Service Design Site Visit Report

Vermont Department of Health

Burlington, Vermont

Dates of Site Visit: May 13–14, 2014

◆ SBIRT ◆

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Prepared for the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment

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Vermont Department of Health

Grantee Name	Vermont Department of Health
Grantee Phone Number	802-951-1258
Grantee Address	108 Cherry Street, P.O. Box 70 Burlington, VT 05402-0070
Site Visit Dates	May 13–14, 2014
Program Name	Vermont SBIRT
Grant TI Number	TI 25105
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Win Turner, Ph.D.	Project Director
Erin O'Keefe, M.S.W.	Project Manager
Jody Kamon, Ph.D.	Project Evaluator

Grantee Project Sites Visited	
Vermont Department of Health	108 Cherry Street, P.O. Box 70 Burlington, VT 05402-0070
People's Health and Wellness Clinic	553 North Main Street, Suite 5 Barre, VT 05641
The Health Center	157 Towne Avenue Plainfield, VT 05667
Community Health Centers of Burlington	617 Riverside Avenue Burlington, VT 05401

Executive Summary

The Vermont Department of Health (VDH) is one of five State entities recently awarded a 5-year cooperative agreement for screening, brief intervention, and referral to treatment (SBIRT) by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of this grant program is to implement SBIRT services in primary and community health care settings for adults at risk for or diagnosed with substance use disorders. The program is designed to expand and enhance the State and tribal continuum of care for substance misuse services, reduce alcohol and drug consumption and the negative health effects, increase abstinence, reduce costly health care use, and promote sustainability of SBIRT services through the use of health information technology (HIT).

The Vermont SBIRT program (VT-SBIRT), administered by VDH, is committed to facilitating sustainable practice change through ongoing collaboration and capacity building with providers, HIT change, and changes related to the Affordable Care Act to standardize substance use identification and brief intervention. This goal will be achieved through—

- Increasing access to universal screening, secondary prevention, early intervention, and treatment for people engaging in substance misuse or abuse by implementing SBIRT in primary care and other health settings
- Developing a systematic training model that efficiently and effectively promotes needed clinical skills learning, practice competency, and fidelity to SBIRT evidence-based practices to a wide scope of health care providers through Webinars, courses, onsite coaching and feedback, and clinical toolbox resources
- Ensuring a sustainable VT-SBIRT model within Vermont's health care system
- Developing the HIT infrastructure to facilitate the use of SBIRT and communication among physical health care and behavioral health care providers

Since the inception of the grant in August 2013, health care providers have begun to implement VT-SBIRT in the following primary care settings: federally qualified health centers, clinics for the uninsured, and the Central Vermont Medical Center's emergency department. Starting in the second year of the grant, VT-SBIRT will implement SBIRT in the University of Vermont Student Health Center. VT-SBIRT is also collaborating with the Vermont Army National Guard to help with training and referrals to treatment. VT-SBIRT plans to reach more than 90,000 adults, markedly increasing access to proactive screening, identification, and needed interventions.

Grantee staff and Vermont Health Department leadership see SBIRT as an integral part of the State's health care delivery system, and buy-in for the SBIRT program has been achieved at all levels of the agency. Grantee staff have made a concerted effort to engage key community members and State-level stakeholders and have successfully recruited representatives from these entities to participate on their diverse policy steering committee. Committee members

include medical and behavioral health providers and representatives of Medicaid and the State's health information exchange (HIE).

The management of VT-SBIRT appears excellent, and all the right stakeholders are at the table. Providers are treated as partners and collaborators, as opposed to simply implementers. VT-SBIRT has established solid relationships with providers in the community and has a diverse range of implementation sites. With its preponderance of community and free clinics, VT-SBIRT is focused on serving Vermonters with low incomes, refugees, migrant farmers, and other subpopulations relying on inexpensive health resources. In keeping with this mission, VT-SBIRT has been thoughtful about the cultural issues surrounding screening and medical/behavioral health care, enlisting the guidance of experienced cultural competency specialists.

A highlight of the VT-SBIRT program is its HIT readiness. Additional funding for cohort 5 will go toward HIT infrastructure upgrades and HIE policies that will facilitate a new communication bridge between medical patient records and specialty treatment providers, which is essential for comprehensive patient care. Program staff aim to meet their HIT goals by—

- Collaborating with State HIT initiatives
- Incorporating SBIRT measures in the Clinical Registry and Vermont Health Information Exchange
- Using a web based global consent portal for medical provider settings and specialty behavioral health settings
- Using SBIRT measures in the Vermont Health Information Exchange to evaluate and inform the State's understanding of the clinical and financial benefits of SBIRT
- Using new HIT linkages to increase patient care coordination

VT-SBIRT has implemented this initiative with thoughtfulness and respect to provider concerns. While the site visit team believes this will help facilitate long-term sustainability, VDH and high-level partners (primary care associations) have been slow to sign agreements, and this has delayed providing SBIRT services to patients in the implementation sites. Although the target numbers for year 1 will be difficult to meet, the site visit team believes VT-SBIRT will readily make them up in subsequent years now that most providers are beginning to implement the program. It was suggested that VT-SBIRT work with Government Project Officer Erich Kleinschmidt to establish a clear plan for achieving grant targets. In response to this suggestion, VT-SBIRT management immediately developed a draft corrective action plan.

Another challenge is that some sites have licensed clinical professionals collecting Government Performance and Results Act (GPRA) data. It was suggested VT-SBIRT hire low-cost data collectors at each site to take care of the tedious task of collecting extensive GPRA data, managing data input and data transmission from each implementation site to the VT-SBIRT evaluation team.

Lastly, while the policy steering committee is strong and diverse, it has traditionally been challenging to keep members engaged throughout the life of a grant. It was suggested committee members be organized into working groups that focus on specific topics and produce concrete deliverables. It was also suggested the committee elect a steering committee chairperson. This would facilitate the development of a more engaged stakeholder base and enable the project director and project manager to dedicate more time to project management.

Grantee Overview and Environmental Context

Vermont's Alcohol and Drug Abuse Programs (ADAP) Division of the Department of Health (VDH) is the single State authority (SSA) for substance abuse services and one of six units within VDH. In turn, VDH is one of six departments within the Agency of Human Services. The other departments are—

- Department for Children and Families
- Department of Corrections
- Department of Disabilities, Aging and Independent Living
- Department of Mental Health
- Vermont Health Access
- Department of Health

Three associated councils—the policy steering committee (PSC), care coordination technology team, and the health disparities workgroup—are engaged with SBIRT implementation. The PSC provides general oversight and support for systems change and sustainability. The care coordination technology team is charged with planning and supporting health information technology (HIT) integration. The Health Disparities Workgroup provides training and technical assistance supporting culturally and linguistically appropriate services.

Environmental Context

According to the 2010 census, Vermont has a population of 630,337, making it the least populous State in New England. Among the 50 States and the District of Columbia, Vermont has the second highest proportion of Whites and the second oldest median age. Vermont also has more highly educated people and fewer young adults, all of which combine to generate lower rates of poverty and unemployment. Vermont has no military installations and few military personnel. The State has 5,125 persons in the National Guard and reserves, with a significant number of members of the National Guard having been deployed to Iraq and Afghanistan.

Since the early 2000s, opioid use and abuse has been a major issue with adults and youth in Vermont, with multiple overdose deaths. Heroin was entering the State from Canada and elsewhere, and at that time, and there was little State capacity to respond to the emerging heroin epidemic, and there were no agonist therapy programs (methadone). Vermont became active in the adoption of and research associated with the use of buprenorphine while the methadone policy and capacity issues were addressed. ADAP was part of a well-organized, statewide capacity-building effort to support the rollout of buprenorphine as the alternate intervention.

ADAP staff describe public attitudes toward the use of substances as laissez-faire. Marijuana decriminalization and legalization represent a topic being actively discussed in Vermont, with support from elected officials. The case for regulating and taxing marijuana in Vermont was bolstered in May 2014 when a poll commissioned by the Marijuana Policy Project and conducted by the Castleton Polling Institute found that 57 percent of respondents support the idea. Only 34 percent of Vermonters were opposed.

The strong support for this reform is reflected at the highest levels of State government. Governor Peter Shumlin has repeatedly said he is open-minded on the issue and that he wants Vermont to learn from what is happening in Colorado and Washington. Commissioner of Public Safety Keith Flynn supports taking "a hard look" at the idea, and Health Commissioner Harry Chen is "open" to the issue. Attorney General William Sorrell has publicly argued in favor of decriminalizing the possession of cannabis plants, and many legislators have gone further by saying they support regulating marijuana similarly to alcohol.[1]

Vermont also has the highest prevalence of underage drinking in the country, according to the National Survey on Drug Use and Health, and has higher than national averages for adult binge drinking.

1. Site Visit Overview

On May 13–14, 2014, the site visit team conducted an implementation site visit at VT-SBIRT to engage the grantee in discussions regarding the status of the SBIRT program, key program strengths, and challenges experienced during implementation. The team worked with the grantee to identify potential enhancements that might be supported by technical assistance as approved by SAMHSA. While on site, the team met with key project staff and State agency senior leadership, visited SBIRT implementation sites, met with administrative staff and service providers, and discussed plans for integration of SBIRT in electronic health records (EHRs) and the State's health information exchange (HIE).

The site visit included several components:

- Meeting with the principal investigator/project director, core senior staff, key partners, project evaluator, project coordinator, and State agency senior leadership
- Reviewing grant implementation and materials
- Reviewing current capacity and plans regarding HIT, including EHRs; the interface between primary care and behavioral health care providers; and participation in the State HIE

[1] http://www.mpp.org/states/vermont/

- Reviewing project evaluation, quality improvement, and Government Performance and Results Act (GPRA) reporting and follow-up
- Visiting three SBIRT implementation sites and interviewing staff

The site visit team toured three Vermont practice sites: The Health Center (Plainfield), the People's Health & Wellness Clinic (Barre), and the Community Health Centers of Burlington (Burlington). See photos below.

Central Vermont Medical Center, in Plainfield

People's Health & Wellness Clinic, in Barre

Community Health Center of Burlington, in Burlington

2. Program Vision and Design

ADAP's vision for substance abuse services is "to create an accountable, community-based system of services and supports that empowers Vermonters to embrace resiliency, wellness, and recovery. This system includes the entire range of services from prevention through recovery, composed of a continuum of timely, interconnected, and coordinated components with multiple

entry points." SBIRT is viewed as an integral element of the State's vision of an integrated public health approach to substance use and misuse and substance use disorders.

3. Grantee Leadership

Under the administrative direction of Barbara Cimaglia, principal investigator, VT-SBIRT is implemented by ADAP and operates through a series of key partnerships, including Evidence Based Solutions, the project management and evaluation contractor, and ADCARE Vermont, the training contractor. ADAP is responsible for overall grants management, reporting, fiscal operations, program planning, and implementation.

VT-SBIRT is directed by Win Turner, Ph.D., with the assistance of Erin O'Keefe, project manager, and Jennifer Gordon, LICSW, quality assurance and training coordinator. The project management team acts under the guidance of ADAP executive management in cooperation with the PSC. The PSC includes representation from key organizations and State offices that are well positioned to support the implementation, dissemination, and sustainability of SBIRT.

Senior leadership within ADAP demonstrate a high level of commitment and buy-in for the SBIRT initiative and view it as an important element of the State's efforts toward the integration of behavioral health and primary care.

4. Implementation Plan

The implementation of VT-SBIRT is guided by a detailed implementation plan. Following the hire of grant-funded project management staff, ADAP confirmed subcontracts with all subrecipients. A significant challenge experienced by VT-SBIRT was the complex and time-consuming contracting process that is standard procedure in the State. From receipt of funding award, 7 months were needed to effect all agreements. This resulted in VT-SBIRT being months behind in its startup and significantly behind on its screening targets. The grantee has discussed necessary actions to rectify this issue with the SAMHSA Government Project Officer (GPO).

VT-SBIRT has begun implementation at four sites. As mentioned, the site visit team toured three of the health care sites located in Plainfield, Barre, and Burlington. The team identified issues concerning program integration, workflow, and staff buy-in, which seemed common startup concerns.

The practice site staffing model integrates support from front desk staff, nursing staff, health educators, and behavioral health staff, with the workflow tailored to each site. The sites visited by the site visit team described a common SBIRT workflow. Patients complete a prescreen (part of a wellness survey) at the check-in desk, either alone or with help from a medical assistant.

Patients who screen negative for substance use risks receive no further services and continue with their appointment. For those who screen positive on the prescreen, a staff member or grant-funded health educator completes a full screen using the Alcohol Use Disorders Identification Test (known as AUDIT), the Drug Abuse Screening Test (DAST), and/or the Patient Health Questionnaire (known as PHQ 2 or 9). Brief intervention and referral to treatment are provided as indicated. The full screening takes place before, during or after the medical visit, depending on the doctor's schedule. All year one sites visited have capacity to deliver brief treatment, and those needing specialty treatment are referred to local community-based programs.

Providers use the brief negotiated interview as the evidence-based brief intervention. Workflow is individualized across sites, with all sites conducting a patient-completed wellness/prescreening tool and full screens conducted by interview or by patient-administered paper screening tool. Brief intervention, brief treatment, and referral to treatment are provided by both grant-funded staff and/or core clinic behavioral health staff. In one setting, clinical social workers are performing routine data collection activities, while others use less credentialed and less costly staff for this purpose. The site visit team suggested a less costly level of "med tech" staff could perform the duties, freeing social work time for activities such as brief intervention or brief treatment.

Vermont has made a noteworthy adaptation to its screening process for adult marijuana use, focusing on the health and social consequences of use. This approach is made with the approval of the SAMHSA GPO and is based on consensus recommendations from Vermont primary care physicians. Marijuana use was separated as a unique substance for screening, and a prescreening tool surveyed frequency of marijuana use. Only persons using marijuana more frequently than weekly completed the full DAST 10 screen. Preliminary results of the full DAST 10 screen indicated the average score is 1.7, placing most patients at the lowest tier of risk for whom a brief intervention seems appropriate. The overall prevalence of Vermont adult marijuana use is higher than the national average, with 23 percent of adults reporting some level of use. This unique approach appears to be consistent with adult use patterns and does not over identify infrequent marijuana users as at risk and requiring intervention.

Vermont has a well-organized, contractor-managed training system. Grantee staff receive training in SBIRT, motivational interviewing, brief treatment, cultural competence, GPRA reporting and evaluation. The Vermont training approach incorporates the use of SAMSHA's Core Curricula, including the online training and the SAMHSA Brief Treatment Guide, which is augmented by further motivational interviewing and cultural competence content. Beyond training, provider staff receive ongoing consultation, including shadowing and coaching that support skills acquisition. Two of the implementation sites appeared to refining workflow and adoption of SBIRT within the practice setting. The site visit team suggested that building the skills and buy-in among nursing staff would likely aid in SBIRT adoption and integration within these settings. The team is readily available to assist solving workflow and staffing challenges at the practice sites.

Vermont plans to implement SBIRT within its Army National Guard. The colonel for the Vermont Guard is supportive of this initiative. The efforts are currently stalled as the Vermont Army National Guard judge adjutant general is opposed to SBIRT implementation until certain policy concerns are addressed. VT-SBIRT continues working with the National Guard Bureau to find solutions to this current impasse.

VT SBIRT Health IT

Vermont's vision for its HIE is broad, and the work effort dedicated to it spans nearly 10 years. Vermont has a functioning HIE and the first focus area for the exchange has been primary care settings. All but one of Vermont's hospitals is connected to the HIE, as are most primary care facilities, with the exception of the State's free clinics that continue to operate using paper records. The State's HIT staff report the type of information collected is site specific and data quality varies. These are areas of improvement over the coming years. The State is now moving into the behavioral health sphere. There are several behavioral health agreements in place, but behavioral health is behind with regard to moving into the full infrastructure.

Vermont is a recipient of a $45 million Centers for Medicare & Medicaid Services Innovation Center grant, a portion of which has been allocated to support behavioral health HIT. The SSA reports that up to 90 percent of the contracted "designated providers" have EHRs and are beginning to participate in the HIE. Opioid treatment programs and freestanding residential programs were the types of providers identified as most likely to lack EHRs. SBIRT primary practice sites are supported by VT-SBIRT, with the integration of SBIRT information into their EHRs. In support of communication and information sharing between providers, the current system has capacity for secure messaging between service providers. An HIT data dictionary work is in preparation. SBIRT data may be entered into this system depending on decisions currently being negotiated.

The Vermont HIE is also creating a data warehouse with capacity to access data across systems and to perform analytics for the purposes of planning and decision making. The system is also creating a provider portal. Patient portals are tools that will likely be created at the provider level and not at the HIE level.

Several questions remain with regard to HIT implementation, including identifying specific SBIRT data elements that will be uploaded into the HIE and how patient information for substance use disorders and SBIRT will become part of the Vermont clinical registry. The State considers the registry would demonstrate completion of a screening or assessment, a risk determination (for patients), and performance elements for disposition (brief intervention, brief treatment, referral to treatment). This task will take time to determine the data elements specifically. The State needs to develop a continuity of care document and work with the vendor to coordinate changes. The State is determining how clinical information regarding patients with substance use disorders can be shared and protected in the HIE in conformance with 42 Code of Federal Regulations (CFR) Part 2 requirements. Vermont's attorney general for the health department

has actively participated in discussions regarding 42 CFR Part 2 and will submit written guidance on this matter.

The site visit team encouraged the VT-SBIRT team and the SSA to develop a plan to guide SBIRT HIT efforts and to align funding for purposes related to SBIRT expansion, integration with health care provider organizations, technology and information management, and the use of data to support clinical and policy decision making.

5. Community Linkages, Partners, and Participation

VDH and the SSA place high value on partnership and collaboration between the State and community providers and among State-level agencies and actively promote a culture of collaboration. VT-SBIRT builds on this history and as a result is able to engage high-level stakeholders on the PSC.

6. Client Outreach, Recruitment, and Referral

All primary care practice sites will universally screen patients. Outreach and recruitment is conducted through provider associations and with targeted primary care organizations. Patient referrals for specialty treatment are made to the SSA's preferred provider organizations. Regional specialty substance abuse provider directories have been prepared for primary care providers.

7. Affordable Care Act Readiness

The state of Vermont has been working on essential elements of the Affordable Care Act years in advance of the legislation. In 2011, the State government enacted a law functionally establishing the first State-level, single-payer health care system in the United States. Green Mountain Care, established by the passage of H.202, creates a system in the State where Vermonters receive universal health care coverage.

The SSA embraces a public health/population health focus to substance use and has dedicated significant effort supporting systems of care. Largely impeded by disparities in funding, behavioral health systems have lagged behind primary care in readiness. This is particularly true regarding HIT.

The State has supported network development to integrate behavioral health and primary care and development of patient-centered medical homes.

8. Sustainability Planning

VT-SBIRT has integrated sustainability principles from the outset of the grant and adopted a funding model that should help support long-term sustainability. Rather than hiring and outplacing staff in practice sites, the State has chosen to provide funding directly to the practice sites to support staff positions to adopt these practices. The State believes that incorporating the SBIRT activities into the routine duties of existing staff increases the likelihood of long-term integration. Experience has demonstrated that grant-funded, outplaced staff are frequently not sustained when funding ends.

Programs have begun exploring viable business practice models to sustain the practices after funding ends. The VT-SBIRT PSC is addressing policy and payer issues that affect sustainability, including revisions to Medicaid, support for health care sites in developing viable business practice models, and SBIRT integration in EHRs and the Vermont HIE.

9. Grantee Evaluation

VT SBIRT has contracted with Evidence Based Solutions for evaluation, including GPRA requirements. The evaluator was closely involved with program startup and operations, and the State uses evaluation data to monitor and improve practices. Performance data are collected and compared to performance targets and benchmarks to monitor and support implementation. The evaluation team has created a quarterly data dashboard for the project and provides weekly feedback to practice sites. GPRA data are being collected on paper and faxed to the evaluator who manually data enters into the Services Accountability Improvement System. The State has considered an automated Web-based system for GPRA data management, but with the anticipated rollout of SAMSHA's Common Data Platform, the State is reluctant to invest resources at this time of systems change. Because of a lack of automation, the grantee has needed to hire staff to collect and manage intake and follow up data.

Strengths and Considerations for Action

Program Vision and Design

STRENGTHS

- Vermont endorses a broad public health approach to substance use and views SBIRT as an essential set of services within primary care.
- The State endorses and supports behavioral health/primary care integration.

CHALLENGES

- The State appears to be identifying and promoting a model of integrated care that aligns with the unique systems and context of the State.

	Potential Enhancements	Grantee Resources To Be Used	May Request TA From CSAT	Information Requested
1	Undertake efforts to identify and describe existing models of integrated care and their key components that would fit within Vermont; identify and build buy-in among key stakeholders necessary to effect this systems change.	X	X	

Grantee Leadership

STRENGTHS

- The SBIRT initiative receives high-level leadership support within VDH.
- The project management team is knowledgeable of SBIRT and implementation of evidence-based programs.
- VT-SBIRT has developed medical professional champions who publicly support SBIRT.
- The State's PSC includes high-level representation from Medicaid, private insurance, the HIE, and primary care and behavioral health.

CHALLENGES

- State purchasing processes are lengthy and resulted in startup delays requiring corrective action to meet grant performance targets.
- Nursing staff appear to need further education and support to build their knowledge base and support for SBIRT adoption.

Grantee Leadership

	Potential Enhancements	Grantee Resources To Be Used	May Request TA From CSAT	Information Requested
1	Develop a plan to expand service capacity to meet agreed-upon performance targets.	X		
2	Groom nursing staff as practice champions.	X		

Implementation Plan

STRENGTHS

- The grantee's implementation approach was designed to achieve the greatest likelihood of program sustainability.
- VT-SBIRT individualizes implementation workflow across practice sites.
- Comprehensive training and coaching are provided to onsite staff to build core SBIRT skills.
- The grantee has developed and piloted a specific approach to screening adult marijuana use that reduces the number of false-positive prescreens and appears better aligned to the use patterns of the adult population.
- Vermont builds on nearly 10 years of dedicated effort in HIT. Most primary care systems are currently engaged with the State's HIE, and the State behavioral health system is preparing for inclusion.

CHALLENGES

- VT-SBIRT was delayed in its startup.
- Several sites are working through issues related to workflow and adoption of SBIRT that are common in startup.
- The State behavioral health systems have lagged behind primary care in adoption of EHRs.
- Questions regarding SBIRT and other substance use-related patient data sharing are still being negotiated between the SSA and the State HIE.

	Potential Enhancement	Grantee Resources To Be Used	May Request TA From CSAT	Information Requested
1	Closely monitor performance and increase the number of providers to meet performance targets.	X		
2	Continue providing support and technical assistance to practice sites working through startup issues.	X		

Implementation Plan

	Potential Enhancement	Grantee Resources To Be Used	May Request TA From CSAT	Information Requested
3	Document findings regarding SBIRT and adult marijuana use as the information may have broad benefit across systems.	X		
4	The State should develop a written plan guiding SBIRT HIT implementation and integration. A planning template has been provided to VT-SBIRT, and the State may wish to seek technical assistance supporting the development of this HIT strategic plan.	X	X	X

Community Linkages, Partners, and Participation

STRENGTHS

- Vermont has successfully engaged with essential stakeholders statewide in support of the SBIRT initiative.

CHALLENGES

- None noted.

	Potential Enhancements	Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
	• None noted.			

Client Outreach, Recruitment, and Referral

STRENGTHS

- Referral relationships are in place between all primary care providers and the State-preferred provider network.

CHALLENGES

- There is a long wait list for services for more intensive levels of care such as residential treatment.

	Potential Enhancements	Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
	• None noted.			

Affordable Care Act Readiness

STRENGTHS

- The State of Vermont has been a national leader in adoption of HIT and the implementation of the Nation's first State single-payer health insurance system.

CHALLENGES

- Behavioral health/primary care integration is a goal of the State. Efforts have begun, but defined models remain a work in progress.

	Potential Enhancements	Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	The State is encouraged to build an understanding of integrated care models and to look beyond broad thematic descriptions of integration to better understand and identify business practice models that would fit within existing State systems.	X	X	X

Sustainability Planning

STRENGTHS

- The State has implemented its grant in ways that support long-term SBIRT implementation beyond grant funding.
- The State has engaged essential stakeholders on its PSC to address policy and payer issues that affect the development of a viable and sustainable business model.

CHALLENGES

- Elements of the current SBIRT insurance policies may create challenges for providers developing viable business practice models.

	Potential Enhancements	Grantee Resources To Be Used	May Request TA From CSAT	Information Requested
1	The State is encouraged to work collaboratively with payers and providers to identify and negotiate necessary payment for services.	X	X	

Evaluation

STRENGTHS

- Vermont has engaged an experienced evaluation group that is closely involved with formative and outcome evaluation activities.
- The evaluator has created an innovative "data dashboard" that graphically represents performance data that are easily understandable to broad constituencies.

CHALLENGES

- Certain practice sites are employing highly trained staff to collect GPRA data. This practice has often proven challenging in other settings.

	Potential Enhancements	Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	Use less credentialed staff to conduct GRPA data collection activities.			

Abbreviations and Acronyms

ADAP	Alcohol and Drug Abuse Program
CSAT	Center for Substance Abuse Treatment
DAST	Drug Abuse Screening Test
GPO	Government Project Officer
GPRA	Government Performance and Results Act
HIE	health information exchange
HIT	health information technology
PSC	policy steering committee
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	screening, brief intervention, and referral to treatment
SSA	single State authority
VDH	Vermont Department of Health