Blueprint for Health Expansion Pilot for Mental Health and Substance Use Disorder

April 19, 2023

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 experiencing mental health concerns, substance use needs, and/or requiring assistance to navigate barriers, facilitators, or other social factors.*

EVALUATION QUESTIONS:

1. **Question: Who was reached by this expansion pilot?**

Indicators:

- Participating PCMH and characteristics
- Rate of patients receiving screenings by type (SDOH, MH, SUD), age group
- Patients receiving CHT interventions, characteristics (age, diagnosis, insurance type)
    - Assessment
    - Treatment
    - Care Coordination
- Patients receiving other OUD and SUD interventions at PCMH (by billing codes), characteristics (age, diagnosis, insurance type)
- Providers and clinicians attending training
- Practices participating in implementation/Quality Improvement activities

2. **Question: How effective was the expansion pilot at providing Vermonters with enhanced screening, care, support, and coordination for circumstances that impact their health and wellbeing, their mental health needs, and substance use concerns in Patient Centered Medical Homes?**

Indicators:

- New SUD episodes resulting in treatment initiation and engagement, stratified by (1) alcohol use disorder, (2) opioid use disorder, and (3) other substance use disorder.
- Clinical outcomes
    - MH
    - SUD
    - SDOH
- Persons receiving PCMH follow up within 30 days after ED, hospital visits, and discharge from residential or IOT services for MH or SUD.
- Change in knowledge, skill, and competency of providers and clinicians.

- Patients receiving assistance to navigate barriers, facilitators, or other social factors.

3. **Question: How well was the expansion pilot adopted by target staff, practices, and institutions?**

Indicators:

- #/FTE staff added to PCMH, by type
- Ability to meet program requirements
    - Screening
    - Intervention
    - Follow-up
    - Referral agreements

4. **Question: Was it implemented as planned? Were there any adaptations made? Were the funds used as intended?**

Indicators:

- Vacancies
- Staff turn-over
- Training attendance
- QI utilization
- Screening type and frequency
- Intervention type and frequency
- Follow up type and frequency
- Referral agreements
- Referrals

5. **Question: What impact did the pilot have on the Administrative Entities tasked with administering the Blueprint for Health Programs/Community Health Teams?**

Indicators:

- Resource distribution practices
- Administration of funds
- Hiring/supervision/management
- Spend/Additional costs

6. **Question: What impact did the pilot have on Patient Centered Medical Homes? Were there any unintended outcomes (positive or negative)?**

Indicators:

- Communities where PCMHs were involved in local program planning/implementation conversations
- Scheduling impact
- Workflow impact
- EMR impact
- Human Resources Impact (hiring, training, management, supervision)
- Team functioning impact
- Space considerations
- Operational cost/infrastructure implications
- Reimbursement changes
- Panel size and distribution impact
- Provider and clinician experience of care
- Spend/additional costs

7. **Question: What impact did the program have on other Mental Health, Substance Use Disorder, and Social Service Providers? Were there any unintended outcomes (positive or negative)?**

Indicators:

- Communities where other service providers were involved in local program planning/implementation conversations
- Duplication of services
- Coordination of care
- Information sharing
- Consultation provision
- Measurement
- Referral rates
- Provider and clinician experience of care

8. **Question: What impact did the pilot have on patients, families, caregivers, and their local communities? Were any Vermonters not previously engaged with a Patient Centered Medical Home able to benefit from any of these services?**

Indicators:

- Communities where families/patients/caregivers were involved in local program planning/implementation conversations
- Community/patient awareness of service availability
- Accessibility
- Acceptability
- Experience of Care

9. **Question: What supports and resources will be needed to maintain the initiative over time?**