Section A: Capacity Building

A. Capacity Building Milestones & Tactics	Original Commitment	Revised 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.				
b) Collaborate with North Sound ACH implementation partners.				
c) Participate in training and technical assistance sessions from the Equity and Tribal Learning Series.				
d) Participate in trainings on topics critical to successful implementation (i.e. Trauma-informed Care, Adverse Childhood Experiences, supporting LGBTQ communities, etc.).				
e) Establish data sharing agreements with ACH partners working on the same or similar strategies.				
f) Establish data sharing agreements with ACH partners working on the same or similar strategies.				
2) Ensure patients/clients are able to connect with your organization. a) Maintain a public-facing website with contact information on the home page.				
b) Maintain a toll-free number and display on the homepage of your website and on printed materials.				
c) Offer language translation options on your website and print materials, when responding to callers, and when offering care and service options.				
d) Offer interpreter services on your website and on print materials, when responding to callers, and when offering care and service options.				

A. Capacity Building Milestones & Tactics	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
e) Offer health insurance enrollment assistance onsite during office operating hours.				
f) Participate in the Choosing Wisely initiative (as supported by ABIM Foundation and WSMA.)				
g) Adopt and support a patient/client facing portal for patient/review of visit histories.				
h) Adopt and support a patient/client facing portal allowing review of narrative notes written by providers (i.e., Open Notes).				
3) Support regional goals to advance equity and reduce health disparities. a) Gather patient/client self-reported race, ethnicity, language, and disability.				
b) Screen for Social Determinants of Health during intake and routine appointments.				
c) Refer patients to community agencies when concerns related to Social Determinants of Health are identified.				
d) Participate with ACH in addressing barriers to standardized identification and tracking of ACH target populations.				
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.				
b) Respond to periodic North Sound ACH requests for information on gaps and subject matter expertise.				
c) Increase use of Prescription Drug Monitoring Program (PMP).				
d) Increase use of Washington Syndromic Surveillance Program/Rapid Health Information Network (RHINO).				
e) Increase use of Washington State Immunization Information Systems (WA IIS).				

A. Capacity Building Milestones & Tactics	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
f) Increase use of Washington State EMS system (WEMSIS).				
g) Report on feasibility of integrating tools like PreManage or EDie.				
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.				

Section B: Cross-Cutting Implementation

B. Cross-Cutting Implementation Milestones & Tactics	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Utilize training and/or technical assistance offered by ACH to address areas identified as needing improvement.				
c) Track and report the number and names of staff trained in the best-practice or evidence- based approach(es).				
2) By March 31, 2019, 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.				
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).				
c) Report on existing quality improvement metrics that align with HCA's pay forperformance metrics				
d) Ensure quality improvement methods are used to apply best-practice/evidence-based approaches for selected strategy				
e) Utilize direct transformation coaching when appropriate and/or available				

B. Cross-Cutting Implementation Milestones & Tactics	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
f) Report strategy implementation progress to monitor performance, provide performance feedback, track strategies, and identify barriers to implementation.				
3) By March 31, 2019, 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				
b) As needed integrate new guidelines, policies, and procedures for selected strategy.				
c) Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By January 1, 2019, 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.				
b) As needed, integrate new guidelines, policies, and procedures for selected strategy.				
c) Monitor implementation of guidelines, policies, procedures, and protocols and adjust as needed.				
2) By January 1, 2019, use continuous quality improvement strategies, measures, and targets to support implementation of selected strategy. a) Train staff in quality improvement methodologies.				
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.				
c) Report on existing quality improvement metrics that align with HCA's pay for performance metrics.				
d) Ensure quality improvement methods are used to apply best-practice/evidence-based approaches for selected strategy.				
e) Report strategy implementation progress to monitor performance, provide performance feedback, track				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
strategies, and identify barriers to implementation.				
f) Participate in review of HUB outcomes performance evaluation.				
g) Utilize Care Coordination Systems (CCS) Platform to track HUB referrals and clients				
2) By January 31, 2019, implement selected strategy for identified populations. a) Assess and report process gaps and alignment opportunities between selected Pathways.				
b) Participate in development and integration of HUB policies, procedures, and protocols for Care Coordination Agencies (CCAs) and care coordination staff.				
c) Participate in HUB Advisory Committee meetings.				

1.2 Acute Care Transitions (physical health 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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				

1.3 Transitional Care after Incarceration Objective: Improve transitional care services care for people returning to the community from prison or jail.	**Original Commitment**	**Revised Commitment**	**Partner Initials**	**ACH Initials**
1) By March 31, 2019, implement selected strategy for identified populations. a) Collaborate with North Sound ACH implementation partners for selected strategy.				
b) Embed community health workers (CHWs) in criminal justice settings				
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.				
d) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Collaborate with North Sound ACH implementation partners for selected strategy.				
b) Embed community health workers (CHWs) in emergency room setting.				
c) Adopt and apply recommendations from Washington State Hospital Association's for emergency department diversion and the Community Paramedicine Model.				
d) Community paramedics or EMTs have partnership with hospitals and social services.				
e) Emergency department has open access, same-day walk-in capacity.				
f) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				

1.5 Cross-sector Care Coordination and Diversion Collaboratives Objectives: Implement collaborative diversion strategies to promote more appropriate use of alternatives to emergency department services, including increased use of primary care and social services.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Participate in regularly scheduled cross-sector care meetings.				

2.1 Prevent Opioid Use and Misuse Objective: Support the state's goals of reducing opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.	**Original Commitment**	**Revised Commitment**	**Partner Initials**	**ACH Initials**
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Use or expand use of the Prescription Drug Monitoring Program (PDMP) into workflow.				
d) Promote use of best practices for prescribing opioids for managing acute and chronic pain.				
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.				
f) Prevent opioid initiation and misuse in communities, particularly among youth.				
g) Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse (i.e., "drug take back").				
h) Providers and staff are trained on guidelines on prescribing opioids for pain.				

2.1 Prevent Opioid Use and Misuse Objective: Support the state's goals of reducing opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
i) Practice/clinic sites has electronic health records (EHRs) or other systems that provide clinical decision support for the opioid prescribing guidelines.				
j) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				
k) Implement the Six Building blocks model improving opioid management in primary care.				
l) Use AMDG guidelines on co-prescribing naloxone for patients on opioid medication.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Build organization's capacity to recognize signs of possible opioid misuse, effectively identify Opioid Use Disorder, and link patients to appropriate treatment resources.				
d) Expand access to, and utilization of, clinically-appropriate evidence-based practices for Opioid Use Disorder treatment in communities, particularly MAT.				
e) Expand access to, and utilization of, Opioid Use Disorder medications in the criminal justice system.				
f) Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing				
g) Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns.				
h) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
dependence on alcohol and illicit drugs. Implement the Six Building blocks model improving opioid management in primary care. Healthcare providers use Opioid Guideline from Washington Agency Medical Directors' Group (AMDG) guidelines.				
i) Organization site connects persons to MAT providers.				
j) Utilize patient agreements for chronic opioid therapy (COT) and review them with patients annually.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
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.				
d) Make system-level improvements to increase availability and use of naloxone.				
e) Promote awareness and understanding of Washington State's Good Samaritan Law with the Center for Opioid Safety Education.				
f) Emergency department has protocols in place for providing overdose education, peer support, and take-home naloxone to individuals seen for opioid overdose.				
g) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				
h) Staff are trained to recognize and appropriately respond to an overdose.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
i) Providers co-prescribe Naloxone with medication-assisted treatment (MAT).				

2.4 Community Recovery Services and Networks for Opioid Use Disorder Objective: Reduce opioid-related morbidity and mortality through strategies that target prevention	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Use Telehealth resources to expand capacity to support opioid use disorder prevention and treatment.				
d) Link to public awareness programs such as "It Starts with One".				
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.				
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.				
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				

2.4 Community Recovery Services and Networks for Opioid Use Disorder Objective: Reduce opioid-related morbidity and mortality through strategies that target prevention	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
for services.				
h) Utilize technical assistance to organize or expand syringe exchange programs.				
i) Mental health and substance use disorder (SUD) providers deliver acute care andrecovery services for people with opioid use disorder (OUD).				
j) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				
k) Give patients information about syringe exchange program.				
l) Support linkages between syringe exchange programs and physical or behavioral health providers.				

2.5 Full Spectrum of Reproductive Health Services (including Long-Acting Reversible Contraception (LARC) Objective: Ensure individuals have access to high quality reproductive health care throughout their lives.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Adopt and apply requirements of CDC's recommendations to Improve Preconception Health and Health Care.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Facilitate referral of all women in first trimester of pregnancy to appropriate prenatal care				
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.				
e) Staff are trained to offer education and information resources to all patients on the full spectrum of contraceptive options and their relative effectiveness.				
f) Incorporate 'One Key Question' into patient/client assessments.				
g) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				
h) Facilitate referral of women with history of adverse pregnancy outcomes to evidence-based community support programs.				

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.	**Original Commitment**	**Revised Commitment**	**Partner Initials**	**ACH Initials**
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Embed Healthy Steps specialist or a trained staff member in pediatric practice to increase well-child visits, support early child behavioral health integration.				
d) Integrate SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs				
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.				

2.7 Population Management in Oral Health Settings Objective: Increase access to oral health services to prevent or control the progression of oral disease.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.				
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.				
c) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
d) Use International Statistical Classification of Diseases (ICD-10) coding in oral health settings.				
e) Increase or expand use of silver diamine fluoride.				
f) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.				
b) Adopt and apply requirements and standards of Dental Health Aide Therapists (DHATs) in Tribal Clinics.				
c) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.				
b) Adopt and apply requirements and standards for mobile dental units and portable dental care equipment.				
c) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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).				
b) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
c) Use SBIRT (Screening, Brief Intervention, Referral to Treatment) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				

2.11 Community Linkages for Chronic Disease Prevention and Management Programs Objective: Integrate health system and community approaches to improve chronic disease management and control for asthma, diabetes, and heart disease.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, 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.				
b) Use quality improvement methods to ensure application ofbest-practice/evidence-based approach.				
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.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s).				
b) Providers are trained on the Collaborative Care Model of Integration.				
c) Adopt and apply standards of the Bree Collaborative in the Behavioral Health Integration Report and Recommendations or Collaborative Care Model.				
d) Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Participate in North Sound Behavioral Health-Administrative Services Organization (BH-ASO) integration committee(s).				
b) Adopt and apply standards of the Bree Collaborative in the Behavioral Health Integration Report and Recommendations or Collaborative Care Model.				
c) Assess current state of integration of physical and behavioral health care using the MeHAF Site Self-Assessment tool.				
d) Enhance collaboration of primary care and behavioral health providers.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Incorporate One Key Question into patient/client assessments.				
b) Train providers on use of most effective contraception options.				
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.				
d) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				

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.	Original Commitment	Revised Commitment	Partner Initials	ACH Initials
1) By March 31, 2019, implement selected strategy for identified populations. a) Participate in North Sound ACH's Local Impact Network (LIN) for Oral Health.]				
b) Adopt and apply action steps for integrating oral health screening, assessment, intervention, and referral into the primary care setting.				
c) Use quality improvement methods to ensure application of best-practice/evidence-based approach.				
d) Physical health providers are trained on screening for oral health needs and engagement with oral health provider.				
e) Physical health providers are trained to apply fluoride varnish.				
f) Physical health providers perform oral health screening when appropriate.				
g) Facilitate referral of all patients/clients needing dental care to community dental providers, and/or mobile dental services.				
h) Follow-up with oral health referral partner after referral is made.				