**Expansion Pilot - Quantitative Data Collection – Reach and Effectiveness**

**May 31, 2023 Evaluation and Measurement Workgroup**

**Measures that will need to be collected and reported by the Administrative Entity/Program Manager (Frequency = quarterly):**

|  |
| --- |
| # of expansion participating practices in each HSA receiving embedded expansion funding |
| # of expansion participating practices in each HSA receiving centralized expansion resources |
| Staffing type, FTE, Location of expansion resource, vacancies at time of reporting |

**Measures that will need to be tracked and reported by the Community Health Teams (Frequency= Quarterly)**

|  |
| --- |
| Count of CHT unique patients served by HSA |
| Count of CHT unique patients served by age group (Birth-1, 2-5, 6-17, 18+) |
| Count of CHT patients served by insurance type (Medicaid, Medicare, Commercial, Other insurance, no insurance) – Frequency: formative and summative |
| Count of CHT patients seen for MH/SUD diagnosis or need |
| # External Referrals Made by CHT for MH/SUD/SDOH support and care |

**Measures that the practice will need to report from their EMR or have a Chart Audit Completed for (Frequency=TBD):**

|  |
| --- |
| % eligible population receiving recommended caregiver screening (unique patients screened/eligible population) |
| % population receiving recommended SDOH screening (unique patients screened/total practice population) |
| % population receiving recommended MH screening (unique patients screened/total practice population) |
| % population receiving recommended SUD screening (unique patients screened/total practice population) |
| Positivity rate of screens (how many patients had a positive screen - any type/total number of screens) |
| Depression Screening and Follow Up for Adolescents and Adults |

**Measures that a QI facilitator may conduct random sample chart reviews for patients seen by CHT for MH/SUD need (n=30, frequency = formative and summative)**

Screening method (portal, form, in person, other)

Positive domains (MH, SUD, SDOH)

Time between positive screen and CHT intervention (same day, same week, following week, other)

MH/SUD CHT Episodes of care (duration, frequency)

Types of MH/SUD interventions provided by CHT (self-management, education/resource provision, peer support, CBT, etc.)

Change in MH/SUD assessment scores (not tracked, improved, worsened)

Evidence of documentation of MH/SUD goal in care plan/ shared care MH/SUD goals among multiple service providers

**Standardized Measures to be monitored (from claims) and reported by (?) practice, HSA, and state:**

|  |
| --- |
| Initiation and Engagement in Treatment – Alcohol |
| Initiation and Engagement in Treatment – Opioid |
| Initiation and Engagement in Treatment – Other |
| 30 Day Follow Up after discharge from ED Visit Mental Illness (FUM) |
| 30 Day Follow Up after discharge from ED Alcohol and Other Drug Abuse or Dependence (FUA) |
| Follow Up after Hospitalization for Mental Illness (FUH) |
| Follow Up after High-Intensity Care for Substance Use Disorder (FUI) |

**Long Term Outcomes to be monitored (VDH data):**

|  |
| --- |
| *Opioid-Related Fatal Overdoses* |
| *Drug Overdose Deaths* |
| *Alcohol Use Among Older Adults* |
| *Young Adult Survey (Alcohol use, cannabis, tobacco, other drug use)* |
| *Alcohol use disorder/substance use disorder/illicit drug use disorder in past year, 12+* |
| *Percentage of Vermont Adults with any mental health conditions receiving treatment* |
| *Rate of suicide deaths per 100,000 Vermonters* |
| *Household food insecurity and hunger* |