

Quality Committee Meeting

August 20, 2024

10:00 am

I. DECLARATION OF QUORUM

II. PUBLIC COMMENTS

III. APPROVAL OF MINUTES

- A. Approve Minutes of the Board of Trustees Quality Committee Held on Tuesday, July 16, 2024
(EXHIBIT Q-1)

IV. REVIEW AND COMMENT

- A. Board Score Card
(EXHIBIT Q-2 Trudy Leidich)
- B. FY 2025 PI Plan
(EXHIBIT Q-3 Trudy Leidich)

V. EXECUTIVE SESSION-

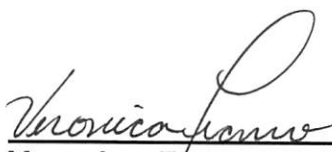
• As authorized by §551.071 of the Texas Government Code, the Board of Trustees reserves the right to adjourn into Executive Session at anytime during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.

• Report by the Interim Director of Pharmacy 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, Kia Walker, Chief Nursing Officer and Holly Cumbie, Interim Director of Pharmacy

VI. RECONVENE INTO OPEN SESSION

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

VIII. ADJOURN



**Veronica Franco, Board Liaison
Robin Gearing, Ph.D., Chairman
Board of Trustees Quality Committee
The Harris Center for Mental Health and IDD**



EXHIBIT Q-1

The HARRIS CENTER for
MENTAL HEALTH and IDD
BOARD OF TRUSTEES
QUALITY COMMITTEE MEETING
TUESDAY, JULY 16, 2024
MINUTES

Dr. R. Gearing, Committee Chair, called the meeting to order at 10:26 a.m. in the Room 109, 9401 Southwest Freeway, noting that a quorum of the Committee was present.

RECORD OF ATTENDANCE

Committee Members in Attendance: Dr. R. Gearing, Dr. L. Fernandez -videoconference

Committee Member Absent: Mrs. B. Hellums

Other Board Member in Attendance: Dr. L. Moore

1. CALL TO ORDER

Dr. Gearing called the meeting to order at 10:26 a.m.

2. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

Dr. Gearing designated Dr. Moore as a voting member.

3. DECLARATION OF QUORUM

Dr. Gearing declared a quorum was present.

4. PUBLIC COMMENT

5. Approve the Minutes of the Board of Trustees Quality Committee Meeting Held on Tuesday, May 21, 2024

MOTION BY: MOORE SECOND BY: GEARING

With unanimous affirmative votes,

BE IT RESOLVED that the Minutes of the Quality Committee meeting held on Tuesday, May 21, 2024, as presented under Exhibit Q-1, are approved.

6. REVIEW AND COMMENT

A. Board Score Card -The Board Score Card presented by Trudy Leidich to the Quality Committee.

B. Patient Experience Sub-Committee Meeting-The Patient Experience Sub-Committee Meeting presented by Trudy Leidich, Luc Josaphat to the Quality Committee.

7. EXECUTIVE SESSION-

Dr. Gearing announced the Quality Committee would enter into executive session at 10:48 am for the following reason:

- In accordance with §551.074 of the Texas government Code, discussion of a personnel matter. *Kendra Thomas, General Counsel*
- In accordance with §§551.071 and 551.074 of the Texas Government Code, discussion of a personnel matter and contemplated litigation in Case 4:23-cv-00297 *Christian Thompson v. The Harris Center for Mental Health & IDD*. *Kendra Thomas, General Counsel*
- In accordance with §§551.071 and 551.072 of the Texas Government Code, to consult with attorney about the due diligence related to the potential acquisition of real property. *Wayne Young, CEO, Stanley Adams, CFO and Kendra Thomas, General Counsel*

8. RECONVENE INTO OPEN SESSION-

The Quality Committee reconvened into open session at 11:21 a.m.

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

The Quality Committee did not take action after Executive Session.

10. ADJOURN

MOTION: GEARING SECOND: MOORE

There being no further business, the meeting adjourned at 11:21 a.m.

**Veronica Franco, Board Liaison
George Santos, Chairman
Quality Committee
THE HARRIS CENTER *for* Mental Health *and* IDD
Board of Trustees**

EXHIBIT Q-2

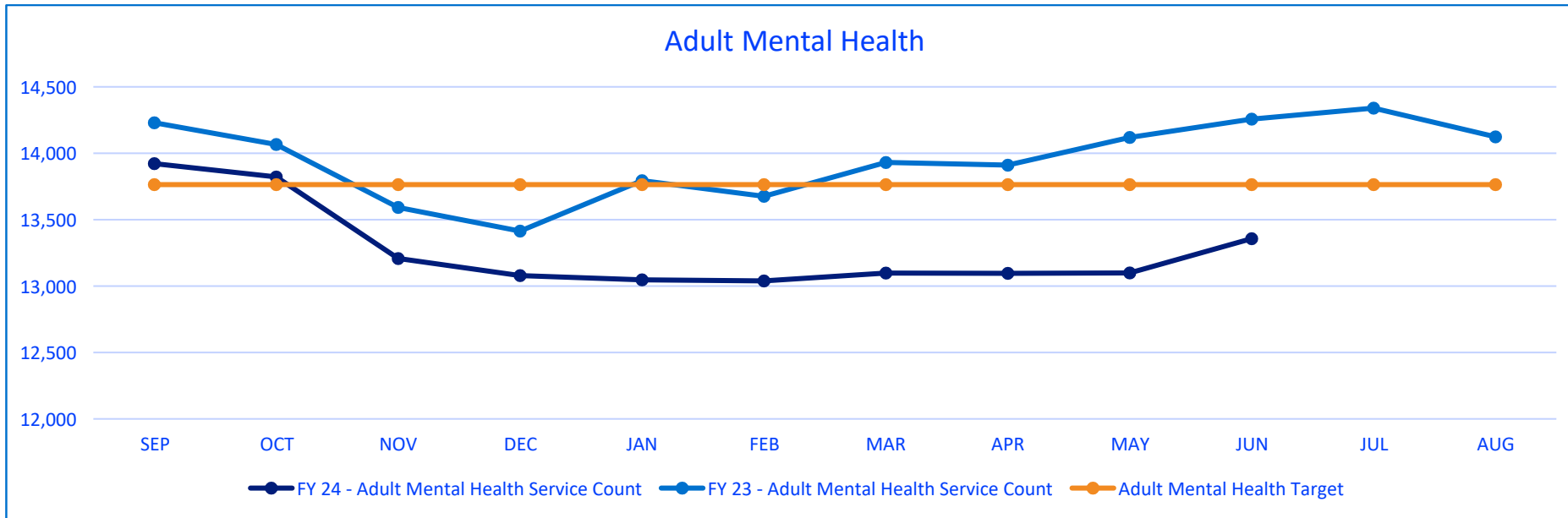
Quality Board Scorecard

Board Quality Committee Meeting

Presented by: Trudy Leidich, MBA, RN
VP of Clinical Transformation and Quality
August 2024 (Reporting June 2024 Data)



Domain	Program	2024 Fiscal Year State Service Care Count Target	2024 Fiscal Year State Care Count Average (Sept. – June)	Reporting Period: June	Desired Direction	Target Type
Access	Adult Mental Health Service Care Count	13,764	13,277	13,357	Increase	Contractual

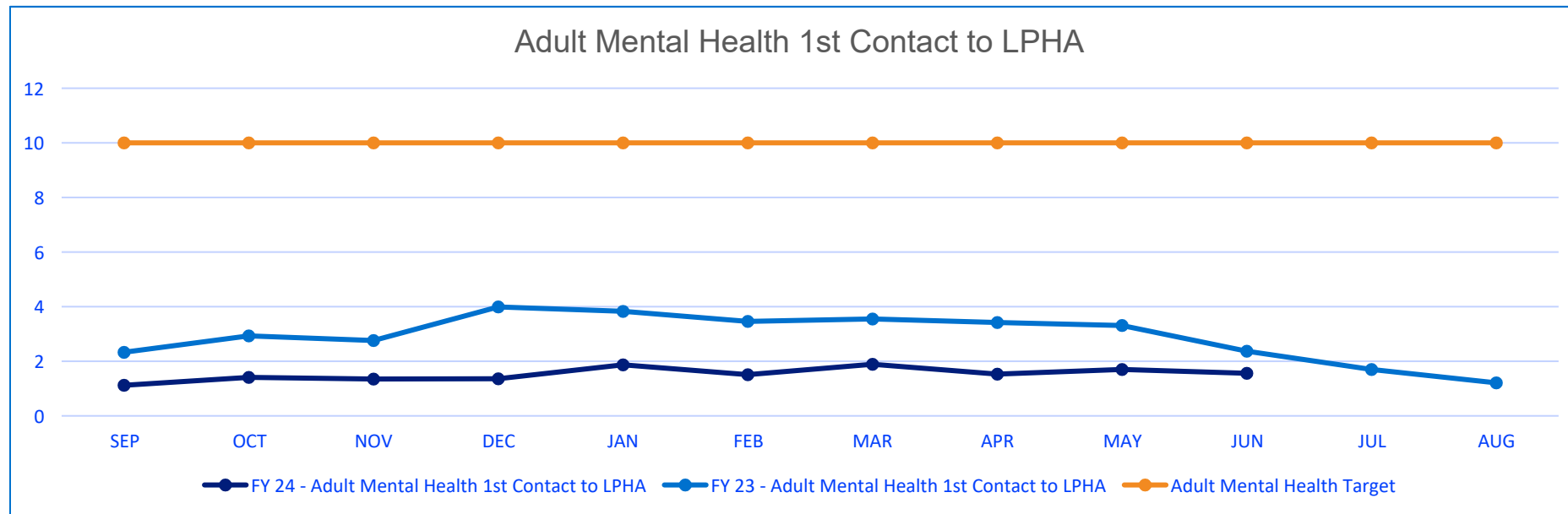


Notes:

- In June 2024, the Adult Service Care Count experienced a decline of 6.31% compared to the same month in the previous year.

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

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sept. – June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Contact to LPHA	<10 days	1.53 Days	1.56	Decrease	Contractual

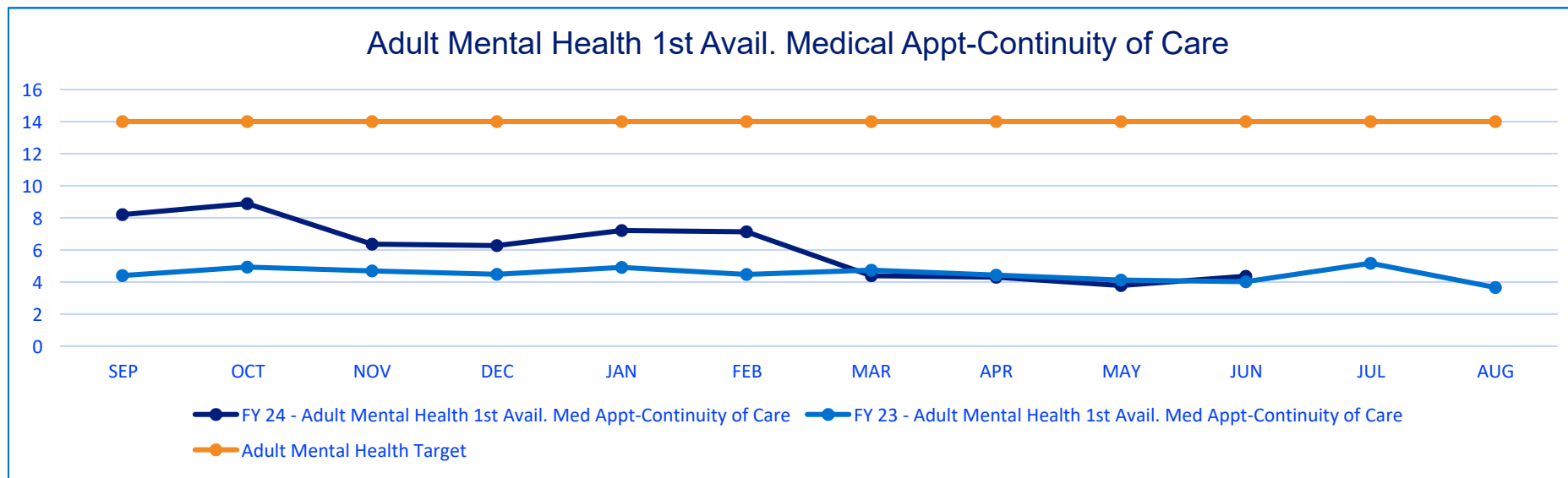


Notes:

- First contact to LPHA taking less than two days during the reported period.
- A year-over-year comparison reveals an improvement, with a 34.18% reduction in the number of days from first contact to LPHA.

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

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sept. – June)	Reporting Period: June	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Continuity of Care	<14 days	6.09 days	4.36 days	Decrease	Contractual

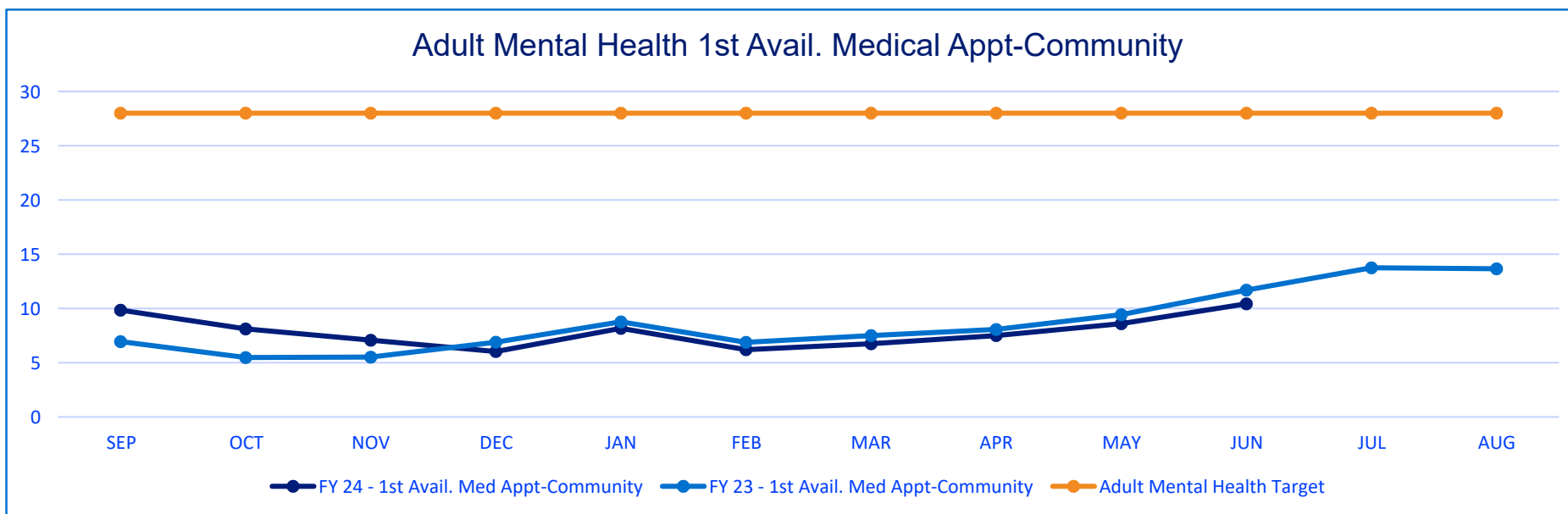


Notes:

- On average individuals are seen with a medical provider within 4 days for continuity of care.
- The measure experienced 8.46% increase from the previous year

Measure definition: Adult - Time between MD Intake Assessment (Continuity of Care) Appt Creation Date and MD Intake Assessment (Continuity of Care) Appt Completion Date

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sep-June)	Reporting Period-June	Target Desired Direction	Target Type
Timely Care	Adult Mental Health 1st Avail. Medical Appt-Community Members	<28 days	7.87 days	10.43 days	Decrease	Contractual

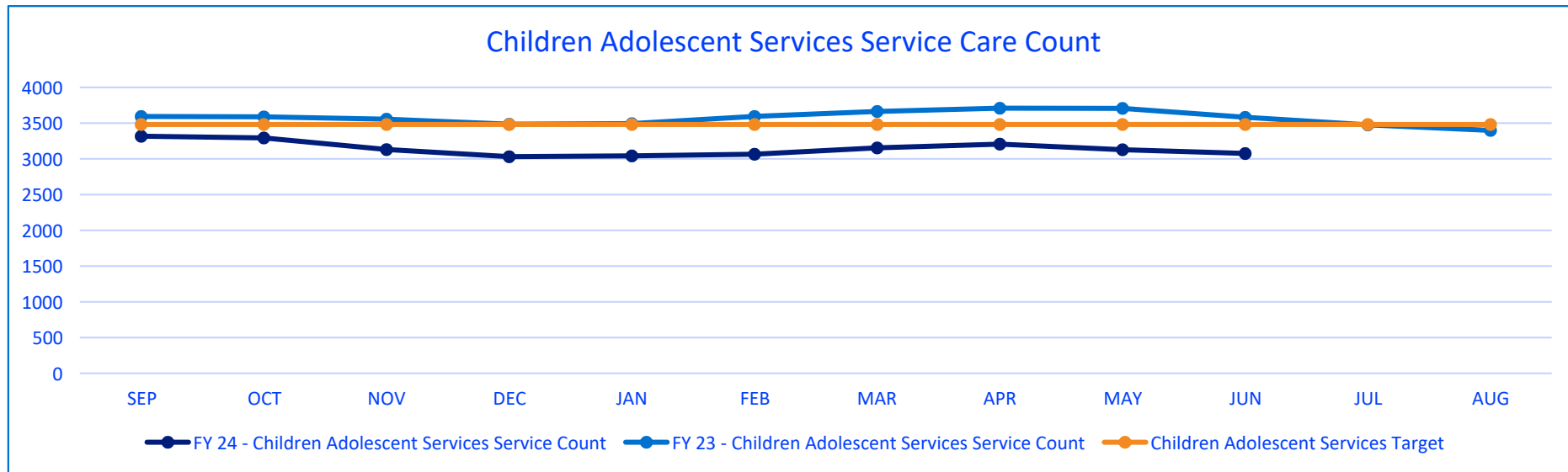


Notes:

- AMH community members appointments are accommodated within 8 days.
- A year-over-year comparative analysis reveals a 10% decrease in this timeframe.

Measure Definition: Adult - Time between MD Intake Assessment for community members walk-ins (Community Members (walkings)). From Appt Creation Date and MD Intake Assessment (Community Members (walkings)) Appt Completion Date

Domain	Program	2024 Fiscal Year State Care Count Target	2024 Fiscal Year State Care Count Average (Sept. – June)	Reporting Period- June	Target Desired Direction	Target Type
Access to Care	Children & Adolescent Services	3,481	3,152	3,128	Increase	Contractual

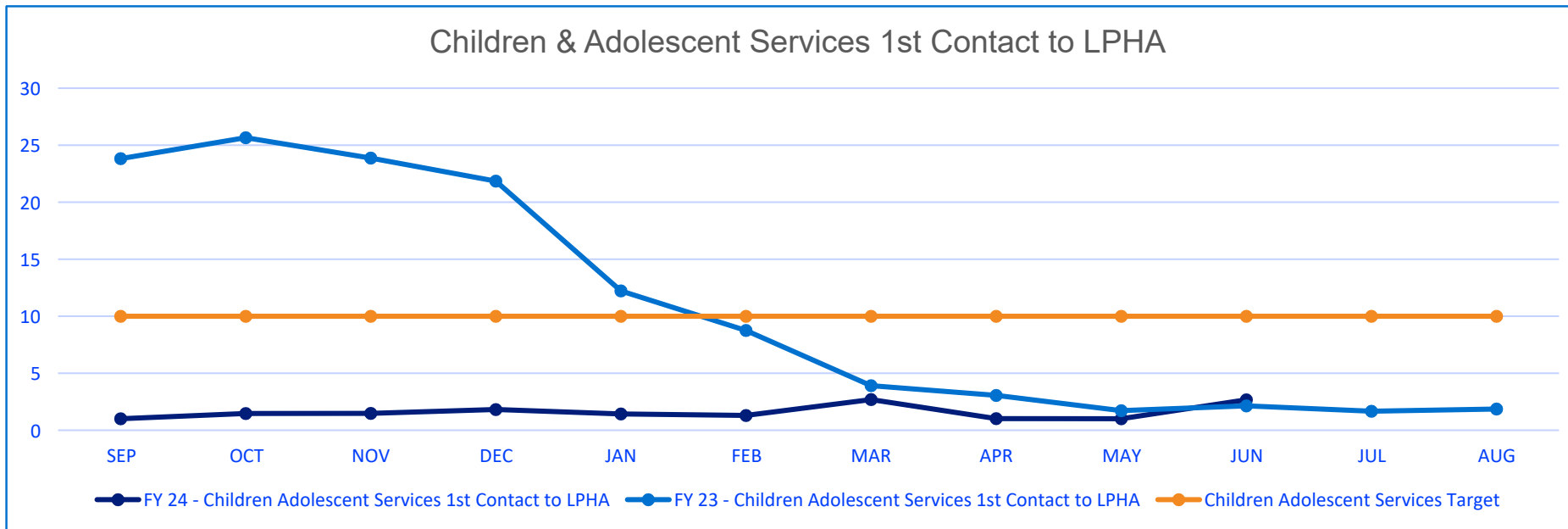


Notes:

- Service care count for the Children and Adolescent Services experienced a 14.13% decline when compared to the previous fiscal year. CAS leadership continues to explore opportunities for improvement and increase the measure.

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

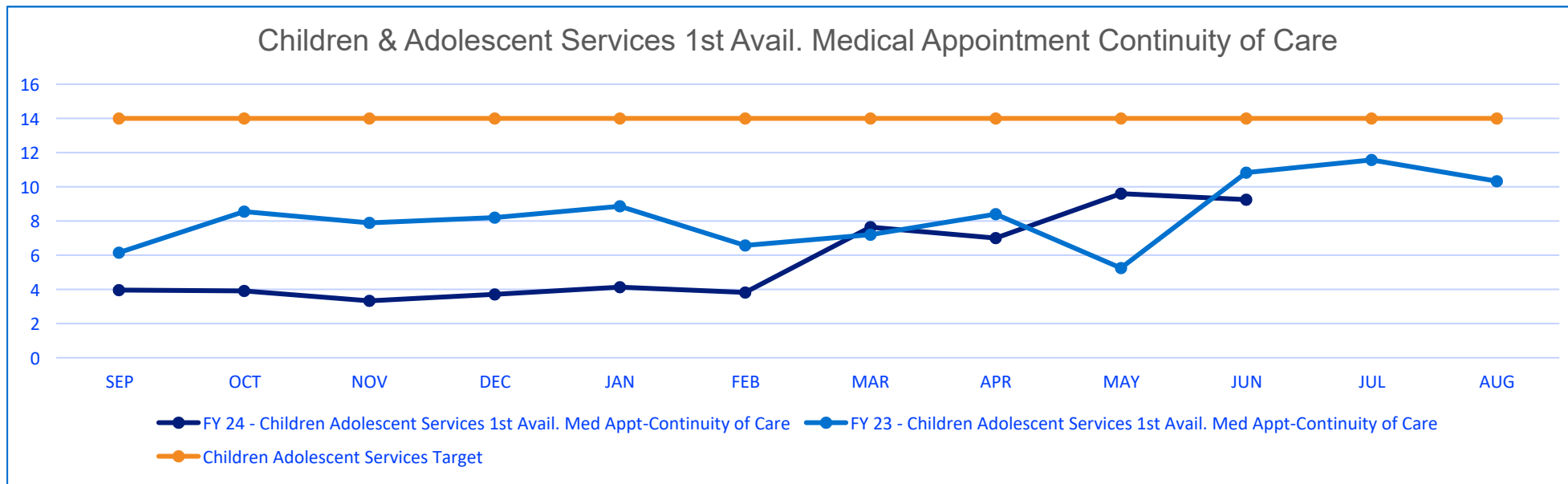
Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sept - June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Contact to LPHA	<10 days	1.59 days	2.67 days	Decrease	Contractual



Notes:

- The hybrid model combines open booking and scheduling for LPHA assessments continue to provide access for individuals seeking services.
- A comparative analysis with the previous year reveals a 25% reduction in the waiting period for individuals to be assessed by an LPHA.

Domain	Program	2024 Fiscal Year Target	2024 Fiscal Year Average (Sep-June)	Reporting Period-June	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Continuity of Care	<14 days	5.64 days	9.25 days	Decrease	Contractual

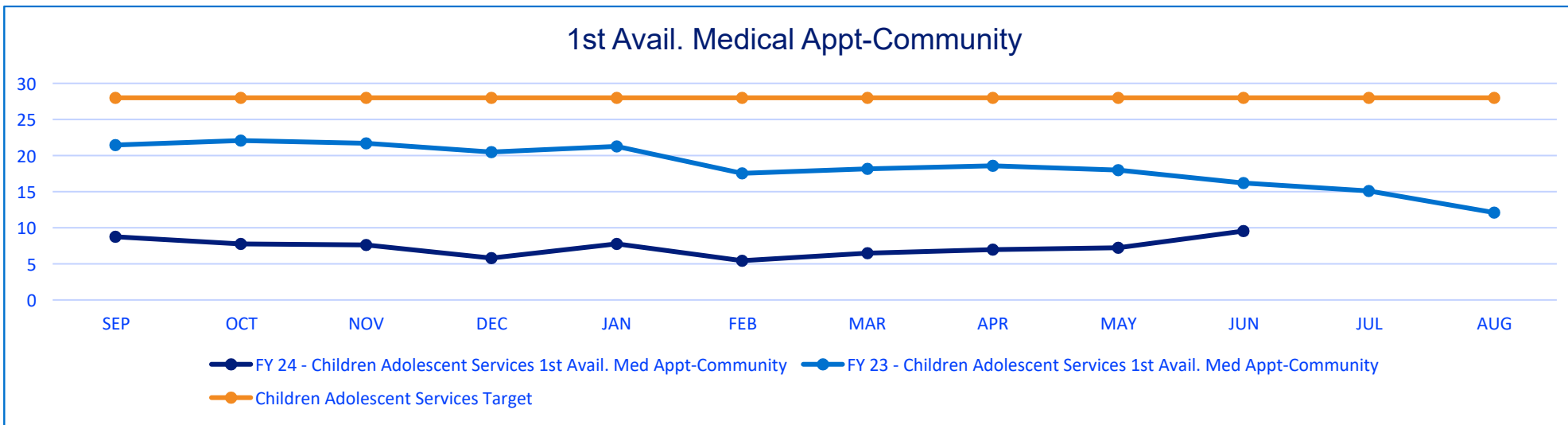


Notes:

- Wait time for medical appointments for continuity of care continues to be lower than the contractual target of 14 days
- The measure shows a 15% reduction in 1st available appointment for continuity of care when compared to the previous year

Measure Definition: Children and Youth - Time between MD Intake Assessment (Continuity of care: after hospital discharge) Appt Creation Date and MD Intake Assessment (Continuity of Care) Appt Completion Date

Domain	Program	2024 Fiscal Year Target	2024Fiscal Year Average (Sept – June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	Children & Adolescent Services 1st Avail. Medical Appt-Community	<28 days	7.34 days	9.54 days	Decrease	Contractual

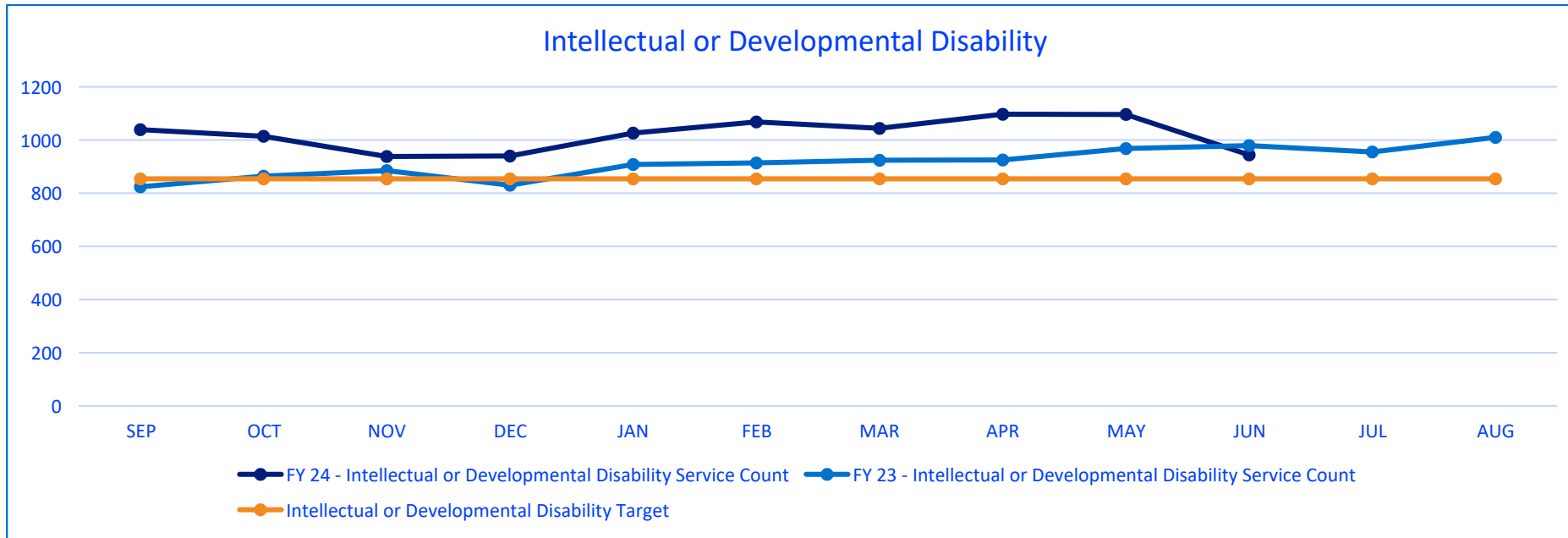


Notes:

- For the reporting period of June 2024, there was a decrease of 41% in the waiting period compared to the same period in the previous fiscal year.
- The wait time was reduced from 16.20 days in June 2023 to about 9.54 days in June 2024.

Measure definition: Children and Youth - Time between MD Intake Assessment (Community members walk-ins) Appt Creation Date and MD Intake Assessment (Community Members) Appt Completion Date

Domain	Program	2024 Fiscal Year State Count Target	2024 Fiscal Year State Count Average (Sept – June)	Reporting Period- June	Target Desired Direction	Target Type
Access	IDD	854	1029	1096	Increase	Contractual

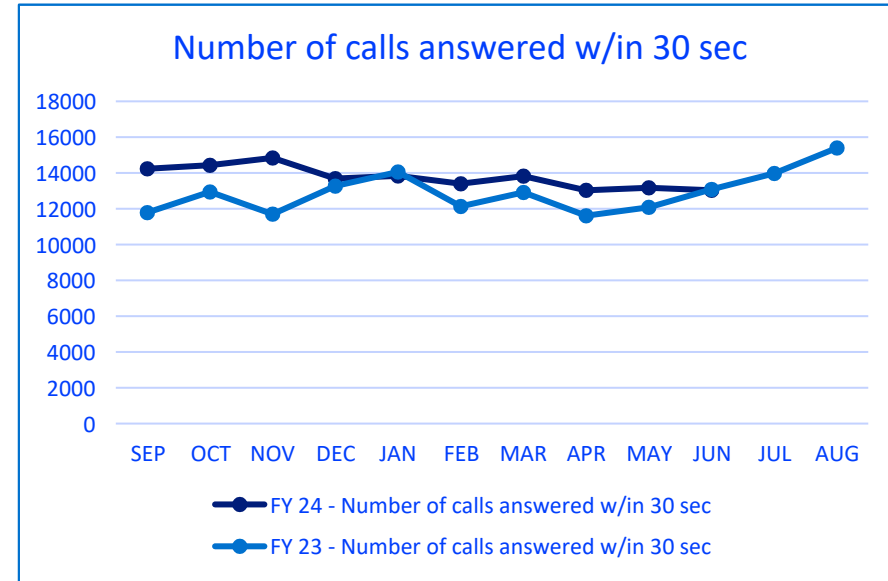
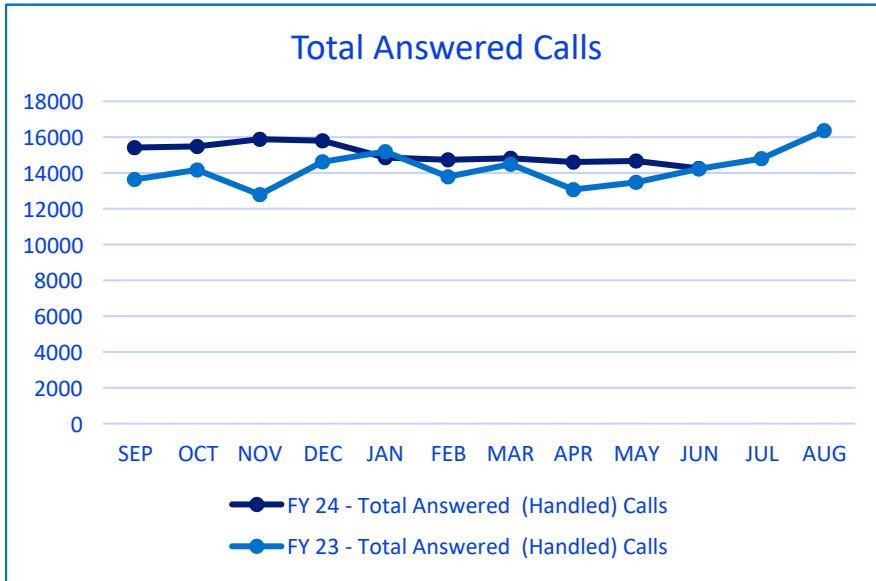


Notes:

- The IDD division service care count is at 944 for this reporting period

Measure definition: # of IDD Target served based on all reported encounter data. (includes encounters that are associated with CARE assignment codes when the service is performed outside of a waiver. Exceptions are for service coordination that is only included for the indigent population and R019 which is included regardless of waiver status.)

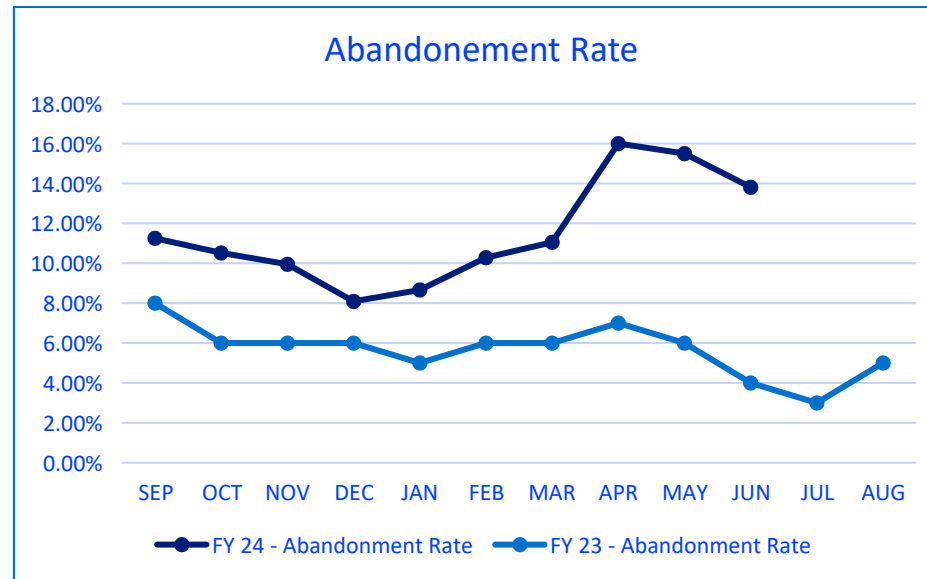
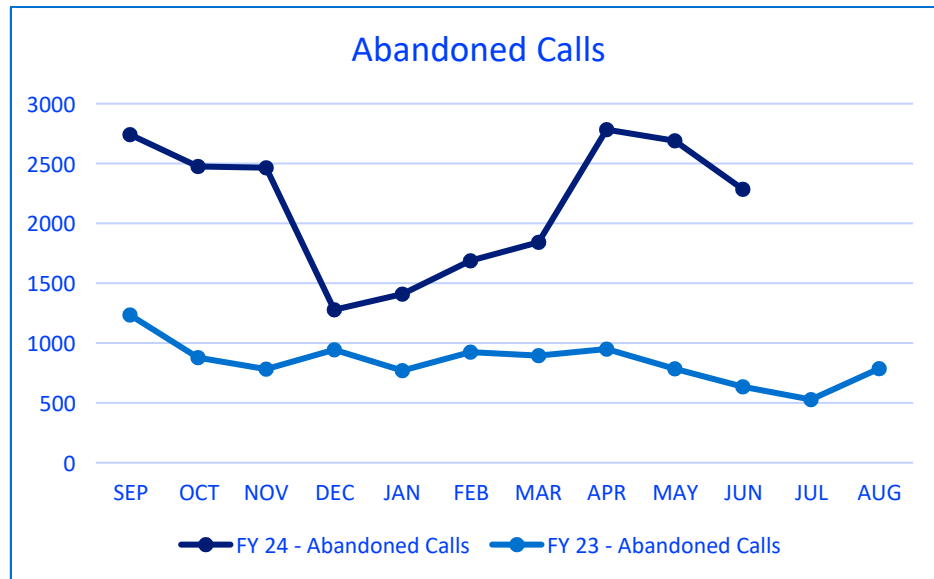
Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	Total Answered Calls	N/A	15,054	14,255	Increase	N/A
	Number of calls answered w/in 30 secs	N/A	13,749	13,032	Increase	Contractual



Notes:

- The Crisis Line team is effectively responding to the increasing demand for their services.

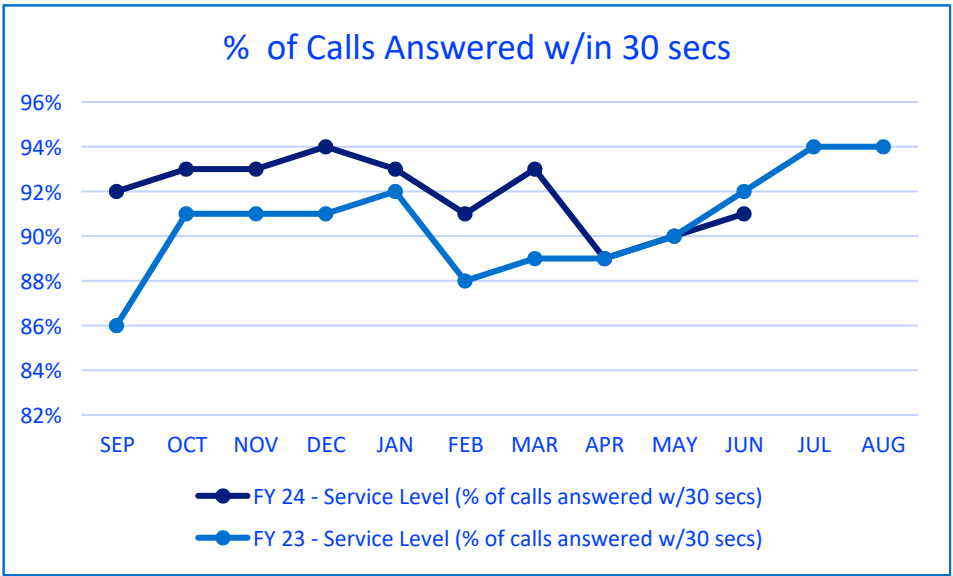
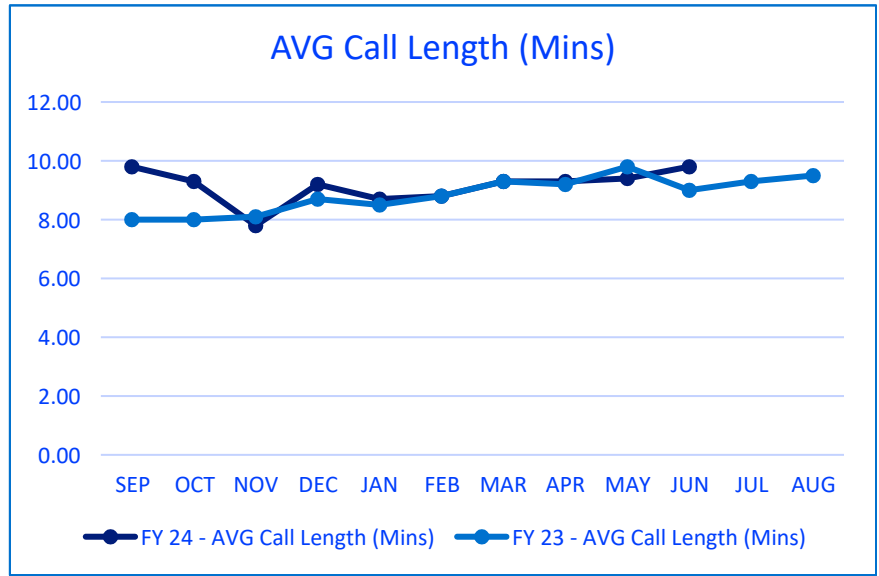
Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	Abandoned Calls	N/A	2,166	2,285	Decrease	Contractual
	Abandonment Rate	<8%	12%	13.81%	Decrease	Contractual



Notes:

- This month abandoned calls reported lower than the previous month.

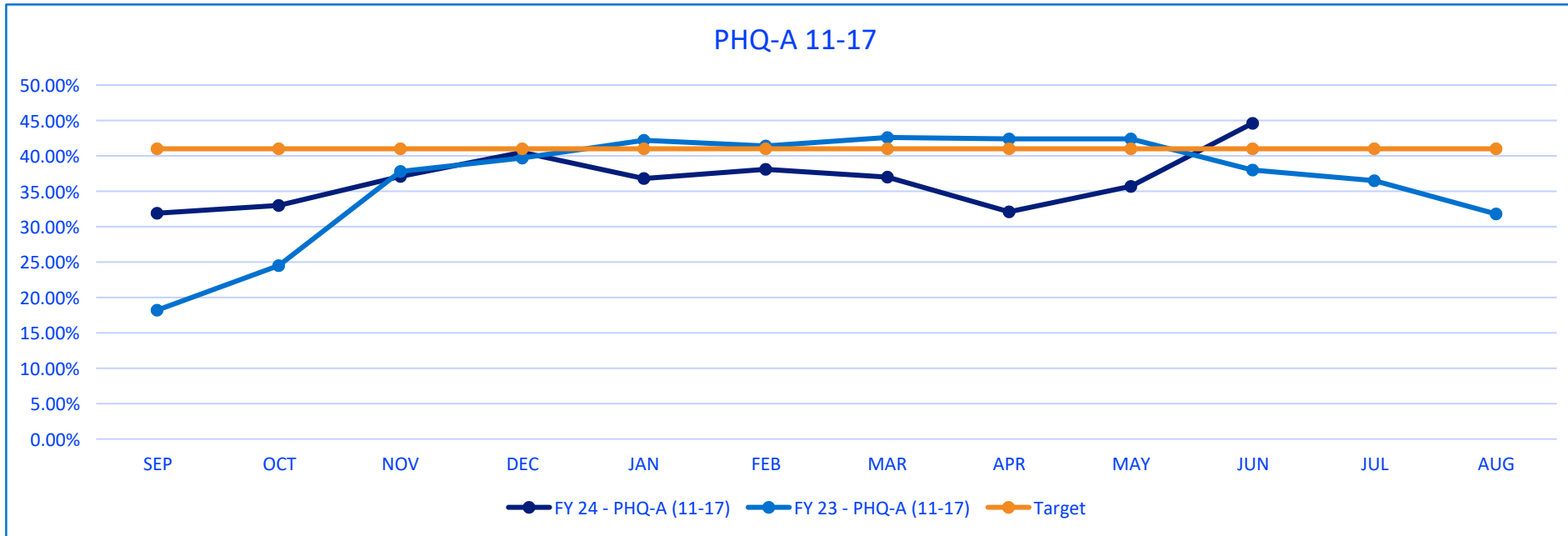
Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept - June)	Reporting Period- June	Target Desired Direction	Target Type
Timely Care	AVG Call Length (Mins)	N/A	9.14	9.80	N/A	Contractual
	Service Level (% of calls answered w/30 secs)	>95%	92.00%	91%	Increase	Contractual



Notes:

- An analysis of recent data reveals an increase in both the duration of calls and the percentage of calls answered within 30 seconds.
- This trend suggests a surge in the volume of calls to the Crisis Line, indicating a heightened demand for crisis support services.

Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept. – June)	Reporting Period- June	Target Desired Direction	Target Type
Effective Care	PHQ-A (11-17)	41.27%	36.%	35.70%	Increase	IOS



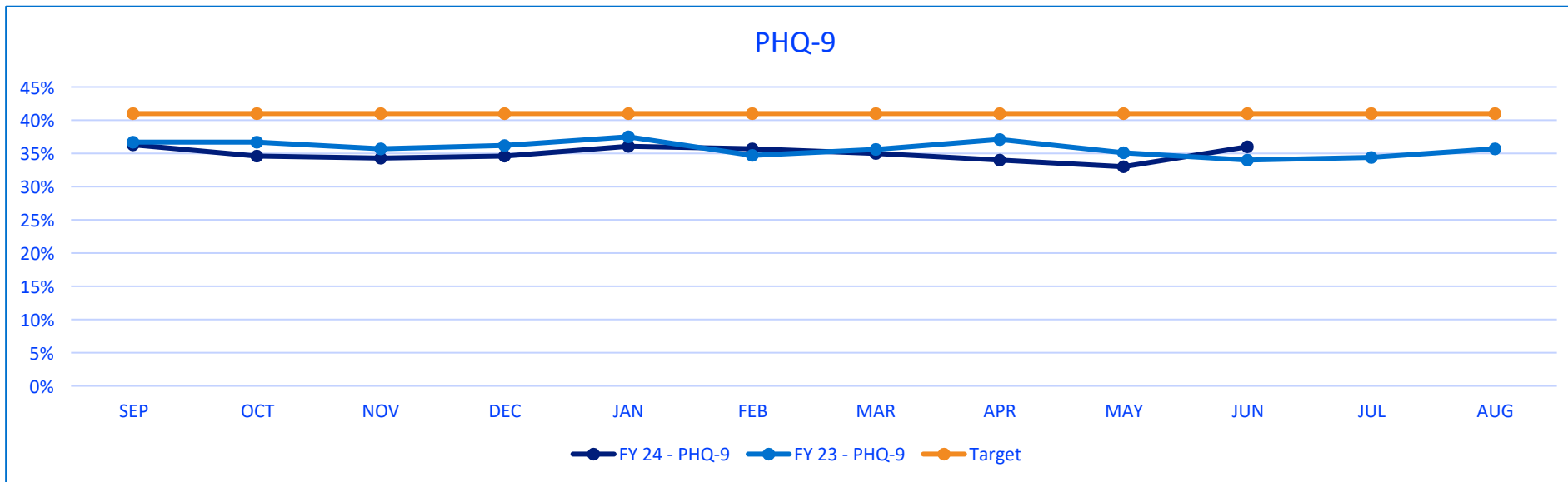
Notes:

- PHQ-A percentage of adolescent and young adult with improve PHQ-A score for new patient.

Measure Computation: % 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)

Measure Definition: PHQ 9/A The Patient Health Questionnaire (PHQ; Spitzer, Kroenke, Williams, 1999) is a self-report version of the Primary Care Evaluation of Mental Disorders (PRIME-MD), designed for screening of psychiatric disorders in an adult primary practice setting. The PHQ comprises the patient questionnaire and clinician evaluation guide from the PRIME-MD, combined into a single, three-page questionnaire.

Domain	Measures (Definition)	FY 2024 Target	2024Fiscal Year Average (Sept – June)	Reporting Period- June	Target Desired Direction	Target Type
Effective Care	PHQ-9	41.27%	35%	36%	Increase	IOS



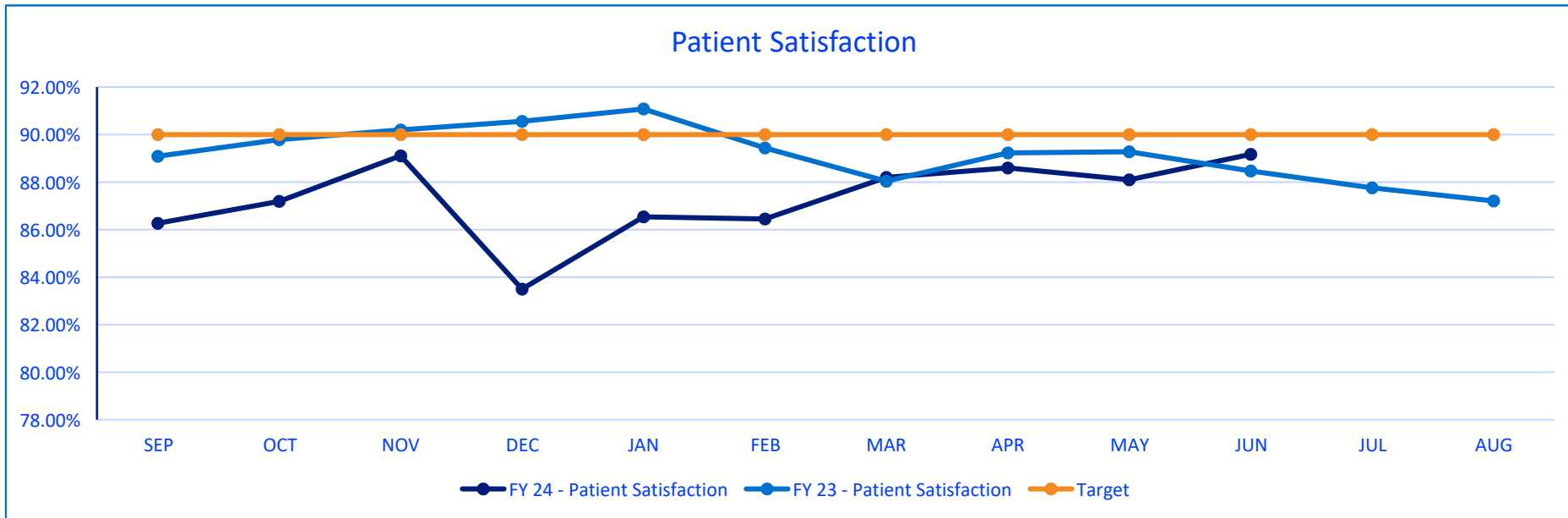
Notes:

- PHQ9 for adult with improve PHQ score, minimal depression rating, is below the target for new patient. Leadership is exploring improvement opportunities

Measure Computation: % of patients that have improved depression scores on PHQ. (New Patient = episode begin date w/in 1 year; Must have 14 days between first and last assessments)

Measure Definition: PHQ 9/A The Patient Health Questionnaire (PHQ; Spitzer, Kroenke, Williams, 1999) is a self-report version of the Primary Care Evaluation of Mental Disorders (PRIME-MD), designed for screening of psychiatric disorders in an adult primary practice setting. The PHQ comprises the patient questionnaire and clinician evaluation guide from the PRIME-MD, combined into a single, three-page questionnaire.

Domain	Measures (Definition)	2024 Fiscal Year Target	2024Fiscal Year Average (Sept – June)	Reporting Period- June	Target Desired Direction	Target Type
Effective Care	Patient Satisfaction	91%	87%	89.17	Increase	IOS



Notes:

- At the beginning of Fiscal Year 2024, the overall patient satisfaction across the center deviated below its targeted monthly threshold. In response to this, a specialized patient satisfaction sub-committee was established to meticulously analyze survey data, discern areas of vulnerability, and formulate quality improvement initiatives. Practice managers are actively engaging with unit-specific patient satisfaction data to pinpoint and address areas warranting enhancement.
- The committee is systematically collating patient narrative feedback from Fiscal Year 2023, with the intention of informing the development of workgroups dedicated to addressing identified areas of improvement and establishing goals for Fiscal Year 2024. The sub-committee's analytical efforts are predominantly rooted in the quantitative data derived from the VSSS instrument.

Appendix

FY 23 - Board of Trustee's PI Scorecard



Target Status:

Green = Target Met	Red = Target Not Met	Yellow = Data to Follow	No Data Available
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	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY23 AVG	FY23 Target	Target Type	Data Origin
Access to Care																
AMH Waitlist (State Defined)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	IOS	MH-BO
Adult Service Target	14,230	14,066	13,592	13,414	13,794	13,676	13,931	13,911	14,119	14,257	14,340	14,124	13,955	13,764	C	MBOW
AMH Actual Service Target %	103.39%	102.19%	98.75%	97.46%	100.22%	99.36%	101.21%	101.07%	102.58%	103.53%	104.08%	102.62%	101.37%	100.00%	C	MBOW
AMH Serv. Provision (Monthly)	48.00%	49.20%	45.90%	47.10%	49.20%	49.60%	52.20%	47.60%	51.30%	51.80%	50.08%	55.90%	49.82%	≥ 65.60%	C	MBOW
CAS Waitlist (State Defined)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	IOS	MH-BO
CAS Service Target	3,593	3,588	3,555	3,485	3,493	3,594	3,663	3,709	3,706	3,582	3,476	3,398	3,570	3,481	C	MBOW
CAS Actual Service Target %	103.22%	103.07%	102.13%	100.11%	100.34%	103.25%	105.23%	106.55%	106.46%	102.90%	99.83%	97.62%	102.56%	100.00%	C	MBOW
CAS Serv. Provision (Monthly)	76.70%	76.00%	74.00%	72.50%	78.20%	76.30%	76.00%	71.00%	75.20%	74.50%	69.50%	77.50%	74.78%	≥ 65.00%	C	MBOW
IDD Service Target	824	864	885	830	908	914	924	925	968	979	955	1011	916	854	SP	MBOW
IDD Actual Service Target %	96.49%	101.17%	103.63%	97.19%	106.32%	104.03%	108.20%	108.31%	113.35%	114.64%	111.83%	118.27%	106.95%	100.00%	C	MBOW
DID Assessment Waitlist		5710	5602	5621	5547	5486	5281	4306	3782	3473	2890	2606				
CW CAS 1st Contact to LPHA	23.82	25.66	23.87	21.85	12.22	8.75	3.91	3.06	1.72	2.14	1.67	1.86	10.88	<10 Days	NS	Epic
CW AMH 1st Contact to LPHA	2.33	2.93	2.76	3.99	3.83	3.46	3.55	3.42	3.31	2.37	1.70	1.21	2.91	<10 Days	NS	Epic
CW CAS/AMH 1st Con. to LPHA	5.88	7.34	6.53	7.42	5.42	4.61	3.63	3.29	3.06	2.34	1.69	1.31	4.38	<10 Days	NS	Epic
CAS 1st Avail. Med Appt-COC	6.15	8.55	7.89	8.20	8.86	6.57	7.20	8.40	5.25	10.83	11.57	10.33	8.32	<14 Days	C	Epic
CAS 1st Avail. Med Appt-COM	21.46	22.08	21.70	20.49	21.27	17.54	18.16	18.58	17.99	16.20	15.10	12.10	18.56	<28 Days	NS	Epic
CAS # Pts Seen in 30-60 Days	49	45	45	44	47	19	51	40	53	33	34	27	40.58	<9.18	IOS	Epic
CAS # Pts Seen in 60+ Days	26	27	35	27	35	43	22	18	14	15	7	8	23.08	0	IOS	Epic

	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY23 AVG	FY23 Target	Target Type	Data Origin
AMH 1st Avail. Med Appt-COC	4.40	4.93	4.69	4.48	4.91	4.47	4.74	4.43	4.12	4.02	5.17	3.66	4.50	<14 Days	C	Epic
AMH 1st Avail. Med Appt-COM	6.95	5.48	5.52	6.89	8.77	6.88	7.50	8.07	9.43	11.69	13.75	13.66	8.72	<28 Days	NS	Epic
AMH # Pts Seen in 30-60 Days	6	2	2	1	4	5	1	1	4	21	81	142	22.50	<45	IOS	Epic
AMH # Pts Seen in 60+ Days	2	1	1	0	0	0	0	0	1	2	1	7	1.25	0	IOS	Epic
Access to Care, Crisis Line																
Total Calls Received	16,427	16,509	14,853	17,512	17,926	16,965	17,374	16,047	16,233	16,323	16,472	18,570	16,768			
AVG Call Length (Mins)	8.00	8.00	8.10	8.70	8.50	8.80	9.30	9.20	9.80	9.00	9.30	9.50	8.85			
Service Level	86.00%	91.34%	91.00%	90.76%	92.00%	88.00%	89.00%	89.00%	89.64%	91.96%	94.44%	94.05%	90.60%	≥ 95.00%	C	Brightmetrics
Abandonment Rate	8.00%	5.32%	6.00%	5.39%	4.30%	6.00%	5.00%	5.92%	4.84%	3.89%	3.21%	4.23%	5.18%	< 8.00%	NS	Brightmetrics
Occupancy Rate	73.00%	69.00%	69.00%	71.00%	72.00%	77.00%	74.00%	76.00%	76.00%	68.00%	65.00%	68.00%	71.50%			Brightmetrics
Crisis Call Follow-Up	100.00%	99.79%	99.76%	99.77%	99.77%	99.76%	100.00%	99.50%	100.00%	100.00%	99.67%	100.00%	99.84%	> 97.36%	IOS	Icarol
Access to Crisis Resp. Svc.	93.50%	87.10%	84.00%	88.80%	89.80%	89.80%	88.50%	86.60%	84.50%	86.50%	88.90%	83.50%	87.63%	> 52.00%	C	MBOW
PES Restraint, Seclusion, and Emergency Medications (Rates Based on 1,000 Bed Hours)																
PES Total Visits	1,194	1,192	1,160	1,173	1,266	1,126	1,126	1,106	1,155	1,104	1,222	1,248	1173			
PES Admission Volume	523	585	560	544	555	498	549	522	558	487	571	562	542.83			
Mechanical Restraints	0	0	0	0	0	0	0	0	0	0	0	0	0.00			
Mechanical Restraint Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	≤ 0.01	IOS	Epic
Personal Restraints	46	40	37	37	43	50	79	76	43	49	48	47	49.58			Epic
Personal Restraint Rate	2.07	1.95	1.78	1.77	1.98	2.68	3.85	3.89	2.36	3.65	3.00	2.51	2.62	≤ 2.80	IOS	Epic
Seclusions	33	35	19	32	20	39	53	58	35	33	34	33	35.33			Epic
Seclusion Rate	1.48	1.61	0.92	1.53	0.92	2.09	2.58	3.22	1.92	2.46	2.13	1.76	1.89	≤ 2.73	SP	Epic
AVG Minutes in Seclusion	46.91	58.66	52.62	51.82	41.70	49.76	44.33	54.92	42.00	49.71	51.92	43.15	48.96	≤ 61.73	IOS	Epic
Emergency Medications	44	54	42	47	58	56	72	72	67	53	59	52	56.33			Epic
EM Rate	1.98	2.48	2.02	2.25	2.67	3.01	3.50	3.99	3.61	3.63	3.45	2.77	2.95	≤ 3.91	IOS	Epic
R/S Monitoring/Debriefing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	IOS	Epic

	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	FY23 AVG	FY23 Target	Target Type	Data Origin
Patient Satisfaction (Based on the Two Top-Box Scores)																
CW Patient Satisfaction	89.09%	89.79%	90.20%	90.56%	91.08%	89.44%	88.04%	89.23%	89.28%	88.47%	87.76%	87.21%	89.18%	90.00%	IOS	Feedtrail
V-SSS 2	88.69%	89.66%	90.24%	90.32%	90.38%	89.33%	87.30%	88.69%	88.65%	87.81%	86.52%	85.22%	88.57%	90.00%	IOS	Feedtrail
PoC-IP	89.71%	89.30%	89.25%	90.14%	95.15%	90.74%	90.61%	91.85%	91.08%	91.03%	91.43%	92.88%	91.10%	90.00%	IOS	McLean
Pharmacy	93.02%	99.09%	96.31%	96.19%	94.87%	100.00%	97.58%	96.37%	97.66%	99.63%	98.11%	94.76%	96.97%	90.00%	IOS	Feedtrail
Adult Mental Health Clinical Quality Measures (Fiscal Year Improvement)																
QIDS-C	25.00%	27.75%	26.88%	26.82%	26.72%	25.77%	25.25%	25.63%	26.55%	27.79%	28.44%	28.52%	26.76%	24.00%	IOS	MBOW
BDSS	30.19%	31.31%	31.83%	33.48%	33.70%	33.36%	33.38%	33.26%	34.49%	35.28%	35.56%	35.58%	33.45%	32.00%	IOS	MBOW
PSRS	26.32%	30.56%	35.26%	35.51%	35.11%	34.49%	34.81%	35.67%	36.83%	37.70%	38.62%	39.30%	35.02%	35.00%	IOS	MBOW
Adult Mental Health Clinical Quality Measures (New Patient Improvement)																
BASIS-24 (CRU/CSU)	0.98	0.76	0.41	0.71	0.90	-0.17	0.67	0.65	0.77	0.91	0.96	0.75	0.69	0.68	IOS	McLean
QIDS-C	53.80%	47.30%	50.10%	50.40%	48.60%	44.50%	47.20%	50.30%	50.70%	60.90%	51.60%	46.80%	50.18%	45.38%	IOS	Epic
BDSS	46.10%	46.20%	51.80%	50.30%	48.70%	47.20%	45.40%	42.80%	49.40%	49.20%	48.50%	46.10%	47.64%	46.47%	IOS	Epic
PSRS	38.20%	41.70%	43.50%	42.40%	36.00%	39.70%	32.30%	39.30%	42.60%	43.50%	42.50%	40.50%	40.18%	37.89%	IOS	Epic
Child/Adolescent Mental Health Clinical Quality Measures (New Patient Improvement)																
PHQ-A (11-17)	18.20%	24.50%	37.80%	39.70%	42.20%	41.40%	42.60%	42.40%	42.40%	38.00%	36.50%	31.80%	36.46%	41.27%	IOS	Epic
Adult and Child/Adolescent Needs and Strengths Measures																
ANSA (Adult)	42.32%	35.32%	36.36%	38.40%	38.27%	37.70%	38.40%	39.50%	41.10%	42.30%	42.80%	43.60%	39.67%	20.00%	C	MBOW
CANS (Child/Adolescent)	43.14%	21.65%	18.14%	19.80%	21.31%	25.30%	27.30%	30.50%	33.00%	35.20%	36.40%	37.80%	29.13%	25.00%	C	MBOW
Adult and Child/Adolescent Functioning Measures																
DLA-20 (AMH and CAS)	49.80%	44.50%	44.30%	47.50%	50.90%	53.80%	50.00%	54.10%	45.20%	43.20%	39.60%	43.20%	47.18%	48.07%	IOS	Epic

Thank you.

EXHIBIT Q-3

Status Pending PolicyStat ID 14358146



Origination	N/A	Owner	Luc Josaphat:
Last Approved	N/A	Director of Quality Assurance	
Effective	Upon	Approval Area Administration	General
Last Revised	N/A	Document	Agency Plan
Next Review	1 year after		Type approval

The Harris Center System Quality, Safety and Experience Performance Improvement Plan FY 2025

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

FY 2025

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.

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 2025 Goals

1. Continue to build upon a learning health system focused on continuous quality improvement, patient safety, improving processes and outcomes. Partner with Organizational Development to enhance educational offerings focused on quality and safety education with all new employee orientation (High Reliability, Just Culture, Advanced Quality Improvement methodology, etc.). Hardwire a process for continuous readiness activities that complies with all legislative regulations and accrediting agencies standards (e.g., CARF, CCBHC).
2. 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.
3. Develop, integrate, and align quality initiatives and cross-functional approaches throughout

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

To ensure alignment with survey readiness as a Certified Community Behavioral Health Clinic and Commission on Accreditation of Rehabilitation Facilities, the System Quality, Safety and Experience plan focuses on indicators related to improved 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 processes to review known significant events including, at a minimum:

- Deaths by suicide or suicide attempts of people receiving services
- Fatal and non-fatal overdoses
- All-cause mortality among people receiving CCBHC services
- 30-day hospital readmissions for psychiatric or substance use reasons

3-Year Long Term Goals (FY 2027)

- Reduction in safety events
- Staff and provider engagement
- Improve Patient satisfaction – Response rate and overall top box score
- Increased access (numbers served)
- Improved outcomes
- Equitable care delivery
- Exemplar in Quality and Safety for Behavioral Health with national recognition Governance Structure

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

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

Governing Body

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

Leadership

The Harris Center leadership is delegated the authority, via the Board of Trustees, and accountability for executing and managing the organization's quality improvement initiatives. Quality leadership provides the framework for planning, directing, coordinating, and delivering the improvement of healthcare services that are responsive to both community and patient needs that improve healthcare outcomes. The Harris Center leaders encourage involvement and participation from staff at all levels within all entities in quality initiatives and provide the stimulus, vision, and resources necessary to execute quality initiatives.

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

Professional Review Committee (PRC)

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

reportable conduct or finding when indicated. The Professional Review Committee has oversight of the following peer protected processes and committees:

- Medical Peer Review
- Pharmacy Peer Review
- Nursing Peer Review
- Licensed Professional Review
- Closed Record Review
- Internal Review Board
- System Quality, Safety and Experience Committee Membership:
 - Chief Executive Officer (Ex-Officio)
 - Chief Medical Officer
 - Chief Operating Officer
 - Chief Nursing Officer (Co-chair)
 - Chief Administrative Officer
 - Legal Counsel
 - Divisional VPs and (CPEP, MH)
 - VP, Clinical Transformation and Quality (Chair)
 - Director Risk Management/ERM
 - Director of Pharmacy Programs

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:

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

- Patient Experience / Satisfaction Subcommittee

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

- High-risk, high-volume, or problem-prone practices, processes, or procedures
- Identified risk to patient safety and medical/healthcare errors
- Identified in The Harris Center Strategic Plan
- Identified as Evidenced Based or "Best Practice"
- Required by regulatory agency or contract requirements Methodologies
- The Model for Improvement 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 Quality, Safety and Experience Committee. 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

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 its 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 actually leads to an improvement.

Selecting Changes

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

Testing Changes

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

Implementing Changes:

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

Spreading Changes:

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

Sources:

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

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

Root Cause Analysis (RCA):

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

Failure Modes and Effects Analysis (FMEA):

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

Steps in the process

Failure modes (What could go wrong?)

Failure causes (Why would the failure happen?)

Failure effects (What would be the consequences of each failure?)

Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis on prevention may reduce 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.
