Blueprint for Health Expansion Logic Model

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.

INPUTS	ACTIVITIES			OUTCOMES	
What we invest	**What we do**	**Who we reach**	**outputs**	**Short/intermediate results**	**long-term results**
➢ **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 ➢ **4 FTE QI Facilitators** ➢ **Education and Training Funds** ($300,000) ➢ **Data and Analysis Funds** ($350,000)	Patient Service Provision ➢ DULCE ➢ Evidence based MH and SUD Services - Screening - Stepped care interventions - Referral to higher level of care - Post Hospital Follow Up - Post Residential/IOT Follow Up - Ongoing care management ➢ Provider/CHT Education and Training ➢ Workforce(CHT) Monitoring ➢ Outcome Monitoring ➢ Quality Improvement Facilitation	➢ Patients ➢ Families ➢ Providers and teams ➢ CHT Members ➢ Program Managers ➢ QI Facilitators	# Staff hired # Unique patients served # Screenings completed # Assessments completed # Care plans completed # Interventions provided # Follow ups completed # Referrals complete # Training sessions delivered # QI Interventions Delivered - In practice facilitation - Academic detailing - Learning collaborative	PCMHs are consistently asking about SDOH, MH, and SU needs of Vermonters. PCMHs are equipped with the workforce, knowledge, and skills necessary to address Vermonters SDOH, MH, and SU needs. PCMHs have systems in place to measure and monitor service demand, service provision, and clinical outcomes of MH and SUD care. PCMHs have protocols, agreements, and systems in place for MH/SUD consultation, co-management, and higher level of care access. Increased percentage of new SUD episodes that result in treatment initiation and engagement, stratified by three diagnosis cohorts: (1) alcohol use disorder, (2) opioid use disorder, and (3) other substance use disorder. Improvement in patient reported outcomes after treatment, including general mental health status and experience of care. Patients and Families experience greater coordination and continuity of care at their PCMH following ED visits, hospitalizations, and discharge from residential or IOT services within required timeframes.	***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*

Assumptions	External Factors
• It is appropriate and necessary to address MH and SUD needs in the PCMH setting, including: 1. Short term/episodic mental health and substance use needs 2. Long term MH and SUD diagnoses 3. 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: 1. PCMH specific intervention goals 2. Referral criteria and pathways 3. 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	➢ 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