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

Quality Committee Meeting
March 19, 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, February 20, 2024
(EXHIBIT Q-1)

IV. **REVIEW AND COMMENT**

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

B. IDD Update
(EXHIBIT Q-3 Evanthe Collins)

C. Board Score Card
(EXHIBIT Q-4 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, Trudy Leidich, Vice President of Clinical Transformation & Quality

• Report by the Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer, and Vice President of Clinical Transformation & Quality related to an audit conducted by the HHSC-Provider Licensing Enforcement & Regulatory Services and compliance with state and federal health care program requirements pursuant to Texas Health & Safety Code Ann. §161.032. Dr. Luming Li, Chief Medical Officer, Kia Walker, Chief Nursing Officer, Keena Pace, Chief Operating Officer, Dr. Evanthe Collins, Vice President of IDD Services and Trudy Leidich, Vice President of Clinical Transformation & Quality

• 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

• 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 and Dr. Luming Li, Chief Medical Officer

VI. **RECONVENE INTO OPEN SESSION**

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

VIII. **ADJOURN**

Veronica Franco

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

EXHIBIT Q-1

The HARRIS CENTER *for* MENTAL HEALTH and IDD BOARD OF TRUSTEES QUALITY COMMITTEE MEETING TUESDAY, FEBRUARY 20, 2024 MINUTES

Dr. R. Gearing, Chairman, called the meeting to order at 10:15 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, , B. Hellums

Committee Member Absent: Dr. G. Santos

Other Board Member in Attendance: Dr. L. Moore, N. Hurtado

1. **CALL TO ORDER**
   Dr. Gearing called the meeting to order at 10:15 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Dr. Gearing designated Dr. Moore and Mrs. Hurtado as voting members.

3. **DECLARATION OF QUORUM**
   Dr. Gearing 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, November 7, 2023**

   MOTION BY: HURTADO SECOND BY: HELLUMS

   With unanimous affirmative votes,
   BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday, November 7, 2023, as presented under Exhibit Q-1, are approved.

6. **REVIEW AND COMMENT**

   A. **FQHC-LAL Discussion -**The Quality Committee Members tabled the item and will review this agenda item in the March Board meeting.
   B. **Psychiatric Emergency Services (PES) Quarterly Update-**Dr. Amber Pastusek presented the PES Quarterly Update to the Quality Committee.

C. IDD Update-Dr. Evanthe Collins presented the IDD Update to the Quality Committee.

D. Board Score Card- Trudy Leidich and Lance Britt presented the Board Score Card to the Quality Committee.

7. EXECUTIVE SESSION-

Dr. Gearing announced the Quality Committee would enter into executive session at 11:12 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 11:31 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: HELLUMS SECOND: HURTADO

There being no further business, the meeting adjourned at 11:31 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

March, 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

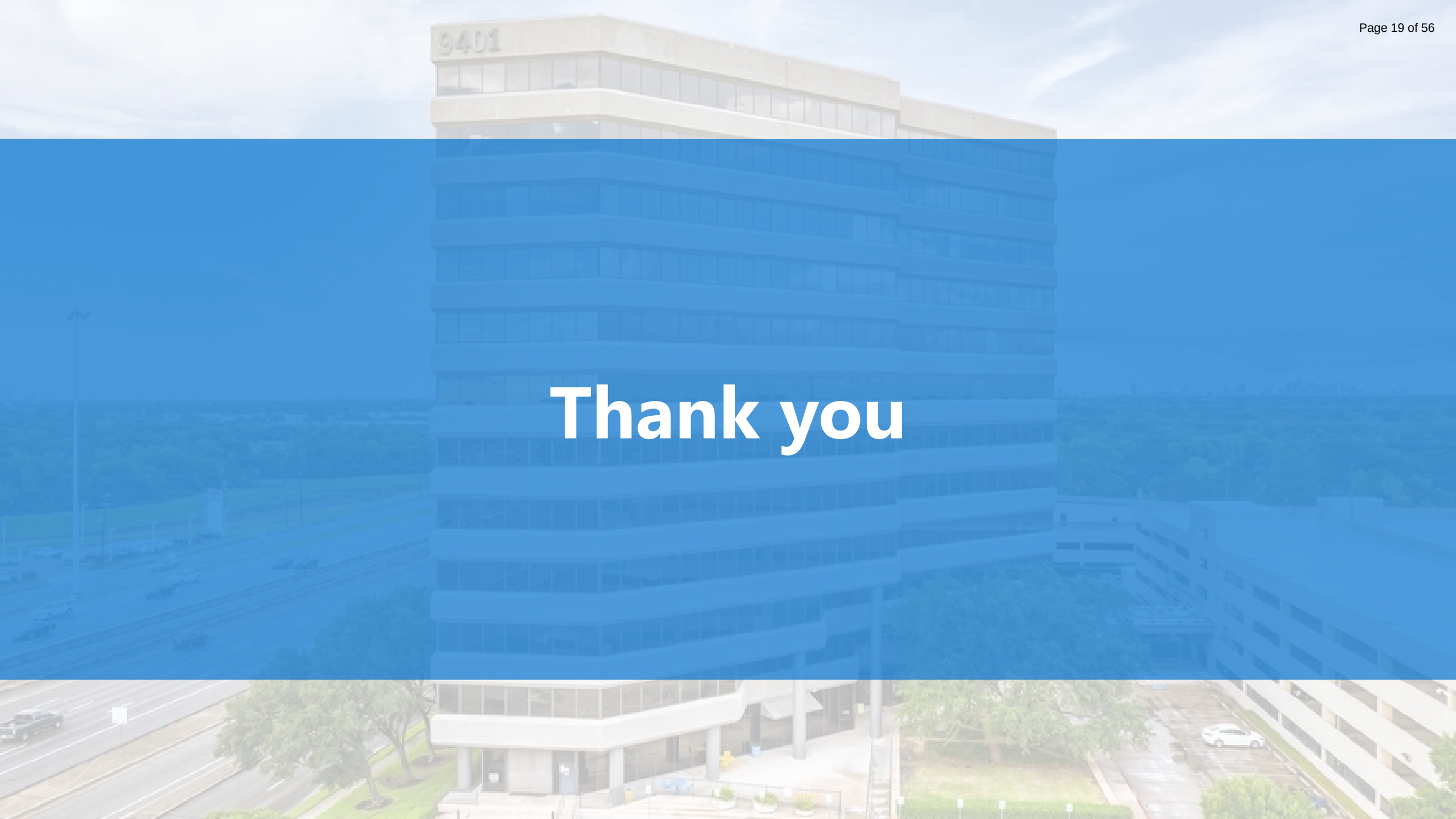
FQHC-LAL
Quality Improvement Awards

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

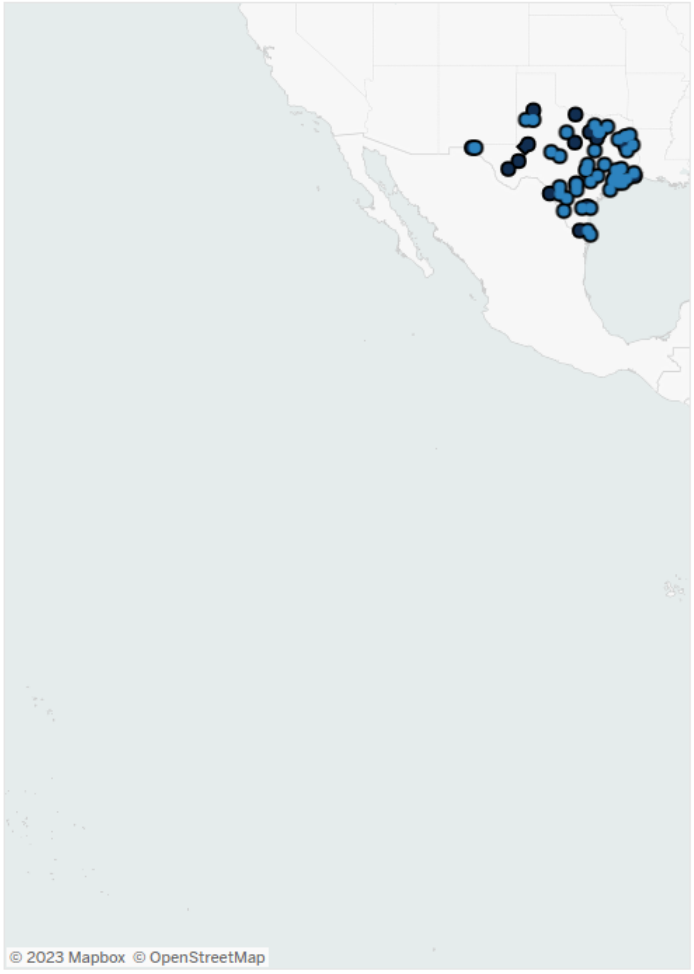
2023 NQL - Behavioral Health badge

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

MARCH IS

DISABILITY AWARENESS MONTH

The HARRIS CENTER for Mental Health and IDD

Transforming Lives

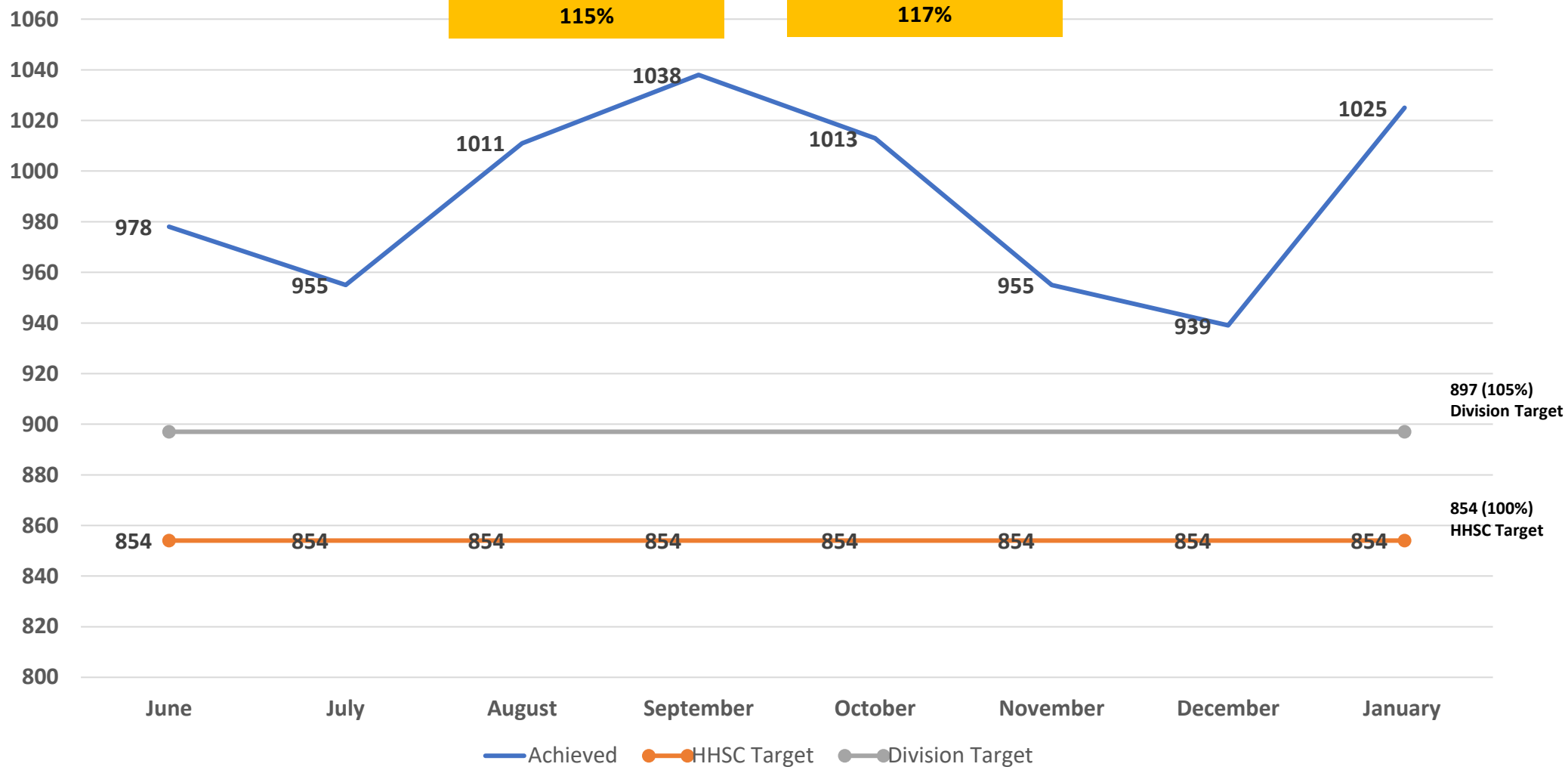
IDD Services Division

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%



Number Interested/GR Services*

*data as reported to HHSC quarterly

HHSC General Revenue **SERVICES**

	2022-JUL	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB
R021 Community Supports		112	112	112	112	112	105	100	99
R022 Out-of-Home Respite		119	120	118	118	119	118	113	113
R023 In Home Respite		742	748	727	732	761	733	680	660
R032 Residential Living		5	5	6	6	6	6	5	5
R041 Employee Assistance		67	67	70	71	71	71	68	78
R042 Supported Employment		5	5	6	6	6	6	6	7
R043 Vocational Training		59	59	62	62	62	62	57	58
R053 Day Habilitation		195	197	192	197	198	194	176	206
R054 Specialized Therapies		562	574	590	640	650	637	604	675
R055 Behavioral Support		459	468	477	488	491	472	460	611
UNDUPLICATED COUNT	**7523**	**4481**	**4001**	**2902**	**1909**	**2531**	**2404**	**2060**	**1849**

HHSC General Revenue **PROCESS** to Access Services Above

	2022-JUL	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB
R005 Eligibility Determination	5831	2891	2606	1422	385	55	0	0	0
R014 Service Coordination							2404	2060	1849

THIS IS A DUPLICATED COUNT FROM THE GR SERVICES TABLE ABOVE

HHSC Process to Access GR Services

To access any HHSC general revenue service, a DID **AND** Service Coordinator (Person-Directed-Plan) are required.

DID (R005): Currently DID providers can respond within 24 hours for crisis cases and within 30 days for routine.

Service Coordination (R014): Currently there is an approximate 3 month wait to receive a service coordinator.

Number of individuals who will need a DID **AND** a service coordinator to access requested GR services: 1,849

Number Interested/GR Services

GR Clients Added Per Month								
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB
R021 Community Supports	0	0	0	0	0	1	0	0
R022 Respite (Out-of-Home)	1	0	0	0	0	0	0	0
R023 Respite (In-Home)	6	7	5	3	5	5	5	15
R032 Residential Living	0	0	1	0	0	0	0	0
R041 Employment Assistance	3	0	2	1	0	0	0	9
R042 supported Employment	0	0	1	0	0	0	0	0
R043 Vocational Training	0	0	3	0	0	0	0	2
R053 Day Habilitation	2	2	1	3	2	1	3	14
R054 Specialized Therapies	10	11	11	9	9	11	10	59
R055 Behavioral Supports	7	5	6	8	3	9	6	40
TOTAL ADDED	**29**	**25**	**30**	**24**	**19**	**27**	**24**	**91**

Waiver/HCPC Data*

MEDICAID WAIVER INTEREST LIST*		
	Home & Community-based Services (HCS)	Texas Home Living Waiver (TXHML)
Interest List Slots Allocated to Harris County YTD	61	212
Total on Interest List in HARRIS COUNTY	24,072	22,533
Total on Interest List in TEXAS	117,957	106,804
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	66
Total Individuals with Re-Admissions	49	67	27
Total Referred to IDD Eligibility	19	45	12
Total in Service Coordination at Time of Hospitalization	32	68	23

***data FYTD through February 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
FEB	95

**Data as of 3/4/24*

DID Report Completion Timeframe

	AVG Completion Time (CALENDAR DAYS)
FY23 AVG	23 days
SEPT	35
OCT	40
NOV	40
DEC	19
JAN	9

**Data as of 3/4/24*

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

ADVANCING ACCESS & EQUITY

EXHIBIT Q-4

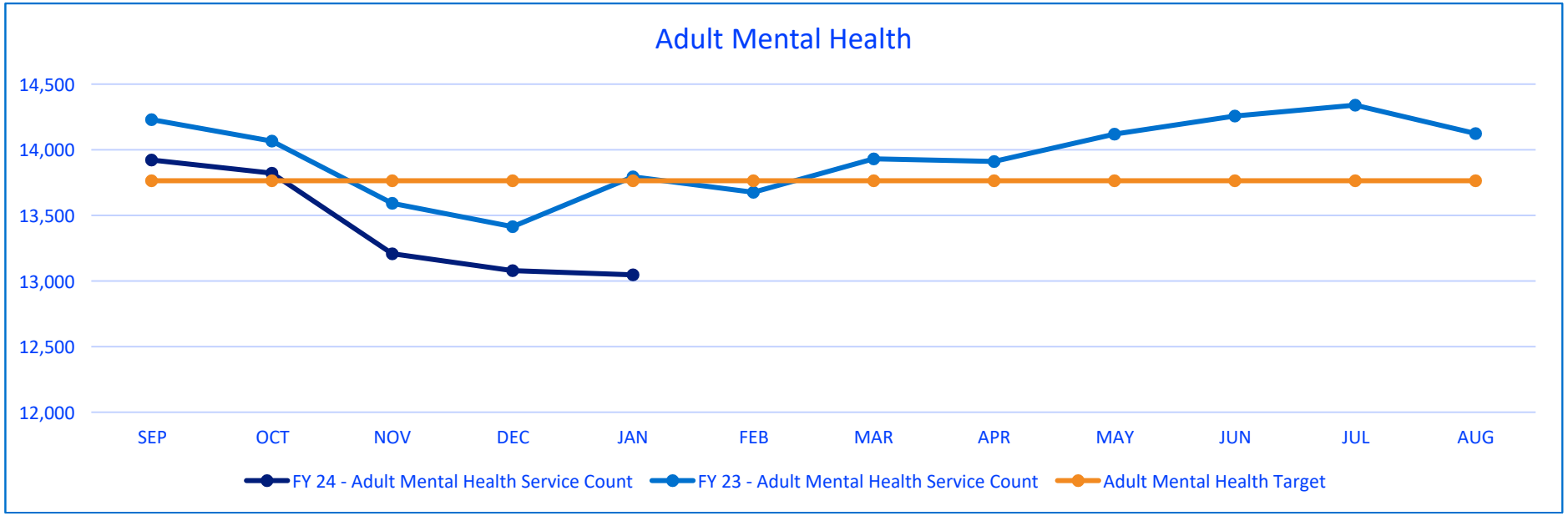
Quality Board Scorecard

Board Quality Committee Meeting

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

March 2024 (Reporting January 2024 Data)

Domain	Program	2024 Fiscal Year State Service Care Count Target	2024 Fiscal Year State Care Count Average (Sept. – Jan.)	Reporting Period: January	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	13,416	13,047	Increase	Contractual

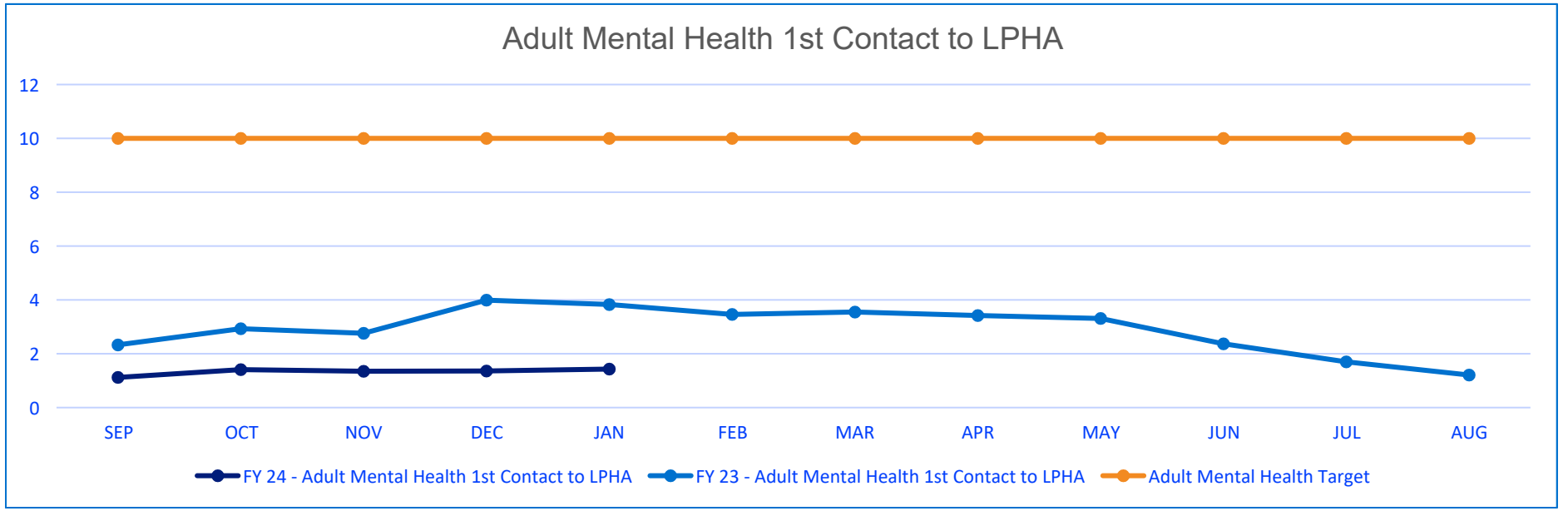


Notes:

- In January2023, the Adult Service Care Count experienced a decline of 5.42% compared to the same month in the previous year, dropping from 13,794 to 13,047. This decrease resulted in the count falling short of the established contractual target.
- The decrease in the Adult Mental Health services care count is consistent with state averages for Houston area service providers. MH leadership are reviewing this trend for opportunities for improvement.

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. – Jan.)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Contact to LPHA	<10 days	1.33 Days	1.43	Decrease	Contractual

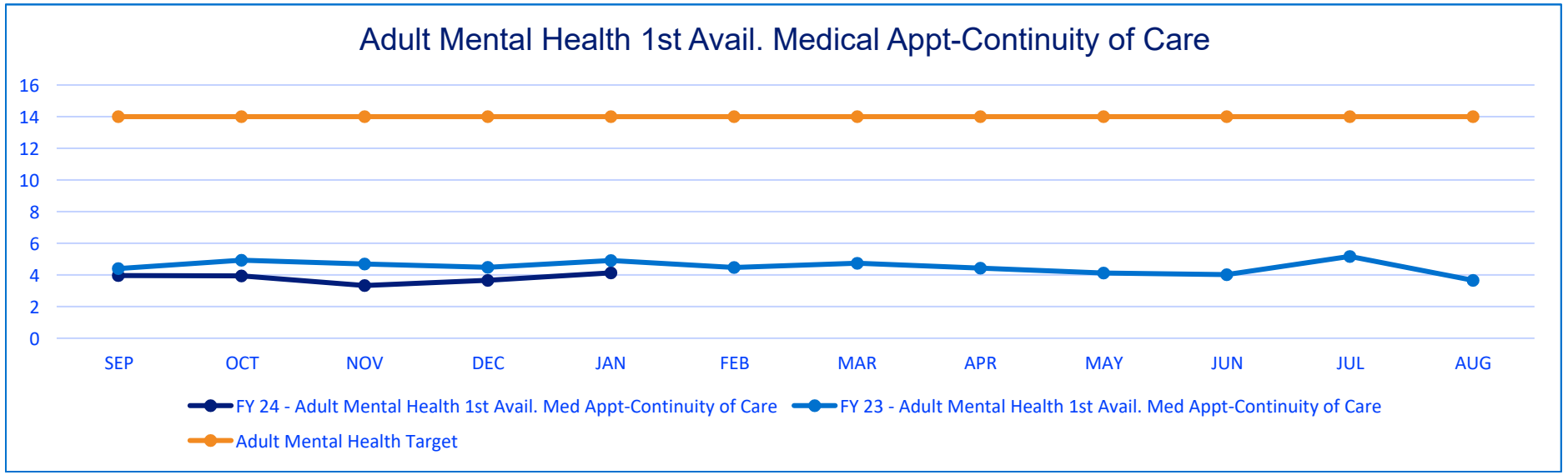


Notes:

- 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 63% reduction in the number of days from first contact to LPHA - decreasing from 3.83 days in January 2023 to just 1.43 days in January 2024. 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. – Jan.)	Reporting Period: January	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Continuity of Care	<14 days	3.80 days	4.13 days	Decrease	Contractual

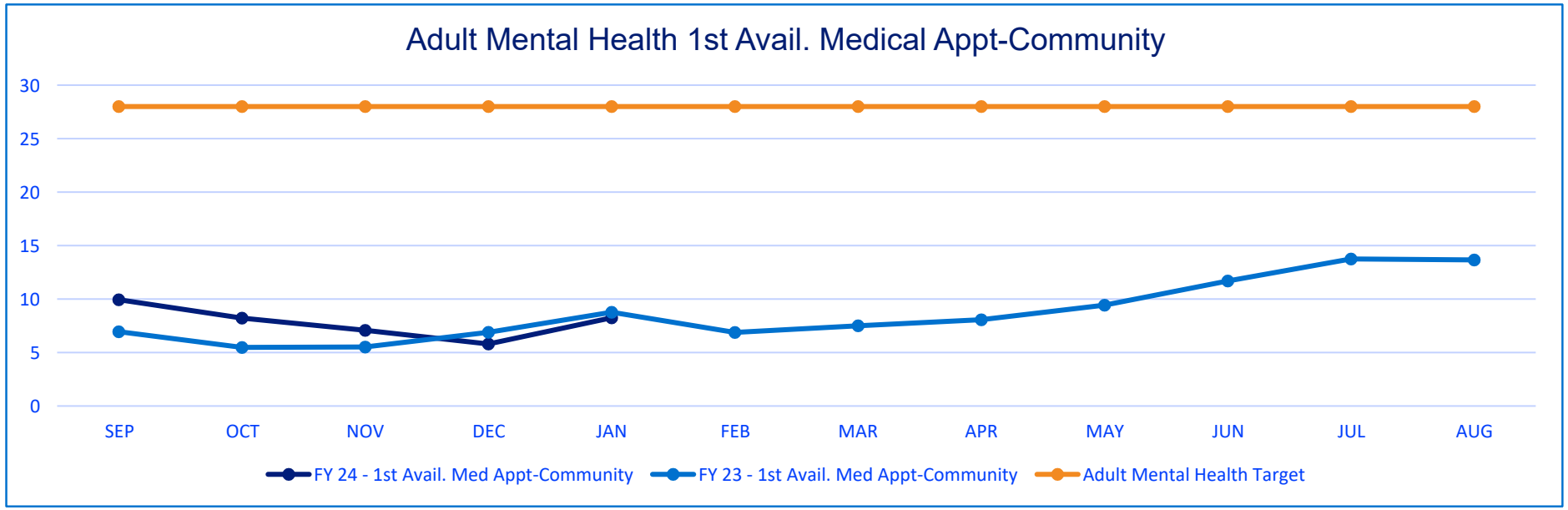


Notes:

- 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 16% 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-Jan)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Community Members	<28 days	7.86 days	8.25 days	Decrease	Contractual

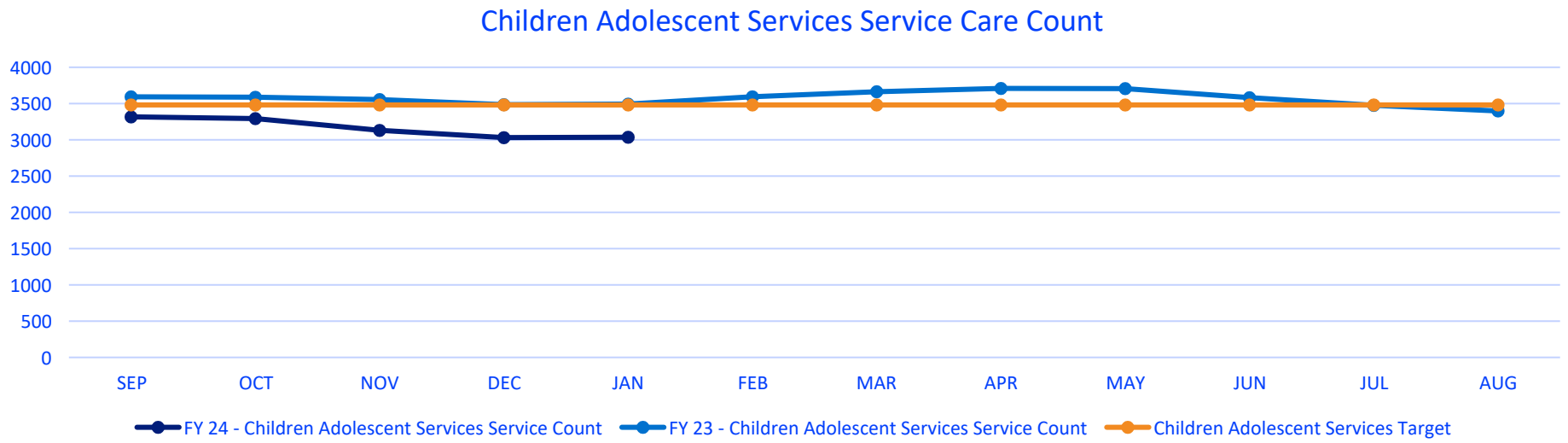


Notes:

- The Adult Mental Health department's adherence to the contractual target for providing access to medical appointments for community members remains commendable. Specifically, community members appointments are accommodated within 8.25 days.
- A year-over-year comparative analysis reveals a 6% decrease in this timeframe, indicating a shorter wait period for patients compared to the previous year.

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. – Jan.)	Reporting Period- January	Target Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	3,162	3,036	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 January 2023.

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

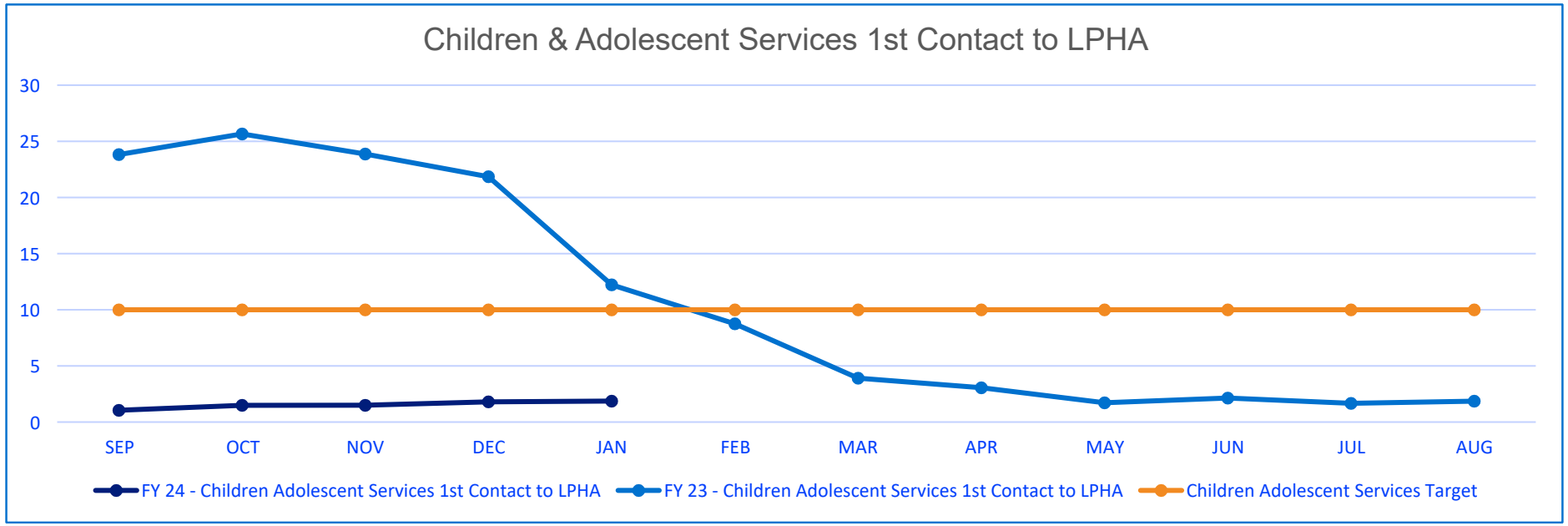
- Difficulties both completing and reporting Nov CANS Data (Breach)
- Drop in referrals

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 - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Contact to LPHA	<10 days	1.54 days	1.87 days	Decrease	Contractual

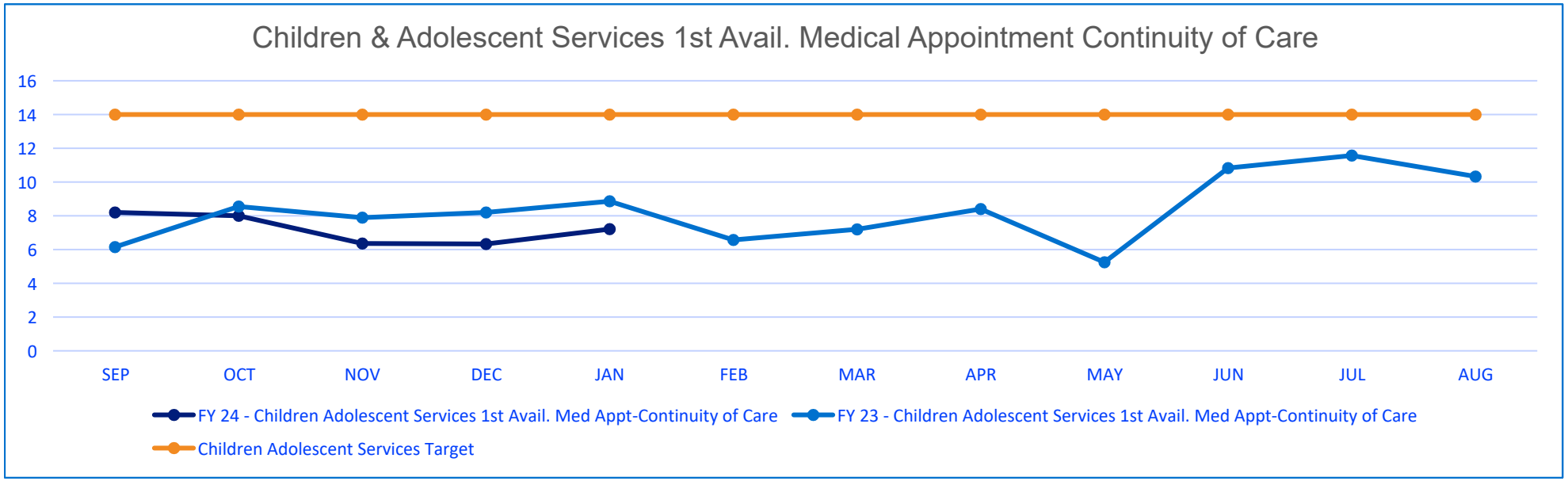


Notes:

- 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 an 85% reduction in the waiting period for individuals to be assessed by an LPHA - decreasing from 12.22 days in January 2023 to just 1.87 days in January 2024. 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-Jan)	Reporting Period-January	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Continuity of Care	<14 days	7.22 days	7.21 days	Decrease	Contractual

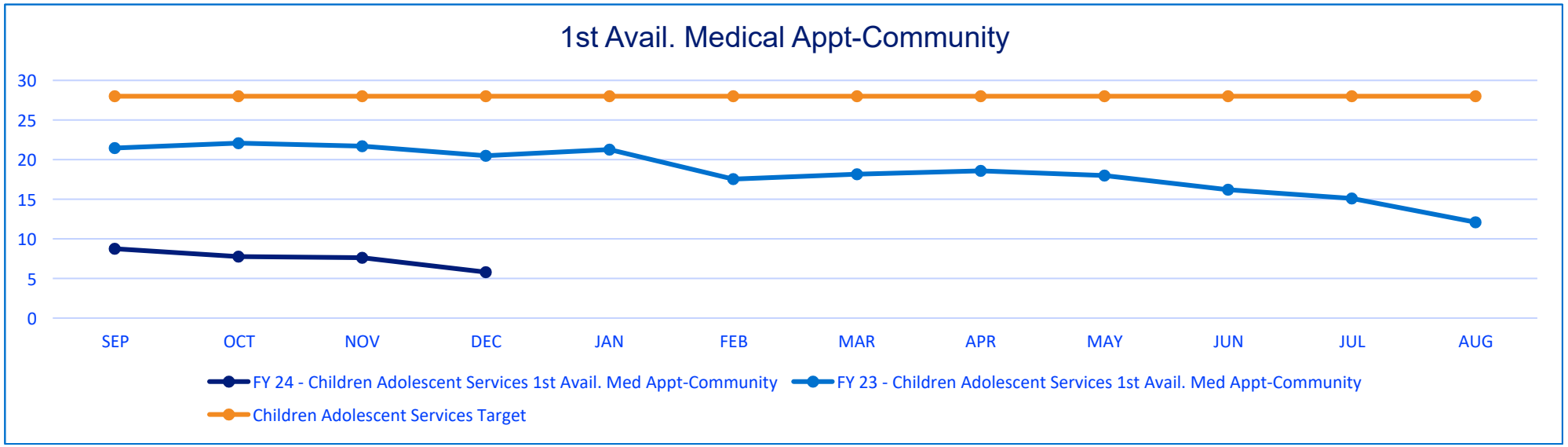


Notes:

- 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 January 2024, there was a notable decrease in the waiting period for patients seeking their first available medical appointment.
- The wait time reduced from 8.86 days in January 2023 to 7.21 days in January 2024, representing a 19% 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 - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Community	<28 days	7.54 days	7.77 days	Decrease	Contractual

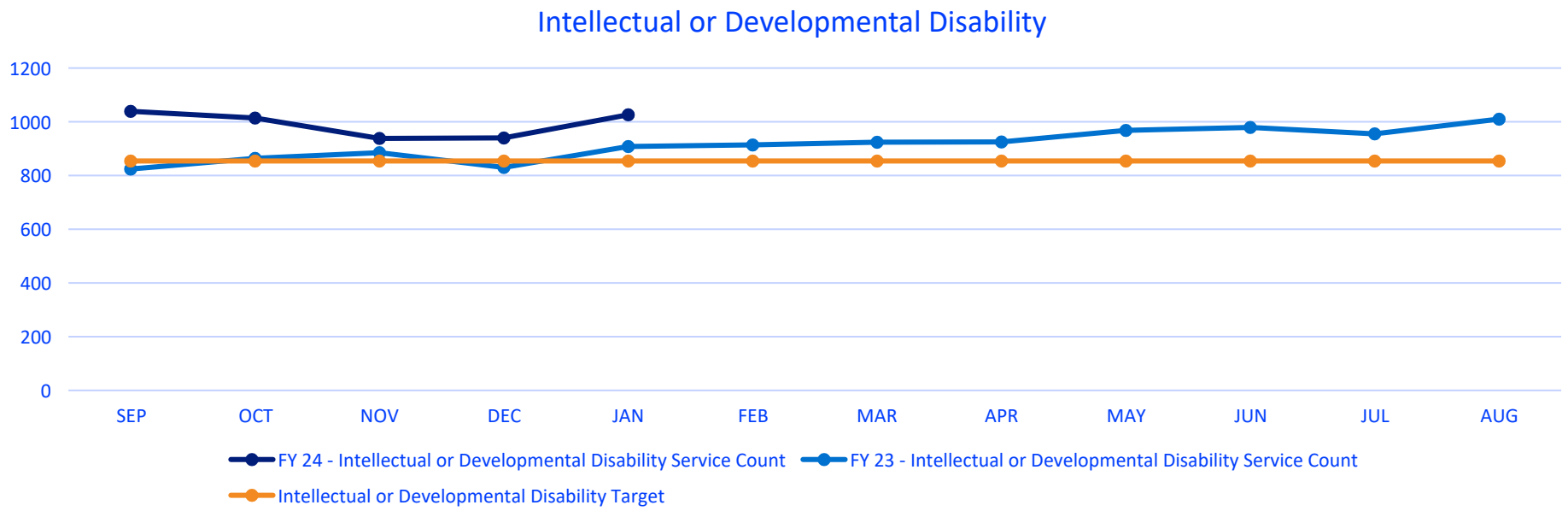


Notes:

- The Children & Adolescent Services department has demonstrated significant improvement in providing medical appointments for community members. Specifically, for the reporting period of January 2024, there was a substantial decrease of 63% in the waiting period compared to the same period in the previous fiscal year.
- The wait time was reduced from 21 days in January 2023 to about 8 days in January 2024.

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 – Jan)	Reporting Period- January	Target Desired Direction	Target Type
Access	IDD	854	991	1026	Increase	Contractual

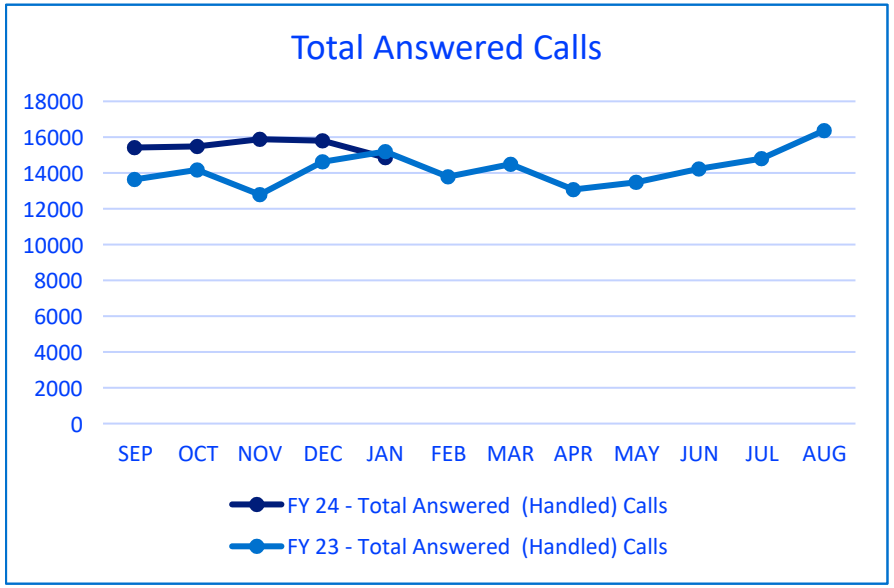


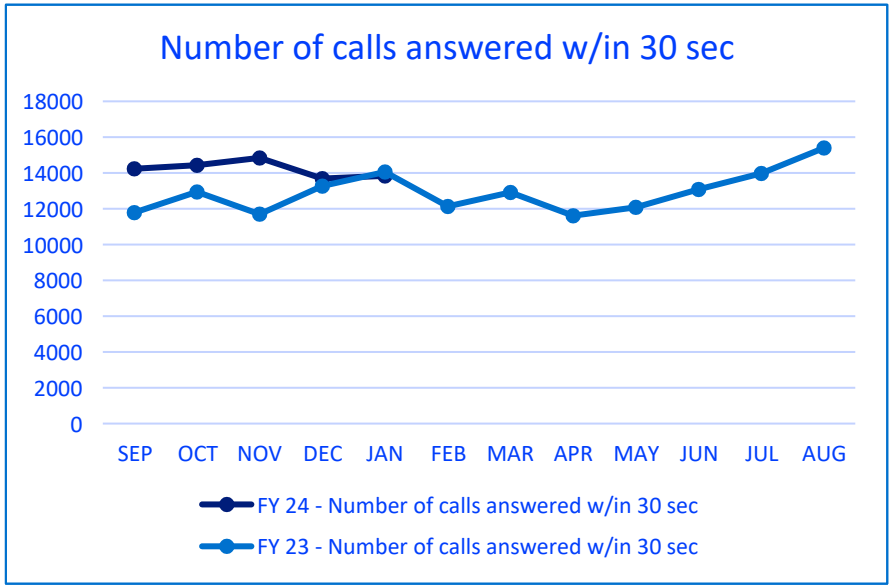
Notes:

- The IDD division service care count is at 1026 for this reporting period. The Division maintained an average of 991 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 908 in January 2023 to 1026 in January 2024. This data underscores the division's consistent efforts in enhancing its service delivery.

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 - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	15,489	14,861	Increase	N/A
	Number of calls answered w/in 30 secs	N/A	14,206	13,838	Increase	Contractual

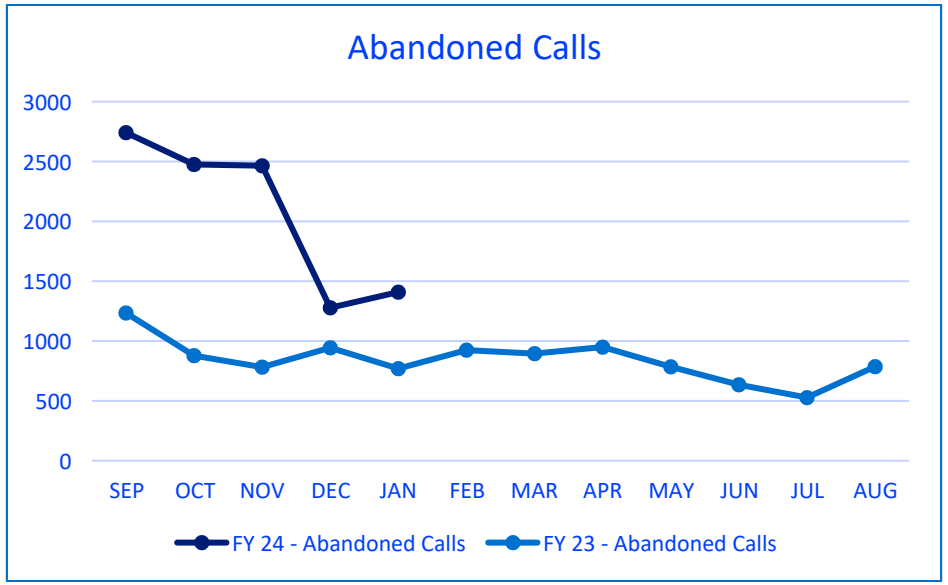


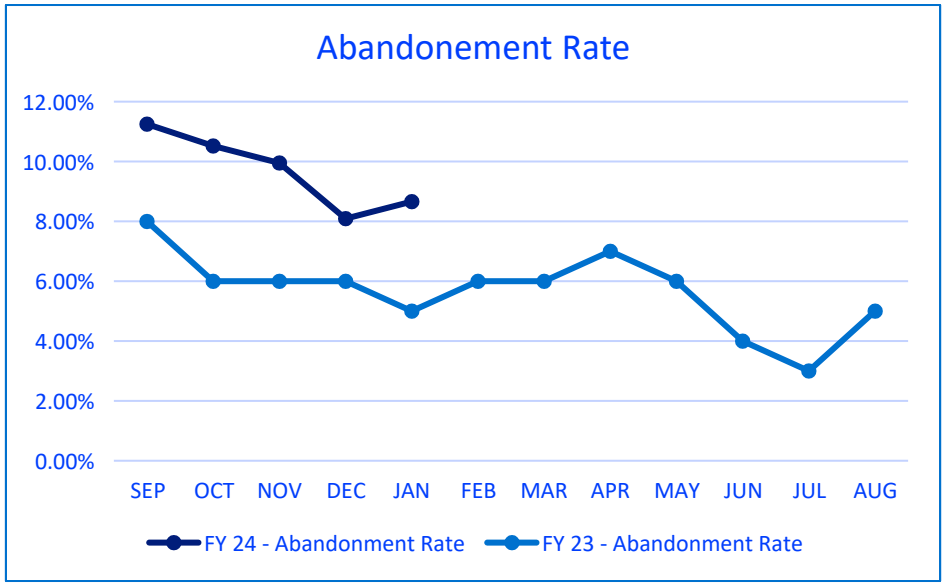


Notes:

The Crisis Line remains a pivotal support for individuals in crisis. The Crisis Line team is effectively responding to the increasing demand for their services. However, a slight decrease in the number of calls answered within 30 seconds from November to January indicates a potential challenge in maintaining prompt response times amidst the rising call volume.

Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	Abandoned Calls	N/A	2,074	1,409	Decrease	Contractual
	Abandonment Rate	<8%	10%	8.66%	Decrease	Contractual

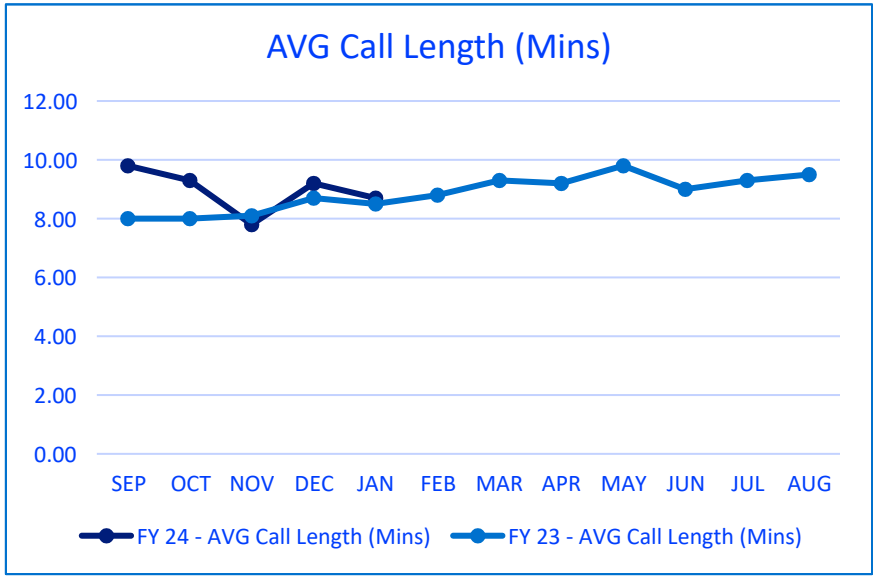


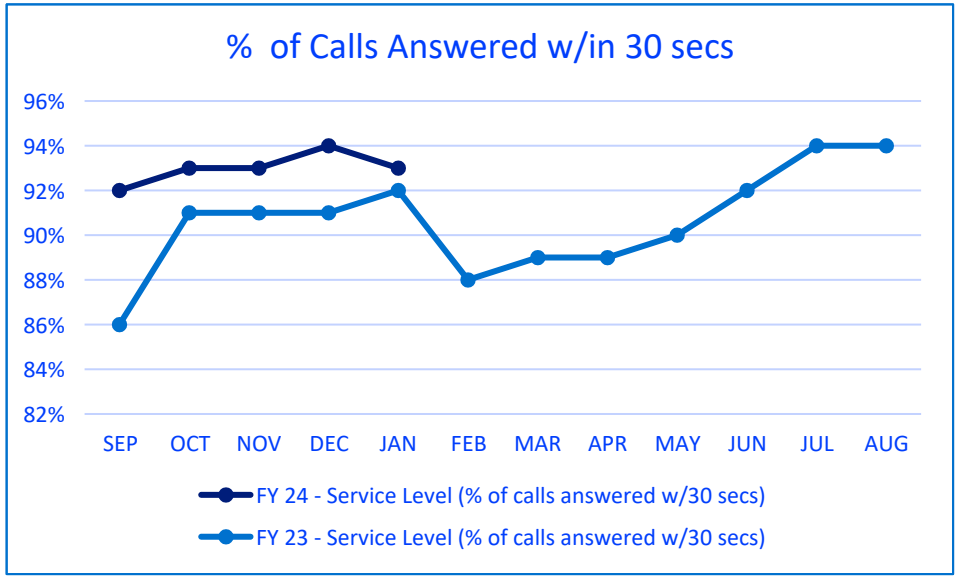


Notes:

The Crisis Line remains a critical resource for individuals in crisis situations. A significant observation is the decrease in the number of abandoned calls in December. This trend suggests that the Crisis Line's interventions are effectively addressing the heightened demand for crisis support. The reduction in abandoned calls could be indicative of improved response times, increased staffing, or more efficient handling of calls. This positive trend underscores the effectiveness of the measures implemented by the Crisis Line to manage the increased call volume and provide timely assistance to those in need.

Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Timely Care	AVG Call Length (Mins)	N/A	8.96	8.70	N/A	Contractual
	Service Level (% of calls answered w/30 secs)	>95%	93.00%	93%	Increase	Contractual

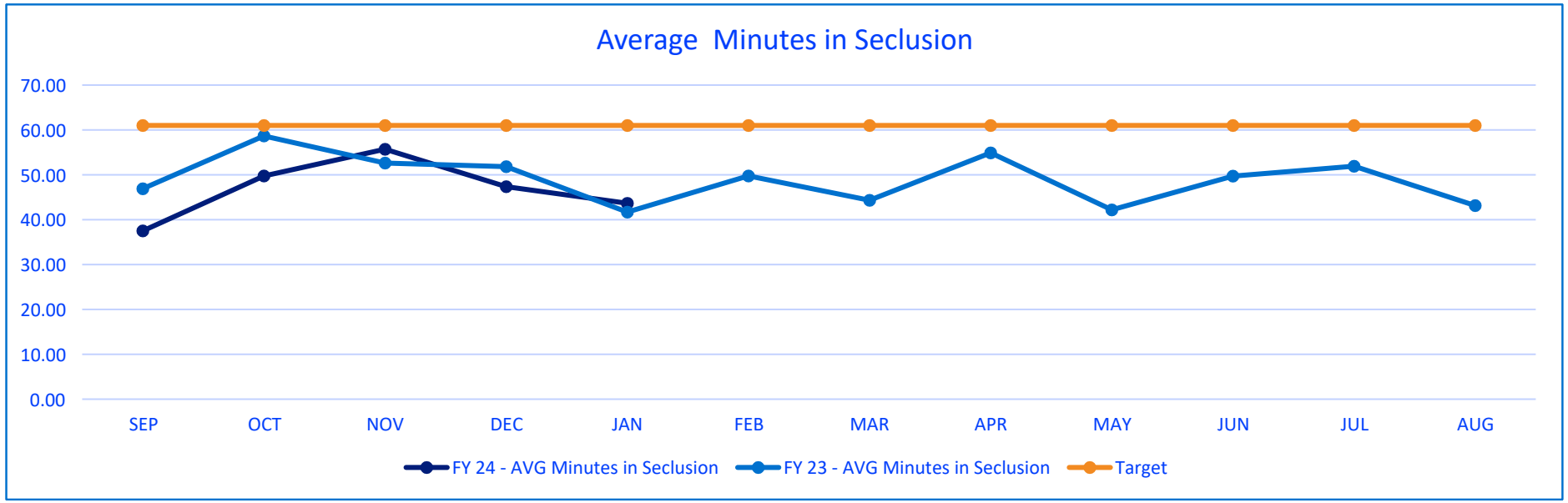




Notes:

The Crisis Line remains a vital resource for individuals in crisis. An analysis of recent data reveals an increase in both the duration of calls and the percentage of calls answered within 30 seconds. This trend suggests a surge in the volume of calls to the Crisis Line, indicating a heightened demand for crisis support services. This could be reflective of an escalating need for immediate assistance among the population served. Further investigation may be warranted to understand the underlying causes of this increase and to ensure the Crisis Line is adequately equipped to handle this growing demand.

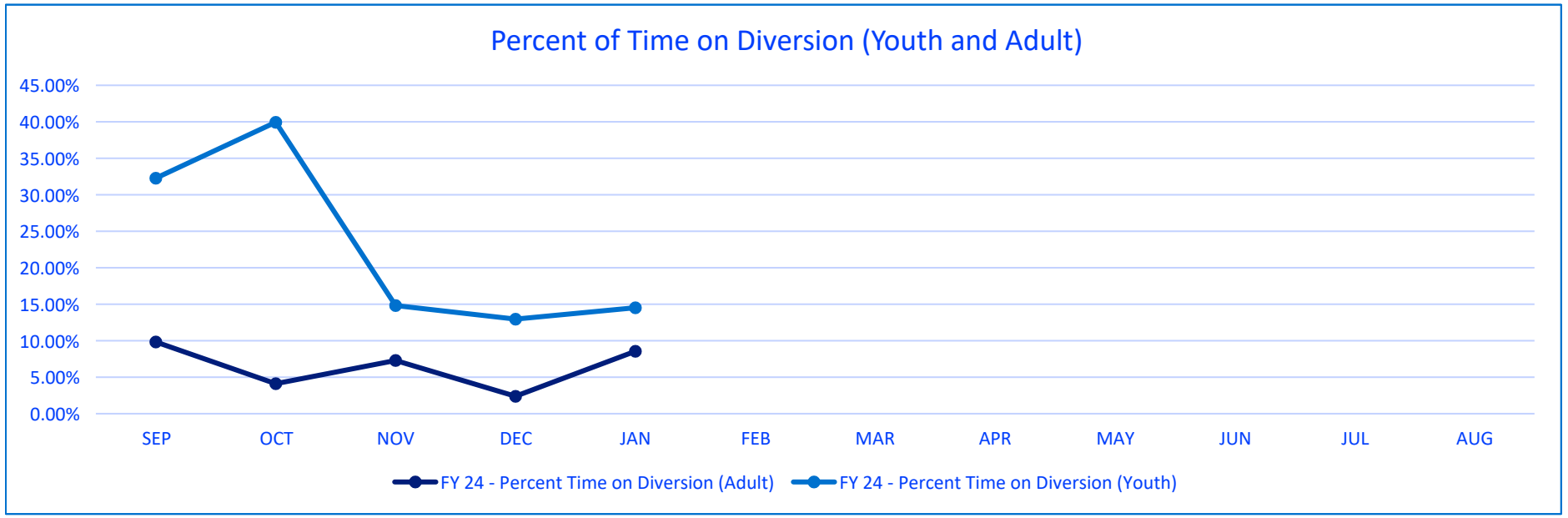
Domain	Measures	2024 Fiscal Year Target	2024Fiscal Year Average (Sept - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Safe Care	Average Minutes in Seclusion	<60.43	55.79	43.66	Decrease	Contractual



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 43.66 minutes.

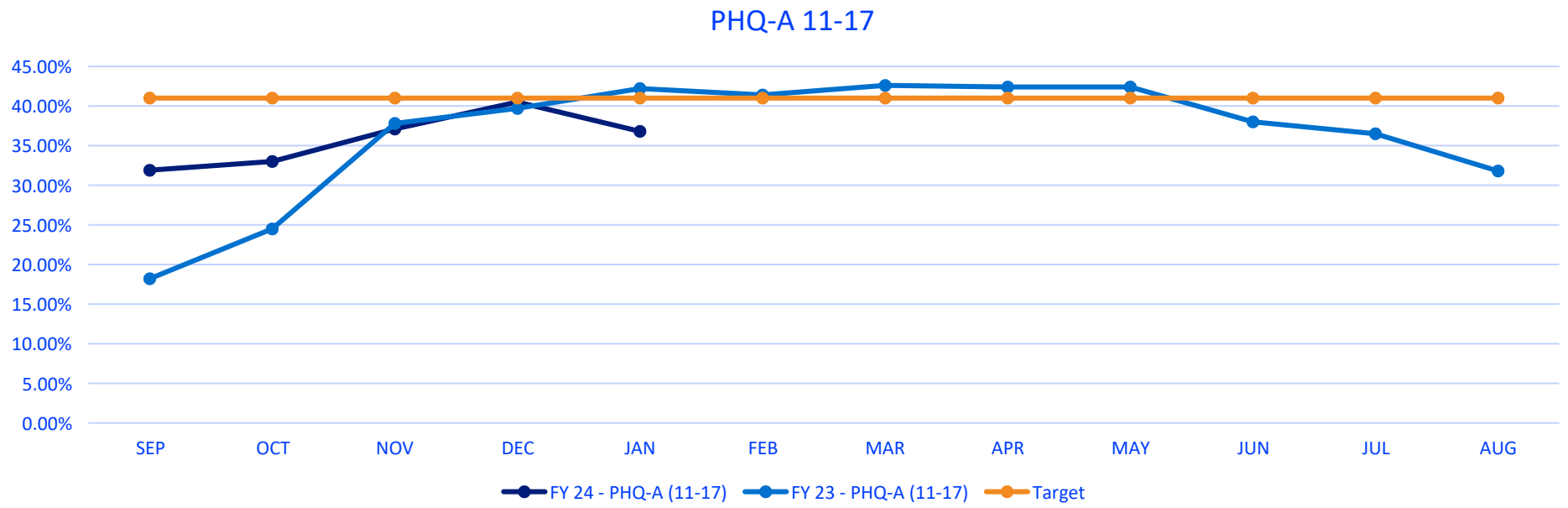
Measures	2024 Fiscal Year Target	2024Fiscal Year Average (Sept - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Time on Diversion (in hours: Adult)	N/A	7.28%	12.96%	N/A	Contractual
Time on Diversion (in hours: Youth)	N/A	22.00%	14.52%	N/A	



Notes:
Although a specific target has not been established for this measure, the overarching objective is to increase the number of at-risk individuals, both youths and adults, being channeled into the diversion program. This program provides support services designed to foster behaviors that are non-criminal in nature.

By doing so, it aims to mitigate the risk of criminal behavior and promote positive societal engagement among these individuals. This strategy underscores the importance of preventive measures and early intervention in addressing potential behavioral issues. It also highlights the role of support services in facilitating behavioral change and reducing the likelihood of criminal activities. The effectiveness of this approach, however, would need to be evaluated through ongoing monitoring and assessment.

Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept. - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Effective Care	PHQ-A (11-17)	41.27%	36.80%	36.50%	Increase	IOS



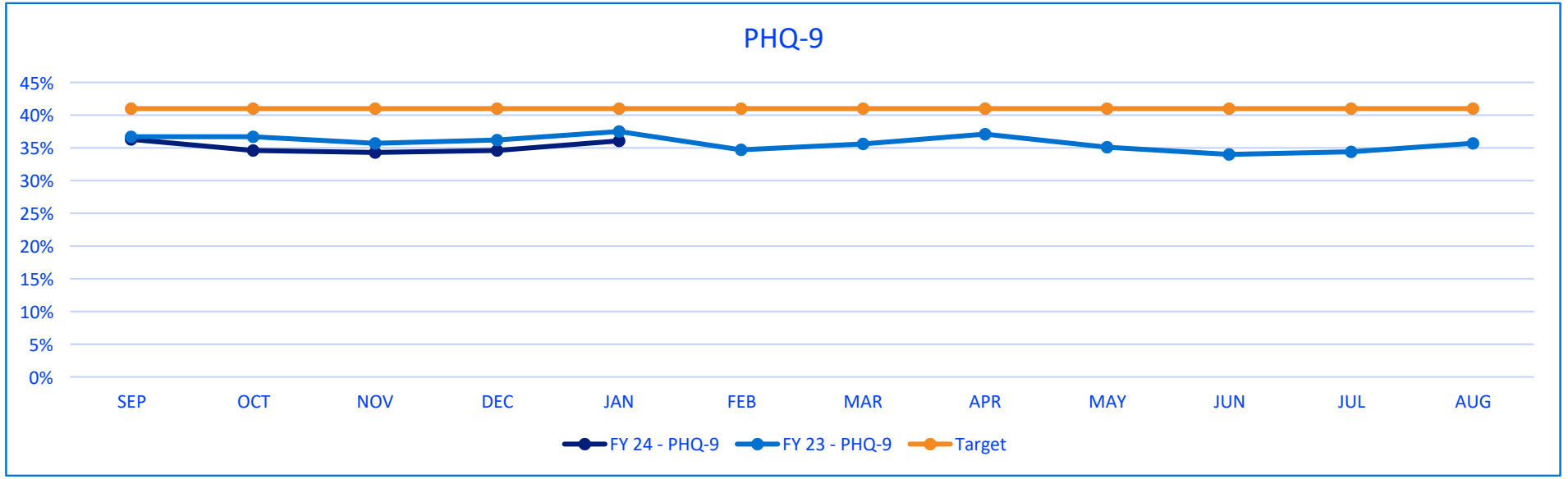
Notes:

- PHQ-A percentage of adolescent and young adult with improve PHQ-A score has fallen below the target for new patient. Leadership is exploring improvement opportunities

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 - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Effective Care	PHQ-9	41.27%	35%	36%	Increase	IOS



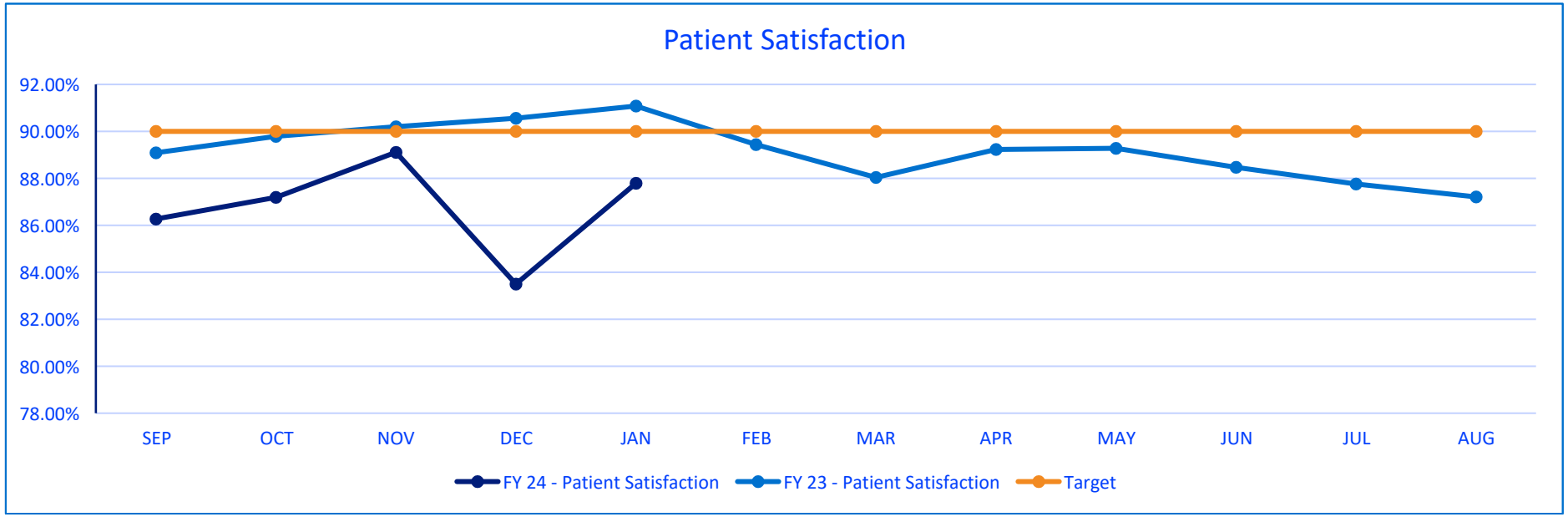
Notes:

- 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, patients have reported lower scores in FY24. When compared to the previous period, patients have reported 3.81% decrease in their overall mental health in the last 14 days prior to their medical appointments

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 - Jan)	Reporting Period- January	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	91%	87.26%	88%	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 meticulously 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.