Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 7.0
Reporting Period:
January 1, 2021 – June 30, 2021
DY5 Q1-Q2

Template Release Date: March 15, 2021
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Purpose and objectives of ACH semi-annual reporting

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

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

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

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

Achievement values

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

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

**Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period January 1 – June 30, 2021**

<table>
<thead>
<tr>
<th>Number of Projects in ACH Portfolio</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>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>Report on quality improvement plan (Replaced by COVID-19 Response)</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>18</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>34</td>
<td>26</td>
<td>18</td>
</tr>
</tbody>
</table>
### Reporting requirements

The semi-annual report for this period (January 1 – June 30, 2021) includes three sections as outlined in the table below.

<table>
<thead>
<tr>
<th>Semi-annual reporting requirements (January 1 – June 30, 2021)</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></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><strong>Section 4. Pay-for-Reporting (P4R) metrics</strong></td>
<td>22</td>
<td>Documentation</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.SAR7 Report.08.02.21
- **Implementation work plan:** ACH Name.SAR7 Implementation work plan.08.02.2021
- **Partnering provider roster:** ACH Name.SAR7 provider roster. 08.02.2021
- **P4R metrics:** ACH Name.SAR6 P4R metrics. 08.02.2021

**Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA’s [Medicaid Transformation resources webpage](https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents).**

**Semi-annual report submission instructions**

ACHs must submit their completed semi-annual reports to the IA no later than August 2, 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 7.”

The folder path in the ACH’s directory is:

*Semi-Annual Reports → Semi-Annual Report 7.*

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**

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2021 – June 30, 2021.
### ACH semi-annual report 7 – submission and assessment timeline

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Responsible party</th>
<th>Anticipated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Distribute semi-annual report instructions for reporting period July 1 – December 31, 2020 to ACHs</td>
<td>IA</td>
<td>March 2021</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>August 2, 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>August 25</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>August 26 – September 9, 2021</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>August 27 – September 24, 2021</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>October 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 (OCH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary contact name</strong></td>
<td>Celeste Schoenthaler</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>360.633.9241</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:celeste@olympicch.org">celeste@olympicch.org</a></td>
</tr>
<tr>
<td><strong>Secondary contact name</strong></td>
<td>Miranda Burger</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>360.633.9579</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:miranda@olympicch.org">miranda@olympicch.org</a></td>
</tr>
</tbody>
</table>
**Section 1. ACH organizational updates**

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

### Attestations

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

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
<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>X</td>
<td></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>X</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>X</td>
<td></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>

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[2](https://wahca.box.com/s/nfesjaldc5m1ye6aobhioou5xemeoh26) https://wahca.box.com/s/nfesjaldc5m1ye6aobhioou5xemeoh26

Semi-annual reporting guidance

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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.

   **No 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.

**Organizational charts as of June 30, 2021:**

**Olympic Community of Health Organizational Structure as of June 30, 2021**
• Provide a narrative explanation of the organizational changes.

In late May, the contracted Epidemiologist from our data contractor organization, Kitsap Public Health District (KPHD), departed his role. KPHD is in-process of hiring and an interim data and analytics staffing plan is in place. In late June, Mel Melmed, program coordinator, offered her resignation. OCH is in-process of determining next steps.


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

See **appendix 1.**

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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](https://hca.wa.gov/assets/program/payment-reconciliation-template-covid.xlsx).
For payments not related to COVID-19 made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.4

See appendix 2.

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

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

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

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

iii. Description of use should be specific but concise.

<table>
<thead>
<tr>
<th>Description of Use</th>
<th>Expenditures ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project incentives to implementation partners to support clinical and financial integration</td>
<td>$636,525</td>
</tr>
<tr>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

**Background:** 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 does not distribute additional funds to support IMC.

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 3 for a visual depiction of how funds were allocated in 2018, 2019, 2020, and 2021.

Physical health and behavioral health change plans are organized around 4 domains which encompass the 6 Medicaid Transformation Project (MTP) 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) provider change plans and hospital change plans do not include the care integration domain. CBOSS and hospital partners do

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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.
engage in activities that support both financial and clinical integration, and their change plans encourage opportunities to strengthen collaborative partnerships.

**Methodology for previous SARs:** In 2018, 2019, and 2020, change plans for all partners included both required and voluntary activities and the 2018, 2019, and 2020 payment models included incentives based on the number of voluntary activities selected by a given partner by each change plan domain. So, OCH was previously able to estimate the dollar amount of incentives allocated to physical and behavioral health partners for voluntary care integration activities. *Note, as OCH took a portfolio approach, estimates for the allocation of required care integration activities was 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**.

**Methodology for SAR 7:** 2021 partner change plans include a more narrowed set of activities, in response to limited partner capacity due to COVID-19 challenges and the OCH Board of Directors desire to focus transformation efforts. The OCH Funds Flow Committee took stock of all change plan activities, regional strengths (including transformation work already accomplished), and regional gaps and recommended a more focused scope of work for 2021 to enable partners flexibility to continue COVID-19 response activities while finishing MTP activities strong. The revised 2021 change plan was approved by the OCH Board of Directors and launched with contracted partners in early 2021. In 2021, all change plans only include required activities under all domains, including care integration. Table 1 summarizes the changes to partner change plans.

**Table 1: Summary of 2021 partner change plan changes by type**

<table>
<thead>
<tr>
<th>Change plan type</th>
<th>2018-2020 Change plan</th>
<th>2021 Change plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>4 Domains</td>
<td>8 Focus areas</td>
</tr>
<tr>
<td></td>
<td>14 Focus areas</td>
<td>11 Outcomes</td>
</tr>
<tr>
<td></td>
<td>40 Outcomes</td>
<td></td>
</tr>
<tr>
<td>Behavioral health</td>
<td>4 Domains</td>
<td>6 Focus areas</td>
</tr>
<tr>
<td></td>
<td>13 Focus areas</td>
<td>7 Outcomes</td>
</tr>
<tr>
<td></td>
<td>31 Outcomes</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>3 Domains</td>
<td>4 Focus areas</td>
</tr>
<tr>
<td></td>
<td>10 Focus areas</td>
<td>6 Outcomes</td>
</tr>
<tr>
<td></td>
<td>25 Outcomes</td>
<td></td>
</tr>
</tbody>
</table>
Community-based organizations and social services (CBOSS)

| 2 Domains | 2 Domains |
| 4 Focus areas | 4 Focus areas |
| 10 Outcomes | 4 Outcomes |

The voluntary activities element was not included in the 2021 payment model, they are not included in 2021 partner change plans (see appendix 4). So, OCH is no longer able to estimate the dollar amount of incentives allocated to physical and behavioral health partners for voluntary care integration activities as reported in previous SARs.

- **Actual expenditures:**
  - In 2021, voluntary care integration activities were not included in the payment model and therefore account for 0% of allocated physical health and behavioral health partner incentive payments, totaling $0.

- **Projected expenditures:**
  - Partner change plan activities are planned to end in December 2021. Decisions have not yet been made regarding 2022 and 2023 scopes of work and payment models. OCH is not able to calculate estimates for 2022 and 2023 at this time.

While the 2021 payment model does not include voluntary activities, partners are continuing to focus on integration-related activities under the community-clinical linkage, addressing behavioral health needs, and enhanced transformation elements of the 2021 payment model.

**Examples of relevant ongoing activities include:**

- Jamestown Family Health Clinic’s community-clinical linkage project is to establish a social navigator program in partnership with the Sequim Police Department and local community-based organizations to help individuals access comprehensive care that meets their physical, behavioral, dental, and social needs.

- The Port Gamble S’Klallam Tribe’s enhanced transformation project is to partner with local organizations to add on-site alternative therapies such as chiropractic, acupuncture, massage, and physical therapy. Providing these therapies as a part of a comprehensive care model will add additional treatment options for patients with behavioral health conditions.

- Discovery Behavioral Health, a mental health agency, and Beacon of Hope, a substance use disorder (SUD) treatment provider, collaborative enhanced transformation projects incorporate enhanced screening and referral processes to ensure clients receive preventative and comprehensive physical and dental services.

**Use of Incentives:** 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. **Examples of incentive uses include:**

- Purchased or upgraded electronic health record (EHR) systems

- Hire additional staff to support enhanced care coordination and other non-reimbursable
services

- Hire additional staff to meet increased administrative demands of IMC (billing, etc.)
- 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.SAR7 Implementation work plan_stage1_.08.02.2021
OCH.SAR7 Implementation work plan_stage2_.08.02.2021
OCH.SAR7 Implementation work plan_stage3_.08.02.2021

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 Primary Care and Behavioral Health (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 Jul-Dec 2020 progress to date reports as “scaling and sustaining” increased from 18% to 20% across all partners. Data is not yet available from Jan-Jun 2021 partner reports and will be reported in SAR 8. Most partners indicate that 2021 will be the year they focus on scaling and sustaining MTP activities with expected continuation of these efforts if a sixth year of MTP is approved. OCH anticipates this work step will be complete in the SAR 8 and SAR 9 reporting periods.

- Coordinate with a mobile dental clinic (Tactic in PHBH and CBOSS Change Plans) (fulfilled for quarter, remains in progress) - Peninsula Community Health Services (PCHS) obtained a mobile dental clinic in October of 2020 and launched
service in Kitsap County in April of 2021. Once Kitsap County services are well established, PCHS will offer to bring the mobile unit to Clallam and Jefferson counties, likely in 2022.

- **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 continued to make 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 the SAR 8 and SAR 9 reporting periods.

- **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)** - To summarize the Olympic region’s history on this subject:
  
  o Prior to 2019, OCH invested in the Digital Health IT Commons platform (aka Commons). The Commons platform was used set up and tested with a few partners in Clallam County (FQHC and an SUD provider). Partners sought clarification about patient consent, data privacy and security, and about alignment with 42 CFR Part 2. Commons then clarified with OCH that a local partner would need to “own” the platform and associated data and that partner should be a HIPAA covered entity (HCE). Regional partners decided to step away from the Commons platform to review other potential models.

  o In 2020, OCH considered the Unite Us platform. Staff and Board members met with Unite Us several times to better understand the cost and functions of the platform. An ad-hoc workgroup was formed. Unite Us was unable to provide sufficient information to OCH and partners about what the platform is, and questions about data privacy and security including alignment with HIPAA and 42 CFR Part 2. At this time, Unite Us is working to establish in Kitsap County, however no medical or behavioral health providers have signed on.

  o Subsequently, a few Clallam County partners have formed Clallam Care Connection, a multi-disciplinary, multi-agency group working to case manage and care coordinate for high-risk, high emergency department (ED) utilizers in the Port Angeles area. OCH provides limited staff support for this group as they are working to set up systems, processes, etc. Other communities in the region have asked to have access to these tools so they can establish similar groups.

  o The Health Care Authority (HCA) submitted a decision package prior to the current legislative session regarding a statewide Community Information Exchange (CIE). While this particular decision package was not passed, HCA indicates they continue to pursue.

  o Recently, staff learned of a different platform, VisionLink. The above-mentioned workgroup was invited to a demo of VisionLink in April. Participating partners generally received this well, although questions persist.
o Staff also learned that Epic, the EHR platform used by many Clallam and Jefferson county partners (but not all) will soon have a new option available for sharing information and making referrals. North Olympic Healthcare Network and Jamestown Family Health Clinic are both piloting Compass Rose, a software module under Epic that works as a care manager and allows for closed loop referrals to community-based organizations.

In April, the OCH Executive directed staff to implement a regional needs assessment to take stock of the functions, purpose, and commitment to a closed-loop, bi-directional, digital communications platform. This needs assessment is scheduled to be complete in the second half of 2021 and next steps will be determined by the OCH Board of Directors.

- **Scale Olympic Digital Health IT Commons or similar technology platform to new partners and use cases (not started)** – Same response as above.

- **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 the SAR 7 reporting period. The workgroup identified and disseminated regional and national standards of practice related to crisis stabilization, withdrawal management, and recovery housing.

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.

**Instructions:**

a) For each partnering provider site identified as participating in transformation activities, the ACH should use the template provided by the IA to indicate:

i. Whether the partnering provider site is pursing 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](#).

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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).
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.⁶

**Modifications to the ACH’s quality improvement strategy:**

- Due to partner and contractor capacity, OCH did not convene the Performance, Measurement, and Evaluation Committee (PMEC) during this reporting period. However, data updates were provided at OCH Board of Directors meeting in March of 2021.
- OCH collected data on the revised set of intermediary metrics in June 2021. Data from the June reporting are not yet available for this report; they will be shared with partners and the OCH Board of Directors in the fall of 2021 and included in SAR 8.

**Summary of findings:**

- Progress-to-date on MTP activities in OCH implementation partner change plans is assessed twice per year at the following stages:
  - not started
  - planning
  - testing
  - limited implementation
  - fully implemented
  - scaling and sustaining
- Median scores across all implementation partners are assessed. Partner progress-to-date was collected in December 2020, and again in June 2021. Median scores from the June reporting are not yet available for this report; they will be shared with partners and the OCH Board of Directors in the fall of 2021 and included in SAR8. Table 3 details the progress of activities as of December 2020 partner reporting:

  **Table 2: Implementation Partner Progress-to-Date Change Status Median by Focus Area, Jan-Jun 2020**

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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
Comparing the December 2020 (table 3) to June 2020 change status summary (table 2 which was also included in SAR6), the percent of outcomes across all implementation partners reported as “not started” decreased from 3% to 2%. The percent of outcomes reported as “scaling and sustaining” increased from 18% to 20%. Sustainability-related outcomes median status moved from “testing” to “limited implementation.” This is continued notable progress in the desired direction.
• **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, which is to be expected as IMC and COVID-19 necessarily demanded much provider attention. Behavioral health implementation partners self-reported MeHAF scores have improved across all dimensions. OCH published a behavioral health report as a step towards better understanding the health of the Olympic region. Peninsula Behavioral Health hired a physical health provider serving approximately 97 clients with severe mental illness. Kitsap Children’s Clinic now contracts with Catholic Community Services to offer behavioral health services both in-person and via telehealth.
  
  - **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 and promoted attendance to webinars hosted by Healthier Here in early 2021. West End Outreach Services implemented Collective Medical tools during the reporting period to better track and serve high utilizers of the emergency department. OCH staff continued to support Clallam Care Connection, a community-based care coordination effort piloted by North Olympic Healthcare Network and the Port Angeles Fire Department Community Paramedicine program and participation expanded to include ReDISCOVERY and Peninsula Behavioral Health. OCH hosted a collaboration call to share best practices from this group in June 2021.
  
  - **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. OCH relaunched the “Save a Life” campaign in response to continued elevated rates of opioid overdoses in the region. The Jamestown Tribe began construction on the Jamestown Health Clinic, a MAT facility, and received a grant to pre-staff in order to establish effective policies and procedures.
  
  - **Project 3B:** Median scores on progress-to-date reports indicated “fully implemented” in reproductive maternal child health activities. Kitsap Public Health District has innovated new ways to connect with families participating in Nurse Family Partnership as visits moved to virtual, delivering welcome and graduation boxes following COVID-19 safety guidelines to all participants. Nurse Family Partnership as well as First Step Family Support Center developed partnerships with local organizations to get needed baby items (diapers, wipes, clothes, car seats, etc.) to families in need.
  
  - **Project 3C:** Median scores on progress-to-date reports indicated “limited implementation” in integrating oral health activities. Peninsula Community Health Services (PCHS) incorporated behavioral health screening at every
dental visit with warm handoffs to its behavioral health program. December 2020, their dental services referred 6 patients who screened positive for depression. PCHS also launched their mobile dental clinic in October 2020 with plans to expand this service to Clallam and Jefferson counties in 2022. Jefferson Healthcare hired a second dentist and are participating in a research project with the University of Washington on food insecurity and dental.

- **Project 3D:** Median scores on progress-to-date reports indicated “limited implementation” in chronic disease prevention activities. Port Gamble S’Klallam Tribe used OCH funds to update their EHR which will allow for enhanced chronic disease management in both primary care and behavioral health settings. The Olympic Area Agency on Aging is a Health Homes Lead organization and is recruiting care coordination organizations across the region to deliver services to eligible clients. Olympic Peninsula Healthy Community Coalition partnered with North Olympic Healthcare Network to offer community resource training for new physicians.

- **Adjustments and lessons learned:**
  - Due to COVID-19 safety guidelines and partner time constraints, OCH continued to limit in-person meetings. Partners also expressed extreme virtual meeting fatigue and OCH limited virtual convenings and connections to those that were most necessary for ongoing operations and beneficial for the Olympic region.

- **Support provided to partnering providers to adjust transformation approaches:**
  - OCH staff participated in the IMC Leadership Forum 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 launch a series of substance use stigma focus groups and surveys to better understand community perceptions and gain ideas to address the stigma of substance addiction.
  - 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 per county (Clallam, Jefferson, and Kitsap), one regional (cross-sector) call to discuss COVID-19 vaccination efforts, and one regional (cross-sector) call to promote community-based care coordination learning opportunities.
  - OCH published a behavioral health report as a step towards better understanding the health of the Olympic region. Three presentations on the Behavioral Health Report findings were given to: the OCH Board of Directors, Salish Behavioral Health Administrative Services Organization (BH-ASO) Executive Committee, and the Clallam County Board of Commissioners. A brief synopsis of the report was presented to the Jefferson County Behavioral Health Consortium, the Clallam County Behavioral Health Advisory Board, and the
Kitsap County Mental Health, Chemical Dependency and Therapeutic Court Citizens Advisory Committee. The report was also featured in an article published by Peninsula Daily News.

- OCH contracted with Kitsap Strong to offer a four-part Trauma Informed Care and Hope Science training for partners throughout the region. The training was recorded and is available for on-demand viewing on the OCH website.
- OCH contracted with Kitsap Strong to offer a Trauma Informed Care train-the-trainer opportunity for 18 individuals in the Olympic region.
- OCH spent $2,627 to send 14 partners to 2 external training opportunities: Motivational Interviewing and Nuka Winter Conference.
- OCH conducted site visits with all implementation partners in June and July 2021 to discuss partner challenges and share best practices alongside possible solutions. Site visits were conducted both in-person and virtually in alignment with partner choice. All partners were provided with a summary of their individual progress based on December 2020 progress to date reports. OCH staff discussed change plan activities that were lagging and offered tailored resources, training, and technical assistance.

- **Identified best practices on transformation approaches:**
  - Jamestown Family Health Clinic piloted the Epic Community Connect integrated telemedicine utilizing Zoom with the online patient portal (MyChart) to allow a more efficient telemedicine experience for the patient. They are now a pilot site for Epic's Compass Rose module.
  - North Olympic Healthcare Network was awarded an integrated behavioral health grant to fully implement the AIMS model.
  - Peninsula Behavioral Health hired a full-time provider to offer on-site integrated primary care services for their most vulnerable clients who would otherwise not access services.
  - Peninsula Community Health Services hired an additional 3 Psychiatric ARNPs, including a Pediatric Psychiatric ARNP and can now provide services to younger children. They also hold chairs in their nearby dental clinic for patients who arrive at neighboring emergency department with dental concerns.
  - Olympic Community Action Programs transformed unused conference room space to a study library for students without internet access as well as hired tutors.
  - The YMCA of Pierce and Kitsap Counties was successful in embedding a referral to Epic EHR utilized by Harrison Health Partners, Northwest Family Medicine Residency, and St. Michael Medical Center. This will allow providers to send electronic referrals directly from the patient chart to the YMCA.

**Narrative responses**

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

**15. COVID-19**

Semi-annual reporting guidance

Reporting period: January 1, 2021 – June 30, 2021
a) Provide an update on COVID-19 activities. If applicable, please describe any support of vaccine efforts, or other ACH COVID-19 activities that emerged or evolved during the reporting period (e.g., PPE, project management, communication and engagement, coordination of funding).

- **Local Health Jurisdictions communication meetings:** OCH staff regularly meet with communications leads from Kitsap Public Health District and Jefferson County Public Health to discuss COVID-19 communication efforts. The group exchanges resources and collaborates biweekly to strengthen and align COVID-19 messaging. This collaborative meeting has lead to creative problem-solving and sharing of best practices regarding vaccine hesitancy. For example, the group shared recent successful outreach with Washington State ferry systems, Department of Health, and connecting with faith-based groups. By sharing messaging, creative approaches, and current challenges, best practices are able to expand beyond a singular community.

- **Making it Happen: Tackling vaccine hesitancy and barriers to access**
  On April 16, OCH brought together partners via Zoom for an action-oriented conversation around COVID-19 vaccine hesitancy and barriers to access. This collaboration call provided space to connect with organizations and Tribes, discuss current challenges, and identify tangible next steps to better reach community members. When it comes to vaccine hesitancy, there is a place for everyone in this effort, all-hands-on-deck. In response, First Step Family Support Center partnered with Clallam County Health and Human Services to host pop-up COVID-19 clinics and integrated vaccine hesitancy conversations into their client interactions. Access call summary and key takeaways here.

- **COVID-19 vaccine resources:** OCH created resources that encourage community members to get a COVID-19 vaccine when eligible. Imagery and messaging were developed alongside partners and shared with the other ACHs. Resources were boosted on social media and reached 8,708 community members with an average engagement rate of 3.5% (industry average 3.2%). Access social media graphics and resources here.

- **Behavioral health resources for COVID-19 vaccination sites:** OCH has compiled a resource packet of creative strategies, example materials, and suggested implementation steps to address behavioral health needs at the same time of COVID-19 vaccination. Ultimately, these strategies provide a way to equip community members with behavioral health resources, information, services, and tools through convenient, low barrier approaches linked with COVID-19 vaccination sites. This tool was created to spark creativity and inspire partners to further address behavioral health needs in the Olympic region. The resource was adopted by St. Michael Medical Center and Kitsap Public Health District and was shared out to over 700 individuals in an OCH newsletter.

- **OCH 2021 COVID-19 relief funds:** In February 2021, OCH announced a funding opportunity open to implementation partners, Tribes, and Local Health Jurisdictions in the three-county region. A total of 13 applications came in totaling over $740k in requests. Project proposals ranged from supporting mass vaccination sites, mobile
response vaccinations, home vaccinations, outreach to populations hesitant to receive vaccines, projects to reduce homelessness and other social needs, communications and marketing efforts, and more. The OCH Executive Committee approved funding for seven of the project proposals received for a total of $399k, aligning with the planned budget for this work.

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Partner Type</th>
<th>Funding Approved</th>
<th>Project Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clallam County Health &amp; Human Services</td>
<td>Public Health</td>
<td>$55,000</td>
<td>Mass vaccinations + mobile response vaccinations + home vaccinations + collaboration with ReDiscovery &amp; community paramedics</td>
</tr>
<tr>
<td>Discovery Behavioral Healthcare</td>
<td>Behavioral Health</td>
<td>$15,000</td>
<td>Smartphones + tablets + prepaid phone cards + bus passes + taxi + gift cards to support clients</td>
</tr>
<tr>
<td>First Step Family Support Center</td>
<td>CBOSS</td>
<td>$75,000</td>
<td>Outreach coordinator + vulnerable population outreach to encourage vaccines + parent support group to address COVID challenges</td>
</tr>
<tr>
<td>Kitsap Mental Health Services</td>
<td>Behavioral Health</td>
<td>$35,000</td>
<td>Onsite &amp; offsite vaccines for clients + emergency kits + food + transportation + phones</td>
</tr>
<tr>
<td>Kitsap Public Health District</td>
<td>Public Health</td>
<td>$75,000</td>
<td>Outreach to hesitant groups + communications + co-creating with community organizations</td>
</tr>
<tr>
<td>Makah Tribe</td>
<td>Tribe</td>
<td>$69,000</td>
<td>Expansion of tiny home village on the Makah Reservation</td>
</tr>
<tr>
<td>Peninsula Community Health Services</td>
<td>FQHC</td>
<td>$75,000</td>
<td>Mass vaccination events + vaccines at high-risk congregate living centers</td>
</tr>
</tbody>
</table>

- **COVID-19 vaccine equity collaborative:** OCH staff attend Kitsap Public Health District’s biweekly equity collaborative. The group elevates community voices and collaborates on health disparities and equitable approaches to vaccine distribution and communication. The biweekly meetings have directly strengthened Kitsap Counties vaccine distribution approach, ultimately leading to easier, more streamlined, and accessible processes (example: pop-up vaccine clinics at community hubs with no appointments necessary and bi-lingual support).

- **PPE distribution:** OCH staff distributed all remaining PPE including 21,700 non-medical masks and 70 boxes of gloves to partners across the Olympic region during the SAR 7 reporting period.

- **Behavioral health report:** OCH released the Olympic Region Behavioral Health Report which includes a section on the impact of COVID-19 on mental health needs in the Olympic region. The Behavioral Health Report and the suggested mitigation strategies were presented to local government, OCH’s Board of Directors, and to numerous other community leaders from across the region.

- **Resilience campaign:** OCH’s “Plant Hope, Grow Resilience” campaign was created to encourage individual, professional, and community resilience during COVID-19. As a part of the campaign, OCH hosted a poster contest to encourage hope and resilience during COVID-19. 22 students submitted poster designs inspired by the theme “Plant Hope, Grow Resilience”. Posters were then made available for OCH partners to distribute within their communities to inspire hope and resilience.
b) During this reporting period, has your ACH made any notable changes or decisions related to your DSRIP activities? For example, are there updates regarding your region’s balancing of COVID-19 response and activities that were already in motion?

2021 partner change plans include a more focused set of activities, as summarized above in the question about IMC and in response to limited partner capacity due to COVID-19 challenges. The OCH Funds Flow Committee took stock of all change plan activities, regional strengths/successes, and regional gaps and recommended a more focused scope of work for 2021 to enable partners flexibility to continue COVID-19 response activities while finishing MTP activities strong. The revised 2021 change plan was approved by the OCH Board of Directors and launched with partners in early 2021. OCH’s path with COVID-19 has stayed stable and partners continue to balance MTP activities with COVID-19 response and other work.

c) Describe any updates, new approaches, or new partnerships related to how your ACH has included Tribes/IHCPs in your COVID-19 response activities.

Stigma Focus Groups
During the reporting period, OCH hosted several focus groups to learn about the presence, prevalence, and perception of stigma of substance addiction in the Olympic region. This project is supported by donated funds from Cambia Health Solutions. COVID-19 has exacerbated behavioral health needs including substance use disorder, further emphasizing the importance of addressing stigma. Stigma exists differently in various communities and OCH feels it is essential to hear directly from Tribes across the Olympic region in order to inform meaningful next steps. Public focus groups were attended by Port Gamble S’Klallam Tribe and HCA Tribal Liaison. OCH also hosted a focus group specifically for Tribal leadership, Tribal staff, and Tribal community members to hear their thoughts and ideas to address this important topic.

Behavioral Health Report
The Behavioral Health Report published by OCH includes a section dedicated to Tribal partners and Indian health care providers. This section provides context of Tribal presence across the Olympic region and geographic barriers to care that some Tribal members experience. For example, it takes over an hour to travel from the Makah reservation to the nearest hospital in the region.
Forks and nearly two hours to reach Port Angeles for specialty referrals and Level III trauma care. This section of the report supports the COVID-19 response of the Olympic region, as it provides background, insights, and recommended strategies catered to the unique communities across the region including local Tribal Nations.

**“Plant Hope, Grow Resilience” Campaign** - OCH prioritized Tribal representation when creating imagery for the “Plant Hope, Grow Resilience” campaign, created in response to behavioral health needs during COVID-19. OCH commissioned a poster for the campaign. The poster includes a woman inspired by the Suquamish Tribe. During the creation process, OCH staff attended the Suquamish Tribe’s Cultural Committee in order to ensure representation that was respectful and meaningful. The final poster was paired with OCH’s 2020 Annual Report and mailed to OCH partners and community members across the region to encourage hope and resilience throughout the COVID-19 pandemic.

**d) Specific to partnering providers, describe any updates, new approaches regarding provider contracts, reporting, type of providers engaged, support provided, and/or payment strategies.**

No updates or new approaches to report.

**e) Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access), including any notable impacts to specific providers or communities. Also highlight any mitigation strategies or activities that shifted as a result, if applicable.**

Difficulty recruiting and retaining staff was reported by health care providers, especially among behavioral health and SUD providers. OCH released a Behavioral Health Report which highlighted this risk and provided strategies to mitigate the impact. The Behavioral Health Report and the suggested mitigation strategies were presented to local government, OCH’s Board of Directors, and numerous other community leaders from across the region.

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

A “bright spot” that emerged was an opportunity to learn, collaborate, and take action regarding health equity as COVID-19 vaccine distribution quickly became a top priority for many OCH partners. In April, OCH brought together partners from across the Olympic region to join an action-oriented conversation around COVID-19 vaccine hesitancy and barriers to access. This collaboration call provided space to connect with organizations and Tribes, discuss current challenges, and identify tangible next steps to better reach community members. When it comes to vaccine hesitancy, there is a place for everyone in this effort, all-hands-on deck. To move the conversation further towards action, participants were prompted to collectively fill out a worksheet mapping out specific barriers to vaccination while brainstorming possible outreach approaches. Once strategies were paired with each hesitant group, participants reflected on their
own strengths, what they bring to the table, and created commitments to address vaccine hesitancy and barriers to access in their communities.

Since the April vaccine convening, OCH partners have made strides in implementing equitable distribution strategies and outreach methods. Below are just a few of the many creative COVID-19 vaccine projects happening in the three-county region:

- First Step Family Support Center partnered with the county health department and other community organizations to support equitable vaccine access, address vaccine hesitancy and provide creative solutions to encourage vaccine acceptance. Program Manager Elisia Anderson shared, “Our first vaccine pop-up event [...] was the most successful pop-up event to date in Clallam County by double, according to the health department. In addition to the funds awarded to us by OCH, we have been able to secure funds from All In Washington to support vaccine equity work. We are connecting with various community partners to support vaccination efforts, pop up events, incentives, education and outreach.” Read OCH’s blog to learn more.

- Peninsula Community Health Services teamed up with the Washington State Department of Transportation to provide vaccines on the Bremerton-Seattle ferry system.

- Kitsap Public Health District (KPHD) set up pop-up clinics with no appointments needed at farmers markets, breweries, food banks, libraries, and local events such as the Bremerton Juneteenth Freedom Festival. KPHD also started a biweekly equity collaborative to elevate community voices on the topic of vaccine access.

- Jamestown S’Klallam Tribe has vaccinated over 18,000 people by generously partnering with Clallam County healthcare providers, social services, and community-based organizations. Jamestown has truly led by example in listening to community needs and meeting people where they are at.

16. Scale and sustain update

a) In SAR 6.0, ACHs reported on activities and/or conversations regarding the sustainability of DSRIP funded infrastructure, activities, and/or evidence-based models. Please describe relevant updates from the reporting period. These could include (but are not limited to) board decision regarding priority ACH investments and projects, strategic planning results, community/partner engagement, sustainability planning TA or coordination, etc.

In SAR 6, OCH provided an update on the initial conversations and decision-making principles of OCH governance regarding the future state of OCH. Since then, OCH staff have engaged partners in a multitude of ways to better understand what focus areas and strategies would be most impactful as we embark on our future state.
Partner feedback was compiled and presented to the Board of Directors who then voted to prioritize the following focus areas:

- **Long-term, affordable, quality housing** - Implement local solutions to provide safer and more accessible housing options for current residents of the Olympic region. OCH serves in a lead role to bring communities together to hear barriers and challenges and advocate for innovative and equitable solutions.

- **Reduced substance misuse & addiction** - Emphasis placed on primary prevention and coordinating region-wide standards of care, ultimately reducing unhealthy use of all substances. Focus on reducing stigma and ensuring broad access to appropriate and preferred treatment options. OCH serves in a lead role, expanding on initial successes with the 3CCORP model to include additional substances such as alcohol.

- **Access to the full spectrum of care** - Health systems are accessible, patient-centered, and effectively integrate physical, behavioral, dental, specialty, and social services. OCH leads integration and coordination efforts by bringing partners together to explore areas of continued need and identify and implement creative solutions. OCH also offers learning opportunities to expand workforce awareness and skills to better care for the unique needs of each community (NEAR sciences, trauma informed care, etc.).

- **Individual needs are met timely, easily, & compassionately** - No wrong door. Community members receive the right care at the right time and place. Care is coordinated across sectors and tribes and is clearly communicated with community members to best meet individual health goals in a safe, accessible, and culturally sensitive way. OCH serves in a lead role to coordinate with emergency departments and other partners to implement tailored solutions and offer opportunities for expanded education on best practices and equitable approaches.
Specific future state activities that align with the above focus areas will be informed by successes and lessons learned that arose during the MTP waiver.

In preparation for many upcoming changes and transitions, OCH staff collectively read and discussed the book “Switch: How to change things when change is hard” by Chip and Dan Heath. The book provided many tangible change management tools and approaches for successfully harnessing partner energy and creatively getting from point A to point B. Strategies presented by the book have already proved beneficial in facilitating conversations and actions relating to the future state of OCH.

b) In SAR 6.0, some ACHs reported that P4P incentives for DY4 and DY5, to be paid out in 2022 and 2023, had been obligated, and others reported they had not been obligated. Please provide any updates based on this reporting period, or simply indicate “no updates” as applicable.

i. Have P4P incentive funds for DY4 and DY5 (to be paid out in 2022 and 2023) been obligated?

The OCH Board-approved funding model, which was finalized in late 2018, includes an estimate that the region will earn 25% of all 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%, the Board of Directors will make a decision on how to allocate the additional dollars.

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

OCH contracted change plan partners including hospitals, mental health agencies, SUD treatment agencies, primary care organizations, community-based organizations, and social service providers. The specific list of partners can be found on the OCH website.

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

This is not known. The Board will make decisions as funds are earned.

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

This is not likely, however the Board has yet to make decisions on funds earned above that already budgeted.

c) 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.

At the June 2021 Board meeting, the OCH Board of Directors voted on how to allocate the 2019 Pay for Performance and High Performance Pool (HPP) dollars. As stated above, the OCH Funds Flow model assumed the region would earn 25% of P4P dollars and the HPP dollars were not accounted for in the Funds Flow Model. The Board voted to set aside the earned 2019 HPP funds for the future state, with specific decisions to be made on their use at a later time. The Board voted to allocate the additional P4P dollars
earned to contracted partners in 2021. P4R dollars are planned to be allocated to partners based on the Funds Flow Model. As some of those funds will be earned in 2022, those dollars will be allocated to partners at that time.

17. Regional integrated managed care implementation update
   
a) For **all regions**, 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?

Regional challenges relating to the implementation of IMC are data collection and inconsistent understanding of the IMC process (as it coincided with the beginning of COVID-19). See the response below for steps OCH has taken during the reporting period to address these challenges.

b) 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 continues to participate in the IMC Problem Solving Forum hosted by the Salish BH-ASO. This group includes interested providers, MCOs, and HCA staff to share and discuss issues related to IMC.

During this reporting period, OCH collaborated with regional providers and MCOs to re-launch sharing of data that was collected during the initial six-month period of the launch of IMC. These “Early Warning System” indicators were requested by providers to continue to be shared through at least 2021. Given the region’s work in IMC simultaneous with COVID-19, there is interest among providers to continue to learn of how the IMC process is progressing. OCH will aggregate these data provided by MCOs and will share with providers on the IMC Problem Solving Forum meetings.

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.

c) For **all regions**, what challenges or opportunities has the ACH identified during the reporting period tied to clinical integration measurement and assessment?

OCH staff met twice with MCOs during this reporting period to discuss the provision of data. Given that the region is still facing issues related to the collision of IMC and COVID-19, the MCOs agreed to continue to send Early Warning System data to OCH through 2021. These are data that HCA gathered for the first half of 2020, largely related to rejected and denied claims by MCOs. Partners requested a continuation of this data to HCA, however they were unable to meet the request. OCH then approached the MCOs directly and they agreed to send these data through 2021 to help the region better understand current IMC issues. In 2019, MCOs agreed to send HEDIS data to OCH on a quarterly basis to help the region assess progress toward
P4P indicators on a more timely schedule than data provided by HCA and the IA. During this reporting period, OCH and the MCOs took stock of this system and agreed to make changes.

OCH continues to stay abreast of the HCA/MCO/ACH workgroup around 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>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identification of partnering provider candidates for key informant interviews.</td>
</tr>
<tr>
<td>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
</tr>
<tr>
<td>• Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.</td>
</tr>
</tbody>
</table>

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

19. 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.

Narrative responses:

20. If the ACH is not providing updates on the MeHAF this reporting period, please describe what, if anything, the ACH is doing to assess partnering provider implementation progress at a clinic/site level?

Not applicable, updates are included in attached workbook.

OCH.SAR6 P4R metrics. 08.02.2021

21. If the ACH is providing updates on the MeHAF this reporting period, please provide any additional context if applicable.

OCH includes the MeHAF in bi-annual partner reports for all implementation partners with

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

Semi-annual reporting guidance
Reporting period: January 1, 2021 – June 30, 2021 Page 32
a behavioral health change plan. The same group of implementation partners completes the MeHAF as a part of bi-annual reporting every reporting period (Jan-Jun and Jul-Dec) twice per year. Completion of the MeHAF is included as a part of the 2021 Payment Model (appendix 4) under “partner reporting”.

**Optional: The ACH may submit P4R metric information**

See attachment **OCH.SAR6 P4R metrics. 08.02.2021.**
## Appendix 1: Payment Reconciliation Spreadsheet (COVID-19)

<table>
<thead>
<tr>
<th>Transaction #</th>
<th>Amount withdrawn ($)</th>
<th>Date funds drawn</th>
<th>FE Use category used to draw down the funds</th>
<th>Expenditure detail (To whom was the payment made to (provider/facility name, etc.)? How did this payment support the partnering provider and/or community in their response to COVID-19?)</th>
<th>Amount paid ($)</th>
</tr>
</thead>
</table>
| 3/22/1928     | $130,000.00          | 4/20/2021        | Health Systems and Community Capacity Building | Clallam County Health & Human Services - COVID-19 vaccination project
Kitsap Public Health District - COVID-19 vaccination project | $55,000.00
$75,000 |

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

**ACH Signature of Authority**

Celeste Schoenthaler/Executive Director/celeste@olympicch.org

July 2021

**Date**

7/1/2021

*Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).
## Appendix 2: Payment Reconciliation Spreadsheet (non-COVID-19)

<table>
<thead>
<tr>
<th>Transaction #</th>
<th>Amount</th>
<th>Date</th>
<th>FE Use category</th>
<th>Payment to:</th>
<th>Expenditure Detail (Narrative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10309</td>
<td>$20,500.00</td>
<td>04/20/21</td>
<td>Provider Engagement, Participation and Implementation</td>
<td>Olympic Community of Health</td>
<td>Meetings and events to support partner work in 2021. Incentives for partners to participate in surveys, etc. in 2021.</td>
</tr>
<tr>
<td>10309</td>
<td>$112,925.00</td>
<td>04/20/21</td>
<td>Health Systems and Community Capacity Building</td>
<td>Olympic Community of Health</td>
<td>Training and technical assistance for partners in 2021.</td>
</tr>
</tbody>
</table>

**Brief description:** The funds listed above were pulled down from the Financial Executor portal and paid to the ACH, however the funds represent payment activity not captured in the portal. For example, funds may have been disbursed to providers or vendors that were not setup in the portal. This template provides an opportunity for ACHs to clarify payments made outside of the portal.

The Accountable Community of Health (ACH) understands that this workbook will be attached to the Semi Annual Report and serves as the record for payment reconciliation. The ACH certifies that this information is complete and accurate.

<table>
<thead>
<tr>
<th><strong>ACH Signature of Authority</strong></th>
<th><strong>Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Celeste Schoenthaler/Executive Director/celeste@olympicch.org</td>
<td>7/1/2021</td>
</tr>
</tbody>
</table>

*Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).*
Appendix 3: OCH Funds Flow Model

Olympic Community of Health (OCH) Funds Flow Model

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

Projected Earned MTP Funds
100% VBP
100% P4R
25% P4P

Clallam NCC
$4,029,340

Jefferson NCC
$2,326,700

Kitsap NCC
$7,831,700

Hospitals
$1,600,000

CBOSS
$1,425,710

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

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

NOTE: Funds Flow model represents original payment estimates provided by HCA and do not include increased funds in 2021
Appendix 4: 2021 OCH Implementation Partner Payment Model

Guidelines to submit a change plan: Must be able to complete all required elements

Scale: 50% of 2021 payments

50% of 2021 payments will be based on the following scale criteria as self-reported by change plan type. Due to COVID-19 response, partners may choose between previously submitted 2019 or new 2020 scale criteria:

- Primary Care = 2019 or 2020 Medicaid lives (partner choice)*
- Behavioral Health = 2019 or 2020 Medicaid encounters (partner choice)
- 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

NOTE: Partners with more than one change plan report and earn separate payments for scale for each applicable change plan type.

* An approved SBAR on January 11, 2021 clarified that scale for primary care is calculated as the number of unduplicated Medicaid beneficiaries served.
**Scope:** 50% of 2021 payments

<table>
<thead>
<tr>
<th>Scope element (absolute %)</th>
<th>Description</th>
<th>Frequency and payment</th>
<th>Partners with more than 1 change plan (report and earn separate payments for scope for each applicable change plan type)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partner reporting</strong> 10%</td>
<td>Complete all reporting elements that apply to change plan type (change status, narrative questions, Health Care Authority P4R metrics, simplified quantitative data)</td>
<td>Report twice, payment twice per year (5% each)</td>
<td>Complete required reporting for all change plans (earn full 10% per change plan).</td>
</tr>
</tbody>
</table>
| **Enhanced transformation activities** 10% | • Submit project plan in Spring 2021 that details work addressing determinants of health.  
• Subsequent reporting on progress towards outlined project plan. Work may consist of continued previous change plan activities or new work that advances the determinants of health. | Submit 1 project plan, payment once (2.5%)  
Report once, payment once (7.5%) | 1 project per change plan, or 1 robust project that spans multiple change plan service lines (earn full 10% per change plan). |
| **Required change plan outcomes status** 7.5% | Self-reported status on selected outcomes.  
*NOTE: At least half of all required change plan outcomes status’ must be “fully implemented”, or “scaling and sustaining” to receive credit.* | Evaluated once (second qualitative reporting of the year), payment once per year (7.5%) | Earn full 7.5% for each full change plan. Earn 2.25% for each partial change plan. |
| **Implementation of enhanced community-clinical linkage work** 7.5% | Progress towards self-identified milestones as outlined in enhanced community clinical linkage work project proposal. If milestones are not progressing as predicted, partners must provide detailed mitigation strategies. | Report once, payment once per year (7.5%) | Project proposals are 1 per full change plan or 1 comprehensive across full change plans – report based on submission (earn full 7.5%). Does not apply to partial change plans (earn 0%). |
| **Addressing behavioral health needs** 5% | Implement and report on (1) activity to respond to increased behavioral health needs. *Activities may include and are not limited to: expand available behavioral health services (in-person or telehealth), participate in statewide advocacy, partner with agency new to OCH network, etc.* | Complete 1 activity and report, payment once per year (5%) | Complete 1 activity per change plan or 1 comprehensive activity across change plans (earn full 5% per change plan). |
| **Learning and convening** 5% | Participation in at least 4 OCH convenings, collaborative events, summits, trainings, and OCH committees/workgroups. | Attend a minimum of 4 (counted by number of events per change plan, not number of people), | Attend minimum of 4 per change plan (earn full 5% per change plan). |
NOTE: Governance related committees and workgroups do not apply (Board of Directors, Executive Committee, Finance Committee, Funds Flow Workgroup).

<table>
<thead>
<tr>
<th>Future state visioning input 2.5%</th>
<th>Partners will be asked to provide input on proposed OCH future state vision, which will then be voted on by the OCH Board of Directors.</th>
<th>Complete once, payment once per year (2.5%)</th>
<th>Complete once per organization/Tribe, applies only to highest change plan payment (earn 2.5% for highest change plan, 0% for all other change plans).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-based payment survey completion 2.5%</td>
<td>Complete Health Care Authority value-based payment survey, which is part of the Health Care Authority P4R requirement. NOTE: CBOSS partners not eligible to participate will automatically receive credit for this element.</td>
<td>Complete once, payment once per year (2.5%)</td>
<td>1 survey completed per organization/Tribe, applies only to highest change plan payment (earn 2.5% for highest change plan, 0% for all other change plans).</td>
</tr>
</tbody>
</table>

NOTE: Site visits are not an element of the 2021 payment model and are a required component of contract monitoring.

### Implementation Partner 2021 Calendar

<table>
<thead>
<tr>
<th>Reporting and Payment 1 Period</th>
<th>Report on work to address behavioral health needs</th>
<th>HCA value-based payment survey</th>
<th>Payment 1 (Jan-Jun) – 40%</th>
<th>Payment 2 (Jul-Dec) – 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2021 contract amendments effective with all signatures</td>
<td>Future state visioning input</td>
<td>Enhanced transformation activities (submit project plan)</td>
<td>Partner reporting</td>
<td>Learning and convening (OCH upcoming events page will be updated with opportunities on quarterly basis)</td>
</tr>
<tr>
<td>Feb</td>
<td></td>
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<td></td>
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<tr>
<td>Mar</td>
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<td>Apr</td>
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<td>May</td>
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<td>Jun</td>
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<td>Nov</td>
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<tr>
<td>Dec</td>
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</tr>
</tbody>
</table>

Learning and convening (OCH upcoming events page will be updated with opportunities on quarterly basis)

NOTE: Timelines are estimates and subject to change. OCH strives to facilitate partner success and will adjust to accommodate changing partner priorities as needed.
### Cumulative snapshot

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds Earned</td>
<td>$25,417,739.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funds Distributed</td>
<td>$19,434,706.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funds available</td>
<td>$5,983,033.46</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 1: Incentive Funds earned

<table>
<thead>
<tr>
<th>Project</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$</td>
<td>- $1,149,578.00</td>
<td></td>
<td></td>
<td>$1,149,578.00</td>
</tr>
<tr>
<td>Project 2D</td>
<td>$</td>
<td>- $394,244.00</td>
<td></td>
<td></td>
<td>$394,244.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$</td>
<td>- $160,490.00</td>
<td></td>
<td></td>
<td>$160,490.00</td>
</tr>
<tr>
<td>Project 3B</td>
<td>$</td>
<td>- $176,822.00</td>
<td></td>
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<td>$176,822.00</td>
</tr>
<tr>
<td>Project 3C</td>
<td>$</td>
<td>- $120,367.00</td>
<td></td>
<td></td>
<td>$120,367.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$</td>
<td>- $303,069.00</td>
<td></td>
<td></td>
<td>$303,069.00</td>
</tr>
<tr>
<td>VBP</td>
<td>$250,000.00</td>
<td>$150,000.00</td>
<td></td>
<td></td>
<td>$400,000.00</td>
</tr>
<tr>
<td>Bonus pool/High Performance Pool</td>
<td>$608,774.00</td>
<td></td>
<td></td>
<td></td>
<td>$608,774.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$250,000.00</td>
<td>$3,063,344.00</td>
<td>$</td>
<td>$</td>
<td>$3,313,344.00</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td></td>
<td>- $</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td></td>
<td>- $</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$</td>
<td>- $511,925.00</td>
<td></td>
<td></td>
<td>$511,925.00</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td></td>
<td>- $</td>
</tr>
<tr>
<td>Project management</td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td></td>
<td>- $</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$132,167.66</td>
<td>$20,500.00</td>
<td></td>
<td></td>
<td>$152,667.66</td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td></td>
<td>- $</td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td></td>
<td>- $</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$132,167.66</td>
<td>$532,425.00</td>
<td></td>
<td></td>
<td>$664,592.66</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 July 21, 2021 to accompany the seventh Semi-Annual Report submission for the reporting period January 1 to June 30, 2021.