The Harris Center for Mental Health and IDD
Transforming Lives

The Harris Center for Mental Health and IDD
9401 Southwest Freeway Houston, TX 77074
Board Room #109

Quality Committee Meeting
May 16, 2023
10:00 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **APPROVAL OF MINUTES**

A. Approve Minutes of the Board of Trustees Quality Committee Held on Tuesday, April 18, 2023
*(EXHIBIT Q-1 )*

IV. **REVIEW AND COMMENT**

A. Quality Board Score Card
*(EXHIBIT Q-2 Luming Li/Trudy Leidich)*

B. IDD Access to Care Update
*(EXHIBIT Q-3 Evanthe Collins)*

C. Nursing Peer Review
*(EXHIBIT Q-4 Kia Walker)*

D. Clinical Pharmacy Specialist
*(Luming Li)*

V. ***EXECUTIVE SESSION-***

***• As authorized by §551.071 of the Texas Government Code, the Board of Trustees reserves the right to adjourn into Executive Session at anytime during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.***

***• Report by the Chief Medical Officer regarding the Quality of Healthcare pursuant to Texas Health & Safety Code Ann. §161.032, Texas Occupations Code Ann. §160.007 and Texas Occupations Code Ann. §151.002 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Healthcare Services. Dr. Luming Li, Chief Medical Officer and Trudy Leidich, Vice President of Clinical Transformation & Quality***

VI. **RECONVENE INTO OPEN SESSION**

VII. **CONSIDER AND TAKE ACTION AS A RESULT OF THE EXECUTIVE SESSION**

VIII. **ADJOURN**

Veronica Franco

**Veronica. Franco, Board Liaison**
**George D. Santos, MD, Chairman**
**Board of Trustees Quality Committee**
**The Harris Center for Mental Health and IDD**

# EXHIBIT Q-1

# *The* HARRIS CENTER *for* MENTAL HEALTH and IDD BOARD OF TRUSTEES QUALITY COMMITTEE MEETING TUESDAY, APRIL 18, 2023 MINUTES

Dr. George Santos, Board of Trustees Chairman, called the meeting to order at 10:00 a.m. in the Room 109, 9401 Southwest Freeway, noting that a quorum of the Committee was present.

**RECORD OF ATTENDANCE**

Committee Members in Attendance: Dr. G. Santos, Dr. R. Gearing

Committee Member Absent: Mrs. B. Hellums

Other Board Member in Attendance: Mr. J. Lykes, Dr. L Moore, Mr. S. Zakaria

1. **CALL TO ORDER**
   The meeting was called to order at 10:00am.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Dr. George Santos designated Dr. L. Moore and Mr. J. Lykes as voting members of the committee.

3. **DECLARATION OF QUORUM**
   Dr. Santos declared a quorum was present.

4. **PUBLIC COMMENT**
   There were no Public Comments.

5. **Approve the Minutes of the Board of Trustees Quality Committee Meeting Held on Tuesday, March 21, 2023**

   **MOTION BY: MOORE SECOND BY: ZAKARIA**

   **With unanimous affirmative votes,**
   **BE IT RESOLVED** that the Minutes of the Quality Committee meeting held on Tuesday, March 21, 2023, as presented under Exhibit Q-1, are approved.

**6. REVIEW AND COMMENT**

- **A. Quality Board Score Card,** presented by Trudy Leidich, was reviewed by the Quality Committee.
- **B. Clinical Pharmacy Specialist,** presented by Angela Babin was reviewed by the Quality Committee. Dr. Santos reported the Board was unaware the Harris Center had implemented

the collaborative drug therapy management for Clinical Pharmacy Specialists and Physicians. Dr. Santos expressed concern the Board has not reviewed any policies and procedures related to Collaborative Drug Therapy management prescriptive authority and had not approved it. Dr. Santos requested Harris Center policies and procedures related to the Collaborative Drug Therapy management for Clinical Pharmacy Specialists and physicians.

**C. Psychiatric Emergency Services (PES),** presented by Dr. Amber Pastusek was reviewed by the Quality Committee.

**D. IDD Access to Care Update,** presented by Dr. Evanthe Collins was reviewed by the Quality Committee

**7. EXECUTIVE SESSION-**

Dr. Santos announced the Quality Committee would enter into executive session at 11:34 am for the following reason:

- Pursuant to Texas Health & Safety Code Ann. §161.032, Texas Occupations Code Ann. §160.007, Texas Occupations Code Ann. §151.002 and Texas Occupations Code Ann. §§564.102-564.103 to Receive Peer Review and/or Medical Committee Report from the Director of Pharmacy in Connection with the Evaluation of the Quality of Pharmacy and Healthcare Services. Angela Babin, Director of Pharmacy, Dr. Luming Li, Chief Medical Officer, and Kia Walker, Chief Nursing Officer

- Pursuant to Texas Occupations Code Ann. Ch. 303 to review Peer Review reports from the Chief Nursing Officer in connection with the Evaluation of the Quality of Nursing and Healthcare services. Kia Walker, Chief Nursing Officer and Shannon Fleming, Senior Legal Counsel

**8. RECONVENE INTO OPEN SESSION-**

The Quality Committee reconvened into open session at 12:04 pm.

**9. CONSIDER AND TAKE ACTION AS A RESULT OF EXECUTIVE SESSION**

No action was taken as a result of the Executive Session.

**10. ADJOURN**

**MOTION: GEARING SECOND: ZAKARIA**

There being no further business, the meeting adjourned at 12:04pm.

**Veronica Franco, Board Liaison**
**George Santos, Chairman**
**Quality Committee**
**THE HARRIS CENTER *for* Mental Health *and* IDD**
**Board of Trustees**

# EXHIBIT Q-2

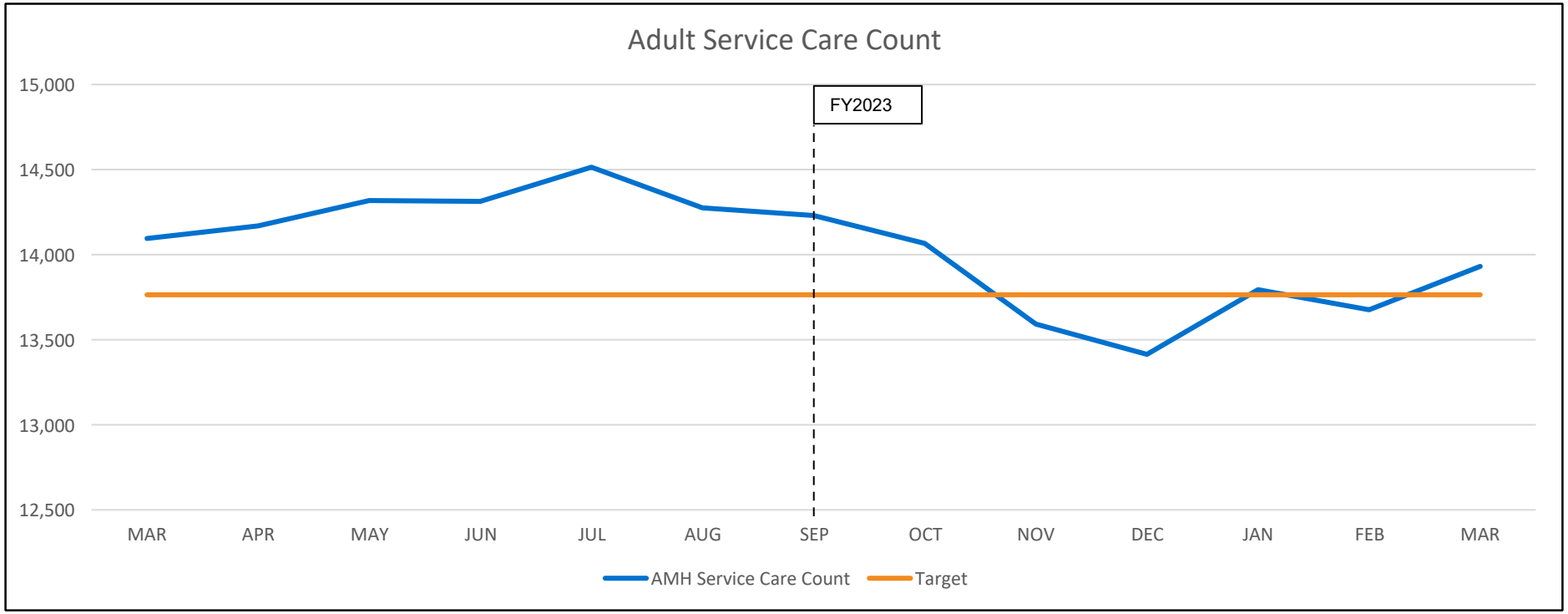
# Quality Board Scorecard

## Board Quality Committee Meeting

Presented by: Trudy Leidich, MBA, RN
VP of Clinical Transformation and Quality

16 May 2023

| Domain | Program | 2023 Fiscal Year State Care Count Target | 2023 Fiscal Year State Care Count Average (Sep-Mar) | Reporting Period: March 2023 Care Count | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | AMH Service Care Count | 13,764 | 13,815 | 13,931 | Increase | Contractual |

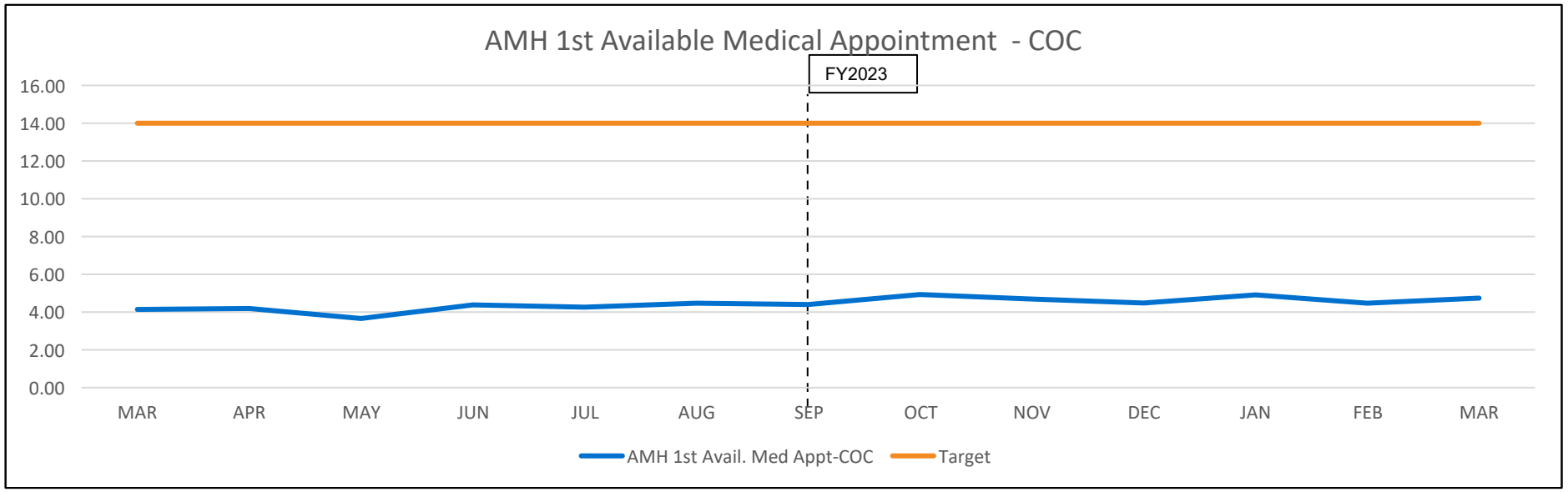



Highlights:

- Adult service care count average is performing well. The program had **achieved a 5% increase year over year.** It averaged 13,815 service care count in fiscal year to date (Sep-Mar 2023) compared to same period in Sep-Mar FY2022 (13,171).
- Adult Service care count is **down less than 1%** this reporting period in March (13,971) compared to February 2022 (14,095) but still above the state contractual target.

*Measure definition: # of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.*

| Domain | Program | 2023 Fiscal Year Target | 2023 Fiscal Year Average (Sep-Mar) | Reporting Period March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AMH 1st Avail. Medical Appt-COC | <14 days | 4.70 Days | 4.74 Days | Decrease | Contractual |



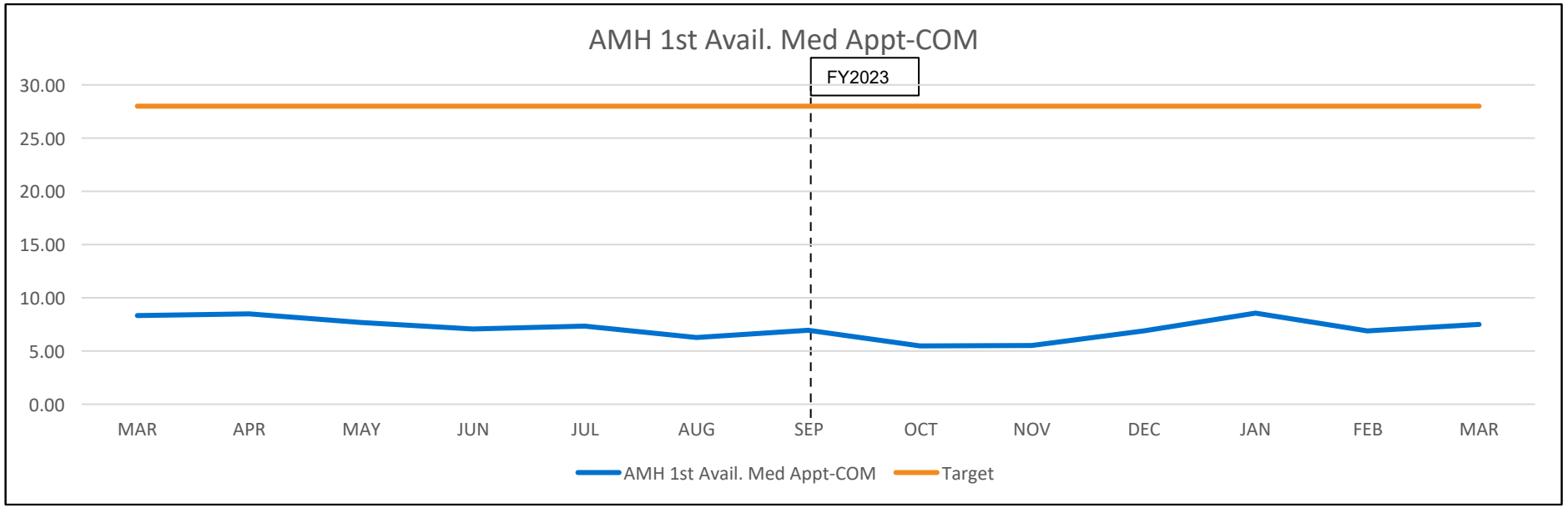

Highlights:
Time to contact COC patients continues to perform well for AMH.

- AMH has achieved **a 17% reduction** in the 1st available medical appointment for continuity of care patients. From an average of 5.67 days (Sep-Mar in FY2022) to 4.70 days in Sep-Mar FY2023.

- For the reporting period March 2023, AMH 1st available medical appointment for continuity of care **increased by 14%** from 4.14 days (Feb 2022) to 4.74 days in Feb 2023, but the program is still 10 days below target.

*Measure definition: Adult - Time between MD Intake Assessment (COC) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date*

| Domain | Program | 2023 Fiscal Year Target | 2023 Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AMH 1st Avail. Medical Appt-COM | <28 days | 6.83 Days | 7.50 Days | Decrease | Contractual |

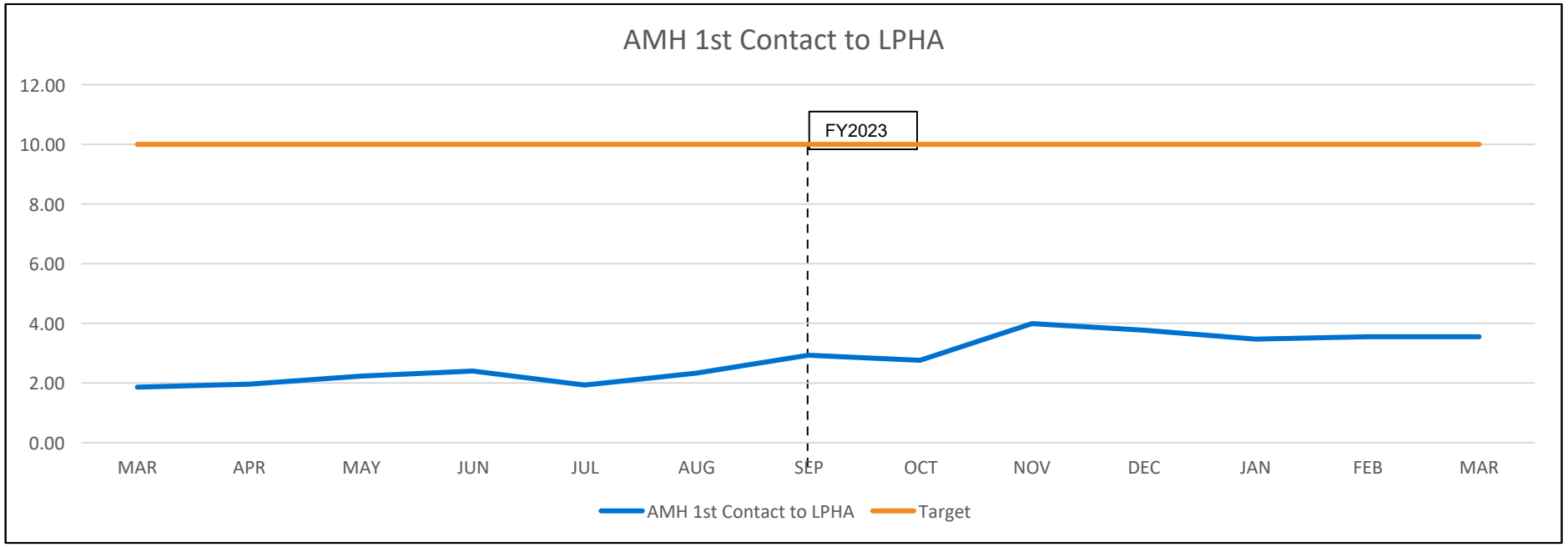



Highlights:
Time to contact patients continues to perform well for AMH.

- AMH has achieved **a 43% reduction** in the 1st available medical appointment for community members (walking-ins without an appointment). From an average of **11.96 days (Sep-Mar)** in 2022 to **6.83 days in Sep-Mar 2023.**
- For the reporting period March 2023, AMH reduced the time for 1st available medical appointment for community members (walking-ins without an appointment) **by 9.96%** from 8.33 days (March 2022) to 7**.50 days in March 2023**

*Measure Definition: Adult - Time between MD Intake Assessment for community members walk-ins (COM). From Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date*

| Domain | Program | 2023 Fiscal Year Target | 2023 Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AMH 1st Contact to LPHA | <10 days | 3.26 Days | 3.55 Days | Decrease | Contractual |



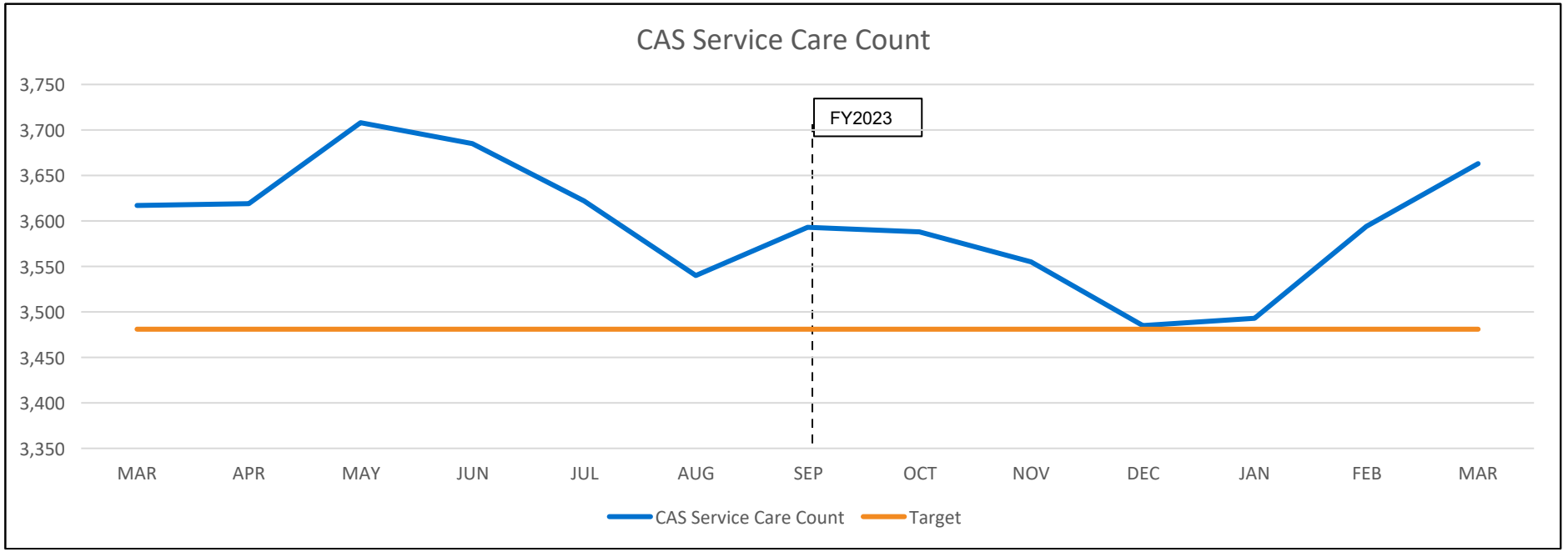

Highlights:

Time to contact patients for assessment continues to perform well for AMH.

- AMH has seen an increase in the number of days for an LPHA assessment from the same period last year. From an average of **1.50 days (Sep-Mar 2022) to 3.26 in the same period in Sep-Mar 2023**; and **increase to** 3.55 days in March 2023 from 1.87 days in March 2022.
- An intake assessment workgroup was developed in February to evaluate the intake process for improvement opportunities. The workgroup have been meeting to explore ways to streamline the process by finding ways for patients to complete certain forms ahead of appointment. A report from the process improvement will be shared soon.

*Measure Definition: Adult Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date*

| Domain | Program | 2023 Fiscal Year State Care Count Target | 2023 Fiscal Year State Care Count Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access to Care | CAS | 3,481 | 3,567 | 3,663 | Increase | Contractual |

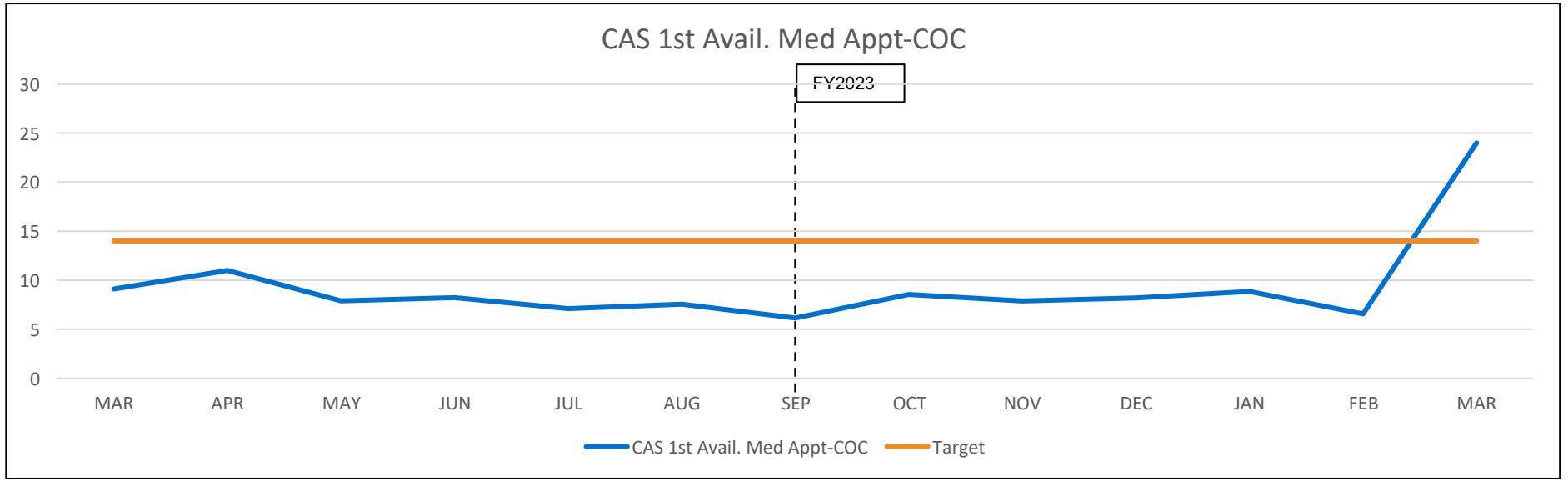



Highlights:

- CAS service care count average is up **4%** in fiscal year to date Sep-Mar 2023 (**3,567**) compared to same period in FY2022 (**3,439**)
- March CAS Service care count is also up **1%** this reporting period (**3,663**) compared to March 2022 (**3,617**)

*Measure Definition: # of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.*

| Domain | Program | 2023 Fiscal Year Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | CAS 1st Avail. Medical Appt-COC | <14 days | 7.54 days | 6.57 days | Decrease | Contractual |




Highlights:

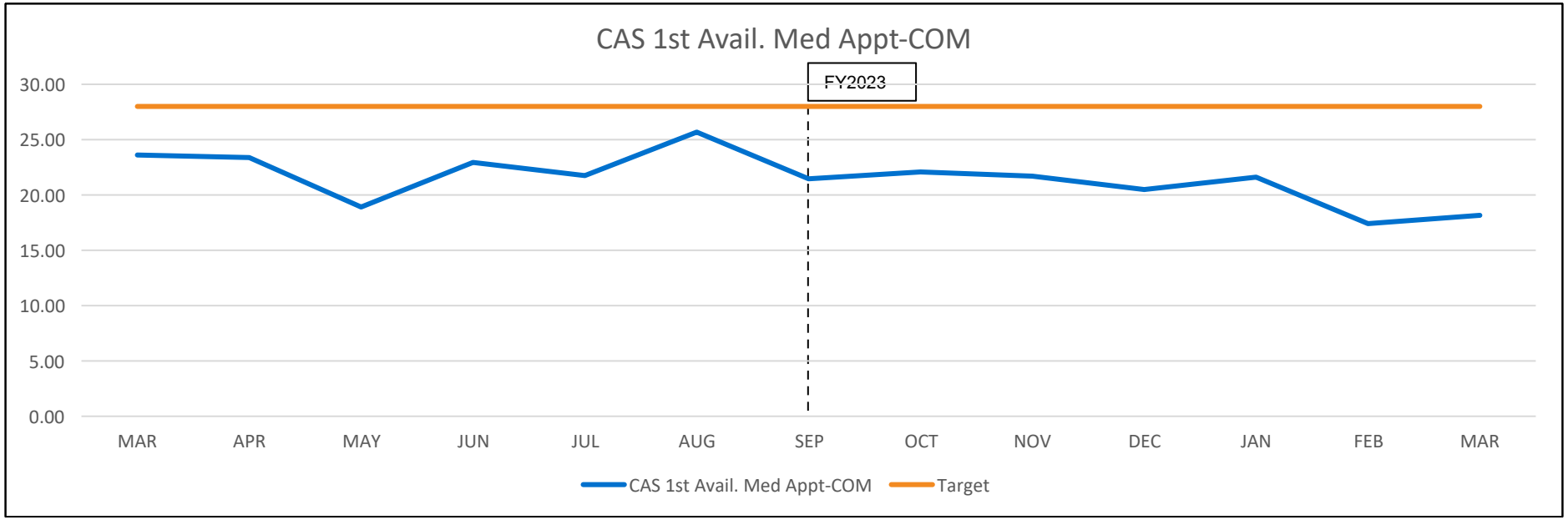
Time to contact patients for continuity of care after hospital discharge continues to perform well for CAS.

- CAS had a **increase** in the 1st available medical appointment for continuity of care patients. From an average of 7**.17 days (Sep-Mar) in 2022 to --- days in Sep-Mar 2023**. **(There are errors in the data. Will update once corrected)**

- For the reporting period March 2023, CAS saw an ----- for 1st available medical appointment by **---%** from --- days (Mar 2022) to **---** days in Mar 2023

*Measure Definition: Children and Youth - Time between MD Intake Assessment (Continuity of care: after hospital discharge) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date*

| Domain | Program | 2023 Fiscal Year Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | CAS 1st Avail. Medical Appt-COM | <28 days | 20.42 | 18.16 | Decrease | Contractual |



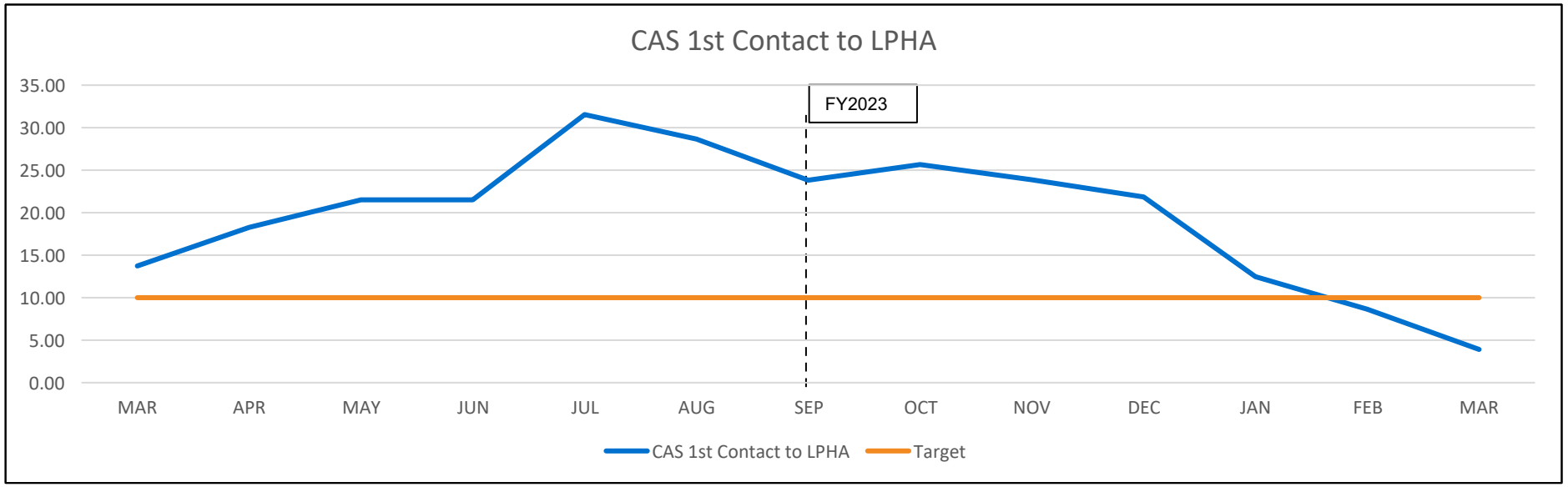

Highlights:

Time to contact patients continues to perform well for CAS.

- CAS 1st available medical appointment for community members walk-ins, had a 8**% decrease** year over year. From an average of **22.11 days (Sep-Mar) in 2022 to 20.42 days in Sep-Mar 2023.**
- For the reporting period March 2023, CAS reduced the number of days for 1st available medical appointment for community members walk-ins by **23% from 23.61 days (Mar 2022) to 18.16 days in Mar 2023**

*Measure definition: Children and Youth - Time between MD Intake Assessment (Community members walk-ins) Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date*

| Domain | Program | 2023 Fiscal Year Target | 2023 Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | CAS 1st Contact to LPHA | <10 days | 17.17 Days | 3.91 Days | Decrease | Contractual |

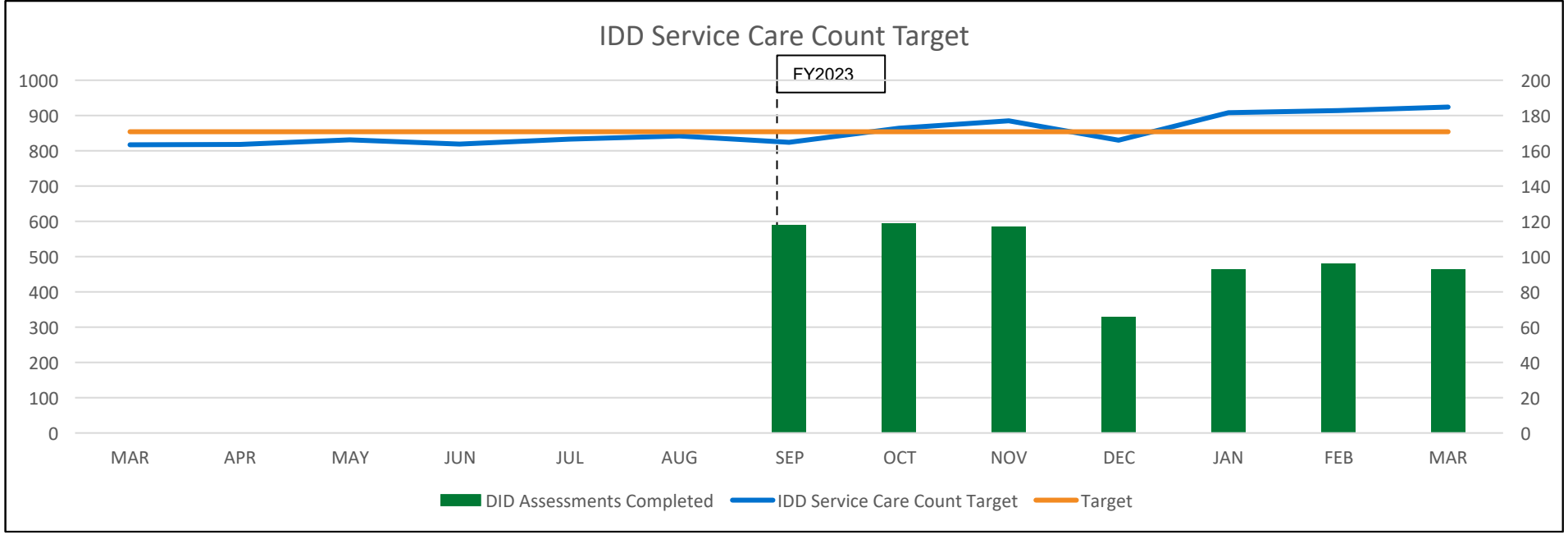



Highlights:

- CAS recent implementation of walk-in model was successful. It reduced its fiscal year to date number of days for an LPHA assessment by 20 days. In September patients were waiting an average of 20 days for an LPHA assessment. The walk-in process reduced it to 3 days.
- There was also a decrease in the month-to-month comparison. From 13.73 days in March 2022 to 3.91 days in March 2023. A 72% reduction in wait time.

*Measure definition: Children and Youth - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date*

| Domain | Program | 2023 Fiscal Year State Count Target | 2023 Fiscal Year State Count Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | IDD | 854 | 878 | 924 | Increase | Contractual |




| | SEP | OCT | NOV | DEC | JAN | FEB | MAR* |
|---|---|---|---|---|---|---|---|
| DID ASSESSMENTS COMPLETED | 118 | 119 | 117 | 66 | 93 | 96 | 93 *as of 4/3/23 |

Highlights:

IDD has achieved its highest care count FY23 to date.

- IDD had **a 12% increase** in the total average service care count: from an average of 785 (Sep-Mar) in 2022 to 878 in Sep-Mar 2023.
- For the reporting period February 2023, IDD has increased the service care count by **13%**, from 817 **(Mar 2022) to 924 in March 2023**

*Measure definition: # of IDD Target served based on all reported encounter data. (includes encounters that are associated with CARE assignment codes when the service is performed outside of a waiver. Exceptions are for service coordination that is only included for the indigent population and R019 which is included regardless of waiver status.)*

# GR ACCESS TO CARE

Call > Appointment 1-2 weeks crisis 30-60 days non-crisis → DID Appointment 3.5-5.5 hours no documents 2-3.5 w documents → Report Writing 20.4 days → Referral > SC 3 days → SC assigned 3 months → SC > Family Contact 24hrs crisis 3 days non-crisis → Discovery > GR referral 14 days

## STEP 1 ELIGIBILITY

DID
Report Writing
Financials
Service Assessment

**Number waiting to receive a DID assessment***

| | July | Oct | Nov | Dec | Jan | Feb** |
|---|---|---|---|---|---|---|
| Beginning of month* | 5,831 | 5,775 | 5,710 | 5,602 | 5,621 | 5,585 |
| Added | - | 37 | 22 | 34 | 30 | 0 |
| Removed | - | 102 | 130 | 15 | 66 | 98 |
| **TOTAL WAITING** | **5,831** | **5,710** | **5,602** | **5,621** | **5,585** | **5,487** |

1. Average wait time from call to appointment for a crisis is 1-2 weeks, non-crisis is 30-60 days. ***
2. Average time for DID appointment: Assessment no documentation 2-4 hours, Assessment w/ documentation 30 minutes – 1 hour; Financial Assessment: 30 minutes; SC Assessment (explanation of available services) – 1 hour.***
3. Average number of days to complete DID report is 20.4 days (based on 5 months of data in FY23).
4. Post report, average time to complete referral to service coordination is 3 days.

**contains invalid data
** Feb data is preliminary as of 2/24/2023
*** Average based on previous workflow

## STEP 2 SERVICE COORDINATION

Discovery
Person-Directed Plan
Monitoring

**Number waiting to receive a GR Service Coordinator***

| Dec | Jan | Feb |
|---|---|---|
| 118 | 84 | 52 |

1. Average wait time to be assigned a service coordinator is 3 months.
2. Once assigned, average wait time for service coordinator to make contact is 24 hours for crisis case and 3 days for non-crisis.
3. Home visit/discovery is dependent on family availability.
4. Post home visit/discovery, average time to complete person directed plan and send referral to GR Services is 14 days (reviewed by supervisor prior to approval).

*data has been validated and is post DID
** Feb data is preliminary as of 2/24/2023

## STEP 3 GR SERVICES

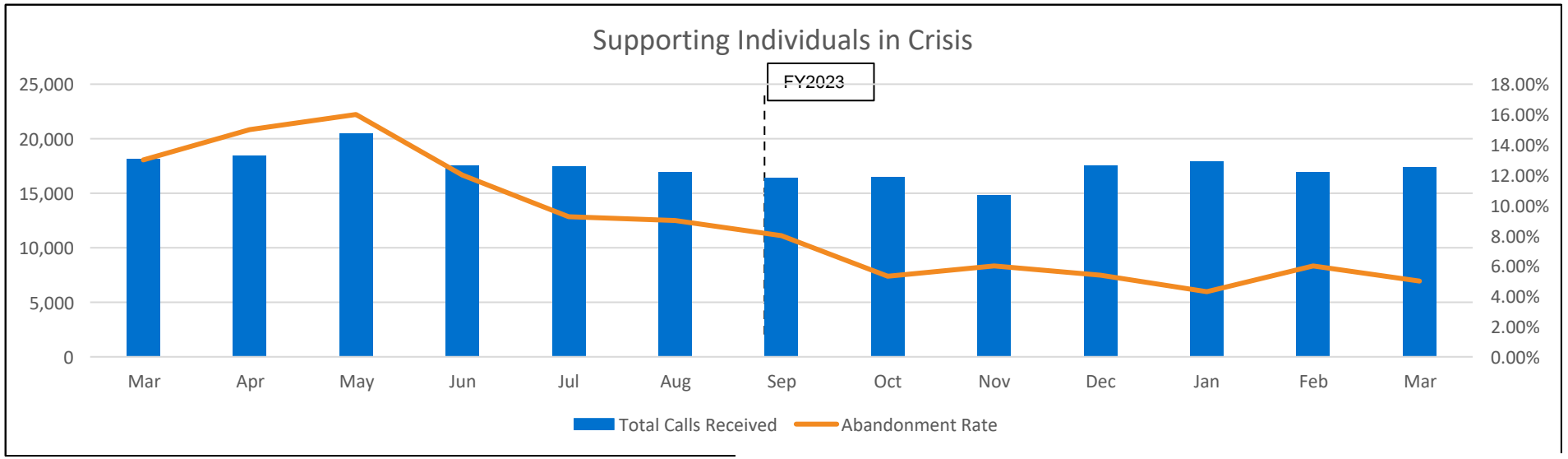
HHSC Contracted Services
Internal/External Providers
Community Linkages

**Number waiting to access an authorized GR service***

| | Dec | Jan | Feb** |
|---|---|---|---|
| In-home respite (Contract) *Avg. wait time: ~1 month* | 9 | 9 | 23 |
| Out-of-home respite (Contract) *Avg. wait time: ~1 month* | 0 | 0 | 0 |
| Day Habilitation (Contract) *Avg, wait time: ~1 month* | 2 | 2 | 15 |
| Employment Services (Contract) *Avg. wait time: ~1 month* | 0 | 0 | 2 |
| Feeding Clinic (Internal) *Avg. wait time: ~1 month* | 24 | 1 | 0 |
| Outpatient Biopsychosocial Services (OBI) (Internal) *Avg. wait time: 12 months* | 99 | 176 | 181 |
| The Coffeehouse (Internal) *Avg. wait time: 6 months* | Not Reported | 8 | 13 |
| **TOTAL WAITING** | **134** | **196** | **234** |

*data has been validated and is post DID
** Feb data is preliminary as of 2/24/2023

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Total Calls Received | N/A | 16,795 | 15,384 | Increase | Contractual |
| | Abandonment Rate | <8% | 5.72% | 5.00% | Decrease | Contractual |




| Category | Count |
|---|---|
| Calls Received (All lines) | 15,384 |
| Calls Received (Harris County Only) | 3,615 |
| *Calls from Harris Center clients with scheduled apptmnts | ***370*** |
| *Appointment made on same day or after call made to Crisis Line* | *271* |
| *Appointment made prior to call made to Crisis Line* | *99* |

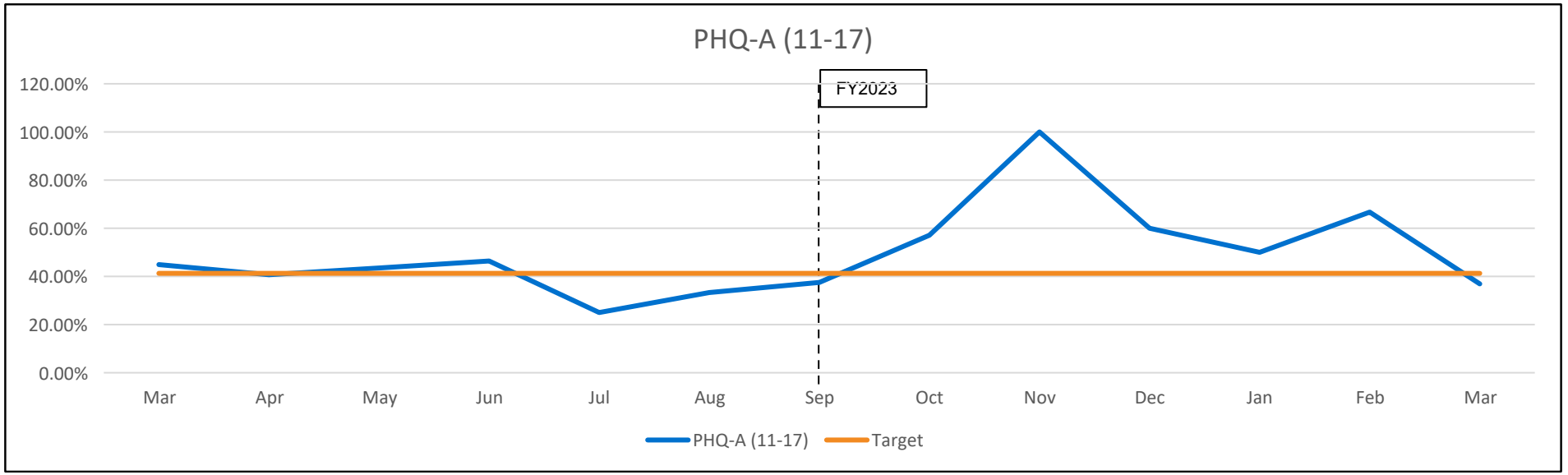
***Of the appointments MADE, 4 appointment types identified for Harris Center Services***

| Appointment Type | Count |
|---|---|
| Office Visit | 303 |
| Patient Outreach | 20 |
| Clinical Case Mgmnt | 33 |
| Nurse Only | 14 |
| ***Total*** | ***370*** |

***Office Visits broken down into 2 categories***

| Types of Office Visits | Count |
|---|---|
| LPHA INTAKE OR ASSESSMENT | 29 |
| **NON** LPHA INTAKE OR ASSESSMENT | 274 |

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | PHQ-A (11-17) | 41.27% | 58.31% | 36.90% | Increase | IOS |

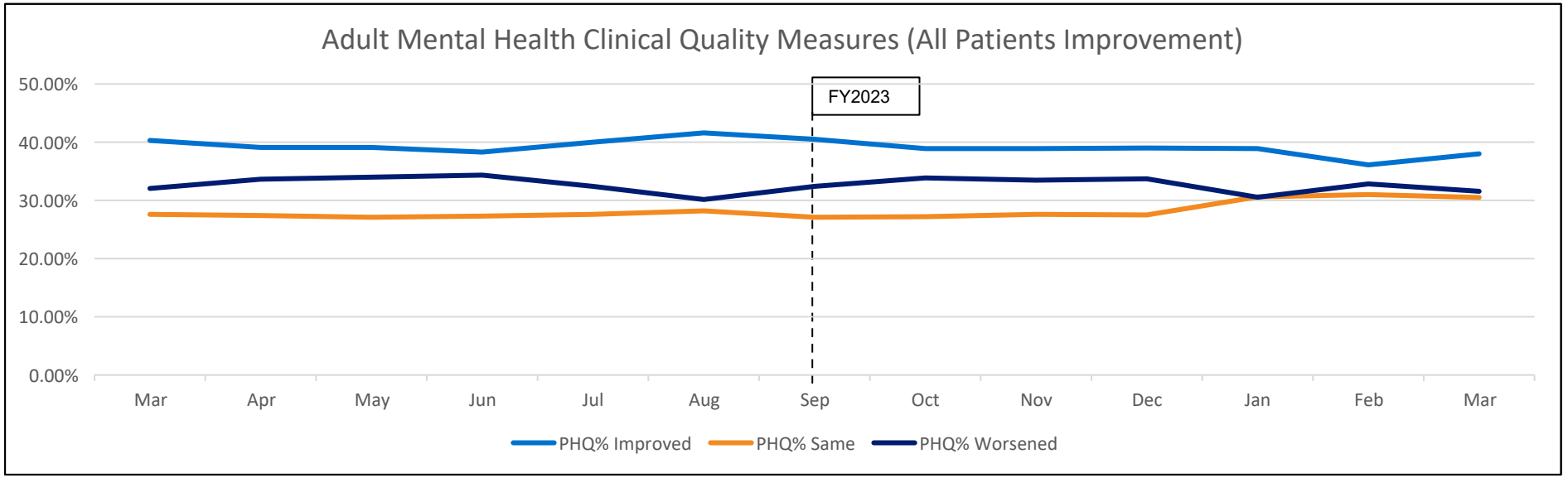



Highlights:

- PHQ (Patient Health Questionnaire) This is a widely used and validated measure of depression.
- PHQ-A measured a 17% decrease in overall adolescent and young adults' depression state this reporting period compared to the previous reporting period in March 2022

*Measure definition: % of new patient child and adolescent clients that have improved depression scores on PHQ. (New Patient = episode begin date w/in 1 year; Must have 14 days between first and last assessments)*

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | PHQ-9 | TBD | 58.31% | 36.90% | Increase | IOS |

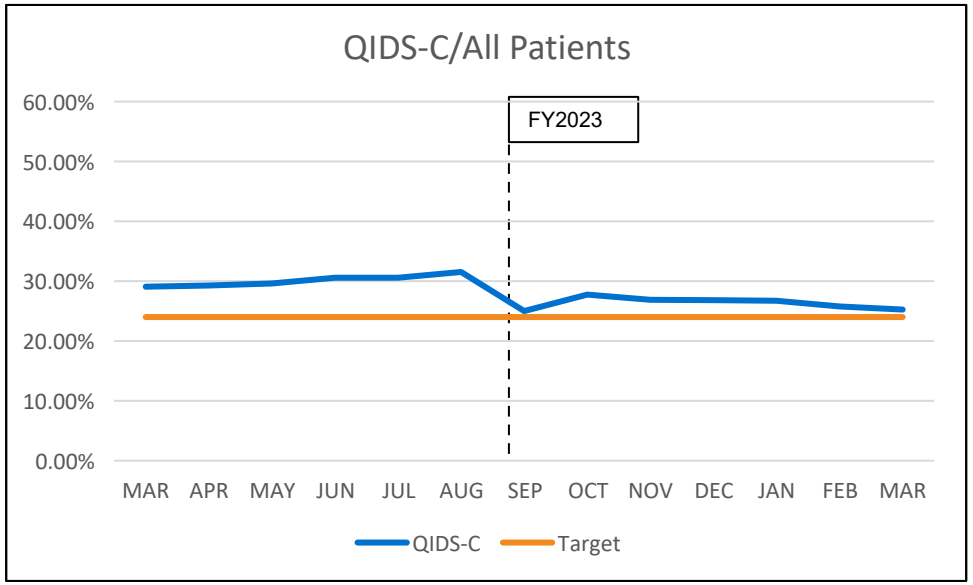


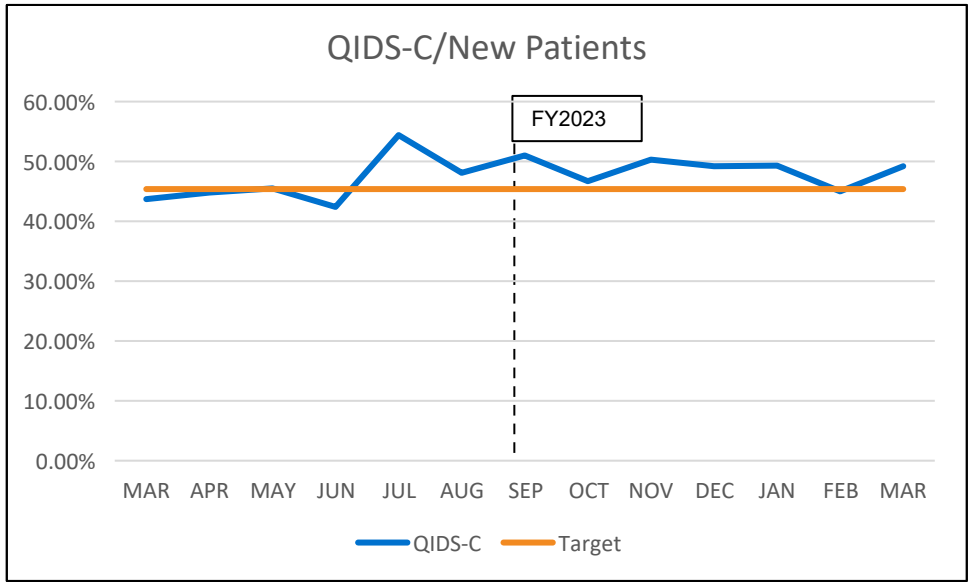

Note:

- PHQ (Patient Health Questionnaire) This is a widely used and validated measure of depression.
- Target determination for this measure is under review

*Measure definition: % of adult patients that have improved/stayed the same/worsened for depression scores on PHQ. (All Patients = Must have 14 days between first and last assessments)*

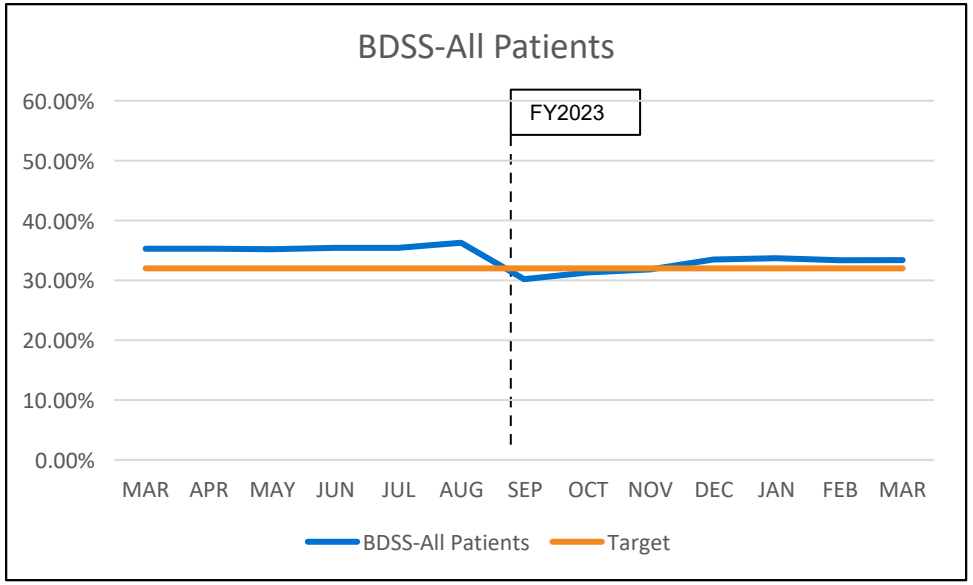
| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | QIDS-C/All Patients | 24% | 26.31% | 25.25% | Increase | IOS |
| | QIDS-C/New Patients | 45% | 48.67% | 49.20% | Increase | IOS |

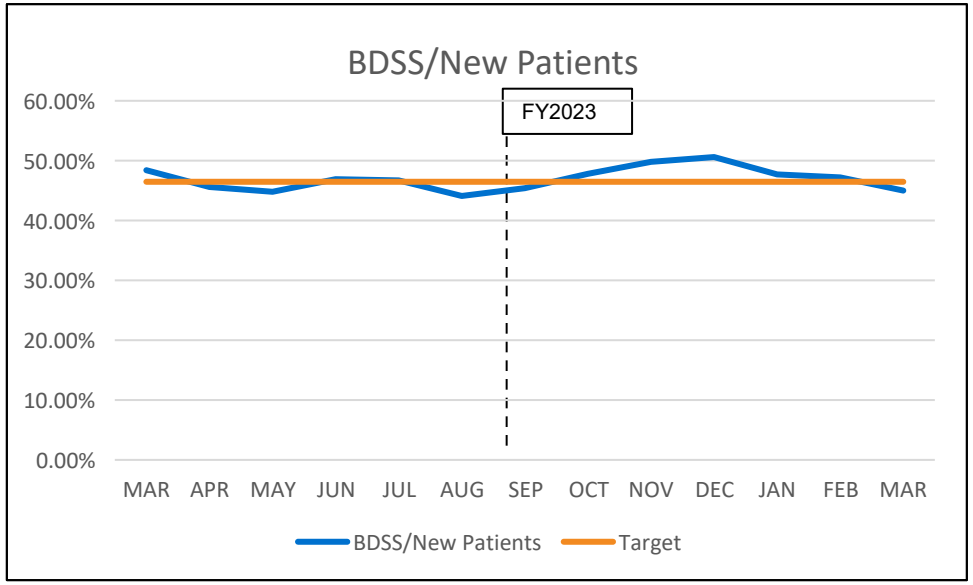



*Measure definition: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the QIDS-C. Clients must have at least 90 days from first assessment to last assessment.*

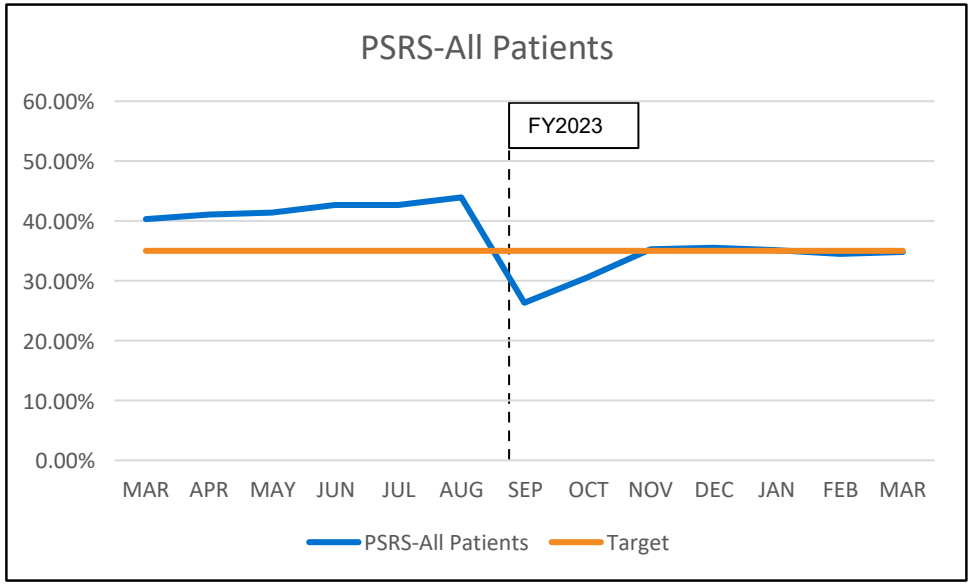
| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | BDSS-All Patients | 32% | 32.46% | 33.38% | Increase | IOS |
| | BDSS-New Patients | 46% | 47.64% | 45.00% | Increase | IOS |

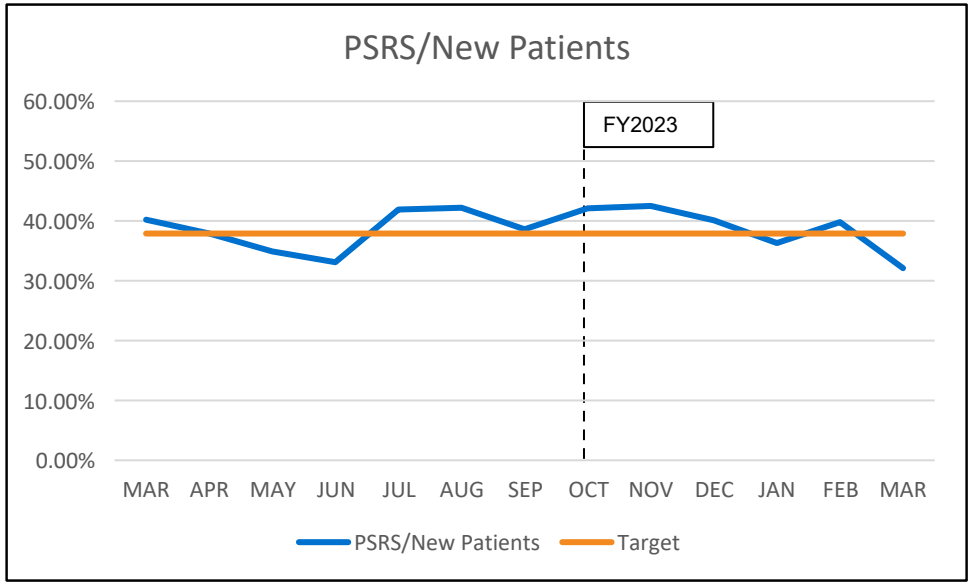



*Measure definition: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the BDSS. Clients must have at least 90 days from first assessment to last assessment*

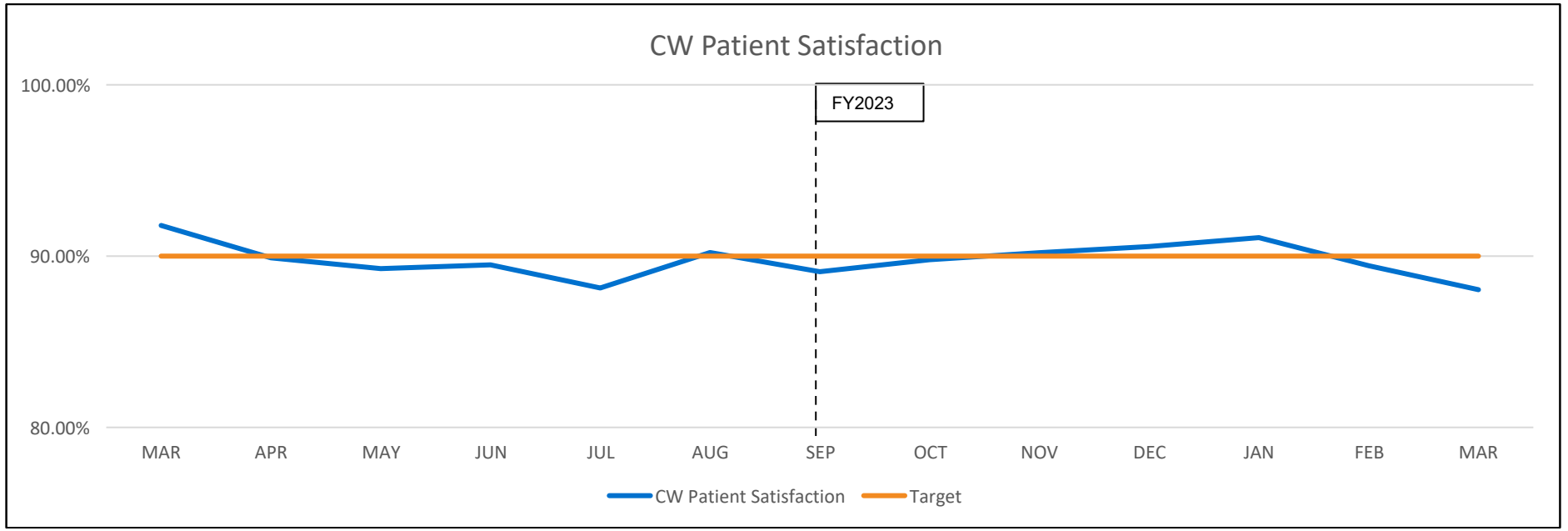
| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Feb) | Reporting Period-February | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | PSRS-All Patients | 35% | 40% | 40% | Increase | IOS |
| | PSRS-New Patients | 53% | 38.90% | 39.80% | Increase | IOS |




*Measure definition: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the PSRS. Clients must have at least 90 days from first assessment to last assessment.*

| Domain | Measures (Definition) | 2023 Fiscal Year Target | 2023Fiscal Year Average (Sep-Mar) | Reporting Period-March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | Patient Satisfaction | 90% | 89.74% | 88.04 | Increase | IOS |




Highlights:

- Center wide patient satisfaction fell below its monthly target. The Clinical Transformation and Quality division is exploring ways to improve response rate and a singular survey tool selection for adoption to meet the needs of the organization. A workgroup is being formed to address of improvement based on patient feedback on perception of care.
- Patient satisfaction survey for **POC-IC increased by 2 percent** (Mar 2022 - 89.25% to Mar 2023 – 90.61%)
- Patient satisfaction survey for Pharmacy **increased by 2 percent** (Mar 2022 – 95.45% to Mar 2023 - 97.58%)

# Appendix

# Children and Adolescent Services Ongoing Interventions

| Date | # of Walk Ins | # Completed | Screened | Exception |
|---|---|---|---|---|
| 3.1.2023 | 17 | 13 | 4 | |
| 3.2.2023 | 17 | 16 | 1 | |
| 3.3.2023 | 10 | 8 | 2 | |
| 3.6.2023 | 19 | 16 | 3 | |
| 3.7.2023 | 14 | 14 | 0 | |
| 3.8.2023 | 5 | 5 | 0 | |
| 3.9.2023 | 11 | 11 | 0 | |
| 3.10.2023 | 7 | 5 | 2 | 2 LPHAs out |
| 3.13.2023 | 13 | 13 | 0 | |
| 3.14.2023 | 13 | 10 | 3 | |
| 3.15.2023 | 10 | 10 | 0 | |
| 3.16.2023 | 17 | 12 | 5 | 1 LPHA out |
| 3.17.2023 | 6 | 3 | 3 | 2 LPHA's out |
| 3.20.2023 | 7 | 7 | 0 | |
| 3.21.2023 | 7 | 7 | 0 | |
| 3.22.2023 | 5 | 5 | 0 | |
| 3.23.2023 | | | | |
| 3.24.2023 | | | | |
| | | | | |
| | **178** | **155** | **23** | |

As per Board request:

- # of Assessment completed indicates LPHA assessment and intake
- # of screened indicates that a brief assessment was completed to ensure patients are safe return for follow up intake. Due to staff shortage or patients who arrive late where the intake was not completed on the same day
- *CAS Leadership team is creatively adjusting resources to meet the goal of 100% assessment for individuals

# Board of Trustee's PI Scorecard

Target Status: Green = Target Met | Red = Target Not Met | Yellow = Data to Follow | No Data Available

| | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY23 AVG | FY23 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | | | | | | | | | | |
| AMH Waitlist (State Defined) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 | 0 | IOS | MH-BO |
| Adult Service Target | 14,230 | 14,066 | 13,592 | 13,414 | 13,794 | 13,676 | 13,931 | | | | | | 13,815 | 13,764 | C | MBOW |
| AMH Actual Service Target % | 103.39% | 102.19% | 98.75% | 97.46% | 100.22% | 99.36% | 101.21% | | | | | | 100.37% | 100.00% | C | MBOW |
| AMH Serv. Provision (Monthly) | 48.00% | 49.20% | 45.90% | 47.10% | 47.90% | 48.70% | 50.90% | | | | | | 48.24% | ≥ 65.60% | C | MBOW |
| CAS Waitlist (State Defined) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 | 0 | IOS | MH-BO |
| CAS Service Target | 3,593 | 3,588 | 3,555 | 3,485 | 3,493 | 3,594 | 3,663 | | | | | | 3,567 | 3,481 | C | MBOW |
| CAS Actual Service Target % | 103.22% | 103.07% | 102.13% | 100.11% | 100.34% | 103.25% | 105.23% | | | | | | 102.48% | 100.00% | C | MBOW |
| CAS Serv. Provision (Monthly) | 76.70% | 76.00% | 74.00% | 72.50% | 76.80% | 75.30% | 75.10% | | | | | | 75.20% | ≥ 65.00% | C | MBOW |
| DID Assessment Waitlist | | | | | | | | | | | | | #DIV/0! | 0 | IOS | IDD-BO |
| IDD Service Target | 824 | 864 | 885 | 830 | 908 | 914 | 924 | | | | | | 878 | 854 | SP | MBOW |
| IDD Actual Service Target % | 96.49% | 101.17% | 103.63% | 97.19% | 106.32% | 104.03% | 108.20% | | | | | | 102.43% | 100.00% | C | MBOW |
| | | | | | | | | | | | | | | | | |
| CW CAS 1st Contact to LPHA | 23.82 | 25.66 | 23.87 | 21.85 | 12.22 | 8.75 | 3.91 | | | | | | 17.15 | <10 Days | NS | Epic |
| CW AMH 1st Contact to LPHA | 2.33 | 2.93 | 2.76 | 3.99 | 3.83 | 3.46 | 3.55 | | | | | | 3.26 | <10 Days | NS | Epic |
| CW CAS/AMH 1st Con. to LPHA | 5.88 | 7.34 | 6.53 | 7.42 | 5.42 | 4.61 | 3.63 | | | | | | 5.83 | <10 Days | NS | Epic |
| | | | | | | | | | | | | | | | | |
| CAS 1st Avail. Med Appt-COC | 6.15 | 8.55 | 7.89 | 8.20 | 8.86 | 6.57 | 24.00 | | | | | | 10.03 | <14 Days | C | Epic |
| CAS 1st Avail. Med Appt-COM | 21.46 | 22.08 | 21.70 | 20.49 | 21.27 | 17.41 | 18.16 | | | | | | 20.37 | <28 Days | NS | Epic |
| CAS # Pts Seen in 30-60 Days | 49 | 45 | 45 | 44 | 47 | 19 | 51 | | | | | | 42.86 | <9.18 | IOS | Epic |
| CAS # Pts Seen in 60+ Days | 26 | 27 | 35 | 27 | 35 | 43 | 22 | | | | | | 30.71 | 0 | IOS | Epic |

| | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY23 AVG | FY23 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AMH 1st Avail. Med Appt-COC | 4.40 | 4.93 | 4.69 | 4.48 | 4.91 | 4.47 | 4.74 | | | | | | 4.66 | <14 Days | C | Epic |
| AMH 1st Avail. Med Appt-COM | 6.95 | 5.48 | 5.52 | 6.89 | 8.77 | 6.88 | 7.50 | | | | | | 6.86 | <28 Days | NS | Epic |
| AMH # Pts Seen in 30-60 Days | 6 | 2 | 2 | 1 | 4 | 5 | 1 | | | | | | 3.00 | <45 | IOS | Epic |
| AMH # Pts Seen in 60+ Days | 2 | 1 | 1 | 0 | 0 | 0 | 0 | | | | | | 0.57 | 0 | IOS | Epic |
| **Access to Care, Crisis Line** | | | | | | | | | | | | | | | | |
| Total Calls Received | 16,427 | 16,509 | 14,853 | 17,512 | 17,926 | 16,965 | 17,374 | | | | | | 16,795 | | | |
| AVG Call Length (Mins) | 8.00 | 8.00 | 8.10 | 8.70 | 8.50 | 8.80 | 9.30 | | | | | | 8.49 | | | |
| Service Level | 86.00% | 91.34% | 91.00% | 90.76% | 92.00% | 88.00% | 89.00% | | | | | | 89.73% | ≥ 95.00% | C | Brightmetrics |
| Abandonment Rate | 8.00% | 5.32% | 6.00% | 5.39% | 4.30% | 6.00% | 5.00% | | | | | | 5.72% | < 8.00% | NS | Brightmetrics |
| Occupancy Rate | 73.00% | 69.00% | 69.00% | 71.00% | 72.00% | 77.00% | 74.00% | | | | | | 72.14% | | | Brightmetrics |
| Crisis Call Follow-Up | 100.00% | 99.79% | 99.76% | 99.77% | 99.77% | 99.76% | 100.00% | | | | | | 99.84% | > 97.36% | IOS | Icarol |
| Access to Crisis Resp. Svc. | 93.50% | 87.10% | 84.00% | 88.80% | 89.80% | 89.80% | 88.50% | | | | | | 88.79% | > 52.00% | C | MBOW |
| **PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours)** | | | | | | | | | | | | | | | | |
| PES Total Visits | 1,194 | 1,192 | 1,160 | 1,173 | 1,266 | 1,126 | 1,126 | | | | | | 1177 | | | |
| PES Admission Volume | 523 | 585 | 560 | 544 | 555 | 498 | 549 | | | | | | 544.86 | | | |
| Mechanical Restraints | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0.00 | | | |
| Mechanical Restraint Rate | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 | ≤ 0.01 | IOS | Epic |
| Personal Restraints | 46 | 40 | 37 | 37 | 43 | 50 | 79 | | | | | | 47.43 | | | Epic |
| Personal Restraint Rate | 2.07 | 1.95 | 1.78 | 1.77 | 1.98 | 2.68 | 3.85 | | | | | | 2.30 | ≤ 2.80 | IOS | Epic |
| Seclusions | 33 | 35 | 19 | 32 | 20 | 39 | 53 | | | | | | 33.00 | | | Epic |
| Seclusion Rate | 1.48 | 1.61 | 0.92 | 1.53 | 0.92 | 2.09 | 2.58 | | | | | | 1.59 | ≤ 2.73 | SP | Epic |
| AVG Minutes in Seclusion | 46.91 | 58.66 | 52.62 | 51.82 | 41.70 | 49.76 | 44.33 | | | | | | 49.40 | ≤ 61.73 | IOS | Epic |
| Emergency Medications | 44 | 54 | 42 | 47 | 58 | 56 | 72 | | | | | | 53.29 | | | Epic |
| EM Rate | 1.98 | 2.48 | 2.02 | 2.25 | 2.67 | 3.01 | 3.50 | | | | | | 2.56 | ≤ 3.91 | IOS | Epic |
| R/S Monitoring/Debriefing | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | | | | | | 100.00% | 100.00% | IOS | Epic |

| | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY23 AVG | FY23 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Satisfaction (Based on the Two Top-Box Scores)** | | | | | | | | | | | | | | | | |
| CW Patient Satisfaction | 89.09% | 89.79% | 90.20% | 90.56% | 91.08% | 89.44% | 88.04% | | | | | | 89.74% | 90.00% | IOS | Feedtrail |
| V-SSS 2 | 88.69% | 89.66% | 90.24% | 90.32% | 90.38% | 89.33% | 87.30% | | | | | | 89.42% | 90.00% | IOS | Feedtrail |
| PoC-IP | 89.71% | 89.30% | 89.25% | 90.14% | 95.15% | 90.74% | 90.61% | | | | | | 90.70% | 90.00% | IOS | McLean |
| Pharmacy | 93.02% | 99.09% | 96.31% | 96.19% | 94.87% | 100.00% | 97.58% | | | | | | 96.72% | 90.00% | IOS | Feedtrail |
| **Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement)** | | | | | | | | | | | | | | | | |
| QIDS-C | 25.00% | 27.75% | 26.88% | 26.82% | 26.72% | 25.77% | 25.25% | | | | | | 26.31% | 24.00% | IOS | MBOW |
| BDSS | 30.19% | 31.31% | 31.83% | 33.48% | 33.70% | 33.36% | 33.38% | | | | | | 32.46% | 32.00% | IOS | MBOW |
| PSRS | 26.32% | 30.56% | 35.26% | 35.51% | 35.11% | 34.49% | 34.81% | | | | | | 33.15% | 35.00% | IOS | MBOW |
| **Adult Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | |
| BASIS-24 (CRU/CSU) | 0.98 | 0.76 | 0.41 | 0.71 | 0.90 | -0.17 | 0.67 | | | | | | 0.61 | 0.68 | IOS | McLean |
| QIDS-C | 51.00% | 46.70% | 50.30% | 49.20% | 49.30% | 45.00% | 49.20% | | | | | | 48.67% | 45.38% | IOS | Epic |
| BDSS | 45.40% | 47.80% | 49.80% | 50.60% | 47.70% | 47.20% | 45.00% | | | | | | 47.64% | 46.47% | IOS | Epic |
| PSRS | 38.60% | 42.10% | 42.50% | 40.10% | 36.30% | 39.80% | 32.10% | | | | | | 38.79% | 37.89% | IOS | Epic |
| **Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | |
| PHQ-A (11-17) | 37.50% | 57.10% | 100.00% | 60.00% | 50.00% | 66.70% | 36.90% | | | | | | 58.31% | 41.27% | IOS | Epic |
| DSM-5 L1 CC Measure (6-17) | 47.30% | 49.40% | 49.60% | 52.30% | 43.00% | | | | | | | | 48.32% | 50.90% | IOS | Epic |
| **Adult and Child/Adolescent Needs and Strengths Measures** | | | | | | | | | | | | | | | | |
| ANSA (Adult) | 42.32% | 35.32% | 36.36% | 38.40% | 38.27% | 37.70% | 38.40% | | | | | | 38.11% | 20.00% | C | MBOW |
| CANS (Child/Adolescent) | 43.14% | 21.65% | 18.14% | 19.80% | 21.31% | 25.30% | 27.30% | | | | | | 25.23% | 25.00% | C | MBOW |
| **Adult and Child/Adolescent Functioning Measures** | | | | | | | | | | | | | | | | |
| DLA-20 (AMH and CAS) | 48.00% | 44.10% | 45.10% | 45.70% | 40.90% | 47.80% | 44.60% | | | | | | 45.17% | 48.07% | IOS | Epic |

| **Adult Mental Health Clinical Quality Measures (All Patients Improvement)** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| PHQ% Imp | 40.30% | 39.10% | 39.10% | 38.30% | 40.00% | 41.60% | 40.50% | 38.90% | 38.90% | 39.00% | 38.90% | 36.10% | 38.00% |
| PHQ% Sam | 27.60% | 27.40% | 27.10% | 27.30% | 27.60% | 28.20% | 27.10% | 27.20% | 27.60% | 27.50% | 30.60% | 31.00% | 30.50% |
| PHQ% Wor | 32.05% | 33.64% | 33.99% | 34.34% | 32.41% | 30.15% | 32.41% | 33.86% | 33.47% | 33.71% | 30.54% | 32.83% | 31.56% |

# Board of Trustee's PI Scorecard FY 2022

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Target Status: Green = Target Met | Red = Target Not Met | Yellow = Data to Follow | No Data Available

| | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY22 AVG | FY22 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | | | | | | | | | | |
| AMH Waitlist (State Defined) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | IOS | MH-BO |
| Adult Service Target | 12,487 | 12,503 | 13,085 | 13,162 | 13,288 | 13,574 | 14,095 | 14,169 | 14,318 | 14,313 | 14,514 | 14,275 | 13,649 | 13,764 | C | MBOW |
| AMH Actual Service Target % | 90.72% | 90.84% | 95.07% | 95.63% | 96.54% | 98.62% | 102.39% | 102.94% | 104.02% | 103.99% | 105.50% | 103.71% | 99.16% | 100.00% | C | MBOW |
| AMH Serv. Provision (Monthly) | 45.90% | 44.20% | 44.60% | 43.60% | 44.80% | 46.50% | 49.90% | 45.70% | 47.30% | 47.50% | 41.20% | 44.90% | 45.51% | ≥ 65.60% | C | MBOW |
| CAS Waitlist (State Defined) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | IOS | MH-BO |
| CAS Service Target | 3,374 | 3,377 | 3,366 | 3,413 | 3,432 | 3,492 | 3,617 | 3,619 | 3,708 | 3,685 | 3,622 | 3,540 | 3,520 | 3,481 | C | MBOW |
| CAS Actual Service Target % | 96.93% | 97.01% | 96.70% | 98.05% | 98.59% | 100.32% | 103.91% | 103.96% | 106.52% | 105.86% | 104.05% | 101.69% | 101.13% | 100.00% | C | MBOW |
| CAS Serv. Provision (Monthly) | 74.00% | 74.20% | 76.20% | 69.80% | 70.40% | 75.50% | 77.90% | 74.10% | 72.70% | 72.20% | 66.60% | 64.70% | 72.36% | ≥ 65.00% | C | MBOW |
| DID Assessment Waitlist | | | | | | | | | | 5,831 | | | 5,831 | 0 | IOS | IDD-BO |
| IDD Service Target | 757 | 822 | 768 | 790 | 768 | 776 | 817 | 818 | 831 | 819 | 833 | 842 | 803 | 854 | SP | MBOW |
| IDD Actual Service Target % | 88.64% | 96.25% | 89.93% | 92.51% | 89.93% | 90.87% | 95.67% | 95.78% | 97.31% | 95.90% | 97.54% | 98.59% | 94.08% | 100.00% | C | MBOW |
| | | | | | | | | | | | | | | | | |
| CW CAS 1st Contact to LPHA | 3.10 | 4.41 | 7.74 | 12.30 | 12.15 | 9.50 | 13.73 | 18.27 | 21.51 | 21.51 | 31.54 | 28.66 | 15.37 | <10 Days | NS | Epic |
| CW AMH 1st Contact to LPHA | 0.98 | 1.10 | 1.10 | 1.21 | 2.43 | 1.83 | 1.87 | 1.86 | 1.96 | 2.23 | 2.40 | 1.93 | 1.74 | <10 Days | NS | Epic |
| CW CAS/AMH 1st Con. to LPHA | 1.34 | 1.67 | 2.39 | 3.40 | 4.80 | 3.40 | 3.96 | 4.97 | 5.55 | 5.78 | 6.46 | 5.86 | 4.13 | <10 Days | NS | Epic |
| | | | | | | | | | | | | | | | | |
| CAS 1st Avail. Med Appt-COC | 4.89 | 11.89 | 7.59 | 4.43 | 6.7 | 5.6 | 9.11 | 11 | 7.9 | 8.23 | 7.11 | 7.56 | 7.67 | <14 Days | C | Epic |
| CAS 1st Avail. Med Appt-COM | 17.34 | 18.32 | 22.53 | 23.15 | 24.91 | 24.88 | 23.61 | 23.38 | 18.91 | 22.94 | 21.75 | 25.68 | 22.28 | <28 Days | NS | Epic |
| CAS # Pts Seen in 30-60 Days | 21 | 32 | 50 | 33 | 45 | 48 | 76 | 67 | 42 | 33 | 24 | 39 | 42.50 | <9.18 | IOS | Epic |
| CAS # Pts Seen in 60+ Days | 18 | 18 | 26 | 26 | 38 | 56 | 40 | 47 | 39 | 32 | 25 | 42 | 33.92 | 0 | IOS | Epic |

| | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY22 AVG | FY22 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AMH 1st Avail. Med Appt-COC | 5.73 | 5.45 | 5.68 | 6.89 | 6.81 | 5.00 | 4.14 | 4.19 | 3.66 | 4.38 | 4.26 | 4.47 | 5.06 | <14 Days | C | Epic |
| AMH 1st Avail. Med Appt-COM | 16.09 | 12.70 | 11.20 | 13.93 | 12.43 | 9.07 | 8.33 | 8.49 | 7.68 | 7.07 | 7.34 | 6.27 | 10.05 | <28 Days | NS | Epic |
| AMH # Pts Seen in 30-60 Days | 32 | 22 | 20 | 85 | 76 | 19 | 5 | 6 | 3 | 3 | 1 | 2 | 22.83 | <45 | IOS | Epic |
| AMH # Pts Seen in 60+ Days | 82 | 70 | 65 | 37 | 1 | 3 | 2 | 0 | 1 | 0 | 3 | 0 | 22.00 | 0 | IOS | Epic |
| **Access to Care, Crisis Line** | | | | | | | | | | | | | | | | |
| Total Calls Received | 18,272 | 18,220 | 15,610 | 16,557 | 16,528 | 15,753 | 18,163 | 18,471 | 20,451 | 17,538 | 17,477 | 16,903 | 17,495 | | | |
| AVG Call Length (Mins) | 7.70 | 7.60 | 8.30 | 8.20 | 8.00 | 7.50 | 8.00 | 8.30 | 8.20 | 8.50 | 8.20 | 8.10 | 8.05 | | | |
| Service Level | 83.00% | 82.13% | 89.00% | 86.58% | 84.43% | 83.77% | 80.00% | 77.00% | 78.00% | 83.00% | 85.84% | 87.00% | 83.31% | ≥ 95.00% | C | Brightmetrics |
| Abandonment Rate | 12.00% | 10.73% | 7.46% | 7.59% | 9.02% | 9.01% | 13.00% | 15.00% | 16.00% | 12.00% | 9.25% | 9.00% | 10.84% | < 8.00% | NS | Brightmetrics |
| Occupancy Rate | 74.00% | 74.00% | 65.00% | 51.24% | 72.00% | 74.00% | 74.00% | 75.00% | 74.00% | 74.00% | 74.00% | 72.00% | 71.10% | | | Brightmetrics |
| Crisis Call Follow-Up | 98.91% | 99.26% | 98.57% | 97.58% | 99.72% | 98.91% | 98.97% | 99.75% | 99.32% | 99.75% | 100.00% | 100.00% | 99.23% | > 97.36% | IOS | Icarol |
| Access to Crisis Resp. Svc. | 77.60% | 81.00% | 86.40% | 86.40% | 87.60% | 86.40% | 87.60% | 88.20% | 87.30% | 85.50% | 93.00% | 89.50% | 86.38% | > 52.00% | C | MBOW |
| **PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours)** | | | | | | | | | | | | | | | | |
| PES Total Visits | 1,116 | 1,127 | 1,014 | 831 | 1,043 | 1,007 | 1,043 | 964 | 1,051 | 1,146 | 1,058 | 1,163 | 1047 | | | |
| PES Admission Volume | 656 | 702 | 637 | 527 | 501 | 490 | 506 | 471 | 565 | 581 | 504 | 562 | 558.50 | | | |
| Mechanical Restraints | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0.17 | | | |
| Mechanical Restraint Rate | 0.00 | 0.00 | 0.05 | 0.00 | 0.00 | 0.00 | 0.05 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.01 | ≤ 0.01 | IOS | Epic |
| Personal Restraints | 70 | 43 | 52 | 59 | 54 | 36 | 35 | 55 | 33 | 33 | 41 | 42 | 46.08 | | | Epic |
| Personal Restraint Rate | 2.75 | 1.72 | 2.38 | 3.09 | 3.03 | 1.95 | 1.58 | 2.64 | 1.55 | 1.75 | 1.85 | 1.99 | 2.19 | ≤ 2.80 | IOS | Epic |
| Seclusions | 40 | 45 | 48 | 54 | 46 | 30 | 34 | 45 | 33 | 34 | 29 | 41 | 39.92 | | | Epic |
| AVG Minutes in Seclusion | 46.50 | 77.29 | 49.07 | 59.15 | 45.37 | 48.1 | 37.44 | 48.44 | 44.45 | 60.15 | 45.66 | 56.9 | 51.54 | ≤ 61.73 | SP | Epic |
| Seclusion Rate | 1.57 | 1.81 | 2.19 | 3.03 | 2.58 | 1.62 | 1.54 | 2.16 | 1.55 | 1.80 | 1.31 | 1.79 | 1.91 | ≤ 2.73 | IOS | Epic |
| Emergency Medications | 65 | 58 | 60 | 58 | 65 | 50 | 48 | 69 | 52 | 44 | 38 | 44 | 54.25 | | | Epic |
| EM Rate | 2.55 | 2.33 | 2.74 | 2.99 | 3.64 | 2.70 | 2.17 | 3.31 | 2.45 | 2.33 | 1.71 | 2.08 | 2.58 | ≤ 3.91 | IOS | Epic |
| R/S Monitoring/Debriefing | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | IOS | Epic |

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| | SEP | OCT | NOV | DEC | JAN | JAN | MAR | APR | MAY | JUN | JUL | AUG | FY22 AVG | FY22 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Satisfaction (Based on the Two Top-Box Scores)** | | | | | | | | | | | | | | | | |
| CW Patient Satisfaction | 90.54% | 89.77% | 92.27% | 92.17% | 92.71% | 92.01% | 91.79% | 89.90% | 89.27% | 89.49% | 88.14% | 90.21% | 90.69% | 89.00% | IOS | Feedtrail |
| CPOSS | 94.11% | 92.24% | 90.11% | 94.75% | 93.64% | 94.75% | 91.96% | 89.58% | 84.30% | 89.60% | 95.54% | 93.46% | 92.00% | 89.00% | IOS | Feedtrail |
| V-SSS 2 | 89.37% | 88.92% | 93.10% | 92.69% | 93.88% | 92.55% | 93.17% | 90.25% | 89.58% | 87.93% | 88.00% | 89.52% | 90.75% | 89.00% | IOS | Feedtrail |
| PoC-IP | 92.00% | 87.31% | 91.30% | 90.04% | 90.57% | 90.57% | 89.25% | 89.90% | 91.58% | 90.46% | 76.73% | 91.33% | 89.25% | 89.00% | IOS | McLean |
| Pharmacy | 91.32% | 98.67% | 97.40% | 95.28% | 100.00% | 100.00% | 95.45% | 87.23% | 95.38% | 96.68% | 94.01% | 94.96% | 95.53% | 89.00% | IOS | Feedtrail |
| **Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement)** | | | | | | | | | | | | | | | | |
| QIDS-C | 29.60% | 26.11% | 29.80% | 30.72% | 30.79% | 30.01% | 29.07% | 29.27% | 29.61% | 30.57% | 30.57% | 31.53% | 29.80% | 24.00% | IOS | MBOW |
| BDSS | 31.68% | 38.57% | 34.24% | 36.25% | 36.64% | 35.50% | 35.28% | 35.29% | 35.20% | 35.43% | 35.43% | 36.28% | 35.48% | 32.00% | IOS | MBOW |
| PSRS | 36.74% | 36.89% | 40.68% | 40.00% | 40.33% | 40.93% | 40.30% | 41.06% | 41.39% | 42.66% | 42.66% | 43.93% | 40.63% | 35.00% | IOS | MBOW |
| **Adult Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | |
| BASIS-24 (CRU/CSU) | | 0.38 | 0.84 | 0.29 | 0.79 | 0.64 | 0.73 | 0.76 | 0.82 | 0.70 | 0.82 | 0.70 | 0.68 | 0.56 | IOS | McLean |
| QIDS-C | 51.00% | 48.20% | 41.90% | 43.80% | 43.90% | 36.90% | 43.70% | 44.80% | 45.50% | 42.40% | 54.40% | 48.10% | 45.38% | 67.12% | IOS | Epic |
| BDSS | 33.30% | 50.90% | 49.50% | 50.40% | 50.50% | 46.50% | 48.40% | 45.60% | 44.80% | 46.90% | 46.70% | 44.10% | 46.47% | 47.02% | IOS | Epic |
| PSRS | 42.40% | 42.50% | 31.90% | 37.60% | 32.40% | 37.70% | 40.20% | 37.90% | 34.90% | 33.10% | 41.90% | 42.20% | 37.89% | 52.75% | IOS | Epic |
| **Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | |
| PHQ-A (11-17) | 46.70% | 43.00% | 43.00% | 45.00% | 45.50% | 38.20% | 44.90% | 40.70% | 43.50% | 46.40% | 25.00% | 33.30% | 41.27% | 57.16% | IOS | Epic |
| DSM-5 L1 CC Measure (6-17) | 48.30% | 49.70% | 47.60% | 54.10% | 48.70% | 50.30% | 51.60% | 48.40% | 52.50% | 51.80% | 53.60% | 54.20% | 50.90% | 62.70% | IOS | Epic |
| **Adult and Child/Adolescent Needs and Strengths Measures** | | | | | | | | | | | | | | | | |
| ANSA (Adult) | 43.63% | 37.88% | 38.56% | 37.54% | 36.50% | 36.97% | 36.95% | 37.94% | 39.03% | 40.17% | 41.20% | 42.25% | 39.05% | 20.00% | C | MBOW |
| CANS (Child/Adolescent) | 36.05% | 18.80% | 20.35% | 20.98% | 23.83% | 27.80% | 31.35% | 34.50% | 36.65% | 39.24% | 40.67% | 42.82% | 31.09% | 25.00% | C | MBOW |
| **Adult and Child/Adolescent Functioning Measures** | | | | | | | | | | | | | | | | |
| DLA-20 (AMH and CAS) | 45.30% | 50.50% | 48.70% | 45.30% | 50.30% | 43.00% | 50.40% | 48.40% | 49.30% | 47.20% | 47.50% | 50.90% | 48.07% | 47.40% | IOS | Epic |

# Board of Trustee's PI Scorecard Data Key

| Access to Care - Strategic Plan Goal #2: To Improve Access to Care | |
|---|---|
| AMH Waitlist | # of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state. |
| Adult Service Target (13,764) | # of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party. |
| AMH Actual Service Target % | % of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party. |
| AMH Serv. Provision (Monthly) | % of adult patients authorized in a FLOC who received at least 1 face to face or televideo encounter in that month. (Exclusions: Individuals in LOC-1M; Individuals recommended and/or authorized for LOC-1S; Non-Face to Face, GJ modifers, and telephone contact encounters; partially authorized months and their associated hours) |
| CAS Waitlist | # of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state. |
| CAS Service Target (3,481) | # of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party. |
| CAS Actual Service Target % | % of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party. |
| CAS Serv. Provision (Monthly) | % of children and youth patients authorized in a FLOC who received at least 1 face to face or televideo encounter in that month. (Exclusions: Non-Face to Face, GJ modifers, and telephone contact encounters; partially authorized months and their associated hours; Client months with a change in LOC-A; childern and adolescents on extended review) |
| DID Assessment Waitlist | # of people who have been referred to the LIDDA for a Determination of Intellectual Disability but have not been contacted within thirty days of the date of the LIDDA received the referral. |
| IDD Service Target (854) | # of ID Target served based on all reported encounter data. (includes encounters that are associated with CARE assignment codes when the service is performed outside of a waiver. Exceptions are for service coordination that is only included for the indigent population and R019 which is included regardless of waiver status.) |
| IDD Actual Service Target % | % of ID Target number served to state target. |
| | |
| CW CAS 1st Contact to LPHA | Children and Youth - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date |
| CW AMH 1st Contact to LPHA | Adult Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date |
| CW CAS/AMH 1st Con. to LPHA | ALL - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date |
| | |
| CAS 1st Avail. Med Appt-COC | Children and Youth - Time between MD Intake Assessment (COC) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date |
| CAS 1st Avail. Med Appt-COM | Children and Youth - Time between MD Intake Assessment (COM) Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date |
| CAS # Pts Seen in 30-60 Days | Children and Youth - # of adolescent patients who completed their MD Intake Assessment Appt Between 30 - 60 days from Appt Creation Date |
| CAS # Pts Seen in 60+ Days | Children and Youth - # of adolescent patients who completed their MD Intake Assessment Appt at 60+ days from Appt Creation Date |
| | |
| AMH 1st Avail. Med Appt-COC | Adult - Time between MD Intake Assessment (COC) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date |
| AMH 1st Avail. Med Appt-COM | Adult - Time between MD Intake Assessment (COM) Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date |
| AMH # Pts Seen in 30-60 Days | Adult - # of adult patients who completed their MD Intake Assessment Appt Between 30 - 60 days from Appt Creation Date |
| AMH # Pts Seen in 60+ Days | Adult - # of adult patients who completed their MD Intake Assessment Appt at 60+ days from Appt Creation Date |
| Access to Care, Crisis Line - Strategic Plan Goal #2: To Improve Access to Care | |

| | |
|---|---|
| **Total Calls Received** | # of Crisis Line calls answered (All partnerships and Lifeline Calls) |
| **AVG Call Length (Mins)** | Monthly Average call length in minutes of Crisis Line calls (All partnerships and Lifeline Calls) |
| **Service Level** | % of Crisis Line calls answered in 30 seconds (All partnerships and Lifeline Calls) |
| **Abandonment Rate** | % of unanswered Crisis Line calls which hung up after 10 seconds (All partnerships and Lifeline Calls) |
| **Occupancy Rate** | % of time Crisis Line staff are occupied with a call (includes: active calls, documentation, making referrals, and crisis call follow-ups) |
| **Crisis Call Follow-Up** | % of follow-up calls that are made within 8 hours to people who were in crisis at time of call |
| **Access to Crisis Resp. Svc.** | % percentage of crisis hotline calls that resulted in face to face encounter within 1 day |
| **PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours) - Strategic Plan Goal #4: To Continuously Improve Quality of Care** | |
| **PES Total Visits** | # of patients interacting with PES services (Includes: intake assessment regardless of admission, triage out, and observation status, PES Clinic) |
| **PES Admission Volume** | # of people admitted to PES ((South, North, or CAPES units). Excludes 23/24 hr observation orders or those patients that have been triaged out) |
| **Mechanical Restraints** | # of restraints where a mechanical device is used |
| **Mechanical Restraint Rate** | # of mechanical restraints/1000 bed hours |
| **Personal Restraints** | # of personal restraints |
| **Personal Restraint Rate** | # of personal restraints/1000 bed hours |
| **Seclusions** | # of seclusions |
| **AVG Minutes in Seclusion** | The average number of minutes spent in seclusion |
| **Seclusion Rate** | # of seclusions/1000 bed hours |
| **Emergency Medications** | # of EM |
| **EM Rate** | # of EM/1000 bed hours |
| **R/S Documentation Monitoring** | % of R/S event documentation which containts all required information in accordance with TAC compliance |
| **Patient Satisfaction (Based on the Two Top-Box Scores) - Strategic Plan Goal #6: Organization of Choice** | |
| **CW Patient Satisfaction** | % of 2 top box scores (2top box answers on form/total answers given on forms)(average of all sat forms together) |
| **Adult Outpatient** | % of 2 top box scores on CPOSS (2top box answers on form/total answers given on forms)(In Clinic Visits - AMH clinics and some CPEP) |
| **Youth Outpatient** | % of 2 top box scores on PSS (2top box answers on form/total answers given on forms)(In Clinic Visits - Youth and Adolescent clinics) |
| **V-SSS 2** | % of 2 top box scores on VSSS2 (2top box answers on form/total answers given on forms)(All Divisions) |
| **PoC-IP** | % of 2 top box scores on PoC-IP (2top box answers on form/total answers given on forms)(CPEP and DDRP) |
| **Pharmacy** | % of 2 top box scores on VSSS2 (2top box answers on form/total answers given on forms)(all pharmacies) |

| | |
|---|---|
| **Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement) - Strategic Plan Goal #4: To Continuously Improve Quality of Care** | |
| **QIDS-C** | % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the QIDS-C. Clients must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease) |
| **BDSS** | % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the BDSS. Clients must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease) |
| **PSRS** | % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the PSRS. Clients must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease) |
| **Adult Mental Health Clinical Quality Measures (New Patient Improvement) - Strategic Plan Goal #4: To Continuously Improve Quality of Care** | |
| **BASIS-24 (CRU/CSU)** | Average of all patient first scores minus last scores (provided at intake and discharge) |

| | |
|---|---|
| **QIDS-C** | % of all new patient adult clients that have improved psychiatric symptomatology as measured by the QIDS-C. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments) |
| **BDSS** | % of all new patient adult clients that have improved psychiatric symptomatology as measured by the BDSS. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments) |
| **PSRS** | % of all new patient adult clients that have improved psychiatric symptomatology as measured by the PSRS. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments) |
| **Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement) - Strategic Plan Goal #4: To Continuously Improve Quality of Care** | |
| **PHQ-A (11-17)** | % of new patient child and adolescent clients that have improved depression scores on PHQ. (New Patient = episode begin date w/in 1 year; Must have 14 days between first and last assessments) |
| **DSM-5 L1 CC Measure (6-17)** | % of new patient child and adolescent clients that have improved symptomoloy as measured by the DSM-5 Cross Cutting tool. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments) |
| **Adult and Child/Adolescent Needs and Strengths Measures - Strategic Plan Goal #4: To Continuously Improve Quality of Care** | |
| **ANSA (Adult)** | % of adult clients authorized in a FLOC that show reliable improvement in at least one of the following ANSA domains/modules: Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Strengths, Adjustment to Trauma, Substance Use (Assessments at least 90 days apart) |
| **CANS (Child/Adolescent)** | % of child and adolescent THC clients authorized in a FLOC that show reliable improvement in at least one following domains: Child Risk Behaviors, Behavioral and Emotional Needs, Life Domain Functioning, Child Strengths, Adjustment to Trauma, and/or Substance Abuse. (Assessments at least 75 days apart) |
| **Adult and Child/Adolescent Functioning Measures - Strategic Plan Goal #4: To Continuously Improve Quality of Care** | |
| **DLA-20 (AMH and CAS)** | % of all THC clients that have improved daily living functionality as measured by the DLA-20 (Must have 30 days between first and last assessments) |

# Thank you.

# EXHIBIT Q-3

**IDD Diamond Awards**
Autism Awareness and Acceptance Month

The HARRIS CENTER for Mental Health and IDD
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# IDD ACCESS-TO-CARE UPDATE

Dr. Evanthe Collins, VP IDD Services Division | May 2023

# GR ACCESS TO CARE

Call > Appointment
1-2 weeks crisis
30-90 days non-crisis

→ DID Appointment
3.5-5.5 hours no documents
2-3.5 w documents

→ Report Writing
23.3 days

→ Referral > SC
3-5 days

→ SC assigned
6 months

→ SC > Family Contact
24hrs crisis
3 days non-crisis

→ Discovery > GR referral
14 days

## STEP 1 ELIGIBILITY

DID
Report Writing
Financials
Service Assessment

**Number waiting to receive a DID assessment***

| | July | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|---|---|---|
| Beginning of month* | 5,831 | 5,775 | 5,710 | 5,602 | 5,621 | 5,547 | 5,486 | 5,287 |
| Added | - | 37 | 22 | 34 | 30 | 59 | 42 | 14 |
| Removed | - | 102 | 130 | 15 | 104 | 120 | 241 | 995 |
| **TOTAL WAITING** | **5,831** | **5,710** | **5,602** | **5,621** | **5,547** | **5,486** | **5,287** | **4,306** |

1. Average wait time from call to appointment for a crisis is 1-2 weeks, non-crisis is 30-90 days. **
2. Average time for DID appointment: Assessment no documentation 2-4 hours, Assessment w/ documentation 30 minutes – 1 hour; Financial Assessment: 30 minutes; SC Assessment (explanation of available services) – 1 hour.***
3. Average number of days to complete DID report is 23.3 days (based on 6 months of data in FY23).
4. Post report, average time to complete referral to service coordination is 3-5 days.

***contains invalid data (as of 4/10/23)**
**** Average based on previous workflow**

## STEP 2 SERVICE COORDINATION

Discovery
Person-Directed Plan
Monitoring

**Number waiting to receive a GR Service Coordinator***

| | |
|---|---|
| **Dec** | 118 |
| **Jan** | 84 |
| **Feb** | 52 |
| **Mar** | 44 |
| **Apr** | 69 |

1. Average wait time to be assigned a service coordinator is 6 months.
2. Once assigned, average wait time for service coordinator to make contact is 24 hours for crisis case and 3 days for non-crisis.
3. Home visit/discovery is dependent on family availability.
4. Post home visit/discovery, average time to complete person directed plan and send referral to GR Services is 14 days (reviewed by supervisor prior to approval).

***data has been validated and is post DID (as of 4/10/23)**

## STEP 3 GR SERVICES

HHSC Contracted Services
Internal/External Providers
Community Linkages

**Number waiting to access an authorized GR service***

| | Dec | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|
| In-home respite (Contract) *Avg. wait time: ~1 month* | 9 | 9 | 23 | 13 | 23 |
| Out-of-home respite (Contract) *Avg. wait time: ~1 month* | 0 | 0 | 0 | 0 | 0 |
| Day Habilitation (Contract) *Avg, wait time: ~1 month* | 2 | 2 | 15 | 15 | 16 |
| Employment Services (Contract) *Avg. wait time: ~1 month* | 0 | 0 | 2 | 9 | 14 |
| Feeding Clinic (Internal) *Avg. wait time: ~1 month* | 24 | 1 | 0 | 0 | 0 |
| Outpatient Biopsychosocial Services (OBI) (Internal) *Avg. wait time: 10 months* | 99 | 176 | 181 | 143 | 120 |
| The Coffeehouse (Internal) *Avg. wait time: 9 months* | Not Reported | 8 | 13 | 24 | 27 |
| **TOTAL WAITING** | **134** | **196** | **234** | **204** | **200** |

***data has been validated and is post DID (as of 4/10/23)**

# Waitlist Clean-Up Project

| GR Clean-Up Project Number of Monthly Calls | |
|---|---|
| January 2023 | 703 |
| February 2023 | 2,602 |
| March 2023 | 979 |
| April 2023 | *507 |
| **Total** | **4,791** **(82.2% of original July number 5,831)** |

10+ year wait ~ 85% no engagement
<10 year wait ~ 40% no engagement

**April data as of 5/1/23*

Cases are allowed 30 days for a disposition. If no engagement, case is closed and removed from list.

Closed cases will immediately be re-opened if requested by individual/family.

# DIDs Completed

| | Number of DIDs Completed |
|---|---|
| SEPT | 135 |
| OCT | 145 |
| NOV | 157 |
| DEC | 89 |
| JAN | 111 (18 external contracts) |
| FEB | 118 (8 external contracts) |
| MAR | 128 (13 external contracts) |
| APR | *90 (12 external contracts) |
| FY23 Total | **973** |

**April data as of 5/1/23*

**April Breakdown:**
62 Full - 33 Updates - 33 Endorsements

**YTD Breakdown:**
506 Full - 261 Updates - 206 Endorsements

# DID Report Completion Timeframe

| | AVG Completion Time (CALENDAR DAYS) |
|---|---|
| SEPT | 21 |
| OCT | 24 |
| NOV | 28 |
| DEC | 28 |
| JAN | 21 |
| FEB | 25 |
| MAR | 16 |
| APR | *9 |
| AVG (excluding April) | **23.3 days** |

**April data as of 5/1/23*

Report writing target is 20 days post assessment.
Reports are written for full DIDs only.

# NEXT STEPS TO IMPROVE IDD ACCESS TO CARE

- Weekend DID Clinic
  Virtual Eligibility Visits
- Procedures to prevent perpetual waitlist clean-up
- Intake Packet 2.0
- Restructure Waitlist

# EXHIBIT Q-4

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# Nursing Peer Review

## Updates

Presented By: Kia Walker RN, MSN and Vanessa Miller, RN MSHEd.

# What is a Nursing Peer Review

- The process of nursing peer review involves the evaluation of nursing services, nurse qualifications, and the quality of patient care provided by nurses. It also includes the evaluation of complaints concerning nurses and nursing care, and the resulting determinations or recommendations regarding complaints.
- The goal of peer review is to promote a collaborative and supportive environment for nurses, and it is not intended to be punitive in nature. The nursing peer review committee was created on October 4, 2017.

# Committee Composition

- Vanessa Miller is the current Chairperson, with Danny Hernandez as Co-Chair.
- The committee appointments are for a term of either one or two years, and individuals may serve up to three consecutive terms. The committee must consist of at least ten members, with a minimum of five present, including the committee chair, to conduct business.
- At least three-fourths of the committee members must be nurses holding either Licensed Vocation Nurse (LVN), Registered Nurse (RN), or Advanced Practice Registered Nurse (APRN) licenses. In the case of peer review of an RN's practice, two-thirds of the committee members must be RNs, and only RNs are eligible to vote.
- Whenever possible, the committee should include at least one nurse who is familiar with the same area of nursing practice as the nurse being reviewed.
- If an APRN is under peer review, the committee should preferably include an APRN member who is licensed in the same role and population focus as the nurse being reviewed.
- Any person(s) with administrative authority for personnel decisions directly relating to the nurse under review is excluded from membership or attendance at the Peer Review Committee hearing. They may only appear as a fact witness

# Two types of Nursing Peer Review

- **Incident-Based Nursing Peer Review (IBNPR).** Focuses on determining if the nurse's action, be it a single event or multiple events, should be reported to the Texas Board of Nursing or if the nurse's conduct does not require reporting because the conduct constitutes a minor incident that can be remediated at the facility level. The review includes whether external factors beyond the nurse's control may have contributed to any deficiency in care by the nurse and to report such findings to a patient safety committee as applicable.
- **Safe Harbor Nursing Peer Review (SHNPR)** A process that protects a nurse from employer retaliation, suspension, termination, discipline, discrimination, and licensure sanction when a nurse makes a good faith request for nursing peer review of an assignment or conduct the nurse is requested to perform that the nurse believes could result in a violation of the Nursing Practice Act (NPA). Safe harbor must be invoked before the nurse engages in the assignment and may be invoked at any time during the work period when the initial assignment changes.

# The role of the Nursing Peer Review Committee

- The committee's primary responsibility is to determine whether the nurse has violated any licensure regulations, and whether it is necessary to report the violations to the Texas Board of Nursing (BON).
- If a report is required, the committee is also responsible for examining whether external factors played a role in the error or incident, and to report the findings to the patient safety committee.
- Employment and licensure issues are separate matters, and the committee does not have the authority to make any disciplinary or employment decisions.
- The employer is responsible for determining appropriate disciplinary actions, and while they may take the committee's findings into account, they are not obligated to do so.
- However, the employer cannot prohibit the nursing peer review committee from filing a report with the BON if the committee has made a good faith determination that the nurse's practice must be reported in compliance with Texas Law.

# Committee Process

- All committee meetings are confidential, and all members are required to sign a Confidentiality Guideline.
- In addition, the committee is responsible for providing written notification of any peer review requests, and the nurse is required to acknowledge receipt of this notification by signing the Peer Review Notice of Receipt Form.
- The nurse under peer review has certain due process rights under Texas Administrative Code §217.19, including the right to representation.

# Nurses Right to Representation:

- The nurse has the right to be accompanied to the hearing by either a nurse peer or an attorney. The nurse is entitled to parity of participation of counsel, which means that their attorney is allowed to participate to the same extent and level as the agency's attorney.
- Both sides must be notified at least seven days in advance if legal counsel will be present during the hearing. The Harris Center Legal Counsel may become involved based on the request of the Peer Review Committee.

# Quarterly Report for Nursing Peer Review

- If an employer terminates a nurse (voluntarily or involuntarily), suspends for 7 or more days, or takes other substantive disciplinary action against a nurse, the employer must report to the Board in writing.

- A copy of the report by the employer must be submitted to the nursing peer review committee and the committee must still meet to determine if external factors beyond the nurse's control impacted the nurse's deficiency in care. If the committee finds external factors the committee is required to also report the issue to the patient safety committee.

# Questions?

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# Thank You