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

Quality Committee Meeting
February 20, 2024
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, November 7, 2023
(EXHIBIT Q-1)

IV. **REVIEW AND COMMENT**

A. Federally Qualified Health Center Look-A-Like (FQHC-LAL)
(EXHIBIT Q-2 Trudy Leidich)

B. Psychiatric Emergency Services (PES) Quarterly Update
(EXHIBIT Q-3 Amber Pastusek)

C. IDD Update
(EXHIBIT Q-4 Evanthe Collins)

D. Board Score Card
(EXHIBIT Q-5 Trudy Leidich)

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, Dr. Amber Pastusek, Vice President of Crisis Medical Services and Trudy Leidich, Vice President of Clinical Transformation & Quality

VI. **RECONVENE INTO OPEN SESSION**

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

VIII. **ADJOURN**

Veronica Franco

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

EXHIBIT Q-1

The HARRIS CENTER *for* MENTAL HEALTH and IDD BOARD OF TRUSTEES QUALITY COMMITTEE MEETING TUESDAY, NOVEMBER 7, 2023 MINUTES

Dr. G. Santos, Chair, called the meeting to order at 9:01 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. R. Gearing, Dr. G. Santos, B. Hellums

Committee Member Absent:

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

1. **CALL TO ORDER**
   Dr. Santos called the meeting to order at 9:01 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Dr. Santos designated Dr. Moore as a voting member.

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

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

5. **Approve the Minutes of the Board of Trustees Quality Committee Meeting Held on Tuesday, October 17, 2023**

   MOTION BY: MOORE SECOND BY: GEARING

   With unanimous affirmative votes,
   BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday, October 17, 2023, as presented under Exhibit Q-1, are approved.

6. **REVIEW AND COMMENT**

   A. FQHC Discussion, presented by Wayne Young, was reviewed by the Quality Committee.

7. EXECUTIVE SESSION-

Dr. Santos announced the Quality Committee would enter into executive session at 9:23 am for the following reason:

- **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, Dr. Amber Pastusek, Vice President of Crisis Medical Services and Trudy Leidich, Vice President of Clinical Transformation & Quality**

8. RECONVENE INTO OPEN SESSION-

The Quality Committee reconvened into open session at 9:54 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: ZAKARIA SECOND: HELLUMS

There being no further business, the meeting adjourned at 9:54 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

Federally Qualified Health Center Look-A-Like (FQHC-LAL)

Quality Improvement/Assurance Requirements

Presented by: Trudy Leidich, RN, MBA
February 20th, 2024

Federally Qualified Health Center Look-Alike (FQHC-LAL) Organizational Vision & Current State

Integrated care is a strategic plan goal for The Harris Center

- Primary care integration operational across major clinic sites and 6160 location (University of Houston contracted services, direct employment)
- Previously and currently funded by SAMHSA and state grants (time-limited)
- Need to establish sustainable model for behavioral health-primary care integration
- Other LMHAs are pursuing similar paths

Most practical paths for integrated care funding

- **FQHC-LAL -> FQHC (current direction)**
- FQHC (direct path, potentially open for application in near future)
- CMS Innovation in Behavioral Health (IBH) Model (announced in January 2024)
- CCBHC prospective payment (Texas not selected to participate)

To-Date:

- Board presentation about FQHC-LAL rationale, focusing on Finance and Governance
- Site visit by Health Management Associates reviewing readiness and requirements
- **Board Request to present about Quality**

FQHC-LAL Priority Focus Areas for Quality

Quality Improvement/Assurance Program
Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high-quality patient care

Clinical Services Management
Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center

Patient Experience
Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances

The Harris Center's Vision for FQHC-LAL Quality Improvement

To ensure the FQHC–LAL for Integrated Care Patients, The Quality requirements are in alignment with the Harris Center's mission, vision, and values for quality:

- Fulfill legal, licensing, certifying, funding and accreditation requirements
- Compliance with laws, regulations, and professional standards
- Promote the concept of continually improving the system for the delivery of health care services
- Provide a mechanism for professional peer review
- Provide baseline data for peer review and other staffing decisions
- Promote appropriate cost-effective and quality health care services

Reporting FQHC Quality Metrics to FQHC Board

- Approval of policies and procedures that are adopted or adapted from system level policies and procedures to meet HRSA requirements
- Develop outcomes metrics and score-card reporting to the FQHC Board
- Align reporting of outcomes metrics to the system level Board for timely visibility of outcomes

FQHC-LAL Requirements

FQHC –LAL Quality Improvement/Assurance Program	Harris Center	FQHC - LAL
A board-approved policy(ies) that establishes a QI/QA program.	In-place	Adapt
An individual(s) to oversee the QI/QA program established by board-approved policy(ies).	In-place	Adapt
Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services	In-place	Adapt
Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions	Safe Care RL	Adopt
Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.	In-place	Adapt

FQHC-LAL Requirements

FQHC-LAL Clinical Services Management	THC	FQHC
Adhere to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services (policies under Peer Review)	In place In-place system wide	Adapt and track through Professional Practice processes
The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records	In place system wide	Adopt

FQHC-LAL Requirements

FQHC-LAL Patient Experience	THC - Status	FQHC
Assessing patient satisfaction	In-place	Adopt
Hearing and resolving patient grievances	In-place	Adopt
The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements	In-place	Adopt

FQHC-LAL Reporting

FQHC Look-alikes must submit the annual Uniform Data System report (UDS).

Its core components include patient demographics, staffing and utilization, selected diagnoses and services rendered, quality of care indicators, health outcomes and disparities, and finances and revenues of awardee health centers

Table	Data Reported	Universal Report
Service Area		
Zip Code Table	Patients by Zip Code	•
Patient Profile		
Table 3A	Patients by Age and by Sex Assigned at Birth	•
Table 3B	Demographic Characteristics	•
Table 4	Selected Patient Characteristics	•
Staffing and Utilization		
Table 5	Staffing and Utilization	•
Table 5A	Tenure for Health Center Staff	•
Clinical		
Table 6A	Selected Diagnoses and Services Rendered	•
Table 6B	Quality of Care Measures	•
Table 7	Health Outcomes and Disparities	•
Financial		
Table 8A	Financial Costs	•
Table 9D	Patient-Related Revenue	•
Table 9E	Other Revenue	•

FQHC-LAL Reporting

FQHC-LAL Clinical Quality Measures: Screening and Preventive Care	THC	FQHC
Cervical Cancer Screening (PAP smears)	Yes	Adopt
Breast Cancer Screening (provide resources - referral and help with scheduling appt at Rose Clinic OR help to apply for gold card)	Yes	Adopt
Body Mass Index (BMI) Screening and Follow-Up Plan	Yes – every visit	Adopt
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	Adopt
Colorectal Cancer Screening (provide fecal occult stool test)	Yes	Adopt
HIV Screening	Yes	Adopt
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Yes	Adopt

Integrated services functions as all primary services

FQHC-LAL Reporting

FQHC-LAL Clinical Quality Measures: Maternal Care and Children's Health	THC	FQHC
Early Entry into Prenatal Care	Partial (pregnancy test and pregnancy referral provided)	Referral
Childhood Immunization Status	Not provided*	Referral
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Yes – every visit	Adopt
Dental Sealants for Children between 6–9 Years	Not Provided*	Referral

*HRSA allows for contracted MOU referrals

FQHC-LAL Reporting

FQHC-LAL Clinical Quality Measures: Disease Management	THC –	FQHC
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Yes	Adopt
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Yes	Adopt
HIV Linkage to Care (refer patients to HIV clinic - give resources - legacy clinics, HIV clinics, Gold cards)	Yes	Referral
Depression Remission at Twelve Months	Yes	Adopt
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Yes	Adopt

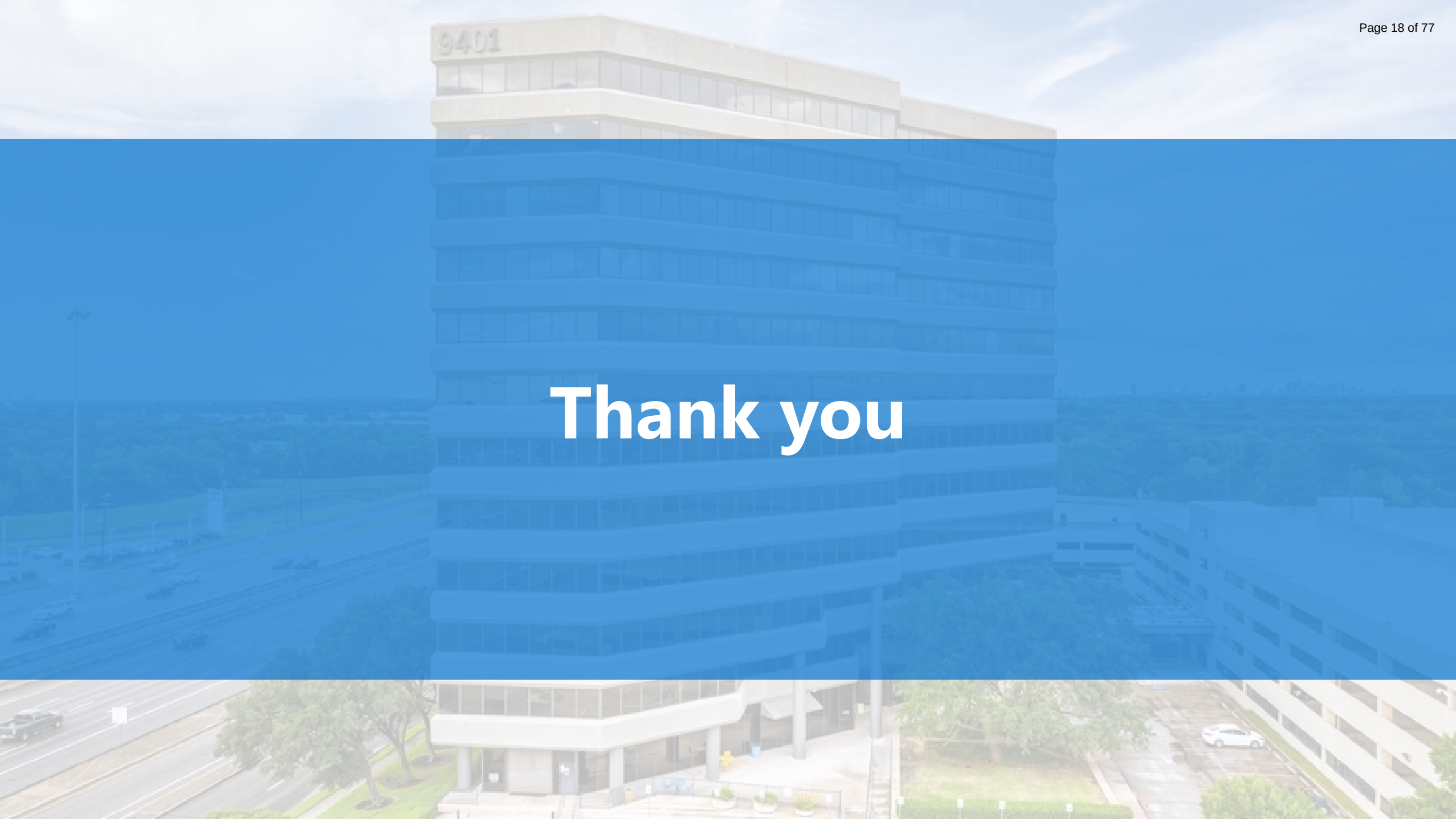
FQHC-LAL
Quality Improvement Awards

Health Center Program awardee or a look-alike (LAL), can earn Community Health Quality Recognition (CHQR) badges.

You must show quality improvements in one of these:
- Access
- Quality
- Equity
- Health IT
- COVID-19 public health emergency response

CHQR badges are awarded annually, based on data from the latest Uniform Data System (UDS) reporting period.

CHQR Badges description in appendix



Thank you

Appendix: CHQR Badges

National Quality Leader (NQL) badges

To earn NQL badges, health centers must

- Meet all criteria for one or more clinical quality areas:
  - Behavioral health
  - Cancer screening
  - Diabetes health
  - Heart health
  - HIV prevention and care
  - Maternal and child health
- For all CQM criteria, report a minimum number of patients in a CQM denominator.
  - Report at least 70 patients for all except:
    - HIV Prevention and Care badge: report at least 30 patients for the HIV linkage to care CQM
    - Maternal and Child Health badge: report at least 30 patients for the low birthweight CQM
  - Meet or go above the target for CQMs in each clinical quality area

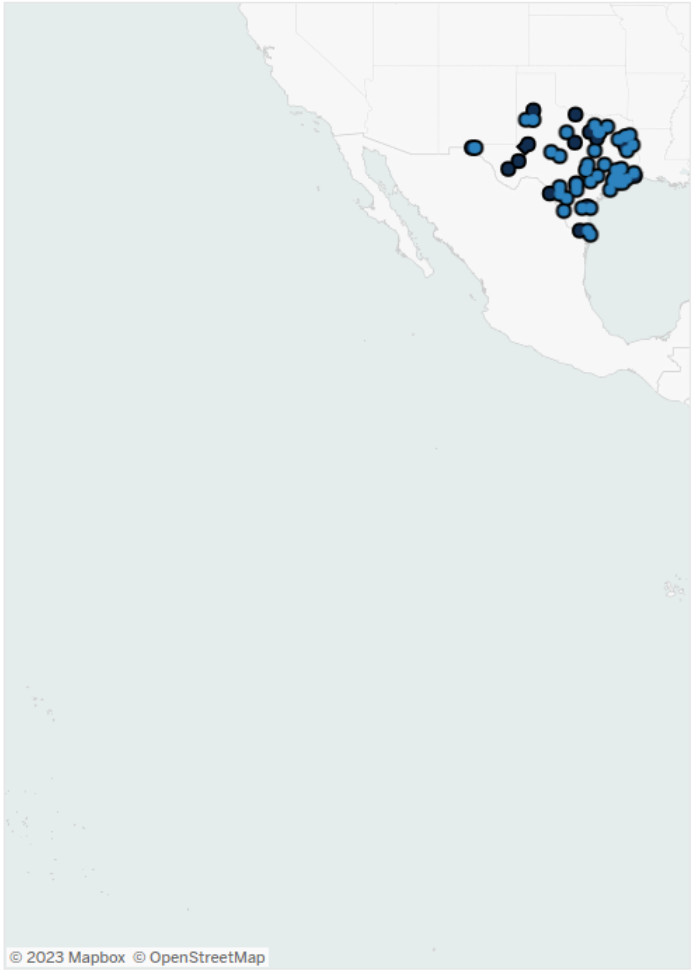
2023 NQL - Behavioral Health badge

Measure	Must meet
Depression remission at 12 months	**18.2%** (Top quintile of 2020 UDS Data)
Depression screening and follow-up plan	**80.5%** (Top quartile of 2020 UDS Data)
Proportion of all patients receiving Screening, Brief Intervention and Referral to Treatment (SBIRT)	**At least 5%**
Relative percent increase in patients receiving medication-assisted treatment (MAT) between consecutive UDS reporting years	**At least 10%**

Appendix: Texas CHQR Badges Award

2021 | 2022 | **2023**

State/Territory	Health Center Type	Health Center Name	Health Center Number	CHQR Badge Category
Texas	(All)	(All)	(All)	(All)



Percent of Health Centers Awarded CHQR Badge
State/Territory/Freely Associated State: Texas

	Program Awardee		Program Look-Alike	
	N	%	N	%
Total Number of Health Centers	72	100.00%	1	100.00%
Health Centers Earning At Least One Badge	53	73.61%	0	0.00%
Access Enhancer	11	15.28%	0	0.00%
Addressing Social Risk Factors to Health	15	20.83%	0	0.00%
Advancing HIT	40	55.56%	0	0.00%
COVID-19 Public Health Champion	9	12.50%	0	0.00%
Health Center Quality Leader - Gold	7	9.72%	0	0.00%
Health Center Quality Leader - Silver	8	11.11%	0	0.00%
Health Center Quality Leader - Bronze	8	11.11%	0	0.00%
Health Disparities Reducer	10	13.89%	0	0.00%
National Quality Leader - Behavioral Health	0	0.00%	0	0.00%
National Quality Leader - Cancer Screening	0	0.00%	0	0.00%
National Quality Leader - Diabetes Health	0	0.00%	0	0.00%
National Quality Leader - Heart Health	0	0.00%	0	0.00%
National Quality Leader - HIV Prevention and Care	0	0.00%	0	0.00%
National Quality Leader - Maternal and Child Health	0	0.00%	0	0.00%

● Program Awardee ◆ Program Look-Alike

Received CHQR badge(s)
Did not receive CHQR badge(s)

Appendix: CHQR Badges

2023 Health Center Quality Leader (HCQL) badge

To earn HCQL badges, health centers must have the best overall CQM performance based on average 2022 Adjusted Quartile Rankings (AQR). We award HCQL badges to health centers with AQR averages in the top three tiers (top 30%).

Measure	Must meet
1st tier (top 10%)	Gold
2nd tier (top 11-20%)	Silver
3rd tier (top 21-30%)	Bronze

Note: We use the latest UDS data to calculate AQRs each year. Tier cutoffs may change every year.

Appendix: CHQR Badges

2023 Access Enhancer badge

Who can earn this badge?

Health centers must

- Achieve at least one of these:
  - Earn at least one HCQL or NQL badge.
  - Improve by at least a 15% in one or more CQMs in back-to-back reporting years.
- Increase by at least 5% in back-to-back reporting years.
  - Total patients.
  - Patients receiving mental health, substance use disorder, vision, dental, or enabling services.

Appendix: CHQR Badges

2023 Health Disparities Reducer badge

Who can earn this badge?

Health centers must

- Qualify for the Access Enhancer badge.
- Meet at least one of these:

1. Improve by at least a 10% in low birth weight, hypertension control, or uncontrolled diabetes CQMs and must:
   - Improve during the two most recent back-to-back reporting years for at least one racial or ethnic group.
   - Perform as well or better than the previous year for the CQM at the health center level.
2. Meet the following targets for all racial or ethnic groups they served within the latest reporting year.

Clinical Quality Measure	Must meet
Low birth weight – *Inverse Measure*	**7.7%** (Adjusted National Vital Statistics System Average)
Hypertension control	**60.8%** (Former Healthy People 2030 Target*)
Uncontrolled diabetes – *Inverse Measure*	**11.6%** (Healthy People 2030 Target)

Appendix: CHQR Badges

2023 Advancing Health Information Technology (HIT) for Quality badge

Who can earn this badge?

Health centers that meet all the following criteria:

1. Adopted an electronic health record (EHR) system.
2. Offered telehealth services.
3. Exchanged clinical information online with key providers health care settings.
4. Engaged patients through health IT.
5. Collected data on patient social risk factors.

Appendix: CHQR Badges

2023 Addressing Social Risk Factors badge

Who can earn this badge?

Health centers that:

- Collect data on patient social risk factors.
- Increase the percentage of patients who received enabling services between the last two UDS reporting years.

Appendix: CHQR Badges

2023 COVID-19 Public Health Champion badge

Who can earn this badge?

The top 10% of health centers providing COVID-19 vaccinations or testing to the largest percentage of patients.

Appendix: Data Reporting Feasibility

FQHC-LAL Reporting				
Measure Name	**Brief Description**	**Data on hand**	**Feasible**	**What's required to provide measure**
Cervical Cancer Screening (PAP smears)	Percentage of patients who were screened for cervical cancer.	N/A	Yes	Need contract or MOU with an organization to assist with follow up of abnormal pap smears
Breast Cancer Screening (provide resources - referral and help with scheduling appt at Rose Clinic OR help to apply for gold card)	Percentage of women who had a mammogram to screen for breast cancer.	N/A	Yes	The Rose Diagnostic Center
Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients with a BMI documented with a BMI outside of normal parameters, a follow-up plan is documented.	DPP (Ref: 2021.01-12 All Payer **38.13%**)	Yes	Modify current syntax
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients who were screened for tobacco use one or more times AND who received tobacco cessation intervention if identified as a tobacco user	DSRIP (Ref: 2020.01-12 All Payer **20.17%**)	Yes	Modify current syntax
Colorectal Cancer Screening (provide fecal occult stool test)	Percentage of patients who had appropriate screening for colorectal cancer	N/A	Yes	FIT testing
HIV Screening	Percentage of patients tested for Human immunodeficiency virus (HIV)	N/A	Yes	
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients screened for depression AND if positive, a follow-up plan is documented.	DPP (Ref: 2020.01-12 Adult All Payer **65.54%**; Child All Payer **36.21%**)	Yes	Modify current syntax
Early Entry into Prenatal Care	Percentage of prenatal care patients who entered prenatal care.	N/A	Yes	
Childhood Immunization Status		**Not Provided**		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) and who had evidence of the following during the measurement period. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity	N/A	Yes	Need to refer to nutrition. Will need procedure for documenting referral
Dental Sealants for Children between 6–9 Years		**Not Provided**		
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Percentage of patients who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) , or who had an active diagnosis of ischemic vascular disease (IVD), and who had documentation of use of aspirin or another antiplatelet during the measurement period.	N/A	Pharmacy Data paired with Axis III Diagnosis	
HIV Linkage to Care (refer patients to HIV clinic - give resources - legacy clinics, HIV clinics, Gold cards)	Percentage of patients who attended a routine HIV medical care visit within 1 month of HIV diagnosis	N/A	Pharmacy Data	
Depression Remission at Twelve Months	Percentage of patients with major depression or dysthymia who reached remission 12 months (+/- 60 days) after previous PHQ-9 assessment.	DPP (Ref: 2023.01-06 six months remission All Payer **8.46%)**	Yes	Modify current syntax
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients with diabetes who had hemoglobin A1c > 9.0% during the measurement period	SAMHSA	Yes	Modify current syntax

EXHIBIT Q-3

Psychiatric Emergency Services (PES) Quarterly Update

Trends & Analysis

Board Quality Committee

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

February 20, 2024

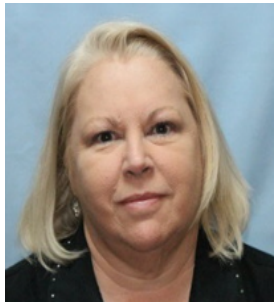
Core Project Team

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

Darchel Richards,
Clinical Team Lead

Kristi Gertson RN,
Senior Nurse Director

Sony John, RN
Nurse Supervisor

Raven Bentley, RN
Nurse Supervisor

Naun Ventura RN,
Lead Nurse

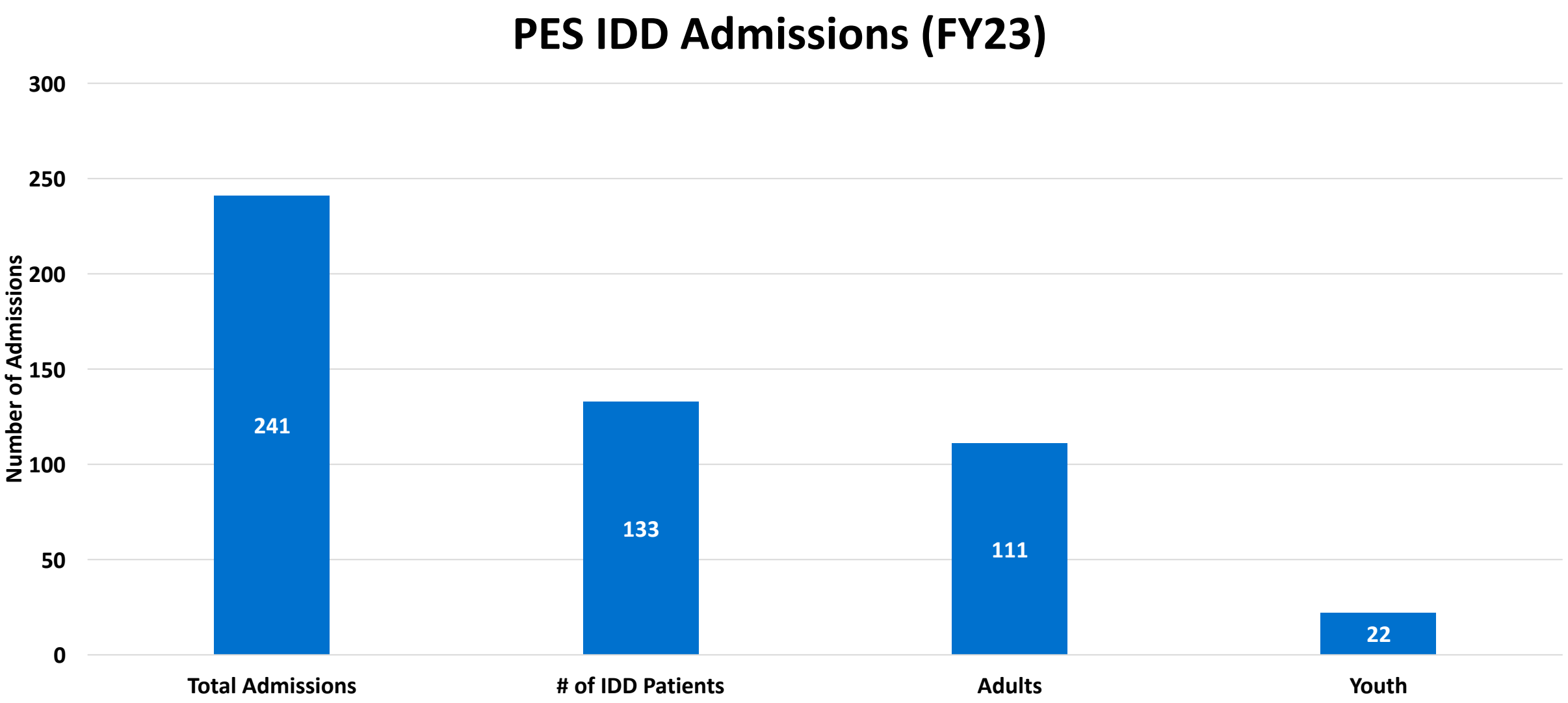
Jason Zacharia,
Lead Psychiatric Technician

Ibifrisolam Max-Alalibo,
Lead Psychiatric Technician

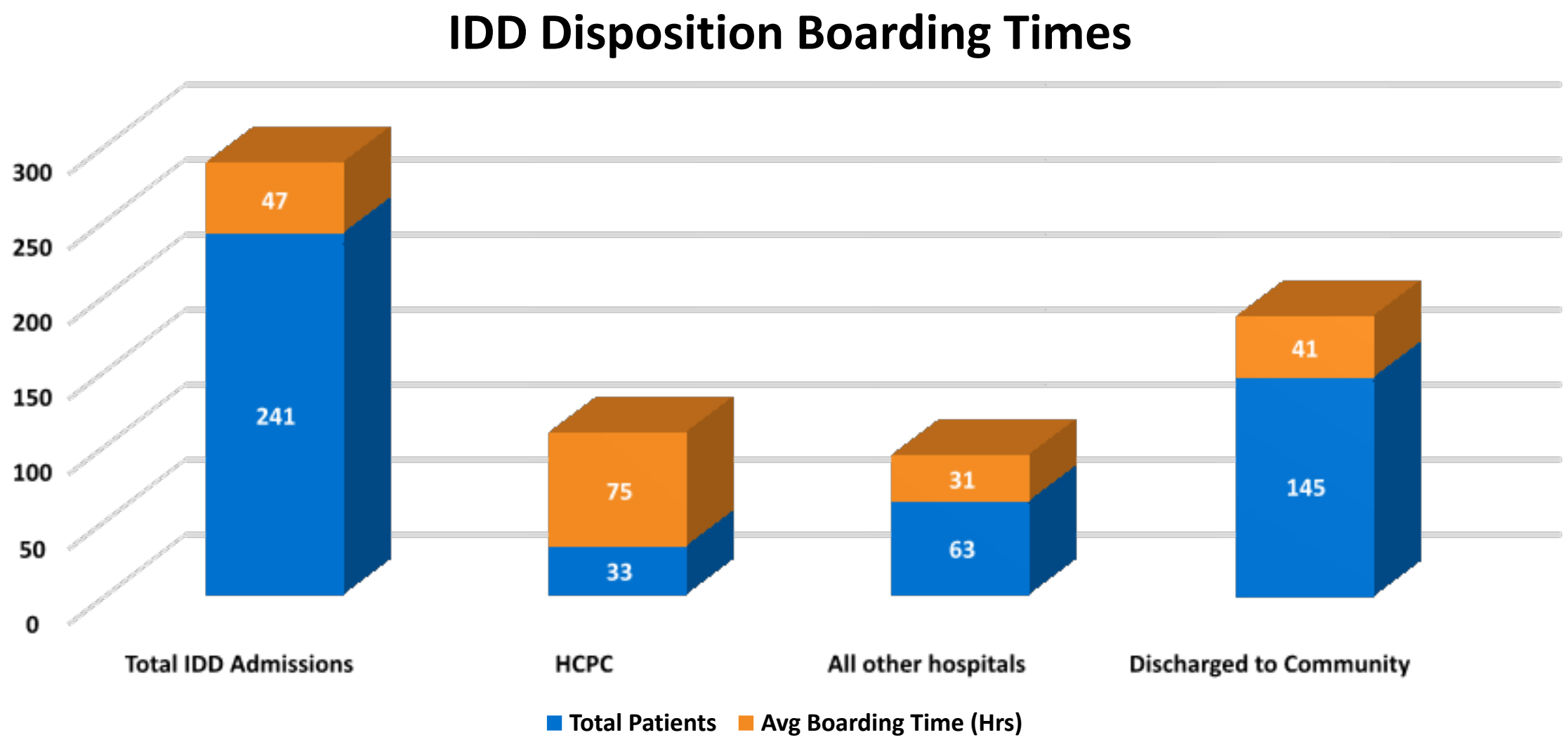
Agenda

- **PES IDD Data for FY23**
  - Persons served
  - Boarding Times
  - Emergency Interventions
  - Diversion Times
- **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

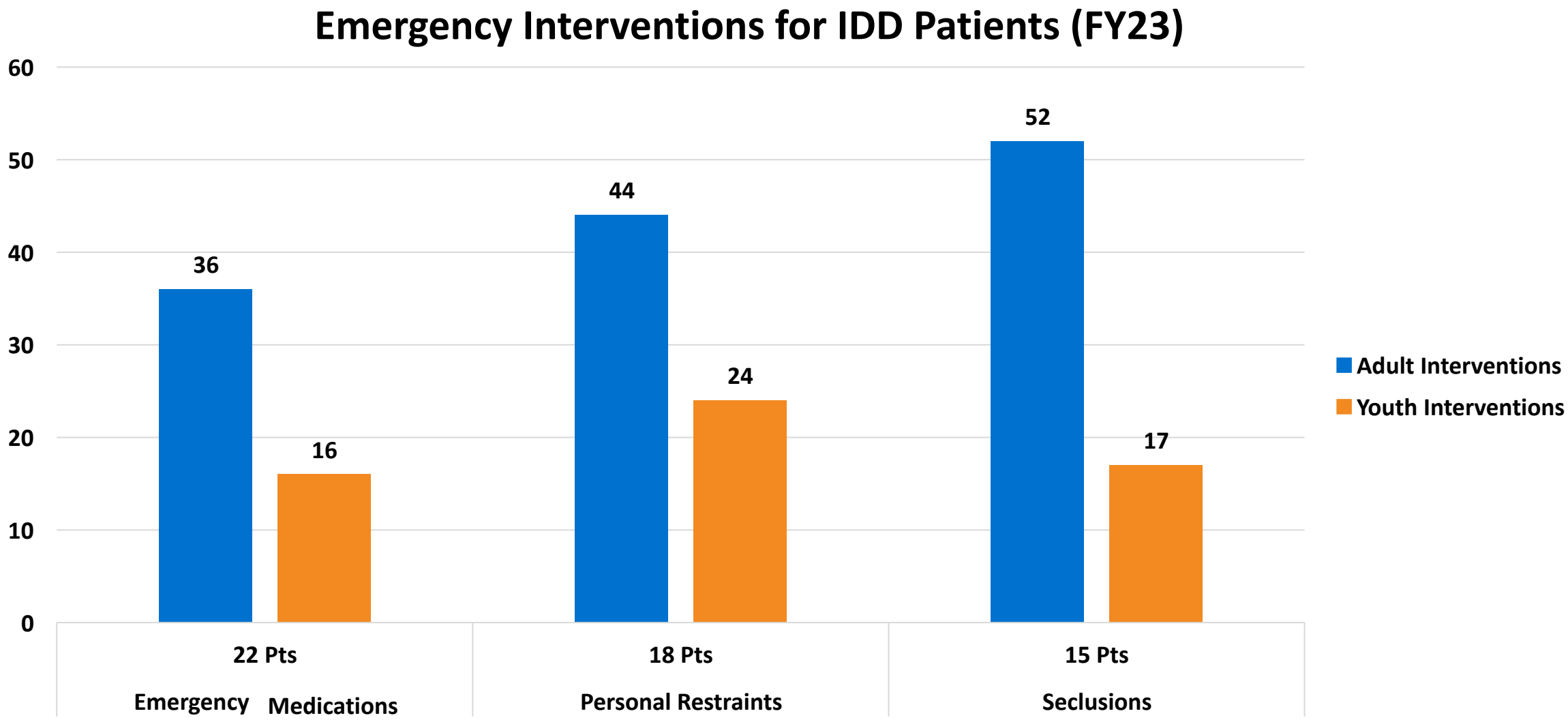
IDD Admissions in PES



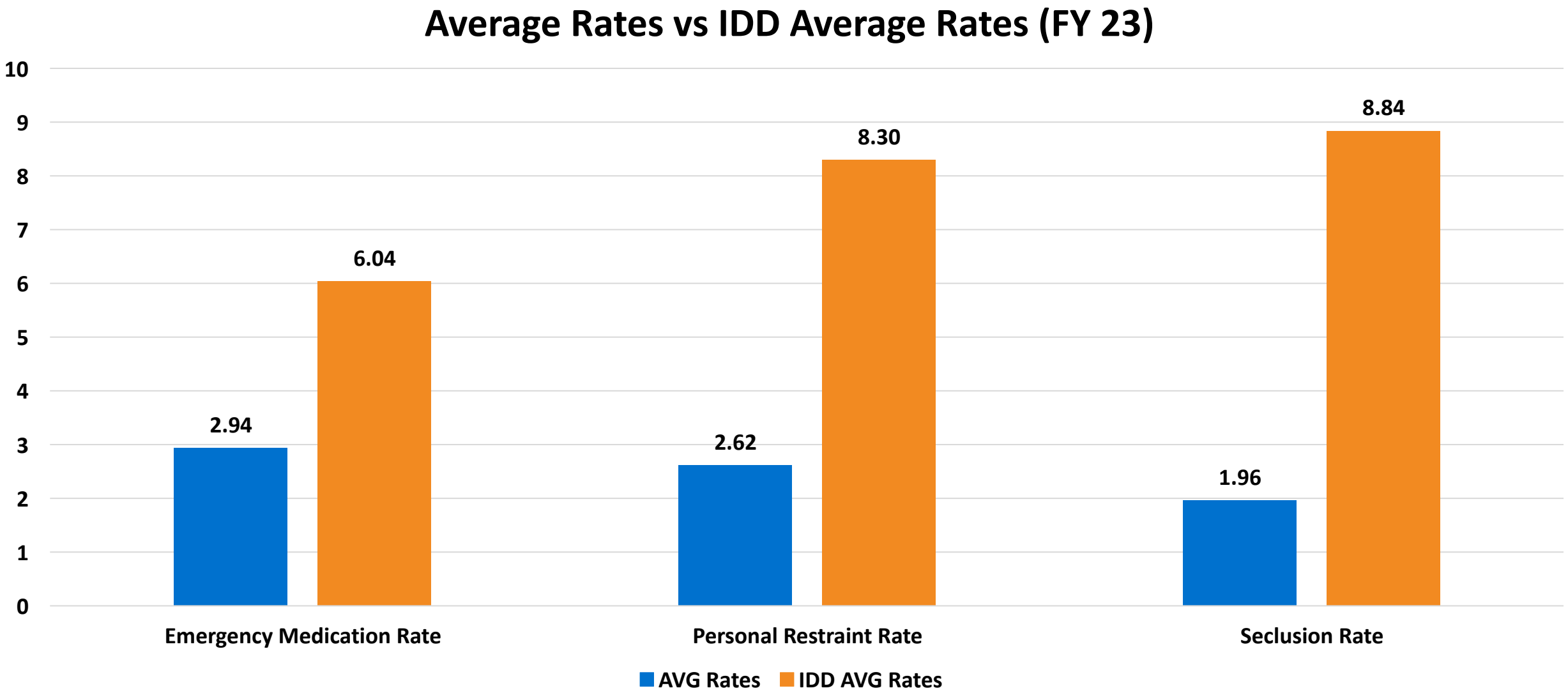
IDD Admissions Disposition & Avg Boarding Times



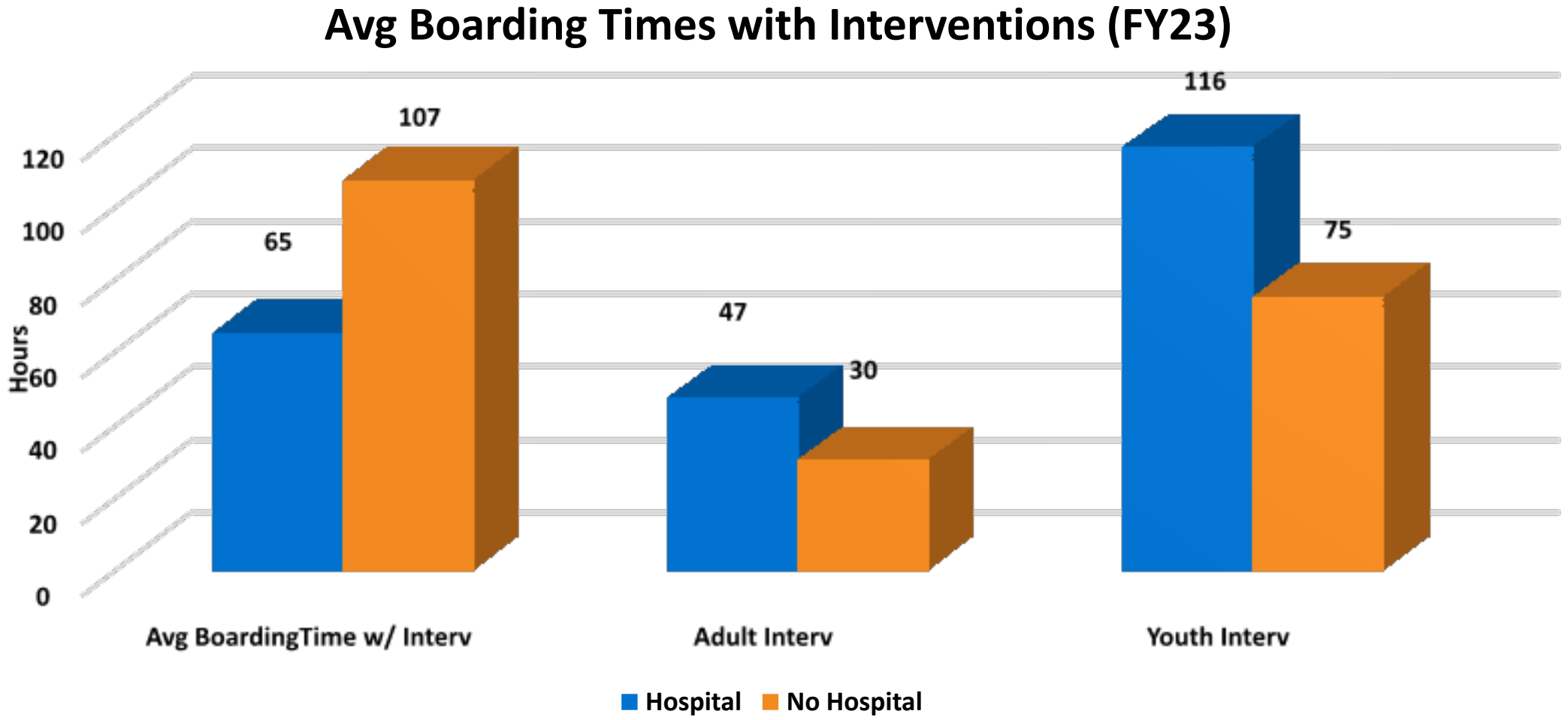
Emergency Interventions for IDD Patients



Emergency Intervention Rates Comparison

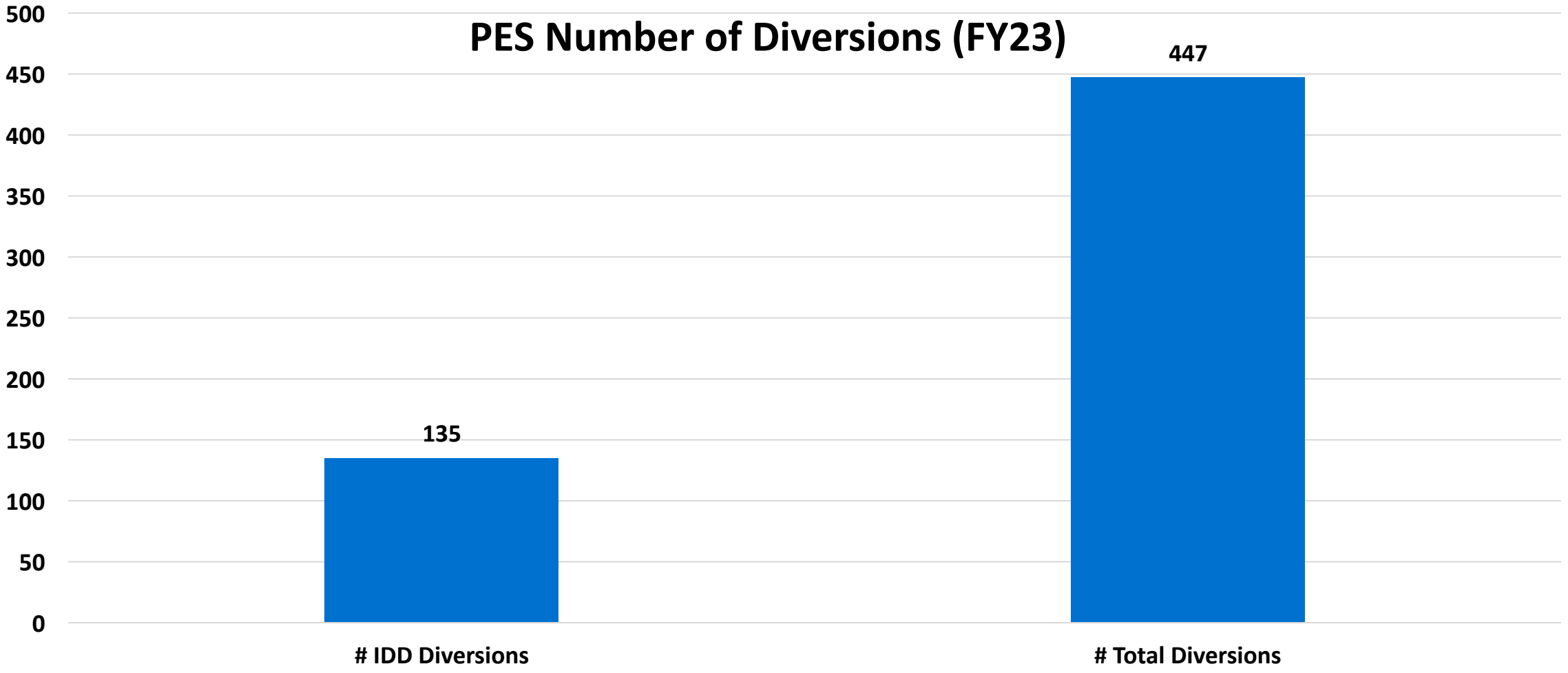


PES Average Boarding Times for IDD Patients Served with Emergency Interventions



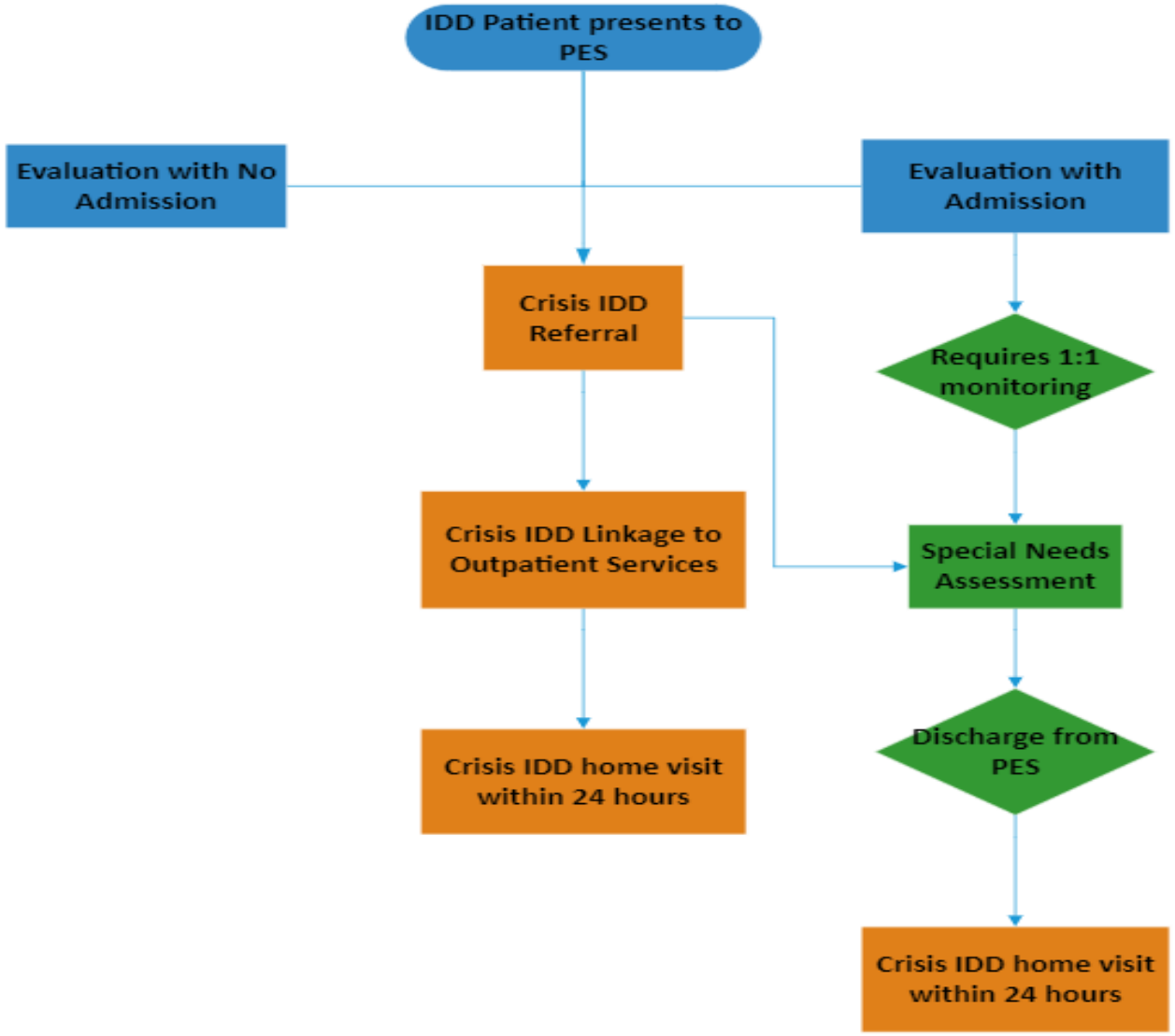
Total Average Boarding Time for IDD Patients = 35hrs
Average Boarding Time IDD Adults = 29hrs
Average Boarding Time IDD Youth = 60hrs

IDD Impact on Diversion Times



**30% Diversions related to IDD Admissions with 1:1 staffing being the limiting factor.

IDD Crisis Care Pathway



Performance Improvement Focus Areas

IDD collaborative workgroup

IDD Clinical Care Pathway

IDD education and training for staff

Thank you.

Appendix

PES Emergency Interventions Data

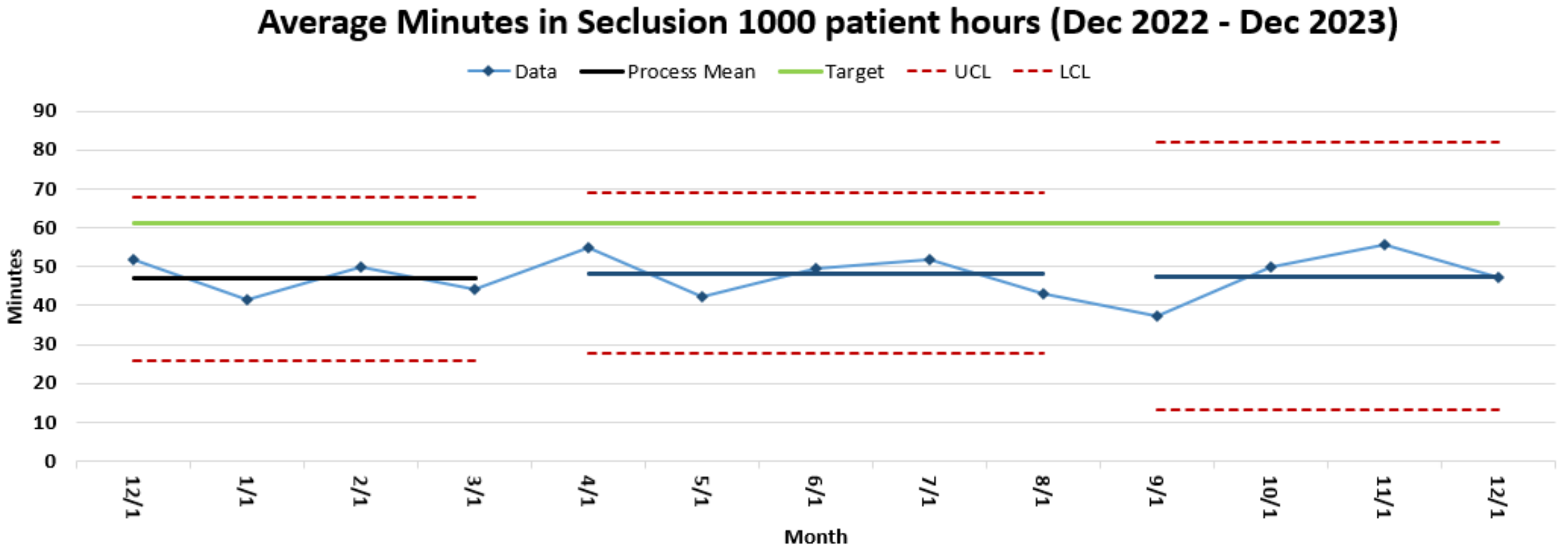
Key Definitions

- 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

PES Board PI Scorecard (Dec 2022 – Dec 2023)

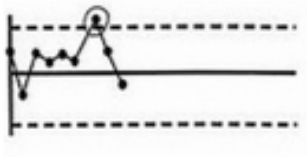
	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	AVG	FY24 Target	Target Type
PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours) - Strategic Plan Goal #4: To Continuously Improve Quality of Care																
PES Total Visits	1,173	1,266	1,126	1,126	1,145	1,155	1,104	1,222	1,248	1,223	1,072	1,049	1,102	1068	1,155	
PES Admission Volume	544	555	498	549	553	558	487	571	562	558	549	571	533	545	545.230769	
Emergency Medications	47	58	56	72	72	67	53	59	52	40	36	27	35	52	51.8461538	
EM Rate	2.25	2.67	3.01	3.5	3.99	3.61	3.63	3.45	2.77	2.07	1.97	2.18	1.97	2.85	≤3.91	IOS
Personal Restraint	37	43	50	79	70	43	49	48	47	42	42	29	41	48		
Personal Restraint Rate	1.77	1.98	2.68	3.85	3.89	2.36	3.65	3.00	2.51	2.17	2.67	2.34	2.31	2.71	≤2.80	IOS
Seclusions	32	20	39	53	58	35	33	34	33	29	34	17	22	34		
Seclusion Rate	1.53	0.92	2.09	2.58	3.22	1.92	2.46	2.13	1.76	1.49	2.16	1.37	1.24	1.91	≤2.73	IOS
AVG Minutes in Seclusion	51.82	41.7	49.76	44.33	54.9	42.2	49.71	51.92	43.15	37.5	49.74	55.71	47.36	47.68	60.43	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		
% Time on Adult Diversion	17	18	21	38	8	37	2	7	5	10	4	7	18	15		
% Time on Youth Diversion	20	33	74	56	41	73	25	41	28	32	40	15	96	44	44.21	
% Time on Diversion	18	25	48	47	24	55	14	24	17	21	22	11	57	29		

Average Minutes in Seclusion

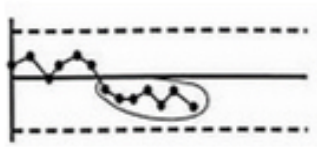


SPECIAL CAUSE VARIATION

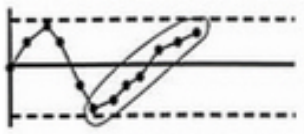
POINT OUTSIDE OF THE LIMIT:
Any point on or outside the limit is considered abnormal and requires investigation.



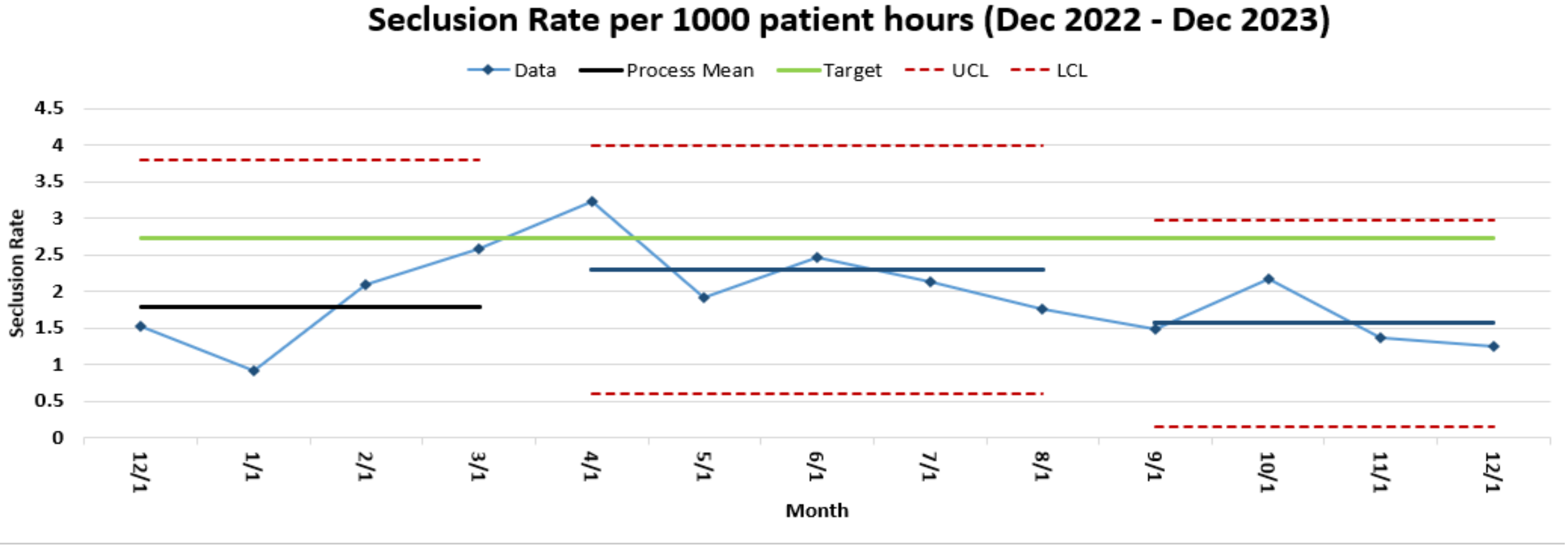
SHIFT (RUN):
A shift is indicated when 7 consecutive points lie continually on one side of the center line.



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

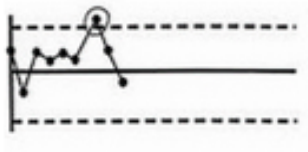


Seclusion Rate

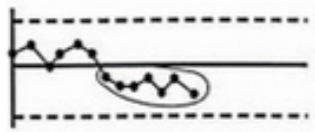


SPECIAL CAUSE VARIATION

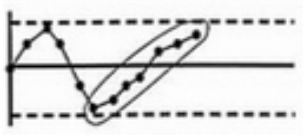
POINT OUTSIDE OF THE LIMIT:
Any point on or outside the limit is considered abnormal and requires investigation.



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

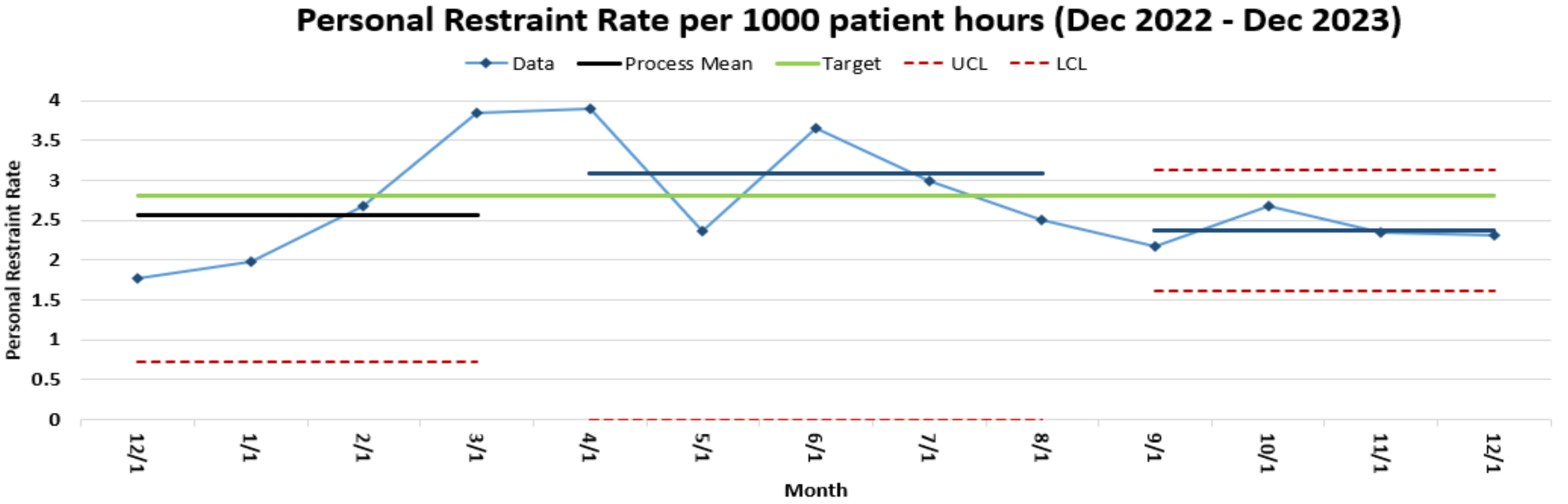


TRENDS:
Seven consecutive points in an upward or downward direction could indicate special cause



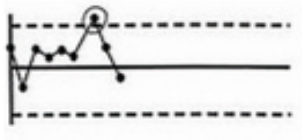
**Uptrend accounted for by # of IDD patients with Multiple Interventions

Personal Restraint Rate

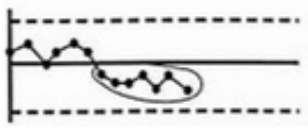


SPECIAL CAUSE VARIATION

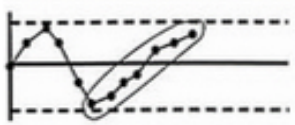
POINT OUTSIDE OF THE LIMIT:
Any point on or outside the limit is considered abnormal and requires investigation.



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

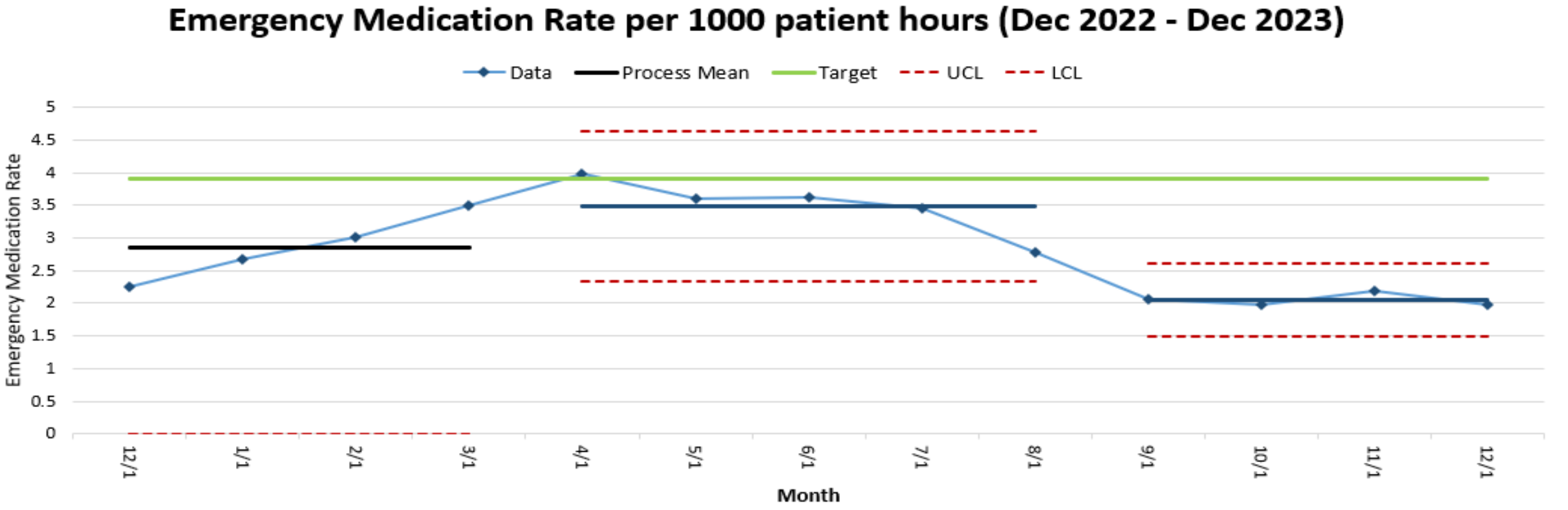


TRENDS:
Seven consecutive points in an upward or downward direction could indicate special cause



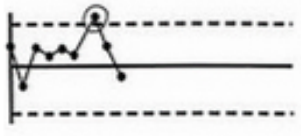
**Uptrend accounted for by # of IDD patients with Multiple Interventions

Emergency Medication Rate

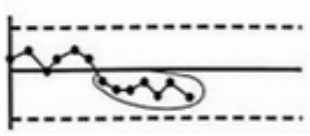


SPECIAL CAUSE VARIATION

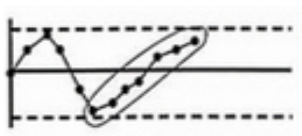
POINT OUTSIDE OF THE LIMIT:
Any point on or outside the limit is considered abnormal and requires investigation.



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



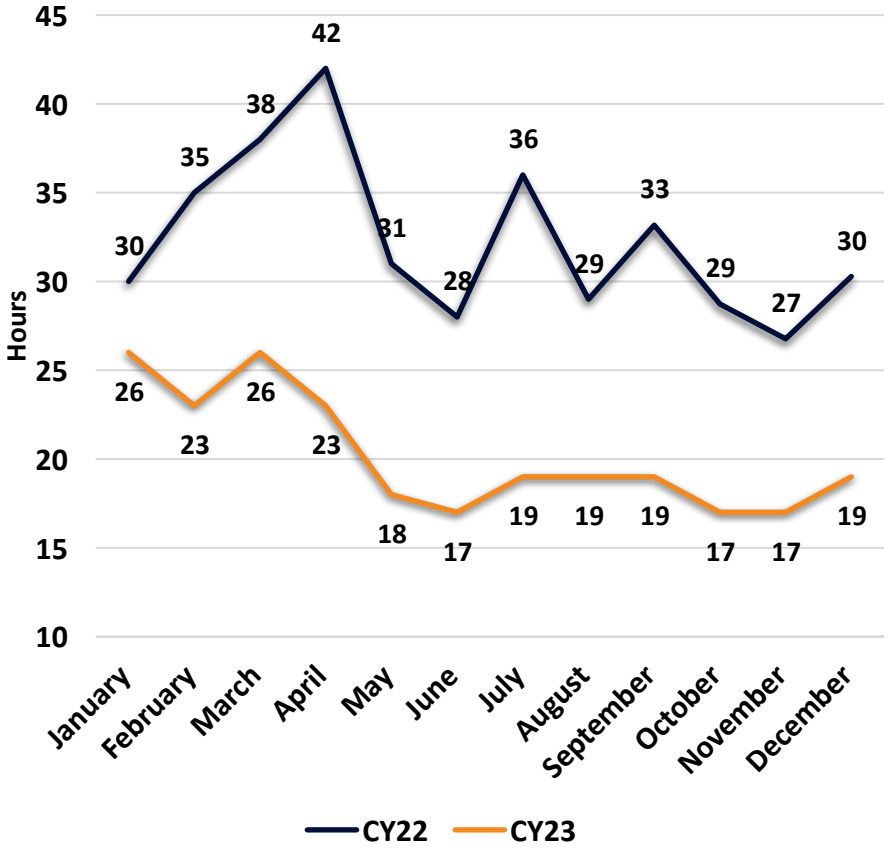
TRENDS:
Seven consecutive points in an upward or downward direction could indicate special cause



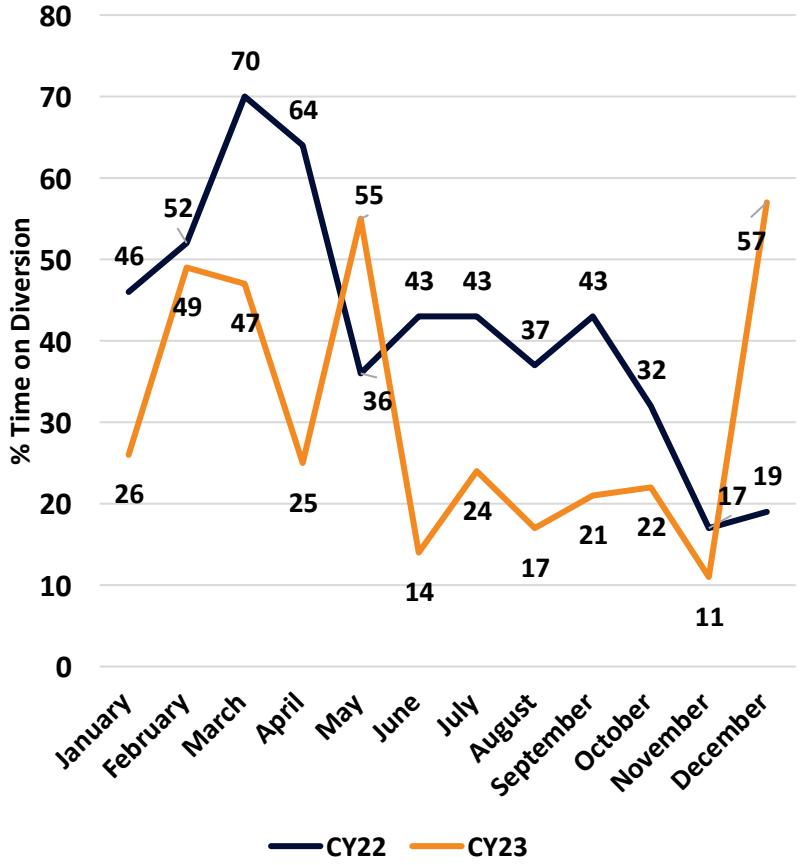
**Uptrend accounted for by # of IDD patients with Multiple Interventions

Boarding Times vs Diversion vs Beds Allocated Trends

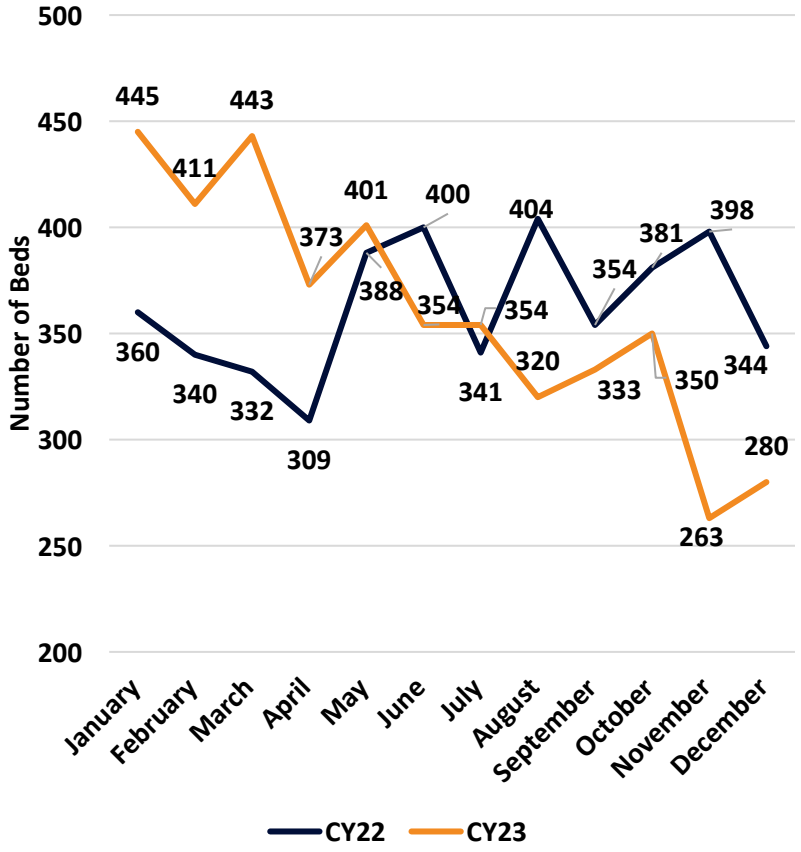
PES Average Boarding Times



% PES Diversion



PES Dispositions



- Average Boarding Times decreased for 2023. *West Oaks contract beds increased from 7 to 11 in June.
- % of Time on Diversion decreased in 2023 to an average 31% (2023) compared to 42% (2022). Youth Diversion times have been higher than adult diversion times starting in January 2023.
- PES Dispositions impacted by the closure of two inpatient psychiatric hospitals in the community in August & September.

EXHIBIT Q-4

New Autism Sensory Room – IDD STARS Clinic

Funding provided by The Harris Center Foundation

The HARRIS CENTER for Mental Health and IDD

Transforming Lives

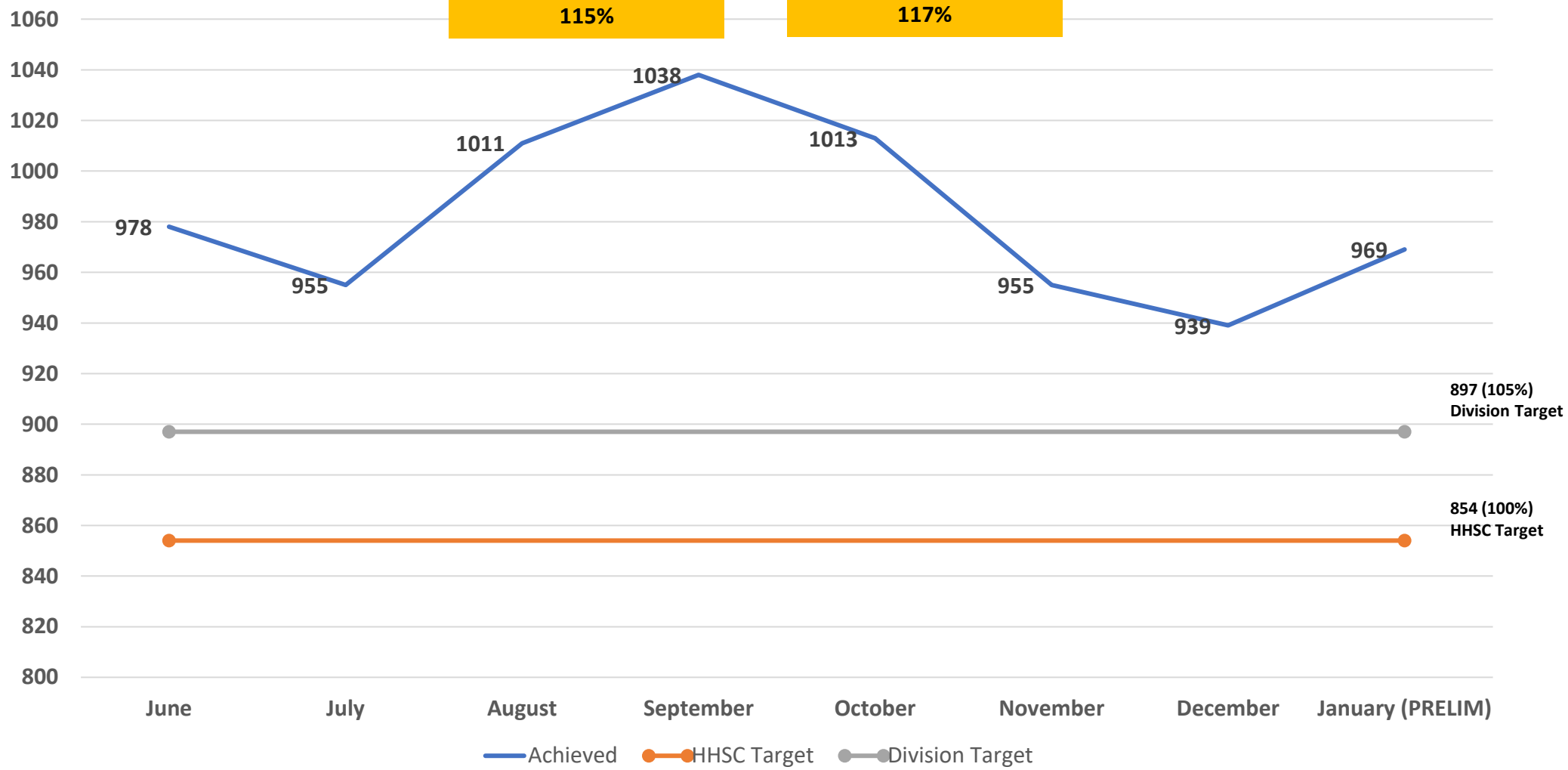
IDD Services Division

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

FY23-24 Performance Targets

FY23 Quarter 4
981
115%

FY24 Quarter 1
1003
117%



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 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*

	Fiscal Year 2022	Fiscal Year 2023 – Q4			Fiscal Year 2024				
	July '22	**Jun 2023**	**July 2023**	**Aug 2023**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**
TOTAL WAITING **R005 DID ONLY**	**5,831**	**3,473**	**2,891**	**2,606**	**1,422**	**385**	**55**	**0**	**0**

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.

*Data as of 2/5/24

STEP 2 SERVICE COORDINATION

Discovery
Person-Directed Plan
Monitoring

Number waiting to receive a GR Service Coordinator*

Fiscal Year 2024	
September	119
October	117
November	111
December	106
January	48

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 as of 2/5/24

STEP 3 GR SERVICES

HHSC Contracted Services
Internal/External Providers
Community Linkages

Number waiting to access an authorized GR service*

	Fiscal Year 2024				
	Sept	**Oct**	**Nov**	**Dec**	**Jan**
In-home respite (Contract) *Avg. wait time: ~1 month*	64	63	70	80	60
Out-of-home respite (Contract) *Avg. wait time: ~1 month*	0	0	0	0	0
Day Habilitation (Contract) *Avg, wait time: ~1 month*	0	0	0	0	0
Employment Services (Contract) *Avg. wait time: ~1 month*	0	0	0	0	0
Feeding Clinic (Internal) *Avg. wait time: ~1 month*	0	0	0	1	0
Outpatient Biopsychosocial Services (OBI) (Internal) *Avg. wait time: 10 months*	113	113	125	126	131
The Coffeehouse (Internal) *Avg. wait time: 5 months*	44	45	45	49	51
TOTAL WAITING	**221**	**221**	**240**	**256**	**242**

*Data as of 2/5/24

Number Interested/GR Services*

*data as reported to HHSC quarterly

	2022-JUL	JUL	AUG	SEPT	OCT	NOV	DEC	JAN
R005 Eligibility Determination	5831	2891	2606	1422	385	55	0	0
R021 Community Supports		112	112	112	112	112	105	100
R022 Out-of-Home Respite		119	120	118	118	119	118	113
R023 In Home Respite		742	748	727	732	761	733	680
R032 Residential Living		5	5	6	6	6	6	5
R041 Employee Assistance		67	67	70	71	71	71	68
R042 Supported Employment		5	5	6	6	6	6	6
R043 Vocational Training		59	59	62	62	62	62	57
R053 Day Habilitation		195	197	192	197	198	194	176
R054 Specialized Therapies		562	574	590	640	650	637	604
R055 Behavioral Support		459	468	477	488	491	472	460
UNDUPLICATED COUNT	**7523**	**4481**	**4001**	**2902**	**1909**	**2531**	**2404**	**2060**

GR Clients Added Per Month							
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN
R021 Community Supports	0	0	0	0	0	1	0
R022 Respite (Out-of-Home)	1	0	0	0	0	0	0
R023 Respite (In-Home)	6	7	5	3	5	5	5
R032 Residential Living	0	0	1	0	0	0	0
R041 Employment Assistance	3	0	2	1	0	0	0
R042 supported Employment	0	0	1	0	0	0	0
R043 Vocational Training	0	0	3	0	0	0	0
R053 Day Habilitation	2	2	1	3	2	1	3
R054 Specialized Therapies	10	11	11	9	9	11	10
R055 Behavioral Supports	7	5	6	8	3	9	6
TOTAL ADDED	**29**	**25**	**30**	**24**	**19**	**27**	**24**

Waiver/HCPC Data*

MEDICAID WAIVER INTEREST LIST*		
	Home & Community-based Services (HCS)	Texas Home Living Waiver (TXHML)
Interest List Slots Allocated to Harris County	28	111
Total on Interest List in HARRIS COUNTY	23,882	22,408
Total on Interest List in TEXAS	117,778	106,811
Average Time on Interest List	16-17 years	14-15 years
FY24/25 Biennial Slots STATEWIDE 88th Session	1,144	305
HHSC Statewide Allocation	1,728	3,720

IDD HCPC ADMISSIONS*			
	FY22	FY23	FY24 FYTD
Total Admissions	130	228	55
Total Individuals with Re-Admissions	49	67	24
Total Referred to IDD Eligibility	19	45	9
Total in Service Coordination at Time of Hospitalization	32	68	19

***data FYTD through January FY2024**

DIDs Completed

Apx. capacity 124
(96 internal/28 external)

	Number of DIDs Completed
FY23 TOTAL	1,413 Avg. 118 per month
SEPT	120
OCT	134
NOV	67
DEC	43
JAN	78

**Data as of 2/5/24*

January Breakdown:
53 Full - 24 Updates - 1 Endorsements

YTD Breakdown:
352 Full - 58 Updates - 32 Endorsements

DID Report Completion Timeframe

	AVG Completion Time (CALENDAR DAYS)
FY23 AVG	23 days
SEPT	35
OCT	37
NOV	30
DEC	14

**Data as of 2/5/24*

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

Fiscal Year 2024 IDD Strategic Priorities

IDD + Community Supports

Re-establish safety-net services

89th Legislative Session
Cost of Waiting Study
IDD/Forensic Study

IDD + Psychiatric Care

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

IDD + Forensic Diversion

Increase community diversions via safety net services

EXHIBIT Q-5

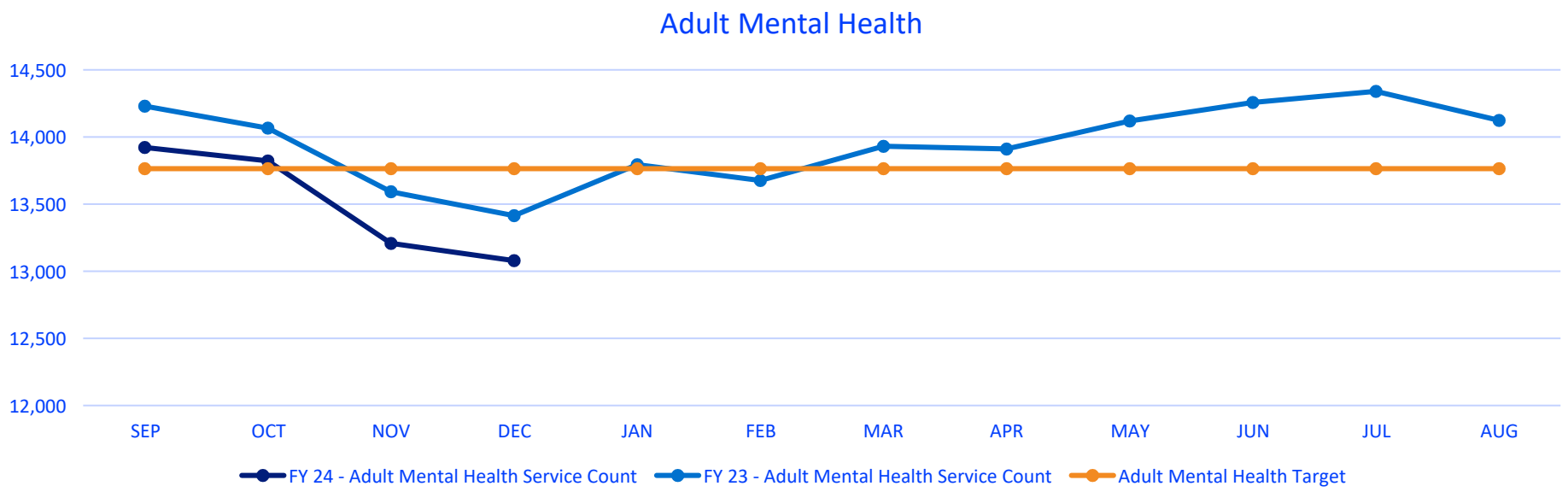
Quality Board Scorecard

Board Quality Committee Meeting

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

Reporting for February, 2023

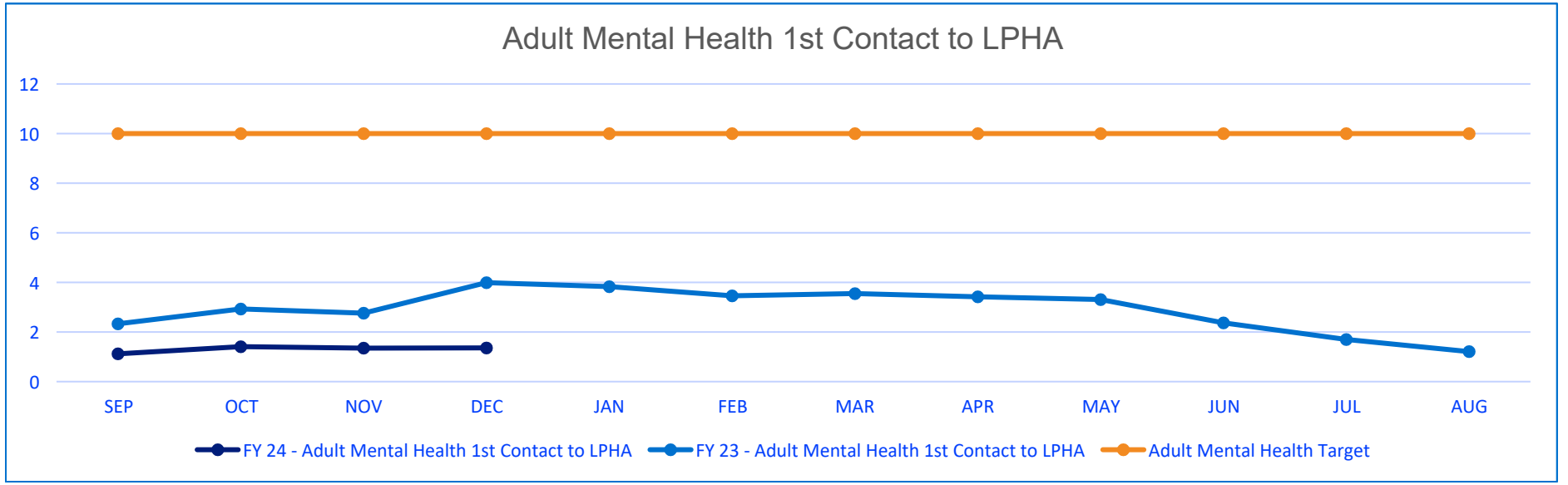
Domain	Program	2024 Fiscal Year State Service Care Count Target	2024 Fiscal Year State Care Count Average (Sept. – Dec.)	Reporting Period: December	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	13,508	13,079	Increase	Contractual



Notes:
- In December 2023, the Adult Service Care Count experienced a decline of 2.50% compared to the same month in the previous year, dropping from 13,414 to 13,079. This decrease resulted in the count falling short of the established contractual target.
- The decrease in the Adult Mental Health services care count mirrors the trend from the previous year during the holiday season, suggesting a potential seasonal pattern in the data.

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

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sept. – Dec.)	Reporting Period- December	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Contact to LPHA	<10 days	1.31 Days	1.36	Decrease	Contractual

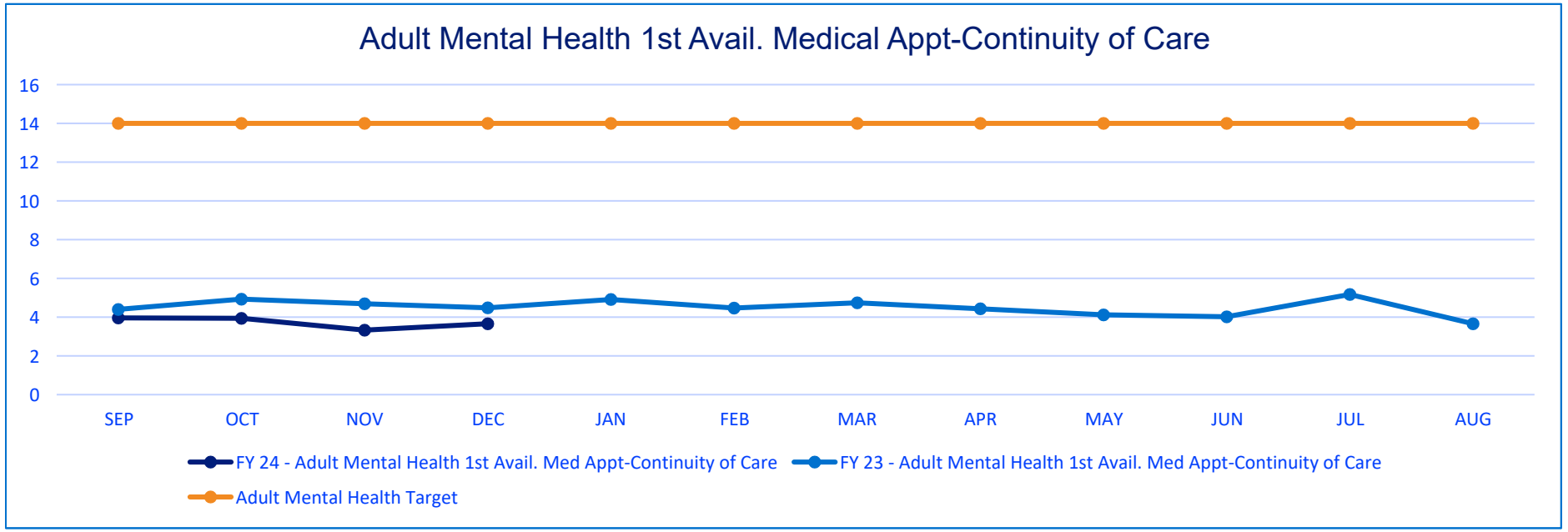


Notes:

- The timeframe for initial patient assessments in Adult Mental Health has shown notable efficiency, with the first contact to LPHA taking less than two days during the reported period.
- A year-over-year comparison reveals a significant improvement, with a 51% reduction in the number of days from first contact to LPHA - decreasing from 2.76 days in December 2022 to just 1.36 days in December 2023. This data suggests an enhanced responsiveness in the Adult Mental Health services over the past year..

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

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sept. – Dec.)	Reporting Period: December	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Continuity of Care	<14 days	3.72	3.66 days	Decrease	Contractual

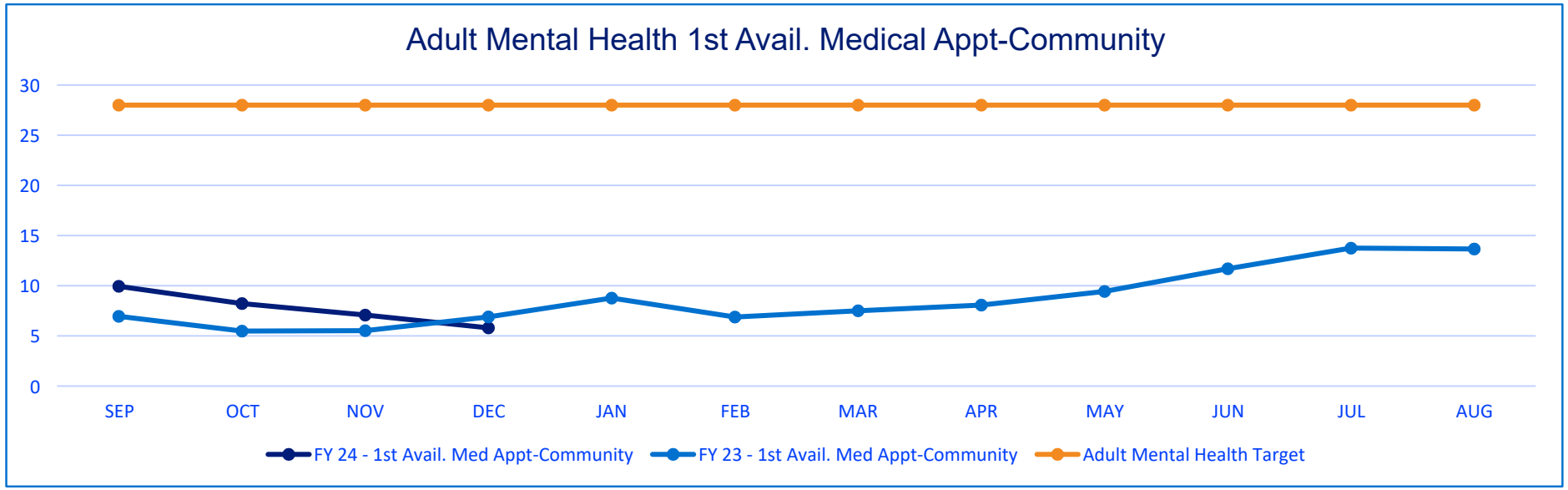


Notes:

- The Adult Mental Health department's performance has shown significant efficiency, averaging less than 5 days to establish a connection with a medical provider. A comparative analysis with the previous year reveals a substantial improvement, with a 19% decrease in the waiting period for individuals to see a medical provider.
- This data suggests an enhanced operational efficiency in the department's patient care continuity process, contributing to a more streamlined patient experience.

Measure definition: Adult - Time between MD Intake Assessment (Continuity of Care) Appt Creation Date and MD Intake Assessment (Continuity of Care) Appt Completion Date

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sep-Dec)	Reporting Period-December	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Community Members	<28 days	7.76 days	5.80	Decrease	Contractual



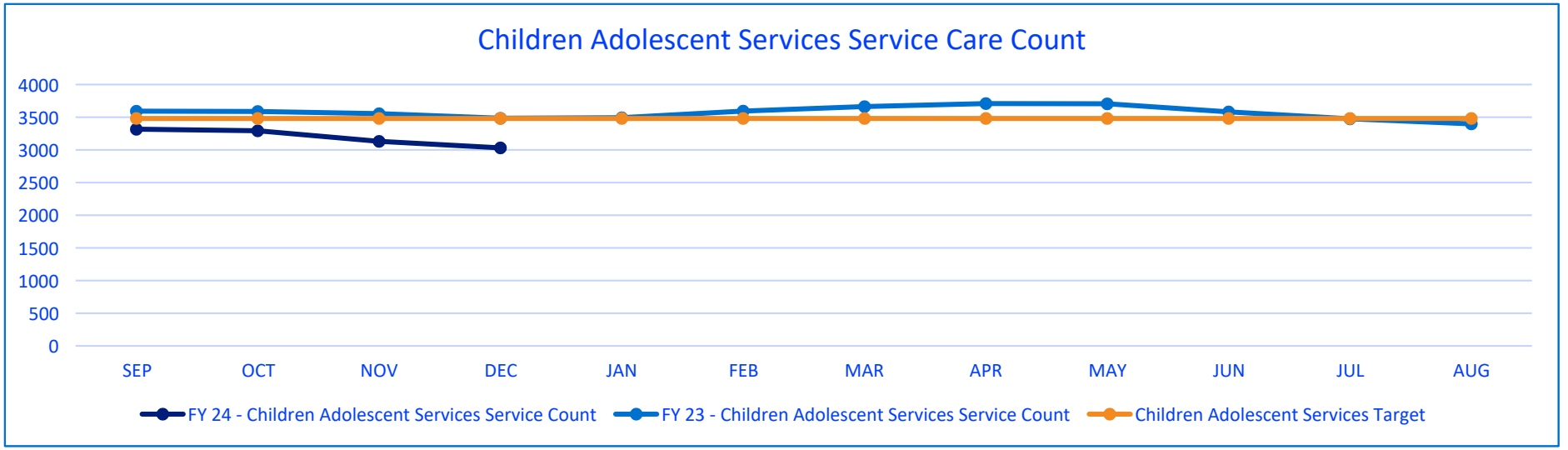
Notes:

- The Adult Mental Health department's adherence to the contractual target for providing access to medical appointments for community members sustains improvements. Specifically, community members appointments are accommodated within 7.08 days.

.

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

Domain	Program	2024 Fiscal Year State Care Count Target	2024 Fiscal Year State Care Count Average (Sept. – Nov.)	Reporting Period- November	Target Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	3,247	3,131	Increase	Contractual



Notes:

Over the past three months, the service care count in the Children & Adolescent Services department has shown a downward trend, with a notable 13% decrease compared to the same period in December 2022.

This decline can be attributed to a couple of key factors:

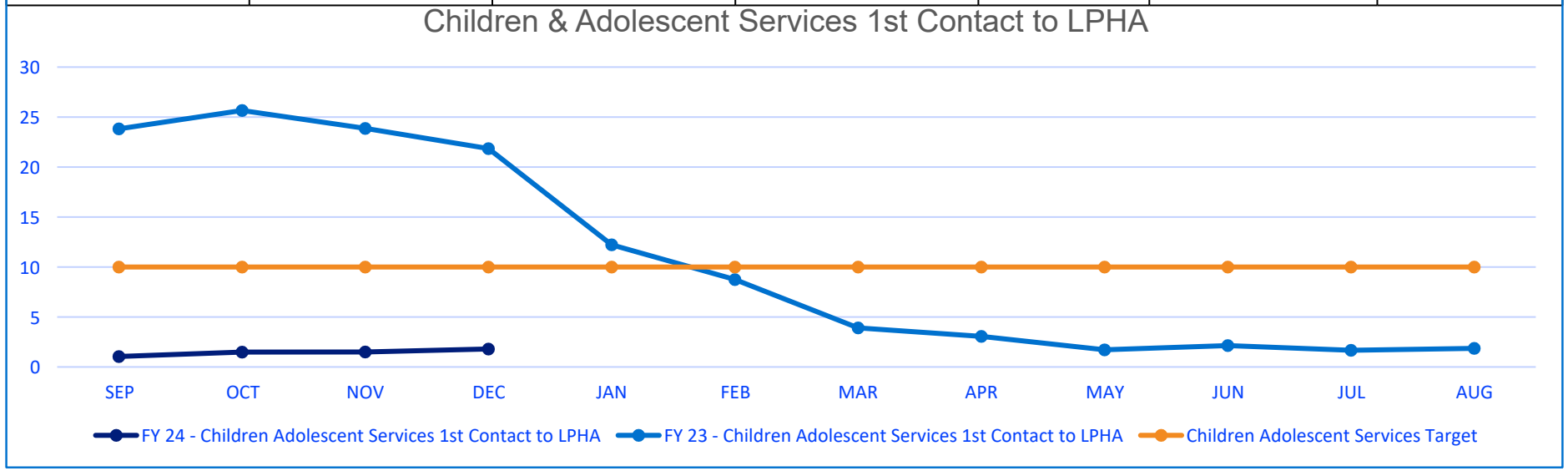
- Holiday fluctuations
- Difficulties both completing and reporting Nov CANS Data (Breach)
- State database accessibility issues (CMBHS downtime have increased)
- A slight drop in referrals

These factors have collectively impacted the care count.

The leadership team is actively investigating potential strategies to counteract this trend and enhance the service care count.

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	2024 Fiscal Year Target	2024 Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Contact to LPHA	<10 days	1.46 days	1.80 days	Decrease	Contractual

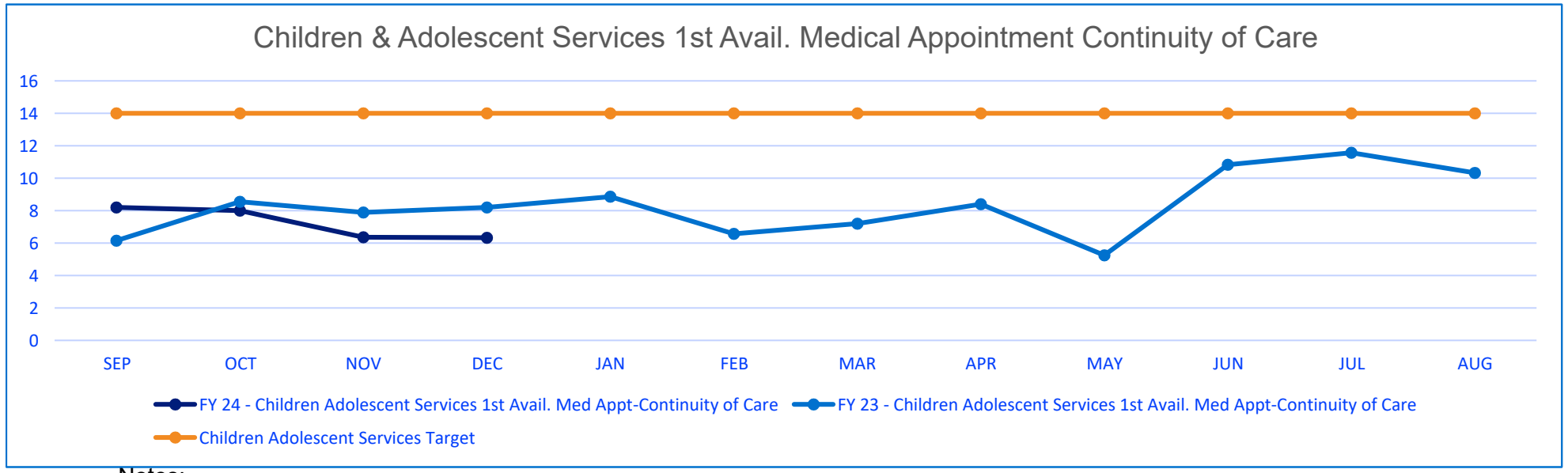


Notes:

- The hybrid model employed by the Children & Adolescent Services department, which combines open booking and scheduling for LPHA assessments, implemented in February, has demonstrated a significant enhancement in care accessibility for children and adolescents.
- A comparative analysis with the previous year reveals a substantial improvement in efficiency, with a 91% reduction in the waiting period for individuals to be assessed by an LPHA - decreasing from 21.85 days in December 2022 to just 1.80 days in December 2023. This data underscores the effectiveness of the hybrid model in streamlining the assessment process and expediting access to care.

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

Domain	Program	2024 Fiscal Year Target	2024Fiscal Year Average (Sep-Dec)	Reporting Period-December	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Continuity of Care	<14 days	7.22 days	6.33 days	Decrease	Contractual

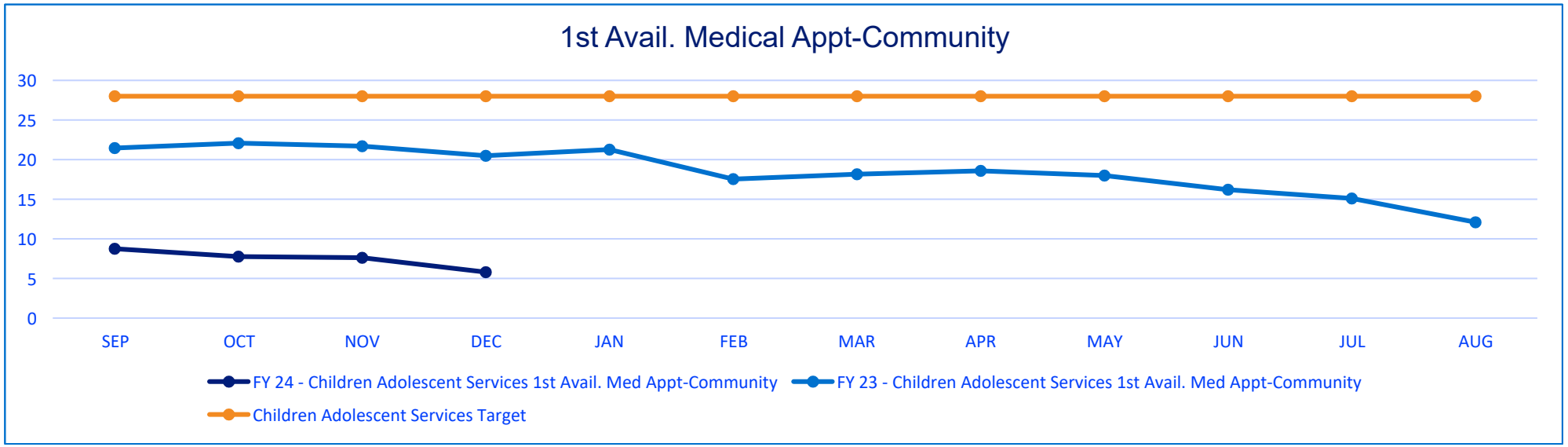


Notes:

- The Children & Adolescent Services department's performance in contacting patients for continuity of care post-hospital discharge has shown significant efficiency. Specifically, for the reporting period of December 2023, there was a notable decrease in the waiting period for patients seeking their first available medical appointment.
- The wait time reduced from 8.20 days in the previous month to 6.36 days, representing a 23% reduction compared to the previous year.

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

Domain	Program	2024 Fiscal Year Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Community	<28 days	7.48 days	5.80 days	Decrease	Contractual

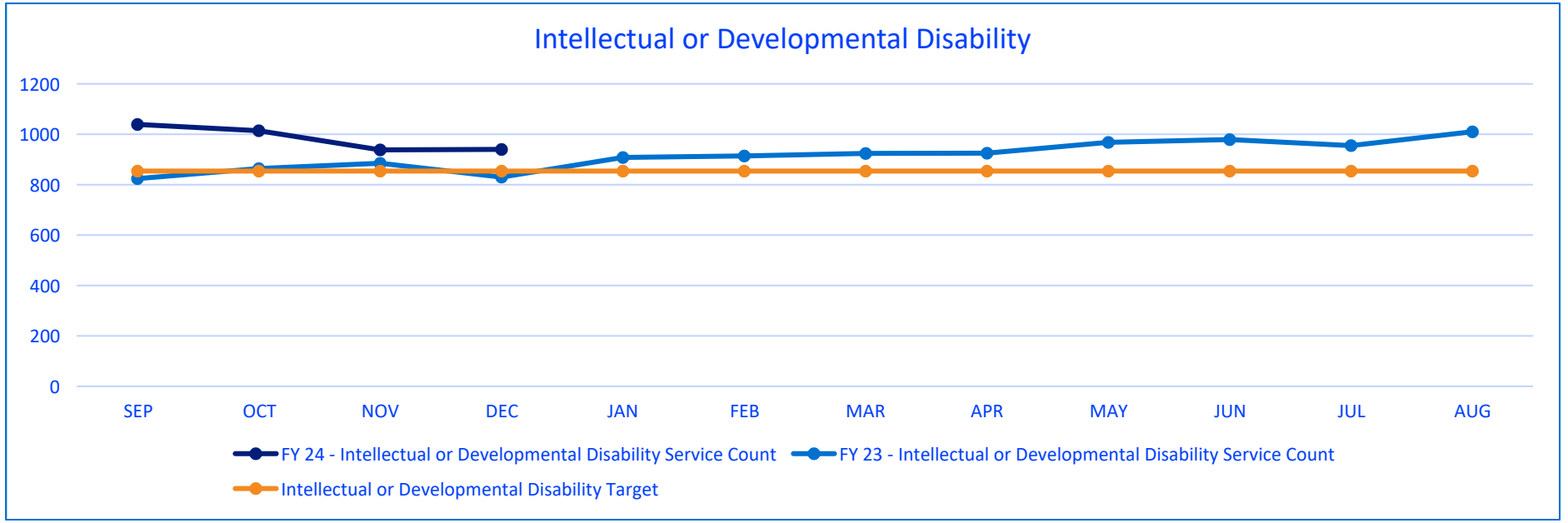


Notes:

- The Children & Adolescent Services department has demonstrated significant improvement in providing medical appointments for community members. Specifically, for the reporting period of December 2023, there was a substantial decrease of 72% in the waiting period compared to the same period in the previous year.
- The wait time was reduced from 20.49 days in December 2022 to fewer than 6 days in December 2023.

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

Domain	Program	2024 Fiscal Year State Count Target	2024 Fiscal Year State Count Average (Sept – Dec)	Reporting Period- December	Target Desired Direction	Target Type
Access	IDD	854	983	940	Increase	Contractual

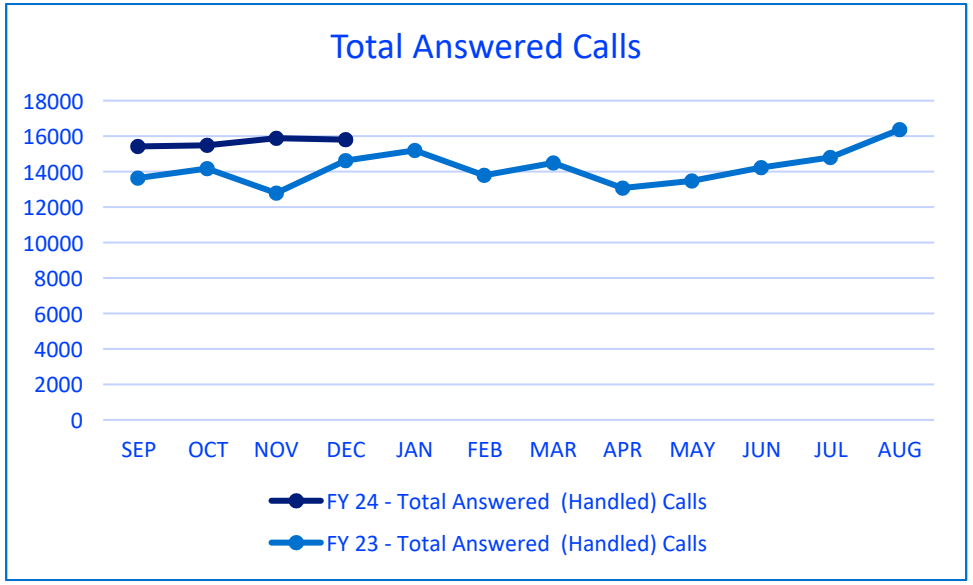


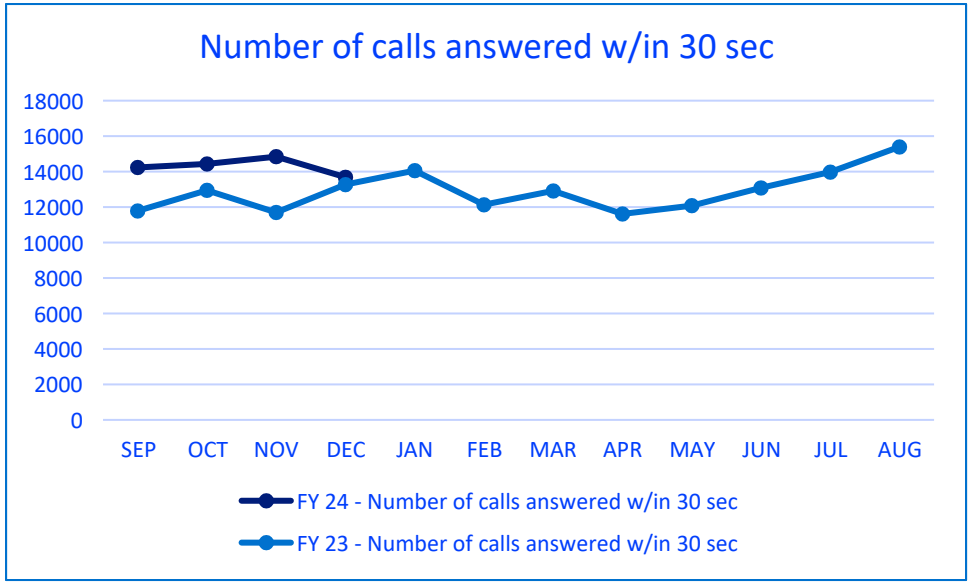
Notes:

- The IDD division has maintained an average of 983 for the 2024 fiscal year.
- A comparative analysis with the previous year reveals an increase of 13% in the service care count. Specifically, the count rose from 830 in December 2022 to 940 in December2023

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.)

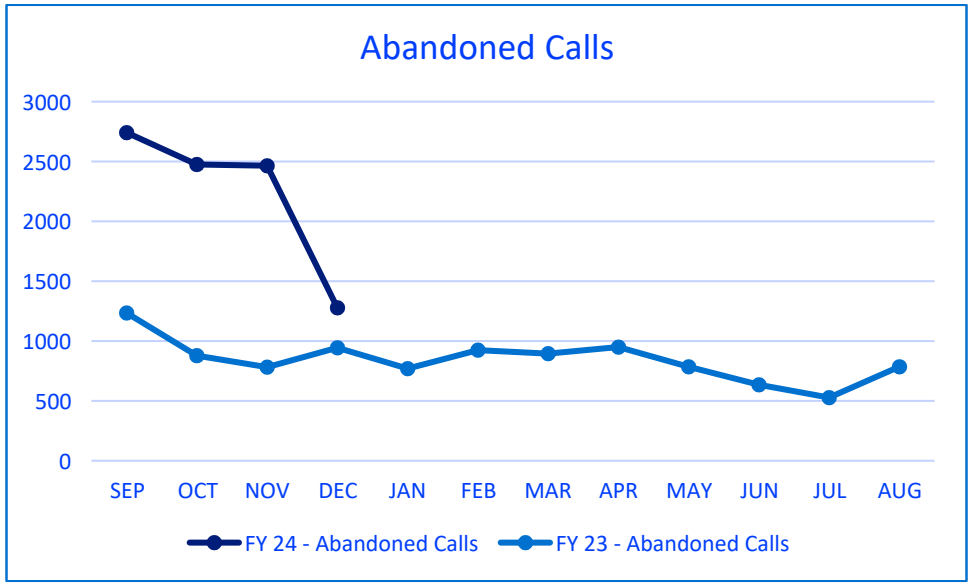
Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	15,647	18,801	Increase	N/A
	Number of calls answered w/in 30 secs	N/A	14,299	13,686	Increase	Contractual

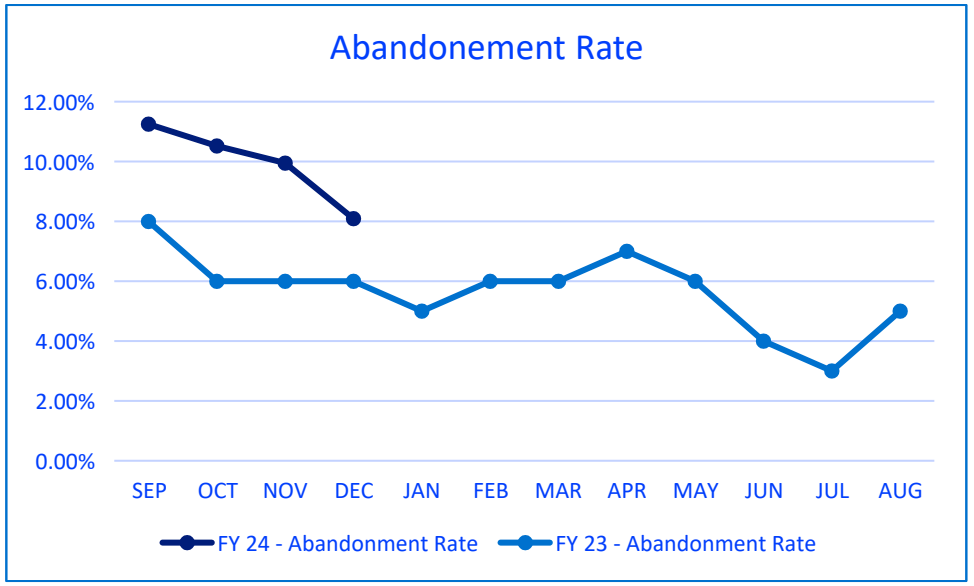




Notes:
Crisis Line continues to support individuals in crisis.

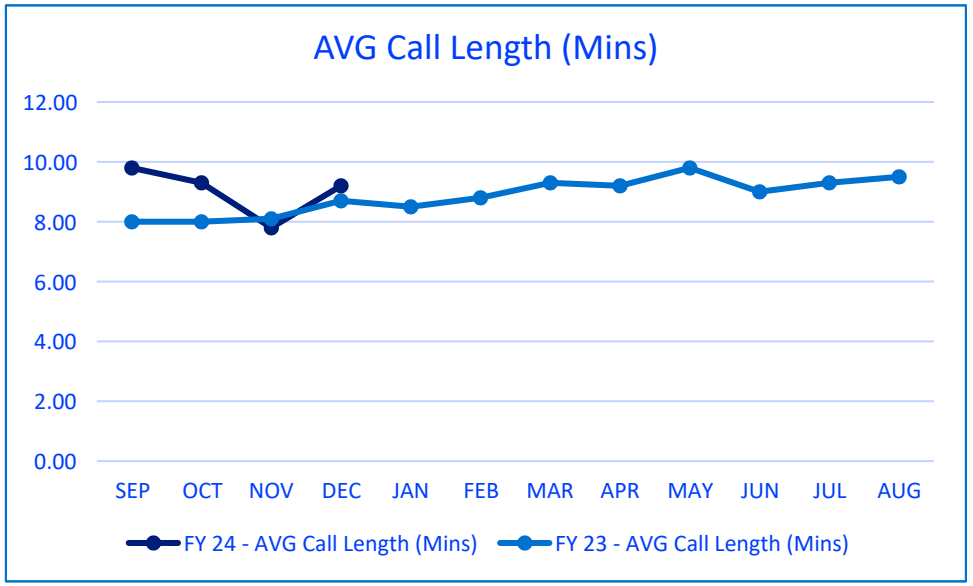
Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Timely Care	Abandoned Calls	N/A	2,240	1,278	Decrease	Contractual
	Abandonment Rate	<8%	10%	8.09%	Decrease	Contractual

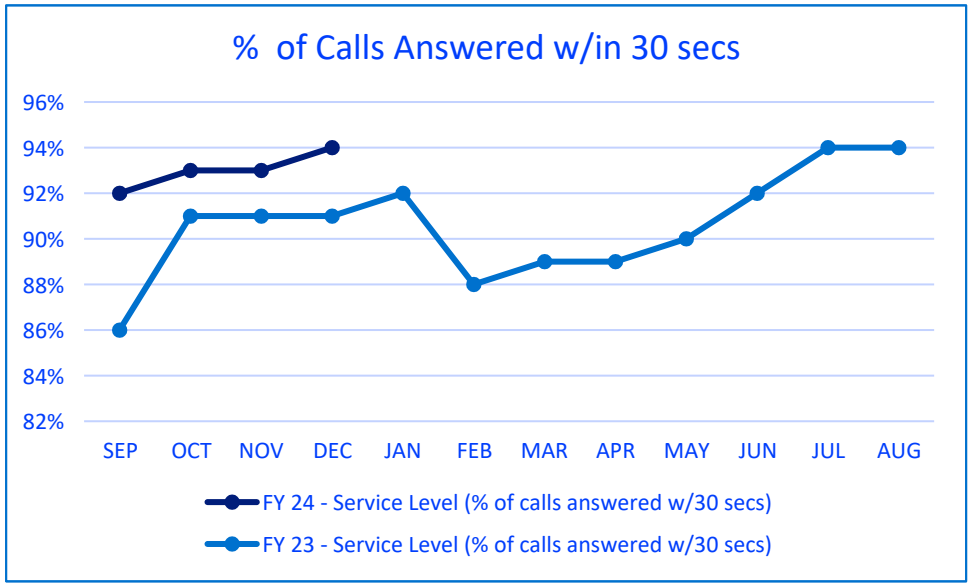




Notes:
Crisis Line continues to support individuals in crisis. The number of abandoned calls spiked in December as a results of the inclusion of abandoned calls from on 988/Lifeline. Recently, the amount of time the 988 calls can remain in queue has increased.

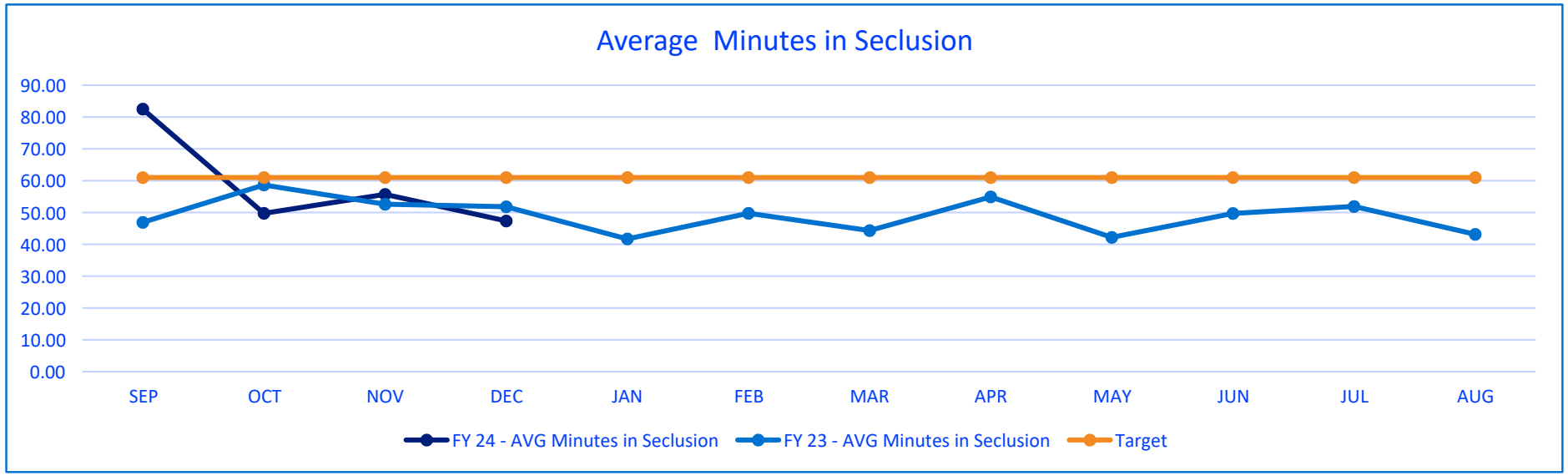
Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Timely Care	AVG Call Length (Mins)	N/A	9.03	9.20	N/A	Contractual
	Service Level (% of calls answered w/30 secs)	>95%	93.00%	94%	Increase	Contractual





Notes:
Crisis Line continues to support individuals in crisis.

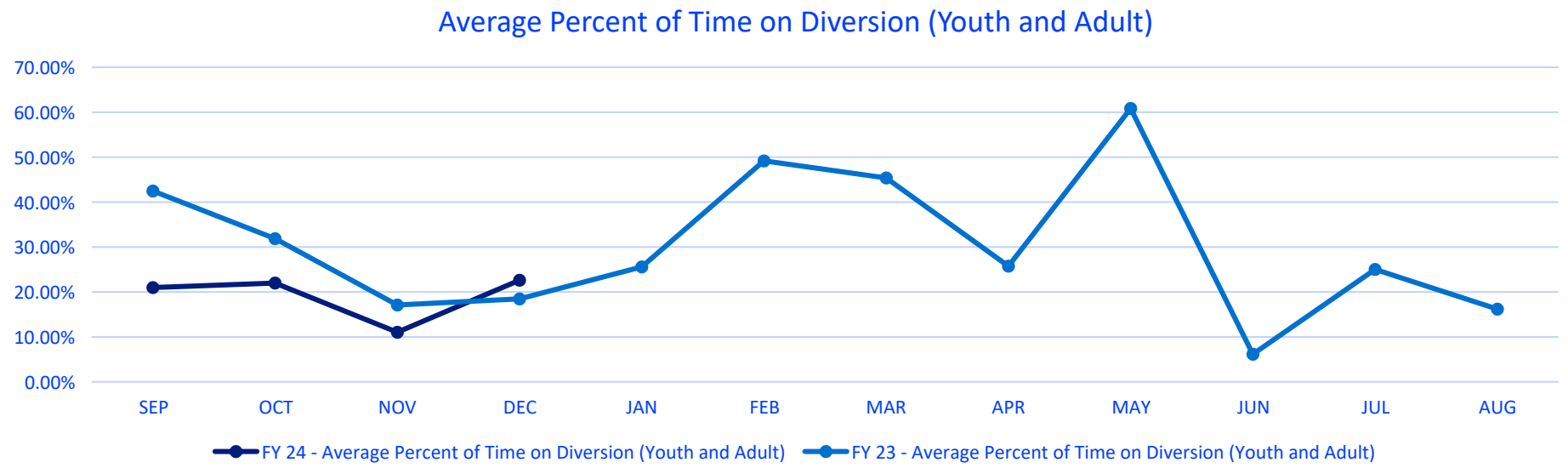
Domain	Measures	2024 Fiscal Year Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Safe Care	Average Minutes in Seclusion	<60.43	58.83	47.36	Decrease	Contractual



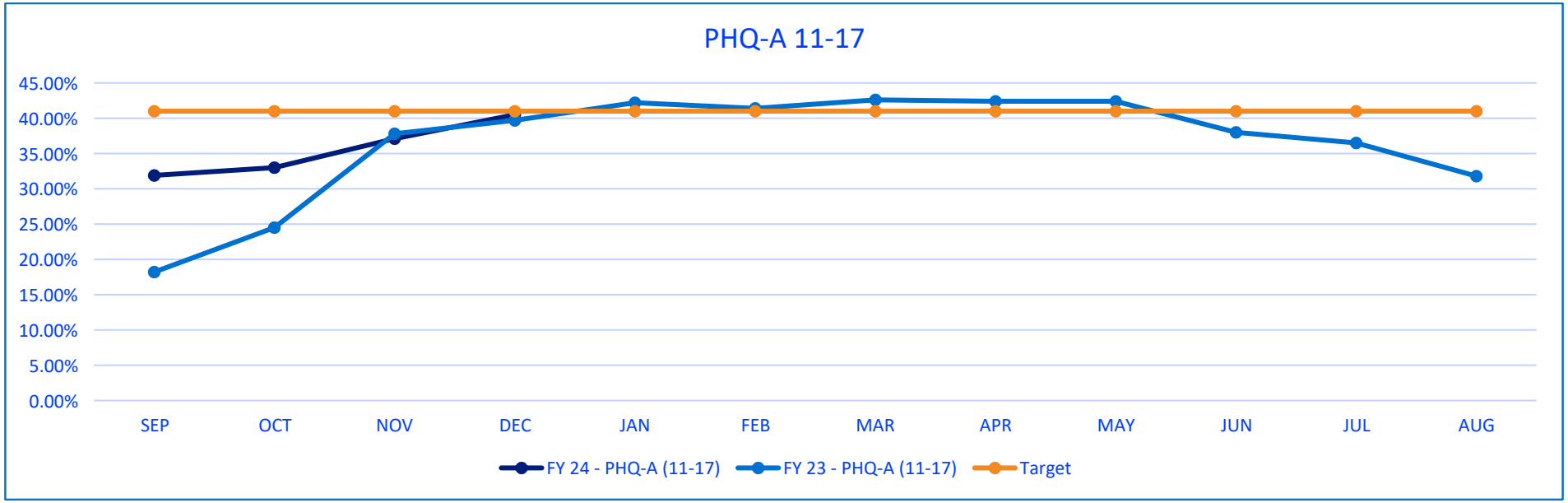
Notes:

- Average minutes in seclusion has performed below contractual target. On average, individuals are spending less than 60 minutes in seclusion. For the reporting period, average minutes in seclusion is at 58.83 minutes.

Domain	Measures	2024 Fiscal Year Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Safe Care	Average Percent of Time on Diversion (Youth and Adult)	N/A	19%	21.61%	N/A	Contractual



Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept. - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Effective Care	PHQ-A (11-17)	41.27%	36.%	40.50%	Increase	IOS



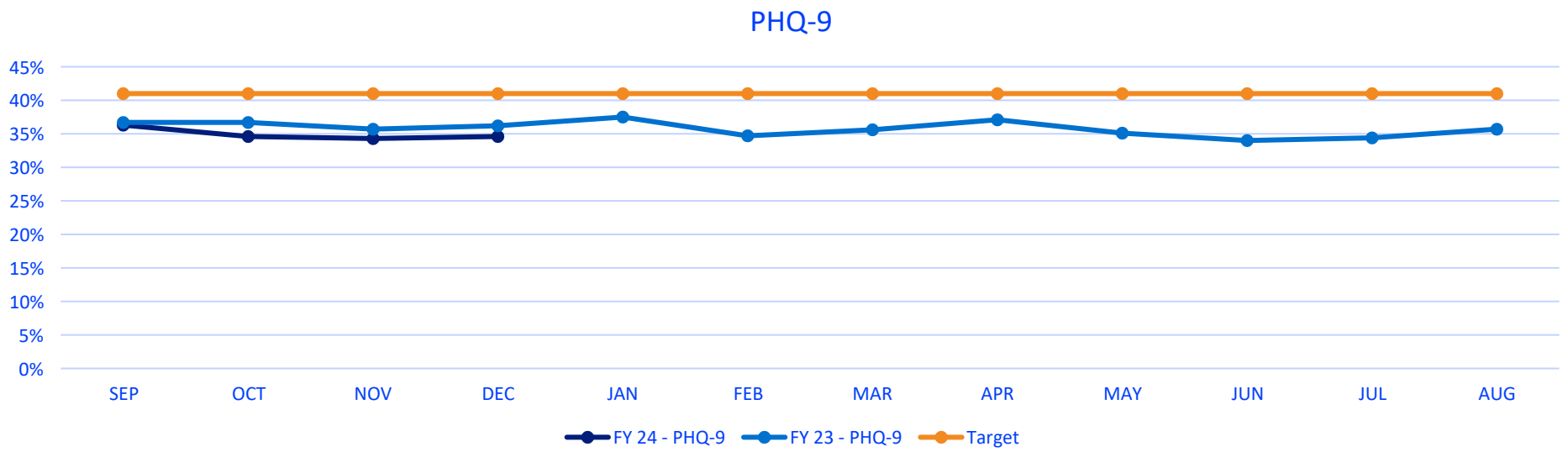
Notes:

- PHQ-A percentage of adolescent and young adult with improve PHQ-A score has leveled slightly from the previous period but the measure is still below the target.

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 2024 Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Effective Care	PHQ-9	41.27%	35%	34%	Increase	IOS



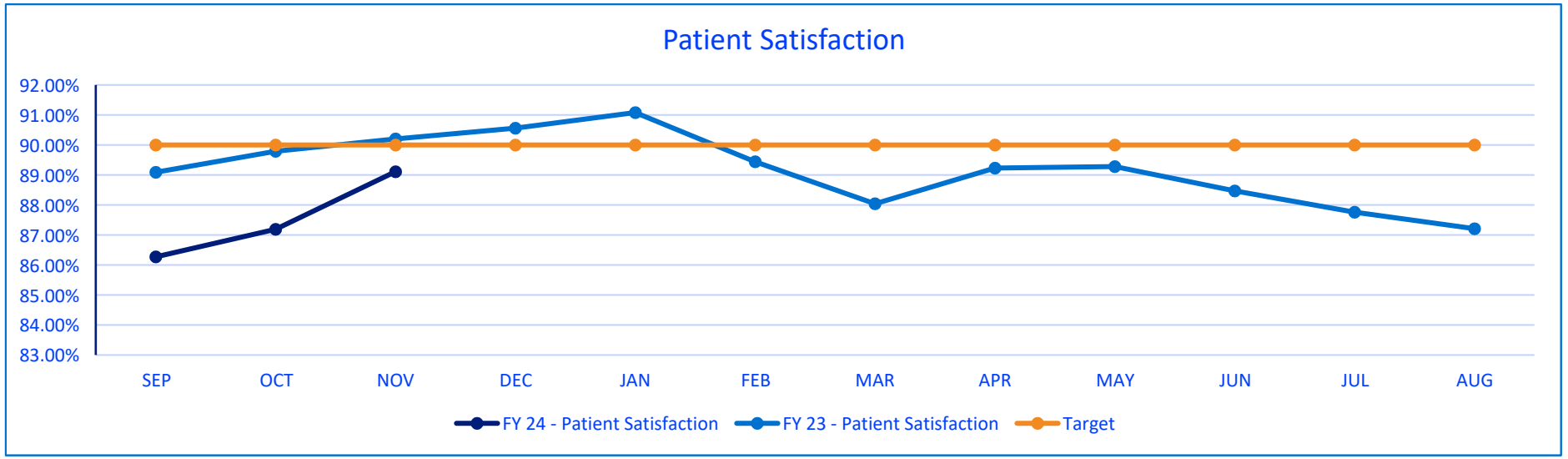
Notes:

- During the current reporting period, fewer number of patients registered lower scores on the self-administered PHQ-9 instrument. When compared to the same period, a total of 35.70% of patients reported lower scores in FY23. This figure has slightly decreased to 34% in FY24, reflecting a sustained positive trend in the context of depressive symptomatology.

Measure Computation: % of patients 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)	2024 Fiscal Year Target	2024Fiscal Year Average (Sept - Dec)	Reporting Period- December	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	90%	88.26%	89.11%	Increase	IOS



Notes:

- At the beginning of Fiscal Year 2024, the overall patient satisfaction across the center deviated below its targeted monthly threshold. In response to this, a specialized patient satisfaction sub-committee was established to analyze survey data, discern areas of vulnerability, and formulate quality improvement initiatives. Practice managers are actively engaging with unit-specific patient satisfaction data to pinpoint and address areas warranting enhancement.

- Moreover, the committee is systematically collating patient narrative feedback from Fiscal Year 2023, with the intention of informing the development of workgroups dedicated to addressing identified areas of improvement and establishing goals for Fiscal Year 2024. The sub-committee's analytical efforts are predominantly rooted in the quantitative data derived from the VSSS instrument.

- The effort of the group has shown a positive trend over the course of the reporting period, with an overall improvement of 3% in patient satisfaction from September. This uptick underscores a concerted commitment to enhancing the patient experience for the individuals under our care.

Appendix

FY 23 -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	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	14,257	14,340	14,124	13,955	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%	104.08%	102.62%	101.37%	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%	50.08%	55.90%	49.82%	≥ 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	3,593	3,588	3,555	3,485	3,493	3,594	3,663	3,709	3,706	3,582	3,476	3,398	3,570	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%	99.83%	97.62%	102.56%	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%	69.50%	77.50%	74.78%	≥ 65.00%	C	MBOW
IDD Service Target	824	864	885	830	908	914	924	925	968	979	955	1011	916	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%	111.83%	118.27%	106.95%	100.00%	C	MBOW
DID Assessment Waitlist		5710	5602	5621	5547	5486	5281	4306	3782	3473	2890	2606				
CW CAS 1st Contact to LPHA	23.82	25.66	23.87	21.85	12.22	8.75	3.91	3.06	1.72	2.14	1.67	1.86	10.88	<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	1.70	1.21	2.91	<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	1.69	1.31	4.38	<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	11.57	10.33	8.32	<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	17.99	16.20	15.10	12.10	18.56	<28 Days	NS	Epic
CAS # Pts Seen in 30-60 Days	49	45	45	44	47	19	51	40	53	33	34	27	40.58	<9.18	IOS	Epic
CAS # Pts Seen in 60+ Days	26	27	35	27	35	43	22	18	14	15	7	8	23.08	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	4.02	5.17	3.66	4.50	<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	9.43	11.69	13.75	13.66	8.72	<28 Days	NS	Epic
AMH # Pts Seen in 30-60 Days	6	2	2	1	4	5	1	1	4	21	81	142	22.50	<45	IOS	Epic
AMH # Pts Seen in 60+ Days	2	1	1	0	0	0	0	0	1	2	1	7	1.25	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	16,472	18,570	16,768			
AVG Call Length (Mins)	8.00	8.00	8.10	8.70	8.50	8.80	9.30	9.20	9.80	9.00	9.30	9.50	8.85			
Service Level	86.00%	91.34%	91.00%	90.76%	92.00%	88.00%	89.00%	89.00%	89.64%	91.96%	94.44%	94.05%	90.60%	≥ 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%	3.21%	4.23%	5.18%	< 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%	65.00%	68.00%	71.50%			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%	99.67%	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%	88.90%	83.50%	87.63%	> 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	1,222	1,248	1173			
PES Admission Volume	523	585	560	544	555	498	549	522	558	487	571	562	542.83			
Mechanical Restraints	0	0	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	0.00	0.00	≤ 0.01	IOS	Epic
Personal Restraints	46	40	37	37	43	50	79	76	43	49	48	47	49.58			Epic
Personal Restraint Rate	2.07	1.95	1.78	1.77	1.98	2.68	3.85	3.89	2.36	3.65	3.00	2.51	2.62	≤ 2.80	IOS	Epic
Seclusions	33	35	19	32	20	39	53	58	35	33	34	33	35.33			Epic
Seclusion Rate	1.48	1.61	0.92	1.53	0.92	2.09	2.58	3.22	1.92	2.46	2.13	1.76	1.89	≤ 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	51.92	43.15	48.96	≤ 61.73	IOS	Epic
Emergency Medications	44	54	42	47	58	56	72	72	67	53	59	52	56.33			Epic
EM Rate	1.98	2.48	2.02	2.25	2.67	3.01	3.50	3.99	3.61	3.63	3.45	2.77	2.95	≤ 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	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%	87.76%	87.21%	89.18%	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%	86.52%	85.22%	88.57%	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%	91.43%	92.88%	91.10%	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%	98.11%	94.76%	96.97%	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%	28.44%	28.52%	26.76%	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%	35.56%	35.58%	33.45%	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%	38.62%	39.30%	35.02%	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	0.96	0.75	0.69	0.68	IOS	McLean
QIDS-C	53.80%	47.30%	50.10%	50.40%	48.60%	44.50%	47.20%	50.30%	50.70%	60.90%	51.60%	46.80%	50.18%	45.38%	IOS	Epic
BDSS	46.10%	46.20%	51.80%	50.30%	48.70%	47.20%	45.40%	42.80%	49.40%	49.20%	48.50%	46.10%	47.64%	46.47%	IOS	Epic
PSRS	38.20%	41.70%	43.50%	42.40%	36.00%	39.70%	32.30%	39.30%	42.60%	43.50%	42.50%	40.50%	40.18%	37.89%	IOS	Epic
Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)																
PHQ-A (11-17)	18.20%	24.50%	37.80%	39.70%	42.20%	41.40%	42.60%	42.40%	42.40%	38.00%	36.50%	31.80%	36.46%	41.27%	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%	42.80%	43.60%	39.67%	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%	36.40%	37.80%	29.13%	25.00%	C	MBOW
Adult and Child/Adolescent Functioning Measures																
DLA-20 (AMH and CAS)	49.80%	44.50%	44.30%	47.50%	50.90%	53.80%	50.00%	54.10%	45.20%	43.20%	39.60%	43.20%	47.18%	48.07%	IOS	Epic

Thank you.