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

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

Quality Committee Meeting
July 21, 2026
11:00 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **APPROVAL OF MINUTES**

A. Minutes of the Board of Trustees Quality Committee Held on Tuesday, May 19,, 2026
*(EXHIBIT Q-1 )*

IV. **REVIEW AND COMMENT**

A. Board Scorecard
*(EXHIBIT Q-2 Trudy Leidich)*

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

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 RETREAT TUESDAY, MAY 19, 2026 MINUTES

Dr. J. Lankford, Board Chair, called the meeting to order at 11:20 a.m. at 16090 City Walk Sugar Land, TX, noting that a quorum of the Committee was present.

**RECORD OF ATTENDANCE**

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

Committee Member Absent: Dr. Q. Moore, Dr. R, Gearing

Other Board Member in Attendance: BG (Ret.) E. Grantham, Dr. M. Miller, Jr.

1. **CALL TO ORDER**
   Dr. J. Lankford called the meeting to order at 11:20 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Dr. Lankford designated BG (Ret.) E. Grantham and Dr. M. Miller, Jr. as voting members to 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, April 21, 2026**

   **MOTION BY: BACON SECOND BY: MILLER, JR.**

   **With unanimous affirmative votes,**
   **BE IT RESOLVED** that the Minutes of the Quality Committee meeting held on Tuesday April 21, 2026 as presented under Exhibit Q-1, are approved.

6. **REVIEW AND COMMENT**

   A. **Board Scorecard-**Dr. Lankford summarized the Quality Board Scorecard.

**B. Patient Satisfaction –** Luc Josaphat and Trudy Leidich presented the Patient Satisfaction to the Quality Committee.

**7. EXECUTIVE SESSION-**Entered into executive session at 11:43am.

- **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 Senior Director-Pharmacy Programs 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. Holly Cumbie, Senior Director-Pharmacy Programs and Dr. Luming Li, Chief Medical Officer**

- **Report by the Chief Medical Officer regarding the Quality of Healthcare pursuant to Texas Health & Safety Code Ann. §161.032, Texas Occupations Code Ann. §160.007 and Texas Occupations Code Ann. §151.002 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Healthcare Services. Dr. Luming Li, Chief Medical Officer and Trudy Leidich, Vice President of Clinical Transformation & Quality**

**8. RECONVENE INTO OPEN SESSION -**Reconvene into open session at 12:26pm
No action was taken.

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

**10. ADJOURN**

**MOTION: BACON SECOND: MILLER, JR.**

There being no further business, the meeting adjourned at 12:25 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

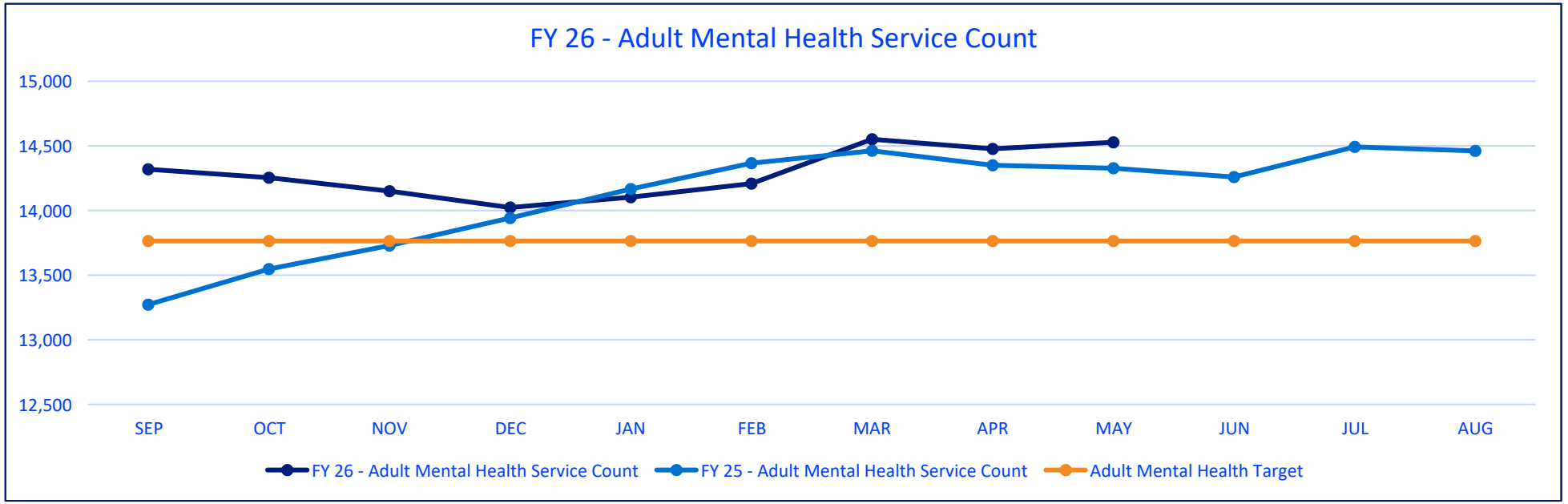
# Quality Board Scorecard

## Board Quality Committee Meeting


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

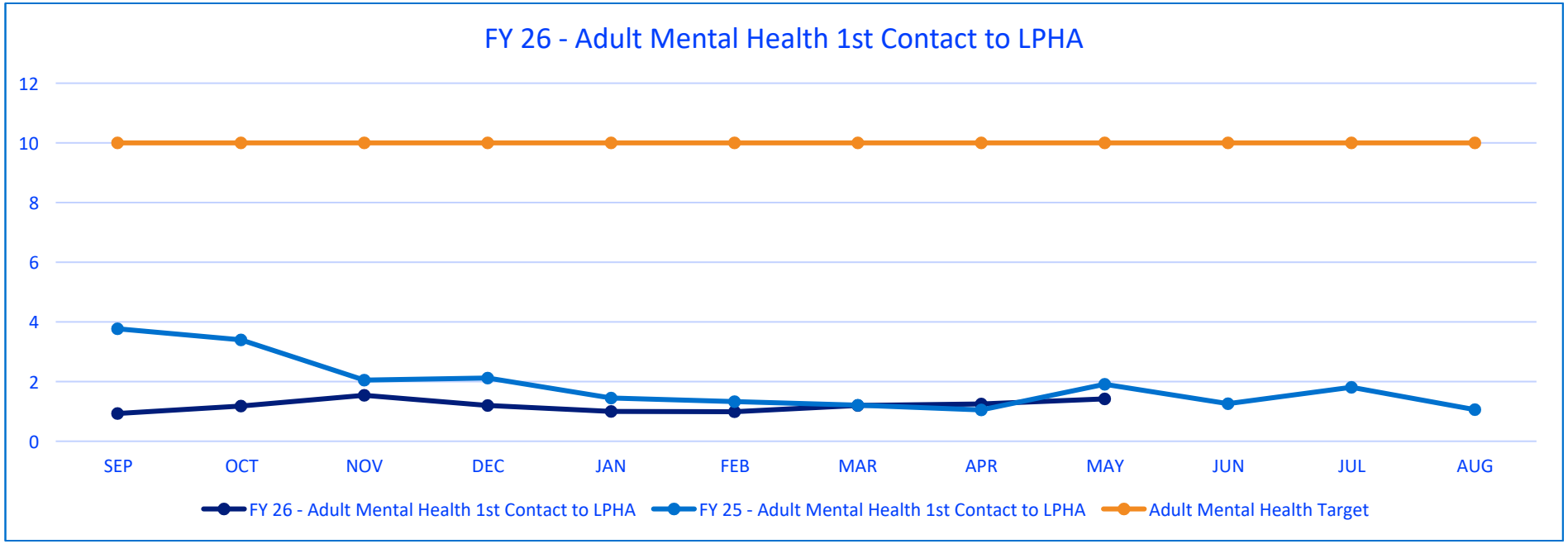
July 2026 (Reporting May 2026 Data)

| Domain | Measure | 2026 Fiscal Year State Service Care Count Target | 2026 Fiscal Year State Care Count Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | Adult Mental Health Service Care Count | 13,764 | 14,293 | 14,528 | Higher is Better | Contractual |



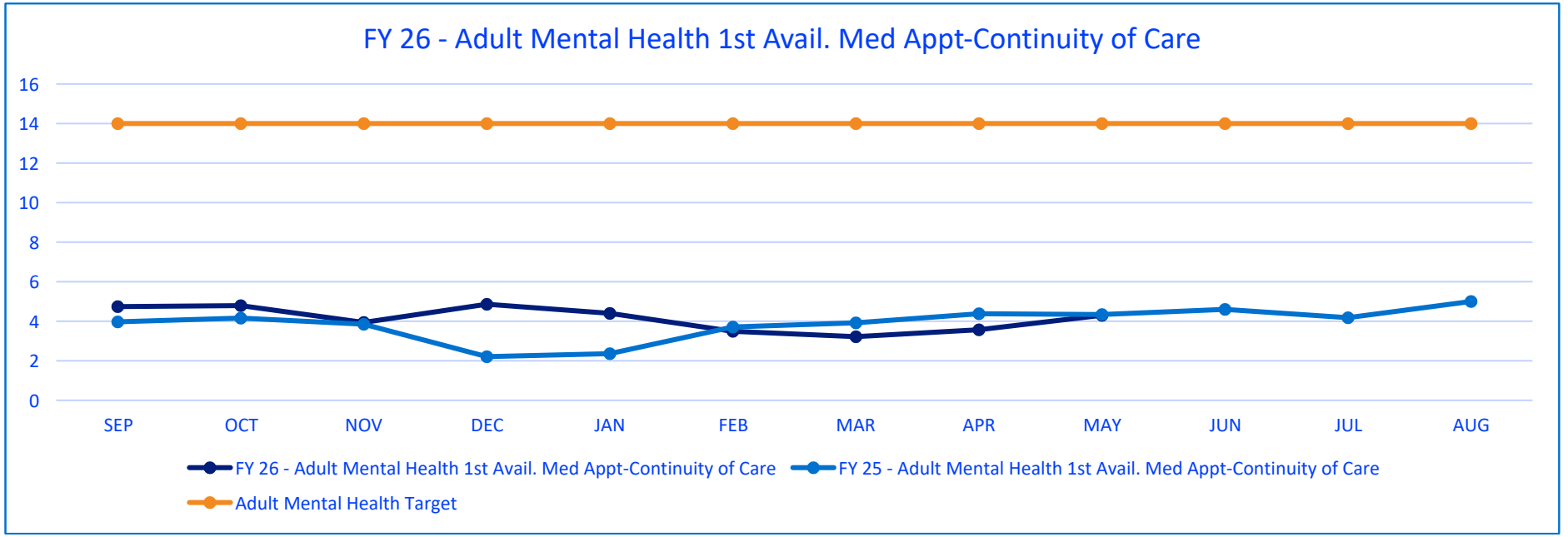

Notes: In May, Adult Mental Health service care count was 14,528, exceeding the FY26 target of 13,764 and remaining above prior year performance.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | First Contact to LPHA | <10 days | 1.20 days | 1.42 days | Lower is Better | Contractual |



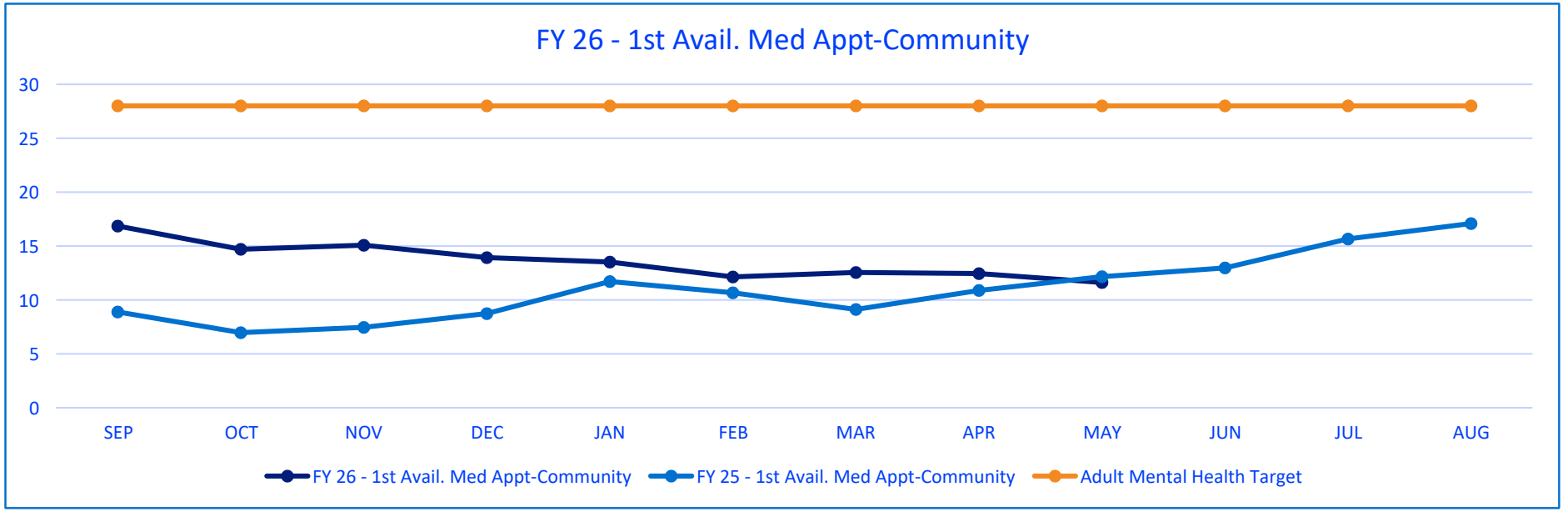

Notes: In May, first contact to LPHA was achieved on average of 1.42 days, exceeding the FY26 target of less than 10 days and above prior year performance.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | First Avail. Med Appt-Continuity of Care | <14 days | 4.15 days | 4.30 days | Lower is Better | Contractual |



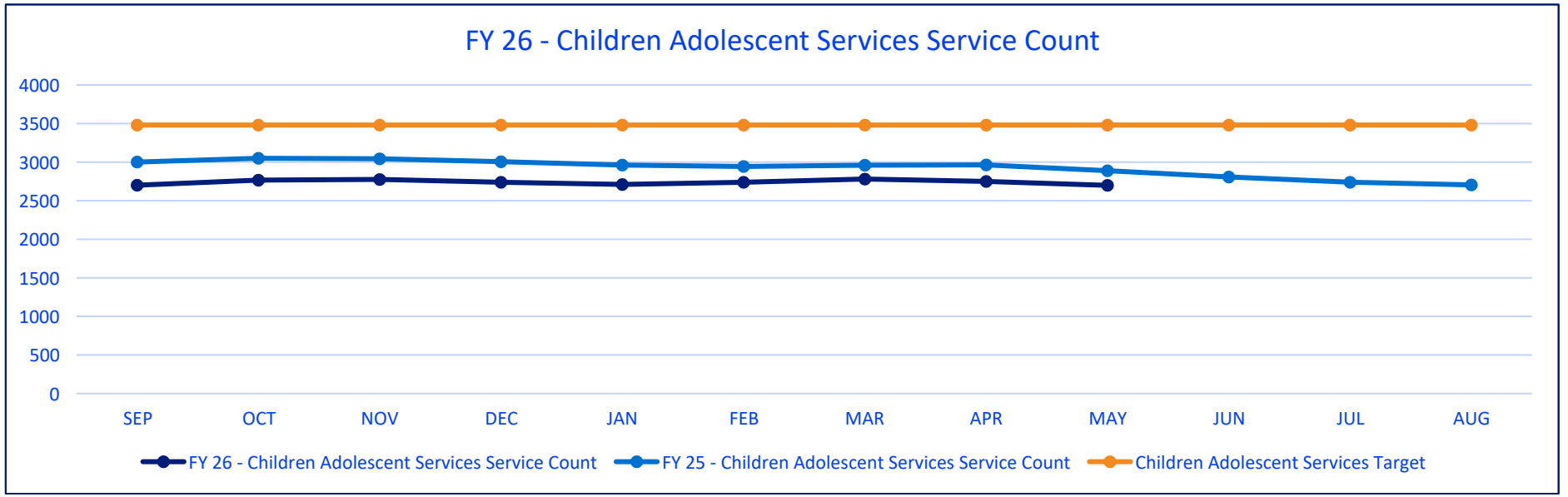

Notes: In May, First Available Med Appt-Continuity of Care was achieved on average of 4.30 days, exceeding the FY26 target of less than 14 days and above prior-year performance.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | First Available Medical Appointment Community | <28 days | 13.77 days | 11.62 days | Lower is Better | Contractual |



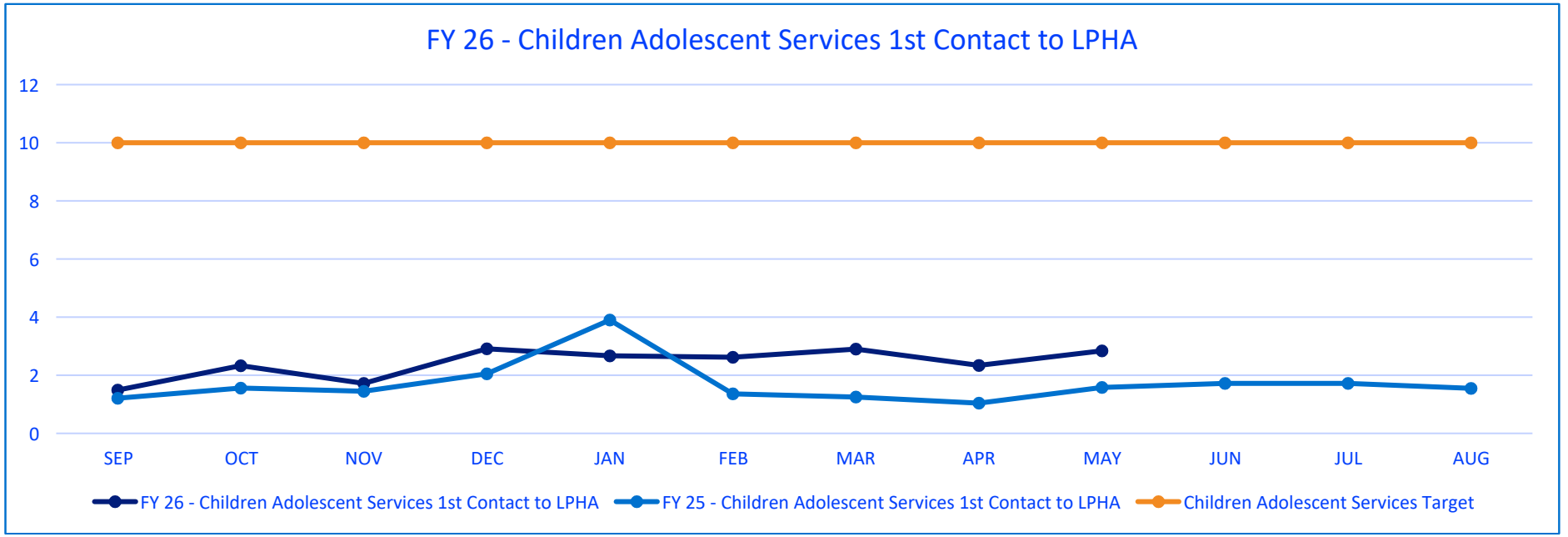

Notes: In May, First Available Medical Appointment Community was achieved on average of 11.62 days, exceeding the FY26 target of less than 28 days and above prior-year performance.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average (September– May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access to Care | Children & Adolescent Services | 3,481 | 2,740 | 2,699 | Higher is Better | Contractual |



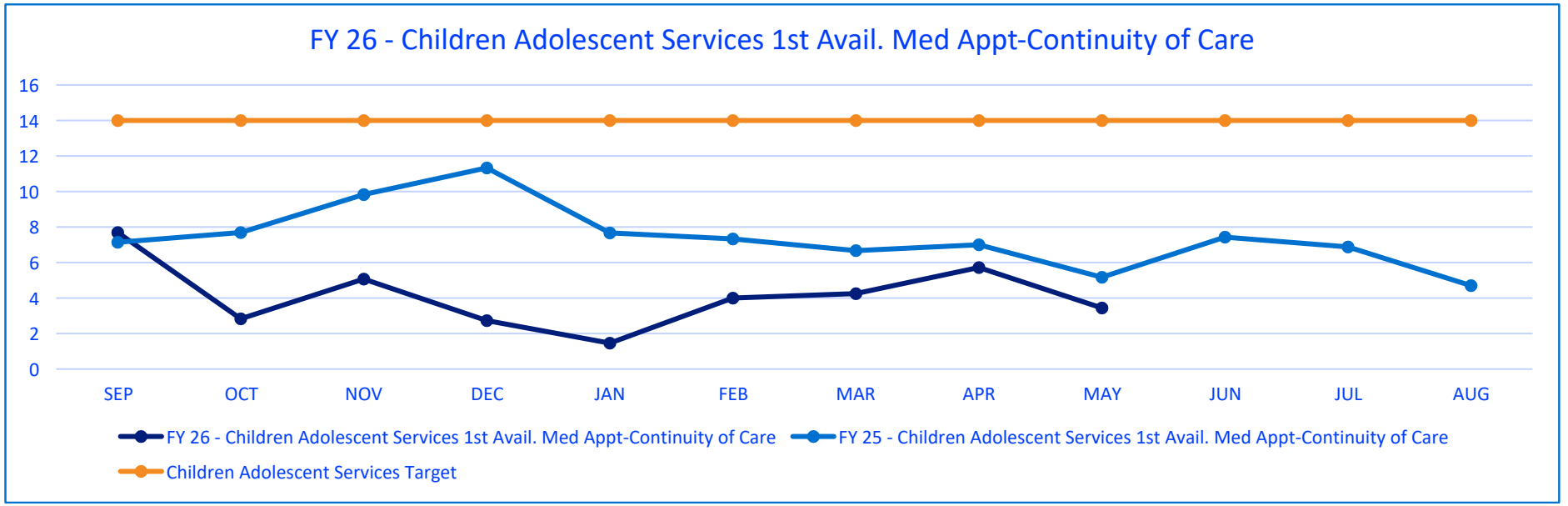

Notes: In May, Children and Adolescent Services recorded 2,699 service care counts, remaining below the FY26 target of 3,481 and below prior-year levels.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | Children and Adolescent First Contact to LPHA | <10 days | 2.43 days | 2.84 days | Lower is Better | Contractual |



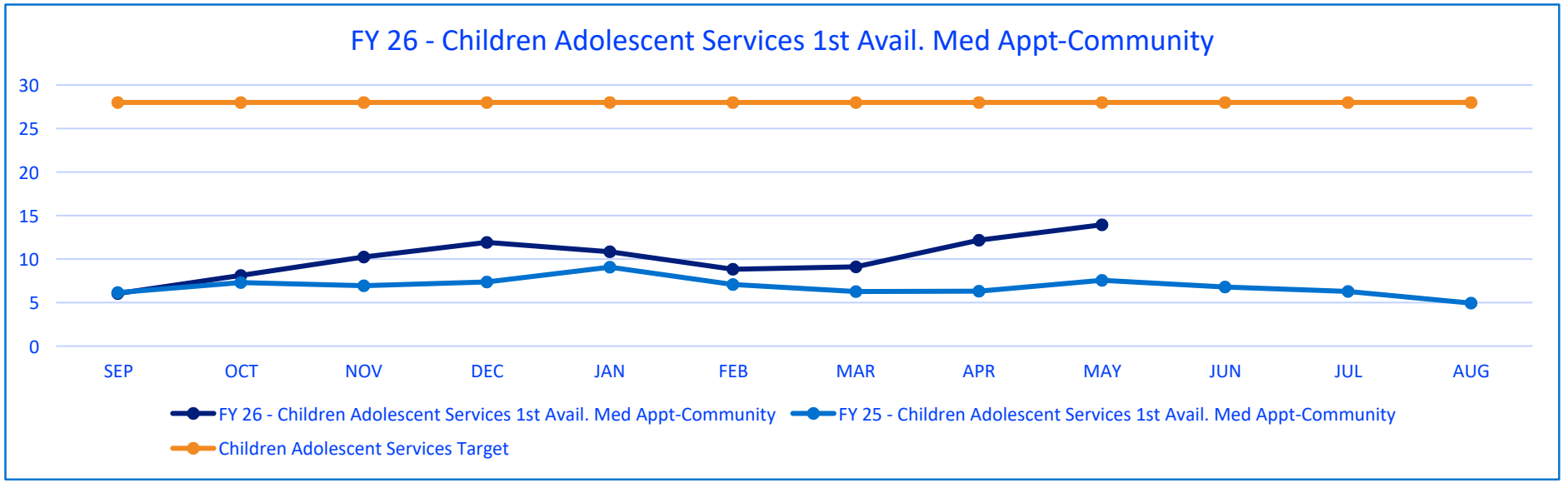

Notes: In May, Children and Adolescent first contact to LPHA was achieved on average of 2.43 days, exceeding the FY26 target of less than 10 days and above prior-year performance.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | Children and Adolescent First Avail. Med Appt-Continuity of Care | <14 days | 4.13 days | 3.44 days | Lower is Better | Contractual |



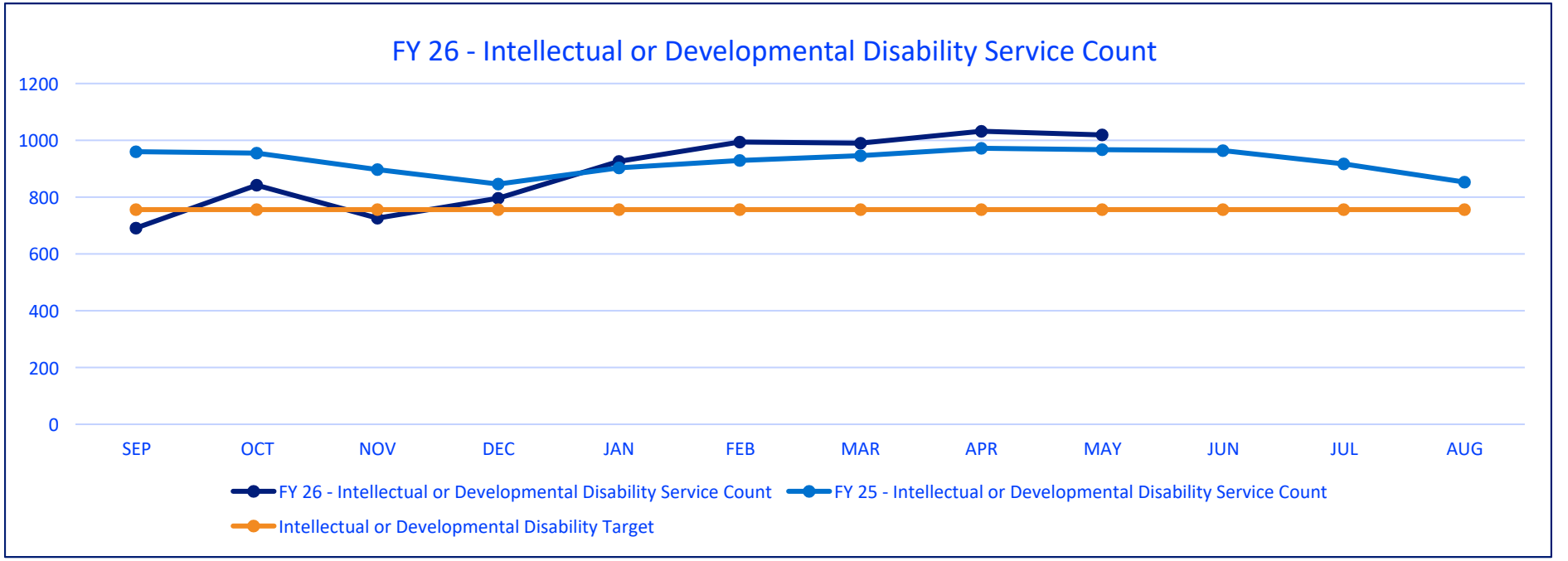

Notes: In May, Children and Adolescent First Available Med Appt-Continuity of Care was achieved on average of 3.44 days, exceeding the FY26 target of less than 14 days and above prior-year performance.

| Domain | Measure | 2026 Fiscal Year Target | 2026 Fiscal Year Average to Date (September – May) | Reporting Period: May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | Children and Adolescent First Available Medical Appointment Community | <28 days | 10.13 days | 13.94 days | Lower is Better | Contractual |



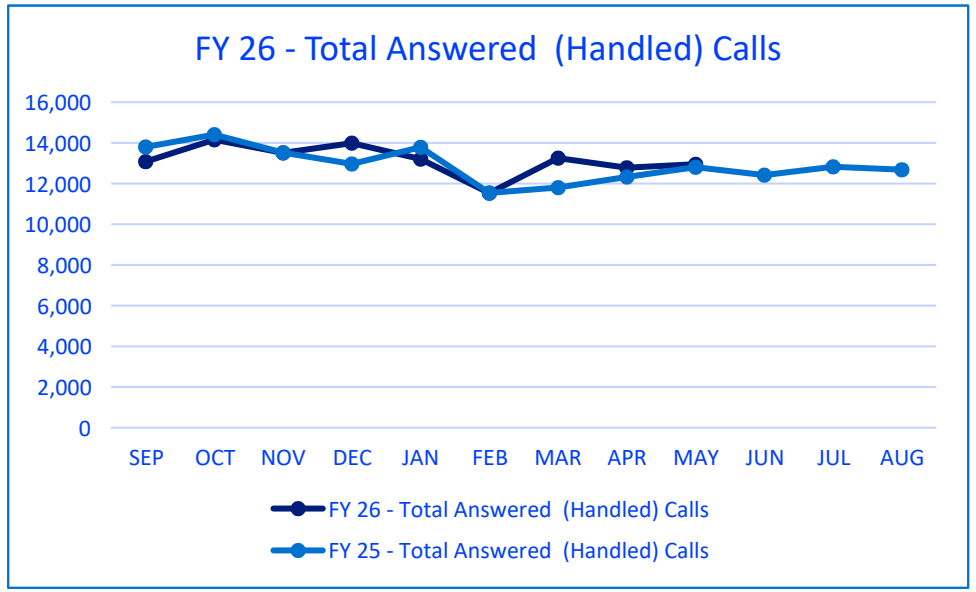

Notes: In May, Children and Adolescent First Available Medical Appointment Community was achieved on average of 13.94 days, exceeding the FY26 target of less than 28 days and above prior-year performance.

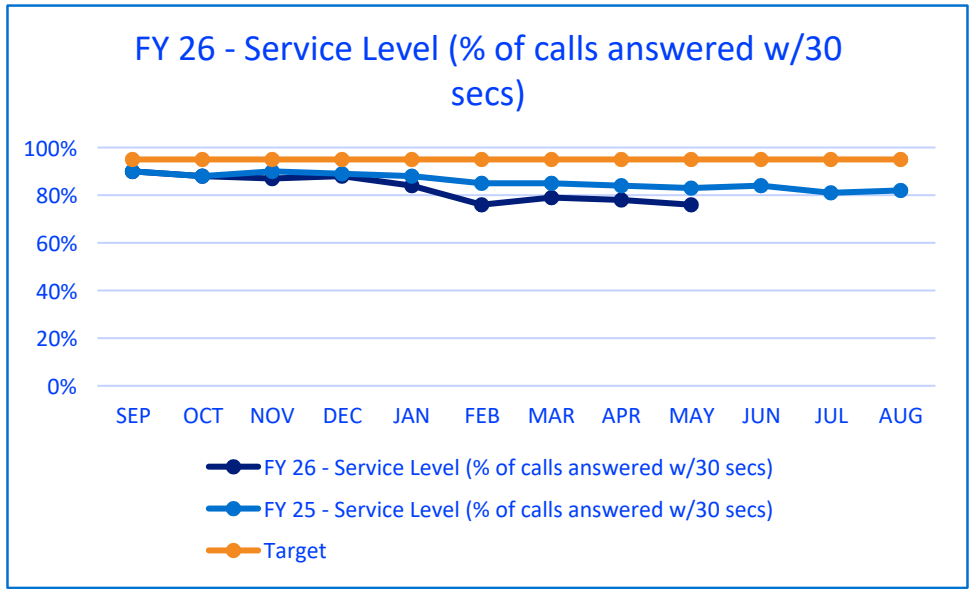
| Domain | Program | 2026 Fiscal Year Target | 2026 Fiscal Year Average (September – May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | IDD | 756 | 893 | 1,019 | Higher is Better | Contractual |




Notes: In May, IDD service count reached 1,019, exceeding the FY26 target of 756 and outperforming prioryear results. Performance demonstrates sustained growth and strong utilization.

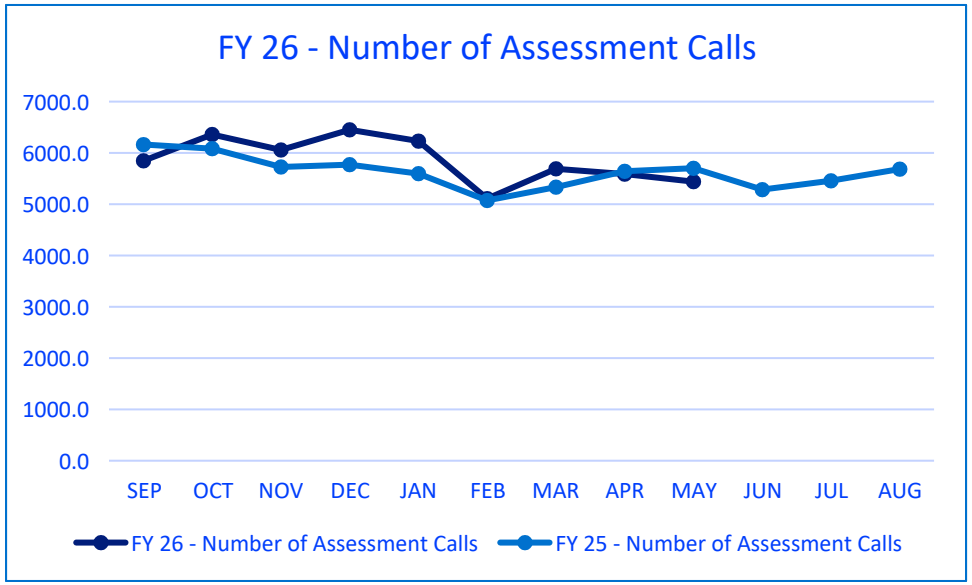
| Domain | Measure | FY 2026 Target | 2026Fiscal Year Average (September - May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Total Answered Calls | N/A | 13,162 | 12,952 | N/A | N/A |
| Timely Care | Percent of calls answered w/in 30 secs | > 95% | 83% | 76% | Higher is Better | Contractual |

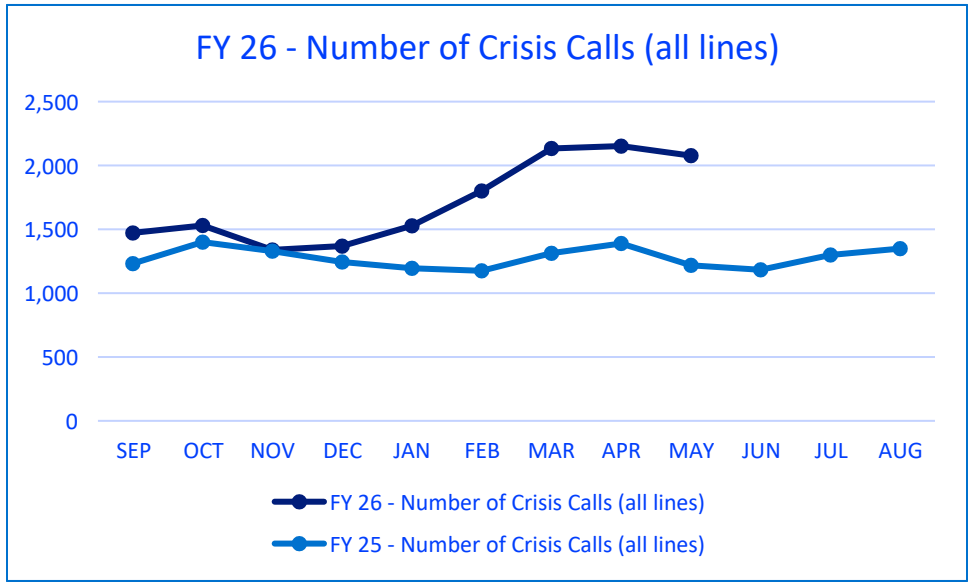



Notes: In May, 12,952 calls were answered, while service level performance was 76%, below the >95% target and lower than prioryear results. Performance reflects ongoing access and capacity pressures.

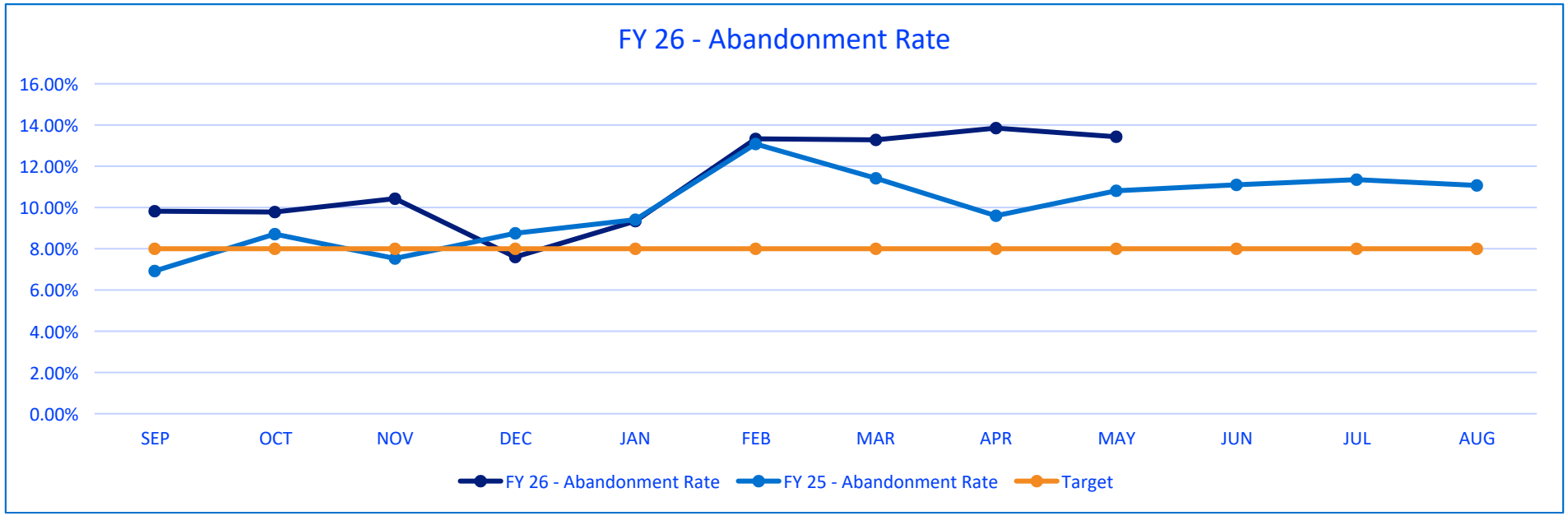
| Domain | Measures (Definition) | FY 2026 Target | 2026Fiscal Year Average (September - May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Number of Assessment Calls | N/A | 5,364 | 5,540 | N/A | |
| Timely Care | Number of Crisis Calls | N/A | 1,711 | 2,077 | N/A | |



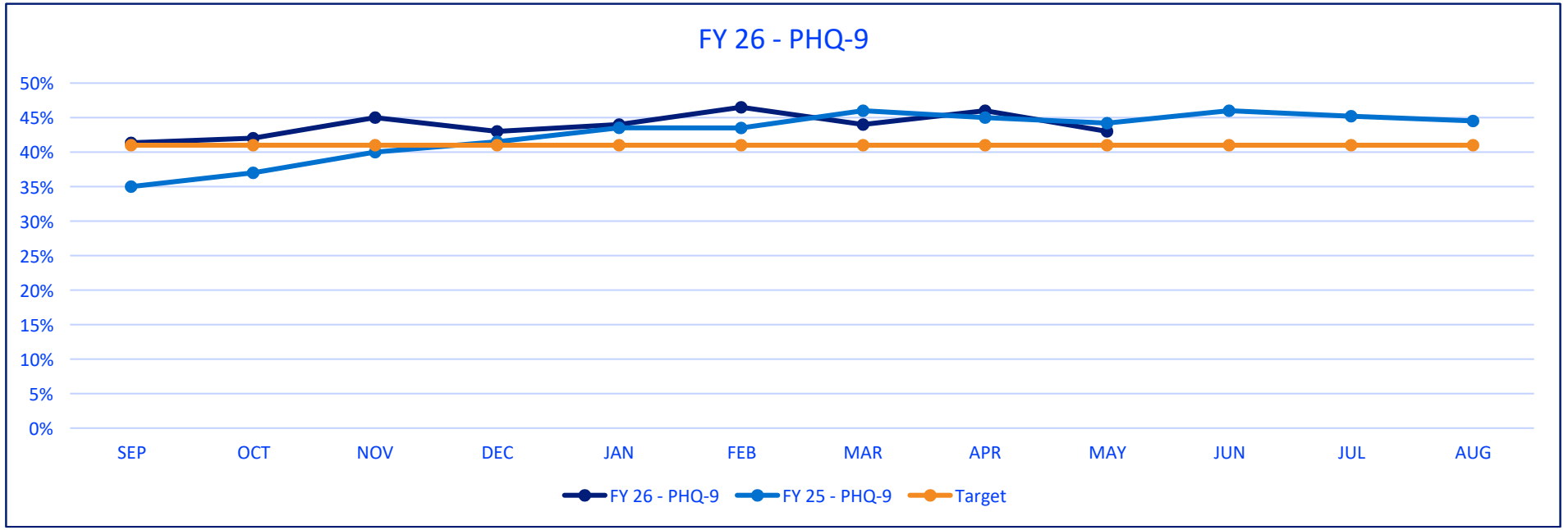

Notes: In May, crisis calls totaled 2,077, exceeding prior-year levels, while assessment calls totaled 5,540, remaining relatively stable year over year. Trends indicate increased crisis demand across access points.

| Domain | Measures | FY 2026 Target | 2026Fiscal Year Average (September - May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Abandonment Rate | <8% | 11.21% | 13.43% | Lower is Better | Contractual |



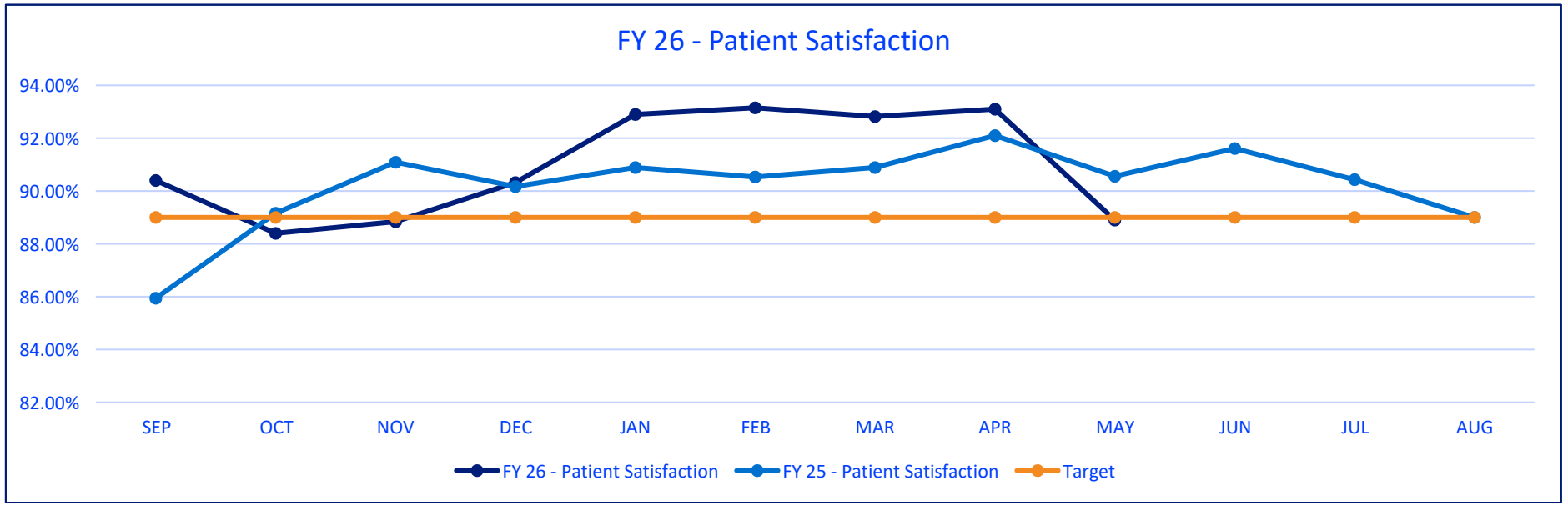

Notes: In May, the call abandonment rate was 13.43%, exceeding the FY26 target of <8% and higher than prior year performance. Results highlight continued access and staffing challenges.

| Domain | Measures | FY 2026 Target | 2026Fiscal Year Averag e (September – May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Clinical Effectiveness | PHQ-9 | 41.27% | 44% | 44% | Increase | IOS |




Notes: In May, PHQ-9 improvement reached 44%, exceeding the FY26 target of 41.27%. Performance demonstrates sustained positive clinical outcomes.

| Domain | Measures (Definition) | 2026 Fiscal Year Target | 2026Fiscal Year Average (September - May) | Reporting Period- May | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Clinical Effectiveness | Patient Satisfaction | 89% | 91% | 88.90% | Higher is Better | IOS |




Notes: In May, patient satisfaction was 88.90%. A sharp decline from the previous month. The patient experience subcommittee is working on expanding engagement and visibility.

# Appendix

# Measure in red > 3 Months

| | APR | MAY | JUN | JUL | FY25 AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY26 AVG | FY26 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | | | | | | | | | | | | | | | |
| CAS Service Target | 2,965 | 2,889 | 2,891 | 2,742 | 2,705 | 2,701 | 2,767 | 2,775 | 2,739 | 2,710 | 2,739 | 2,781 | 2,751 | 2,693 | | | | 2,740 | 3,481 | C | MBOW |
| CAS Actual Service Target % | 85.18% | 82.99% | 83.05% | 78.77% | 77.71% | 77.59% | 79.49% | 79.72% | 78.68% | 77.85% | 78.68% | 79.89% | 79.03% | 77.36% | | | | 78.70% | 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 | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | | FY25 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access to Care, Crisis Line** | | | | | | | | | | | | | | | | | | | | | |
| Service Level | 84.00% | 83.00% | 84.00% | 81.00% | 82.00% | 85.00% | 86.00% | 86.00% | 88.00% | 84.00% | 76.00% | 79.00% | 78.00% | 76.00% | | | | 82.00% | 95.00% | C | Brightmetrics |
| Abandonment Rate | 9.60% | 10.81% | 11.10% | 11.35% | 11.07% | 9.82% | 9.78% | 10.43% | 7.60% | 9.34% | 13.33% | 13.28% | 13.85% | 13.43% | | | | 11.21% | < 8.00% | NS | Brightmetrics |

**Crisis Line Team:** As of July 1st, 2026, we have dedicated 20 staff members to answer only LMHA calls with the rest of our team answering both LMHA and 988 calls. We are hoping this will help us answer more LMHA calls in a timelier fashion. In addition, we have simplified our model on how we handle 988 calls while continuing to be compliant with the 988 guidelines. We have also simplified the documentation for our 988 calls. We hope this will help us maintain our answer levels for 988 calls, while using less staff to answer these lines.

# Next Steps for Measures in Red > 3 Months

Performance Review
Measures remaining below target for greater than three consecutive months will be subject to structured review to identify contributing factors. Performance Review Team will include representation from Quality, Operations, Access to Care, and affected service areas.

Corrective Action Planning
Improvement actions will be established to address identified operational or process-related drivers impacting performance.

Ongoing Monitoring
Performance measures will continue to be monitored on a routine basis to evaluate trends and assess improvement efforts.

Leadership Oversight
Summary findings and performance status will be incorporated into scheduled leadership and Board reporting, with additional review as warranted.

# 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 | FY25 AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | FY26 AVG | FY26 Target | Target Type | Data Origin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | | | | | | | | | | | | | | | |
| Adult Service Target | 14,363 | 14,327 | 14,269 | 14,525 | 14,460 | 14,319 | 14,254 | 14,150 | 14,026 | 14,105 | 14,209 | 14,554 | 14,489 | 14,514 | | | | 14,291 | 13,764 | C | MBOW |
| AMH Actual Service Target % | 104.35% | 104.09% | 103.67% | 105.53% | 105.06% | 104.03% | 103.56% | 102.80% | 101.88% | 102.48% | 103.23% | 105.74% | ####### | ####### | | | | 103.83% | 100.00% | C | MBOW |
| CAS Service Target | 2,965 | 2,889 | 2,891 | 2,742 | 2,705 | 2,701 | 2,767 | 2,775 | 2,739 | 2,710 | 2,739 | 2,781 | 2,751 | 2,693 | | | | 2,740 | 3,481 | C | MBOW |
| CAS Actual Service Target % | 85.18% | 82.99% | 83.05% | 78.77% | 77.71% | 77.59% | 79.49% | 79.72% | 78.68% | 77.85% | 78.68% | 79.89% | 79.03% | 77.36% | | | | 78.70% | 100.00% | C | MBOW |
| IDD Service Target | 972 | 969 | 966 | 920 | 851 | 689 | 839 | 722 | 790 | 920 | 990 | 1037 | 1031 | 1019 | | | | 893 | 756 | SP | MBOW |
| IDD Actual Service Target % | 113.82% | 113.47% | 113.11% | 107.73% | 99.65% | 91.14% | 110.98% | 95.50% | 104.50% | 121.69% | 130.95% | 137.17% | ####### | ####### | | | | 118.12% | 100.00% | C | MBOW |
| | | | | | | | | | | | | | | | | | | | | | |
| CW CAS 1st Contact to LPHA | 1.04 | 1.58 | 1.74 | 1.72 | 1.55 | 1.50 | 2.33 | 1.72 | 2.91 | 2.67 | 2.64 | 2.90 | 2.34 | 2.84 | | | | 2.43 | <10 Days | NS | Epic |
| CW AMH 1st Contact to LPHA | 1.05 | 1.91 | 1.26 | 1.81 | 1.06 | 0.93 | 1.18 | 1.54 | 1.20 | 1.00 | 0.99 | 1.20 | 1.35 | 1.42 | | | | 1.20 | <10 Days | NS | Epic |
| | | | | | | | | | | | | | | | | | | | | | |
| CAS 1st Avail. Med Appt-COC | 7.00 | 5.17 | 7.50 | 6.88 | 4.70 | 7.69 | 2.83 | 5.07 | 2.73 | 1.46 | 4.00 | 4.25 | 5.72 | 3.44 | | | | 4.13 | <14 Days | C | Epic |
| CAS 1st Avail. Med Appt-COM | 6.16 | 7.56 | 6.84 | 6.32 | 4.94 | 6.09 | 8.12 | 10.24 | 11.92 | 10.84 | 8.78 | 9.04 | 12.19 | 13.94 | | | | 10.13 | <28 Days | NS | Epic |
| CAS # Pts Seen in 30-60 Days | 0 | 1 | 2 | 5 | 0 | 0 | 1 | 12 | 33 | 15 | 0 | 5 | 4 | 11 | | | | 9.00 | <9.18 | IOS | Epic |
| CAS # Pts Seen in 60+ Days | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | | 0.11 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AMH 1st Avail. Med Appt-COC | 4.38 | 4.34 | 4.62 | 4.18 | 5.00 | 4.74 | 4.79 | 3.94 | 4.86 | 4.40 | 3.49 | 3.22 | 3.57 | 4.3 | | | | 4.15 | <14 Days | C | Epic |
| AMH 1st Avail. Med Appt-COM | 10.94 | 12.16 | 12.77 | 15.52 | 17.09 | 16.80 | 14.70 | 15.08 | 13.93 | 13.52 | 12.86 | 13.05 | 12.37 | 11.62 | | | | 13.77 | <28 Days | NS | Epic |
| AMH # Pts Seen in 30-60 Days | 56 | 79 | 85 | 150 | 165 | 102 | 133 | 104 | 120 | 70 | 51 | 103 | 72 | 52 | | | | 89.67 | <45 | IOS | Epic |
| AMH # Pts Seen in 60+ Days | 1 | 0 | 0 | 0 | 17 | 25 | 29 | 24 | 18 | 65 | 28 | 3 | 16 | 13 | | | | 24.56 | 0 | IOS | Epic |
| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | | FY25 Target | Target Type | Data Origin |
| **Access to Care, Crisis Line** | | | | | | | | | | | | | | | | | | | | | |
| Total Calls Received | 16,377 | 17,758 | 17,457 | 18,518 | 18,277 | 18,616 | 19,396 | 18,689 | 18,081 | 18,259 | 18,851 | 20,700 | 20,567 | 22,164 | | | | 19,480 | | | |
| Total Answered (Handled) Calls | | | | | | 13,077 | 14,156 | 13,510 | 13,987 | 13,206 | 11,534 | 13,252 | 12,781 | 12,952 | | | | 13,162 | | | |
| AVG Call Length (Mins) | 11.1 | 11.6 | 11.10 | 10.80 | 11.60 | 11.10 | 11.30 | 11.40 | 12.10 | 12.00 | 11.40 | 11.70 | 11.8 | 11.6 | | | | 11.60 | | | |
| Service Level | 84.00% | 83.00% | 84.00% | 81.00% | 82.00% | 85.00% | 86.00% | 86.00% | 88.00% | 84.00% | 76.00% | 79.00% | 78.00% | 76.00% | | | | 82.00% | 95.00% | C | Brightmetrics |
| Abandonment Rate | 9.60% | 10.81% | 11.10% | 11.35% | 11.07% | 9.82% | 9.78% | 10.43% | 7.60% | 9.34% | 13.33% | 13.28% | 13.85% | 13.43% | | | | 11.21% | < 8.00% | NS | Brightmetrics |
| Occupancy Rate | 83.00% | 85.00% | 85.00% | 89.00% | 86.00% | 85.00% | 85.00% | 85.00% | 84.00% | 86.00% | 93.00% | 92.00% | 93.00% | 93.00% | | | | 88.44% | | | Brightmetrics |
| Avg staff per day | 36 | 32 | 33 | 34 | 31 | 36 | 37 | 34 | 40 | 35 | 33 | 36 | 38 | 32 | | | | | | IOS | Icarol |
| Access to Crisis Resp. Svc. | 76.80% | 77.60% | 87.00% | 93.70% | 90.30% | 95.90% | 87.70% | 92.30% | 89.40% | 92.90% | 95.20% | 93.20% | 97.90% | ######## | | | | 93.83% | 52.00% | C | MBOW |
| **PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours)** | | | | | | | | | | | | | | | | | | | | | |
| PES Total Visits | 1,017 | 1,044 | 1,063 | 1,139 | 1,078 | 1097 | 1,098 | 933 | 1,012 | 1,004 | 885 | 1,069 | 951 | 956 | | | | 1001 | | | |
| PES Admission Volume | 460 | 499 | 431 | 471 | 447 | 468 | 460 | 435 | 608 | 430 | 511 | 720 | 593 | 552 | | | | 530.78 | | | |
| Mechanical Restraints | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | 0.22 | | | |
| Mechanical Restraint Rate | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.07 | 0.00 | 0.00 | | 0.00 | 0.00 | 0.00 | 0.00 | | | | 0.01 | ≤ 0.01 | IOS | Epic |
| Personal Restraints | 46 | 48 | 47 | 36 | 11 | 36 | 47 | 35 | 13 | 44 | 35 | 69 | 23 | 39 | | | | 37.89 | | | Epic |
| Personal Restraint Rate | 3.67 | 3.13 | 3.41 | 2.84 | 0.89 | 1.45 | 3.35 | | | | | | | | | | | 2.40 | ≤ 2.80 | IOS | Epic |
| Seclusions | 42 | 41 | 35 | 31 | 8 | 31 | 48 | 34 | 48 | 45 | 38 | 72 | 29 | 42 | | | | 43.00 | | | Epic |
| Seclusion Rate | 3.35 | 2.68 | 2.54 | 2.45 | 0.65 | 1.09 | 3.42 | | | | | | | | | | | 2.26 | ≤ 2.73 | SP | Epic |
| AVG Minutes in Seclusion | 82.57 | 46.93 | 43.14 | 60.68 | 42.00 | 42 | 12.13 | 12.23 | 39.20 | 30.90 | 48.89 | 49.67 | 38.27 | 71.21 | | | | 38.28 | ≤ 61.73 | IOS | Epic |
| Emergency Medications | 28 | 38 | 33 | 37 | 8 | 30 | 56 | 38 | 39 | 43 | 29 | 81 | 26 | 55 | | | | 44.11 | | | Epic |
| EM Rate | 2.13 | 2.48 | 2.39 | 2.92 | 0.65 | 1.21 | 3.99 | | | | | | | | | | | 2.60 | ≤ 3.91 | IOS | Epic |
| R/S Monitoring/Debriefing | 100.00% | 100.00% | 100.00% | 100.00% | | | | | | | | | | | | | | #DIV/0! | 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 | 92.10% | 90.56% | 91.61% | 90.43% | 88.84% | 90.48% | 88.40% | 88.84% | 90.32% | 92.90% | 93.15% | 92.82% | 93.10% | 88.90% | | | | 90.99% | 88.70% | IOS | Qualtrics |
| **Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement)** | | | | | | | | | | | | | | | | | | | | | |
| QIDS-C | 28.66% | 29.11% | 30.30% | 31.54% | 31.93% | 25.27% | 24.47% | 27.26% | 27.36% | 27.20% | 27.02% | 27.76% | 28.48% | 28.71% | | | | 27.06% | 24.00% | IOS | MBOW |
| BDSS | 30.27% | 31.29% | 31.98% | 32.53% | 32.94% | 30.86% | 31.57% | 31.57% | 30.91% | 31.71% | 30.86% | 31.28% | 32.48% | 33.38% | | | | 31.62% | 32.00% | IOS | MBOW |
| PSRS | 36.75% | 38.00% | 38.79% | 40.26% | 40.36% | 35.52% | 36.68% | 35.78% | 34.97% | 35.45% | 35.83% | 36.87% | 38.28% | 39.91% | | | | 36.59% | 35.00% | IOS | MBOW |
| **Adult Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | | | | | | |
| BASIS-24 (CRU/CSU) | 94% | 118% | 86% | 84% | | | | | | | | | | | | | | #DIV/0! | 68% | IOS | McLean |
| QIDS-C | 47.50% | 49.70% | 48.80% | 51.30% | 48.10% | 47.00% | 49.80% | 47.00% | 45.30% | 48.30% | 48.00% | 50.20% | 50.60% | 44.50% | | | | 47.86% | 45.38% | IOS | Epic |
| BDSS | 44.70% | 46.60% | 46.50% | 46.50% | 47.10% | 45.30% | 46.80% | 45.70% | 47.20% | 48.10% | 48.70% | 43.90% | 45.00% | 45.70% | | | | 46.27% | 46.47% | IOS | Epic |
| PSRS | 37.80% | 36.80% | 35.90% | 36.40% | 36.90% | 39.50% | 37.70% | 36.10% | 39.90% | 36.10% | 40.70% | 37.70% | 36.40% | 41.80% | | | | 38.43% | 37.89% | IOS | Epic |
| **Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)** | | | | | | | | | | | | | | | | | | | | | |
| PHQ-A (11-17) | 44.50% | 44.30% | 48.90% | 41.50% | 42.10% | 43.40% | 45.40% | 50.50% | 43.50% | 31.00% | 41.60% | 35.20% | 36.20% | 43.60% | | | | 41.16% | 41.27% | IOS | Epic |
| PHQ-9 | 45.00% | 44.20% | 46.00% | 45.20% | 44.00% | 41.35% | 42.15% | 45.23% | 43.00% | 44.00% | 46.50% | | | | | | | 43.71% | 41.00% | IOS | Epic |
| **Adult and Child/Adolescent Needs and Strengths Measures** | | | | | | | | | | | | | | | | | | | | | |
| ANSA (Adult) | 37.70% | 39.40% | 40.70% | 42.10% | 42.80% | 32.50% | 33.30% | 34.70% | 35.20% | 36.00% | 36.60% | 37.70% | 39.10% | 40.20% | | | | 36.14% | 32.50% | C | MBOW |
| CANS (Child/Adolescent) | 28.60% | 30.70% | 32.80% | 35.00% | 36.20% | 17.20% | 18.80% | 19.20% | 22.20% | 25.70% | 30.70% | 35.70% | 44.50% | 48.90% | | | | 29.21% | 42.80% | C | MBOW |
| **Adult and Child/Adolescent Functioning Measures** | | | | | | | | | | | | | | | | | | | | | |
| DLA-20 (AMH and CAS) | 40.50% | 41.50% | 42.50% | 50.90% | 48.40% | 46.10% | 44.90% | | | | | | | | | | | 45.50% | 48.07% | IOS | Epic |

Plot Area

# 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.