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

Quality Committee Meeting
August 15, 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, July 18, 2023
(EXHIBIT Q-1)

IV. **CONSIDER AND RECOMMEND ACTION**

A. Performance Improvement Plan 2024
(EXHIBIT Q-2 Trudy Leidich)

V. **REVIEW AND COMMENT**

A. Quality Board Score Card
(EXHIBIT Q-3 Luming Li/Trudy Leidich)

B. Psychiatric Emergency Services Update
(EXHIBIT Q-4 Amber Pastusek)

C. IDD Update
(EXHIBIT Q-5 Evanthe Collins)

VI. ***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. Sylvia Muzquiz, Vice President of Medical Services and Trudy Leidich, Vice President of Clinical Transformation & Quality

VII. **RECONVENE INTO OPEN SESSION**

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

IX. **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, JULY 18, 2023 MINUTES

Dr. G. Santos, Chair, called the meeting to order at 10:02 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. R. Gearing, Dr. G. Santos

Committee Member Absent: Mrs. B. Hellums

Other Board Member in Attendance: Dr. L Moore

1. **CALL TO ORDER**
   Dr. Santos called the meeting to order at 10:00am.

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

3. **DECLARATION OF QUORUM**
   Dr. G. 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, June 20, 2023**

   MOTION BY: GEARING SECOND BY: MOORE

   With unanimous affirmative votes,
   BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday, June 20, 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. **Substance Use Disorder Internal Learning Collaborative Update,** presented by Dr. Luming Li and Trudy Leidich was reviewed by the Quality Committee.

C. Care Pathway Update, 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-

Dr. Santos announced the Quality Committee would enter into executive session at 10:58 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.

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

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: MOORE

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 Q-2

The Harris Center
System Quality, Safety and Experience Performance Improvement Plan
FY 2024

Introduction

The Quality, Safety, and Experience Plan (previously named The Harris Center's Annual PI Plan) is established in accordance with The Harris Center's mission to transform the lives of people with behavioral health and IDD needs. The center's vision is to empower people with behavioral health and IDD needs to improve their lives through an accessible, integrated, and comprehensive recovery-oriented system of care. Our values as a center include collaboration, compassion, excellence, integrity, leadership, quality, responsiveness, and safety. The Quality, Safety and Experience Plan has been established to embrace the principles of transparency of measures and outcomes, accurate measurement and data reporting, and personal and collective accountability for excellent outcomes.

Vision

Our vision is to create a learning health system focused on a culture of continuous quality improvement and safety at The Harris Center to help people live their healthiest lives possible, and to become a national leader in quality and safety in the behavioral healthcare space as it influences dissemination of evidence-based practices.

Mission

We aim to improve quality, efficiency, and access to care and associated behavioral health and IDD services by delivering education, providing technical support, generating, and disseminating evidence, and conducting evaluation of outcomes in support of operational and service excellence and process management across The Harris Center and with external partners.

FY 2024 Goals

1. Build a learning health system that focuses on continuous quality improvement, patient safety, improving processes and outcomes.
    - Partner with Organizational Development to enhance educational offerings focused on quality and safety education with all new employee orientation (High Reliability, Just Culture, Advanced Quality Improvement methodology, etc.)
    - Hardwire a process for continuous readiness activities that complies with all legislative regulations and accrediting agencies standards (e.g., CARF, CCBHC).
2. Use transparent, simplified meaningful measures to champion the delivery of high-quality evidence-based care and service to our patients and their families and assure that it is safe, effective, timely, efficient, equitable, and patient centered care
    - Define and implement a data management governance strategy to support a transparent environment to provide accessible, accurate, and credible data about the quality and equity of care delivered.

    - Create a transparent and accurate process for public reporting (e.g., MIPS)
3. Develop, integrate, and align quality initiatives and cross-functional approaches throughout The Harris Center organization, including all entities.
    - Enhance current committee structure to cover broad quality and safety work through the System Quality, Safety and Experience Committee (formerly the Patient Safety Committee)
    - Develop a decentralized Quality Forum that reaches frontline performance improvement (PI) and Health Analytics/Data staff to provide education and tools to lead PI initiatives at their local sites.
    - Develop and strengthen internal learning collaborative process to align with the Harris Center strategic plan for care pathways.
        - IDD Care Pathway

3-Year Long Term Goals (FY 2027)

- Zero preventable serious safety events
- Top quartiles for staff and provider engagement
- Top quartiles for patient satisfaction
- Increased access (numbers served)
- Improved outcomes
- Equitable care delivery
- Exemplar in Quality and Safety for Behavioral Health with national recognition

Governance Structure

Governing Body

The Harris Center for Mental Health and IDD Board of Trustees is responsible for ensuring a planned, system-wide approach to designing quality goals and measures; collecting, aggregating, analyzing data; and improving quality and safety. The Board of Trustees shall have the final authority and responsibility to allocate adequate resources for assessing and improving the organization's clinical performance. The Board shall receive, consider, and act upon recommendations emanating from the quality improvement activities described in this Plan. The Board has established a standing committee, Quality Committee of the Board of Trustees, to assess and promote patient safety and quality healthcare. The Committee provides oversight of all areas of clinical risk and clinical improvement to patients, employees, and medical staff.

Leadership

The Harris Center leadership is delegated the authority, via the Board of Trustees, and accountability for executing and managing the organization’s quality improvement initiatives. Quality leadership provides the framework for planning, directing, coordinating, and delivering the improvement of healthcare services that are responsive to both community and patient needs that improve healthcare outcomes. The Harris Center leaders encourage involvement and participation from staff at all levels within all entities in quality initiatives and provide the stimulus, vision, and resources necessary to execute quality initiatives.

Executive Session

The Executive Session of the Quality Committee of the Board is the forum for presenting closed record case reviews, pharmacy dashboard report including medication errors, and the Professional Review Committee report.

Professional Review Committee (PRC)

The Chief Medical Officer (CMO) is delegated the oversight, via the Board of Trustees, to evaluate the quality of medical care and is accountable to the Board of Trustees for the ongoing evaluation and improvement of the quality of patient care at The Harris Center and of the professional practice of licensed providers. The PRC will act as the authorizing committee for professional peer review and system quality committees (Exhibit A). The committee will also ensure that licensing boards of professional health care staff are properly notified of any reportable conduct or finding when indicated. The Professional Review Committee has oversight of the following peer protected processes and committees:

Oversight:

- Medical Peer Review
- Pharmacy Peer Review
- Nursing Peer Review
- Licensed Professional Review
- Closed Record Review
- Internal Review Board
- System Quality, Safety and Experience Committee

Membership:

- Chief Executive Officer (Ex-Officio)
- Chief Medical Officer (Chair)
- Chief Operating Officer
- Chief Nursing Officer
- Chief Administrative Officer
- Legal Counsel
- Divisional VPs and (CPEP, MH)
- VP, Clinical Transformation and Quality
- VP, Enterprise Risk Management
- Director of Pharmacy Programs

System Quality, Safety and Experience Committee

The Quality Committee of the Board of Trustees has established a standing committee, The System Quality, Safety and Experience Committee (previously the Patient Safety Committee) to evaluate, prioritize, provide general oversight and alignment, and remove any significant barriers for implementation for quality, safety, and experience initiatives across Harris Center programs. The Committee is composed of Harris Center leadership, including operational and medical staff. The Committee will approve annual system-wide quality and safety goals and review progress. The patient safety dashboard and all serious patient safety events are reviewed. Root Cause Analysis, Apparent Cause Analysis, Failure Modes and Effects Analysis, quality education projects, are formal processes used by the Committee to evaluate the quality and safety of mental

health and IDD services, and thus are privileged and confidential. All performance improvement projects through The Harris Center's quality training program or other performance improvement training programs are privileged and confidential as part of the Quality, Safety & Experience Committee efforts. The Committee also seeks to ensure that all The Harris Center entities achieve standards set forth by the Commission on Accreditation and Rehabilitation Facilities (CARF) and Certified Community Behavioral Health Clinic (CCBHC).

The System Quality, Safety and Experience Committee has oversight of the following committees and/or processes: (Appendix A)

Oversight:

- Pharmacy and Therapeutics Committee
- Infection Prevention
- System Accreditation
- All PI Councils and internal learning collaboratives (e.g., Zero Suicide, Substance Use Disorders)
- Approval of Care Pathways
- Patient Experience / Satisfaction

Membership:

- Chief Executive Officer (Ex-Officio)
- VP, Clinical Transformation and Quality (Co-Chair)
- Chief Nursing Officer (Co-Chair)
- Chief Medical Officer
- Chief Operating Officer
- Legal Counsel
- Division Medical VPs and Medical Directors
- Chief Administrative Officer
- Director Risk Management / Audit
- Director of Compliance
- Chief Financial Officer
- Director Health Analytics
- Director, Clinical Transformation, and Innovation
- Director of Quality Assurance
- Director of Pharmacy Programs
- Director of Integrated Care
- Nursing Directors
- Infection Control Director

Priority Setting

The criteria listed below provide a framework for the identification of improvements that affect health outcomes, patient safety, and quality of care, which move the organization to our mission of providing the finest possible patient care. The criteria drive strategic planning and the establishment of short and long-term goals for quality initiatives and are utilized to prioritize quality improvement and safety initiatives.

- High-risk, high-volume, or problem-prone practices, processes, or procedures
- Identified risk to patient safety and medical/healthcare errors
- Identified in The Harris Center Strategic Plan
- Identified as Evidenced Based or "Best Practice"
- Required by regulatory agency or contract requirements

Methodologies

- The Model for Improvement (Appendix B) and other quality frameworks (e.g., Lean, Six Sigma) are used to guide quality improvement efforts and projects
- A Root Cause Analysis (RCA) is conducted in response to serious or sentinel events
- Failure Mode and Effects Analysis (FMEA) is a proactive tool performed for analysis of a high-risk process/procedure performed on an as needed basis (at least annually)

Data Management Approach and Analysis

Data is used to guide quality improvement initiatives throughout the organization to improve, safety, treatment, and services for our patients. The initial phase of a project focuses on obtaining baseline data to develop the aim and scope of the project. Evidence-based measures are developed as a part of the quality improvement initiative when the evidence exists. Data is collected as frequently as necessary for various reasons, such as monitoring the process, tracking balancing measures, observing interventions, and evaluating the project. Data sources vary according to the aim of the quality improvement project, examples include the medical record, patient satisfaction surveys, patient safety data, financial data. Benchmarking data supports the internal review and analysis to identify variation and improve performance. Reports are generated and reviewed with the quality improvement team. Ongoing review of organization wide performance measures are reported to committees described in the Quality, Safety and Experience governance structure.

Reporting

Quality, Safety and Experience metrics are routinely reported to the Quality, Safety and Experience Committee. Quality, Safety and Experience Committee is notified if an issue is identified. Roll up reporting to the Quality Board of Trustees on a quarterly basis and more frequently as indicated.

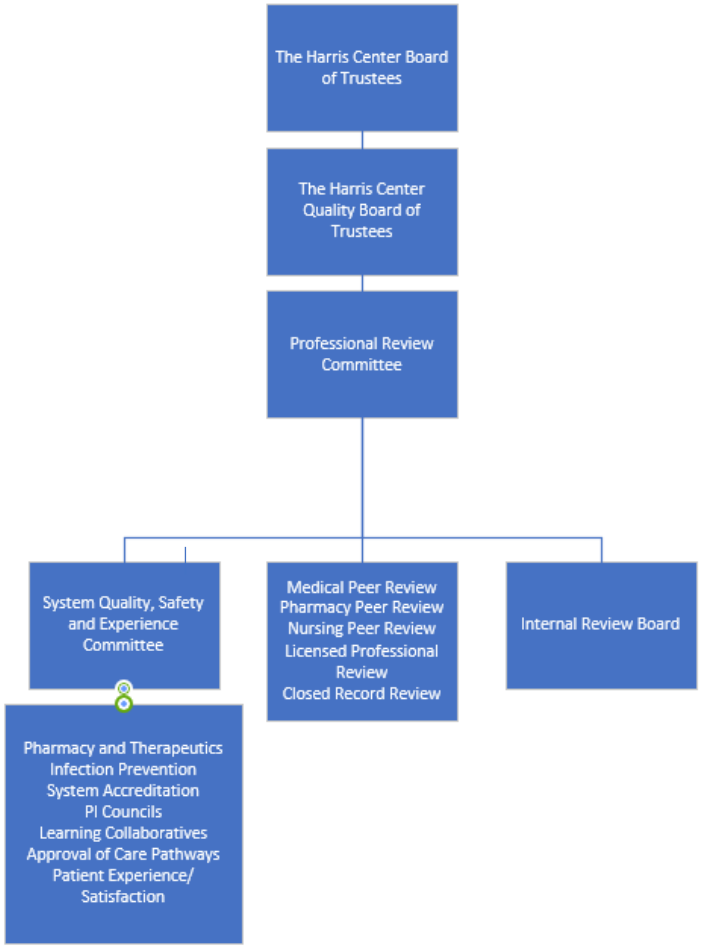
Evaluation and Review

At least annually, the Quality, Safety and Experience leadership shall evaluate the overall effectiveness of the Quality, Safety and Experience Plan and program. Components of the plan

that need to be expanded, revised, or deleted shall be identified to ensure that the objectives are met, and this document is maintained to reflect an accurate description of the Quality, Safety and Experience program.

(Appendix A)

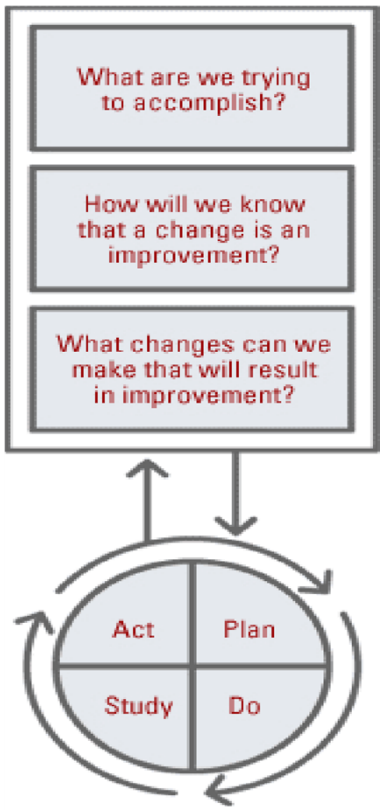
Committee Oversight



(Appendix B)

The Model for Improvement

Forming the Team
Including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.



Setting Aims
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Establishing Measures
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes
Al improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

Testing Changes
The Plan-do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

Implementing Changes After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

Spreading Changes After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

Sources:

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance.

The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.]

(Appendix C)

Root Cause Analysis (RCA):

The key to solving a problem is to first truly understand it. Often, our focus shifts too quickly from the problem to the solution, and we try to solve a problem before comprehending its root cause. What we think is the cause, however, is sometimes just another symptom.

One way to identify the root cause of a problem is to ask "Why?" five times. When a problem presents itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" again and again until you reach the root cause.

Failure Modes and Effects Analysis (FMEA):

FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur. In an FMEA, a team representing all areas of the process under review convenes to predict and record where, how, and to what extent the system might fail. Then, team members with appropriate expertise work together to devise improvements to prevent those failures — especially failures that are likely to occur or would cause severe harm to patients or staff. The FMEA tool prompts teams to review, evaluate, and record the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis on prevention may reduce risk of harm to both patients and staff. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

EXHIBIT Q-3

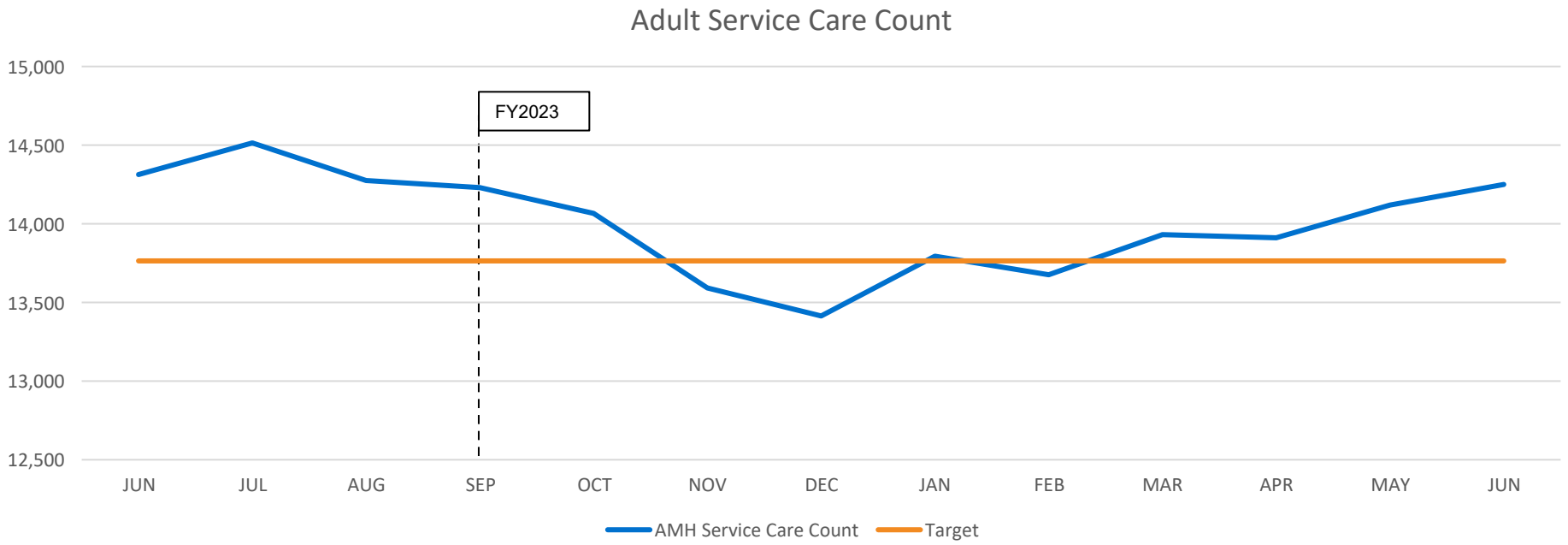
Quality Board Scorecard

Board Quality Committee Meeting

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

Reporting for June 2023

Domain	Program	2023 Fiscal Year State Care Count Target	2023 Fiscal Year State Care Count Average (Sep-Jun)	Reporting Period: June 2023 Care Count	Target Desired Direction	Target Type
Access	AMH Service Care Count	13,764	13,898	14,250	Increase	Contractual

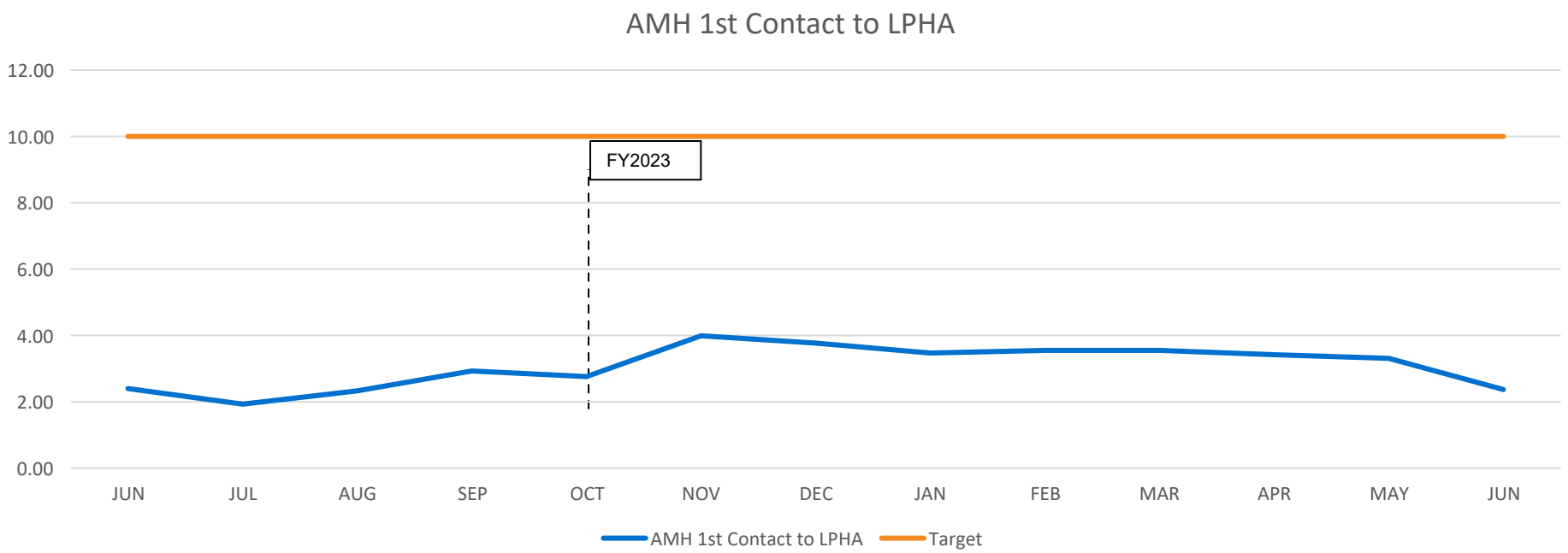


Highlights:

- Adult service care count average is performing above contractual target. The fiscal year over year average is **up 2.96%,** the fiscal year to date (Sep-Jun 2023) average of 13,898 compared to same period in (Sep-Jun FY2022) 13,499).
- Adult Service Care Count is **3.53%** above the contractual target for the current period.
- The AMH team led by Dr. Jennifer Boswell, under the guidance of Lance Britt, VP of MH, has been focused on the timely delivery of contractual services (ANSA) to all eligible patients

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-June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	AMH 1st Contact to LPHA	<10 days	3.31 Days	2.37 days	Decrease	Contractual

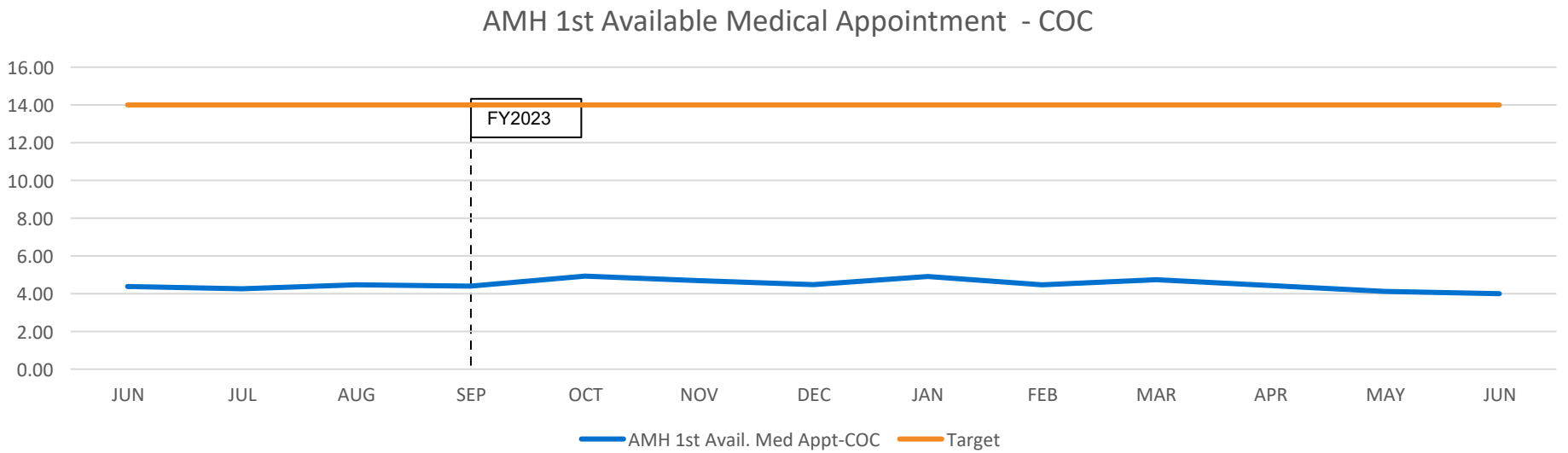


Highlights:

- Time for patients' initial assessment continues to perform well for AMH.
- AMH 1st Contact to LPHA has seen a slight increase in the number of days for an LPHA assessment from the same period last year. From an average of **1.61 days (Sep-Jun 2022) to 3.31 in the same period in Sep-Jun 2023**

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

Domain	Program	2023 Fiscal Year Target	2023 Fiscal Year Average (Sep-Jun)	Reporting Period: Jun 2023	Target Desired Direction	Target Type
Timely Care	AMH 1st Avail. Medical Appt-COC	<14 days	4.52 days	4.00 days	Decrease	Contractual



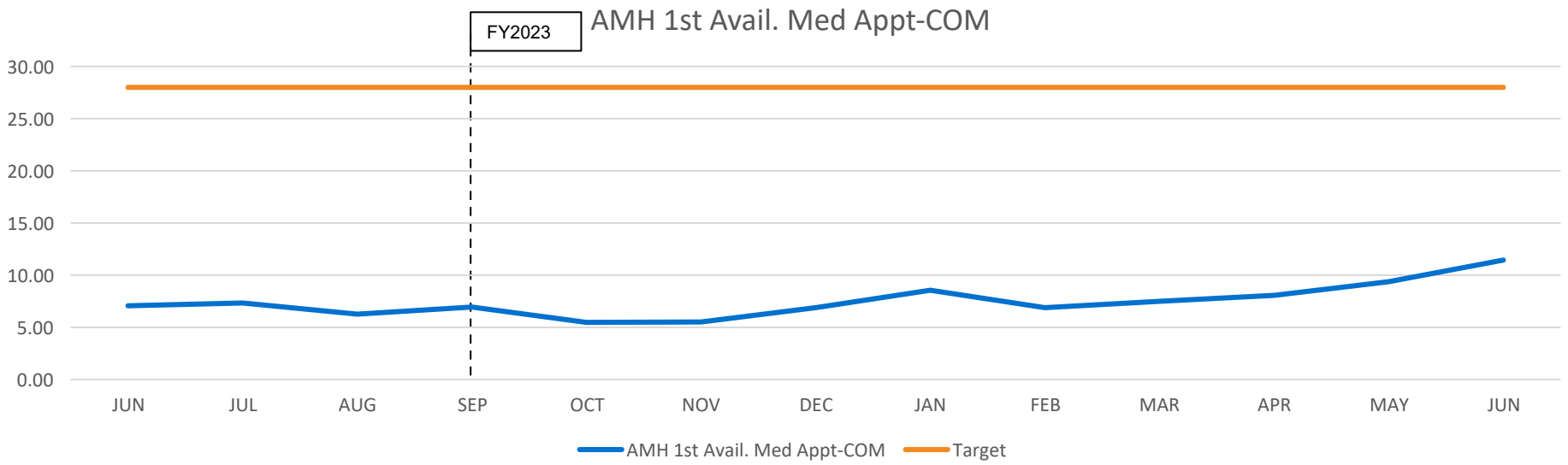
Highlights:

- 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 5.19 days in Sep-Jun in FY2022, to 4.52 days in Sep-Jun FY2023.

- For the reporting period Jun 2023, AMH 1st available medical appointment for continuity of care **increased by 9%** from 3.66 days (June 2022) to 4.00 days in June 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-Jun)	Reporting Period- June 2023	Target Desired Direction	Target Type
Timely Care	AMH 1st Avail. Medical Appt-COM	<28 days	7.67 days	11.45 days	Decrease	Contractual

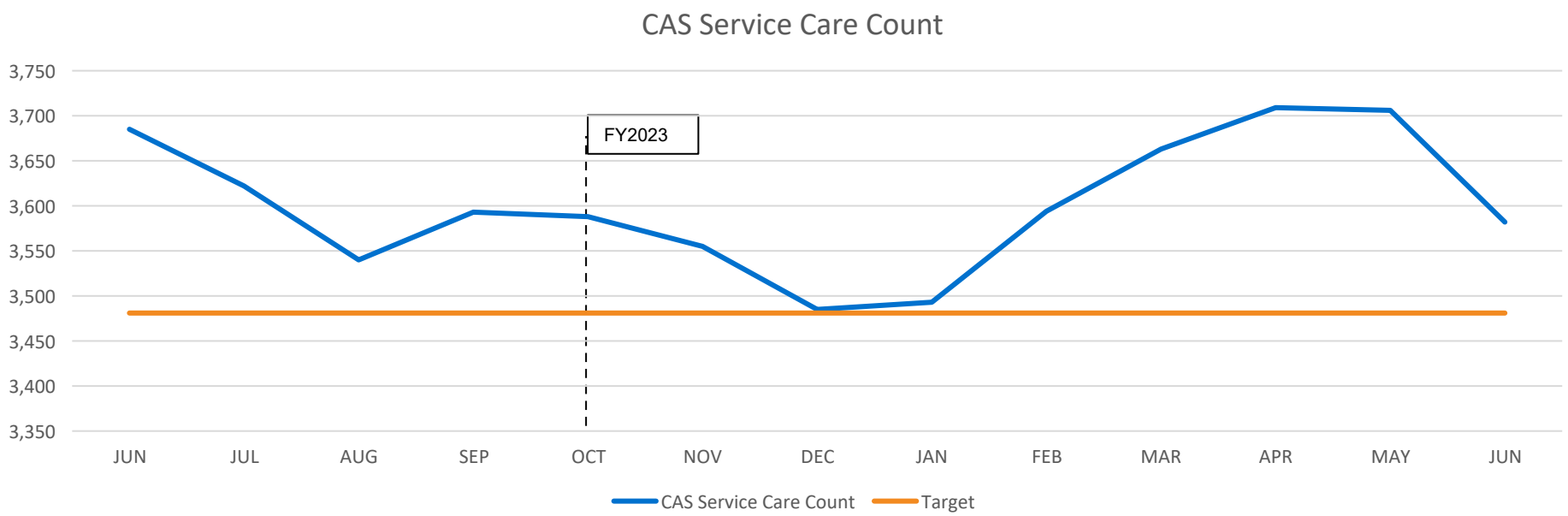


Highlights:

- Access to medical appointment for community members (walking-ins without an appointment) continues to perform well below the contractual target for AMH.
- AMH has achieved **a 24.06% reduction** in the number of days for the 1st available medical appointment for community members (walking-ins without an appointment). From an average of **10.10 days Sep-June** in 2022 to **7.67 days in Sep-June 2023.**
- For the reporting period June 2023, AMH reduced the time for 1st available medical appointment for community members (walking-ins without an appointment) is below the contractual target **by more than 15 days**

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 State Care Count Target	2023 Fiscal Year State Care Count Average (Sep-June)	Reporting Period-June	Target Desired Direction	Target Type
Access to Care	CAS	3,481	3,597	3,582	Increase	Contractual

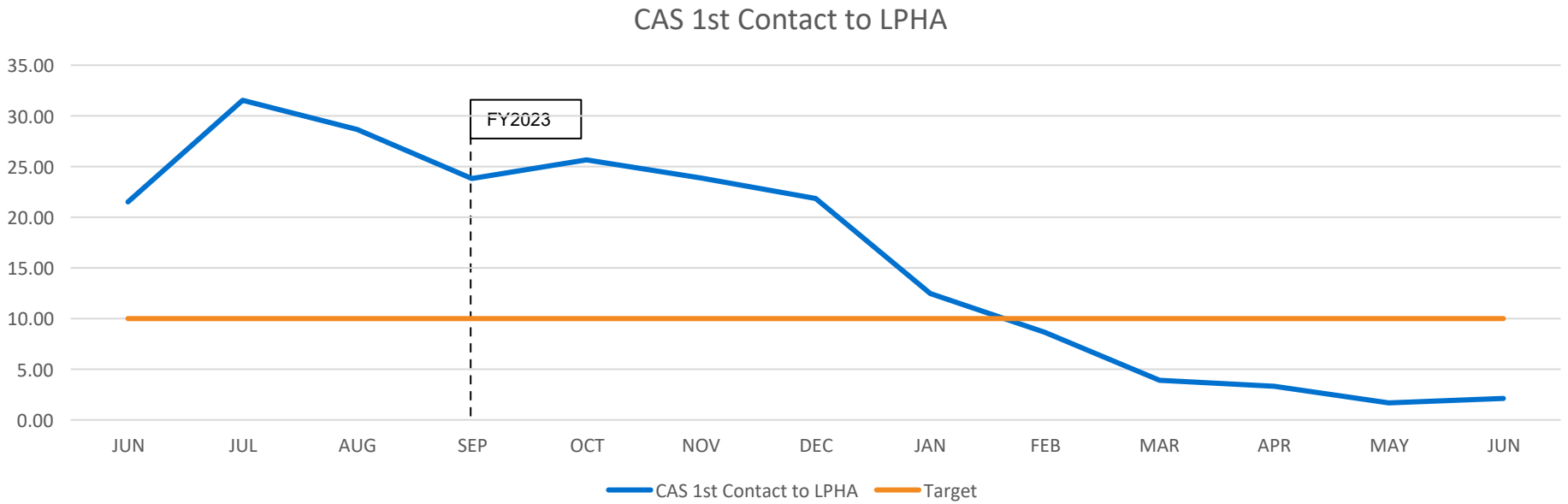


Highlights:

- CAS service care count continues to be above the contractual target for June
- Compared to the same period last year, CAS service care count average is down by about **2%** in fiscal year to date Sep-June 2023 (**3,582**) compared to same period in FY2022 (**3,685**)

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	2023 Fiscal Year Average (Sep-June)	Reporting Period-June	Target Desired Direction	Target Type
Timely Care	CAS 1st Contact to LPHA	<10 days	12.73 days	2.12 days	Decrease	Contractual

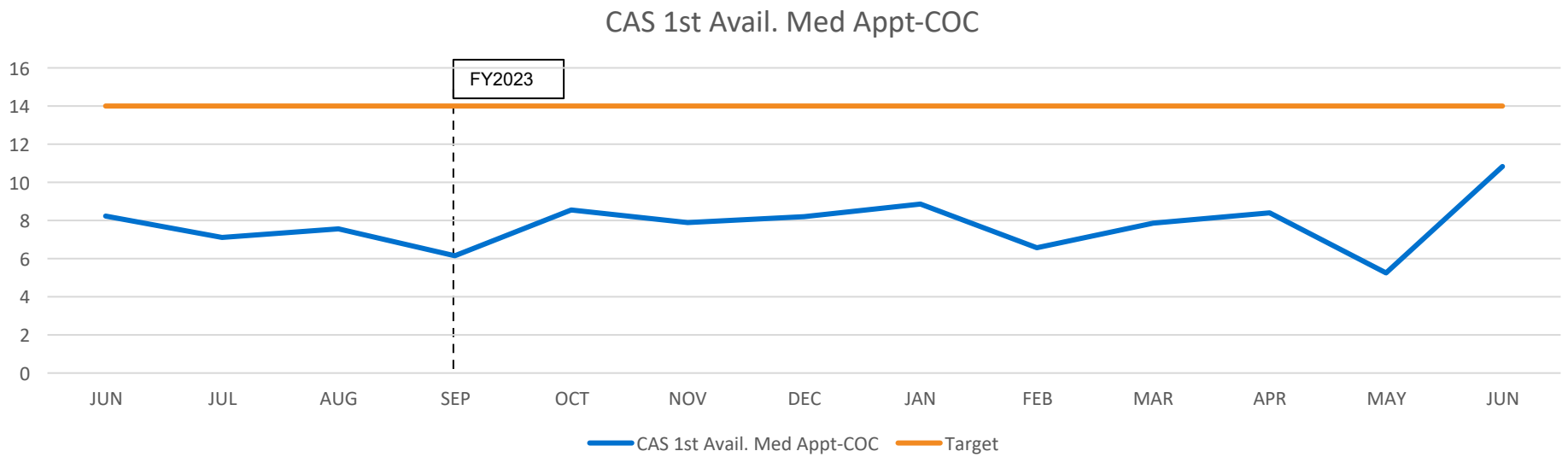


Highlights:

- CAS hybrid model (combination of open booking and scheduling) for LPHA assessment continues to improve access to care for children and adolescent seeking care.
- In September patients were waiting an average of 23 days for an LPHA assessment. As a result of the hybrid walk-in process, patient are waiting on average of about 2 days.
- There was also a decrease in the month-to-month comparison. **From 21.51 days in June 2022 to 2.12 days in June 2023. A 90% 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 Target	2023Fiscal Year Average (Sep-June)	Reporting Period-June 2023	Target Desired Direction	Target Type
Timely Care	CAS 1st Avail. Medical Appt-COC	<14 days	7.86 days	10.83 days	Decrease	Contractual

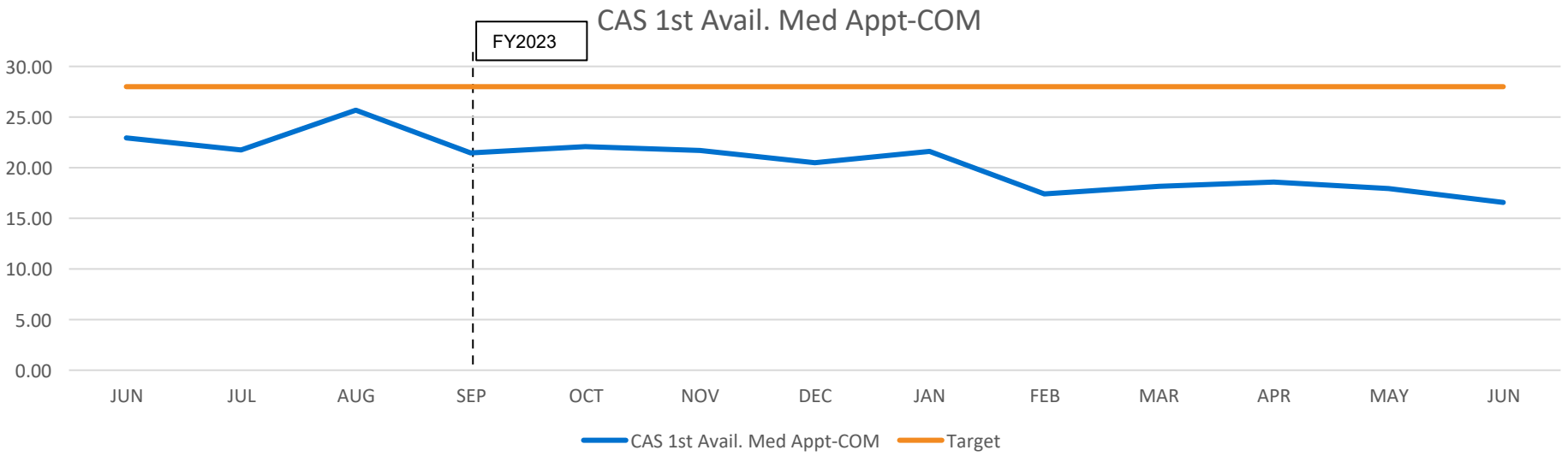


Highlights:

- Time to contact patients for continuity of care after hospital discharge continues to perform well for CAS.
- CAS has a slight increase in the number of the days for 1st available medical appointment for continuity of care patients when comparing year to year averages. From an average of **7.73 days (Sep-June) in 2022 to 7.86 days in Sep-June 2023**.
- For the reporting period, June 2023, CAS saw an increase in the number of days for 1st available medical appointment from **7.9 days** (June 2022) to **10.83 days** in June 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-June)	Reporting Period-June 2023	Target Desired Direction	Target Type
Timely Care	CAS 1st Avail. Medical Appt-COM	<28 days	19.60 days	16.57 days	Decrease	Contractual

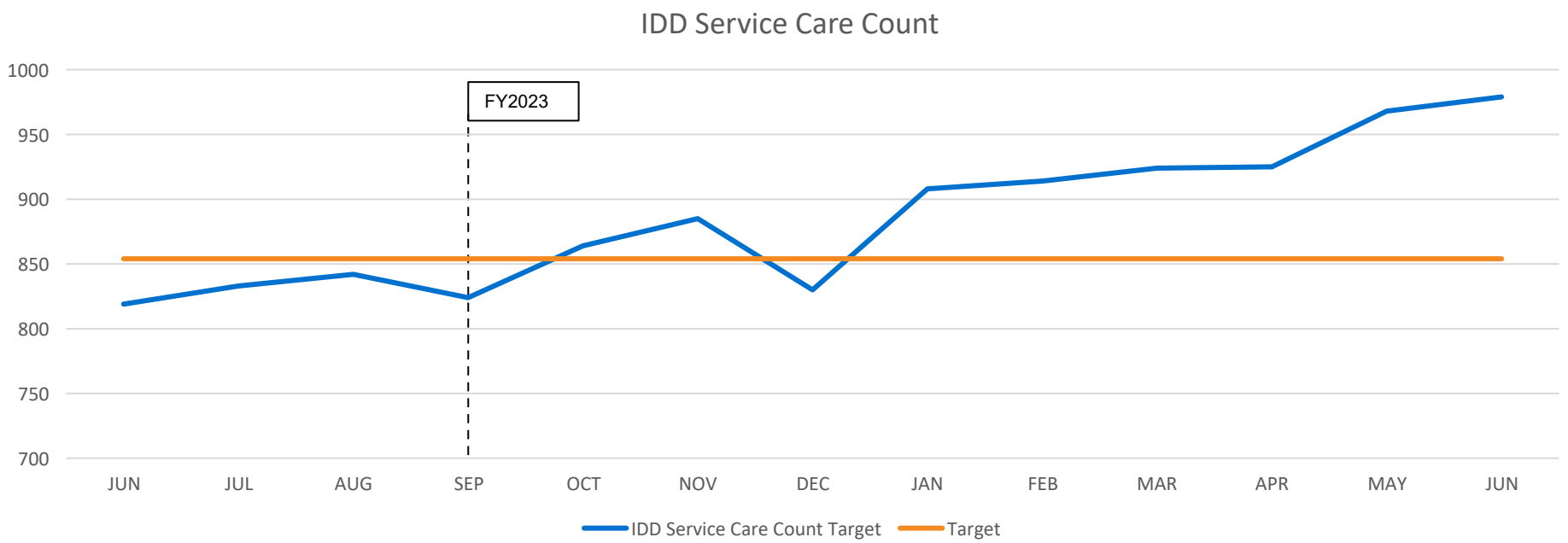


Highlights:

- Time to contact patients continues to perform well for CAS.
- CAS 1st available medical appointment for community members walk-ins, the program reduced the time it takes for a community member to see a medical provider by average of **3 days** year over year. From an average of **21.89 days in Sep-June 2022 to 19.94 days in Sep-June 2023.**
- For the reporting period June 2023, CAS reduced the number of days for 1st available medical appointment for community members walk-ins by about **6 days from 22.94 days in June 2022 to 16.57 days in June 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 State Count Target	2023 Fiscal Year State Count Average (Sep-June)	Reporting Period-June	Target Desired Direction	Target Type
Access	IDD	854	902	979	Increase	Contractual



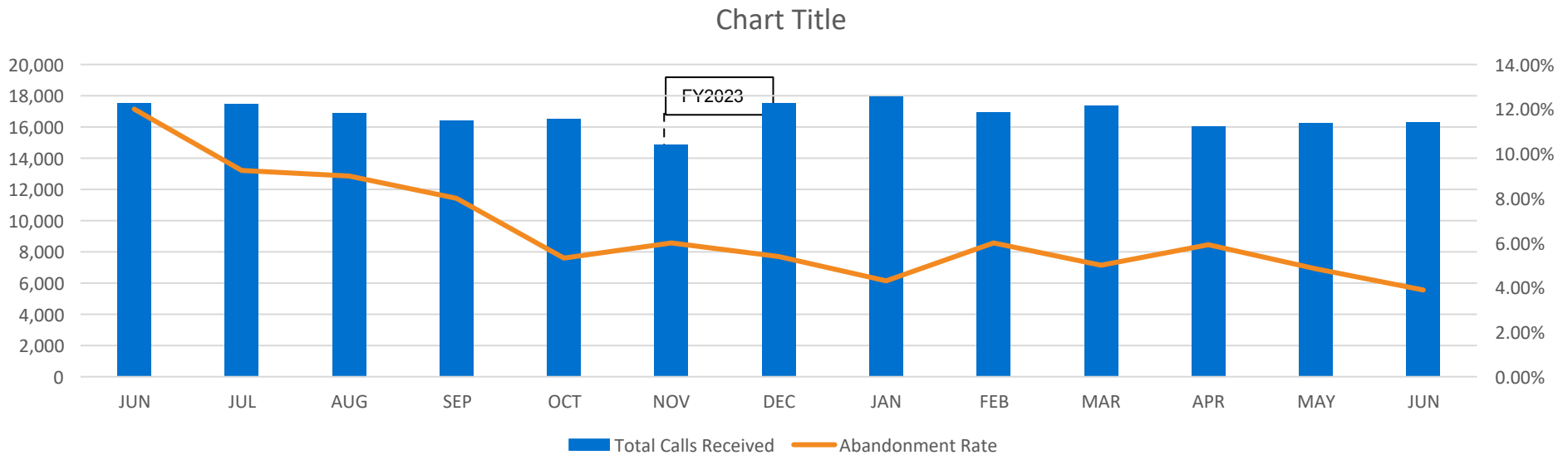
Highlights:

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

- IDD had **a 13% increase** in the total average service care count when comparing the same period in 2022: from an average of 796 in Sep-June 2022 to 902 in Sep-June 2023.
- For the reporting period May 2023, IDD has increased the service care count by **20%** in comparison to June 2022, **from 819 for June 2022 to 979 in June 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.)

Domain	Measures (Definition)	FY 2023 Target	2023Fiscal Year Average (Sep-June)	Reporting Period-June 2023	Target Desired Direction	Target Type
Timely Care	Total Calls Received	N/A	16,617	16,323	Increase	Contractual
	Abandonment Rate	<8%	5.47%	3.89%	Decrease	Contractual



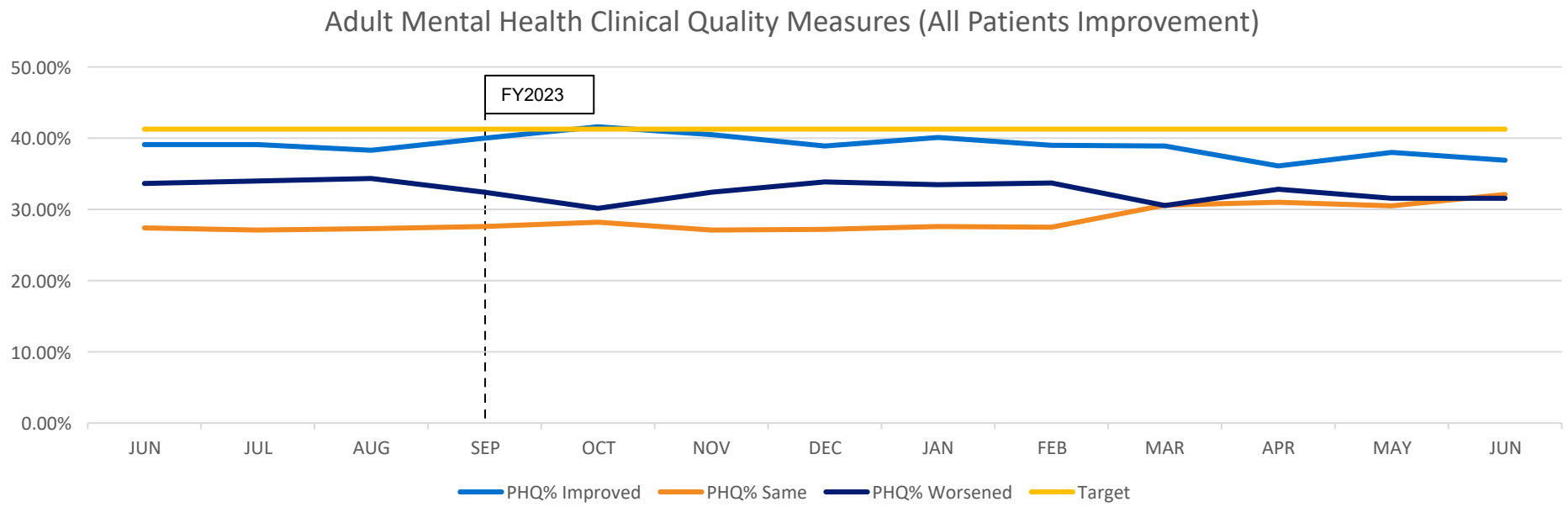
Highlights:

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 (Definition)	FY 2023 Target	2023Fiscal Year Average (Sep-Jun)	Reporting Period-June	Target Desired Direction	Target Type
Effective Care	PHQ-9	41.27%	41.43%	44.80%	Increase	IOS



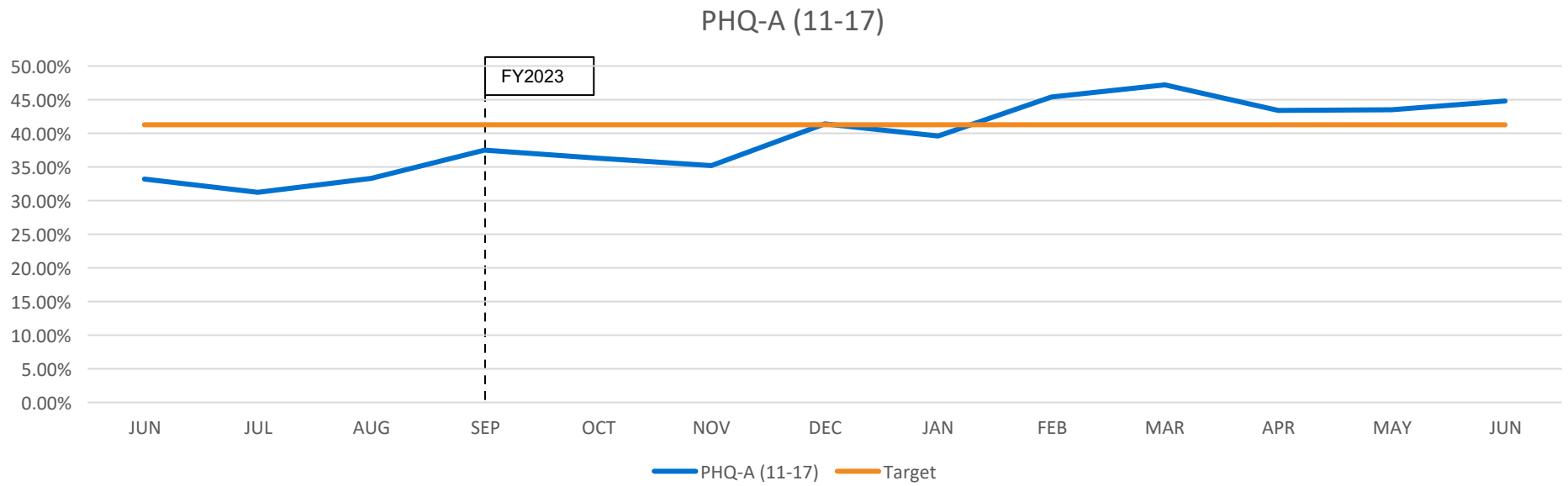
Highlights:

- PHQ-9 measured a slight decrease in overall depression state this reporting period (36%) compared to the previous reporting period (39%) in June 2022.

Measure Computation: % 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)

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-Jun)	Reporting Period-June	Target Desired Direction	Target Type
Effective Care	PHQ-A (11-17)	41.27%	41.43%	44.80%	Increase	IOS



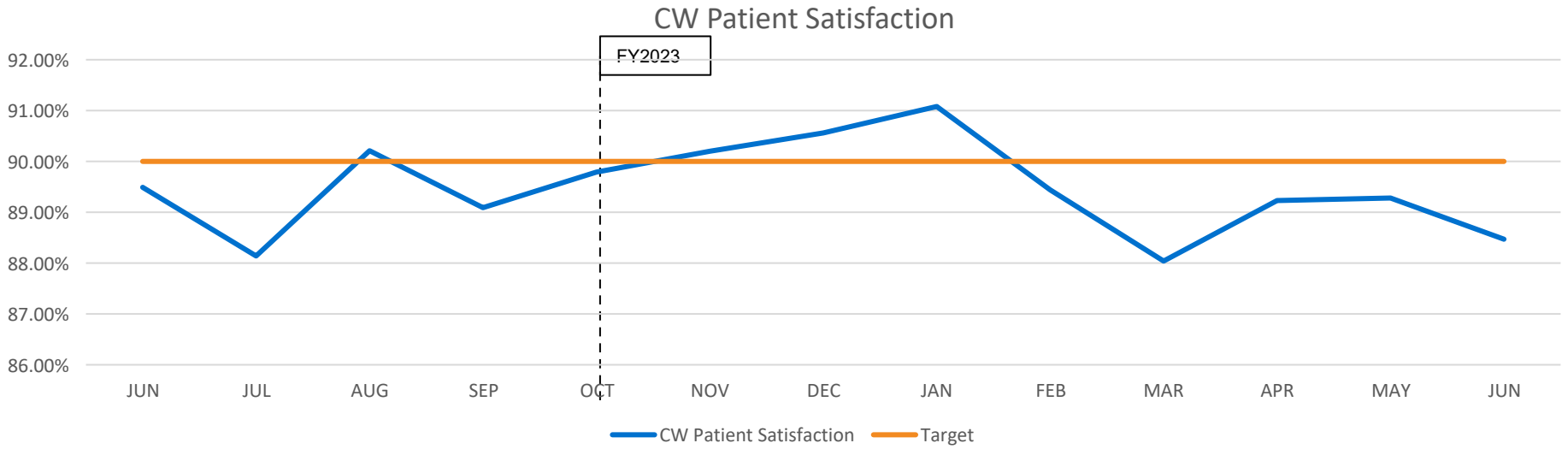
Highlights:

- PHQ (Patient Health Questionnaire) This is a widely used and validated measure of depression.
- PHQ-A measured a 33% decrease in overall adolescent and young adults' depression state this reporting period (44.80%) compared to the previous reporting period (33%) in June 2022.

Measure Computation: % 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)

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)	2023 Fiscal Year Target	2023Fiscal Year Average (Sep-Jun)	Reporting Period-June	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	90%	89.63%	88.47%	Increase	IOS



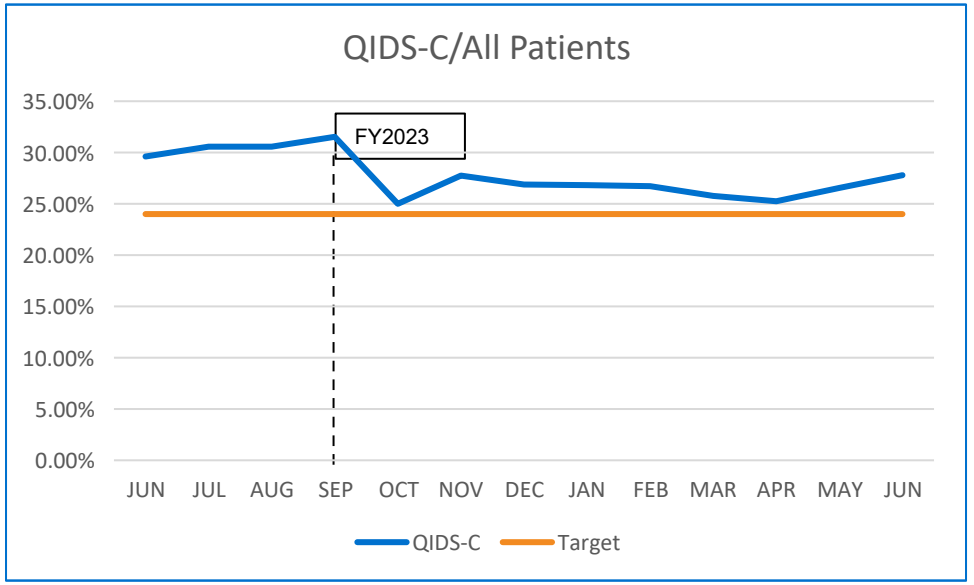
Highlights:

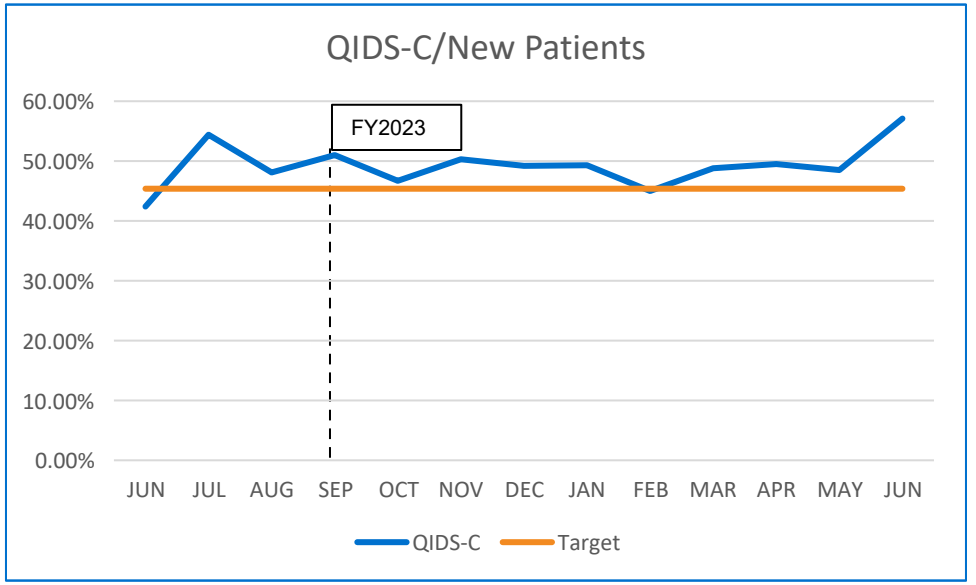
- Center wide patient satisfaction fell below its monthly target. While the dip below target is consistent around this period, a patient satisfaction sub-committee has been created to review data from the survey and develop quality improvement project in areas of vulnerabilities

- 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

Domain	Measures (Definition)	FY 2023 Target	2023Fiscal Year Average (Sep-Jun)	Reporting Period-June	Target Desired Direction	Target Type
Effective Care	QIDS-C/All Patients	24%	26.42%	27.79%	Increase	IOS
	QIDS-C/New Patients	45%	49.54%	57.01%	Increase	IOS



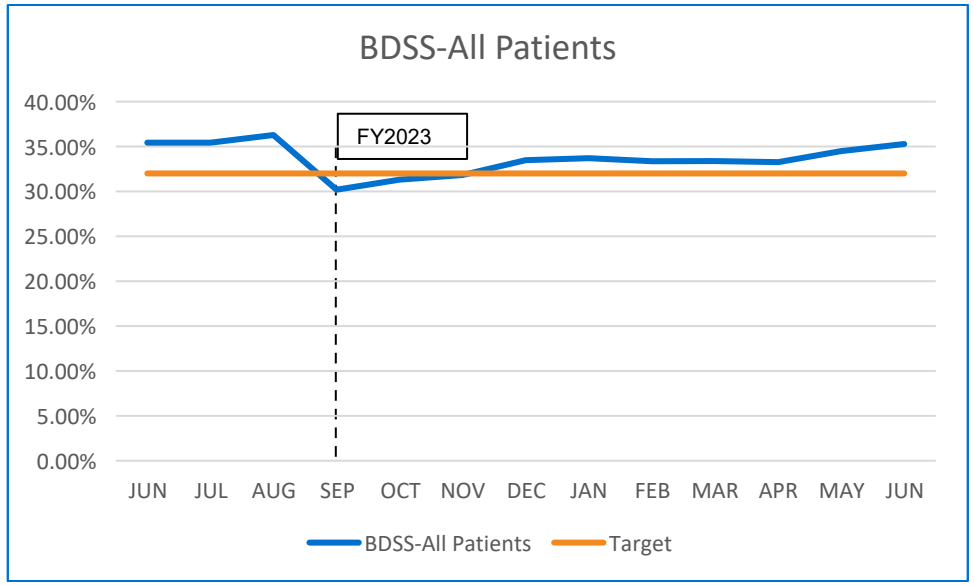


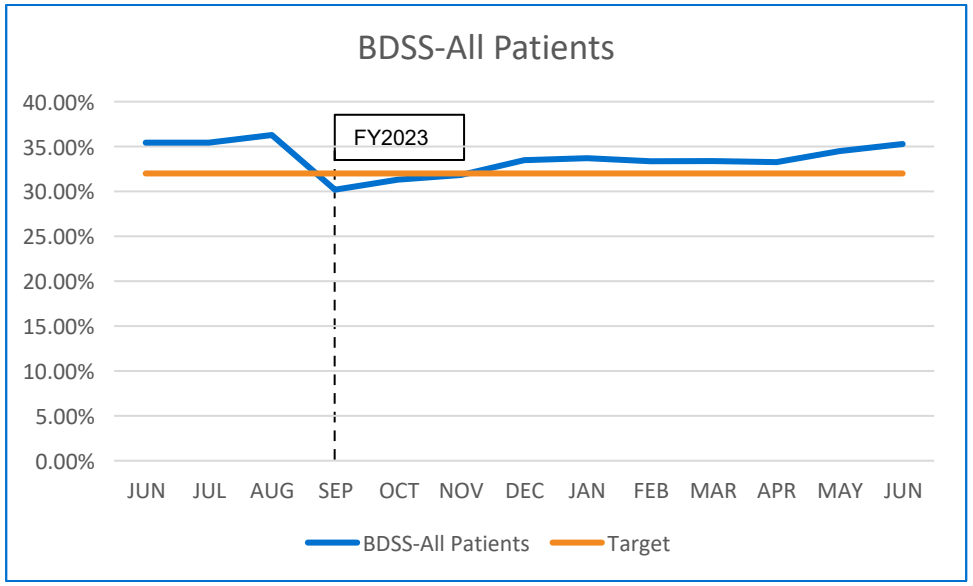
- This measure is under review as part of an intervention for measurement-based care by the MH and Quality team
- The intervention, led by Dr. Muzquiz and the Quality team, will conduct a test of change for administering patients' self-assessment mental health scales are completed on the day of appointment 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 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-Jun)	Reporting Period- June 2023	Target Desired Direction	Target Type
Effective Care	BDSS-All Patients	32%	33.30%	35.28%	Increase	IOS
	BDSS-New Patients	46%	47.28%	47.0%	Increase	IOS





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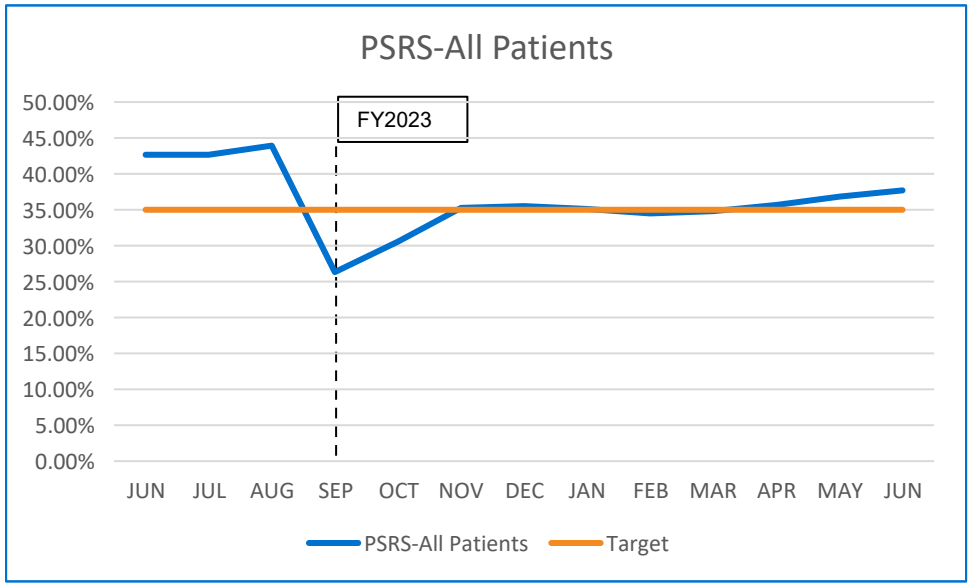
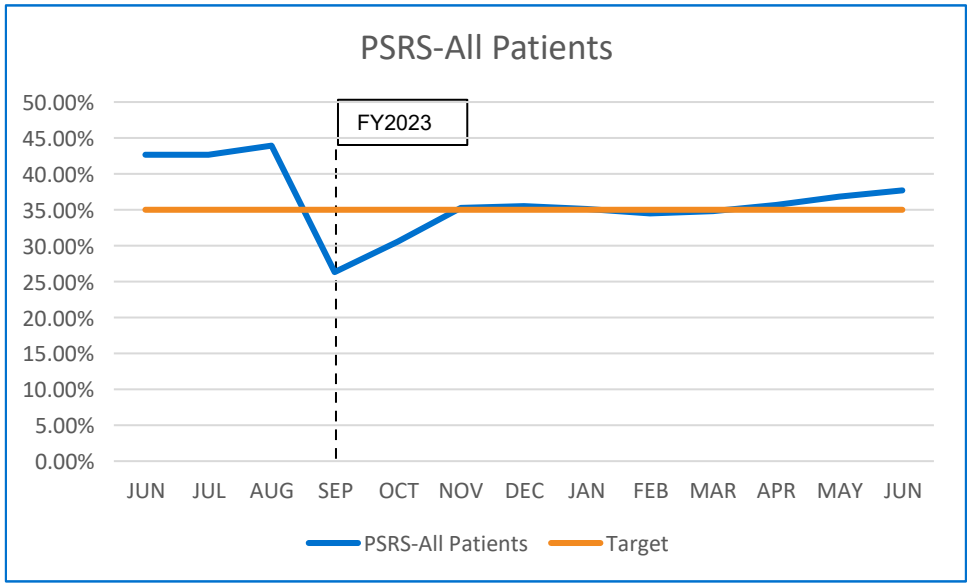
Measure computation: % of all THC adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the BDSS. Clients must have at least 90 days from first assessment to last assessment

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-Jun)	Reporting Period-June	Target Desired Direction	Target Type
Effective Care	PSRS-All Patients	35%	34.23%	37.70%	Increase	IOS
	PSRS-New Patients	53%	39.36%	40.07%	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).*

Board of Trustee's PI Scorecard

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Data Validation Status: Data Validation Completed | Data Validation In-Progress

	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	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	14,250			13,898	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%	103.53%			100.98%	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%	51.80%			49.19%	≥ 65.60%	C	MBOW
CAS Waitlist (State Defined)	0	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	3,582			3,597	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%	102.90%			103.33%	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%	74.50%			75.04%	≥ 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	979			902	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%	114.64%			105.33%	100.00%	C	MBOW
CW CAS 1st Contact to LPHA	23.82	25.66	23.87	21.85	12.22	8.75	3.91	3.06	1.72	2.12			12.70	<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	2.37			3.20	<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	3.29	3.06	2.34			4.95	<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	10.83			7.79	<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	16.57			19.58	<28 Days	NS	Epic
CAS # Pts Seen in 30-60 Days	49	45	45	44	47	19	51	40	53	33			42.60	<9.18	IOS	Epic
CAS # Pts Seen in 60+ Days	26	27	35	27	35	43	22	18	14	15			26.20	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	4.00			4.52	<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	11.45			7.69	<28 Days	NS	Epic
AMH # Pts Seen in 30-60 Days	6	2	2	1	4	5	1	1	4	21			4.70	<45	IOS	Epic
AMH # Pts Seen in 60+ Days	2	1	1	0	0	0	0	0	1	2			0.70	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	16,323			16,617			
AVG Call Length (Mins)	8.00	8.00	8.10	8.70	8.50	8.80	9.30	9.20	9.80	9.00			8.74			
Service Level	86.00%	91.34%	91.00%	90.76%	92.00%	88.00%	89.00%	89.00%	89.64%	91.96%			89.87%	≥ 95.00%	C	Brightmetrics
Abandonment Rate	8.00%	5.32%	6.00%	5.39%	4.30%	6.00%	5.00%	5.92%	4.84%	3.89%			5.47%	< 8.00%	NS	Brightmetrics
Occupancy Rate	73.00%	69.00%	69.00%	71.00%	72.00%	77.00%	74.00%	76.00%	76.00%	68.00%			72.50%			Brightmetrics
Crisis Call Follow-Up	100.00%	99.79%	99.76%	99.77%	99.77%	99.76%	100.00%	99.50%	100.00%	100.00%			99.84%	> 97.36%	IOS	Icarol
Access to Crisis Resp. Svc.	93.50%	87.10%	84.00%	88.80%	89.80%	89.80%	88.50%	86.60%	84.50%	86.50%			87.91%	> 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	1,104			1160			
PES Admission Volume	523	585	560	544	555	498	549	522	558	487			538.10			
Mechanical Restraints	0	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			0.00	≤ 0.01	IOS	Epic
Personal Restraints	46	40	37	37	43	50	79	76	43	49			50.00			Epic
Personal Restraint Rate	2.07	1.95	1.78	1.77	1.98	2.68	3.85	4.23	2.36	3.65			2.63	≤ 2.80	IOS	Epic
Seclusions	33	35	19	32	20	39	53	74	35	33			37.30			Epic
Seclusion Rate	1.48	1.61	0.92	1.53	0.92	2.09	2.58	4.11	1.92	2.46			1.96	≤ 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	49.71			49.24	≤ 61.73	IOS	Epic
Emergency Medications	44	54	42	47	58	56	72	72	67	53			56.50			Epic
EM Rate	1.98	2.48	2.02	2.25	2.67	3.01	3.50	4.00	3.61	3.63			2.92	≤ 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%	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%	88.47%			89.52%	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%	87.81%			89.11%	90.00%	IOS	Feedtrail
PoC-IP	89.71%	89.30%	89.25%	90.14%	95.15%	90.74%	90.61%	91.85%	91.08%	91.03%			90.89%	90.00%	IOS	McLean
Pharmacy	93.02%	99.09%	96.31%	96.19%	94.87%	100.00%	97.58%	96.37%	97.66%	99.63%			97.07%	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%	27.79%			26.42%	24.00%	IOS	MBOW
BDSS	30.19%	31.31%	31.83%	33.48%	33.70%	33.36%	33.38%	33.26%	34.49%	35.28%			33.03%	32.00%	IOS	MBOW
PSRS	26.32%	30.56%	35.26%	35.51%	35.11%	34.49%	34.81%	35.67%	36.83%	37.70%			34.23%	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	0.77	0.91			0.66	0.68	IOS	McLean
QIDS-C	53.80%	47.30%	50.10%	50.40%	48.60%	44.50%	47.20%	49.70%	48.50%	57.10%			49.72%	45.38%	IOS	Epic
BDSS	46.10%	46.20%	51.80%	50.30%	48.70%	47.20%	45.40%	42.80%	49.10%	47.00%			47.46%	46.47%	IOS	Epic
PSRS	38.20%	41.70%	43.50%	42.40%	36.00%	39.70%	32.30%	39.30%	42.80%	40.70%			39.66%	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%	44.80%			32.78%	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%	42.30%			38.97%	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%	35.20%			27.53%	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%	47.60%	44.30%	43.40%			45.68%	48.07%	IOS	Epic

* DSM data requires validation .

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 Q-4

Psychiatric Emergency Services (PES) Quarterly Update

Trends & Analysis

Board Quality Committee

Presented by: Amber Pastusek, MD – VP, Crisis Medical Services

August 15, 2023

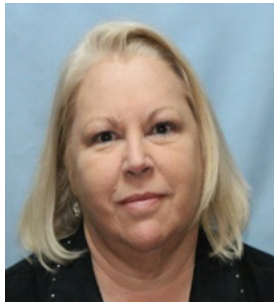
Core Project Team

Luming Li MD,
Chief Medical Officer

Kia Walker,
Chief Nursing Officer

Amber Pastusek MD,
VP of Crisis Medical Services

Trudy Leidich,
VP of Clinical Transformation



Kim Kornmayer,
VP of Crisis Services

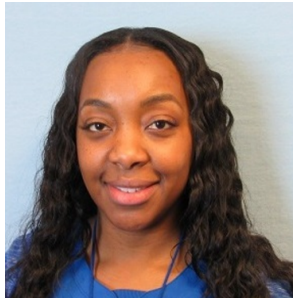
Wendy Martinez,
Director of Projects

Evelyn Locklin,
Director of Emergency Services

Susan Brock-Roberts,
Program Director V

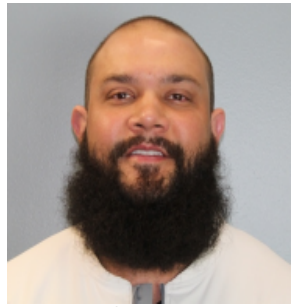
Greg Gigax RN,
Senior Nurse Manager

Sony John, RN
Nurse Supervisor



Raven Bentley, RN
Nurse Supervisor

Daniel Scott RN,
Lead Nurse



Kirby Bray,
Lead Psychiatric Technician

Chalmas Leonard,
Lead Psychiatric Technician

Agenda for Safer Workplace

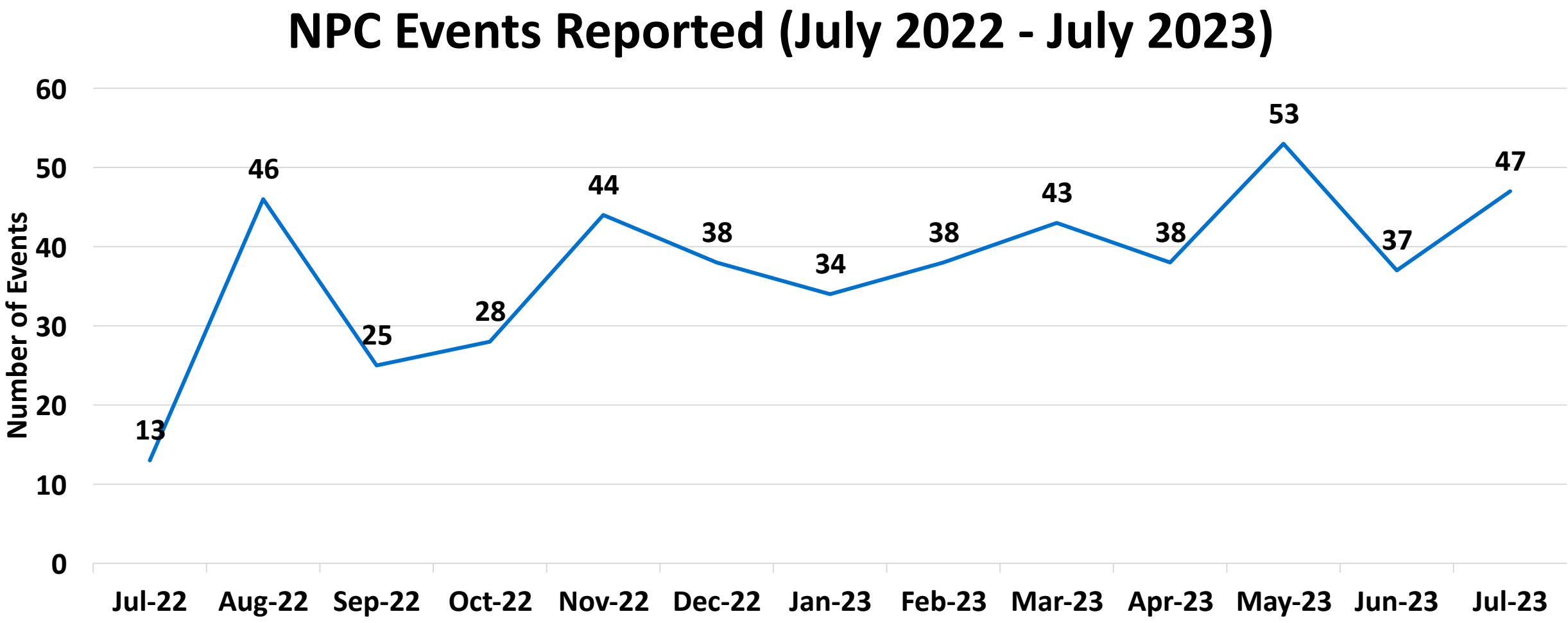
- **Physical Safety**
  - Environment of Care which includes physical space coupled with staff and patients
- **Psychological Safety**
  - Employee wellness, collaboration, shared accountability
- **Evaluate Trends in Data**
  - Unsafe Behaviors
- **Performance Improvements Focus Areas**

- Appendix
  - PES Board PI Scorecard (June 2022– June 2023)
  - Emergency Interventions Control Charts
  - Boarding Times vs Diversion Times vs Beds Allocated

Workplace Safety

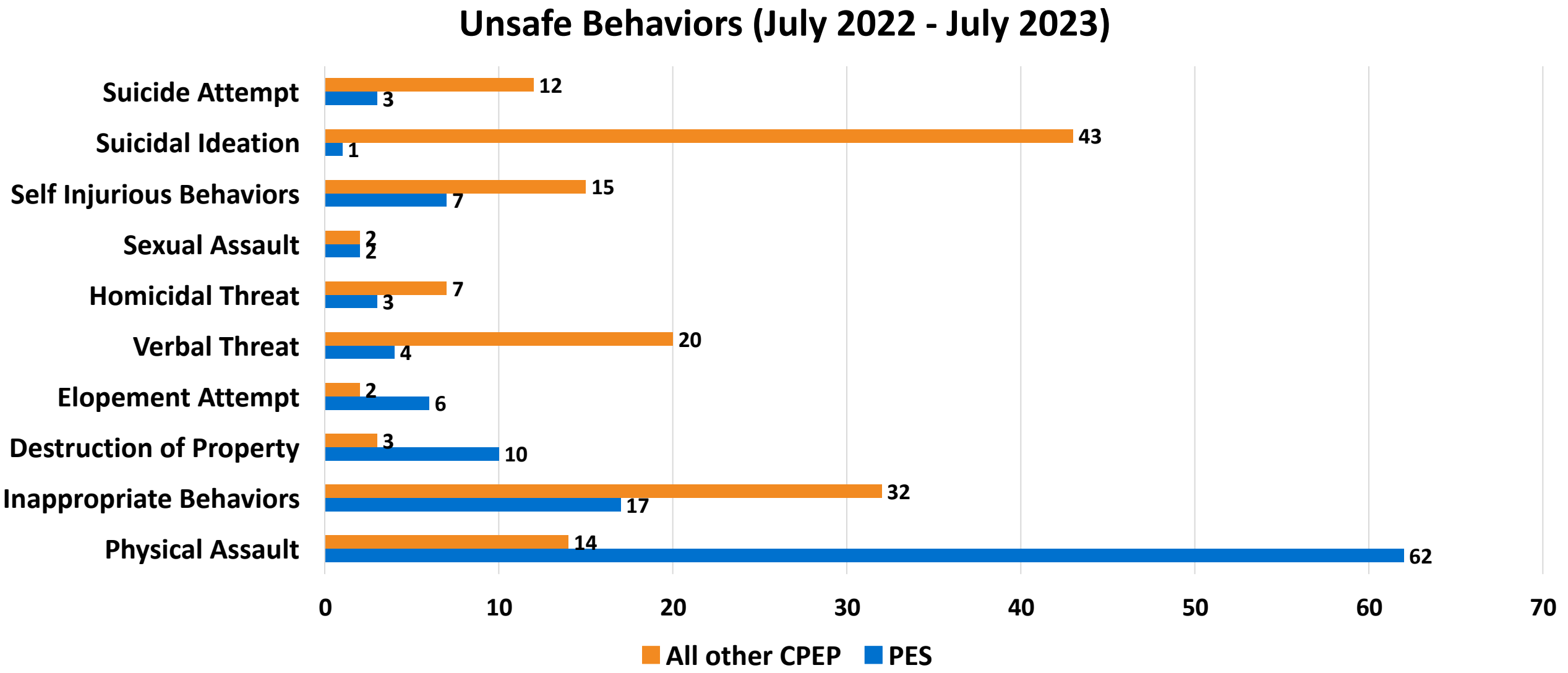
- **Physical Safety**
  - Alert buttons at NPC in key areas
  - Alert buttons being evaluated for 6160 location
  - Safety Officers being considered for NPC & 6160 locations
  - Evaluating the terms of the Security Contract for 6160 location
  - Law Enforcement Officers being considered for NPC & 6160 locations
- **Psychological Safety**
  - Just Care Culture pilot launched at NPC 2/2023 to foster an environment of psychological safety, employee wellness, teamwork, collaboration, respect, and shared accountability
  - Just Care Culture Decision Tree implemented
  - Psychological Safety Survey initial and follow up administered
  - RISE team in progress with upcoming launch

NPC Events Reported in Safe Care



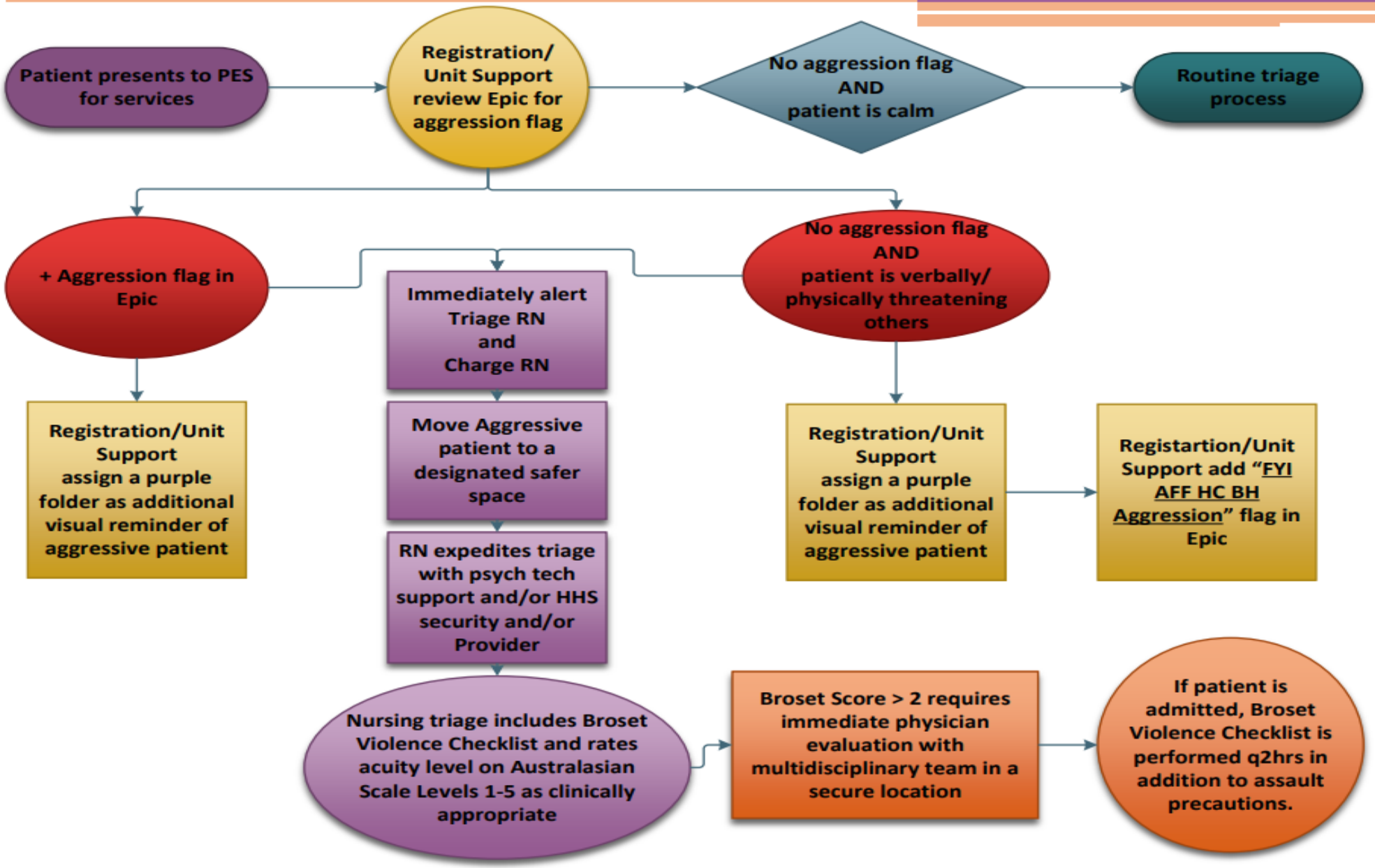
Events = Provision of Care & Services; Unsafe Behaviors; Abuse, Neglect, Exploitation; Employee Injuries, Falls, Environment of Care; Medication Issue; Death of Person Served; HIPAA/Privacy Issue

Unsafe Behaviors Trends



Aggressive Patient Care Pathway - NPC

Updated 2/2023



Just Care Culture Updates

Psychological Safety Survey	Apr-22	Jul-23
People at this organization are able to bring up problems & tough issues.	3	**3.48**
I feel safe to take a risk in this organization.	2.72	**2.92**
It is difficult to ask other members of this organization for help.	2.72	**2.76**
No one at this organization would act deliberately in a way that undermines my efforts.	3.21	**3.26**
Working with members of this organization, my unique skills and talents are valued and utilized.	3.28	**3.56**
If I make a mistake at this organization, it is often held against me.	2.64	**2.82**
People at this organization sometimes reject others for being different.	2.59	2.59
Total Respondents	58/274	105/355

Likert Scale

1 = Strongly Disagree
2 = Disagree
3 = Neutral
4 = Agree
5 = Strongly Agree

Performance Improvement Focus Areas

- Assembled a Workplace Safety group
- Implemented an Aggressive Patient Care Pathway
- Provided additional tools for a safer workplace
- Expand and implement Just Care Culture across other care settings and monitor
- Continue to encourage reporting in Safe Care and monitor trends
- Internal collaborations to evaluate resources within the Harris Center
- Community collaborations to support the needs of highest risk areas

Thank you.

Appendix

PES Emergency Interventions Data

Key Definitions

- Emergency Interventions required to prevent imminent threat of harm to self/others
  - **Personal Restraint** – Restricting patient's free movement
    - Adults ≤ 15 minutes, Youth ≤ 15 minutes
  - **Mechanical Restraint** – Restricting patient's free movement by using 4-point, 3-point, 2-point, mittens, and/or helmet
    - Adults ≤ 4 hours, ages 9-17 ≤ 2 hours, ages 3-8 ≤ 1 hour
  - **Seclusion** – Confinement of a patient in a room/area that free exit is prevented
    - Adults ≤ 4 hours, ages 9-17 ≤ 2 hours, ages 3-8 ≤ 1 hour
  - **Emergency Medications** – Administered without patient consent to prevent imminent harm to self/others
- Emergency Interventions Rate Calculation:
  - (Number of Interventions/Total Patient Hours) x 1,000

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PES Board PI Scorecard (June 2022 – June 2023)

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	FY23 AVG	FY3 Target	Target Type
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	1,014	1,058	1,163	1,194	1,192	1,160	1,173	1,266	1,126	1,126	1,145	1,155	1,104	1164.10		
PES Admission Volume	584	504	562	523	585	560	544	555	498	549	553	558	487	541.20		
Emergency Medications	44	38	44	44	54	42	47	58	56	72	72	67	53	56.50		
EM Rate	2.3	1.71	1.98	1.98	2.48	2.02	2.25	2.67	3.01	3.5	3.99	3.61	3.63	2.91	≤3.91	IOS
Personal Restraint	33	41	42	46	40	37	37	43	50	79	70	43	49	49.40		
Personal Restraint Rate	1.73	1.85	1.99	2.07	1.95	1.78	1.77	1.98	2.68	3.85	3.89	2.36	3.65	2.60	≤2.80	IOS
Seclusions	34	29	41	33	35	19	32	20	39	53	58	35	33	35.70		
Seclusion Rate	1.78	1.31	1.79	1.48	1.61	0.92	1.53	0.92	2.09	2.58	3.22	1.92	2.46	1.87	≤2.73	IOS
AVG Minutes in Seclusion	60.15	45.66	56.9	46.91	58.66	52.62	51.82	41.7	49.76	44.33	54.9	42.2	49.71	49.26	61.11	IOS
Mechanical Restraints	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Mechanical Restraint Rate	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

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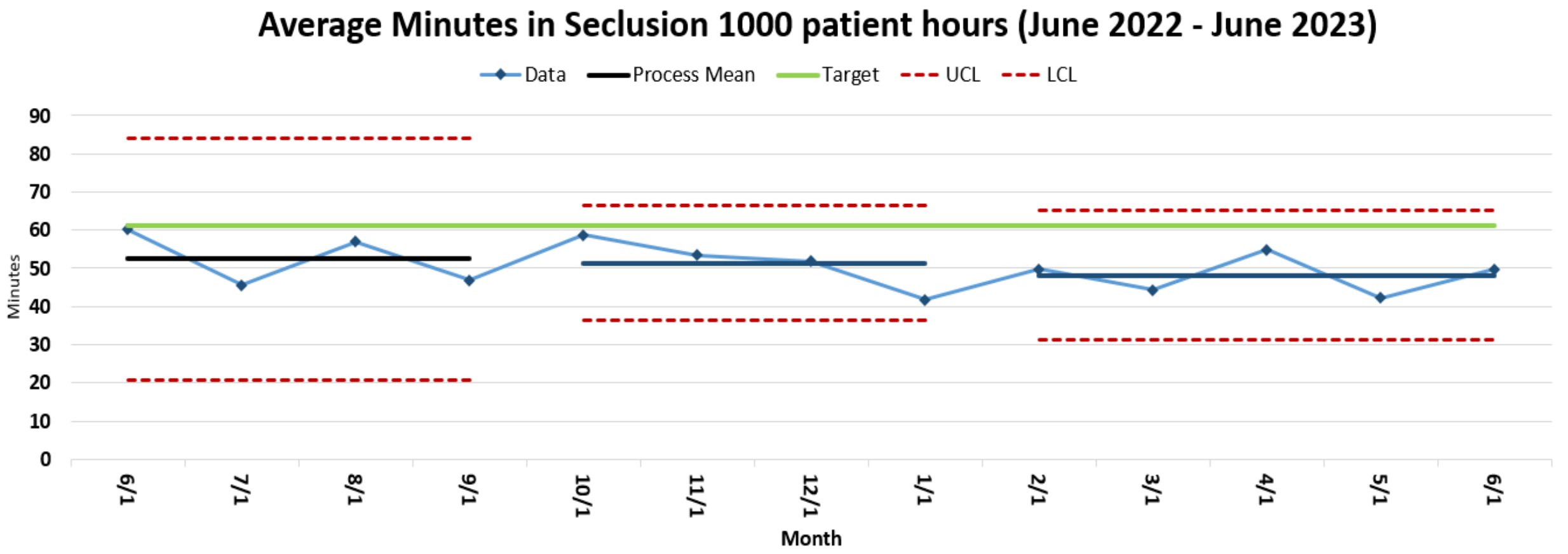
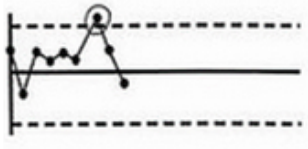
Average Minutes in Seclusion

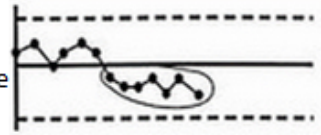


SPECIAL CAUSE VARIATION

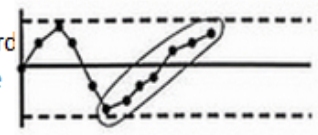
POINT OUTSIDE OF THE LIMIT:
Any point on or outside the limit is considered abnormal and requires investigation.



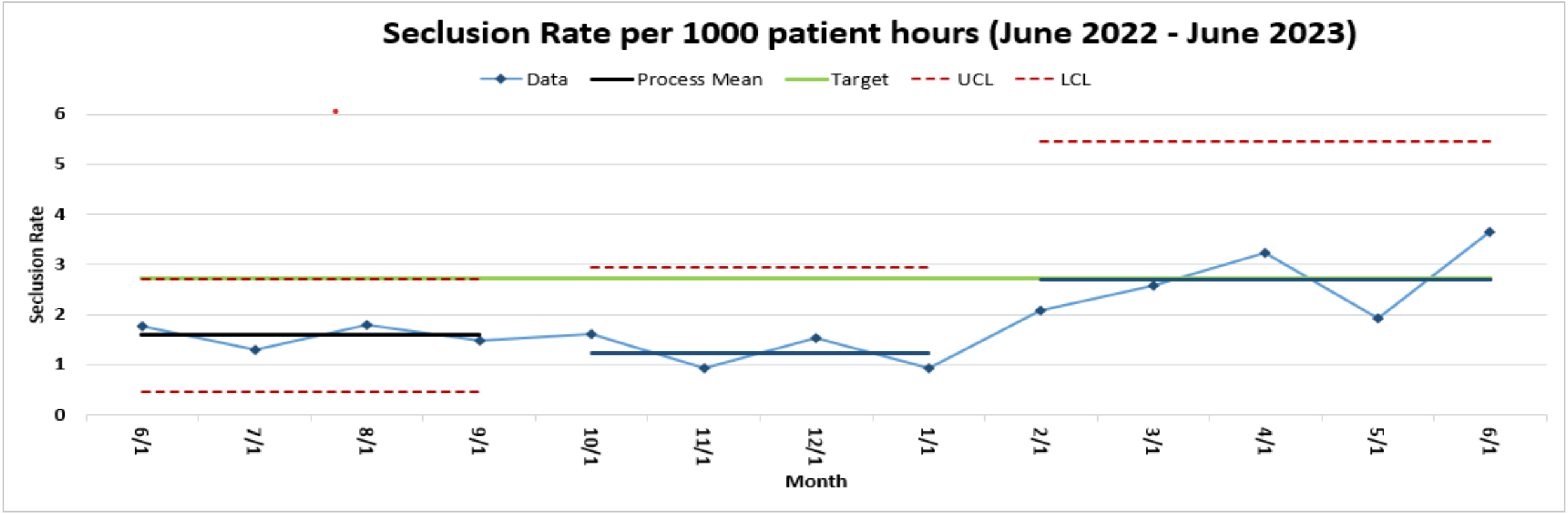
SHIFT (RUN):
A shift is indicated when 7 consecutive points lie continually on one side of the center line.



TRENDS:
Seven consecutive points in an upward or downward direction could indicate special cause



Seclusion Rate



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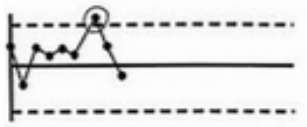

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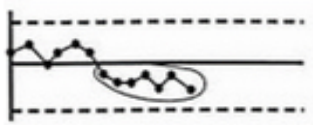

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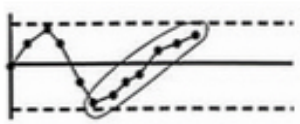
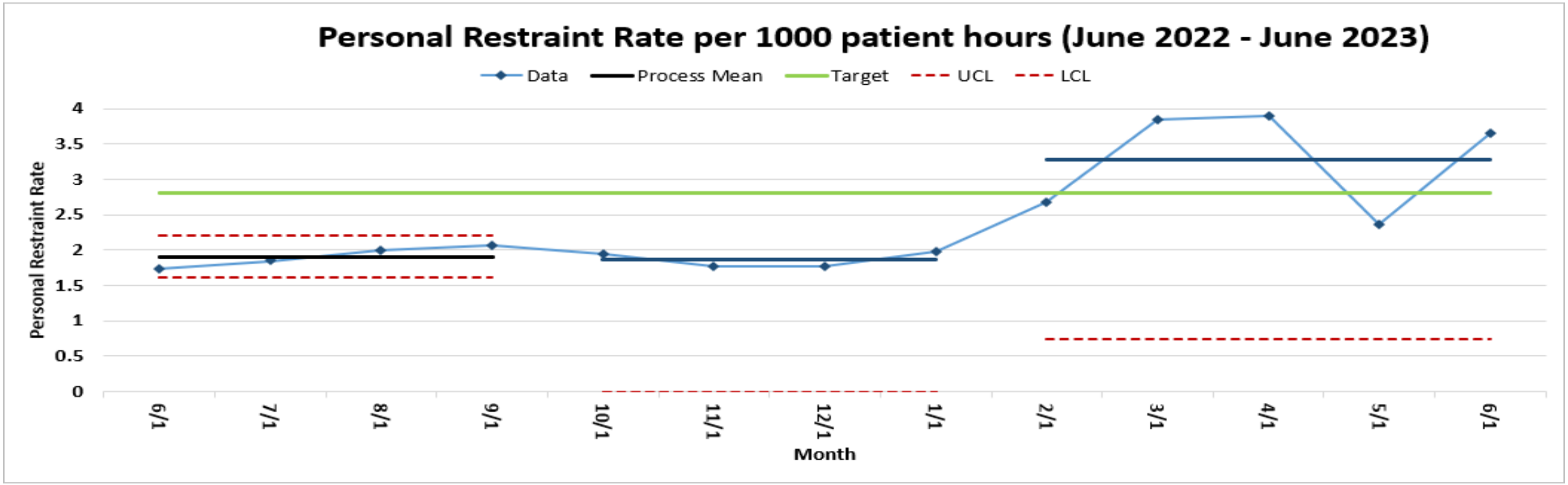


**Uptrend accounted for by # of IDD patients with Multiple Interventions

2/2023 = 1
3/2023 = 2
4/2023 = 3
5/2023 = 4
6/2023 = 3

Personal Restraint Rate



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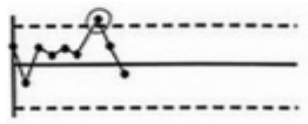

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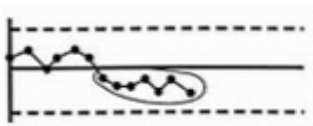
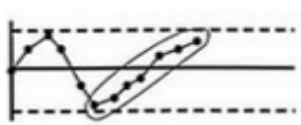


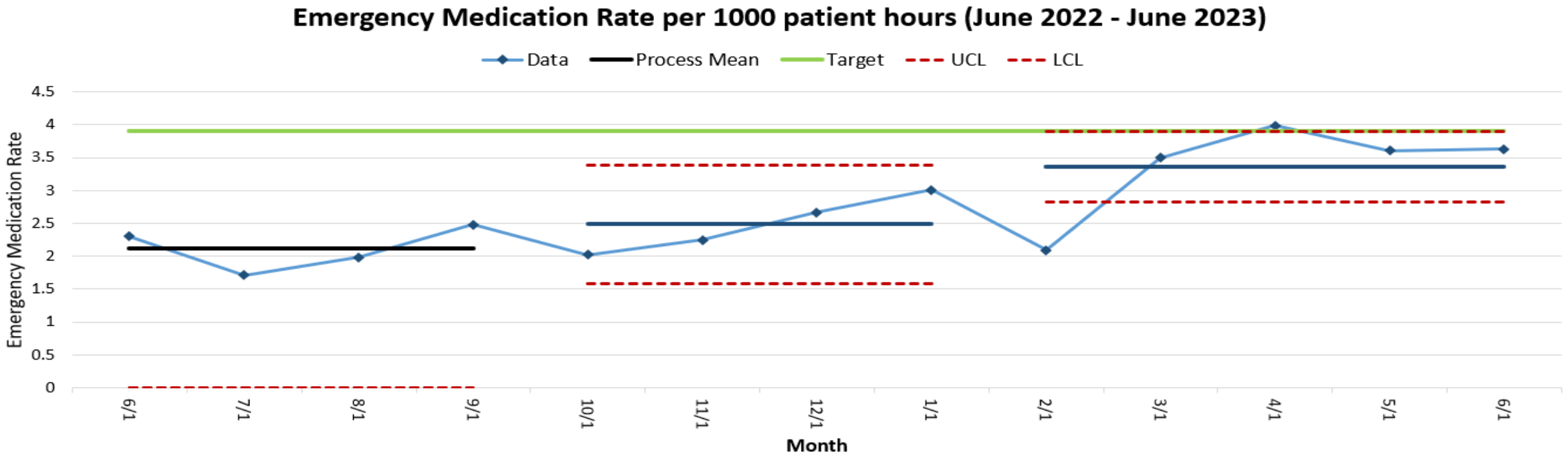
TRENDS:
Seven consecutive points in an upward or downward direction could indicate special cause



**Uptrend accounted for by # of IDD patients with Multiple Interventions

2/2023 = 1
3/2023 = 2
4/2023 = 3
5/2023 = 4
6/2023 = 3

Emergency Medication Rate



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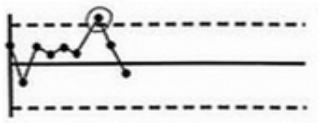

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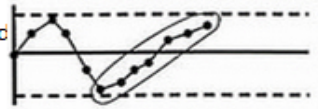

**Uptrend accounted for by # of IDD patients with Multiple Interventions

2/2023 = 1
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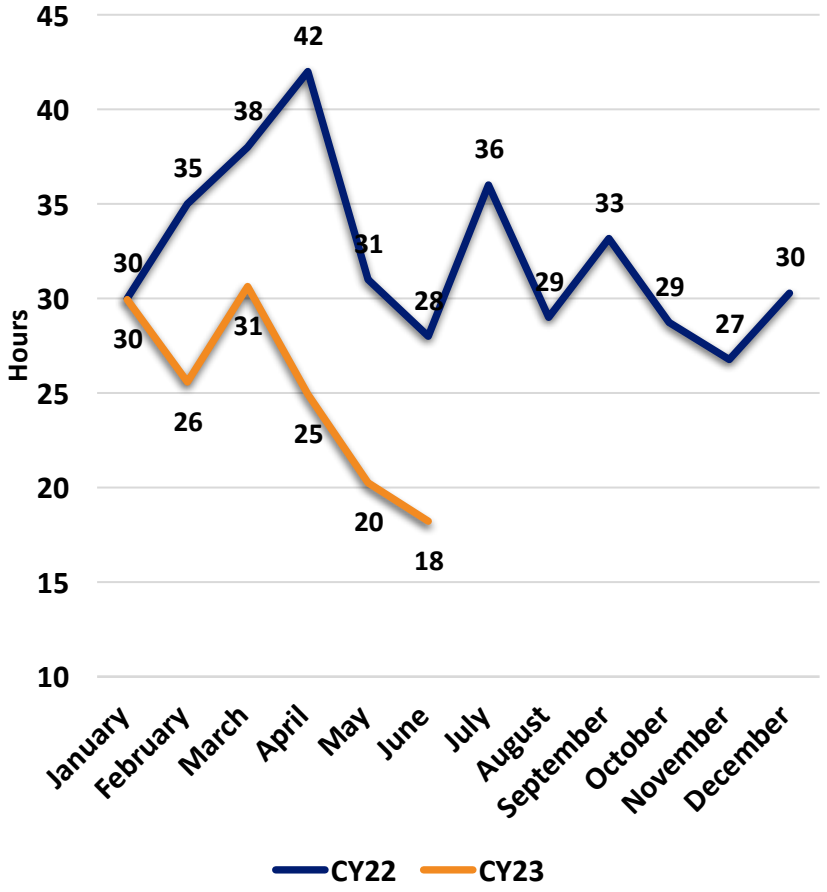
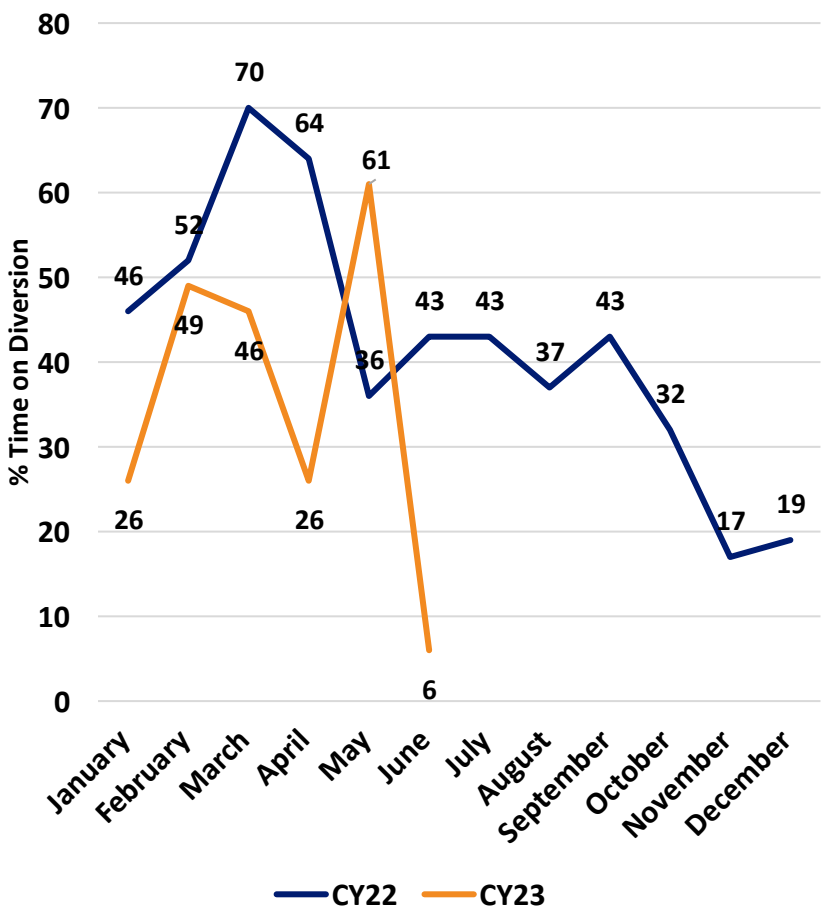
4/2023 = 3
5/2023 = 4
6/2023 = 3

Boarding Times vs Diversion vs Beds Allocated Trends

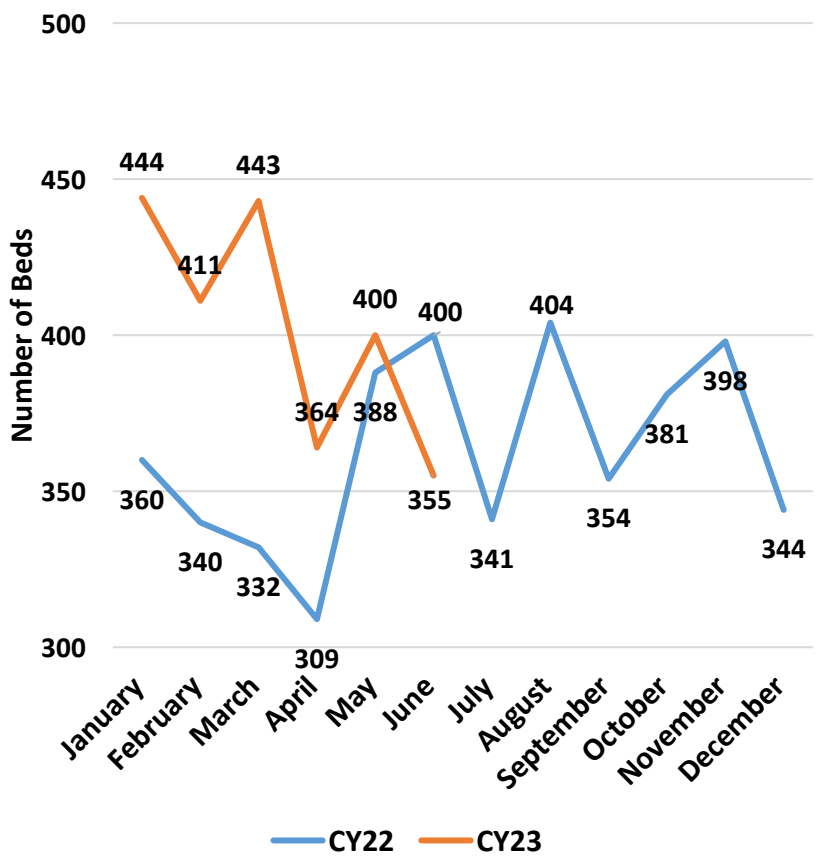
PES Average Boarding Times



% PES Diversion



PES Dispositions



Average Boarding Times decreased for 2023. *June had 9% less admissions resulting in less boarding and diversion times. West Oaks contract beds increased from 7 to 11 in June.

% of Time on Diversion decreased for 2023. Youth Diversion times have been higher than adult diversion times starting in January 2023. *February (77%) & May (85%) had significantly increased youth diversion times compared to previous months (averaging 36%).

Increase in Total Beds available for 2023. HCPC beds averaged in 2022 = 153 compared to 2023 = 175. All other hospital beds averaged in 2022 = 210 compared to 2023 = 225.

EXHIBIT Q-5

IDD Summer Enrichment Program + Healing Species

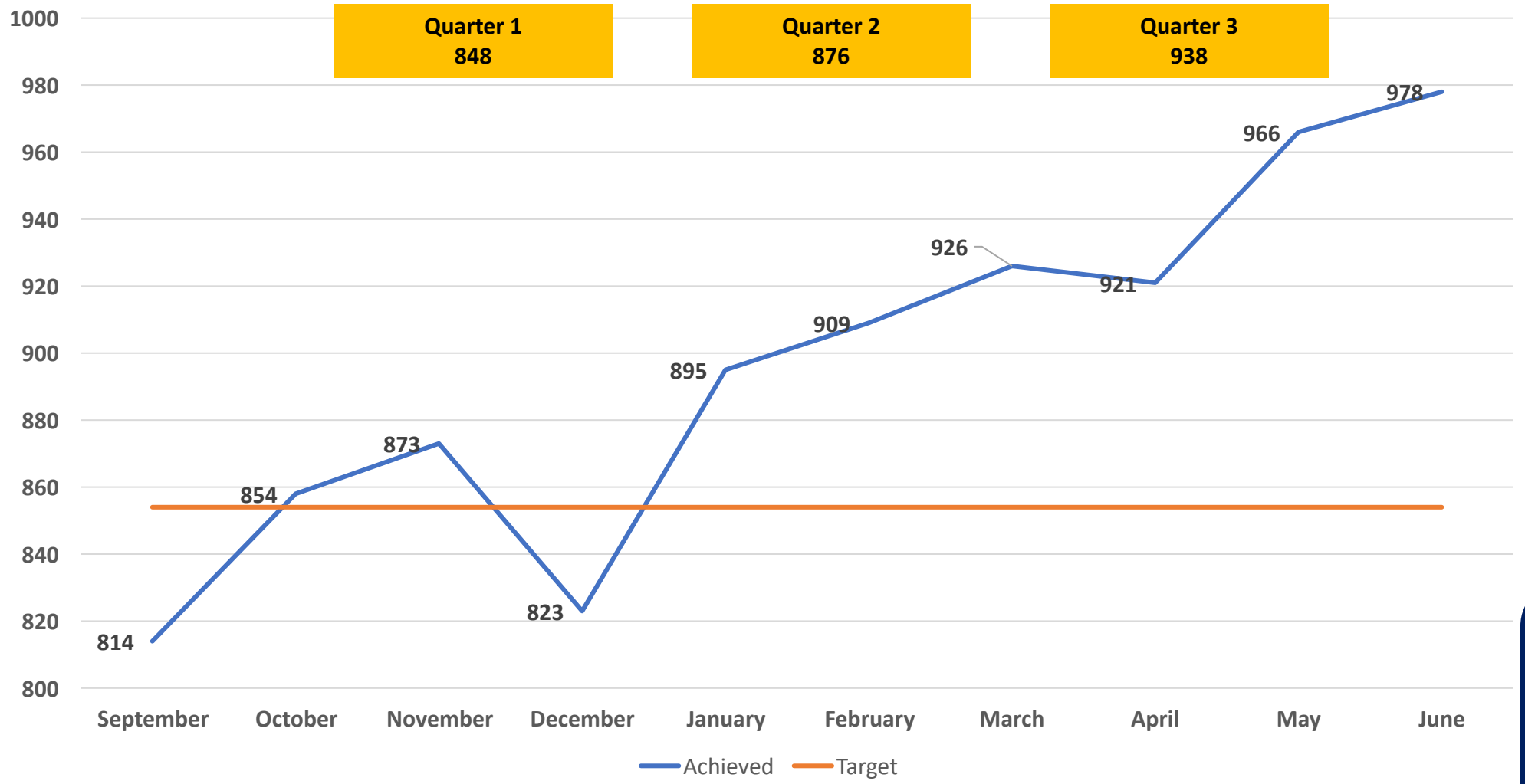
The HARRIS CENTER for Mental Health and IDD

Transforming Lives

IDD Services Division

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

FY23 Performance Targets



Last achieved FY2015

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	July
Beginning of month*	5,831	5,775	5,710	5,602	5,621	5,547	5,486	5,287	4,306	3,782	3,473
Added	-	37	22	34	30	59	42	14	0	0	0
Removed	-	102	130	15	104	120	241	995	524	309	582
TOTAL WAITING	**5,831**	**5,710**	**5,602**	**5,621**	**5,547**	**5,486**	**5,287**	**4,306**	**3,782**	**3,473**	**2,891**

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 7/31/23)

STEP 2 SERVICE COORDINATION

Discovery
Person-Directed Plan
Monitoring

Number waiting to receive a GR Service Coordinator*

Feb	52
Mar	44
Apr	69
May	36
June	32
July	26

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 7/31/23)

STEP 3 GR SERVICES

HHSC Contracted Services
Internal/External Providers
Community Linkages

Number waiting to access an authorized GR service*

	Feb	Mar	Apr	May	June	July
In-home respite (Contract) *Avg. wait time: ~1 month*	23	13	23	34	45	51
Out-of-home respite (Contract) *Avg. wait time: ~1 month*	0	0	0	0	0	0
Day Habilitation (Contract) *Avg, wait time: ~1 month*	15	15	16	13	15	19
Employment Services (Contract) *Avg. wait time: ~1 month*	2	9	14	14	14	14
Feeding Clinic (Internal) *Avg. wait time: ~1 month*	0	0	0	1	0	0
Outpatient Biopsychosocial Services (OBI) (Internal) *Avg. wait time: 10 months*	181	143	120	102	105	106
The Coffeehouse (Internal) *Avg. wait time: 4 months*	13	24	27	29	37	37
TOTAL WAITING	**234**	**204**	**200**	**193**	**216**	**227**

*data has been validated and is post DID (as of 7/31/23)

GR Number Added & Process

GR Clients Added Per Month	
	JULY
Respite (Out-of-Home)	1
Respite (In-Home)	6
Employment Assistance	3
Day Habilitation	2
Nursing	10
Behavioral Supports	7
TOTAL ADDED	**29**

Step 1

- Initial call to Harris Center
- Screened for needs (probing script)
- Caller added to Medicaid Waivers (HCS/TXHML)
- Average wait time discussed

Step 2

- If caller agrees to wait times, individual is added to requested service code
- Intake packet is provided (if not already completed) and assistance is given to help family access records if needed

Step 3

- Once service coordination is available, family is contacted to complete the DID process
- **If service coordination is available, and a DID cannot be scheduled within 60 days, then individual is considered 'waiting for a DID'**

HCS – Home and Community-based Services
TXHML – Texas Home Living

DID No-Show Rate

No-Show Monthly Percentage	
NOV	45.3%
DEC	36.0%
JAN	39.8%
FEB	31.0%
MAR	44.8%
APR	25.5%
MAY	26.2%
JUNE	28.6%
JULY	26.3%

Increasing virtual and weekend appointments

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)
JULY	107* (28 external contracts)
FY23 Total	**1,294**

**Data as of 7/31/23*

July Breakdown:
68 Full - 27 Updates - 12 Endorsements
YTD Breakdown:
729 Full - 316 Updates - 249 Endorsements

DID Report Completion Timeframe

	AVG Completion Time (CALENDAR DAYS)
SEPT	21
OCT	24
NOV	28
DEC	33
JAN	22
FEB	24
MAR	22
APR	27
MAY	25
JUNE	16
JULY	8*
AVG (excluding July)	**24.2 days**

**Data as of 7/31/23*

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