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)*

<u>Requirements of a Quality Improvement Plan:</u> 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 • 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 • Outcomes can be measured
A – Attainable	• Goal can be accomplished • 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 • Goal is consistent with short and long-term plans • 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. • 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. • 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. • 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 • Discussing barriers to clients attending scheduled appointments and developing a plan to address them	• Client/Staff/Stakeholder Satisfaction Survey • Local Program Standing Committee input • Data collected from Electronic Health Record • 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) • Increasing Supported Employment staff time to allow for more clients to achieve career development goals	• Client/Staff/Stakeholder Satisfaction Survey • Local Program Standing Committee input • Data collected from Electronic Health Record • Informal feedback sessions with staff
Overall Agency Administration	• Updating the Electronic Health Record to include a dashboard to assist in utilization review. • 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 • Local Program Standing Committee input • Data collected from Electronic Health Record • 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?

Type here!

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?

Type here!

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?

Type here!

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 **How does the agency ensure that…**	**Potential Procedure**
Client Level	• Clients are getting the appropriate service and frequency of service • 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 • 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 • 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 • Supervisors review monthly notes with clinicians at least quarterly • 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?

Type here!

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?

Type here!

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?

Type here!

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): ☒Children, Youth, and Family Services (CYFS) ☐Emergency Services (ES) ☐Adult Mental Health Programs (CRT & AOP Combined) --OR-- ☐Community Rehabilitation and Treatment (CRT) ☐Adult Outpatient (AOP)	**Year 1:** Due May 1, 2021	**Year 2:** Due May 1, 2022	**Year 3:** Due May 1, 2023
	Staff Completing Form:	**Staff Completing Form**:	**Staff Completing Form**:
	Nicole Grenier	Jessica Kell	

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	17	Date(s):	October 2020	**Unified Client Satisfaction Survey**
Families	45	Date(s):	October 2020	**Unified Client Satisfaction Survey**
Local Program Standing Committee	6	Date(s):	April 2021	**Please see below**
Board of Directors		Date(s):	CYFS Director attends WCMHS Board meeting at least annually	**CYFS Director is invited to the meeting by the ED.**
Agency Staff *(optional but strongly recommended)*		Date(s):	CYFS Director reviews the staff survey results from CYFS staff	**Please see below**

Stakeholder Organizations		Name of Organizations:		**Please see below**
Specialized Service Agency		Name and Date(s):		
Other			The CYFS Local System of Care Plan has been developed with input and collaboration of representatives from various groups including clients, families, Local Program Standing Committee members, the WCMHS Board of Directors, agency staff, and multiple stakeholder organizations. The feedback and experiences of *clients and families* have been considered and reflected in this plan based on input they have shared via annual consumer satisfaction surveys, discussions at client/family team meetings, *Local Interagency Team* (LIT) meetings, and provided throughout the course of engaging in services and supports. All feedback has been synthesized to reflect common themes to help point to current system challenges and priorities for plan goals. CYFS *Local Program Standing Committee* (LPSC) has resumed (online) and is working toward expanding its current membership. LPSC members have been invited to share their experiences with accessing the system of care, and summaries of other groups' experiences have also been reported back to them with the collective feedback serving to help inform this plan's goals. Representatives of the agency's *Board of Directors* also attend the LPSC to hear directly from family members and to remain informed of the current successes and challenges across the system of care. *Agency staff* have contributed to the development of this plan's goals via their reporting across various division and agency meetings about their own experiences delivering services to clients and assisting clients with accessing supports both within and outside of WCMHS. These meetings include individual and group clinical supervision meetings, program staff meetings, CYFS Leadership meetings, Case Consultation and Referral Committee meetings, Children's Redesign Committee meetings, and WCMHS Senior Managers meetings. Finally, feedback reported by various *stakeholders* has been considered and reflected including, but not limited to, the following groups not previously mentioned above: Local Children's Integrated Services Team; WCMHS Governance Board meetings with Local Education Agency Special Education Directors; joint meetings with CYFS and DCF Leadership; Coordinated Service Plan team members; and more.	

*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): Reducing Waitlists for Children's Services

Why is this goal a priority? What service gaps currently exist? CYFS specifically, and WCMHS in general, was experiencing an increase in the need for supports and services across our community prior to, and even more so since, the COVID-19 pandemic. Coupled with an increase in staff vacancies across CYFS (see Goal #2), staff are challenged by increased caseloads, increased intensity and acuity of client needs posing more demand on their time, and the resulting delay in their ability to accept referrals and begin services for children and families to keep up with demand.

New and current clients, potentially in need of additional or different services, are triaged and assigned to staff and programs specific to their specialty, training, and availability through our Case Consultation and Referral Committee (CCRC). This committee was established in 2011 to "provide case consultation and to review requests for new or additional services for clients (ages 0-22) who are open to any WCMHS program".

WCMHS has also implemented two distinct Adult and Children's Redesign Committees led by the Executive Director. The purpose of these committees is to ensure that the agency is meeting requirements of payment reform measures and to identify opportunities to improve service delivery for clients. The CCRC is currently working with the Children's Redesign Committee to expand how programs work together to assess resource utilization and waitlist management using client and service data that is becoming more readily available under the recent launch of the agency's new UEMR.

	Current Status	Action Steps / Strategies Planned	Resources Needed	Timeline / Due Date	Measure(s) of Progress / Data Point
Year 1	Moving in the Wrong Direction	**#1:** The Navigation Team recently filled the vacancy for its (1) remaining full-time position. This new staff will be assigned cases starting in May 2021 to support the team with intakes, referral management, and client triage. **#2:** The CCRC is working with the Children's Redesign Committee to define how WCMHS can expand program collaboration to assess resource utilization and waitlist management using client and service data from the agency's new UEMR. **#3:** Continue staff training and increase utilization of UEMR to improve capturing, reporting, and analyzing of client, program, and outcome data.	Onboarding and training time for the new Navigation Team member is required to prepare them to begin accepting case assignments as of May 1, 2021. This ramp up time means case load size will grow incrementally. CYFS is committed to working diligently with the Quality Director, Information Technology Director, and Data Analyst to ensure that meaningful reporting can be accessed and utilized as soon as possible, and by no later than November 1, 2021.	7/1/21 11/1/2021	Navigation Team staff has full caseload by 7/21. Meaningful reporting, specific to goal of reducing waitlists can be accessed and utilized as soon as possible, and by no later than November 1, 2021. Utilization of reporting capabilities will continue to be expanded upon thereafter on an ongoing basis as part of our commitment to continuous quality improvement.
Year 2	Stalled	**#1:** The Navigation Team continues with one vacancy following turnover and high case load numbers to balance client demand. Recruiting is ongoing but market competition has reduced number of	Viable applicants, onboarding and ramp-up time to build case load. Options for sustainable pay increases, incentives that motivate high performers,	7/1/22 12/1/22	Navigation Team has full staffing w/ balanced caseloads. Completed recruitment and retention strategy. Completed strategic plan for performance incentives.

		applicants and CYFS pay-scales struggle to position us as a strong employer of choice. WCMHS is applying for CCBHC grant funding w/ goals focused on expanding access to care through a new payment model that may improve conditions for hiring/ staff retention. #2: CCRC committee continues to facilitate client referrals and supports w/ access management. A utilization management system is scheduled for development, coupled with a CQI plan to resolve admin. and operational complexity and system lag/ waste to free up time for increased client contact. Improvements to treatment plan utilization to drive care and forecast lengths of stay, combined with whole system buy-in to using the scheduling calendar in the UEMR are emerging as strategic focus areas for the year. #3. Staff competency w/ UEMR utilization has improved and some administrative supports are in place to help w/ data	opportunities to reduce administrative burdens to make working at CYFS more desirable. Resources and time for training new workflows that reduce waste and system lag. Resources and time for root cause analysis and process improvement strategizing to decrease documentation burden by 50%. A quality based mental health service delivery administration system that assigns agencies documentation and reporting requirements based on performance, quality, and outcome achievements. Increase in administrative support to carry the admin. burden.	7/1/22 5/1/23 3/1/23 6/1/23 8/1/22	Completed white paper and advocacy strategy to garner support for State commitment to a 50% reduction in administrative burden. Clear process improvement plan to decrease system redundancies and waste reduction by 25%. Completed pilot proposal to demonstrate the success of a quality-based monitoring system that decreases administrative, reporting, and documentation burden based on agency performance. Hiring of additional admin. staff and re-design of their responsibilities to provide more admin. support to clinical staff.

		entry to alleviate documentation burden. We are developing an improved approach to these supports to broaden their reach. CCBHC grant criteria also require significant access to care improvements and program expansion and the CYFS division will align itself with new agency policies and procedures to see improvements in this area.	CCBHC grant approval and implementation of system changes to achieve improved payment system.	10/1/22	Successful grant award and launch into certification activities. Completed CCBHC certification by 1/30/23
Year 3	Choose an item.				

Goal 2: (Program effectiveness) **Reducing Staff Turnover and Vacancy Rates**

Why is this goal a priority? What service gaps currently exist? CYFS struggled with a persistent staff turnover rate of 25% and lacks a viable retention strategy. This directly contributes to increased transitions and reassignments of staff, long-term vacancies, difficulty in maintaining continuity and quality of services; lost productivity during new staff ramp-up and departing staff ramp-down times, expensive and time consuming recruitment, hiring, training and re-training of staff; increased pressures on existing staff's caseloads and staff burnout; persistent wait-lists; difficulty to forecast supply and demand for program planning, and constant difficulty to meet payment reform targets. Staff turnover rates for CYFS have remained at a constant average of 25% and, although this is in line with national averages, still affects the stability of our division and service delivery.

FY 2010: 26% FY 2011: 35% FY 2012: 24%	FY 2013: 22% FY 2014: 26% FY 2015: 25%	FY 2016: 20% FY 2017: 25% FY 2018: 18%	FY 2019: 23% FY 2020: 25% FY 2021: YTD: 26%

As staff turnover rates continue, the pressures and impacts cited above continue to increase and are coupled with an unprecedented increase in demand for services that are exacerbated by COVID-19 outcomes. Additional challenges include the current unemployment rate of approximately 2%, and the chronically low wages at DA, soaring national inflation, and significant market competition for staff that makes recruitment the most difficult it has been in 10 years.

	Current Status	Action Steps / Strategies Planned	Resources Needed	Timeline / Due Date	Measure(s) of Progress / Data Point
Year 1	**Moving in the Wrong Direction**	**#1:** Continue efforts to increase staff wages. **#2:** Continue to work closely with Human Resources regarding expanded recruitment efforts. **#3:** Examine possible improvements and additions to staff retention strategies.	Time and $$ Time Time and staff to develop staff survey	7/1/21 8/1/21 8/1/21 9/1/21 12/1/21	Increase wages for Behavior Interventionists working in School Based Services, ChOICE Academy, and the Residential Treatment Programs Increase of successful hires versus interviews held and start measuring every 3 months. Data Collected from Staff Survey. Start to see reduction from current rate of staff turnover. Review data to see if we are headed in right direction or need to further adjust our efforts.

Year 2	Moving in the Wrong Direction	**#1:** Although we successfully increased base pay rates for BI's across our division, we have not seen a shift in retention, recruiting, or hiring. Pay increases were marginal and likely did not reach the right price-point to position CYFS as a competitive employer in the market. Staff feedback and market research also indicate that wages alone are not the solution. Private practitioners and independent businesses are entering the market as competitors who face much lower thresholds and requirements to do the same work as DA's. As a result, we loose staff to these businesses who can pay more and require less administrative work of their staff. In addition, schools are experiencing an increased demand for services that DA's can't meet and they are recruiting DA staff to work directly for them. Finally, AOE rates have yet to be published and additional administrative burdens are being configured along with these rates, that risk further burdening our system.	Ongoing		Improved pay grades, improved retention rates, improved staff satisfaction survey results. Increased competitive edge against independent businesses by resolving the burden of documentation and administrative requirements by 50%. Improved relationship and understanding between AOE, DMH, and DA's that shares common goals and vision.
		#2: CYFS is working closely with its own divisional recruiter and Human Resources to expand recruitment efforts. We have developed a larger online presence, improved our website design, created compelling radio ads, have updated job descriptions, group interview strategies, and successfully reach out to candidates within 24 hrs. of receiving their application, have improved the work-flow for new-hire paperwork, finger-printing, background and reference check processes to ensure our time to hire is as short as possible. Compared to national data, we are almost 13 days faster at brining applicants into our system than many other mental health organizations.	Ongoing		

		#3: Although improvements have been made in the areas of increased flexibility around work-schedules, work from home, opportunities for re-assignment to different positions to avoid burn-out, more improvements and additions to staff retention strategies are needed. These include offering a BI-floating pool to maximize use of our hourly staff, to offer opportunities to work across programs to expand knowledge and skills, and to allow for staff exploration of best program fit before committing.	10/1/22		Completed and implemented floating BI pool.
Year 3	Choose an item.				

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.

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 time and 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. 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	Time	5/1/22	Are there still unresolved issues in UEMR committee? Have Adult and Children's Redesign, Senior Managers, Quality Committee decided on new reports they want written?

		data. Adult Redesign / Children Redesign / Senior Managers / Quality Committee/, Division Staff identify service metrics that they want to have reported on. Agency Wide Key Performance Indicators get approved, developed, written and distributed. The agency provides training to staff and managers to learn to run their own reports			Are KPI dashboards or reports in place? 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 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.	Time	5/1/2023	Progress: UEMR Committee still meets 2x month to review ongoing non-implementation 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. 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.				

GOAL 4 (Optional):

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

	Current Status	Action Steps / Strategies Planned	Resources Needed	Timeline / Due Date	Measure(s) of Progress / Data Point
Year 1	Choose an item.				
Year 2	Choose an item.				
Year 3	Choose an item.				