

Quality Committee Meeting
September 16, 2025
11:00 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, August 19, 2025
(EXHIBIT Q-1)

IV. REVIEW AND COMMENT

- A. Board Scorecard
(EXHIBIT Q-2 Trudy Leidich)
- B. Zero Suicide Awareness Month
(EXHIBIT Q-3 Tiffany Bittner)

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 Code Section 161.032, Texas Occupations Code Sec. 160.007 and Texas Occupations Code Section 151.002 and 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, Kia Walker, Chief Nursing Officer, and Trudy Leidich, Vice President of Clinical Transformation & Quality.

• Report by the Senior Director of Pharmacy regarding the Quality of Healthcare pursuant to Texas Health Code Section 161.032, Texas Occupations Code Sec. 160.007 and Texas Occupations Code Section 151.002 and to receive peer review and/or a report in connection with the evaluation of the quality of healthcare services. Dr. Holly Cumbie, Senior Director of Pharmacy Programs 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
Jeremy Lankford, M.D. Chairman
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, AUGUST 19, 2025
MINUTES

Dr. J. Lankford, Board Chair, called the meeting to order at 11:00 a.m. in the Room 109, 9401 Southwest Freeway, noting that a quorum of the Committee was present.

RECORD OF ATTENDANCE

Committee Members in Attendance: Dr. R. Gearing, Dr. K. Bacon, Dr. J. Lankford

Committee Member Absent:

Other Board Member in Attendance:

1. CALL TO ORDER

Dr. J. Lankford called the meeting to order at 11:00 a.m.

2. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

3. DECLARATION OF QUORUM

Dr. Lankford declared a quorum was present.

4. PUBLIC COMMENT

5. Approve the Minutes of the Board of Trustees Quality Committee Meeting Held on Tuesday, July 15, 2025

MOTION BY: GEARING

SECOND BY: BACON

With unanimous affirmative votes,

BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday July 15, 2025 as presented under Exhibit Q-1, are approved.

6. REVIEW AND COMMENT

- A. Board Score Card** -The Board Score Card presented by Luc Josaphat and Lance Britt to the Quality Committee.

7. EXECUTIVE SESSION-

Dr. Lankford announced the Quality Committee would enter into executive session at 11:25am 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, Kia Walker, Chief Nursing Officer, and Trudy Leidich, Vice President of Clinical Transformation & Quality

8. RECONVENE INTO OPEN SESSION-

The Quality Committee reconvened into open session at 12:15 p.m.

9. CONSIDER AND TAKE ACTION AS A RESULT OF EXECUTIVE SESSION

The Quality Committee did not take action after Executive Session.

10. ADJOURN

MOTION: BACON SECOND: GEARING

There being no further business, the meeting adjourned at 12:15 p.m.

Veronica Franco, Board Liaison
 Jeremy Lankford, M.D. Chairman
 Quality Committee
THE HARRIS CENTER *for* Mental Health *and* IDD
 Board of Trustees

EXHIBIT Q-2

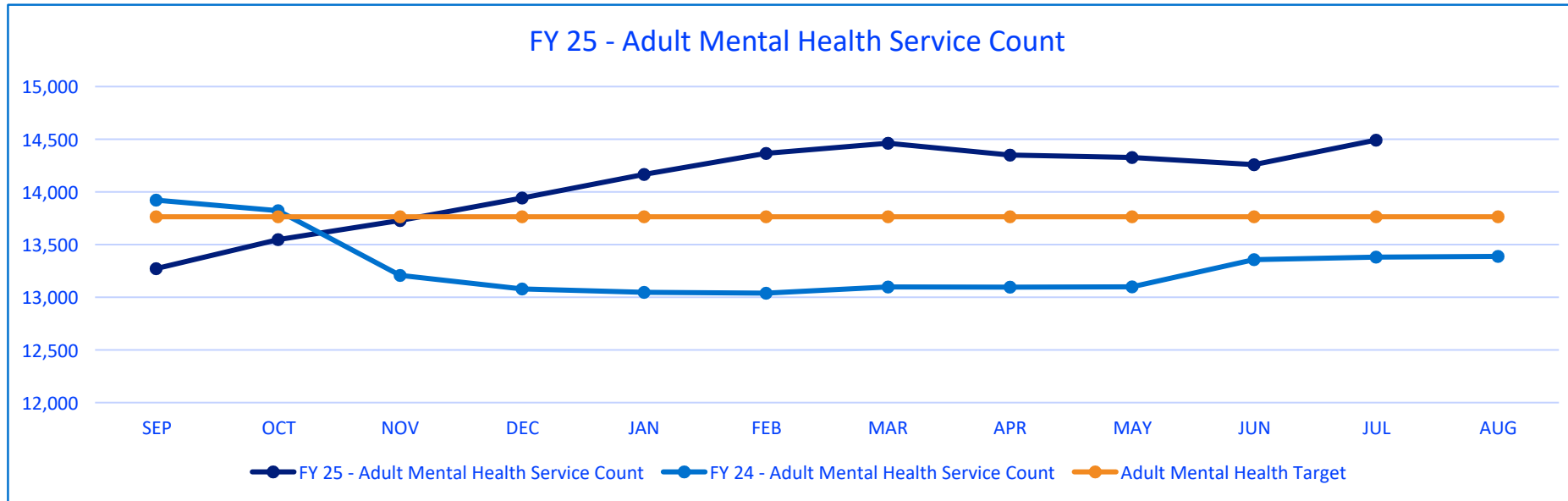
Quality Board Scorecard

Board Quality Committee Meeting

Presented by: Trudy Leidich, MBA, RN
VP of Clinical Transformation and Quality
September 2025 (Reporting July 2025 Data)



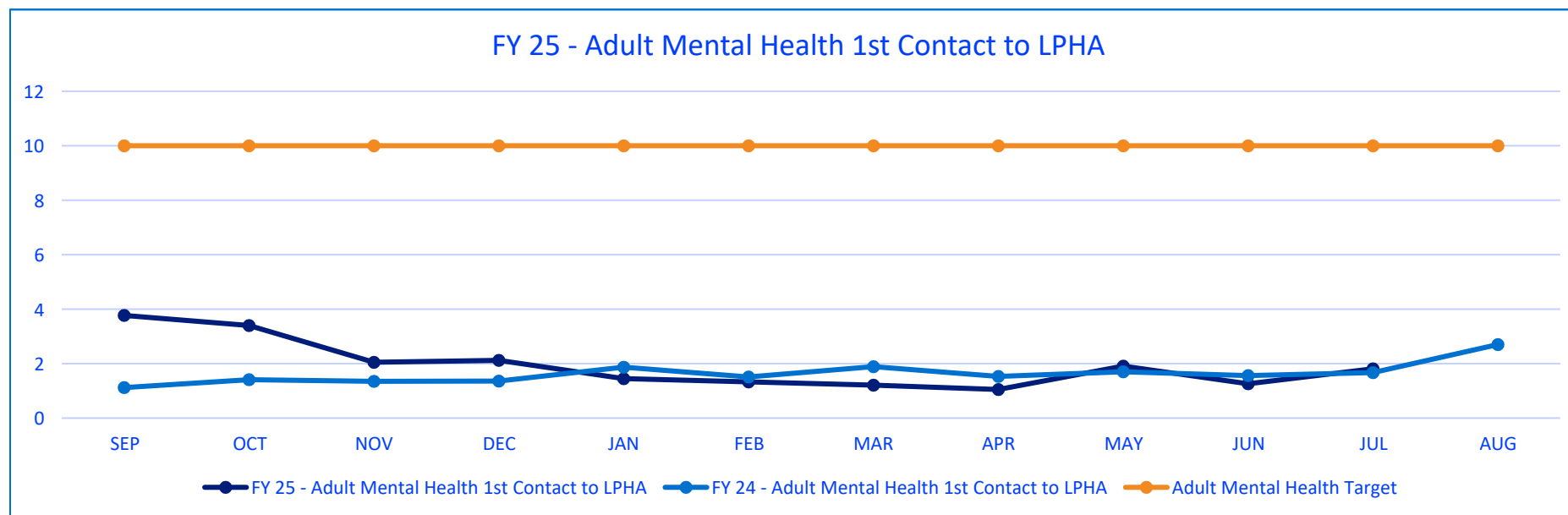
Domain	Program	2025 Fiscal Year State Service Care Count Target	2025 Fiscal Year State Care Count Average (September – July)	Reporting Period: July	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	14,042	14,492	Increase	Contractual



Overall Trend:

- **For the reporting period:** Care count increased by 8.30% in the number of services provided in July FY 25 (14,492) compared to (13,381) July FY 24.
- **FY 25 Performance:** The service count average for FY 25 (14,083) is higher than the average service count for FY 24 (13,295)

Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September – July)	Reporting Period- July	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Contact to LPHA	<10 days	1.94 Days	1.81 Days	Decrease	Contractual

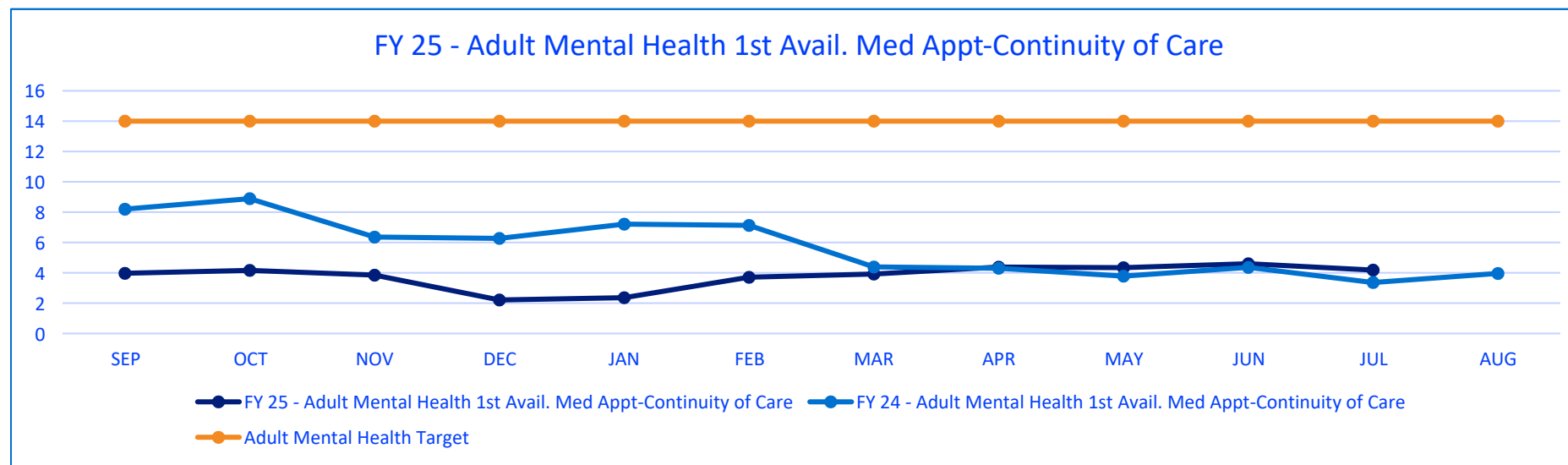


Notes:

The first contact to LPHA (Licensed Professional of the Healing Arts) in the reporting period is 8.30% higher at 1.81 days compared to 1.67 days in July 2024 but still exceeding the 10.00 days target.

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

Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September – July)	Reporting Period: July	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Continuity of Care	<14 days	3.79 days	4.18 days	Decrease	Contractual

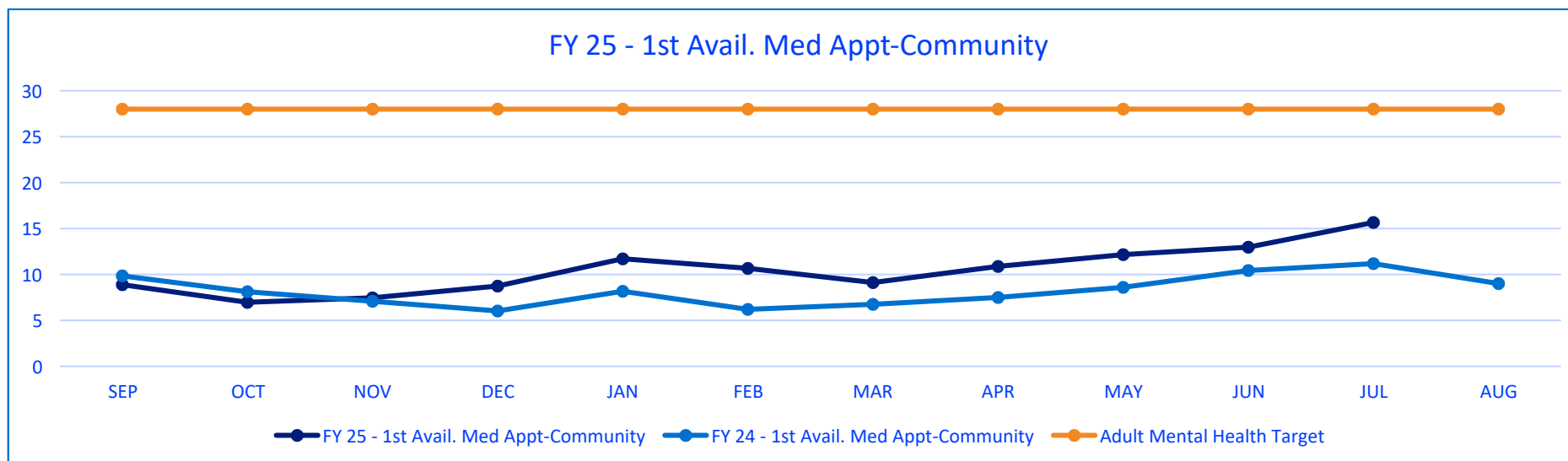


Notes:

There was a marginal increase in the time taken for the first available medical appointment for continuity of care when comparing July FY 24 to July FY 25. However, the measure exceeds the target of 14.00 days, demonstrating that the service is performing efficiently and exceeding expectations.

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

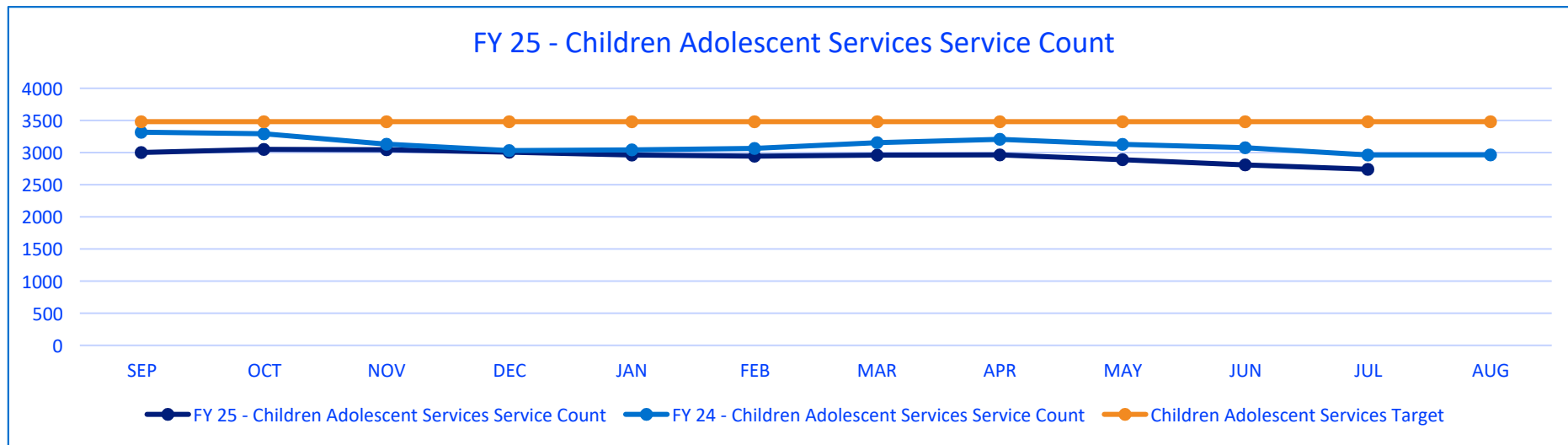
Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September-July)	Reporting Period-July	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Community Members	<28 days	10.48 days	15.66 days	Decrease	Contractual

**Notes:**

The time taken for the first available medical appointment in the community continues to perform well. The average days for Adult Mental Health 1st Avail. Medical Appt-Community Members of 15.66 days exceed the target of 28.00 days, demonstrating that the service is performing well and providing timely access to medical appointments.

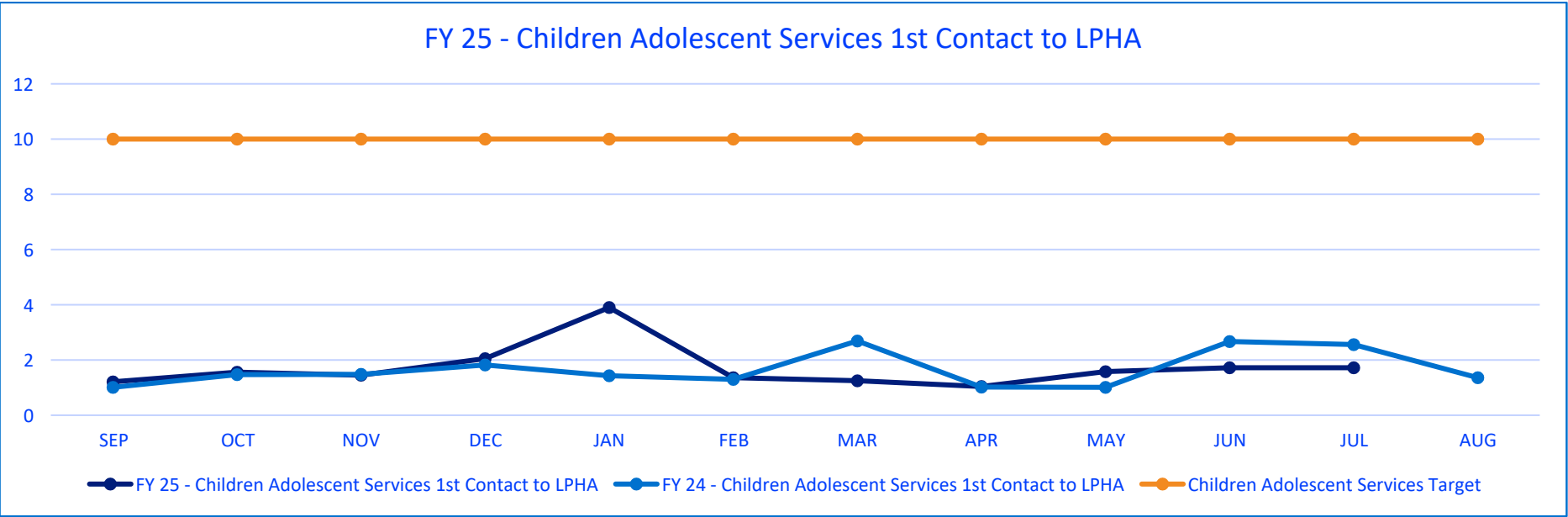
Measure Definition: Adult - Time between MD Intake Assessment for community members walk-ins (Community Members (walkings)). From Appt Creation Date and MD Intake Assessment (Community Members (walkings)) Appt Completion Date

Domain	Program	2025 Fiscal Year State Care Count Target	2025 Fiscal Year State Care Count Average (September – July)	Reporting Period- July	Target Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	2,943	2,740	Increase	Contractual

**Notes:**

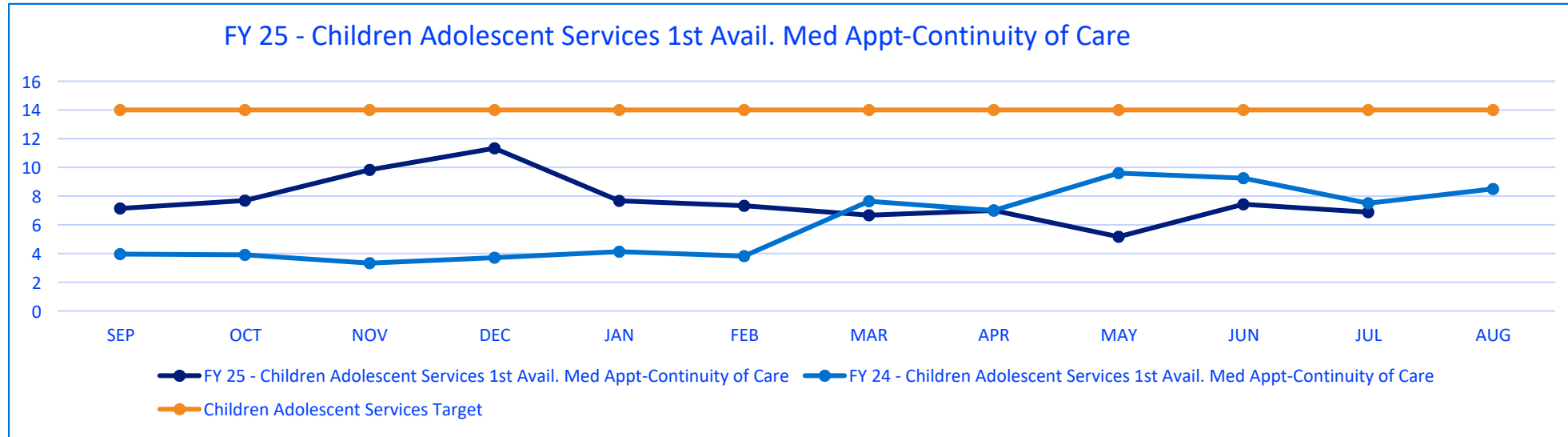
There was an 7.53% decrease in the number of services provided in this reporting period (FY 25) compared to FY 24 to date. A process improvement workgroup is working to improve this measure

Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September - July)	Reporting Period- July	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Contact to LPHA	<10 days	1.71 days	1.72 days	Decrease	Contractual



Notes:
First contact to LPHA (Licensed Professional of the Healing Arts) continues to perform well (1.72 days) and exceeding 10 days target. This suggests that the service is operating efficiently within the target range.

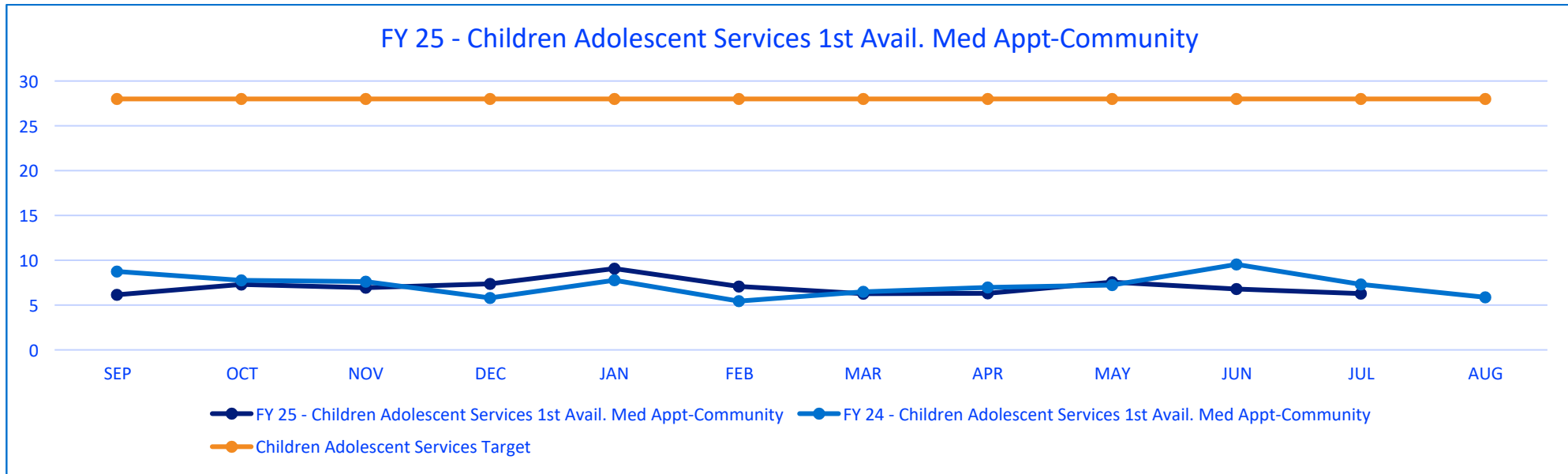
Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September - July)	Reporting Period- July	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Continuity of Care	<14 days	7.65 days	6.88 days	Decrease	Contractual

**Notes:**

The time taken for the first available medical appointment for continuity of care in FY 25, at 6.88 days for this reporting period, continues to exceed the 14 days target. Showing that consumers are seen by a medical provider in a timely manner.

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

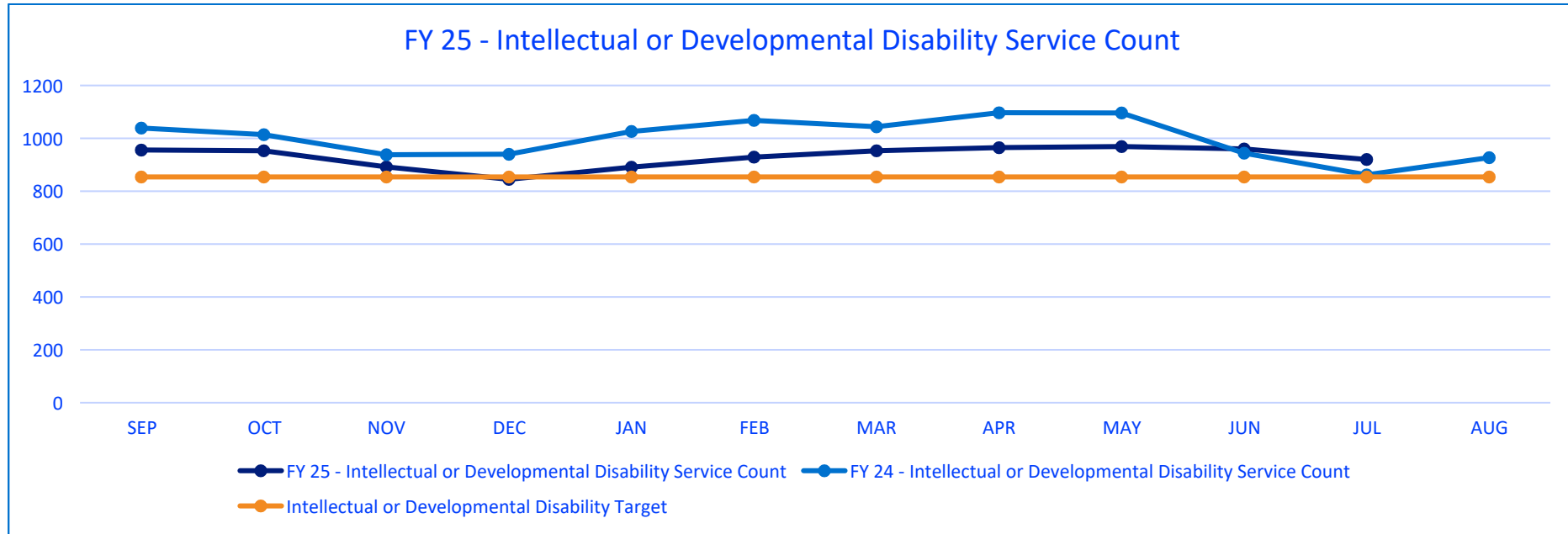
Domain	Program	2025 Fiscal Year Target	2025Fiscal Year Average (September – July)	Reporting Period-July	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Community	<28 days	7.01 days	6.28 days	Decrease	Contractual

Notes:

Children & Adolescent Services 1st Avail. Medical Appt-Community continue to exceed the target of 28 days.

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

Domain	Program	2025 Fiscal Year State Count Target	2025 Fiscal Year State Count Average (September – July)	Reporting Period- July	Target Desired Direction	Target Type
Access	IDD	854	930	920	Increase	Contractual

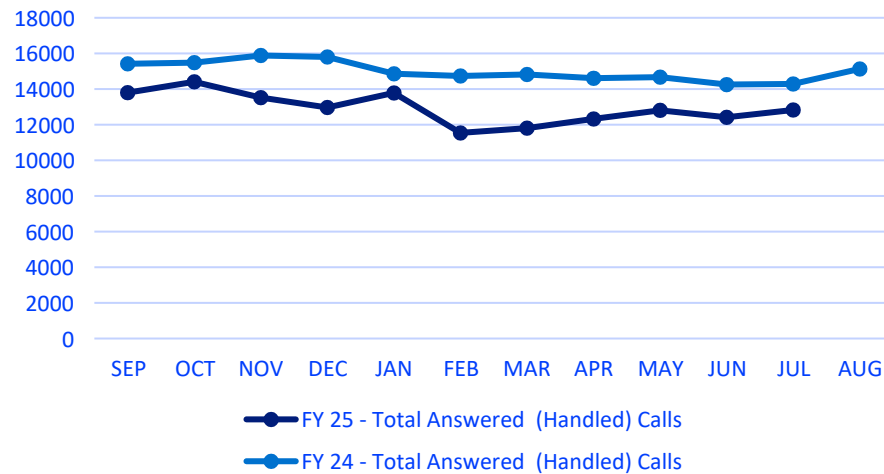
**Notes:**

- The IDD division service care count is at 920 for this reporting period

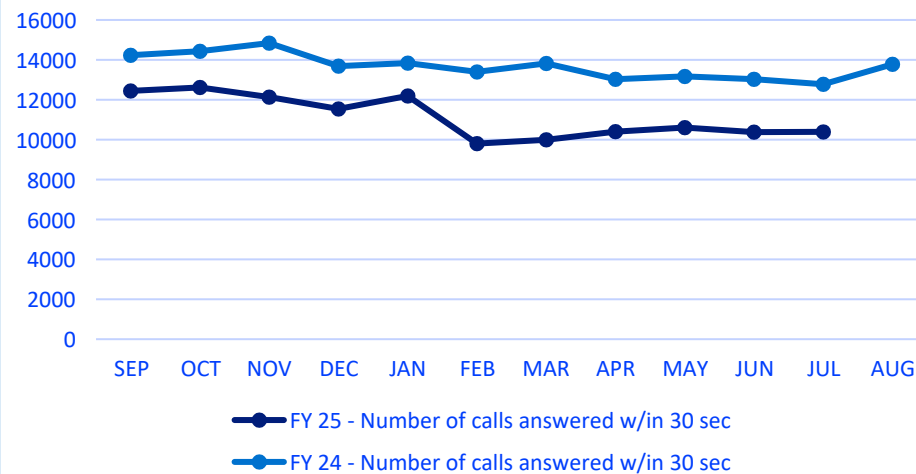
Measure definition: # of IDD Target served based on all reported encounter data. (includes encounters that are associated with CARE assignment codes when the service is performed outside of a waiver. Exceptions are for service coordination that is only included for the indigent population and R019 which is included regardless of waiver status.)

Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Average (September - July)	Reporting Period- July	Target Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	12,927	12,826	Increase	N/A
	Number of calls answered w/in 30 secs	N/A	11,137	10,392	Increase	Contractual

FY 25 - Total Answered (Handled) Calls

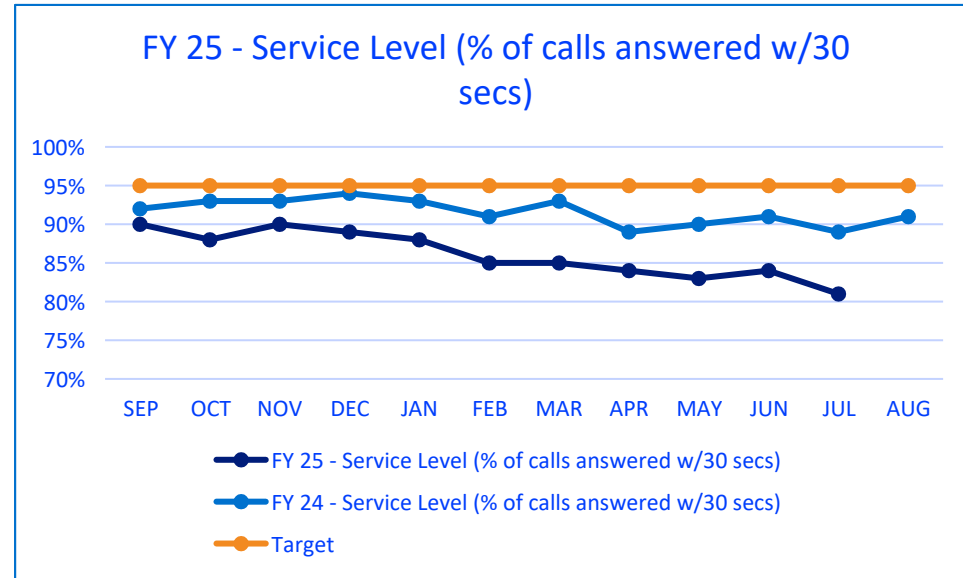
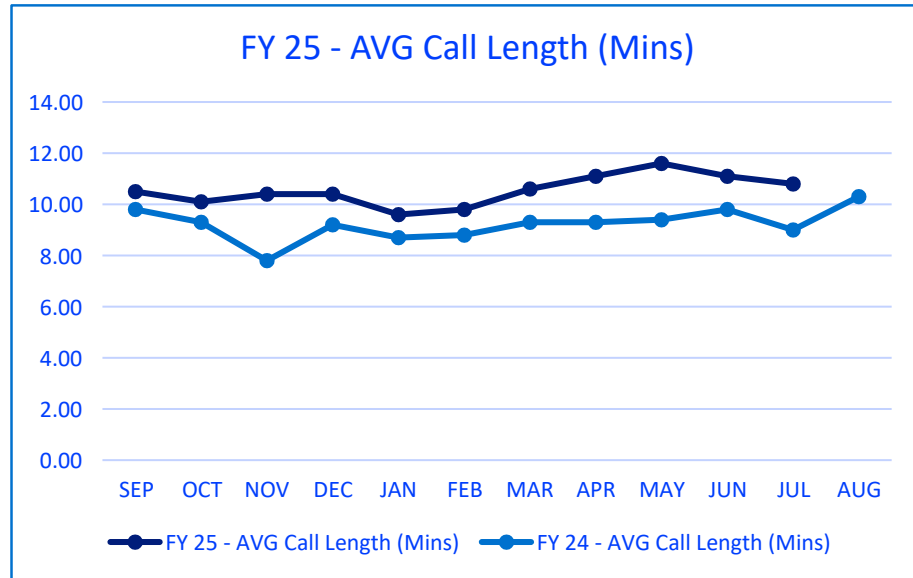


FY 25 - Number of calls answered w/in 30 sec

Notes:

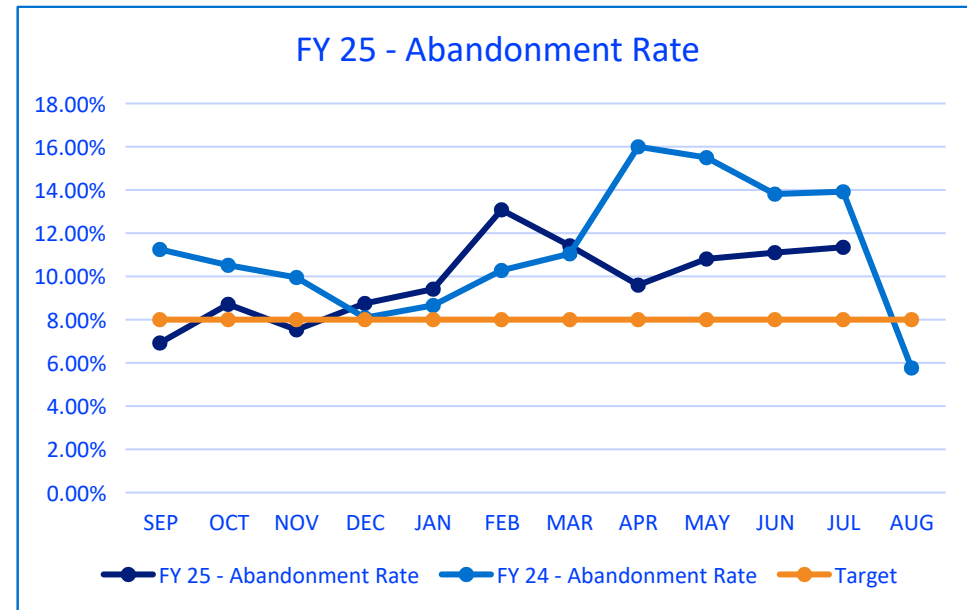
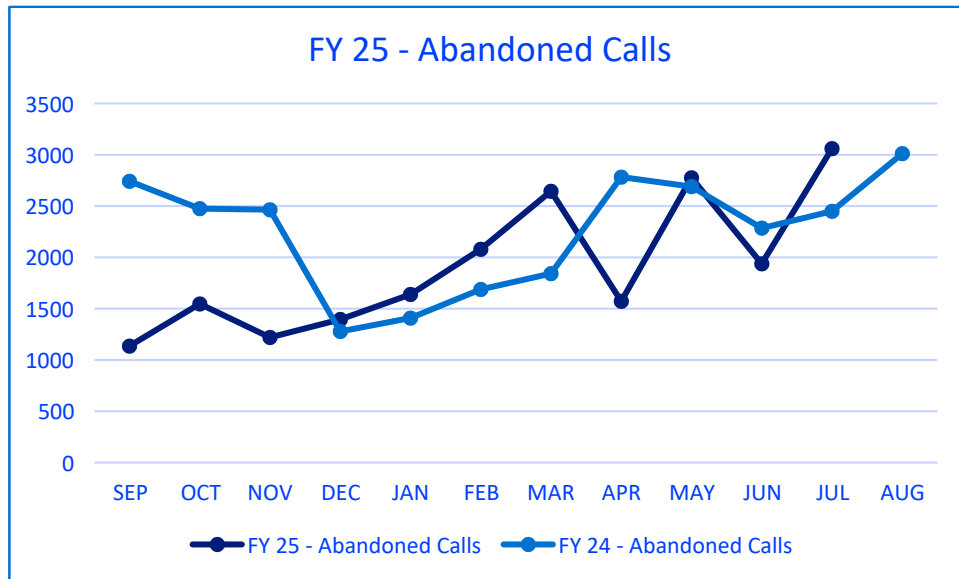
- Team is working on the Crisis measures, which will include targets, industry standard benchmarks, trending challenges due in October reporting

Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Average (September - July)	Reporting Period- July	Target Desired Direction	Target Type
Timely Care	AVG Call Length (Mins)	N/A	10.55	10.80	N/A	Contractual
	Service Level (% of calls answered w/30 secs)	>95%	86.00%	81%	Increase	Contractual

**Notes:**

- Team is working on the Crisis measures, which will include targets, industry standard benchmarks, trending challenges due in October reporting

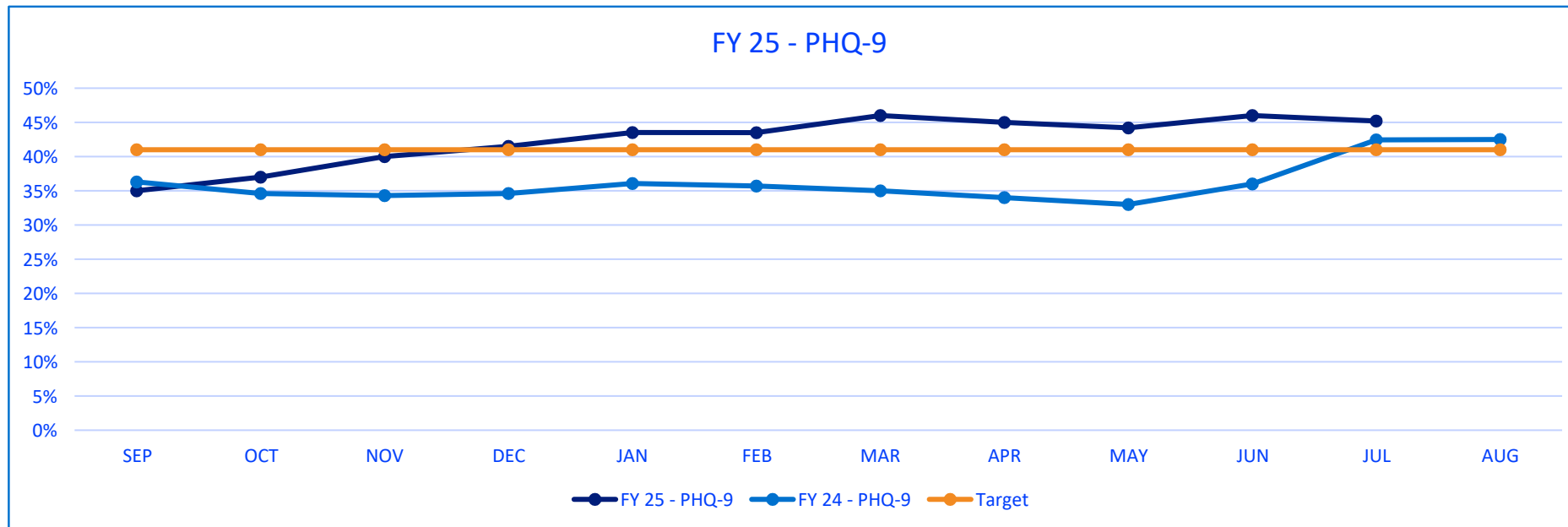
Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Average (September - July)	Reporting Period- July	Target Desired Direction	Target Type
Timely Care	Abandoned Calls	N/A	1,910	3,061	Decrease	Contractual
	Abandonment Rate	<8%	10.00%	11.35%	Decrease	Contractual



Notes:

- Team is working on the Crisis measures, which will include targets, industry standard benchmarks, trending challenges due in October reporting

Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Average (September – July)	Reporting Period- July	Target Desired Direction	Target Type
Effective Care	PHQ-9	41.27%	42%	45.00%	Increase	IOS



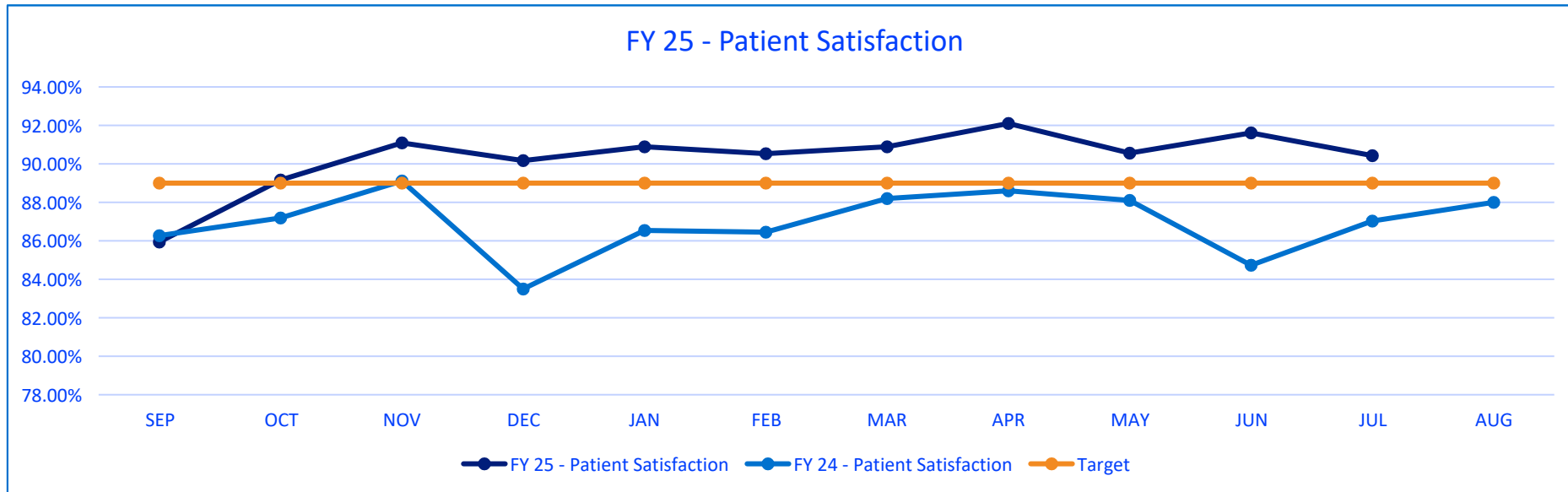
Notes:

- There was an increase in the adult PHQ-9 (Patient Health Questionnaire-9) with low score comparing July FY 24 to July FY 25.

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)	2025 Fiscal Year Target	2025Fiscal Year Average (September - July)	Reporting Period- July	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	89%	90.00%	90.43%	Increase	IOS

**Notes:**

For the reporting period Patient satisfaction exceeded the target, showing improvement over the same FY 24. Overall, patient satisfaction in FY 25 shows a positive trend.

Measure in red > 3 Months

			APR	MAY	JUN	JUL	FY24 AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY25 AVG	FY25 Target	Target Type	Data Origin
Access to Care																							
CAS Service Target			3,206	3,128	3,083	2,963	2,965	3,001	3,050	3,039	3,005	2,964	2,947	2,961	2,965	2,889	2,810	2,740		2,943	3,481	C	MBOW
CAS Actual Service Target %			92.10%	89.86%	88.56%	85.12%	85.18%	86.21%	87.62%	87.30%	86.33%	85.15%	84.66%	85.06%	85.18%	82.99%	80.72%	78.71%		84.54%	100.00%	C	MBOW

- **CAS Service target:** CAS Team has a workgroup in the process for improving care counts and service target. New strategies have been implemented including outreach at local community organizations, schools and other programs that serve CAS population

			APR	MAY	JUN	JUL	FY24 AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY25 AVG	FY25 Target	Target Type	Data Origin
Access to Care, Crisis Line																							
Service Level			89.00%	90.00%	91.00%	89.00%	91.00%	90.00%	88.00%	90.00%	89.00%	88.00%	85.00%	85.00%	84.00%	83.00%	84.00%	81.00%		86.09%	95.00%	C	Brightmetric
Abandonment Rate			16.00%	15.50%	13.81%	13.92%	5.77%	6.92%	8.71%	7.53%	8.75%	9.41%	13.08%	11.42%	9.60%	10.81%	11.10%	11.35%		9.88%	< 8.00%	NS	Brightmetric

- The Crisis team plans to present a detailed recovery plan with KPIs and timelines at the October board meeting.

Appendix

Board of Trustee's PI Scorecard



Target Status: Green = Target Met Red = Target Not Met Yellow = Data to Follow No Data Available

	APR	MAY	JUN	JUL	FY24 AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY25 AVG	FY25 Target	Target Type	Data Origin
Access to Care																					
Adult Service Target	13,096	13,099	13,380	13,381	13,388	13,272	13,547	13,720	13,942	14,178	14,375	14,462	14,363	14,327	14,269	14,492		14,086	13,764	C	MBOW
AMH Actual Service Target %	95.15%	95.17%	97.21%	97.22%	97.27%	96.43%	98.42%	99.68%	101.29%	103.01%	104.44%	105.70%	104.35%	104.09%	103.67%	105.29%		102.40%	100.00%	C	MBOW
CAS Service Target	3,206	3,128	3,083	2,963	2,965	3,001	3,050	3,039	3,005	2,964	2,947	2,961	2,965	2,889	2,810	2,740		2,943	3,481	C	MBOW
CAS Actual Service Target %	92.10%	89.86%	88.56%	85.12%	85.18%	86.21%	87.62%	87.30%	86.33%	85.15%	84.66%	85.06%	85.18%	82.99%	80.72%	78.71%		84.54%	100.00%	C	MBOW
IDD Service Target	1097	1096	943	858	927	956	953	892	839	901	928	945	972	969	966	920		931	854	SP	MBOW
IDD Actual Service Target %	128.45%	128.34%	110.42%	100.47%	108.55%	111.94%	111.59%	104.50%	98.24%	105.50%	108.67%	110.66%	113.82%	113.47%	113.11%	107.73%		109.02%	100.00%	C	MBOW
CW CAS 1st Contact to LPHA	1.02	1.01	2.67	2.56	1.36	1.21	1.56	1.45	2.05	3.90	1.36	1.25	1.04	1.58	1.74	1.72		1.71	<10 Days	NS	Epic
CW AMH 1st Contact to LPHA	1.53	1.70	1.56	1.67	2.70	3.77	3.40	4.21	4.52	3.81	1.33	1.21	1.05	1.91	1.26	1.81		2.57	<10 Days	NS	Epic
CAS 1st Avail. Med Appt-COC	7.00	9.60	9.25	7.50	8.50	7.14	7.69	9.83	11.33	7.67	7.33	6.67	7.00	5.17	7.50	6.88		7.66	<14 Days	C	Epic
CAS 1st Avail. Med Appt-COM	6.97	7.23	9.54	7.31	5.87	6.15	7.30	6.94	7.26	9.18	7.06	6.19	6.16	7.56	6.84	6.28		6.99	<28 Days	NS	Epic
CAS # Pts Seen in 30-60 Days	3	3	3	1	3	2	0	2	2	18	8	3	0	1	2	5		3.91	<9.18	IOS	Epic
CAS # Pts Seen in 60+ Days	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0		0.00	0	IOS	Epic

CAS Service target: CAS Team has a workgroup in the process for improving care counts and service target

					FY24														FY25	FY25	Target	Data
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	AVG	Target	Type	Origin	
AMH 1st Avail. Med Appt-CO	4.30	3.78	4.36	3.36	3.96	3.97	4.16	3.85	4.91	4.32	3.71	3.92	4.38	4.34	4.62	4.18		4.21	<14 Days	C	Epic	
AMH 1st Avail. Med Appt-COM	7.50	8.60	10.43	11.18	9.01	8.89	6.97	7.46	8.76	11.67	10.63	9.16	10.94	12.16	12.77	15.66		10.46	<28 Days	NS	Epic	
AMH # Pts Seen in 30-60 Days	3	2	2	1	4	2	4	5	8	44	61	45	56	78	83	147		48.45	<45	IOS	Epic	
AMH # Pts Seen in 60+ Days	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0		0.18	0	IOS	Epic	
Access to Care, Crisis Line																						
Total Calls Received	18,117	18,190	17,343	17,601	17,447	16,427	17,765	16,196	15,951	17,410	15,899	16,264	16,377	17,758	17,457	18,518		16,911				
AVG Call Length (Mins)	9.30	9.40	9.80	9.00	10.30	10.50	10.10	10.40	10.40	9.60	9.80	10.60	11.1	11.6	11.10	10.80		10.55				
Service Level	89.00%	90.00%	91.00%	89.00%	91.00%	90.00%	88.00%	90.00%	89.00%	88.00%	85.00%	85.00%	84.00%	83.00%	84.00%	81.00%		86.09%	95.00%	C	Brightmetric	
Abandonment Rate	16.00%	15.50%	13.81%	13.92%	5.77%	6.92%	8.71%	7.53%	8.75%	9.41%	13.08%	11.42%	9.60%	10.81%	11.10%	11.35%		9.88%	< 8.00%	NS	Brightmetric	
Occupancy Rate	76.00%	75.00%	76.00%	81.00%	71.00%	78.00%	80.00%	80.00%	76.00%	78.00%	82.00%	83.00%	83.00%	85.00%	85.00%	89.00%		81.73%			Brightmetric	
Crisis Call Follow-Up	100.00%	99.04%	99.67%	99.60%	99.10%	99.28%	99.29%	99.32%	99.58%	100.00%	100.00%	100.00%	99.69%	99.67%	100.00%	99.68%		99.68%	97.36%	IOS	Icarol	
Access to Crisis Resp. Svc.	0.00%	82.40%	83.30%	87.10%	74.70%	79.50%	91.00%	83.30%	87.10%	83.30%	90.00%	85.50%	76.80%	77.60%	87.00%	93.70%		84.98%	52.00%	C	MBOW	
PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours)																						
PES Total Visits	1,183	1,147	1,022	1,143	1,102	1102	1,047	984	944	934	1,036	1,081	1,017	1,044	1,063	1,139		1036				
PES Admission Volume	496	485	429	448	449	494	453	430	419	419	452	455	460	499	431	471		453.00				
Mechanical Restraints	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0		0.09				
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	0.00	0.00	0.00		0.00	≤ 0.01	IOS	Epic	
Personal Restraints	39	31	26	25	37	30	26	39	39	23	56	38	46	48	47	36		38.91			Epic	
Personal Restraint Rate						1.23	2.02	3.15	3.86	2.19	4.34	2.99	3.67	3.13	3.41	2.84		2.98	≤ 2.80	IOS	Epic	
Seclusions	39	26	20	32	29	29	20	27	32	18	49	33	42	41	35	31		32.45			Epic	
Seclusion Rate						1.19	1.62	2.18	3.25	1.71	3.86	2.59	3.35	2.68	2.54	2.45		2.49	≤ 2.73	SP	Epic	
AVG Minutes in Seclusion	39.54	35.36	49.40	66.58	91.19	92.07	27.48	42.59	43.67	42.00	56.61	47.00	82.57	46.93	43.14	60.68		53.16	≤ 61.73	IOS	Epic	
Emergency Medications	38	33	27	18	32	32	31	18	35	20	38	34	28	38	33	37		31.27			Epic	
EM Rate	2.30	1.07	1.78	1.01	0.96	1.31	1.55	1.45	2.26	2.60	2.91	3.05	2.13	2.48	2.39	2.92		2.28	≤ 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%	100.00%	100.00%		100.00%	100.00%	IOS	Epic	

			APR	MAY	JUN	JUL	FY24 AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY25 AVG	FY25 Target	Target Type	Data Origin
Patient Satisfaction (Based on the Two Top-Box Scores)																							
CW Patient Satisfaction			88.60%	88.10%	84.73%	87.03%	85.98%	86.66%	89.16%	91.09%	90.17%	90.89%	90.53%	90.89%	92.10%	90.56%	91.61%	90.43%		90.37%	90.00%	IOS	Feedtrail
Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement)																							
QIDS-C			25.36%	25.99%	26.52%	27.36%	27.94%	23.16%	22.60%	25.19%	26.60%	26.35%	27.20%	27.99%	28.66%	29.11%	30.30%	31.54%		27.15%	24.00%	IOS	MBOW
BDSS			29.87%	30.16%	30.85%	31.50%	31.80%	24.64%	27.39%	28.14%	28.19%	27.93%	28.09%	29.25%	30.27%	31.29%	31.98%	32.53%		29.06%	32.00%	IOS	MBOW
PSRS			35.81%	36.64%	36.96%	37.94%	38.50%	33.33%	34.48%	33.78%	33.12%	33.94%	34.42%	35.12%	36.75%	38.00%	38.79%	40.26%		35.64%	35.00%	IOS	MBOW
Adult Mental Health Clinical Quality Measures (New Patient Improvement)																							
BASIS-24 (CRU/CSU)			77%	78%	93%	44%	110%	67%	84%	140%	84%	105%	33%	98%	94%	118%	86%	84%		90%	68%	IOS	McLean
QIDS-C			45.60%	48.20%	47.00%	48.50%	44.70%	47.60%	46.90%	52.20%	47.80%	49.20%	50.70%	50.60%	46.70%	50.00%	47.80%	50.70%		49.11%	45.38%	IOS	Epic
BDSS								44.10%	45.30%	47.90%	42.40%	41.60%	46.60%	44.10%	45.80%	46.20%	46.10%	47.38%		45.23%	46.47%	IOS	Epic
PSRS			34.90%	38.60%	40.50%	37.00%	38.80%	41.40%	38.70%	35.80%	35.50%	41.00%	40.10%	40.80%	38.20%	38.50%	36.00%	39.85%		38.71%	37.89%	IOS	Epic
Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)																							
PHQ-A (11-17)			42.10%	44.60%	44.60%	52.90%	47.00%	35.90%	41.20%	44.50%	43.20%	45.10%	41.00%	44.40%	44.50%	44.30%	48.80%	41.00%		43.08%	41.27%	IOS	Epic
PHQ-9			34.00%	33.00%	36.00%	42.44%	42.50%	35.00%	37.00%	40.00%	41.50%	43.52%	43.50%	46.00%	45.00%	44.20%	46.00%	45.20%		42.45%	41.00%	IOS	Epic
Adult and Child/Adolescent Needs and Strengths Measures																							
ANSA (Adult)			37.38%	38.84%	39.69%	41.44%	42.59%	34.30%	34.60%	35.10%	34.60%	34.40%	34.60%	36.30%	37.70%	39.40%	40.70%	42.10%		36.71%	20.00%	C	MBOW
CANS (Child/Adolescent)			30.13%	32.33%	33.26%	35.97%	36.95%	18.60%	16.60%	15.70%	16.80%	20.40%	22.90%	25.20%	28.60%	30.70%	32.80%	35.00%		23.94%	25.00%	C	MBOW
Adult and Child/Adolescent Functioning Measures																							
DLA-20 (AMH and CAS)			49.20%	47.60%	42.30%	47.40%	44.90%	46.60%	42.20%	42.30%	43.70%	36.10%	43.20%	37.00%	40.50%	41.40%	41.90%	52.50%		42.49%	48.07%	IOS	Epic

Board of Trustee's PI Scorecard Data Key



Access to Care - Strategic Plan Goal #2: To Improve Access to Care

AMH Waitlist	# of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state.
(13,764)	# of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.
Target %	% of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.
AMH Serv. Provision (Monthly)	% of adult patients authorized in a FLOC who received at least 1 face to face or televideo encounter in that month. (Exclusions: Individuals in LOC-1M; Individuals recommended and/or authorized for LOC-1S; Non-Face to Face, GJ modifiers, and telephone contact encounters; <u>partially authorized months and their associated hours</u>)
CAS Waitlist	# of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state.
(3,481)	# of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.
Target %	% of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.
CAS Serv. Provision (Monthly)	% of children and youth patients authorized in a FLOC who received at least 1 face to face or televideo encounter in that month. (Exclusions: Non-Face to Face, GJ modifiers, and telephone contact encounters; <u>partially authorized months and their associated hours; Client months with a change in LOC-A: children and adolescents on extended review</u>)
IDD Service Target (854)	# of ID Target served based on all reported encounter data. (includes encounters that are associated with CARE assignment codes when the service is performed outside of a waiver. Exceptions are for service coordination that is only included for the indigent population and <u>R019 which is included regardless of waiver status.</u>)
%	% of ID Target number served to state target.

LPHA	Children and Youth - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date
LPHA	Adult Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date
LPHA	ALL - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date
Appt-COC	Date
Appt-COM	Completion Date
Days	Date
Days	Children and Youth - # of adolescent patients who completed their MD Intake Assessment Appt at 60+ days from Appt Creation Date
Appt-COC	Adult - Time between MD Intake Assessment (COC) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date
Appt-COM	Adult - Time between MD Intake Assessment (COM) Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date
Days	Adult - # of adult patients who completed their MD Intake Assessment Appt Between 30 - 60 days from Appt Creation Date
Days	Adult - # of adult patients who completed their MD Intake Assessment Appt at 60+ days from Appt Creation Date
Access to Care, Crisis Line - Strategic Plan Goal #2: To Improve Access to Care	
Total Calls Received	# of Crisis Line calls answered (All partnerships and Lifeline Calls)
AVG Call Length (Mins)	Monthly Average call length in minutes of Crisis Line calls (All partnerships and Lifeline Calls)
Service Level	% of Crisis Line calls answered in 30 seconds (All partnerships and Lifeline Calls)
Abandonment Rate	% of unanswered Crisis Line calls which hung up after 10 seconds (All partnerships and Lifeline Calls)
Occupancy Rate	% of time Crisis Line staff are occupied with a call (includes: active calls, documentation, making referrals, and crisis call follow-ups)
Crisis Call Follow-Up	% of follow-up calls that are made within 8 hours to people who were in crisis at time of call
Svc.	% percentage of crisis hotline calls that resulted in face to face encounter within 1 day

Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement) - Strategic Plan Goal #4: To Continuously Improve Quality of Care

QIDS-C	must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = \leq 30% improvement/decrease; Worse = $>$ 30% decrease)
BDSS	must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = \leq 30% improvement/decrease; Worse = $>$ 30% decrease)
PSRS	must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = \leq 30% improvement/decrease; Worse = $>$ 30% decrease)

Care

BASIS-24 (CRU/CSU)	Average of all patient first scores minus last scores (provided at intake and discharge)
QIDS-C	% of all new patient adult clients that have improved psychiatric symptomatology as measured by the QIDS-C. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)
BDSS	% of all new patient adult clients that have improved psychiatric symptomatology as measured by the BDSS. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)
PSRS	% of all new patient adult clients that have improved psychiatric symptomatology as measured by the PSRS. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)

Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement) - Strategic Plan Goal #4: To Continuously Improve Quality of Care

PHQ-A (11-17)	% of new patient child and adolescent clients that have improved depression scores on PHQ. (New Patient = episode begin date w/in 1 year; Must have 14 days between first and last assessments)
DSM-5 L1 CC Measure (6-17)	% of new patient child and adolescent clients that have improved symptomology as measured by the DSM-5 Cross Cutting tool. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)

Adult and Child/Adolescent Needs and Strengths Measures - Strategic Plan Goal #4: To Continuously Improve Quality of Care

ANSA (Adult)	Behaviors, Behavioral Health Needs, Life Domain Functioning, Strengths, Adjustment to Trauma, Substance Use (Assessments at least 90 days apart)
CANS (Child/Adolescent)	% of child and adolescent THC clients authorized in a FLOC that show reliable improvement in at least one following domains: Child Risk Behaviors, Behavioral and Emotional Needs, Life Domain Functioning, Child Strengths, Adjustment to Trauma, and/or Substance Abuse. (Assessments at least 75 days apart)

Adult and Child/Adolescent Functioning Measures - Strategic Plan Goal #4: To Continuously Improve Quality of Care

DLA-20 (AMH and CAS)	% of all THC clients that have improved daily living functionality as measured by the DLA-20 (Must have 30 days between first and last assessments)
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PES Restraint, Se		
PES Total Visits		# of patients interacting with PES services (Includes: intake assessment regardless of admission, triage out, and observation status, PES Clinic)
PES Admission Vol		# of people admitted to PES ((South, North, or CAPES units). Excludes 23/24 hr observation orders or those patients that have been triaged out)
Mechanical Restraints		# of restraints where a mechanical device is used
Rate		# of mechanical restraints/1000 bed hours
Personal Restraints		# of personal restraints
Personal Restraint Rate		# of personal restraints/1000 bed hours
Seclusions		# of seclusions
AVG Minutes in Seclusion		The average number of minutes spent in seclusion
Seclusion Rate		# of seclusions/1000 bed hours
Emergency Medications		# of EM
EM Rate		# of EM/1000 bed hours
Monitoring		% of R/S event documentation which contains all required information in accordance with TAC compliance
Patient Satisfaction (Based on the Two Top-Box Scores) - Strategic Plan Goal #6: Organization of Choice		
CW Patient Satisfaction		% of 2 top box scores (2top box answers on form/total answers given on forms)(average of all sat forms together)
Adult Outpatient		% of 2 top box scores on CPOSS (2top box answers on form/total answers given on forms)(In Clinic Visits - AMH clinics and some CPEP)
Youth Outpatient		% of 2 top box scores on PSS (2top box answers on form/total answers given on forms)(In Clinic Visits - Youth and Adolescent clinics)
V-SSS 2		% of 2 top box scores on VSSS2 (2top box answers on form/total answers given on forms)(All Divisions)
PoC-IP		% of 2 top box scores on PoC-IP (2top box answers on form/total answers given on forms)(CPEP and DDRP)
Pharmacy		% of 2 top box scores on VSSS2 (2top box answers on form/total answers given on forms)(all pharmacies)

Thank you.

EXHIBIT Q-3

Suicide Care Update

FY25 Year in Review

Presented by: Tiffany Bittner, MSN, RN, CPHQ, NE-BC,
PMH-BC
March 18, 2025



Agenda

- Zero Suicide Team
- Suicide Care Pathway Update
- Key Initiatives & Highlights
- Opportunities for Growth & Future Direction

The Harris Center Zero Suicide Team



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Suicide Care Pathway Elements

1	Progression toward pathway adherence	22-Sep	Aug-23	Sep-23	Dec-23	Jan-24	Feb 24 to Dec 24	Jan 25 to May 2025	Jun-25
2	C-SSRS Screening		92.63%	93.31%	96.14%	94.74%	90.63%	92.69%	93.68%
3	Comprehensive Risk Assessment	N/A	73.68%	77.70%	89.42%	89.86%	93.09%	93.67%	91.92%
4	Safety Plans	N/A	N/A	N/A	N/A	88.11%*	92.77%	89.36%	92.21%
5	Calm Assessments	N/A	N/A	N/A	N/A	N/A	N/A	7.26%*	46.72%
6									

- Screening:
 - Initial intake with Columbia Lifetime Tool
 - Rescreening at all clinical visits prompted by BPA (Best Practice Alert)
- Risk Assessment:
 - Same day as positive intake screening
 - Addressed at all prescriber return visits and with any positive screen
 - FY25 Enhancement: Adding templated lethal means access discussion within risk assessment (Phase II of roll out)
- Intervention:
 - Same day safety planning with positive intake assessment
 - Same day review of safety plan with positive assessment of a returning client
 - FY25: Same day access to lethal means counseling documentation and intervention

Key Initiatives: Training Enhancements

- Goal: Provide targeted, role specific suicide care training to clinical staff at The Harris Center as well as define requirements for refresher training
 - Replaced required 4-hour gate-keeper training with an evidence-based 1-hour course to provide targeted training during the time saved
 - Developed and implemented a required "Suicide Skills Enhancement Bundle" training for all QMHP and LPHA (clinical level) staff upon hire
 - CSSRS (Columbia Suicide Severity Rating Scale)
 - Risk Assessment
 - Safety Planning Intervention
 - CALM (Counseling on Access to Lethal Means)
 - Updated the existing Suicide/Homicide training to include key refresher points around required trainings
 - Now required annually for ALL staff
 - Added refresher training requirement to policy and procedure

Key Initiatives: Procedure Updates

- Goal: Optimize current policies and procedures to reflect The Harris Center commitment to evidence-based care with a focus on compassion fatigue through approved standard processes
 - Thorough review and update of current Behavioral Crisis Intervention Procedure to align with The Harris Center commitment to safer suicide care
 - Updated terms and definitions
 - Added suicide care pathway process expectations for crisis and non-crisis divisions
 - Updated documentation expectations
 - Added new, detailed training requirements for onboarding and refresher training
 - Incorporated employee care into procedure for those who have a client die by suicide
 - Approved bereavement day at leadership discretion

Key Initiatives: HCSO Zero Suicide Partnership

- Goal: Work collaboratively toward implementing the Zero Suicide framework within the Harris County Sheriff's Office
- Zero Suicide Principles Training
 - Currently over 4500 HCSO employees have been trained
 - In-person for all new detention officers during orientation
- AS+K Training
 - Evidence based suicide prevention training being taught to incarcerated individuals
 - Set schedule of trainings:
 - WEC: Every 6 weeks
 - Brothers in Arms: Every 6 months
 - Re-entry: scheduling as we go
- Multiple conference presentations
 - 11th Annual Mental Health Conference (Correctional Management Institute of Texas)
 - 2025 Women in Criminal Justice Conference (Correctional Management Institute of Texas)
 - Upcoming: 2026 Women in Criminal Justice Conference

Final Points for Discussion

- High level wins
 - Positive feedback on internal and external messaging
 - Staff feel supported in their own mental health and wellness
 - In the media/multiple speaking engagements
 - LIFE Pathway growth
 - Advances in documentation
 - September events calendar (<https://vimeo.com/1112162564/d3c69f98e3>)
- Opportunities for growth and focus
 - Continued education around meaningful and descriptive documentation in charting
 - Expanding the use of therapeutic methods to treat suicidality
 - Explore enhanced requirements around refresher trainings for suicide care

Thank you.

Appendix A

SEPTEMBER 2025

**SUICIDE PREVENTION
+ NATIONAL RECOVERY MONTHS!**

REMINDERS

Don't forget to take
team photos in your
shirts and enter it into
the photo contest!

The winners will receive
a pizza party!

*Wear jeans every Friday
in September with your
LIVE to Empower shirt!*



MON	TUE	WED	THU	FRI	SAT	SUN
1 Labor Day	2 Main Lobby Kick off of the month at 9401 7 AM to 11 AM	3 6160 Site Visit 10 AM to 1 PM	4	5 Virtual Training by HHS Postvention 10 AM	6	7
8	9 NW Clinic Site Visit 11 AM to 1 PM	10 SE Clinic Site Visit 11 AM to 1 PM	11 Kahoot Suicide Prevention on Teams Noon to 1 PM	12 Navigation Site Visit with staff and clients 10 AM to 2 PM Virtual Training by HHS Language Matters 10:30 AM	13 Unite the Fight 10 AM to 2 PM Independent Park in Pearland 3449 Pearland Parkway, 77581	14
15 SW 6 th Floor 8 AM to 12:30 PM	16 NE Clinic Site Visit 11 AM to 1 PM	17 NPC Site Visit 11 AM to 5 PM	18	19 Virtual Training by HHS Voices of Lived Experience	20	21
22	23	24 Airline Clinic Site Visit 11 AM to 1 PM	25 Kahoot Recovery Month on Teams Noon to 1 PM	26 Virtual Training by HHS The Role of Mindfulness in Suicide Prevention 11 AM	27 Out of Darkness Walk Location: Burke Crenshaw Park - 4950 Burke Rd. Pasadena, TX 9:30 AM Rally for Recovery 10 AM to 2 PM Mabee WholeLife Service Center 1905 Jacquelyn Dr. 77055	28
29	30					

**RECOVERY IS REAL!
#RECOVERYMONTH**