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

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

Quality Committee Meeting
August 18, 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, July 21, 2026
(EXHIBIT Q-1)

IV. **REVIEW AND COMMENT**

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

B. Strategic Plan Goal-Dashboard
(EXHIBIT Q-3 Trudy Leidich)

V. ***EXECUTIVE SESSION-***

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

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

VI. **RECONVENE INTO OPEN SESSION**

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

VIII. **ADJOURN**

Veronica Franco

Veronica. Franco, Board Liaison
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, July 21, 2026 MINUTES

Dr. J. Lankford, Board Chair, called the meeting to order at 11:25 a.m. in Room 109, 9401 Southwest Freeway, noting that a quorum of the Committee was present.

RECORD OF ATTENDANCE

Committee Members in Attendance: Dr. J. Lankford, Dr. K. Bacon, Dr. Q. Moore, Dr. R, Gearing
R. Thomas-videoconference

Committee Member Absent:

Other Board Member in Attendance:

1. **CALL TO ORDER**
   Dr. J. Lankford called the meeting to order at 11:25 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Dr. Lankford designated R. Thomas as a voting member of the Quality Committee meeting.

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, May 19, 2026**

   MOTION BY: MOORE SECOND BY: BACON

   With unanimous affirmative votes,
   BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday May 19, 2026 as presented under Exhibit Q-1, are approved.

6. **REVIEW AND COMMENT**

   A. **Board Scorecard-**Luc Josphat and Lance Britt presented the Quality Board Scorecard to the Quality Committee

7. EXECUTIVE SESSION-No executive session needed.

8. **RECONVENE INTO OPEN SESSION -**

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

10. ADJOURN

MOTION: GEARING SECOND: BACON

There being no further business, the meeting adjourned at 11:33 a.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

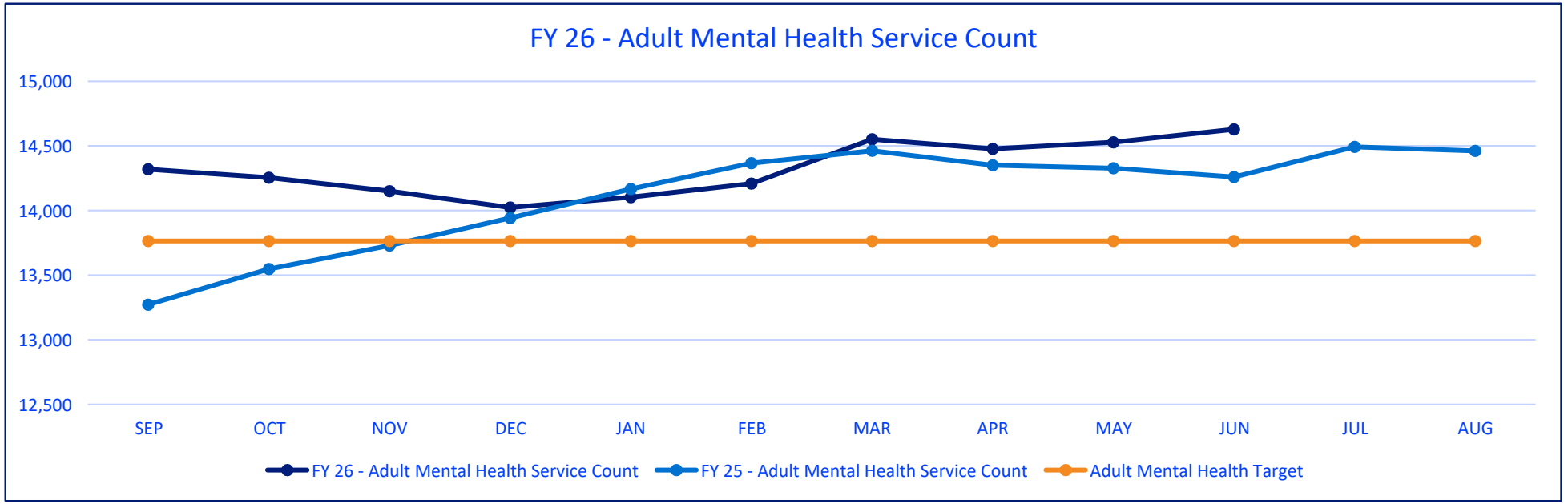
Quality Board Scorecard

Board Quality Committee Meeting

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

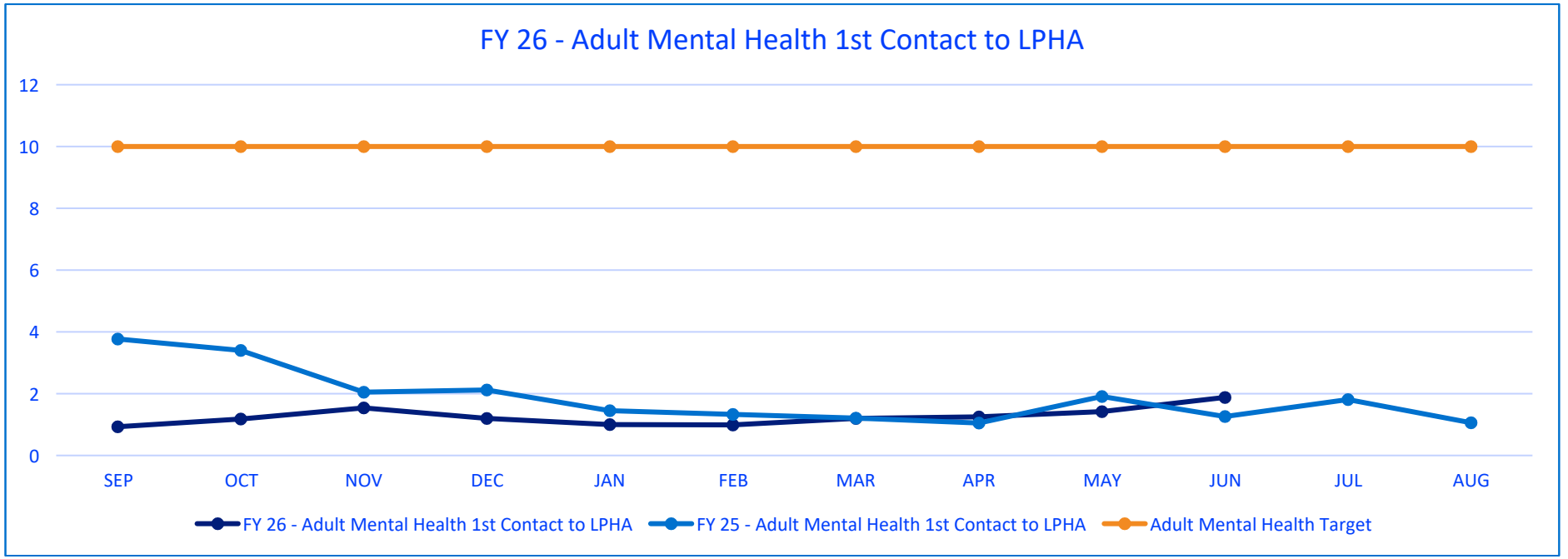
August 2026 (Reporting June 2026 Data)

Domain	Measure	2026 Fiscal Year State Service Care Count Target	2026 Fiscal Year State Care Count Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	14,324	14,628	Higher is Better	Contractual



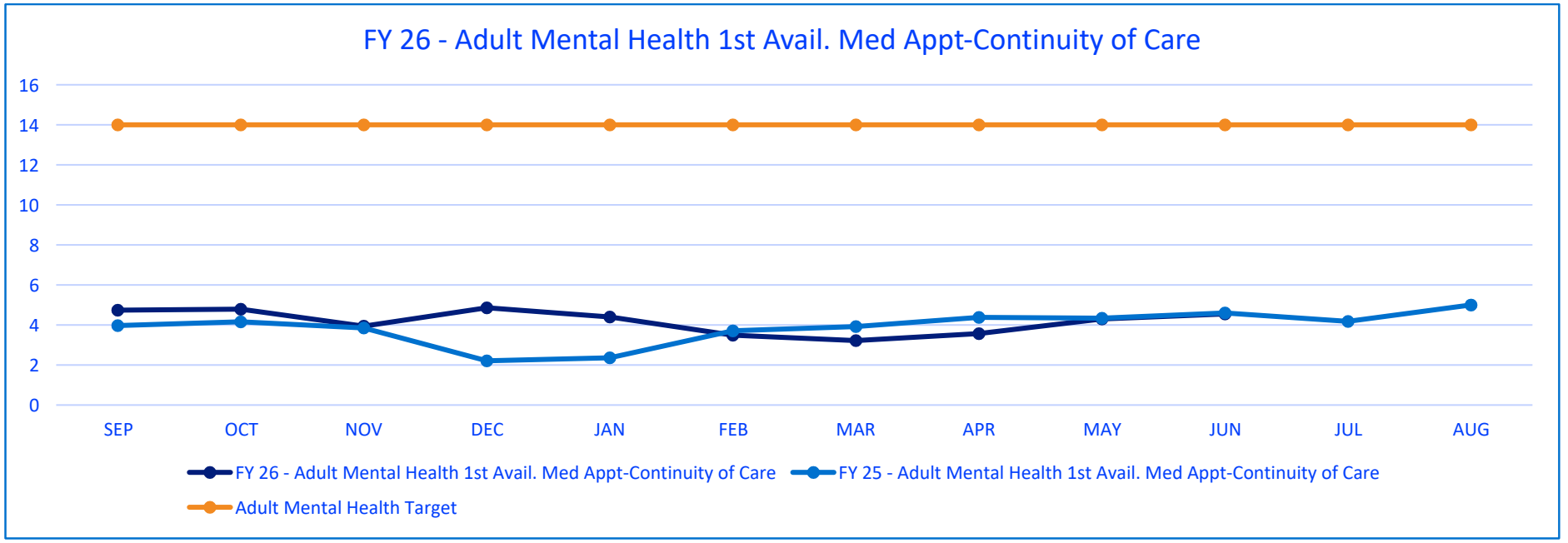
Notes: In June, Adult Mental Health service care count was 14,628, exceeding the FY26 target of and remaining above prior-year performance.

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	First Contact to LPHA	<10 days	1.26 days	1.88 days	Lower is Better	Contractual



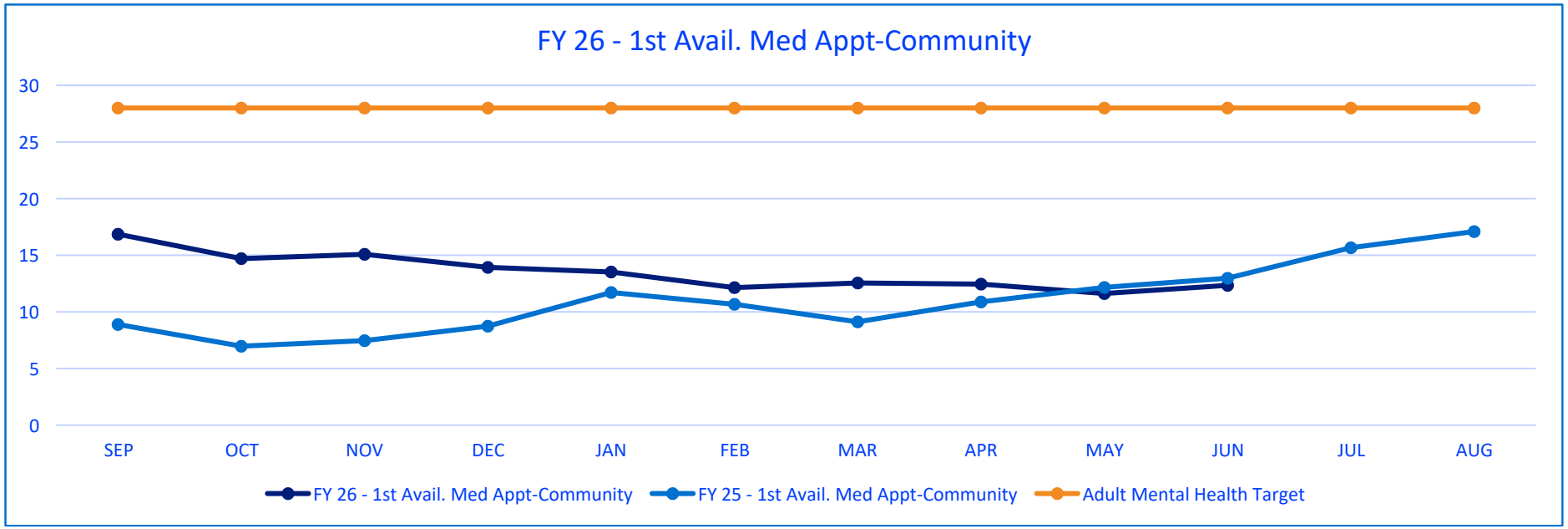
Notes: In June, first contact to LPHA was achieved on average of 1.88 days, exceeding the FY26 target of less than 10 days and above prior-year performance.

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	First Avail. Med Appt-Continuity of Care	<14 days	4.19 days	4.55 days	Lower is Better	Contractual



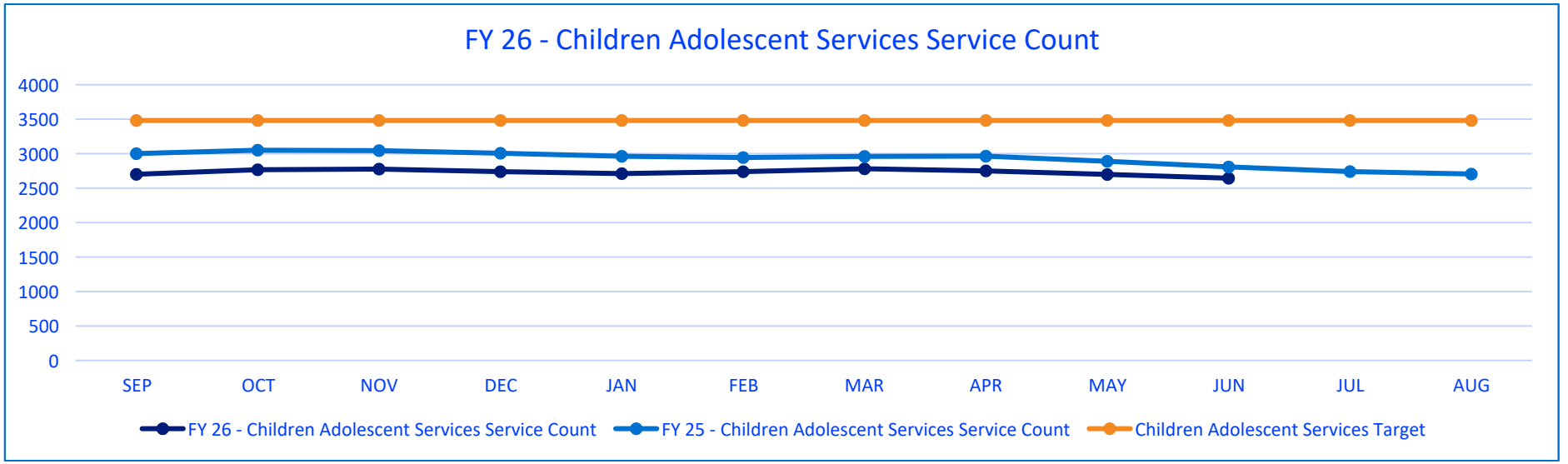
Notes: In June, First Available Med Appt-Continuity of Care was achieved on average of 4.55 days, exceeding the FY26 target of less than 14 days

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	First Available Medical Appointment Community	<28 days	13.52 days	12.34 days	Lower is Better	Contractual



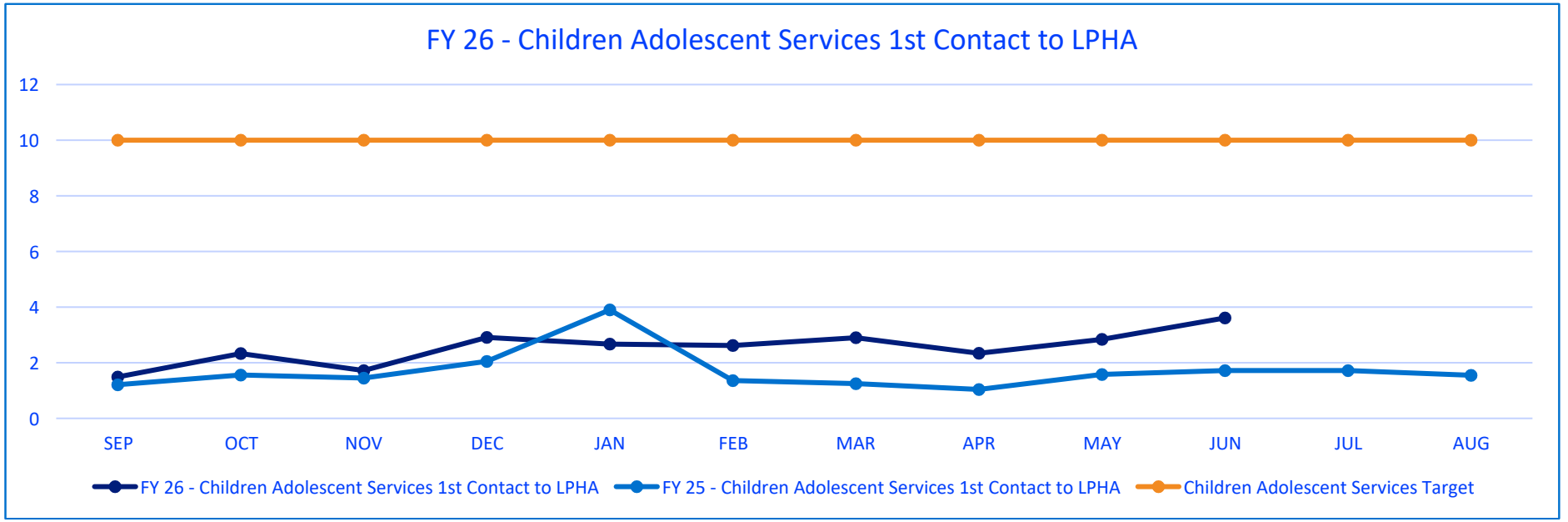
Notes: In June, First Available Medical Appointment Community was achieved on average of 12.34 days, exceeding the FY26 target of less than 28 days

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average (September–June)	Reporting Period- June	Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	2,731	2,644	Higher is Better	Contractual



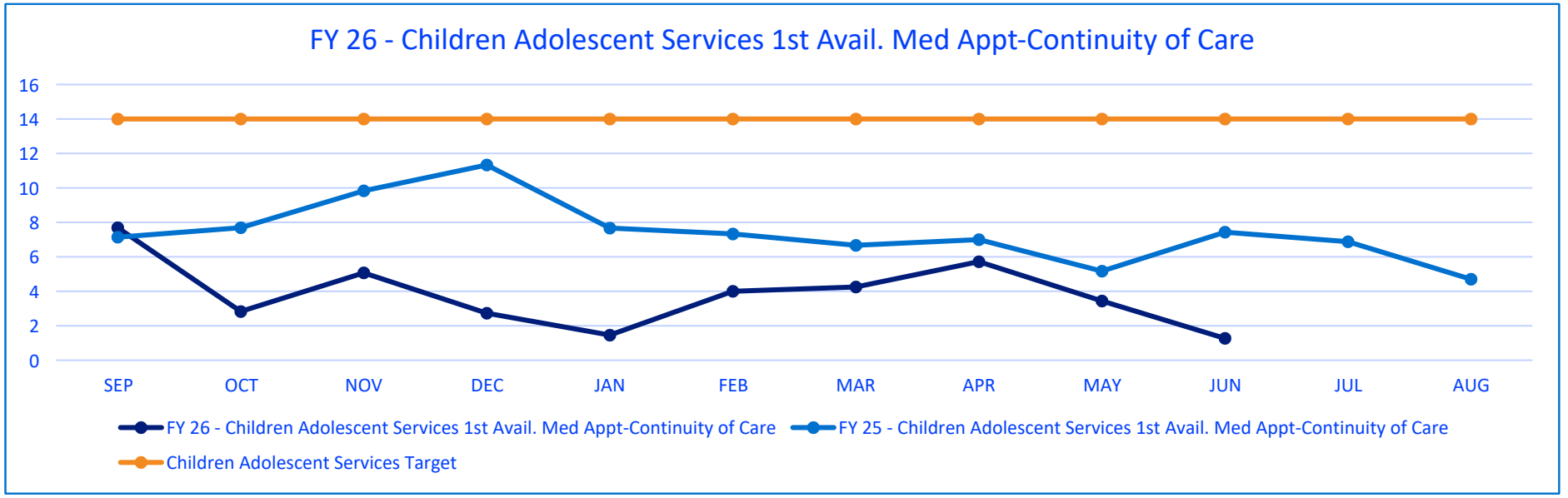
Notes: In June, Children and Adolescent Services recorded 2,644 service care counts, remaining below the FY26 target of 3,481

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	Children and Adolescent First Contact to LPHA	<10 days	2.54 days	3.61 days	Lower is Better	Contractual



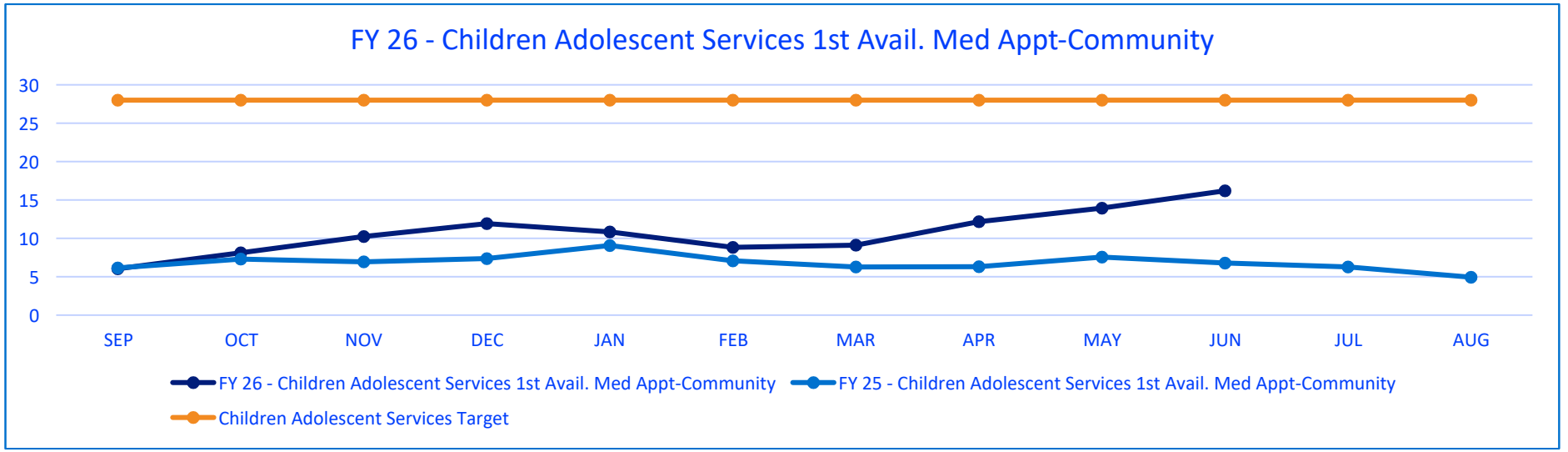
Notes: In June, Children and Adolescent first contact to LPHA was achieved on average of 3.61 days, exceeding the FY26 target of less than 10 days

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	Children and Adolescent First Avail. Med Appt-Continuity of Care	<14 days	3.85 days	1.27 days	Lower is Better	Contractual



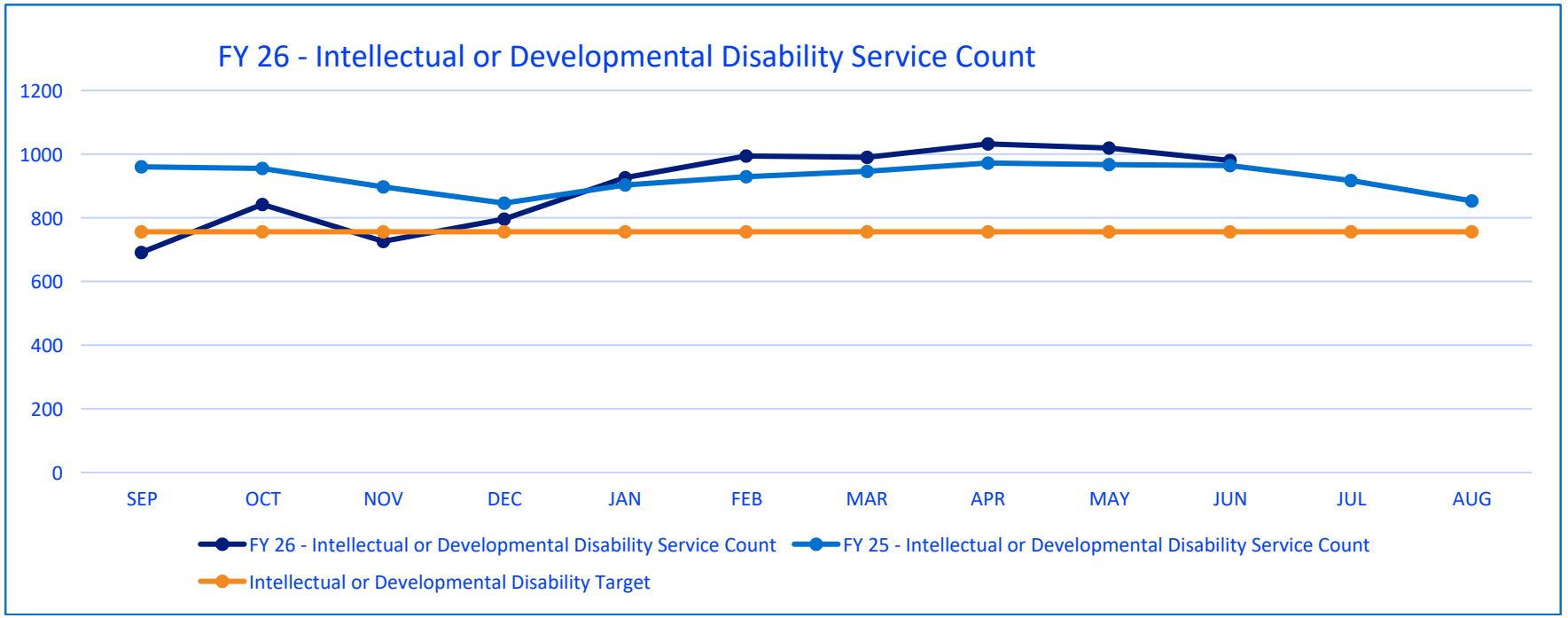
Notes: In June, Children and Adolescent First Available Med Appt-Continuity of Care was achieved on average of 1.27 days, exceeding the FY26 target of less than 14 days and above prior-year performance.

Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – June)	Reporting Period: June	Desired Direction	Target Type
Access	Children and Adolescent First Available Medical Appointment Community	<28 days	10.74 days	16.19 days	Lower is Better	Contractual



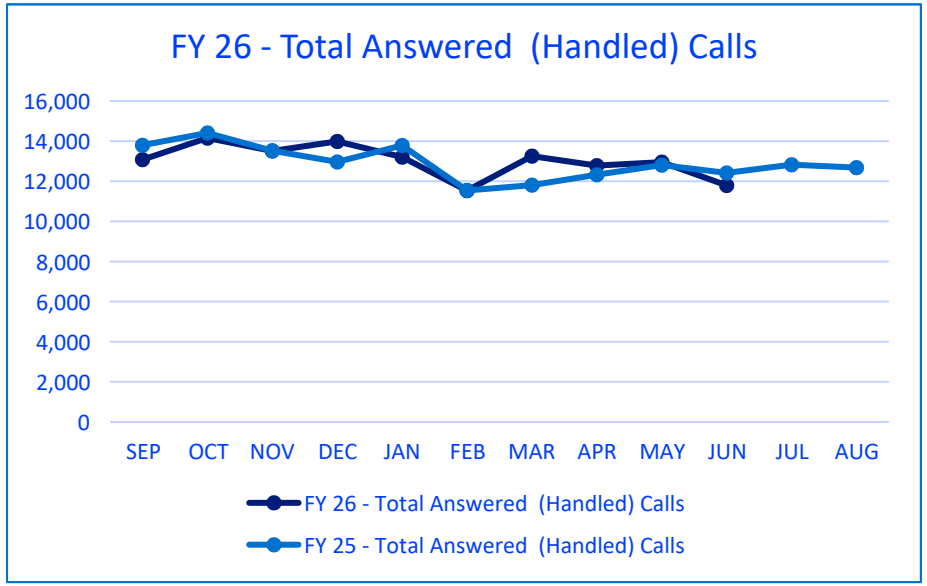
Notes: In June, Children and Adolescent First Available Medical Appointment Community was achieved on average of 16.19 days, exceeding the FY26 target of less than 28 days.

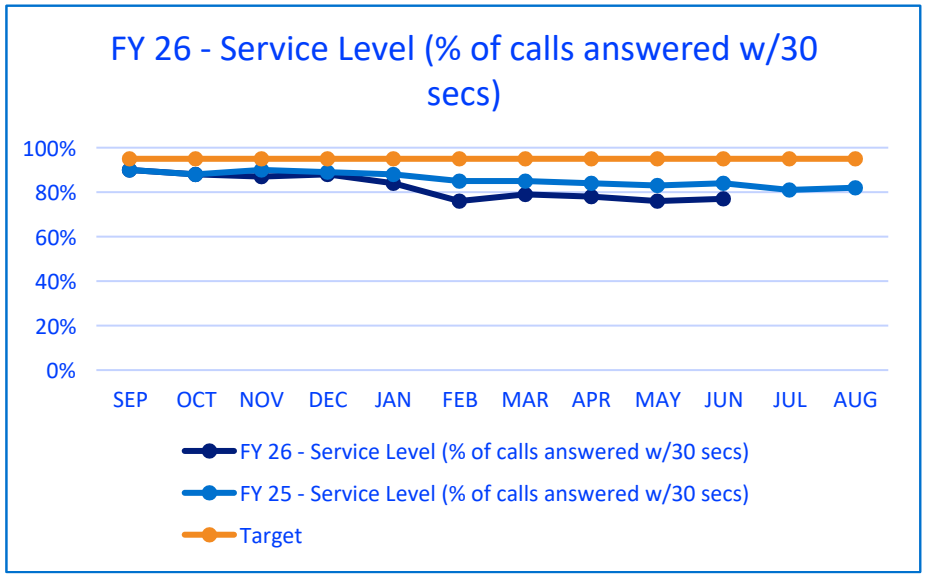
Domain	Program	2026 Fiscal Year Target	2026 Fiscal Year Average (September – June)	Reporting Period- June	Desired Direction	Target Type
Access	IDD	756	900	980	Higher is Better	Contractual



Notes: In June, IDD service count reached 980, exceeding the FY26 target of 756 and outperforming prioryear results. Performance demonstrates sustained growth and strong utilization.

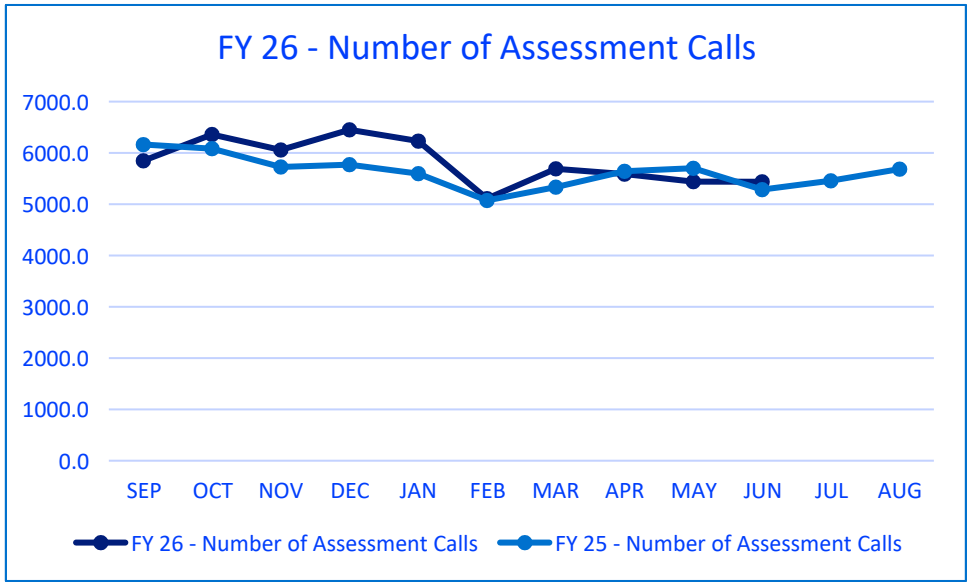
Domain	Measure	FY 2026 Target	2026Fiscal Year Average (September - June)	Reporting Period- June	Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	13,025	11,795	N/A	N/A
Timely Care	Percent of calls answered w/in 30 secs	> 95%	82%	77%	Higher is Better	Contractual

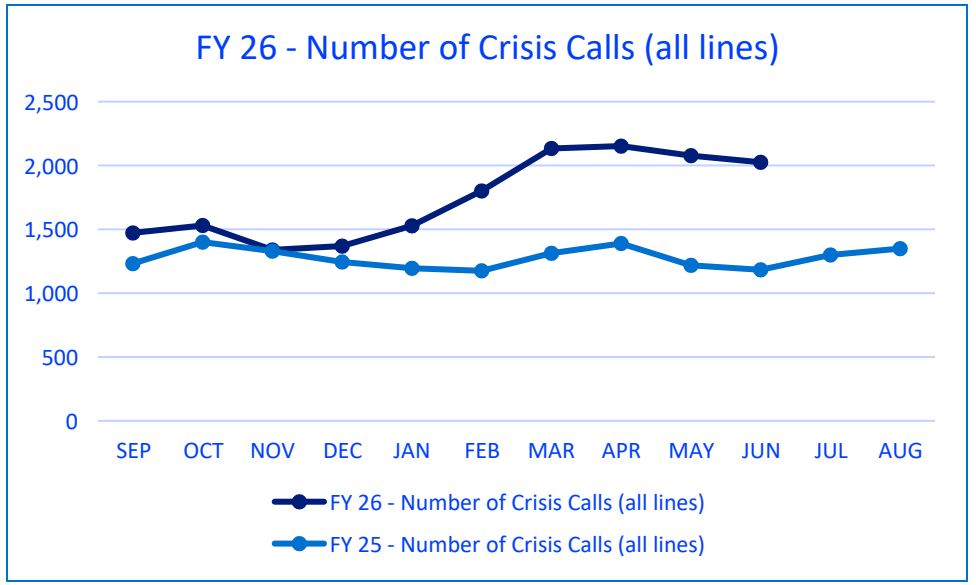




Notes: In June, 11,795 calls were answered, while service level performance was 77%, below the >95% target and lower than prioryear results. Performance reflects ongoing access and capacity pressures.

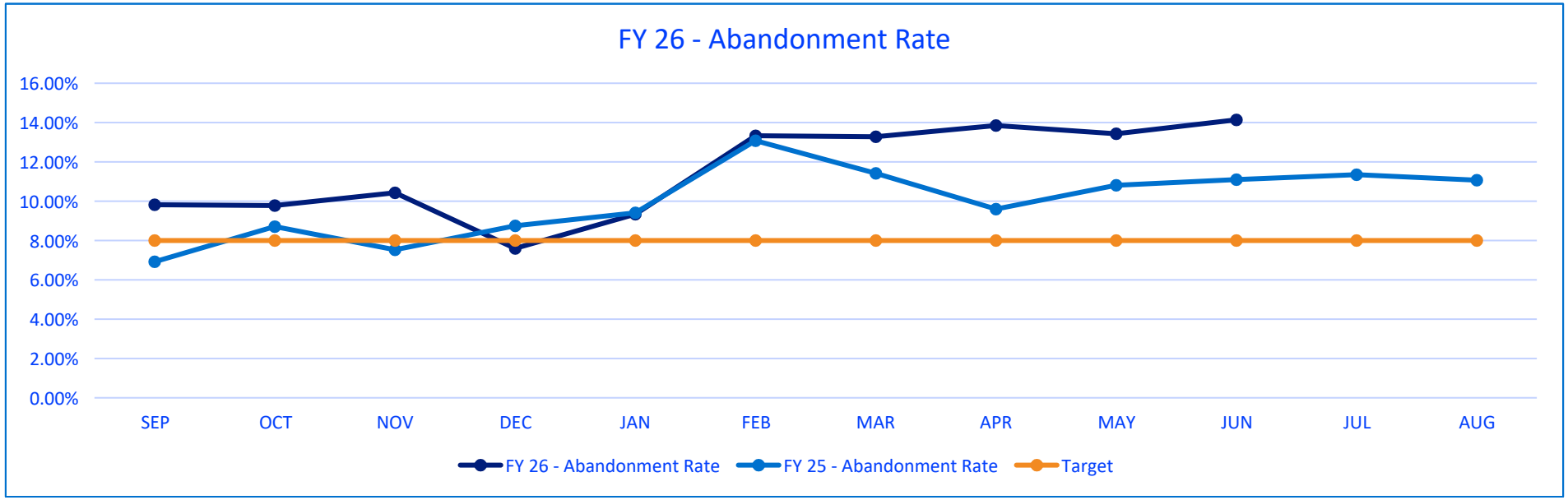
Domain	Measures (Definition)	FY 2026 Target	2026Fiscal Year Average (September - June)	Reporting Period- June	Desired Direction	Target Type
Timely Care	Number of Assessment Calls	N/A	5,821	5,438	N/A	
Timely Care	Number of Crisis Calls	N/A	1,743	2,025	N/A	





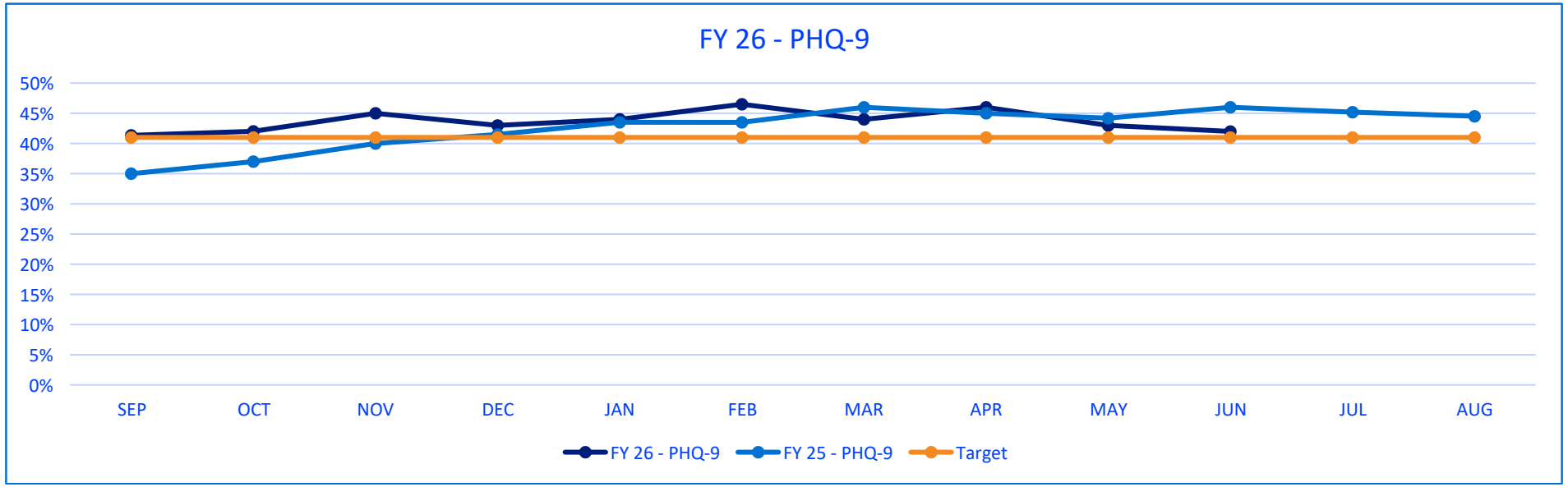
Notes: In June, crisis calls totaled 2,025, exceeding prior-year levels, while assessment calls totaled 5,438, remaining relatively stable year over year. Trends indicate increased crisis demand across access points.

Domain	Measures	FY 2026 Target	2026Fiscal Year Average (September - June)	Reporting Period- June	Desired Direction	Target Type
Timely Care	Abandonment Rate	<8%	11.50%	14.14%	Lower is Better	Contractual



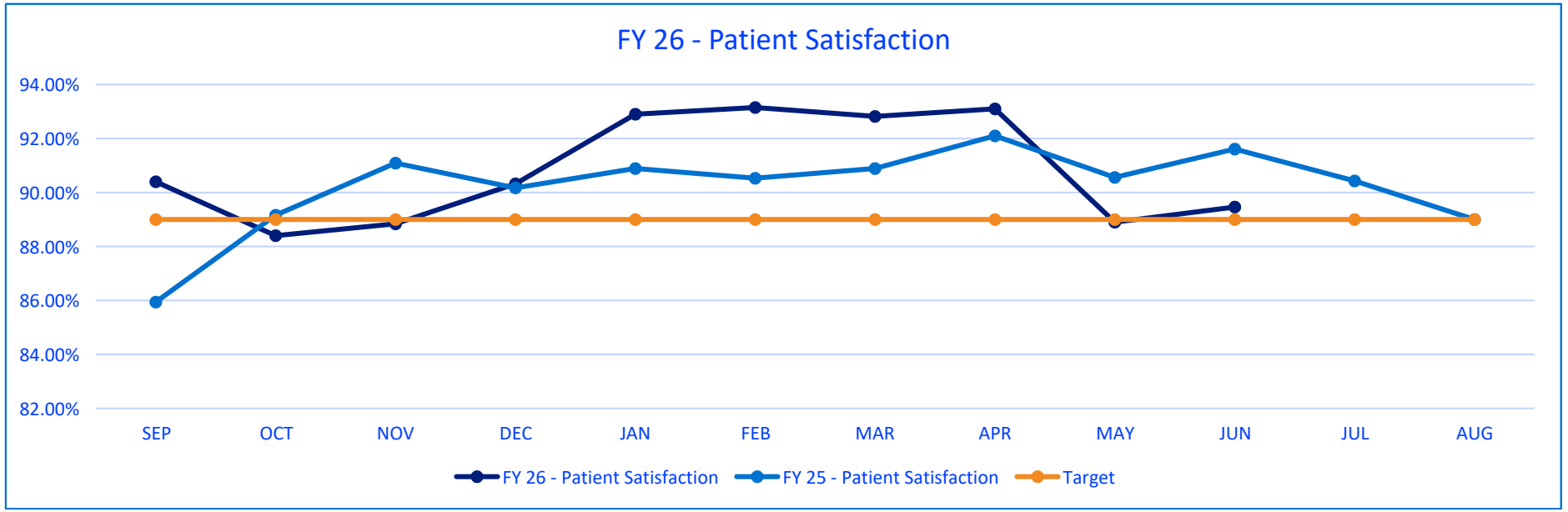
Notes: In June, the call abandonment rate was 14.14%, exceeding the FY26 target of <8% and higher than prior-year performance. Results highlight continued access and staffing challenges.

Domain	Measures	FY 2026 Target	2026Fiscal Year Averag e (September – June)	Reporting Period- June	Desired Direction	Target Type
Clinical Effectiveness	PHQ-9	41.27%	44%	42%	Higher is Better	IOS



Notes: In June, PHQ-9 improvement reached 42%, exceeding the FY26 target of 41.27%. Performance demonstrates sustained positive clinical outcomes.

Domain	Measures (Definition)	2026 Fiscal Year Target	2026Fiscal Year Average (September - June)	Reporting Period- June	Desired Direction	Target Type
Clinical Effectiveness	Patient Satisfaction	89%	90.83%	89.46%	Higher is Better	IOS



Notes: In June, patient satisfaction was 89.46%. A reversal of the 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	2,699	2,644			2,731	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%	77.54%	75.96%			78.44%	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%	77.00%			81.50%	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%	14.14%			11.50%	< 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	14,528	14,628			14,326	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%	105.27%	105.55%	106.28%			104.08%	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	2,699	2,644			2,731	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%	77.54%	75.96%			78.44%	100.00%	C	MBOW
IDD Service Target	972	969	966	920	851	689	839	722	790	920	990	1037	1031	1016	980			901	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%	136.38%	134.39%	129.63%			119.23%	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	3.61			2.55	<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	1.88			1.27	<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	1.27			3.85	<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	13.83	16.19			10.72	<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	35			11.60	<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			0.10	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	4.55			4.19	<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	12.34			13.63	<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	63			87.00	<45	IOS	Epic
AMH # Pts Seen in 60+ Days	1	0	0	0	17	25	29	24	18	65	28	3	16	13	10			23.10	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																					
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%	77.00%			81.50%	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%	14.14%			11.50%	< 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%	93.00%			88.90%			Brightmetrics
Avg staff per day	36	32	33	34	31	36	37	34	40	35	33	36	38	32	36					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%	100.00%	97.60%			94.21%	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	944			995			
PES Admission Volume	460	499	431	471	447	468	460	435	608	430	511	720	593	552	551			532.80			
Mechanical Restraints	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0			0.20			
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	0.00			0.01	≤ 0.01	IOS	Epic
Personal Restraints	46	48	47	36	11	36	47	35	13	44	35	69	23	39	60			40.10			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						38	72	29	42	63			45.00			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	46.22			39.07	≤ 61.73	IOS	Epic
Emergency Medications	28	38	33	37	8	30	56	38	39	43	29	81	26	55	65			46.20			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

Series "Children Adolescent Services Target" Legend Entry

	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%	89.46%			90.84%	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%	30.16%			27.37%	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%	34.31%			31.89%	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%	41.35%			37.06%	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%	51.00%			48.17%	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%	44.50%			46.09%	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%	35.90%			38.18%	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%	48.20%			41.86%	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%	42.50%			36.78%	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%	52.30%			31.52%	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

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-3

Quality Strategic Plan Goal

Operationalize Just-in-Time Organizational Dashboards

Presented by: Trudy Leidich,
VP of Clinical Transformation & Quality
August 18, 2026

Goal 1.3

Operationalize just-in-time organizational dashboards for different staff and management levels and disseminate to core programs and departments

01 Build

Complete operational dashboards supporting the Bringing Leaders Together (BLT) Leadership Team.

02 Tailor

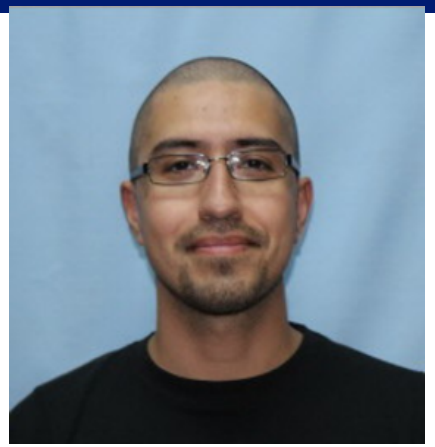
Deploy dashboards for staff, managers, and leadership levels across core programs and departments.

03 Automate

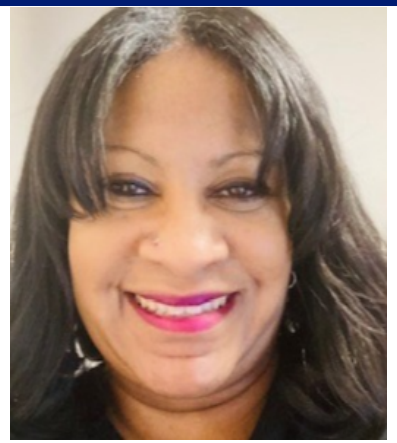
Develop Power BI push notifications to deliver dashboard insights directly to leaders.

FY2025 develop | FY2026 focus: 50% reports automated | FY2027 target: 75% reports automated

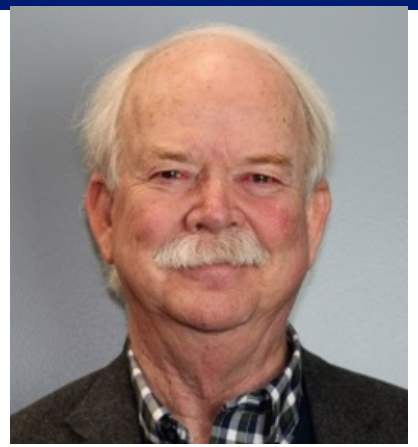
Development Team



Juan Castaneda
IT Principal Data Scientist



Dana Thomas
Data Extractor



Dr. Scott Hickey
Sr. Director Health Analytics and Research

Dr. Holly Cumbie
Sr. Director Pharmacy

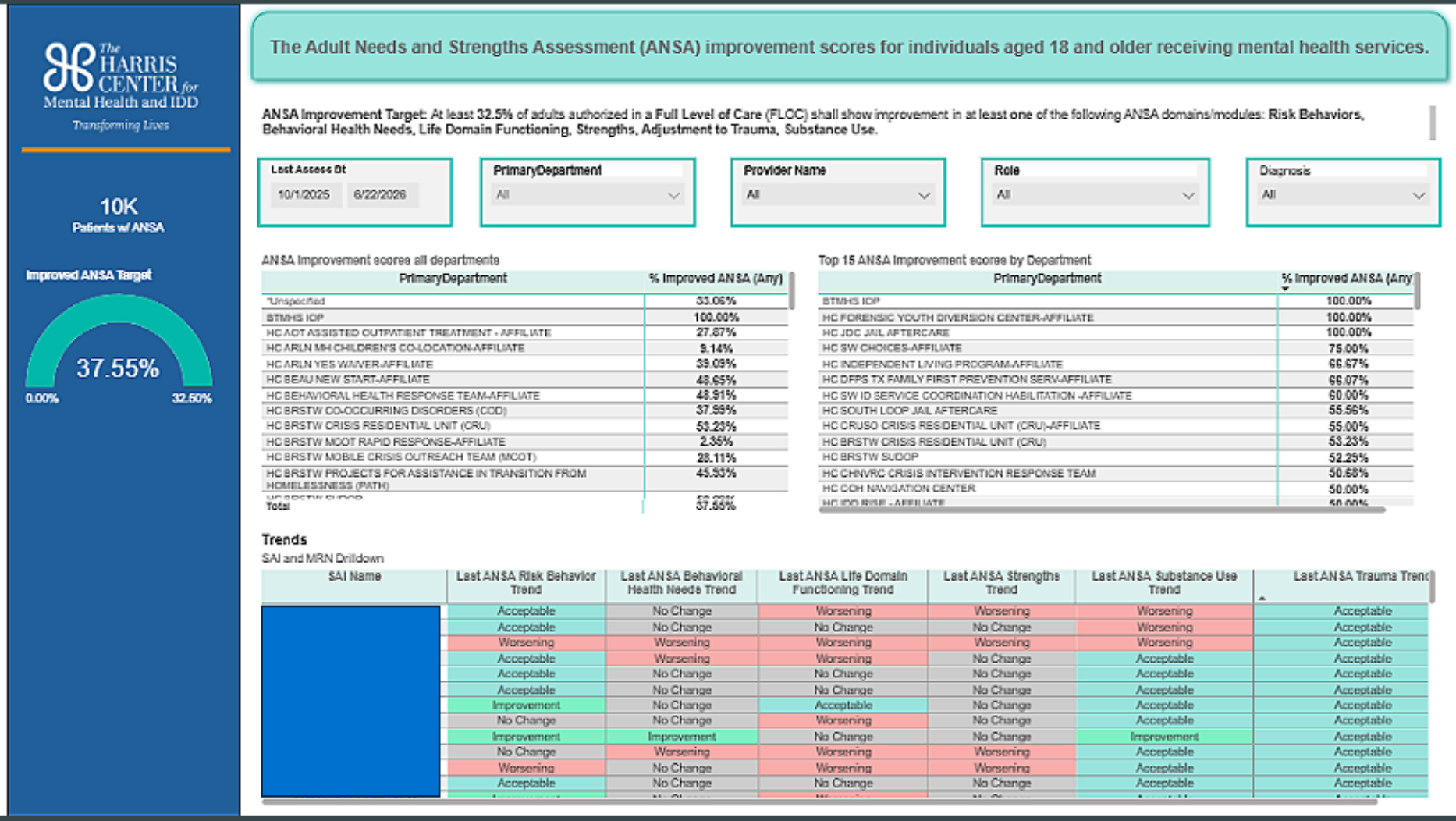
Luis Morales
Data Systems Manager

Sara Sanchez
Program Director III

Trudy Leidich
VP Clinical Transformation and Quality

Sridatri Chakraborty
Health Analytics Analyst III

AMH MBOW

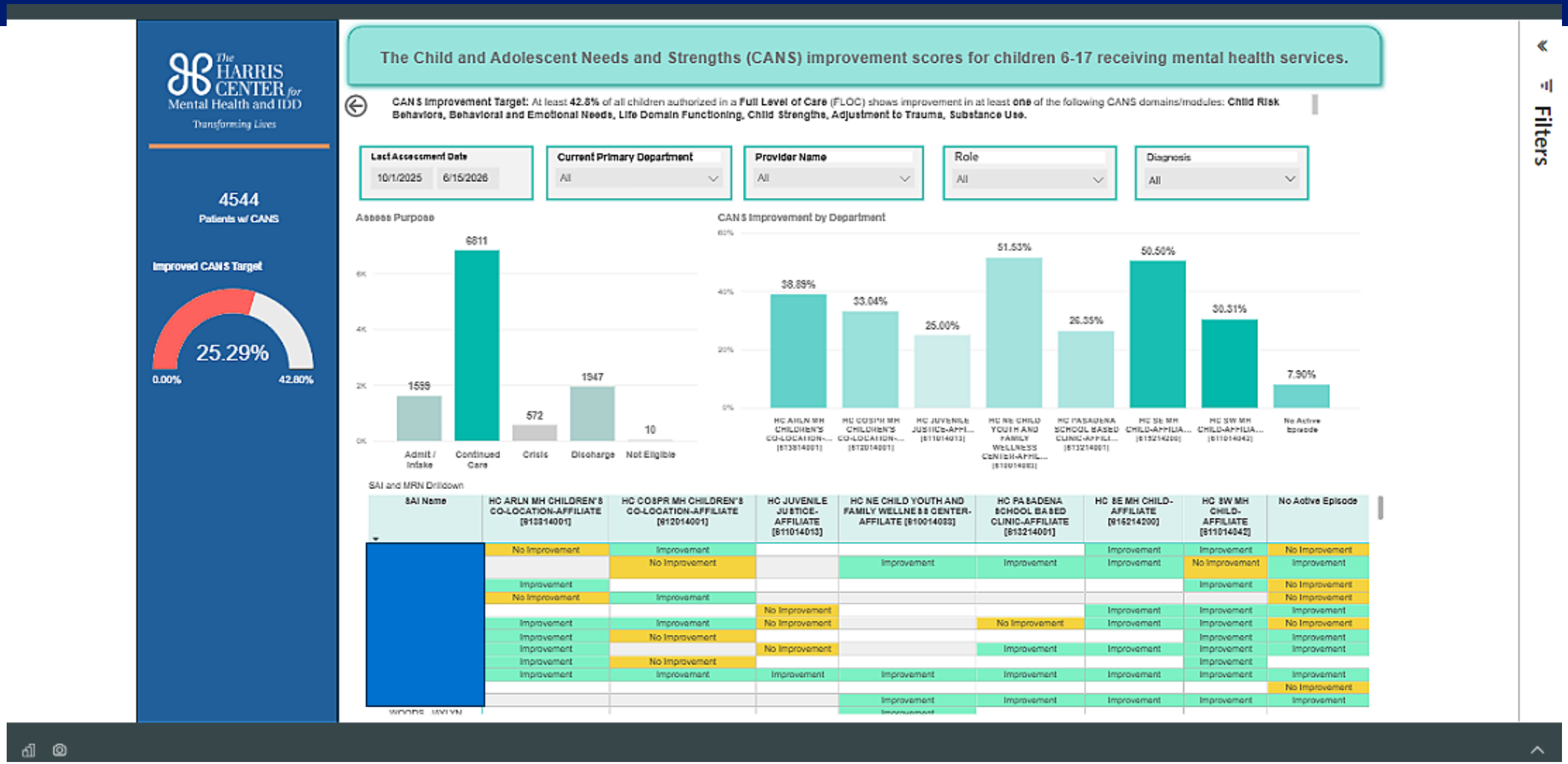


Contact: Dana Thomas or Data Services Team

AMH MBOW — Adult Mental Health Dashboard

- **What it shows:** a screenshot of the live AMH MBOW dashboard, covering the Adult Needs and Strengths Assessment (ANSA) improvement scores for adults aged 18 and older receiving mental health services.
- **Headline metric:** a gauge tracking assessment performance against target, currently reading roughly 37–38%, alongside a total population count.
- **Drill-down views:** paired tables ranking measures by highest and lowest performance, plus a detail grid with color coding (green/red) flagging where results are meeting or missing thresholds.
- **Filters built in:** slicers across the top let users slice by program, provider, and time period, so it works as a self-service tool rather than a static report.

Child and Adolescent Needs and Strengths (CANS)

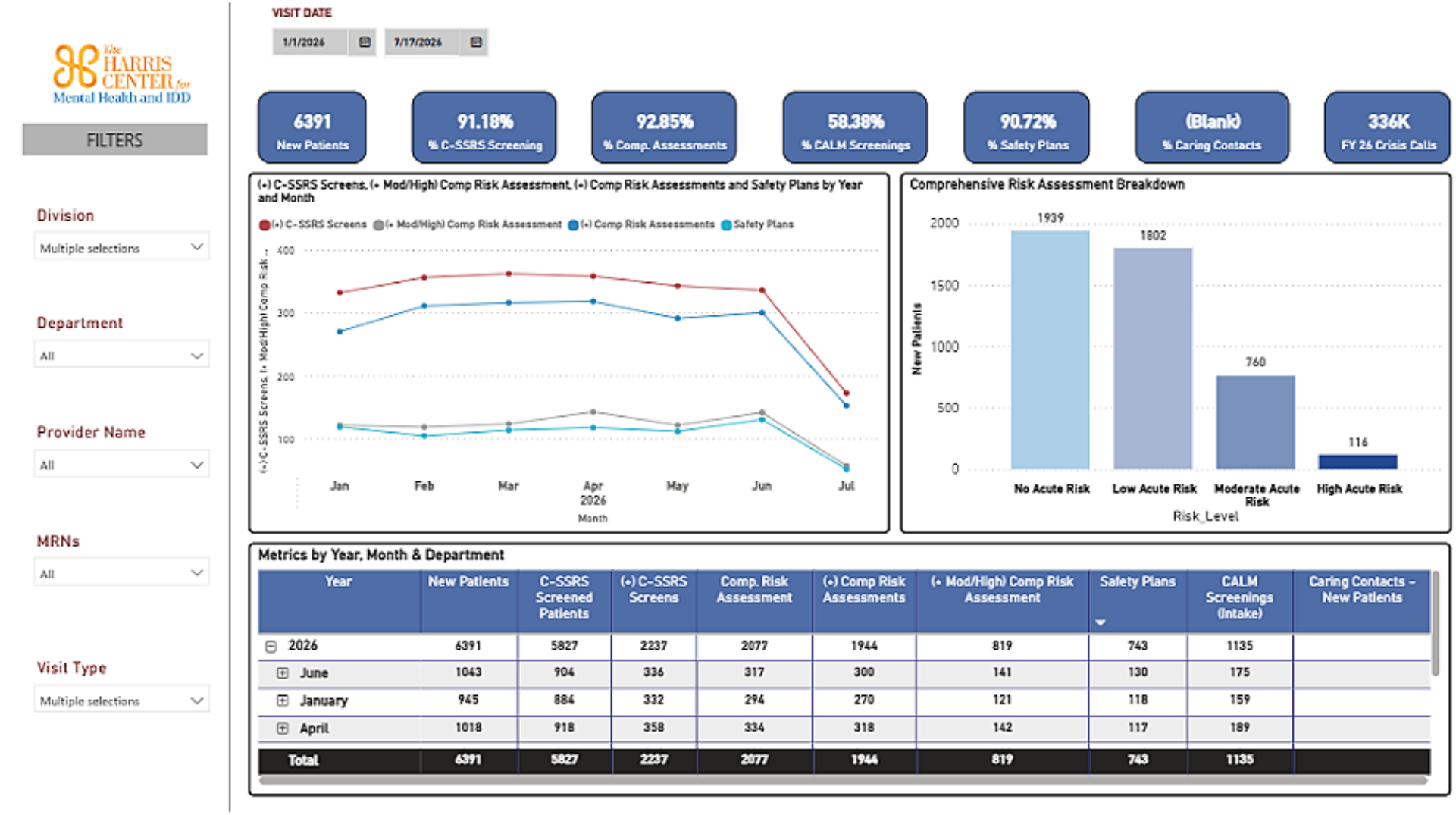


Contact: Dana Thomas or Data Services Team

Child and Adolescent Needs and Strengths (CANS) Dashboard

- This is the child and adolescent counterpart to the adult view you just saw. Same warehouse, same reporting standard. CANS is the state-mandated assessment for youth, where ANSA covers adults 18 and older
- CANS measures needs and strengths across a young person's life domains, behavioral health, functioning, risk, and caregiver supports, so improvement here reflects the whole picture around the child, not just symptom counts.
- The dashboard reads the same way as the adult one on purpose: a headline improvement rate against target up front, then a breakdown of where we're performing best and worst by measure.
- Program and provider filters mean a youth services manager can pull their own caseload view in seconds instead of routing a request through the data team, that's the just-in-time piece of Goal 1.3 in practice.
- Because the layout mirrors the adult dashboard, leaders who work across both populations don't have to relearn anything moving between them. That consistency is deliberate and it's a big part of making adoption smooth

Zero Suicide



Contact: Dana Thomas or Data Services Team

Zero Suicide

- **What it tracks**: fidelity to the Zero Suicide model across the system: who got screened, who got a risk assessment, and who left with a safety plan
- **Top row is the scorecard**: KPI tiles showing total encounters plus completion rates on each step, most sitting in the low-to-high 90s. That's the "are we doing the basics every time" read
- **Trend lines show consistency, not just level**: Month-over-month performance by measure
- **Bar chart:** Compares assessment completion across categories so we can see which settings lag
- **Detail table breaks it out by year and department**: This is where a program director finds their own numbers rather than the system average. Filters by division, department, program, and visit type, so the same dashboard serves clinic-level and executive audiences
- **Why it matters**: Screening without a completed safety plan is the gap that actually costs lives. This makes that gap visible in near real time

MDD Remission Pharmacy

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FILTERS

MRN

All

PHQ9 Date

1/1/2024

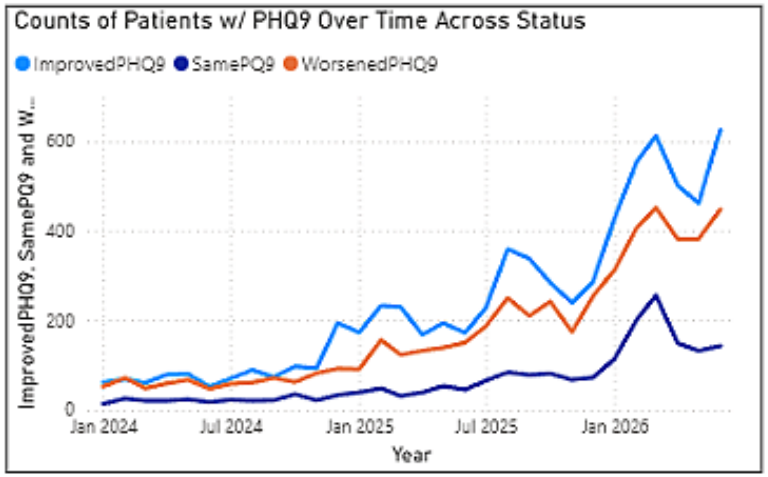
7/15/2026

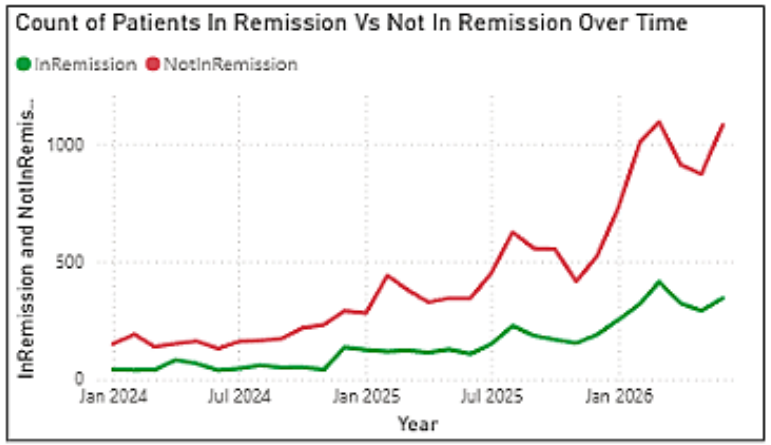
PHQ9 Status

- Select all
- Decrease
- Increase
- Same

Department Name

All





Year	ImprovedPHQ9	SamePQ9	WorsenedPHQ9
2026	**3455**	**1074**	**2570**
March	613	256	452
February	553	200	406
April	502	149	382
June	626	143	448
May	462	132	382
January	429	114	313
July	270	80	187
2025	**2904**	**702**	**2108**
August	359	84	250
October	284	81	242
September	338	78	210
December	286	72	254
November	239	67	174
July	228	65	187
May	194	53	139
February	233	48	156
June	172	45	150
January	173	39	91
April	168	39	132
March	230	31	123
2024	**1015**	**270**	**770**
October	97	35	62
December	194	33	92
February	68	25	71
May	80	23	67
July	70	22	58
September	73	21	71
Total	**7374**	**2046**	**5448**

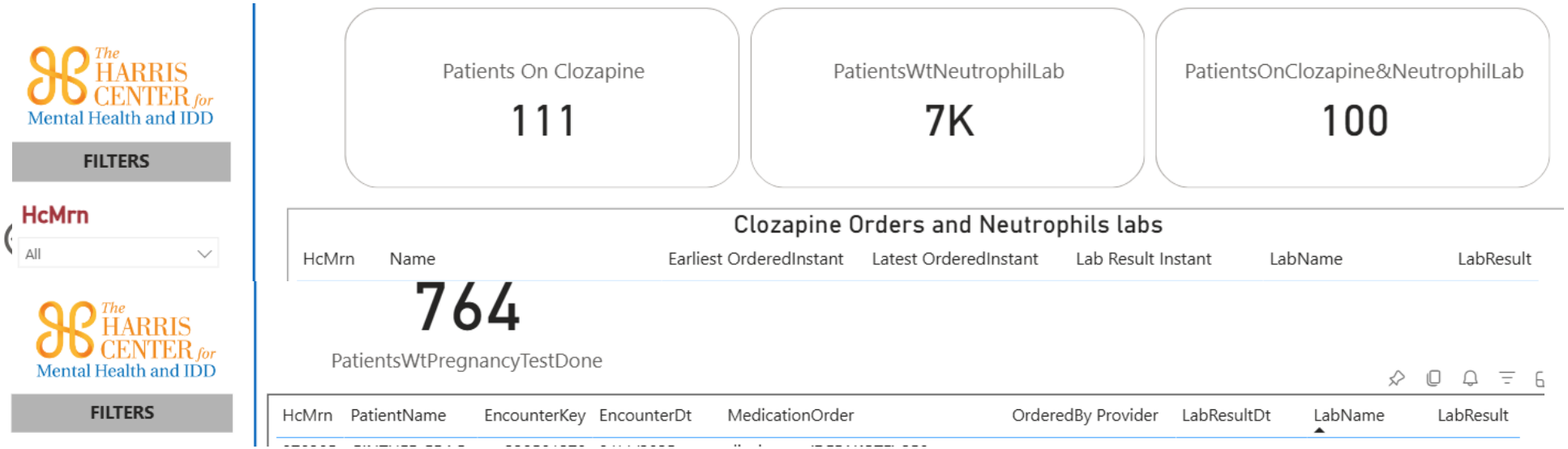
Contact: Pharmacy or Data Services Team

MDD Remission

- **What it tracks**: Remission from major depressive disorder for patients on pharmacotherapy, PHQ-9 screening, follow-up interval, and response or remission at follow-up
- **Goal 1.3 — just-in-time dashboards**: Prescribers and program leaders see their own panel in near real time, filtered by department, program, and provider, instead of waiting on a report request
- **Clinical quality and outcomes**: Remission is an outcome measure, not a process count, it tells us whether treatment is working, not just whether a visit happened
- **Where the gaps show up**: Patients never re-screened at the follow-up interval, and patients whose scores stall. Both are visible early enough to change a medication or care plan
- **Why it matters**: Paired with the pharmacy safety dashboards, this gives one view of whether medication management is both safe and effective

Pharmacy Clinical Dashboards

- Developed clinical dashboards to support medication safety monitoring.
- Implemented dashboards for Clozapine, Antipsychotic Polypharmacy, and Teratogenic Medications.
- Identifies monitoring gaps and required laboratory assessments.
- Enables provider intervention to improve medication safety and patient safe care.



Thank you.

Questions