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
September 15, 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, August 18, 2026
(EXHIBIT Q-1)

IV. **CONSIDER AND RECOMMEND ACTION**

A. Performance Improvement Plan FY 2027
(EXHIBIT Q-2 Trudy Leidich)

V. **REVIEW AND COMMENT**

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

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.

• 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

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, AUGUST 18, 2026 MINUTES

Dr. J. Lankford, Board Chair, called the meeting to order at 11:00 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. R, Gearing, BG (Ret) E. Grantham, Dr. Q. Moore-videoconference
Committee Member Absent: R. Thomas

Other Board Member in Attendance: Dr. M. Miller, Jr.

1. **CALL TO ORDER**
   Dr. J. Lankford called the meeting to order at 11:00 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   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, July 21, 2026**

   MOTION BY: GEARING SECOND BY: BACON

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

6. **REVIEW AND COMMENT**

   A. **Board Scorecard-**Trudy Leidich and Lance Britt presented the Quality Board Scorecard to the Quality Committee

B. Strategic Plan Goal Dashboard-Trudy Leidich 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: GRANTHAM SECOND: BACON

There being no further business, the meeting adjourned at 11:34 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

The Harris Center System Quality, Safety and Experience Performance Improvement Plan FY 2027

Introduction

The Harris Center System Quality, Safety and Experience Performance Improvement Plan FY 2027 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 2027 Goals

- Continue to build upon a learning health system focused on continuous quality improvement, patient safety, improving processes and outcomes.
- Transition the Change + Transformation Institute (CTI) from a successful pilot to a sustainable leadership development program embedded within The Harris Center. Building on the FY26 launch, FY27 will focus on establishing CTI as an ongoing investment in our workforce, strengthening leadership development, succession planning, and staff retention.
- 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 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.

FY2027 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.
- ~~Substance Use Program Development: Expansion of treatment capacity and integrated support for substance use disorders.~~
- Law Enforcement Collaboration: Joint training and engagement initiatives focused on identifying and referring individuals with IDD and/or ASD.
- Strengthen the Major Depressive Disorder (MDD) Remission Program by advancing a consistent, outcomes-driven approach to improving depression care. FY27 will focus on increasing remission outcomes through standardized measurement, timely clinical follow-up, and data-driven improvement, supporting The Harris Center's commitment to quality, accountability, and better outcomes for the people we serve.

  ~~MDD~~

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.~~
- **Close the Loop on CQI Data:** Every quarter, review CQI outcomes against targets, name the gaps, and assign owners and deadlines for the staffing, service, and scheduling fixes that follow.

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- 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)
- Chief Administrative Officer
- 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
- Director of Quality Assurance and PI Director of Adult MH
- Director of Children and Adolescent Services Lead PI specialist
- Southwest Practice Manager Southeast Practice Manager Northeast Practice Manager
- Northwest Practice Manager
- Health Analytics
- IDD Representative
- Risk Management Representative
- Nursing Representative
- Ad Hoc members as needed

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.

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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.]

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.

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

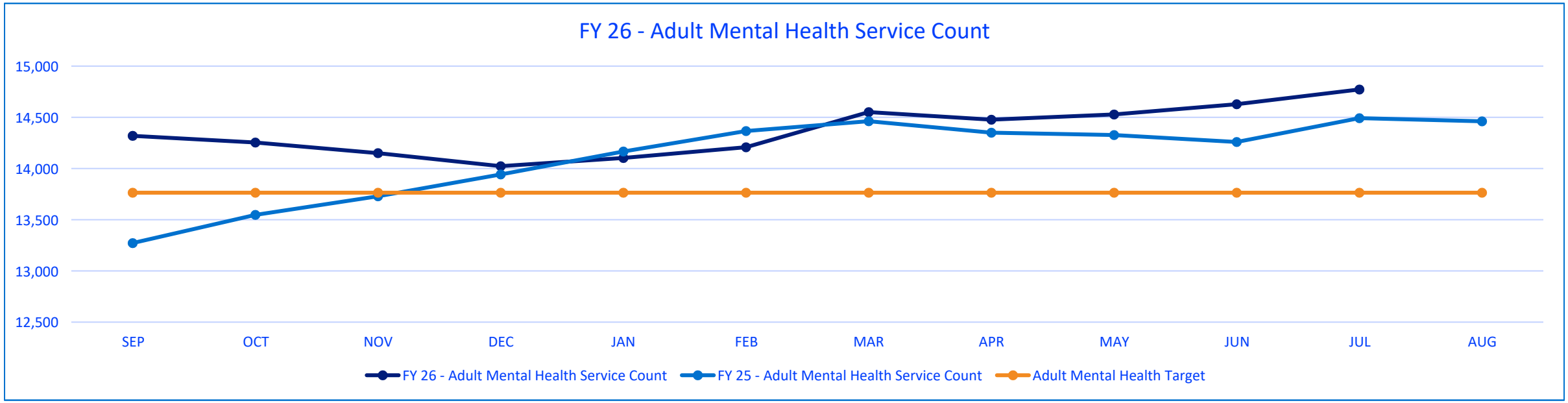
Board Quality Committee Meeting

Trudy Leidich, MBA, RN
VP of Clinical Transformation and Quality

September 2026 (Reporting July 2026 Data)

Adult Mental Health Service Count

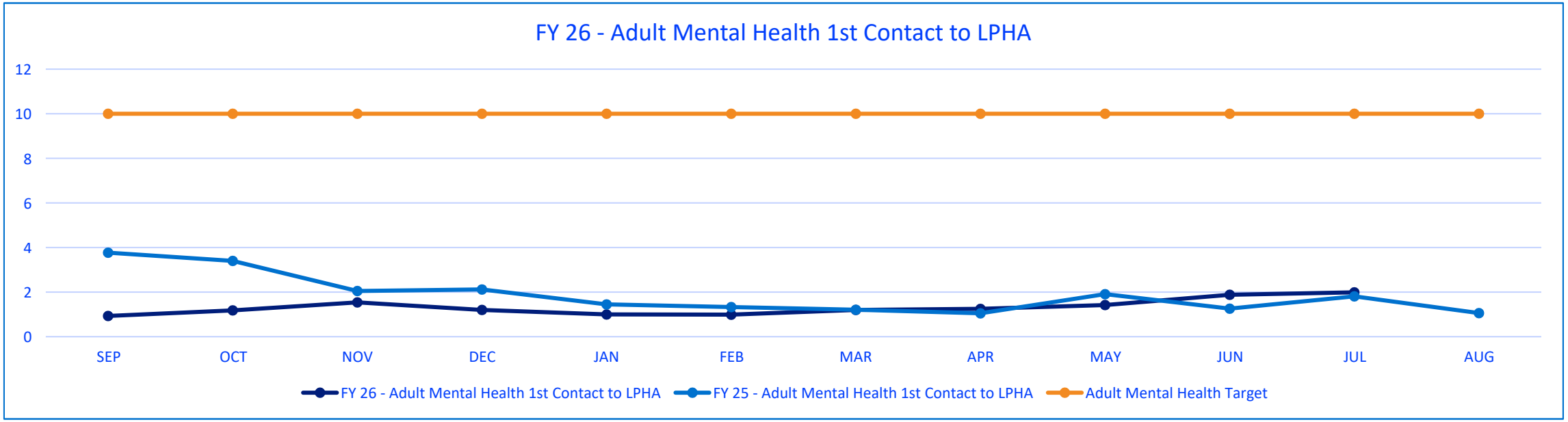
Domain	Measure	2026 Fiscal Year State Service Care Count Target	2026 Fiscal Year State Care Count Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	14,368	14,782	Higher is Better	Contractual



Notes: In July, Adult Mental Health service care count was 14,772, exceeding the FY26 target of and remaining above prior-year performance.

Adult Mental Health First Contact to LPHA

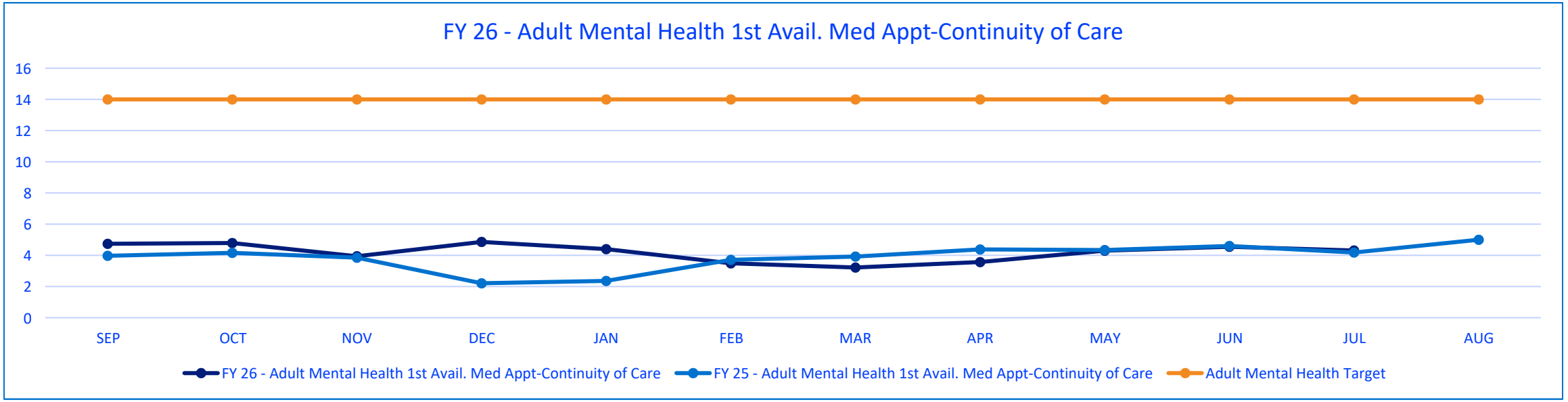
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	First Contact to LPHA	<10 days	1.33 days	1.99 days	Lower is Better	Contractual



Notes: In July, first contact to LPHA was achieved on average of 1.99 days, exceeding the FY26 target of less than 10 days and above prior-year performance.

Adult Mental Health 1st Available Med Appt - COC

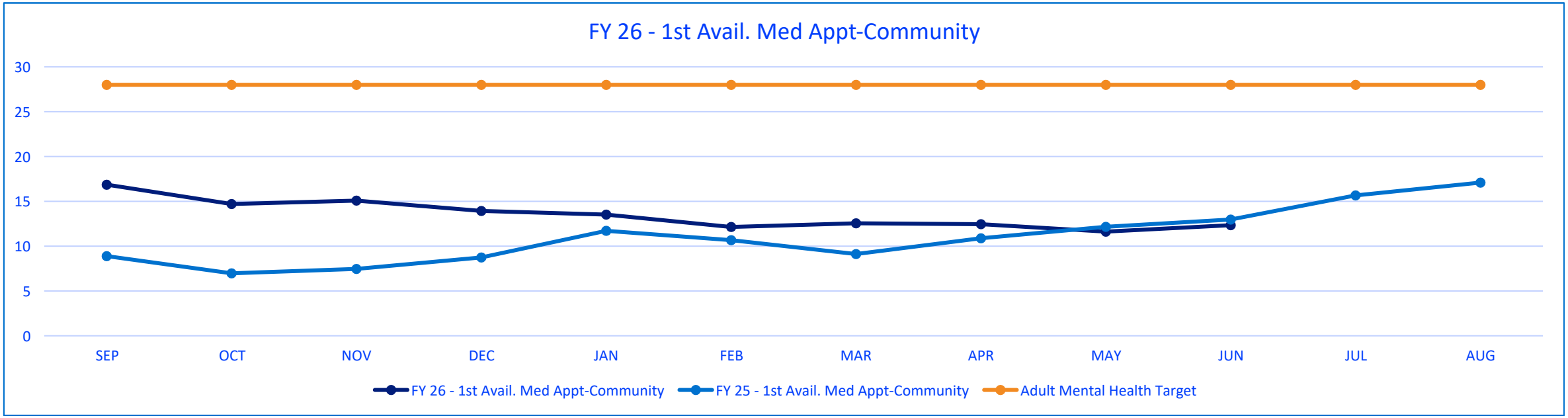
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	First Avail. Med Appt-Continuity of Care	<14 days	4.20 days	4.31 days	Lower is Better	Contractual



Notes: In July, First Available Med Appt-Continuity of Care was achieved on average of 4.31 days, exceeding the FY26 target of less than 14 days

First Available Med Appointment – Community

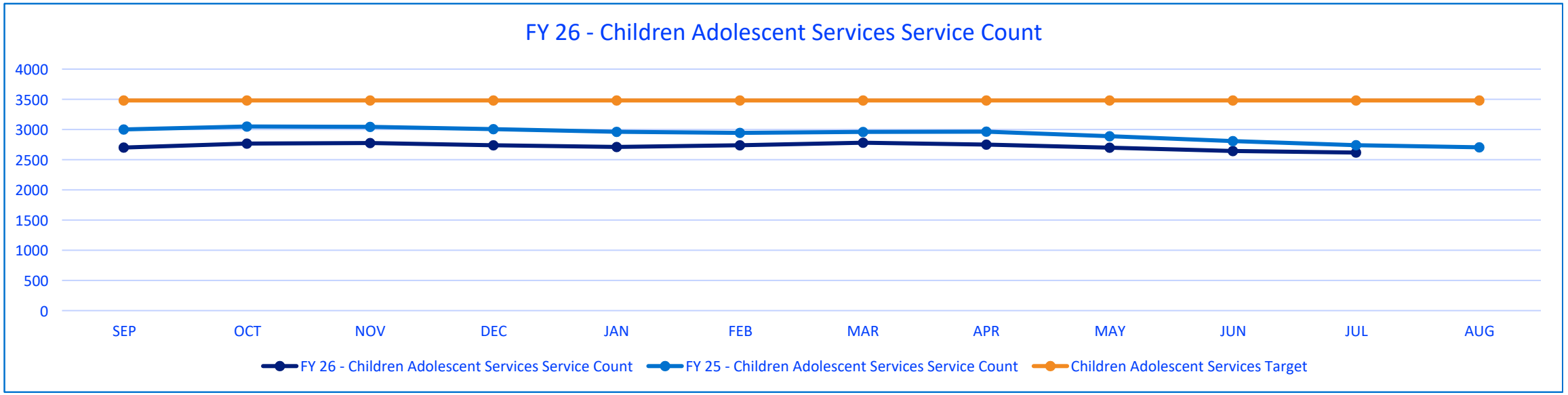
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	First Available Medical Appointment Community	<28 days	13.53 days	13.62 days	Lower is Better	Contractual



Notes: In July, First Available Medical Appointment Community was achieved on average of 13.62 days, exceeding the FY26 target of less than 28 days

Children & Adolescent Services Count

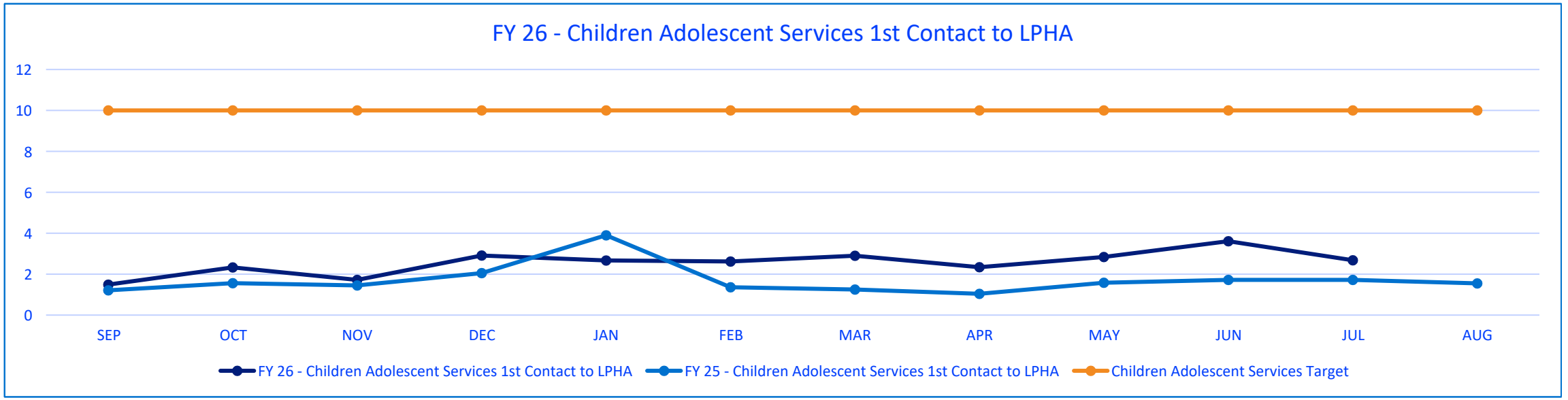
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average (September– August)	Reporting Period- July	Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	2,720	2,619	Higher is Better	Contractual



Notes: In July, Children and Adolescent Services recorded 2,618 service care counts below the FY26 target of 3,481

Children & Adolescent Services 1st Contact to LPHA

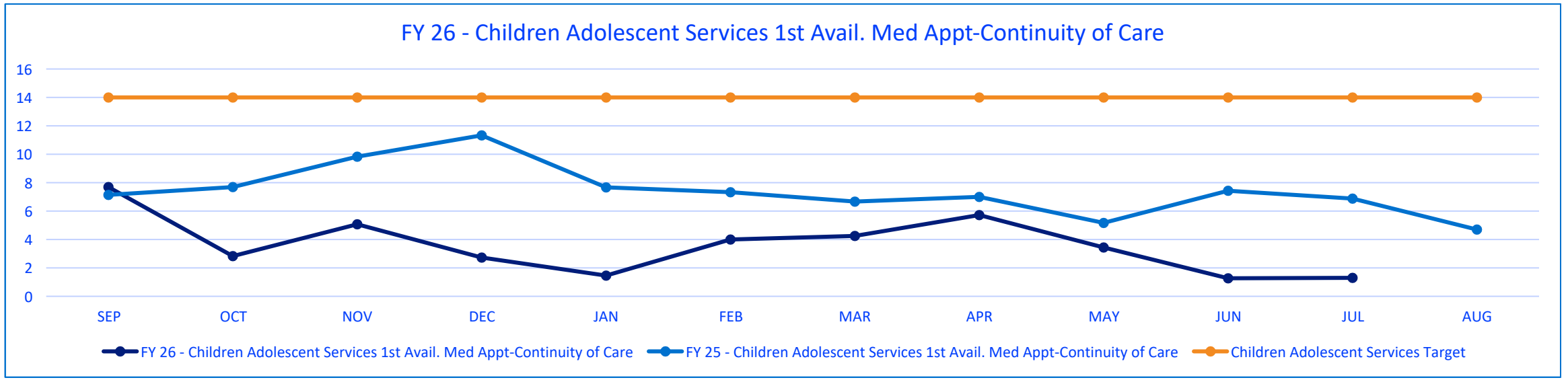
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	Children and Adolescent First Contact to LPHA	<10 days	2.56 days	2.68 days	Lower is Better	Contractual



Notes: In July, Children and Adolescent first contact to LPHA was achieved on average of 2.68 days, exceeding the FY26 target of less than 10 days

Children & Adolescent Services 1st Avail Med Appt – COC

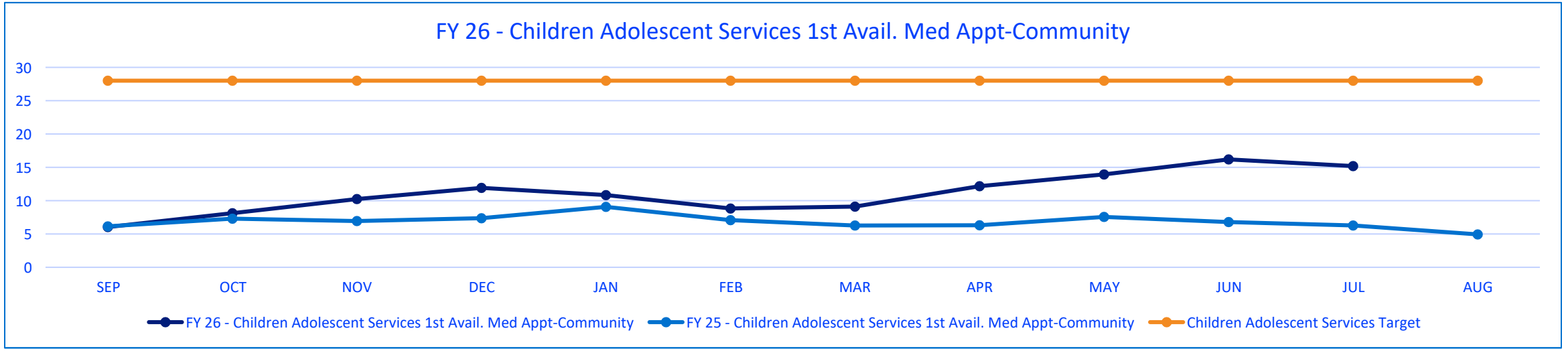
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	Children and Adolescent First Avail. Med Appt-Continuity of Care	<14 days	3.61 days	1.30 days	Lower is Better	Contractual



Notes: In July, Children and Adolescent First Available Med Appt-Continuity of Care was achieved on average of 1.30 days, exceeding the FY26 target of less than 14 days and above prioryear performance.

Children & Adolescent Services 1st Avail Med Appt – Community

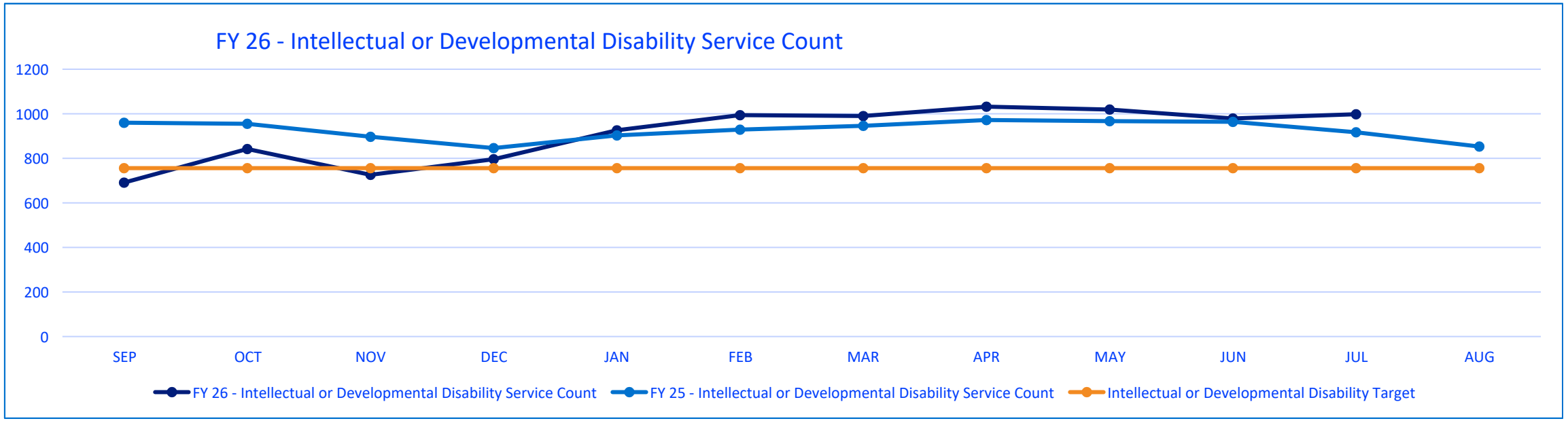
Domain	Measure	2026 Fiscal Year Target	2026 Fiscal Year Average to Date (September – August)	Reporting Period: July	Desired Direction	Target Type
Access	Children and Adolescent First Available Medical Appointment Community	<28 days	11.14 days	15.19 days	Lower is Better	Contractual



Notes: In July, Children and Adolescent First Available Medical Appointment Community was achieved on average of 15.19 days, exceeding the FY26 target of less than 28 days.

IDD Service Count

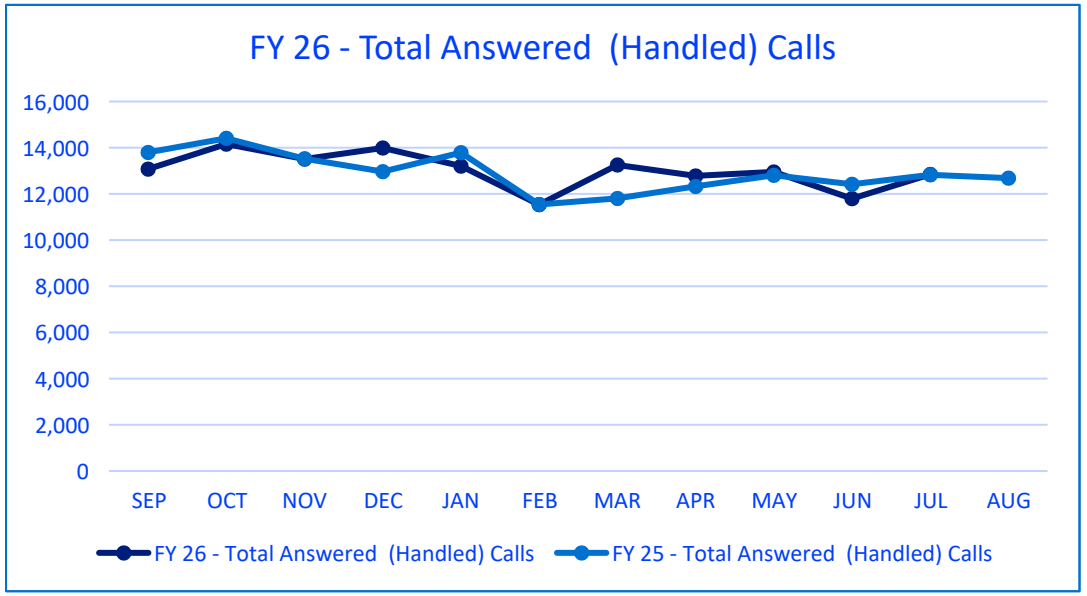
Domain	Program	2026 Fiscal Year Target	2026 Fiscal Year Average (September – August)	Reporting Period- July	Desired Direction	Target Type
Access	IDD	756	908	998	Higher is Better	Contractual

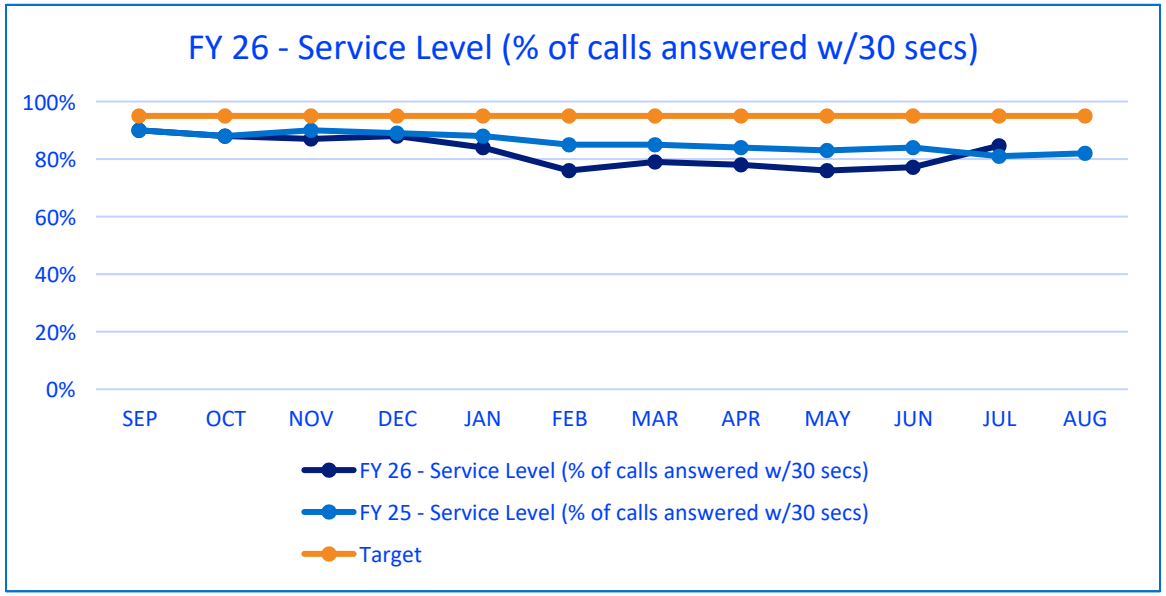


Notes: In July, IDD service count reached 998, exceeding the FY26 target of 756 and outperforming prioryear results. Performance demonstrates sustained growth and strong utilization.

Answered Calls & Service Levels

Domain	Measure	FY 2026 Target	2026Fiscal Year Average (September - August)	Reporting Period- July	Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	13,008	12,843	N/A	N/A
Timely Care	Percent of calls answered w/in 30 secs	> 95%	83%	85%	Higher is Better	Contractual

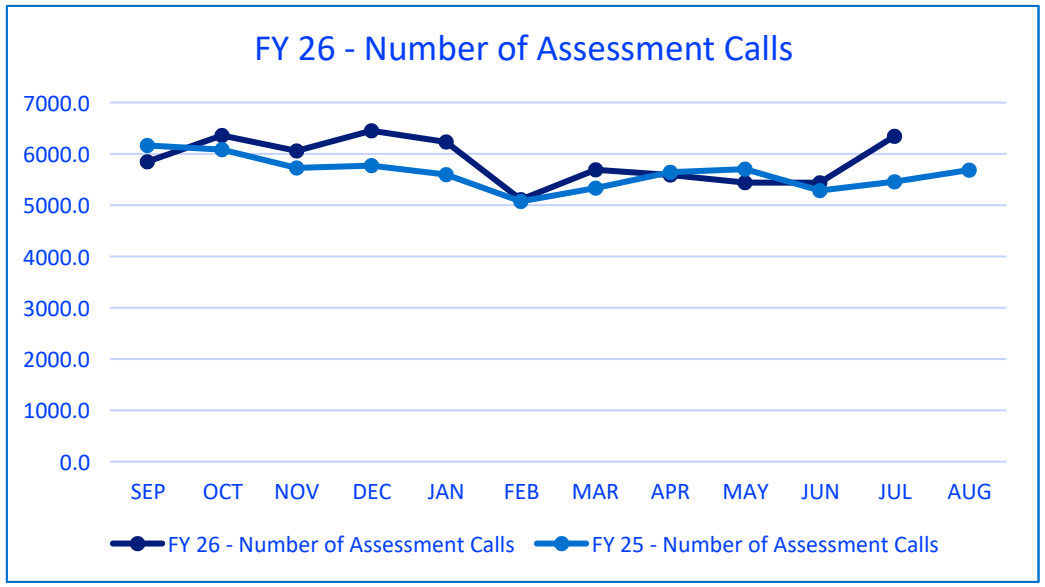


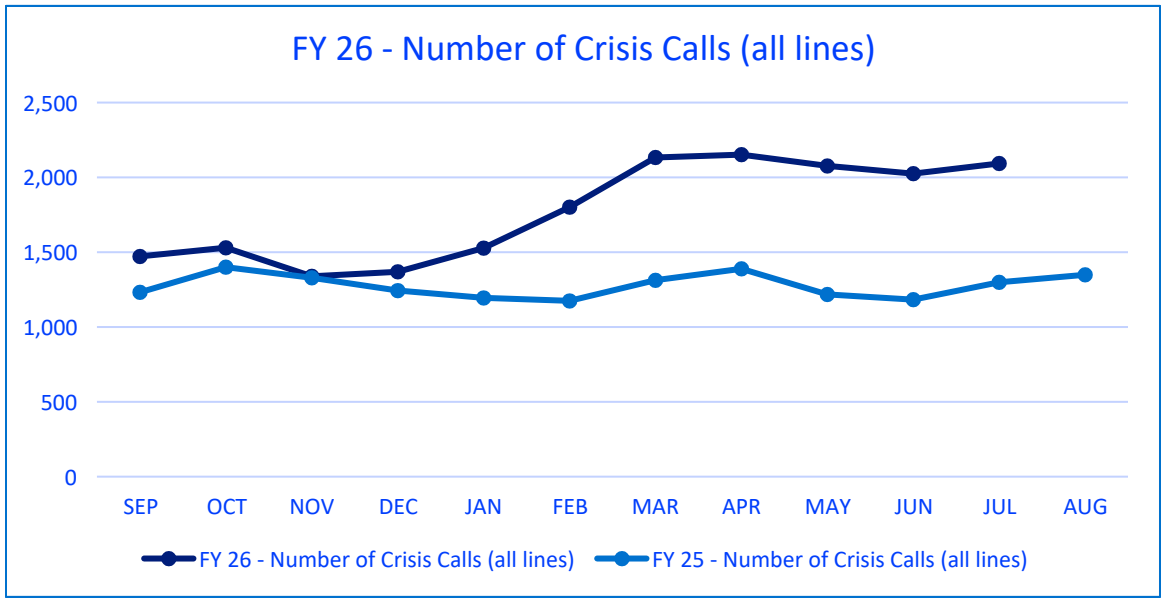


Notes: In July, 12,843 calls were answered, while service level performance was 85%, below the >95% target and lower than prioryear results. Performance reflects ongoing access and capacity pressures.

Assessment & Crisis Calls

Domain	Measures (Definition)	FY 2026 Target	2026Fiscal Year Average (September - August)	Reporting Period- July	Desired Direction	Target Type
Timely Care	Number of Assessment Calls	N/A	5,869	6,342	N/A	
Timely Care	Number of Crisis Calls	N/A	1,774	2,093	N/A	

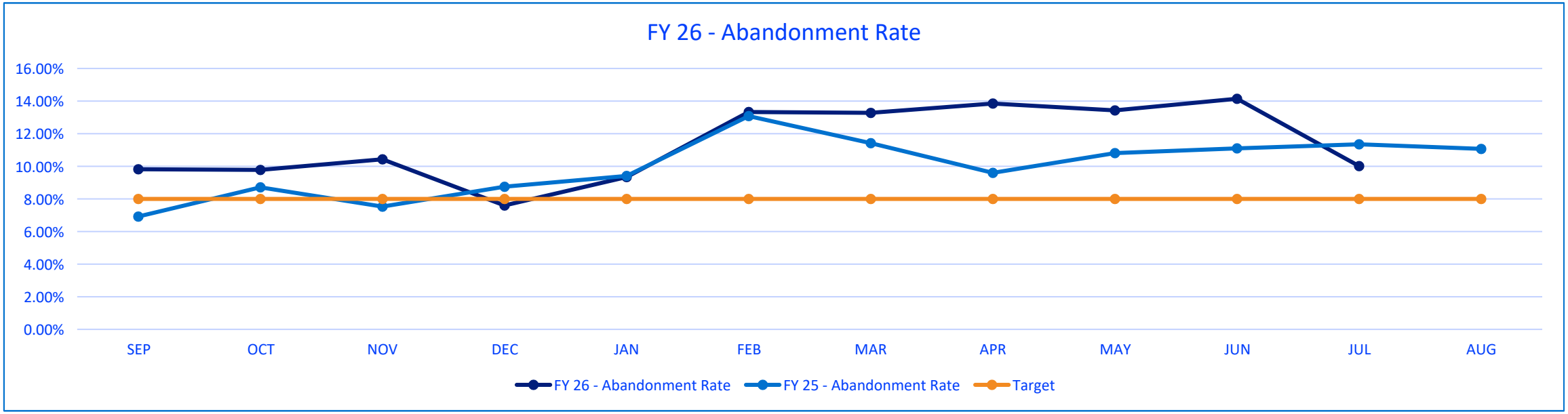




Notes: In July, crisis calls totaled 2,093, exceeding prior-year levels, while assessment calls totaled 6,342 remaining relatively stable year over year. Trends indicate increased crisis demand across access points.

Call Abandonment Rate

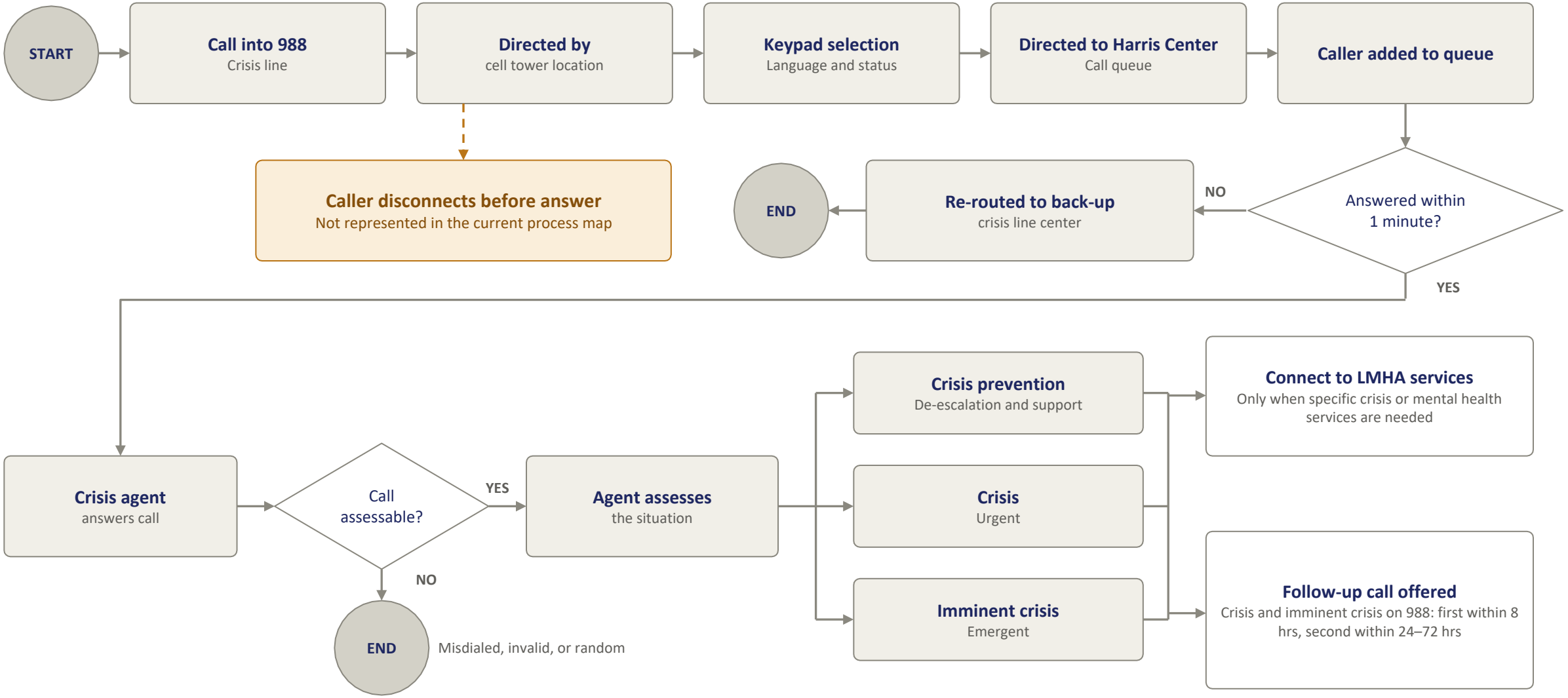
Domain	Measures	FY 2026 Target	2026Fiscal Year Average (September - August)	Reporting Period- July	Desired Direction	Target Type
Timely Care	Abandonment Rate	<8%	11.37%	11.37%	Lower is Better	Contractual



Notes: In July, the call abandonment rate was 11.37%, exceeding the FY26 target of <8% and higher than prioryear performance. Results highlight continued access and staffing challenges.

Crisis line process flow

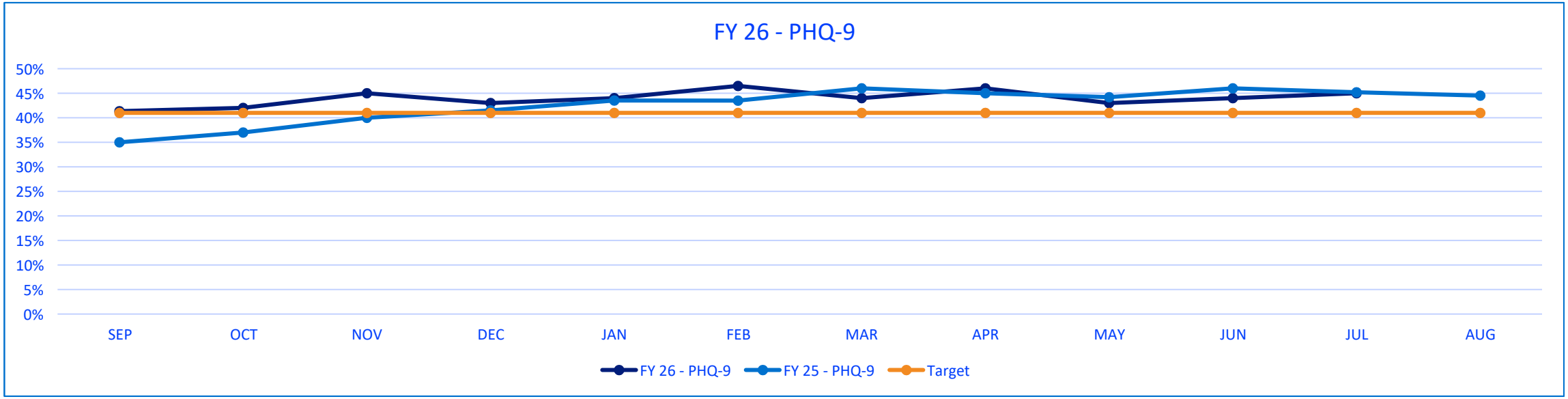
The Harris Center for Mental Health and IDD — existing process map



Current Status & Next Steps: Mapped the current-state process and decision gates. Next, we will measure yield at each gate to locate call leakage and isolate defects prior to root-cause analysis.

PHQ-9

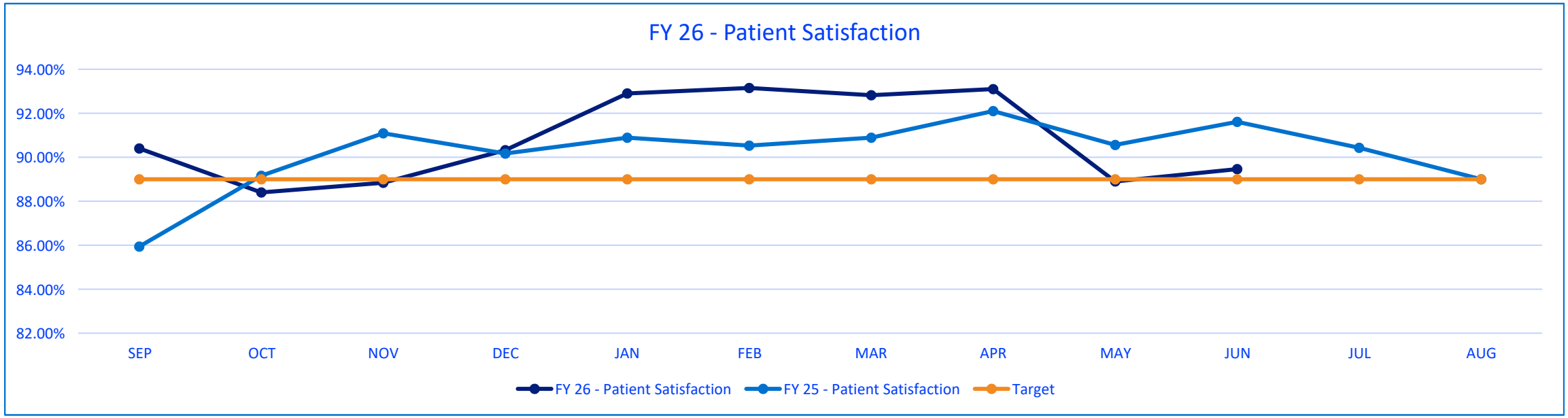
Domain	Measures	FY 2026 Target	2026Fiscal Year Average (September – August)	Reporting Period- July	Desired Direction	Target Type
Clinical Effectiveness	PHQ-9	41.27%	44%	45%	Higher is Better	IOS



Notes: In July, PHQ-9 improvement reached 45%, exceeding the FY26 target of 41.27%. Performance demonstrates sustained positive clinical outcomes.

Patient Satisfaction

Domain	Measures (Definition)	2026 Fiscal Year Target	2026Fiscal Year Average (September - August)	Reporting Period- July	Desired Direction	Target Type
Clinical Effectiveness	Patient Satisfaction	89%	90.63%	88.67%	Higher is Better	IOS



Notes: In July, patient satisfaction was 88.67%. A reversal of the decline from the previous month. The patient experience subcommittee is working on expanding engagement and visibility.

Upcoming Key Enhancements to the Board Quality Scorecard

Looking Ahead: We propose moving select operational measures to the appendix after twelve trailing months of sustained performance above target. If approved, these measures would remain under active monitoring through the monthly System Quality, Safety and Experience Committee meetings.

Access and Timeliness Measures to be moved to Appendix

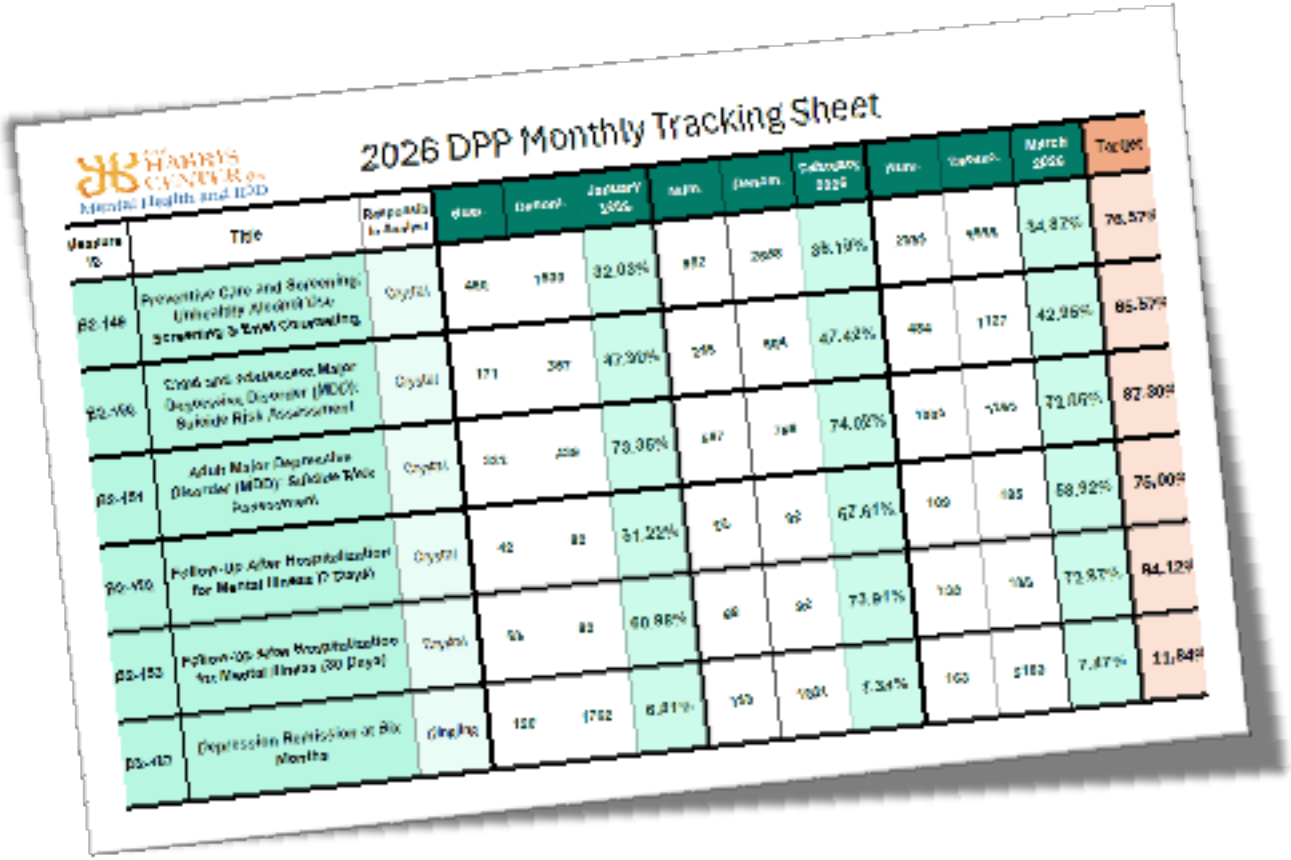
- Adult Mental Health First Contact to LPHA
- Adult Mental Health First Available Medical Appointment – Continuity of Care
- Adult Mental Health First Available Medical Appointment – Community Access
- Children & Adolescent Services First Contact to LPHA
- Children & Adolescent Services First Available Medical Appointment – Continuity of Care
- Children & Adolescent Services First Available Medical Appointment – Community Access

Upcoming Key Enhancements to the Board Quality Scorecard

Looking Ahead: We are recommending the addition of DPP clinical measures to the dashboard. Failure to meet federal performance targets requires the return of funds, and this exposure is anticipated within the next several years. Incorporating these measures into regular reporting now will provide the visibility needed to identify performance gaps early and take corrective action before financial consequences are realized. Pending Board approval, these measures would be incorporated beginning with the next reporting cycle.

Direct Payment Program Clinical Measures to be Added

- Preventive Care and Screening: Unhealthy Alcohol Use Screening & Brief Counseling
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Follow-Up After Hospitalization for Mental Illness (7 Days)
- Follow-Up After Hospitalization for Mental Illness (30 Days)
- Depression Remission at Six Months



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	2,618		2,720	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%	75.21%		78.15%	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%	85.00%		81.82%	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%	10.01%		11.36%	< 8.00%	NS	Brightmetrics

- **Crisis Line Team:** To address high abandonment rates, on July 1st, the Crisis Line dedicated a portion of our staff to answer the LMHA lines only, leaving the rest of the staff to answer both 988/Lifeline calls and LMHA calls. This helped us improve our abandoned calls greatly (14% in June to 10% July) because we are able to make sure that more LMHA calls got answered.
- 988/Lifeline calls are a part of a nationwide network. When they are routed to our center, the calls will only remain in our call queue for up to 1 minute before they are connected to a back-up center. The calls that are re-routed are not counted in our abandonment rate.
- LMHA calls, on the other hand, do not reroute to a back-up center and will remain in our call queue until answered. All of these calls are counted in our abandonment rate. By dedicating staff to answer LMHA calls only, we were able to make sure that the high volume of 988 calls being offered to us did not drown out our LMHA calls.

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 PI Scorecard

	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	14,772		14,367	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%	107.32%		104.38%	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	2,618		2,720	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%	75.21%		78.15%	100.00%	C	MBOW
IDD Service Target	972	969	966	920	851	689	839	722	790	920	990	1037	1014	1016	979	998		909	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%	134.13%	134.39%	129.50%	132.01%		120.18%	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	2.68		2.56	<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	1.99		1.33	<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	1.30		3.61	<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	15.19		11.13	<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	35	18		12.18	<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		0.09	0	IOS	Epic
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	4.31		4.20	<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	13.62		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	88		87.09	<45	IOS	Epic
AMH # Pts Seen in 60+ Days	1	0	0	0	17	25	29	24	18	65	28	3	16	13	10	27		23.45	0	IOS	Epic

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

Board of Trustee PI Scorecard

	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%	85.00%		81.82%	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%	10.01%		11.36%	< 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%	87.00%		88.73%			Brightmetrics
Avg staff per day	36	32	33	34	31	36	37	34	40	35	33	36	38	32	36	33				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%	96.80%		94.45%	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	1,038		999			
PES Admission Volume	460	499	431	471	447	468	460	435	608	430	511	720	593	552	551	513		531.00			
Mechanical Restraints	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0		0.18			
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	0.00		0.01	≤ 0.01	IOS	Epic
Personal Restraints	46	48	47	36	11	36	47	35	13	44	35	69	23	39	60	35		39.64			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	63	33		43.91			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	45.36		39.64	≤ 61.73	IOS	Epic
Emergency Medications	28	38	33	37	8	30	56	38	39	43	29	81	26	55	65	32		44.91			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

Target Status

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

Board of Trustee PI Scorecard

	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%	88.67%		90.64%	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%	30.60%		27.66%	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%	34.92%		32.17%	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%	42.36%		37.55%	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%	49.50%		48.29%	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%	44.10%		45.91%	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%	34.80%		37.87%	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%	47.70%	32.80%		40.99%	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%				44.00%	45.00%		43.90%	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%	43.60%		37.40%	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%	53.30%		33.50%	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

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

Board of Trustee PI Scorecard Data Key

Access Volumes & Service Targets

MEASURE	DEFINITION	TYPE
AMH Waitlist	# of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state.	VOLUME
Adult Service Target (13,764)	# of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.	VOLUME
AMH Actual Service Target %	% of adult patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.	RATE
AMH Service Provision (Monthly)	% of adult patients authorized in a FLOC who received at least 1 face to face or televideo encounter in that month. (Exclusions: Individuals in LOC-1M; Individuals recommended and/or authorized for LOC-1S; Non-Face to Face, GJ modifiers, and telephone contact encounters; partially authorized months and their associated hours)	RATE
CAS Waitlist	# of people waiting to see an LPHA for assessment (from all clinics added together) as defined by the state.	VOLUME
CAS Service Target (3,481)	# of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.	VOLUME
CAS Actual Service Target %	% of children and youth patients authorized in a FLOC (LOCA 1-4). Does not include unauthorized consumers who are 100% Third Party.	RATE
CAS Service Provision (Monthly)	% of children and youth patients authorized in a FLOC who received at least 1 face to face or televideo encounter in that month. (Exclusions: Non-Face to Face, GJ modifiers, and telephone contact encounters; partially authorized months and their associated hours; Client months with a change in LOC-A; children and adolescents on extended review)	RATE

IDD Access & Time to First Assessment

MEASURE	DEFINITION	TYPE
DID Assessment Waitlist	# of people who have been referred to the LIDDA for a Determination of Intellectual Disability but have not been contacted within thirty days of the date of the LIDDA received the referral.	VOLUME
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.)	VOLUME
IDD Actual Service Target %	% of ID Target number served to state target.	RATE
CW CAS 1st Contact to LPHA	Children and Youth - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date	TIME
CW AMH 1st Contact to LPHA	Adult Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date	TIME
CW CAS/AMH 1st Contact to LPHA	ALL - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date	TIME

Time to First Available Medication Appointment

MEASURE	DEFINITION	TYPE
CAS 1st Available Med Appt—COC	Children and Youth - Time between MD Intake Assessment (COC) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date	TIME
CAS 1st Available Med Appt—COM	Children and Youth - Time between MD Intake Assessment (COM) Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date	TIME
CAS Patients Seen in 30–60 Days	Children and Youth - # of adolescent patients who completed their MD Intake Assessment Appt Between 30 - 60 days from Appt Creation Date	VOLUME
CAS Patients Seen in 60+ Days	Children and Youth - # of adolescent patients who completed their MD Intake Assessment Appt at 60+ days from Appt Creation Date	VOLUME
AMH 1st Available Med Appt—COC	Adult - Time between MD Intake Assessment (COC) Appt Creation Date and MD Intake Assessment (COC) Appt Completion Date	TIME
AMH 1st Available Med Appt—COM	Adult - Time between MD Intake Assessment (COM) Appt Creation Date and MD Intake Assessment (COM) Appt Completion Date	TIME
AMH Patients Seen in 30–60 Days	Adult - # of adult patients who completed their MD Intake Assessment Appt Between 30 - 60 days from Appt Creation Date	VOLUME
AMH Patients Seen in 60+ Days	Adult - # of adult patients who completed their MD Intake Assessment Appt at 60+ days from Appt Creation Date	VOLUME

Crisis Line Demand, Responsiveness & Follow-Up

MEASURE	DEFINITION	TYPE
Total Calls Received	# of Crisis Line calls answered (All partnerships and Lifeline Calls)	VOLUME
Average Call Length	Monthly Average call length in minutes of Crisis Line calls (All partnerships and Lifeline Calls)	TIME
Service Level	% of Crisis Line calls answered in 30 seconds (All partnerships and Lifeline Calls)	RATE
Abandonment Rate	% of unanswered Crisis Line calls which hung up after 10 seconds (All partnerships and Lifeline Calls)	RATE
Occupancy Rate	% of time Crisis Line staff are occupied with a call (includes active calls, documentation, making referrals, and crisis call follow-ups)	RATE
Crisis Call Follow-Up	% of follow-up calls that are made within 8 hours to people who were in crisis at time of call	RATE
Access to Crisis Response Services	% percentage of crisis hotline calls that resulted in face-to-face encounter within 1 day	RATE

PES Volume & Restrictive-Intervention Measures

MEASURE	DEFINITION	TYPE
PES Total Visits	# of patients interacting with PES services (Includes: intake assessment regardless of admission, triage out, and observation status, PES Clinic)	VOLUME
PES Admission Volume	# of people admitted to PES (South, North, or CAPES units). Excludes 23/24 hr. observation orders or those patients that have been triaged out)	VOLUME
Mechanical Restraints	# of restraints where a mechanical device is used	VOLUME
Mechanical Restraint Rate	# of mechanical restraints/1000 bed hours	RATE
Personal Restraints	# of personal restraints	VOLUME
Personal Restraint Rate	# of personal restraints/1000 bed hours	RATE
Seclusions	# of seclusions	VOLUME

PES Duration, Medication & Documentation

MEASURE	DEFINITION	TYPE
Average Minutes in Seclusion	The average number of minutes spent in seclusion	TIME
Seclusion Rate	# of seclusions/1000 bed hours	RATE
Emergency Medications	# of emergency-medication.	VOLUME
Emergency Medication Rate	# of Emergency-medications per 1,000 bed hours.	RATE
R/S Documentation Monitoring	% of R/S event documentation which contains all required information in accordance with TAC compliance	RATE

Patient Experience Across Services

MEASURE	DEFINITION	TYPE
CW Patient Satisfaction	% of 2 top box scores (2top box answers on form/total answers given on forms)(average of all sat forms together)	OUTCOME
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)	OUTCOME
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)	OUTCOME
V-SSS 2	% of 2 top box scores on V-SSS 2 (2top box answers on form/total answers given on forms)(All Divisions)	OUTCOME
PoC-IP	% of 2 top box scores on PoC-IP (2top box answers on form/total answers given on forms)(CPEP and DDRP)	OUTCOME
Pharmacy	% of 2 top box scores on V-SSS 2 (2top box answers on form/total answers given on forms)(all pharmacies)	OUTCOME

Adult Clinical Improvement Measures

MEASURE	DEFINITION	TYPE
QIDS-C — Fiscal Year	% of all adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the QIDS-C. Clients must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease)	OUTCOME
BDSS — Fiscal Year	% of all adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the BDSS. Clients must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease)	OUTCOME
PSRS — Fiscal Year	% of all adult clients served during the fiscal year that have improved psychiatric symptomatology as measured by the PSRS. Clients must have at least 90 days from first assessment to last assessment. (Improved = 30%+ improvement; Static = </= 30% improvement/decrease; Worse = > 30% decease)	OUTCOME
BASIS-24 (CRU/CSU)	Average of all patient first scores minus last scores (provided at intake and discharge)	OUTCOME
QIDS-C — New Patients	% 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)	OUTCOME
BDSS — New Patients	% 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)	OUTCOME
PSRS — New Patients	% 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)	OUTCOME

Child & Adolescent Clinical Improvement

MEASURE	DEFINITION	TYPE
PHQ-A (Ages 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)	OUTCOME
DSM-5 Level 1 Cross-Cutting (Ages 6–17)	% of new patient child and adolescent clients that have improved symptomology as measured by the DSM-5 Cross Cutting tool. (New Patient = episode begin date w/in 1 year; Must have 30 days between first and last assessments)	OUTCOME

Needs, Strengths & Daily Functioning

MEASURE	DEFINITION	TYPE
ANSA (Adult)	% of adult clients authorized in a FLOC that show reliable improvement in at least one of the following ANSA domains/modules: Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Strengths, Adjustment to Trauma, Substance Use (Assessments at least 90 days apart)	OUTCOME
CANS (Child/Adolescent)	% of child and adolescent 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)	OUTCOME
DLA-20 (AMH and CAS)	% of all clients that have improved daily living functionality as measured by the DLA-20 (Must have 30 days between first and last assessments)	OUTCOME

Appendix