Introduction

Welcome

Introductions

October Minutes

November Agenda
<table>
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<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
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<tr>
<td><strong>1. Introduction</strong></td>
<td>11:00</td>
<td><strong>Introductions</strong></td>
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<tr>
<td>Wendy Brzezny</td>
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<td>Consent agenda</td>
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<td>Agenda</td>
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<td>Minutes</td>
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<tr>
<td><strong>2. Announcements &amp; Updates</strong></td>
<td>11:10</td>
<td>Monthly Report due November 3rd</td>
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<tr>
<td>Wendy Brzezny</td>
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<td>PH LAN</td>
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<td>QI Affinity</td>
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<td>NCACH has moved</td>
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<td>NCACH updates</td>
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<td><strong>3. Catholic Charities</strong></td>
<td>11:20</td>
<td>Integration of the PHQ-9</td>
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<td>Jason Guest &amp; Michelle Ferber</td>
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<td><strong>4. Family Health Centers</strong></td>
<td>11:45</td>
<td>Quality Improvement Program: Hypertension care</td>
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<td>Virginia O'Kelly</td>
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<td><strong>5. NCACH/WPCC Update</strong></td>
<td>12:10</td>
<td>2022 NCACH Priorities &amp; Estimated Budget</td>
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<td>Future WPCC Meetings</td>
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<td><strong>6. Adjourn</strong></td>
<td>12:45</td>
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**Next Meeting: December 6, 2021**  
(Virtual Only)
<table>
<thead>
<tr>
<th>Location</th>
<th>Attendees</th>
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| Virtual      | **Attendance:** Deb Miller, Whitney Lak, Paul Hadley, Aileen Morelos, Tessa Timmons, Stephen Johnson, Shoshannah Palmansteer, Tawn Thompson, Becky Corson, Jackie Weber, Donny Guerreo, Misty Queen, Lisa Apple, Chenia Flint, Sara VanHorn, Matti Osborn, Hayley Middleton  
**Consultants:** Connie Davis  
**NCACH Staff:** Wendy Brzezny, Mariah Kelley, Linda Parlette, John Schapman, Joey Hunter and Teresa Davis – Minutes |

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Minutes</th>
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| **Announcements & Updates**     | • Monthly reports due October 6th - payments are tied to monthly reports  
• Population Health LAN is Tuesday, October 12th  
• October QI Affinity Group – Risk Stratification will be led by Kathy Reims on Wednesday October, 27th  
• WPCC Feedback Survey – Survey Monkey: [https://www.surveymonkey.com/r/WPCCPlanEval](https://www.surveymonkey.com/r/WPCCPlanEval)  
• The COVID 19 Student Survey was done by DOH in March 2021. The results are out [https://cssswashington.org/](https://cssswashington.org/)  
• LPN Apprenticeship webinar on October 22, 2021 agenda was attached to meeting invite  
• Sentinel Network Survey is out sign up at website [https://uwfamilymedicine.co1.qualtrics.com/jfe/form/SV_bCUvhGGN0726IJC](https://uwfamilymedicine.co1.qualtrics.com/jfe/form/SV_bCUvhGGN0726IJC)  
• HB 1504: Workforce Education Investment Act: NCACH received $292,666 to implement over 2 years. Presenting a plan for additional funding to our Board today.  
• Mental Health Tech Transfer Center Network Training – For providers in the region 10 area [https://washington.zoom.us/webinar/register/WN_vJFiZm1FT06Fd9K8u4G0Nw](https://washington.zoom.us/webinar/register/WN_vJFiZm1FT06Fd9K8u4G0Nw) |
| **Presentations (recording can be found at ncach.org/wpcc)** | • Chenia Flint from Samaritan Healthcare presented on Hgba1C Poor Control (>9%)  
• Shoshannah Palmansteer from Coulee Medical Center presented on their implementation of Collaborative Care  
• Joseph Hunter from NCACH presented on the Recovery Coach Network |
| **Adjournment**                  | • Meeting adjourned by Wendy Brzezny at 12:45 PM                                                                                                                                                         |
Announcements

Monthly Reports due Wednesday, November 3\textsuperscript{rd}
Quarterly payments are tied to monthly reports

Population Health LAN – November 9\textsuperscript{th}
PH LAN awards – for those participating, please nominate your peers for each award no later than Friday, November 5\textsuperscript{th}.
https://www.surveymonkey.com/r/PHLANPeerAwards

QI affinity group: Open Discussion – November 24\textsuperscript{th}
NCACH has moved:
801 Eastmont Ave, Suite C
Announcements

NCACH Updates:

Senator Parlette is retiring Dec 31st
John Schapman – Acting ED Jan 1st
David Goehner - New Communications Manager
Partner Updates

• Managed Care Organizations
• Community Based Organizations
• Clinical Partners
Catholic Charities
Catholic Charities
Integration of the PHQ-9
A little History…..

- As a Community Mental health agency, we have always used the PHQ-9 in the delivery of services
- Administered the PHQ-9 at intake for all clients 13 and older
- The PHQ-9 was not required to be completed at the 6 month review
Initial Depression screening

GOAL: 100% of patients with a positive depression screen have a documented follow-up plan

- Administered to ages 12 and older at intake
- To have a scheduled appointment within 30 days
- Develop a treatment plan to support diagnosis
- Modify the PHQ-9 to track follow-up services
Initial PHQ-9 screening

Depression Screening and Follow up

- Sept 2020
- October 2020
- November 2020
- Dec 2020
- Jan 2021
- Feb 2021
- March 2021
- Apr 2021
- May 2021
- June 2021
Challenges and Successes

Challenges

- Review and modify workflows
  - 12 year vs 13 years
  - Telehealth services resulted in verbal administration of PHQ-9
  - PHQ-9 not given at every intake
- Not all clients are able to complete assessment tools

Successes

- It was easy to modify work flows as the PHQ-9 was already being administered at intake
- Consistency across time and during times of change
Depression monitoring

Goal: 75% of adolescent and adult patients with depression have timely monitoring of their symptoms using the PHQ-9 or other validated tool

- No formal process to track depressive symptoms across departments
- Inconsistency among staff on when and how the PHQ-9 was re-administered
Depressive Disorder 6 month Monitoring
Challenges and Successes

Challenges

- Pandemic challenges
  - Recording of the PHQ-9
  - Difficulty engaging clients
  - Telehealth services disrupted workflows

- Staffing and training challenges
  - Monitoring staff adherence to procedures
  - Training of new staff
  - Retraining current staff in new work-flows

Successes

- Numbers improved
  - Developed auditing tools within the ECR to identify clinicians who might need more support
  - Returning to the office
  - Developed a formal process to track depressive symptoms
  - Administered the PHQ-9 regularly

- Train and retrain staff on Motivational interviewing to improve client engagement
The road ahead...

- Continue to utilize PHQ-9 auditing tool
- Train new staff on the proper use and tracking of PHQ-9
- Continue agency focus on 6 month readministration of PHQ-9
- Utilize PHQ-9 to look at outcomes of services
- Continue to focus on ways to close gap
Questions/Discussion
Quality Improvement Program

Hypertension Care

Presented by
Virginia O'Kelly RDN, CDCES
Nov 1, 2021 NCACH WPCC
COVID created an opportunity for FHC to provide telehealth services to reduce exposure. We recognized that for patients with hypertension we were going to miss monitoring the vital measure of blood pressure.
Creating the Project

QIP Committee under the direction of Clinical Director Brendan Smith ND developed a PDSA for home blood pressure monitoring. Virginia heard about the availability of free blood pressure monitors. Liza Lugo CHW and an MA-C offered to help show the patients how to use the free cuffs.
The WA State DOH heard about our work through the request for free BP Cuffs. They created a specific grant to fund this QI project from our PDSA. Virginia designed a reporting tool for monthly updates required by the Heart Disease, Stroke, and Diabetes Prevention Unit of the Washington State Department of Health. We met with them monthly during the grant period.
### What did we agree to track?

<table>
<thead>
<tr>
<th>Trainer Name</th>
<th>Pt #</th>
<th>Trainer Credentials</th>
<th>Source of Patient Referral</th>
<th>Type of Monitor</th>
<th>Module 1-date completed, Pt shows competency with self-monitoring</th>
<th>Module 2-date completed, Healthy Lifestyle with Hypertension</th>
<th>Health Action Plan</th>
<th>BP @ INITIAL on Home Monitor device</th>
<th>Optional: SMBP check prior to 3 months.</th>
<th>BP @ 3 mo. Average for 30 days on home monitor</th>
<th>BP @ approx. 4 mo. in-office</th>
<th>Optional: Smoking cessation module if smoker</th>
<th>Link to results graphs</th>
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<tbody>
<tr>
<td>Liza</td>
<td>4 CHW</td>
<td>PCP</td>
<td>Omron 3 Se</td>
<td>1/13/2021</td>
<td>Completed 148/85</td>
<td>145/80</td>
<td>154/72</td>
<td>flu by Liza, May; pt states monitors bp 2 x day but did not show stability</td>
<td></td>
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<tr>
<td>Liza</td>
<td>5 CHW</td>
<td>PCP</td>
<td>Omron 3 Se</td>
<td>1/13/2021</td>
<td>Completed 164/98</td>
<td>150/100</td>
<td>129/80 Average Home 4/12/2023</td>
<td>Quit smoking care plan scribed by Virgina; flu education 4/13/21</td>
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</tr>
<tr>
<td>Liza</td>
<td>6 CHW</td>
<td>PCP</td>
<td>Omron 3 Se</td>
<td>1/13/2021</td>
<td>Completed 148/96 @ card 130/96 3/12/21</td>
<td>136/76 Average Home 110/60</td>
<td>care plan scribed by Virgina; flu covisit with PCP/CHW</td>
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Family Health Centers Narrative Reporting
DOH Hypertension Home Monitoring Project

Note: This document should grow every month. Fill this in as you go to document your improvement journey. Please submit your narrative on the first Tuesday of every month.

Key contacts: Brendan Smith ND and Virginia O’Kelly RDN, CDECS

Aim statement:
We aim to improve whole person health for the patients we serve at Family Health Centers. We will improve cardiovascular health outcomes using population health strategies, enhanced team-based care, and implementation of patient self-monitoring of blood pressure.

What are we trying to accomplish?
- Explore and test innovative ways to engage non-physician team members (e.g. nurses, medical assistants and community health workers) in hypertension and heart healthy habits instruction in a clinical setting.
- Explore means to obtain insurance reimbursement for monitors and home monitoring assessment by a Primary Care provider. Provide donated monitors for patients without coverage or denial of coverage.
- Provide heart healthy habit counseling along with monitoring instruction with self-management as the primary tool for long term change.
- Create Uncontrolled Hypertension Registries for Care Teams to identify patients who could benefit from home monitoring of blood pressure.
- Identify barriers and successes specific to the FHC population.
- Follow-up contact with patients during a 4 month interval to evaluate changes in control.
- Implement improvements to barriers and cost prohibitive measures.
- Modify policies to facilitate the spread of home monitoring throughout all FHC sites.

Collaborative team

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Team Members</th>
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<tbody>
<tr>
<td>Nov 2020</td>
<td>Brendan Smith ND, Virginia O’Kelly RDN, Tawn Thompson Manager, Alma Ildefonso MA-C, Alicia Lugo CHW</td>
</tr>
<tr>
<td>Dec 2020</td>
<td>Brendan, Virginia, Tawn, Alma, Liza, Berenice Lopez, RN &amp; Sheena Kitterman RN (RN competency trainers) [Sara Eve Sarlaker from DOH]</td>
</tr>
<tr>
<td>Jan 2021</td>
<td>Brendan, Virginia, Tawn, Alma, Liza, Adding Marcy Elyn RN and Jennifer Ramirez MA-C to the team this month (Omak) [Sara Eve Sarlaker and Peter Dierenger from DOH]</td>
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</table>
The Steps...

We train staff to train and support patients
- Provide BP Monitor and arm cuff (QI Grant, Community Foundation of NCW and working with MCOs for coverage)
- Modules: Patient can demonstrate self monitored BP, Healthy Lifestyle education (AHA Healthy 7), and Develop a Health Action Plan
- Monitor initial BP with Home Monitor, Initial BP in office, optional interim check, BP averages at 3 months from home monitor and Primary Care Provider at visit w/ BP check~ 4 months. Optional smoking cessation for patients who are smokers on enrollment.
Sample Tools for instructors

Self-measured blood pressure
Patient training checklist

Instructions: To ensure all necessary steps and components are covered, use this checklist when training your patient's on how to perform self-measured blood pressure (SMBP).

Gather supplies
- Tape measure
- What is SMBP? (PDF)
- SMBP infographic (PDF in English and Spanish)
- SMBP recording log (PDF)
- SMBP device accuracy test (PDF)

Provide background information on SMBP to the patient (if not explained by provider). Explain how SMBP allows the provider to get a more accurate and complete picture of the patient's blood pressure outside of the office (more readings, over a longer period of time, in the patient's normal environment).

Tip: Hand out the "What is SMBP?" document.

Determine SMBP cuff size
Use tape measure to measure the circumference of the patient’s mid-upper arm in centimeters (see image for more detail).

Tip: Ideally, this is done before the patient purchases a device so you can ensure the device and cuff purchased are appropriate for the patient.

Check patient's SMBP device for accuracy
Tip: Use the SMBP device accuracy test.

Determine the patient's blood pressure arm if not
How to measure your blood pressure at home

Follow these steps for an accurate blood pressure reading

1) PREPARE
- Avoid caffeine, cigarettes and other stimulants 30 minutes before you measure your blood pressure.
- Wait at least 30 minutes after a meal.
- If you’re on blood pressure medication, measure your BP before you take your medication.
- Empty your bladder beforehand.
- Find a quiet space where you can sit comfortably without distraction.

2) POSITION
- Position arm on top of a level surface.
- Put cuff on arm, above heart at mid-arm.
- Keep arm supported, palm up with muscles relaxed.
- Sit with legs uncrossed.
- Keep feet flat on the floor.

3) MEASURE
- Rest for five minutes while in position before starting.
- Take two or three measurements, one minute apart.
- Keep your body relaxed and in position during measurements.
- Sit quietly with no distractions during measurements—avoid conversations, TV, phones and other devices.
- Record your measurements when finished.

TARGET: BP
Gathering the Data for Reporting Population Health
PDSA in Action: Improving BP

- 61 Patients Enrolled in Hypertension Self Monitoring Blood Pressure project.
- Tonasket MA-C and South Clinics CHW engage and enroll patients into program.

Highlight: individual success stories of weight loss, smoking cessation, increased exercise - all due to individual attention outside of the traditional provider visit.

THIS IS TEAM BASED CARE!
What are we seeing in the provider’s visit?
What are we seeing from home results?

Self-Monitoring of Blood Pressure Project 2021

- Initial Office Reading Systolic
- Initial Office Reading Diastolic
- Average SMBP Systolic@ 3-4 mo
- Average SMBP Diastolic @ 3-4 mo
What are we seeing at a systemic level?
Lessons Learned

★ Evaluate effectiveness in registry vs population targets. Measure small focus group of patients to start, gather feedback, expand to larger group. Spotlight effect?
  ○ Participation and engagement of the patient is required
  ○ Some patients are not ready for self-management
  ○ What number qualifies as “success”?
★ MA-C + CHW II: Provider ratio to support population health work is necessary for translating a “PDSA” into a standard “process”.
★ Skills training needed (for providers and other support persons). Develop a curriculum and then recreate it until it fits your staffing.
• Blood pressure monitors need to be verified for accuracy and appropriate size (best practice to use arm cuff not a wrist cuff). Some patients will need another person in the home to help.
• Home monitoring programs works well to identify “white coat syndrome” and provide change feedback.
• CHW’s and clinical staff need experience with home monitors and teaching patients (we wrongly assumed that competency taking BP in clinic would translate to home monitors)
Provider-Perceived Barriers

Surveys of healthcare providers indicate they are concerned about the possible inaccuracy of self-measured BP monitoring devices and low adherence to self-measured BP monitoring schedules by patients. Providers also report concerns about self-measured BP monitoring increasing patient anxiety, leading to frequent interactions with the healthcare system. A concern is that increased use of self-measured BP monitoring, along with education and communication, will affect practice resources: staff workload, telephone calls, email messages, or other electronic communications via electronic health record systems. Additional provider concerns include extra time needed for interpreting self-measured BP readings and lack of reimbursement for self-measured BP monitoring devices.
Patients and providers recognize that effective reduction of high BP is a team effort. Self-measured BP monitoring for hypertension provides the needed link between the limited care in clinics and the true locus of risk and benefit: the patient’s life outside of the clinic where self-monitoring is crucial.

https://www.ahajournals.org/doi/10.1161/CIR.0000000000000803
FHC Team Based Care Transition

Structure of Provider teams Fall 2020

- Centralized Call Center
- Patient Registration
- Patient Navigator
- MA-R
- MA-C
Structure of Provider teams Fall 2021:

- **Call Center and Patient Registration**: Cross training with the goal of mobility between clinics and call centers. Pay incentive and training opportunities to perform both sets of job duties.
- **CHW2**: Cross train job duties of MA-R competencies and Community Health Worker competencies. Work with MA-C on patient flow with a focus on Social Determinants of Health. Goal of same day completion of prior authorizations and referrals.
- **MA-C**: In house MA apprentice program, encouraging MA-R to apply AND stay with FHC.
- **Centralized Medical Records**: Specifically handles medical documents in and out of FHC.
- **Central Navigator/OB**: Responsible as the Lead Navigator; informing which work is handled agency wide vs individual clinics.
Questions?

If you are interested in support and potential grants for managing hypertension, contact SaraEve Sarliker at WA State DOH saraeve.sarliker@doh.wa.gov or heartdisease@doh.wa.gov

Big “THANK YOU” to NCW Community Foundation for their generous support for monitors/cuffs.
Questions/Discussion
NCACH/WPCC Update
2022 NCACH Priorities

- Board Retreat Recording of Budget Presentation Link: October 2021 Governing Board Retreat - YouTube

- **Link to full Board Packet**: Budget presentation is on Pages #4 to #28. The presentation is also in the Board retreat meeting request.
Shifting our Mission

Mission under MTP

The mission of NCACH is to **improve the health** of the North Central region’s communities and the people who live in them, **improve health care access, quality, and the experience of care, and lower per capita health care costs** in the North Central region which includes Chelan, Douglas, Grant and Okanogan counties (the “North Central Regional Service Area”).

New Mission

The mission of the North Central Accountable Community of Health is to **advance whole-person health and health equity** in North Central Washington by **unifying stakeholders, supporting collaboration, and driving systemic change**, with particular attention to the social determinants of health.
Moving towards Systems of Care

Projects

Medicaid Transformation (2017-2021)
- Bi-Directional Integration of Physical and Behavioral Health
- Community-based Care Coordination
- Transitional Care
- Diversion Intervention
- Addressing the Opioid Use Public Health Crisis
- Chronic Disease Prevention and Control

Systems of care

Bridge Year (2022)
- Whole Person Health
- Health Equity
- Social Determinants of Health
- Behavioral Health
- Care Coordination (in the broad sense)
Moving towards Transformation

Moving from this...
- TCDI
- WPCC
- CBCC
- Opioid
- CHI
- Tribal

To this...
- Develop a culture of equity and increase community resilience by investing in skill building and capacity building.
- Promote coordinated whole system responses to whole person health needs by increasing cross-sector collaborations and integrated partnerships.
- Improve health outcomes for people struggling with behavioral health issues by increasing the network of behavioral health supports across the community.
- Ensure that policy solutions effectively support our region’s needs and the health of our residents by ensuring that North Central partners and residents have a voice in local and state policies.
- Help partners respond to demand for services by increasing capacity-building supports for partner organizations.

By topic & partner
By type of transformation
2022 Staff Strategic Goals

Develop a culture of equity and increase community resilience by investing in skill building and capacity building.

Promote coordinated whole system responses to whole person health needs by increasing cross-sector collaborations and integrated partnerships.

Improve health outcomes for people struggling with behavioral health issues by increasing the network of behavioral health supports across the community.

Ensure that policy solutions effectively support our region’s needs and the health of our residents by ensuring that North Central partners and residents have a voice in local and state policies.

Help partners respond to demand for services by increasing capacity-building supports for partner organizations.

“BUILDING HEALTHIER COMMUNITIES ACROSS NORTH CENTRAL WASHINGTON”
Budget Categories

Capacity Building
Range of in-kind investments (e.g. trainings, learning activities, underwriting evaluations or planning)

Organizational Redesign
Funding for organizations to work on internal processes and systems that will set them up for cross-sector collaboration

System Redesign
Funding for cross-sector collaborations and partners working on joint efforts to achieve whole person health
Budget Categories

Operations
• Staff support for work with partners (convening, facilitating, planning, project management)
• Administrative support for organization
• Purchase of physical items to support both operations and initiatives

Consultants
• Subject Matter Experts to support partners with their work
• Support to build out NCACH strategic vision and 3 Pillars
What’s next….

There are a lot of changes within NCACH

• Change in leadership in 2022
• Move from CDHD as host to NCACH stand alone agency
  • Change in physical space
  • New policies
  • Change in roles/responsibilities internally
  • New emails, document storage, etc.
• Process of strategic planning for future state
• Continue to wait to hear from HCA if 6th year is approved and what that will entail.
What’s next….

• Creating funding criteria
• Developing an application process
• Developing a calendar of events for capacity building
• Redesigning how we convene with partners
Future Partner Meetings

Review of previous conversations and updates from NCACH
What Role Would You Like NCACH to Play

• Support, facilitator, cheerleader
• Working on gaps that address SDOH
• Liaison (MCOs, HCA, etc.)
• Share best practices and evidence based work
• Facilitate conversations on care coordination
Future meetings

What is your primary purpose for wanting to continue meeting?
Future meetings

What topic would you most like to discuss with your colleagues?
You indicated peer sharing was valuable, what topic do you want to learn from your peers?
Some of you have indicated that internal improvement needs to continue before you engage with external partners.

What area of internal improvement would you like to see as a guided learning activity?
Future meetings

What would you like to hear from your MCO partners?

MCOs: What topics could you present on?
Future meetings

Topics for consideration:
type in:

• Not interested
• Webinar: 1-2 hour
• Workshop: ½ day – 2 days
• Learning Activity: longer term
• Interested but not sure which format I prefer
Future meetings

Topics for consideration: type in not interested, webinar, workshop, learning activity, interested but not sure

• Leadership development
• Health equity
• SDOH
• Transitions of care
• Staffing
• Trauma Informed Care
• Care Coordination
• Integrating clinical care and communities

Not interested
Webinar: 1-2 hour
Workshop: ½ day – 2 days
Learning Activity: longer term
Interested but not sure which format I prefer
Future meetings

Topics for consideration: type in not interested, webinar, workshop, learning activity, interested but not sure

Topic specific:
• Depression
• Diabetes
• Heart disease
• SUD
• Bidirectional integration
• Care of older adults
• Other?

Not interested
Webinar: 1-2 hour
Workshop: ½ day – 2 days
Learning Activity: longer term
Interested but not sure which format I prefer
Key NCACH Staffing Transitions

- **Linda Evans Parlette** → Retiring December 31st
- **John Schapman** → Acting Executive Director January 1st, 2022
- **Wendy Brzezny** → Clinical Partner Support
- **Caroline Tillier** → Supporting Community Partners & Wendy in Clinical community linkages
- **Mariah Kelley** → Partner support (Both clinical & non clinical)
- **Joseph Hunter** → Recovery Coach Network
- **David Goehner (New)** → NCACH communications and outreach
- **Teresa Davis** → Office Management
- **Data Director** → To be hired (Looking for applicants)
Next Meeting: December 6th

Virtual Only