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 • 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?

In Emergency Services we have a weekly 3 hour staff meeting for all emergency screeners. During that staff meeting, we review clinical situations from the week and provide supervisor feedback regarding response protocols and best practice clinical strategies. Supervisors are available for direct supervision in crisis situations as well as for individual clinical supervision. For our urgent care programs, we also have weekly staff meetings with supervisors facilitating to provide clinical feedback. Our clinicians receive weekly individual supervision as well. Supervisors also review clinical documentation and provide feedback. Supervisors also utilize client feedback given to integrate into supervision and ongoing clinical best practice. We also utilize the annual client satisfaction survey

results to give screeners and clinicians feedback and integrate into our ongoing clinical practice patterns. Our urgent care clinicians also participate in the two weekly utilization management/review meetings (adult and children) established at our agency to monitor client care and improve our practice patterns. We will utilize data analysis across ICS Programs to examine our efforts and to continuously improve our client care.
The Intensive Care Services Director and Program Managers are responsible for each part of this quality improvement process. We utilize our RBA measures to guide this process as well as the Client Satisfaction Survey results specific to Emergency Services response to analyze our response patterns. We also provide ongoing training and supervision to adhere to the response protocols as outlined in the Provider Manual (which will lead to best practice client clinical interactions.)

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?

We utilize our Emergency Services protocols to train our emergent and urgent care staff. We provide ongoing individual and group supervision to ensure clinicial staff are adhering to our protocols. We develop our protocols based on SAMSHA emergency services best practice standards as well as the Provider Manual. Supervisors and emergency services clinical staff attend trainings to learn about emergent and urgent care best practice standards. We then integrate new clinical information into our protocols and training materials. We will utilize data analysis across ICS Programs to examine our efforts and continuously improve ICS program effectiveness to serve our clients.
The Intensive Care Services Director and Intensive Care Services Program Directors are responsible for each part of this process. We utilize our RBA measures as well as the Annual Client Satisfaction Survey to inform our programmatic decisions. (Some programs utilize pre/post measures to identify clinical progress for clients/families and improve program effectiveness.)

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?

The focus for the Overall Agency Administration is on maximizing the power of data from My Avatar (our new UEMR since December 2020) and other WCMHS data monitoring systems. We monitor the Overal Agency Administration by determining the reports we are able to generate from our EMR system as well as determining the accuracy of the information we are able to report out of our system (i.e. any variance between what we report and what DMH receives.) We utilize the feedback from clients, end user clinical staff, program managers and division directors on how useful the EMR is to them, both with ease of use within MyAvatar as well as the reports that are generated from it.
WCMHS has recently started a new UEMR Clinical Committee. This committee was convened to help problem solve the issues that

have been arisen since the UEMR launched in December 2020. WCMHS has also created a new Quality Committtee which has ICS representation present for the monthly meetings. The agency continues to work with the other Core 4 agencies for the UEMR project. The agency is committed to being able to identify consistent Key Performance Indicators across Divisions, including ICS, as well as help generate meaningful reports for staff from MyAvatar.
We are using outcomes to guide this process by giving us milestones to make sure we are making progress. An important outcome from the UEMR Clinical Committee is increasing staff satisfaction and effiency with the new system. The measures we have chosen are all SMART goals.

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?

Our urgent care programs attend our utilization review/management meetings weekly (there are two meetings at WCMHS, one for adults and one for children and families.) The Intensive Care Services Director and ICS Program Managers are responsible. Payment Reform is regularly discussed at these meetings to ensure we're meeting quality standards.

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?

Our emergency screeners discuss our response protocols weekly at our staff meeting. We discuss our coverage needs and how to ensure we're meeting all clinical standards. Our urgent care programs discuss utilization review at all weekly staff meetings. Urgent care programs triage clinical needs to ensure we're meeting client and family clinical needs.
The Intensive Care Services Director and ICS Program Managers are responsible for each part of the procedure. The ICS Director and ICS Program Managers attend monthly meeting for Children's System Design and Adult System Design that have resulted from Payment Reform. The weekly utilization review meetings serve to meet Payment Reform standards.

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?

WCMHS Utilization Review procedure at the agency level is to analyze all programmatic data across the agency to ensure clients are better off and outcomes related to Payment Reform are being met. We have already created compliance reports in our new EMR (MyAvatar.) Our goals for this year are to have a Dashboard in MyAvatar that monitors Key Performance Indicators across the agency, and can be more specific for more focused reporting. The Senior Managers and UEMR Clinical Committee are responsible for each part of the procedure. WCMHS has started Adult and Childrens Redesign monthly meetings during Payment Reform which have been led by the Executive Director for the past year to focus on challenges arising across all agency divisions. As a result of those meetings, more non categorical case management resources have been developed, as well as opening up CSP services to clients who are not enrolled in the CSP program. WCMHS developed an Adult Utilization Review/Utilization Management meeting focused on client and program issues, which has led to clients accessing clinically indicated services faster. The meeting has also identified clinical needs across divisions and has allowed for targeted investments in staff.

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**:
	Karen Kurrle, Nick Roos	Karen Kurrle	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	Numerous calls, meetings throughout the year	Date(s):	Ongoing feedback directly from clients about their experience in emergent and urgent care.	We publize our emergency services number and people call to give feedback ongoing.
Families	Numerous calls, meetings throughout the year	Date(s):	Ongoing feedback directly from families about their experience in emergent and urgent care	We publize our emergency services number and people call to give feedback ongoing.
Local Program Standing Committee	Adult and Children's Standing Committee Members	Date(s):	ICS Director attends the Children and Adult Standing Committee meetings when invited to talk about	Connection with the Children's and CSP Directors.

			emergent and urgent care services	
Board of Directors	Click or tap here to enter text.	Date(s):	Intensive Care Services Director attends Board meeting at least annually.	ICS Director is invited by WCMHS Executive Director to attend the Board meeting.
Agency Staff *(optional but strongly recommended)*	Click or tap here to enter text.	Date(s):	ICS Director utilizes the agency staff survey to integrate feedback from staff both in ICS and other WCMH divisions.	WCMHS Quality Improvement Director sends the ICS Director the WCMHS Annual Staff Survey results to review and integrate feedback.
Stakeholder Organizations	Click or tap here to enter text.	Name of Organizations:	Local Law Enforcement, Local EMS and Fire, Schools, Courts, Central Vermont Medical Center, Good Samaritan Haven Homeless Shelter	Numerous meetings and collaborative contacts throughout the year with each of these entities to talk through how collaboration and communication is working overall and in specific situations as well as to identify system gaps and problem solve potential solutions.
Specialized Service Agency	Click or tap here to enter text.	Name and Date(s):	Pathways, NFI	Phone calls, meetings throughout the year to talk through specific clinical situations as well as overall collaboration and communication related to response protocols and role expectations.
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): Implement Zero Suicide framework throughout ICS programs.

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

Through the utilization of a framework that uses evidenced based, best practices, all clinicians in the Intensive Care Services Division will be better able to serve Vermonters in the Washington County catchment area. These clinicians will help current and prospective clients navigate mental health crises that present in their lives to proactively engage in suicide prevention.

Some of the current gaps in services are, but not limited to; additional funding, staffing, and training. There may also be a need for additional investment from community stakeholders.

	Current Status	Action Steps / Strategies Planned	Resources Needed	Timeline / Due Date	Measure(s) of Progress / Data Point
Year 1	The ICS Director will work with the WCMHS Zero Suicde Committee to implement the Zero Suicide Framework across ICS Program.	All ICS staff will be trained re: the Zero Suicide framework. All ICS staff will have the proper training level for their role (i.e. UMatter, CALM, CAMS.)	Time for staff to take required trainings; funding for CAMS, UMatter training	Completed by 5/1/22	Tracking system to document when staff have completed trainings.
Year 2	WCMHS ICS is implementing the Zero Suicide framework	Emergency Screeners now have the Columbia Suicide Severity Risk Screen built into our face to face screening document. Screeners will continue to receive training	Time for staff to take required trainings; funding	Continue to train ICS staff by 5/1/23	Continue to maintain and update ICS training spreadsheet. Offer monthly CAMS consultation group meetings for

	through training staff and will continue trainings through the next year of the LSOC plan	on the CSSRS in the coming year. 61% of the ICS clinicians have been trained in CALM and CAMS. The ICS Director will become a UMatter trainer in May 2022. The Emergency Services Coordinator is a UMatter trainer. ICS will continue to offer UMatter, CALM and CAMS training for all staff in the upcoming year.	for CAMS, UMatter trainings.		ICS and other WCMHS clinical staff.
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): Foster a collaborative effort with law enforcement to implement best practice mental health crisis response.

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

By continuing to foster a collaborative effort with law enforcement, WCMHS employees will better be able to respond to a variety of situations that may present themselves in the midst of a mental health crisis. The coordinated effort between mental health staff and law enforcement will simultaneously decrease potential safety risks to all Vermonters (i.e. clients, mental health workers, and law enforcement officers included), while increasing access to services for individuals experiencing a mental health crisis.

Current potential gaps in services are ever changing safety protocols for both law enforcement officers and mental health workers in their respective realms. The need for ongoing, and regular trainings and meetings between the aforementioned parties(i.e. Team Two) can meet those needs

	Current Status	Action Steps / Strategies Planned	Resources Needed	Timeline / Due Date	Measure(s) of Progress / Data Point
Year 1	ICS staff will be trained in collaboration and joint response with law enforcement	WCMHS screeners will all have Team Two training. WCMHS will continue to have a police clinician with Barre City PD and Montpelier PD. All ICS clinical staff will receive training in collaborative response expectations with law enforcement.	Team Two training; ongoing funding for police clinician	5/1/22	Team Two training attendance tracking; Quarterly Report for Police Clinician

Year 2	All ICS staff will be trained in collaboration and joint response with law enforcement. ICS staff will have an understanding of law enforcement's policies and procedures related to Use of Force legislation.	All current WCMHS screeners are trained in Team Two. 2 WCMHS screeners are trainers for Team Two. WCMHS Emergency Services Coordinator is a member of the Team Two faculty. WCMHS Emergency Services Coordinator is a member of the Washington County CIT Committee. WCMHS has 2 positions for police mental health clinicians. WCMHS ICS Director and Emergency Services Director attended all ICS staff meetings for emergent and urgent care programs since October 2021 to talk about the new Use of Force legislation and resulting law enforcements procedures as well as talk through collaboration and communication with law enforcement in our county.	Team Two training; ongoing funding for police clinician	5/1/23	Team Two training attendance tracking; Quarterly Report for Police clinicians.
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 improve clients lives. To use the new EMR to its full potential for clients, end user staff, and all levels of agency management

**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 todays modern health care environment, the agency needs to be able to show accurate data to its funders. WCMHS has invested staff time, and agency dollars to implement a new EMR (MyAvatar.) WCMHS will extract accurate, useful and meaningful data from MyAvatar. needs to be able to start pulling data out of its new EMR, ASAP.

	Current Status	Action Steps / Strategies Planned	Resources Needed	Timeline / Due Date	Measure(s) of Progress / Data Point
Year 1	MyAvatar went live in December 2020. KPI indicators are being planned.	UEMR Clinical Committee continue to meet weekly to resolve current short term issues. KPI indicators across agency, will get approved, developed, written and distributed.	Click or tap here to enter text.	5/1/2022	Are there still unesolved issues in UEMR committee? Are KPI dashboards or reports in place? Have Adult and Childrens

	Very few reports are able to be run from new system.	Adult Redesign Committee Children Redesign Committee; Senior Managers; and Program Managers will identify service metrics that they want to have reported on. The agency provides training to staff and managers to learn to run their own reports			Redesign Committees, Senior Managers, and Program Managers determined new reports that should be generated in MyAvatar? Program Managers will receive the training to generate their own reports in the EMR.
Year 2	Moving in the Right Direction	The WCMHS Quality Committee meets regularly and continuously reviews MyAvatar reports. Program Managers and Senior Managers are consistently asked what reports they need. WCMHS is working with the other DA's using MyAvatar to develop the requested reports. As part of WCMHS' CCBHC grant application, WCMHS will work to expand our Health Information Technology systems to facilitate care coordination through integrated treatment plans; improve health information exchange; develop and maintain care coordination agreements with partners; support procedures for collecting, reporting and tracking encounter, outcome and quality data; and will develop and implement a CCBHC data driven continuous quality improvement plan for clinical services and clinical management.	Click or tap here to enter text.	5/1/2023	The UEMR Clinical Committee continues to meet twice a month to review ongoing non-implementation issues. A list of other requested reports is being kept and is actively being worked on to get reports to Senior Managers and Program Managers. KPI Dashboards are in place but Senior Managers and other staff have not been trained to utilize those dashboards yet. Goals for year 3: Have Senior Managers and Program Managers received training to run their own reports and view/utilize the KPI Dashboards? Has WCMHS successfully expanded our Health Information Technology 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.