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

**Quality Committee Meeting**
September 17, 2024
11:00 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, August 20, 2024
*(EXHIBIT Q-1 )*

IV. **REVIEW AND COMMENT**

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

B. Suicide Care Initiatives
*(EXHIBIT Q-3 Tiffany Bittner)*

C. PI Plan FY 2025
*(EXHIBIT Q-4 Trudy Leidich)*

V. ***EXECUTIVE SESSION-***

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

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

VI. **RECONVENE INTO OPEN SESSION**

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

VIII. **ADJOURN**

Veronica Franco

**Veronica. Franco, Board Liaison**
**Luis A. Fernandez, M.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, AUGUST 20, 2024 MINUTES

Dr. R. Gearing, Committee Chair, called the meeting to order at 11:15 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, Mrs. B. Hellums

Committee Member Absent:

Other Board Member in Attendance: Dr. L. Moore

1. **CALL TO ORDER**
   Dr. Gearing called the meeting to order at 11:15 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: FERNANDEZ**

   **With unanimous affirmative votes,**
   **BE IT RESOLVED** that the Minutes of the Quality Committee meeting held on Tuesday, July 16, 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. FY2025 PI Plan**-FY2025 PI Plan was presented by Trudy Leidich to the Quality Committee.

7. **EXECUTIVE SESSION-**

Dr. Gearing announced the Quality Committee would enter into executive session at 11:45 am for the following reason:

- 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

**8. RECONVENE INTO OPEN SESSION-**

The Quality Committee reconvened into open session at 12:06 p.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: MOORE SECOND: FERNANDEZ**

There being no further business, the meeting adjourned at 12:06 p.m.

**Veronica Franco, Board Liaison**
**Robin Gearing, PhD, Chairman**
**Quality Committee**
**THE HARRIS CENTER *for* Mental Health *and* IDD**
**Board of Trustees**

# EXHIBIT Q-2

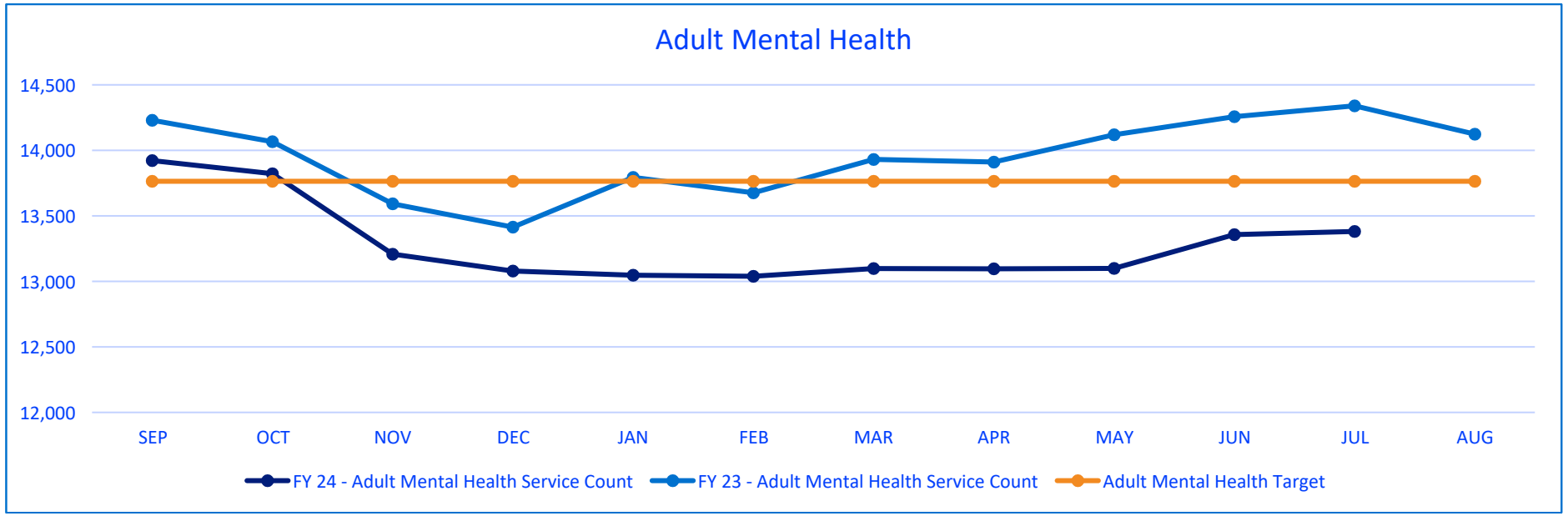
# Quality Board Scorecard

## Board Quality Committee Meeting


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

September 2024 (Reporting July 2024 Data)

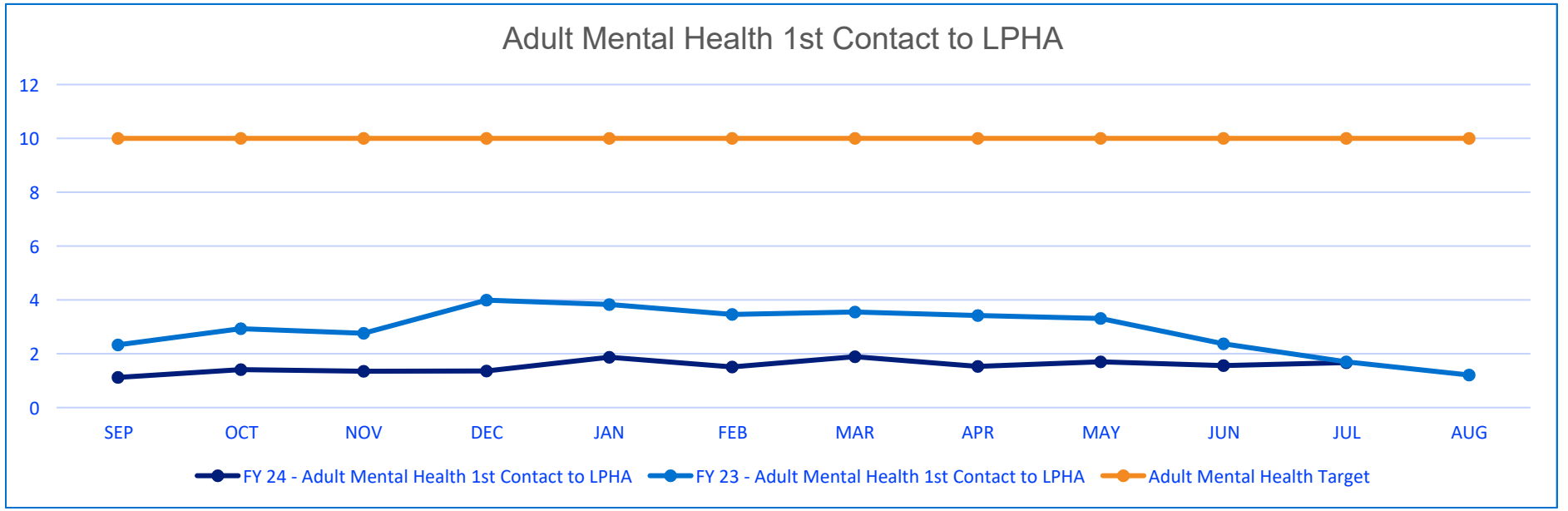
| Domain | Program | 2024 Fiscal Year State Service Care Count Target | 2024 Fiscal Year State Care Count Average (Sept. – July) | Reporting Period: July | Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | Adult Mental Health Service Care Count | 13,764 | 13,281 | 13,381 | Increase | Contractual |




Notes:
- In July 2024, the Adult Service Care Count experienced a decline of 7.11% 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.*

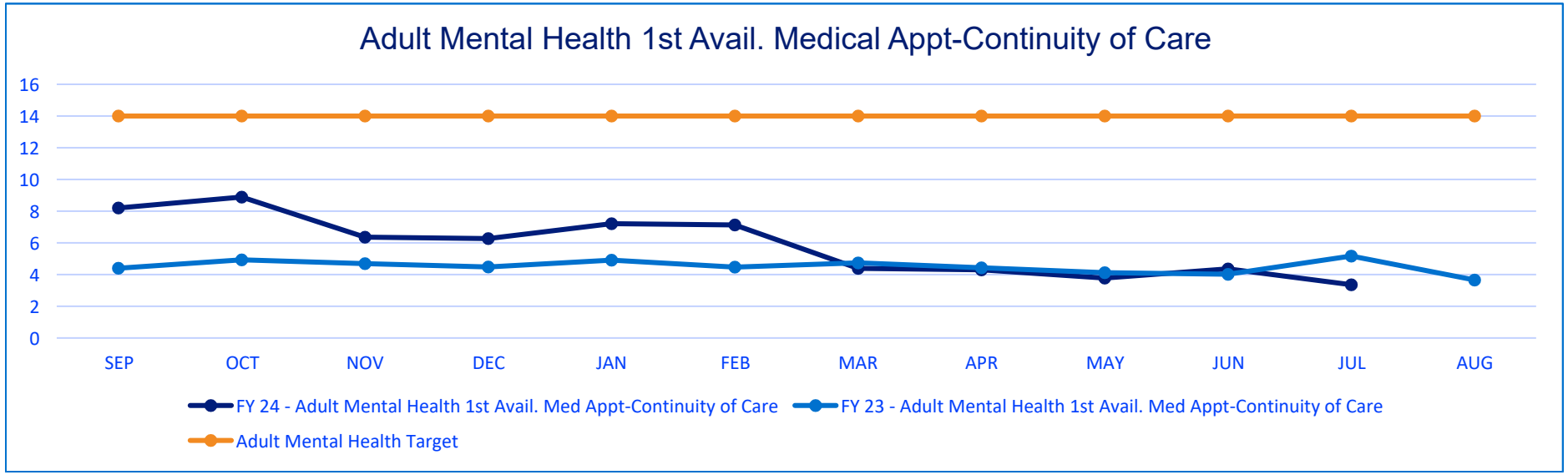
| Domain | Program | 2024 Fiscal Year Target | 2024 Fiscal Year Average (Sept. – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Adult Mental Health 1st Contact to LPHA | <10 days | 1.54 Days | 1.67 | Decrease | Contractual |




Notes:
- First contact to LPHA taking less than two days during the reported period.
- A year-over-year comparison reveals an improvement, with a 1.76% 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. – July) | Reporting Period: July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Adult Mental Health 1st Avail. Medical Appt-Continuity of Care | <14 days | 5.84 days | 3.36 days | Decrease | Contractual |

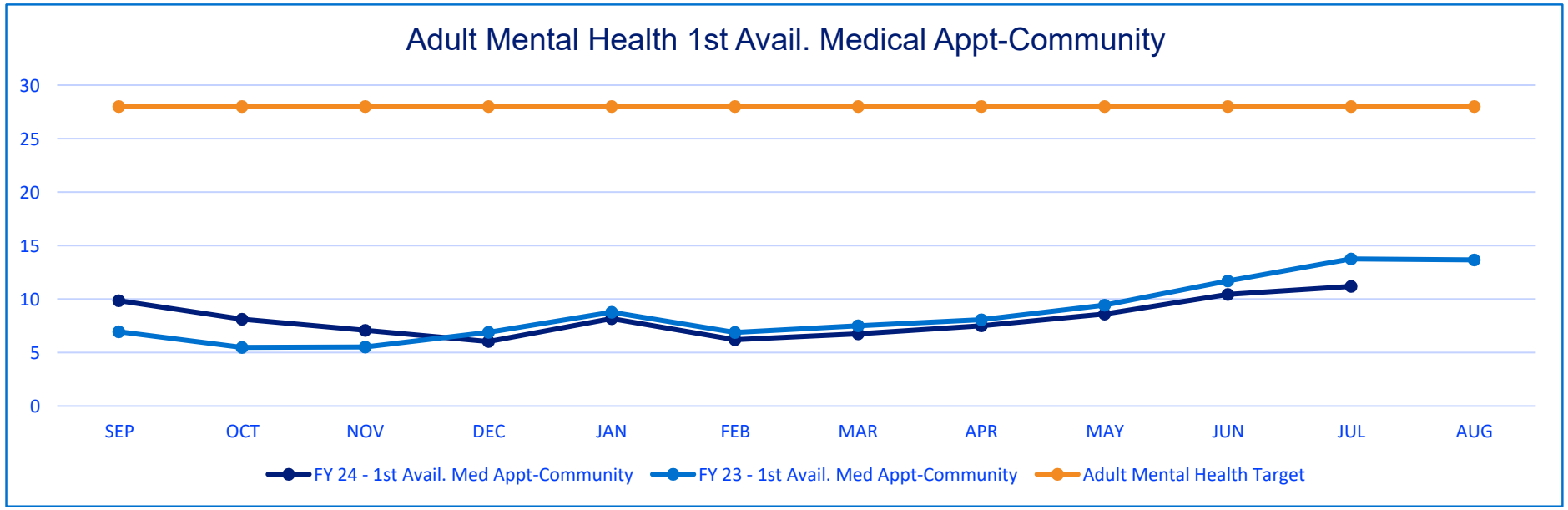



Notes:

- A year-over-year comparison reveals an improvement, with a 35.01% reduction in the number of days from first medical appointment for continuity of care .

*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-July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Adult Mental Health 1st Avail. Medical Appt-Community Members | <28 days | 8.17 days | 11.18 days | Decrease | Contractual |

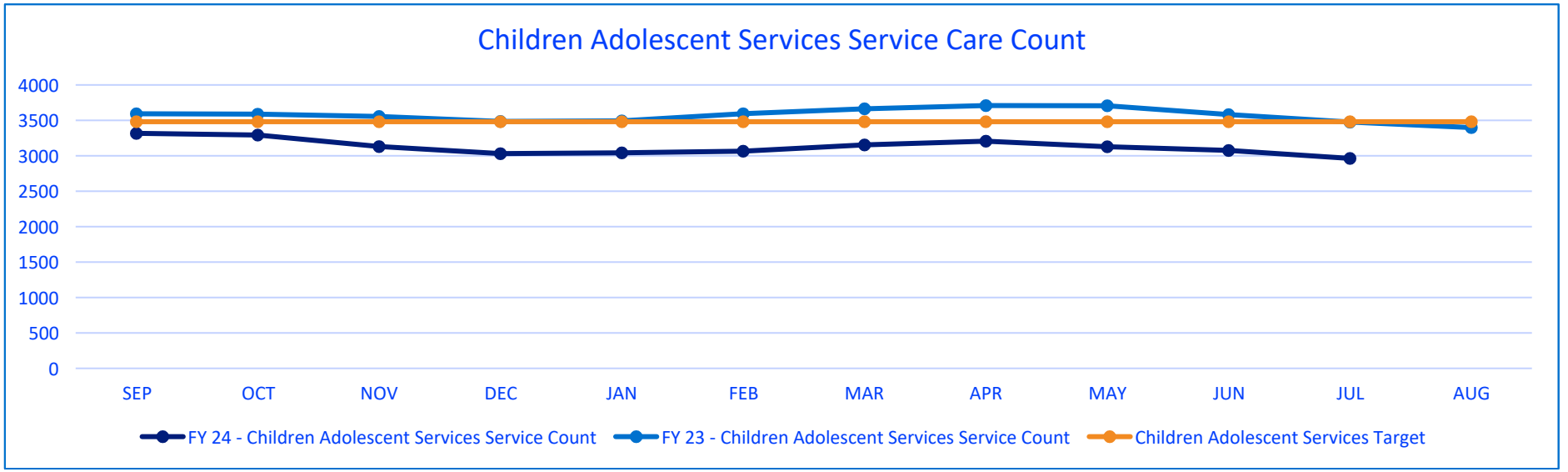



Notes:

- AMH community members appointments are accommodated within 11 days.
- A year-over-year comparative analysis reveals a 18.69% 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. – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access to Care | Children & Adolescent Services | 3,481 | 3,128 | 2,963 | Increase | Contractual |

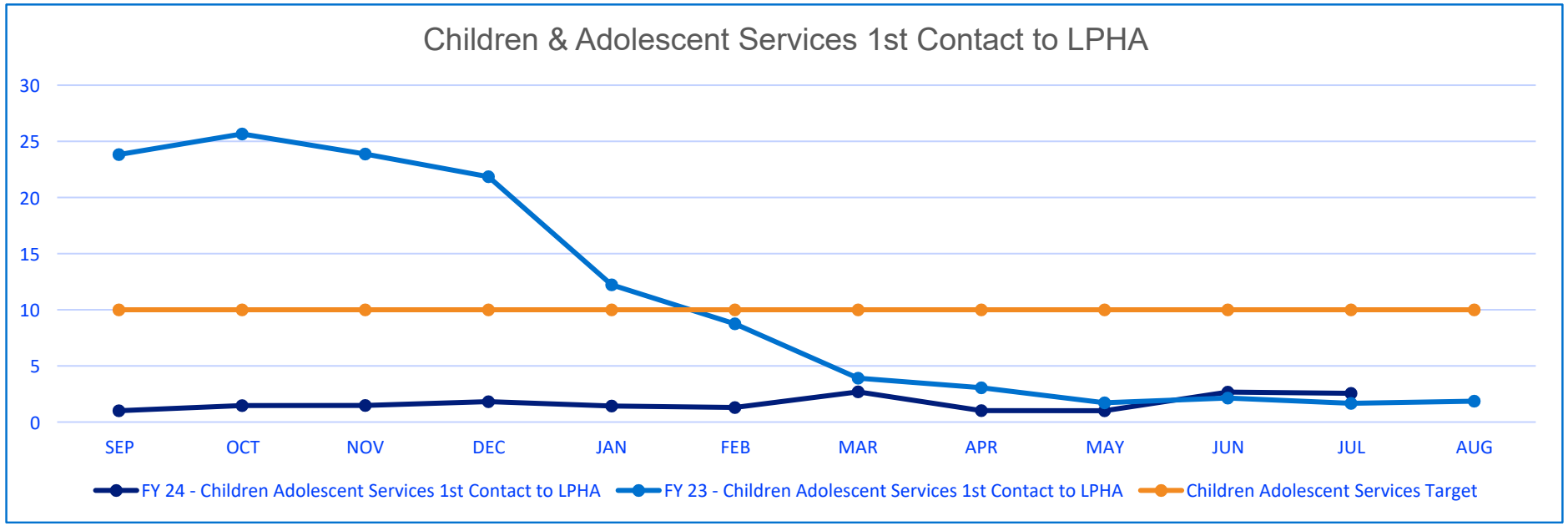



Notes:

- Service care count for the Children and Adolescent Services experienced a 14.84% 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 - July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Children & Adolescent Services 1st Contact to LPHA | <10 days | 1.68 days | 2.56 days | Decrease | Contractual |



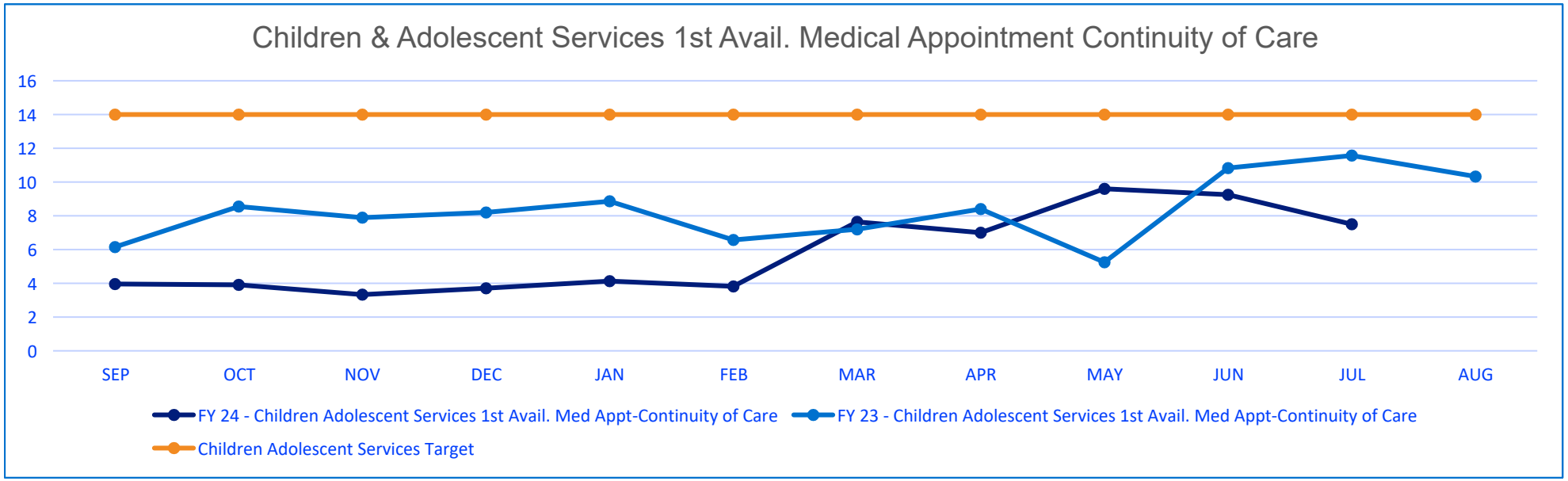

Notes:

- 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 50% increase in the waiting period for individuals to be assessed by an LPHA. However, the waiting period is still below 2 days on average and 2.56 days for the reporting period



*Measure definition: Children and Youth - Time between LPHA Assessment Appt Creation Date and LPHA Assessment Appt Completion Date*

| Domain | Program | 2024 Fiscal Year Target | 2024Fiscal Year Average (Sep-July) | Reporting Period-July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Children & Adolescent Services 1st Avail. Medical Appt-Continuity of Care | <14 days | 5.80 days | 7.50 days | Decrease | Contractual |

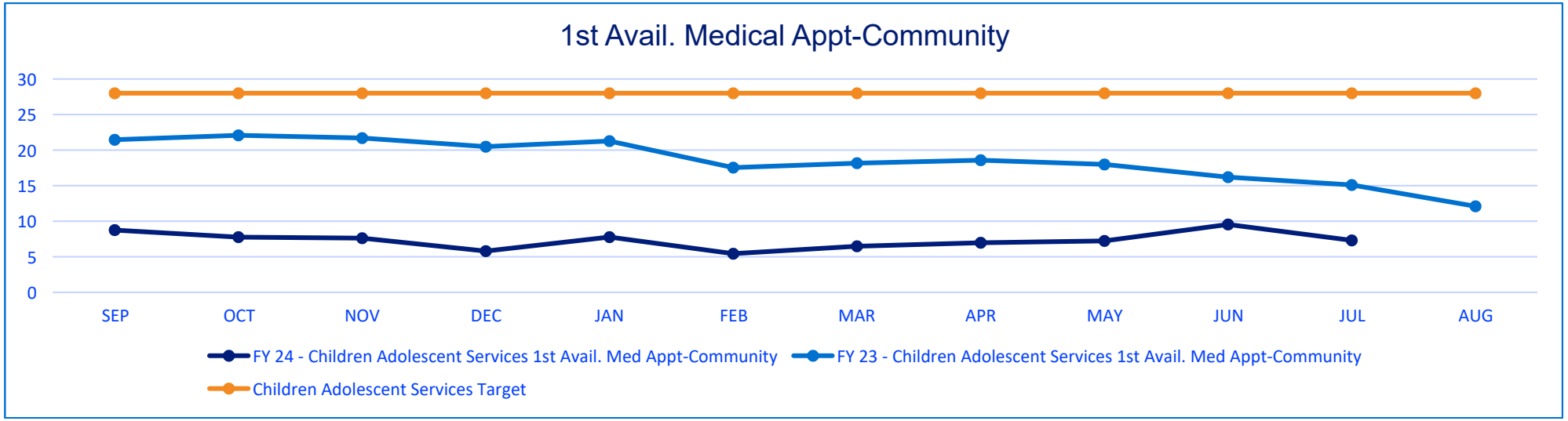



Notes:

- Wait time for medical appointment for continuity of care continues to exceed the contractual target of 14 days by providing appointments for medical visit within 6 days on average.
- The measure shows a 35% 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 – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Children & Adolescent Services 1st Avail. Medical Appt-Community | <28 days | 7.33 days | 7.31 days | Decrease | Contractual |

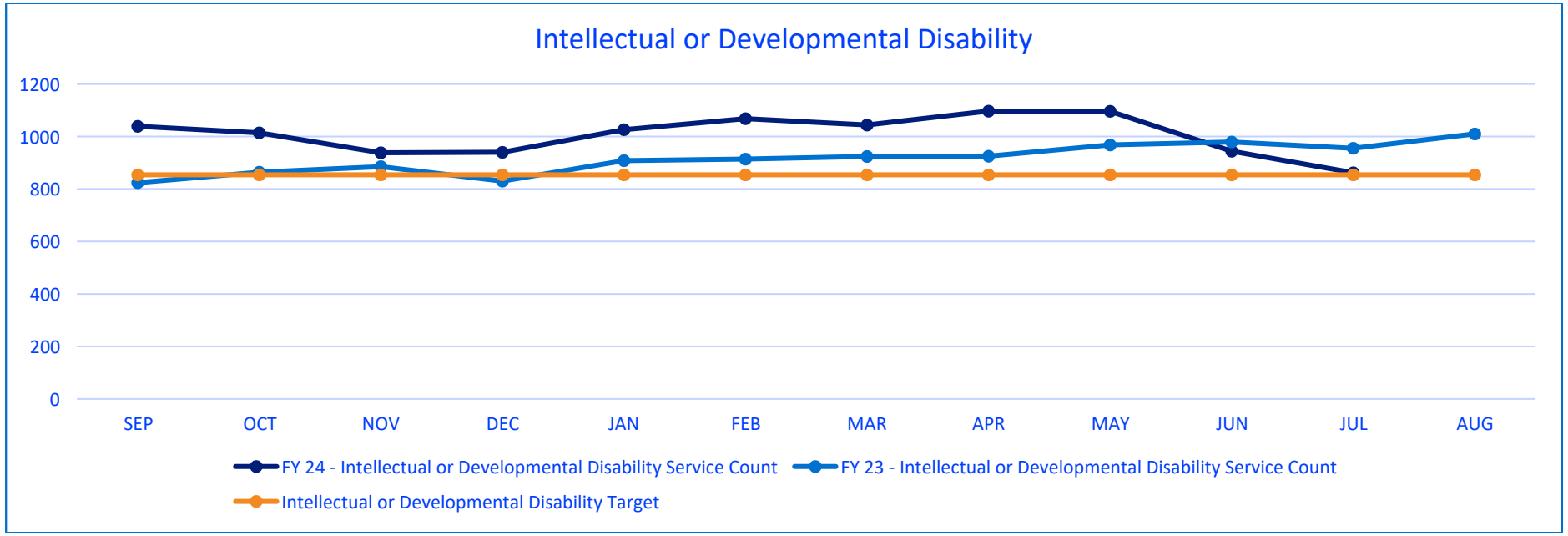



Notes:

- For the reporting period of July 2024, there was a decrease of 51% in the waiting period compared to the same period in the previous fiscal year.
- The wait time was reduced from 15.10 days in July 2023 to 7.31 days in July 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 – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Access | IDD | 854 | 1006 | 862 | Increase | Contractual |

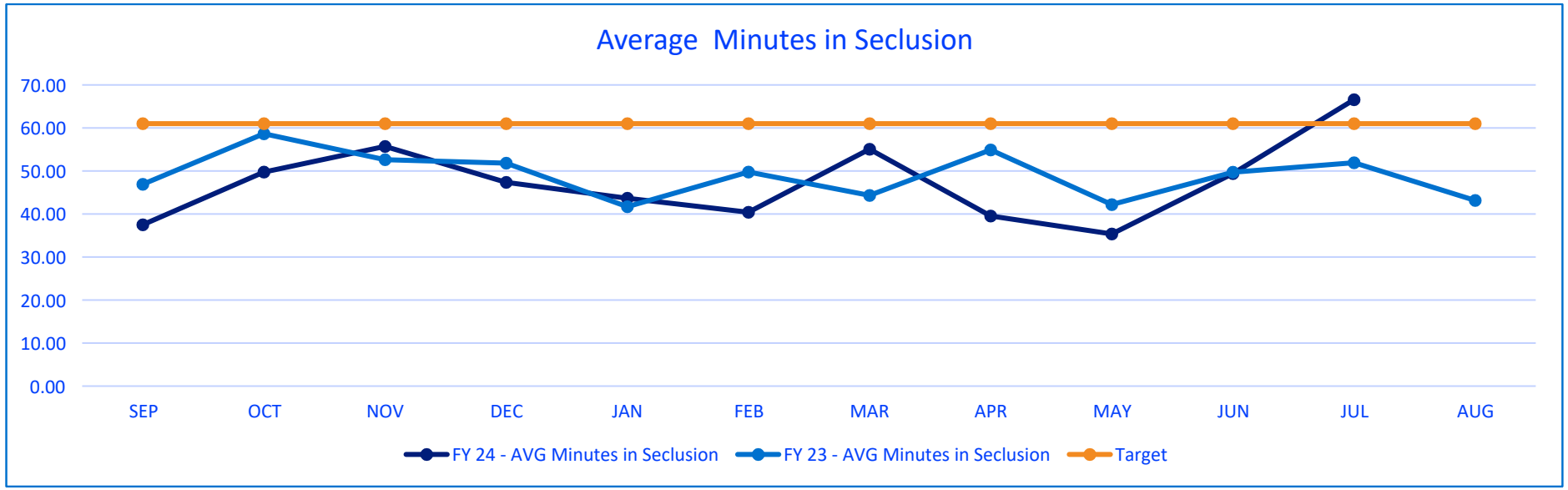



Notes:

- The IDD division service care count is at 862 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.)*

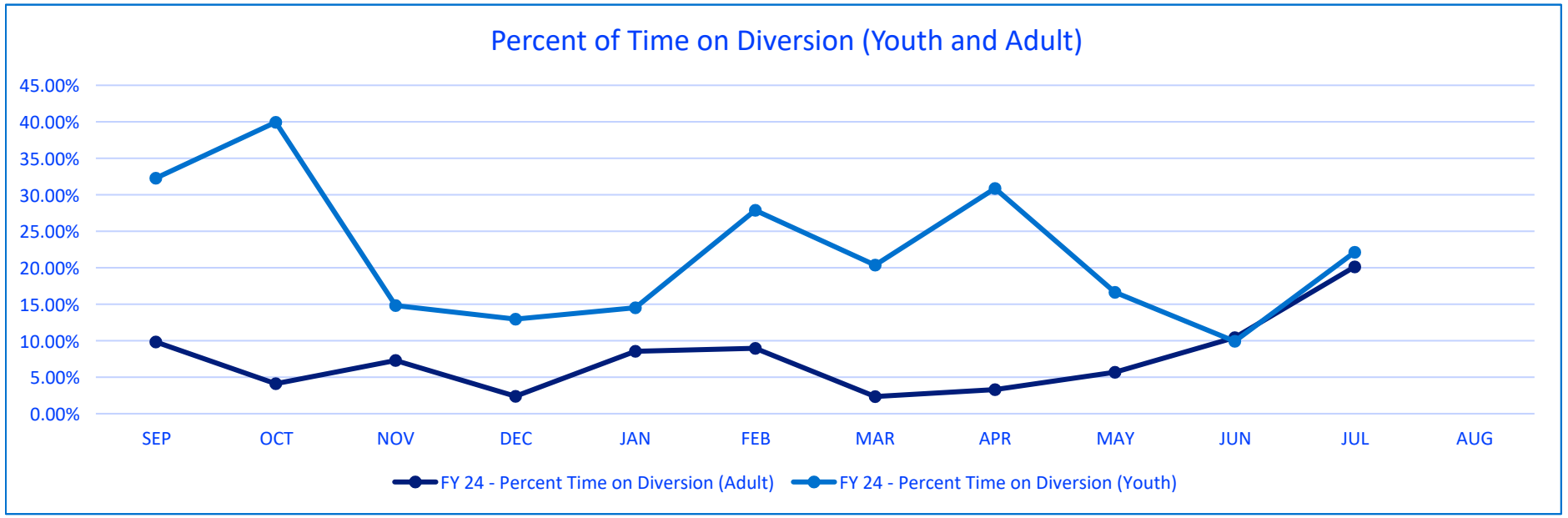
| Domain | Measures | 2024 Fiscal Year Target | 2024Fiscal Year Average (Sept – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Safe Care | Average Minutes in Seclusion | <60.43 | 47.30 | 66.58 | Decrease | Contractual |




Notes:

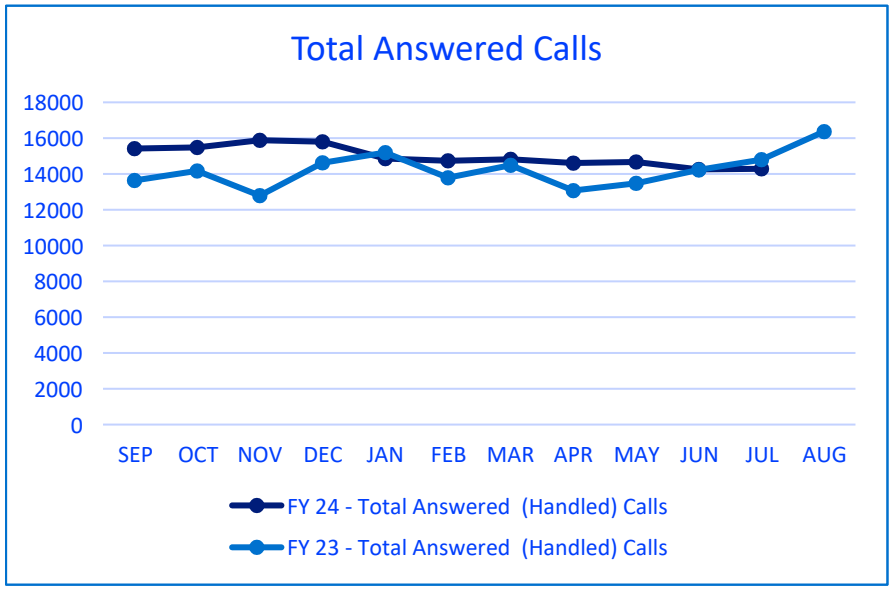
- Average minutes in seclusion has performed below contractual target.
- On average, individuals are spending less than 60 minutes in seclusion.
- For the reporting period, average minutes in seclusion is at 55.07 minutes.

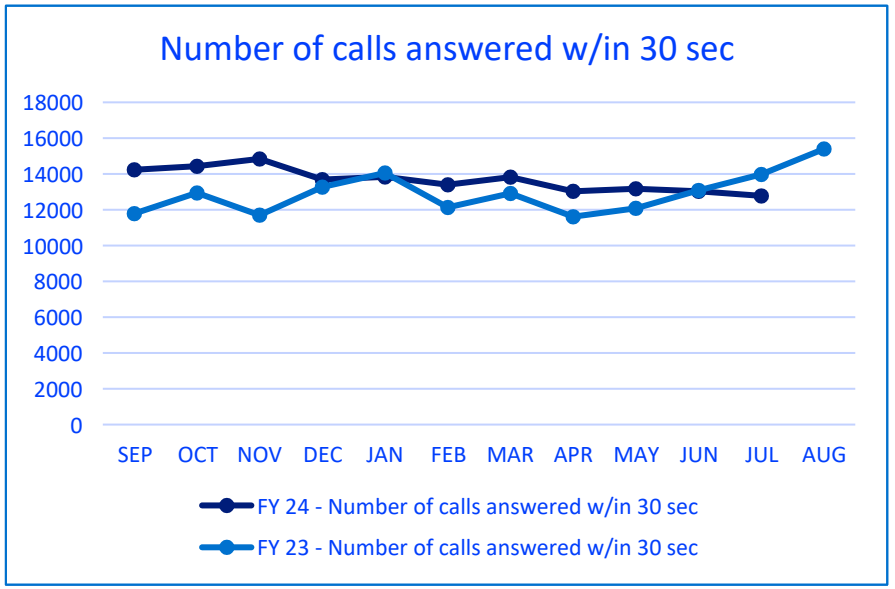
| Measures | 2024 Fiscal Year Target | 2024Fiscal Year Average (Sept – Mar.) | Reporting Period- March | Target Desired Direction | Target Type |
|---|---|---|---|---|---|
| Time on Diversion (in hours: Adult) | N/A | 7.55% | 20.13% | N/A | Contractual |
| | | | | | |
| Time on Diversion (in hours: Youth) | N/A | 22.03% | 22.13% | N/A | |




Notes:
Although a specific target has not been established for this measure, the overarching objective is to increase the number of at-risk individuals, both youths and adults, being channeled into the diversion program. This program provides support services designed to foster behaviors that are non-criminal in nature.

| Domain | Measures (Definition) | FY 2024 Target | 2024Fiscal Year Average (Sept - July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Total Answered Calls | N/A | 14,984 | 14,287 | Increase | N/A |
| | Number of calls answered w/in 30 secs | N/A | 13,660 | 12,777 | Increase | Contractual |

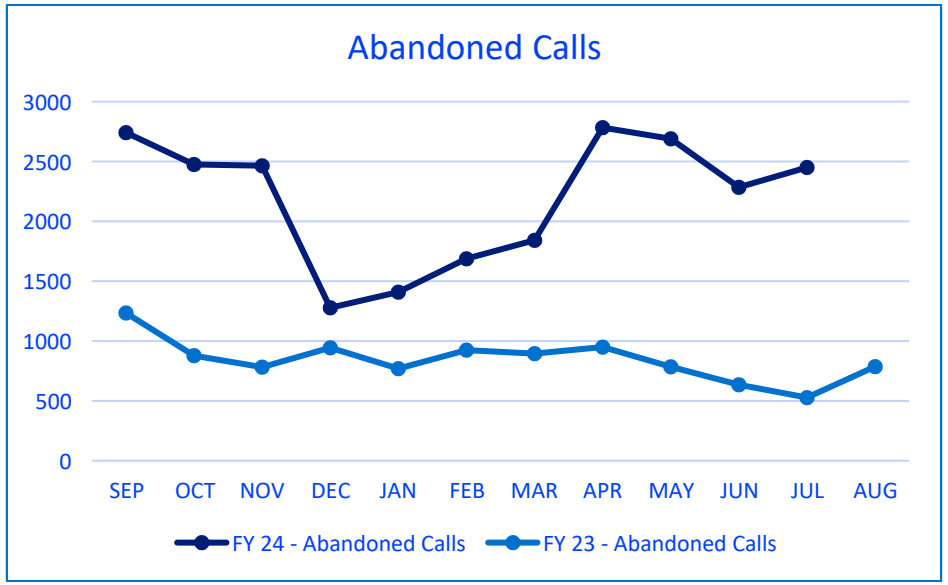


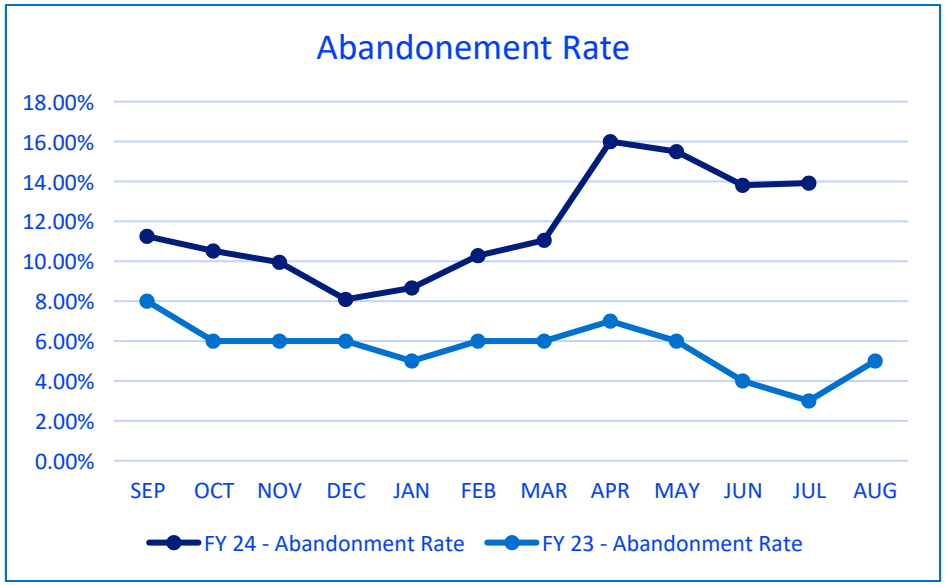




Notes:

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

| Domain | Measures (Definition) | FY 2024 Target | 2024Fiscal Year Average (Sept - July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | Abandoned Calls | N/A | 2,192 | 2,450 | Decrease | Contractual |
| | Abandonment Rate | <8% | 12% | 13.92% | Decrease | Contractual |

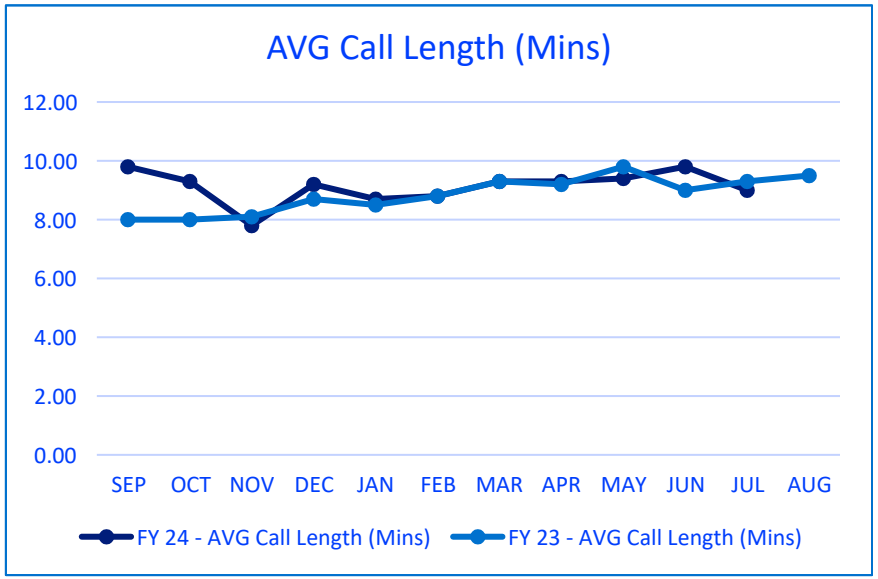


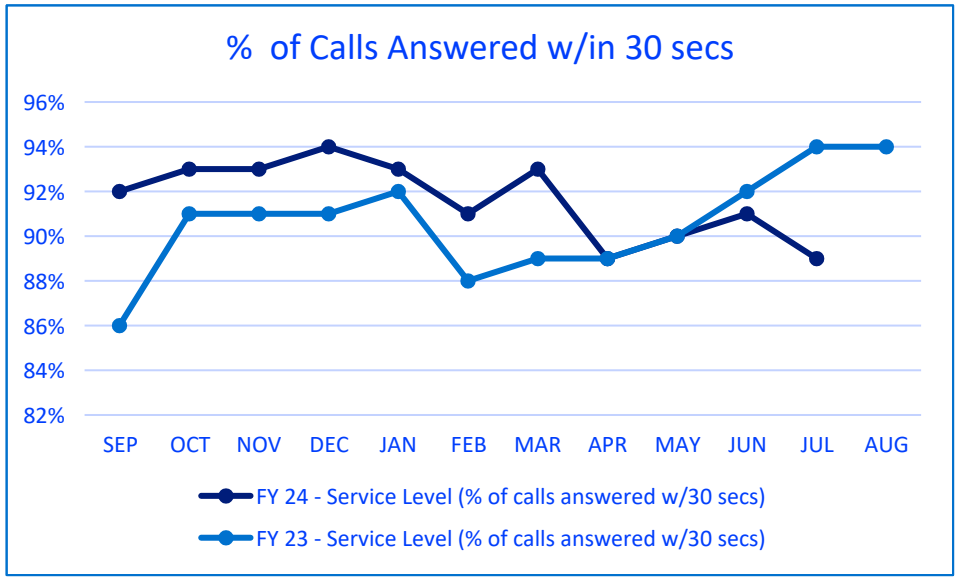




Notes:

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

| Domain | Measures (Definition) | FY 2024 Target | 2024Fiscal Year Average (Sept - July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Timely Care | AVG Call Length (Mins) | N/A | 9.13 | 9.00 | N/A | Contractual |
| | Service Level (% of calls answered w/30 secs) | >95% | 92.00% | 89% | Increase | Contractual |

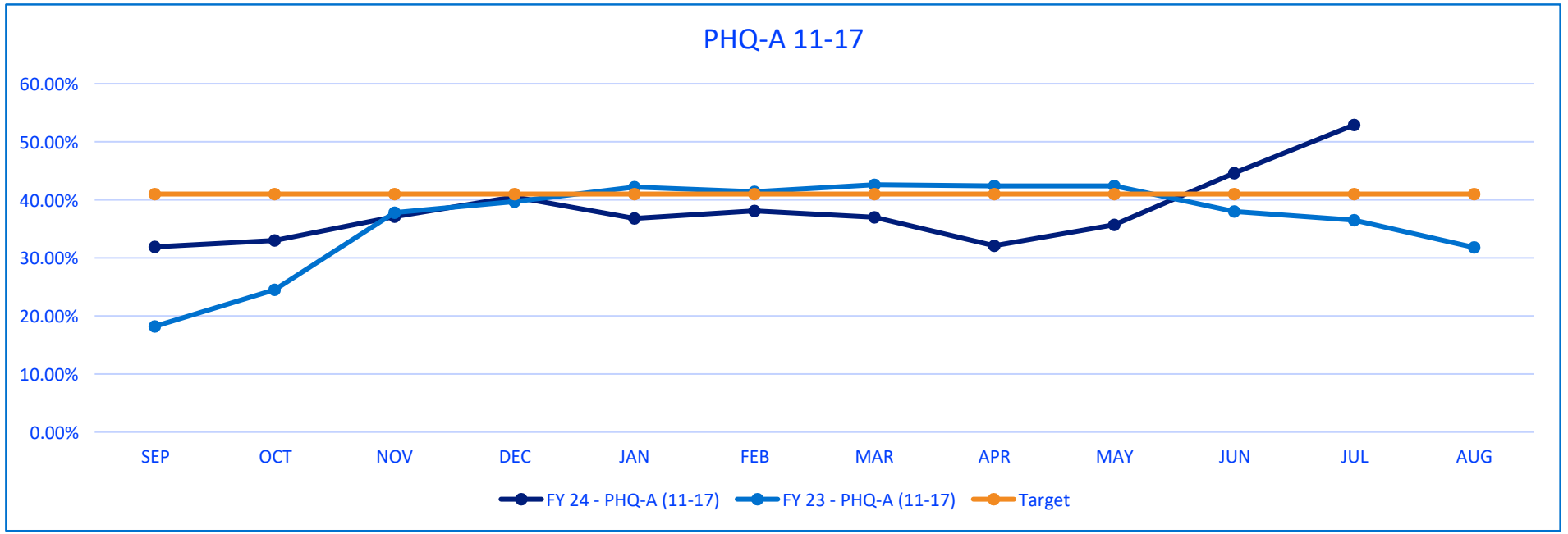



Notes:

- 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. – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | PHQ-A (11-17) | 41.27% | 38.% | 52.90% | Increase | IOS |



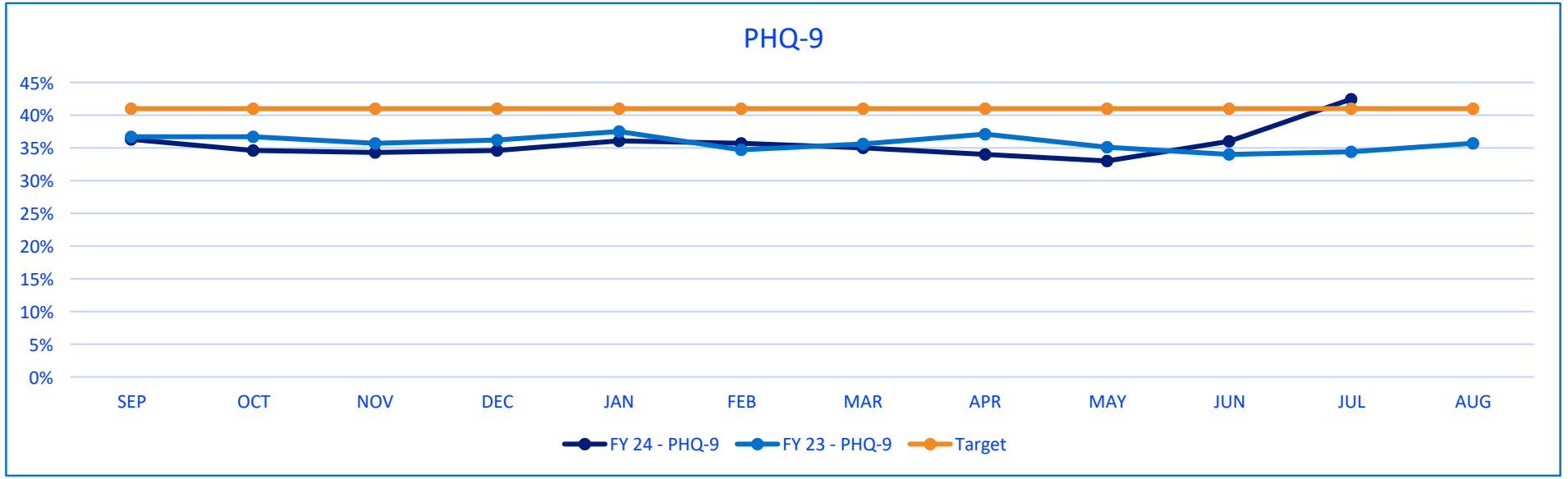

Notes:

- PHQ-A percentage of adolescent and young adult with improved 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 – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | PHQ-9 | 41.27% | 35% | 36% | Increase | IOS |



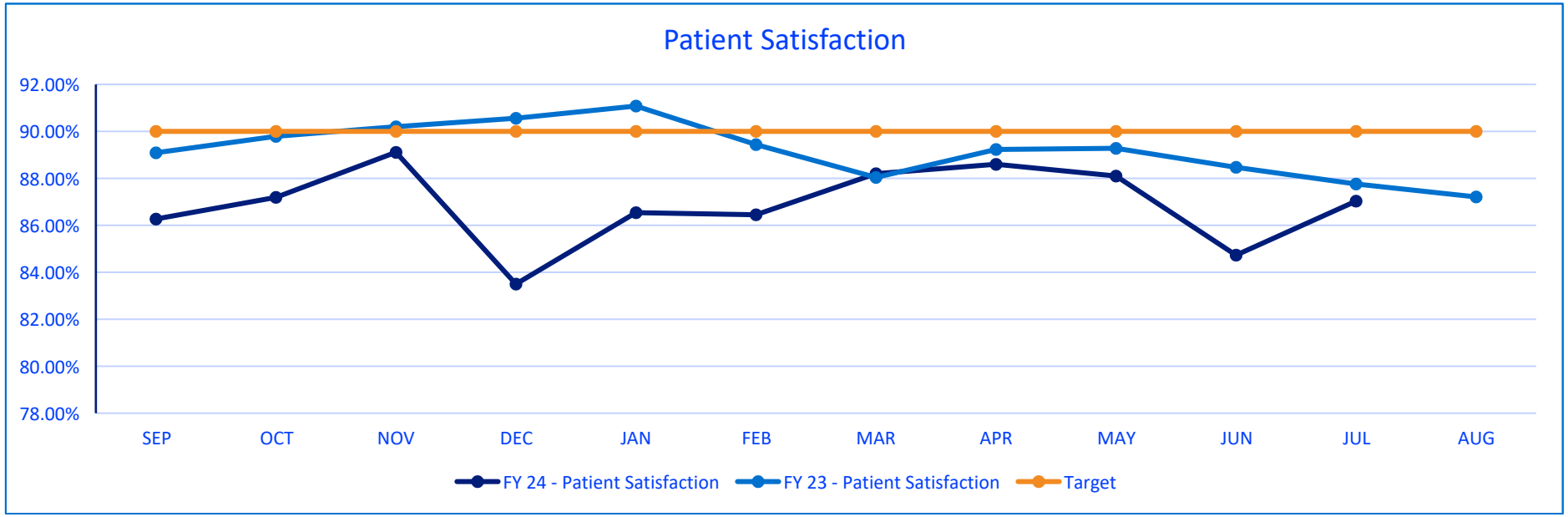

Notes:

- 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 – July) | Reporting Period- July | Target Desired Direction | Target Type |
|---|---|---|---|---|---|---|
| Effective Care | Patient Satisfaction | 91% | 87% | 87.03% | 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

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

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

| | 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

Transforming Lives

The HARRIS CENTER for Mental Health and IDD


# Suicide Care Initiatives

## Clinical Transformation and Quality

Date: September 17, 2024

Presented By: Tiffany Bittner MSN, RN, CPHQ, NE-BC, PMH-BC

The HARRIS CENTER for Mental Health and IDD
Transforming Lives


# Presentation Agenda

1. Introduction
2. Suicide Care Pathway
3. Zero Suicide

# Introduction & Context

- Suicide Care Goals
  - Enhance evidence-based suicide care for clients served at The Harris Center
  - Create a suicide care pathway during the FY22-FY24 Strategic Plan period with 70% adherence
  - Increase the number of staff trained in Zero Suicide at the Harris County Sheriff's Office over the FY22-FY24 Strategic Plan period

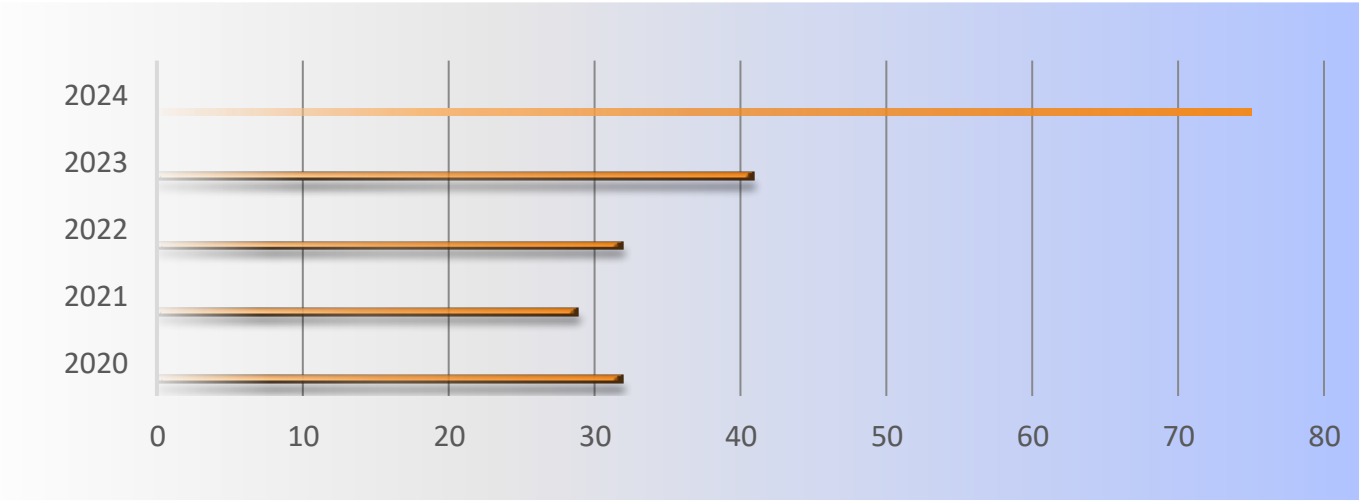
- Baseline: September 1, 2022
  - Minimal standardization of evidence-based suicide care practices
  - Suicide care pathway not yet started
  - FY22 Zero Suicide Site Visit Score: 32%
  - No active Zero Suicide training with HCSO

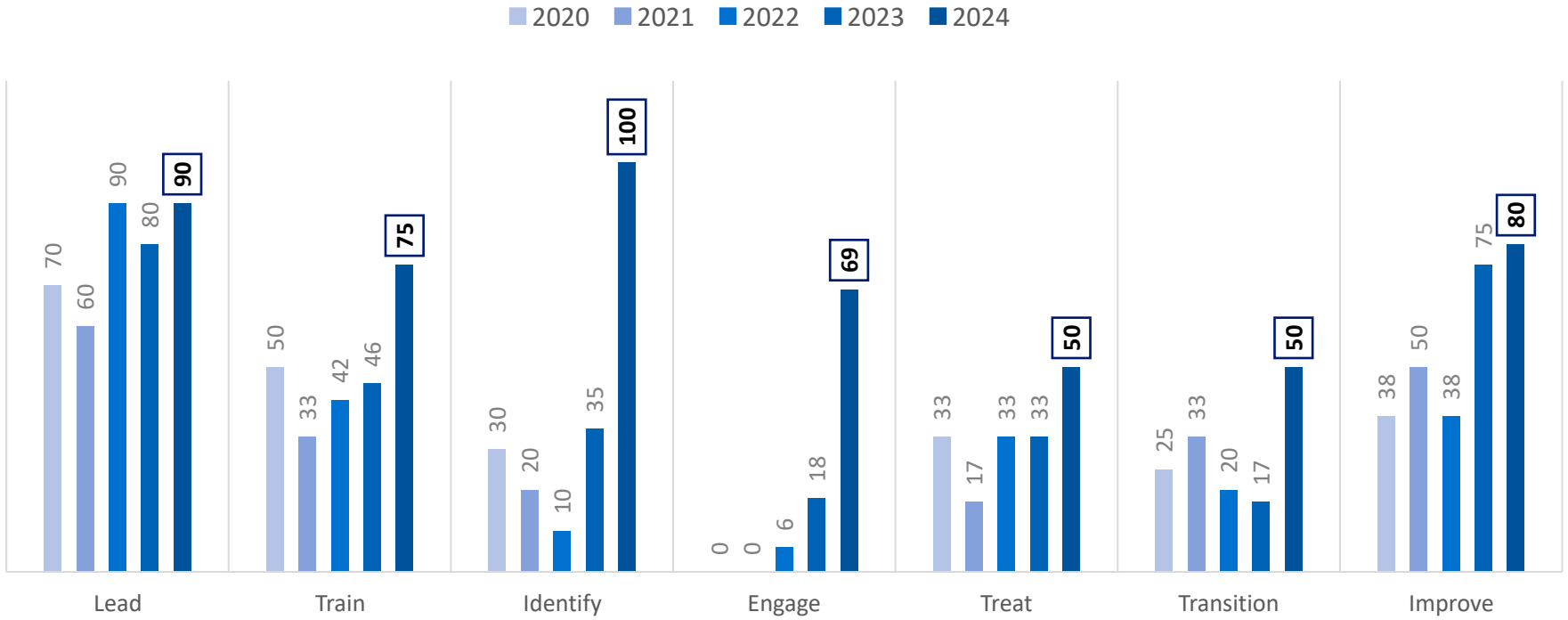
# Suicide Care Pathway

- New intake screening process started October 2022 using CSSRS Lifetime
  - Consistently over 90% compliant
- Same day risk assessment started April 2023 using standardized tool
  - Consistently above 88% compliant
- Same day risk intervention (safety planning) started October 2023
  - Consistently above 75% compliant
- Started tracking via dashboard October 2023
- Received 5 year SAMHSA grant funding for creation and implementation of a new suicide care pathway team at NW clinic
  - 4 team members dedicated to suicide care of moderate and high risk clients
  - Increased interventions and follow up
- **Over 10K new visits to AMH and CAS during this time**

# Zero Suicide Site Visit

- Previous Site Visit Scores:
  - 2020: 32%
  - 2021: 29%
  - 2022: 32%
  - 2023: 41%



# Element Breakdown

**Lead (90%):**
- Clear, concise goals with a structured implementation team that meets regularly
- Innovative communication measures added such as Yammer, Newsletter, SharePoint dedicated to Zero Suicide communication

**Train (75%):**
- Recent workforce survey with improvement noted
- Job descriptions reflected value of safety and goals of using least restrictive measures
- Clear gatekeeper training
- Implementation of multiple staff directed efforts to reduce compassion fatigue and burnout

**Identify (100%):**
- Use of a standardized screening and assessment tool consistently with same day risk assessments implemented
- Standardized definitions of risk with good documentation of risk formulation

**Engage (69%):**
- Rolled out LIFE Pathway at NW Clinic with documentation in chart of eligibility for pathway
- Significant improvement in initial safety planning, reviewing safety plans and safety plan content
- Significant increase in clients with access to lethal means counseling

# Element Breakdown

**Treat (50%):**

- Staff received training in CBT-SP
- Clear documentation that staff were comfortable recommending intervention other than hospitalization

**Transition (50%):**

- Evidence of teams visiting clients while hospitalized to start follow up care
- Significant improvement in time between discharge and f/u appt (2 weeks previously, now 48 hrs)
- New and improved caring contact cards and documentation

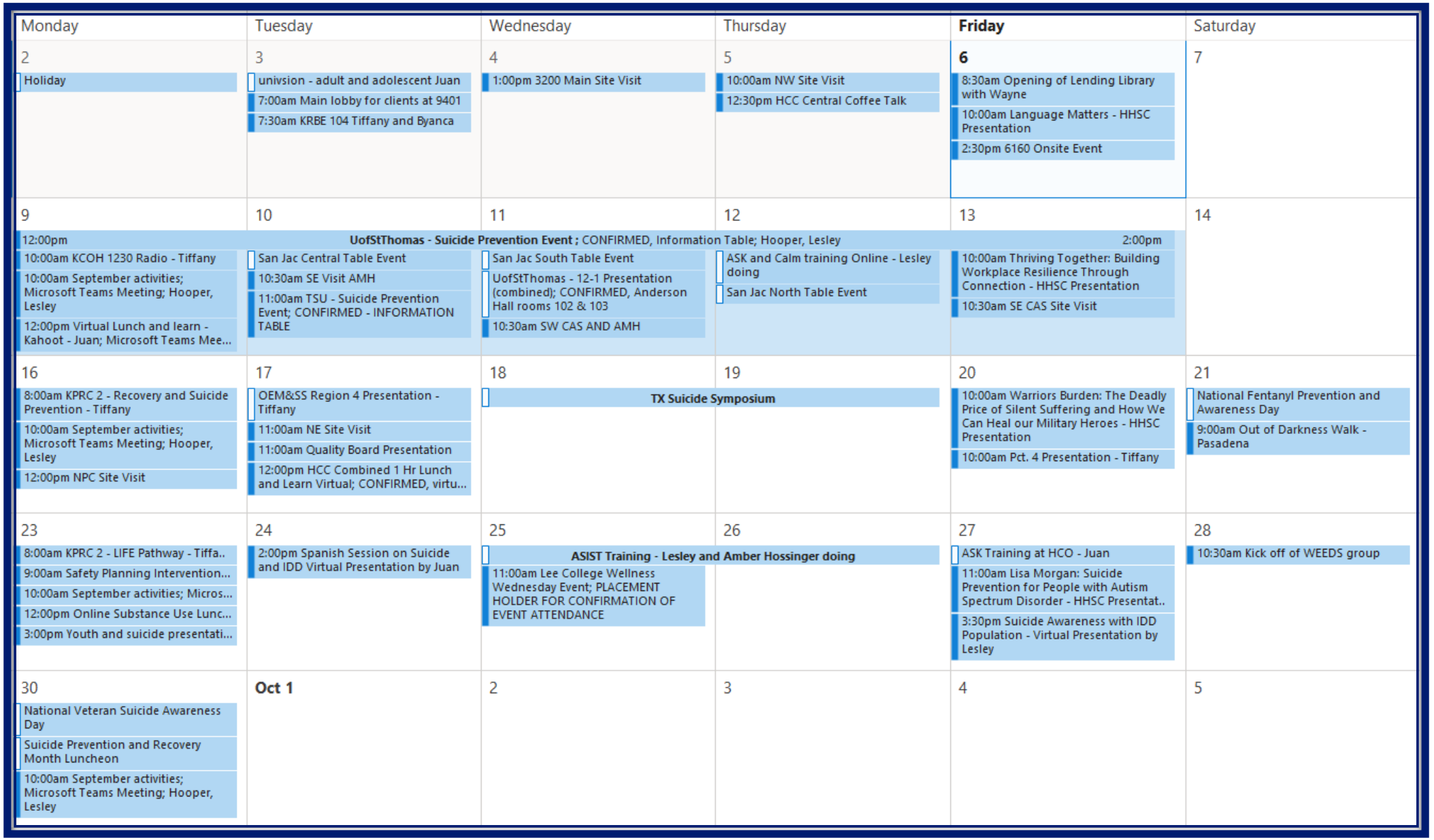
**Improve (80%):**

- Data dashboard with real time data and enhancements to look at data from socio-economic perspective
- Formally review suicide deaths inappropriate committee
- New data specialist hired specifically for suicide care data reporting

# Spreading the Word

- Media
  - Over 10 different media opportunities and counting with local print, tv and radio stations
- Presentations
  - All reached out directly to our team
  - Multiple local colleges, precincts and other entities
- Site Visits
  - 9 Different Harris Center locations with scheduled events
  - Visiting staff at all 4 main clinics
  - Bringing the PAWS Program along

# September Happenings



| Monday | Tuesday | Wednesday | Thursday | **Friday** | Saturday |
|---|---|---|---|---|---|
| 2<br>Holiday | 3<br>univsion - adult and adolescent Juan<br>7:00am Main lobby for clients at 9401<br>7:30am KRBE 104 Tiffany and Byanca | 4<br>1:00pm 3200 Main Site Visit | 5<br>10:00am NW Site Visit<br>12:30pm HCC Central Coffee Talk | **6**<br>8:30am Opening of Lending Library with Wayne<br>10:00am Language Matters - HHSC Presentation<br>2:30pm 6160 Onsite Event | 7 |
| 9<br>12:00pm **UofStThomas - Suicide Prevention Event ;** CONFIRMED, Information Table; Hooper, Lesley 2:00pm<br>10:00am KCOH 1230 Radio - Tiffany<br>10:00am September activities; Microsoft Teams Meeting; Hooper, Lesley<br>12:00pm Virtual Lunch and learn - Kahoot - Juan; Microsoft Teams Mee... | 10<br>San Jac Central Table Event<br>10:30am SE Visit AMH<br>11:00am TSU - Suicide Prevention Event; CONFIRMED - INFORMATION TABLE | 11<br>San Jac South Table Event<br>UofStThomas - 12-1 Presentation (combined); CONFIRMED, Anderson Hall rooms 102 & 103<br>10:30am SW CAS AND AMH | 12<br>ASK and Calm training Online - Lesley doing<br>San Jac North Table Event | 13<br>10:00am Thriving Together: Building Workplace Resilience Through Connection - HHSC Presentation<br>10:30am SE CAS Site Visit | 14 |
| 16<br>8:00am KPRC 2 - Recovery and Suicide Prevention - Tiffany<br>10:00am September activities; Microsoft Teams Meeting; Hooper, Lesley<br>12:00pm NPC Site Visit | 17<br>OEM&SS Region 4 Presentation - Tiffany<br>11:00am NE Site Visit<br>11:00am Quality Board Presentation<br>12:00pm HCC Combined 1 Hr Lunch and Learn Virtual; CONFIRMED, virtu... | 18<br>**TX Suicide Symposium** | 19 | 20<br>10:00am Warriors Burden: The Deadly Price of Silent Suffering and How We Can Heal our Military Heroes - HHSC Presentation<br>10:00am Pct. 4 Presentation - Tiffany | 21<br>National Fentanyl Prevention and Awareness Day<br>9:00am Out of Darkness Walk - Pasadena |
| 23<br>8:00am KPRC 2 - LIFE Pathway - Tiffa..<br>9:00am Safety Planning Intervention...<br>10:00am September activities; Micros...<br>12:00pm Online Substance Use Lunc...<br>3:00pm Youth and suicide presentati... | 24<br>2:00pm Spanish Session on Suicide and IDD Virtual Presentation by Juan | 25<br>**ASIST Training - Lesley and Amber Hossinger doing**<br>11:00am Lee College Wellness Wednesday Event; PLACEMENT HOLDER FOR CONFIRMATION OF EVENT ATTENDANCE | 26 | 27<br>ASK Training at HCO - Juan<br>11:00am Lisa Morgan: Suicide Prevention for People with Autism Spectrum Disorder - HHSC Presentat..<br>3:30pm Suicide Awareness with IDD Population - Virtual Presentation by Lesley | 28<br>10:30am Kick off of WEEDS group |
| 30<br>National Veteran Suicide Awareness Day<br>Suicide Prevention and Recovery Month Luncheon<br>10:00am September activities; Microsoft Teams Meeting; Hooper, Lesley | **Oct 1** | 2 | 3 | 4 | 5 |

# Future Directions

- Focus on expanding the care pathway to all divisions
- Expand the LIFE Pathway Program
- Focus on evidence-based treatment options
- Review training refresher time frames and standards

The HARRIS CENTER for Mental Health and IDD

*Transforming Lives*

# Thank You

# EXHIBIT Q-4

Status Pending PolicyStat ID 14358146

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

# 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.