Healthier Washington Medicaid Transformation
North Sound Accountable Community of Health

Semi-annual Report 5.0
Reporting Period:
January 1, 2020 – June 30, 2020
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## ACH Contact information

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>North Sound ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary contact name</td>
<td>Liz Baxter, MPH</td>
</tr>
<tr>
<td>Phone number</td>
<td>(360) 386-5745</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:Liz@NorthSoundACH.org">Liz@NorthSoundACH.org</a></td>
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<tr>
<td>Secondary contact name</td>
<td>Nicole Willis, MPH</td>
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<td>(360) 543-8860</td>
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<tr>
<td>E-mail address</td>
<td><a href="mailto:Nicole@NorthSoundACH.org">Nicole@NorthSoundACH.org</a></td>
</tr>
</tbody>
</table>
Section 1. ACH Organizational Updates

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 that addresses internal controls, including financial audits.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>7) The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td></td>
<td>X</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></td>
<td>X</td>
</tr>
</tbody>
</table>
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.

**Response:**
North Sound ACH uploaded Attachment A: North Sound ACH Revised Organizational Chart.

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

- Optional: The ACH may provide any context that may add clarity regarding the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal).

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

**Response:**

a) North Sound ACH has no additional clarifying comments to add to this question about the report from the Financial Executor portal.

b) North Sound ACH uploaded Attachment B: North Sound ACH SAR5 Payment Reconciliation Sheet, for COVID-19 payments outside of the Financial Executor 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.
   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.

Response:

There are no changes to this distribution since prior reporting period.

<table>
<thead>
<tr>
<th>Description of Use</th>
<th>Expenditures ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant (XPIO) who worked with BHAs to identify resource needs for IMC readiness</td>
<td>Actual: $553,320</td>
</tr>
<tr>
<td></td>
<td>Projected: $553,320</td>
</tr>
<tr>
<td>BHO contract to support $ for BHAs with IMC readiness assessment and implementation</td>
<td>Actual: $5,936,049</td>
</tr>
<tr>
<td></td>
<td>Projected: $5,936,049</td>
</tr>
</tbody>
</table>
Section 2. Project Implementation Status Update

Attachments

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

12) Implementation work plan

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

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

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

Response:

North Sound ACH is not submitting an updated work plan for this reporting period.

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.

Response:

North Sound ACH uploaded Attachment C: North Sound ACH Provider Roster, with a list of provider sites that are participating with North Sound ACH.

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1 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).
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.²

Response:

North Sound ACH is not submitting a quality improvement strategy update for this reporting period.

Narrative Responses

ACHs must provide concise responses to the following prompts:

15) COVID-19

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

Response:

No partners reported to us that their project activities or areas of focus were delayed, put on hold or altered due to COVID-19, but all were feeling pressures to varied degrees. COVID-19 did impact their ability to respond to requests for reporting and site visits. To provide ease to partnering providers while they were rapidly responding to the coronavirus, North Sound ACH took the following actions during the reporting period, including:

1. Delayed Spring 2020 reporting by opening the reporting portal one month later (May instead of April) and allowing partners two months of instead of one for reporting.

² Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section
2. Pushed out 50% of 2020 anticipated implementation distribution to partners in March 2020 to support their ability to be nimble and responsive while adapting their operations in response to COVID-19.

3. Provided $1.1M in capacity-building funds to community action agencies, tribes, family coalitions, food banks, and organizations supporting farmworkers and other vulnerable communities.

4. Implemented a telehealth and remote worker support fund which distributed funds up to $10,000 to 57 community organizations ($480,000 total). Funds were used to pay for equipment, technology licenses, and staff time necessary to provide telehealth services and transition staff to remote work.

5. Held open-office hour technical assistance sessions with ACH partners to address COVID-19 mitigation strategies such as applying for CARES Act assistance, employee resources available, and instituting an emergency response command structure (akin to FEMA’s Incident Command Structure).

6. All North Sound staff completed two modules of FEMA’s training on Incident Command Structure (modules 100 and 700) to enhance our preparedness to partner with PH.

7. Published and continually update a COVID-19 Resources webpage pointing to practice, resources and treatment guidelines from local health jurisdictions, Washington Department of Health and the CDC.

8. Published a COVID-19 Vulnerability Dashboard and COVID-19 Impact Model that included data from the five counties and eight tribal nations in the North Sound region, linked on our website COVID-19 resource page.

9. Assigned North Sound ACH staff to support COVID-19 response activities for Whatcom County’s Unified Command Structure (UCS). North Sound ACH staff developed disease monitoring models and conducted regular surveillance of local resources on behalf of UCS.

10. Offered support to all five Local Health Jurisdictions, resulting in varied requests for support in communications and connecting to community organizers to get information out to community.

11. Coordinated connections between local health jurisdictions and community action agencies who serve individuals experiencing homelessness or unstable housing, farmworkers, and low-income residents.

12. Provided support in linking public health teams to resources in indigenous languages, especially critical for beginning of growing season, and influx of migrant workers.
13. Gave partners the option to delay or cancel their site visits, or to reschedule to complete using Zoom video conferencing. Through end of this reporting period, the only partners who did not complete site visits in any manner were public health departments, who were consumed with COVID-19 response efforts.

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

Response:

Project intervention supports that enabled COVID-19 response activities through improved delivery system infrastructure include:

1. Published and update a COVID-19 Vulnerability Dashboard and COVID-19 Impact Model available for partners and emergency responders.
2. Holding open-office hour sessions with ACH partners to address COVID-19 mitigation strategies.
3. Research and distribute public health messaging and directives to partners.
5. Promoted the use of a pre-visit COVID-19 screening tool for Pathways community health workers.
6. Partners using Julota (EMS and high-utilizer care coordination) had access to a COVID-19 tracking tool, allowing them to see other partners working with patients after discharge.
7. Partners using the Care Coordination HUB, and the Care Coordination Systems platform were able to use the platform for all patients discharging from county quarantine sites, regardless of whether they met the state HUB criteria or not.
9. Provided financial support that allowed community resource paramedics to purchase mobile tablets. These devices were used by clients to take pictures.
around their house for analysis of fall risk and medications while minimizing COVID-19 exposure.

These intervention supports were focused across the region and were not limited to any specific subpopulations.

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

Response:
North Sound ACH included Tribes/IHCPs in multiple COVID-19 response activities, including:

1. Committed $75,000 in capacity-building funds to each of the eight tribes in the North Sound region.
2. Provided support to seven organizations led by tribal nations for telehealth and remote worker activities.
3. Continued North Sound ACH’s Tribal Learning series, led by experts from tribal nations, and open to all native and non-native partnering organizations.
4. Researched and distributing a comprehensive funding document listing all known available funding resources for tribal partners.
5. Stayed connected with tribal leadership meetings at the local, state and national levels to stay updated on COVID-19 response efforts related to tribal communities.
6. Offered technical assistance to Tribal partners to apply for grants and other funding applications.
7. Provided support and technical assistance to tribes and tribal partners who wanted to become implementation partners (partnering providers.)
8. Assisted three tribes with North Sound ACH implementation partner applications.

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

Response:
North Sound ACH did not adjust contracts with partnering providers. Payment allocation approaches for 2020 were not altered, although North Sound ACH distributed 50% of anticipated 2020 funds to partners three months earlier than we did in 2019.
North Sound ACH both delayed and extended the Spring 2020 reporting deadlines for all partners (delayed opening by one month, and extended reporting period by one month).

After beginning the winter/spring 2020 site visits in person, North Sound ACH pivoted the balance to virtual meetings and gave partners (such as public health jurisdictions) the option to delay or cancel their site visit until the fall of 2020.

Those partners who participated in site visits provided information about the impact COVID-19 had on their organization and services. North Sound ACH held COVID-19 open ‘office hours’ for all partnering providers to provide technical assistance in implementing community mitigation strategies. The ACH also hosted two specific office hour sessions for community paramedicine/EMS partners and partners providing opioid use disorder services. These topic-specific sessions provided partners the opportunity to share COVID-19 mitigation strategies with peers and to share technical assistance needs with North Sound ACH staff.

The ACH also hosted two webinars for partners – one around COVID-19 paid time off resources (FFCRA), and the second focused on COVID-19 business support options (CARES). After both sessions, the presenters were paid to offer one-one technical assistance to partner organizations that requested an individual call.

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

Response:

The biggest challenge that COVID-19 presented was a requirement to limit in-person access and communication. It was unclear whether all of the regions partnering providers would be able to rapidly do so, and what support they might need. It was our goal to anticipate their potential needs, and develop strategies and approaches to meet those needs.

One specific issue that emerged during the reporting period was how to quickly transition staff to remote work and adapt staff schedules to accommodate childcare and family sick leave needs. Equipment, connectivity, phone lines, mail delivery, and whether staff actually had space at home to effectively work remotely became immediate challenges to overcome. Internally the North Sound ACH team was facing the same issues as every partner, so our problem solving allowed us to be more helpful to partners than we might otherwise have been able to be.

Specific risks/issues that emerged during the reporting period for North Sound ACH partners included:
1. Challenges implementing protocols, policies and equipment to transition staff to remote work.


3. Adapting operations to make services available virtually or in-person with appropriate physical distancing measures in place.

4. Placing staff on furlough due to revenue shortfalls caused by the temporary cancellation of non-essential services and events, while also trying to respond to higher needs in the community.

5. For public health partners, having to pivot all of their teams to COVID-19 response, working long days, every day. Burnout and stress are emerging.

6. Learning new technologies and best practices rapidly and in real time. Zoom, Skype, Microsoft Teams, Google Meet – all having to adapt to having ‘everyone’ using them. Our team has been able to provide TA in Zoom, for example, as we had been using it for more than two years.

North Sound ACH distributed 50% of anticipated implementation distribution to partners in March and extended partner reporting deadlines by two months – both were intended to alleviate pressure. In response to the challenges of transitioning to remote work, North Sound ACH implemented an Internal Command Structure (ICS) for its internal operations, provided technical assistance to partners developing their own ICS structures, and set up a Telehealth and Remote Work Fund available to community organizations in the North Sound Region, with a very low barrier request form, recognizing that especially in a crisis, no one had time for something complex and cumbersome.

North Sound ACH published a COVID-19 resources page with links to Local Health Jurisdiction, tribal nations, the Washington State Department of Health, the Centers for Disease Control, and other reliable sources for policy updates, disease monitoring, and COVID-19 assistance. Our goal was to push partners to trusted sources of information, rather than creating our own.

North Sound ACH also published a COVID-19 Vulnerable Populations Dashboard and a COVID-19 Modeling Tool that include all North Sound counties and tribal nations in the region. The dashboard and modeling tool show how COVID-19 is currently impacting different populations in the North Sound region and can assist organizations in determining how they can effectively invest resources for COVID-19 recovery.

In addition to making information publicly available, North Sound ACH staff responded to specific, COVID-19 information requests from partners. For instance, North Sound ACH staff provided local health jurisdictions with promising practices to provide outreach to
field and farmworkers and push agricultural workplaces to protect the health and safety of their workers.

Throughout the reporting period, North Sound ACH mitigation strategies have started due to a request from one or more partners, but we have then shared the results broadly, not limiting them to any specific subpopulations within our region.

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

Response:

One “bright spot” that emerged during this reporting period as a result of COVID-19 is the increased adoption of telehealth and remote services among North Sound ACH partnering providers. Partners developed policies, trained staff in new protocols, and purchased equipment to provide telehealth services (virtual consults with medical and behavioral health providers, virtual peer counseling sessions, and online exercise classes, as examples).

This strategy improved access to care for those who have limited access to transportation or live far away from services. One partner shared that recovery support groups were better attended after transitioning from in-person to virtual sessions in response to COVID-19. This partner heard from attendees that many felt they could more freely discuss their recovery needs when they weren’t face-to-face with other participants. Another partner shared that no-show rates for behavioral appointments were lower for telehealth visits than they were for in-person visits. Partners report they are committed to building on their initial telehealth investments to continue providing the option for virtual services long term.

16) Regional integrated managed care implementation update

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

Response: Not Applicable

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

Response: Not Applicable
c) For all early- and mid-adopters, briefly describe any challenges the region continues to experience due to the implementation of integrated managed care. What steps has the ACH taken during the reporting period, or what steps does the ACH plan to take, to address these challenges?

Response:

Challenges related to the transition to integrated managed care:

- After the transition to MCO payers, the crisis response line and crisis dispatch, managed regionally by the Volunteers of America, lost its ability to view service history of Behavioral Health Agencies (BHAs). This information was previously centralized in the BHO system. The ACH is participating in a cross-ACH workgroup with Collective Medical to identify data elements and use cases for their platform to resolve this issue. (The Interlocal Leadership Structure’s Joint Operating Committee is also discussing the use of the Collective Medical Platform to distribute this information.)

- Decrease in non-Medicaid funding for crisis triage. The BHASO had to decrease non-Medicaid funding to crisis triage in order to maintain crisis outreach teams and other services. The ACH is participating in the Interlocal Leadership Structure, which is discussing this funding gap and the use of state non-Medicaid fund allocation to address the issue. Coding changes in the way the BHASO delivers crisis services may increase Medicaid crisis funding in the future.

- Decreased availability of non-Medicaid funds to support people on Medicare in spend down. The BHASO needed to decrease the use of non-Medicaid funding to BHAs that was previously used to cover spend downs. This has created an increase in referrals to agencies that accept Medicare for behavioral health services, including FQHCs, who are feeling the impact. The ACH has participated in several provider meetings to discuss the increase and the best routes for advocacy regarding non-Medicaid funding needs for the region.

- High claims denial rates reported in the early warning system for 2-3 MCOs. Some ACH partners are reporting issues with provider payment. The ACH has distributed the regional provider survey to partners, participated in the Early Warning System webinars, and connected providers to the HCA and MCOs to address payment challenges.

- The bright spot listed above related to telehealth, also pointed to a gap. Not everyone has access to broadband or wi-fi, or has a device that allows face-to-face communication. Even though many Medicaid enrollees can receive free mobile phones, there may be limits on minutes, or they operate within a limited range. Some community members are dependent on phone cards which may also have limitations. In order for telehealth to continue its applicability we have to address the
broadband coverage gap. On the positive side, with businesses closed, some allowed people to sit in their parking lots and use their wi-fi access for telehealth appointments.

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

Response:

North Sound ACH has identified steps that we can 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, including:

- North Sound ACH participates in the Interlocal Leadership Structure (ILS) to support coordination with local, regional, and statewide partners. The ILS brings together managed care organizations, the North Sound Administrative Services Organization (ASO), North Sound ACH, and County Health and Human Services partners to co-design regional response strategies to the barriers impacting the health system’s response to integrated managed care implementation. Quarterly, ILS meetings expand to include a broader coalition of providers to discuss the integrated care transition and service network.

- The ACH also attends quarterly regional integrated provider meetings and reviews ACH partners’ reporting on integrated care progress to identify and respond to technical assistance needs that arise from partners committed to implementing integrated care teams.

- The ACHs statewide are working together to align strategies to support integrated managed care, trying to find ways to partner across ACH regions.

- The ACHs are working with Medicaid MCOs to align partner assessment of progress toward integration, a contractual requirement of the MCOs in the coming year. Since all ACHs are using the MeHAF, MCOs aim to build on that tool to eliminate partnering providers being asking for redundant information from different sources.
### 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></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17) <strong>The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation.</strong> ACH support or engagement may include, but is not limited to:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identification of partnering provider candidates for key informant interviews.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.</td>
<td></td>
</tr>
</tbody>
</table>
Section 3. Pay-for-Reporting (P4R) Metrics

Documentation

18) P4R Metrics

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

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

**Related resources and guidance:**

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets](https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121).
- 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](https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121) provided by the state.

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

**Response:**

North Sound ACH is not submitting P4R metrics updates for this reporting period and instead responded to COVID-19 related responses in the “Narrative Responses” section.
### North Sound

January 1, 2020 - June 30, 2020

**Cumulative snapshot**

<table>
<thead>
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<th>Funds Earned</th>
<th>$ 84,809,280.51</th>
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<tbody>
<tr>
<td>Funds Distributed</td>
<td>$ 71,496,864.88</td>
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<td>Funds available</td>
<td>$ 13,312,415.63</td>
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### Table 1: Incentive Funds earned

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<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
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<tbody>
<tr>
<td>Project 2A</td>
<td>$ 2,244,998.00</td>
<td>$ 1,964,838.00</td>
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<td>$ 4,209,836.00</td>
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<td>Project 2B</td>
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<td>Project 3A</td>
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<td></td>
<td>$ 657,787.00</td>
</tr>
<tr>
<td>Project 3C</td>
<td>$ 210,469.00</td>
<td>$ 184,210.00</td>
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<td>$ 394,679.00</td>
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<tr>
<td>Project 3D</td>
<td>$ 561,250.00</td>
<td>$ 491,210.00</td>
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<td>$ 1,052,460.00</td>
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<tr>
<td>Integration</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
<td></td>
<td>$ -</td>
</tr>
<tr>
<td>VBP</td>
<td>$ -</td>
<td>$ 350,000.00</td>
<td></td>
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<td>$ 350,000.00</td>
</tr>
<tr>
<td>Total</td>
<td>$ 7,015,618</td>
<td>$ 6,490,122.00</td>
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<td></td>
<td>$ 13,505,740.00</td>
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</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$ 21,271.05</td>
<td>$ -</td>
<td></td>
<td></td>
<td>$ 21,271.05</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared domain 1</td>
<td>$ 4,384,761.00</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 4,384,761.00</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$ 3,647,584.27</td>
<td>$ -</td>
<td></td>
<td></td>
<td>$ 3,647,584.27</td>
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<tr>
<td>Community health fund</td>
<td>$ 3,932,369.07</td>
<td>$ 21,271.05</td>
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<td>$ 3,953,640.12</td>
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<tr>
<td>Health systems and community capacity building</td>
<td>$ 1,661,012.55</td>
<td>$ 1,168,886.97</td>
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<td></td>
<td>$ 2,829,899.52</td>
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<tr>
<td>Integration incentives</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
<td></td>
<td>$ -</td>
</tr>
<tr>
<td>Project management</td>
<td>$ 1,539,283.01</td>
<td>$ 16,936.00</td>
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<td></td>
<td>$ 1,556,219.01</td>
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<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$ 3,827,586.00</td>
<td>$ 349,715.00</td>
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<td>$ 4,177,301.00</td>
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<tr>
<td>Provider performance and quality incentives</td>
<td>$ -</td>
<td>$ -</td>
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<td></td>
<td>$ -</td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>$ 789,624.93</td>
<td>$ -</td>
<td></td>
<td></td>
<td>$ 789,624.93</td>
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<tr>
<td>Total</td>
<td>$ 15,397,459.83</td>
<td>$ 1,556,809.02</td>
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<td></td>
<td>$ 16,954,268.85</td>
</tr>
</tbody>
</table>

Table 4: Incentive funds distributed, by use category