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

**Quality Committee Meeting**
June 20, 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, May 16, 2023
*(EXHIBIT Q-1 )*

IV. **REVIEW AND COMMENT**

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

B. Merit-based Incentive Payment System and Direct Payment Program Update
*(EXHIBIT Q-3 Luming Li/Trudy Leidich)*

C. Quality Annual Review of Accomplishments
*(EXHIBIT Q-4 Trudy Leidich)*

D. IDD Update
*(EXHIBIT Q-5 Evanthe Collins)*

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 R-1

# *The* HARRIS CENTER *for* MENTAL HEALTH and IDD BOARD OF TRUSTEES QUALITY COMMITTEE MEETING TUESDAY, May 16, 2023 MINUTES

Dr. George Santos, Board of Trustees Chair, 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, Mrs. B. Hellums

Committee Member Absent: None

Other Board Member in Attendance: 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 as a voting member 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, April 18, 2023**

   **MOTION BY: GEARING SECOND BY: ZAKARIA**

   **With unanimous affirmative votes,**
   **BE IT RESOLVED** that the Minutes of the Quality Committee meeting held on Tuesday, April 18, 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. **IDD Access to Care Update,** presented by Dr. Evanthe Collins was reviewed by the Quality Committee.

**C. Nursing Peer Review** presented by Kia Walker and Vanessa Miller was reviewed by the Quality Committee.

**D. Clinical Pharmacy Review,** Dr. Santos commented on the Physician Assistant, Advanced Practice Registered Nurse, Pharmacist Delegation policy and next steps.

**7. EXECUTIVE SESSION-**

Dr. Santos announced the Quality Committee would enter into executive session at 11:05 am for the following reason:

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

**8. RECONVENE INTO OPEN SESSION-**

The Quality Committee reconvened into open session at 11:41 a.m.

**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 11:41 a.m.

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

# EXHIBIT R-2

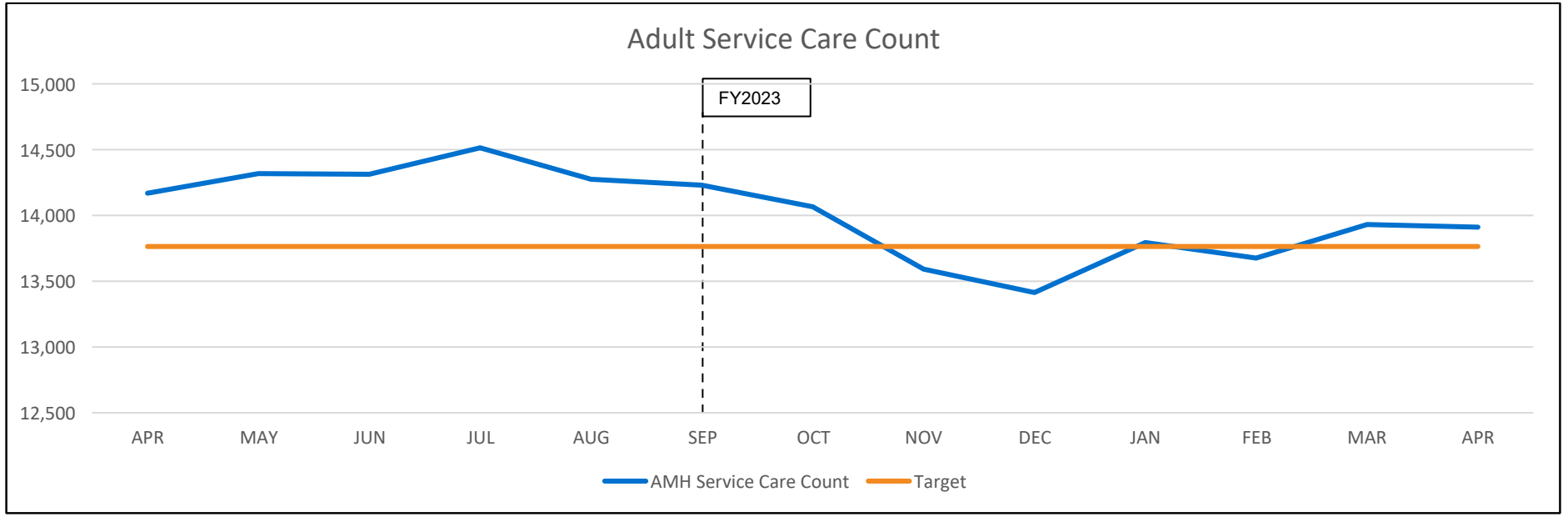
# Quality Board Scorecard

## Board Quality Committee Meeting

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

2023

| Domain | Program | 2023 Fiscal Year State Care Count Target | 2023 Fiscal Year State Care Count Average (Sep-Apr) | Reporting Period: April 2023 Care Count | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | AMH Service Care Count | 13,764 | 13,827 | 13,911 | Increase | Contractual |

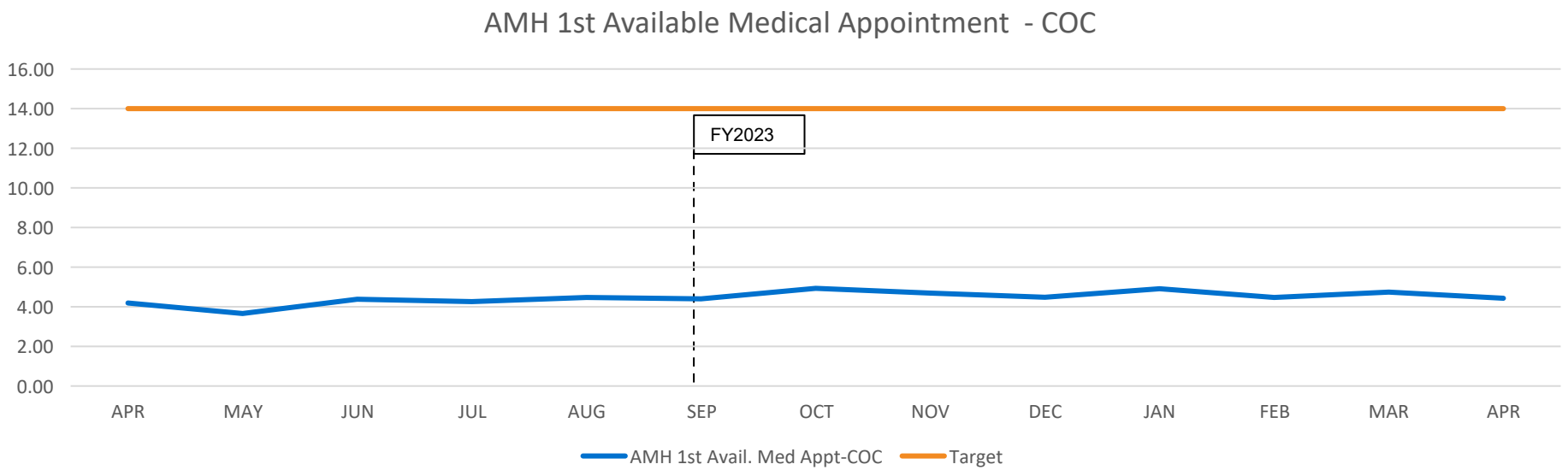



Highlights:

- Adult service care count average is performing above contractual target. The fiscal year over year average is **up 4.02%.** Fiscal year to date (Sep-Apr 2023) average of 13,827 compared to same period in (Sep-Apr FY2022) 13,292).
- The Adult Service Care Count for April is **down less than 2%. April 2023 is** 13,911 compared to 14,169 in April 2022 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-Apr) | Reporting Period April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AMH 1st Avail. Medical Appt-COC | <14 days | 4.63 Days | 4.43 Days | Decrease | Contractual |



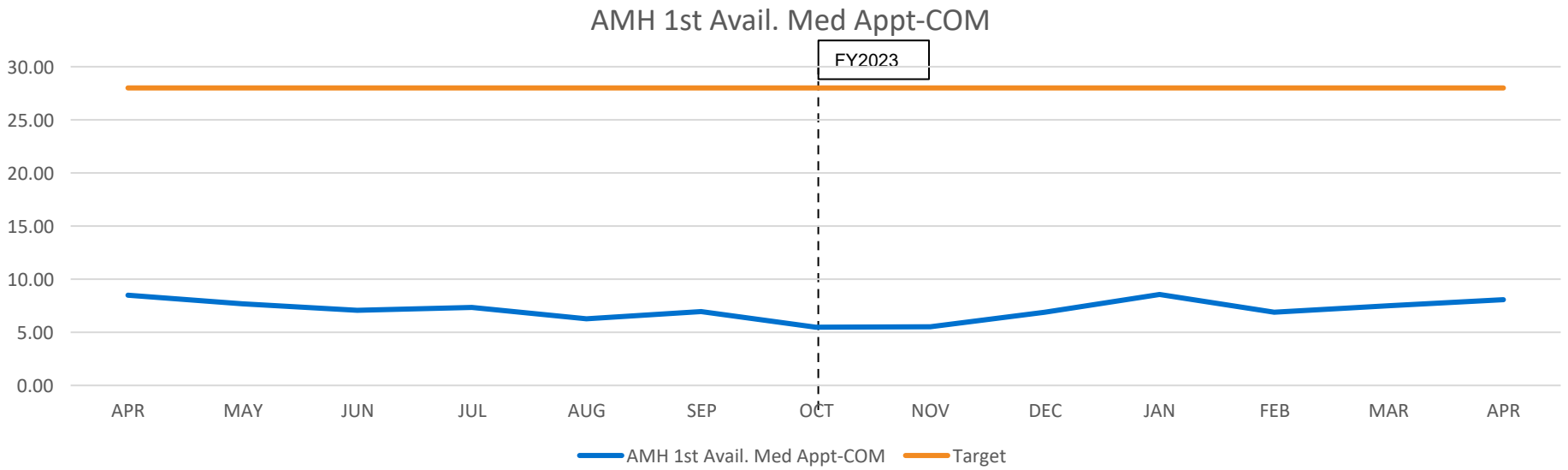

Highlights:
Time to contact COC patients continues to perform well for AMH.

- AMH has achieved **a 16% reduction** in the 1st available medical appointment for continuity of care patients. From an average of 5.49 days, Sep-Apr in FY2022, to 4.63 days in Sep-Apr FY2023.

- For the reporting period April 2023, AMH 1st available medical appointment for continuity of care **increased by 6%** from 4.19 days (April 2022) to 4.43 days in Apr. 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-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AMH 1st Avail. Medical Appt-COM | <28 days | 6.98 Days | 8.07 Days | Decrease | Contractual |

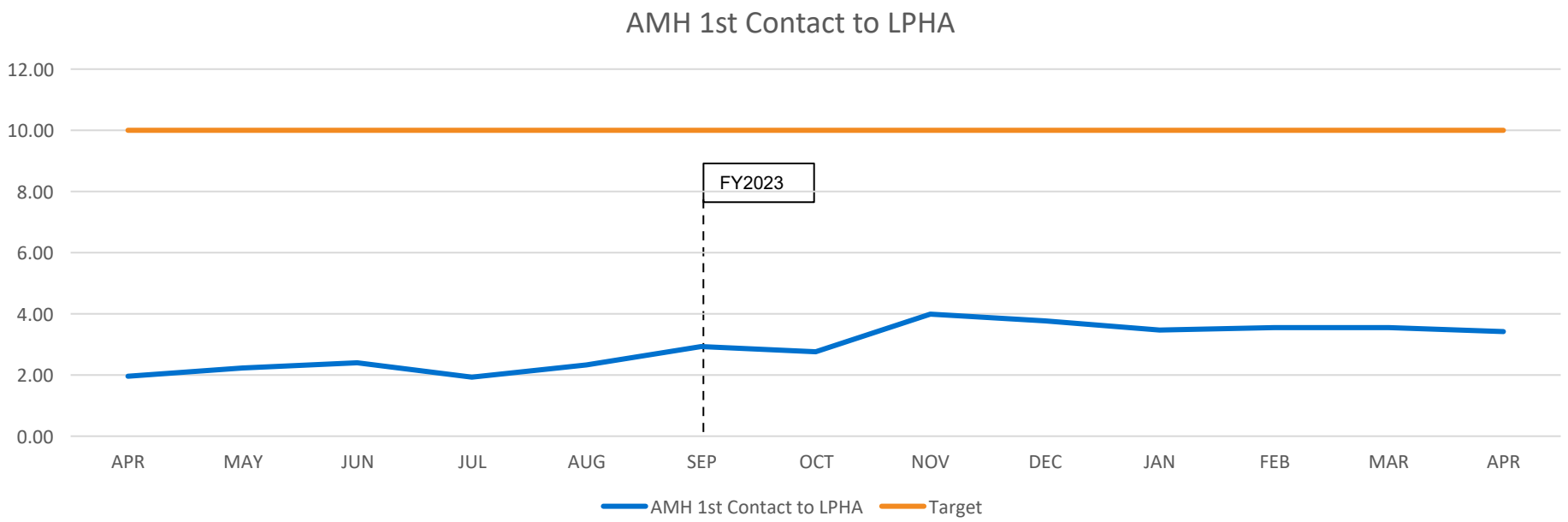



Highlights:
Access to medical appointment for community members (walking-ins without an appointment) continues to perform well for AMH.

- AMH has achieved **a 39% reduction** in the 1st available medical appointment for community members (walking-ins without an appointment). From an average of **11.53 days Sep-Apr** in 2022 to **7.01 days in Sep-Apr 2023.**
- For the reporting period April 2023, AMH reduced the time for 1st available medical appointment for community members (walking-ins without an appointment) **by 5%** from **8.49** days (April 2022) to **8.07 days in April 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-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AMH 1st Contact to LPHA | <10 days | 3.43 Days | 3.42 Days | Decrease | Contractual |

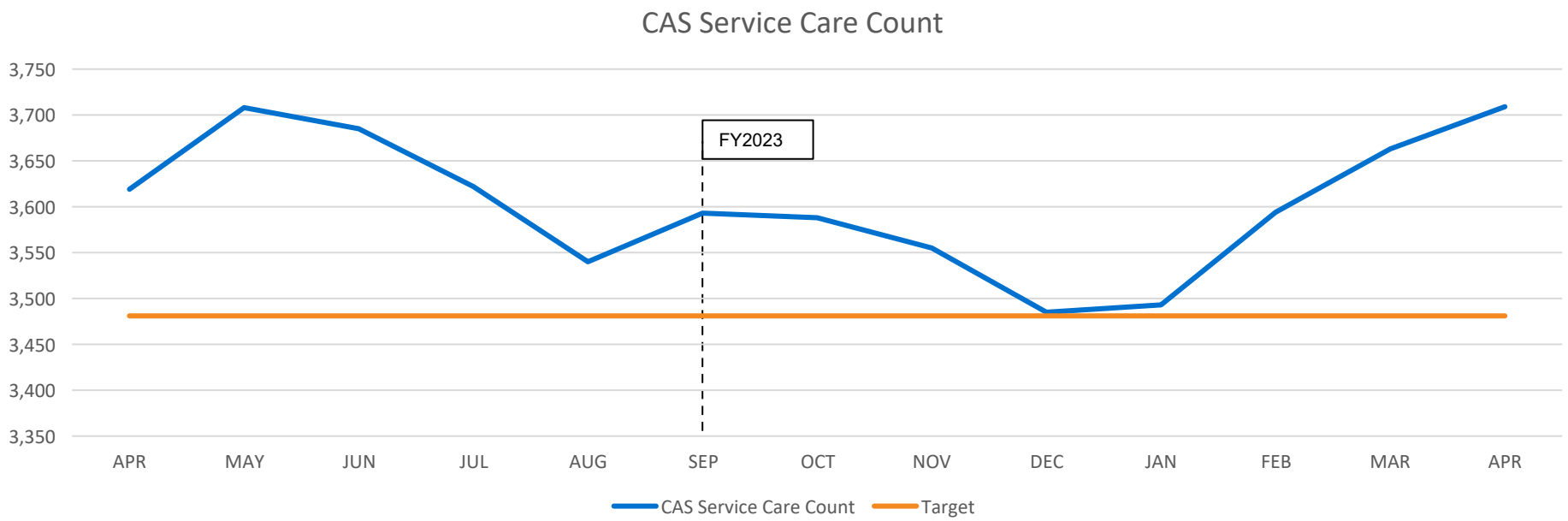



Highlights:
Time for patients' initial assessment continues to perform well for AMH.

- AMH has seen an increase in the number of days for an LPHA assessment from the same period last year. From an average of **1.55 days (Sep-Apr 2022) to 3.43 in the same period in Sep-Apr 2023**; and **increase to 3.42 days in April 2023 from 1.86 days in April 2022**.

*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-Apr) | Reporting Period- April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access to Care | CAS | 3,481 | 3,585 | 3,709 | Increase | Contractual |

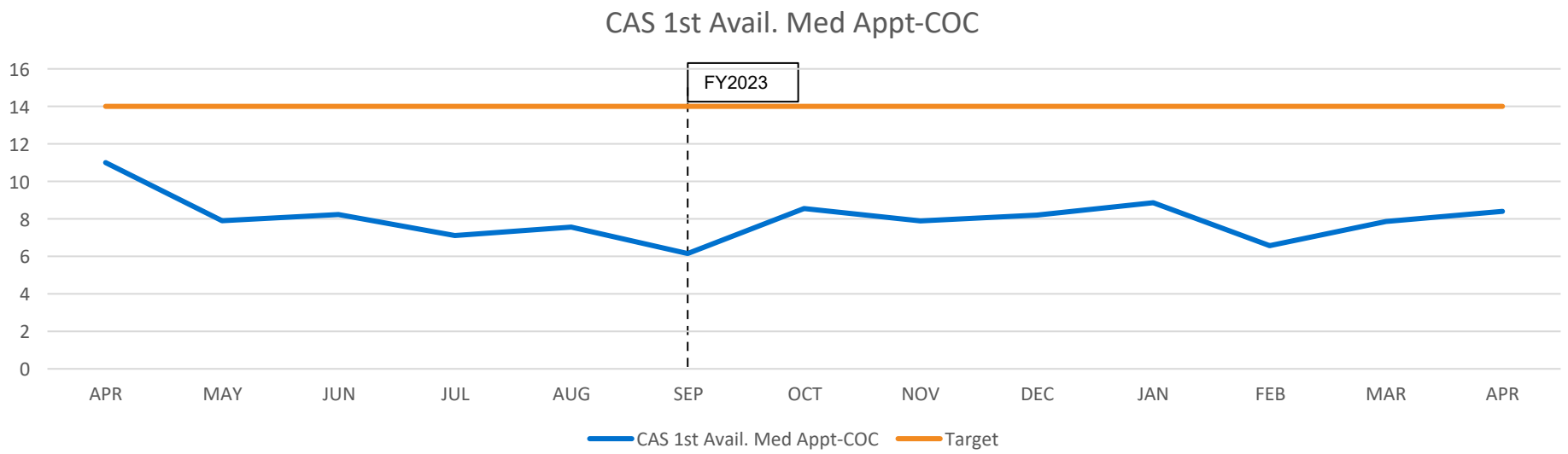



Highlights:

- CAS service care count average is up **4%** in fiscal year to date Sep-Apr 2023 (**3,585**) compared to same period in FY2022 (**3,461**)
- April CAS Service care count is also up **2.50%** this reporting period (**3,709**) compared to April 2022 (**3,619**)

*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-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | CAS 1st Avail. Medical Appt-COC | <14 days | 7.81 days | 8.40 days | Decrease | Contractual |




Highlights:

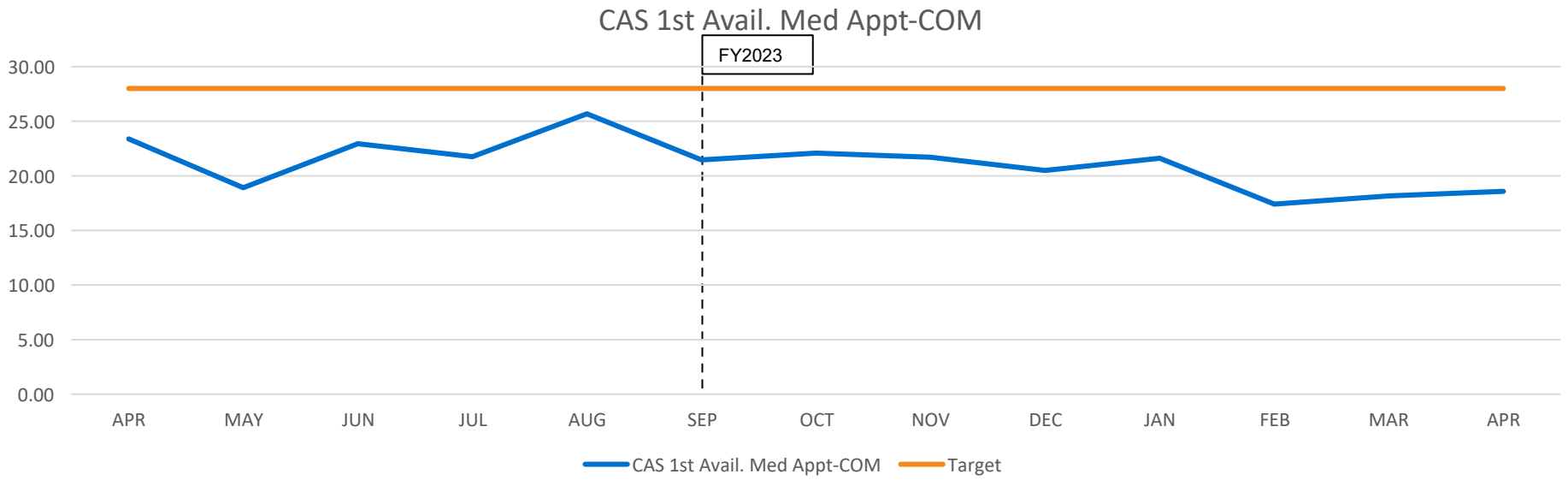
Time to contact patients for continuity of care after hospital discharge continues to perform well for CAS.

- CAS had a slight **increase** in the 1st available medical appointment for continuity of care patients. From an average of **7.65 days (Sep-Apr) in 2022 to 7.81 days in Sep-Apr 2023**.

- For the reporting period, April 2023, CAS saw about a **24% reduction** in the number of days for 1st available medical appointment from **11 days** (April 2022) to **8.40 days** in April 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-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | CAS 1st Avail. Medical Appt-COM | <28 days | 20.16 | 18.58 | Decrease | Contractual |



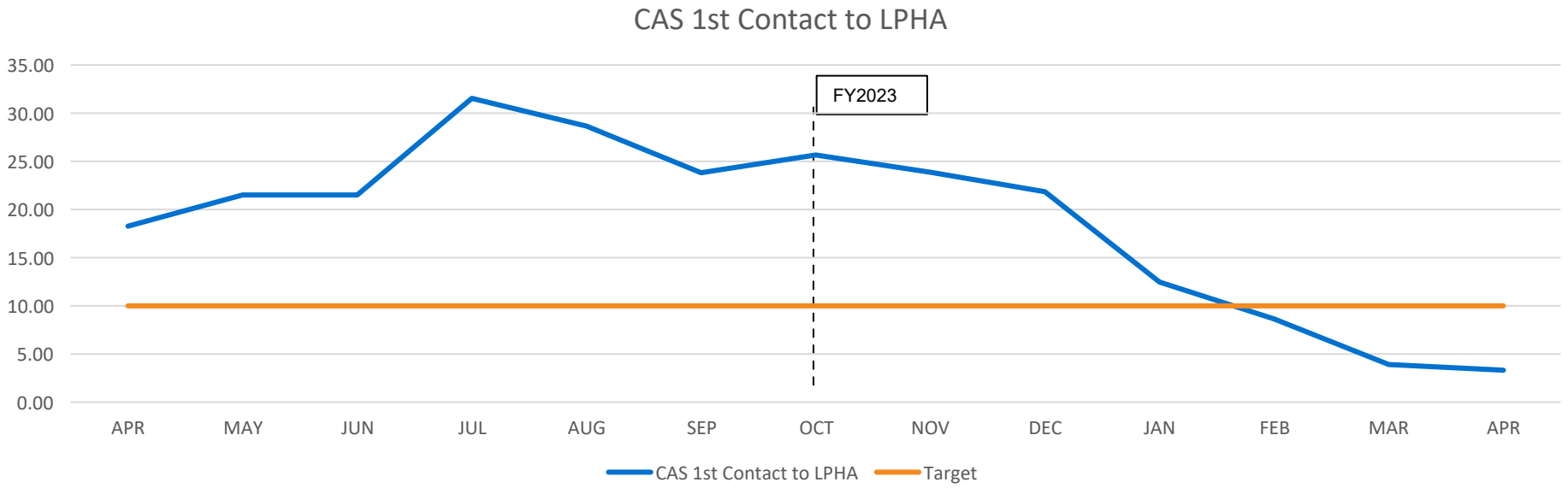

Highlights:

Time to contact patients continues to perform well for CAS.

- CAS 1st available medical appointment for community members walk-ins, had **9% decrease** year over year. From an average of **22.27 days in Sep-Apr 2022 to 20.16 days in Sep-Apr 2023.**
- For the reporting period April 2023, CAS reduced the number of days for 1st available medical appointment for community members walk-ins by **23% from 23.38 days in Apr 2022 to 18.58 days in April 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-Apr) | Reporting Period- April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | CAS 1st Contact to LPHA | <10 days | 15.43 Days | 3.32 Days | Decrease | Contractual |

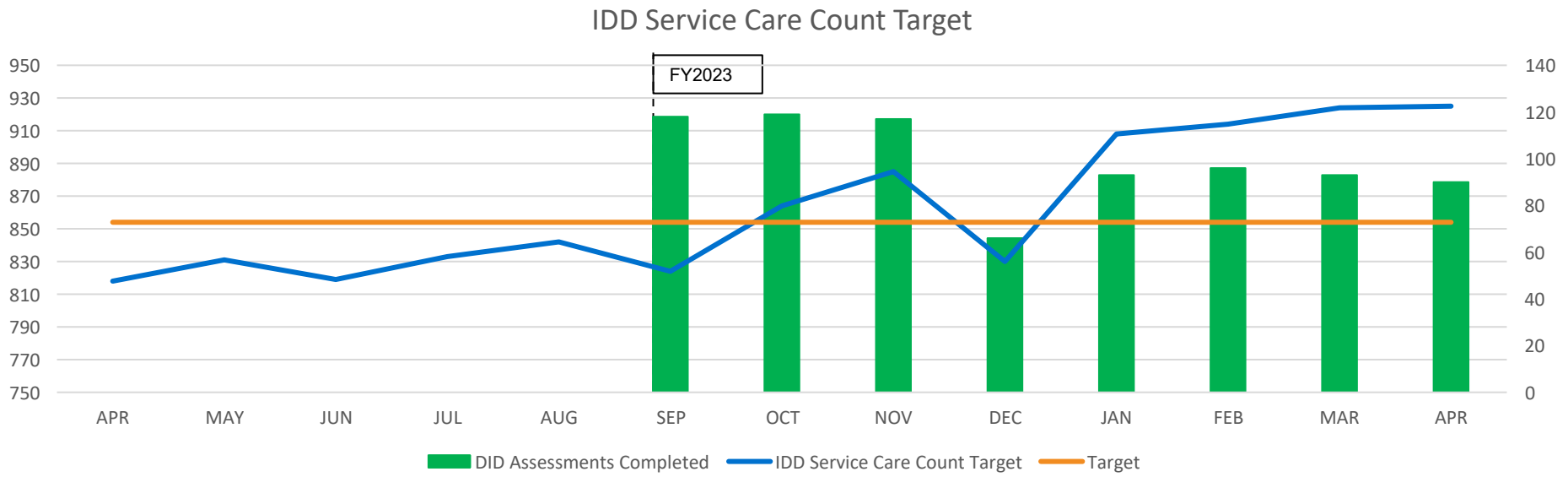



Highlights:

- CAS hybrid model (combination of open booking and scheduling) for LPHA assessment continues to improve access to care for children and adolescent seeking care. It reduced its fiscal year to date number of days for an LPHA assessment by more than 20 days. In September patients were waiting an average of 23 days for an LPHA assessment. The hybrid walk-in process reduced it to 3 days.
- There was also a decrease in the month-to-month comparison. From **18.27 days in April 2022 to 3.32 days in April 2023. An 82% 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-Apr) | Reporting Period- April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | IDD | 854 | 884 | 925 | Increase | Contractual |




| | SEP | OCT | NOV | DEC | JAN | FEB | MAR | April |
|---|---|---|---|---|---|---|---|---|
| DID ASSESSMENTS COMPLETED | 118 | 119 | 117 | 66 | 93 | 96 | 93 | 90 |

Highlights:

IDD has achieved its highest care count FY23 to date (Again!).

- IDD had **a 11% increase** in the total average service care count when comparing the same period in 2022: from an average of 790 in Sep-Apr 2022 to 884 in Sep-Apr 2023.
- For the reporting period April 2023, IDD has increased the service care count by **13%** in comparison to April 2022, from 818 for **April 2022 to 925 in April 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
30-90 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**
**** 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**

## STEP 3 GR SERVICES

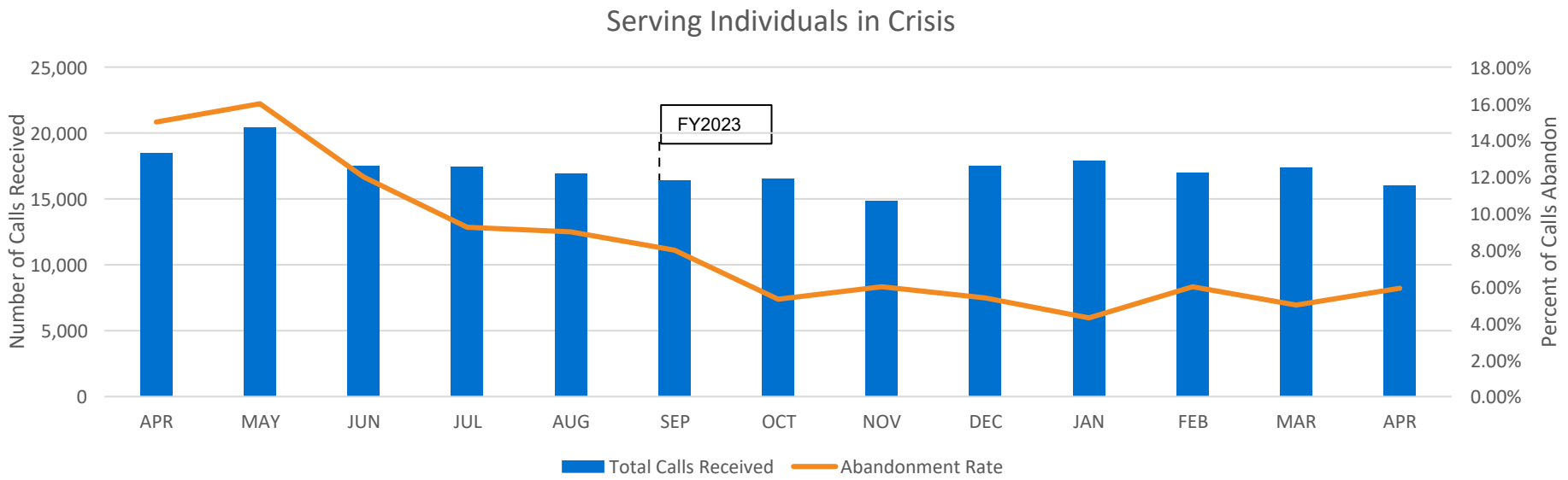
HHSC Contracted Services
Internal/External Providers
Community Linkages

**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**

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Total Calls Received | N/A | 16,702 | 16,047 | Increase | Contractual |
| | Abandonment Rate | <8% | 5.74% | 5.92% | Decrease | Contractual |

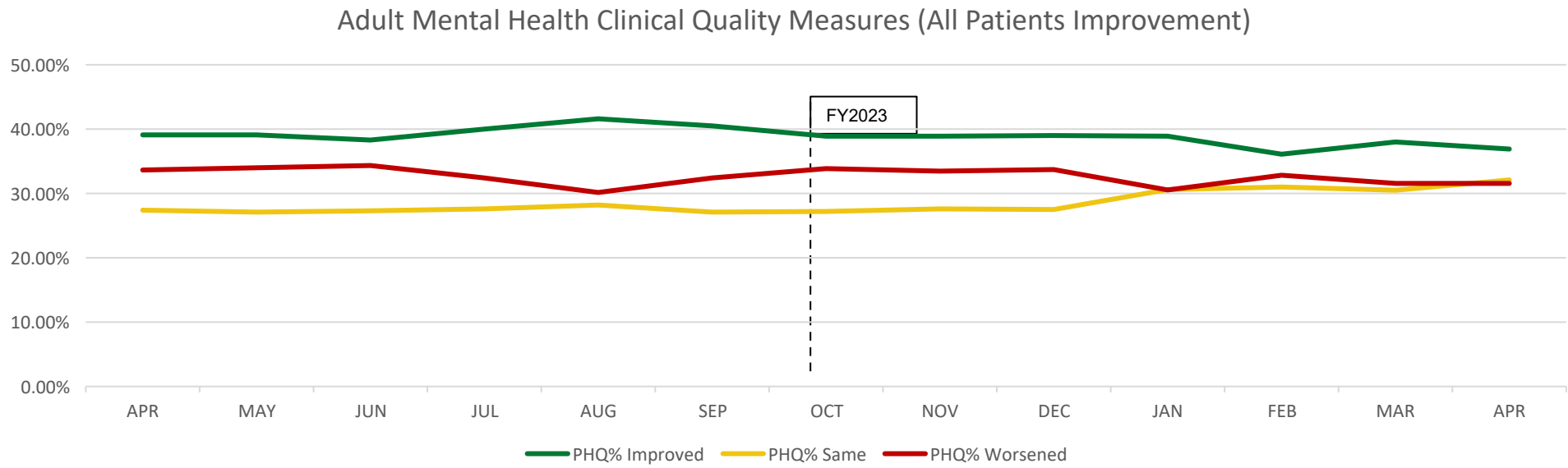



| Category | Count |
|---|---|
| Calls Received (Harris Only) | 3,258 |
| *Calls from Harris Center clients with scheduled apptmnts | ***326*** |
| *Appointment made on same day or after call made to Crisis Line* | *269* |
| *Appointment made prior to call made to Crisis Line* | *57* |

***Of the appointments MADE, 4 appointment types identified (see below)***

| Appointment Type | Count |
|---|---|
| Office Visit | 266 |
| Patient Outreach | 16 |
| Clinical Case Mgmnt | 36 |
| Nurse Only | 8 |
| ***Total*** | ***326*** |

| Domain | Measures | PHQ Status | 2023Fiscal Year Average (Sep-Apr) | Reporting Period- April |
|---|---|---|---|---|
| Effective Care | PHQ-9 | % Improved | 38.40% | 36.90% |
| | | % Same | 29.20% | 32.10% |
| | | % Worsened | 32.42% | 30.95% |



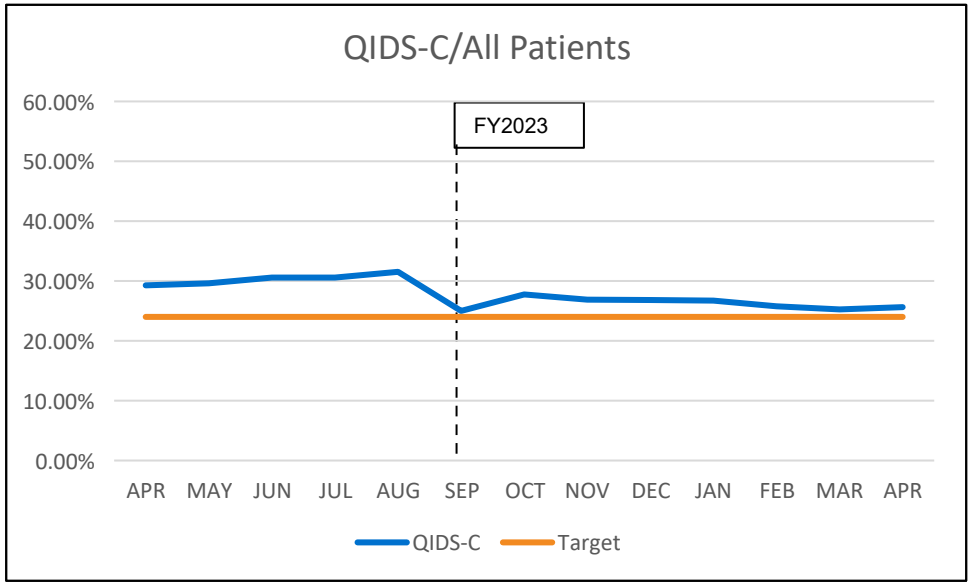

Note:

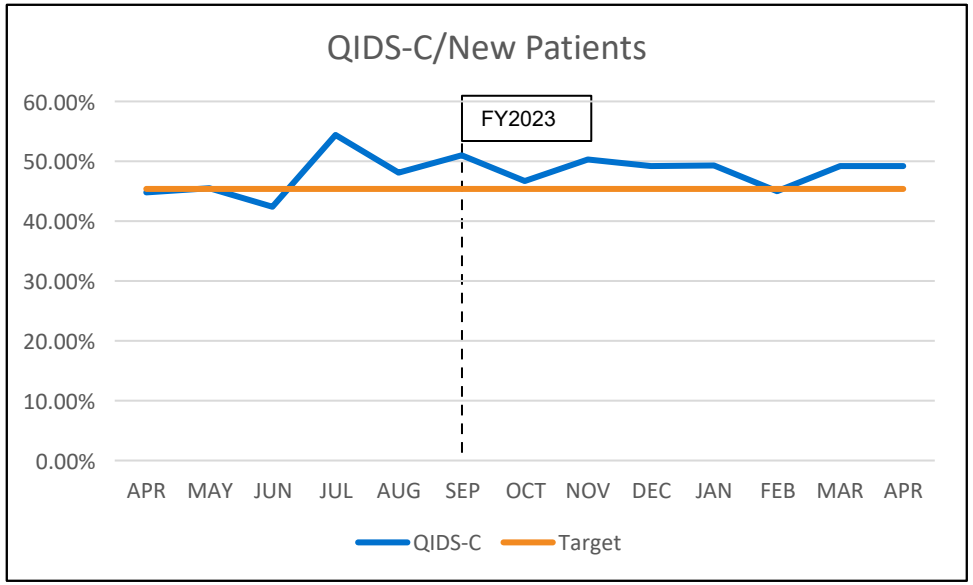
- PHQ (Patient Health Questionnaire) This is a widely used and validated measure of depression. This measure is under review. A workgroup is being formed to explore opportunities to improve on this measure

*Measure computation: % 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)*

*Measure Definition: PHQ 9/A The Patient Health Questionnaire (PHQ; Spitzer, Kroenke, Williams, 1999) is a self-report version of the Primary Care Evaluation of Mental Disorders (PRIME-MD), designed for screening of psychiatric disorders in an adult primary practice setting. The PHQ comprises the patient questionnaire and clinician evaluation guide from the PRIME-MD, combined into a single, three-page questionnaire.*

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | QIDS-C/All Patients | 24% | 26.23% | 25.63% | Increase | IOS |
| | QIDS-C/New Patients | 45% | 49.13% | 49.50% | Increase | IOS |

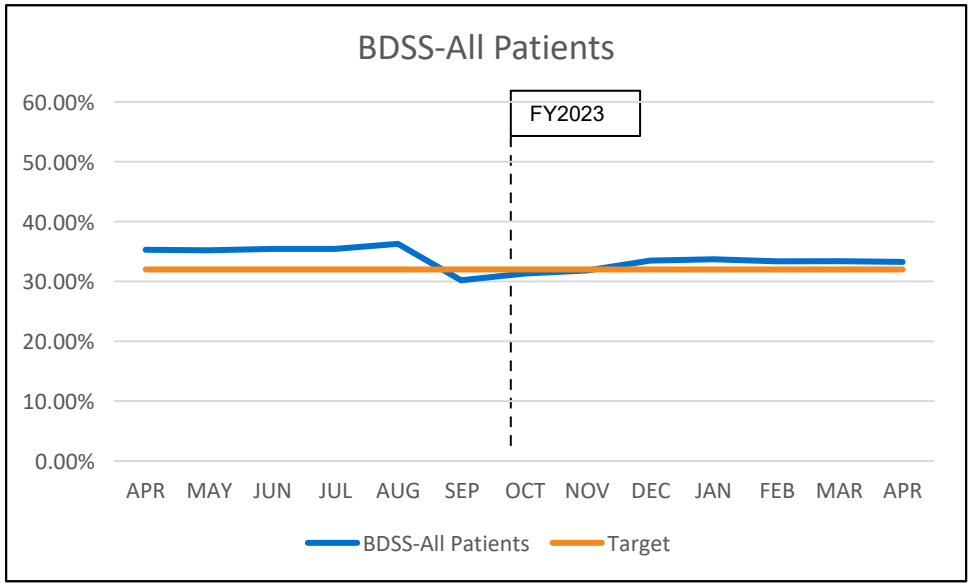


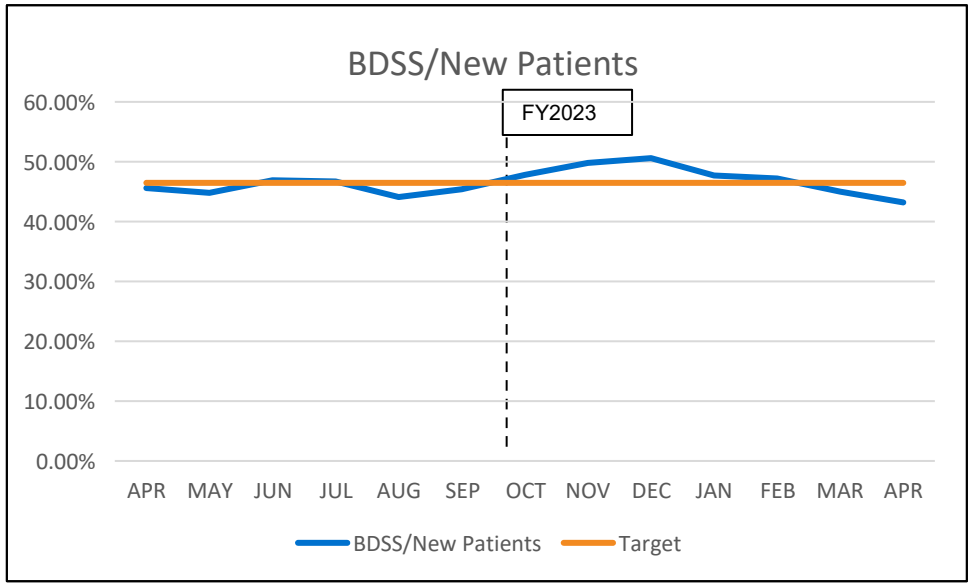




*Measure computation: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the QIDS-C. Clients must have at least 90 days from first assessment to last assessment.*

*Measure definition: QIDS-C = Quick Inventory of Depressive Symptomology-Clinician Rated: The QIDS-C measures the severity of depressive symptoms in adults 18 and older. There are 16 measures, selected from the Inventory of Depressive Symptomology (IDS, 2000). These symptoms correspond to the diagnostic criteria from the DSM-IV. Respondents use a 4-point Likert-type scale to assess their behaviors and mood over the course of the past week. It takes five to seven minutes to complete the report.*

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | BDSS-All Patients | 32% | 32.56% | 33.26 | Increase | IOS |
| | BDSS-New Patients | 46% | 47.36% | 43.20% | Increase | IOS |

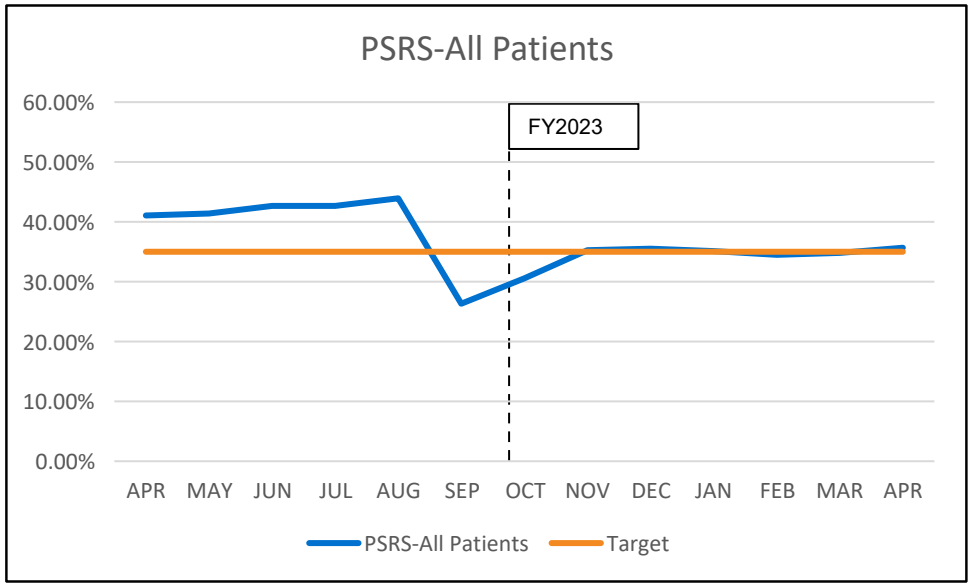


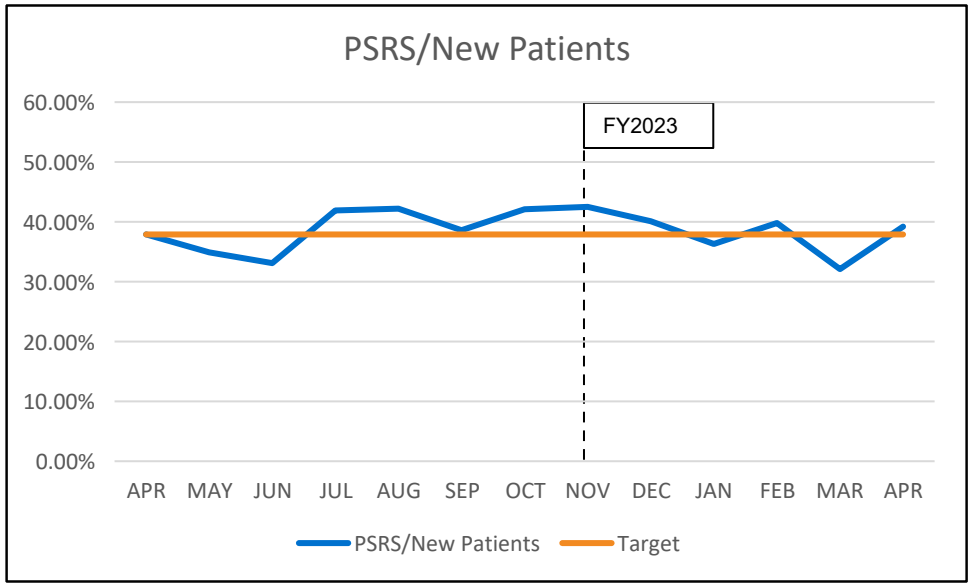




*Measure computation: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the BDSS. Clients must have at least 90 days from first assessment to last assessment*

*Measure Definition: BDSS = Brief Bipolar Disorder Symptom Scale: The Brief Bipolar Disorder Symptom Scale (BDSS) is a 10-item measure of symptom severity that was derived from the 24-item Brief Psychiatric Rating Scale (BPRS24). It was developed for clinical use in settings where systematic evaluation is desired within the constraints of a brief visit.*

| Domain | Measures (Definition) | FY 2023 Target | 2023Fiscal Year Average (Sep-Apr) | Reporting Period-April | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | PSRS-All Patients | 35% | 33.47% | 35.67% | Increase | IOS |
| | PSRS-New Patients | 53% | 39.16% | 39.80% | Increase | IOS |

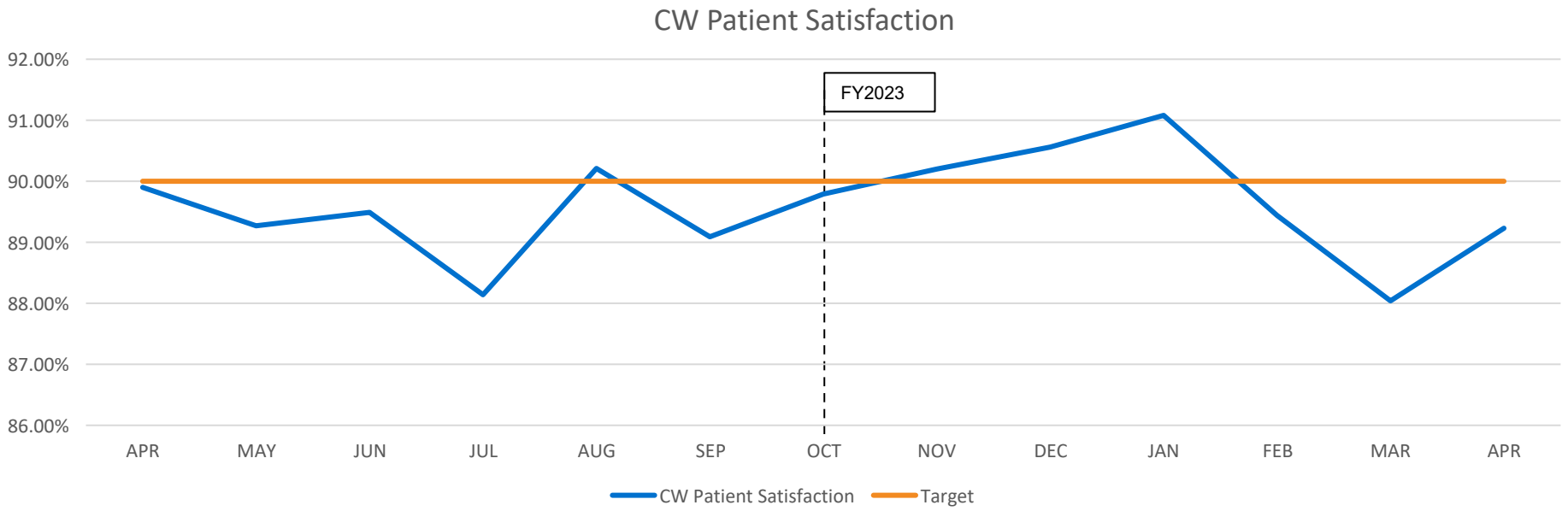



*Measure computation: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the PSRS. Clients must have at least 90 days from first assessment to last assessment.*

*Measure definition: Positive Symptom Rating Scale (PSRS) is a psychiatric assessment tool that assesses temporal paranoia or agitation. The PSRS consists of a 4-item Positive Symptom Rating Scale (1. Suspiciousness; 2. Unusual Thought Content; 3. Hallucinations; 4. Conceptual Disorganization). It is an interviewer-administered assessment. The responses for the Positive Symptom Rating Scale are rated on a 7-point scale (1. Not Present; through 7. Extremely Severe).*

| 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 has assembled a team that will develop a subcommittee that will report to the System Quality Safety and Experience to improve response rate and a singular survey tool selection for adoption to meet the needs of the organization.

# Appendix

| | 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 | 4.43 | | | | | 4.63 | <14 Days | C | Epic |
| AMH 1st Avail. Med Appt-COM | 6.95 | 5.48 | 5.52 | 6.89 | 8.77 | 6.88 | 7.50 | 8.07 | | | | | 7.01 | <28 Days | NS | Epic |
| AMH # Pts Seen in 30-60 Days | 6 | 2 | 2 | 1 | 4 | 5 | 1 | 1 | | | | | 2.75 | <45 | IOS | Epic |
| AMH # Pts Seen in 60+ Days | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | 0.50 | 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 | 16,047 | | | | | 16,702 | | | |
| AVG Call Length (Mins) | 8.00 | 8.00 | 8.10 | 8.70 | 8.50 | 8.80 | 9.30 | 9.20 | | | | | 8.58 | | | |
| Service Level | 86.00% | 91.34% | 91.00% | 90.76% | 92.00% | 88.00% | 89.00% | 89.00% | | | | | 89.64% | ≥ 95.00% | C | Brightmetrics |
| Abandonment Rate | 8.00% | 5.32% | 6.00% | 5.39% | 4.30% | 6.00% | 5.00% | 5.92% | | | | | 5.74% | < 8.00% | NS | Brightmetrics |
| Occupancy Rate | 73.00% | 69.00% | 69.00% | 71.00% | 72.00% | 77.00% | 74.00% | 76.00% | | | | | 72.63% | | | Brightmetrics |
| Crisis Call Follow-Up | 100.00% | 99.79% | 99.76% | 99.77% | 99.77% | 99.76% | 100.00% | 99.50% | | | | | 99.79% | > 97.36% | IOS | Icarol |
| Access to Crisis Resp. Svc. | 93.50% | 87.10% | 84.00% | 88.80% | 89.80% | 89.80% | 88.50% | 86.60% | | | | | 88.51% | > 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 | 1,145 | | | | | 1173 | | | |
| PES Admission Volume | 523 | 585 | 560 | 544 | 555 | 498 | 549 | 553 | | | | | 545.88 | | | |
| Mechanical Restraints | 0 | 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 | | | | | 0.00 | ≤ 0.01 | IOS | Epic |
| Personal Restraints | 46 | 40 | 37 | 37 | 43 | 50 | 79 | 70 | | | | | 50.25 | | | Epic |
| Personal Restraint Rate | 2.07 | 1.95 | 1.78 | 1.77 | 1.98 | 2.68 | 3.85 | 3.89 | | | | | 2.50 | ≤ 2.80 | IOS | Epic |
| Seclusions | 33 | 35 | 19 | 32 | 20 | 39 | 53 | 58 | | | | | 36.13 | | | Epic |
| Seclusion Rate | 1.48 | 1.61 | 0.92 | 1.53 | 0.92 | 2.09 | 2.58 | 3.22 | | | | | 1.79 | ≤ 2.73 | SP | Epic |
| AVG Minutes in Seclusion | 46.91 | 58.66 | 52.62 | 51.82 | 41.70 | 49.76 | 44.33 | 54.92 | | | | | 50.09 | ≤ 61.73 | IOS | Epic |
| Emergency Medications | 44 | 54 | 42 | 47 | 58 | 56 | 72 | 72 | | | | | 55.63 | | | Epic |
| EM Rate | 1.98 | 2.48 | 2.02 | 2.25 | 2.67 | 3.01 | 3.50 | 3.99 | | | | | 2.74 | ≤ 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% | 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% | 89.23% | | | | | 89.68% | 90.00% | IOS | Feedtrail |
| V-SSS 2 | 88.69% | 89.66% | 90.24% | 90.32% | 90.38% | 89.33% | 87.30% | 88.69% | | | | | 89.33% | 90.00% | IOS | Feedtrail |
| PoC-IP | 89.71% | 89.30% | 89.25% | 90.14% | 95.15% | 90.74% | 90.61% | 91.85% | | | | | 90.84% | 90.00% | IOS | McLean |
| Pharmacy | 93.02% | 99.09% | 96.31% | 96.19% | 94.87% | 100.00% | 97.58% | 96.37% | | | | | 96.68% | 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% | 25.63% | | | | | 26.23% | 24.00% | IOS | MBOW |
| BDSS | 30.19% | 31.31% | 31.83% | 33.48% | 33.70% | 33.36% | 33.38% | 33.26% | | | | | 32.56% | 32.00% | IOS | MBOW |
| PSRS | 26.32% | 30.56% | 35.26% | 35.51% | 35.11% | 34.49% | 34.81% | 35.67% | | | | | 33.47% | 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 | 0.65 | | | | | 0.61 | 0.68 | IOS | McLean |
| QIDS-C | 53.80% | 47.30% | 50.10% | 50.40% | 48.60% | 44.50% | 48.80% | 49.50% | | | | | 49.13% | 45.38% | IOS | Epic |
| BDSS | 46.10% | 46.20% | 51.80% | 50.30% | 48.70% | 47.20% | 45.40% | 43.20% | | | | | 47.36% | 46.47% | IOS | Epic |
| PSRS | 38.20% | 41.70% | 43.50% | 42.40% | 36.00% | 39.70% | 32.60% | 39.20% | | | | | 39.16% | 37.89% | IOS | Epic |
| **Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | |
| PHQ-A (11-17) | 18.20% | 24.50% | 24.00% | 30.00% | 39.20% | 38.50% | 33.10% | 41.30% | | | | | 31.10% | 41.27% | IOS | Epic |
| DSM-5 L1 CC Measure (6-17) | 48.20% | 50.10% | 49.60% | 52.60% | 42.00% | | | | | | | | 48.50% | 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% | 39.50% | | | | | 38.28% | 20.00% | C | MBOW |
| CANS (Child/Adolescent) | 43.14% | 21.65% | 18.14% | 19.80% | 21.31% | 25.30% | 27.30% | 30.50% | | | | | 25.89% | 25.00% | C | MBOW |
| **Adult and Child/Adolescent Functioning Measures** | | | | | | | | | | | | | | | | |
| DLA-20 (AMH and CAS) | 49.80% | 44.50% | 44.30% | 47.50% | 43.80% | 47.40% | 43.20% | 42.30% | | | | | 45.35% | 48.07% | IOS | Epic |

# Board of Trustee's PI Scorecard

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 | FY23 AVG | FY23 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | | | | | | | | | | |
| AMH Waitlist (State Defined) | 0 | 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 | 13,911 | | | | | 13,827 | 13,764 | C | MBOW |
| AMH Actual Service Target % | 103.39% | 102.19% | 98.75% | 97.46% | 100.22% | 99.36% | 101.21% | 101.07% | | | | | 100.46% | 100.00% | C | MBOW |
| AMH Serv. Provision (Monthly) | 48.00% | 49.20% | 45.90% | 47.10% | 49.20% | 49.60% | 52.20% | 47.60% | | | | | 48.60% | ≥ 65.60% | C | MBOW |
| CAS Waitlist (State Defined) | 0 | 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 | 3,709 | | | | | 3,585 | 3,481 | C | MBOW |
| CAS Actual Service Target % | 103.22% | 103.07% | 102.13% | 100.11% | 100.34% | 103.25% | 105.23% | 106.55% | | | | | 102.99% | 100.00% | C | MBOW |
| CAS Serv. Provision (Monthly) | 76.70% | 76.00% | 74.00% | 72.50% | 78.20% | 76.30% | 76.00% | 70.00% | | | | | 74.96% | ≥ 65.00% | C | MBOW |
| DID Assessment Waitlist | | | | | | | | | | | | | #DIV/0! | 0 | IOS | IDD-BO |
| IDD Service Target | 824 | 864 | 885 | 830 | 908 | 914 | 924 | 925 | | | | | 884 | 854 | SP | MBOW |
| IDD Actual Service Target % | 96.49% | 101.17% | 103.63% | 97.19% | 106.32% | 104.03% | 108.20% | 108.31% | | | | | 103.17% | 100.00% | C | MBOW |
| | | | | | | | | | | | | | | | | |
| CW CAS 1st Contact to LPHA | 23.82 | 25.66 | 23.87 | 21.85 | 12.22 | 8.75 | 3.91 | 3.32 | | | | | 15.43 | <10 Days | NS | Epic |
| CW AMH 1st Contact to LPHA | 2.33 | 2.93 | 2.76 | 3.99 | 3.83 | 3.46 | 3.55 | 3.42 | | | | | 3.28 | <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 | 3.40 | | | | | 5.53 | <10 Days | NS | Epic |
| | | | | | | | | | | | | | | | | |
| CAS 1st Avail. Med Appt-COC | 6.15 | 8.55 | 7.89 | 8.20 | 8.86 | 6.57 | 24.00 | 8.40 | | | | | 9.83 | <14 Days | C | Epic |
| CAS 1st Avail. Med Appt-COM | 21.46 | 22.08 | 21.70 | 20.49 | 21.27 | 17.54 | 18.16 | 18.58 | | | | | 20.16 | <28 Days | NS | Epic |
| CAS # Pts Seen in 30-60 Days | 49 | 45 | 45 | 44 | 47 | 19 | 51 | 40 | | | | | 42.50 | <9.18 | IOS | Epic |
| CAS # Pts Seen in 60+ Days | 26 | 27 | 35 | 27 | 35 | 43 | 22 | 18 | | | | | 29.13 | 0 | IOS | Epic |

# 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 |

| | 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

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

| 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 R-3

# Merit-based Incentive Payment System and DPP

## Performance Year 2022 Feedback

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

June 15th 2023

# Merit-based Incentive Payment System (MIPS)

Under MIPS, The Harris Center for Mental Health and IDD earns a payment adjustment for Medicare Part B-covered professional services based on evaluation across four performance categories. These categories focus on the quality and cost of the patient care you provide, improvements to your clinical care processes and patient engagement, and your use of certified electronic health record technology (CEHRT) to support and promote the electronic exchange of health information.

## How Your Final Score Is Created

Your final score, available in Summer 2023, is created by combining the scores from each applicable performance category plus your complex patient bonus points, if applicable. Your final score will be out of 100 points.

| Quality | | Promoting Interoperability | | Improvement Activities | | Cost | | Final Score |
|---|---|---|---|---|---|---|---|---|
| 55% | + | 0% | + | 15% | + | 30% | = | **100%** |

# Merit-based Incentive Payment System (MIPS)

Preliminary Score

**70.00** / 100

- Quality 55.00 / 55
- Promoting Interoperability N/A
- Improvement Activities 15.00 / 15
- Cost -- / 30

## Quality 55.00 / 55

This performance category assesses the quality of care delivered by the Harris Center.

## Improvement Activities 15.00 / 15

This performance category assesses how the Harris Center improves care processes, enhance patient engagement in care, and increase access to care.

## Promoting Interoperability N/A

This performance category promotes patient engagement and the electronic exchange of health information using certified electronic health record technology.

## Cost 0.00 / 30

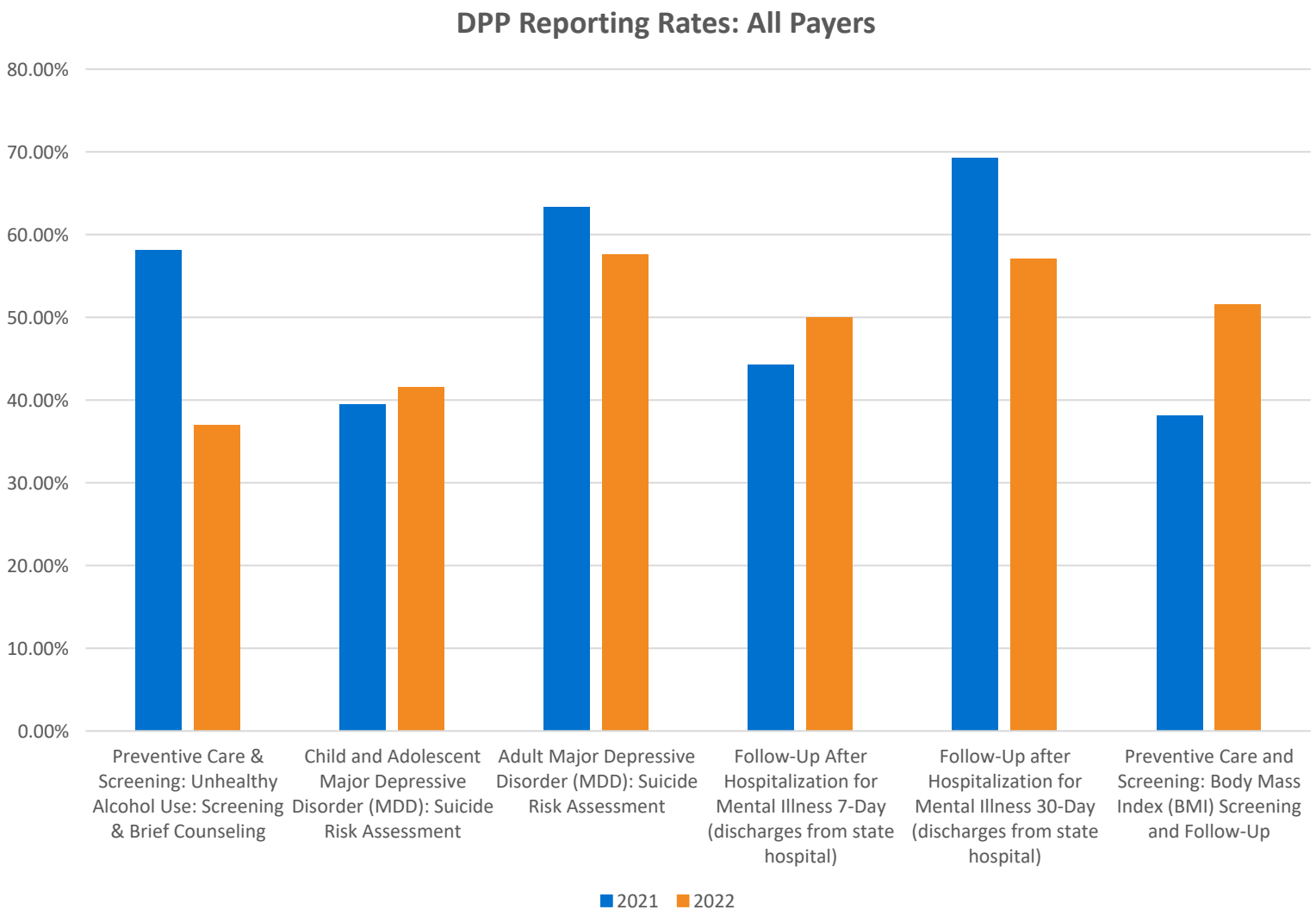
This performance category assesses the cost of patient care delivered by the Harris Center. Cost measures are calculated based on Medicare claims, to determine the cost of the care you provide to certain patients.

Cost scores will be available at the start of Final Score Preview after all claims data is processed.

# Directed Payment Program

- Value-based payment program to align Medicaid services with the Certified Community Behavioral Health Clinic (CCBHC) model of care
- Continue successful Delivery System Reform Incentive Payment (DSRIP) innovations
- DPP BHS payments included in MCO capitation rates
- Promote access to behavioral health services, care coordination, and successful care transitions for individuals enrolled in STAR, STAR+PLUS and STAR Kids
- We report data semi-annually for all measures as a condition of participation
- Year-by-year CMS approval
- Proposed Year 3 (2024) measures with payment for reporting only:
  - **Structural** *In Place*: +HIE participation, +CCBHC Certification, +Provision of Integrated Care
    *To be Implemented*: - Screening & Follow up of Non-Medical Drivers
  - **Process** *In Place*: + Current measures (see next slide)
    *To Be Implemented*: - Depression Remission at 6 months

# Directed Payment Program Accomplishments




## DPP Revenue Generated

**2021: $ 3,383,215.90**
**2022: $15,432,018.44**

# Merit-based Incentive Payment System (MIPS)

## Appendix

# Improvement Activities Score System (MIPS)

## Traditional MIPS Improvement Activities Score

The following is a detailed overview of your Improvement Activities category information.

**Total Category Score**

**15.00** / 15

| Measure Name<br>Expand All | Weight | Activity Score |
|---|---|---|
| **Implementation of Integrated Patient Centered Behavioral Health Model**<br>Measure ID: IA_BMH_7 | High | +40 |
| **Promoting Clinician Well-Being**<br>Measure ID: IA_BMH_12 | High | +40 |
| **Implementation of co-location PCP and MH services**<br>Measure ID: IA_BMH_6 | High | +40 |

| Measure Name<br>Expand All | Weight | Activity Score |
|---|---|---|
| **Regularly Assess Patient Experience of Care and Follow Up on Findings**<br>Measure ID: IA_BE_6 | High | +40 |
| **Drug Cost Transparency**<br>Measure ID: IA_BE_25 | High | +40 |

# MIPS Quality Score

## Traditional MIPS Quality Score

The following is a detailed review of your Quality category information.

**Total Category Score**

**55.00** / 55

### Measures that count toward Quality Performance Score

Your Measure Score includes both performance points and bonus points.

| Measure Name<br>Expand All | Performance Rate | Measure Score |
|---|---|---|
| **HIV Screening**<br>Measure ID: 475 | 48.45% | 10.00 |
| **Appropriate Treatment for Upper Respiratory Infection (URI)**<br>Measure ID: 065 | 99.55% | 9.77 |
| | Sub-Total: | **19.77** |

### Measures submitted but don't count towards quality performance category score

These measures either fall outside the top six measures or exceed the maximum bonus points allowed. They don't contribute any points to your score. The "Points from Benchmark Decile" identifies the score you would have received if the measure contributed to your score.

- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Anti-Depressant Medication Management
- Appropriate Testing for Pharyngitis
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Preventive Care and Screening: Influenza Immunization
- Pneumococcal Vaccination Status for Older Adults
- Breast Cancer Screening
- Colorectal Cancer Screening
- Diabetes: Eye Exam
- Diabetes: Medical Attention for Nephropathy
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Documentation of Current Medications in the Medical Record

# Thank you.

# EXHIBIT R-4

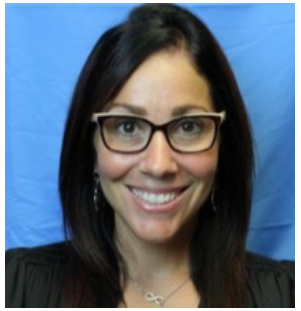
# Quality Year Accomplishments

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

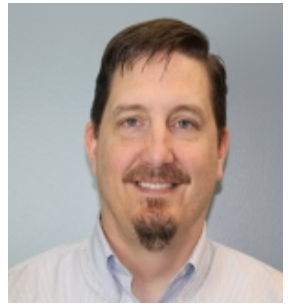
June 15th , 2023

# Quality Team

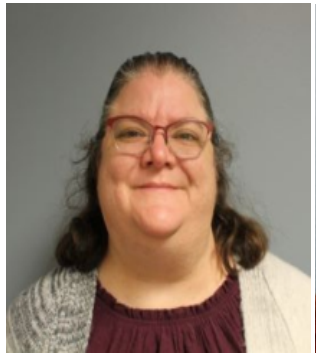
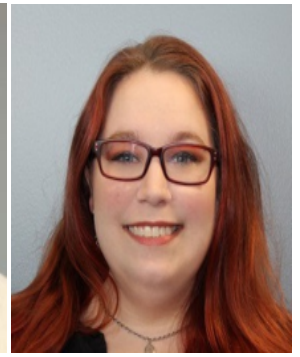


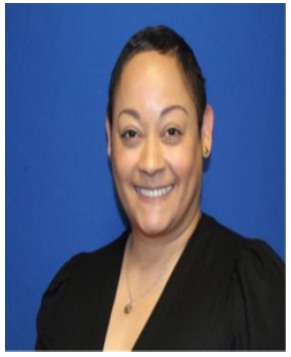











# Performance Improvement /Quality Assurance

- Performance improvement whole system measures – Board Score Card
- First Annual Healthcare Quality Symposium
- Built Partnerships
  - Vaccine Program
  - Patient Satisfaction
  - Access
  - RCA, ACA, FMEA
  - Just Care Culture
- CARF/CCBHC – System Accreditation and Audit support
- Safe Care RL
  - Dashboards and reporting
  - Data storage and protections
  - Efficient review of closed records / deaths

# Performance Improvement/Quality Assurance Projects

- **Closed Record Review**- As of 2/24/23, 170 deaths of individuals served have been submitted to Closed Record Review Committee for an assessment of care. 131 have been closed out with only nine of them requiring further action.

- **CAS PI Project**- A workgroup was formed to assess the No Show rate at CAS due to a reported No Show rate of over 60%. After data and definition clean up, the CAS No Show rate hovers around the goal of 40% for June 2022-January of 2023. A survey is currently being administered to individuals served that No Show appointments to better understand why appointments are missed. Several Access initiatives are underway in the CAS program, to improve the No Show rate. The group will continue to monitor.

- **Workforce Violence**- A workgroup was formed to assess the safety of staff, as there have been numerous incidents of staff being assaulted by the individuals we serve. After further review, it was determined most of these instances are occurring at PES and over 50% of those resulted in injury to our staff. This led to an Aggressive Patient flag being created in Epic and a Care of the Aggressive Patient Pathway was put into place at NPC.

- **Root Cause Analysis**- the team has conducted one clinical RCA, Provider Attack, and one business RCA, ECI Personnel File Audits. There were a few opportunities for improvement identified, one of which led to an assessment of panic alarms being used across the institution to ensure staff safety.

- **Seclusion and Restraint –** Analysis and procedures focused on patient safety

- **IDD** – Analysis and response to wait time data

# Clinical Transformation & Innovation

- Zero Suicide
  - Zero Suicide dashboard
  - ASK training and CALM training
  - Regional and internal training and tracking for suicide care
  - Complete Suicide care pathway for new intakes in MH CLINIC and actively measuring initial metrics

- Substance Use Disorder (SUD)
  - Implemented multiple new processes in detox including training in Epic and training on overdose (OD) safety planning
  - Completed SUD detox pathway and actively measuring initial metrics
  - Established referral process for substance use referrals from the MH CLINIC
  - Arranged for and implemented training for all intake LPHAs in MH with pre and post test tracking to ensure competency
  - Same day risk assessment and safety planning for all MH CLINICS

# Clinical Transformation & Innovation

- Leading IHI pursuing equity learning. Network initiative, recently organized and completed the healthcare racial equity progress report collaborating with multiple areas
- Texas Mental Health Art Contest by collaborating with multiple areas and their leaders, we are assisting with supply costs as well as submission to the state and will have an art show to showcase our clients' creative arts coping strategies
- Pet Therapy
- Established and maintaining substance use disorder internal learning collaborative with three subgroups to improve substance use care within The Harris Center.
- Collaborating with IDD leadership for high level process for persons served expressing suicidal ideation while in programs like coffeehouse/STARS or out in the field the uses the new risk assessment tool created by our providers
- NPC suicide care pathway

# Health Analytics and Research Projects

- Create Research Strategic Plan
- Report All Cause Deaths
- Work with Justice Partners Inc to evaluate Jail Diversion Program
- Obtain, match and report suicide and drug deaths from county medical examiner
- Calculate and report Missed LPHA intakes rate
- Establish Collaborative relationship with Kinder Institute of Urban Research
- Evaluate Coffee House outcomes
- Estimate impact of housing instability on use of jail, hospital and crisis services
- Provide Research Support for STARS Clinic
- CAS A1c and BP abnormal cases with insurance status( Monthly)
- MH A1c and BP abnormal cases with insurance status (Monthly)
- DPP bi-annual report
- M&S audit request for DSRIP reporting
- No show rates for all physician procedures in MH clinics
- Research on  All Cause Deaths including DSHS IRB Application
- U of H hospital to home program evaluation
- SUD data exploration

# Health Analytics and Research Projects continued…

- DX syntax generation
- Patient Satisfaction V-SSS 2 Surveys (monthly)
- PoC-IP Surveys and Analysis (monthly)
- HR Vacancy Report (monthly)
- Complaint Call Tracking (monthly)
- Contracts Data (monthly)
- Patient Satisfaction Comment Analysis
- Toxicity & Drug Death Reporting
- Mine EPIC for Clinical Notes Containing Suicide Attempt Details
- Lit review for social skills outcomes measures; write intro for Coffeehouse Outcomes Data

- Review incident reporting system and EPIC to ensure patient deaths are being reported
- Track number of patient satisfaction surveys completed vs. distributed (monthly)
- Track patient satisfaction tool utilization (monthly)
- Develop tool to analyze V-SSS 2.1 - PES' patient satisfaction survey
- Patient Satisfaction Feedtrail & Centerwide (Monthly)
- Basis 24 - data entry & Analysis (Monthly)
- NPC Law Enforcement Consumer  data entry & Analysis (Monthly)
- Involuntary Consumer Transfer  data entry & Analysis (Monthly)
- Renew McLean Contracts (Annually)

# Health Analytics and Research Projects

- Suicide Death Rate
- Termination Rate (Monthly)
- CCBHC SAMHSA NOMS's comparison (Monthly)
- CCBHC Yearly and SemiYear reporting
- Intake CAS No show Questionnaire
- Individuals vs PCP BP BMI A1C information
- Coffee house participation level-summary & hospitalization
- Metrics for Integrated Care & Insurance Information
- Pre and Post abnormal blood pressure for open episode individuals
- Healthy Minds Healthy Communities
- ANSA and CANS with active episode
- DLA-20 Data pull
- Jail Diversion, H2H, Independent Living, and CRU open episode vs encounter

# IRB

- Ongoing development and transfer of the Committee for Protection of Human Subjects (CPHS) under Clinical Transformation & Quality leadership.
- Improved and hardwired processes to support Internal Review Board (IRB)
- Developed new policies and procedures, and accompanying templates for Proposal Review (initial, expedited, and exempt), Conflict of Interest, Change Request, Informed Consent, and Statement of Research Principles. Confirmed IRB membership, voting and non-voting members.
- Assumed administrative responsibility for CITI training program.
- Monthly IRB committee meetings for 2023 began in February. SMART IRB application targeted for 3rd quarter.

# Thank you.

# Questions

# EXHIBIT R-5

The HARRIS CENTER for Mental Health and IDD

Transforming Lives

# IDD Services Division

Presented By: **Dr. Evanthe Collins |** Vice President, IDD Division/Grants & State Contracts

# 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
24 days

→ Referral > SC
3-5 days

→ SC assigned
3.5 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 | May |
|---|---|---|---|---|---|---|---|---|---|
| Beginning of month* | 5,831 | 5,775 | 5,710 | 5,602 | 5,621 | 5,547 | 5,486 | 5,287 | 4,306 |
| Added | - | 37 | 22 | 34 | 30 | 59 | 42 | 14 | 0 |
| Removed | - | 102 | 130 | 15 | 104 | 120 | 241 | 995 | 524 |
| **TOTAL WAITING** | **5,831** | **5,710** | **5,602** | **5,621** | **5,547** | **5,486** | **5,287** | **4,306** | **3,782** |

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 24 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 6/5/23)

## 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 |
| **May** | 36 |

1. Average wait time to be assigned a service coordinator is 3.5 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 6/5/23)

## 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 | May |
|---|---|---|---|---|---|---|
| In-home respite (Contract) *Avg. wait time: ~1 month* | 9 | 9 | 23 | 13 | 23 | 34 |
| Out-of-home respite (Contract) *Avg. wait time: ~1 month* | 0 | 0 | 0 | 0 | 0 | 0 |
| Day Habilitation (Contract) *Avg, wait time: ~1 month* | 2 | 2 | 15 | 15 | 16 | 13 |
| Employment Services (Contract) *Avg. wait time: ~1 month* | 0 | 0 | 2 | 9 | 14 | 14 |
| Feeding Clinic (Internal) *Avg. wait time: ~1 month* | 24 | 1 | 0 | 0 | 0 | 1 |
| Outpatient Biopsychosocial Services (OBI) (Internal) *Avg. wait time: 9 months* | 99 | 176 | 181 | 143 | 120 | 102 |
| The Coffeehouse (Internal) *Avg. wait time: 9 months* | N/A | 8 | 13 | 24 | 27 | 29 |
| **TOTAL WAITING** | **134** | **196** | **234** | **204** | **200** | **193** |

*data has been validated and is post DID (as of 6/5/23)

# 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 |
| MAY 2023 | 1,040 |
| TOTAL | **5,831** **(100% of original July number)** |

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

**May data as of 6/5/23*

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 | 95 (12 external contracts) |
| MAY | 100 (12 external contracts) |
| FY23 Total | **973** |

**May data as of 6/5/23*

**May Breakdown:**
64 Full - 19 Updates - 17 Endorsements

**YTD Breakdown:**
570 Full - 280 Updates - 223 Endorsements

# DID Report Completion Timeframe

| | AVG Completion Time (CALENDAR DAYS) |
|---|---|
| SEPT | 21 |
| OCT | 24 |
| NOV | 28 |
| DEC | 33 |
| JAN | 23 |
| FEB | 25 |
| MAR | 21 |
| APR | 18 |
| MAY | 8* |
| AVG (excluding May) | **24 days** |

**May data as of 6/5/23*

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

# So, What's Next?

## Continue Case Closure

Apx. 500 cases have received a certified letter and need a final disposition. Final number will likely range between 2,500 and 3,000. **THIS LIST WILL NEVER BE ZERO.**

## Individuals Seeking Services

All callers (with permission) will be put on both Medicaid Waiver interest lists. Callers are screened for GR services and informed of current wait times. Callers are NOT classified by DID wait, rather will be listed as waiting for an identified GR service.

## Transition from GR WL to Services

Once an opening is available in service coordination (step 2), individuals will be contacted to complete the DID process. Individuals will not receive a DID until service coordination is available.*

## Of Note

Individuals will not be schedule for a DID until an intake packet is completed.*
Wait data collected by GR service type will be shared with HHSC.
We have appropriate DID capacity to meet the number of cases service coordination can receive.


*With the exception of crisis cases