MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Produced by Myers and Stauffer on behalf of the Washington Health Care Authority

Washington State Medicaid Transformation

Independent Assessment of Semi-annual Report 6

Reporting Period July 1, 2020 – December 31, 2020

Findings Report: May 2021

Table of Contents

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 Healthier Washington Medicaid Transformation (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 July 1, 2020 to December 31, 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 five 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 6

All ACHs submitted their SARs by the January 31, 2021 deadline.

- **Findings.** Upon submission of RFI responses, all SARs included sufficient detail to reflect performance during the reporting period of July 1, 2020 to December 31, 2020.
- **Recommendation.** The IA recommends HCA approve and award full credit to ACHs for milestone achievement towards Medicaid Transformation.

4. COVID-19 Pandemic

Due to the impact of the novel coronavirus (COVID-19), the health care system and the communities of Washington State saw continued burden throughout the remainder of 2020. The duration of the pervasive challenges of the pandemic declared on March 11, 2020 by the World Health Organization (WHO), and extent of morbidity, resulted in escalating anxiety and medical risks. Between the first reported case and the end of

December 2020, there were 250,614 reported cases, with 15,194 hospitalizations and 3,776 deaths.[1] In the same timespan, the United States had over 56.3 million confirmed cases with over 328,000 deaths. There were over 79.2 million cases and over 1.7 million deaths reported across the world.[2]

Table 1 - COVID-19 Impact in Washington State

Time Period	Reported Cases	Cumulative Hospitalizations	Cumulative Death
Case 1 – June 2020	33,447	4,524	1,304
Case 1 – December 31, 2021	250,614	15,194	3,776

While hospital bed capacity and surge capacity improved, communities continued to require strategies to address housing, food insecurity, and ongoing remote education. HCA, the ACHs, and partnering providers maintained pandemic response protocols, including modifications and flexibilities to the Medicaid Transformation waiver approved by the Centers for Medicare and Medicaid Services (CMS). 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.

Health Inequities and Social Injustice

As the pandemic continued into the latter part of the year, additional challenges and pressure on systems and communities in Washington State surfaced. The first related to data and evidence that made clear that black, indigenous and people of color (BIPOC) were at increased risk for negative COVID-related outcomes due to inequities in social determinants of health (SDOH).[3] The second involved the largest protests in U.S. history against systemic racism.[4]

In their responses, all nine ACHs addressed these subjects.

5. Highlights of the ACHs' Semi-Annual Report 6

The following summary describes findings noted by ACHs within their SAR 6 responses.

- **Project Updates:** Although the pandemic continued, ACHs indicated that their Medicaid Transformation Project (MTP) activities were generally back on track. Updates indicated:
    - ACH activities to mitigate COVID-19 impact and support partnering providers continued.
    - Release of funding continued to be accelerated by some ACHs.
    - Some ACHs reported that partnering providers revised the focus of their interventions (primarily as a result in the increased need for behavioral health services) or delayed start dates of activities.
    - Reporting requirements and schedules had generally returned to pre-COVID conditions.

[1] Washington State Department of Health. https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard. [Accessed on March 12, 2021.]

[2] World Health Organization. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20201229_weekly_epi_update_con_20_cleared.pdf?sfvrsn=f92679b8_13&download=true https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200701-covid-19-sitrep-163.pdf?sfvrsn=c202f05b_2 [March 12, 2021.]

[3] Centers for Disease Control. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity. (Accessed March 15, 2021)

[4] New York Times. https://www.nytimes.com/article/george-floyd.html; (Accessed March 15, 2021)

Recommendation: HCA and ACHs may wish to conduct a more structured survey of the status of projects during future reporting cycles and/or require completion of the Implementation Plan update during SAR 8.

- **Health and Social Equity Impact.** Addressing equity was a pillar of MTP, however, ACHs noted that further action was being taken as a result of recent events, such as:
  - BHT is working to build a "culture of belonging" and developed an Equity Lens Reduction Tool. They released an Request for Proposal (RFP) aimed at supporting anti-racism efforts in their community that resulted in contracting with an additional 19 new organizations.
  - GCACH noted their large Hispanic population is equal to thirteen percent of the total population in the region, yet one third was impacted by COVID-19 and required tailored outreach campaigns.
  - HealthierHere described actions taken to serve hard-to-reach communities including the development of the Traditional Medicine Fund to support American Indians/Alaska Natives/Indigenous populations.
  - North Sound ACH commented that "During this crisis, we couldn't worry about getting a response perfect, as people were in immediate need of support. This is a lesson learned for responding to other crises like housing and racial injustice: the time to act is now."

  Recommendation: Significant change has occurred in the national conversation related to equity and SDOH since the commencement of MTP. HCA and ACHs should refresh the state's approach to equity to ensure that it considers available resources, approaches, and lessons learned that may not have been available prior to 2020. This may include systematic approaches to collection and reporting of SDOHdata, public reporting, implementation of closed loop referral processes, and additional population health value-based care payment approaches. HCA has already signaled a desire to elevate this topic through the hiring of a Health Equity Social Justice and Strategy Manager who could be designated to advance such approaches.

- **Escalating Behavioral Health Risks**. Integration of primary and behavioral health was another pillar of MTP, and yet due to the impacts of COVID-19, including social-isolation, the need for behavioral health services has increased even further. ACHs indicated:
  - ACHs are advocating for increased broadband service to support provision of behavioral services via telehealth.
  - BHT's Ferry County Collaborative changed their focus to address the immense need emerging for behavioral health services. Their plan was modified to concentrate on suicide prevention for all residents.
  - North Central ACH noted that the gap in communication patterns between primary care and behavioral health providers became even more apparent as a result of COVID-19.
  - GCACH noted that presentations related to behavioral health concerns held in their Leadership Council led them to take further action for creating community resilience to combat the predictable pattern of psychological stressors. Figure 1 below is an example of the research shared from the presentation and included in the report.

Figure 1- GCACH SAR 6 Report "Figure 9; Reactions and Behavioral Health Symptoms from Disasters"

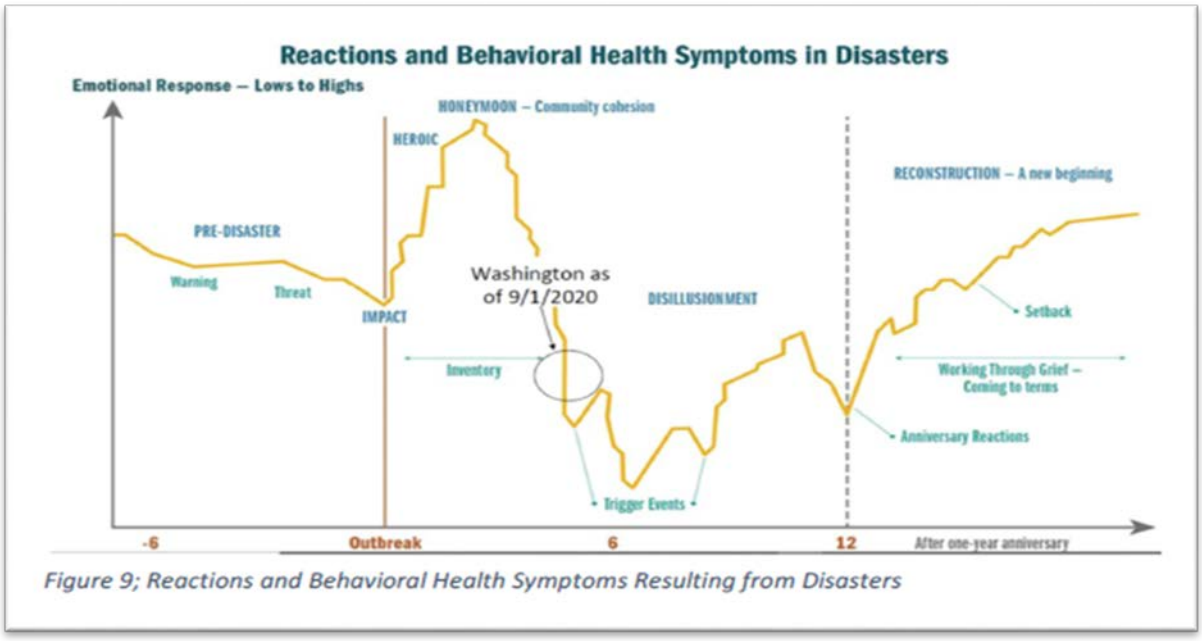

Figure 9; Reactions and Behavioral Health Symptoms Resulting from Disasters

Recommendation: To support Washingtonians, including those who may be experiencing elevated behavioral health concerns for the first time, HCA and ACHs should continue to convene frequent, action-oriented discussions amongst partnering providers and payers, including Managed Care Organizations (MCO), related to approaches for the identification, referral to treatment, service provision and data analysis of behavioral health service utilization by subpopulations.

- **Finances.** As observed in Table 2 below, the total funds earned during the reporting period does not have a direct linkage to the total funds distributed during the same reporting period. Distribution of funds may not occur in the same period that funds were earned due to reasons such as, awaiting board approval for release of funds or partnering provider attainment of project milestones. Data presented in this table is provided by HCA from the Financial Executor Portal reports.

Table 2. Funds Earned and Distributed During the Reporting Period

	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
Total Funds Earned During Reporting Period	$2,674,964	$2,431,785	$2,918,142	$3,404,499	$5,349,926	$1,215,893	$3,647,677	$972,714	$1,702,250
Total Funds Distributed During Reporting Period	$3,622,347	$3,047,538	$6,502,781	$6,410,556	$14,256,879	$1,448,249	$4,604,063	$2,122,040	$6,295,026

- **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 3 summarizes the active partnering providers included in each ACH partnering provider roster. During the reporting period some ACHs saw an increase in active partners (e.g. BHT, CPAA, EH, SWACH), while others reported a decline (e.g. GCACH, HH, NSACH). Elevate Health reported a significant increase in active partners supporting Project 2B: Community-Based Care Coordination; 91 partners compared to 44 partners during the SAR 5 reporting period.

Table 3. Active Project Partnering Providers

Project	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
2A: Bi-directional Integration of Care	122	57	59	85	110	41	115	59	34
2B: Community-Based Care Coordination	124	36	91	●	●	42	8	●	13
2C: Transitional Care	●	36	●	86	97	46	109	●	●
2D: Diversions Interventions	●	●	●	●	●	47	112	59	●
3A: Addressing Opioid Use	120	59	47	88	103	55	150	59	14
3B: Reproductive and Maternal and Child Health	●	67	●	●	●	●	87	59	●
3C: Access to Oral Health Services	●	●	●	●	●	●	36	59	●
3D: Chronic Disease Prevention and Control	120	46	24	85	94	41	92	59	34

- **Scale and Sustain.** ACHs remain committed to sustaining improvements, but appear to be at different phases for determining what comes next. ACHs emphasized the need for collaboration and system-thinking in their reporting:
  - BHT noted about the collaborative model developed in the region that includes six county-based collaboratives comprised of a wide array of stakeholders, "This model will remain a mainstay of how we organize our work, distribute funds, and plan to move forward. We believe this model supports our vision of whole-person care and emphasizes a connection between the health system and social determinants of health supports."
  - HealthierHere noted that stakeholders have identified the multi-sector convening among HealthierHere's greatest strengths. "Through the MTP, HealthierHere has been able to establish a "balcony perspective" on the region's needs and partners' competencies to meet those needs."
  - North Central ACH noted: "To support the path towards sustainability for clinical partners, NCACH has focused on quality improvement work, data collection, partnership/collaboration building, and population health management."

  Recommendation: Among sustainability efforts, HCA and ACHs should consider focused approaches that continue community-level needs assessment, planning and connection efforts, along with health information exchange efforts that support patient-centered care.

- **Pay-for-Reporting (P4R) Value-Based Payment (VBP).** During the SAR 6 reporting cycle, funding was available for Project P4R VBP milestones which supported Health and Community Systems Capacity Building objectives. The reporting period for P4R VBP milestones covered the full calendar year (January 1 through December 31, 2020). In their reports, ACHs identified barriers impeding the move toward value-based care and provided examples of how they helped partnering providers overcome those barriers. They note the largest barrier to implementation is the reluctance of MCOs to form VBP arrangements with small, rural providers.

  - CPAA noted the lack of historical data on standardized metrics for behavioral health providers to support a value-based contract and the need for sufficient patient volume by payor for providers to take on clinical risk. They continue to offer open forums for providers to discuss VBP, provide VBP educational materials, and encourage discussion between providers and MCOs.
  - SWACH noted the variation in MCO VBP programs and the administrative challenge for small providers to navigate the different VBP structures. They also note a need for MCOs to modify contract requirements for small providers as their needs don't always align with larger provider

groups. "There has been significant variation in MCO approaches with provider groups. It is not clear what the role of ACH's should be in the implementation of VBP structures with providers."
- OCH noted that most substance use disorder (SUD) providers and pediatric clinics report a lack of VBP contracting opportunities with MCOs due to being too small. Due to the confidential contracting process between providers and MCOs, some providers have difficultly sharing data with ACHs compared to other providers. This limits the role of the ACH in technical support and assisting providers with VBP implementation.

- **Pay-for-Reporting Metrics.** 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 6 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, NCACH, OCH, and SWACH.

  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.

6. Success Stories:

ACHs provided lessons learned or "success stories" that emerged during the response to the COVID-19 pandemic. Highlights include:

- **Better Health Together (BHT):** BHT released the first round of Community Resiliency Fund dollars aimed at supporting anti-racism efforts in the community. The RFP design process was supported by BHT's newly developed Equity Lens Reflection tool, which BHT noted was born out of the equity journey that was accelerated by the murder of George Floyd and the disparate impact of the COVID-19 pandemic on BIPOC communities.

  BHT acknowledged that the communities impacted by systems of oppression are the ones who also suffer the most in times of crisis. BHT intentionally designed the program and outreach with awareness of the barriers systemic inequities create for BIPOC leaders and organizations in the nonprofit and philanthropy granting settings. As a result of this modified approach, 19 of the 34 organizations who applied for funds had no previous official relationship with BHT.

  BHT shared several examples of ways their team made the RFP process less burdensome to the BIPOC community. This included, implementing a low-barrier Letter of Interest, which included the language about BHT's commitment to anti-racism and truth and reconciliation; investing in advertising in the local publication, the Black Lens; offering one-on-one coaching and technology support; prioritizing BIPOC led projects; offering the funds as unrestricted; and, providing the opportunity for check-ins with BHT staff on project progress instead of required reporting.

- **Cascade Pacific Action Alliance (CPAA):** CPAA shared a patient story that was submitted by a partnering provider in their Q3 report. The 41 year old female, was being seen in an internal addiction department. Her origin of opioid use disorder (OUD) was due to a motor vehicle accident that left her dependent on pain medication that transitioned to heroin. During her treatment regimen, she began Suboxone and was stable for over four years, however treatment through her primary care physician (PCP) was limited. Through the support of an assigned navigator, this too improved. CPAA's partnering provider shared the patient's reaction to this support, "I just think I was shocked that anyone cared about my health care." The patient voice and concerns were heard, which led to offering support and choices as to her own health care needs. This helped identify the importance of the patient lens for the partnering provider.

- **Elevate Health (EH):** Elevate Health notes the development of a COVID-19 Care Coordination model for assessing and addressing SDOH needs. This model was developed to be utilized with any other community care coordination program, so as to increase workforce capacity for COVID-19 response with an agnostic workflow, and better accommodate CARES Act funding structures and audit requirements. The programmatic work to include the workflow developed for local CARES Act funding established foundations for the Department of Health (DOH) Care Connect work Elevate Health will be undertaking as the Regional Care Coordination Hub.

- **Greater Columbia ACH (GCACH):** GCACH discussed Garden Village, a partnering provider located in Yakima County, that has been participating in practice transformation since January 2020. Garden Village provides patients and their families with a holistic approach to long-term, skilled nursing healthcare, in an interactive and innovative environment. The organization offers programs designed to serve populations whose needs cannot be met in a traditional nursing home, including residents with complex psychiatric and behavioral issues that have resulted in multiple failed placements at other facilities.

  Since beginning practice transformation, Garden Village has gone from using paper patient records to using an Office of the National Coordinator of Information Technology (ONC) Certified Electronic Medical Record. This implementation was facilitated by GCACH financial incentives and technical assistance. In response to the coronavirus pandemic, Garden Village incorporated some other significant changes. Risk stratification of patients, an essential milestone in the Greater Columbia Cares Model process, has been updated to incorporate the diagnosis of COVID-19. Patients who test positive are included in this highest risk stratum and receive appropriate care management.

  The PHQ-9 screening tool for depression is also utilized to monitor patients' self-assessed physical and mental well-being. Increased isolation has negatively impacted the patients at Garden Village, therefore all patients are assessed for marked changes in their scores. All patients at Garden Village also receive integrated care that addresses both physical and mental health. The team at Garden Village continues to progress in their efforts at practice transformation despite the new challenges associated with the pandemic. Adding nursing facilities into the Greater Columbia Cares model was a radical departure from the affected concept of the traditional patient centered medical home as it was first devised. The success of Garden Village shows that this innovation can work to bring about evidence-based care into new practice types.

- **HealthierHere (HH):** HealthierHere noted that COVID-19 placed an unprecedented strain on King County's healthcare system. It also created an opportunity for HealthierHere to demonstrate its maturity and value to the healthcare system as an ACH, and to serve the King County region by

coordinating an integrated response to the public health emergency with clinical services, community services, social services and public health.

Prior to the onset of COVID-19, HealthierHere developed a strong multi-stakeholder table, brokering relationships across the King County healthcare ecosystem and extending beyond clinical care to community-based and social services, as well as public and tribal health. In response to the COVID-19 pandemic, HealthierHere was well-positioned to promote health equity and center community, consumer and tribal voice throughout its COVID-19 response. COVID-19 put a spotlight on the racial and ethnic healthcare inequities and structural impediments to health that exist in King County and across the United States. These and other racial inequities were further magnified by the series of injustices committed against members of the Black community that took place in 2020. Now more than ever, partnering providers and other stakeholders in the region are embarking on efforts to further embed health equity and racial justice in their work. HealthierHere's years of experience in the space is allowing it to share lessons learned and provide guidance to others in their equity journey.

- **North Central ACH (NCACH):** North Central ACH noted that community paramedicine, a model embraced by several of their emergency medical services (EMS) providers, is proving to be a critical part of Okanogan County's COVID-19 response which shows the impact of some of the prior investments in Transitional Care and Diversion Intervention efforts. Additionally, some organizations within the Whole Person Care Collaborative report that their ability to pivot and adapt to changes, such as adding new patient screening protocols, testing sites, and soon vaccine sites caused by COVID-19, can be attributed to quality improvement methods emphasized throughout North Central ACH learning activities they have previously participated in.

- **North Sound ACH (NSACH):** One "bright spot" that North Sound ACH observed during this reporting period as a result of COVID-19 was acting as a regional source for personal protective equipment (PPE) such as masks, gowns, hand sanitizer, face shields to over hundreds of unique providers and organizations in the North Sound Region. This occurred due to the relationship with the Health Care Authority, who linked ACHs to the state's emergency command center, which had access to stores of supplies, but no mechanism to distribute across the state. In just one example, North Sound ACH provided Everett Gospel Mission with over 200,000 cloth and KN95 masks to distribute to those they serve in Snohomish County. Because of the PPE they received, they were able to build 40 new shelter beds for those experiencing homelessness.

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

    - Forks Community Hospital and Chinook Pharmacy offered several opportunities for drive-thru flu shots. Since Clallam Bay is a remote community, the drive-thru approach was especially effective and important.

    - The Suquamish Tribe Community Health Program offered drive-thru events that offered flu shots for both adults and children, COVID-19 tests, swag bags from health vendors, and a

chance for safe community connection. The Suquamish Tribe distributed approximately 400 flu shots, over double the amount distributed in 2019.

- Kitsap Children's Clinic hosted a flu clinic where they distributed over 350 youth flu shots in Silverdale, WA. Kitsap Children's Clinic implemented a new check-in process that prioritized patient safety, as the whole process was streamlined and reorganized so there was minimal contact with others.

- **SWACH:** SWACH, in partnership with Clark County Public Health, Klickitat County Public Health and Skamania County Community Health, received DOH approval to implement a COVID Response program, Care Connect Washington. The program offers support to those experiencing COVID and needing to isolate and quarantine in the home, and integrates with existing HealthConnect Hub infrastructure and community care coordination partners.

  While the program did not officially launch until January 11, 2021, a significant amount of planning and procurement took place in the final quarter of 2020 to ensure a successful launch. Planning included transitioning most of SWACH's staff to work outside of their traditional roles in an "all hands on deck" approach. This included project management, procurement, communications, and stakeholder engagement, to name a few. SWACH staff worked with DOH staff to order food and care kits and establish processes for referrals and grocery ordering. Partnering with DOH and existing care coordinating agencies allowed seventeen community health workers and supervisors to receive training in the new care model prior to launch.

7. Summary Recommendations for Payment of Incentives

Tables 4 through 7 below provide an overview of ACH projects, AVs, and incentives that ACHs can earn for achieving project milestones for the reporting period July 1, 2020 to December 31, 2020 and for P4R VBP milestones for the reporting period January 1, 2020 to December 31, 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 4 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 4. Potential P4R AVs for Project Incentives, July 1, 2020 – December 31, 2020

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	9	8	-	-	9	-	-	8	34
Cascade Pacific Action Alliance	9	8	8	-	9	8	-	8	50
Elevate Health	9	8	-	-	9	-	-	8	34
Greater Columbia ACH	9	-	8	-	9	-	-	8	34
HealthierHere	9	-	8	-	9	-	-	8	34
North Central ACH	9	8	8	8	9	-	-	8	50
North Sound ACH	9	8	8	8	9	8	8	8	66
Olympic Community of Health	9	-	-	8	9	8	8	8	50
SWACH	9	8	-	-	9	-	-	8	34

Table 5 depicts the number of AVs each ACH has earned by milestone for the reporting period based on the results of the independent assessment.

Table 5. Potential P4R Achievement Values (AVs) by Milestone by ACH for Semi-annual Reporting Period July 1 – December 31, 2020

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
Potential AVs for semi-annual reporting period July 1 – December 31, 2020									
Description of scale & sustain Transformation activities	4	6	4	4	4	6	8	6	4
Description of continuous quality improvement methods to refine/revise Transformation activities	4	6	4	4	4	6	8	6	4
Demonstrate facilitation of ongoing supports for continuation and expansion	4	6	4	4	4	6	8	6	4
Demonstrate sustainability of Transformation activities	4	6	4	4	4	6	8	6	4
Completion of Semi-annual Report	4	6	4	4	4	6	8	6	4
Completion/maintenance of partnering provider roster	4	6	4	4	4	6	8	6	4
Engagement/Support of Independent External Evaluator (IEE) Activities	4	6	4	4	4	6	8	6	4
Report on quality improvement plan (Replaced by COVID-19 Response)	4	6	4	4	4	6	8	6	4
Completion of all P4R metrics (Project 2A, 3A only) (Replaced by COVID-19 Response)	2	2	2	2	2	2	2	2	2
Achievement Values for Second Reporting Period									
Assessed February 2021	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**
Total AVs Earned	34	50	34	34	34	50	66	50	34
Total AVs Available	34	50	34	34	34	50	66	50	34

For each ACH, Table 6 provides incentives available by funding source for completion of SAR 6.

Table 6. Total P4R Project Incentives Available by ACH for Achievement of the Implementation Plan Milestone

ACH	Earned AVs	Project Incentives
Better Health Together	34	$4,670,391
Cascade Pacific Action Alliance	50	$4,245,810
Elevate Health	34	$5,094,972
Greater Columbia ACH	34	$5,944,135
HealthierHere	34	$9,340,783
North Central ACH	50	$2,122,905
North Sound ACH	66	$6,368,716
Olympic Community of Health	50	$1,698,325
SWACH	34	$2,972,067
Total		**$42,458,104**

Table 7 depicts the number of VBP P4RAVs each ACH has earned by milestone for the reporting period.

Table 7. P4R VBP Achievement Values (AVs) by Milestone by ACH for January 1 – December 31, 2020

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Potential AVs for semi-annual reporting period January 1 – December 31, 2020									
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1	1	1	1	1	1	1	1	1
Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	1	1	1	1	1	1	1	1	1
	Full Credit	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**
Total AVs Earned	2	2	2	2	2	2	2	2	2
Total AVs Available	2	2	2	2	2	2	2	2	2

Table 8 depicts the number of VBP P4RAVs each ACH has earned by milestone for the reporting period.

Table 8. P4R VBP Achievement Incentives Available by ACH for Achievement of Milestones

ACH	Earned AVs	VBP Incentives
Better Health Together	2	$150,00
Cascade Pacific Action Alliance	2	$150,00
Elevate Health	2	$150,00
Greater Columbia ACH	2	$150,00
HealthierHere	2	$150,00
North Central ACH	2	$150,00
North Sound ACH	2	$150,00
Olympic Community of Health	2	$150,00
SWACH	2	$150,00
Total		**$1,350,000**

8. COVID-19 Observations by ACH

In addition to the overall response themes identified in Section 5 across ACHs, Tables 9 through 35 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.[5] 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.

[5] https://en.wikipedia.org/wiki/Resilience_(engineering_and_construction); Accessed September 14, 2020.

Better Health Together (BHT)

Table 9. Better Health Together (BHT) COVID-19 Observations

Findings for Better Health Together (BHT)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Telehealth: BHT has an Equity Technical Assistance (TA) Bank (15 trainers on race and equity) that was able to quickly adapt to a virtual setting. An RFP was released to give trainers up to $1,200 for assistance moving training to a virtual setting. This funding helped purchase laptops, webcams, mics, and zoom accounts while also paying for staff time and education. • Telehealth Access: BHT worked with the state Broadband Office to identify areas most in need of broadband improvements and assessed needed infrastructure investment. In December, the Spokane Tribe applied for $3.3 million in broadband funds from the Community Connects fund at USDA. • Care Coordination: Using their prior experience with Pathways Hub, BHT supported the Care Connect Washington program which provides COVID-19 care coordination. This is a collaboration between BHT, local health jurisdictions, and health care and community partnerships. By December there were six contracts with partner organizations and another two starting in 2021 when the program launches. • Capacity Connect: Providers asked BHT to put together a web-based "dashboard" to help track the real-time capacity of regional organizations in preparation for increased behavioral health services demand. Capacity Connect went live in December 2020. BHT is conducting outreach to ensure partnering providers are able to input information in the system before scaling to the larger health community.	• Behavioral Health Workforce: A behavioral health forum was formed at the beginning of 2020 to allow for cross-section discussion and sharing. Workforce challenges have been exacerbated by COVID-19. The BHT Board approved funding to be used in 2021 to support workforce-related strategies. - Support supervision costs of clinicians - Provide training(s) that include CEU's at no charge - Support SUDP certification costs for master's level clinicians • Rural Counties Workforce: Due to the shift in remote work many outreach events and home visits were canceled and there were limited non-essential visits. Remote workers adapted by contacting patients by phone to schedule and educate on telehealth services and community resources. • Rural County Access to Care: Due to broadband access issues, partnering providers are concerned that patients were not receiving patient care during the pandemic when services were being done virtually.

Table 10. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

Better Health Together			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$2,264,432
2B: Community-based Care Coordination	8	8	$1,556,797
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$283,054
3D: Chronic Disease Prevention and Control	8	8	$566,108
Total	**34**	**34**	**$4,670,391**

Table 11. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

Better Health Together			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

Cascade Pacific Action Alliance (CPAA)

Table 12. Cascade Pacific Action Alliance (CPAA) COVID-19 Observations

Findings for Cascade Pacific Action Alliance (CPAA)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Care Coordination: - Community CarePort (Project 2B) policies and procedures were adapted to allow and promote the shift to phone-based care coordination as needed. - CPAA's Community CarePort expanded its care coordination services into a new program and partnership with the WA Department of Health named Care Connect WA. Individuals that test positive for COVID-19 can access this service and receive assistance with accessing community resources and food while under quarantine. • Information Exchange: CPAA participated in a Collective Medical workgroup focused on establishing transitions of care guidelines for organizations using the Collective Medical platform. Partners provided input for the completion of this document and a final copy will be presented in 2021. • Telehealth: Implementation and expansion of telehealth continued across the region for behavioral health agencies, primary care clinics, and hospitals. • Behavioral Health: One of CPAAs behavioral health partners established a COVID phone line which is serving as a method to connect clients with community services. • Collaboratives: Many Pediatric Collaborative Calls focused on COVID-19 response in Pediatrics across the CPAA region.	• Workforce Shortage: CPAA continues to see a shortage of providers, particularly in rural areas. • Financial challenges: There are still reductions in revenues due to reduced services, especially for clinical partners, behavioral health and substance use disorder (SUD) providers, and smaller stand-alone clinics. Providers are also seeing an increase in expense due to costs for PPE, physical distancing requirements and the shift to telehealth/remote services. • Access to Care: - 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. - There was also an increase in demand for Medication for Opioid Disorder (MOUD) and behavioral health services with insufficient capacity. • Housing: A lack of affordable housing for recipients of services continues to be a risk to the community. • 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.

Table 13. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

Cascade Pacific Action Alliance (CPAA)			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$1,617,451
2B: Community-based Care Coordination	8	8	$1,111,998
2C: Transitional Care	8	8	$657,090
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$202,181
3B: Reproductive and Maternal and Child Health	8	8	$252,727
3D: Chronic Disease Prevention and Control	8	8	$404,363
Total	**50**	**50**	**$4,245,810**

Table 14. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

Cascade Pacific Action Alliance (CPAA)			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

Elevate Health of Washington

Table 15. Elevate Health of Washington COVID-19 Observations

Findings for Elevate Health of Washington	
Examples of Pandemic Response Resiliency	• **Examples of Pandemic Response Vulnerability**
• OnePierce Community Resiliency Fund: The funding relationships developed by OnePierce Community Resiliency Fund with behavioral health providers enabled OnePierce to allocate CARES Act dollars for behavioral health in a quick and efficient manner, maximizing providers' time to spend the dollars before December 31. • Care Coordination: Through the initial CARES Act COVID-19 Care Coordination response initiative, Elevate Health has been able to expand their network of community providers with two additional organizations taking part in these activities: Integrity Nurse Consultants and CHI Franciscan Health. • Shared Data Platform: Elevate Health has hosted community-based organizations (CBOs) for demonstrations on Innovaccer's closed-loop referral product, which offers a solution for continuity of care in and amongst CBOs. • Funding Access: OnePierce reduces the barriers to accessing CARES Act funding through bridge loans and extends the County's ability to administer the funds to providers and community-based organizations. Without bridge loans, newer or smaller providers may not be able to access upfront funding that is critical to drawing down federal funds. • Care Coordination: Elevate Health initiated the planning phase of a large-scale pilot for 2021 for the evidence-based Pathways Community Hub model with a proposed VBP structure. They are working with two community partners to address the evidence-based health and behavioral health disparities in the black community: Casteele Williams and Associates (Behavioral Health, Domestic Violence, and Intensive Wrap Services for Youth) and Quilted Health (Midwifery Organization for black women). Elevate Health is funding a community health worker in each of these organizations for one year to encourage integration and whole-person care.	• Social Determinants of Health: The COVID-19 pandemic has only served to worsen health-care disparities in economically suppressed communities of color. - 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 district, which has historically been a low-income neighborhood impacted by rapid gentrification. - Elevate Health has initiated funding conversations with Tacoma Ministerial Alliance (TMA) around in-culture initiatives in response to the COVID-19 pandemic. • Workforce Shortages: There is a continued workforce shortage, specifically in Behavioral Health. Elevate Health is working with partners to secure workforce training and region wide expansion focused on equity in the workforce.

Table 16. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

Elevate Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$2,470,290
2B: Community-based Care Coordination	8	8	$1,698,324
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$308,786
3D: Chronic Disease Prevention and Control	8	8	$617,572
Total	**34**	**34**	**$5,094,972**

Table 17. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

Elevate Health			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

Greater Columbia ACH (GCACH)

Table 18. Greater Columbia ACH (GCACH) COVID-19 Observations

Findings for Greater Columbia ACH (GCACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Care Coordination: GCACH helped forge a collaborative, referral relationship between an SUD treatment provider and a regional medical center. The SUD provider had lost its primary source of patients when there were no in-person trials and the local court system was not making referrals. • Population Health Management: GCACH practice transformation incentive funding led a regional medical center to develop a Population Health Management department (PHM) prior to the pandemic. This allowed them to partner with the County Department of Community Health and travel to employers, such as Tyson foods, to complete COVID tests on employees on site. Testing helped stem flow of infections and reduced time the plant was offline. The PHM also started to employ CHWs who became involved in care coordination and wraparound services for quarantined patients. The integrated PHM team with the hospital, emergency department, and urgent care led to a more coordinated pandemic response. • Information Exchange: GCACH has partnered with WA211 and provided funding to develop a more user-friendly, public-facing search application for community resources listed on the www.WA211.org website. GCACH researched referral platforms and resource directories to develop a matrix of optimal features. The research shared with WA211 was utilized in the application redesign. There are already future enhancements being made and GCACH is looking to expand relationships to potentially partner around a community-based care coordination platform.	• Telehealth and Broadband Access: The pandemic highlighted the widespread demand for telehealth services and associated lack of broadband access by under-served populations and geographic service areas. GCACH has provided funding for organizations to add infrastructure and ramp-up telehealth. For small providers in rural areas, cost is high and there is limited capacity for high-speed broadband. GCACH has promoted completion of the state's broadband survey through its newsletter and other outlets. They have also made presentations to legislators, county commissioners, and federal senators asking for increased funding and support of broadband capacity in rural areas of Washington. They continue to advocate for adequate provider reimbursement for telehealth services. • Racial disparities: The Hispanic population in the GCACH region continues to be disproportionately affected by COVID-19. GCACH has the highest percentage and number of Hispanics of any ACH in Washington. Recent data shows that Hispanics make up around 13% of Washington's population, but are one-third of all COVID-19 cases. The workers and residents of skilled nursing facilities, food processing, and agricultural jobs continue to be hot spots. GCACH partnered with the Benton-Franklin Health District to promote successful campaigns encouraging masking and testing for COVID. Masking use and use of the promoted COVID-19 test site increased more than ten-fold compared to another site not promoted in the county.

Table 19. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

Greater Columbia ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$3,337,058
2C: Transitional Care	8	8	$1,355,680
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$417,132
3D: Chronic Disease Prevention and Control	8	8	$834,265
Total	**34**	**34**	**$5,944,135**

Table 20. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

Greater Columbia ACH			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

HealthierHere

Table 21. HealthierHere COVID-19 Observations

Findings for HealthierHere	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Information Exchange: The Connect2 Community Network has launched and will support regional care coordination efforts, including the COVID-19 Care Coordination Hub. HealthierHere worked with more than 75 clinical and community partners to co-design a community information exchange (CIE) for King County aiming to "connect social service, community, tribal, physical, and behavioral health organizations" and make and receive referrals electronically. • Network of Clinical and Community Partners: HealthierHere continues to bring partners from multiple sectors together to develop regional priorities and strategies around behavioral health. The impact to behavioral health due to COVID-19 has led to new and expanded partnerships, community partner investments in BIPOC communities, and discussions around shared investments to address increasing behavioral health needs. • Focus on Equity and Culturally Responsive and Appropriate Care: - HealthierHere has funded Multilingual Response Teams to support BHAs, CBOs, and FQHCs in hiring multilingual and multicultural staff to help serve hard-to-reach communities that aren't getting tested or have the necessary supports to isolate and quarantine. - The Resilience Funds allowed partners to provide services to communities with significant disparities due to COVID-19. Homebound individuals and those with job loss and reduced income had access to essential food and groceries to meet basic needs. • Information Exchange: Collective Medical deployed new COVID-19 flags and cohorts that allowed organizations to share needed information quickly. HealthierHere had around 20 partners using Collective Medical as of August 2020. This has allowed for better care coordination for at-risk members with COVID-19 and quicker outreach to ensure patients have medical and social supports they need within days instead of weeks.	• Behavioral Health Needs: HealthierHere is anticipating a surge in behavioral needs due to COVID-19 including increases in depression, anxiety, isolation, and suicide. They have convened multisector groups to identify gaps in capabilities and resources and determine how they can complement existing efforts including increased funding. • 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. • 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. • Access to Care: HealthierHere noted the following risks to access: - The lack of access to accurate, relevant, culturally appropriate and in-language information and care. - The increased need for SDOH services and supports without increased capacity to deliver such services and supports. - 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). • Housing Instability: HealthierHere noted the following risks due to housing instability: - Housing costs affect workforce shortages as they are a barrier to recruiting and retaining staff. - COVID-19 has resulted in loss of or reduced employment and many individuals are struggling to pay their rent or mortgage.

Table 22. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

HealthierHere			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$5,243,948
2C: Transitional Care	8	8	$2,130,354
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$655,494
3D: Chronic Disease Prevention and Control	8	8	$1,310,987
Total	**34**	**34**	**$9,340,783**

Table 23. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

HealthierHere			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

North Central ACH

Table 24. North Central ACH COVID-19 Observations

Findings for North Central ACH (NCACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Population Health: The Whole Person Care Collaborative (WPCC) has Population Health Learning and Action Networks (LANs) that focus on stratifying populations and creating registries so clinical organizations can identify at-risk populations. This enabled participating partners to identify patients infected with COVID and have coordinated effort to monitor symptoms, and to allow outreach to vulnerable populations and ensure needs were met. The monthly collaborative meeting discussions included alternative modalities of care including parking lot clinics and drive-up laboratories. • Coalitions for Health Improvement (CHI): NCACH and the CHI support COVID-19 response efforts and activities through regular meetings that provide partners to connect with public health response efforts. The Okanogan County CHI hosted a series of COVID-19 panel discussions that included COVID-19 impacts and wildfire, Q&As with local public health officials, and a candidate forum focused on community health and COVID-19. • Recovery Coach Network Coordinator: NCACH hired a Recovery Coach Network Coordinator in the fourth quarter of 2020. COVID-19 shifted focus for this role from transition out of the justice system to recovery support as a whole across the community. The coordinator position will continue to build out the Recovery Coach Network in the region, engage community stakeholders in the in the Network through Recovery Coach trainings, outreach to community-based organization, and convene Opioid Workgroup meetings. NCACH is currently recruiting partners to work within the recovery continuum outside of the jail setting including Chelan County Drug Court, the Regional Central Washington Recovery Coalition, and treatment centers.	• Behavioral Health: The pandemic highlighted the communication challenges between primary care and behavioral health. NCACH is facilitating discussions between organizations to identify issues and prioritize areas for improvement. They are evaluating how this process can be scaled to other counties in the region. • 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.

Table 25. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

North Central ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$738,402
2B: Community-based Care Coordination	8	8	$507,651
2C: Transitional Care	8	8	$299,976
2D: Diversions Interventions	8	8	$299,976
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$92,300
3D: Chronic Disease Prevention and Control	8	8	$184,600
Total	**50**	**50**	**$2,122,905**

Table 26. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

North Central ACH			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

North Sound ACH

Table 27. North Sound ACH COVID-19 Observations

Findings for North Sound ACH	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Data for Change Initiative: North Sound launched the Community Data for Change Initiative which allows for regional discussion of shared metrics to respond to COVID-19 and plan long-term for the region. This was possible through the partnerships built through DSRIP activities. • Care Coordination: - The Care Coordination HUB on the Care Coordination Systems (CCS) platform allows partners to see all patients discharging from county quarantine sites. - North Sound assisted partners with access to a COVID-19 tracking tool within Julota (an EMS and high-utilizer are coordination). This allowed them to see other partners working with patients after discharge. • Communication: North Sound has bi-weekly calls with local health jurisdictions, WA Department of Health, Department of Social and Health Services, and Northwest Healthcare Response Network around Long-term Care COVID-19 response. They also continue to have partner meetings about common goals and projects including Community Resource Paramedicine, opioids, oral health, etc. These meetings allow the ACH and partners to share resources and strategies about their COVID response. • COVID-19 Testing: North Sound facilitated several free COVID-19 testing events for Spanish-speaking and farmer populations with local health jurisdictions.	• Workforce: - Providers were not able to meet the demand for access due to staff who were forced to flex hours and take time off due to COVID-19 health and childcare needs. - Many non-English speakers and individuals are not able to access services during regular business hours. Lack of staffing at local health jurisdictions meant that extended hours could not be provided for COVID-19 testing and access to educational materials for these individuals. - External training sessions were delayed or cancelled due to COVID meaning staff aren't able to access needed training. • Financial Strain: Some partners have continued to provide in-person services and are seeing the financial strain of increasing expenses for PPE and delays in filling open staff positions due to remote onboarding. • Evidence-Based Practices: Providers face challenges moving to a remote environment, and shifting their practices to ensure evidence-based practices are being followed.

Table 28. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

North Sound ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$2,037,989
2B: Community-based Care Coordination	8	8	$1,401,118
2C: Transitional Care	8	8	$827,933
2D: Diversions Interventions	8	8	$827,933
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$254,749
3B: Reproductive and Maternal and Child Health	8	8	$318,436
3C: Access to Oral Health Services	8	8	$191,061
3D: Chronic Disease Prevention and Control	8	8	$509,497
Total	**50**	**50**	**$6,368,716**

Table 29. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

North Sound ACH			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

Olympic Community Health (OCH)

Table 30. Olympic Community Health (OCH) COVID-19 Observations

Findings for Olympic Community Health (OCH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Collaboration: - Existing collaboration infrastructure and partnerships allowed OCH to effectively pivot to coordinating COVID-19 response across the region. - The role OCH plays in bring partners together, along with robust distribution lists, helped partners navigate the overwhelming flow of information. • Partner Capacity: The importance of honoring partner capacity has been magnified, particularly as Zoom fatigue became more pronounced over the course of the reporting period.	• Workforce: COVD-19 magnified rural workforce challenges due to burnout, illness, home schooling, and lack of childcare. • Telehealth: Providers are struggling to adapt to online telehealth platforms for the hearing impaired community. • Financial Strain: The cost of providing services has increased due to COVID-19 while capacity has been reduced and there are fewer individuals scheduling services. • Partner and Provider Capacity: Many lower priority MTP activities and capacity building, such as identifying a regional CIE, have been put on hold or are moving much more slowly.

Table 31. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

Olympic Community Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$836,099
2D: Diversions Interventions	8	8	$339,665
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$104,512
3B: Reproductive and Maternal and Child Health	8	8	$130,640
3C: Access to Oral Health Services	8	8	$78,384
3D: Chronic Disease Prevention and Control	8	8	$209,025
Total	**50**	**50**	**$1,698,325**

Table 32. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

Olympic Community Health			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000

SWACH

Table 33. SWACH COVID-19 Observations

Findings for SWACH	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Amplifying Voices Initiative: SWACH is leveraging the "Amplifying Voices Initiative" to solicit information regarding needs related to COVID-19 and to disseminate COVID-19 information across the region. • Integration: SWACH has provided ongoing forums for partners to discuss and receive technical assistance to help with integration challenges such as telehealth as a result of COVID-19. • SWACH Health Connect Partnerships: Community Care Coordination and Chronic Disease Management activities enabled HealthConnectHub and partners to navigate and response to COVID-19 through four ways: - Established a partnership with Clark County Public Health (CCPH) case investigation, contract tracing systems and wraparound service systems. - Partnered with DOH to provide immediate and long term supports to those experiencing COVID-19 and needing to isolate and quarantine in the home. - Partnered with Clark County's Quarantine and Isolation (Q&I) Hotel which allowed for outreach and immediate supports for Q&I Hotel guests through HealthConnect along with CHW support including food assistance, health insurance support, housing assistance, medical transportation, hygiene and PPE, and others). - Created a HealthConnect community-based care cohort to support community members impacted by COVID-19 with crisis services, behavioral and physical health care, transportation, food security, and flu vaccinations.	• Financial Strain: There is a continued decrease in health system revenue due to government mandates to pause procedures and elective surgeries. Dental revenue is also decreased due to limitations to care. Behavioral health organizations are seeing decreases in referrals and overall patient numbers. • Telehealth: Telehealth has been a benefit in many areas, but isn't always a solution for decreased visits as they don't easily translate to children and youth due to shorter attention spans, and increased screen time already due to virtual school. Many youth also aren't comfortable discussing health issues remotely as there is not always privacy. • Community Care Coordination and Chronic Disease Management: Three specific risks/issues related to Community Care Coordination and Chronic Disease Management focus areas: - Compounding impacts of COVID-19 severely affect housing security. There are lower rent collections and demand for housing is much greater than supply. - Workforce Development Opportunity for CHWs/Peers derailed by COVID - There was a disruption to HealthConnect Hub community engagement and partnerships through technology platform proliferation.

Table 34. Achievement Values and Earned Incentives for Reporting Period July 1, 2020 – December 31, 2020

SWACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	9	9	$1,441,002
2B: Community-based Care Coordination	8	8	$990,689
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	9	9	$180,125
3D: Chronic Disease Prevention and Control	8	8	$360,251
Total	**34**	**34**	**$2,972,067**

Table 35. Total VBP P4R Incentives Earned for January 1, 2020 – December 31, 2020

SWACH			
	Total AVs Achieved	**Maximum Possible AVs**	**Incentives Earned**
Value Based Payment Incentives	2	2	$150,000