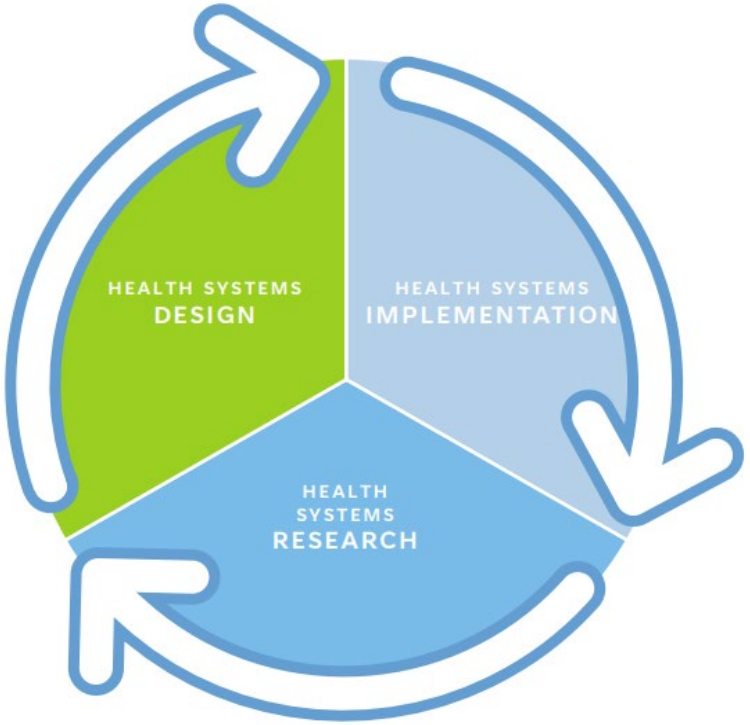
Measurement and Evaluation Committee



BLUEPRINT EXPANSION PILOT

VERMONT Blueprint for Health

Today's Work

Welcome

- Newly joining members

Recap

- Minutes/work group records
- Deliverables completed to date

Logic Model

- Problem/Aim
- **Assumptions* (group input)**
- Inputs
- Activities
- Outputs
- **Outcomes* (group discussion)**
- Impact
- External Factors

VERMONT Blueprint for Health

www.blueprintforhealth.vermont.gov

Workgroups and Committees

The Blueprint for Health is guided by stakeholder groups that include experts in healthy systems design, evaluation, payment implementation, and mental health and substance use disorder treatment.

Blueprint Executive Committee

Payment Implementation Workgroup

Blueprint News

News

March 23, 2023

BP Executive Committee Minutes March 16 2023 Now Availble

News

March 14, 2023

BP Executive Committee Agenda March 16 2023

News

February 21, 2023

DVHA Is Seeking to Establish Contracts for Quality Improvement Facilitators

Recap – What we've accomplished

- Background/Evaluation Purpose/Scope
- Logic Model or Theory of Change
- Program Goals and Objectives
- Assumptions
- Evaluation Questions
- Data Collection Plan(Sources, Methods, Timing, Responsibility)
- ~~Stakeholder Matrix~~
- Data Sources/Evaluation Question Matrix
- ~~Ethical Considerations~~
- Reporting Products
- Communication Plan
- Timelines

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Logic Model (High Level)

Expand Community Health Team Capacity to Support Patient's Mental Health and Substance Use Disorder Needs

Inputs

- Community Health Team Funding
- Education and Training Funding
- Quality Improvement Facilitators
- Data and Measurement Funding

Activities/Outputs

- Screening
- Intervention
- Care management and coordination
- Training Sessions
- Implementation and integration activities
- Continuous quality improvement activities

Outcomes

- Increased Screening Rates
- Increased Access to Intervention
- Improved Coordination of Care
- Greater patient and provider satisfaction
- Neutral or decreased cost of overall care

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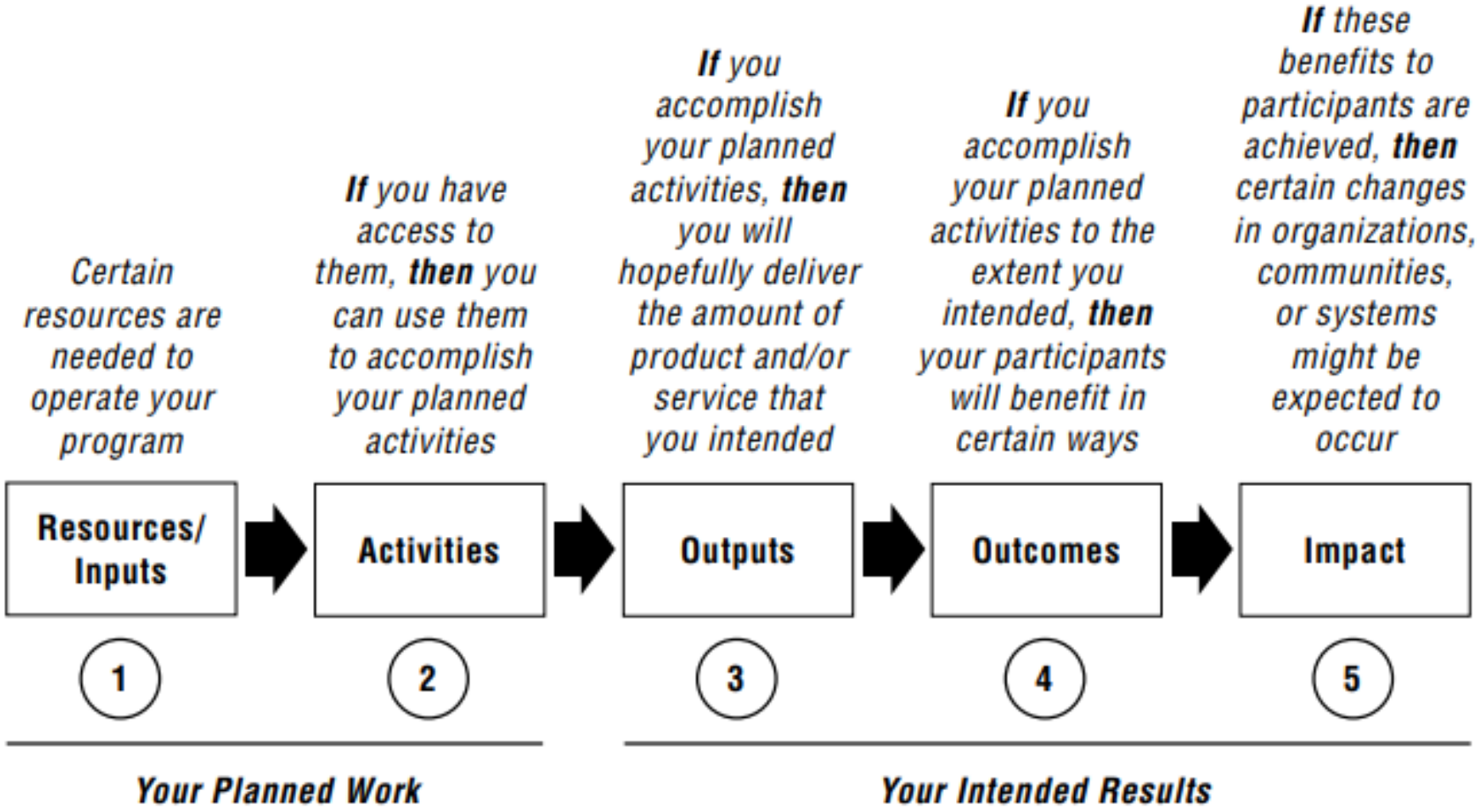
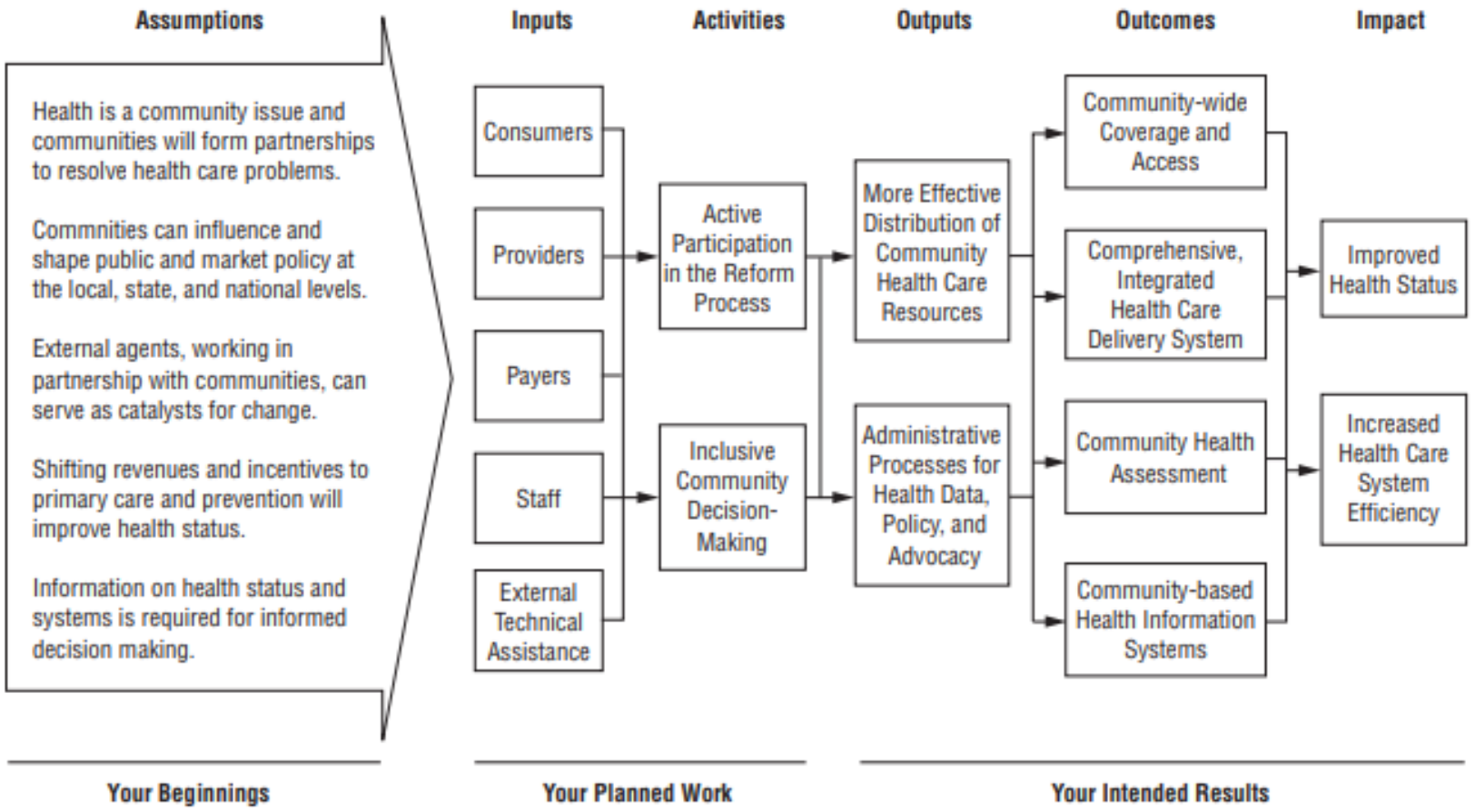
If…..Then


Certain resources are needed to operate your program
If you have access to them, then you can use them to accomplish your planned activities
If you accomplish your planned activities, then you will hopefully deliver the amount of product and/or service that you intended
If you accomplish your planned activities to the extent you intended, then your participants will benefit in certain ways
If these benefits to participants are achieved, then certain changes in organizations, communities, or systems might be expected to occur
Resources/ Inputs
Activities
Outputs
Outcomes
Impact
1
2
3
4
5
Your Planned Work
Your Intended Results

Logic Model Sample - Detailed



for Health

Beginnings - Aim

AIM: To provide Vermonters with enhanced screening, care, support, and coordination for circumstances that impact their health and wellbeing, their mental health needs, and substance use concerns throughout their lifespan by formally incorporating services into Patient Centered Medical Homes across the state. Within 1-2 years, the Blueprint for Health will increase the number of health professionals working in Patient Centered Medical Homes who possess the knowledge, skills, and competencies necessary to provide high quality, person-centered, coordinated care for individuals at risk for and currently experiencing mental health concerns, substance use needs, and/or requiring assistance to navigate barriers, facilitators, or other social factors.

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Beginnings - Assumptions

Group Input: Any that you would add/remove/question/ challenge?

It is appropriate and necessary to address MH and SUD needs in the PCMH setting, including:

- Short term/episodic mental health and substance use needs
- Long term MH and SUD diagnoses
- Co-occurring conditions

Pediatric/adolescent population and adult population service needs will differ

A lot of work is already occurring; these additional resources and program activities will relieve some of the challenges faced by providers and teams in PCMH settings

This work will integrate into a continuum of care – working in parallel and partnership with existing programs in DAs, HUBs, Spokes, Private Practices, Peer Support Programs, etc. Additional work will be required to articulate:

- PCMH specific intervention goals
- Referral criteria and pathways
- Referral expectations: consultation, co-management, or comprehensive and coordinated care

Local communities are best able to determine the CHT staffing mix and location based on their unique practice types and population needs (within defined parameters)

Adding CHT staff is possible in this workforce climate

There is an existing need and desire for developing knowledge, skills, and competencies for treatment of SUD and MH needs in primary care

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Planned Work - Resources/Inputs

Community Health Team Staff (50-60 FTE total), which may include

- Community Health Workers
- Drug and Alcohol Counselors
- Masters Level Mental Health Clinicians/Social Workers
  - Coordinated, Co-located, or Integrated

4 FTE QI Facilitation, which may include

- MH/SUD Physician
- Clinician
- Quality Improvement Specialist
- Project Manager

Education and Training Funds ($300,000)

Data and Analysis Funds ($350,000)

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Planned Work – Possible Activities

Program Design Work Group

&

Payment Work Group Dependencies

Mental Health	Substance Use (NQF Evidence Based Domains)	Education	Implementation and Quality Improvement	Monitoring and Measurement
Identify mental health problems	Screening/Case Identification	Standardized Orientation	Implementation Support and practice coaching (Workflow, policies, protocols, etc.)	CHT Position Management
Therapeutic interventions	Initiation and Engagement of Treatment	Trainings (CME, CEU, CEs)	Learning Collaborative	CHT Workload Measurement
Monitor mental health outcomes	Therapeutic Interventions	Lunch and Learns	Academic Detailing	EMR Configuration (Outcomes)
Coordinate treatment with specialists	Care Management	ECHO	Stepped Care Systems Mapping/Referral Agreements	

Evidence Supported Interventions Addressing Mental Health Needs in PCMHs (Pediatric and Adolescent)

Infants and young children (DULCE Model)

- Screening
- Referral to Services (SDOH, Legal, perinatal depression and anxiety)
- Parenting support

Children and Adolescents

- Screening and assessment
- Prevention Strategies – Family Systems Support
- Stepped Care Intervention Strategies
- Outcome monitoring

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Evidence Supported Interventions Addressing Mental Health Needs in PCMHs (Adult)

Screening for depression, anxiety, and suicidality

Stepped care protocol for mental health in PCMH

- Self management
- Low Intensity Services (address social supports and situational stressors)
- Moderate Intensity Services (peer supports and lifestyle interventions)
- High Intensity Services (Psychosocial support and community supports such as peer support, social participation or lifestyle interventions)
- Acute/Specialist Community Level Services (Intensive team-based specialist assessment and intervention)

Post Acute Episode Follow Up (post hospitalization follow up)

- Provide treatment plan continuity
- Address new or changed physical health, mental health (anxiety, depression, PTSD), substance use, and physical function needs resulting from hospitalization
- Set up preventative/chronic care appointments

Stepped Care (post discharge from residential or intensive outpatient treatment)

- Provide treatment plan continuity
- Support social adjustment (finances/employment, housing, food security, safety, general health status, relationships, recreational and social activities)

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Evidence Supported Interventions Addressing Substance Use Disorder in PCMHs

Needs Identification (new needs and episodes)

- Screen target population(s)
- Complete assessment (hazardous use, substance abuse, substance dependence)
- Create individualized care plans/provide and coordinate care
  - Motivational Interviewing
  - Brief behavioral change counseling
  - Behavioral therapy
  - Pharmacotherapy
  - Referral management/follow up/support

Post Acute Episode Follow Up (post hospitalization follow up)

- Provide treatment plan continuity
- Address new or changed physical health, mental health (anxiety, depression, PTSD), and physical function needs resulting from hospitalization
- Set up preventative/chronic care appointments

Stepped Care (post discharge from residential or intensive outpatient treatment)

- Provide treatment plan continuity
- Support social adjustment (finances/employment, housing, food security, safety, general health status, relationships, recreational and social activities)

Continuous Care (long term relationship with PCMH)

- Addressing Relapse Risks
- Providing support for co-occurring issues and needs
- Medication Adherence
- Harm Reduction
- Self-management

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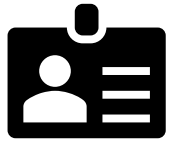
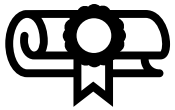
Intended Results - Outputs



Staff hired



Training sessions delivered

Unique patients served

Screenings completed

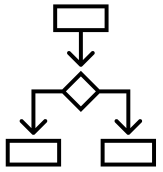
Assessments completed

Care plans completed

Interventions provided

Follow ups completed

Referrals completed



QI Interventions Delivered

- In practice facilitation

- Academic detailing

- Learning collaborative

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Identifying Outcomes

Outcomes reflect reasonable, progressive steps that participants can make toward longer-term results.

Outcomes address awareness, attitudes, perceptions, knowledge, skills, and/ or behavior of participants.

Outcomes are within the scope of the program's control or sphere of reasonable influence.

The outcomes are specific, measurable, action-oriented, realistic, and timed.

The outcomes are written as change statements (e.g. things increase, decrease, or stay the same).

The outcomes are achievable within the funding and reporting periods specified

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Changes in behavior, knowledge, skills, health status, and level of functioning

S-Specific, M-Measurable, A-Action Oriented, R-Realistic, T-Timely

Intended Results - Short Term Outcomes

If we put in these additional CHT staff doing these activities, then we might see…..

e.g. increased preventative care completed for populations with SUD.

If we put in education and training for providers and their teams, then we might see…..

If we put in additional QI facilitation, then we might see….

If we invest in data and analysis, then we might see….

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Intended Results - Impact

Morbidity

Decreased physical morbidity – diabetes, stroke, myocardial infarction*

Mortality

Decreased deaths of Vermont Residents related to drug overdose and suicide*

Decreased deaths associated with chronic physical illness*

Function

Improved physical, psychological, social, and role functioning

Quality of Life

Improved Social Adjustment and Participation, Purpose, Belonging, Wellbeing

Systems of Care

Access - Improved timeliness and appropriateness to MH and SUD services

Improved Patient Experience of Care

Improved Provider Experience of Care

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External Factors

Practice organizational structure (e.g. independent, affiliated, integrated)

Practice environment (e.g., patient demographics and health literacy, practice size leadership)

Health care environment (e.g., payment approaches, general practice patterns, level of market competition and integration)

Community resources (e.g., availability of social services, linkages between health care delivery and local public health programs)

Existing incentives, supports, and initiatives

National/world health and social change

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Timeline

~~***Session 1 - March 22, 2023 - Group formation, Stakeholders, Evaluation Principles***~~

~~***Session 2 - April 5, 2023 – Logic Model***~~

Session 3 - April 19, 2023 - Forming Evaluation Questions

Session 4 - May 3, 2023 – Matching Questions with Measures

Session 5 - May 17, 2023 - Measures (continued) / Data Collection

Session 6 - May 31, 2023 - Data Collection (continued) / Communication of Results

Session 7 – June 14, 2023 – Final *Evaluation Plan Review*

Session 8 – June 28, 2023 - Flex

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Next Session – Forming Evaluation Questions

Preparation – 5-minute read

How to Write Good Evaluation Questions — Eval Academy

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