CASCADE PACIFIC ACTION ALLIANCE

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Medicaid Transformation

The Medicaid Transformation Project (MTP) is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems to benefit Apple Health (Medicaid) clients.

MTP work is led by nine Accountable Communities of Health (ACH), each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health.

ACHs aim to transform the health system statewide: **better health, better care, and lower costs.**

Cascade Pacific Action Alliance (CPAA) Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum Counties

Confederated Tribes of the Chehalis, Cowlitz Indian Tribe, Nisqually Indian Tribe, Quinault Indian Nation, Skokomish Indian Tribe, Shoalwater Bay Tribe, and Squaxin Island Tribe

ACH Regions Map

P4P Metrics

MTP Implementation Partners, providers, and community-based organizations in the CPAA region are working together to transform care delivery and improve the state's Pay for Performance (P4P) metrics. **Our combined work to improve our region's P4p metrics culminate in better patient outcomes, healthier communities, and more money** to give to partners for Transformation work.

If the CPAA region meets all of its milestones and the state meets all their metrics, **CPAA will earn up to $51.4 million** in Transformation funding for the region.

P4P metrics, which are broadly accepted as the standard of care, focus on health conditions that are of significant concern for population health. P4P metrics include, but are not limited to:

- All cause ED visits
- Well-child visits
- Comprehensive diabetes care: A1c testing
- Percent homeless
- Mental health treatment penetration
- Substance use disorder treatment penetration

CPAA Projects

Bi-Directional Care Integration focuses on delivering whole-person care, closing the gap between primary care and behavioral health services, and addressing physical and behavioral health in an integrated system. Moving into an integrated system means implementing Collaborative Care principles, including patient-centered team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care.

Care Coordination brings a structured, standardized approach to care by connecting high-risk individuals to physical health, behavioral health, and social support services with the help of a care coordinator. Community CarePort, CPAA's Pathways HUB, is a community-wide, evidence-based approach that emphasizes empowered patients, ensures those patients at greatest risk are identified, and that individual's medical, behavioral health, and social risk factors are addressed.

Transitional Care coordinates services when a patient moves from one health care setting to another, ensuring patients get the right care in the right place at the right time. Many patients are not fully recovered when they leave the hospital, and increasing access to care to reduce adverse health events and coordinating transitional care services results in lower health care costs and healthier, more satisfied patients.

The Opioid Response project address the opioid epidemic and reduces the burdens this crisis places on individuals, families, and communities. It is an opportunity to use practical, evidence-based approaches to prevent initiation of use by changing the way opioids are prescribed, prevent overdose deaths, reduce stigma and judgement, and increase recovery supports and access to medication assisted treatment (MAT).

Reproductive/Maternal & Child Health works with partners to support healthy families, which are the center of a healthy community. CPAA intends to help young men and women, mothers, and children access health services, mitigate the impact of adverse childhood experiences (ACEs), and build resilience in our region.

Chronic Disease Prevention and Control focuses on educating our communities about health risks and chronic disease prevention: our community members eat healthy, exercise, and practice other healthy lifestyle behaviors (e.g., not smoking) to prevent chronic diseases, our workplaces and built environments support them in doing so, and community members who suffer from chronic diseases have the tools, resources, and motivational support systems to successfully manage their conditions.

Social Determinants of Health

It's harder to be healthy if you don't have a home, you don't have food, or you don't have a job. CPAA's cross-sector stakeholders and partners focus on community-clinical linkages and address social determinants of health, **the social and environmental conditions that influence a person's health:**

- Prevent and mitigate adverse childhood experiences (ACEs)
- Decrease the impact of socioeconomic factors like poverty, chronic pain, untreated depression and anxiety, unstable housing, food insecurity, insufficient health literacy and self-management training, and substandard working conditions
- Increase access to care, including oral health, primary care, behavioral health, recovery supports for substance use disorder, regular check-ups and preventative screenings, and transportation to appointments

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