Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

*SAR 5.0*

**Reporting Period:**

*January 1, 2020 – June 30, 2020*

*DY4 Q1-Q2*

*Template Release Date: April 30, 2020*
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Purpose and objectives of ACH semi-annual reporting

As required by the Medicaid Transformation’s Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports on project implementation and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each year of the Medicaid Transformation:

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved project plans and corresponding implementation plans. The Washington State Health Care Authority (HCA) and the state’s contracted Independent Assessor (IA) will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted for the purposes of monitoring and auditing, or for general follow-up and learning discussions with HCA, the IA and/or the Independent External Evaluator (IEE).

**Achievement values**

The amount of incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given reporting period.

AVs associated with Project Incentives for this reporting period are identified in the table below.

<table>
<thead>
<tr>
<th>Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period January 1 – June 30, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Projects in ACH Portfolio</strong></td>
</tr>
<tr>
<td>BHT</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>Attestation of successfully integrated managed care for DY4, Q1 2020 regions (Project 2A)</td>
</tr>
<tr>
<td>Completion of Semi-annual Report</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
</tr>
<tr>
<td>Engagement/Support of Independent External Evaluator (IEE) Activities</td>
</tr>
<tr>
<td>Report on quality improvement plan</td>
</tr>
<tr>
<td>Completion of all P4R metrics (Project 2A, 3A only)</td>
</tr>
<tr>
<td><strong>Total AVs Available</strong></td>
</tr>
</tbody>
</table>
Table 2. Potential P4R AVs for Project Incentives, January 1, 2020 – June 30, 2020

<table>
<thead>
<tr>
<th>ACH</th>
<th>2A</th>
<th>2B</th>
<th>2C</th>
<th>2D</th>
<th>3A</th>
<th>3B</th>
<th>3C</th>
<th>3D</th>
<th>Total Potential AVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health Together</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Cascade Pacific Action Alliance</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Elevate Health</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Greater Columbia ACH</td>
<td>5</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>HealthierHere</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>North Central ACH</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>North Sound ACH</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Olympic Community of Health</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>SWACH</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
</tbody>
</table>

Reporting requirements

The semi-annual report for this period (January 1, 2020 – June 30, 2020) includes three sections as outlined in the table below.

<table>
<thead>
<tr>
<th>Semi-annual reporting requirements (January 1, 2020 – June 30, 2020)</th>
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</thead>
<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
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<tr>
<td><strong>Section 1. ACH organizational updates</strong></td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Section 2. Project implementation status update</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Section 3. Pay-for-Reporting (P4R) metrics</strong></td>
</tr>
</tbody>
</table>

There is no set template for the semi annual report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

Semi-annual reporting guidance
Reporting period: January 1, 2020 – June 30, 2020
While ACHs have flexibility in how to develop the report, the main report should be navigable for reviewers and ready to publish to HCA’s webpage. See instructions for how to format the report below.

**File format**

ACHs are to submit all required elements as a single searchable PDF, with the exception of the Implementation work plan, the partnering provider roster, and the P4R metrics, which are to be submitted as separate Microsoft Excel files or PDFs. Below are examples of the file naming conventions ACHs should use:

- **Main Report or Full PDF**: ACH Name.SAR5 Report. 7.31.20
- **Implementation work plan**: ACH Name.SAR5 Implementation work plan. 7.31.20
- **Partnering provider roster**: ACH Name.SAR5 provider roster.7.31.20
- **P4R metrics**: ACH Name.SAR5 P4R metrics.7.31.20

**Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA’s Medicaid Transformation resources webpage.**¹

**Semi-annual report submission instructions**

ACHs must submit their completed semi-annual reports to the IA **no later than July 31, 2020 at 3:00p.m. PST.**

**Washington Collaboration, Performance, and Analytics System (WA CPAS)**

ACHs must submit semi-annual reports through the WA CPAS: [https://cpaswa.mslc.com/](https://cpaswa.mslc.com/).

**ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 5 – July 31, 2020.”**

The folder path in the ACH’s directory is:


See WA CPAS User Guide available in each ACH’s directory on the CPAS website for further detail on document submission.

**Semi-annual report submission and assessment timeline**


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ACH semi-annual report 5 – submission and assessment timeline

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Responsible party</th>
<th>Anticipated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Distribute semi-annual report instructions for reporting period January 1 – June 30, 2020 to ACHs</td>
<td>IA</td>
<td>April 30, 2020</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>July 31, 2020</td>
</tr>
<tr>
<td>3.</td>
<td>Conduct assessment of reports</td>
<td>IA</td>
<td>August 3 – August 25, 2020</td>
</tr>
<tr>
<td>4.</td>
<td>If needed, issue information request to ACHs within 30 calendar days of report due date</td>
<td>IA</td>
<td>August 25-31, 2020</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>August 25-September 09, 2020</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>August 26-September 24, 2020</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>October 2020</td>
</tr>
</tbody>
</table>

**Contact information**

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.
ACH contact information

Include in the semi-annual report the contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH’s semi-annual report. If secondary contacts should be included in communications, also include their information.

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>Olympic Community of Health (OCH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary contact name</td>
<td>Celeste Schoenthaler</td>
</tr>
<tr>
<td>Phone number</td>
<td>360.633.9241</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:celeste@olympicch.org">celeste@olympicch.org</a></td>
</tr>
<tr>
<td>Secondary contact name</td>
<td>Miranda Burger</td>
</tr>
<tr>
<td>Phone number</td>
<td>360.633.9579</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:miranda@olympicch.org">miranda@olympicch.org</a></td>
</tr>
</tbody>
</table>
**Section 1. ACH organizational updates**

The following sub-sections are required components of the ACH’s semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

**Attestations**

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
| 3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories:  
  - Primary care providers  
  - Behavioral health providers  
  - Health plans, hospitals or health systems  
  - Local public health jurisdictions  
  - Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region  
  - Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region. | X | |
| 4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants. | X | |
| 5. Meetings of the ACH’s decision-making body are open to the public. | X | |
| 6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this [template](https://wahca.box.com/s/nfesjaldc5m1y6aobhiouu5xemebh26) or a similar format) that addresses internal controls, including financial audits. | X | |
| 7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy. | X | |
| 8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress. | X | |
If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

**Documentation**

The ACH should provide applicable documents or additional context for clarity that addresses the following:

9. **Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use *bold italicized font* to highlight changes to key staff positions during the reporting period.

*If applicable, include current organizational chart.*

See [Appendix 1: OCH Organizational Chart](#) (page 31) for an updated organizational chart. During this reporting period, the Director of Administration departed the organization for a new opportunity. Additionally, the second Program Coordinator left the organization. The Operations Coordinator was promoted to an Interim Operations Manager role effective June 1. The interim period will last for 3 months while the staff person gains experience to fill the role permanently. Duties from the former Director of Administration are divided between the Operations Manager and Executive Director. Given that OCH is not hosting in-person meetings or events due to COVID-19, OCH will hold on backfilling the Operations Coordinator role until in-person activities resume. The second Program Coordinator also had many duties related to in-person events, so OCH will not be backfilling that position at this time. The OCH Executive Committee reviews staffing needs periodically and makes decisions with the Executive Director.

10. **Budget/funds flow.**

   a) **Financial Executor Portal activity for the reporting period.** The Independent Assessor will receive an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. *No action is required by the ACH for this item.*

   - Optional: The ACH may provide additional context to add clarity about the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal.

OCH portal activity for this reporting period:

- $2,058,356 – The OCH Board of Directors approved the drawdown of these dollars for a reserve fund. Funds were deposited in to OCH investment accounts. Purpose and use of funds to be determined later.
- $199,587 – The OCH Board of Directors approved an Olympic Region COVID-19 Response Fund. These dollars were drawn down to the OCH bank account and other dollars were included in the total amount allocated to partners. This was a competitive application process among organizations and tribes in the region to support COVID-19 response efforts. See [Appendix 2: OCH COVID-19 Response Funds](#) (page 32) for a summary of projects and partners funded. Partners were paid directly by OCH and not through the FE portal to support a more efficient and timely allocation of funds. Also, five of the partners that received these dollars are non-implementation partners, so they...
would have had to create FE portal accounts, which would have slowed down the process further.

- $69,641 – These dollars were drawn down in alignment with the approved 2020 OCH budget to support partner engagement, convening, and other partner support activities.

- $1,413,180.96 – The OCH Executive Committee approved early payments to implementation partners in alignment with the Board-approved 2020 payment model, Appendix 3: 2020 OCH Implementation Partner Payment Model (page 33). Partners were paid in April instead of June, given the pandemic and economic crises. Partners were paid for activities already completed for the year. OCH did not provide advance payments for work yet to be completed.

b) For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.\(^3\)

See Appendix 4: 2020 Reconciliation Spreadsheet (page 36)

Please note that while only $199,587 was drawn down from the FE portal for COVID-19 partner payments, a total of $457,700 was dispersed to partners under the OCH Board of Directors approved Olympic Region COVID-19 Response Fund. Funds beyond the $199,587 were re-purposed from OCH’s 2020 budget and unspent funds from 2019. These funds were already available in OCH accounts. Of note, five of the partners that received COVID-19-related payments are not OCH implementation partners.

11. Incentives to support integrated managed care. Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support the region in transition to integrated managed care.

a) List of use and expenditures that reflect a cumulative accounting of all incentives distributed or projected to support the transition to integrated managed care. It is not limited to the reporting period.

i) ACHs may use the table below or an alternative format as long as the required information is captured.

ii) Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.

iii) Description of use should be specific but concise.

<table>
<thead>
<tr>
<th>Description of Use</th>
<th>Expenditures ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Incentives to implementation partners to support clinical and financial integration</td>
<td>$636,525</td>
</tr>
<tr>
<td></td>
<td>$148,971</td>
</tr>
</tbody>
</table>

As an on-time adopter, OCH did not receive additional funds to support the transition to IMC. Project incentives are distributed to implementation partners in accordance with the annual Board-approved payment model and individual change plan. OCH did not distribute additional funds to support IMC, outside of the payment model.

\(^3\) HCA issued the reconciliation spreadsheet and related guidance on April 7, 2020
OCH partner incentive payments are calculated based on the total balance of available incentives by partner type and county according to the OCH funds flow model, approved by the Board of Directors in August of 2018. See Appendix 5: OCH Funds Flow Model (page 38) for a visual depiction of the funds flow model and for how funds were allocated in 2018, 2019 and 2020.

**Physical health and behavioral health** change plans are organized around 4 domains which encompass the 6 MTP toolkit project areas: care coordination, care integration, care transformation, and care infrastructure. Relevant activities are included under each domain. Integration activities, including activities to support IMC, are encompassed in the care integration domain of both the physical health and behavioral health change plans. **Community-based organizations and social services (CBOSS)** and **hospital** change plans do not include the care integration domain, and therefore are not included in this calculation. CBOSS and hospital partners do engage in activities that support both financial and clinical integration, and their change plans encourage opportunities to strengthen collaborative partnerships.

Change plans for all partners include both required and **voluntary** activities, and implementation partners have the option to add or remove voluntary activities annually. Under the scope element of the 2018, 2019, and 2020 payment models, the policies include incentives based on the number of voluntary activities selected by a given partner by each change plan domain. So, OCH is able to **estimate the dollar amount of incentives allocated to physical and behavioral health partners for voluntary care integration activities** (see Appendix 5: OCH Funds Flow Model). As OCH took a portfolio approach, estimates for the allocation of required care integration activities is not available.

- **Actual expenditures:**
  - In 2018, voluntary care integration activities accounted for 13.5%* of allocated physical health and behavioral health partner incentive payments, totaling $483,300*.
  - In 2019, voluntary care integration activities accounted for 2.4%* of allocated physical health and behavioral health partner incentive payments, totaling $68,100*.
  - In 2020, voluntary care integration activities accounted for 3%* of allocated physical health and behavioral health partner incentive payments, totaling $85,125.

- **Projected expenditures:** The 2021 and beyond payment models have yet to be approved by the Board of Directors. Projections are based on the 2020 payment model and Board-approved funds flow model and are subject to change as future payment models further outline the percentage of partner incentive payments for voluntary outcomes.
  - 2021 – assume voluntary care integration activities account for 3% of allocated physical health and behavioral health partner incentive payments, totaling $63,843.
  - 2022 – assume voluntary care integration activities account for 3% of allocated physical health and behavioral health partner incentive payments, totaling $42,564.
  - 2023 – assume voluntary care integration activities account for 3% of allocated physical health and behavioral health partner incentive payments, totaling $42,564.

*Please note, the percentage and total assume that all partners complete all transformation activities and earn 100% of allocated payments.
OCH does not require implementation partners to report on their use of earned incentive funds. Implementation partner qualitative reporting responses and site visit interviews yield some information about how partners choose to spend funds. Many implementation partners have purchased or upgraded EHR systems. Additionally, many have hired additional staff to support enhanced care coordination, administrative tasks to meet increased demands of IMC, and increased behavioral health/physical health/dental staff capacity to offer integrated services.
Section 2. Project implementation status update

The following sub-sections are required components of the ACH’s semi-annual report unless otherwise noted. ACHs may report in the format of their choosing, as long as all required elements are addressed.

Attachments

The ACH should provide applicable attachments or additional context that addresses the following:

12. Implementation work plan

The reporting requirements for the implementation work plan updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. The submission of implementation work plan updates are considered optional for this reporting period but are encouraged to the extent the ACH has an updated work plan.

Implementation plans are “living documents” that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH’s implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA information to monitor ACH activities and project implementation timelines.

- Optional: The ACH may submit an updated implementation plan reflecting progress made during the reporting period.

See attachments:

**OCH.SAR5 Implementation Work Plan 1. 7.31.20**

**OCH.SAR5 Implementation Work Plan 2. 7.31.20**

**OCH.SAR5 Implementation Work Plan 3. 7.31.20**

All work steps under stage 1 and stage 2 are now either complete or a part of ongoing activities. The updated implementation plan reflects a reduced number of delayed work steps compared to the previous submission. Work steps in stage 2 are no longer delayed. This update addresses concerns raised in the Mid-Point Assessment. Delayed work steps in stage 3 are a result of COVID-19 adjustments, including delays to convening partners in-person as originally planned.

Summary of delayed or not started work steps under stage 3:

- **Include breakout sessions and/or training in chronic disease prevention and control at Natural Community of Care (NCC) convenings** – NCC convenings are planned for October of 2020, assuming partners have capacity given the pandemic.

- **Scale Olympic Digital HIT Commons or similar technology platform to new partners and use cases** – OCH decided to step away from the Digital HIT Commons due to partner concerns of data security and privacy. This platform requires a local partner to be the owner of the platform and all associated data, which is not appropriate. OCH is now exploring the Unite Us Community Information Exchange platform. OCH participated in two demonstrations during the reporting period and plan to bring this forth to the Board
of Directors for a decision later in 2020.

- **Establish real-time exchange of health information between providers for bidirectional referral and care coordination for shared patient with Opioid Use Disorder (OUD) under the Olympic Digital HIT Commons or similar technology platform** – See the response to the above bullet. This is still a use case under consideration for the Unite Us platform.

- **Explore rural global payment strategies** – This work step requires engagement from regional hospitals, state, and federal agencies. During the reporting period, OCH heard twice from HCA about rural health transformation. OCH is planning to convene hospital partners later in 2020 and the HCA team working on rural health transformation is invited to present and discuss this option with hospital partners. The Olympic region is now (July 2020) seeing a surge and rise in COVID-19 cases, so this event may be postponed into 2021.

- **Regional standards of practice for referral and treatment of opioid use disorder** First steps on this action were taken at the February Three-County Coordinated Opioid Response Project (3CCORP) treatment workgroup meeting. Further action was halted as behavioral health and primary care providers focused all their efforts on pandemic response to ensure services remained available and accessible for clients. Therefore, this action may be delayed into 2021.

- **Disseminate regional standards of practice** – This work step is planned for 2020 and may be delayed as partners’ ability to fully engage on this topic has been curtailed due to pandemic response efforts.

- **3CCORP treatment workgroup to develop regional standards of practice** – This work step is delayed given the priority focus of the pandemic. Late 2019, the treatment workgroup prioritized this project for 2020. Partners began to work on this at the February 3CCORP meeting. Partners have not had time to focus on this since then due to pandemic response efforts.

13. **Partnering provider roster.**

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.4 To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

**Instructions:**

a) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:

i. Whether the partnering provider site is pursing tactics or strategies in support of

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4 Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).
specific project areas from the Project Toolkit. Populate the appropriate project column(s) with Y/N.

ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

b) Update partnering provider site information as needed over each reporting period.

Submit updated partnering provider roster.

See attachment: OCH.SAR5 Provider Roster. 7.31.20. One addition was made to the partnering provider roster as 1 partner added a site during the reporting period.

Documentation

The ACH should provide documentation that addresses the following:

14. Quality improvement strategy update

The reporting requirements for the quality improvement strategy updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. The submission of quality improvement strategy updates are considered optional for this reporting period but are encouraged to the extent the ACH has an updated quality improvement strategy to keep HCA and the IA apprised of quality improvement activities and findings. If submitting updates, ACHs may determine the format to convey this information.5

Quality improvement strategy update:

• Modifications to the ACH’s quality improvement strategy:
  o Partner site visits for this reporting period were originally scheduled for March and April. Due to the pandemic, OCH staff canceled planned site visits to allow partners time to respond to COVID-19. OCH staff plan to resume site visits in the next reporting period, assuming provider capacity allows.

• Summary of findings:
  o Progress-to-date on MTP activities in OCH implementation partner change plans is assessed twice per year at the following stages: not started, planning, testing, limited implementation, fully implemented, scaling, and sustaining. Median scores across all implementation partners are assessed. Partner progress-to-date was collected in January 2020, and again in June 2020. Median scores from the June reporting are not yet available for this report; they will be shared with partners and the OCH Board of Directors in the fall of 2020 and included in SAR6. Table 2 details the progress of activities as of January 2020 partner reporting:

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5 Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section.
Comparing the January 2020 (table 2) to June 2019 change status summary (table 1), included in SAR4, the percent of outcomes reported as “not started” decreased from 8% to 4% and the percent of outcomes reported as “fully implemented” increased from 17% to 26%. Sustainability-related outcomes median status is the only one that remains as “planning” which is to be expected as most partners report 2021 as the year they will shift focus to sustainability activities.
This is notable progress as the Independent Assessor expressed concerns about the number of outcomes marked as “not started” in the Mid-Point Assessment.

- In addition to progress-to-date, OCH staff collected quantitative reports from implementation partners for the first time in February 2020. Due to partner differences in ability to report, these data will be most useful once another report is available to compare partner progress against themselves. The next planned quantitative report is due in August 2020 and results will be more extensively reported on in SAR6. Quantitative data collected from partners measure various metrics, based on partner type, that serve as an intermediary to examine the region’s progress towards Pay for Performance metrics. Partners self-report and their progress is compared against themselves. Progress is tracked as an additional means of evaluation.

- **Findings by project:**

  - **Project 2A:** Median scores on progress-to-date reports indicated “limited implementation” in integration efforts. During the reporting period, much focus was placed on successful transition to IMC. Despite MCO reimbursement and COVID-19 challenges, all implementation partners have remained in business and continue to serve clients. To date, more emphasis has been placed on physical health integrating behavioral health and future efforts will center on the reverse. Peninsula Behavioral Health was awarded a large Substance Abuse and Mental Health Administration (SAMSHA) grant which will increase available funding for their agency to effectively integrate physical health.

  - **Project 2D:** Median scores on progress-to-date reports indicated “limited implementation” in ED diversion activities and “fully implemented” in jail diversion activities. OCH staff participate in the statewide Collective Ambulatory workgroup led by HealthierHere and disseminate learnings as appropriate. Peninsula Community Health Services continues to expand their Community Health Worker program, with presence in the local hospital, jail, and schools.

  - **Project 3A:** Median scores on progress-to-date reports indicated “limited implementation” in opioid use disorder treatment and opioid misuse and abuse prevention, while reports indicated “fully implemented” in opioid overdose prevention focus areas of the change plan. Some 3CCORP activities remained active during this reporting period with renewed attention to opioid overdoses as an increase has been seen over the course of the COVID-19 pandemic. OCH convened the 3CCORP steering committee to review available overdose data. In response, OCH is in process of developing an opioid overdose community education campaign which will be published during the SAR 6 reporting period.

  - **Project 3B:** Median scores on progress-to-date reports indicated “fully implemented” in reproductive maternal child health activities. As the Independent Assessor noted this as a delayed area in the Mid-Point Assessment, it is worth mentioning that median change status improved from limited implementation as reported in SAR4. Pediatric practices struggled during this reporting period as they saw a drastic decrease in patient visits due to COVID-19 fears. OCH staff remained in close contact with Kitsap Children’s Clinic, as well as other practices, and based off their expressed needs, OCH developed community communication materials to encourage patients to seek preventative
Project 3C: Median scores on progress-to-date reports indicated “limited implementation” in integrating oral health activities. OCH continues to coordinate with the Arcora Foundation’s practice coach to enhance medical-dental integration throughout the region, particularly in rural communities where limited access to oral health services remains a challenge. During the reporting period, OCH staff participated in three trainings provided by the Arcora Foundation at Olympic Medical Physicians primary care and pediatric clinics, reaching 35 primary care providers and medical assistants who will provide oral health prevention, education, and referral services for youth age 6 months – 18 years of age. OCH promoted Arcora educational materials and information on training opportunities in weekly newsletters and on the website.

Project 3D: Median scores on progress-to-date reports indicated “limited implementation” in chronic disease prevention activities. Olympic Peninsula Healthy Communities Coalition implemented Memorandums of Understanding (MOUs) with six physical health and behavioral health partners for community-based chronic disease prevention outreach and clinical referrals. CHI Franciscan Medical Group (Harrison Health Partners), a primary care provider, continued planning a diabetic retinopathy screening program, on track to pilot this fall. Across partners, there is growing concern about the long-term impacts for patients not seeking appropriate preventative care due to COVID-19 fears. OCH supported partners by developing marketing materials that promote preventative care and will continue to provide supporting materials as needs arise.

**Adjustments and lessons learned:**

- Due to COVID-19 safety guidelines and partner time constraints, the following adjustments were made during the reporting period:
  - Cancelled site visits. OCH staff plan to conduct virtual site visits with implementation partners in the fall assuming partners have capacity.
  - Adapted social determinants of health assessment from a 90 minute in-person meeting to a 30-minute online survey.
  - Cancelled several planned in-person convenings/trainings. OCH staff adjusted activities for the remainder of 2020 to comply with safety guidelines. Some events will be rescheduled in the SAR6 reporting period and early 2021, assuming safety guidelines and partner capacity allows.
    - The in-person, region-wide social determinants of health (SDOH) convening planned for June was cancelled and reconfigured into three individual county-level virtual meetings. Meetings will take place in July and will address the SDOH assessment findings and explore next steps.
  - Partner barriers largely centered around the need to prioritize COVID-19 response over MTP activities. Initially, there was confusion around Governor Inslee’s orders and what was considered “essential” care, leading some organizations to temporarily close or cancel routine services. Additionally,
decreased revenue streams have required many organizations to lay off and/or furlough staff.

- In addition to responding to COVID-19, the region transitioned to IMC during the reporting period, contributing additional time and financial constraints for partners as issues with MCO reimbursement arose. OCH staff participated in all Salish rapid response calls and Early Warning System webinars, as well as advocated partner concerns to the HCA and MCOs. OCH staff conducted multiple outreach calls to all implementation partners throughout the reporting period to stay connected and maintain an understanding of challenges partners faced in both the IMC transition and COVID-19.

**Support provided to partnering providers to adjust transformation approaches:**

- OCH staff participated in all Salish rapid response calls and Early Warning System webinars. OCH tracked and advocated for partner needs to the HCA and MCOs as the region transitioned to IMC. OCH posted relevant resources to website and promoted in weekly newsletters.

- In January 2020, OCH financially supported three partners from the region to attend the State of Reform Health Policy Conference in Seattle.

- OCH contracted with Collaborative Consulting to complete a comprehensive social determinants of health environmental scan and to develop and deploy a regional assessment, which all implementation partners completed. Results have been compiled into a comprehensive report and will be shared in three virtual convenings in July 2020.

- OCH hosted several collaboration calls to provide partners with an opportunity to discuss and problem-solve challenges, make requests to OCH, and safely connect with partnering organizations across the region during COVID-19. Calls were hosted in a variety of formats: two calls for community-based organizations and social services partners, one call for primary care and hospitals, three calls for behavioral health providers, and one call per county (Clallam, Jefferson, and Kitsap).

- OCH released Olympic Region COVID-19 Response Funds, $457,700 to seventeen organizations/tribes to support the regional response under these strategies: telehealth support, increase capacity for serving vulnerable populations, community resilience, clinical resilience, and other.

**Identified best practices on transformation approaches:**

- Discovery Behavioral Health continues to work towards establishing a medication assisted treatment program. Two providers are now waivered. Next steps include formalizing a referral agreement with Beacon of Hope, the local SUD provider.

- Jefferson Healthcare implemented the Wisdom Epic Module for dental care. This allows one patient chart to be utilized for primary care, behavioral health, and dental. As the largest primary care provider and only hospital in Jefferson
County, this is a major step towards fully integrated care for a large portion of the Jefferson County population.

- Kitsap Medical Group joined the Bree Collaborative and now utilize registries to track and improve patient care. Kitsap Medical Group providers have also begun routinely prescribing naloxone.

- North Olympic Healthcare Network trained all staff on ACES/NEAR sciences and Trauma-Informed Care. Next steps include additional training for all staff related to LGBTQ care and SOGI (sexual orientation and gender identity) education.

- West Sound Treatment Center implemented a contactless UA system as a result of COVID-19 precautions. The system enabled clients engaged with drug court to maintain compliance and accountability with outlined treatment plans.

- First Step Family Support Center implemented virtual visits and services as a result of COVID-19 precautions, which has allowed additional clients previously unable to access in-person services to seek resources.

Narrative responses

ACHs must provide *concise* responses to the following prompts:

**15. COVID-19**

a) Provide an update on ACH activities in response to COVID-19 during the reporting period. Include a summary of how DSRIP activities and timelines have been impacted (i.e., which projects remain on track, which projects or areas of focus are on hold, etc.).

**OCH activities in response to COVID-19:**

- OCH hosted nine collaboration calls with partners across the three-county region, in various formations, to discuss and align COVID-19 response activities. Calls were hosted in a variety of formats: two calls for community-based organizations and social services partners, one call for primary care and hospitals, three calls for behavioral health providers, and one call per county (Clallam, Jefferson, and Kitsap).

- OCH released an additional, unplanned $457,700 to seventeen organizations/tribes to support the regional COVID-19 response under these strategies: telehealth support, increase capacity for serving vulnerable populations, community resilience, clinical resilience, and other.

- OCH convened a special meeting of the 3CCORP steering committee to address a rise in opioid overdoses. OCH provided quantitative and qualitative data to inform the discussion. The steering committee identified negative consequences related to COVID-19, including disruption in behavioral health treatment, and an increase in fentanyl use. OCH is currently creating an overdose prevention and intervention community education campaign to share with partners and the community. This campaign will be launched in the beginning of the next reporting period.

- OCH launched a partner kindness initiative to support those on the front lines of
COVID-19. OCH provided lunch to four partners and gift cards to local businesses to an additional seven partners. Gift cards were given to partners to allow them to treat staff in the way that makes most sense for their organization, given busy schedules and varied work environments. Recipients included the three local health jurisdictions, behavioral health providers, substance use disorder providers, and a pediatric practice. Additionally, OCH sponsored eleven staff from various agencies in the region to attend online mindfulness and stress reduction events.

- OCH maintained a comprehensive COVID-19 resources page and repurposed weekly emails in March/April/May to focus on sharing available resources related to the pandemic.

- OCH staff developed and distributed the Stay Healthy, Stay Connected toolkit, a community education campaign, in response to expressed needs from partners. Partners are encouraged to download fliers as well as social media posts and share broadly. Materials are available in both English and Spanish. OCH offered to print materials as needed for partner use and delivered 500 fliers to the Port Angeles Food Bank and other rural food banks to be distributed with meal kits. OCH promoted several resources on Facebook with a budget of $130, the boosted Facebook posts reached over 11,000 people in the Olympic region. The toolkit resources on OCH’s website have been downloaded over 400 times. Additionally, the resources have been shared with other ACH’s and adapted to their brand and unique needs. Specific resources include:
  - Slow the Spread: Wear a Mask: Language encouraging community members to wear a mask, as it is an act of kindness
  - Behavioral Health Care is Essential: Resource encouraging community to prioritize behavioral health care (therapy, SUD treatment, emergency helpline, mental health screenings, etc.) during the pandemic
  - Approach Others with Kindness: Reminder that just because someone may appear to break local health recommendations, does not always mean they are doing something wrong
  - Preventative Care is Essential: Resource encouraging community to prioritize preventative health care (wellness checks, chronic disease screenings, pediatric screenings, vaccinations, oral exams, etc.) during the pandemic
  - Your Health is Essential: Resource encouraging community to prioritize health care especially if you have a chronic disease
  - Working from Home: Tips for staying connected to your team
  - Supporting Someone Who is Self-Isolating: Tips for safely supporting a neighbor who may be sick or self-isolating
  - Is It Safe to Go Outside? A checklist for safely leaving the house
  - Physical Distancing vs. Social Distancing: Tips for staying socially connected and encouragement to use the term “physical distancing” as opposed to “social distancing”
  - Managing Screen Time During COVID-19: Tips to reduce screen time
  - COVID-19 Conversation Starters: Questions to ask your friends and family during the pandemic

Summary of DSRIP activities and timelines:
• COVID-19 cases in the Olympic region were relatively low for the first few months of the pandemic. June marked a notable increase in cases and outbreaks and many systems in the region moved to surge plans.

• Partner reporting continued as planned during the reporting period. Some questions were adapted to address COVID-19 specific concerns in the June qualitative report. Most partners reported minimal progress on MTP activities during the reporting period due to time, attention, and resources being necessarily pulled to COVID-19 response. Many partners reported that initial planning and systems have been implemented (such as telehealth and incident command structures) and some attention is now able to be refocused back to MTP activities.

• OCH released the first 2020 payment to implementation partners early, in April rather than July. Early payments mitigated some financial strains experienced by partners due to COVID-19. Partners were paid for work that had already been completed. When informed that payments would be released early, implementation partners reported, “That will be very helpful during this time. We appreciate that so much,” and “Thank you for this good news at a time when it is so deeply appreciated!”

• Through June qualitative reporting, many implementation partners indicated the need to prioritize bi-directional integration of physical and behavioral health in order to meet the anticipated increased demands on the behavioral health system as a result of COVID-19.

b) Describe any project intervention supports that enabled COVID-19 response activities through improved delivery system infrastructure (e.g., care coordination, information exchange, telehealth access, data analytics, population health training and technical assistance, etc.), as applicable. Indicate whether this applied to specified sub-populations within your region.

• Technical Assistance – OCH connected providers and partners with myriad of technical assistance opportunities.
  
  o OCH informed behavioral health partners of upcoming webinars and remote training opportunities that provided technical assistance on issues including: how to use telehealth platforms such as Zoom, understanding and complying with state and federal telehealth regulations (including COVID-19 waivers), strategies to improve telehealth sessions with clients, and more.

  o OCH provided direct technical assistance for partners having trouble accessing telehealth equipment and internet access. OCH conducted targeted outreach to partners to identify gaps and challenges (such as lack of Zoom licenses, computers, phones, internet access points, etc.) and provided information and resources. As a result, providers were able to rapidly pivot care delivery systems and continue providing services.

  o As all three counties entered Phase 2 of Governor Inslee’s Safe Start Plan, OCH provided technical assistance on procedures to safely resume in-person services. OCH hosted a call for behavioral health providers to discuss strategies as well as share resources on best approaches to safely resume in-person services and to re-engage clients who were lost to follow-up during the first months of the pandemic. OCH also informed tribes of upcoming technical assistance webinars offered by tribal-affiliated agencies including the Indian Health Service.

• Telehealth – There was initial confusion across the region regarding Governor Inslee’s
emergency orders. Temporary closures, reduced services, and fear prevented many people from accessing needed physical and behavioral health care. Most organizations did not have the necessary equipment and systems to immediately implement telehealth. In response, OCH quickly identified resources to support partners who needed to learn how to use telehealth platforms and to understand the changing rules and guidance. OCH conducted targeted outreach and problem solving with partners. OCH’s Executive Director participates on the Behavioral Health Institute (BHI) and on the statewide Broadband Subcommittee. OCH promoted the BHI survey to identify technical assistance needs. OCH advocates to the HCA, BHI, and other statewide partners about challenges with internet access in the region.

**Information Exchange** – OCH continued to explore options for a Community Information Exchange (CIE) platform that will allow for communication and referral between clinical and community partners. While a platform is yet to be selected and launched, COVID-19 highlighted opportunities and need for an effective system. OCH and a few partners participated in 2 demonstrations with Unite Us and plan to bring this to the Board of Directors for a decision later in 2020.

**Data Analytics** – OCH called a special meeting of the 3CCORP steering committee to discuss an increase in opioid overdoses and to make recommendations as needed. OCH provided quantitative data comparing previous and current opioid overdose data. OCH also gathered qualitative data from local public health departments, syringe exchange programs, and key behavioral health practices. Qualitative data supported that the increase was limited to Clallam County and that the impact of COVID-19 stressors including isolation, unemployment, and disruptions in SUD services were likely causes of increased overdoses. As a result of this meeting, a gap in available data was identified: Jefferson and Kitsap Counties track only fatal overdoses while Clallam County tracks fatal and non-fatal overdoses, providing a more complete overdose record. The 3CCORP steering committee discussed strategies for Jefferson and Kitsap Counties to begin tracking non-fatal overdoses, possibly using existing syringe exchange programs as a resource. Jefferson and Kitsap Health Officers committed to exploring opportunities to begin tracking non-fatal overdoses. A second outcome is that OCH is developing a opioid overdose community education campaign.

Describe how your ACH included Tribes/IHCPs in your COVID-19 response activities.

OCH’s COVID-19 response activities engaged all seven Tribes in the region.

- OCH conducted targeted outreach to all seven Tribes to understand needs and concerns among Tribal communities. This input informed the planning and implementation of COVID-19 response activities.
- OCH connected with the region’s HCA Tribal Liaison, Nicole Earls. Through collaborative outreach efforts, all tribes were informed of available HCA resources such as computer loan programs, Zoom licensing, and cell phone distribution. OCH staff conducted targeted outreach to identify challenges in accessing resources. The Tribal Liaison and OCH worked collaboratively to identify and resolve reported challenges.
- Implementation partners, local health departments, and all seven Tribes were encouraged to apply for Olympic Region COVID-19 Response Funds. Six of the seven tribes applied for funding and each were awarded funds totaling $170,000 (37% of total funding).
• As HCA’s rapid response calls and Early Warning System webinars conclude, OCH, in collaboration with the HCA Tribal Liaison, is working with the seven regional Tribes to identify and support challenges with IMC implementation. One point of interest is to track ongoing problems with billing and payment denials. The financial challenges due to COVID-19 have caused all payment issues to be critical. Timely and accurate payments will affect the ability of IHCPs to continue providing a full range of services within their communities.

• OCH created a comprehensive COVID-19 response webpage with information organized by topic. A Tribal resources section provides Tribal partners with easy access to credible sources of information such as webinars, print materials, and guidance (sources include Indian Health Service, Northwest Portland Area Indian Health Board, American Indian Health Commission of Washington, and others).

• OCH staff participate on Tribal COVID-19 webinars and calls to learn about issues and solutions for Indian Country. Tribes are informed of these resources through direct outreach, weekly emails, and the COVID-19 resource webpage.

• OCH advocated for needs of Jamestown Family Health Clinic, a Tribal FQHC which was at risk of closing some services due to poor reimbursement for telehealth services. OCH connected Jamestown Family Health Clinic with the HCA Tribal Liaison who was able to prioritize their HCA computer and Zoom license applications. These efforts ensured the continuity of critical services for both tribal members and a broader range of Medicaid members who utilize the clinic.

• Early partner payments were made to all implementation partners, including 3 Tribes, in response to financial challenges related to COVID-19.

c) Specific to partnering providers, describe how the ACH has adjusted contracts, reporting, type of provider engaged, and/or payment strategies.

OCH did not adjust implementation partner contracts or reporting cadence. OCH altered some questions in the June qualitative report to simplify reporting and address COVID-19. There have been no changes to the types of providers engaged. While no new partners were added, Jefferson Healthcare and Kitsap Medical Group added an additional partial behavioral health change plan to their scope of work, and Peninsula Community Health Services and North Olympic Healthcare Network added full behavioral health change plans (previously partial) due to expanding services and further bi-directional integration efforts. OCH chose to release the first 2020 implementation partner payment early, in April instead of July. Partners were paid for work that had already been completed at the time of payment. The next planned partner payment is for December 2020 and OCH staff are considering if additional payment cadence adjustments are prudent.

d) Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access). Also highlight any mitigation strategies, if applicable. Indicate whether this applied to specified sub-populations within your region.

OCH staff continues to stay highly engaged with partners across the region, albeit remotely. OCH is connected to regional risks and issues through collaboration calls (described above), Board of Directors and various committee meetings, and informal outreach. At the June Board
of Directors meeting, OCH staff facilitated a conversation that took stock of how to proceed with COVID-19 recovery and ramp-up MTP activities.

Themes from recent partner discussions (note that this discussion occurred prior to recent spikes in COVID-19 cases):

- The Olympic region is **still amid COVID-19**. Recovery will come when there is a vaccine and many also think the region will be in true recovery when the economy begins to rebound.

- Organizations in the region took **different paths regarding service delivery** and many are starting to slowly and cautiously re-open for in person services.

- While compared to other parts of the state, the Olympic region has not experienced as many cases of COVID-19, it is still **deeply impacted and OCH recognizes this is a marathon, not a sprint**.

- COVID-19 allowed for quick advancements for telehealth. The region does not have widespread access to broadband and telehealth is not a solution for all community members. The region would like to see **telehealth advancements supported and sustained for the long-term**.

- Upcoming **state budget cuts** will pose a significant challenge; presenting an opportunity for collaborative advocacy.

- The pandemic revealed “cracks” in the health care system including **payment models, continuity of care, and social needs**.

- Discussion participants were asked to choose priorities for the remainder of MTP. Topics with the most responses were: **Bi-directional integration, ED utilization, SDOH, and opioid use**.

- There is interest among partners to **focus the final months of MTP on areas where the region has seen success and where there is more work to do**. SDOH work is a long haul and OCH needs to take stock of the integration work and define what success means.

- **Community-wide education** launched during COVID-19 by OCH is an important component of the work moving forward.

Regarding mitigation strategies, we are in various stages for the themes above.

- OCH staff are staying in close contact with local Public Health Departments to learn of outbreaks and surges. While the region did not see many cases in the first few months, case numbers are now increasing. This impacts OCH’s ability to coordinate and collaborate with partners on MTP activities.

- On one of the behavioral health collaboration calls with behavioral health partners, two County Health Officers provided insights on how to safely re-launch in-person services to support clients with severe needs and for whom telehealth may not be ideal or realistic. Since May, the three Health Officers have been invited to join the monthly behavioral health collaboration calls to provide updates and answer questions.

- OCH is connected to the BHI. OCH staff promoted the BHI survey and are participating on their Broadband Subcommittee which includes staff from the Governor’s Office.
• OCH staff is paying attention to the state process to balance the budget based on the economic crisis. Actions related to this will likely happen later in the year.

• OCH staff continues to discuss with partners and Board members how best to proceed with MTP activities. With 18 months left in the project, it is likely work will need to be prioritized once the region is soundly in a recovery phase.

• OCH staff continues to add materials to the Stay Healthy, Stay Connected campaign to support community-wide norms associated with the pandemic.

• OCH staff placed a significant amount of time and effort this reporting period on activities around SDOH. COVID-19 has significantly impacted community resources, exacerbating the social factors that negatively impact health, such as unemployment, housing, transportation, and financial strain. As COVID-19 brought to light local social needs, it became even more apparent that SDOH activities must be a priority of OCH.

e) Highlight one best practice or “bright spot” that emerged during this reporting period as a result of COVID-19, if applicable.

The biggest “bright spot” to emerge as a result of COVID-19 is the embrace of technology and telehealth services in the Olympic region. Telehealth allowed partner organizations to continue providing services in a way that is safe, accessible, and sustainable. A few examples of specific telehealth successes in the region:

• Peninsula Community Health Services successfully launched a HIPAA compliant telehealth platform that they can leverage permanently in the future.

• Port Gamble S’Klallam Health Services initiated telehealth services allowing counselors and MAT providers to provide individual and group services via telehealth. Telehealth has been implemented across primary care and behavioral health services.

• Beacon of Hope has seen a decrease in client no-shows due to telehealth. Access to treatment through Zoom has allowed for a timelier assessment process which has also reduced no show numbers for entry into treatment.

• Kitsap Mental Health Services implemented virtual Dialectical Behavior Therapy (DBT) within the Child and Family Department. The program has since seen a 100% participation rate.

• Peninsula Behavioral Health launched telehealth services and have adapted service models to reduce the duration of services while increasing the frequency of contacts to meet the increasing demands on the behavioral health system.

Note: It is worth mentioning that, while telehealth is critical to support access at this time, many residents in the Olympic region do not have access to broadband internet. Upwards of 20-30% of households in Clallam and Jefferson counties do not have access. OCH now participates on a statewide broadband subcommittee and actively engages with local elected officials to solve this. It is also widely recognized that telehealth is not appropriate for all persons or health conditions.

Community-based organizations have also benefited from the embrace of technology:

• The Olympic Area Agency on Aging adapted their trauma-informed care training to a digital platform, allowing them to cater the training to a remote workforce and engage more staff than initially planned.
- The YMCA of Pierce and Kitsap Counties converted many support resources to a virtual platform while their facilities remain closed due to WA State orders (fitness classes, art classes, virtual cooking classes, YMCA Diabetes Prevention Program and Weight loss classes, small group meetings, stress management resources and spiritual supports).

16. Regional integrated managed care implementation update

a) For 2020 adopters, list the date in which the ACH region implemented integrated managed care.

The region transitioned to IMC on 1/1/2020.

b) For 2020 adopters, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken, in partnership with providers and MCOs, to address these challenges?

- **Client enrollment/eligibility** – In an effort to assure smooth transition to IMC and client access to care several providers including Olympic Medical Physicians, North Olympic Healthcare Network, and Jamestown Family Health Clinic requested to proactively address primary care provider assignment. The process of provider assignment took much longer than anticipated and continued to be an issue into February. Kitsap Children’s Clinic reported thousands of established pediatric patients assigned to MCOs they did not contract with, leading to children being sent unnecessarily to the emergency room for services. OCH lifted these issues to the attention of HCA and advocated for rapid resolution of each lack of payment issue. OCH also educated providers on the necessary steps to take so that accurate clients lists would be updated appropriately by HCA and MCOs.

- **Provider payments** – Behavioral health and physical health providers, particularly those in Clallam County, experienced unwarranted claim denials and rejections due to new billing codes, group visit issues, and use of telehealth. OCH advocated on behalf of providers to HCA on numerous occasions. For example, Olympic Personal Growth in Clallam County did not receive payment for telehealth visits. OCH brought this issue for discussion with HCA and MCO, leading to identification of problem and resolution of the issue with provider payments being made.

- **Denied and rejected claims** – The additional staffing costs for resubmitting claims and refiguring electronic billing platforms to accommodate new billing codes causes financial hardship for many providers. For example, Beacon of Hope, a small SUD provider in Jefferson County, was at risk of closing due to lack of payment along with the additional costs to resubmit claims. The MCO offered Beacon of Hope monetary advances which did not resolve the issue for an agency which prior to IMC had never incurred debt. OCH worked with Beacon of Hope to identify the core issues and advocated to HCA and the MCO for priority review and action. OCH regularly updated HCA on need to continue working with MCOs to resolve the issues. OCH encouraged Beacon of Hope to remain open and provided regular updates on resolution steps. OCH also made early partner payments which offered some financial relief.
• **Communication with independent pharmacies:** A challenge that arose early on in the transition was a lack of HCA communication to independent pharmacies in the region. This led to a lack of awareness of IMC for those pharmacies; incorrect assignments of Medicaid beneficiaries to primary care providers with closed panels and, adults assigned to pediatricians. Many challenges also arose with rejections and slow payment processing to providers.

• In addition to advocating to HCA, OCH provided education and guidance to providers on how to report challenges directly to HCA so they would receive timely attention. OCH encouraged providers to voice challenges at rapid response calls and Early Warning System webinars. For providers who weren’t able to participate in the rapid response calls, OCH shared call highlights and updated resolution guidance on the webpage and in weekly emails.

c) For **all early- and mid-adopters**, briefly describe any challenges the region continues to experience due to the implementation of integrated managed care. What steps has the ACH taken during the reporting period, or what steps does the ACH plan to take, to address these challenges?

Not applicable.

d) For **all regions**, what steps has the ACH taken, or what steps does the ACH plan to take, to support coordination with local, regional and statewide partners to design and implement strategies to address gaps and barriers impacting the health system in response to integrated managed care implementation?

With the January transition to IMC, systems were in place to understand gaps and barriers and many challenges arose. Note that, the transition to IMC also impacted physical health providers in Clallam county, a county that was not mandated to contract with MCOs for primary care or hospital services until 2020. OCH staff participated in all HCA-led rapid response calls. In the Olympic region, these calls took place for a 6-month period, which is unusual (in most regions, these calls lasted for one or two months) which demonstrates the significant number of challenges faced. As barriers and challenges arose on these calls, OCH staff discussed and coordinated with many parties to get to solutions. For example, OCH advocated with MCOs to expedite payments for small SUD treatment provider organizations. OCH also met individually with partners to better understand the challenges.

OCH staff also participated in HCA-led Early Warning System (EWS) webinars from February through June. The webinars provided opportunities to learn of challenges through quantitative data provided by providers, MCOs, and the Salish BH-ASO. As of late June, the group identified a rising demand on the crisis system: call numbers are increasing, length of calls are increasing, and acuity of the calls is becoming more urgent. We attribute much of these increases to the pandemic and associated economic crisis. Early in the EWS process, quantitative data provided by MCOs aligned with provider concerns – many claims were denied or rejected and many providers waited months to be paid by MCOs. This had significant impact, especially on small SUD treatment providers.

Through partner outreach, OCH learned that the early implementation partner payment in April and some success with federal PPP loans helped to offset the payments owed by MCOs, however a few providers came close to permanently closing doors during this time. OCH advocated with
MCOs and HCA to support timely provider payments. OCH staff continue to partner with the region’s BH-ASO. BH-ASO staff were invited to behavioral health partner collaboration calls and OCH staff meet with them frequently to discuss solutions and identify challenges including the potential launch of a region-wide Behavioral Health Collaborative.

**Attestations**

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

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<th>Yes</th>
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<tr>
<td>17. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:</td>
<td>Yes</td>
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<td></td>
<td>Identification of partnering provider candidates for key informant interviews.</td>
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</tr>
<tr>
<td></td>
<td>ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.</td>
<td></td>
</tr>
</tbody>
</table>

If the ACH checked “No” in item above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.
Section 3. Pay-for-Reporting (P4R) metrics

Documentation

18. P4R Metrics

The reporting requirements for the P4R Metrics updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. ACHs may use discretion, and will not be penalized, surrounding the timing and volume of P4R metric data collection during the COVID-19 pandemic. For example, an ACH may choose to delay data collection, make participation optional, or target participation. The submission of P4R Metrics are considered optional for this reporting period but are encouraged.

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH’s Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: How to read metric specification sheets.
- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under “ACH pay for reporting metrics.”

Instructions:

a) Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).

b) Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the reporting template.

Format:

a) ACHs submit P4R metric information using the reporting template provided by the state.

Optional: The ACH may submit P4R metric information.

Please see attachment OCH.SAR5 P4R. 7.31.20

6 https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121
Appendix 1: OCH Organizational Chart

Olympic Community of Health Organizational Structure as of June 30, 2020

Olympic Community of Health Governance Structure as of June 30, 2020
### Appendix 2: OCH COVID-19 Response Funds

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Amount</th>
<th>County</th>
<th>Funds will support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon of Hope</td>
<td>$22,700</td>
<td>Jefferson</td>
<td>Purchase of equipment to support telehealth services as well as infrastructural costs of expanding telehealth services while establishing new billing procedures.</td>
</tr>
<tr>
<td>Clallam County Health and Human Services</td>
<td>$45,000</td>
<td>Clallam</td>
<td>Additional capacity to process COVID-19 tests and outreach to the most vulnerable populations in Clallam County.</td>
</tr>
<tr>
<td>Discovery Behavioral Health</td>
<td>$20,000</td>
<td>Jefferson</td>
<td>Expanded ability to offer services to under/uninsured and Medicare clients. Wrap around services including food deliveries, etc.</td>
</tr>
<tr>
<td>First Step</td>
<td>$20,000</td>
<td>Clallam</td>
<td>Expanded ability to connect clients to services virtually as well as outreach to vulnerable populations and those living in the West End of Clallam County.</td>
</tr>
<tr>
<td>Hoh Tribe</td>
<td>$20,000</td>
<td>Jefferson</td>
<td>Establish safe space for members to utilize internet and equipment to access telehealth services.</td>
</tr>
<tr>
<td>Jamestown S'Klallam Tribe</td>
<td>$20,000</td>
<td>Clallam</td>
<td>Ensure continued access to emergency pediatric dental care.</td>
</tr>
<tr>
<td>Jefferson County Public Health</td>
<td>$40,000</td>
<td>Jefferson</td>
<td>Outreach and communications to students who receive services at school-based health clinics and the purchase of equipment necessary to continue in-person services at clinic sites.</td>
</tr>
<tr>
<td>Jefferson Healthcare</td>
<td>$20,000</td>
<td>Jefferson</td>
<td>The purchase of necessary equipment to expand telehealth in outpatient primary care, specialty care, and inpatient.</td>
</tr>
<tr>
<td>Kitsap Mental Health Services</td>
<td>$25,000</td>
<td>Kitsap</td>
<td>Purchase of equipment to provide more efficient telehealth services.</td>
</tr>
<tr>
<td>Makah Tribe</td>
<td>$25,000</td>
<td>Clallam</td>
<td>Creation and distribution of home care and oral hygiene kits as well as purchase of supplies for medical staff.</td>
</tr>
<tr>
<td>Olympic Peninsula Healthy Communities</td>
<td>$15,000</td>
<td>Clallam</td>
<td>Operational costs of the newly established Clallam County Helpline.</td>
</tr>
<tr>
<td>Coalition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peninsula Community Health Services</td>
<td>$50,000</td>
<td>Kitsap</td>
<td>Continued operations of expanded mobile services to ensure access to preventative care.</td>
</tr>
<tr>
<td>Port Gamble S'Klallam Tribe</td>
<td>$40,000</td>
<td>Kitsap</td>
<td>Streamlined telehealth services across the spectrum of care.</td>
</tr>
<tr>
<td>Quileute Tribe</td>
<td>$25,000</td>
<td>Clallam</td>
<td>The creation and distribution of wellness kits for isolated community members.</td>
</tr>
<tr>
<td>Suquamish Tribe</td>
<td>$40,000</td>
<td>Kitsap</td>
<td>Adaptations to offices to allow for safe re-opening of services as well as culturally appropriate relapse prevention supplies and materials.</td>
</tr>
<tr>
<td>West Sound Treatment Center</td>
<td>$15,000</td>
<td>Kitsap</td>
<td>Costs of continued telehealth services and contactless urine analysis to support Kitsap County Drug Court activities.</td>
</tr>
<tr>
<td>YMCA</td>
<td>$15,000</td>
<td>Kitsap</td>
<td>Staff time to provide virtual general health and wellness checks for seniors in Kitsap County.</td>
</tr>
</tbody>
</table>

**Total**                                           $457,700
Appendix 3: 2020 OCH Implementation Partner Payment Model

2020 Olympic Community of Health Implementation Partner Payment Model

Principles

The OCH Implementation Partner 2020 Payment Model will:

- Facilitate and support partner success toward the broad MTP vision and goals
- Encompass the full body of work requested of partners
- Ensure flexibility to adapt to unforeseen requests and opportunities
- Uphold and align with the established funds flow methodology
- Employ a simplistic approach
- Acknowledge and incent work that results in transformation

Scale/Scope Split

On March 12, 2018, the Board approved the following: “Each subsequent year, an increasingly larger proportion of incentives will be earned based on performance.”

Additional detail determined by Funds Flow, May 29, 2018:

<table>
<thead>
<tr>
<th>Year</th>
<th>Proportion of Payment Based on Scale</th>
<th>Proportion of Payment Based on Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>2020</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2021</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2022</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>2023</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

NOTE: Percentages are absolute, 50% scale, 50% scope, and 100% total.
Scale=50%

50% of 2020 payments will be based on the following scale criteria as self-reported by partner type:

- Primary Care = 2019 Medicaid lives
- Behavioral Health = 2019 Medicaid encounters
- CBOSS = Number of OCH core metrics impacted (based on 2020 change plan)
- Hospital = Scale calculation does not apply to payment calculation, although data are collected

Scope=50%

<p>| Pay for Participation - 15% absolute - elements apply to all change plan types. Pay for participation aims to incent partners for participation elements. |</p>
<table>
<thead>
<tr>
<th>Scope element (with absolute percent of payment)</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative reporting (5%)</td>
<td>Reporting on required OCH intermediary metrics. <em>Incentives for reporting on optional metrics is included in 2020 operations budget, not this payment model.</em></td>
<td>Twice per year</td>
</tr>
<tr>
<td>Qualitative reporting (5%)</td>
<td>Complete all qualitative reporting elements (change status, narrative questions, HCA P4R metrics including MeHAF assessment for BH) that apply to change plan type.</td>
<td>Twice per year</td>
</tr>
<tr>
<td>VBP survey completion (2.5%)</td>
<td>Complete HCA value-based payment survey, which is part of the HCA P4R requirement. CBOSS partners not eligible to participate will automatically receive credit for this element.</td>
<td>VBP survey is once per year</td>
</tr>
<tr>
<td>Learning and convening (2.5%)</td>
<td>Participation at convenings, summits, trainings, OCH committees, and other OCH-hosted events. Governance related committees and workgroups do not apply (Board of Directors, Executive Committee, Finance Committee, Funds Flow). Committee participation such as PMEC and 3CCORP do apply.</td>
<td>Attend a minimum of 4 learnings/convenings per year (counted by number of events per change plan, not number of people)</td>
</tr>
</tbody>
</table>

Note: Site visits are not part of the payment model in 2020 and are a part of contract monitoring.
**Pay for Performance – 35% absolute –** elements apply to all change plan types. Pay for performance aims to incent partners for doing transformational work.

<table>
<thead>
<tr>
<th>Scope element (with absolute percent of payment)</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change plan voluntary outcomes (10%)</td>
<td>Selected voluntary outcomes in 2020 change plan. Calculated as a percentage of selected voluntary outcomes of the total available voluntary outcomes.</td>
<td>Once per year, based on 2020 change plan</td>
</tr>
<tr>
<td>Change plan outcomes status (10%)</td>
<td>Self-reported status on selected outcomes (not started, planning, testing, limited implementation, fully implemented, scaling and sustaining). 50.0% or more of all selected change plan outcomes status’ must be at “limited implementation”, “fully implemented”, or “scaling and sustaining” to receive credit.</td>
<td>Once per year (second reporting of the year), to be completed with qualitative reporting</td>
</tr>
<tr>
<td>Enhanced Social Determinants of Health work (5%)</td>
<td>Participation in a regional SDOH assessment (component of 2020 site visit agenda)</td>
<td>Once per year</td>
</tr>
<tr>
<td>Enhanced community-clinical linkage work (5%)</td>
<td>Demonstration of implementation of new work to advance community-clinical linkage work selected in change plan (second half of 2020, staff to provide guidance based on above SDOH assessment).</td>
<td>Once per year</td>
</tr>
<tr>
<td>Enhanced emergency department utilization work (5%)</td>
<td>Participate in strategy session(s) to determine collaborative action toward ED utilization P4P metric.</td>
<td>Once per year</td>
</tr>
</tbody>
</table>

**Acronyms:**

BH – Behavioral Health, CBOSS – Community Based Organizations and Social Services, CCL – Community Clinical Linkages, ED – Emergency Department, HCA – Health Care Authority, OCH – Olympic Community of Health, P4R – Pay for Reporting, SDOH – Social Determinants of Health, VBP – Value Based Payment
### Appendix 4: 2020 Reconciliation Spreadsheet

<table>
<thead>
<tr>
<th>Transaction #</th>
<th>Amount withdrawn ($)</th>
<th>Date funds drawn</th>
<th>FE Use category used to draw down the funds</th>
<th>Expenditure detail</th>
<th>Amount paid ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6557</td>
<td>$199,587</td>
<td>5/5/2020</td>
<td>Health Systems and Community Capacity Building</td>
<td>Clallam County Health and Human Services - Lab costs for testing vulnerable citizens and part-time contact tracer/case manager to facilitate outreach.</td>
<td>$45,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First Step Family Support Center - Telehealth systems and equipment. Additional staff time too provide outreach and case management to vulnerable populations.</td>
<td>$20,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Suquamish Tribe - Infrastructure modifications and PPE to re-open sites and culturally appropriate relapse prevention supplies and health promotion materials.</td>
<td>$40,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YMCA of Pierce and Kitsap Counties - Staff time to offer general health and wellness checks and case management to those aged 65 plus.</td>
<td>$15,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jefferson County Public Health - Purchase equipment for students to access telehealth, communication outreach to vulnerable populations, PPE, and support temporary on-site services.</td>
<td>$40,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Peninsula Community Health Services - Support costs and offset revenue losses for mobile programs.</td>
<td>$50,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Quileute Tribe - Wellness kits for tribal members.</td>
<td>$25,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Olympic Peninsula Healthy Communities Coalition - Operational expenses of Clallam County COVID Helpline.</td>
<td>$15,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Port Gamble S’Klallam Tribe - Support telehealth investments.</td>
<td>$40,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kitsap Mental Health Services - Purchase necessary equipment for outpatient staff to provide telehealth.</td>
<td>$25,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>West Sound Treatment Center - Support costs of establishing telehealth and contactless UA system.</td>
<td>$15,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Makah Tribe - Purchase uniform scrubs for medical staff and home care and oral hygiene kits for tribal members.</td>
<td>$25,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Discovery Behavioral Health - Supplement re-imbursement for continuing services for at risk non-Medicaid clients.</td>
<td>$20,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hoh Tribe - Infrastructure investments to establish safe area in clinic for tribal members to access telehealth.</td>
<td>$20,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jamestown S’Klallam Tribe - Staff time to continue emergency and pediatric dental services.</td>
<td>$20,000.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Beacon of Hope - Purchase telehealth equipment purchases and supplement financial loss due to temporary agency closure.</td>
<td>$22,700.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jefferson Healthcare - Purchase equipment and support additional staff time to improve telehealth in outpatient primary care, specialty care, and inpatient.</td>
<td>$20,000.00</td>
</tr>
</tbody>
</table>

6557

$199,587. Please note that the total distributed to partners is higher than this amount as we paid the balance of Board-approved funding out of dollars already drawn down from the portal. See our SAR for a summary.

**ACH:** Olympic

**Contact**

**Name/Title/Email:** Celeste Schoenthaler/ Executive Director/ celeste@olympicch.org

**Date form completed:** 5/5/2020
Brief description: The funds listed above were pulled down from the Financial Executor portal and paid to the ACH, however the funds represent payment activity not captured in the portal. ACHs used these funds to support their partnering providers and communities who were impacted by COVID-19. This template provides an opportunity for ACHs to clarify payments made outside of the portal.

ACH Signature of Authority*  Date

7/2/2020

*Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).

Payment reconciliation form, October 2019
Appendix 5: OCH Funds Flow Model

Olympic Community of Health (OCH) Funds Flow Model

Projected DSRIP Incentive Partner Payments 2018-2023 (VBP, P4R, P4P)

Projected Earned MTP Funds

Clallam NCC
$4,029,340

Jefferson NCC
$2,326,700

Kitsap NCC
$7,831,700

Hospitals
$1,600,000

CBOSS
$1,425,710

100% VBP
100% P4R
25% P4P

Additional Earned MTP Funds (Bonus Pool)

Funds earned above the projected P4P percentages. TBD

PH
$2,766,400

BH
$1,262,630

PH
$1,597,500

BH
$729,240

PH
$5,377,000

BH
$2,454,520

Specific partner payments are earned based on annual Board approved payment model.

Legend:
- BH: Behavioral Health
- CBOSS: Community Based Organizations & Social Services
- HCA: Health Care Authority
- MTP: Medicaid Transformation Project
- PH: Physical Health
- P4R: Pay for Performance
- P4P: Pay for Reporting
- VBP: Value Based Payment
2020 OCH Board Approved Payment Model

PH

50% Scope

BH

50% Scale

35% Pay for Performance

Voluntary Outcomes in Change Plan 10%

Change Plan Outcome Status 10%

Enhanced SDOH work 5%

Enhanced Community- Clinical Linkages Work 5%

Enhanced ED Utilization Work 5%

15% Pay for Participation

Qualitative Reporting Completion 5%

Quantitative Reporting Completion 5%

VBP Survey Completion 2.5%

Learning & Convening Participation 2.5%

Individual Partner Change Plan Incentives

Care Coordination 3%

Care Integration 3%

Care Transformation 3%

Care Infrastructure 1%

Note: Percentages are absolute
2019 OCH Board Approved Payment Model

Note: percentages are absolute
2018 OCH Board Approved Payment Model

Note: percentages are absolute
## Olympic Cumulative snapshot

January 1, 2020 - June 30, 2020

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds Earned</td>
<td>$21,131,681.59</td>
</tr>
<tr>
<td>Funds Distributed</td>
<td>$16,648,073.34</td>
</tr>
<tr>
<td>Funds available</td>
<td>$4,483,608.25</td>
</tr>
</tbody>
</table>

### Table 1: Incentive Funds earned

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$921,025.00</td>
<td>$806,088.00</td>
<td>-</td>
<td>-</td>
<td>$1,727,113.00</td>
</tr>
<tr>
<td>Project 2D</td>
<td>$374,166.00</td>
<td>$327,473.00</td>
<td>-</td>
<td>-</td>
<td>$701,639.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$115,128.00</td>
<td>$100,761.00</td>
<td>-</td>
<td>-</td>
<td>$215,889.00</td>
</tr>
<tr>
<td>Project 3B</td>
<td>$143,910.00</td>
<td>$125,951.00</td>
<td>-</td>
<td>-</td>
<td>$269,861.00</td>
</tr>
<tr>
<td>Project 3C</td>
<td>$86,346.00</td>
<td>$75,571.00</td>
<td>-</td>
<td>-</td>
<td>$161,917.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$230,256.00</td>
<td>$201,522.00</td>
<td>-</td>
<td>-</td>
<td>$431,778.00</td>
</tr>
<tr>
<td>Integration</td>
<td>-</td>
<td>-</td>
<td>$350,000.00</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>VBP</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$350,000.00</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$1,870,831</td>
<td>$1,987,366.00</td>
<td>-</td>
<td>-</td>
<td>$3,858,197.00</td>
</tr>
</tbody>
</table>

### Table 2: Interest accrued for funds in FE portal

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$2,834.69</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$2,834.69</td>
</tr>
</tbody>
</table>

### Table 3: Distribution of funds for shared domain 1 partners

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared domain 1</td>
<td>$1,169,269.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$1,169,269.00</td>
</tr>
</tbody>
</table>

### Table 4: Incentive funds distributed, by use category

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community health fund</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>-</td>
<td>$199,587.00</td>
<td>-</td>
<td>-</td>
<td>$199,587.00</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Project management</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$1,288,475.10</td>
<td>$194,346.86</td>
<td>-</td>
<td>-</td>
<td>$1,482,821.96</td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>-</td>
<td>$2,058,356.00</td>
<td>-</td>
<td>-</td>
<td>$2,058,356.00</td>
</tr>
<tr>
<td>Total</td>
<td>$1,288,475.10</td>
<td>$2,452,289.86</td>
<td>-</td>
<td>-</td>
<td>$3,740,764.96</td>
</tr>
</tbody>
</table>