# Local System of Care & Quality Improvement Plan

## Fiscal Year 2022-2024

## Purpose and Guidance

### The Vermont Department of Mental Health (DMH): Vision and Mission

**Vision:** Mental Health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to the mental health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities.

**Mission:** The mission of the Department of Mental Health is to promote and improve the health of Vermonters.

### Purpose and Requirements

**Purpose:** DMH wishes to provide all Vermonters with a better understanding of:

1. What the system of care is trying to accomplish;
2. How the system of care serves Vermonters;
3. How tax dollars and resources are used;
4. The level of resources necessary to support these vulnerable populations and, when possible, to develop services and supports for unmet needs; and
5. The priorities for this three-year period.

Annual grant awards to designated agencies (DA) require the submission of Local System of Care Plans and Quality Improvement Plans consistent with 18 V.S.A. §8908.

**Requirements of a Local System of Care Plan:** The *Administrative Rules on Agency Designation (2003)* outlines requirements for Local System of Care Plans. The *Administrative Rules* state: *The agency must determine the service needs of the community for each population for which it is designated and develop a plan to address the identified needs within the geographic area*. *The agency must:*

1. *Determine the needs of consumers, families, and other organizations based on information that includes satisfaction with agency services and operations (4.16.1);*
2. *Include the need for services and training, including service and training gaps; resources available within the geographic area to meet the need; and the anticipated provision or need for new or additional services or training to meet the identified gaps (4.16.2);*
3. *Facilitate the involvement of people who live in the geographic area in the development of the plan, in accordance with DMH policy and procedures (4.16.13); and*
4. *Review the plan annually and update with new information if appropriate. The plan must be fully revised every three years (4.16.4)*

**Requirements of a Quality Improvement Plan:** The *Administrative Rules on Agency Designation (2003)* also outline requirements Quality Improvement Plans. The Administrative Rules require that each DA:

1. Actively engages in quality improvement and has demonstrated the ability to use outcomes from all levels of agency operations (consumer care, program effectiveness, overall agency administration) to inform decision making and improve service delivery (4.8);
2. Has a written description of the QI program describing structure, procedures, and assigns responsibility to individuals for maintaining service quality (4.8.1.1);
3. Is updated annually to match current needs, monitor previous year's issues, and evaluate QI effectiveness (4.8.1.2);
4. Responds in a timely and effective manner to DMH reviews and reports (4.8.2);
5. Includes a written description of Utilization Review (UR) for each program, with structure and procedures, and assigns responsibility for UR to agency staff (4.8.3); and
6. Includes UR criteria, which are based on DMH practice guidelines and/or reasonable scientific evidence, reviewed at specific intervals, and available to practitioners, clients, and family upon request (4.8.3.1)

## Guidance Regarding the Development of This Combined Plan

The *Administrative Rules on Agency Designation (2003)* require a new Local System of Care Plan every three years, and an annual update of the Quality Improvement and Local System of Care Plan. DMH understands that some strategies and goals are long-term and may require more than three years to accomplish. While a new engagement process is required triennially, an agency can continue working on a previous goal if there is still demonstrated need.

DMH clarifies that submitting a strategic plan is not a requirement under the *Administrative Rules*, but that some agencies find the process of creating a strategic plan helpful to their overall administration, and so the same stakeholder/client/staff engagement processes may be used for this and other processes.

DMH recognizes that some goals may be shared across programs, since some areas, such as 'Overall Agency Administration' may affect multiple programs. In these cases, sharing of goals across plans is acceptable. However, DMH would reject the plan if all goals were shared across two or more programs (*programs* here defined as AHM, CYFS, and ES).

## Questions to Consider When Developing this Combined Plan

1. Which client, staff, and community needs has the agency or program addressed in the previous three years?
2. What are your agency's strengths and how do you plan to build on them?
3. What are the gaps in your service delivery system and how does the agency plan to address them?
4. How is your agency using data to inform the service delivery system?
5. Which promotion or prevention strategies does your agency need to focus on?
6. Which innovative practices would you like to develop or promote?
7. Have you invited/included all the relevant participants to this plan (community stakeholders, agency board of directors, local program standing committees, clients and families, Specialized Service Agencies in your catchment area)?

## Developing Goals

In the Agency of Human Services Common Language document – which is built off the Results Based Accountability (R.B.A.) Framework – a goal is defined as "the desired accomplishment of staff, strategy, program, agency, or service system".

Whenever possible, goals should be **S.M.A.R.T.** (specific, measurable, attainable, relevant, and time-bound)

| | |
|---|---|
| **S – Specific** | • Use clear language<br>• Define who is involved, what is to be accomplished, where it will be done, why it needs to be done, and/or which requirements must be met |
| **M – Measurable** | • Progress can be tracked<br>• Outcomes can be measured |
| **A – Attainable** | • Goal can be accomplished<br>• Goal is appropriate; it is neither over-reaching nor below standard performance |
| **R – Relevant** | • Goal is consistent with the needs of the community or organization<br>• Goal is consistent with short and long-term plans<br>• Goal doesn't undermine other goals of the agency |
| **T – Time-Bound** | • Establish a due date or timeline |

## Examples of Potential Goal Topics

| | |
|---|---|
| Client Care | • By the end of 2022, all clients in the AOP program will be seen for an initial clinical visit within ten days of their intake.<br>• Each quarter during the next three years, 25% of people enrolled in CRT will receive two face-to-face, community-based supported employment services by a trained IPS employment specialist. |
| Program Effectiveness | • By the end of 2021, all youth ages 0-21 years old will have a CANS assessment completed within the last six months in their chart accessible to all agency team members.<br>• When compared to the previous fiscal year, 10% more satisfaction surveys will be completed by ES program clients. |
| Overall Agency Administration | • Increase the number of client and/or family member participants on the CYFS Local Program Standing Committee by two clients or family units each fiscal year.<br>• Meet at least three times each calendar year with the [hospital name] Emergency Department to discuss utilization review and how to reduce frequent utilizer visits. |

# Quality Improvement and Utilization Review Processes

*The following prompts need to be completed in year one of the three-year cycle only. The purpose of quality improvement (QI) is to continuously assess what aspects of service are working well and what could be working better for clients, staff, and stakeholders and adjust agency actions accordingly. One QI/UR plan per agency is acceptable, please give an example for each program*. Please respond to the following prompts:

## Examples of Quality Improvement Monitoring at each Level

| | Focus of the QI Plan | Monitoring Used to Determine Need |
|---|---|---|
| **Client Care** | • Adjusting the times when services are offered in response to client request<br>• Discussing barriers to clients attending scheduled appointments and developing a plan to address them | • Client/Staff/Stakeholder Satisfaction Survey<br>• Local Program Standing Committee input<br>• Data collected from Electronic Health Record<br>• Informal feedback sessions with staff |
| **Program Effectiveness** | • Adding/retraining staff on an Evidence Based Practice that aligns with an identified need (such as a growing clientele with co-occurring disorders)<br>• Increasing Supported Employment staff time to allow for more clients to achieve career development goals | • Client/Staff/Stakeholder Satisfaction Survey<br>• Local Program Standing Committee input<br>• Data collected from Electronic Health Record<br>• Informal feedback sessions with staff |
| **Overall Agency Administration** | • Updating the Electronic Health Record to include a dashboard to assist in utilization review.<br>• Developing a working partnership with a key stakeholder that impacts multiple programs, such as Emergency Department, Economic Services, Homelessness Prevention. | • Client/Staff/Stakeholder Satisfaction Survey<br>• Local Program Standing Committee input<br>• Data collected from Electronic Health Record<br>• Informal feedback sessions with staff |

I. Quality Improvement Process for *Client Care* - please give an example specific to AMH, CYFS, and ES:
**How do you monitor client care?**
**How do you improve it?**
**Who is responsible for each part of the process?** *Please provide the role of responsible party, names are not necessary.*
**How do you use outcomes to guide this process?**

Click or tap here to enter text.

II. Quality Improvement Process for *Program Effectiveness* - please give an example specific to AMH, CYFS, and ES:
**How do you monitor program effectiveness?**
**How do you improve it?**
**Who is responsible for each part of the process?** *Please provide the role of responsible party, names are not necessary.*

**How do you use outcomes to guide this process?**

Click or tap here to enter text.

III. Quality Improvement Process for *Overall Agency Administration*:

**How do you monitor overall agency administration?**

**How do you improve it?**

**Who is responsible for each part of the process?** *Please provide the role of responsible party, names are not necessary.*

**How do you use outcomes to guide this process?**

Click or tap here to enter text.

# Quality Improvement and Utilization Review Processes (continued)

*The following prompts need to be completed in year one of the three-year cycle only. The purpose of utilization review (UR) is to continuously assess that clients and staff are getting what they need to be successful, at the right frequency, in a timely manner. DMH guidance for creation of UR criteria can be found in the Mental Health Provider Manual: 6.3 Quality Oversight Section. One QI/UR plan per agency is acceptable, please give an example for each program*. Please respond to the following prompts:

## Examples of Utilization Review at each Level

| | **Optional Prompts**<br>**How does the agency ensure that…** | **Potential Procedure** |
|---|---|---|
| **Client Level** | • Clients are getting the appropriate service and frequency of service<br>• Intakes are triaged to staff specific to their specialty, training, and availability | • Clients and treatment team review progress (i.e. CANS, standardized tool for adults) and adjust IPC based on results<br>• Staff specialties are known, staff are asked by supervisors if they have the capacity to support an appropriate client when their caseload is large |
| **Program Level** | • Review aggregate client level data to get a program overview to compare against bundled case rate to ensure that the agency is providing the right level of service to meet client need and stay within the allotted budget<br>• Staff are getting the training, support, and supervision they need to support clients on their caseload | • The Electronic Health Record runs a monthly program utilization report<br>• Supervisors review monthly notes with clinicians at least quarterly<br>• Staff are asked by supervisors what they need to be successful during annual performance evaluations |
| **Agency Level** | • Analyzing all programmatic data across the agency to ensure clients are better off and outcomes related to Payment Reform are being met. | • Create a dashboard in the EHR to monitor agency wide service utilization and performance outcomes |

I. Utilization Review at *Client Level* - please give an example specific to AMH, CYFS, and ES:
**What is your Utilization Review procedure at the client level?**
**Who is responsible for each part of the procedure**? *Please provide the role of responsible party, names are not necessary.*
**What changes has your agency made under payment reform?**

Click or tap here to enter text.

II. Utilization Review at *Program Level* - please give an example specific to AMH, CYFS, and ES:
**What is your Utilization Review procedure at the program level?**

**Who is responsible for each part of the procedure?** *Please provide the role of responsible party, names are not necessary.*
**What changes has your agency made under payment reform?**

Click or tap here to enter text.

*III.* Utilization Review at *Agency Level*:

**What is your Utilization Review procedure at the agency level?**
**Who is responsible for each part of the procedure?** *Please provide the role of responsible party, names are not necessary.*
**What changes has your agency made under payment reform?**

Click or tap here to enter text.

# Local System of Care & Quality Improvement Plan Form

## Fiscal Year 2022-2024

*Please complete a separate form for AMH, CYFS, and ES programs at your agency.*
*Alternately, your agency could complete separate forms for CRT and AOP in lieu of a combined AMH form.*

| **Agency Name:** | Click or tap here to enter text. | | |
|---|---|---|---|
| **Program (check one):**<br>☐Children, Youth, and Family Services (CYFS)<br>☐Emergency Services (ES)<br>☐Adult Mental Health Programs (CRT & AOP Combined)<br>--OR--<br>☒Community Rehabilitation and Treatment (CRT)<br>☐Adult Outpatient (AOP) | **Year 1:**<br>Due May 1, 2021 | **Year 2:**<br>Due May 1, 2022 | **Year 3:**<br>Due May 1, 2023 |
| | **Staff Completing Form**: | **Staff Completing Form**: | **Staff Completing Form**: |
| | Keith Grier, CSP Director | Click or tap here to enter text. | Click or tap here to enter text. |

# Process for Creating & Updating LSOC Plan / QI Plan

*Identify the groups/individuals involved in the creation of your Local System of Care Plan / Quality Improvement Plan and how you facilitated their involvement.*
*Examples of potential involvement included below.*

| **People/Group** | **Number Involved** | **Date(s) or Names** | | **How did you facilitate the involvement of people/groups in your catchment area? *** |
|---|---|---|---|---|
| Clients | Over 40 | Date(s): | Spring/Summer 2020 | Client Satisfaction Surveys |
| Families | 6 | Date(s): | Individual family members who discussed the support needs of loved ones | Individual conversations |
| Local Program Standing Committee | 6-10 | Date(s): | Standing Committee meets monthly. Our LSOC has been on the agenda for several months and members have been invited to stakeholder input meetings | During Committee Meetings and Stakeholder Meetings |
| Board of Directors | 2 | Date(s): | Sarah Holland (Board President) and Regan Demasi (Board Member) | Members of Local Standing Committee |

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| Agency Staff *(optional but strongly recommended)* | Over 100 | Date(s): | Management Team and Staff members have been present in the LSOC discussion about priorities | Management and Staff Meetings |
| Stakeholder Organizations | 9 | Name of Organizations: | DMH, AHS, Kirby House, CYFS, Good Samaritan Shelter, CVHHH, CVAAA, CVMC | Stakeholder Meetings |
| Specialized Service Agency | 1 | Name and Date(s): | Amos Meacham, Pathways | Stakeholder Meeting |
| Other | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |

*e.g., open forum, survey with clients/staff/stakeholders, telephone contact, data review and analysis, program management team discussion, interagency team meeting, board input and review, etc.

## Goals

*List your program's top three or four goals for this three-year plan. In year one, please include a short paragraph explaining the process for arriving at these goals, including what services gaps this goal potentially addresses. If you choose, you may include additional data or documentation to give background to this goal. According to AHS common language, goals should be Specific, Measurable, Attainable, Realistic, and Time-Bound (SMART). In year one you only need to complete the 'year one' row of the table. You do not need to 'project' the plan for year two and three- complete them one at a time as each year arises. If a goal is accomplished or otherwise discontinued during the cycle, please identify a new goal that addresses that area, providing background context for its inclusion.*

**GOAL 1 (Client Care): Improve coordination and care for individuals who are aging or experiencing complex medical needs**

**Why is this goal a priority? What service gaps currently exist?**

**Nearly 1/3rd of the CSP/CRT population served by WCMHS is over the age of 60. The Median age of our clients is 50. It is well documented that individuals experiencing major mental illness die younger (in some studies up to 25 years younger) than the average person in our nation. Studies also find that the contributing factors in this divergence are not necessarily the mental health condition itself, but rather comorbidities (including but not limited to: Diabetes, COPD, SUD, etc.) as well as the social contributors to health (including but not limited to: isolation, loneliness, disconnection from natural supports, and poverty). Our resources, including case management, community supports, and crisis services are increasingly being devoted to assisting individuals we serve in navigating the complex health care system to ensure their needs are met. In some cases, we are providing medication management services, personal care supports, and activities of daily living support to individuals we serve due to physical health**

**care needs rather than mental health care needs. Our crisis bed has, on more than one occasion, housed individuals in need of higher levels of care due to physical limitations (accessible and supported housing) for long periods of time. There has been a gradual reduction in level 3 facilities (community care homes) in WaCo over the last several years. For many of the individuals we serve, WCMHS is the most stable long term relationship they have.**

| | Current Status | Action Steps / Strategies Planned | Resources Needed | Timeline / Due Date | Measure(s) of Progress / Data Point |
|---|---|---|---|---|---|
| Year 1 | Moving in the Right Direction | Identify emerging needs for the aging population. Develop a CSP Steering committee comprised of staff and standing committee members to meet monthly for needs assessment, data review, assessment of collaboration with service providers, and identify opportunities for additional training and resource allocation. | No additional resources necessary in the first year | 4/30/22 | While these data points may change based upon our assessment and data available, examples of data points we can use to assess our progress include: Accurate baseline on the number of clients with Advanced Directives in our EMR, Accurate baseline on the number of clients eligible or near eligible for alternative supports and funding including (AAA, CFC Waiver, etc.) Trainings regarding broader aging system of care (at least two such trainings), Active participation in ONE CARE's care coordination efforts (Care Navigator) for CSP attributed lives who have signed ONE CARE releases (50% care coordinator assignment and 80% care team meetings documented) |
| Year 2 | Moving in the Right Direction | The committee will continue to meet monthly to review data and monitor progress on goals. Future trainings for case managers/clinicians include: Advanced Directives, Long Term Care Applications (Medicaid), Medicare Benefits, Veterans Benefits, APS reporting and Self-Neglect, | Collaboration with Community Partners, Trained Staff, Leveraged and Shared resources, State Support (policy | 5/1/2023 | We can now export data from our information management system to get accurate information on client demographics including age (KPI Dashboards, MyAvatar). Case managers continue to engage |

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| | | Substance Abuse in Older Adults, Grief & Loss, etc. The committee has identified accessible housing and residential support as a critical area of need requiring increased investment and attention. | changes and financial investment). | | the data to help identify critical and future needs. Trainings will be documented. We will be applying for the Certified Community Behavioral Health Center demonstration grant which if awarded, will allow us to increase our data analytics capacity. We do not currently have an accurate understanding of data and information sharing goals with ONE CARE. |
| Year 3 | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click/Tap | Click or tap here to enter text. |

**GOAL 2 (Program Effectiveness): Develop and Improve upon services and supports for individuals transitioning from CYFS services with intensive needs**

**Why is this goal a priority? What service gaps currently exist?**

**As our understanding of the emerging adult and their needs evolve, including our understanding of the developmental needs of this cohort, CSP/CRT is challenged in how best to support individuals in this age cohort. Independent living programming, educational and vocational support, and community belonging are essential areas of improvement. Additionally, individuals who have experienced trauma during childhood, have experienced homelessness, DCF involvement, and/or experience severe emotional and behavioral challenges are more apt at having skill deficits in these areas and require more support toward their success including help seeking and supportive networks.**

| | Current Status | Action Steps / Strategies Planned | Resources Needed | Timeline / Due Date | Measure(s) of Progress / Data Point |
|---|---|---|---|---|---|
| Year 1 | Not started | Identify emerging needs for the youth in transition population. Develop a committee to meet monthly in coordination with the broader WCMHS effort for the purpose of needs assessment, relevant data review, assessment of collaboration with service providers (including CHOICE, CYFS, CDS and YSB, DVR), and identify opportunities for additional training and resource allocation. | No additional resources necessary in the first year | 4/30/22 | Hospitalization rates for individuals in the 18 – 25 age range. Establish baselines. Referral source data. We will develop internal transition of care metrics. Engagement Rates. |

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|---|---|---|---|---|---|
| Year 2 | Moving in the Right Direction | This population (16-26 years old) represents only a very small percentage of the CSP population served. Given eligibility barriers to accessing CRT/CSP services, we have broadened our committee's participation to include WCMHS divisional representation (CYFS, Adult Outpatient). The committee has been meeting monthly. Over the course of the last year the committee has sponsored a variety of stakeholder engagement activities to help us better understand gaps and needs but more importantly to hear people's hopes and dreams for the future. Goals for the coming year include developing a transitional living program, increasing access to case management, community and employment supports for individuals that aren't eligible for CRT services and furthering our collaborations with local partners. | funding to expand case management and community supports for individuals not eligible for CRT services but older than 22. | 5/1/2023 | Employment rates, hospitalization rates, and housing stability rates for individuals served. Other measures of progress will include satisfaction survey information. We'll also consider how the ANSA might be used to measure progress for this population during year 2 of the LSOC. |
| Year 3 | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click/Tap | Click or tap here to enter text. |

**GOAL 3 (Overall Agency Administration):** To use the power of data to identify and support changes that improve Vermont's healthcare system for clients, staff and our community.

**this goal may lend itself to being shared across programs at the agency. That is acceptable to DMH.*

**Why is this goal a priority? What service gaps currently exist?**

In today's modern health care environment, the agency needs to be able to show accurate data to its funders, and has invested staff timeand agency dollars to implement a new Electronic Medical Record (EMR) system. WCMHS is working on extracting data from its EMR. WCMHS has only been on its system for four months and continues to improve capabilities in this area.The system will be a considerable improvement over the previous

document-driven record, which did not present managers with consistent accurate data. WCMHS considers this a high priority.

Data will also lead us forward with continuous quality improvement in areas of service delivery. It will assist us in determining best practice and quality of care to a degree we have not achieved in the past.

| | Current Status | Action Steps / Strategies Planned | Resources Needed | Timeline / Due Date | Measure(s) of Progress / Data Point |
|---|---|---|---|---|---|
| Year 1 | Moving in the Right Direction | UEMR Clinical Committee continues to meet, resolving current short-term issues.<br>The UEMR Governing Board meets regularly and a structure has been built and will continue to evolve for escalating system changes that will improve the collection of data.<br>Adult Redesign / Children Redesign / Senior Managers / Quality Committee/, Division Staff identify service metrics that they want to have reported on.<br>Agency Wide Key Performance Indicators get approved, developed, written and distributed.<br>The agency provides training to staff and managers to learn to run their own reports | Time | 5/1/22 | Are there still unresolved issues in UEMR committee?<br>Have Adult and Children's Redesign, Senior Managers, Quality Committee decided on new reports they want written?<br>Are KPI dashboards or reports in place?<br>Can staff and managers run their own reports? |
| Year 2 | Moving in the Right Direction | Quality Committee meets regularly and is reviewing reports that are being run on regular basis. Managers, Senior Managers | Time and funding of CCBHC grant | 5/1/2023 | Progress: UEMR Committee still meets 2x month to review ongoing non-implementation |

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| | | are regularly asked what additional reports they want run, and the agency is working on those reports with other agencies collaborating on the UEMR. As part of the agency CCBHC grant, the agency is also working to expanding Health Information Technology (HIT) systems to facilitate care coordination through integrated treatment plans, improved health information exchanges, developing and maintaining care coordination agreements with partners, supporting processes and procedures for collecting, reporting, and tracking encounter, outcome, and quality data, and developing and implementing a CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinical services and clinical management. | | | issues. All needed, and most requested reports are in place. A list of other requested reports is kept and worked on. KPI Dashboards are in place, but Senior Management and other staff are not trained in it yet. Managers can run their own productivity reports.<br>Future Data Points: Can Directors and managers run their own reports, see specific Dashboards. Has agency been able to expand its Health Information Technology (HIT) systems as planned. |
| Year 3 | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click/Tap | Click or tap here to enter text. |

**GOAL 4 (Optional):** Click or tap here to enter text.

**Why is this goal a priority? What service gaps currently exist?**

Click or tap here to enter text.

| | Current Status | Action Steps / Strategies Planned | Resources Needed | Timeline / Due Date | Measure(s) of Progress / Data Point |
|---|---|---|---|---|---|
| Year 1 | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click/Tap | Click or tap here to enter text. |
| Year 2 | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click/Tap | Click or tap here to enter text. |
| Year 3 | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click/Tap | Click or tap here to enter text. |