ARTIFACT 1: LOGIC MODEL

INPUTS	OUTPUTS		OUTCOMES-IMPACT		
What we invest	What we do	Who we reach	Short	Medium	Long-Term
Mental Health & Substance Abuse Counselors & Other experts	Provide physical & mental health services mobile/brick	Children Birth to 8	Co-design effective care integration program and materials for physical, mental, pandemic & emergency response	Co-Develop Collaborative Networks, policy, and practice for program replication	Support Long-term recovery & resiliency
Micro-Enterprises for Wellness	Provide substance abuse services	Youth 8 to 20-Preventive			Decrease High-end-high-cost services
Assessments & Surveys	Case Management & Care Coordination	Adults 21-64 Treatment	Train participants in program implementation and resource acquisition	Effectively connect participants with benefits & Decrease progression disruption	Eliminate the use of acute crisis for physical & behavioral intervention
Evaluation Instruments & Data segmentation and analysis tools	Healthcare recruitment, training & coaching	Seniors 65+ Treatment	Conduct evidence-based program review and align to patient population	Effectively improve population health.	Decrease hospital readmission
Physical & Behavioral Health Services & experts	Emerging technology solutions to diagnose and treat	Government entities Prevention & Treatment	Increase the collaborative network capacity of prevention, treatment, and supportive services	Integrate mental and physical screening, prevention, management & treatment strategies across the Care Continuum	Eliminate Federal Entities as payor
Facilities, Materials, Mobile Units & Technology	Community & Family Engagement, Care Integration	Families Prevention & Treatment	Develop line of business and construction project framework and tools.		Decrease adverse effects of SA & MH illness and chronic disease

ARTIFACT 2: PRODUCT & PROCESS (Short & Midterm Goals & Objectives)

Goal 1: Fully renovate the Emergency Response Facility by the end of July 2024.			
Objective	**Measurement Tool**	**Timeline**	**Key Personnel**
Objective 1.1: Updated and validated design from architect ERF.	Architectural drawing	June 2023-Feb 2024	Architect/Technical Experts/GC/CEO/ PD/PM/Facilities Manager/IT
Objective 1.2: ERF Demolition	N/A	March 2024	Architect/Technical Experts/GC
Objective 1.3: ERF Construction	Certificate of Occupancy	April-July 2024	Architect/Technical Experts/GC
Goal 2: Fully renovate the Madison Health & Wellness Center Facility by 2025 second QTR.			
Objective	**Measurement Tool**	**Timeline**	**Key Personnel**
Objective 2.1: Updated and validated design from architect MHWC.	Architectural drawing	Feb 2024-April 2024	Architect/Technical Experts/GC/CEO/ PD/PM/Facilities Manager/IT
Objective 2.2: MHWC Demolition	N/A	July 2024-October 2024	Architect/Technical Experts/GC
Objective 2.3: MHWC Construction	Certificate of Occupancy	Oct 2024-December 2025	Architect/Technical Experts/GC
Goal 3: Fully developed Lines of Businesses by 2025.			
Objective	**Measurement Tool**	**Timeline**	**Key Personnel**
Objective 3.1: Fully developed Mental Wellness LOB.	LOB Template and Marketing Plan, process & systems	Jan-July 2024	MWU/TCC/HiH
Objective 3.2: Fully developed Infusion LOB.	LOB Template and Marketing Plan, process & systems	Jan-July 2024	MWU/NP with certification in Infusion Therapy

Objective 3.3: Fully developed Medical Retail Equipment LOB.	LOB Template and Marketing Plan, process & systems	Oct 2024-April 2025	MWU/CMO
Objective 3.4: Fully developed Employee Wellness LOB.	LOB Template and Marketing Plan, process & systems	Nov 2024-May 2025	MWU/HR/Marketing
Objective 3.5: Fully developed Wound Care LOB.	LOB Template and Marketing Plan, process & systems	Jan-July 2024	MWU/Wound Care experts
Objective 3.6: Fully developed Cardiopulmonary LOB.	LOB Template and Marketing Plan, process & systems	Dec 2024-June 2025	MWU/TBD
Objective 3.7: Fully developed Alternative Pain Management LOB.	LOB Template and Marketing Plan, process & systems	Jan 2025-July 2025	MWU/TBD
Objective 3.8: Fully developed Nutrition LOB.	LOB Template and Marketing Plan, process & systems	Feb 2025-August 2025	MWU/TBD
Objective 3.9: Fully developed Chronic Disease LOB.	LOB Template, Marketing Plan, process & systems	Oct 2024-July 2025	MWU/DOH/Barnes
Objective 3.10: Fully developed Men/Women's Health LOB.	LOB Template and Marketing Plan, process & systems	Oct 2024-July 2025	MWU/TBD
Objective 3.11: Fully developed Geriatric Wellness LOB.	LOB Template and Marketing Plan, process & systems	Sept 2024-September 2025	MWU/HiH
Objective 3.12: Fully evaluate and determine other LOB.	LOB Template and Marketing Plan, process & systems	Feb 2024-July 2025	MWU/CMO/CEO/CNO
Objective 3.13: developed Primary Care LOB.	LOB Template and Marketing Plan, process & systems	Jan 2024-July 2025	MWU/CMO/CEO/CNO

Goal 4: Evaluation Management System fully functioning, monitored, and measured.			
Objective	Measurement Tool	Timeline	Key Personnel
Objective 4.1 Fully integrated Data Schemes, Protocol, processes, systems, tools, etc.	Survey Monkey, LMS, EHR, IRP, Case Management Report,	June 2024-2025	MWU/TCC/HTC
Objective 4.2 Cascading Goals and Objectives throughout MWU, MHWC, ERF, MCMH, CHNA, QI, and Strategic Initiatives.	Social Media Metrics, Survey Monkey, LMS, EHR, IRP, Case Management Report, Excel Export, CHNA	June 2025-2024	MWU/TCC/HTC
Objective 4.3 Fully tested and validated evaluation and performance management system across all lines of business.	Social Media Metrics, Survey Monkey, LMS, EHR, IRP, Case Management Report, Excel Export, CHNA, QI, Web metrics	June 2024-2025	MWU/TCC/HTC
Objective 4.4 Updated EHR system and Business Requirements identified and built for all MCMH Lines of Business.	EHR screenshots of forms/data schematics	Jan 2024-December 2025	MWU/ Development
Objective 4.5 Update diagnostic and healthcare supplies and equipment as applicable MCMH/MCHHS.	PO/Invoices/Useful Life	Jan 2024-December 2025	MWU/ Development

PERFORMANCE GOALS & SMART OBJECTIVES-Mid & Long Range

Performance Goal 1: Ensure mental wellness-adults and children in rural counties by increasing capacity and identifying best practices of a local Behavioral Health Network (reducing disparities in access, service use, and outcomes regionally).		
SMART Obj.: Who, What, When	How We Do It	How Do We Know Success
O1A. By December 2025 staff have trained a minimum of 75 hospital, partner, and community members on the selected, evidence-based behavioral wellness curriculum.	Telementoring, Peer Support, Coaching, Training, Workshops, Rise n' Dine, Lunch n	# attended/trained, % implementing/supporting strategies, sign-in sheets

	Learns, Council Meetings	
O1B. By the *end of 2025* *Wellness Ambassadors* have conducted thirty-six (36) community outreach initiatives about Behavioral Health and Mental Wellness awareness.	Social media, electronic/ print disseminated, Advertising, special events, community & family engagement	# % likes, follows, shares, sign-in sheets, knowledge, attitudes and behavior surveys
O1C. *By the end of the project*, the EHR system adequately monitors and reports Behavioral Health Data.	Configure existing system, create new reports, add attributes, dashboard	Quality of reports, VPNs established/expanded, Dashboard
O1D. By the beginning of year 2, services addressing primary, secondary and tertiary prevention will be offered to clients.	Hire staff/contracts 1st month, competencies, professional development	Pre/post-test, # internal/external service providers, # clients assessed/ registered Amount of funds expended
O1E. By the end of 2025, client satisfaction via improved community perception of behavioral health will be demonstrated.	Awareness campaign, rallies, events, print and electronic communication	Community Assessment Survey, Client Satisfaction & Stakeholder Survey Amount of funds expended
Performance Goal 2: Decrease at-risk behavior-youth and adults by implementing evidence-based practices-primary (health promotion), secondary (intervention) and tertiary (treatment and recovery) prevention (coaching, measuring, & diagnosis).		
SMART Obj.: Who, What, When	How We Do It	How Do We Know Success
O2A. By the end of a 3-year period, following the establishment of a baseline, to decrease by a minimum of 20% the number of behavioral modification relapses such as alcohol other drug abuse and other mental illnesses.	Coaching, Health Education, Self-Care, Case management, ongoing assessments Remote Monitoring, Med Management	EHR, IRP, BHP SBIRT and URICA Amount of funds expended

O2B. By the end of the three-year project period, following the establishment of a baseline, to decrease by a minimum of 20% the number of readmits by promoting positive behavior management.	All strategies, Follow-up, and Referral	EHR
O2C. By 2025, a minimum of 10% of the clients will be participating with a Wellness Coach.	Coaching, Assessments, Partners-Barnes, Disc, CRMC, Community	IRP, Case Management, SBIRT and URICA
O2D. By the end of 2025 modified MOU/Contracts delineate roles, partner responsibilities/treatment services to include inpatient, outpatient, mental health, hospice, community-based administration, and other relevant services.	SOP, protocols, capacity building	Integrated continuum of care Amount of funds expended
Following are key baselines/objectives (detailed Community Health Improvement Plan (CHIP): Mental Health Baseline Indicators: Decrease the percentage of adults reporting they do not have good mental health 17% to 15%; Ensure that adults who have been told they have a depressive disorder and want help are able to receive services 435.6 rate and a total of 554 hospitalizations; and Drug and Alcohol Induces 12%. Feeling nervous or anxious 15%. Awareness-increase know where to get services 56%.		
Performance Goal 3: Decrease Chronic Disease impact (obesity, heart, stroke, diabetes, cancer) through increased access to healthcare, prevention strategies, and wellness coaching.		
SMART Obj.: Who, What, When	How We Do It	How Do We Know Success
O3A. By the end of the project period, 1) Lower Obese Risk-37%; 2) Physically Inactive Risk -36%; 3) 14% cause death heart disease; 4) Cancer 22%.	Resiliency Coaching, case management, ongoing assessments	EHR Patient Demographics, Coaching Portfolios
O3B. By the end of the project period, Increase Access to Care: Uninsured Adults (19-64) 14.5% & children less than 19 at 5%.	Employees, contractors, affiliation agreements, partnerships.	CHNA Report
O3C. By the end of the project period, decrease % of readmits by promoting positive healthy lifestyle behaviors.	All strategies, Follow-up, and Referral	EHR Patient Demographics, Coaching Portfolios

O3D. By 2025, 20% of clients are placed in the appropriate chronic treatment program(s).	Coaching, Assessments, Professional Development, Case Management and Referral	IRP, Case Management, EHR
O3E. By the end of 2025 modified MOU/Contracts delineate roles, partner responsibilities/treatment services.	SOP, protocols, MOU, Contracts, Affiliation Agreements	Integrated continuum of care
O3F: *By the end of the project period, increase the number and types of health/wellness experts.*	Recruit employees, contractors, partners, and vendors	Minimum of 10 new providers/experts.
Following are key baselines/objectives (detailed Community Health Improvement Plan (CHIP): Chronic Disease: 1) Lower Obese Risk-37%; 2) Physically Inactive Risk -36%; 3) 34% cause death heart; b4) Diabetic Risk-14%; 5) decrease cancer deaths (22% of all) and advanced diagnosis 52.6%. Access to Care: Uninsured Adults 14.5% & children under 19 at 5%. Family Practice: 5, Physician Assistant: 1, ARNP: 26; Pediatrician: 1, Cardiologist: 2; Dentist: 5 ; Internal: 1, Chiropractors: 3, Other: 0; Mental Health: 6, Psychologist: 1, Clinical Social Workers: 2.		

ACRONYMS & TERMINOLOGY

MH-Mental Health
SA-Substance Abuse
GC-General Contractor
PD-Project Director
PM-Program Manager
ERF-Emergency Response Facility
MHWC-Madison Health & Wellness Center
MWU-Mobile Wellness Unit
MCHHS-Madison County Health & Hospital Systems
MCMH-Madison County Memorial Hospital
TCC-Transition to Coaching & Counseling
HiH-Hand in Hand Network (MH & SA experts)
NP-Nurse Practitioner
LOB-Lines of Business
EHR-Electronic Health Record
IRP-Individual Resiliency Plan
LMS-Learning Management System
SOP-Standard Operating Procedures
MOU-Memorandum of Understanding
CHNA-Community Health Needs Assessment
CHIP-Community Health Improvement Plan
CRMC-Capital Regional Medical Center
SBIRT-Screening, Brief Intervention, Referral & Treatment Assessment
URICA-University of Rhode Island Change Assessment Tool
BHP-Behavioral Health Protocols
VPN-Virtual Private Network
QI-Quality Indicators
PO-Purchase Order