Washington State Medicaid Transformation

Independent Assessment of Semi-annual Report 5

Reporting Period January 1, 2020 – June 30, 2020

Findings Report: October 2020
# Table of Contents

Table of Contents................................................................................................................................. 1

1. Overview.................................................................................................................................................. 2
2. Independent Assessor Review Process................................................................................................. 2
3. Findings of the ACHs’ Semi-Annual Report ...................................................................................... 2
4. COVID-19 Pandemic .................................................................................................................................. 2
5. Highlights of the ACHs’ Semi-Annual Report .................................................................................. 3
6. Success Stories ......................................................................................................................................... 7
7. Summary Recommendations for Payment of Incentives ................................................................. 7
8. COVID-19 Observations by ACH........................................................................................................ 12
   Better Health Together.......................................................................................................................... 13
   Cascade Pacific Action Alliance .......................................................................................................... 15
   Greater Columbia ACH .................................................................................................................... 17
   HealthierHere ....................................................................................................................................... 19
   North Central ACH ............................................................................................................................. 21
   North Sound ACH............................................................................................................................... 24
   Olympic Community Health .............................................................................................................. 27
   Pierce County ACH dba Elevate Health of Washington .................................................................. 30
   SWACH .................................................................................................................................................. 31
1. Overview

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor for the state’s Medicaid Transformation, Section 1115 Medicaid waiver. The focus of the Independent Assessor’s work is on Initiative 1, Transformation through Accountable Communities of Health (ACHs).

As part of this engagement, and as required by the Special Terms and Conditions (STCs) of the waiver, Myers and Stauffer assesses semi-annual reports submitted by each of the nine ACHs. These reports must demonstrate progress and attainment of project-specific milestones and metrics achieved during the reporting period to receive incentive dollars. This findings report represents Myers and Stauffer’s assessment of ACH semi-annual reports for reporting period January 1, 2020 to June 30, 2020.

2. Independent Assessor Review Process

The Independent Assessor (IA) used the following process to assess submitted semi-annual reports (SAR).

- **Minimum Submission Requirements Review.** Upon receipt of each ACH’s report, a high-level review was conducted to confirm the ACH submitted responses to all questions. Where missing information was identified, a request was made to the ACH for an updated submission.

- **Detailed Assessment.** Primary reviewers conducted detailed assessments of the ACHs’ reports. The IA assessed that each ACH addressed all sections of the report and that responses provided detail to confirm progress has been made. Each response to a question within a report sub-section was assessed as complete or incomplete. Where the primary reviewer found a response to be incomplete or requested an additional review, a secondary reviewer conducted additional assessment.

- **Requests for Additional Information.** The IA sent requests for additional information (RFIs) to eight ACHs. The RFIs served as an opportunity for ACHs to offer clarification to responses that were initially found to be incomplete and to address identified gaps.

3. Findings of the ACHs’ Semi-Annual Report

All ACHs submitted their SARs by the July 31, 2020 deadline.

- **Findings.** Upon submission of RFI responses, all SARs included sufficient detail to reflect performance during the reporting period of January 1, 2020 to June 30, 2020.

- **Recommendation.** The IA recommends HCA approve and award full credit to ACHs for milestone achievement towards Medicaid Transformation.

4. COVID-19 Pandemic

On January 1, the World Health Organization (WHO) requested information related to reports of viral pneumonia cases of unknown cause in Wuhan, China. By January 21, 2020, the Centers for Disease Control and Prevention (CDC) confirmed the first case related to the novel coronavirus disease (COVID-19) in the United
States in the state of Washington. COVID-19 was observed to be a rapidly spreading respiratory illness where individuals required significant medical care or hospitalization and experienced a high mortality rate. Due to the exponential rise in COVID-19 cases across multiple countries affecting a large number of people, the WHO declared a worldwide pandemic on March 11, 2020.

In the state of Washington, Governor Jay Inslee declared a state of emergency on February 29, and subsequently issued a statewide stay-at-home order by March 23, 2020. The “Stay Home, Stay Healthy” order required every Washingtonian to stay home unless they were pursuing an essential activity, banned all gatherings, and closed all businesses except essential businesses. Between the first reported case and the end of June 2020, there were 33,447 known cases in Washington, 4,524 hospitalizations, and 1,304 deaths. In the same timespan, the United States had 2,573,393 confirmed cases with 126,573 deaths. Globally, over 10 million cases were reported and death totals were over 500,000.

Due to the pandemic, there was a need for large-scale, expedited adjustments by the entire health care system that posed a formidable challenge. Health care systems required personal protective equipment (PPE), telehealth capabilities, and significant hospital bed capacity. Communities required new and expanded approaches to address housing, food insecurity, and remote education. HCA, the ACHs, and partnering providers were required to focus their attention on responding to this unprecedented crisis. As a result, HCA requested and the Centers for Medicare and Medicaid Services (CMS) approved, modifications and flexibilities to the authorities that govern the Medicaid program and the Medicaid Transformation waiver.

These flexibilities allowed for the semi-annual report template to be modified to collect COVID-19 response information. The implementation plan update, quality improvement strategy update, and pay for reporting metrics became optional reporting requirements.

5. Highlights of the ACHs’ Semi-Annual Report 5

The following summary describes findings noted by ACHs within their SAR 5 responses.

- **Rapid Response Capabilities:** ACHs described their ability to quickly respond to Governor Inslee’s Stay Home, Stay Healthy order based on the needs of their communities. ACHs offered expedited financial support, training, distribution of personal protective equipment (PPE), dissemination of curated resources and COVID-19 case counts, partner reporting flexibilities, and staff support for their communities and health care systems. Examples include:
  - Cascade Pacific Action Alliance (CPAA) provided $1 million in COVID-19 Emergency Funding, including additional support for food insecurity.
  - HealthierHere released $5.1 million in funding through five emergency funds, with the aim to maintain continuity of care, build partner infrastructure and capacity to respond to COVID-19,

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and ensure the most vulnerable populations in King County have access to the care and social service supports they need.

- North Central ACH (NCACH) joined Local Health Jurisdictions’ (LHJ) Incident Command Systems on March 16, 2020 to support their community mitigation response needs.
- North Sound ACH (NSACH) published a COVID-19 Vulnerability Dashboard and COVID-19 Impact Model available for partners and emergency responders. The dashboard and modeling tool shows how COVID-19 is impacting different populations in the North Sound region and can be used by organizations in determining how they can effectively invest resources for COVID-19 recovery.
- SWACH connected the Clark County COVID-19 Homelessness Quarantine and Isolation Project with harm reduction and recovery support services on site.
- SWACH offered temporary staffing support to assist the Clark County Public Health and Council for the Homeless.

**Recommendation:** We recommend HCA and ACHs further inventory and analyze the supports and response approaches (e.g., financial support, partner relationships and coordination, information exchange and dissemination, and technology solutions) leveraged during the pandemic. We recommend that as sustainability is considered, HCA and ACHs focus on those areas with the greatest opportunity to build on activities and lessons learned through the Medicaid Transformation for long-term, community-wide improvements.

**Telehealth.** During the midpoint assessment, several interviewee comments centered on telehealth services. It was noted that telehealth could be utilized to support partnerships between physical health, behavioral health, and community agencies for integrated care approaches. One interviewee asserted that the inability to resolve workforce issues by addressing telehealth reimbursement reflected a lack of focus on sustainability.

Soon after that assessment, a historic chain of events made telehealth a primary vehicle to serve patients for non-COVID related needs throughout the country. A recent Health Affairs article indicates, “Surveys conducted in April 2020 suggest that up to 90 percent of physicians were offering telehealth visits in response to COVID-19. The Centers for Medicare and Medicaid Services has announced that 22–30 percent of Medicare beneficiaries received telehealth services from March through June. Estimated growth rates are in the thousands of percentage points.”

All ACHs discussed telehealth services in their SAR 5 responses. NCACH noted, “The COVID-19 pandemic compelled our region (along with the world) into involuntary innovation mode, which led to creative responses to a rapidly changing situation.” Telehealth services became available in primary care, behavioral health, hospital, and rural settings. ACHs were able to help the providers in Washington state pivot services by offering financial support to obtain laptops, webcams, expanded bandwidth, software, and technical assistance. ACHs also provided training to understand the various technologies, such as Zoom, Skype, Microsoft Teams, Google Meet, and methods to provide bi-directional integration via telehealth through the AIMS Center.

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9 North Central ACH SARS Report.
Challenges were described in doing this “…rapidly and in real time,” as North Sound ACH noted. Sustained challenges remain regarding the continued spread and access to broadband as well as reimbursement in the long-term.

**Recommendation:** We recommend HCA and ACHs engage with MCOs to analyze the results of telehealth utilization and consider long term approaches (e.g., reimbursement, telephonic vs video services, and broadband needs) to ensure telehealth continues to be an option available to resolve workforce shortage and access issues, including rural access and access to specialty services issues.

◆ **ACH Support and Collaboration.** ACHs described their continued support for coordinated, statewide actions. ACH leadership continued to meet regularly during the pandemic to assess statewide challenges and priorities, to discuss their COVID-19 response activities, and to share lessons learned. Cross-ACH achievements during the SAR reporting period include:

- Developing a joint [ACH website](#).
- Developing a [joint one-pager](#) on the role of ACHs in the COVID-19 response.
- Developing a [joint statement](#) on racism and the racial justice movement.
- Creating a [shared vision](#) for a community information exchange and for community-based care coordination.
- Drafting a concept paper for a social investment model to support social determinants of health (SDOH) services beyond the Medicaid Transformation waiver demonstration period.
- Participating in the Behavioral Health Institute (BHI) telehealth training for behavioral health agencies

**Recommendation:** We recommend ACHs continue this approach to reviewing common challenges and lessons learned to rapidly accelerate shared system improvements statewide.

◆ **Integrated Managed Care (IMC).** Two ACH regions, CPAA and Olympic Community of Health (OCH), transitioned to integrated managed care on January 1, 2020. Specific issues noted by these ACHs during transition included:

- Claim denials
- Claim reconciliations taking longer than expected
- Reimbursement delays; in some instances significant delays with at least one instance that required an MCO to advance payment in order for an organization to stay open
- Confusion related to the use of billing code modifiers
- Interpreter services dropping jobs without notice
- OCH also noted that provider assignment took much longer than anticipated and continued to be an issue into February.

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10 North Sound ACH SAR 5 Report.
◆ **Finances.** As noted in Table 1, a variance in fund distribution was observed across ACHs. Data presented in this table is provided by HCA from the Financial Executor Portal reports.

<table>
<thead>
<tr>
<th>BHT</th>
<th>CPAA</th>
<th>EH</th>
<th>GCACH</th>
<th>HH</th>
<th>NCACH</th>
<th>NSACH</th>
<th>OCH</th>
<th>SWACH</th>
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<td>$9,120,493</td>
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<td>$19,645,085</td>
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<td>$2,746,927</td>
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◆ **Partnering provider roster.** As part of the submission of materials and to earn the associated achievement value (AV), ACHs are required to update and submit the list of partnering provider sites participating in Medicaid Transformation Project Toolkit activities. Table 2 summarizes the active partners included in each ACH partnering provider roster. SAR 5 had a slight overall increase in active project partners as compared to the prior reporting period.

<table>
<thead>
<tr>
<th>Project</th>
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<th>GCACH</th>
<th>HH</th>
<th>NCACH</th>
<th>NSACH</th>
<th>OCH</th>
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<td>3A: Addressing Opioid Use</td>
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</table>

**Pay for Reporting (P4R).** Twice per year, ACHs gather detailed partnering provider implementation information at a clinic/site level and report aggregate results to the state. P4R metrics provide detailed information on partnering provider progress. The P4R metrics were an optional reporting requirement for SAR 5 and multiple ACHs provided flexibility in P4R reporting requirements to their partnering providers. The following ACHs submitted an updated Pay for Reporting workbook: BHT, CPAA, GCACH, HH, OCH, and EH.

During this reporting period, questions that pertained to Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation requested summary statistics related to partner completion of the Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey. This survey allows partnering providers an opportunity to evaluate their level of integration over the course of the waiver. For Project 3A: Addressing the Opioid Use Public Health Crisis, P4R metric data sought to gather information related to use of prescribing guidelines and protocols in place to support patients with opioid use disorders.

The state reviews this aggregate information for trends to confirm participation and continued self-assessment. The number of respondents for BHT and OCH increased during this reporting period compared to the SAR 4 reporting period.
6. Success Stories:

ACHs provided best practices or “bright spots” that emerged during the response to the COVID-19 pandemic. Highlights include:

- **Better Health Together (BHT):** Partnering providers quickly transitioned to provide telehealth services, especially for the behavioral health and SDOH network. While the transition resulted in increased cost, almost all providers have indicated the ability to engage individuals they hadn’t previously, and telehealth allowed them to quickly maintain pre-COVID service levels.

- **Cascade Pacific Action Alliance (CPAA):** Increased flexibility in prescribing and accessing medications for opioid use disorder (MOUD) has been an important policy change for individuals with OUD. These individuals have increased and exacerbated vulnerability to COVID-19 due to effects of opioid use on respiratory and pulmonary health, increased likelihood of homelessness or incarceration, and increased risk of overdose when using alone. Examples of increased flexibility have included, the ability to provide MOUD via telehealth, a temporary increase in case load from 100 to 275 patients, extending prescription lengths, requiring the co-prescription of naloxone, removing prior authorization requirements for all forms of buprenorphine, and removing cost-sharing requirements. CPAA noted that permanent changes to these regulatory barriers after the COVID-19 public health emergency would help address long-term challenges to MOUD access and curb provider stigma that prevents many providers from prescribing MOUD as part of their typical practice.

- **Elevate Health (EH):** In collaboration with the Pierce County Connected Fund, EH developed South Sound 2-1-1, a single point of access resource registry that includes twelve behavioral health, mental health, and substance abuse disorder providers. The call center works with over 400 providers, nonprofits, and other services to help bridge individuals to basic necessities such as housing, utility assistance, and child care. EH indicates that call navigators know which providers have availability, what services are provided, and what insurances they accept. A May 7, 2020 article in The News Tribune headlined “Bright Side to the COVID-19 Pandemic? Mental Health Care Easier to Access in Pierce County” highlighted the success of agreeing on a single point of access and of campaigning for its use to clarify entry into the behavioral health system. The article is available here: [https://www.thenewstribune.com/news/local/article242523596.html](https://www.thenewstribune.com/news/local/article242523596.html)

- **Greater Columbia ACH (GCACH):** Due to the increase in the number of COVID-19 cases occurring in Skilled Nursing Facilities (SNFs) and Assisted Living Facilities, GCACH started a special initiative directed toward SNFs to address the isolation of residents and the suspension of normal group activities. Three SNFs had contracts as part of the practice transformation, so the ACH worked with the Activity Directors and piloted a small “Care Packages” project. Each SNF identified a “care package” from the following list of options that would best meet the needs of residents at their facility: Gardening, Poker Night, Beach Vacation, Craft Heaven, 50’s Diner, Bowling, and Bingo. In May, due to the success of the pilot, the project was scaled across the nine-county service area to include an additional 23 facilities. GCACH is working with a local credit union to scale up the project to include assisted living facilities across Benton and Franklin Counties.
HealthierHere (HH): HH acknowledged that years of authentic community, clinical, and tribal engagement gave them a deep understanding of community needs, and allowed them to rapidly co-design and launch five emergency funds. By working with partnering providers and community-based organizations, HH continues to ensure those closest to the challenges facing the region are also at the table guiding solutions. Emergency funding was given to 97 organizations. The five emergency funds include:

- **Traditional Medicine Fund:** This fund allows tribal communities to provide traditional medicine and healing resources and to help ensure availability of culturally appropriate health resources to native communities. The fund is serving as a model for how to center tribal and native voices across other regions and the state.

- **Telehealth/Remote SDOH Services Fund:** This fund is used to provide infrastructure to assist community-based providers in rapidly developing innovative approaches to service delivery models. Investments made possible by this fund have enabled community members to stay connected with service providers. Maintaining these connections is integral to effective SDOH service delivery, and allows community providers to informally screen for SDOH, physical, and behavioral health needs.

- **Community Navigator Fund:** Community partners are using this fund to assist “low-income and underserved individuals who have suffered from lapses in employment and have otherwise
been impacted by COVID-19” with enrollment and navigation of public benefits and social services. These services are critical for helping ensure basic needs are met and to assist people from falling into, or deeper into, poverty.

- **Multilingual Response Teams Fund**: This fund is used to proactively direct services and resources to communities with limited English proficiency to mitigate health disparities. Partnering providers with multilingual and multicultural staff are providing linguistically and culturally responsive COVID-19 recovery support services.

- **Resilience Fund**: This fund prioritizes organizations that can meet the needs of hard-to-reach communities and those experiencing disparities (e.g., elders, those with limited English proficiency, refugees, immigrants, homeless individuals, and racial/ethnic groups disproportionately impacted).

Using local data on COVID-19 cases and economic impacts, along with qualitative data from local partner organizations, HH identified groups being disproportionately impacted (e.g., Latinx and Native Hawaiian communities, unemployment individuals, and those with limited English proficiency) and used funding applications to ensure potential recipients adequately served these populations and communities.

For example, Pamoja Church received funding through the Multilingual Response Teams Fund for its culturally and linguistically appropriate COVID-19 response programming. They serve predominantly Kiswahili- and Kikuyu-speaking immigrants from East African communities. Pamoja is using the funding to provide virtual emotional support on coping with social stigma and isolation, grocery deliveries, transportation to doctor’s appointments, and gift cards when needed. Their community leader is a mental health nurse from the community the church serves. He and his team are able to provide critical spiritual wellness with a culturally appropriate approach to support community members through this crisis.

- **North Central ACH (NCACH)**: North Central communities worked together to implement a variety of initiatives and provide direct financial support including food delivery volunteers, sewing brigades to make masks, expanded telehealth delivery, and virtual peer support meetings. The pandemic response helped deepen NCACH’s commitment to addressing inequity and has affirmed the importance of transformative and systemic work and how much more work there is to do. COVID-19 has pushed the ACH to be intentional about making initiatives more accessible to a wider audience, including expanding work with a translator to ensure materials are multi-lingual.

- **North Sound ACH (NSACH)**: Increased adoption of telehealth and remote services among partnering providers has improved access to care for those with limited access to transportation or who live far away from services. Partners have developed policies, trained staff in new protocols, and purchased equipment to provide telehealth services. One partner reported that recovery support groups have better attendance after transitioning to virtual sessions in response to COVID-19. Many attendees felt more comfortable discussing recovery needs when they weren’t face-to-face with other participants. Another partnering provider shared that no-show rates for behavioral appointments have decreased since moving to telehealth visits. Partners are committed to building on their initial telehealth investments to continue providing the option for virtual services long term.

- **Olympic Community of Health (OCH)**: The Olympic region has embraced technology and telehealth services in the wake of the COVID-19 pandemic. Partnering providers continue to provide services in a
safe, accessible, and sustainable way. As many residents in the Olympic region do not have access to broadband internet, OCH is participating on a statewide broadband subcommittee and actively engages with local elected officials to help increase access. Specific technology and telehealth successes in the region include:

- Peninsula Community Health Services successfully launched a HIPAA compliant telehealth platform they can leverage permanently in the future.
- Port Gamble S’Klallam Health Services initiated telehealth services allowing counselors and MAT providers to provide individual and group services via telehealth. Telehealth has been implemented across primary care and behavioral health services.
- Beacon of Hope has seen a decrease in client no-shows due to telehealth. Access to treatment through Zoom has allowed for a timely assessment process which has also reduced no show numbers for entry into treatment.
- Kitsap Mental Health Services implemented virtual Dialectical Behavior Therapy (DBT) within the Child and Family Department with a 100% participation rate.
- The Olympic Area Agency on Aging adapted their trauma-informed care training to a digital platform, allowing the training to cater to a remote workforce and engage more staff.
- The YMCA of Pierce and Kitsap Counties converted many support resources to a virtual platform while their facilities are closed (e.g., fitness classes, art classes, virtual cooking classes, YMCA Diabetes Prevention Program and Weight Loss classes, stress management resources).

**SWACH:** In April, Clark County established a Quarantine and Isolation Hotel (Q&I Hotel) with 116 hotel rooms for unhoused people who had come into contact with COVID-19. SWACH and the HealthConnect HUB partnered with Clark County Public Health, Clark County Department of Community Services, and community based and clinical agencies to create a coordinated model where hotel “guests” are connected to community health workers (CHWs). CHWs assist community members at the hotel with the stress of quarantine, managing a positive COVID-19 diagnosis, and addressing pre-existing challenges (e.g., social, behavioral, physical health). They also act as liaisons to providers and community resources while in quarantine by connecting guests with supports and services including food boxes, PPE, medical transportation, health insurance enrollment, coordination with schools, resources on rental assistance, employment, etc. CHWs also provide a warm hand-off to continued community care coordination after quarantine through referrals to care models such as Pathways HealthConnect.

HealthConnect HUB has strengthened its network of referral agencies and improved system efficiencies to streamline consent and ROI processes that expedite connection to community care coordination. Over 80 Q&I Hotel guests have received care coordination outreach and engagement, support, and services through the HealthConnect HUB. Feedback from guests has been “very positive and inspirational.”
7. Summary Recommendations for Payment of Incentives

Tables 3 through 5 below provide an overview of ACH projects, Achievement Values (AVs), and incentives that ACHs can earn for achieving milestones for the reporting period January 1, 2020 to June 30, 2020. Each ACH can earn 1.0 AV per milestone per project. After review of responses to RFIs, the IA found all ACH reports to be fully responsive and complete, and the IA recommends HCA award full credit to each ACH for all milestones as noted in Table 4.

Table 3 provides the total potential AVs for each ACH by project that can be earned. If an ACH is not participating in a project, the table will display a dash (-).

Table 3. Potential P4R AVs for Project Incentives, January 1, 2020 – June 30, 2020

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<th>ACH</th>
<th>2A</th>
<th>2B</th>
<th>2C</th>
<th>2D</th>
<th>3A</th>
<th>3B</th>
<th>3C</th>
<th>3D</th>
<th>Total Potential AVs</th>
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<td>Better Health Together</td>
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Table 4 depicts the number of AVs each ACH has earned by milestone for the reporting period based on the results of the independent assessment.

Table 4. Potential P4R Achievement Values (AVs) by Milestone by ACH for Semi-annual Reporting Period January 1 – June 30, 2020

<table>
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<th>Number of Projects in ACH Portfolio</th>
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<tbody>
<tr>
<td>Attestation of successfully integrated managed care for DY4, Q1 2020 regions (Project 2A)</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of Semi-annual Report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Engagement/Support of Independent External Evaluator (IEE) Activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>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) Replaced by COVID-19 Response</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>
</tbody>
</table>
For each ACH, Table 5 provides incentives available by funding source for completion of Semi-annual Report 5.

**Table 5. Total P4R Project Incentives Available by ACH for Achievement of the Implementation Plan Milestone**

<table>
<thead>
<tr>
<th>ACH</th>
<th>Earned AVs</th>
<th>Project Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health Together</td>
<td>18</td>
<td>$2,674,964</td>
</tr>
<tr>
<td>Cascade Pacific Action Alliance</td>
<td>27</td>
<td>$2,431,785</td>
</tr>
<tr>
<td>Elevate Health</td>
<td>18</td>
<td>$2,918,142</td>
</tr>
<tr>
<td>Greater Columbia ACH</td>
<td>18</td>
<td>$3,404,499</td>
</tr>
<tr>
<td>HealthierHere</td>
<td>18</td>
<td>$5,349,926</td>
</tr>
<tr>
<td>North Central ACH</td>
<td>26</td>
<td>$1,215,893</td>
</tr>
<tr>
<td>North Sound ACH</td>
<td>34</td>
<td>$3,647,677</td>
</tr>
<tr>
<td>Olympic Community of Health</td>
<td>27</td>
<td>$972,714</td>
</tr>
<tr>
<td>SWACH</td>
<td>18</td>
<td>$1,702,250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$24,317,850</strong></td>
</tr>
</tbody>
</table>

8. **COVID-19 Observations by ACH**

In addition to the overall response themes identified in Section 5 across ACHs, Tables 6 through 23 provide ACH-specific observations of regional resiliency and vulnerability in handling the pandemic response. A resilient structure/system/community is one that has the ability to respond, absorb, and adapt to, as well as recover from, a disruptive event with minimal damages and functionality disruptions.\(^{11}\) Vulnerability refers to weaknesses in a system to withstand such disruptions. ACHs described project intervention supports that enabled COVID-19 response activities through improved delivery system infrastructure, as well as described risks or issues that impacted their response activities.

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### Better Health Together (BHT)

**Table 6. Better Health Together (BHT) COVID-19 Observations**

<table>
<thead>
<tr>
<th>Findings for Better Health Together (BHT)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples of Pandemic Response Resiliency</strong></td>
</tr>
<tr>
<td>- Telehealth: BHT noted that the system of care swiftly transitioned to telehealth which allowed providers to continue to serve individuals and reach those that were previously not engaging in care. BHT also transitioned to holding pertinent trainings to support providers around telehealth and COVID all via Zoom or other electronic means.</td>
</tr>
<tr>
<td>- Cross-Collaboration: BHT’s Learning Cohorts and Collaboratives have supported increased coordination between organizations and exercised the muscle of working across sectors around a project(s) and target populations. This made it easier for organizations to quickly address issues related to the COVID crisis because there are fewer communication silos.</td>
</tr>
</tbody>
</table>
| - Information Exchange:  
  - On April 1, BHT convened a Behavioral Health Forum to gather and share challenges, successes, and lessons learned from implementing telehealth. BHT noted that due to prior ACH experience, partners trusted this would be a good use of time and a great way to benefit from shared learning.  
  - Providers asked BHT to put together a web-based “dashboard” to track the real-time capacity of regional organizations in preparation for increased behavioral health services demand. BHT began in June with an anticipated launch in early September. Also, BHT became the go-to source for COVID information synthesis and exchange. Trainings: Within that forum, BHT heard from providers that support around telehealth and self-care was needed. As a response, BHT put together a series of self-care “trainings” and worked with the UW AIMS Center to offer telehealth training centered around delivering care. | - As a result, BHT released a policy statement around racism as a public health issue; approved $1M in grants to combat racism; and approved the creation of an Equity Accountability Council. |
<p>| - IMC Transition/Technical Assistance: BHT observed that the transition to IMC readied providers to bill and more easily adapt to the new billing codes allowed for COVID. | |</p>
<table>
<thead>
<tr>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
<td>5</td>
<td>5</td>
<td>$1,296,952</td>
</tr>
<tr>
<td>2B: Community-based Care Coordination</td>
<td>4</td>
<td>4</td>
<td>$891,655</td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
<td>5</td>
<td>$162,119</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
<td>4</td>
<td>4</td>
<td>$324,238</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>18</td>
<td>$2,674,964</td>
</tr>
</tbody>
</table>
**Cascade Pacific Action Alliance (CPAA)**

Table 8. Cascade Pacific Action Alliance (CPAA) COVID-19 Observations

<table>
<thead>
<tr>
<th>Examples of Pandemic Response Resiliency</th>
<th>Examples of Pandemic Response Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Rapid Response Capabilities: CPAA was able to quickly respond to the Stay Home, Stay Healthy order with $1M COVID-19 Emergency Funding, including additional support for food insecurity.</td>
<td>- Workforce Shortage: CPAA noted there were not enough providers, particularly in rural areas.</td>
</tr>
<tr>
<td>- PPE Distribution: CPAA distributed 1000 KN-95 masks to partners around the region.</td>
<td>- Legal Services: There was insufficient access to legal services to respond to the high demand for support by recipients of services.</td>
</tr>
<tr>
<td>- Care Coordination: Community CarePort (Project 2B) developed a new service, CarePort COVID-19 Community Support and Monitoring Program, to provide clients with regular connection to a trained care coordinator who can help them feel supported while in self-isolation or quarantine. Care coordinators, who share lived experiences with the clients they serve, are a trusted, reliable source to help connect clients access food, medicine, and other essentials needed to safely stay home.</td>
<td>- Financial challenges:</td>
</tr>
<tr>
<td>- Telehealth: Telehealth usage significantly increased for behavioral health agencies, primary care clinics, and hospitals. CPAA was able to support this transition through AIMS Center trainings on telehealth.</td>
<td>- Included the costs associated with quickly transitioning to telehealth.</td>
</tr>
<tr>
<td>- Chronic Care Management: The flexibility of remote delivery of Evidence-Based Programs allowed for the Chronic Disease Self-Management health education classes to be shifted to an online format.</td>
<td>- Three out of four of CPAA’s pediatric partners were severely affected by the pandemic due to the fact that the majority of their patient populations are on Medicaid. No other insurance reimbursement options were available to buffer the revenue losses from the decreased patient visits.</td>
</tr>
<tr>
<td></td>
<td>- CPAA noted that behavioral health and substance use disorder (SUD) service providers and smaller stand-alone clinics were particularly affected.</td>
</tr>
<tr>
<td></td>
<td>- Access to Care:</td>
</tr>
<tr>
<td></td>
<td>- While an increase in telehealth improved access to clinical services for some people in rural areas and for some people who were reluctant to physically visit a clinic, there was a significant decrease in utilization of services for children and adolescents who are reluctant to use telehealth. A decrease in well child visits creates concerns about immunization rates and spread of preventable diseases other than COVID-19.</td>
</tr>
<tr>
<td></td>
<td>- There was also an increase in demand for Medication for Opioid Disorder (MOUD) and behavioral health services with insufficient capacity.</td>
</tr>
<tr>
<td></td>
<td>- Housing: A lack of affordable housing for recipients of services was observed as a risk to the community.</td>
</tr>
<tr>
<td></td>
<td>- Domestic Violence: State-wide school closings caused a decrease in reporting of child abuse and there was considered to be an increased risk of domestic violence.</td>
</tr>
</tbody>
</table>
Table 9. Achievement Values and Earned Incentives for Reporting Period January 1, 2020 – June 30, 2020

<table>
<thead>
<tr>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
<td>6</td>
<td>6</td>
<td>$926,394</td>
</tr>
<tr>
<td>2B: Community-based Care Coordination</td>
<td>4</td>
<td>4</td>
<td>$636,896</td>
</tr>
<tr>
<td>2C: Transitional Care</td>
<td>4</td>
<td>4</td>
<td>$376,348</td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
<td>5</td>
<td>$115,799</td>
</tr>
<tr>
<td>3B: Reproductive and Maternal and Child Health</td>
<td>4</td>
<td>4</td>
<td>$144,749</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
<td>4</td>
<td>4</td>
<td>$231,599</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27</td>
<td>27</td>
<td>$2,431,785</td>
</tr>
</tbody>
</table>
### Greater Columbia ACH (GCACH)

**Table 10. Greater Columbia ACH (GCACH) COVID-19 Observations**

<table>
<thead>
<tr>
<th>Findings for Greater Columbia ACH (GCACH)</th>
<th>Examples of Pandemic Response Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples of Pandemic Response Resiliency</strong></td>
<td><strong>Examples of Pandemic Response Vulnerability</strong></td>
</tr>
<tr>
<td>• Telehealth: Because of the alignment between ACHs and provider organizations, the HCA used ACHs as a conduit for getting out information to providers on how to use telehealth and bill for telehealth/telephone services in order to maintain their viability.</td>
<td>• Substance use disorder relapse rates: Rates have increased with the corresponding increases in anxiety and depression brought on by social isolation from the governor’s stay-at-home order. This is of particular concern as the GCACH’s Substance Use Treatment Penetration rate (P4P) was already below the statewide average. The GCACH had previously contracted with four Opioid Resource Networks (ORNs) throughout its region to mitigate SUD relapse.</td>
</tr>
<tr>
<td>- GCACH expended $300,000 to help providers obtain laptops, webcams, expanded bandwidth, software, and technical assistance while HCA purchased a limited number of Zoom teleconferencing licenses to mitigate the effects of decreasing in-office client visits.</td>
<td>• Racial disparities: At one point, the Hispanic population in Yakima alone, which makes up about 50% of its total population, represented almost 70% of all COVID-19 cases in that county. The workers and residents of skilled nursing facilities, food processing, and agricultural jobs were hot spots. As a result, GCACH is supporting a campaign to educate on the importance of social distancing and masking.</td>
</tr>
<tr>
<td><strong>Information Exchange:</strong></td>
<td>• Financially instability for primary care practices:</td>
</tr>
<tr>
<td>- HCA worked with Collective Medical – a health information technology vendor that specializes in admit-discharge-transfer event notification technology – to allow Medicaid claims information relating to laboratory testing for COVID-19 be included in Collective Medical’s reporting to provider organizations. Through this arrangement, providers would be able to identify when a patient received testing for the virus, regardless of where the testing took place. As part of GCACH Practice Transformation Toolkit Milestone 6A.1: Care Coordination Across the Medical Neighborhood, practice transformation providers receive incentive funding at the site level, in part, for implementing HIT strategies, including the implementation of the Collective Medical platform. This strategy supports practices expanding their view of what happens to their patients outside of the office as they receive care from other health care entities in the community.</td>
<td>- GCACH referred to a national survey that recently revealed that only one-third of primary care clinicians feel sure their practices have enough cash on hand to function for four weeks and projections show up to 60,000 primary care practices nationwide may close or significantly scale back. - As a result, GCACH has petitioned for more stable revenue support for primary care providers. This might include providing primary care providers with a monthly fixed payment per patient (capitation), which would replace any previous fee-for-service payments the practice would have received during this time under normal patient volume. A global budget for primary care would allow primary care to offer an expanded array of services not currently being reimbursed through Apple Health; e.g., managing transitional care, case management services for high needs patients, and chronic care coordination technology information technology (CIE). The Greater Columbia Cares Model and Patient-Centered Medical Home supports facilitates and incentivizes these processes.</td>
</tr>
<tr>
<td>- GCACH became a central resource for its providers and stakeholders to help them navigate the local, state, regional and national resources available to them due to the COVID-19 crisis. GCACH revised its website to a directory of resources and aids for its provider organizations. The directory contains updated numbers of confirmed COVID-19 cases, links to telehealth and COVID billing resources, community resource directories,</td>
<td></td>
</tr>
</tbody>
</table>

---

**Examples of Pandemic Response Resiliency**

- Telehealth: Because of the alignment between ACHs and provider organizations, the HCA used ACHs as a conduit for getting out information to providers on how to use telehealth and bill for telehealth/telephone services in order to maintain their viability.
- GCACH expended $300,000 to help providers obtain laptops, webcams, expanded bandwidth, software, and technical assistance while HCA purchased a limited number of Zoom teleconferencing licenses to mitigate the effects of decreasing in-office client visits.

**Examples of Pandemic Response Vulnerability**

- Substance use disorder relapse rates: Rates have increased with the corresponding increases in anxiety and depression brought on by social isolation from the governor’s stay-at-home order. This is of particular concern as the GCACH’s Substance Use Treatment Penetration rate (P4P) was already below the statewide average. The GCACH had previously contracted with four Opioid Resource Networks (ORNs) throughout its region to mitigate SUD relapse.
- Racial disparities: At one point, the Hispanic population in Yakima alone, which makes up about 50% of its total population, represented almost 70% of all COVID-19 cases in that county. The workers and residents of skilled nursing facilities, food processing, and agricultural jobs were hot spots. As a result, GCACH is supporting a campaign to educate on the importance of social distancing and masking.
- Financially instability for primary care practices:
  - GCACH referred to a national survey that recently revealed that only one-third of primary care clinicians feel sure their practices have enough cash on hand to function for four weeks and projections show up to 60,000 primary care practices nationwide may close or significantly scale back.
  - As a result, GCACH has petitioned for more stable revenue support for primary care providers. This might include providing primary care providers with a monthly fixed payment per patient (capitation), which would replace any previous fee-for-service payments the practice would have received during this time under normal patient volume. A global budget for primary care would allow primary care to offer an expanded array of services not currently being reimbursed through Apple Health; e.g., managing transitional care, case management services for high needs patients, and chronic care coordination technology information technology (CIE). The Greater Columbia Cares Model and Patient-Centered Medical Home supports facilitates and incentivizes these processes.
Findings for Greater Columbia ACH (GCACH)

- Consumer and patient information from health plans, clinical guidance on treating COVID-19, situation reports from the regional Emergency Operations Center and other resources.
- Distributing PPE: As a goodwill gesture, the consulting firm, Deloitte, passed on 10,000 N-95 face masks to the HCA, who then passed these onto the individual ACHs for distribution to their communities. HCA determined that the ACHs would be a good vehicle to determine how best to distribute this PPE. Through this process, the GCACH received 1,400 face masks that were sent to the Yakima Emergency Operations Center (EOC) in Union Gap.
- Cross-ACH Activities: ACHs released the white paper, “ACHs - A Resource for Communities During COVID-19,” that describes the functions and services common to all ACHs, including regional coordination, local support and training for providers, and multi-sector collaborations important to stakeholders especially during the COVID-19 pandemic.

Table 11. Achievement Values and Earned Incentives for Reporting Period January 1, 2020 – June 30, 2020

<table>
<thead>
<tr>
<th>Greater Columbia ACH</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
<td>5</td>
<td>5</td>
<td>$1,911,298</td>
</tr>
<tr>
<td>2C: Transitional Care</td>
<td>4</td>
<td>4</td>
<td>$776,465</td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
<td>5</td>
<td>$238,912</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
<td>4</td>
<td>4</td>
<td>$477,824</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>18</td>
<td>$3,404,499</td>
</tr>
</tbody>
</table>
### Findings for HealthierHere

<table>
<thead>
<tr>
<th>Examples of Pandemic Response Resiliency</th>
<th>Examples of Pandemic Response Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Rapid Response Capabilities: HealthierHere noted the COVID-19 pandemic created an urgent need to help clinical, tribal healthcare, and community providers meet the growing demands of community members, especially those most vulnerable and at risk of being exposed to and contracting COVID-19. HealthierHere released $5.1 million in funding through five emergency funds, with the aim to maintain continuity of care, build partner infrastructure and capacity to respond to COVID-19, and ensure the most vulnerable populations in King County have access to the care and social service supports they need.</td>
<td>- Financial Instability: The lost income due to reduced visits and closure of nonessential services and facilities, along with the decreased federal/state/local funding due to budget crises, are considered risks to the health care system by HealthierHere.</td>
</tr>
<tr>
<td>- Cross-ACH Meetings: ACH leadership teams continue to meet regularly to discuss statewide challenges and priorities, including regularly to discuss their COVID-19 response activities and share lessons learned. Cross-ACH achievements during the SAR reporting period include:</td>
<td>- Workforce Shortages: The loss of staff and the insufficient supply of behavioral health professionals to meet increased demand for services (now and in the future) are considered risks to the health care system.</td>
</tr>
<tr>
<td>- Developing a joint ACH website; a joint one-pager on the role of ACHs in the COVID-19 response; a joint statement on racism and the racial justice movement; creating a shared vision for CIE and for community-based care coordination; drafting a concept paper for a social investment model to support SDOH services beyond the Medicaid Transformation waiver; and participating in the Behavioral Health Institute (BHI) telehealth training for BHAs</td>
<td>- Access to Care: HealthierHere noted the following risks to access:</td>
</tr>
<tr>
<td>- Information Exchange:</td>
<td>- The lack of access to accurate, relevant, culturally appropriate and in-language information and care</td>
</tr>
<tr>
<td>- HealthierHere continues to lay the groundwork for the development of a regional Community Information Exchange (CIE) for King County. In light of COVID-19, HealthierHere CIE coalition and community partners are exploring how this platform could play a role in COVID-19 recovery, wraparound services and future pandemics.</td>
<td>- The increased need for social determinants of health (SDOH) services and supports without increased capacity to deliver such services and supports</td>
</tr>
<tr>
<td>- A CIE is a network of cross-sector partners (e.g., social service, community, tribal, physical and behavioral health providers) that use a shared technology platform and resource database to coordinate care so individuals have</td>
<td>- The forgoing of preventive and chronic care by individuals who fear contracting COVID-19, resulting in exacerbation of existing health issues, undiagnosed illnesses, and fewer well-child visits and associated vaccines, potentially leading to other disease outbreaks (e.g., measles).</td>
</tr>
</tbody>
</table>
### Findings for HealthierHere

- Better access to the healthcare and social supports they need in order to improve their health.
- The vision for the CIE is for participating clinical and community partners, as well as many others from the King County health ecosystem, to have access to a network database where they contribute to a single longitudinal client record, share information, and make bidirectional, closed-loop referrals.
- HealthierHere will aim to take the lessons learned during COVID-19 to develop a platform that can be leveraged in future crisis response initiatives.
Table 13. Achievement Values and Earned Incentives for Reporting Period January 1, 2020 – June 30, 2020

<table>
<thead>
<tr>
<th>HealthierHere</th>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
<td>5</td>
<td>5</td>
<td>$3,003,467</td>
</tr>
<tr>
<td>2C: Transitional Care</td>
<td>4</td>
<td>4</td>
<td>$1,220,159</td>
<td></td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
<td>5</td>
<td>$375,433</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
<td>4</td>
<td>4</td>
<td>$750,867</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>18</td>
<td><strong>$5,349,926</strong></td>
<td></td>
</tr>
</tbody>
</table>
## North Central ACH

**Table 14. North Central ACH COVID-19 Observations**

<table>
<thead>
<tr>
<th>Findings for North Central ACH (NCACH)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples of Pandemic Response Resiliency</strong></td>
<td><strong>Examples of Pandemic Response Vulnerability</strong></td>
</tr>
</tbody>
</table>
| • Rapid Response Capabilities:  
  - NCACH joined Local Health Jurisdictions’ (LHJ) Incident Command Systems on March 16, 2020. NCACH worked with each LHJ to support their community mitigation response needs, including developing tools for communities practicing social isolation, providing outreach, and creating messaging tools to encourage communities to “Stay Home, Stay Safe, and Stay Healthy” during the Governor’s stay-home and Phase 1 orders.  
  - The NCACH Governing Board also approved up to $300,000 in funding for community partners through a variety of short-term response funding opportunities including a community support fund, an essential worker recognition campaign, a youth educational video contest, and direct support to local Incident Command operations.  
  - NCACH also launched a rapid-cycle COVID-19 Community Response Fund that provided direct assistance to community groups, schools, and nonprofits who were helping communities Stay Home and Stay Healthy. From April to June 2020, NCACH awarded a total of $150,000 to 43 unique projects through that fund.  
  - Community Paramedicine: EMS partners drew from their expertise providing Community Paramedicine to support monitoring patients placed under quarantine for suspected or confirmed COVID-19 cases. Using this model, EMS providers offer regular wellness checks on quarantine patients, checking on symptoms, and providing connection. NCACH is helping to fund these efforts for partners in Okanogan County.  
  - Telehealth:  
    - NCACH verified that an important support for the rural community was the change in policy to allow for expanded telehealth billing, which was previously a barrier to many mental health providers in the region.  
    - The COVID-19 pandemic compelled the region (along with the world) into involuntary innovation mode, which led to creative responses to a rapidly changing environment.  | • Health Homes Client Engagement: NCACH observed individuals who have a lower socio-economic status and/or live more rurally could only access services telephonically because they did not have access to a device that provided tele-video/audio or broadband to support the service. This disparity was evident when the telephone visit was subpar compared to the tele-video visit. In addition, the lead for the Health Homes program in the NCACH region noted challenges specific to the in person outreach for high-risk and isolated clients served by the Health Homes program.  
  - Financial Instability for Rural Providers: Remaining financially viable during a major pandemic has continued to be an issue for rural providers. Many clinical providers in NCACH’s rural setting have had to rapidly change the way they provide care, including investing in telehealth technology, while seeing significant decreases in revenue due to canceled non-emergent procedures and visits. Expansion of reimbursement models through telehealth have helped mitigate some of these issues, but without the continued expansion or support of those reimbursement models, it will be difficult for healthcare providers to remain viable in small rural areas. |
Findings for North Central ACH (NCACH)

changing situation. With the addition of increased telehealth visit availability, NCACH has seen an increase in behavioral health access in some of the more rural areas of the region that historically lacked robust access to health services.

Table 15. Achievement Values and Earned Incentives for Reporting Period January 1, 2020 – June 30, 2020

<table>
<thead>
<tr>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
<td>5</td>
<td>5</td>
<td>$422,919</td>
</tr>
<tr>
<td>2B: Community-based Care Coordination</td>
<td>4</td>
<td>4</td>
<td>$290,757</td>
</tr>
<tr>
<td>2C: Transitional Care</td>
<td>4</td>
<td>4</td>
<td>$171,811</td>
</tr>
<tr>
<td>2D: Diversions Interventions</td>
<td>4</td>
<td>4</td>
<td>$171,811</td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
<td>5</td>
<td>$52,865</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
<td>4</td>
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</tr>
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<td><strong>Total</strong></td>
<td>26</td>
<td>26</td>
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</table>
### North Sound ACH

**Table 16. North Sound ACH COVID-19 Observations**

**Findings for North Sound ACH**

<table>
<thead>
<tr>
<th>Examples of Pandemic Response Resiliency</th>
<th>Examples of Pandemic Response Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Exchange:</strong></td>
<td>• Workforce Support:</td>
</tr>
<tr>
<td>- North Sound ACH published a COVID-19 Vulnerability Dashboard and COVID-19 Impact Model available for partners and emergency responders. The dashboard and modeling tool shows 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.</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
</tr>
<tr>
<td>- Facilitated two meetings of community resource paramedics to share best practices and learnings in COVID-19 response.</td>
<td></td>
</tr>
<tr>
<td><strong>Long-term Care:</strong> North Sound ACH convened and continues to moderate weekly Long-term Care COVID-19 response calls with Local Health Jurisdictions, WA Department of Health, Department of Social and Health Services, and Northwest Healthcare Response Network.</td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination:</strong></td>
<td>• Information Exchange:</td>
</tr>
<tr>
<td>- Promoted the use of a pre-visit COVID-19 screening tool for Pathways community health workers.</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
</tr>
</tbody>
</table>
### Table 17. Achievement Values and Earned Incentives for Reporting Period January 1, 2020 – June 30, 2020

<table>
<thead>
<tr>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
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<td>2C: Transitional Care</td>
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<tr>
<td>2D: Diversions Interventions</td>
<td>4</td>
<td>4</td>
<td>$474,198</td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
<td>5</td>
<td>$145,907</td>
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<tr>
<td>3B: Reproductive and Maternal and Child Health</td>
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<tr>
<td>3C: Access to Oral Health Services</td>
<td>4</td>
<td>4</td>
<td>$109,430</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
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<td><strong>Total</strong></td>
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<td><strong>34</strong></td>
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</tbody>
</table>
Olympic Community Health (OCH)

Table 18. Olympic Community Health (OCH) COVID-19 Observations

<table>
<thead>
<tr>
<th>Findings for Olympic Community Health (OCH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples of Pandemic Response Resiliency</strong></td>
</tr>
</tbody>
</table>
| • Telehealth: OCH noted there was initial confusion across the region regarding Governor Inslee’s emergency orders, indicating that temporary closures, reduced services, and fear prevented many people from accessing needed physical and behavioral health care.  
  - Most organizations did not have the necessary equipment and systems to immediately implement telehealth. In response, OCH quickly identified resources to support partners who needed to learn how to use telehealth platforms and to understand the changing rules and guidance. OCH conducted targeted outreach and problem solving with partners.  
  - OCH’s Executive Director participates on the Behavioral Health Institute (BHI) and on the statewide Broadband Subcommittee. OCH promoted the BHI survey to identify technical assistance needs. OCH advocates to the HCA, BHI, and other statewide partners about challenges with internet access in the region. | • General: OCH noted that while compared to other parts of the state, the Olympic region has not experienced as many cases of COVID-19, it is still deeply impacted and OCH recognizes this is a marathon, not a sprint. The pandemic revealed “cracks” in the health care system including payment models, continuity of care, and social needs.  
  - There is interest among partners to focus the final months of MTP on areas where the region has seen success and where there is more work to do. SDOH work is a long haul and OCH needs to take stock of the integration work and define what success means.  
  - Education: Community-wide education launched during COVID-19 by OCH is an important component of the work moving forward.  
  - Telehealth: COVID-19 allowed for quick advancements for telehealth. However, the region does not have widespread access to broadband and telehealth is not a solution for all community members. The region would like to see telehealth advancements supported and sustained for the long-term.  
  - State Budget Cuts: Upcoming state budget cuts will pose a significant challenge while also presenting an opportunity for collaborative advocacy. |
| • Information Exchange: OCH continued to explore options for a Community Information Exchange (CIE) platform that will allow for communication and referral between clinical and community partners. While a platform is yet to be selected and launched, COVID-19 highlighted opportunities and need for an effective system. OCH and a few partners participated in two demonstrations with Unite Us and plan to bring this to the Board of Directors for a decision later in 2020.  
  • Data Analytics:  
    - OCH called a special meeting of the 3CCORP steering committee to discuss an increase in opioid overdoses and to make recommendations as needed. OCH provided quantitative data comparing previous and current opioid overdose data. OCH also gathered qualitative data from local public health departments, syringe exchange programs, and key behavioral health practices. Qualitative data supported that the increase was limited to Clallam County and that the impact of COVID-19 stressors including isolation, unemployment, and disruptions in SUD services were likely causes of increased overdoses. | |


Findings for Olympic Community Health (OCH)

- As a result of this meeting, a gap in available data was identified: Jefferson and Kitsap Counties track only fatal overdoses while Clallam County tracks fatal and non-fatal overdoses, providing a more complete overdose record. The 3CCORP steering committee discussed strategies for Jefferson and Kitsap Counties to begin tracking non-fatal overdoses, possibly using existing syringe exchange programs as a resource. Jefferson and Kitsap Health Officers committed to exploring opportunities to begin tracking non-fatal overdoses. A second outcome is that OCH is developing an opioid overdose community education campaign.
<table>
<thead>
<tr>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
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<td>6</td>
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<tr>
<td>2D: Diversions Interventions</td>
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<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
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<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
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<td>$59,859</td>
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<tr>
<td>3B: Reproductive and Maternal and Child Health</td>
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<td>4</td>
<td>$74,824</td>
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<tr>
<td>3C: Access to Oral Health Services</td>
<td>4</td>
<td>4</td>
<td>$44,894</td>
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<tr>
<td>3D: Chronic Disease Prevention and Control</td>
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<tr>
<td><strong>Total</strong></td>
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<td>27</td>
<td>$972,714</td>
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### Findings for Pierce County ACH dba Elevate Health of Washington

<table>
<thead>
<tr>
<th>Examples of Pandemic Response Resiliency</th>
<th>Examples of Pandemic Response Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Information Exchange: Elevate Health’s existing relationship with technology vendor Innovaccer enabled the rapid development of virtual intervention supports to assist in healthcare delivery during the pandemic. Elevate Health worked with Innovaccer to develop the following supports for providers in Pierce County: - A COVID-19 app accessible to Community Health Workers for assisting clients to arrange a telehealth visit directly with health care providers. - A COVID-19 protocol to assist Community Health Workers in screening clients for symptoms or problems requiring further medical evaluation at every virtual visit. - A closed loop referral app that enables partners to make referrals to other organizations for physical or social support needs, and allows the receiving organization to share outcomes related to the referral. Note that this is currently being tested with several community partners.</td>
<td>• Health Disparities: People of color and people with low-incomes already experience worse health outcomes than white, affluent communities. The COVID-19 pandemic is worsening these disparities at the community level. - To address this issue, Elevate Health has engaged with the African American faith community to develop strategies that will address the pandemic’s impact on residents of Tacoma’s Hilltop neighborhood, historically a low-income area experiencing rapid gentrification. - Elevate Health’s investment arm, OnePierce Community Resiliency Fund, is also working with churches and housing developers to understand and address the causes of health inequalities, including a lack of affordable and supportive housing and workforce opportunities.</td>
</tr>
<tr>
<td>• Whole Person Care Collaborative: In partnership with Elevate Health, the University of Washington AIMS Center provided a webinar to assist participating organizations in navigating telehealth. The webinar gave organizations the opportunity to understand how to implement telehealth for the bi-directional collaborative care model. Additionally, it provided access to trainers who could provide best practices. - Elevate Health is also collaborating with seven (7) Fire Districts to develop a telehealth model for EMS providers.</td>
<td>• Workforce Shortages: Elevate Health observed that an expected surge in behavioral health needs resulting from the pandemic’s impact may coincide with a reduction in workforce for behavioral health organizations due to furloughs and staff layoffs. Elevate Health has worked closely with its behavioral health partners to understand funding needs and allocate additional funds where possible. - Additionally, Elevate Health’s investment arm, OnePierce, is managing $1.5M of CARES Act funding for behavioral health organizations on behalf of Pierce County, and it has utilized Elevate Health’s strong networks within behavioral health to ensure the funds are accessible to all organizations.</td>
</tr>
<tr>
<td>• Care Coordination: Elevate Health has also found that care coordination through its Care Continuum Network (CCN) is critical during this health crisis. It has collaborated with Tacoma-Pierce County Health Department to address the social support needs of individuals testing positive for COVID-19 or with exposure to COVID-19 through its existing care coordination programs within the CCN.</td>
<td>• COVID-19 Resurgence: COVID-19 cases have increased, especially in the 20-29-year age range, during the reopening of Pierce County. Elevate Health is helping to mitigate this risk of resurgence by determining how to partner with health systems and community-based organizations to collaborate on COVID-19 screenings and referrals. Elevate Health is in the process of applying for additional CARES Act funding to contribute to a county-wide COVID-19 response. This funding would be used to expand the Pathways program to help those in quarantine and isolation.</td>
</tr>
<tr>
<td>Pierce County ACH</td>
<td></td>
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<tr>
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</tr>
<tr>
<td><strong>Table 21. Achievement Values and Earned Incentives for Reporting Period January 1, 2020 – June 30, 2020</strong></td>
<td></td>
</tr>
<tr>
<td>Project</td>
<td>Total AVs Achieved</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
<td>5</td>
</tr>
<tr>
<td>2B: Community-based Care Coordination</td>
<td>4</td>
</tr>
<tr>
<td><strong>Domain 3: Prevention and Health Promotion</strong></td>
<td></td>
</tr>
<tr>
<td>3A: Addressing the Opioid Use Crisis</td>
<td>5</td>
</tr>
<tr>
<td>3D: Chronic Disease Prevention and Control</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>
**SWACH**

**Table 22. SWACH COVID-19 Observations**

<table>
<thead>
<tr>
<th>Findings for SWACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of Pandemic Response Resiliency</td>
</tr>
</tbody>
</table>

- **Rapid Response Capabilities:**
  - SWACH was able to help connect the Clark County COVID-19 Homelessness Quarantine and Isolation Project with harm reduction and recovery support services on site.
  - Offered temporary staffing support to assist the Clark County Public Health and Council for the Homeless.
  - Provided contracted partners with one-time, emergency funding to support their response efforts. Up to $300,000 of SWACH funding was allocated for this response.
  - Contributed $200,000 to the Community Foundation of Southwest Washington for their COVID-19 response fund.

- **Amplifying Voices Initiative:** SWACH is developing a forum to elevate community voice and share information across the region related to COVID-19.
  - SWACH will collect information to 1) Understand regional needs, barriers and challenges, 2) Understand how responses to COVID-19 have magnified discrimination, racism, and/or stigma, 3) Identify priorities to achieve policy and organizational change, 4) Identify regional trainings needs, and 5) Provide feedback for collective impact response.
  - As a result of this process, SWACH will be positioned to provide shared learning opportunities to collectively solve problems, influence policy and system change, and support health partners at local, regional and state levels related to COVID-19.

- **Telehealth:** COVID-19 created a need to provide services via telehealth which many partners were not already providing. Integration experts provided technical assistance to partners as needed to help them walk through setting up their telehealth services in response to COVID-19. SWACH has also helped partners think through how to utilize and optimize telehealth sustainability beyond COVID-19.

- **Care Coordination:** Pathways HealthConnect expanded eligibility for Community Care Coordination to broadly include vulnerable populations impacted by COVID-19.
  - Quadrupled to 48 the number of regional community-based workforce trained to use HealthConnect technology platform and Pathways HealthConnect care model to

- **Workforce Shortage:** The already existing behavioral health workforce shortage was exacerbated by COVID-19. Behavioral health agencies and their clients were not able to quickly adjust to a virtual environment. Mitigation strategies included financial assistance to buy telehealth equipment and training and support for providers to adjust to a virtual environment.
## Findings for SWACH

- Work with community members to access social need, behavioral health, physical health services and supports.
- Target populations for Pathways HealthConnect contracted agencies to include vulnerable populations impacted by COVID-19.
- **Chronic Disease Management:** SWACH observed that Community Paramedicine opportunities to collaborate across sectors, programs and agencies in the COVID-19 response will not be fully realized if Community Paramedicine work is occurring in a systems silo. Therefore, SWACH collaborated with Community Paramedicine partners and provided HealthConnect HUB systems integration training which allows access to a community health record that can follow supported community members across provider sectors and agencies.
<table>
<thead>
<tr>
<th>Project</th>
<th>Total AVs Achieved</th>
<th>Maximum Possible AVs</th>
<th>Incentives Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Care Delivery Redesigns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation</td>
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<td>2B: Community-based Care Coordination</td>
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