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

Live View: https://theharriscentertx.new.swagit.com/views/834/

October 21, 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, September 16, 2025
(EXHIBIT Q-1)

IV. **CONSIDER AND TAKE ACTION**

A. 2026 PI Plan
(EXHIBIT Q-2 Trudy Leidich)

V. **REVIEW AND COMMENT**

A. Board Scorecard
(EXHIBIT Q-3 Trudy Leidich)

B. Crisis Line and 988 Metric Update
(EXHIBIT Q-4 Luming Li, Jennifer Battle)

VI. ***EXECUTIVE SESSION-***

• As authorized by §551.071 of the Texas Government Code, the Board of Trustees reserves the right to adjourn into Executive Session at anytime during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.

VII. **RECONVENE INTO OPEN SESSION**

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

IX. **ADJOURN**

Veronica Franco

Veronica. Franco, Board Liaison
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, SEPTEMBER 16, 2025 MINUTES

Dr. J. Lankford, Board Chair, called the meeting to order at 11:01 a.m. in the Room 109, 9401 Southwest Freeway, noting that a quorum of the Committee was present.

RECORD OF ATTENDANCE

Committee Members in Attendance: Dr. R, Gearing, Dr. 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 11:01 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   All members present are members of the Quality Committee.

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, September 16, 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 September 16, 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.
   B. **Zero Suicide Awareness Month-**The Zero Suicide Awareness Month presentation was presented by Tiffany Bittner to the Quality Committee.

7. **EXECUTIVE SESSION-**

Dr. Lankford announced the Quality Committee would enter into executive session at 11:21am 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 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

8. RECONVENE INTO OPEN SESSION-

The Quality Committee reconvened into open session at 12:19 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 12:18 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

The Harris Center System Quality, Safety and Experience Performance Improvement Plan FY 2026

Introduction

The Harris Center System Quality, Safety and Experience Performance Improvement Plan FY 2026 Introduction The Quality, Safety, and Experience Plan is established in accordance with The Harris Center's mission to transform the lives of people with behavioral health and IDD needs. The center's vision is to empower people with behavioral health and IDD needs to improve their lives through an accessible, integrated, and comprehensive recovery-oriented system of care. Our values as a center include collaboration, compassion, excellence, integrity, leadership, quality, responsiveness, and safety. The Quality, Safety and Experience Plan has been established to embrace the principles of transparency of measures and outcomes, accurate measurement and data reporting, and personal and collective accountability for excellent outcomes consistent with Certified Community Behavioral Health Clinic standards and the Commission on Accreditation of Rehabilitation Facilities requirements.

Vision

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

Mission

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

FY 2026 Goals

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

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

To ensure alignment with survey readiness as a Certified Community Behavioral Health Clinic (CCBHC) and

Commission on Accreditation of Rehabilitation Facilities (CARF), the System Quality, Safety and Experience plan focuses on indicators related to improving behavioral and physical health outcomes and takes actions to demonstrate improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Plan incorporates continuous quality improvement (CQI) processes to review known significant events.

The Harris Center CQI process is systematic and data-informed, fostering continuous learning and sustainable improvements across programs. The following steps are core to our quality infrastructure and are actively applied in alignment with the SQSE Plan:

Identify Areas for Improvement (Monthly): Regular analysis of performance measures and outcome data highlights targeted opportunities for improvement.
Root Cause Analysis (RCA): Structured RCA is conducted to uncover systemic or process-level gaps that contribute to performance shortfalls.
Action Plan Development: Multi-disciplinary teams create specific, measurable, and time-bound action plans to address root causes.
Implementation via PDSA Cycle: We employ Plan-Do-Study-Act (PDSA) cycles to test, adapt, and spread interventions.
Monitor and Adjust: Ongoing data collection and performance monitoring ensure responsiveness in quality improvement.
Documentation and Knowledge Transfer: Key learnings and outcomes are documented to support organizational learning and replication.
Transparent Communication: Findings and progress are communicated monthly with leadership and front-line teams to promote a culture of accountability and shared ownership.

FY2026 SQSE Priority Initiatives

The SQSE Plan focuses on initiatives that directly contribute to measurable improvements across key health domains. Highlights include:

- Enhanced Workforce Training: Trainings in suicide screening, de-escalation, trauma-informed care, and care management protocols.
- Standardized Clinical Pathways: Development and implementation of clinical care pathways to ensure best practice adherence.
- Law Enforcement Collaboration: Joint training and engagement initiatives focused on identifying and referring individuals with IDD and/or ASD.

Performance Monitoring and Outcomes:

Progress is tracked using established clinical and operational indicators, with monthly reviews conducted by senior leadership. The SQSE goals support the agency's strategic vision and long-term goals through FY2027, including:

- Zero preventable serious safety events
- Reduction in harm events
- Increased access and improved health outcomes
- Enhanced staff and provider engagement
- Improved patient satisfaction (response rates and top-box scores)
- Equity in service delivery

Key Performance Measures: T-CCBHC Selected Quality Measures

- I-Serv- Time to Service
- DEP-REM-6- Depression Remission at Six Months
- Unhealthy Alcohol Use: Screening & Brief Counseling
- Screening for Non-Medical Drivers of Health
- Adult Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Follow-up After Emergency Department Visit for Mental Health

The integrated Continuous Quality Improvement (CQI) and System, Quality, Safety, and Experience (SQSE) Plan reflect our unwavering commitment to delivering exceptional care. This comprehensive framework not only ensures alignment with regulatory requirements but also drives measurable improvements in clinical outcomes, patient experience, and population health. It empowers teams across the organization to continuously enhance care quality and safety, supports frontline innovation, and fosters a culture of excellence. By ensuring that all improvement efforts are data-driven and patient-centered, the plan serves as a vital tool in advancing our mission and sustaining high performance.

To ensure these goals are met, the System Quality, Safety and Experience Committee will:

- Establish a Rigorous Review Process: Implement a systematic review of CQI outcomes to identify areas for improvement and make necessary adjustments to staffing, services, and availability.
- Focus on Key Performance Indicators: Prioritize indicators related to behavioral and physical health outcomes, emergency department use, rehospitalization rates, and crisis episode frequency.
- Involve Medical Leadership: Engage the Medical Director in overseeing the quality of medical care, ensuring effective coordination and integration with primary care services.
- Address Significant Events: Develop protocols to review and respond to critical incidents, including suicides, overdoses, all-cause mortality, and 30-day hospital readmissions.
- Utilize Data-Driven Strategies: Leverage both quantitative and qualitative data to inform CQI activities, with a particular focus on addressing health disparities among minority populations.
- Implement Continuous Monitoring and Reporting: Establish mechanisms for ongoing monitoring, evaluation, and reporting of CQI activities and outcomes to relevant stakeholders and accreditation bodies.
- Adapt and Improve: Use feedback and data analysis to continuously refine and enhance the CQI plan, ensuring it remains responsive to emerging issues and effective in improving overall performance.

Governing Body

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

Leadership

The Harris Center leadership is delegated the authority, via the Board of Trustees, and accountability for executing and managing the organization's quality improvement initiatives. Quality leadership provides the framework for planning, directing, coordinating, and delivering the improvement of healthcare services that are responsive to

both community and patient needs that improve healthcare outcomes. The Harris Center leaders encourage involvement and participation from staff at all levels within all entities in quality initiatives and provide the stimulus, vision, and resources necessary to execute quality initiatives.

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

Professional Review Committee (PRC)

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

- Medical Peer Review
- Pharmacy Peer Review
- Nursing Peer Review
- Licensed Professional Review
- Closed Record Review
- Internal Review Board

System Quality, Safety and Experience Committee Membership:

- Chief Executive Officer (Ex-Officio)
- Chief Medical Officer
- Chief Operating Officer
- Chief Nursing Officer (Co-chair)
- Legal Counsel
- Divisional VPs (CPEP, MH, IDD)
- VP, Clinical Transformation and Quality (Chair)
- Director Risk Management/ERM
- Director of Pharmacy Programs
- Director of Quality Assurance and PI
- Director of Behavioral Health
- Director of Children and Adolescents
- Ad Hoc members as needed

System Quality, Safety and Experience Committee

The Quality Committee of the Board of Trustees has established a standing committee, The System Quality, Safety and Experience Committee to evaluate, prioritize, provide general oversight and alignment, and remove any significant barriers for implementation for quality, safety, and experience initiatives across Harris Center programs. The Committee is composed of Harris Center leadership, including operational and medical staff. The Committee will approve annual system-wide quality and safety goals and review progress. The patient safety dashboard and all serious patient safety events are reviewed. Root Cause Analysis, Apparent Cause Analysis, Failure Modes and Effects Analysis, quality education projects, are formal processes used by the Committee to evaluate the quality and safety of mental projects through The Harris Center's quality training program or other performance improvement training programs are privileged and confidential as part of the Quality, Safety & Experience Committee efforts. The Committee also seeks to ensure that all The Harris Center entities achieve standards set forth by the Commission on Accreditation and Rehabilitation Facilities (CARF) and Certified

Community Behavioral Health Clinic (CCBHC).

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

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

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

- High-risk, high-volume, or problem-prone practices, processes, or procedures
- Identified risk to patient safety and medical/healthcare errors
- Identified in The Harris Center Strategic Plan
- Identified as Evidenced Based or "Best Practice"
- Required by regulatory agency or contract requirements Methodologies
- The Model for Improvement (Appendix B) and other quality frameworks (e.g., Lean, Six Sigma) are used to guide quality improvement efforts and projects
- A Root Cause Analysis (RCA) is conducted in response to serious or sentinel events
- Failure Mode and Effects Analysis (FMEA) is a proactive tool performed for analysis of a high risk process/procedure performed on an as needed basis (at least annually)
- Data Management Approach and Analysis

Data is used to guide quality improvement initiatives throughout the organization to improve safety, treatment, and services for our patients. The initial phase of a project focuses on obtaining baseline data to develop the aim and scope of the project. Evidence-based measures are developed as a part of the quality improvement initiative when the evidence exists. Data is collected as frequently as necessary for various reasons, such as monitoring the process, tracking balancing measures, observing interventions, and evaluating the project. Data sources vary according to the aim of the quality improvement project, examples include the medical record, patient satisfaction surveys, patient safety data, financial data.

Benchmarking data supports the internal review and analysis to identify variation and improve performance. Reports are generated and reviewed with the quality improvement team. Ongoing review of organization wide performance measures are reported to committees described in the Quality, Safety and Experience governance structure.

Reporting

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

Evaluation and Review

At least annually, the Quality, Safety and Experience leadership shall evaluate the overall effectiveness of the Quality, Safety and Experience Plan and program. Components of the plan met, and this document is maintained to reflect an accurate description of the Quality, Safety and Experience program.

The Model for Improvement[1]

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

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

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

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

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

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

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

1 Sources:

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

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

Root Cause Analysis (RCA):
The key to solving a problem is to first truly understand it. Often, our focus shifts too quickly from the problem to the solution, and we try to solve a problem before comprehending its root cause. What we think is the cause, however, is sometimes just another symptom. One way to identify the root cause of a problem is to ask "Why?" five times. When a problem presents itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" again and again until you reach the root cause.

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

Steps in the process
Failure modes (What could go wrong?)
Failure causes (Why would the failure happen?)
Failure effects (What would be the consequences of each failure?)
Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis on prevention may reduce the risk of harm to both patients and staff. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

EXHIBIT Q-3

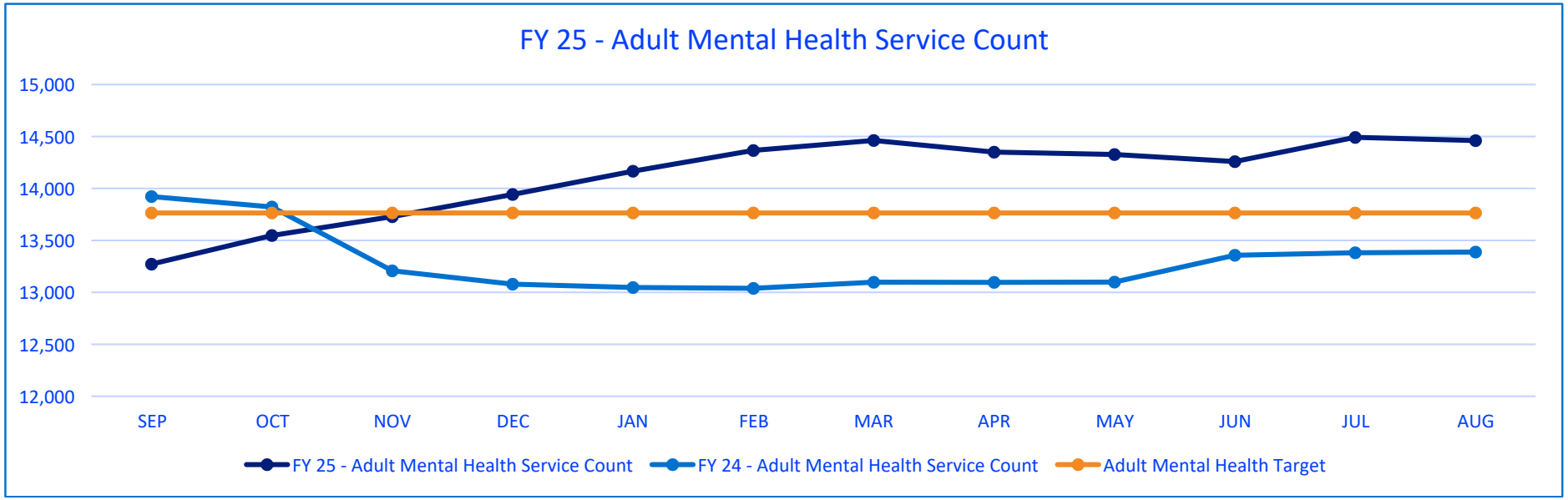
Quality Board Scorecard

Board Quality Committee Meeting

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

October 2025 (Reporting August 2025 Data)

Domain	Program	2025 Fiscal Year State Service Care Count Target	2025 Fiscal Year State Care Count Average (September – August)	Reporting Period: August	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	14,114	14,461	Increase	Contractual

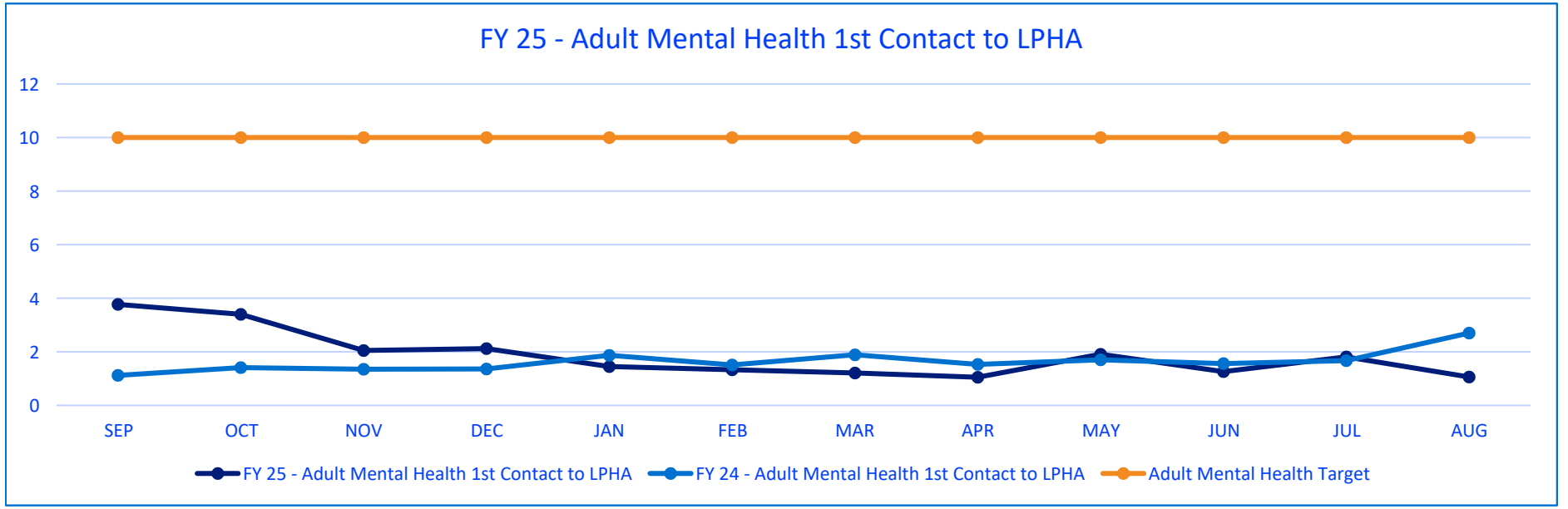


Overall Trend:

- **For the reporting period:** There was an 8.01% increase in the number of services provided in August FY 25 (14,461) compared to (13,388) August FY 24.
- **FY 25 Performance**: The service count average for FY 25 (14,114) is higher than the average service count for FY 24 (13,295)

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

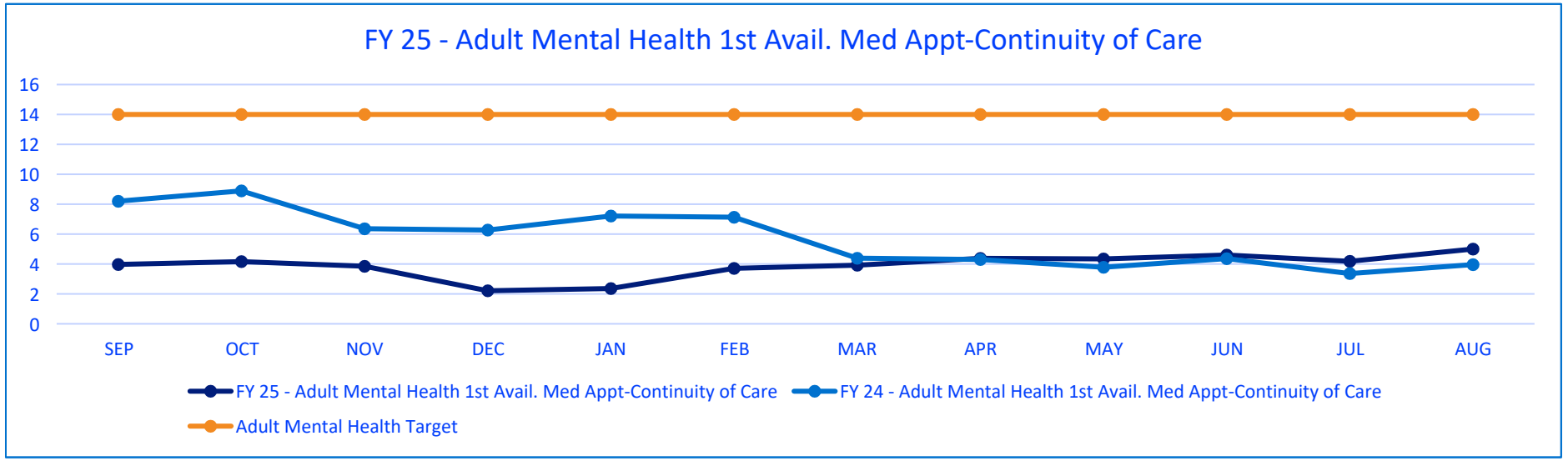
Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September – August)	Reporting Period- August	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Contact to LPHA	<10 days	1.87 Days	1.06 Days	Decrease	Contractual



Notes:
The first contact to LPHA (Licensed Professional of the Healing Arts) in the reporting period is 60.74% lower at 1.06 days compared to 2.70 days in August 2024, exceeding the target of 10.00 days. This suggests this measure is operating efficiently.

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

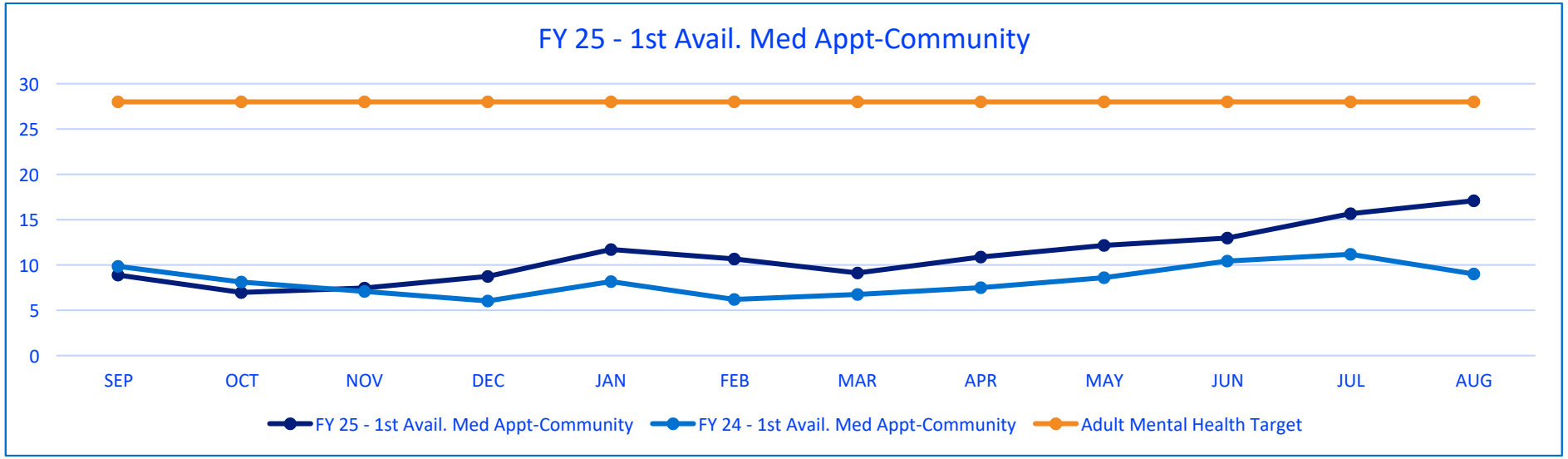
Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September – August)	Reporting Period: August	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Continuity of Care	<14 days	3.89 days	5.00 days	Decrease	Contractual



Notes:
There was a marginal increase in the time taken for the first available medical appointment for continuity of care when comparing August FY 24 to August 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

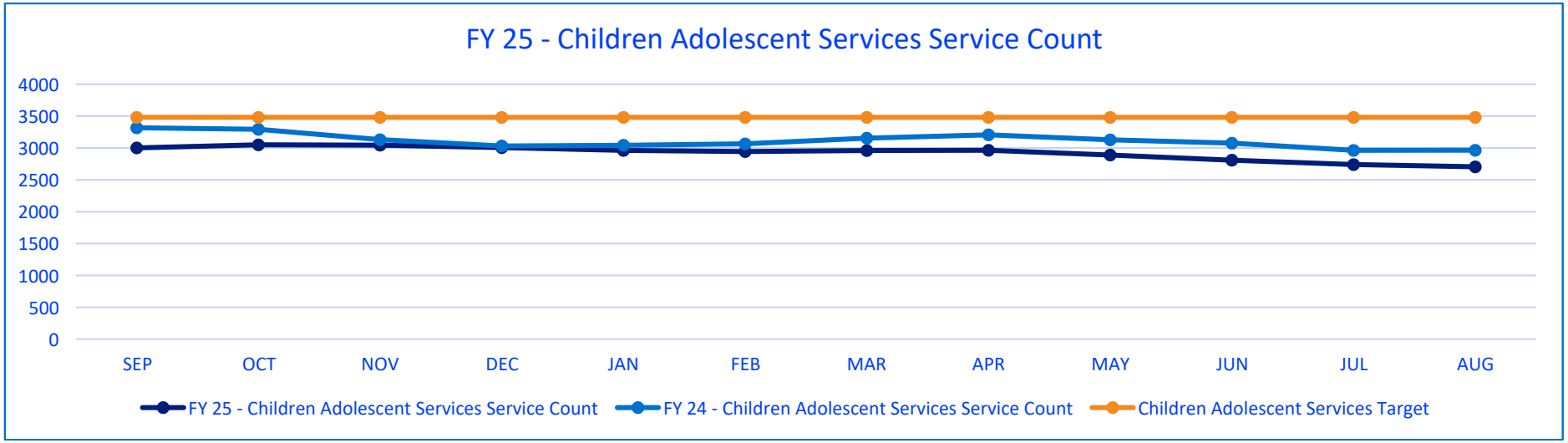
Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September-August)	Reporting Period-August	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Community Members	<28 days	11.03 days	17.09 days	Decrease	Contractual



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 17.09 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

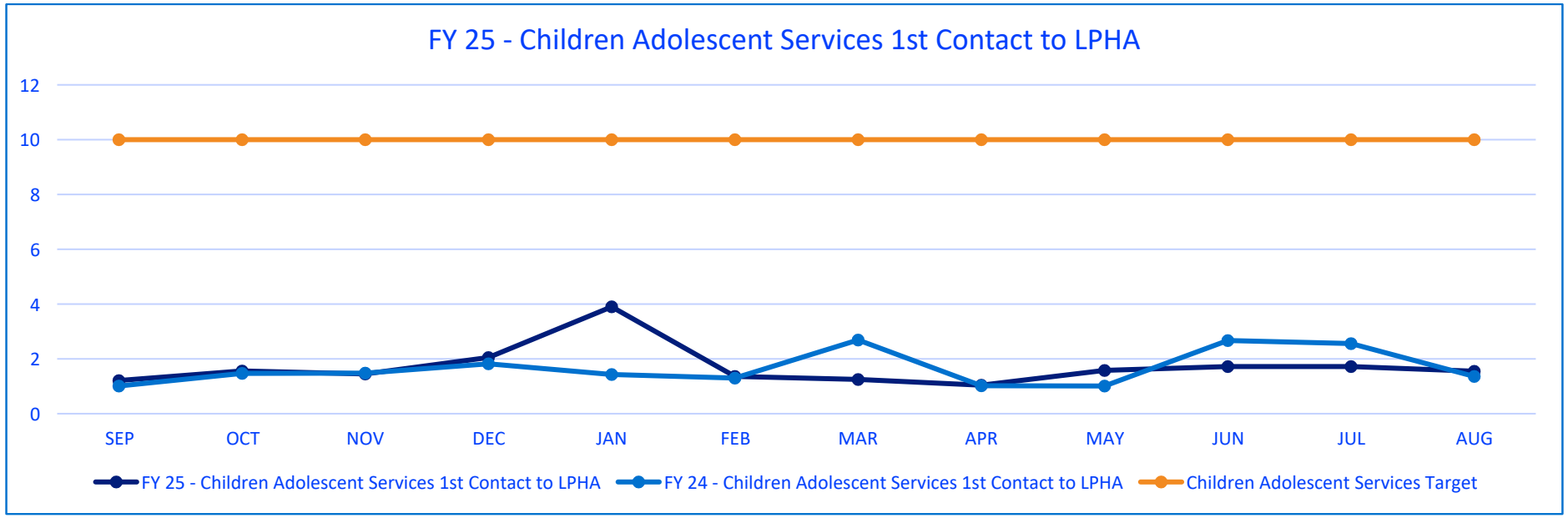
Domain	Program	2025 Fiscal Year State Care Count Target	2025 Fiscal Year State Care Count Average (September – August)	Reporting Period- August	Target Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	2,923	2,705	Increase	Contractual



Notes:
There was an 8.77% 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

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

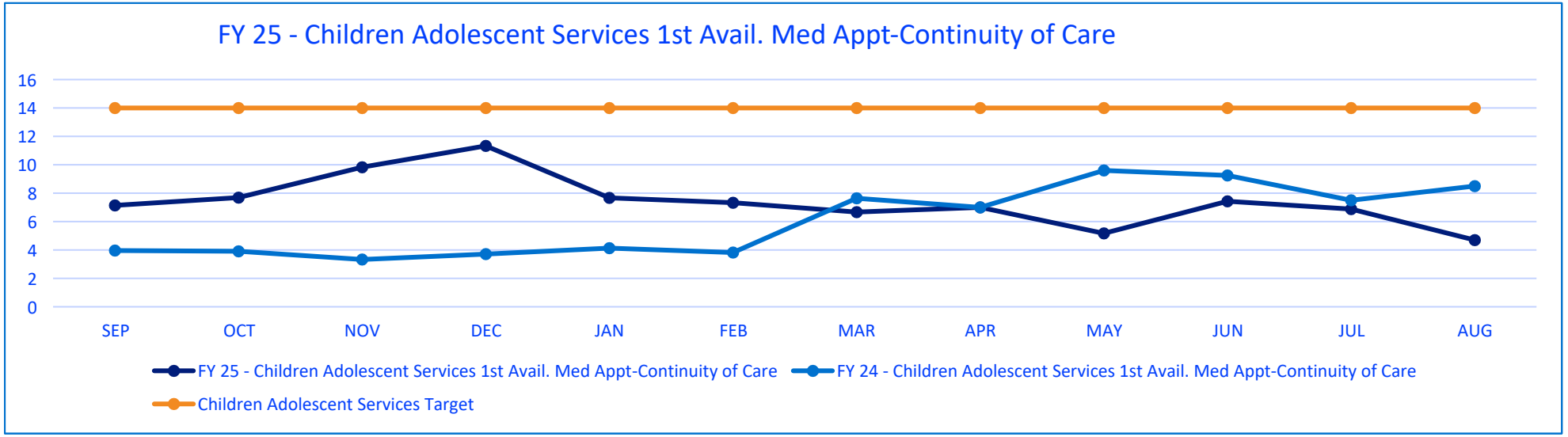
Domain	Program	2025 Fiscal Year Target	2025 Fiscal Year Average (September - August)	Reporting Period- August	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Contact to LPHA	<10 days	1.70 days	1.55 days	Decrease	Contractual



Notes:
First contact to LPHA (Licensed Professional of the Healing Arts) continues to perform well (1.55 days) and exceeding 10 days target. This suggests that the service is operating efficiently within the target range.

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

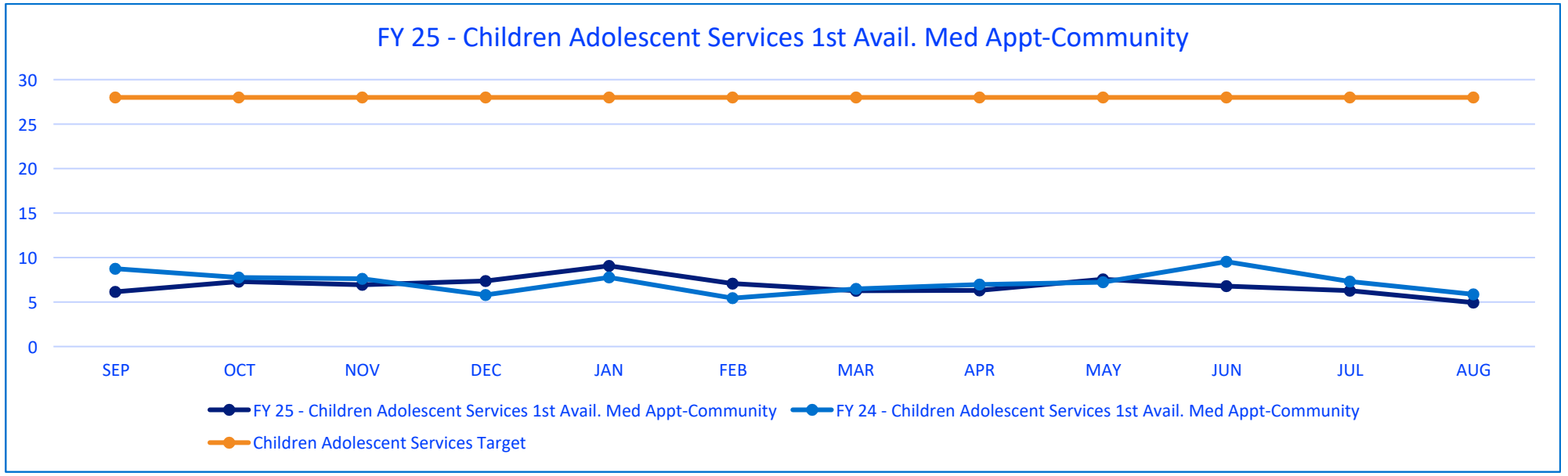
Domain	Program	2025 Fiscal Year Target	2025Fiscal Year Average (September - August)	Reporting Period- August	Target Desire d Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Continuity of Care	<14 days	7.40 days	4.70 days	Decrease	Contractual



Notes:
The time taken for the first available medical appointment for continuity of care in FY 25, at 4.70 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

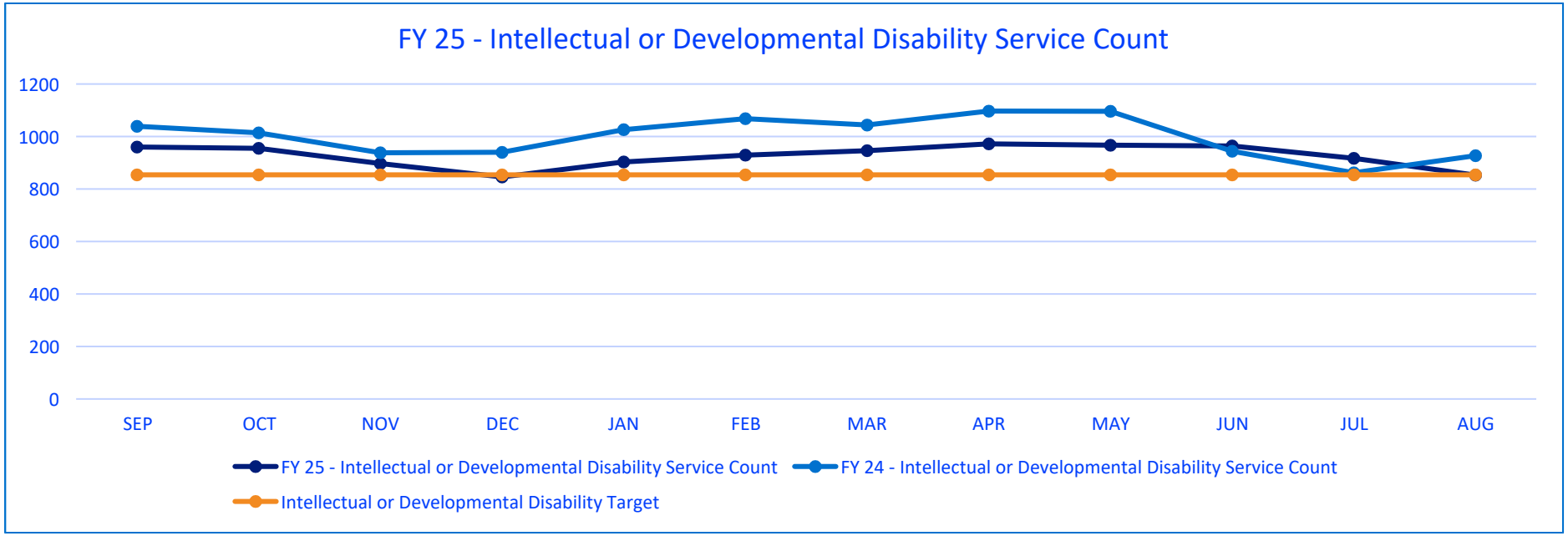
Domain	Program	2025 Fiscal Year Target	2025Fiscal Year Average (September – August)	Reporting Period- August	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Community	<28 days	6.84 days	4.94 days	Decrease	Contractual



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 – August)	Reporting Period- August	Target Desired Direction	Target Type
Access	IDD	854	926	853	Increase	Contractual

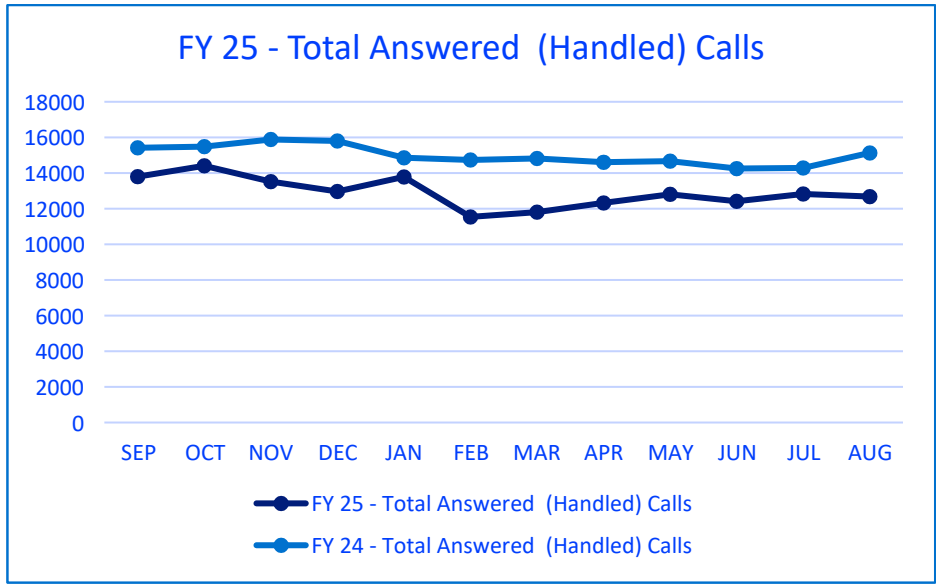


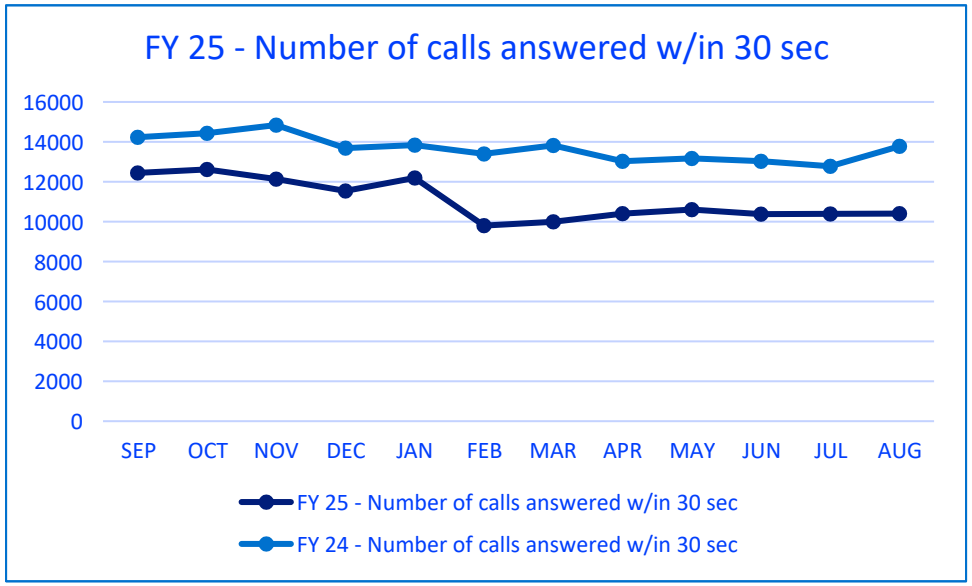
Notes:

- The IDD division service care count is at 853 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 - August)	Reporting Period- August	Target Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	12,907	12,683	Increase	N/A
	Number of calls answered w/in 30 secs	N/A	11,076	10,404	Increase	Contractual

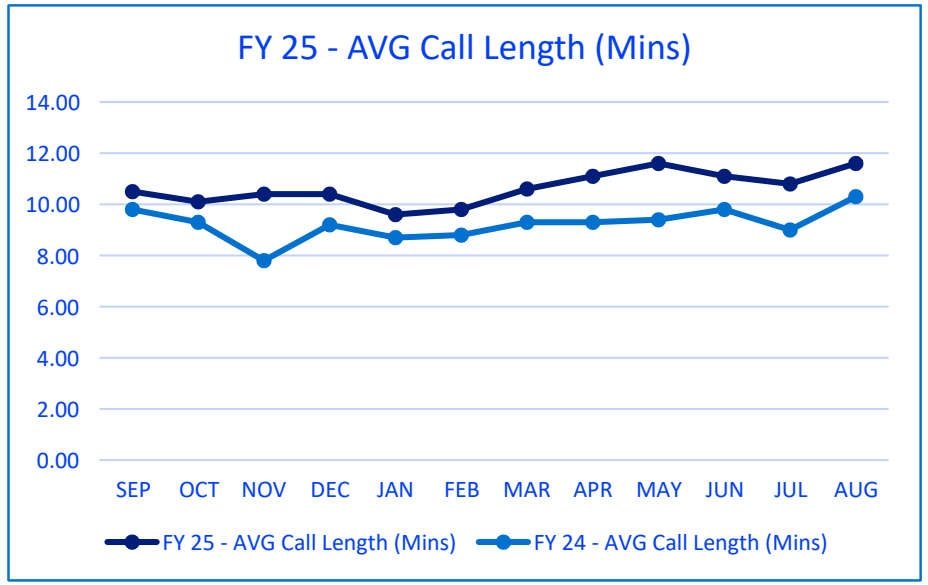


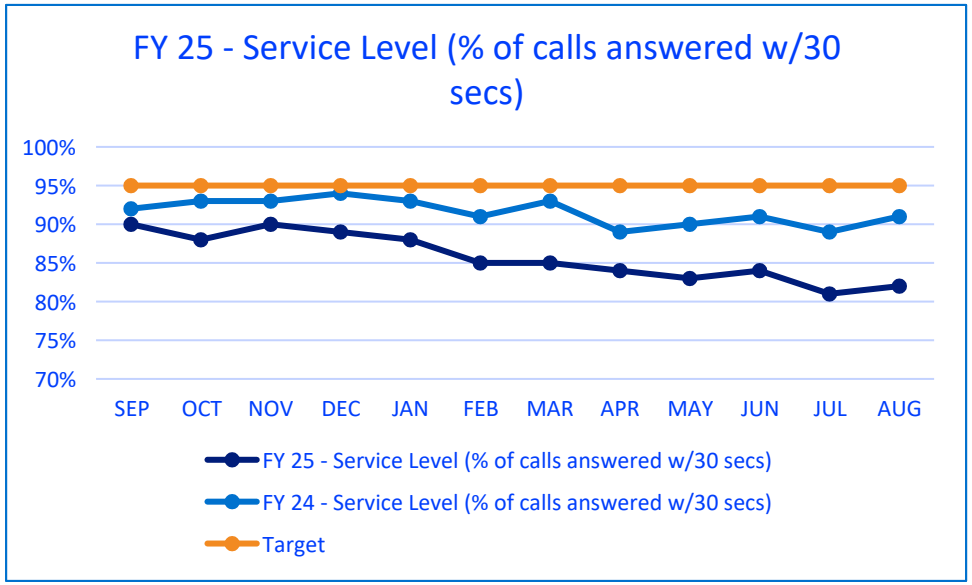


Notes:

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

Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Average (September - August)	Reporting Period- August	Target Desired Direction	Target Type
Timely Care	AVG Call Length (Mins)	N/A	10.60	11.60	N/A	Contractual
	Service Level (% of calls answered w/30 secs)	>95%	86.00%	82%	Increase	Contractual

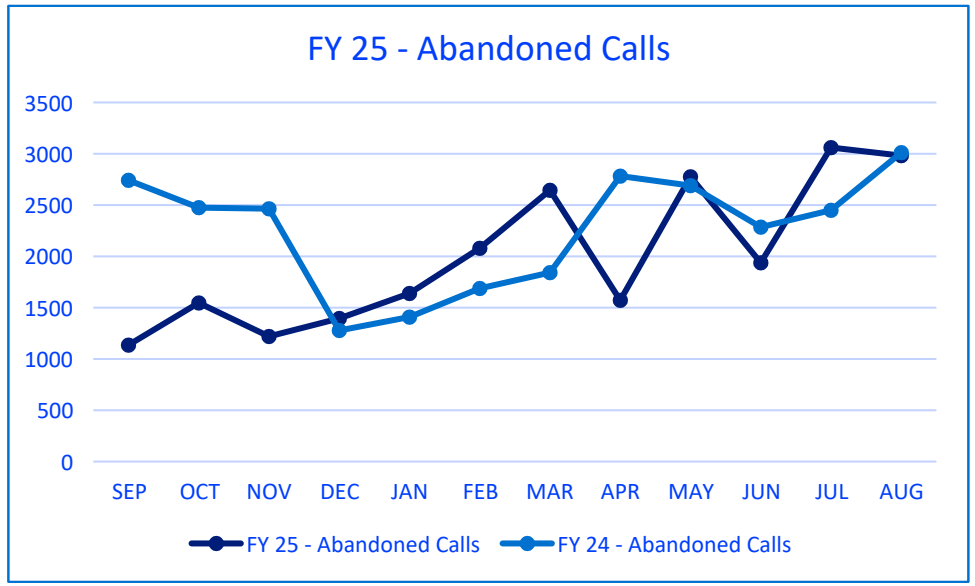


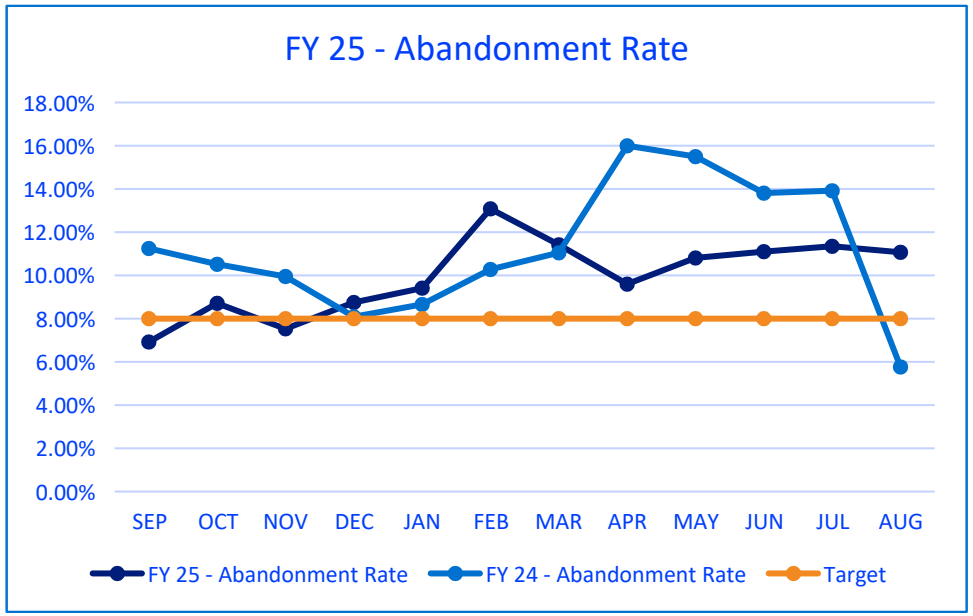


Notes:

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

Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Average (September - August)	Reporting Period- August	Target Desired Direction	Target Type
Timely Care	Abandoned Calls	N/A	1,999	2,982	Decrease	Contractual
	Abandonment Rate	<8%	10.00%	11.07%	Decrease	Contractual

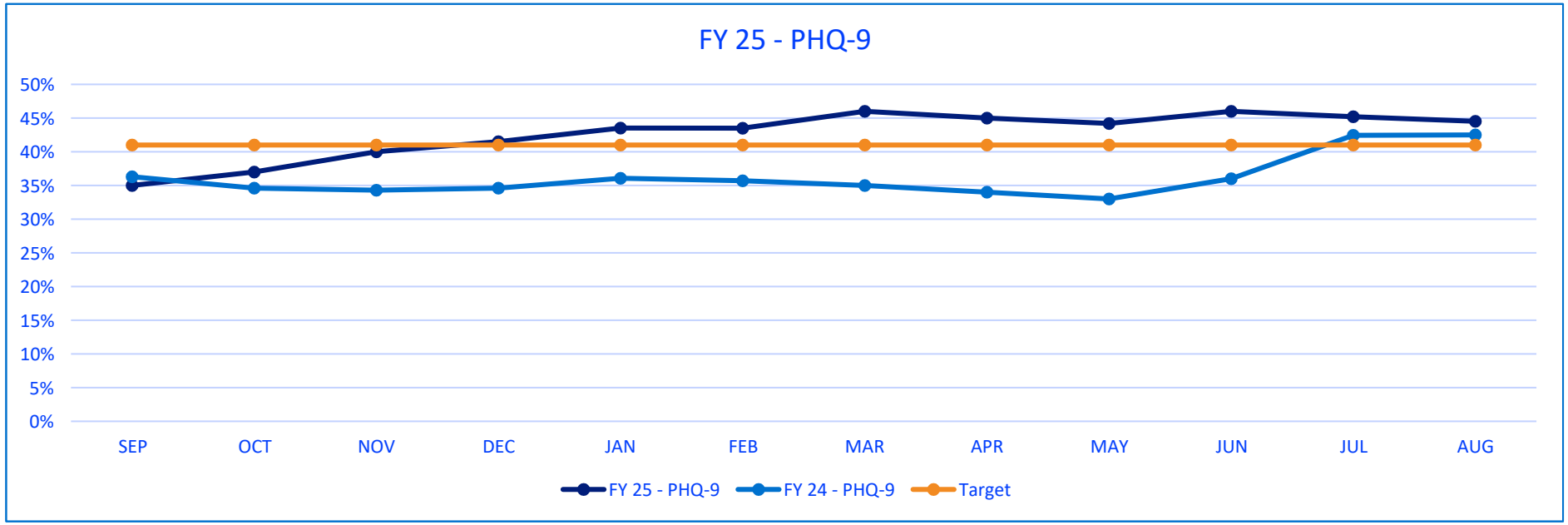




Notes:

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

Domain	Measures (Definition)	FY 2025 Target	2025Fiscal Year Averag e (September – August)	Reporting Period- August	Target Desired Direction	Target Type
Effective Care	PHQ-9	41.27%	43%	45.00%	Increase	IOS



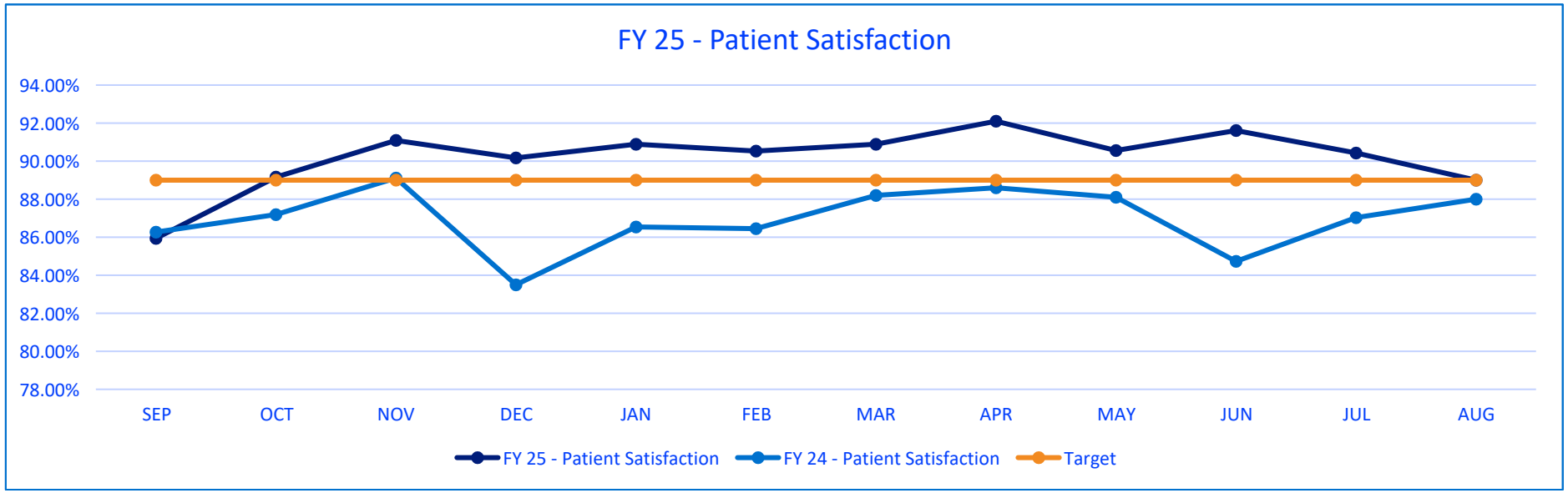
Notes:

- There was an increase in the adult PHQ-9 (Patient Health Questionnaire-9) with low score comparing August FY 24 to August 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 - August)	Reporting Period- August	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	89%	90.00%	89.00%	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.

Appendix

Measure in red > 3 Months

	APR	MAY	JUN	JUL	FY24 AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	FY25 AVG	FY25 Target	Target Type	Data Origin
Measures in Red > 3 Months																				
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	2,891	2,742	2,930	3,481	C	MBOW
AMH # Pts Seen in 30-60 Days	3	2	2	1	4	2	4	5	8	44	61	45	56	79	85	150	58.67	<45	IOS	Epic
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%		< 8.00%	NS	Brightmetrics
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%	37.80%	36.80%	35.90%	36.40%	38.09%	37.89%	IOS	Epic

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

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

	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	14,525	14,460	14,120	13,764	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	2,891	2,742	2,705	2,930	3,481	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%	113.00%	107.49%	100.00%	108.24%	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	1.55	1.70	<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	1.06	2.45	<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	4.70	7.41	<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	6.32	4.94	6.83	<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	0	3.58	<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	0.00	0	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
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	18,277	17,025			
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	11.60	10.63			
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%	82.00%	85.75%	95.00%	C	Brightmetrics
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%	11.07%	9.98%	< 8.00%	NS	Brightmetrics
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%	86.00%	82.08%			Brightmetrics
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%	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%	90.30%	85.43%	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%	88.84%	90.24%	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%	31.93%	27.55%	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%	32.94%	29.39%	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%	40.36%	36.03%	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%	51.20%	47.50%	49.70%	48.80%	51.30%	47.50%	49.20%	45.38%	IOS	Epic
BDSS						44.10%	45.30%	47.90%	42.40%	41.60%	46.60%	43.80%	44.70%	46.60%	46.50%	46.50%	48.40%	45.37%	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%	37.80%	36.80%	35.90%	36.40%	36.90%	38.09%	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%	48.90%	41.50%	42.10%	43.05%	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%	42.80%	37.22%	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%	36.20%	24.96%	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%	41.50%	42.50%	54.20%	47.90%	43.14%	48.07%	IOS	Epic

Board of Trustee's PI Scorecard Data Key

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Access to Care - Strategic Plan Goal #2: To Improve Access to Care	
AMH Waitlist	# of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state.
(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 modifers, and telephone contact encounters; partially authorized months and their associated hours)
CAS Waitlist	# of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state.
(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 modifers, and telephone contact encounters; partially authorized months and their associated hours; Client months with a change in LOC-A: childern and adolescents on extended review)
IDD Service Target (854)	# of ID Target served based on all reported encounter data. (includes encounters that are associated with CARE assignment codes when the service is performed outside of a waiver. Exceptions are for service coordination that is only included for the indigent population and R019 which is included regardless of waiver status.)
%	% 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 Car	
QIDS-C	must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease)
BDSS	must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease)
PSRS	must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease)
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 C	
PHQ-A (11-17)	% of new patient child and adolescent clients that have improved depression scores on PHQ. (New Patient = episode begin date w/in 1 year; Must have 14 days between first and last assessments)
DSM-5 L1 CC Measure (6-17)	% of new patient child and adolescent clients that have improved symptomoloy as measured by the DSM-5 Cross Cutting tool. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)
Adult and Child/Adolescent Needs and Strengths Measures - Strategic Plan Goal #4: To Continuously Improve Quality of Care	
ANSA (Adult)	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)

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 containts all required information in accordance with TAC compliance
Patient Satisfaction (Based on the Two Top-Box Scores) - Strategic Plan Goal #6: Organization of Choice	
CW Patient Satisfaction	% of 2 top box scores (2top box answers on form/total answers given on forms)(average of all sat forms together)
Adult Outpatient	% of 2 top box scores on CPOSS (2top box answers on form/total answers given on forms)(In Clinic Visits - AMH clinics and some CPEP)
Youth Outpatient	% of 2 top box scores on PSS (2top box answers on form/total answers given on forms)(In Clinic Visits - Youth and Adolescent clinics)
V-SSS 2	% of 2 top box scores on VSSS2 (2top box answers on form/total answers given on forms)(All Divisions)
PoC-IP	% of 2 top box scores on PoC-IP (2top box answers on form/total answers given on forms)(CPEP and DDRP)
Pharmacy	% of 2 top box scores on VSSS2 (2top box answers on form/total answers given on forms)(all pharmacies)

Thank you.

EXHIBIT Q-4

Board Quality Committee Presentation:

Crisis Line and 988 Metric Update

Presented by: Dr. Luming Li, Chief Medical Officer
Jennifer Battle, MSW, VP Community Access and Engagement

October 21, 2025

Outline

The HARRIS CENTER for Mental Health and IDD

- Benchmarks, Metrics, and Explanations
- Data sub-analysis
- Rationale for changes over time
- QI interventions

Call Benchmarks: National, State (TX), and Harris Center

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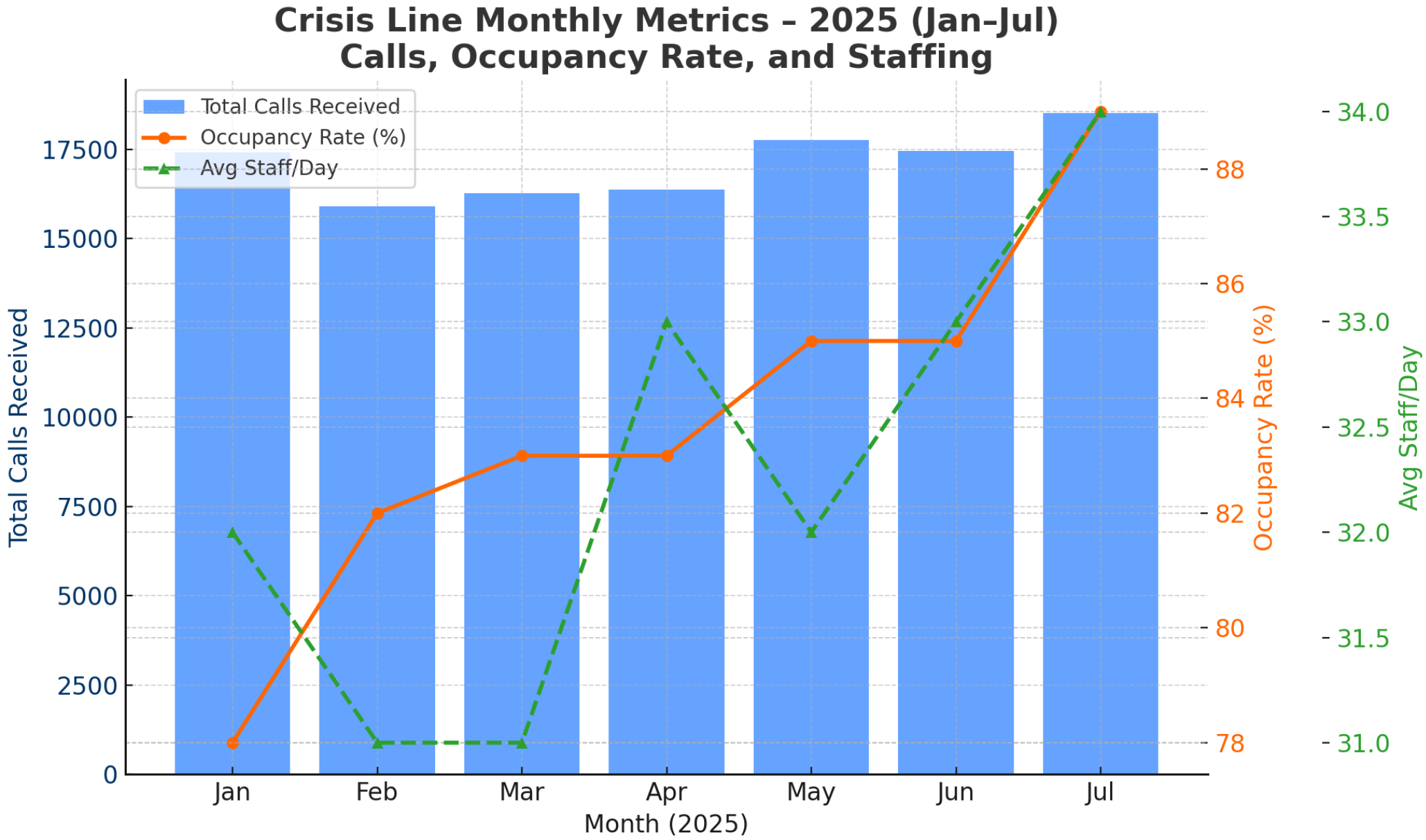
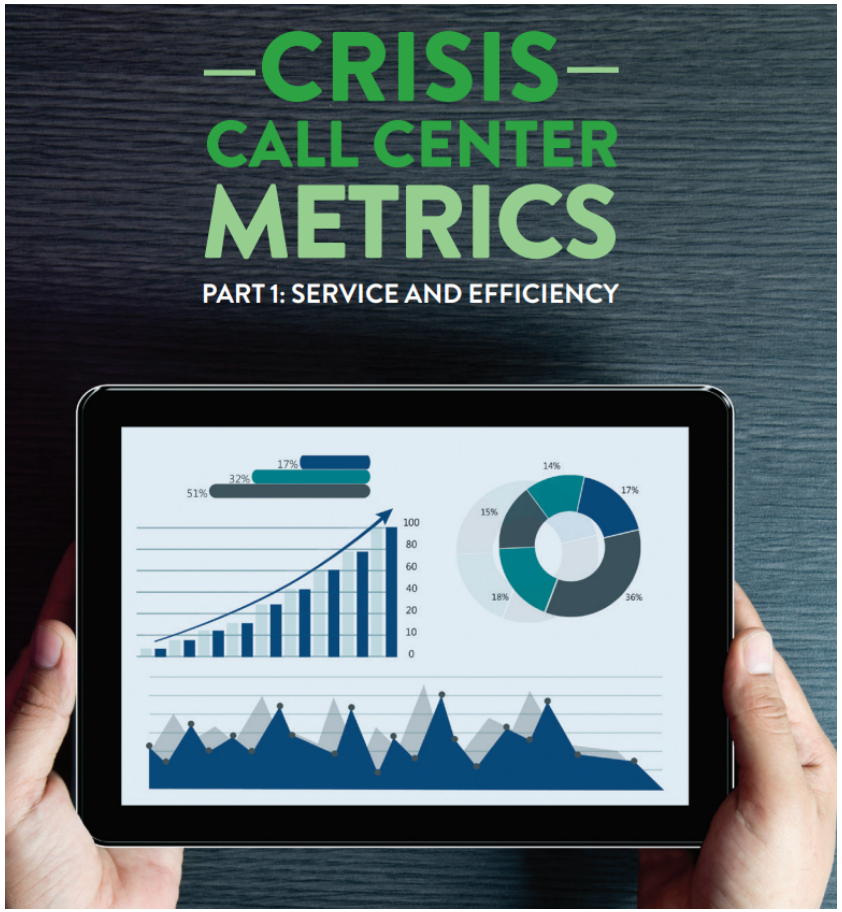
Metric	National - 988 (Avg: Jan - July 2025)	Texas (Avg: Jan - July 2025) - 988	Harris Center (Avg: Jan - July 2025) - 988 + Crisis Line
Total call volume per month (Answered calls)	419,279	16,990	12,501
Service Level (calls answered within 30 sec)	89%	82% in-state answer rate	84%
Abandonment Rate	11%	18%	10%
Avg Speed-to-Answer (ASA)	34 seconds	41.8 seconds	35 seconds
Average Call Length	13m 54s	15m 09s	10m 55s

Industry standards are not defined for call abandonment rate, service level (X% calls answered in Y secs or less), average speed to answer, and hold time. Crisis call centers are not providing a service comparable to technical support lines or sales call centers and cannot be held to standards of operation reflective of these industries.

National Suicide Prevention Lifeline. (2019). Call Center Metrics: A Guide for Crisis Contact Centers. Retrieved from http://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf


Crisis Line Monthly Metrics – 2025 (Jan–Jul)
Calls, Occupancy Rate, and Staffing
Total Calls Received
Occupancy Rate (%)
Avg Staff/Day
Total Calls Received
Occupancy Rate (%)
Avg Staff/Day
0
2500
5000
7500
10000
12500
15000
17500
78
80
82
84
86
88
31.0
31.5
32.0
32.5
33.0
33.5
34.0
Jan
Feb
Mar
Apr
May
Jun
Jul
Month (2025)

988 and Crisis Line Quality Metrics



- **Currently reported measures are process metrics**
  - Answered (Handled) Calls
  - Call Abandonment
  - Average Speed-to-Answer (ASA)
  - Staff Occupancy Rate

- **Opportunities for Metric Evaluation**
  - Quality of clinical assessment during the call
  - Clinical outcomes (Upcoming national evaluation efforts)

National Suicide Prevention Lifeline. (2019). Call Center Metrics: A Guide for Crisis Contact Centers. Retrieved from http://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf

Call Acuity & Clinical Complexity

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Calls that receive full assessment: ~5,200–5,700 per month

Crisis assessed as urgent or emergent: ~1,200–1,400 per month

Common Concerns:

- Mental Health (69–75%)
- Suicide (34–37%)
- Violence (17–21%)
- Substance Use (10–13%)

Average Call Length: 10–11 min — reflects clinical complexity: coordination of care, follow up and documentation

Pilot Post-Call Survey (PCS): Key Highlights

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📝 Purpose
Assess caller experience & gather demographic data for internal evaluation.

⚙️ Center Role
Inform staff; answer caller questions; no tech setup needed.

📅 Timeline
Launch: Summer 2025 | Duration: 3 months minimum.

📊 Data Use
Used only for feasibility & evaluation, not individual performance.

📞 Sample Questions
1. *How much did the crisis line help you?*
2. *Were you calling for yourself or someone else?*
3. *Did you have thoughts of suicide?*
4. *How likely were you to act on those thoughts?*
5. *To what extent did the call stop you from harming yourself?*
6. *Counselor empathy: "I felt the counselor cared about my well-being."*
7. *Demographics: age, race/ethnicity*

Current Crisis Caller Experience feedback:

Would call back if in crisis? 96% said Yes.

Was I able to provide you with the support and information you were looking for?" 98% said Yes

Action Plan

STRATEGIC CONTACT

The Harris Center
Crisis Line Contact Center Assessment and Plan

External Consultant Recommendations (2024)

Technology: Updated phone system and workforce management software	**Call documentation system**	**Staffing & Education: +12 staff members since July 2025**

Timeframe – target for Q4 2025 and train staff on utilization in Q1 2026

- Hired an LPHA to exclusively manage regular caller data and create call management plans, reducing stress on the team.
- Hired 2 Quality Assurance Specialists, shifting QA responsibilities away from Crisis Line Supervisors. Planning to integrate limited AI for QA long-term; initiated conversations with a vendor successfully working with other crisis centers.
- Hired a Data Analyst to take over data reporting projects from Crisis Line Supervisors.
- Trained all Access Line Specialists in basic emotional support skills to manage non-crisis Harris Center Crisis Line calls, reducing call volume.
- Split Crisis Line Counselor training into two components to get staff on the phones faster and complete the second half of training in intervals.
- Partnering with HR to explore career ladder opportunities (previously CLC 1, CLC 2, CLC 3 roles were collapsed).
- Partnering with HR to conduct a market review for Crisis Line Counselor positions.

Thank you.

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