Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 6.0
Reporting Period:
July 1, 2020 – December 31, 2020
DY4 Q3-Q4

Template Release Date: October 2, 2020
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Semi-annual report information and submission instructions

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>Description of scale &amp; sustain Transformation activities</th>
<th>BHT</th>
<th>CPAA</th>
<th>EH</th>
<th>GCACH</th>
<th>HH</th>
<th>NC</th>
<th>NS</th>
<th>OCH</th>
<th>SWACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of continuous quality improvement methods to refine/revise Transformation activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrate facilitation of ongoing supports for continuation and expansion</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrate sustainability of Transformation activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of semi-annual report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Engagement/support of Independent External Evaluator (IEE) activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of all P4R metrics (Project 2A, 3A only)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total AVs Available</td>
<td>30</td>
<td>44</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>44</td>
<td>58</td>
<td>44</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period July 1 – December 31, 2020
### Reporting requirements

The semi-annual report for this period (July 1 – December 31, 2020) includes three sections as outlined in the table below.

<table>
<thead>
<tr>
<th>Semi-annual reporting requirements (July 1 – December 31, 2020)</th>
<th>Section</th>
<th>Item num</th>
<th>Sub-section components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ACH organizational updates</strong></td>
<td>1-8</td>
<td>Attestations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9-11</td>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Key staff position changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Budget/funds flow update</td>
<td></td>
</tr>
<tr>
<td><strong>Section 2. Project implementation status update</strong></td>
<td>12-13</td>
<td>Attachments</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Implementation work plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Partnering provider roster</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Quality improvement strategy update</td>
<td></td>
</tr>
<tr>
<td><strong>Section 3. Value-based Payment</strong></td>
<td>15-17</td>
<td>Narrative responses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- General implementation update</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Regional integrated managed care implementation update</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Scale and sustain update</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Attestations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19-21</td>
<td>Narrative responses</td>
<td></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.

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.SAR6 Report.2.01.21
- **Implementation work plan:** ACH Name.SAR6 Implementation work plan.2.01.21
- **Partnering provider roster:** ACH Name.SAR6 provider roster.2.01.21
- **P4R metrics:** ACH Name.SAR6 P4R metrics.2.01.21

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

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA no later than February 1, 2021 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 6 – February 1, 2021.”

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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Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2020 – December 31, 2020.

<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 July 1 – December 31, 2020 to ACHs</td>
<td>IA</td>
<td>August 2020</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>February 1, 2021</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>February 25 – March 2, 2021</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>February 26 – March 12, 2021</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>February 27 – March 29, 2021</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>April 2021</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</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></td>
<td>X</td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Primary care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health plans, hospitals or health systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local public health jurisdictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

* [template](https://wabca.box.com/s/nfesjalde5m1ye6a0bhiou5xemeoh26)

Semi-annual reporting guidance

Reporting period: July 1, 2020 – December 31, 2020
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.

- Include staff names and titles in the organizational chart. For vacant positions, mark each applicable position as “vacant” on the organizational chart.
- Provide a narrative explanation of the organizational changes.

*If applicable, include current organizational chart.*

During this reporting period, OCH hired one new employee, a Program Generalist. This position was added to support key activities including events (virtual and in-person) management, project management, and general support. See organizational charts below.

**Olympic Community of Health Organization Structure as of December 31, 2020**
   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.
   b) The ACH is asked to provide additional context to add clarity about the portal activity payments made outside the portal.
      • For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.³
      • For payments not related to COVID-19 made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.⁴

No portal activity payments were made outside the portal during the reporting period.

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.

³ The HCA issued COVID 19 reconciliation spreadsheet can be found at the following link: https://hca.wa.gov/assets/program/payment-reconciliation-template-covid.xlsx.
⁴ The HCA issued non-COVID reconciliation spreadsheet can be found at the following link: https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx.
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>
</tbody>
</table>

As implementation partner payments are based on an annual payment model, OCH answered this question for the full 2020 calendar year in SAR5. The dollar amounts and response below are largely duplicative of OCH’s SAR 5 response.

As an on-time adopter, OCH did not receive additional funds to support the transition to integrated managed care (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.

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 1: OCH Funds Flow Model (page 36) for a visual depiction of 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 1: 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:** 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. During COVID-19 many providers used incentive funds to keep services available and open while experiencing significantly decreased revenue due to less patient volume and the added cost to providing care.
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 an updated implementation work plan is considered optional for this reporting period but is 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 updated implementation plan attachments:

- OCH.SAR6 Implementation work plan. Stage1. 2.01.21
- OCH.SAR6 Implementation work plan. Stage2. 2.01.21
- OCH.SAR6 Implementation work plan. Stage3. 2.01.21

All milestones and associated work steps are marked as complete for stages 1 and 2. Explanations for work steps not yet marked as complete in stage 3 are included below:

- **Scale fully implemented Outcomes and Tactics in PHBH and CBOSS Change Plans (multiple work steps)** (fulfilled for quarter, remains in progress)— Significant progress was made during the reporting period and the percent of outcomes in the Jan-Jun 2020 progress to date reports as “scaling and sustaining” increased from 11% to 18% across all partners. Most partners indicate that 2021 will be the year they focus on scaling and sustaining MTP activities. OCH anticipates this work step will be complete in 2021.

- **Coordinate with a mobile dental clinic (Tactic in PHBH and CBOSS Change Plans)** (fulfilled for quarter, remains in progress) - Peninsula Community Health Services obtained a mobile dental clinic October 2020. Further work on coordinating with this new service is anticipated in 2021.

- **Employ QI methods to improve care and care delivery (Recommended Tactic in PHBH Change Plan)** (fulfilled for quarter, remains in progress) - Select partners working on this tactic have made progress and indicate that 2021 will be the year they focus on scaling and sustaining this as well as other MTP activities. OCH anticipates this work step will be complete in 2021.

- **Update provider specific data reports** (fulfilled for quarter, remains in progress) - OCH staff regularly communicate with implementation partners regarding progress and...
performance in MTP activities. In early 2021, OCH staff plan to provide each implementation partner with a unique report that tracks their progress on change plan activities. OCH anticipates this work step will be complete in 2021.

- **Establish real-time exchange of health information between providers for bidirectional referral and care coordination for shared patient with OUD under the Olympic Digital HIT Commons or similar technology platform** (fulfilled for quarter, remains in progress) - OCH continues to explore a regional CIE platform. The OCH Board of Directors formed a small workgroup to move this work along, and OCH will continue to explore a suitable technology platform in 2021. OCH is monitoring a decision package set forth by HCA regarding a statewide CIE platform as well.

- **Scale Olympic Digital HIT Commons or similar technology platform to new partners and use cases** (not started) - OCH continues to explore a regional CIE platform and therefore scaling and sustaining has not yet taken place. As mentioned above, OCH will continue to explore a suitable platform in 2021 and is monitoring statewide efforts.

- **Educate lawmakers, State partners, and payers on barriers to sustainability due to scope of practice, billing, coding, and HIT constraints** (fulfilled for quarter, remains in progress) - OCH frequently advocates to MCOs and State partners. In December 2020 OCH staff began intentional outreach with state and county elected officials to further this work and anticipates this work step will be complete in 2021.

- **Disseminate regional standards of practice** (fulfilled for quarter, remains in progress) - The Three County Coordinated Opioid Response Project (3CCORP) treatment workgroup continued to meet throughout 2020 and developed regional standards of practice that are revisited annually. These standards will be disseminated in early 2021 via the 3CCORP treatment workgroup. OCH anticipates this work step will be complete in 2021.

- **Scale fully implemented outcomes and tactics in PHBH and CBOSS change plans related to SDOH and health equity** (fulfilled for quarter, remains in progress) - Significant progress was made during the reporting period and the percent of outcomes reported as “scaling and sustaining” increased from 11% to 18% across all partners. Most partners indicate that 2021 will be the year they focus on scaling and sustaining MTP activities. OCH anticipates this work step will be complete in 2021.

### 13. Partnering provider roster.

The roster should reflect all partnering providers that are participating in project implementation efforts through the ACH under Medicaid Transformation. 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. ACHs should maintain the roster provided by HCA at the time of the SAR4 release for the remaining semi-annual reporting periods.

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5 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).
Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
   i. Whether the partnering provider site is pursuing tactics or strategies in support of 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.SAR6 provider roster.2.01.21. No changes were made to the partnering provider roster 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.

Quality improvement strategy update:

• Modifications to the ACH’s quality improvement strategy:
  o Due to the pandemic, OCH staff conducted virtual site visits (instead of in-person) with implementation partners.
  o Due to partner and contractor capacity, OCH did not convene the Performance, Measurement, and Evaluation Committee (PMEC). However, data updates were provided at OCH Board of Directors meetings.

• 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:
    o not started
    o planning
    o testing
    o limited implementation

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6 Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section.

Semi-annual reporting guidance

Reporting period: July 1, 2020 – December 31, 2020
Median scores across all implementation partners are assessed. Partner progress-to-date was collected in June 2020, and again in December 2020. Median scores from the December reporting are not yet available for this report; they will be shared with partners and the OCH Board of Directors in the spring of 2021 and included in SAR7. Table 2 details the progress of activities as of June 2020 partner reporting:

Table 1: Implementation Partner Progress-to-Date Change Status Median by Focus Area, **Jul-Dec 2019:**
Comparing the June 2020 (table 2) to January 2020 change status summary (table 1), included in SAR5, the percent of outcomes across all implementation partners reported as “not started” decreased from 4% to 3%. The percent of outcomes reported as “scaling and sustaining” increased from 11% to 18%. Sustainability-related outcomes median status moved from “planning” to “testing” which is to be expected as most partners report 2021 as the year they will shift focus to sustaining activities. This is notable progress in the desired direction.

In addition to progress-to-date reports, OCH staff collected quantitative reports from implementation partners for the second time in August 2020. 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 assessment. OCH collected the second round of intermediary metrics and learned that partner reporting capabilities drastically vary across the region and as a result, standardization and comparison across partners is unreliable. Moving forward, OCH will reduce the number of intermediary metrics to those that provided meaningful data. OCH will be able to report on the revised set of intermediary metrics in SAR7.
Findings by project:

- **Project 2A:** Median scores on progress-to-date reports indicated “fully implemented” in primary care integrating behavioral health activities and “limited implementation” in behavioral health integrating primary care efforts. Behavioral health partners continue to place necessary focus on successful transition to IMC. All implementation partners have remained in business and continue to serve clients, despite COVID-19 and ongoing IMC reimbursement challenges. Implementation partners identified bi-directional integration as a top priority area to meet the increased demands on an already taxed and under resourced behavioral health system. Peninsula Behavioral Health obtained a large SAHMSA grant to integrate physical health and enhanced care coordination services into their clinics. As a result, Peninsula Behavioral Health and North Olympic Healthcare Network have begun coordinating appropriate behavioral health and physical health services for high-needs patients.

- **Project 2D:** Median scores on progress-to-date reports indicated “fully implemented” in ED and jail diversion activities. OCH staff continued to participate in and disseminate learnings from the statewide Collective Ambulatory workgroup led by HealthierHere. Kitsap Recovery Center and Peninsula Behavioral Health implemented Collective Medical tools during the reporting period to better track and serve high utilizers of the emergency department. OCH staff supported the development of Clallam Care Connection, a multi-disciplinary care coordination effort piloted by North Olympic Healthcare Network and the Port Angeles Fire Department Community Paramedicine program. OCH staff support the group through developing workflows and ensuring practices are standardized. Next steps include expanding participants to other key partners in Clallam County. There is also interest in potentially expanding this model to Jefferson and Kitsap counties in the future.

- **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. The 3CCORP treatment workgroup remained active during this reporting period with renewed attention to address recovery housing support services across the region. OCH developed the “Save a Life” campaign, a five-week opioid overdose community education campaign, in response to increased need for community-wide education.

- **Project 3B:** Median scores on progress-to-date reports indicated “fully implemented” in reproductive maternal child health activities. OCH developed the “Stay Strong, Olympic Region” campaign to enhance public education on the importance of flu and well-child immunizations. During the reporting period, Kitsap Children’s Clinic hosted a flu clinic where they vaccinated over 350 children in Kitsap County.

- **Project 3C:** Median scores on progress-to-date reports indicated “limited implementation” in integrating oral health activities. Dental services were able to resume during the reporting period. OCH helped navigate PPE and reimbursement challenges to HCA at the request of partners providing dental services.
Project 3D: Median scores on progress-to-date reports indicated “limited implementation” in chronic disease prevention activities. Across partners, there is continued concern about the long-term impacts for patients not seeking appropriate preventative care due to COVID-19 fears. The YMCA of Pierce and Kitsap Counties partnered with Peninsula Community Health Services’ Community Health Workers to retrain staff in blood-pressure self-monitoring and has adapted most programs to virtual.

Adjustments and lessons learned:
Due to COVID-19 safety guidelines and partner time constraints, the following adjustments were made during the reporting period:

- OCH staff conducted virtual site visits with implementation partners in November 2020 (as opposed to in-person).
- OCH staff continued to adapt planned in-person convenings and trainings to virtual platforms.
- 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 in July 2020. Over 70 individuals attended from across the region.
- OCH collected the second round of intermediary metrics and learned that partner reporting capabilities vary across the region and as a result, standardization and comparison across partner’s is unreliable. Moving forward, OCH will reduce the number of intermediary metrics to those that provide meaningful data.
- Due to partner and contractor capacity, OCH did not convene PMEC. Instead, OCH staff presented regular data updates directly to the OCH Board of Directors.

Support provided to partnering providers to adjust transformation approaches:

- OCH staff participated in the July Early Warning System webinar and continued to work closely with both the Salish BH-ASO and behavioral health partners to find ongoing avenues to meet partner needs.
- 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 were compiled into a comprehensive report and shared with each county in the Olympic region at 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. Calls were hosted in a variety of formats: one call for community-based organizations and social services partners, one call for primary care partners, one call for hospitals, three calls for behavioral health providers, two calls per county (Clallam, Jefferson, and Kitsap), one regional (cross-sector) call to discuss immunization strategies, and one call with public health and large regional medical providers to discuss COVID-19 vaccination planning.
OCH hosted an equity presentation in October 2020 for the OCH Board of Directors. The presentation was open to the public and many partners participated. Thirty-nine individuals from across the region attended.

OCH contracted with Kitsap Strong to offer a two-part NEAR (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resiliency) training for partners throughout the region. Forty-nine individuals attended.

OCH conducted virtual site visits with all implementation partners in November 2020 to discuss partner challenges and share best practices/possible solutions.

OCH assisted First Step Family Support Center in securing additional funds from Amerigroup to meet community needs.

OCH paid for the costs to translate Olympic Peninsula Healthy Communities Coalition’s 2-1-1 resource materials into Spanish.

- **Identified best practices on transformation approaches:**
  - Discovery Behavioral Healthcare (DBH), the mental health agency in Jefferson County, continues to grow their medication assisted treatment (MAT) program and now have three waivered providers on staff. Next steps are to formalize a referral agreement with Beacon of Hope (BoH), the local substance use disorder (SUD) provider. Rather than DBH growing a substance use disorder (SUD) Program, DBH and BoH are complementing each other’s services and integrating their strengths to provide clients with complete treatment and recovery services. DBH clients receive SUD counseling from BoH and BoH clients have access to receive MAT services from DBH. A weekly collaborative meeting is used to identify client needs, make timely referrals, and to provide coordinated care management for clients of both agencies.
  - North Olympic Healthcare Network (NOHN) collaborated with WSU Extension, Olympic Peninsula Healthy Communities Coalition, First Step Family Support Center, and Molina Healthcare to produce a series of cooking shows featuring NOHN providers, using the recipes from Good and Cheap cookbook. The first video is now online and was inspired by First Step Family Support Center’s transition to digital resources and services during COVID-19.
  - The Clallam Resilience Project, a project of United Way Clallam County, sponsored the Take Care and Be Well tiny video series. The video series consists of bite-sized videos of partners from across Clallam County sharing resilience skills that they use. The video series also offers Spanish resources. So far, Take Care and Be Well videos have been made by a range of partners including: Olympic Community of Health, Clallam County Health and Human Services, Clallam County Commissioner Ozias, Quillayute Valley School District, WSU Extension, Jefferson Healthcare, Olympic Nature Experience, North Olympic Library System, OlyCAP, Planned Parenthood, and Serenity House.
  - Kitsap Medical Group and Kitsap Children’s Clinic both implemented universal social determinants of health screening for all patients as well as developed comprehensive resource materials to coordinate patient needs.
  - Kitsap Mental Health Services launched a supportive employment program. To date, 3 clients have gained successful employment and 1 additional client is enrolled in a training program.
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 changed (i.e., which projects remain on track, which projects or areas of focus have expanded, which capacity building efforts have emerged, etc.).

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

- OCH hosted twelve collaboration calls with partners across the three-county region, to discuss and align COVID-19 response activities and to keep Medicaid transformation activities moving forward. Calls were hosted in a variety of formats: one call for community-based organizations and social services partners, one call for primary care, one call for hospitals, three calls for behavioral health providers, one call per county (Clallam, Jefferson, and Kitsap), one call per county for social determinants of health (Clallam, Jefferson, and Kitsap), one regional cross-sector call to discuss flu and childhood immunization strategies, and one regional call with major health systems and local public health to discuss COVID-19 vaccination planning.

- OCH created the “Save a Life” campaign, an overdose prevention and intervention community education initiative. In May 2020, the local Health Officers stated that the OCH region was experiencing an increase in opioid overdoses and asked OCH to investigate. OCH compiled qualitative and quantitative data which were presented at a special meeting of the 3CCORP Steering Committee. Data from the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) showed opioid overdoses had increased in the Olympic region during the first two quarters of 2020 compared with the same two quarters in 2019. Overdose is a notifiable condition in Clallam County. Clallam County’s Health Officer reported that from January - April 2020, Clallam had 67 overdoses reported and four of them were fatal. During that same time frame in 2019, Clallam County reported 25 overdoses and none were fatal. Based upon the data and discussion, the 3CCORP Steering Committee recommended that OCH create and disseminate overdose prevention educational materials. The campaign reached a total of 5,498 people over the span of five weeks. All campaign resources are available to the public via OCH’s webpage. The resources include social media graphics, print fliers, draft captions, and Spanish translations. Topics covered in the campaign include:
  - How to safely secure your medications
  - Learn how to save a someone from an overdose
  - Call 9-1-1 and use naloxone
  - How to get naloxone
  - Recognizing and responding to an overdose

- OCH continued the partner kindness initiative to support those on the front lines of COVID-19. OCH provided self-care baskets to four partner organizations which included a self-care bingo game for partner staff and a list of creative ways to support your workforce. Additionally, OCH highlighted various regional successes by sending
gift baskets and certificates to partners in all three counties. The awards were presented at county collaboration calls, allowing other partners to learn from and celebrate these successes. These small gestures of support, gratitude, and celebration have helped lift partner spirits during these difficult times.

- **OCH maintains a comprehensive COVID-19 resources page.** The page is organized by topic area and updated frequently as new resources emerge.

- **OCH published multiple blog posts featuring partner creativity, innovation, and resiliency in the face of COVID-19.** Aside from the OCH home page, the blog is consistently the OCH webpage with most traffic. Partner spotlight blogs capture local projects, partner quotes, and advice for other partners. Additionally, OCH creates blogs to summarize recent events, making the key takeaways accessible for the community. These summaries serve as a helpful resource for partners, as they have limited capacity to join live events. Published blogs related to COVID-19 include:
  - Door to Door: Delivering Care to the Community (Quileute Tribe)
  - Determinants of Health: Summary of Virtual Convenings
  - Finding Opportunity in Challenging Times (First Step Family Support Center)
  - Summary of Immunization Collaboration Call
  - Clinic to Kitchen (North Olympic Healthcare Network)
  - Drive-Thru Flu Clinics: Safe, Convenient, & Innovative (Forks Hospital)
  - Tiny Video Projects (Clallam Resilience)
  - Drive-Thru Health (Suquamish Tribe Community Health Program)
  - Summary of Natural Community of Care Convenings

- **OCH staff developed and distributed the “Stay Strong, Olympic Region” campaign,** a community education campaign, in response to increased concerns about immunization rates during COVID-19 (flu shot and child immunizations). Partners and community members are encouraged to download posters and 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 OCH staff distributed print materials across the region. OCH promoted several resources on Facebook with a budget of $100, the OCH Facebook posts reached over 13,259 people in the Olympic region. The campaign was picked up by all three library systems in the region. Additionally, the resources have been shared and used by other ACHs. Specific resources include downloadable resources, additional information/resources, and a region-wide creative immunization strategy list. Below
are a few examples of social media posts shared during the “Stay Strong, Olympic region” campaign.

**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. The region has continued to navigate surges, particularly following Independence Day, and Labor Day holidays. Most recently the region experienced a drastic increase in cases in November and December.
- Partner reporting continued as planned. Some questions were adapted to address COVID-19 specific concerns in the December qualitative report.
- OCH released three payments to implementation partners in 2020 (April, September, and December). More frequent payments mitigated some financial strains experienced by partners due to COVID-19. Partners were paid for work that had already been completed.
- COVID-19 continues to highlight the need for comprehensive care coordination and expanded social service supports. During the reporting period, much partner focus was diverted to addressing increased behavioral health needs, expanding flu immunization efforts, and planning for COVID-19 vaccinations.
- An OCH staff member who is a Registered Nurse was asked to support contact tracing and case investigation at Clallam Health and Human Services. This staff member helped one day per week for most of this reporting period.

b) **Describe any DSRIP activities that enabled the ACH and partners to respond to and navigate the COVID-19 pandemic (e.g., care coordination, information exchange, telehealth access, data analytics, population health training and technical assistance, etc.), as applicable. If applicable, indicate whether certain activities applied to specified sub-populations within your region. Describe any lessons learned that the ACH will use to support projects and partnerships moving forward.**

OCH’s established collaboration infrastructure and partnerships allowed for an effective pivot to coordinating COVID-19 response across the region. OCH’s robust distribution lists and role in bringing partners together helped partners navigate the overwhelming flow of information. OCH learned the importance of honoring partner capacity, particularly as Zoom fatigue became more pronounced over the course of the reporting period.

c) **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 ongoing planning and implementation of COVID-19 response activities. For example, the Sophie Trettevick Indian Health Care clinic (Makah Tribe) experienced at least one COVID-19 outbreak. The Port Gamble S’Klallam Tribe moved all services to virtual and reported that the OCH’s COVID-19 funding opportunity was instrumental in their ability to move to virtual services.
• OCH connected with the region’s HCA Tribal Liaisons, Nicole Earls and Lena Nachand. Through collaborative outreach efforts, all tribes were informed of available COVID-19 resources from HCA, Indian Health Service, and other local, state, and national agencies. OCH staff conducted targeted outreach to identify challenges in accessing resources. The HCA Tribal Liaison and OCH staff worked collaboratively to identify and resolve reported challenges.

• OCH maintains 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 supported COVID-19 resiliency with self-care gift baskets containing self-care bingo, a few prizes, and creative strategies to support the workforce. These were shared with Lower Elwha Klallam Tribe health & wellness staff (53 employees) and Port Gamble S’Klallam Tribe health & wellness staff (41 employees).

• OCH staff participate in 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 newsletters, and the COVID-19 resource webpage.

• OCH connected Tribes with county and regional partners, highlighting their culturally relevant strategies for preventing illness and strengthening wellness within their communities. For example, OCH wrote and disseminated an article highlighting successful strategies and programs of the Quileute and Suquamish Tribes. The Quileute Tribe used COVID-19 funds provided by OCH (as described in SAR5) to create and distribute wellness bags to the households on their reservation. These wellness bags included activities for youth and for elders to help them build cultural resiliency and wellness skills to support them through the social isolation required by COVID-19 response. A spotlight article on the Suquamish Tribe featured their implementation of a drive-through flu immunization clinic to quickly and effectively vaccinate their community. Tips for success and lessons learned by the Suquamish Tribe were shared to help other regional partners benefit from their experience.

• Additionally, OCH invited Vicki Lowe of the American Indian Health Commission (AIHC), to provide a culturally appropriate introduction during the equity presentation to the OCH Board of Directors and additional partners. COVID-19 has highlighted existing inequities in the healthcare system and OCH was honored to partner with the AIHC on this important training.

d) 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 December qualitative report to simplify reporting and address COVID-19. There have been no changes to the types of providers engaged. OCH chose to split partner incentives across three 2020 payments instead of two, to mitigate some of the added COVID-19 financial burdens. Partners were paid for work that had already been completed at the time of payment (April, September, and December 2020).

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

Two key risks/issues that emerged this year throughout the region are the region’s **transition to IMC** and the **COVID-19 pandemic**. These have been discussed at length throughout this report. These two significant events are challenging the rural workforce in unprecedented ways and are more significant in the outlying areas of the region. Burnout, illness (COVID-19 or otherwise), home schooling, and lack of childcare, and more contribute to continued workforce challenges. The adjustment to telehealth has also had unintended consequences – for example, the hearing impaired community is struggling to adapt to online telehealth platforms such as Zoom. High cost of doing business coupled with reduced capacity and/or fewer patients and clients seeking services – both associated with the pandemic - are also key issues this year. The big issue at play is partner and provider capacity. Many MTP activities and capacity building projects are on hold or moving more slowly such as progress toward identifying a regional CIE, and other lower priority projects. Examples of OCH mitigation strategies:

- Early and more frequent partner payments
- Additional partner funding to support COVID-19 response
- Collaboration calls and check-ins with partners
- One OCH staff member assigned to a local health department to support COVID-19 response
- New communication campaigns to support positive COVID-19 norms, resilience, and community cohesion.
- Partner kindness activities aimed at supporting the health care workforce
- Establishment of a workgroup to identify a region-wide, digital information exchange platform

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

During these difficult times, many are grappling with misinformation, fear of going into public spaces, and how to prioritize physical and behavioral health. Preventative immunizations are an important component of COVID-19 response activities. OCH identified well-child immunization and flu immunization rates as areas for improvement and collaborative problem solving. A bright spot during the SAR 6 reporting period is the creative immunization strategies implemented by partners across the region.

- Forks Community Hospital and Chinook Pharmacy offered several opportunities for drive-thru flu shots. The drive-thru clinics reached almost 100 individuals, many of which were elderly patients. “The community really liked it and it was really well received!” shared Melanie Koskela, Administrative Clinic Supervisor at Forks Community Hospital. Since Clallam Bay is a remote community, the drive-thru approach was especially effective and important.
- Peninsula Community Health Services, CHI Franciscan, and Kitsap Public Health District partnered to provide free drive-thru flu shots in Bremerton and Port Orchard for uninsured adults and children.
- The Suquamish Tribe Community Health Program offered drive-thru events that offered flu shots for both adults and children, COVID-19 tests, swag bags from
health vendors, and a chance for safe community connection. The Suquamish Tribe distributed approximately 400 flu shots, over double the amount distributed in 2019.

- Kitsap Children’s Clinic recently hosted a flu clinic where they distributed over 350 youth flu shots in Silverdale, WA. Kitsap Children’s Clinic implemented a new check-in process through their online portal before the appointment. They started scheduling a month prior to the flu clinic and ended up with waiting list of community members. The clinic was set up in a way that prioritized patient safety, as the whole process was streamlined and reorganized so there was minimal contact with others.

16. Scale and sustain update

Per the Project Toolkit, ACH SAR 6 must include a section on scale and sustain activities undertaken by ACHs during the reporting period. This section will appear in each SAR thereafter, with questions revised and added to reflect the current phase of work. In answering these questions, please focus on activities that took place during the six-month reporting period. Recognizing P4P incentives for DY4 and DY5 will be paid out in 2022 and 2023, have these funds been obligated? In addition to answering yes/no, please provide relevant context regarding this question and each of the following components.

i. What types of entities are those funds obligated to?

ii. Will the ACH retain some of this funding for post-2021 admin?

iii. Are providers receiving any of these funds for P4P or for future deliverables?

The OCH Board-approved funding model, which was finalized in late 2018, includes an estimate that the region will earn 25% of available P4P incentives. These dollars are accounted for in the OCH funds flow model and will be allocated to current implementation partners accordingly. If the region earns below this amount, partner payments will be adjusted down. If the region earns above 25%, a separate pool of funding will be established. OCH staff convened the OCH Funds Flow Workgroup in early November of 2020 to begin to discuss how these dollars will be allocated. No decisions have been made at this time, so OCH is unable to answer this question fully and specifically. Please see the Funds Flow Model (Appendix 1).

a) If applicable, describe how any other P4R or P4P funds (already earned or to be earned before the end of the DSRIP period) have been obligated for ACH or provider payments post-2021.

The OCH Funds Flow model includes all available funding through 2023. As the region will earn two payments post-2021 for P4P and one for P4R, those dollars will be allocated to partners as a part of our approved funds flow model.

b) Assessment of DSRIP sustainability:

i. Describe activities and/or conversations, if any, your ACH has supported with partners related to sustainability priorities and mechanisms. For example, have there been activities or conversations around defining sustainability, evaluating results, or establishing criteria to determine what DSRIP activities would continue post-DSRIP
funding?
Through implementation partner change plans, most partners indicate that 2021 will be the year that they begin to think through the notion of scaling and sustaining. OCH facilitates discussions about this with the Board of Directors and included a question about this on the late 2020 partner qualitative report. Data from this report will be analyzed in time for SAR 7. Early in 2020, the OCH Board established a Visioning Taskforce that reports to the Board. The group was established to propose principles, goals, functions, and potential funding streams to the Board of Directors for review and approval. OCH staff keep this group informed regarding cross-ACH and other statewide sustainability conversations.

In September 2020, the OCH Board of Directors held a longer meeting to discuss the potential future state of the organization and MTP projects. Two key themes emerged through the review of various inputs: determinants of health and bi-directional integration. While other MTP toolkit activities are also important, these are the two that consistently emerge as needing to continue post-MTP. OCH has not yet made final decisions about post-MTP sustainability, those decisions are expected sometime in 2021.

At the implementation partner level, providers are ascertaining this in their own ways. Through qualitative reporting, OCH staff are engaging implementation partners to better understand what criteria they are using to make determinations about sustainability. A question about this was included on the late 2020 partner qualitative report. Data from this report will be analyzed in time for SAR 7.

At the Board level, staff compile quantitative and qualitative data to support data-driven decision making regarding the potential future state of the work and the organization. The decision-making principles and criteria determined by the OCH Visioning Taskforce and the Board of Directors are:

- Continue to serve and benefit the 3-county region of Clallam, Jefferson, and Kitsap and the seven sovereign Tribal nations.
- Maintain current mission statement of “to solve health problems through collaborative action”, purpose statement of “to tackle health issues that no single sector or Tribe can tackle alone”, and vision statement of “a healthier, more equitable three-county region”.
- Promote equity and social justice.
- Act in collaboration and not in competition with organizations, and Tribes throughout the region.
- Tackle projects, initiatives, and programs in alignment with funding and capacity of the organization.
- Take a data-driven approach in congruence with community and leadership feedback and context.
- Build the future state with both the vision and funding in mind.
- Create a future state that first meets the needs and interests of the region and incorporates interests of the state as they align with local priorities.
- Continue the journey started with MTP of working toward the quadruple aim.
ii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation of DSRIP funded activities (e.g., capacity building, practice transformation, and collaboration among partners), beyond waiver funding. If you have not supported related activities and/or conversations during the reporting period, please explain why.

As mentioned above, no concrete decisions have been made about the future state of OCH or the MTP work being implemented by partners. 2020 was focused primarily on the region’s transition to IMC and COVID-19 response. Additionally, OCH is engaged with ACHs and HCA regarding the potential for a year 6 of MTP. The OCH Board did hear a presentation in September with draft ideas regarding the future state and decisions are expected in late 2021.

Partners consistently identify collaboration among sectors, disciplines, and communities as the greatest value add OCH has brought to the region. One implementation partner shared, “There is no Plan B – other than the health departments (with their very limited resources), there is no other organizational entity that can convene and sustain a three-county regional partnership.” There is interest in maintaining OCH as a central convener to continue collaboration beyond MTP and further decisions will be made in 2021.

iii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation and/or scaling of specific DSRIP project toolkit evidence-based models and/or pilots (e.g. Community Based Care Coordination, CoCM). If you have not supported related activities and/or conversations during the reporting period, please explain why.

OCH is engaging implementation partners to better understand how they are approaching potential spread and scale for promising or successful projects/activities. A question about this was included in late 2020 partner qualitative reports and data analysis from this report will be available in time for SAR 7. Additional activities that OCH has conducted related to scaling include:

- OCH staff promote local successes in weekly newsletters and partner spotlights of promising initiatives.
- OCH provides opportunities for informal connections among partners with like-projects and activities to promote peer learning and sharing.
- OCH staff attend various meetings, coalitions, and committees to learn more about promising projects happening around the region. Staff attendance at various meetings also provides an opportunity for OCH to share successful projects with different audiences.
- OCH staff created a peer-to-peer learning plan to increase and improve opportunities for partners to share about promising initiatives (see Appendix 3).

17. Regional integrated managed care implementation update

   a) 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** – Behavioral health and physical health providers continued to experience some challenges with client enrollment and eligibility. 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 continue to experience unwarranted claim denials and rejections due to new billing codes, group visit issues, and use of telehealth. For example, Kitsap Recovery Center was able to leverage their role as the only detox provider in the region to renegotiate their contract with one MCO for sustainable rates. This took considerable effort and time from the provider. Providers state that impact of COVID-19 is that their costs are higher due to expenses, like purchase of PPE, and client capacity is lower than expected when the MCO contracts were negotiated. Peninsula Community Health Services describes “astronomical” cost increases due to COVID-19. Two SUD providers received upfront funding from one MCO based on their contract, and now, due to smaller client numbers than anticipated, owe money back to the MCO. Providers report that MCOs are not providing additional COVID-19 funding support to all providers. OCH is collaborating with the BH-ASO to bring together providers and MCOs to address these issues and identify solutions.

**Denied and rejected claims** – Some providers report ongoing challenges with 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, Kitsap Mental Health Services and Kitsap Recovery Center report regularly receiving delayed inpatient claim denials, which represents a challenge to providing effective emergent care for clients. Both providers report necessarily assuming the risk of providing treatment, sometimes for several days, before receiving MCO authorization for treatment. They report that a rejection is received after providing several days of necessary inpatient care, which results in time-consuming back and forth with the MCOs.

**Tribal Partners** - OCH, in collaboration with the HCA Tribal Liaison, continues to work 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 affect the ability of IHCPs to continue providing a full range of services within their communities.

OCH participated on two IMC problem-solving calls led by the BH-ASO. OCH continued to support individual providers in reaching out to MCOs and HCA for resolution on specific challenges. Additionally, OCH began drafting a regional behavioral health report which will be used to uplift specific regional challenges to the legislature as well as provide peer learning opportunities amongst partners.

b) 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.

c) 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?

OCH collaborates with the newly established Behavioral Health Administrative Services Organization (BH-ASO), clinical partners, state agencies, state association, local governments, other ACHs, and health systems to support implementation of integrated managed care (IMC). 2020 marks the region’s first year of experience with IMC and the experience of the pandemic has exacerbated many of the gaps and barriers.

Much of the response to this question is summarized in other sections of this report. A few key areas to note:

- **IMC Problem Solving Forum** – Created by the Salish BH-ASO, the IMC problem solving forum was established after the HCA-led IMC supports concluded. BH-ASO staff bring BH providers together to share and discuss challenges and solutions. These are rolled up to the state and MCOs for action and remedy.

- **Behavioral Health Collaboration Calls** – Hosted by OCH, regional BH providers come together on a regular basis to hear COVID-19 updates from local health officers, to share in successes and challenges, and for a shared learning space. OCH and BH-ASO staff co-create these agendas with feedback from providers. Summaries of the calls are posted on the OCH website.

- **Cross-ACH and MCO Project** – A workgroup was formed in 2020 with a few ACH and MCO representatives to review the myriad of ways that ACHs and MCOs are measuring and tracking progress on clinical integration. The intent is to streamline and simplify tools used to ease provider burden. OCH is not a participant of this group but does hear regular updates from the workgroup.

- **BH-ASO Executive Board** – The OCH Executive Director is a non-voting member of the Salish BH-ASO Executive Board. This Board is led by county commissioners from the region. The group regularly reviews processes, policies, and systems including budget issues related to IMC.

- **OCH Board of Directors** – As many of the OCH Board members are clinical providers, the OCH Board regularly shares information and updates related to IMC.

d) For all regions, how are you supporting efforts to measure and report on clinical integration?

OCH staff participated in HCA-led Early Warning System (EWS) webinars from February through July. The webinars provided opportunities to learn of challenges through quantitative data provided by providers, MCOs, and the Salish BH-ASO. As of July, 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. Much of these increases are attributed to the pandemic and associated economic crisis. OCH requested that HCA continue the Early Warning System beyond the usual 6 month-period and this request was denied. OCH and the Salish BH-ASO continued to regularly collaborate. The Salish BH-ASO hosted a regional IMC problem-solving forum in
October and December and OCH participated. The OCH Executive Director is a non-voting member of the Salish BH-ASO Executive Board and actively engages in discussions about allocation of crisis and non-Medicaid resources. OCH also continued to host several collaboration calls for regional behavioral health partners.

As a part of OCH’s qualitative reports, all behavioral health implementation partners are required to complete the MeHAF on a semi-annual basis. OCH tracks the region’s progress over time. As a part of the peer-to-peer learning strategy (see Appendix 3), OCH also finds opportunities to spotlight and spread clinical integration best practices for both primary care and behavioral health.

Additionally, OCH is working to finalize a regional behavioral health report. This report will inform advocacy efforts during the upcoming legislative session, as well as provide a meaningful resource for behavioral health partners across the region.

Through the cross-ACH partnership, a small workgroup was formed in mid-2020 with a few ACH Executives and MCO partners to discuss the approach for measuring clinical integration by each ACH and each MCO. The group continues to meet in hopes of creating a simplified and standardized approach. While OCH is not on this workgroup, reports are shared with all ACHs on a regular basis.

### 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>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| 18. 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:  
  - Identification of partnering provider candidates for key informant interviews. 
  - ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. 
  - 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. | X |

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. Value-based Payment

This section outlines questions specific to value-based payment (VBP) milestones in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 4, Q4.

Note: The reporting period for VBP milestones cover the full calendar year (January 1 through December 31, 2020).

Narrative responses

19. Identification of barriers impeding the move toward value-based care

Describe the barriers the region is facing regarding implementation of value-based care and methods the ACH continues to use to identify providers struggling to implement practice transformation and move toward value-based care.

Barriers the region is facing regarding implementation of value-based care:

- Many behavioral health providers reported difficulty entering into sustainable value-based care contracts as this was the first year they contracted with MCOs. Additionally, most SUD providers in the Olympic region are quite small and have reported that, according to the MCOs, they are unable to enter into value-based contracts. Pediatric clinics also report a lack of VBP contracting opportunities. OCH has raised these concerns to HCA.

- COVID-19 has posed unprecedented financial challenges across all partners. Partners report significant additional costs to providing care (PPE, cleaning, etc.) which are not reimbursed. Many partners report necessity to adjust established contracts and reluctance to take on additional risk at this time.

- Continued uncertainty about the role of community-based organizations in value-based care contracting pose barriers to partners effectively sub-contracting, or MCOs directly contracting, for these important services.

Methods used to identify providers struggling to implement practice transformation, move toward value-based care, and overview of activities OCH conducts to support those providers:

- In December 2020, OCH asked providers to report on progress, barriers, and lessons learned with VBP contracting through qualitative reporting. Many small providers report difficulty or inability to engage MCOs in discussions around VBP contracting. Some providers have been informed by MCOs that their organizations are too small to qualify for VBP contracting. This is concerning, as a rural region OCH has a significant number of small providers and has raised this issue to HCA. Some providers report successfully negotiating capitated contracts as a means of ensuring financial sustainability during a financially challenging year. A few providers were able to renegotiate contracts with MCOs to shore up financial sustainability, which was at risk due to poor initial contract terms. Even larger health systems in the region report significant barriers to achieving VBP metrics in 2020, and some have been able to negotiate altered achievement values.

- OCH uses results from the VBP survey to identify top barriers in the region towards VBP contracting progress. OCH uses results to inform investments in training and technical assistance, as well as to advocate regional barriers up to MCOs and HCA.

- Implementation partners reported on the OCH Board approved intermediary metrics twice in 2020. The intermediary metrics provide OCH with more timely data of the
region’s progress towards pay for performance measures and are designed to prepare providers for value-based contracting. From this process, OCH learned that partner reporting capabilities drastically vary across the region and as a result, standardization and comparison across partners is unreliable. Moving forward, OCH will reduce the number of intermediary metrics to those that provided meaningful data.

- VBP resources are easily accessible on OCH’s partner resource webpage and promoted in weekly emails to OCH’s continuously growing distribution list.
- In March 2020, OCH invited HCA’s JD Fischer to present 2019 VBP survey results to the OCH Board of Directors. OCH then shared the presentation materials with partners.

20. **Support providers to implement strategies to move toward value-based care**

   a) Describe how the ACH has helped providers overcome barriers; indicate if the scope or intensity of support has been different for small providers (25 FTEs or fewer), or behavioral health providers.

   OCH shares resources and responds to partner needs and requests. However, OCH is not privy to the MCO/partner contracting process. According to providers, the MCO contracting process is confidential and providers have been unable to share with OCH as well as other providers based on their agreements with MCOs. Given these limitations, the role of technical support and moving contracts towards value-based care necessarily falls to the MCOs. OCH supports partners in overcoming barriers by:

   - Launching the intermediary metrics to prepare implementation partner systems to successfully track and report on value-based care incentive measures. This was a more challenging task for small providers.
   - Continuing to outreach to partners to track emerging issues and potential risks to an already burdened behavioral health access system. During 2020, OCH conducted rigorous outreach, particularly to small SUD providers, which account for much of the SUD access in the OCH region. OCH advocated partner needs on provider’s behalf and at their request, to HCA.
   - OCH reached out to HCA VBP staff to share feedback from small providers that they are not being engaged in VBP contracts due to the small number of Medicaid lives served and the lack of a VBP model for pediatric clinics. Many providers report lack of communication by MCOs.

21. **Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the state-issued Paying for Value Provider Survey**

   a) Provide an example of the ACH’s efforts to support completion of the state’s 2020 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

   OCH included completion of the Paying for Value survey as a component of the 2020 Payment Model for implementation partners (see Appendix 2). This was a new tactic to increase regional participation and accounted for 2.5% of 2020 payments to partners. Leading up to the survey deadline, OCH reached out directly to implementation partners, encouraging participation. OCH also invited HCA’s JD Fischer to present 2019 regional survey findings to the OCH Board of Directors in March 2020. The survey was also promoted via the weekly newsletter communication to the broad OCH distribution
list, including over 600 subscribers. HCA reports that the Olympic region had eleven more respondents to the survey compared to the prior year.

b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

HCA’s JD Fischer shared results from the 2019 survey with the OCH Board of Directors in March 2020. Additionally, materials from his presentation were included in OCH’s weekly newsletter as well as on the OCH website.

OCH also reviewed individual responses and aggregate data of Paying for Value surveys and implementation partner qualitative reports. OCH uses available data to understand where regional challenges may exist. OCH is also responsive to partner needs and requests as they arise, and frequently advocates to HCA with both partner and regional needs. However, as OCH is not privy to the VBP contracting process between partners and MCOs the role of technical support falls to the MCOs. Anecdotally, smaller providers report that MCOs will not engage in VBP contracting with them. Additionally, many providers reported that they worked with MCOs to adjust contract terms based on COVID-19.
Section 4. Pay-for-Reporting (P4R) metrics

Documentation

22. 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.SAR6 P4R metrics.2.01.21

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

100% VBP
100% P4R
25% P4P

Additional Earned MTP Funds (Bonus Pool)
Funds earned above the projected P4P percentages. TBD

Clallam NCC
$4,029,340

Jefferson NCC
$2,326,700

Kitsap NCC
$7,831,700

Hospitals
$1,600,000

CBOSS
$1,425,710

PH
BH
$2,766,400
$1,262,830

$1,597,500
$729,240

$5,377,000
$2,454,320

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

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

Semi-annual reporting guidance
Reporting period: July 1, 2020 – December 31, 2020
Appendix 2: 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%

**Pay for Participation - 15% absolute** - elements apply to all change plan types. Pay for participation aims to incent partners for participation elements.

<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. Incentives for reporting on optional metrics is included in 2020 operations budget, not this payment model.</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><strong>Scope element</strong> (with absolute percent of payment)</th>
<th><strong>Description</strong></th>
<th><strong>Frequency</strong></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 statuses 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 3: Peer-to-Peer Learning Plan

Purpose: Olympic Community of Health provides opportunities and platforms for partners and communities to share resources, best practices, success stories with one another. This learning plan guides OCH’s intentional efforts to foster and empower meaningful partnerships among organizations, Tribes, and communities to promote healthy people, thriving communities.

Relevant North Star Strategies:

- **Well-being:** promote best practices that fit the needs of the community
- **Empowerment:** provide opportunities for growth and learning. Share and build community successes and lessons learned
- **Connection:** Exchange information across sectors, tribes, and communities. Foster connections between community-based organizations and clinical providers.
- **Place:** Optimize access to resources

Taking stock of current approaches/platforms:

<table>
<thead>
<tr>
<th>Platform</th>
<th>Type of resource</th>
<th>Plan to increase peer-peer learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Newsletter</td>
<td>Webinars, Upcoming events, Job openings, Digital resources, Funding opportunities, Success stories</td>
<td>Include weekly highlights featuring brief snippets of partner projects.</td>
</tr>
<tr>
<td></td>
<td>Lead: Amy</td>
<td></td>
</tr>
<tr>
<td>Website</td>
<td>Digital resources, Blog - Success stories</td>
<td>Organize partner resource page by focus areas.</td>
</tr>
<tr>
<td></td>
<td>Lead: Amy</td>
<td></td>
</tr>
<tr>
<td>Convenings</td>
<td>Success stories, Best practices</td>
<td>Prompt people to connect and exchange contact info/networking, encouraging organic peer-peer learning.</td>
</tr>
<tr>
<td></td>
<td>Lead: Miranda</td>
<td></td>
</tr>
</tbody>
</table>

Semi-annual reporting guidance
Reporting period: July 1, 2020 – December 31, 2020
Add “permission to share contact info” in event evaluation forms.

Add “I have resources I would like to share with the group regarding this topic” to event evaluation forms.

<table>
<thead>
<tr>
<th><strong>Site-Visits</strong></th>
<th>Success stories</th>
<th>Problem-solving</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead:</strong> Miranda</td>
<td>Ask partners to prepare/share resources that may be helpful to other partners.</td>
<td>Ask partners to identify resources that may be helpful to have.</td>
</tr>
<tr>
<td></td>
<td>At the end of each round of site-visits OCH will provide a summary of resources to share out with all partners and OCH network.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3CCORP-Treatment Workgroup</strong></th>
<th>Success stories</th>
<th>Best practices</th>
<th>Problem-solving</th>
<th>Crowdsourcing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead:</strong> Mel</td>
<td>Invite guest speakers/presenters to share their experience or a project they are working on. Frame this around bringing a challenge to the group or a success in navigating a challenge.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Collaboration Calls</strong></th>
<th>Success stories</th>
<th>Best practices</th>
<th>Problem-solving</th>
<th>Crowdsourcing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead:</strong> Miranda</td>
<td>Ask participants to prepare/share 1 resource that may be helpful to other partners. Include this in the evaluation, or if there’s time in the convening, open it up for discussion and sharing.</td>
<td>At the end of each call, OCH will compile a report of resources to share out with all partners and OCH network.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Areas for more collaboration and peer sharing:**

**Topics:**
- Family planning
- Chronic disease
- SDOH
- ED utilization
- Community/workforce resilience
- COVID recovery
- Telehealth
- Housing
- Vaccinations
• Broadband
• Childcare
• Transportation
• Healthy, affordable food access
• Workforce support
• Equity
• Resilience
# Olympic

**July 1, 2020 - December 31, 2020**

## Cumulative snapshot

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds Earned</td>
<td>$22,104,395.59</td>
</tr>
<tr>
<td>Funds Distributed</td>
<td>$18,770,113.47</td>
</tr>
<tr>
<td>Funds available</td>
<td>$3,334,282.12</td>
</tr>
</tbody>
</table>

## Table 1: Incentives earned

<table>
<thead>
<tr>
<th>Project</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$</td>
<td>-</td>
<td>$478,875.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$478,875.00</td>
</tr>
<tr>
<td>Project 2D</td>
<td>$</td>
<td>-</td>
<td>$194,543.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$194,543.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$</td>
<td>-</td>
<td>$59,859.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$59,859.00</td>
</tr>
<tr>
<td>Project 3B</td>
<td>$</td>
<td>-</td>
<td>$74,824.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$74,824.00</td>
</tr>
<tr>
<td>Project 3C</td>
<td>$</td>
<td>-</td>
<td>$44,894.00</td>
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<tr>
<td></td>
<td></td>
<td>$</td>
<td>$44,894.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$</td>
<td>-</td>
<td>$119,719.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$119,719.00</td>
</tr>
<tr>
<td>VBP</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>-</td>
<td>$972,714.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$972,714.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>-</td>
</tr>
</tbody>
</table>

## Table 3: Incentive funds distributed, by use category

<table>
<thead>
<tr>
<th>Use Category</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adminstration</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Project management</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provider engagement, participation, and</td>
<td>$1,238,166.45</td>
<td>$883,873.68</td>
<td>$2,122,040.13</td>
</tr>
<tr>
<td>implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$1,238,166.45</td>
<td>$883,873.68</td>
<td>$2,122,040.13</td>
</tr>
</tbody>
</table>

**Note:** Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 22, 2021 to accompany the sixth Semi-Annual Report submission for the reporting period July 1 to December 31, 2020.