature	Printed Name and Title	Date Signed

Section A: Capacity Building

A. Capacity Building Milestones & Tactics	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Exercise effective leadership, management, transparency, and accountability of the Medicaid Transformation Project activities. a) Participate in North Sound ACH partner convenings.	Committed	Committed		
b) Collaborate with North Sound ACH implementation partners.	Committed	Committed		
c) Participate in training and technical assistance sessions from the Equity and Tribal Learning Series.	Committed	Committed		
d) Participate in trainings on topics critical to successful implementation (i.e. Trauma-informed Care, Adverse Childhood Experiences, supporting LGBTQ communities, etc.).	Committed	Committed		
e) Establish data sharing agreements with North Sound ACH.	Committed	Committed	--	--
f) Establish data sharing agreements with ACH partners working on the same or similar strategies.	Committed	Committed	--	--
2) Ensure patients/clients are able to connect with your organization. a) Maintain a public-facing website with contact information on the home page.	Committed	Committed		
b) Maintain a toll-free number and display on the homepage of your website and on printed materials.	Committed	Committed		
c) Offer language translation options on your website and print materials, when responding to callers, and when offering care and service options.	Committed	Committed		
d) Offer interpreter services on your website and on print materials, when responding to callers, and when offering care and service options.	Committed	Committed		
e) Offer health insurance enrollment assistance onsite during office operating hours.	Committed	Committed	--	--

f) Participate in the Choosing Wisely initiative (as supported by ABIM Foundation and WSMA.)	Not Committed	Not Committed	--	--
g) Adopt and support a patient/client facing portal for patient/review of visit histories.	Not Committed	Not Committed	--	--
h) Adopt and support a patient/client facing portal allowing review of narrative notes written by providers (i.e., Open Notes).	Not Committed	Not Committed	--	--
3) Support regional goals to advance equity and reduce health disparities. a) Gather patient/client self-reported race, ethnicity, language, and disability.	Committed	Committed		
b) Screen for Social Determinants of Health during intake and routine appointments.	Committed	Committed		
c) Refer patients to community agencies when concerns related to Social Determinants of Health are identified.	Committed	Committed		
d) Participate with ACH in addressing barriers to standardized identification and tracking of ACH target populations.	Committed	Committed		
4) Leverage and expand systems for population health management. a) Participate in regional discussions of shared health information and a health information exchange (HIE) gaps and opportunities.	Committed	Committed		
b) Respond to periodic North Sound ACH requests for information on gaps and subject matter expertise.	Committed	Committed		
c) Increase use of Prescription Drug Monitoring Program (PMP).	Not Committed	Not Committed	--	--
d) Increase use of Washington Syndromic Surveillance Program/Rapid Health Information Network (RHINO).	Not Committed	Not Committed	--	--
e) Increase use of Washington State Immunization Information Systems (WA IIS).	Not Committed	Not Committed	--	--
f) Increase use of Washington State EMS system (WEMSIS).	Not Committed	Not Committed	--	--

g) Report on feasibility of integrating tools like PreManage or EDie.	Not Committed	Not Committed	--	--
5) Implement strategies to increase readiness of providers to enter into advanced Value Based Payment contracts. a) Examine and report barriers of successful adoption of Value Based Purchasing.	Not Committed	Not Committed	--	--

Section B: Cross-Cutting Implementation

B. Cross-Cutting Implementation Milestones & Tactics	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Participate in trainings and utilize technical assistance resources necessary to perform role in selected strategy. a) Identify and report any gaps in workforce capacity to implement selected strategy and evidence-based approach.	Committed	Committed		
b) Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.	Committed	Committed		
c) Track and report the number and names of staff trained in the best-practice or evidence- based approach(es).	Committed	Committed		
2) Use continuous quality improvement strategies, measures, and targets to support implementation of selected strategy. a) Assess and report the state of organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	Committed	Committed		
b) Staff are trained in quality improvement methodologies (i.e., Institute for Healthcare Improvement (IHI), Quality Improvement, Results Based Accountability (RBA), Plan Do Study Act (PDSA), Lean Project Management).	Committed	Committed		
c) Report on existing quality improvement metrics that align with HCA's pay for performance metrics	Committed	Committed		
d) Ensure quality improvement methods are used to apply best-practice/evidence-based approaches for selected strategy	Committed	Committed		
e) Utilize direct transformation coaching when appropriate and/or available	Committed	Committed		

f) Report strategy implementation progress to monitor performance, provide performance feedback, track strategies, and identify barriers to implementation.	Committed	Committed	
3) Develop guidelines, policies, procedures, and protocols to support selected strategy. a) Review and assess existing guidelines, policies, procedures, and protocols that serve as best practices for selected strategy	Committed	Committed	
b) As needed integrate new guidelines, policies, and procedures for selected strategy.	Committed	Committed	
c) Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	Committed	Committed	

Section C: Implementation Strategies

1.1 North Sound Community Hub, using Pathways Model Objective: Promote care coordination across the continuum of health, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Develop guidelines, policies, procedures and protocols to support selected strategy. a) Review and assess existing guidelines, policies, procedures, and protocols that serve as best practice for selected strategy	Not Committed to Section C, 1.1	NA	--	--
b) As needed, integrate new guidelines, policies, and procedures for selected strategy.	NA	NA	--	--
c) Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.	NA	NA	--	--
2) Use continuous quality improvement strategies, measures, and targets to support implementation of selected strategy. a) Train staff in quality improvement methodologies.	NA	NA	--	--
b) Assess and report the state of organization's quality improvement capacity, including: workforce trained, quality improvement (QI) tools and methodologies in use, quality improvement (QI) specific policies and procedures.	NA	NA	--	--
c) Report on existing quality improvement metrics that align with HCA's pay for performance metrics.	NA	NA	--	--
d) Ensure quality improvement methods are used to apply best-practice/evidence-based approaches for selected strategy.	NA	NA	--	--

e) Report strategy implementation progress to monitor performance, provide performance feedback, track strategies, and identify barriers to implementation.	NA	NA	--	--
f) Participate in review of HUB outcomes performance evaluation.	NA	NA	--	--
g) Utilize Care Coordination Systems (CCS) Platform to track HUB referrals and clients	NA	NA	--	--
3) Implement selected strategy for identified populations. a) Assess and report process gaps and alignment opportunities between selected Pathways.	NA	NA	--	--
b) Participate in development and integration of HUB policies, procedures, and protocols for Care Coordination Agencies (CCAs) and care coordination staff.	NA	NA	--	--
c) Participate in HUB Advisory Committee meetings.	NA	NA	--	--

1.2 Acute Care Transitions (physical and behavioral health settings) Objective: Improve transitional care services to reduce avoidable hospital utilization and ensure individuals eligible or enrolled in Medicaid are getting the right care in the right place.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply evidence-based approaches from Interventions to Reduce Acute Care Transfers (INTERACT), Transitional Care Model (TCM), The Care Transitions Intervention (CTI), or Care Transitions Interventions in Mental Health.	Not Committed to Section C, 1.2	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--

1.3 Transitional Care after Incarceration Objective: Improve transitional care services care for people returning to the community from prison or jail.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Collaborate with North Sound ACH implementation partners for selected strategy.	Not Committed to Section C, 1.3	NA	--	--
b) Embed community health workers (CHWs) in criminal justice settings	NA	NA	--	--
c) Adopt and apply evidence-based approaches from one of the following: Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison; A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model; and/or American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services.	NA	NA	--	--
d) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--

1.4 Emergency Department Diversion Objective: Implement diversion strategies to promote more appropriate use of alternatives to emergency department services, including increased use of primary care and social services.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Collaborate with North Sound ACH implementation partners for selected strategy.	Not Committed to Section C, 1.4	NA	--	--
b) Embed community health workers (CHWs) in emergency room setting.	NA	NA	--	--
c) Adopt and apply recommendations from Washington State Hospital Association's for emergency department diversion and the Community Paramedicine Model.	NA	NA	--	--
d) Community paramedics or EMTs have partnership with hospitals and social services.	NA	NA	--	--
e) Emergency department has open access, same-day walk-in capacity.	NA	NA	--	--
f) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--

1.5 Cross-Sector Care Coordination and Diversion Collaboratives Objective: Implement collaborative diversion strategies to promote more appropriate use of alternatives to emergency department services, including increased use of primary care and social services.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply evidence-based approaches from one of the following: Interventions to Law Enforcement Assisted Diversion (LEAD), Transitional Care Model (TCM), The Care Transitions Intervention (CTI), or Care Transitions Interventions in Mental Health.	Not Committed to Section 1.5, C	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
c) Participate in regularly scheduled cross-sector care meetings.	NA	NA	--	--

2.1 Prevent Opioid Use and Misuse Objective: Support the states goals of reducing opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply evidence-based approaches from Washington State Interagency Opioid Working Plan and North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan.	Committed	Committed		
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	Committed	Committed		
c) Use or expand use of the Prescription Drug Monitoring Program (PDMP) into workflow.	Not Committed	Not Committed	--	--
d) Promote use of best practices for prescribing opioids for managing acute and chronic pain.	Committed	Committed	--	--
e) 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.	Committed	Committed	--	--
f) Prevent opioid initiation and misuse in communities, particularly among youth.	Committed	Committed	--	--
g) Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse (i.e., "drug take back").	Committed	Committed	--	--
h) Providers and staff are trained on guidelines on prescribing opioids for pain.	Not Committed	Not Committed	--	--

i) Practice/clinic sites has electronic health records (EHRs) or other systems that provide clinical decision support for the opioid prescribing guidelines.	Not Committed	Not Committed	--	--
j) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	Not Committed	Not Committed	--	--
k) Implement the Six Building blocks model improving opioid management in primary care.	Not Committed	Not Committed	--	--
l) Use AMDG guidelines on co-prescribing naloxone for patients on opioid medication.	Not Committed	Not Committed	--	--

2.2 Link Individuals with Opioid Use Disorder with Treatment Objective: Reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply evidence-based approaches from the Washington State Interagency Opioid Working Plan and North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan.	Not Committed to Section C, 2.2	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
c) Build organization's capacity to recognize signs of possible opioid misuse, effectively identify Opioid Use Disorder, and link patients to appropriate treatment resources.	NA	NA	--	--
d) Expand access to, and utilization of, clinically-appropriate evidence-based practices for Opioid Use Disorder treatment in communities, particularly MAT.	NA	NA	--	--
e) Expand access to, and utilization of, Opioid Use Disorder medications in the criminal justice system.	NA	NA	--	--
f) Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing	NA	NA	--	--
g) Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns.	NA	NA	--	--
h) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	NA	NA	--	--

i) Implement the Six Building blocks model improving opioid management in primary care.	NA	NA	--	--
j) Healthcare providers use Opioid Guideline from Washington Agency Medical Directors' Group (AMDG) guidelines.	NA	NA	--	--
k) Organization site connects persons to MAT providers.	NA	NA	--	--
l) Utilize patient agreements for chronic opioid therapy (COT) and review them with patients annually.	NA	NA	--	--

2.3 Intervene in Opioid Overdoses to Prevent Death Objective: Reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply evidence-based approaches from the Washington State Interagency Opioid Working Plan and North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan.	Committed	Committed	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	Committed	Committed	--	--
c) 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.	Committed	Committed	--	--
d) Make system-level improvements to increase availability and use of naloxone.	Committed	Committed	--	--
e) Promote awareness and understanding of Washington State's Good Samaritan Law with the Center for Opioid Safety Education.	Committed	Committed	--	--
f) Emergency department has protocols in place for providing overdose education, peer support, and take-home naloxone to individuals seen for opioid overdose.	Not Committed	Not Committed	--	--
g) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	Not Committed	Not Committed	--	--
h) Staff are trained to recognize and appropriately respond to an overdose.	Not Committed	Not Committed	--	--
i) Providers co-prescribe Naloxone with medication-assisted treatment (MAT).	Not Committed	Not Committed	--	--

2.4 Community Recovery Services and Networks for Opioid Use Disorder Objective: Reduce opioid-related morbidity and mortality through strategies that target prevention.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply evidence-based approaches from the Washington State Interagency Opioid Working Plan and North Sound Behavioral Health Organization (BHO) Opioid Reduction Plan.	Not Committed	Committed		
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	Not Committed	Committed		
c) Use Telehealth resources to expand capacity to support opioid use disorder prevention and treatment.	Not Committed	Not Committed	--	--
d) Link to public awareness programs such as "It Starts with One".	Not Committed	Committed		
e) 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.	Not Committed	Not Committed	--	--
f) 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.	Not Committed	Committed		
g) 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.	Not Committed	Committed		

h) Utilize technical assistance to organize or expand syringe exchange programs.	Not Committed	Not Committed	--	--
i) Mental health and substance use disorder (SUD) providers deliver acute care and recovery services for people with opioid use disorder (OUD).	Not Committed	Not Committed	--	--
j) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	Not Committed	Not Committed	--	--
k) Give patients information about syringe exchange program.	Not Committed	Not Committed	--	--
l) Support linkages between syringe exchange programs and physical or behavioral health providers.	Not Committed	Not Committed	--	--

2.5 Full Spectrum of Reproductive Health Services (including Long-Action Reversable Contraception (LARC) Objective: Ensure individuals have access to high quality reproductive health care throughout their lives.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply requirements of CDC's recommendations to Improve Preconception Health and Health Care.	Not Committed to Section C, 2.5	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
c) Facilitate referral of all women in first trimester of pregnancy to appropriate prenatal care	NA	NA	--	--
d) Facilitate referral of all women/individuals with high risk behaviors (alcohol or drug use, etc.) to evidence-based community support programs and specialty care.	NA	NA	--	--
e) Staff are trained to offer education and information resources to all patients on the full spectrum of contraceptive options and their relative effectiveness.	NA	NA	--	--
f) Incorporate 'One Key Question' into patient/client assessments.	NA	NA	--	--
g) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	NA	NA	--	--
h) Facilitate referral of women with history of adverse pregnancy outcomes to evidence-based community support programs.	NA	NA	--	--

2.6 Pediatric Practices to Promote Child Health, Well-child Visits and Childhood Immunizations Objective: Ensure children and families have access to high quality health care and promote the health of Washington's children.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply requirements and standards of evidence-based model or promising practices that improve well-child visit rates (for ages 3-6) and childhood immunization rates.	Not Committed to Section C, 2.6	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
c) Embed Healthy Steps specialist or a trained staff member in pediatric practice to increase well-child visits, support early child behavioral health integration.	NA	NA	--	--
d) Integrate SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs	NA	NA	--	--
e) Facilitate clinical-community linkages with schools and early intervention programs (i.e. child care, preschools, home visiting) to promote well-child visits and immunizations.	NA	NA	--	--

2.7 Population Management in Oral Health Settings Objective: Increase access to oral health services to prevent or control the progression of oral disease.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.	Not Committed	Committed		
b) Adopt and apply requirements and standards of evidence-based model or promising practices that improves access to oral health services, especially among children and pregnant women.	Not Committed	Committed		
c) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	Not Committed	Committed		
d) Use International Statistical Classification of Diseases (ICD-10) coding in oral health settings.	Not Committed	Not Committed	--	--
e) Increase or expand use of silver diamine fluoride.	Not Committed	Committed		
f) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	Not Committed	Not Committed	--	--

2.8 Dental Health Aide Therapists (DHATs) in Tribal Clinics (only tribal clinics or related organizations may respond to this strategy) Objective: Increase access to oral health services to prevent or control the progression of oral disease.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.	Not Committed to Section C, 2.8	NA	--	--
g) Adopt and apply requirements and standards of Dental Health Aide Therapists (DHATs) in Tribal Clinics.	NA	NA	--	--
h) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--

2.9 Mobile Dental Care in Community Settings Objective: Increase access to oral health services in remote and rural locations to prevent or control the progression of oral disease.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.	Not Committed to Section C, 2.9	NA	--	--
i) Adopt and apply requirements and standards of mobile dental units and portable dental care equipment.	NA	NA	--	--
j) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--

2.10 Clinical Transformation for Prevention and Management Objective: Integrate health system and community approaches to improve chronic disease management and control for asthma, diabetes, and heart disease.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
Implement selected strategy for identified populations. a) Adopt and apply requirements of the Chronic Care Model, Diabetes Prevention Program (DPP) and Chronic Disease Self-Management (CDSM).	Not Committed to Section C, 2.10	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
c) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.	NA	NA	--	--

2.11 Community Linkages for Chronic Disease Prevention and Management Programs Objective: Increase health system and community approaches to improve chronic disease management and control for asthma, diabetes, and heart disease.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Adopt and apply requirements of the Chronic Care Model, The Community Guide, Community Paramedicine Model and/or Million Hearts Campaign.	Not Committed to Section C, 2.11	NA	--	--
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
c) 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 diagnosis and profile.	NA	NA	--	--

3.1 Integrate Behavioral Health Services in Primary Care Settings Objective: Address physical and behavioral health needs in one system, through an integration of behavioral and physical health services.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s).	Not Committed to Section C, 3.1	NA	--	--
b) Providers are trained on the Collaborative Care Model of Integration.	NA	NA	--	--
c) Adopt and apply standards of the Bree Collaborative in the Behavioral Health Integration Report and Recommendations or Collaborative Care Model.	NA	NA	--	--
d) Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool.	NA	NA	--	--

3.2 Integrate Physical Health Services in Behavioral Health Settings Objective: Address physical and behavioral health needs in one system, through an integration of behavioral and physical health services.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s).	Not Committed to Section C, 3.2	NA	--	--
b) Adopt and apply standards of the Bree Collaborative in the Behavioral Health Integration Report and Recommendations or Collaborative Care Model.	NA	NA	--	--
c) Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool.	NA	NA	--	--
d) Enhance collaboration of primary care and behavioral health providers.	NA	NA	--	--

3.3 Integrate Reproductive Health Services in Clinical and Community Settings Objective: Address reproductive health needs of women and families, offering better coordinated care for patients and more seamless access to the services they need.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Incorporate One Key Question into patient/client assessments.	Not Committed to Section C, 3.3	NA	--	--
b) Train providers on use of most effective contraception options.	NA	NA	--	--
c) Adopt and apply requirements of CDC's recommendations to Improve Preconception Health and Health Care, including, but not limited to: integrate risk assessment, educational and health promotion counseling to patients of childbearing age to reduce reproductive risk and improve pregnancy outcomes; integrate consumer-friendly tools and resources to help patients identify risks and make plans related to their reproductive health; and screen sexually active females aged 16-24 for chlamydia.	NA	NA	--	--
d) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--

3.4 Integrate Oral Health Care into Physical Health or Behavioral Health Settings Objective: Address physical, oral, and behavioral health needs in one system through an integrated approach, offering better coordinated care for patients and more seamless access to the services they need.	2019 Commitment	2020 Commitment	Partner Initials	ACH Initials
1) Implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.	Not Committed to Section C, **3.4**	NA	--	--
b) Adopt and apply action steps for integrating oral health screening, assessment, intervention, and referral into the primary care setting.	NA	NA	--	--
c) Use quality improvement methods to ensure application of best-practice/evidence-based approach.	NA	NA	--	--
d) Physical health providers are trained on screening for oral health needs and engagement with oral health provider.	NA	NA	--	--
a) Physical health providers are trained to apply fluoride varnish.	NA	NA	--	--
b) Physical health providers perform oral health screening when appropriate.	NA	NA	--	--
c) Facilitate referral of all patients/clients needing dental care to community dental providers, and/or mobile dental services.	NA	NA	--	--
d) Follow-up with oral health referral partner after referral is made.	NA	NA	--	--