

Quality Committee Meeting
October 20, 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, September 15, 2026
(EXHIBIT Q-1)
- IV. **REVIEW AND COMMENT**
 - A. Board Scorecard
(EXHIBIT Q-2 Trudy Leidich/Lance Britt)
 - B. MDD Remission Goal
(EXHIBIT Q-3 Trudy Leidich/Maheshkumar Patel)
- 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, SEPTEMBER 15, 2026
MINUTES

Dr. J. Lankford, Board Chair, called the meeting to order at 11:12 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-videoconference

Committee Member Absent: Dr. Q. Moore

Other Board Member in Attendance:

1. CALL TO ORDER

Dr. J. Lankford called the meeting to order at 11:12 a.m.

2. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

3. DECLARATION OF QUORUM

Dr. Lankford declared a quorum was present.

4. PUBLIC COMMENT

There were no public comments.

5. Approve the Minutes of the Board of Trustees Quality Committee Meeting Held on Tuesday, August 18, 2026

MOTION BY: BACON SECOND BY: GEARING

With unanimous affirmative votes,
BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday August 18, 2026 as presented under Exhibit Q-1, are approved.

6. CONSIDER AND RECOMMEND ACTION

A. Performance Improvement Plan FY 2027

MOTION BY: GEARING SECOND BY: BACON

With unanimous affirmative votes,
BE IT RESOLVED that the Performance Improvement Plan FY 2027 as presented under Exhibit Q-2, are approved.

7. REVIEW AND COMMENT

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

8. EXECUTIVE SESSION-Dr. Lankford announced the Quality Committee entered into Executive Session at 11:33am for the following reasons:

- **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**

9. RECONVENE INTO OPEN SESSION-reconvene to open session at 12:01pm

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

11. ADJOURN

MOTION: BACON SECOND: GEARING

There being no further business, the meeting adjourned at 12:02 p.m.

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

EXHIBIT Q-2

Quality Board Scorecard

Board Quality Committee Meeting

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

Lance Britt, LPC
VP of Mental Health

October 2026 (Reporting August 2026 Data)

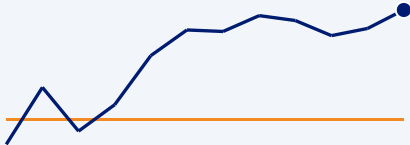


Medical Services – Service Counts

MEASURE	FY26 TARGET	AVG TO DATE	REPORTING PERIOD	DESIRED DIRECTION	FY26 TREND
 Adult Mental Health service care count	13,764	14,404	14,837	Higher is Better	
 Children & Adolescent service count	3,481	2,712	2,623	Higher is Better	
Green = Target Met Red = Target Not Met Yellow = Data to Follow No Target Set					

Notes: In August, Adult Mental Health service care count reached 14,829, above the FY26 target of 13,764 and above prior-year performance. Children & Adolescent service count was 2,619, below the FY26 target of 3,481 and below prior year; the measure has declined since March.

IDD – Service Count

MEASURE	FY26 TARGET	AVG TO DATE	REPORTING PERIOD	DESIRED DIRECTION	FY26 TREND
 IDD service count	756	920	1,047	Higher is Better	

Green = Target Met

Red = Target Not Met

Yellow = Data to Follow

No Target Set

Notes: In August, IDD service count reached 1,047, exceeding the FY26 target of 756 and outperforming prior year. The measure has been above target every month since January.

Crisis Management

MEASURE	FY26 TARGET	AVG TO DATE	REPORTING PERIOD	DESIRED DIRECTION	FY26 TREND
 Total answered (handled) calls	No target	13,050	13,505	N/A	
 Number of assessment calls	No target	5,980	7,208	N/A	
 Number of crisis calls (all lines)	No target	1,822	2,346	N/A	
 Service level – calls answered within 30 seconds	>95%	82.6%	84.0%	Higher is Better	
 Abandonment rate	<8%	11.4%	11.9%	Lower is Better	

Green = Target Met

Red = Target Not Met

Yellow = Data to Follow

No Target Set

Notes: In August, 13,505 calls were answered and crisis calls reached 2,346, well above prior-year levels. Service level was 84%, below the >95% target, and the abandonment rate was 11.95%, above the <8% target. Both contractual measures have been off target for most of FY26.

PI and the Crisis team will continue to work on the abandonment process for improvement. More detail will be shared at the beginning of the second quarter of the fiscal year.

Access Measure Stoplight – August 2026

MEASURE	CURRENT	TARGET	VARIANCE TO	STATUS	TREND (SEP–AUG)
ACCESS TO CARE – TIME TO APPOINTMENT Lower is better · reporting period: August 2026 · FY26					
CAS 1st Contact to LPHA	2.11 days	<10 days	7.89 days under	TARGET MET	 +0.6 days
CAS 1st Avail. Med Appt-COC	2.40 days	<14 days	11.60 days under	TARGET MET	 -5.3 days
CAS 1st Avail. Med Appt-COM	12.87 days	<28 days	15.13 days under	TARGET MET	 +6.8 days
AMH 1st Contact to LPHA	2.23 days	<10 days	7.77 days under	TARGET MET	 +1.3 days
AMH 1st Avail. Med Appt-COC	4.26 days	<14 days	9.74 days under	TARGET MET	 -0.5 days
AMH 1st Avail. Med Appt-COM	13.28 days	<28 days	14.72 days under	TARGET MET	 -3.6 days

Lower is better. FY26 monthly trend; change shown Sep→Aug. Sparklines share a minimum 5-day scale.

Green = Target Met

Red = Target Not Met

Yellow = Data to Follow

Clinical Quality

MEASURE	FY26 TARGET	AVG TO DATE	REPORTING PERIOD	DESIRED DIRECTION	FY26 TREND
FISCAL YEAR MEASURES · reporting period August 2026					
 PHQ-9 improvement	41.0%	44.2%	47.0%	Higher is Better	
 Patient satisfaction (two top-box)	89.0%	90.8%	89.5%	Higher is Better	
DPP MEASURES · calendar-year to date through July 2026					
 B2-149 Unhealthy Alcohol Use Screening & Brief Counseling	76.57%	35.61%	39.47%	Higher is Better	
 B2-150 MDD Suicide Risk Assessment – Child & Adolescent	65.57%	43.62%	40.45%	Higher is Better	
 B2-151 MDD Suicide Risk Assessment – Adult	87.30%	72.56%	72.87%	Higher is Better	
 B2-152 Follow-Up After Hospitalization – 7 Days	75.00%	57.43%	57.12%	Higher is Better	
 B2-153 Follow-Up After Hospitalization – 30 Days	94.12%	71.97%	71.35%	Higher is Better	
 B2-167 Depression Remission at Six Months	11.84%	7.23%	7.75%	Higher is Better	
Green = Target Met Red = Target Not Met Yellow = Data to Follow No Target Set					

Notes: In August, PHQ-9 improvement was 47%, above the 41% FY26 target. Patient satisfaction last reported for June at 89.46%; July and August are data to follow. None of the six DPP measures met target as of July; the widest gap is B2-149 at 39.47% against a 76.57% target.

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	Brightmetric
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	Brightmetric

- **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

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	14,782	14,829	14,406	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%	107.40%	107.74%	104.66%	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	2,619	2,712	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%	75.24%	77.91%	100.00%	C	MBOW
IDD Service Target	972	969	966	920	851	689	839	722	790	920	990	1037	1014	1016	979	998	1,047	920	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%	138.49%	121.70%	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	2.11	2.52	<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	2.23	1.41	<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	2.40	3.51	<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	12.87	11.28	<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	10	12.00	<9.18	IOS	Epic
CAS # Pts Seen in 60+ Days	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0.17	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	4.26	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	13.28	13.60	<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	93	87.58	<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	6	22.00	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		Target	Type	Origin
Access to Care, Crisis Line																					
Total Calls Received	16,377	17,758	17,457	18,518	18,277	18,616	19,396	18,689	18,081	18,259	18,851	20,700	20,567	22,164				19,480			
Total Answered (Handled) Calls						13,077	14,156	13,510	13,987	13,206	11,534	13,252	12,781	12,952				13,162			
AVG Call Length (Mins)	11.1	11.6	11.10	10.80	11.60	11.10	11.30	11.40	12.10	12.00	11.40	11.70	11.8	11.6				11.60			
Service Level	84.00%	83.00%	84.00%	81.00%	82.00%	85.00%	86.00%	86.00%	88.00%	84.00%	76.00%	79.00%	78.00%	76.00%	77.00%	85.00%	84.00%	82.00%	95.00%	C	Brightmetric
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%	11.95%	11.41%	< 8.00%	NS	Brightmetric
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%	86.00%	88.50%			Brightmetric
Avg staff per day	36	32	33	34	31	36	37	34	40	35	33	36	38	32	36	33	34			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%	95.60%	94.54%	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	1,097	1,098	933	1,012	1,004	885	1,069	951	956	944	1,038	1,036	1002			
PES Admission Volume	460	499	431	471	447	468	460	435	608	430	511	720	593	552	551	513	427	522.33			
Mechanical Restraints	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	0.25			
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	44	40.00			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	45	44.00			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	45.36	38.55	39.55	≤ 61.73	IOS	Epic
Emergency Medications	28	38	33	37	8	30	56	38	39	43	29	81	26	55	65	32	48	45.17			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

					FY24														FY25	FY25	Target	Data			
					AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	AVG	Target	Type	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%	88.46%	90.46%	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%	31.19%	27.96%	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%	35.36%	32.43%	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%	42.70%	37.98%	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%	48.10%	48.28%	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%	45.60%	45.88%	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%	38.40%	37.92%	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%	40.20%	40.93%	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%	47.00%	44.25%	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%	44.20%	37.97%	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%	54.10%	35.22%	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% decrease)	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% decrease)	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% decrease)	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

EXHIBIT Q-3

MDD Remission Quality Strategic Goal

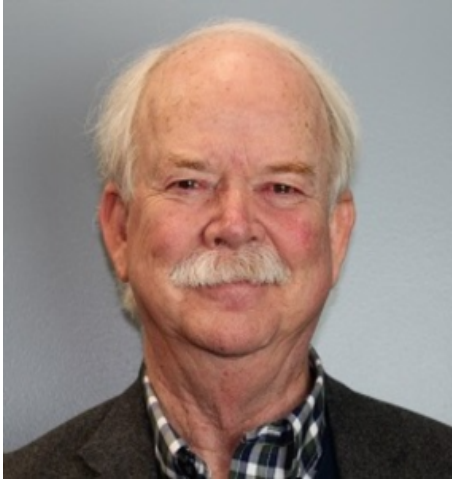
Increase MDD Remission at 6 Months
Measure by 5% per year. (baseline 8.46%)

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

Mahesh Patel, MD
VP of Medical Outpatient & Medical Education Programs



MDD Steering Team



Understanding DPP Depression Remission Metric

- **Program:** The Directed Payment Program for Behavioral Health Services (**DPP BHS**) supports access to behavioral health services, care coordination, and successful care transitions.
- **Measure: Depression Remission at Six Months (DEPREM-6)** is a required DPP quality measure that tracks documented remission using follow-up **PHQ-9 assessments**
- **Calculation:** The remission rate reflects the percentage of qualifying patients who have documented remission at six months, using DPP eligibility and reporting rules, not simply the percentage of patients who return for screening.
- **Strategic alignment:** This measure underpins our goal to increase six-month MDD remission by **5% per year**, from an **8.46% baseline**.
- **Why follow-up matters:** Consistent re-screening helps capture patient progress and ensures documented remission is reflected in reported results

Impact of Patient Dropout on Remission Results

- **Completed a closer review of the remission metric** to better understand the gap in reported improvement.
- **Identified patient dropout as a key factor:** approximately **30% of qualifying patients** drop out within the measure's six-month timeframe.
- **Quantified the impact:** reported remission rates would be **4% higher** if the metric included only patients who had not dropped out.

Other Influences

- **Demographics**
 - Children and teens responded better than adults
 - Males and Females responded equally well
- **Clinical Characteristics**
 - ACT Team Patients respond well
 - Level of Care 3 patients (Intensive Services with Team Approach) lag in improvement
 - Higher PHQ-9 need longer than 6 months to recover
- **Social Determinants**
 - Financial : Those with family incomes below the Federal Poverty Guidelines had marginally poorer outcomes
 - Food Insecurities: Worry About Having Enough Money to Buy Food led to poorer outcomes
 - Transportation Worries were negatively associated

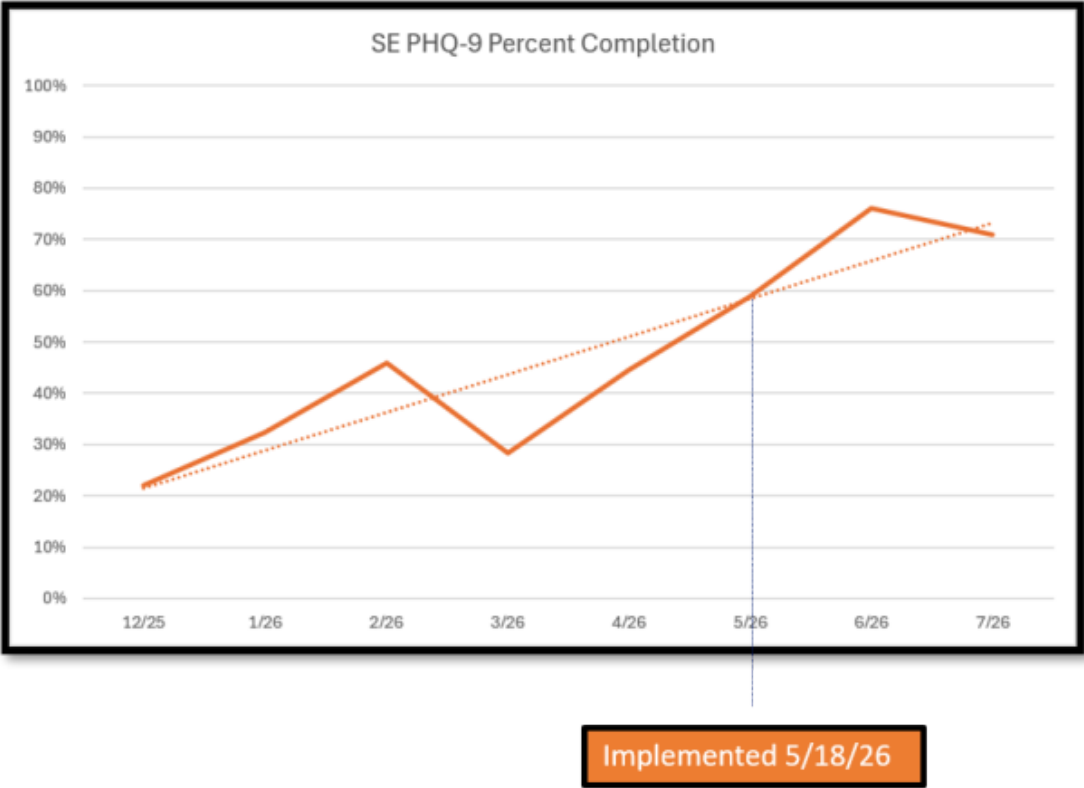
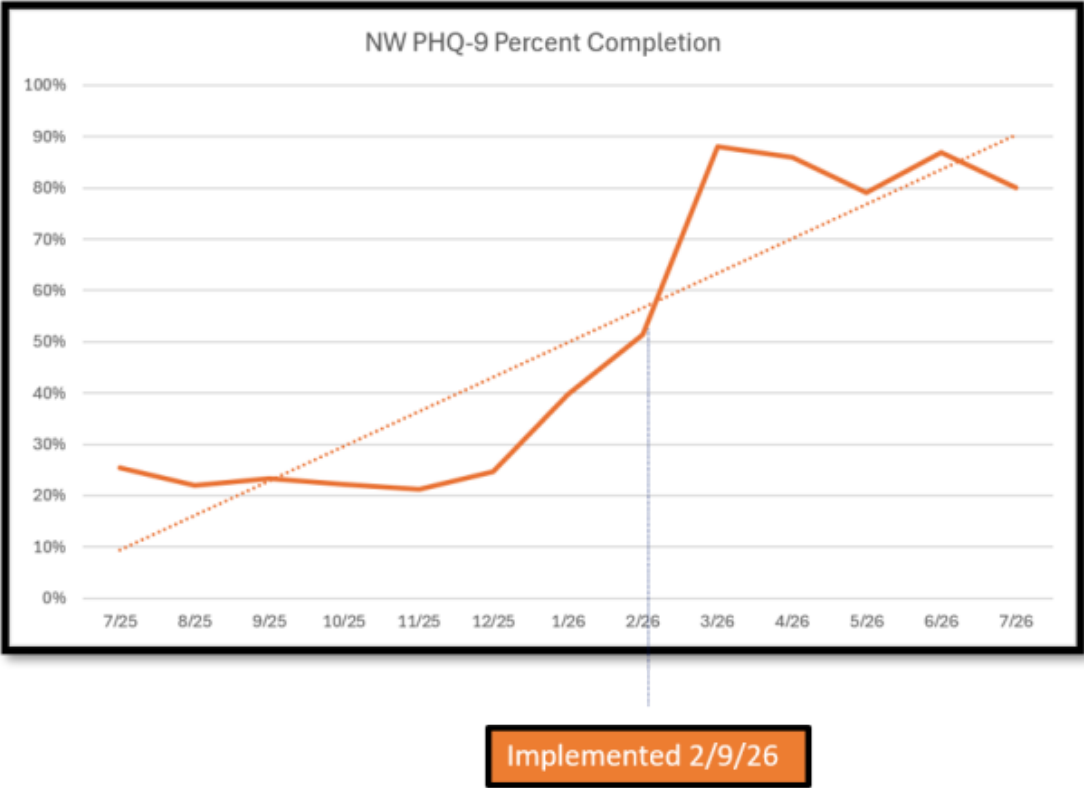
Identified Follow-Up Screening as the Priority for Improvement

- **Clarified a key driver of the performance gap:** measurement capture accounts for a large share of the gap against the **8.46% baseline / +5% annual improvement goal**.
- **Identified a practical improvement lever:** close the re-screening gap through workflow changes rather than new treatment models.
- **Defined the immediate priority:** strengthen follow-up screening so remission outcomes are consistently measured and recognized

Screening Improvement Project

- PHQ-9 Evidence-based screening tool used to provide quantitative data on MDD. Working towards strategic plan goal of improving depression treatment
- Nursing developed workflow and collaborated with Epic and clinical team to implement clinic process
- Implemented:
 - NW MH Adult – 2/9/26
 - SE MH Adult – 5/18/26
 - NE MH Adult – 9/14/26
 - SW MH Adult – 11/2026

Project Outcomes



The six-month MDD remission rate improved by 17%

Pharmacy MDD Clinical Dashboard

- **Developed a Major Depressive Disorder (MDD) Clinical Dashboard** to identify patients not achieving remission who may need additional support.
- **Integrated key clinical indicators**, including PHQ-9 scores, antidepressant therapy, recent provider visits, and symptom-improvement trends.
- **Enabled real-time identification of patients newly prescribed antidepressants**, supporting early pharmacist outreach between provider appointments.
- **Established a tool for timely, data-driven intervention** to support adherence, address adverse effects, and guide treatment optimization.

MDD Remission Pharmacy Dashboard



FILTERS

MRN

All

PHQ9 Date

1/1/2024

7/15/2026

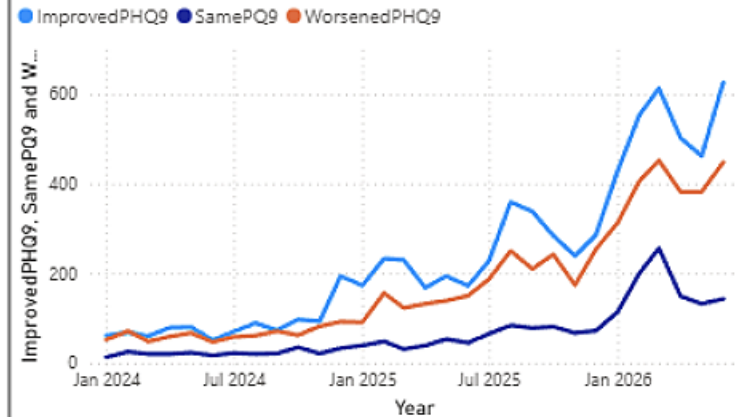
PHQ9 Status

- ☐ Select all
- ☐ Decrease
- ☐ Increase
- ☐ Same

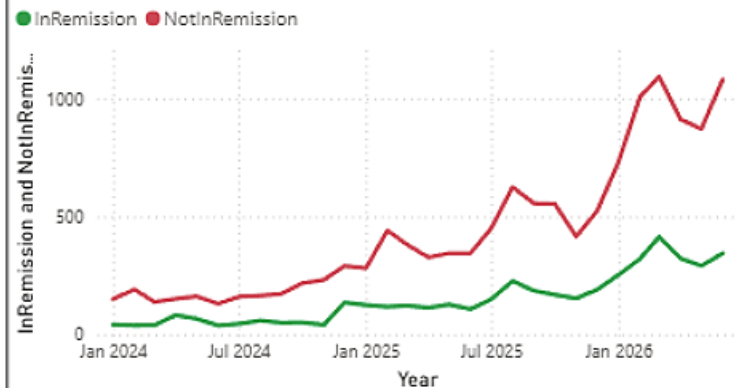
Department Name

All

Counts of Patients w/ PHQ9 Over Time Across Status



Count of Patients In Remission Vs Not In Remission Over Time



Year	ImprovedPHQ9	SamePHQ9	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

FY2027 Building on Progress

- **Strengthen performance reporting:** Clarify the official remission rate and evaluate a complementary rate adjusted for closed cases to provide a fuller picture of outcomes.
- **Improve follow-up continuity:** Identify opportunities in the six-month re-screening workflow to keep patients engaged and capture follow-up results.
- **Deepen understanding of improvement:** Assess results across clinical severity, care setting, and assessor type to better understand progress and guide targeted action.
- **Inform whole-person care:** Examine how social determinants of health influence remission to identify opportunities for more tailored patient support.