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

Quality Committee Meeting
July 18, 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, June 20, 2023
(EXHIBIT Q-1)

IV. **REVIEW AND COMMENT**

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

B. Substance Use Disorder Internal Learning Collaborative Update
(EXHIBIT Q-3 Luming Li/Trudy Leidich)

C. Care Pathway Update
(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.

• 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

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, JUNE 20, 2023 MINUTES

Mr. Shaukat Zakaria, Board of Trustees Chair, called the meeting to order at 10:01 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 (virtual), 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**
   Mr. Zakaria called the meeting to order at 10:01am.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Mr. Shaukat Zakaria designated Dr. L. Moore as a voting member of the committee.

3. **DECLARATION OF QUORUM**
   Mr. Zakaria 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, May 16, 2023**

   MOTION BY: GEARING SECOND BY: GEARING

   With unanimous affirmative votes,
   BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday, May 16, 2023, as presented under Exhibit Q-1, are approved.

6. **REVIEW AND COMMENT**

   A. **Quality Board Score Card,** presented by Dr. Luming Li and Trudy Leidich, was reviewed by the Quality Committee.
   B. **Merit-based Incentive Payment System and Direct Payment Program Update,** presented by Dr. Luming Li and Trudy Leidich was reviewed by the Quality Committee.

C. Quality Annual Review of Accomplishments presented by Dr. Luming Li and Trudy Leidich was reviewed by the Quality Committee.

D. IDD Update, presented by Dr. Evanthe Collins was reviewed by the Quality Committee.

7. EXECUTIVE SESSION-

Mr. Zakaria announced the Quality Committee would enter into executive session at 10:49 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 11:22 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: MOORE SECOND: HELLUMS

There being no further business, the meeting adjourned at 11:22 a.m.

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

EXHIBIT Q-2

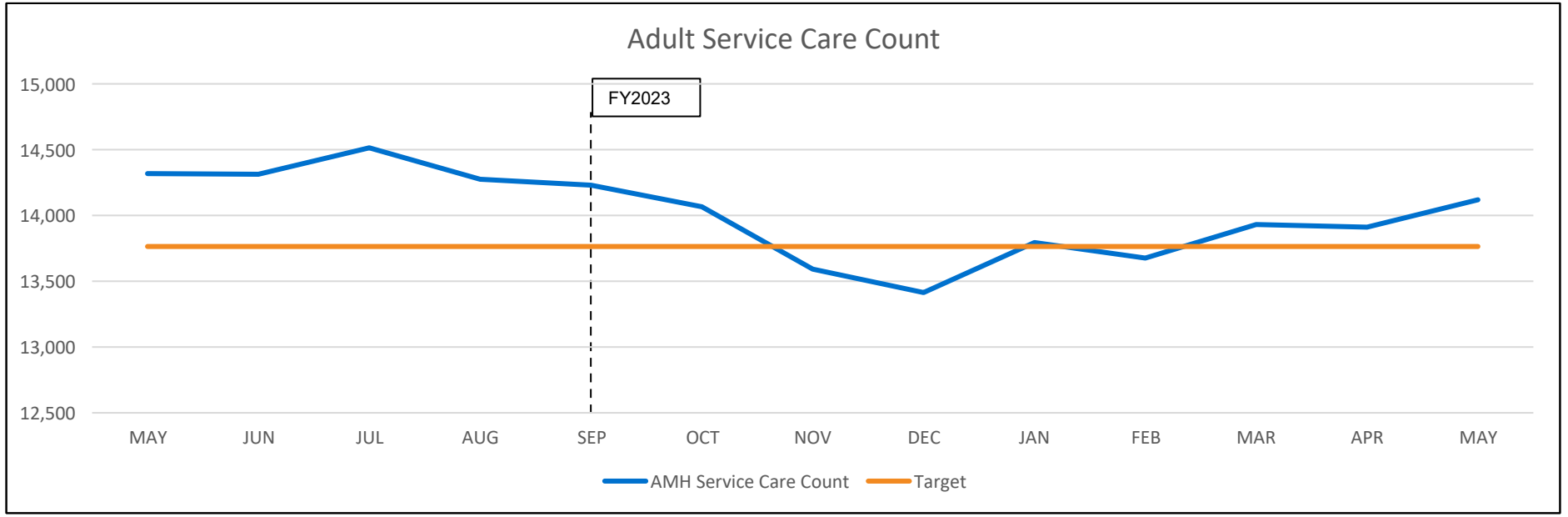
Quality Board Scorecard

Board Quality Committee Meeting

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

Reporting for May 2023

Domain	Program	2023 Fiscal Year State Care Count Target	2023 Fiscal Year State Care Count Average (Sep-May)	Reporting Period: May 2023 Care Count	Target Desired Direction	Target Type
Access	AMH Service Care Count	13,764	13,859	14,119	Increase	Contractual

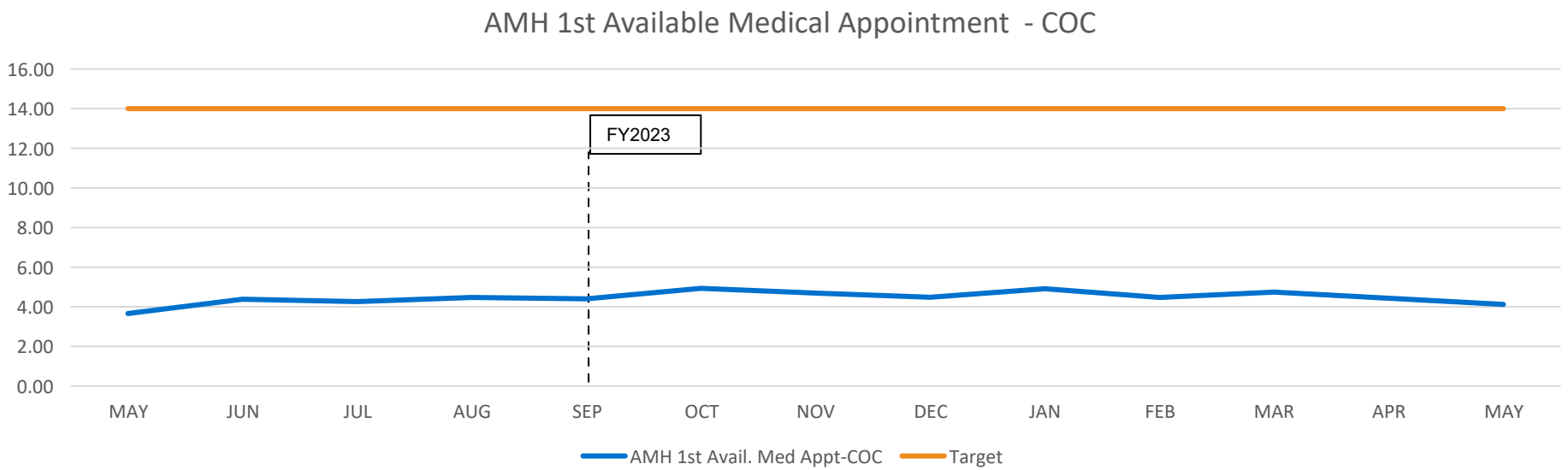


Highlights:

- Adult service care count average is performing above contractual target. The fiscal year over year average is **up 3.36%,** the fiscal year to date (Sep-May 2023) average of 13,859 compared to same period in (Sep-May FY2022) 13,409).
- The Adult Service Care Count for May is **2.58%** above the contractual target.
- Adult service care count is down slightly (less than 2%) compared to the same period in 2022.

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-May)	Reporting Period May	Target Desired Direction	Target Type
Timely Care	AMH 1st Avail. Medical Appt-COC	<14 days	4.57 Days	4.12 Days	Decrease	Contractual



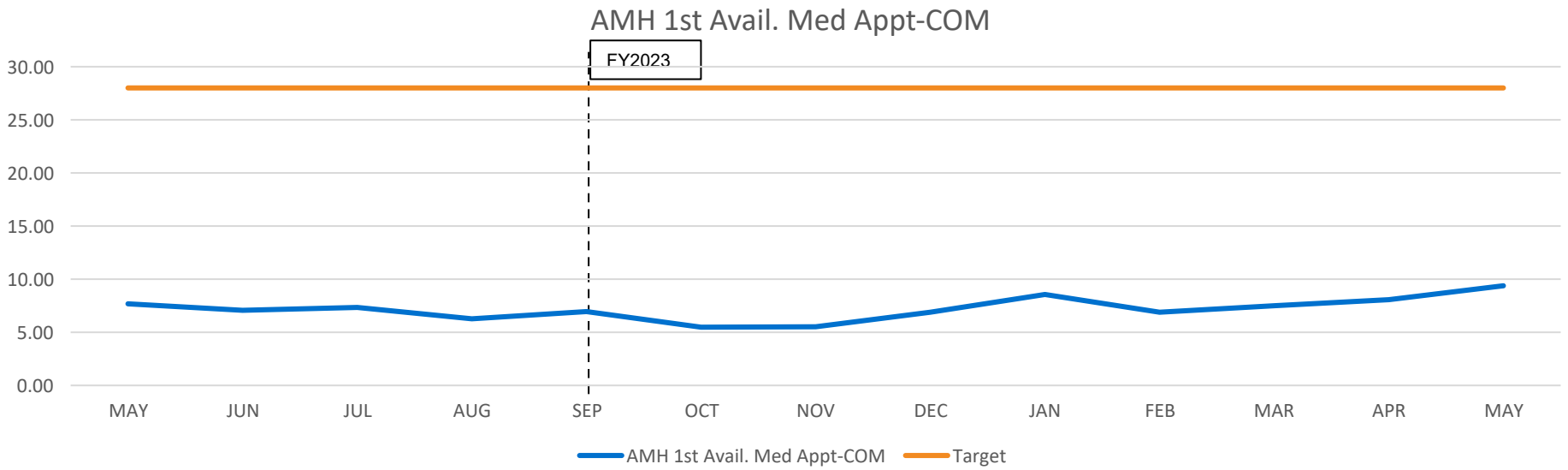
Highlights:

- Time to contact COC patients continues to perform well for AMH.
- AMH has achieved **a 13% reduction** in the 1st available medical appointment for continuity of care patients. From an average of **5.28** days in Sep-May in FY2022, to **4.57** days in Sep-May FY2023.

- For the reporting period May 2023, AMH 1st available medical appointment for continuity of care **increased by 12%** from **3.66 days (May 2022) to 4.12 days in May 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-May)	Reporting Period-May	Target Desired Direction	Target Type
Timely Care	AMH 1st Avail. Medical Appt-COM	<28 days	7.25 Days	9.38 Days	Decrease	Contractual

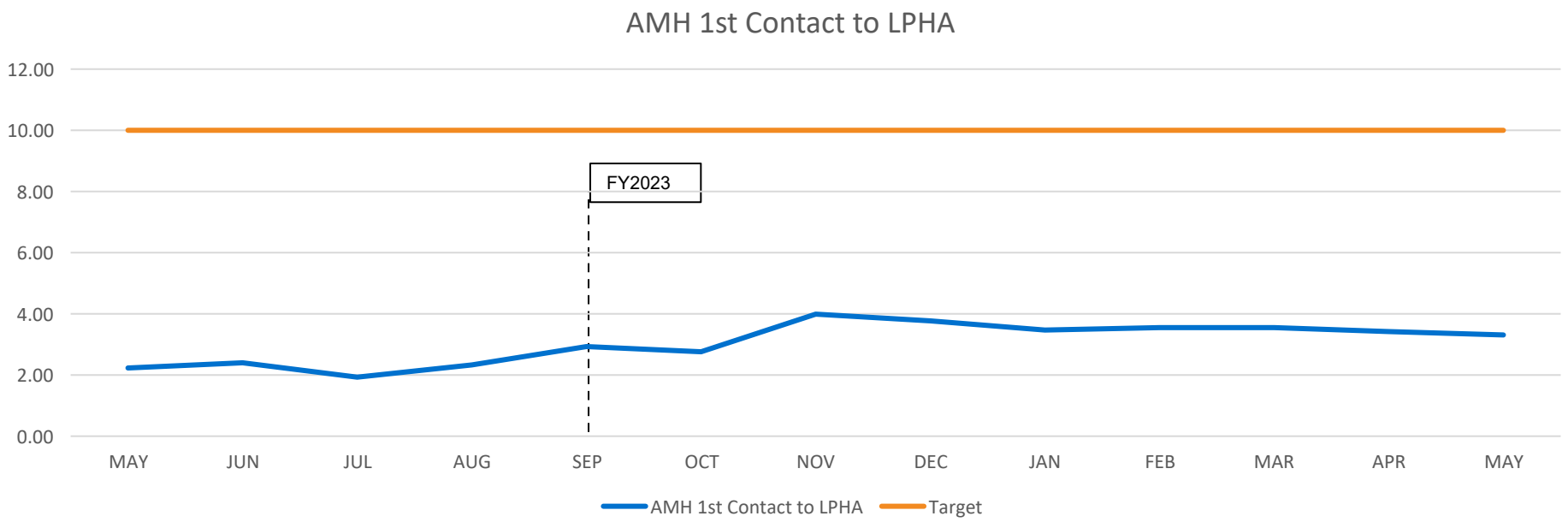


Highlights:

- Access to medical appointment for community members (walking-ins without an appointment) continues to perform well for AMH.
- AMH has achieved **a 66% reduction** in the 1st available medical appointment for community members (walking-ins without an appointment). From an average of **21.89 days Sep-May** in 2022 to **7.25 days in Sep-May 2023.**
- For the reporting period May 2023, AMH reduced the time for 1st available medical appointment for community members (walking-ins without an appointment) **by 50%** from **18.91** days (May 2022) to **9.38 days in May 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-May)	Reporting Period-May	Target Desired Direction	Target Type
Timely Care	AMH 1st Contact to LPHA	<10 days	3.42 Days	3.31 Days	Decrease	Contractual

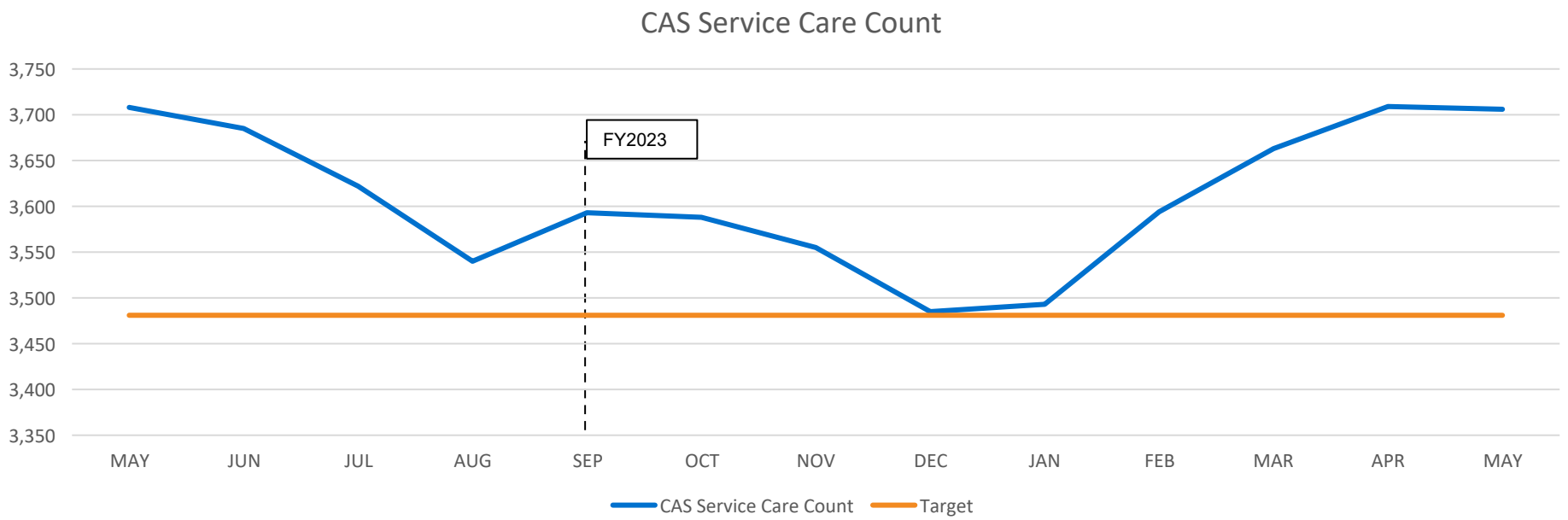


Highlights:

- 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 **1.59 days (Sep-May 2022) to 3.42 in the same period in Sep-May 2023**; and **increase to 3.31 days in May 2023 from 1.96 days in May 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-May)	Reporting Period- May	Target Desired Direction	Target Type
Access to Care	CAS	3,481	3,598	3,706	Increase	Contractual

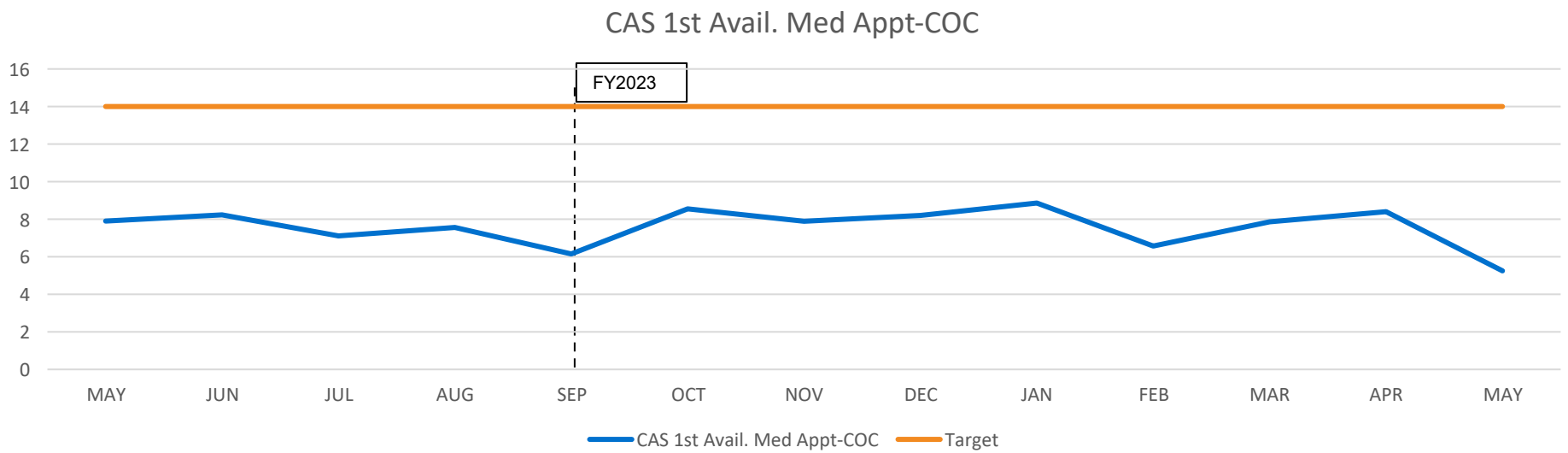


Highlights:

- CAS service care count average is up **3%** in fiscal year to date Sep-May 2023 (**3,598**) compared to same period in FY2022 (**3,489**)
- May CAS Service care count is about the same this reporting period (**3,709**) compared to May 2022 (**3,708**)

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-May)	Reporting Period-May	Target Desired Direction	Target Type
Timely Care	CAS 1st Avail. Medical Appt-COC	<14 days	7.45 days	5.25 Days	Decrease	Contractual



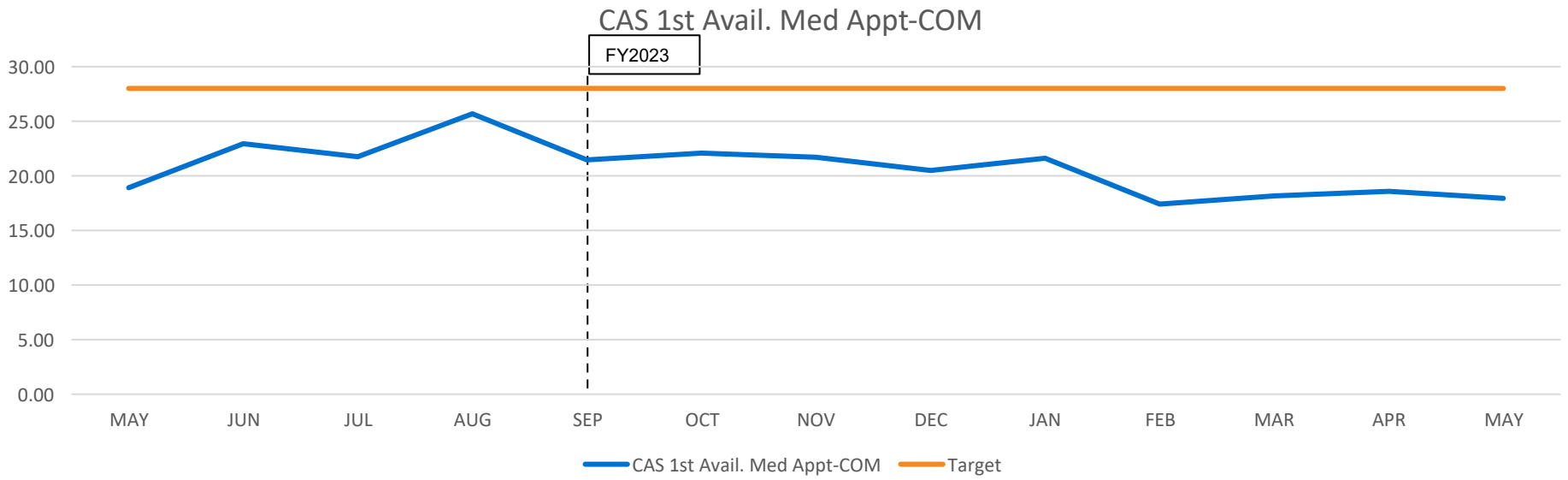
Highlights:

- Time to contact patients for continuity of care after hospital discharge continues to perform well for CAS.
- CAS reduced the days for 1st available medical appointment for continuity of care patients by 3% when comparing year to year averages. From an average of **7.68 days (Sep-May) in 2022 to 7.45 days in Sep-Apr 2023**.

- For the reporting period, May 2023, CAS saw about a **33% reduction** in the number of days for 1st available medical appointment from **7.9 days** (May 2022) to **5.25 days** in May 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-May)	Reporting Period-May	Target Desired Direction	Target Type
Timely Care	CAS 1st Avail. Medical Appt-COM	<28 days	19.94 Days	17.94	Decrease	Contractual

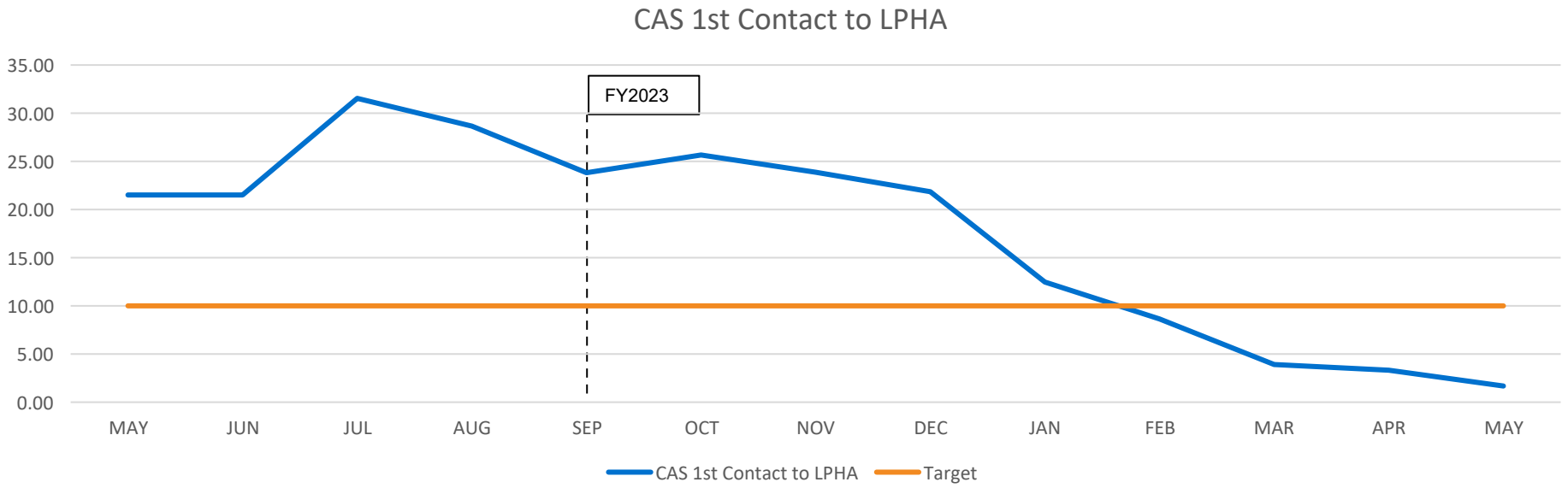


Highlights:

- Time to contact patients continues to perform well for CAS.
- CAS 1st available medical appointment for community members walk-ins, had **8.91% decrease** year over year. From an average of **21.89 days in Sep-May 2022 to 19.94 days in Sep-May 2023.**
- For the reporting period May 2023, CAS reduced the number of days for 1st available medical appointment for community members walk-ins by **5% from 18.91 days in May 2022 to 17.94 days in May 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-May)	Reporting Period-May	Target Desired Direction	Target Type
Timely Care	CAS 1st Contact to LPHA	<10 days	13.91 Days	1.68	Decrease	Contractual

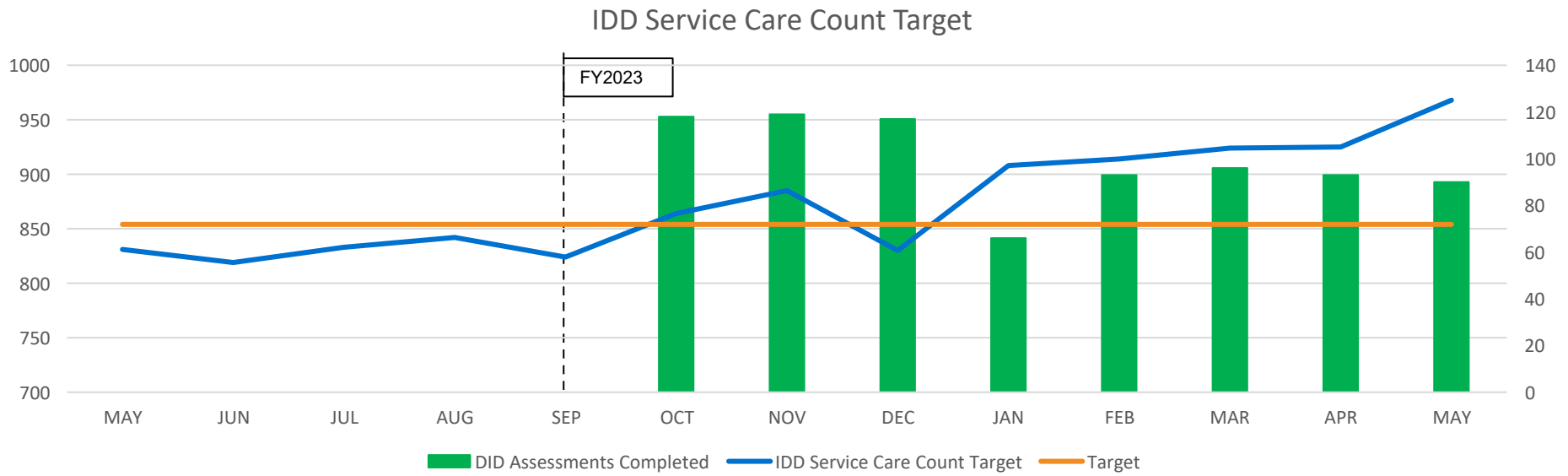


Highlights:

- CAS hybrid model (combination of open booking and scheduling) for LPHA assessment continues to improve access to care for children and adolescent seeking care.
- In September patients were waiting an average of 23 days for an LPHA assessment. Due to the implementation of the hybrid walk-in process, patient are waiting on average less than 2 days.
- There was also a decrease in the month-to-month comparison. From 21.51 days in May 2022 to 1.68 days in May 2023. An 92% reduction in wait time compared to the same period in 2022.

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-May)	Reporting Period-May	Target Desired Direction	Target Type
Access	IDD	854	894	968	Increase	Contractual



	SEP	OCT	NOV	DEC	JAN	FEB	MAR	April	May
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 12% increase** in the total average service care count when comparing the same period in 2022: from an average of 794 in Sep-May 2022 to 894 in Sep-May 2023.
- For the reporting period May 2023, IDD has increased the service care count by **16%** in comparison to May 2022, from 831 for **May 2022 to 968 in May 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.

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).

STEP 3 GR SERVICES

HHSC Contracted Services
Internal/External Providers
Community Linkages

Number waiting to access an authorized GR service*

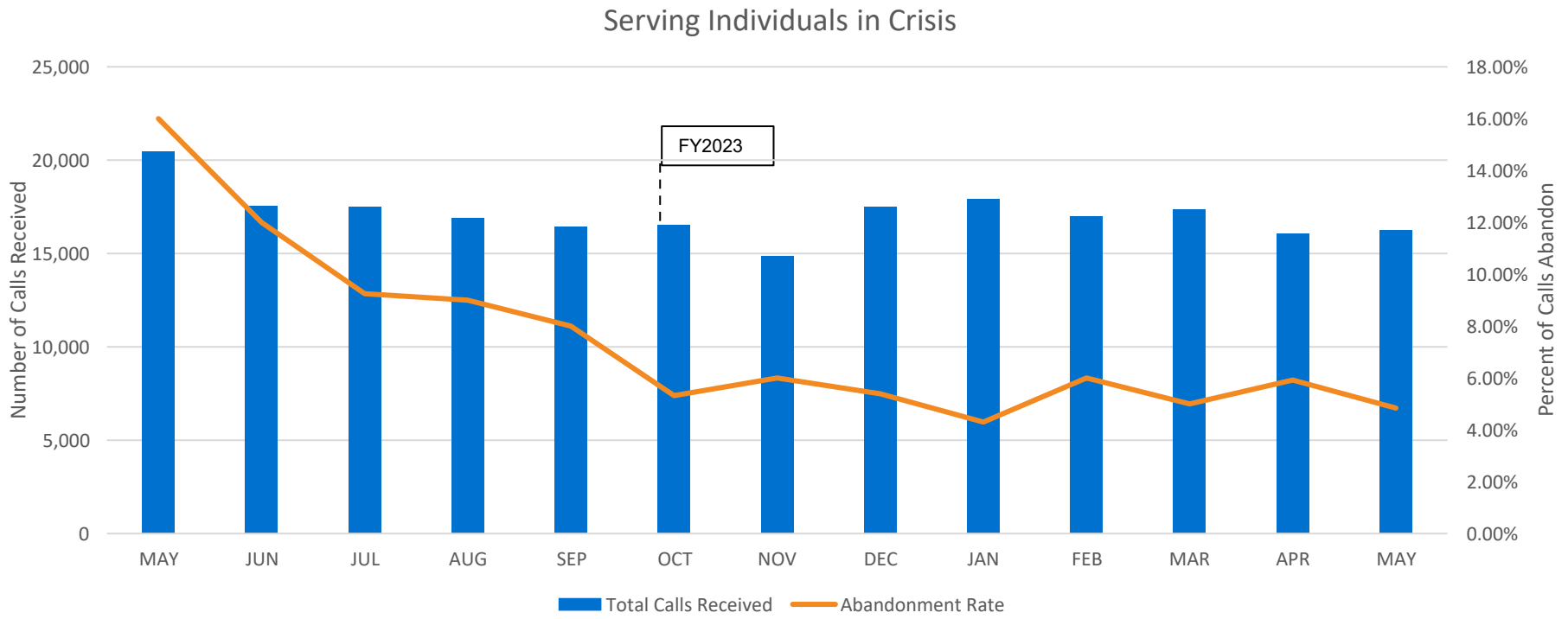
	Dec	Jan	Feb	Mar	Apr
In-home respite (Contract) *Avg. wait time: ~1 month*	9	9	23	13	23
Out-of-home respite (Contract) *Avg. wait time: ~1 month*	0	0	0	0	0
Day Habilitation (Contract) *Avg, wait time: ~1 month*	2	2	15	15	16
Employment Services (Contract) *Avg. wait time: ~1 month*	0	0	2	9	14
Feeding Clinic (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**

***contains invalid data**
**** Average based on previous workflow**

***data has been validated and is post DID**

***data has been validated and is post DID**

Domain	Measures (Definition)	FY 2023 Target	2023Fiscal Year Average (Sep-May)	Reporting Period-May	Target Desired Direction	Target Type
Timely Care	Total Calls Received	N/A	16,650	16,233	Increase	Contractual
	Abandonment Rate	<8%	5.64%	4.84%	Decrease	Contractual



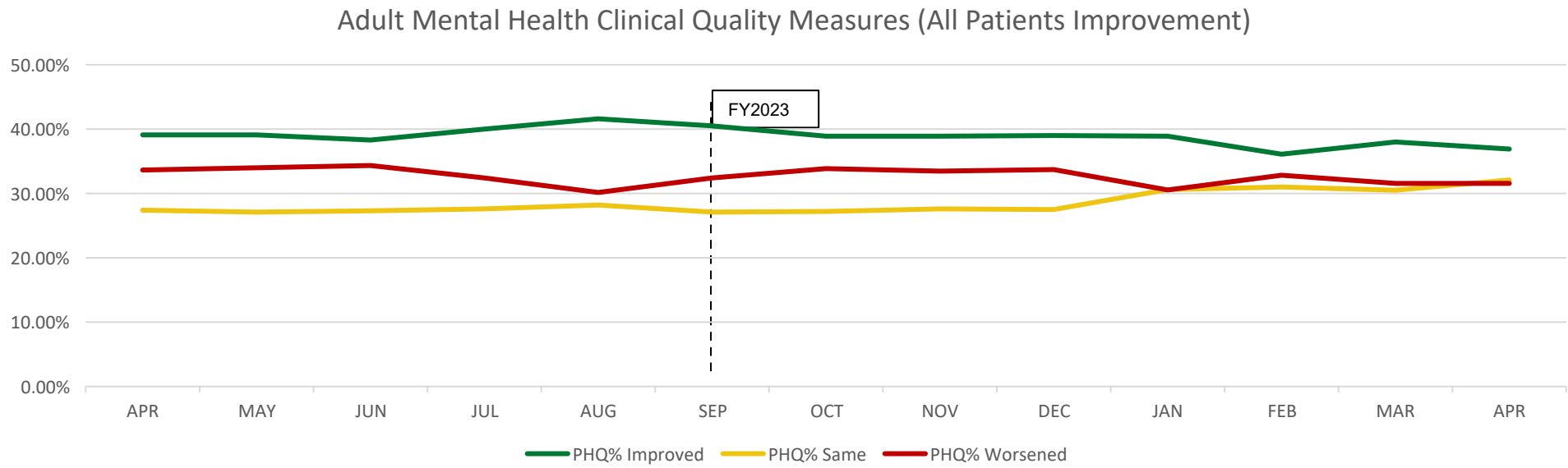
Highlights:

Crisis Line continues to support individuals in crisis.

- The crisis line team handled more than 16,000 calls for the reporting period. It reduced its abandonment rate, calls unanswered by a team member within 8 seconds, to less than 5%.

Measure definition:
Total Calls Received: # of Crisis Line calls answered (All partnerships and Lifeline Calls)
Abandonment Rate: % of unanswered Crisis Line calls which hung up after 10 seconds (All partnerships and Lifeline Calls)

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%

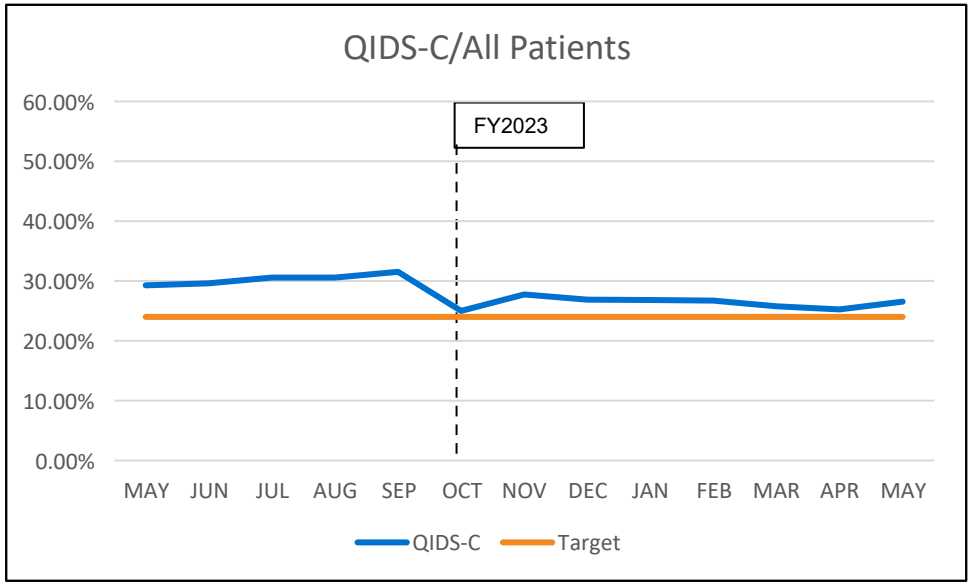


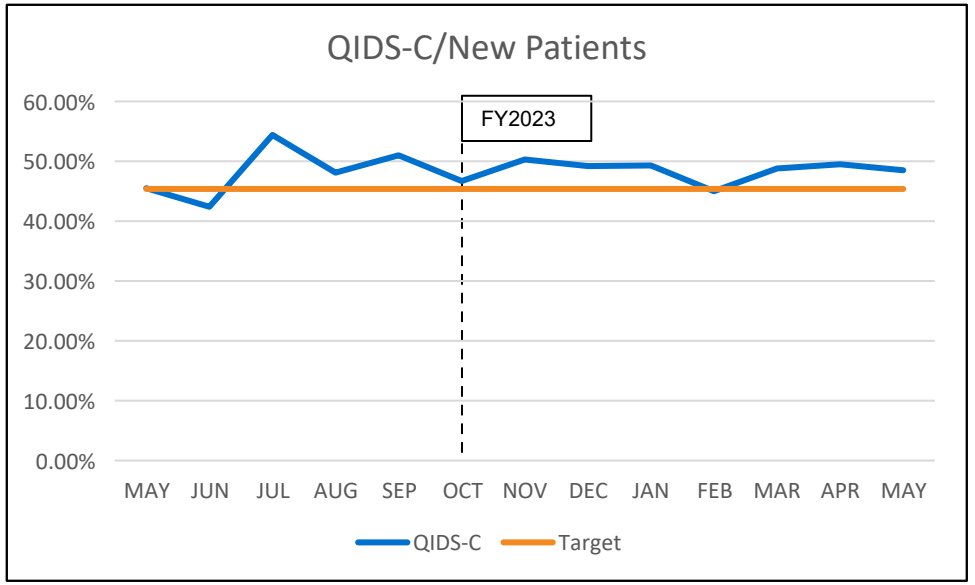
- This measure is under review as part of an intervention for measurement-based care by the MH and Quality team
- The intervention, led by Dr. Muzquiz and the Quality team, will conduct a test of change for administering patients' self-assessment mental health scales are completed on the day of appointment for patients. This intervention will start at the Southeast clinic. Upon review of the data, the BH team leadership will determine how to spread the process across the system.

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





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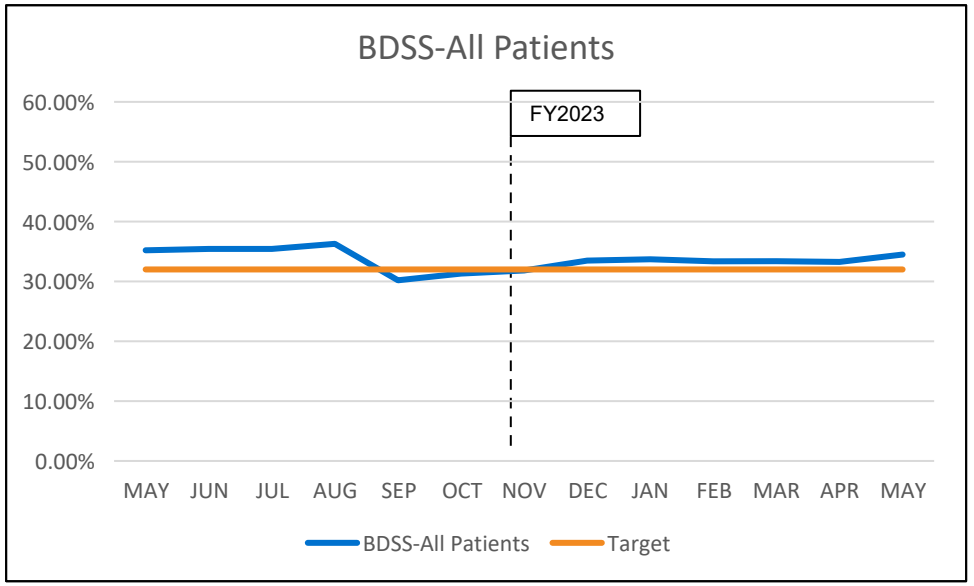
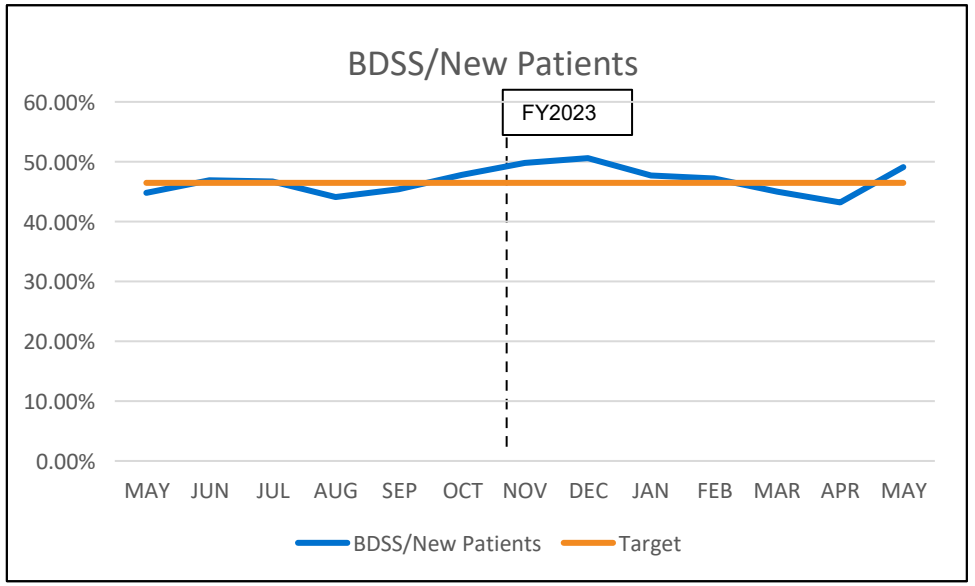
Measure computation: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the QIDS-C. Clients must have at least 90 days from first assessment to last assessment.

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





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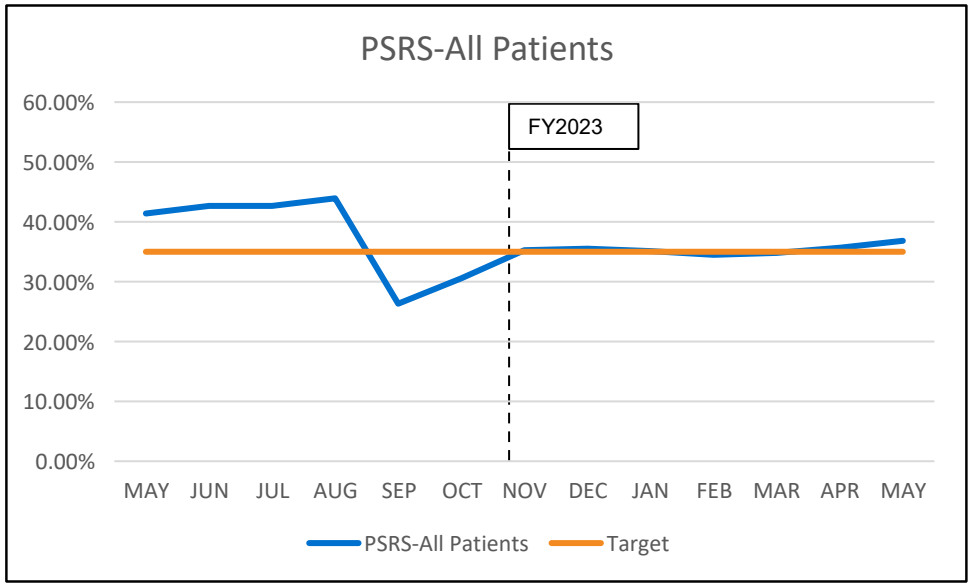
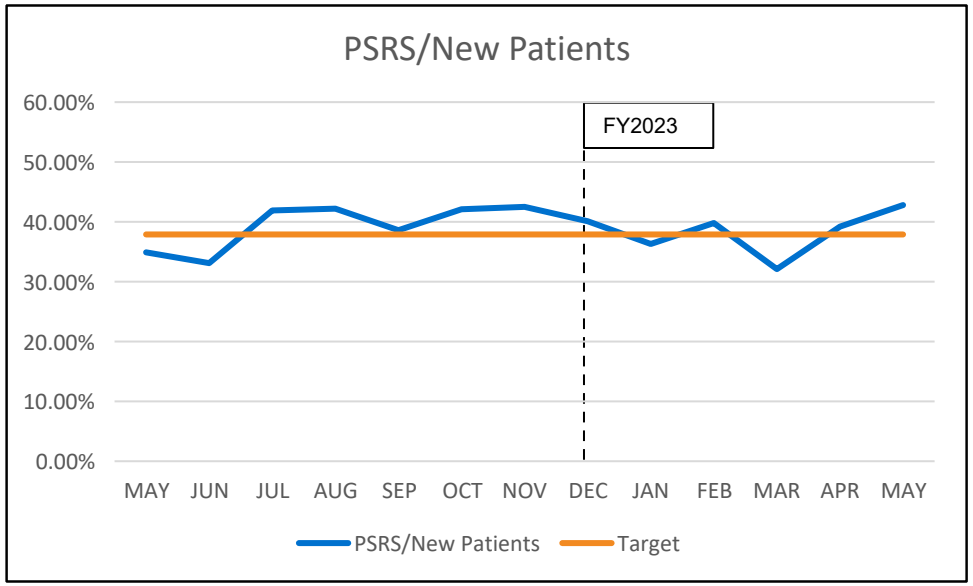
Measure computation: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the BDSS. Clients must have at least 90 days from first assessment to last assessment

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

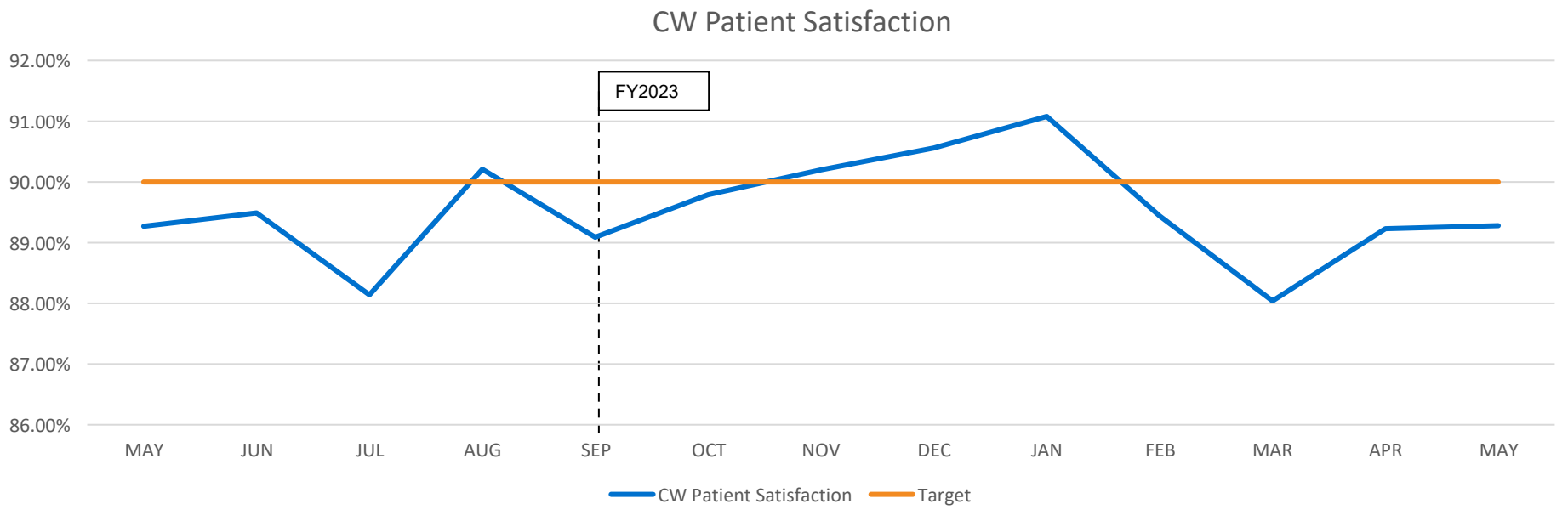




- This measure is under review as part of an intervention for measurement-based care by the MH and Quality team
- The intervention, led by Dr. Muzquiz and the Quality team, will conduct a test of change for administering patients' self-assessment mental health scales are completed on the day of appointment for patients. This intervention will start at the Southeast clinic. Upon review of the data, the BH team leadership will determine how to spread the process across the system.

- *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-May)	Reporting Period-May	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	90%	89.63%	89.28	Increase	IOS



Highlights:

- Center wide patient satisfaction fell below its monthly target.

- This measure is under review. A patient satisfaction subcommittee was formed to address the dip in patient satisfaction. The sub-committee consist of a multidisciplinary team members along the care delivery pathway, including members with lived experience as patients receiving services from the Center. The subcommittee will report to the System Quality Safety and Experience and its goal is to improve patient satisfaction and experience. The subcommittee will review patients' feedback on a monthly basis and work with divisions to improve overall satisfaction.

Appendix

CAS Project
Improving 1st Contact to LPHA

Children and Adolescent Services Project Team

Southwest Children and Adolescent Services Walk-in Process Team: (L to R)

Kathena Collins, JaQuece L. Haney, Georgetta Medlock, Dawn Barras, Darus Gonzalez, and Tiffanie Williams-Brooks

CAS Scheduling Project Overview

WHY

- Individuals in need of medical appointment must be assessed by an LPHA before scheduling a psychiatric appointment. Individuals are scheduled based on LPHA's availability for the assessment.
- In September, the director of analytics ran a report that showed a correlation between pre-scheduled wait times for an appointment and the no-show rate. Twenty seven percent of pre-scheduled patients no showed for appointments scheduled 7 days out, compared to 75% for appointments scheduled at more than 60 days.

WHAT

- Tiffanie Williams-Brooks, director of CAS, formed a workgroup that implemented the walk-in model, to reduce the number of days for children and adolescents seeking care to be assessed by an LPHA.

HOW

Project CAS Intake Rebuild began January 18th with the assistance of the Business Office Team and 5 volunteer LPHA's

Intakes were scheduled out for months due to most clients requesting prescheduled appointments since he start of the pandemic

All intakes were contacted and provided information about walk-ins and only specifically identified clients were prescheduled

126 clients were scheduled with the volunteers

Since January 18th, the volunteers assessed and admitted 55 clients; 40 no showed; and there are 31 pending appointments

The EC will have 5 LPHA's who will be able to manage the Walk-ins and Prescheduled intakes

Project CAS Intake Rebuild ends March 10th and the volunteers return to their units

IMPACT

The project, implemented from January through March 2023, was impactful in two ways:

- It reduced the number of individuals, on the LPHA panel, waiting for an appointment to be assessed from 450 to 0.
- It reduced the number of days that children/adolescents had to wait to be assessed by LPHA from 23 days in September 2022 to less than 2 days in May 2023.

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	0	IOS	MH-BO
Adult Service Target	14,230	14,066	13,592	13,414	13,794	13,676	13,931	13,911	14,119				13,859	13,764	C	MBOW
AMH Actual Service Target %	103.39%	102.19%	98.75%	97.46%	100.22%	99.36%	101.21%	101.07%	102.58%				100.69%	100.00%	C	MBOW
AMH Serv. Provision (Monthly)	48.00%	49.20%	45.90%	47.10%	49.20%	49.60%	52.20%	47.60%	51.30%				48.90%	≥ 65.60%	C	MBOW
CAS Waitlist (State Defined)	0	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	3,706				3,598	3,481	C	MBOW
CAS Actual Service Target %	103.22%	103.07%	102.13%	100.11%	100.34%	103.25%	105.23%	106.55%	106.46%				103.37%	100.00%	C	MBOW
CAS Serv. Provision (Monthly)	76.70%	76.00%	74.00%	72.50%	78.20%	76.30%	76.00%	71.00%	75.20%				75.10%	≥ 65.00%	C	MBOW
DID Assessment Waitlist													#DIV/0!	0	IOS	IDD-BO
IDD Service Target	824	864	885	830	908	914	924	925	968				894	854	SP	MBOW
IDD Actual Service Target %	96.49%	101.17%	103.63%	97.19%	106.32%	104.03%	108.20%	108.31%	113.35%				104.30%	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	1.68				13.90	<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	3.31				3.29	<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	3.06				5.25	<10 Days	NS	Epic
CAS 1st Avail. Med Appt-COC	6.15	8.55	7.89	8.20	8.86	6.57	7.20	8.40	5.25				7.45	<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	17.94				19.91	<28 Days	NS	Epic
CAS # Pts Seen in 30-60 Days	49	45	45	44	47	19	51	40	53				43.67	<9.18	IOS	Epic
CAS # Pts Seen in 60+ Days	26	27	35	27	35	43	22	18	14				27.44	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	4.43	4.12				4.57	<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	9.38				7.27	<28 Days	NS	Epic
AMH # Pts Seen in 30-60 Days	6	2	2	1	4	5	1	1	4				2.89	<45	IOS	Epic
AMH # Pts Seen in 60+ Days	2	1	1	0	0	0	0	0	1				0.56	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	16,233				16,650			
AVG Call Length (Mins)	8.00	8.00	8.10	8.70	8.50	8.80	9.30	9.20	9.80				8.71			
Service Level	86.00%	91.34%	91.00%	90.76%	92.00%	88.00%	89.00%	89.00%	89.64%				89.64%	≥ 95.00%	C	Brightmetrics
Abandonment Rate	8.00%	5.32%	6.00%	5.39%	4.30%	6.00%	5.00%	5.92%	4.84%				5.64%	< 8.00%	NS	Brightmetrics
Occupancy Rate	73.00%	69.00%	69.00%	71.00%	72.00%	77.00%	74.00%	76.00%	76.00%				73.00%			Brightmetrics
Crisis Call Follow-Up	100.00%	99.79%	99.76%	99.77%	99.77%	99.76%	100.00%	99.50%	100.00%				99.82%	> 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%	84.50%				88.07%	> 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	1,106	1,155				1166			
PES Admission Volume	523	585	560	544	555	498	549	522	558				543.78			
Mechanical Restraints	0	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				0.00	≤ 0.01	IOS	Epic
Personal Restraints	46	40	37	37	43	50	79	76	43				50.11			Epic
Personal Restraint Rate	2.07	1.95	1.78	1.77	1.98	2.68	3.85	4.23					2.54	≤ 2.80	IOS	Epic
Seclusions	33	35	19	32	20	39	53	74	35				37.78			Epic
Seclusion Rate	1.48	1.61	0.92	1.53	0.92	2.09	2.58	4.11					1.91	≤ 2.73	SP	Epic
AVG Minutes in Seclusion	46.91	58.66	52.62	51.82	41.70	49.76	44.33	54.92	42.00				49.19	≤ 61.73	IOS	Epic
Emergency Medications	44	54	42	47	58	56	72	72	67				56.89			Epic
EM Rate	1.98	2.48	2.02	2.25	2.67	3.01	3.50	4.00	3.61				2.84	≤ 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%	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%	89.28%				89.63%	90.00%	IOS	Feedtrail
V-SSS 2	88.69%	89.66%	90.24%	90.32%	90.38%	89.33%	87.30%	88.69%	88.65%				89.25%	90.00%	IOS	Feedtrail
PoC-IP	89.71%	89.30%	89.25%	90.14%	95.15%	90.74%	90.61%	91.85%	91.08%				90.87%	90.00%	IOS	McLean
Pharmacy	93.02%	99.09%	96.31%	96.19%	94.87%	100.00%	97.58%	96.37%	97.66%				96.79%	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%	26.55%				26.26%	24.00%	IOS	MBOW
BDSS	30.19%	31.31%	31.83%	33.48%	33.70%	33.36%	33.38%	33.26%	34.49%				32.78%	32.00%	IOS	MBOW
PSRS	26.32%	30.56%	35.26%	35.51%	35.11%	34.49%	34.81%	35.67%	36.83%				33.84%	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%	47.20%	49.70%	48.50%				48.90%	45.38%	IOS	Epic
BDSS	46.10%	46.20%	51.80%	50.30%	48.70%	47.20%	45.40%	42.80%	49.10%				47.51%	46.47%	IOS	Epic
PSRS	38.20%	41.70%	43.50%	42.40%	36.00%	39.70%	32.30%	39.30%	42.80%				39.54%	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%	35.20%	36.20%	37.20%				31.44%	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%	41.10%				38.60%	20.00%	C	MBOW
CANS (Child/Adolescent)	43.14%	21.65%	18.14%	19.80%	21.31%	25.30%	27.30%	30.50%	33.00%				26.68%	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%	44.20%	45.00%	44.20%				45.63%	48.07%	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
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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)

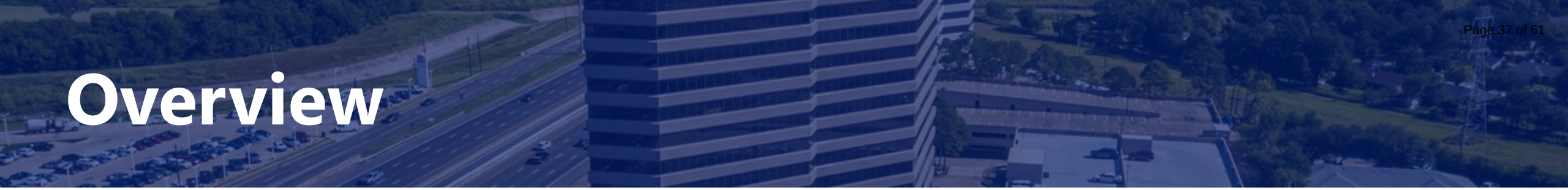
QIDS-C	% of all new patient adult clients that have improved psychiatric symptomatology as measured by the QIDS-C. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)
BDSS	% of all new patient adult clients that have improved psychiatric symptomatology 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

Substance Use Disorder Internal Learning Collaborative

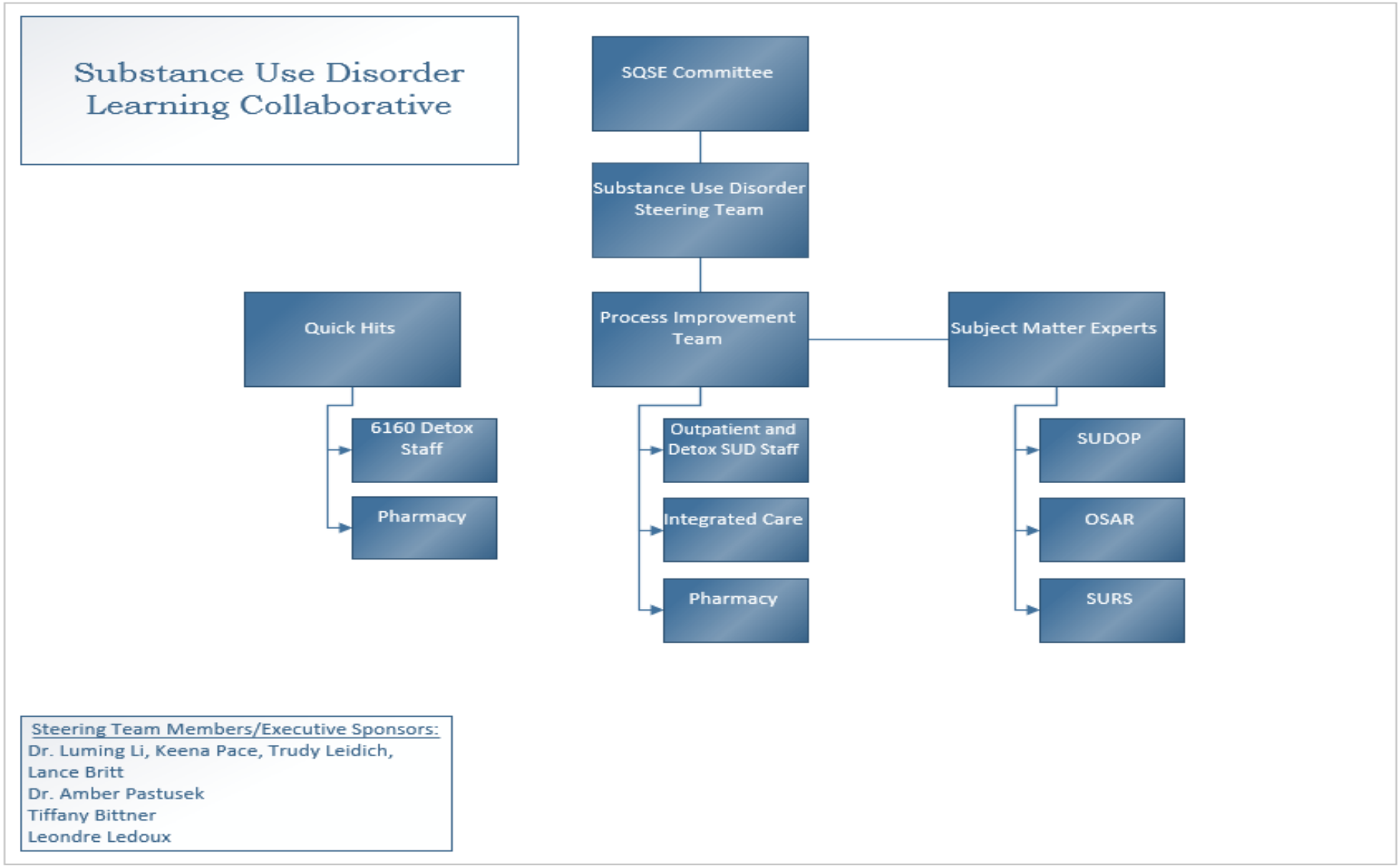
Presented by: Trudy Leidich
July 18th, 2023



Overview

- Structure
- Implementation of a substance use disorder care pathway
- Internal and External Resources
- Connecting programs and divisions
- Accomplishments

Structure and Key Leaders



Connecting Programs and Divisions

Learning Collaborative Representation – connecting programs and leaders throughout the agency to better understand and use the substance use disorder (SUD) services available at The Harris Center

- Mental Health (Adult and Child and Adolescent Services)
- Comprehensive Psychiatric Emergency Programs (CPEP)
  - Neuro-Psychiatric Center (NPC)
  - Detox
  - Residential
- Substance Use Disorder Outreach Program (SUDOP)
- Outpatient Screening, Assessment and Referral (OSAR)
- Clinical Transformation and Quality

Creation of streamline referral pathways and processes between programs to get clients to the right place and level of care the first time

Internal Resources

Adult Outpatient Services:

- Chemical dependency counselling
- Group sessions
- Linkage to community resources for inpatient, outpatient and residential treatment
- Work with SUDOP and OSAR for community needs when needed

Detox Program:

- Medication Assisted Treatment for opioid use disorder, alcohol use disorder and benzo misuse
- Chemical dependency counselling
- Group and individual sessions
- Assistance with discharge to next level of care (long term residential, outpatient services, mental health services, etc.)

External Resources

OSAR: Outpatient Screening, Assessment and Referral

- Embedded at 4 Mental Health (MH) clinic locations
- Link existing MH clients with various vetted resources in the community and throughout the state
  - Inpatient, Outpatient and Residential
  - Also refer to Harris Center detox program
- Use Clinical Management for Behavioral Health Services (CMBHS) documentation system and screenings

SUDOP: Substance Use Disorder Outreach Program

- Embedded in the community for new outreach and those not started at The Harris Center
- Clinic space to intake clients
- Access to multiple community resources via MOUs, standing relationships and needs specific placement
- Work with Texas Clinic under MOU for clients needing Medication Assisted Therapy (MAT) placement as well as UT Health

Implementation – Detox Program Care Pathway

New Best Practice Processes:

- Overdose Safety Plan
- Brief Negotiated Interview (Motivational Interviewing)
- Enhanced Medical Clearance Process – Client Retention into Detox Program
  - Direct phone and specific chart communication with receiving hospital
  - Client information packet with detox program phone numbers and contacts, SUD resources and information, activity pages for Emergency Center (EC) waiting periods, pertinent assessment documentation
  - Client assisted with check in at EC before detox team departs
- Narcan Provided on Discharge

Other Accomplishments/Successes

Other improvements made within Detox and outpatient SUD services

- Enhanced documentation in EPIC and CMBHS
- Trackable data elements
- Additional programmatic offerings:
  - Increased number of 1:1 sessions with counselors and nurses
  - Increased educational touchpoints for clients
- Additional staff training around substance use disorders

Robust conversation around the future of outpatient medication assisted treatment (MAT) for substance use

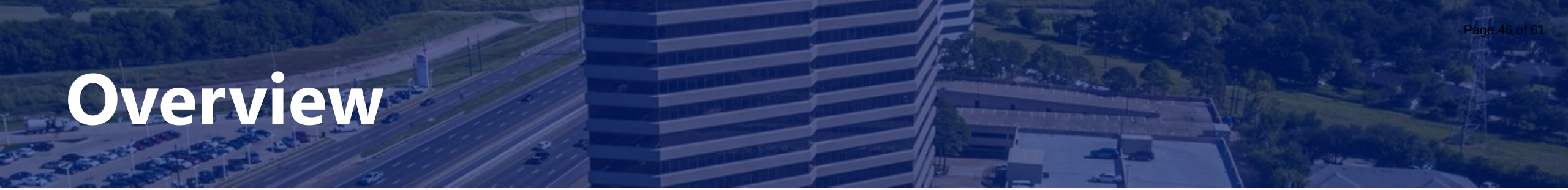
- Narcan distribution and documentation roll out

Thank You

EXHIBIT Q-4

Strategic Goal: Develop and Implement Clinical Care Pathways

Presented by: Trudy Leidich
July 18th, 2023



Overview

Suicide Care Pathway

- Training
- Current Metrics
- Challenges
- Next Steps

Detox Care Pathway

- Training
- Current Metrics
- Challenges
- Next Steps

MENTAL HEALTH NEW INTAKE SUICIDE PATHWAY TO CARE

Updated: 1/2023

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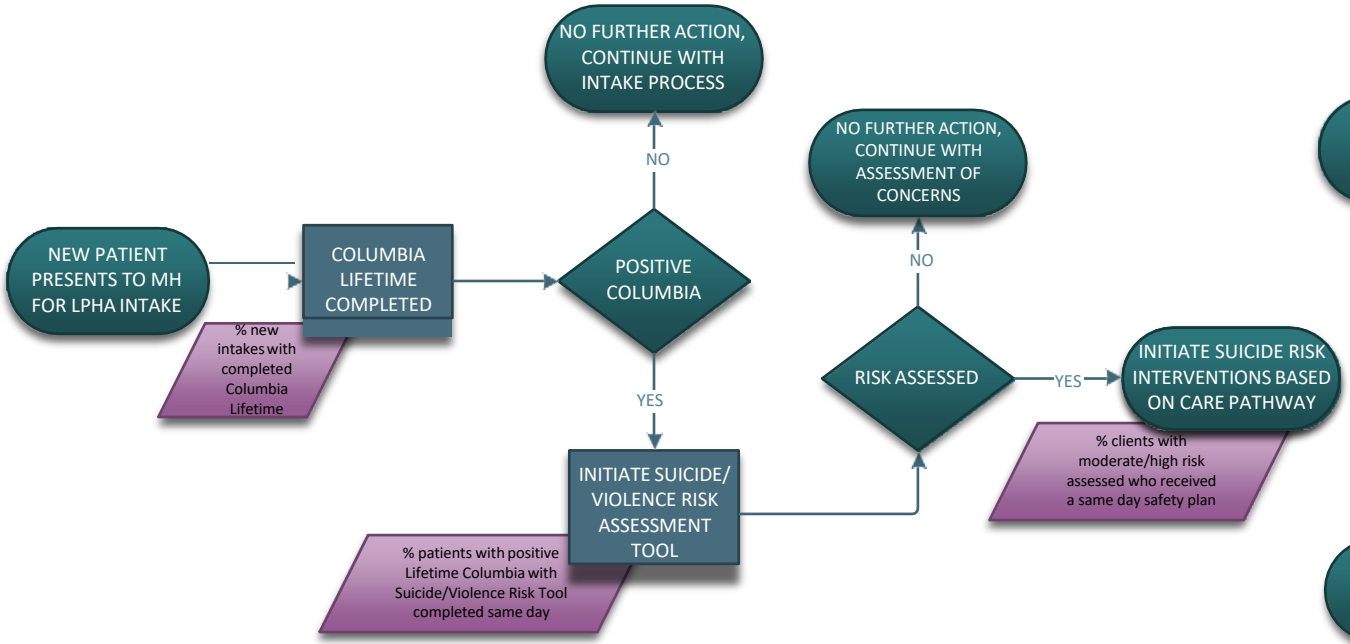
The interventions listed in this pathway serve as a menu of options and are not all inclusive and may not all apply to every client



LOW
In the Past 3 Months
Suicidal/Homicidal Ideation(s)
and/or
Engaged in aggression towards others or self harm behavior(s)

Psychoeducation Active Monitoring
Safety Plan
Advise to Remove Weapons Outpatient therapy
Psychiatric Referral

MODERATE
In the Past 1 Month
Suicidal/Homicidal Ideation(s)
and/or
Engaged in aggression towards others or self harm behavior(s)

Psychoeducation Active Monitoring
Safety Plan
Advise to Remove Weapons
Outpatient therapy focused on Suicide strategies and/or Anger Management
Psychiatric Evaluation/ Management (within 2 weeks)
Intensive Outpatient Services
Partial Hospitalization Program (PHP)

HIGH
In the Past 2 Weeks
Suicidal/Homicidal Ideation(s)
and/or
Engaged in aggression towards others or self harm behavior(s)

Initiate Crisis Response
Voluntary Psychiatric Evaluation (Video visit, Voluntary transport, MCOT Rapid Response)
Involuntary Psychiatric Evaluation (911 Dispatch)
Initiate Mental Health Warrant
Advise to Remove Weapons

Associated Care Douments:

1. Suicide Care Pathway – New Intake (System)

2.Suicide Risk Assessment Training Presentation

Suicide Care Pathway – Staff Training

- Suicide Violence Risk Assessment Tool Training
  - Approximately 60 Eligibility Center intake workers trained to perform appropriate suicide risk assessment
- Safety Planning Intervention (SPI) Trainer Training
  - Licensed and non-licensed clinicians are now trained to be master trainers in safety planning
- Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP)
  - Licensed staff are trained in evidence based suicide treatment for use with suicide risk clients

Suicide Care Pathway – Next Steps

Training Logistics

- Next steps require the training of licensed and non-licensed clinical staff in suicide risk assessment tool (400-500)
- Build into Harris Center training tracking portal
- New hire training

Data

- Multiple Epic builds needed for appropriate data collection
- Staff education for documentation changes
- Build of “Epic Registry” for tracking clients “on and off” the suicide care pathway

Resource Availability for Increased Intervention

- Interventions are time intensive and require 1:1 client care
- Large portion of clients require:
  - Increased follow up and touch point calls
  - Safety planning
  - Referrals for therapy (Cognitive Behavioral Therapy (CBT), Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP), group sessions, etc.)
  - Counseling on access to lethal means

Suicide Care Pathway – Next Steps (continued)

Finalize and implement Existing Client Suicide Care Pathway with key metrics

- Re-screening
- Re-assessment
- Same day safety planning for those who need it (currently being rolled out)

Initiate new suicide care pathways in other divisions

- IDD new intakes will have a risk assessment done (build phase)
- Crisis divisions
- Neuropsychiatric Center

SUBSTANCE USE DISORDER – DETOX CARE PATHWAY

Updated 6/2023

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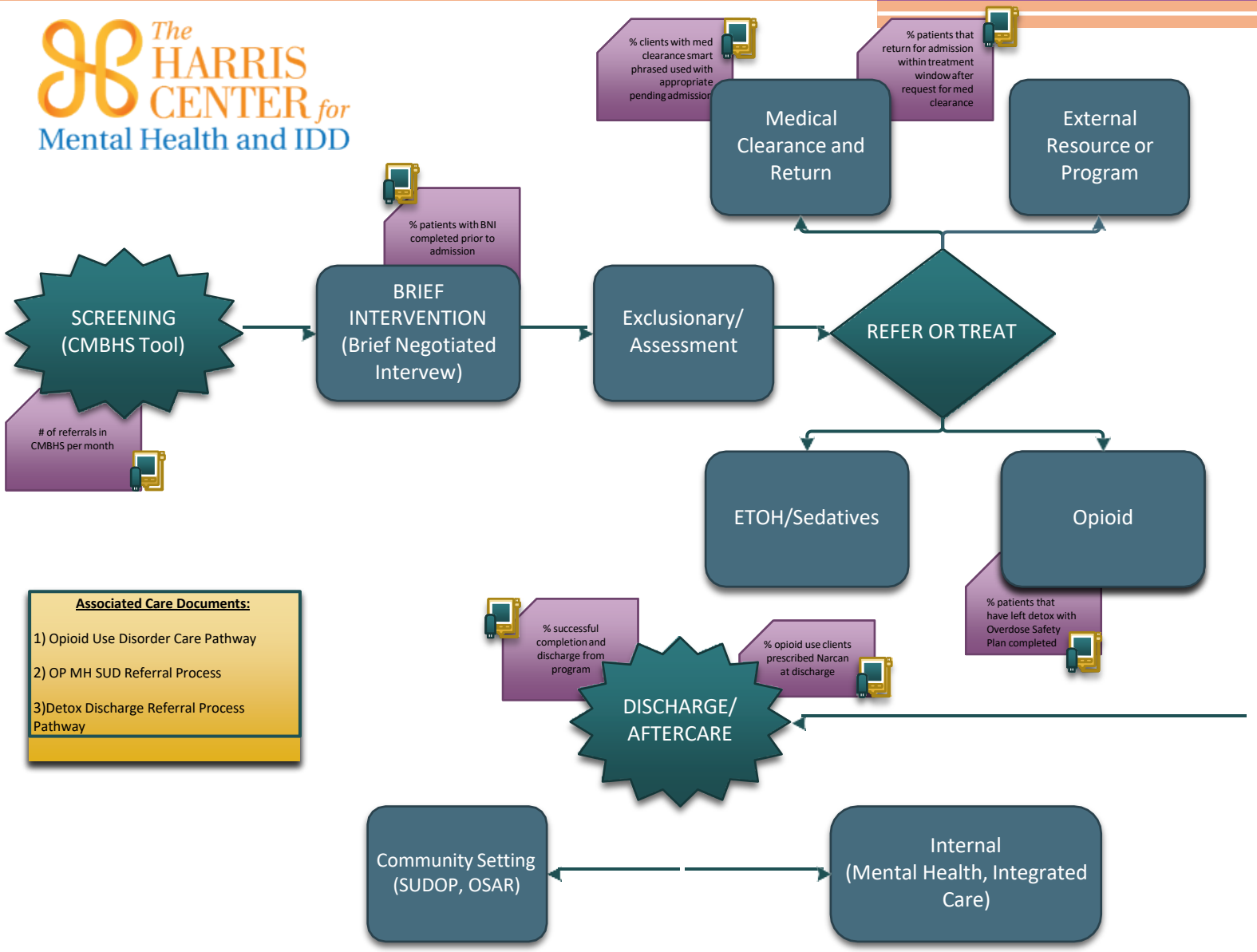


Associated Care Documents:

1) Opioid Use Disorder Care Pathway

2) OP MH SUD Referral Process

3)Detox Discharge Referral Process Pathway

Substance Use Disorder Detox Care Pathway – Staff Training (some new and some refresher)

- Motivational Interviewing
- Trauma Informed Care
- Cultural Competence
- Abuse, Neglect and Exploitation
- Intake, Screening and Admission
- Detox Care Specific Training:
  - Signs of withdrawal
  - Clinical Institute Withdrawal Assessment scale
  - Clinical Opiate Withdrawal scale
  - Pregnancy related complications
  - Emergencies in detox

Substance Use Disorder – Next Steps

Hardwire required documentation

- Required state documentation system (CMBHS) and EPIC
- Key time frames around specific elements of documentation

Data

- Many elements of required documentation were not built into Epic, several builds now in progress
- Automate reports (in progress) – currently this is still manual chart reviews

Substance Use Disorder - Next Steps (continued)

Documentation

- Build of additional documentation elements in Epic
- Audit for completions
- Streamline discharge documentation

Treatment

- Creation of Detox admission order set
  - Evidence based suboxone dosing
  - Narcan order will be included in admission orders so that it is ready for clients when they leave or are discharged
- Follow Up
  - Pathway to Integrated Care at discharge

THANK YOU

Suicide Care Pathway – Current Metrics

SUICIDE CARE PATHWAY (MH) Board 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
MENTAL HEALTH														
Lifetime C-SSRS Screening														
Adult Mental Health	-	-	-	85.05%	90.82%	91.28%	91.70%	90.92%	91.65%	92.43%			90.55%	50.00%
Child & Adolescent Services	-	-	-	68.23%	76.50%	62.75%	63.64%	61.47%%	69.4%%	85.47%			72.09%	50.00%
Suicide/Violence Risk Assessment														
Adult Mental Health	-	-	-	-	-	-	87.77%	85.11%	81.67%	79.74%			83.57%	50.00%
Child & Adolescent Services	-	-	-	-	-	-	37.25%	33.00%	25.00%	30.77%			31.51%	50.00%
Safety Planning Intervention														
Adult Mental Health	-	-	-	-	-	-	48.23%	48.21%	56.62%	68.06%			55.28%	50.00%
Child & Adolescent Services	-	-	-	-	-	-	50.00%	0.00%	28.57%	37.50%			29.02%	50.00%

CAS numbers low due to documentation discrepancies with:

1. Safety plans were being done on paper and not put into Epic flowsheet appropriately (has been addressed and now showing improvement)
2. Not utilizing correct documentation templates to capture data elements, instead using old templates or copy/paste from outside of Epic like Word document (has been addressed and showing improvement)
3. Data dashboard will allow leaders to speak with specific individuals with low compliance about this

Substance Use Disorder – Detox Care Pathway Current Metrics

SUBSTANCE USE DISORDER Scorecard (Board)

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
Substance Use Disorder Metrics														
Medical Screening Clearence						-	1	1	2				1	
Patient Retention into Detox						-	0.00%	0.00%	100.00%				33.33%	100.00%
Patient D/C with Safety Plan #						8	4	5	8				6	
Patient D/C with Safety Plan %						53.33%	30.77%	55.56%	88.89%				57.14%	75.00%
Completed BNI #						-	0	6	8				5	
Completed BNI %						-	0.00%	66.67%	88.89%				51.85%	50.00%
Program Discharge														
Opioid Use Disorder														
Opioid Use Disorder #						7	6	5	4				6	
Opioid Use Disorder %						55.56%	46.15%	55.56%	44.44%				50.43%	45.00%
Alcohol Use Disorder														
Alcohol Use Disorder #						8	7	4	5				6	
Alcohol Use Disorder %						53.33%	53.85%	44.44%	55.56%				51.80%	45.00%
Total Use Disorder Discharge #						15	13	9	9				11.50	
Total Use Disorder Discharge %						50.00%	50.00%	50.00%	50.00%				50.00%	45.00%
Discharge Type														
Treatment Completed						7	5	7	4				6	
Program D/C Completion						46.67%	38.46%	77.78%	44.44%				51.84%	45.00%
Prescribed Medication														
Narcan						-	-	-	-				#DIV/0!	

EXHIBIT Q-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 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	June
Beginning of month*	5,831	5,775	5,710	5,602	5,621	5,547	5,486	5,287	4,306	3,782
Added	-	37	22	34	30	59	42	14	0	0
Removed	-	102	130	15	104	120	241	995	524	309
TOTAL WAITING	**5,831**	**5,710**	**5,602**	**5,621**	**5,547**	**5,486**	**5,287**	**4,306**	**3,782**	**3,473**

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 9 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 7/3/23)

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
June	32

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 (as of 7/3/23)

STEP 3 GR SERVICES

HHSC Contracted Services
Internal/External Providers
Community Linkages

Number waiting to access an authorized GR service*

	Jan	Feb	Mar	Apr	May	June
In-home respite (Contract) *Avg. wait time: ~1 month*	9	23	13	23	34	45
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	15	15	16	13	15
Employment Services (Contract) *Avg. wait time: ~1 month*	0	2	9	14	14	14
Feeding Clinic (Internal) *Avg. wait time: ~1 month*	1	0	0	0	1	0
Outpatient Biopsychosocial Services (OBI) (Internal) *Avg. wait time: 9 months*	176	181	143	120	102	105
The Coffeehouse (Internal) *Avg. wait time: 9 months*	8	13	24	27	29	37
TOTAL WAITING	**196**	**234**	**204**	**200**	**193**	**216**

*data has been validated and is post DID (as of 7/3/23)

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)

Project Complete as of June 2023

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)
JUNE	109 (20 external contracts)
FY23 Total	**1,187**

**June data as of 7/3/23*

June Breakdown:
86 Full - 9 Updates - 14 Endorsements

YTD Breakdown:
656 Full - 289 Updates - 237 Endorsements

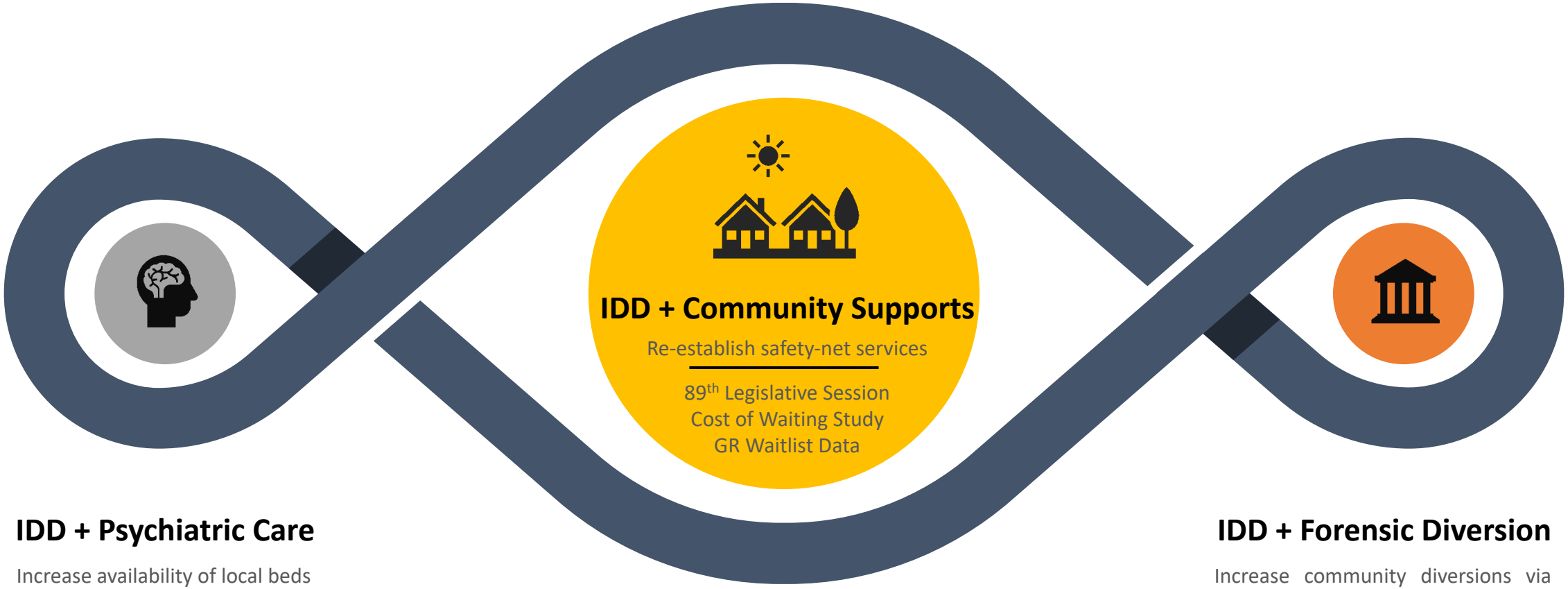
DID Report Completion Timeframe

	AVG Completion Time (CALENDAR DAYS)
SEPT	21
OCT	24
NOV	28
DEC	33
JAN	22
FEB	24
MAR	21
APR	25
MAY	18
JUNE	10*
AVG (excluding June)	**24 days**

**June data as of 7/3/23*

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

Fiscal Year 2024 Strategic Priorities



IDD + Community Supports

Re-establish safety-net services

89th Legislative Session
Cost of Waiting Study
GR Waitlist Data

IDD + Psychiatric Care

Increase availability of local beds
IDD Step-Down: Adults/Youth

IDD + Forensic Diversion

Increase community diversions via safety net services