# Stage 1 Planning: Assess Current State Capacity

<table>
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<tr>
<th>Project</th>
<th>Project Stage Milestones</th>
<th>Deadline (DY, Qtr)</th>
<th>ACH Approach for Accomplishing Milestones</th>
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<td>2A Bidirectional Integration</td>
<td>Assess current state capacity of Integrated Care Model Adoption: Describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the five levels of collaboration as outlined in the <strong>Standard Framework for Integrated Care</strong></td>
<td>DY 2, Q2</td>
<td>Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical providers in the region to gauge the current state of capacity for effective bidirectional care integration services delivery by the end of DY2, Q1. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key clinical partners as well as technical assistance partners (e.g., Qualis Health). We also plan to utilize the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub. In addition to understanding providers’ level of integration, CPAA will identify specific care models that are already being implemented, such as the Collaborative Care Model (CoCM), Patient-Centered Medical Home (PCMH), or Bree Collaborative Behavioral Health Integration Recommendations in order to get a better understanding of the alignment needed to achieve all collaborative care principles. To date, CPAA has been coordinating with Qualis Health regarding their work conducting the MeHAF Site Self Assessment and PCMH-A assessments with medical clinics and behavioral health organizations in the CPAA region. The SAMHSA-HRSA Center for Integrated Health Solutions offers additional assessment tools for organizations integrating primary care and behavioral health. A further review of the following assessment tools will be conducted by the Clinical Provider Advisory Committee and/or Bi-Directional Care Integration Work Group to determine which additional tool(s) will best meet the local needs of the CPAA region. Ultimately, these assessments will allow us to describe where each provider/organization falls in the five levels of collaboration defined by <strong>A Standard Framework for Levels of Integrated Care</strong>. The five levels include: 1) minimal collaboration, 2) basic collaboration at a distance, 3) basic collaboration onsite, 4) close collaboration in a partly integrated system, and 5) close collaboration in a fully integrated system.</td>
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1) **MeHAF Site Self-Assessment (SSA)**: This tool assesses the level of integration achieved by organizations by focusing on two domains: 1) integrated services and patient and family services; and 1) practice/organization.  
2) **PCMH-A Assessment**: identifies current level of “medical homeness” and opportunities for improvement.  
3) **AIMS Center Milestones Checklist to Evaluate Your Practice Team’s Readiness for Integrated Behavioral Health Care**: This tool features questions and links to determine organizational readiness to launch collaborative care.  
4) **WA Council for Behavioral Health/National Council for Behavioral Health/AIMS Center Milestones Checklist to Evaluate Your Team’s Readiness for Integrating Primary Care in**
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| 2B - Pathways | Assess current state capacity to effectively focus on the need for regional community-based care coordination | DY 2, Q2 | Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical and social service providers in the region to gauge the current state of capacity for effective community-based care coordination services delivery. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key clinical and social service partners as well as technical assistance partners (e.g., Pathways Community HUB Institute). We also plan to utilize the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub. Providence CORE will continue to provide support. The Care Coordination Work Group will review data and provide input into the final report. *We will complete final analysis by end of Q2 in DY2.* |

| 2C – Transitional Care | Assess current state capacity to effectively deliver care transition services | DY 2, Q2 | Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical and social service providers in the region to gauge the current state of capacity for effective care transition services delivery. Particular emphasis will be placed on potential partnering providers, i.e., key partners, including major Medicaid providers, identified during the project design phase to date. We will augment this survey through a discussion of survey results with key clinical and social service providers as well as technical assistance partners (e.g., Qualis Health) in order to gain a shared understanding of the survey results, assess the implications of the survey, and backfill missing information. We also plan to use the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub to round this current state capacity analysis. These efforts will result in an updated, comprehensive assessment of our region’s current state capacity to effectively deliver care transition services. |

| 3A – Opioid Response | Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps. | DY 2, Q2 | Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical and social service providers in the region to gauge the current state of capacity for effective opioid response services delivery by the end of DY2, Q1. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key clinical and social service partners as well as technical assistance partners (e.g., Qualis Health and DOH) to identify missing resources and assets. We also plan to utilize the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub. The Opioid Response Work Group will review data and provide input into the final landscape analysis by DY2 Q2.* |

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**Behavioral Health Agencies:** This tool features questions and links to determine if your behavioral health agency is ready to launch integrated primary care in a behavioral health setting.

**5.) Integrated Practice Assessment Tool (IPAT):** This tool places providers/practices/organizations in one of five levels that determine the current state of integration/collaboration.
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To date, the following service providers in the CPAA region have been identified as potential partners as part of the current regional assets to effectively impact the current opioid crisis:

1. Eleven hospitals (Capital Medical Center, Grays Harbor, Legacy Salmon Creek, Mason General, Morton General, Ocean Beach, Peace Health St. Johns Medical Center, Providence Centraila, Providence St. Peter, Summit Pacific, and Willapa Harbor)
2. Four short or long-term inpatient chemical dependency programs (Harbor Crest, NW Indian Treatment Center, and Providence Centraila, Cowlitz Family health Center)
3. One licensed Opioid Treatment Program (OTP) (Evergreen Treatment Services)
4. Numerous outpatient chemical dependency treatment programs
5. Six multi-site behavioral health care organizations (Behavioral Health Resources, Great Rivers BHO, SeaMar, Thurston-Mason BHO, and Valley View, Cowlitz Family Health Centers)
6. Three syringe exchange programs in Thurston, Cowlitz and Grays Harbor counties.
7. Public Health Departments throughout the region are expanding their service provision around the opioid issue; Mason and Cowlitz counties have received State Targeted Response grants.

A further review of all the available interventions by the Opioid Response Work Group will determine which additional strategies will best meet the local needs of the CPAA region, with emphasis on addressing the following identified gaps to providing an integrated program to address the opioid crisis:

1. Large geographical distance between people needing resources and the physical location of service providers, due in part to the rural nature of much of the region
2. Stigma, which is identified as a primary barrier after geography
3. Limited availability of MAT due to a) only one Opioid Treatment Program, which has insufficient space and workforce capacity to accommodate its census cap; and b) a shortage of medical providers trained and willing to prescribe buprenorphine, particularly outside Lewis and Thurston counties
4. A shortage of chemical dependency professionals, particularly those educated about MAT
5. Lack of communication, coordination, and digital information exchange among service providers
6. Limited access to inpatient treatment for SUD
7. Lack of education among the general population, professionals (medical, chemical dependency, and law enforcement), and families and individuals living with OUD on topics including the stigma of OUD, MAT as the established evidence-based
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| 3B – Reproductive Maternal and Child Health | Assess current state capacity to effectively focus on the need for high-quality reproductive and maternal and child health care | DY 2, Q2 | The assessment of current state capacity will be a continuation of data collection and analysis CPAA has engaged in throughout project selection and development. CORE will continue to provide analytical data support. The Reproductive and Maternal & Child Health Work Group will review current state data and provide input into the final report. An assessment of current state capacities will be completed to avoid duplicating efforts and instead build upon existing assets and resources to the greatest extent possible. This includes an assessment of existing home visiting programs in our region. Again, this current state assessment will be reviewed across different project areas to develop maximum leverage and avoid duplication. In the implementation plan, the service delivery mode will be clearly articulated based on the selected target population/s. *We will complete final analysis by end of Q1 in DY2.* |
| 3D- Chronic Disease Prevention and Control Implementation Approach | Assess current state capacity to effectively impact chronic disease | DY 2, Q2 | Building on past regional capacities, CPAA will conduct an online survey of key clinical providers and public health departments in the region to gauge the current state capacity for implementing the Chronic Care Model and specific corresponding strategies outlined in the Project Toolkit by the end of DY2, Q2. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key partners, advisory committees, and work groups. In addition to understanding the impact of the Chronic Care Model, CPAA will identify how specific strategies, such as the Community Guide, Million Hearts Campaign, Stanford Chronic Disease Self-Management Program (CDSMP), and Community Paramedicine model, are being implemented to get a better understanding of alignment opportunities with other project areas and how current capacities can be expanded. |