

Department of State Health Services
State Hospitals Section
**Mission, Vision, Goals and
2006 Work Plan**

**Statewide Performance Indicators
1st Quarter FY 2006**

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The Mission of Texas State Government

Texas state government must be limited, efficient, and completely accountable. It will foster opportunity and economic prosperity, focus on critical priorities, and support the creation of strong family environments for our children. The stewards of the public trust will be men and women who administer state government in a fair, just, and responsible manner. To honor the public trust, state officials must seek new and innovative ways to meet state government priorities in a fiscally responsible manner.

HHS SYSTEM MISSION

The mission of health and human services agencies in Texas is to develop and administer an accessible, effective, efficient health and human services delivery system that is beneficial and responsive to the people of Texas.

HHS SYSTEM PHILOSOPHY

Every Texan should be able to access and utilize available health and human services provided by State agencies in the most integrated, cost-effective setting possible. The Texas Health and Human Services system is dedicated to developing client-focused program and policy initiatives that are relevant, timely and within the means of the taxpayers of the State of Texas. The HHS system will advocate for client-choice, appropriate funding, and streamlined service delivery. Additionally, we hold to these guiding principles:

Every person, regardless of income, race, ethnicity, physical or mental limitation, gender, religion, or age, is entitled to dignity, independence and respect.

Texans deserve openness, fairness and the highest ethical standards from us, their public servants.

Taxpayers, and their elected representatives, deserve conscientious stewardship of public resources and the highest level of accountability.

We work in partnership with lawmakers, agency personnel, customers, service providers, and the public to continually improve the quality of our service.

HHS SYSTEM STRATEGIC GOALS

The following system strategic goals represent a unifying element for the system as a whole.

Preserve, enhance, and maintain independence – enable the aging, people with disabilities, including those with mental retardation and other developmental conditions, to live as Independently as possible for as long as possible through an effective, individualized system of service provision in community and institutional settings

Promote and protect good health – protect public health and promote the overall physical and mental health of Texans through the provision of education, early intervention, substance abuse treatment, health insurance, and appropriate health services for eligible populations.

Achieve economic self-sufficiency – enable low-income individuals and clients of family violence, refugee, and vocational rehabilitation programs to achieve self-sufficiency for themselves and their families by providing income assistance and/or related support services necessary on a temporary basis.

Ensure safety and dignity – ensure safety and protection from abuse, neglect, or exploitation of children and adults through comprehensive regulatory and enforcement systems that include certification, training, and assistance to health and child care providers and personnel.

HEALTH AND HUMAN SERVICES COMMISSION

VISION

Through the Texas Health and Human Services Commission’s strategic direction and leadership, we envision a coordinated health and human services system that ensures quality services, cost-effective service delivery, and careful stewardship of public resources. HHSC will direct and support collaboration and partnerships of agencies with consumers and local communities to establish systems that support individual choices and personal responsibility.

MISSION

The mission of the Health and Human Services Commission is to provide the leadership and direction and foster the spirit of innovation needed to achieve an efficient and effective health and human services system for Texans.

DEPARTMENT OF STATE HEALTH SERVICES

VISION

Texans in need have access to effectively delivered public health, mental health, and substance abuse services, and all Texans live and work in safe, healthy communities.

MISSION

To promote optimal health for individuals and communities while providing effective health, mental health, and substance abuse services to qualified Texans in need.

DSHS SCOPE

The Department of State Health Services (DSHS) administers and regulates health, mental health, and substance abuse programs. The Department began its formal operations September 1, 2004.

HEALTH AND HUMAN SERVICES OVERVIEW

The enactment of House Bill 2292 (H.B. 2292), 78th Legislature, Regular Session, 2003, began a dramatic transformation of the Texas Health and Human Services (HHS) system. This legislation requires the consolidation of administrative and service delivery structures and policy changes to address higher demands for services with limited funds. It also requires new mechanisms, such as outsourcing, to achieve greater efficiency and effectiveness of the system as a whole. In addition, H.B. 2292 provides the authority to ensure effective implementation of these changes by expanding the leadership role of HHSC and the Executive Commissioner for Health and Human Services. House Bill 2292 abolished 10 of 12 existing HHS agencies and transferred their powers and duties into four new agencies and to the Health and Human Services Commission. Thus, the consolidated HHS system is composed of the following five entities:

- Health and Human Services Commission (HHSC);
- Department of Aging and Disability Services (DADS);
- Department of Assistive and Rehabilitative Services (DARS);
- Department of Family and Protective Services (DFPS); and
- Department of State Health Services (DSHS).

STATE DSHS HOSPITALS SECTION VISION

The State Hospitals section will be a partnership of consumers, family members, volunteers, policy makers, and service providers that work together to provide quality services that are responsive to each patient's needs and preferences in eleven (11) state Hospitals.

**Legislative Budget Board
Performance Measures
Directly Relating to State Mental Health Hospitals**

Outcome Measures:

*Percent of consumers receiving MH campus services whose functional level stabilized or improved. **Reported Annually to the LBB.** **

Percent of customers discharged from state mental health hospitals whose symptoms stabilized or decreased during course of treatment. **Reported Annually to the LBB.**

*Percent of cases of tuberculosis treated at TCID as inpatients in which the patients are treated to cure. **Reported quarterly to the LBB.***

Output Measures:

*Average daily census of state mental health hospitals. **Reported Quarterly to the LBB.** **

Average monthly number of state mental health hospital consumers receiving atypical antipsychotic new generation medications. **Reported Quarterly to the LBB.**

Number of admissions to state hospitals. **Reported Quarterly to the LBB.**

Number of Inpatient days at TCID. ***Reported Quarterly to the LBB.***

Number of Outpatient visits at TCID and STHCS component of RGSC. ***Reported Quarterly to the LBB.***

Efficiency Measures:

*Average daily hospital cost per occupied state mental health hospital bed. **Reported Quarterly to the LBB.** **

*Average monthly cost of new generation atypical antipsychotic medications per mental health hospital customer receiving new generation medication services. **Reported Quarterly to the LBB.** **

*Average cost of outpatient visits for TCID and STHCS component of RGSC. **Reported quarterly to the LBB.***

** Key measures that are reported in the Appropriations Bill. If not met plus or minus 5% an explanation must be provided.*

**WE WILL BE RECOGNIZED AS PROVIDING QUALITY:
-SERVICE-
-TRAINING-
-WORK ENVIRONMENT-**

HOW DO WE KNOW WE ARE PROVIDING QUALITY SERVICES?				
We Ask Our Customers	We Maintain Accreditation And Certification	We Identify Key Functions Of State Mental Health Facilities And Establish Measurable Performance Indicators	Priority Focus Areas	We Maintain A Qualified And Diverse Workforce
<ul style="list-style-type: none"> - Patients - Families - Guardians - LMHAs & LMRAs - Courts - Staff - Legislature - Advocates - Third Party Payors - Volunteers - Students - Hospital Districts - Regional Public Health Authority -Department of Aging & Disability Services State Schools for Mental Retardation 	<ul style="list-style-type: none"> - Medicare - JCAHO - Medicaid - ICF/MR - CAP - Agency clinical and administrative performance indicator compliance 	<p style="text-align: center;"><u>Patient-Focused Functions</u></p> <p>A1 Rights of Patients and Organizational Ethics</p> <p>A2 Provision of Care</p> <p>A3 Continuity of Care</p> <p>A4 Medication Management</p> <p>A5 Surveillance, Prevention, and Control of Infection</p> <p style="text-align: center;"><u>Organizational Functions</u></p> <p>B1 Leadership</p> <p>B2 Management of Information</p> <p>B3 Management of Human Resources</p> <p>B4 Management of Environment</p> <p>B5 Improving Organizational Performance Through Customer Satisfaction</p> <p style="text-align: center;"><u>Structures with Functions</u></p> <p>C1 Medical Staff</p> <p>C2 Nursing</p>	<ul style="list-style-type: none"> -Assessment and Care/Services -Communication -Credentialed Practitioners -Equipment Use -Infection Control -Information Management -Medication Management -Organization Structure -Orientation and Training -Rights and Ethics -Physical Environment -Quality Improvements – Expertise & Activity - Patient Safety - Staffing 	<p>We assess competence:</p> <ul style="list-style-type: none"> ➤ Skills/Job, ➤ Professional, and ➤ Cultural. <p>We assess performance.</p> <p>We grant clinical privileges.</p> <p>We set expectations for education and training and ensure this continuing knowledge acquisition process.</p> <p>We implement strategies to ensure our workforce is recognized, treated and rewarded in a manner that reflects a commitment to valuing workforce diversity.</p>

**STATE HOSPITAL SECTION
FY 2006 MANAGEMENT PLAN**

The State Hospitals Section FY 2006 Management Plan has been divided into performance objectives and performance measures.

Performance Objectives: Involve activities where specific tasks are to be performed or a specific purpose is to be achieved.

Performance Measures: Involve the presentation of data that will be monitored, analyzed for variation, and used as the basis for continuous improvement.

Required Reporting to Governing Body

All performance objectives and measures that are in bold print are required to be reported at Governing body meetings. ALL THE PERFORMANCE OBJECTIVES AND MEASURES THAT ARE IN BOLD PRINT AND IN CAPS ARE “STATEWIDE PERFORMANCE INDICATORS” AND HAVE SPECIFIC OPERATIONAL DEFINITIONS APPROVED BY THE DIRECTOR OF STATE HOSPITALS SECTION. REPORTS ON THESE “STATEWIDE INDICATORS” ARE PREPARED BY THE OFFICE OF QUALITY MANAGEMENT DATA SERVICES OF STATE HOSPITALS SECTION.

HEALTH & HUMAN SERVICES COMMISSION
DEPARTMENT STATE HEALTH SERVICES
MENTAL HEALTH AND SUBSTANCE ABUSE DIVISION
STATE HOSPITALS SECTION
GOALS AND PERFORMANCE OBJECTIVES AND MEASURES

GOAL I

PROVIDE LEADERSHIP: The leadership of the state hospitals will provide the framework for planning, directing, coordinating, providing and improving services which are cost effective and responsive to community and patient needs and improve patient outcomes. A governing body and management structure will ensure that the organization provides quality services in a culture focused on a safe and therapeutic environment. This goal also addresses the relationship between the governing body and the chief executive officer and the functional responsibilities of executive level management. Specific management responsibilities include maintaining and/or setting up the structure needed for effective operations; establishing an integrated safety program as well as information and support systems, recruiting and maintaining appropriately trained staff, conserving physical and financial assets, and maximizing reimbursement potential.

Performance Objectives

Key Functions

- | | | |
|----|--|-----------|
| A. | Guidelines for the state hospital’s annual planning process for FY2007 will be presented at the December meeting of The Executive Committee of the Governing Body Meeting. | B1 |
| B. | A standardized method for determining outside medical costs utilizing current cost centers will be developed by Facility Support Services Oversight Committee (FSSOC). | |
| C. | STATE HOSPITALS WILL MAINTAIN JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATION (JCAHO) ACCREDITATION, MEDICARE CERTIFICATION, INSTITUTE OF MENTAL DISEASES (IMD) CERTIFICATION (where appropriate) AND INTERMEDIATE CARE FACILITY-MENTAL RETARDATION (ICF-MR) CERTIFICATION (where appropriate) DURING FY 2006. | B1 |
| D. | FY 2005 REVENUE TARGETS FOR MEDICARE, TEXAS HEALTH STEPS, INSTITUTE FOR MENTAL DISEASES (IMD), AND PRIVATE SOURCE FUNDS WILL BE MET BY EACH STATE HOSPITAL SO AS TO SATISFY SPECIFIC METHODS OF FINANCE. | B1 |
| E. | The State Mental Health Hospitals Section will update the Trust Fund Methodology which identifies the relationship between the state MH hospitals and the Local Mental Health Authority (LMHA). | B1 |

- F. EACH STATE HOSPITAL-INPATIENT SERVICES WILL OPERATE A PROJECTED GENERAL REVENUE AVERAGE DAILY CENSUS (ADC) AND THIRD PARTY ADC WITHIN THE FUNDS THAT ARE ALLOCATED AND PROJECTED.** **B1**
- G. The state hospitals FY 07 Governing Body Bylaws Template will be revised and approved by August 1, 2006. **B1**
- H. Each state hospital will analyze integrated safety programs according to JCAHO standards and state regulatory requirements, and report annually to the Governing Body. **B1,B4**
- I. State hospitals will monitor the utilization of the Over Capacity Plan and report findings to the Governing Body:**
- 1. Number of days each MH Hospital was over capacity for children/adolescents and adults,**
 - 2. Number of patients who were transferred to another state MH hospital,**
 - 3. Number of patients each MH hospital received as transfers or diversions,**
 - 4. Number of patients the MH hospital assisted the local authority in diverting to another state hospital and**
 - 5. Number of times all MH hospitals were over capacity for adults and child/adolescents.**
 - 6. Number of patients by month awaiting admission to TCID.**
 - 7. Length of time on waiting list for TCID.** **B1**
- J. Interagency Cooperation Contracts will be entered into with the Health and Human Services Commission and the Department of Aging and Disability Services for the continued provision of facility support services.
- K. State Mental Health Hospitals will implement the statewide forensic plan developed by the Forensic Committee of the Executive Committee of the Governing Body beginning on September 1, 2005.

Performance Measures

Key Functions

- A. AVERAGE COST PER PATIENT SERVED WILL BE CALCULATED AND REPORTED FOR EACH STATE HOSPITAL IN THE FOLLOWING CATEGORIES:** **B1**
- 1. LBB COST**
 - 2. STATE COST; AND**
 - 3. TOTAL STATE COST.**
- B. AVERAGE COST PER OCCUPIED BED WILL BE CALCULATED AND REPORTED FOR EACH STATE HOSPITAL.** **B1**

- C. **AVERAGE DAILY CENSUS OF CAMPUS-BASED SERVICES WILL BE CALCULATED AND REPORTED FOR EACH STATE HOSPITAL ON A QUARTERLY BASIS.** **B1**
- D. **South Texas Healthcare System (STHCS) contract cost of Inpatient care will be calculated and reported on a quarterly basis.** **B1**
- E. **Texas Center for Infectious Disease (TCID) contract cost will be calculated and reported on a quarterly basis.** **B1**

GOAL 2:

RECOGNIZE AND RESPECT THE RIGHTS OF EACH PATIENT BY CONDUCTING BUSINESS IN AN ETHICAL MANNER: Patients deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychological, and spiritual values. The ethics, rights, and responsibilities function is to improve care treatment, services, and outcomes by recognizing and respecting the rights of each patient and by conducting business in an ethical manner. The State Hospitals will assure that each patient is respected and recognized in the provision of treatment and care in accordance with fundamental human, civil, constitutional, and statutory rights. Patients and when appropriate, their families are informed about outcomes of care including unanticipated outcomes.

Performance Objectives

Key Functions

- A. **STATE HOSPITALS WILL DEMONSTRATE A DOWNWARD TREND OF CONFIRMED ALLEGATIONS OF ABUSE OR NEGLECT.** **A1**
- B. State Hospital Client Rights Officers will develop a process for identifying complaints and classify these complaints according to established categories. **A1**
- C. **Each state hospital will report the findings of all Medicare Complaint visits. Plans of correction for substantiated complaints will be evaluated by the Clinical Performance Indicator Committee (CPIC) to identify system issues and/or opportunities for system improvement.** **A1**

GOAL 3:

PROVIDE INDIVIDUALIZED AND EVIDENCE BASED TREATMENT: The state hospitals will ensure that hospital staff, in conjunction with the patients and patient's local health authority, determines individualized treatment through comprehensive assessment. Data will be collected to assess each patient's needs and then analyzed to create the information necessary to match evidence based treatment described from analysis of the information gathered from the patient, the family, hospital staff and or local health authority.

Treatment priorities will be established based on assessment findings. Patients will be involved in their treatment and patients and family (with the patient's authorization when appropriate) will be educated in order to improve patient outcomes. The highest quality individualized, planned and evidence based-treatment will be provided.

Performance Objectives

Key Functions

- A. **The Restraint and Seclusion Reduction Workgroup of the Clinical Oversight Committee (COC) will conduct a survey of all the hospitals to determine the readiness of the culture to reduce seclusion and restraint by January 1, 2006. A training conference will be planned to share the recommendations of the workgroup by May 1, 2006.** A1,A2

- B. **State hospitals will continue to implement plans to reduce the use of behavioral restraint and seclusion based on FY05 performance. Current plans or recommendations from the Restraint and Seclusion Reduction Workgroup will be implemented. Interventions to be monitored are:** A1,A2
 - 1. **Personal Restraint,**
 - 2. **Mechanical Restraint, and**
 - 3. **Seclusion**

- C. **THE BEHAVIORAL RESTRAINT AND SECLUSION MONITORING INSTRUMENT WILL BE UTILIZED TO ASSURE THE CORRECT IMPLEMENTATION OF RESTRAINT AND SECLUSION WHEN IT IS NECESSARY TO UTILIZE THESE PROCEDURES.** A2

- D. **According to the National Patient Safety Goal 9B each state hospital will implement a fall reduction program and evaluate the effectiveness of the program.** A2

- E. **State hospitals will implement guidelines for the assessment and management of medical risks in obese patients through the Clinical Oversight Committee.** A2

- F. **PATIENTS WILL BE TREATED IN ACCORDANCE WITH TIMA GUIDELINES AS MEASURED BY:**
 - 1. **ASSIGNMENT OF THE APPROPRIATE ALGORITHM AS MEASURED BY MATCHING DIAGNOSIS TO ALGORITHM AT THE TIME OF DISCHARGE**
 - 2. **USE OF TIMA RATING SCALES AS MEASURED BY PERCENT OF PATIENTS WITH SCORES FROM 2 OR MORE DIFFERENT DATES.***

*** THIS REPORT WILL BE PULLED FROM CWS** A4

- G. According to National patient Safety goal 2E each state hospital will implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions. A2

Performance Measures

Key Functions

- A. BPRS: IMPROVEMENT IN PATIENT TREATMENT OUTCOMES IN STATE MH FACILITIES WILL BE MEASURED BY SHOWING A SIGNIFICANT DECREASE OF CLINICAL SYMPTOMS WITH A REDUCTION OF MORE THAN TWELVE (12) POINTS. A2
- B. GAF: IMPROVEMENT IN PATIENT TREATMENT OUTCOMES IN STATE MH FACILITIES WILL BE ANALYZED BY SHOWING: A2
1. THE PERCENT OF PATIENTS RECEIVING CAMPUS SERVICES WHOSE GAF SCORE INCREASED.
 2. THE PERCENT OF PATIENTS RECEIVING CAMPUS SERVICES WHOSE GAF SCORE STABILIZE. A2
- C. Percentages of patients treated to cure calculated and reported by TCID. A2

GOAL 4

IMPLEMENT AN EFFECTIVE AND SAFE MEDICATION MANAGEMENT SYSTEM THAT IMPROVES THE QUALITY OF CARE, TREATMENT, AND SERVICES: An effective and safe medication management system involves multiple services and disciplines working closely together to reduce practice variation, errors, and misuse; monitoring medication management processes; standardizing equipment and processes associated with medication management and handling all medications in the same manner.

Performance Objectives

Key Functions

- A. Every hospital will successfully implement the WORx pharmacy system based upon the published implementation schedule. A4
- B. Chief nurse executives of the state hospitals will evaluate the new system for reporting medications errors in all categories. A4
- C. According to the National Patient Safety Goal 8B, each state hospital will ensure that a complete list of the patient’s medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within OR outside the organization. A4

- D. According to the National Patient Safety Goal 3C, each state hospital will identify and, at a minimum, annually review a list of look-alike/sound alike drugs used in the hospital, and take action to prevent errors involving the interchange of these drugs.
- E. Each hospital will have a process in place to identify, collect, aggregate, and analyze medication errors and report to the Governing Body.

Performance Measures

- A. THE NUMBER OF PATIENTS RECEIVING NEW GENERATION ATYPICAL ANTIPSYCHOTIC MEDICATION WILL BE TRACKED AND ANALYZED QUARTERLY. B1,A4
- B. AFTER THE FULL IMPLEMENTATION OF THE PHARMACY DISTRIBUTION AND ACCOUNTING SYSTEM, WORx, THE COSTS OF MEDICATIONS, INCLUDING PSYCHIATRIC MEDICATIONS, MEDICATIONS FOR MEDICAL ISSUES, AND DISCHARGE MEDICATIONS WILL BE TRACKED AND ANALYZED QUARTERLY.

GOAL 5

ASSURE CONTINUUM OF CARE: All state hospitals will collaborate and work cooperatively with designated local health authorities to assure patient access to an integrated system of setting, services, and care levels. To facilitate discharge or transfer, the hospital assesses the patient needs; plans for discharge or transfer process; and helps to ensure that continuity of care, treatment, and services are maintained.

Performance Objectives

Key Functions

- A. Dually diagnosed patients with mental illness and mental retardation in state mental health hospitals will be discharged or transferred within 30 days of being placed on the “Patients Determined No Longer in need of Inpatient Hospitalization” list. A3
- B. Each state MH hospital will maintain a current Utilization Management Agreement for all non-statewide services with all the local health authorities in their service area and identify issues between facilities and centers related to use of the agreement. A3
- C. At the end of each quarter patients having been in the state mental health hospital over 365 days will be identified by four categories:
 - 1. need continued hospitalization,
 - 2. accepted for placement,
 - 3. barrier to placement, and
 - 4. criminal court involvement.

The hospital and the local mental health authority will update a new continuity of care plan for any patient who is on the list in category 3. This plan should be developed within 30 days after being identified. The progress of placements from category 3 will be reviewed at each Governing Body meeting.

A3

- D. According to the National patient Safety Goal 2C, each state hospital will measure, assess, and if appropriate take action to improve the timeliness of reporting and the timelines of receipt by the responsible licensed caregiver of critical test results and values.

Performance Measures

- A. NUMBER AND TYPE OF ALL ADMISSIONS AND DISCHARGES , AND THE PERCENTAGE OF PATIENTS NEW TO THE SYSTEM WILL BE CALCULATED AND REPORTED FOR EACH HOSPITAL ON A QUARTERLY BASIS.

A3

- B. PERCENT OF FORENSIC/NON FORENSIC DISCHARGES RETURNED TO THE COMMUNITY WILL BE CALCULATED ON A QUARTERLY BASIS.

A3

- 7 days or less,
- 8 to 30 days,
- 31 to 90 days,

- C. AVERAGE LENGTH OF STAY IN THE HOSPITAL WILL BE CALCULATED ON A QUARTERLY BASIS FOR THOSE PATIENTS:
-ADMITTED AND DISCHARGED WITHIN 12 MONTHS, AND
-ALL DISCHARGES.

A3

GOAL 6

IMPLEMENT AN INTEGRATED PATIENT SAFETY PROGRAM: The state hospitals address the safety of all patients and all staff. Safety priorities should be integrated into all relevant hospital processes, functioning, and services. The program should improve safety by reducing the risk of system and process failures.

Performance Objectives

- A. Each state hospital will maintain a prioritized budget list to address needed environmental and physical plant improvements but for which no centralized designated funds have been allocated.

B4

- B. STATE HOSPITALS WILL MANAGE WORKERS' COMPENSATION CLAIM EXPENSES SO THAT AN INDIVIDUAL HOSPITAL TOTAL FY 2005 CLAIMS EXPENSE WILL BE AT OR BELOW THE DOLLAR TARGET AMOUNT ESTABLISHED FOR THAT HOSPITAL.

B4

- C. **EMPLOYEE INJURIES RESULTING IN A WORKERS' COMPENSATION CLAIM WILL NOT EXCEED 1.11 PER 1000 BED DAYS.** B4

- D. **STATE HOSPITAL INFECTION CONTROL PRACTITIONERS (ICP) WILL COLLECT AND COMPARE DATA ON FACILITY HEALTHCARE ASSOCIATED INFECTION RATES.** B4

- E. **According to National Patient Safety Goal #7A State Hospital ICP's will monitor facility compliance with centers for disease control (CDC) hand hygiene guidelines and report compliance to state hospital section governing body.** B4

- F. **RATE OF PATIENT INJURIES WILL BE CALCULATED, TRENDED AND REVIEWED FOR QUALITY IMPROVEMENT OPPORTUNITIES. INJURIES WILL BE REPORTED BY AGE CATEGORIES AS FOLLOWS:**
 - Age 0-17
 - Age 18-64
 - Age 65-olderB4

- G. **Each hospital will monitor and assess influenza and pneumococcal immunizations for identified patient population.**

- H. **THE RATE OF PATIENT INJURY RELATED TO BEHAVIORAL SECLUSION AND RESTRAINT FOR FY 06 WILL NOT EXCEED 0.49 PER 1000 BED DAYS FOR FY 05.** B4

- I. **EMPLOYEES INJURED DURING RESTRAINT OR SECLUSION WILL NOT EXCEED 0.92 PER 1000 BED DAYS ACROSS ALL STATE HOSPITALS IN FY 2005.** B4

- J. **THE RATE OF UNAUTHORIZED DEPARTURES WILL NOT EXCEED 0.42 PER 1000 BED DAYS ACROSS ALL STATE HOSPITALS DURING FY 2005.** B4

GOAL 7

OBTAIN, MANAGE, AND USE INFORMATION: Information management is a set of processes and activities focused on meeting the organizations information needs which are derived from a thorough analysis of internal and external information requirements. State hospitals will obtain, analyze, manage and assure the integrity and accuracy of data in order to use information to enhance and improve individual and organizational performance in patient treatment, safety, governance, management and support processes.

Performance Objectives

Key Functions

- A. CPIC will review Performance Measures for new Data Integrity Review (DIR) focus and submit to Executive Committee of Governing Body in FY06. B2
- B. Service level agreements with Health and Human Services Commission (HHSC) Information Technology (IT) for Enterprise Applications and Wide Area Network (WAN) services will be completed by January 1, 2006. B2
- C. Service level agreements with Department of State Health Services (DSHS) IT for DeskTop support will be completed by September 30, 2005. B2
- D. **State Hospitals will monitor medical records delinquency rates. The average of the total number of delinquent records calculated from the last four quarterly measurements will not exceed 50 percent of the average monthly discharges. These data are trended and performance improvement initiatives are taken as appropriate.** B2
- E. **Information Management Committee (IMC) will evaluate ways to expand access to medical records at other facilities to simplify exchange of healthcare information and report recommendations to Executive Committee Governing Body (ECGB).** B2
- F. **State Mental Health Hospitals will have fully implemented Clinician Work Station (CWS) by the end of FY06.**

GOAL 8

ASSURE A COMPETENT WORKFORCE: The State Hospital Section provides leadership, resources, and expectations that hospitals create an environment that fosters self-development and continued learning to support the organization’s mission. This function focuses on essential processes which includes planning that defines the qualifications competencies and staffing needed to carry out the organization’s mission; providing competent members either through traditional employer-employee arrangements on contractual arrangement; developing and implementing processes designed to ensure the competence of all staff members is assessed, maintained, improved and demonstrated throughout their association with the organization; and providing a work environment that promotes self-development and learning.

Performance Objectives

Key Functions

- A. **95 PERCENT OF ALL STAFF WILL BE CURRENT WITH REQUIRED TRAINING AT ALL TIMES.** B3
- B. **97 PERCENT OF ALL STAFF WILL HAVE CURRENT DATE PERFORMANCE EVALUATIONS ON FILE AT ALL TIMES.** B3

- C. **Each hospital will monitor and assess effectiveness of at least two clinical/service-screening indicators in combination with two human resource-screening indicators related to at least two specific units/departments.**

B3

Performance Measures

- A. **“STAFF TURNOVER” RATES FOR CRITICAL SHORTAGE STAFF WILL BE MAINTAINED AND REPORTED QUARTERLY.**

B3,B3

- B. **NUMBER OF STATEWIDE VACANCIES FOR CRITICAL SHORTAGE STAFF WILL BE MAINTAINED AND REPORTED QUARTERLY.**

GOAL 9

Improve Organizational Performance: Performance improvement focuses on outcomes of care, treatment, and services. This goal focuses on designing an effective and continuous program to systematically measure performance through data collection, assess current performance and improve performance, patient safety and business process outcomes.

Performance Objectives

Key Functions

- A. **CHILDREN AND PARENT(S) OR THE LEGALLY AUTHORIZED REPRESENTATIVE WILL BE SATISFIED WITH THE TREATMENT AND SAFE MILIEU PROVIDED IN STATE MENTAL HEALTH HOSPITALS BY ACHIEVING THE FOLLOWING AVERAGE RESPONSE ON THE PATIENT SATISFACTION SURVEYS (PSAT):**

- 1. **AN AVERAGE SCORE OF “4” ON THE PARENT SATISFACTION SURVEY,**
- 2. **AN AVERAGE SCORE OF “1.698” ON THE CHILDREN SATISFACTION SURVEY.**

B6

- B. **ADULTS AND ADOLESCENTS WILL BE SATISFIED WITH THEIR CARE AT STATE MENTAL HEALTH HOSPITALS AS REPRESENTED BY ACHIEVING AN AVERAGE SCORE OF 3.60 ON THE NRI INPATIENT CONSUMER SURVEY.**

B6

- C. **Hospitals will monitor and evaluate the JCAHO priority focus areas of communication, patient safety and assessment of care and treatment through the clinical performance improvement process. The aggregate information will be collected through and evaluated by the Clinical Performance Improvement Committee (CPIC) and reported to the Executive Committee.**

- D. Each State Hospital will prepare a status report on the implementation of the CPIC Plan for FY 06 by June 2006. CPIC will review and incorporate recommendation into the CPIC Plan for FY 07. B6**
- E. Regularly scheduled assessments will be conducted using established criteria and improvement opportunities identified by each state hospital on the following Facility Support Performance Indicators (FSPI). B6**
- 1st Quarter:**
- Pharmacy Inventory Controls
 - Medication Room Controls
 - HRD
- 2nd Quarter:**
- Facility CMM
 - Procurement Card Controls
 - Warehousing
- 3rd Quarter:**
- Accounting
 - Facility Personnel Actions
- 4th Quarter:**
- CAFM
 - Information/LAN Security
- F. FSSOC will develop a methodology to evaluate the impact of Access HR on business process outcomes.**
- G. Clinical Oversight Committee (COC) will develop a methodology to evaluate the impact of Access HR on clinical outcomes.**

GOAL 1: Provide Leadership

Performance Objective 1C:

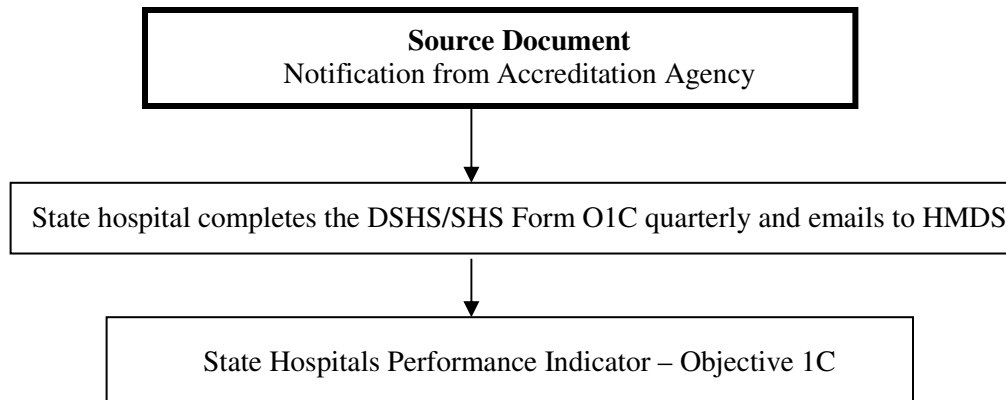
State hospitals will maintain Joint Commission on Accreditation of Healthcare Organization (JCAHO) accreditation, Medicare certification, Institute of Mental Diseases (IMD) certification (where appropriate) and Intermediate Care Facility-Mental Retardation (ICF-MR) (where appropriate) during FY 2006.

Performance Objective Operational Definition: The state hospital's current status in JCAHO accreditation, Medicare certification (based on the last Medicare-related survey [TDH or CMS]), ICF-MR certification, and IMD review.

Performance Objective Data Display and Chart Description:

Table shows the date, grid score and year accredited by JCAHO; Medicare last date certified and the number of certified beds; number of Medicare complaint visits; date of the last IMD Review; and ICF-MR last date certified and number of certified beds for individual state hospital.

Data Flow:



Data Integrity Review Process:

N/A

Objective 1C - Maintain Accreditation and Certifications
(As of November 30, 2005)

	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TCID	TSH	WCFY
JCAHO Accreditation											
Date of accreditation:	Jun-03	Jan-03	Aug-03	Jul-03	Mar-04	Mar-05	Mar-04	Aug-04	Oct-03	Aug-04	Jul-04
Years accredited:	3	3	3	3	3	3	3	3	3	3	3
Unannounced Visit							Feb-05				
Medicare Certification											
No. certified beds:	201	152	40	76	100	27	106	160	72	94	N/A
No. of Complaint Visits for Q1	0	0	0	0	0	1	0	0	0	0	N/A
No. of Complaint Visits for FY	0	0	0	0	0	1	0	0	0	0	N/A
Date of last IMD Review:	May-04	Jul-05	N/A	Dec-03	Jul-04	N/A	Oct-05	Nov-05	N/A	May-04	N/A
ICF-MR Certification											
Last date certified:	N/A	N/A	N/A	N/A	N/A	Nov-05	N/A	N/A	N/A	N/A	N/A
No. certified beds:	N/A	N/A	N/A	N/A	N/A	110	N/A	N/A	N/A	N/A	N/A

*Based on the Behavioral Health Care Accreditation Standards

Performance Objective 1D:

FY2006 revenue targets for Medicare, Texas Health Steps, Institute for Mental Diseases (IMD), and Private Source funds will be met by each state hospital so as to satisfy specific methods of finance.

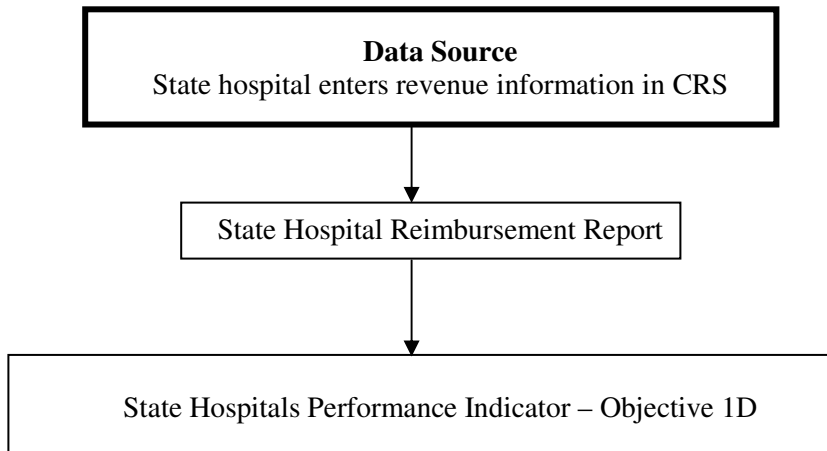
Performance Objective Operational Definition: The state hospital collections for Medicare, THSteps, Private Source, and IMD per month.

Performance Objective Formula: Collections per individual category and total collections are reported monthly in CRS.

Performance Objective Data Display and Chart Description:

- ◆ Chart with monthly data points of revenue collection and accrued from each source for individual state hospital and system-wide.
- ◆ Chart with monthly data points of progress toward annual target from each source for individual state hospital and system-wide.

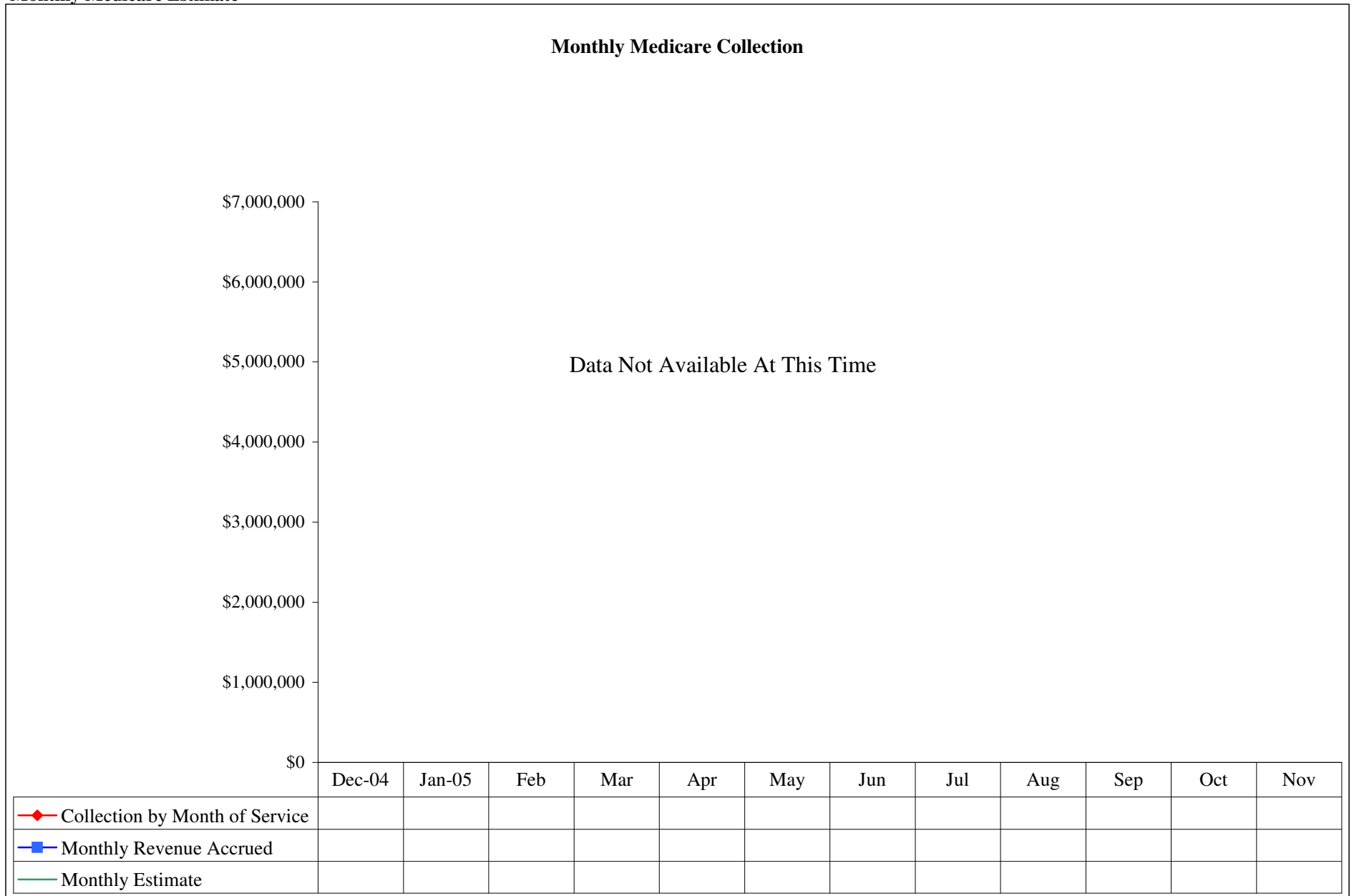
Data Flow:



Data Integrity Review Process:

N/A

Objective 1D - FY 2005 Revenue Estimates
All Mental Health Facilities
Monthly Medicare Estimate



Performance Objective 1F:

Each state hospital-inpatient services will operate a projected General Revenue ADC and Third Party ADC within the funds that are allocated and projected.

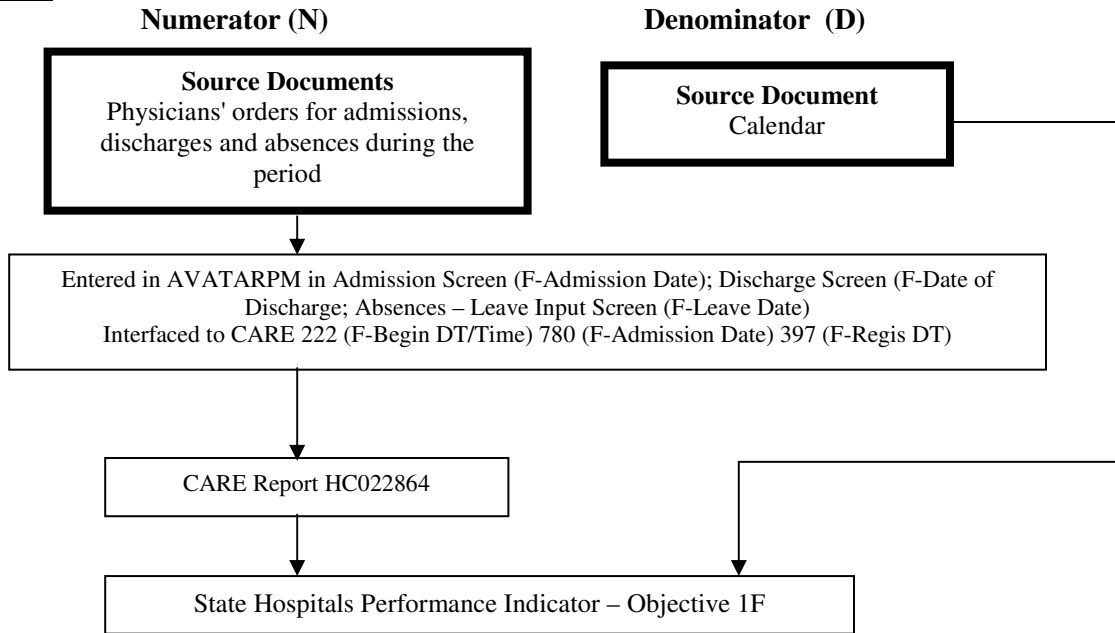
Performance Objective Operational Definition: DSHS Hospital Section will project total ADC, GR ADC and 3rd Party ADC for FY06. Extract report will divide episodes into 3rd Party episodes and GR episodes and calculate monthly ADC, monthly GR ADC and monthly 3rd Party ADC.

Performance Objective Formula:
$$\frac{\text{ADC}}{\text{Projected ADC}}$$

Performance Objective Data Display and Chart Description:

Chart with monthly data points of actual General Revenue and 3rd Party average daily census and funded census for individual state hospital and system-wide.

Data Flow:

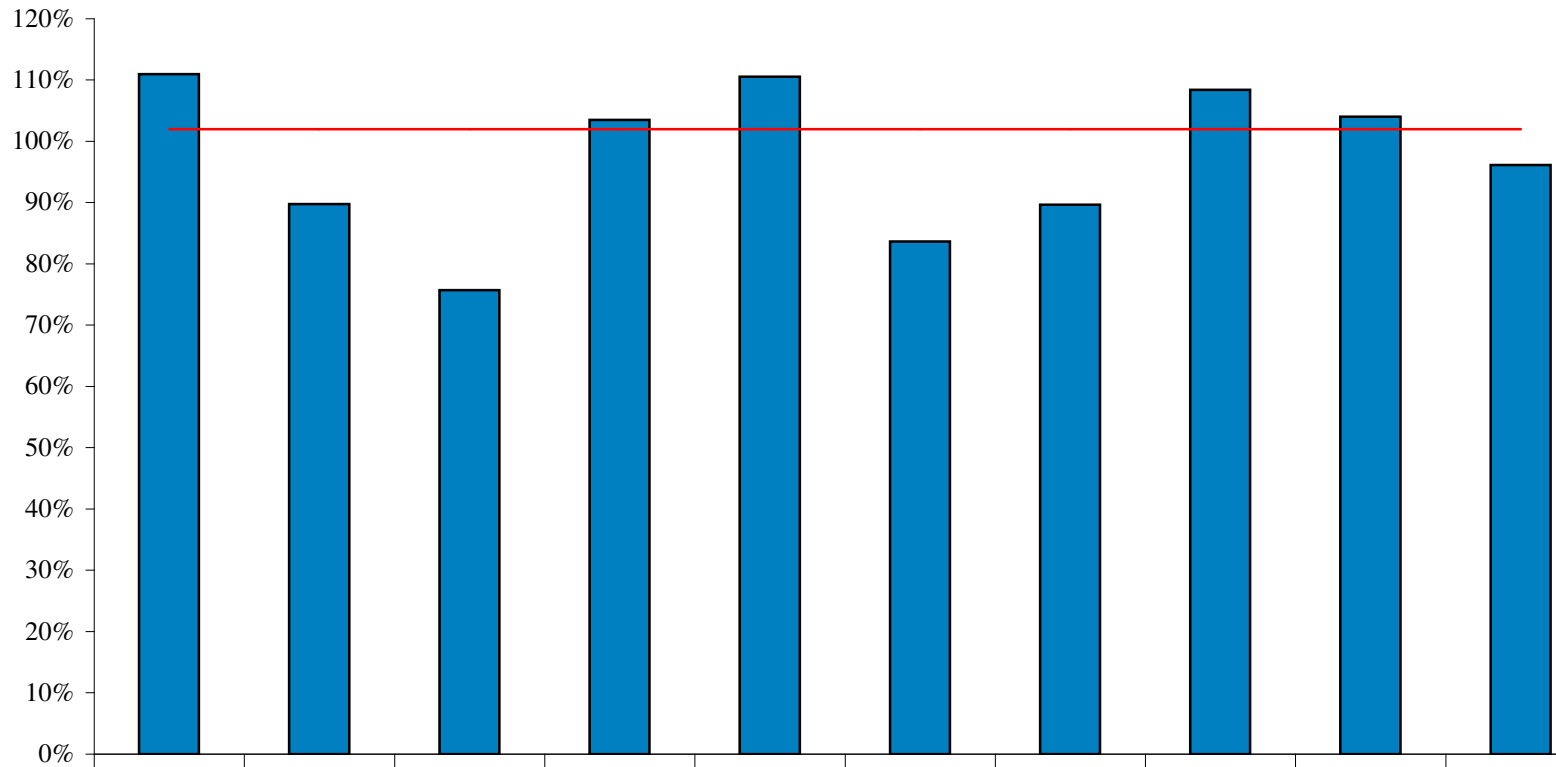


Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Note: Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record on the Physician's Order.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including findings and data analysis.

Objective 1F & Measure 1C - Average Daily Census
All MH Facilities -As of November 30, 2005

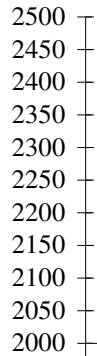
**Average Daily Census As Percent of Adjusted Funded Census
 FY 2006**



	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY
% Occupancy	111%	90%	76%	104%	111%	84%	90%	108%	104%	96%
ADC	294	175	53	207	630	46	277	283	286	75
Funded Census	265	195	70	200	570	55	309	261	275	78
ALL MH	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%

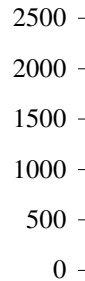
Objective 1F & Measure 1C - Average Daily Census
All MH Facilities

Average Daily Census



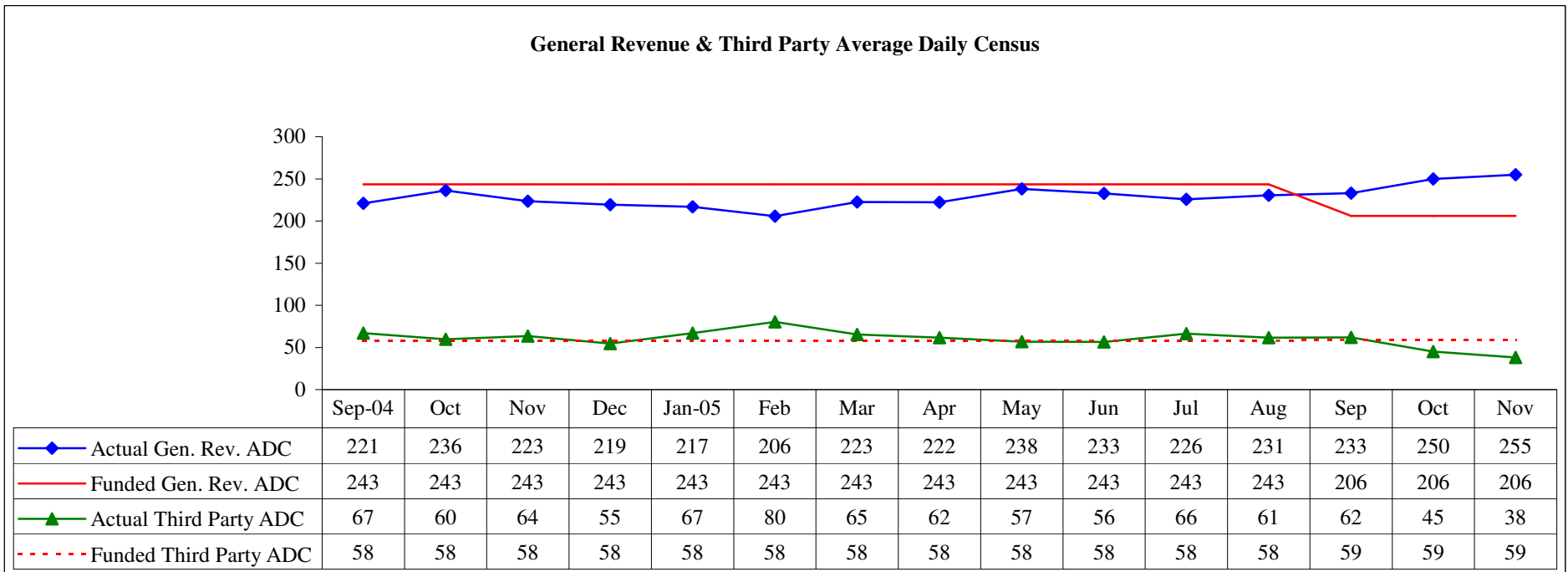
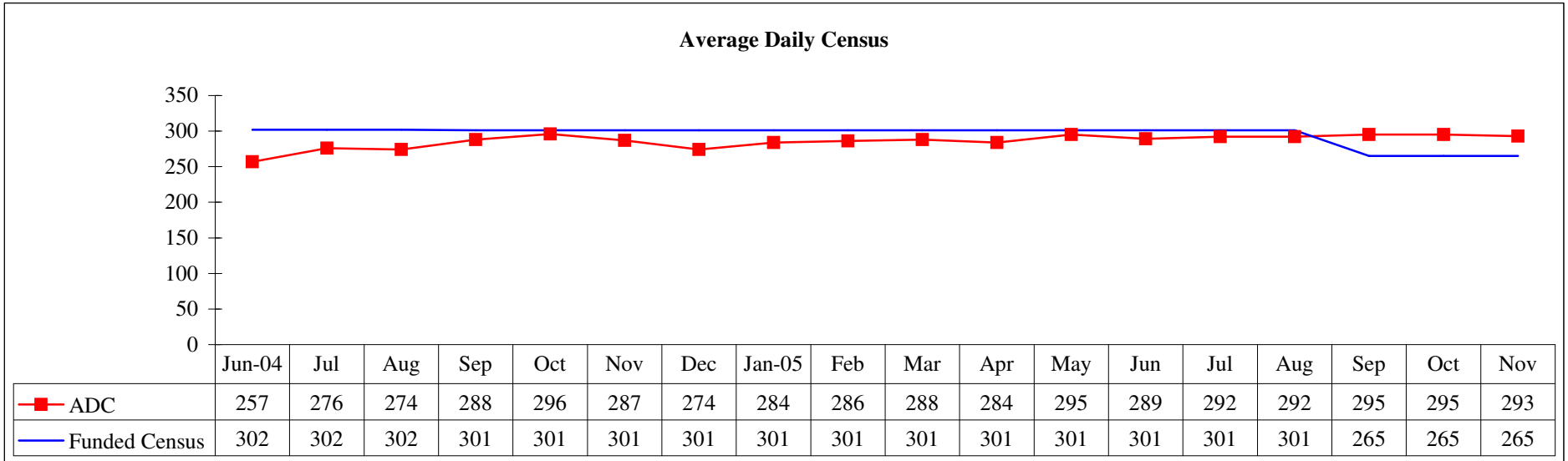
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
■ ADC	2218	2265	2274	2345	2306	2310	2237	2248	2244	2260	2291	2304	2305	2325	2316	2297	2336	2343
— Funded Census	2285	2285	2285	2268	2268	2268	2268	2268	2268	2268	2268	2268	2268	2268	2268	2278	2278	2278

General Revenue & Third Party Average Daily Census
(WCFY not Included in this Chart)

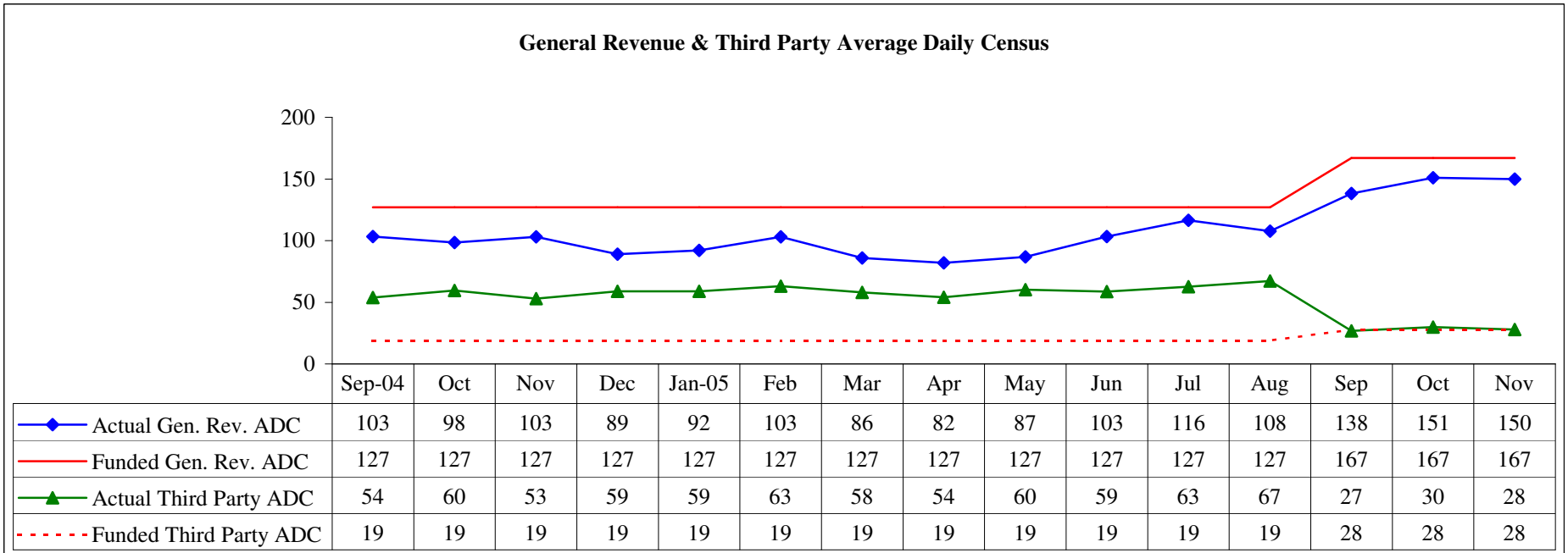
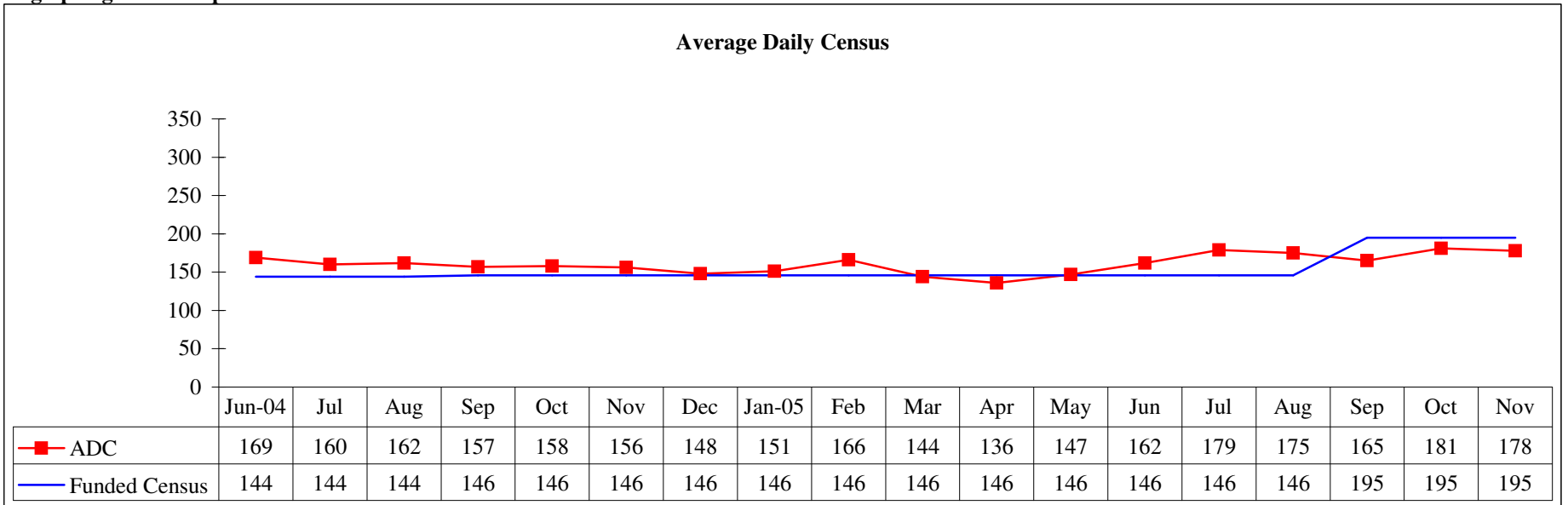


	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ Actual Gen. Rev. ADC	1865	1845	1848	1810	1803	1767	1795	1842	1867	1900	1927	1924	1948	1970	2008
— Funded Gen. Rev. ADC	1862	1862	1862	1862	1862	1862	1862	1862	1862	1862	1862	1862	1866	1866	1866
▲ Actual Third Party ADC	402	385	388	354	367	398	390	371	360	331	326	316	273	291	262
- - - Funded Third Party ADC	329	329	329	329	329	329	329	329	329	329	329	329	334	334	334

Objective 1F & Measure 1C - Average Daily Census
Austin State Hospital

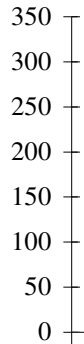


Objective 1F & Measure 1C - Average Daily Census
Big Spring State Hospital



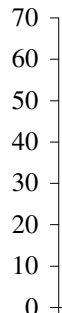
Objective 1F & Measure 1C - Average Daily Census
El Paso Psychiatric Center

Average Daily Census



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
■ ADC	54	49	51	54	55	51	54	55	50	48	53	50	50	56	52	55	53	50
— Funded Census	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	70	70	70

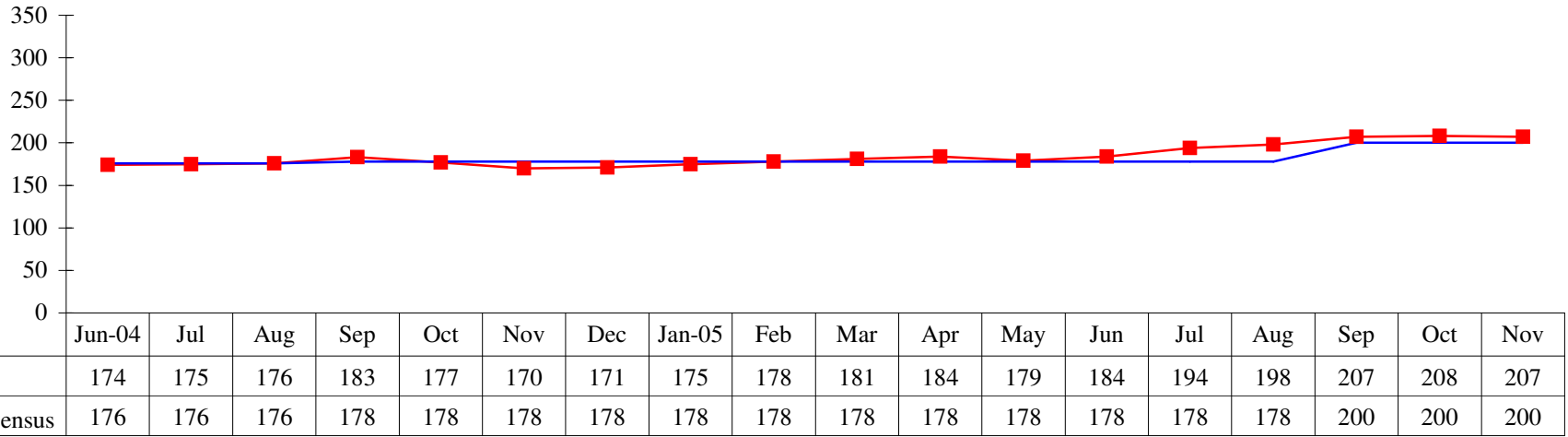
General Revenue & Third Party Average Daily Census



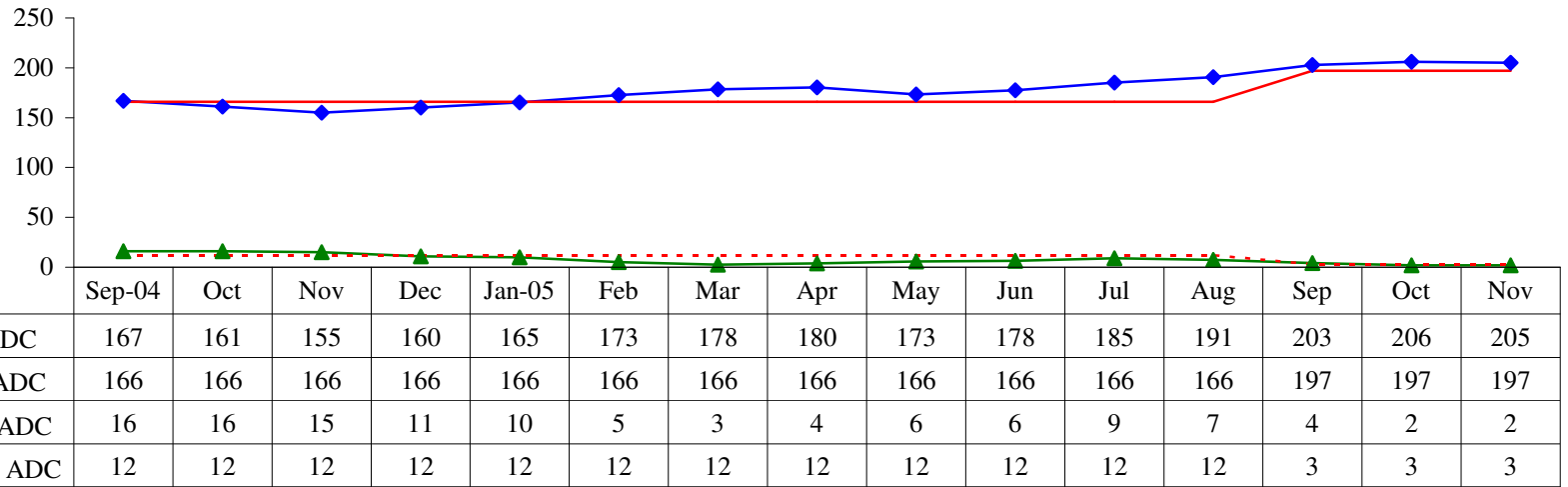
	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ Actual Gen. Rev. ADC	41	40	38	43	45	34	30	34	34	33	41	38	38	36	38
— Funded Gen. Rev. ADC	52	52	52	52	52	52	52	52	52	52	52	52	60	60	60
▲ Actual Third Party ADC	13	15	13	11	10	16	18	19	16	17	15	14	17	17	12
- - - Funded Third Party ADC	11	11	11	11	11	11	11	11	11	11	11	11	10	10	10

Objective 1F & Measure 1C - Average Daily Census
Kerrville State Hospital

Average Daily Census

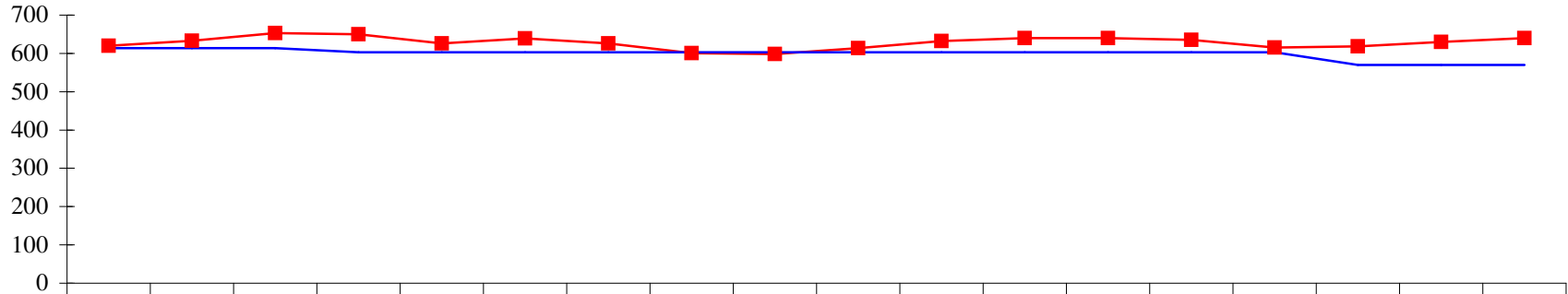


General Revenue & Third Party Average Daily Census



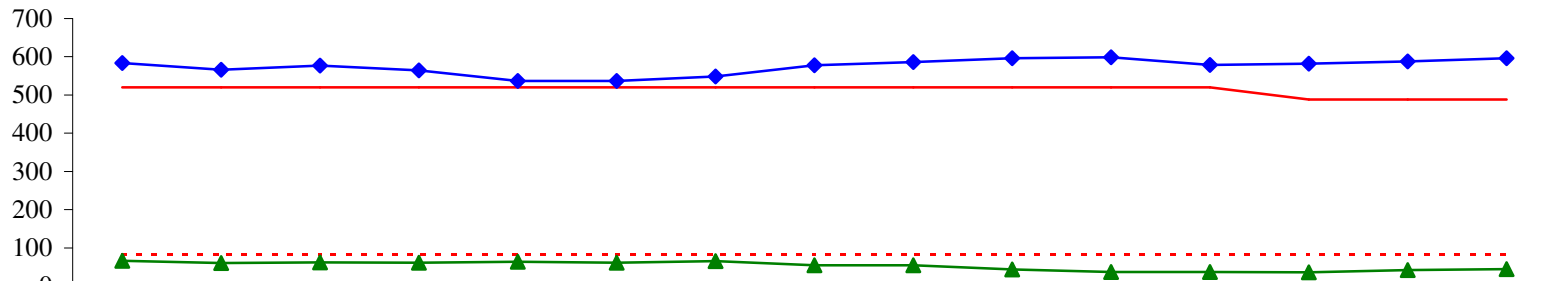
Objective 1F & Measure 1C - Average Daily Census
North Texas State Hospital

Average Daily Census



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
■ ADC	620	633	653	650	626	639	626	601	598	614	632	640	640	635	615	618	630	640
— Funded Census	614	614	614	603	603	603	603	603	603	603	603	603	603	603	603	570	570	570

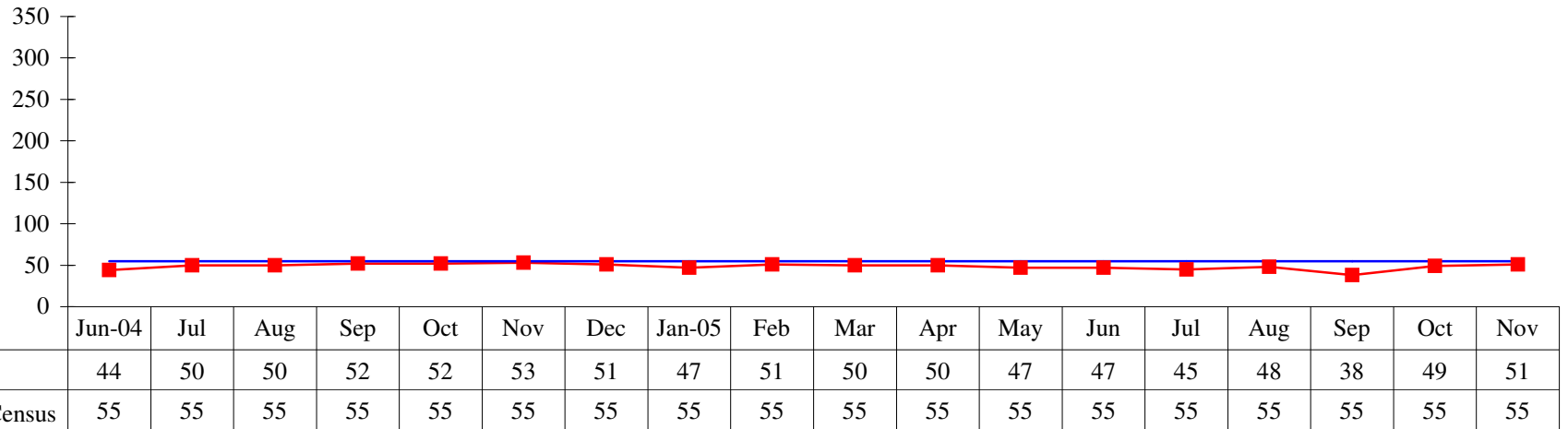
General Revenue & Third Party Average Daily Census



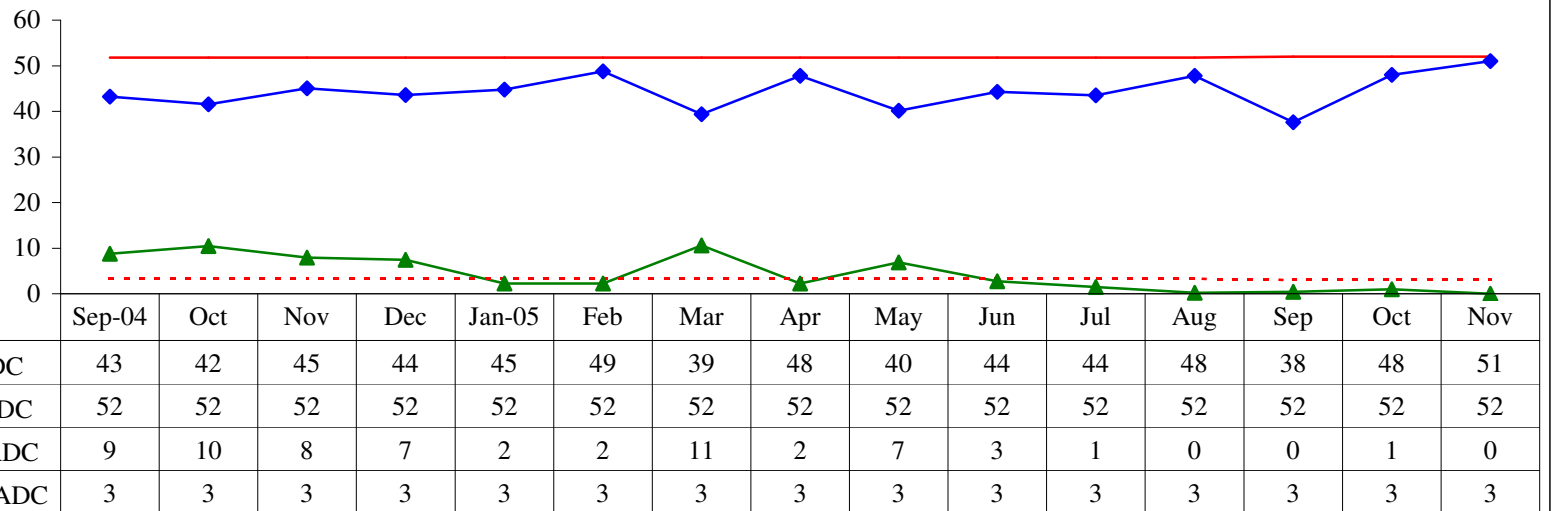
	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ Actual Gen. Rev. ADC	584	566	577	565	537	537	549	577	586	596	599	578	582	588	596
— Funded Gen. Rev. ADC	520	520	520	520	520	520	520	520	520	520	520	520	488	488	488
▲ Actual Third Party ADC	66	60	62	62	64	61	65	55	54	44	36	37	36	42	44
- - - Funded Third Party ADC	83	83	83	83	83	83	83	83	83	83	83	83	82	82	82

Objective 1F & Measure 1C - Average Daily Census
Rio Grande State Center–MH

Average Daily Census

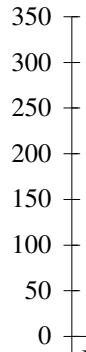


General Revenue & Third Party Average Daily Census



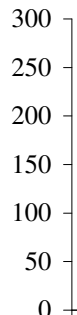
Objective 1F & Measure 1C - Average Daily Census
Rusk State Hospital

Average Daily Census



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
■ ADC	268	274	281	278	277	280	275	281	276	281	283	278	276	282	283	280	274	278
◆ Funded Census	274	274	274	275	275	275	275	275	275	275	275	275	275	275	275	309	309	309

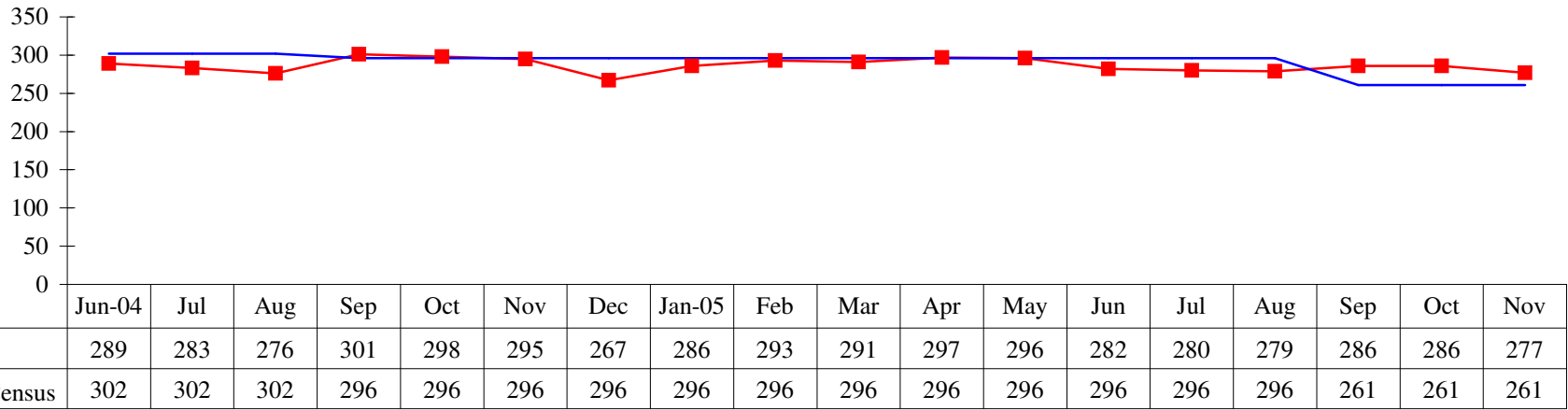
General Revenue & Third Party Average Daily Census



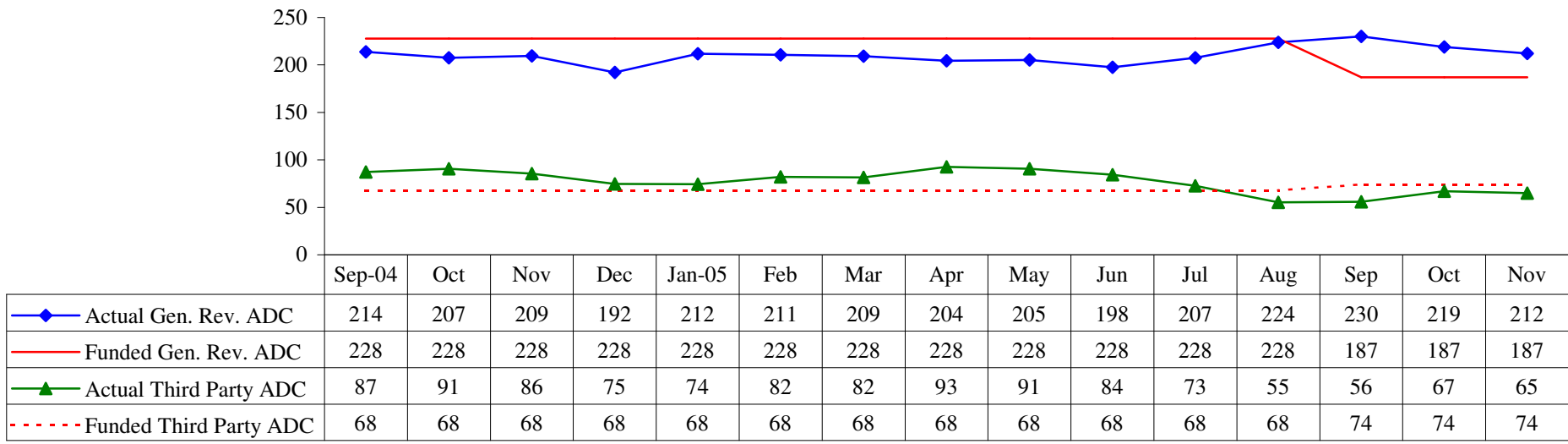
	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ Actual Gen. Rev. ADC	242	247	245	247	245	237	253	252	254	253	256	251	254	240	253
— Funded Gen. Rev. ADC	244	244	244	244	244	244	244	244	244	244	244	244	278	278	278
▲ Actual Third Party ADC	36	30	35	28	36	39	28	31	25	23	26	32	26	34	25
- - - Funded Third Party ADC	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31

Objective 1F & Measure 1C - Average Daily Census
San Antonio State Hospital

Average Daily Census

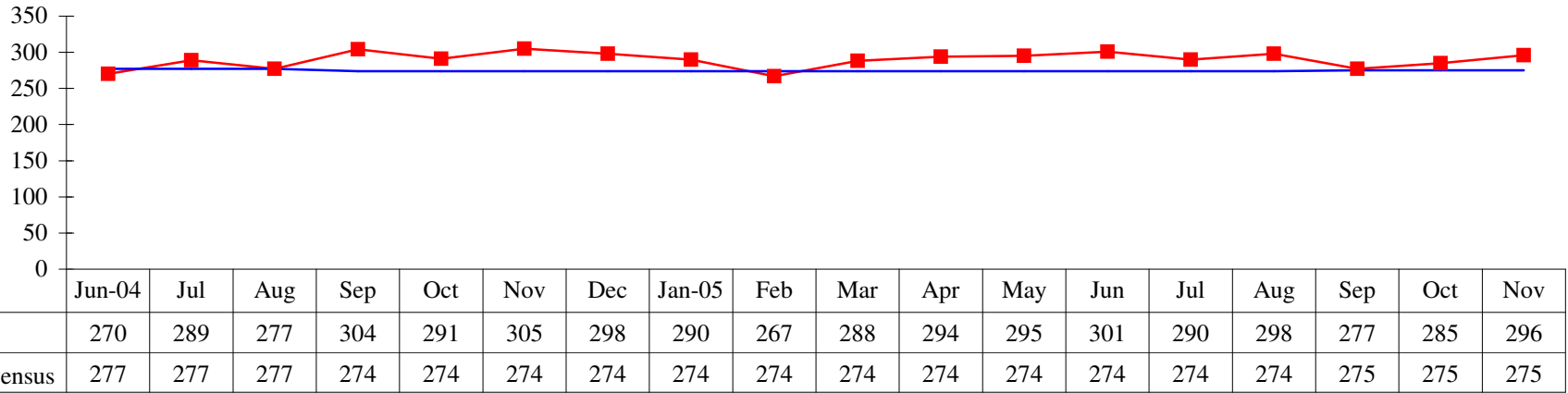


General Revenue & Third Party Average Daily Census

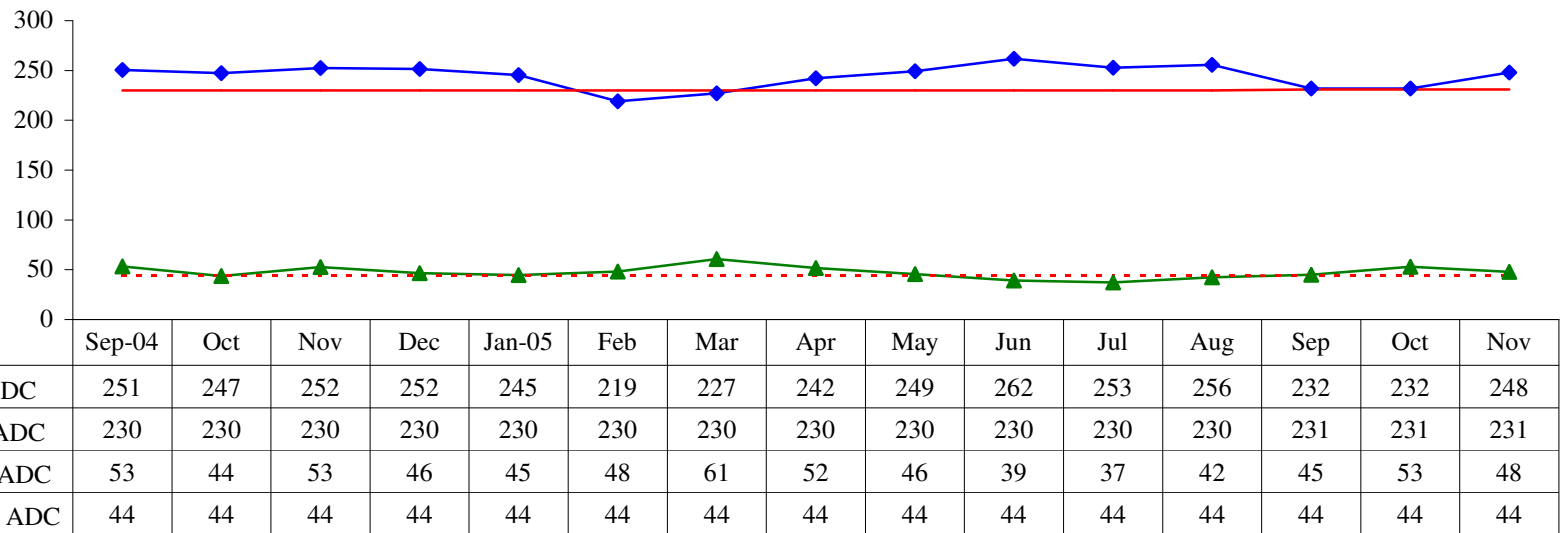


Objective 1F & Measure 1C - Average Daily Census
Terrell State Hospital

Average Daily Census

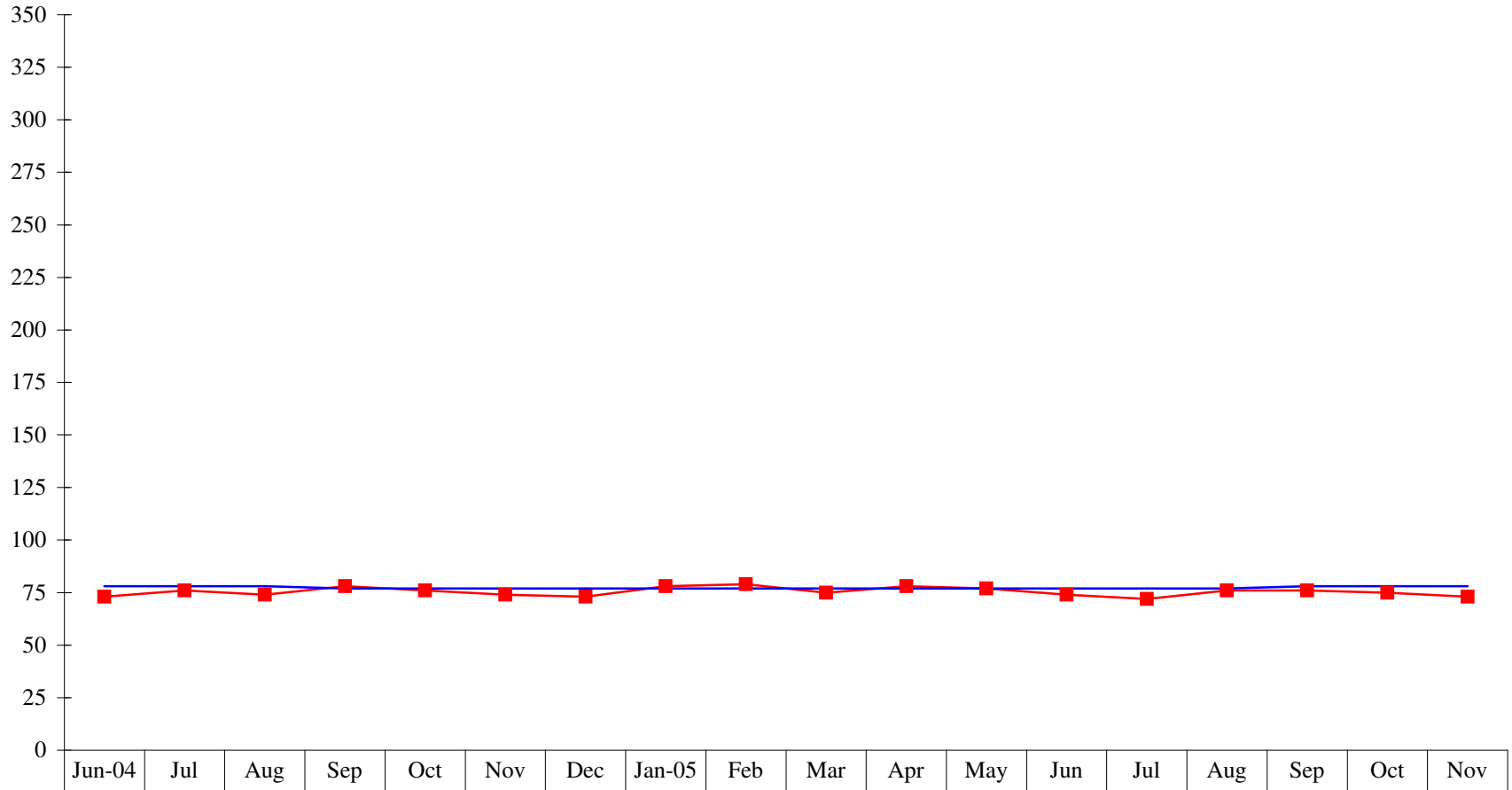


General Revenue & Third Party Average Daily Census



**Objective 1F & Measure 1C - Average Daily Census
Waco Center For Youth**

Average Daily Census



ADC	73	76	74	78	76	74	73	78	79	75	78	77	74	72	76	76	75	73
Funded Census	78	78	78	77	77	77	77	77	77	77	77	77	77	77	77	78	78	78

Performance Measure 1A:

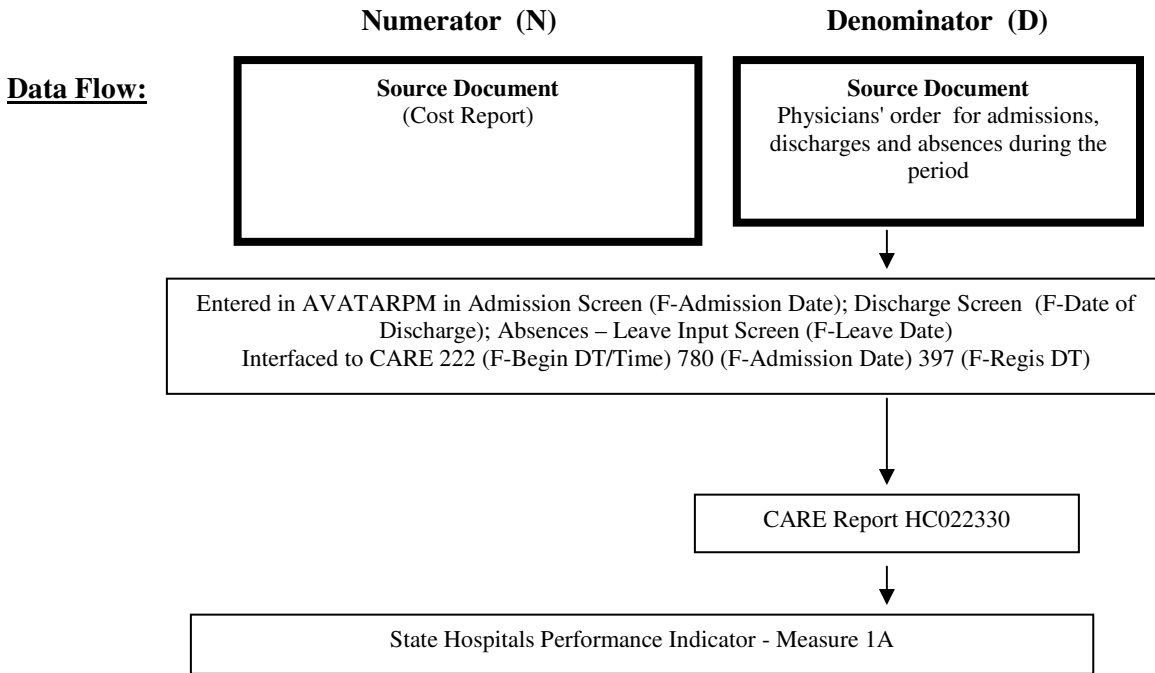
Average cost per patient served will be calculated and reported for each state hospital in the following categories: LBB Cost; State Cost; and Total State Cost.

Performance Measure Operational Definition: State hospital cost per person served represents the average cost of care for an individual per FY quarter.

Performance Measure Formula: Quarterly Average Cost Per Patient = LBB Cost [total state hospital cost – (benefits + depreciation) / quarterly total bed days derived from the Cost Report] x Average Patient Days * During Period (unduplicated count of patient's served). *Average patient days means the net stay in days at the component during the quarter divided by the number of unduplicated count of patient's served during the quarter.

Performance Measure Data Display and Chart Description:

- ◆ Table shows average patient days, cost per bed day and average cost for FY quarter for individual state hospitals and system-wide.
- ◆ Chart with accumulated quarterly data points of average cost per persons served for individual state hospitals and system-wide.



Data Integrity Review Process: (Denominator Only)

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Note: Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record (Physician's Order).

Measure 1A - Average Cost Per Patient Served
All MH Facilities

	FY03				FY04				FY05	FY06			
	Q1	Q2	Q3	FYTD	Q1	Q2	Q3	FYTD		Q1	Q2	Q3	FYTD
Austin State Hospital													
Avg. Patient Days	24	23	22	22	22	21	20	20				22	
LBB Cost/Bed Day	\$384	\$337	\$332	\$347	\$349	\$339	\$345	\$340				\$319	
Average Cost	\$9,251	\$7,630	\$7,467	\$7,488	\$7,654	\$7,068	\$6,745	\$6,899	\$0			\$7,174	
Big Spring State Hospital													
Avg. Patient Days	33	32	32	31	31	34	33	34				38	
LBB Cost/Bed Day	\$332	\$360	\$360	\$380	\$429	\$401	\$380	\$366				\$334	
Average Cost	\$11,009	\$11,668	\$11,455	\$11,902	\$13,252	\$13,554	\$12,399	\$12,331	\$0			\$12,812	
El Paso Psychiatric Center													
Avg. Patient Days	8	7	8	9	12	15	16	19				18	
LBB Cost/Bed Day	\$362	\$416	\$438	\$458	\$432	\$424	\$413	\$423				\$431	
Average Cost	\$3,034	\$3,091	\$3,373	\$4,008	\$5,076	\$6,373	\$6,579	\$7,948	\$0			\$7,949	
Kerrville State Hospital													
Avg. Patient Days	47	48	42	46	47	49	47	49				68	
LBB Cost/Bed Day	\$317	\$340	\$340	\$351	\$351	\$345	\$334	\$325				\$289	
Average Cost	\$14,775	\$16,378	\$14,256	\$16,286	\$16,350	\$17,043	\$15,564	\$15,837	\$0			\$19,754	
North Texas State Hospital													
Avg. Patient Days	45	48	45	46	47	48	47	46				46	
LBB Cost/Bed Day	\$275	\$290	\$290	\$298	\$307	\$305	\$302	\$298				\$303	
Average Cost	\$12,480	\$13,868	\$13,146	\$13,696	\$14,463	\$14,494	\$14,106	\$13,830	\$0			\$13,972	
Rusk State Hospital													
Avg. Patient Days	34	35	35	32	35	34	32	33				35	
LBB Cost/Bed Day	\$310	\$331	\$318	\$333	\$342	\$334	\$323	\$317				\$298	
Average Cost	\$10,438	\$11,744	\$10,990	\$10,566	\$11,837	\$11,299	\$10,426	\$10,547	\$0			\$10,506	
San Antonio State Hospital													
Avg. Patient Days	30	30	30	29	28	30	28	27				24	
LBB Cost/Bed Day	\$320	\$327	\$314	\$345	\$374	\$361	\$340	\$334				\$341	
Average Cost	\$9,482	\$9,853	\$9,445	\$10,136	\$10,423	\$10,689	\$9,673	\$9,088	\$0			\$8,314	

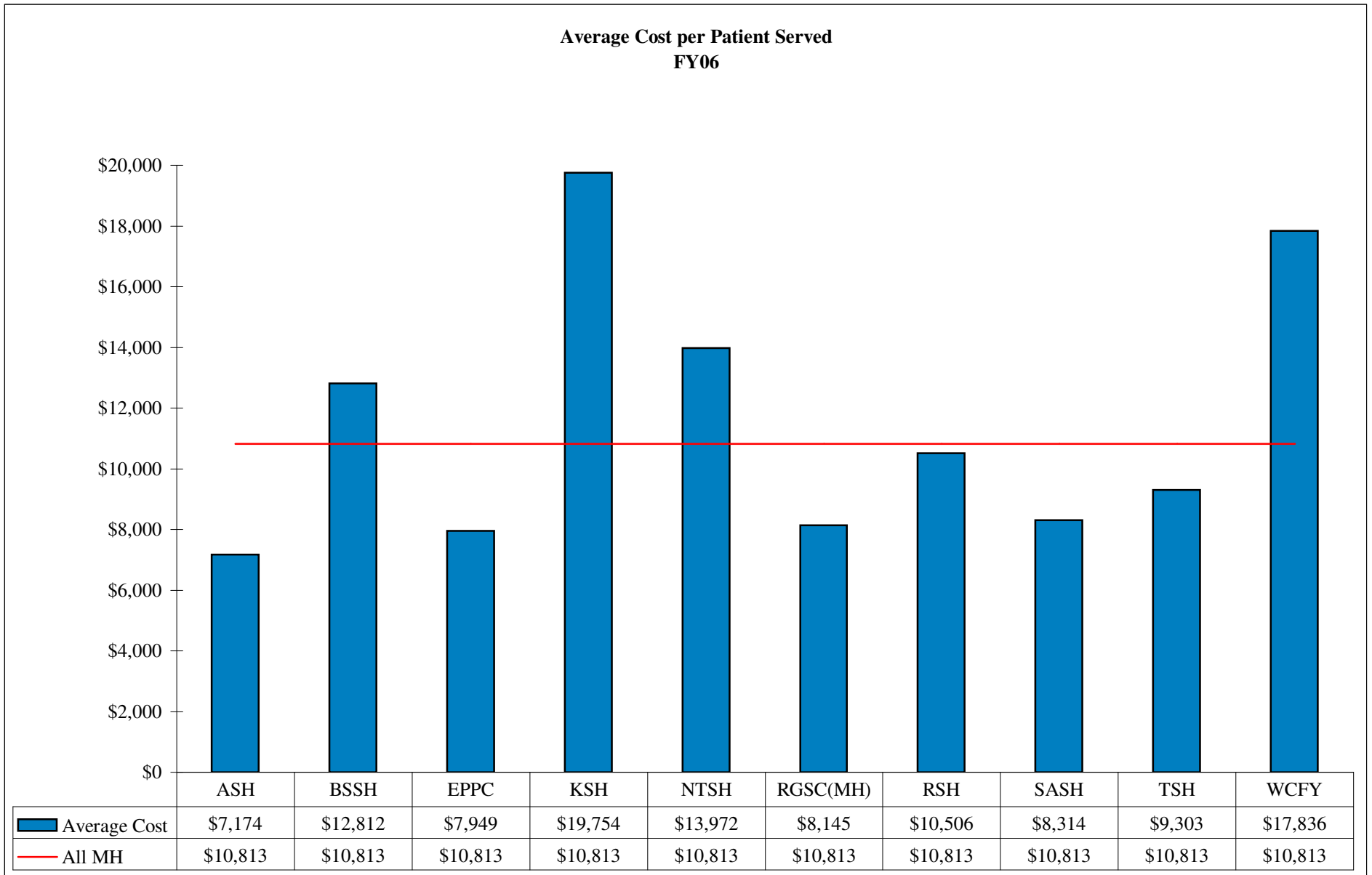
Source: CARE Report HC022330,
Financial Statistical Report-Fiscal Services;
Q1FY06 - Direct Communication from FSHS Budgeting Forecasting Dept.

Measure 1A - Average Cost Per Patient Served
All MH Facilities

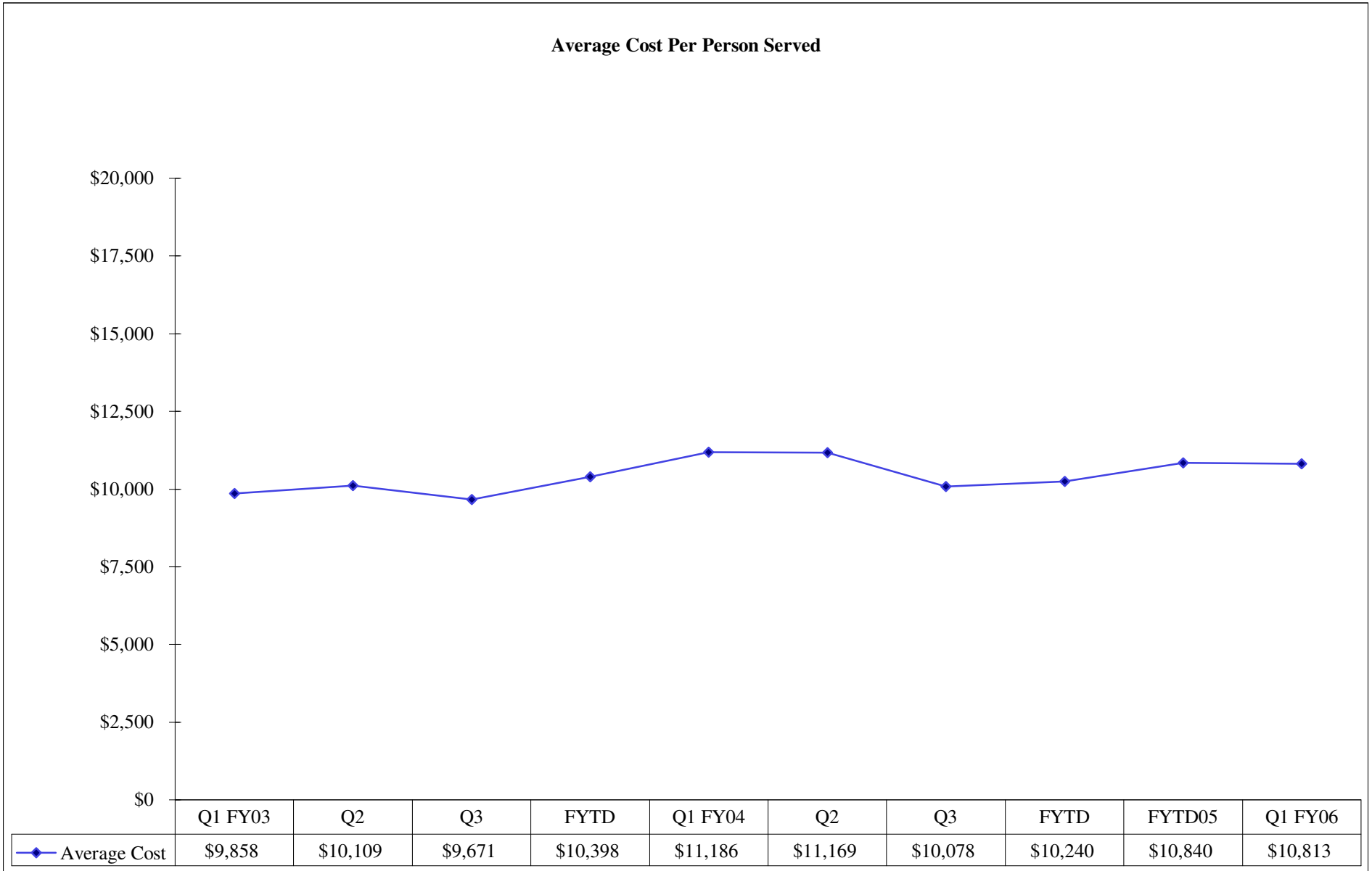
	FY03				FY04				FY05 FYTD	FY06			
	Q1	Q2	Q3	FYTD	Q1	Q2	Q3	FYTD		Q1	Q2	Q3	FYTD
Terrell State Hospital													
Avg. Patient Days	31	32	31	30	33	31	30	31			31		
LBB Cost/Bed Day	\$247	\$283	\$286	\$302	\$329	\$323	\$316	\$312			\$302		
Average Cost	\$7,588	\$9,048	\$8,760	\$8,948	\$10,801	\$10,116	\$9,341	\$9,606	\$0		\$9,303		
Waco Center for Youth**													
Avg. Patient Days	65	61	63	52	59	64	60	60			61		
LBB Cost/Bed Day	\$274	\$289	\$292	\$332	\$168	\$227	\$242	\$252			\$292		
Average Cost	\$17,810	\$17,537	\$18,253	\$17,101	\$9,887	\$14,617	\$14,527	\$15,102	\$0		\$17,836		
All SMHFs													
Avg. Patient Days	32	32	31	31	33	33	31	32	33		34		
LBB Cost/Bed Day	\$305	\$319	\$315	\$332	\$340	\$334	\$327	\$322	\$325		\$319		
Average Cost	\$9,858	\$10,109	\$9,671	\$10,398	\$11,186	\$11,169	\$10,078	\$10,240	\$10,840		\$10,813		
Rio Grande State Center (MH)													
Avg. Patient Days	13	12	14	15	12	13	11	13			13		
LBB Cost/Bed Day	\$473	\$442	\$414	\$420	\$450	\$424	\$418	\$418			\$606		
Average Cost	\$6,379	\$5,397	\$5,597	\$6,212	\$5,549	\$5,639	\$4,615	\$5,325	\$0		\$8,145		

**WCFY - Q1 & Q2 FY04 artificially low due to budget adjustments for prior fiscal year.
Starting with FY03 Q2 - RGSC (MH) is included in All SMHF Average Cost.
LBB Cost - total facility expense minus benefits and depreciation

**Measure 1A - Average Cost Per Patient Served
All MH Facilities**

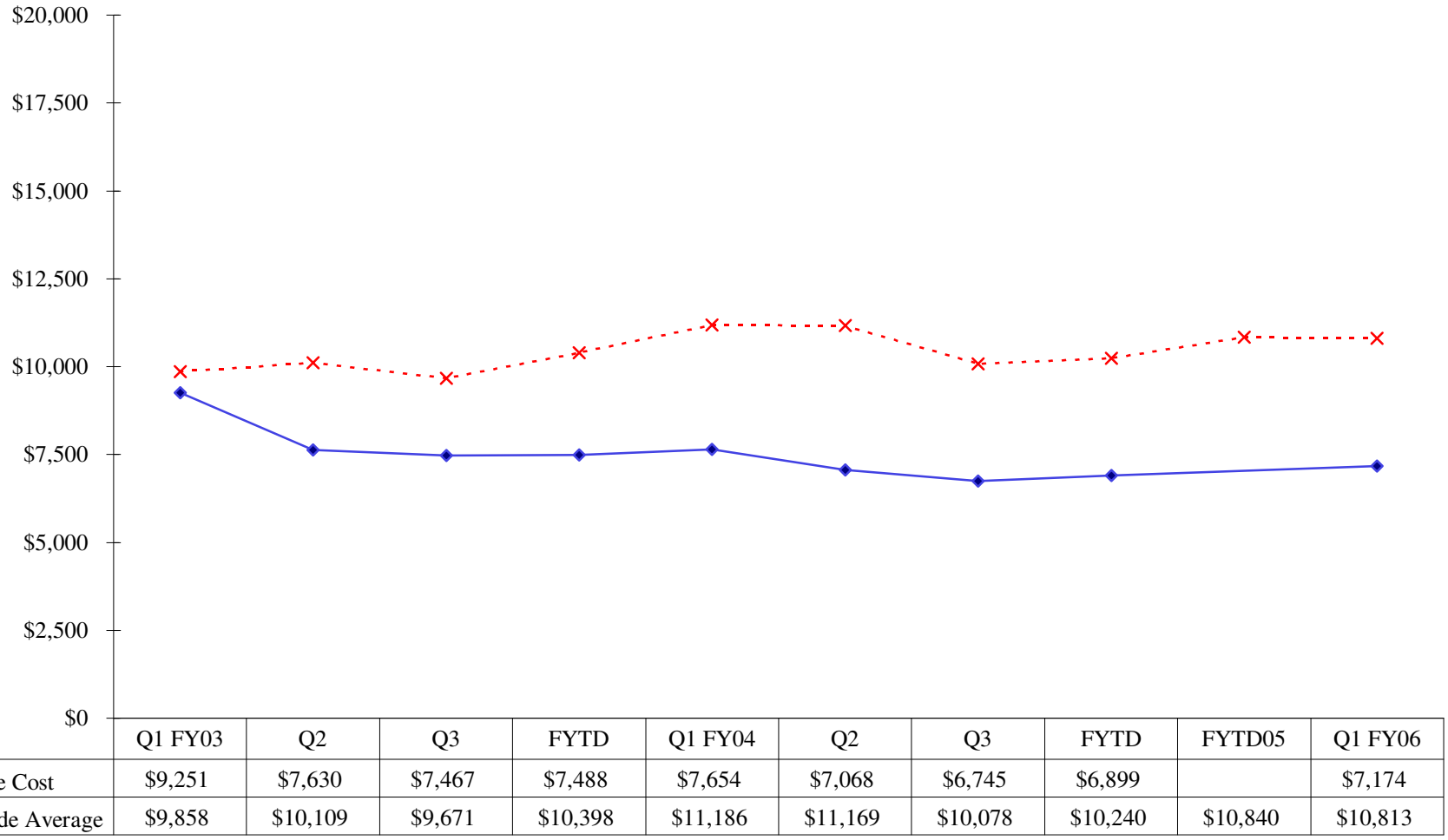


Measure 1A - Average Cost Per Patient Served
All MH Facilities



Measure 1A - Average Cost Per Patient Served
Austin State Hospital

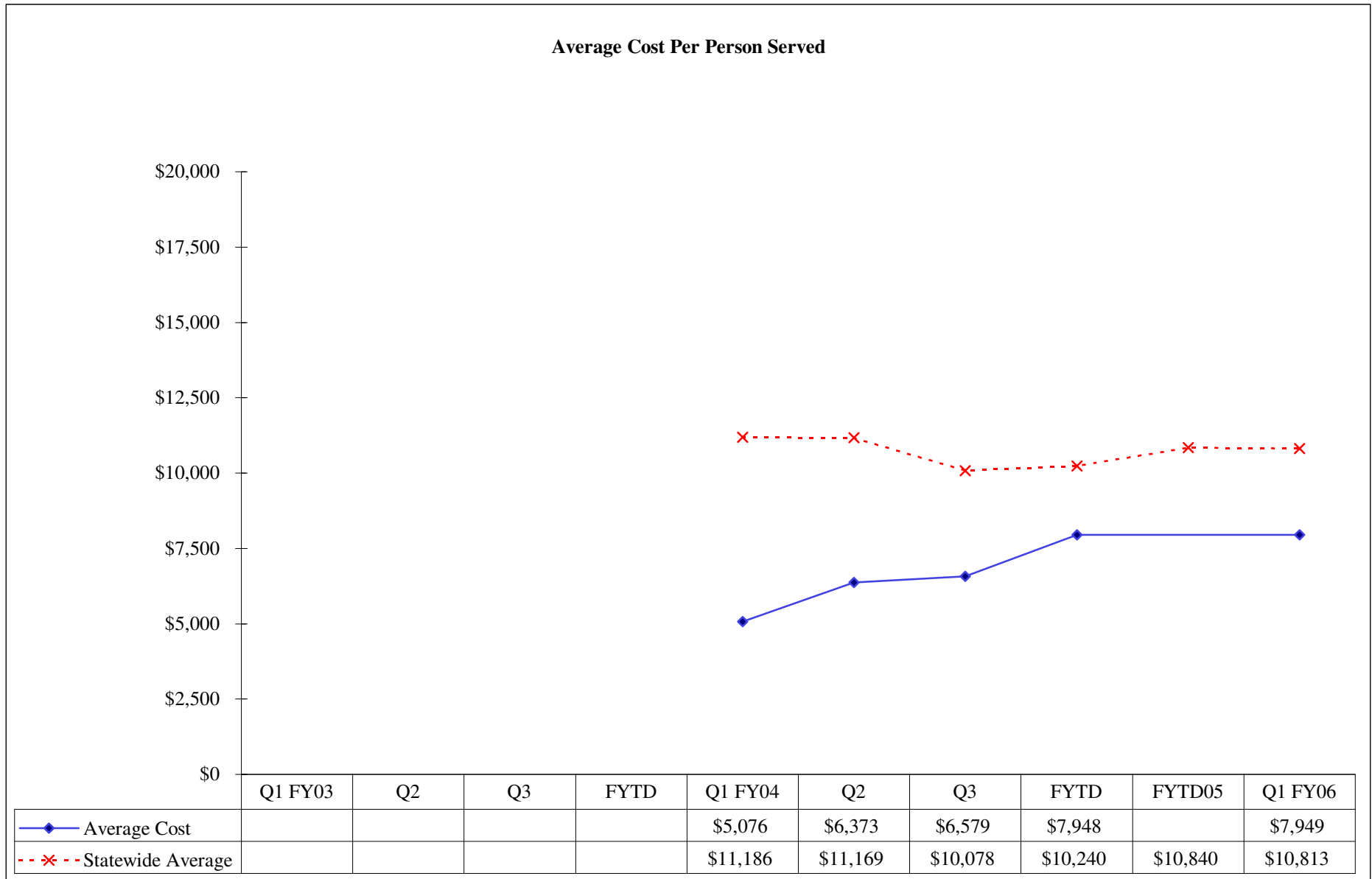
Average Cost Per Person Served



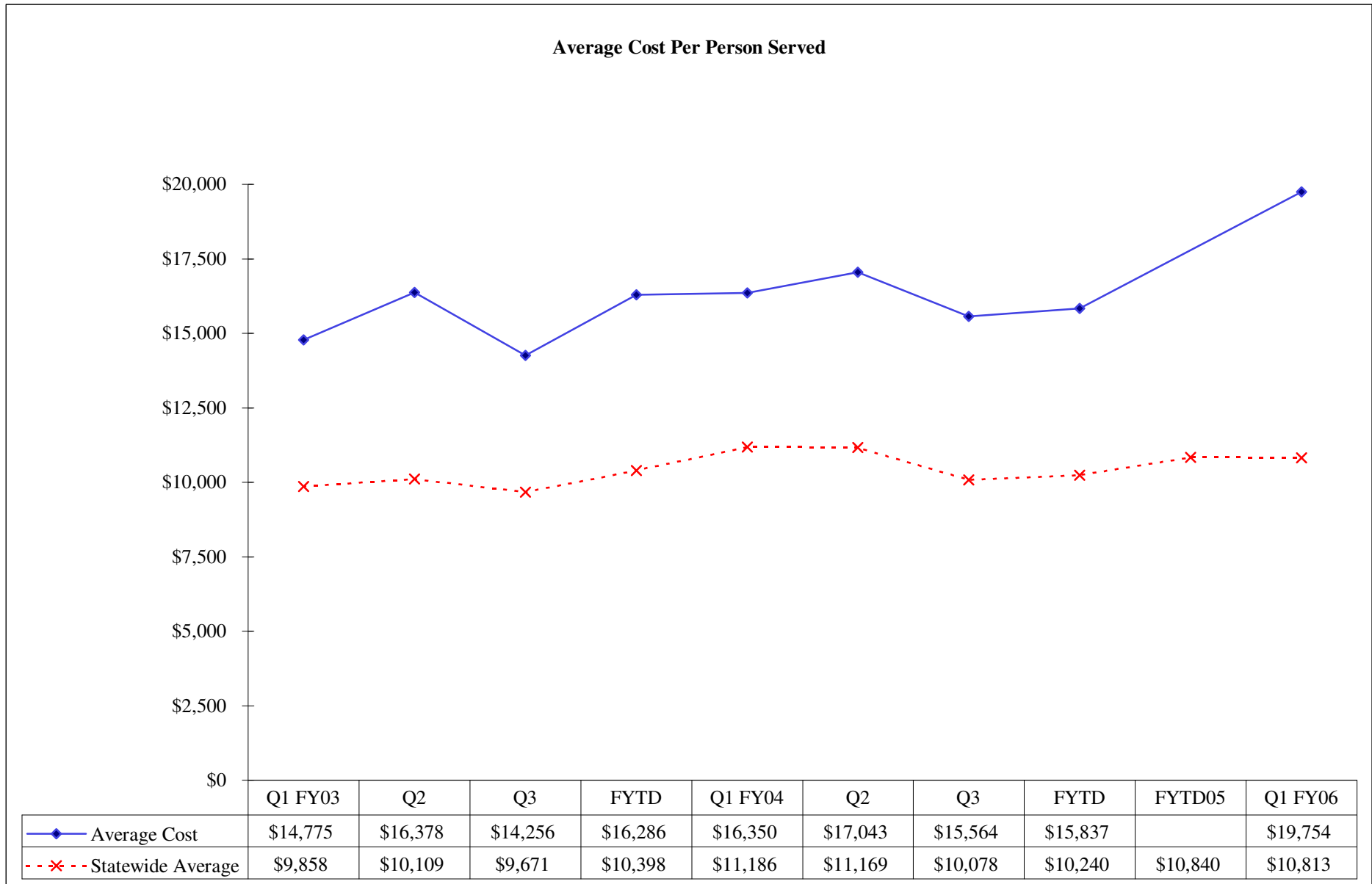
Measure 1A - Average Cost Per Patient Served
Big Spring State Hospital



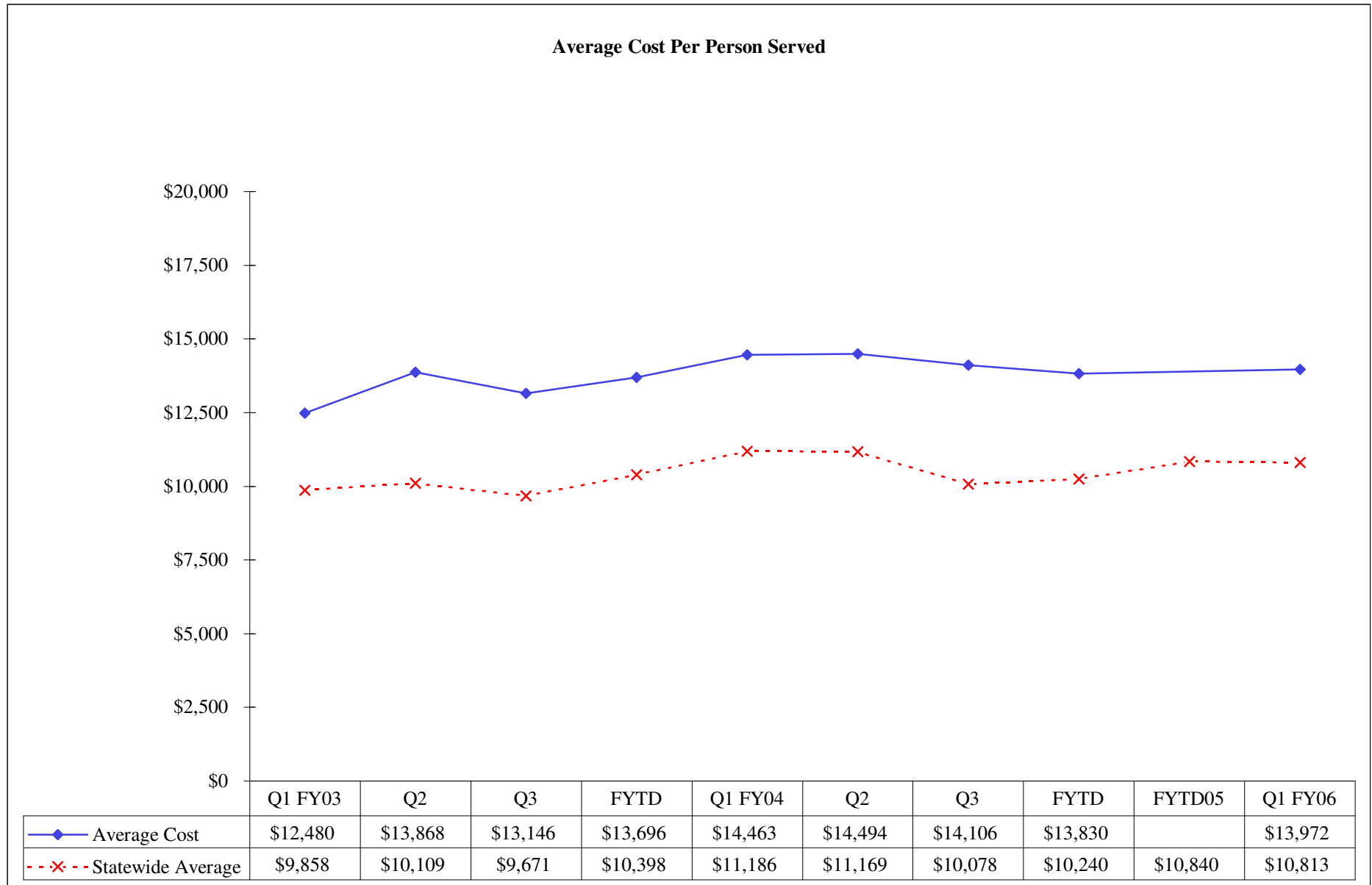
Measure 1A - Average Cost Per Patient Served
El Paso Psychiatric Center



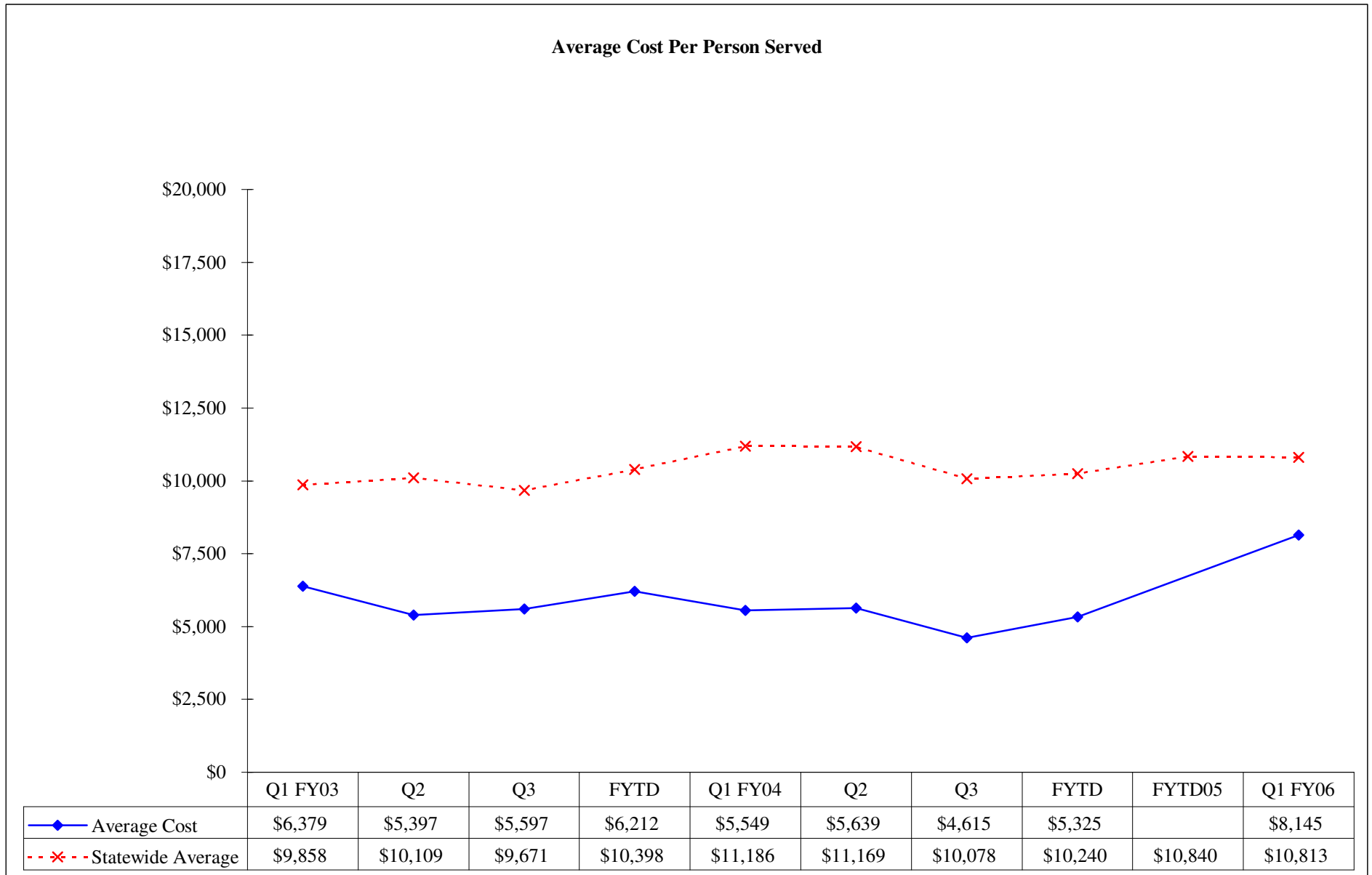
Measure 1A - Average Cost Per Patient Served
Kerrville State Hospital



Measure 1A - Average Cost Per Patient Served
North Texas State Hospital



Measure 1A - Average Cost Per Patient Served
Rio Grande State Center (MH only)



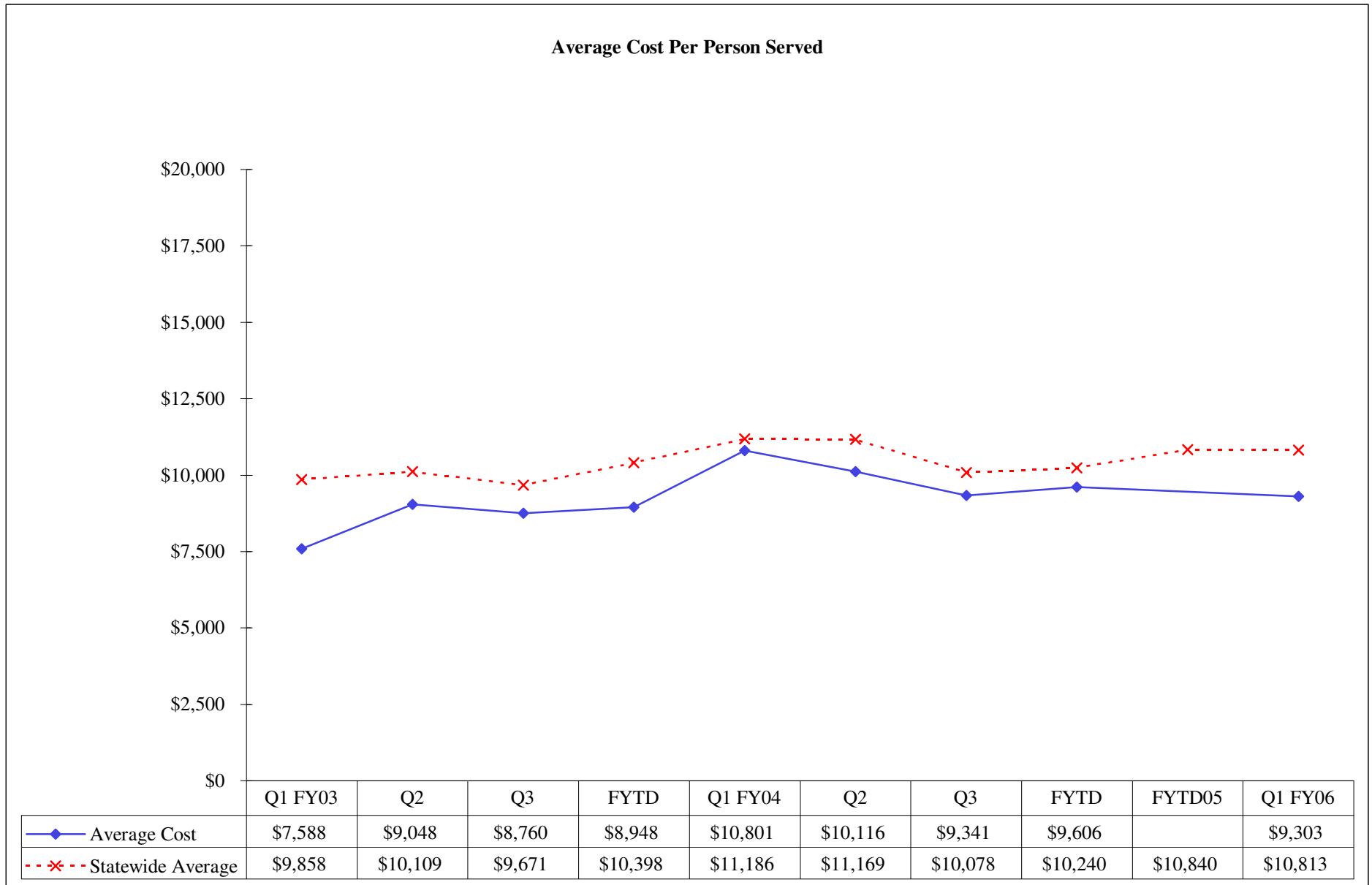
Measure 1A - Average Cost Per Patient Served
Rusk State Hospital



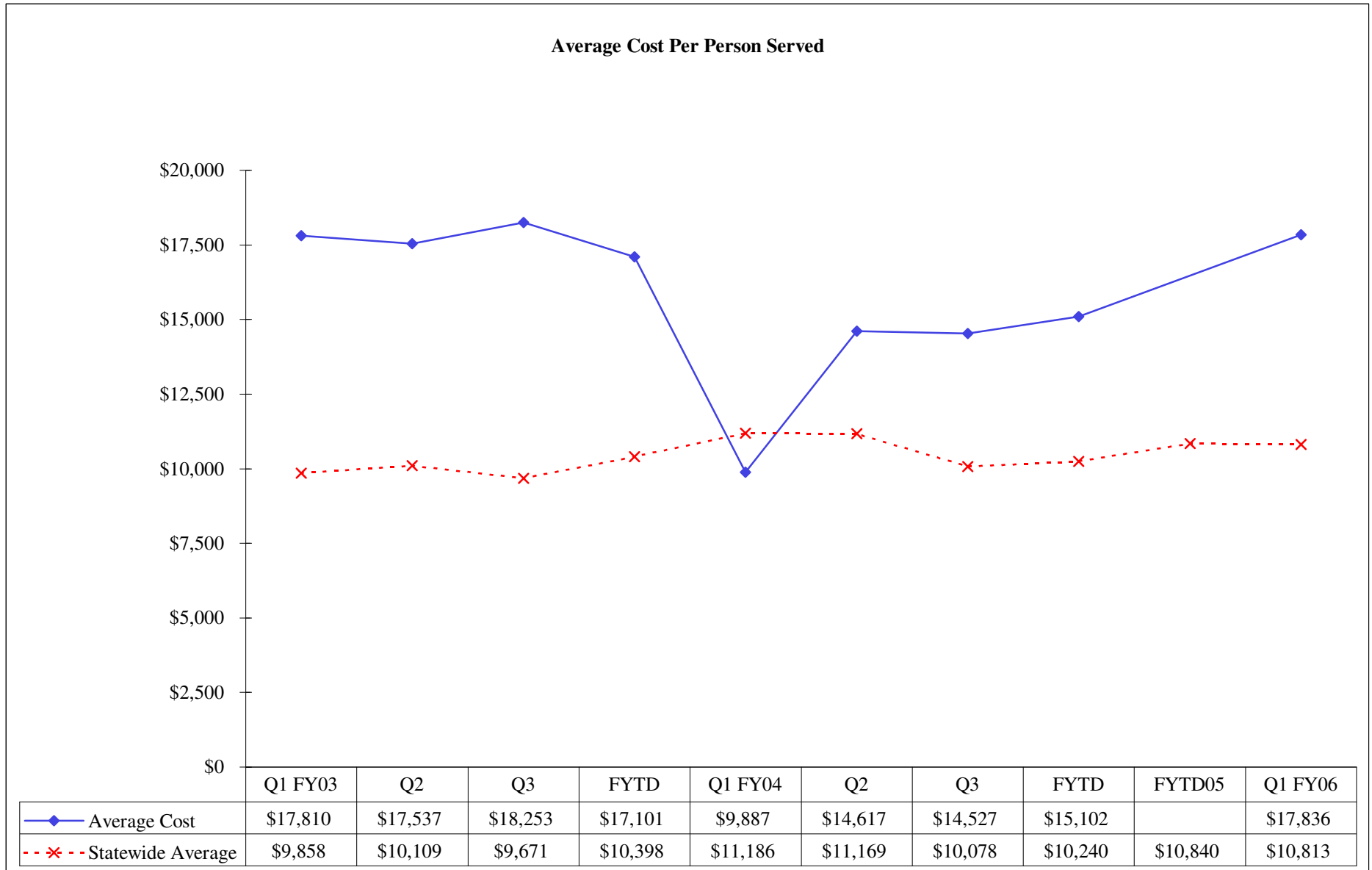
Measure 1A - Average Cost Per Patient Served
San Antonio State Hospital



**Measure 1A - Average Cost Per Patient Served
Terrell State Hospital**



**Measure 1A - Average Cost Per Patient Served
Waco Center for Youth**



**Q1 & Q2 FY04 artificially low due to budget adjustments for prior fiscal year.

Performance Measure 1B:

Average cost per occupied bed day will be calculated and reported for each state hospital.

Performance Measure Operational Definition: The state hospital average cost per occupied bed day.

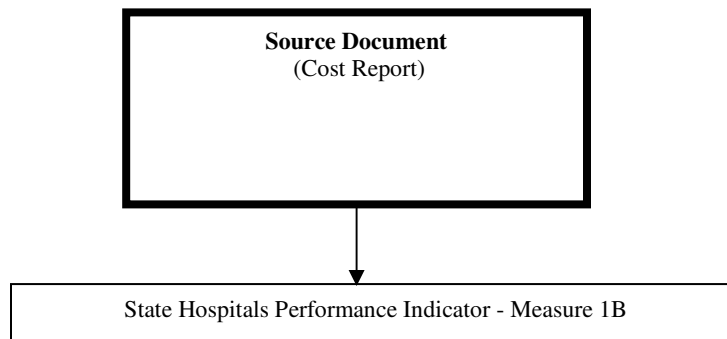
Performance Measure Formula: The state hospital's average cost per occupied bed day per FY quarter is calculated three ways.

- 1) State Hospital Cost Per Bed Day = Total Facility Expense / Total Bed Days
- 2) Cost per Bed Day with DICAP+SWICAP = Total State Hospital Expense including DICAP+SWICAP / Total Bed Days
- 3) Appropriated Fund Cost (for LBB) = Total State Hospital Expense – (Benefits + Depreciation) / Total Bed Days]

Performance Measure Data Display and Chart Description:

- ◆ Table shows cost per bed day, cost per bed day w/DICAP+SWICAP and LBB cost per bed day for FY quarter for individual state hospitals and system-wide.
- ◆ Chart with quarterly data points of cost per bed day, cost per bed day w/DICAP+SWICAP and LBB cost per bed day for FY quarter for individual state hospitals and system-wide.

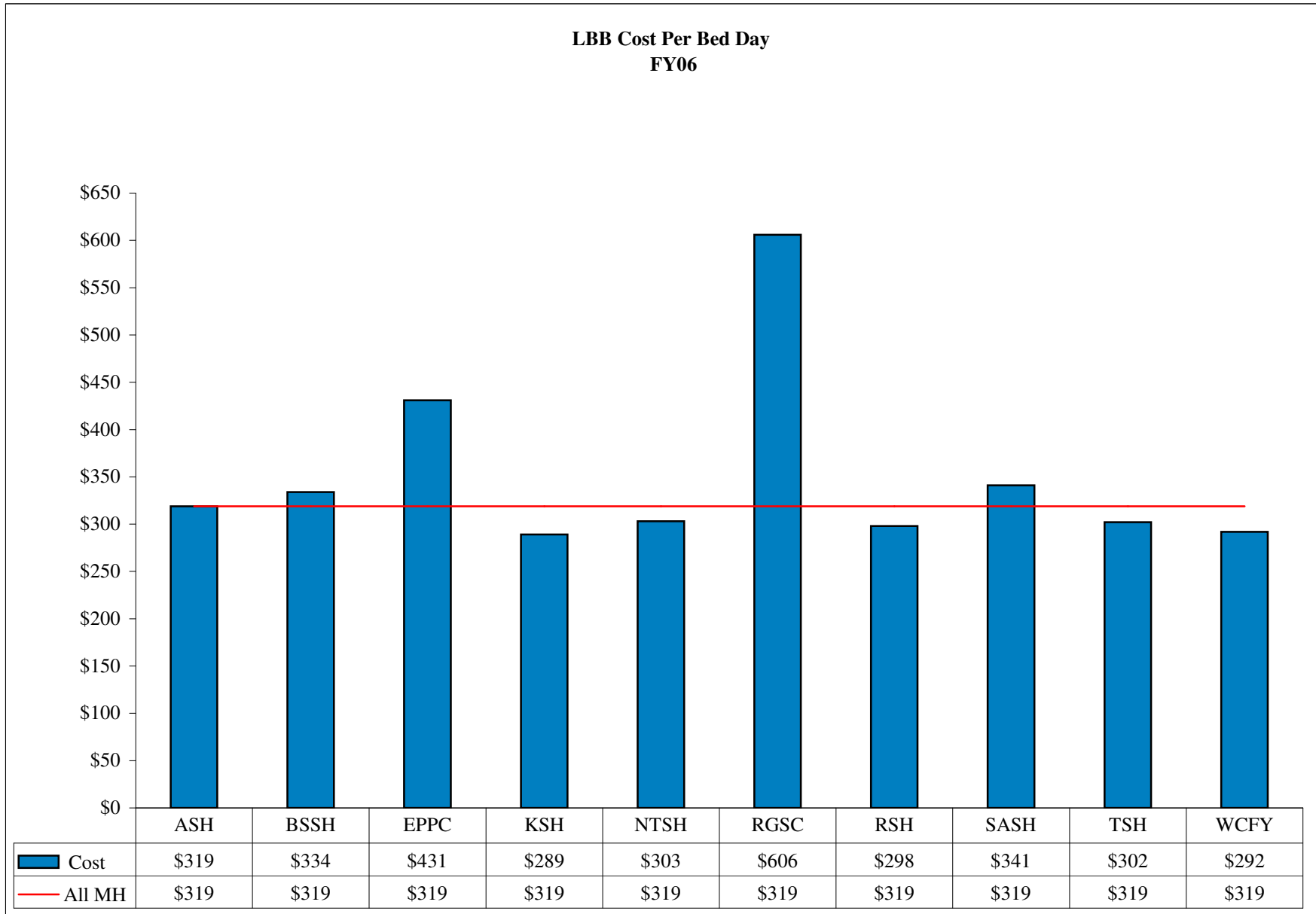
Data Flow:



Data Integrity Review Process: (Verifies accuracy of “total bed day” in cost report)

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record on Physician’s Order.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including findings and data analysis.

Measure 1B - Cost Per Bed Day
All MH Facilities



Measure 1B - Cost Per Bed Day

All MH Facilities

	FY03				FY04				FY05	FY06			
	Q1	Q2	Q3	FYTD	Q1	Q2	Q3	FYTD	FYTD	Q1	Q2	Q3	FYTD
Austin State Hospital													
Cost Per Bed Day	\$468	\$422	\$415	\$425	\$419	\$414	\$419	\$415					
Cost Per Bed Day w/DICAP/SWICAP	\$498	\$455	\$449	\$465	\$459	\$456	\$460	\$461					
LBB Cost Per Bed Day	\$384	\$337	\$332	\$347	\$349	\$339	\$345	\$340		\$319			
Big Spring State Hospital													
Cost Per Bed Day	\$443	\$463	\$458	\$468	\$522	\$492	\$467	\$451					
Cost Per Bed Day w/DICAP/SWICAP	\$478	\$501	\$498	\$520	\$575	\$547	\$520	\$512					
LBB Cost Per Bed Day	\$332	\$360	\$360	\$380	\$429	\$401	\$380	\$366		\$334			
El Paso Psychiatric Center													
Cost Per Bed Day	\$457	\$522	\$535	\$560	\$533	\$515	\$499	\$509					
Cost Per Bed Day w/DICAP/SWICAP		\$524	\$540	\$583	\$538	\$519	\$503	\$521					
LBB Cost Per Bed Day	\$362	\$416	\$438	\$458	\$432	\$424	\$413	\$423		\$431			
Kerrville State Hospital													
Cost Per Bed Day	\$432	\$449	\$443	\$439	\$438	\$430	\$417	\$405					
Cost Per Bed Day w/DICAP/SWICAP	\$469	\$488	\$484	\$490	\$480	\$474	\$460	\$456					
LBB Cost Per Bed Day	\$317	\$340	\$340	\$351	\$351	\$345	\$334	\$325		\$289			
North Texas State Hospital													
Cost Per Bed Day	\$376	\$383	\$378	\$375	\$379	\$378	\$375	\$370					
Cost Per Bed Day w/DICAP/SWICAP	\$405	\$414	\$410	\$411	\$412	\$413	\$409	\$406					
LBB Cost Per Bed Day	\$275	\$290	\$290	\$298	\$307	\$305	\$302	\$298		\$303			
Rusk State Hospital													
Cost Per Bed Day	\$415	\$438	\$414	\$415	\$419	\$413	\$399	\$398					
Cost Per Bed Day w/DICAP/SWICAP	\$447	\$472	\$449	\$453	\$459	\$454	\$439	\$442					
LBB Cost Per Bed Day	\$310	\$331	\$318	\$333	\$342	\$334	\$323	\$322		\$298			
San Antonio State Hospital													
Cost Per Bed Day	\$433	\$426	\$404	\$422	\$453	\$441	\$419	\$411					
Cost Per Bed Day w/DICAP/SWICAP	\$465	\$460	\$440	\$461	\$496	\$486	\$463	\$458					
LBB Cost Per Bed Day	\$320	\$327	\$314	\$345	\$374	\$361	\$340	\$334		\$341			
Terrell State Hospital													
Cost Per Bed Day	\$336	\$372	\$370	\$373	\$404	\$397	\$389	\$384					
Cost Per Bed Day w/DICAP/SWICAP	\$365	\$403	\$402	\$410	\$443	\$438	\$428	\$427					
LBB Cost Per Bed Day	\$247	\$283	\$286	\$302	\$329	\$323	\$316	\$312		\$302			

LBB Cost Per Bed Day = Total Financial Expenses minus Benefits and Depreciation

Measure 1B - Cost Per Bed Day
All MH Facilities

	FY03				FY04				FY05	FY06			
	Q1	Q2	Q3	FYTD	Q1	Q2	Q3	FYTD	FYTD	Q1	Q2	Q3	FYTD
Waco Center for Youth*													
Cost Per Bed Day	\$359	\$372	\$374	\$413	\$237	\$295	\$310	\$319					
Cost Per Bed Day w/DICAP/SWICAP	\$388	\$404	\$408	\$453	\$273	\$333	\$348	\$361					
LBB Cost Per Bed Day	\$274	\$289	\$292	\$332	\$168	\$227	\$242	\$252		\$292			
All Hospitals													
Cost Per Bed Day	\$405	\$415	\$406	\$411	\$417	\$412	\$404	\$398					
Cost Per Bed Day w/DICAP/SWICAP	\$436	\$448	\$440	\$451	\$456	\$452	\$444	\$442					
LBB Cost Per Bed Day	\$305	\$319	\$315	\$332	\$340	\$334	\$327	\$322	\$325	\$319			
Rio Grande State Center (MH)													
Cost Per Bed Day	\$362	\$557	\$534	\$525	\$556	\$530	\$525	\$524					
Cost Per Bed Day w/DICAP/SWICAP		\$637	\$591	\$585	\$621	\$596	\$596	\$600					
LBB Cost Per Bed Day	\$473	\$442	\$414	\$420	\$450	\$424	\$418	\$418		\$606			

*WCFY - FY04 artificially low due to budget adjustments for prior fiscal year.

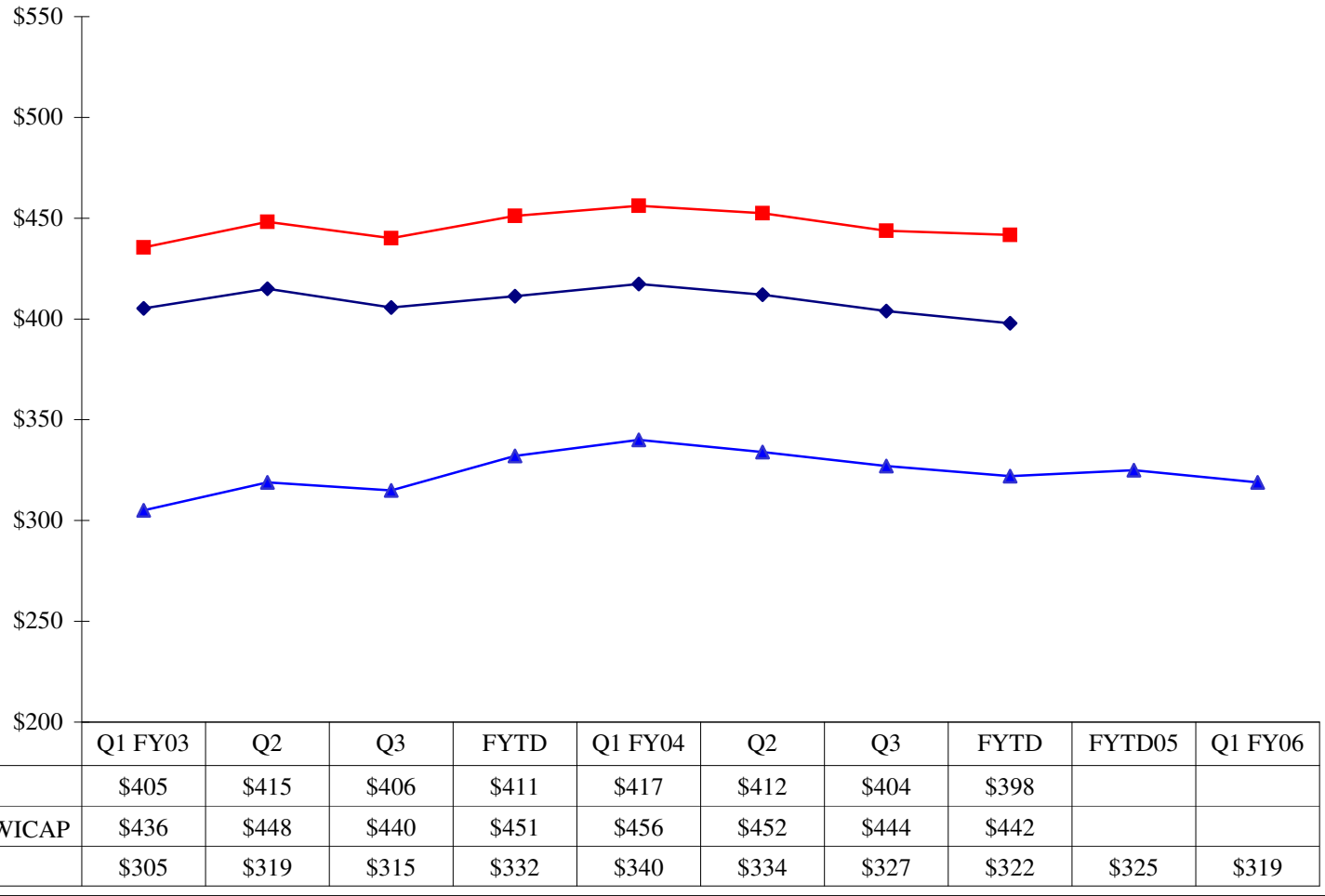
LBB Cost Per Bed Day = Total Financial Expenses minus Benefits and Depreciation

Starting with FY03 Q2 RGSC (MH) is included in All SMHF Average Cost.

Q1 FY06 - Data source is direct communication from DSHS Budgeting and Forecasting Department

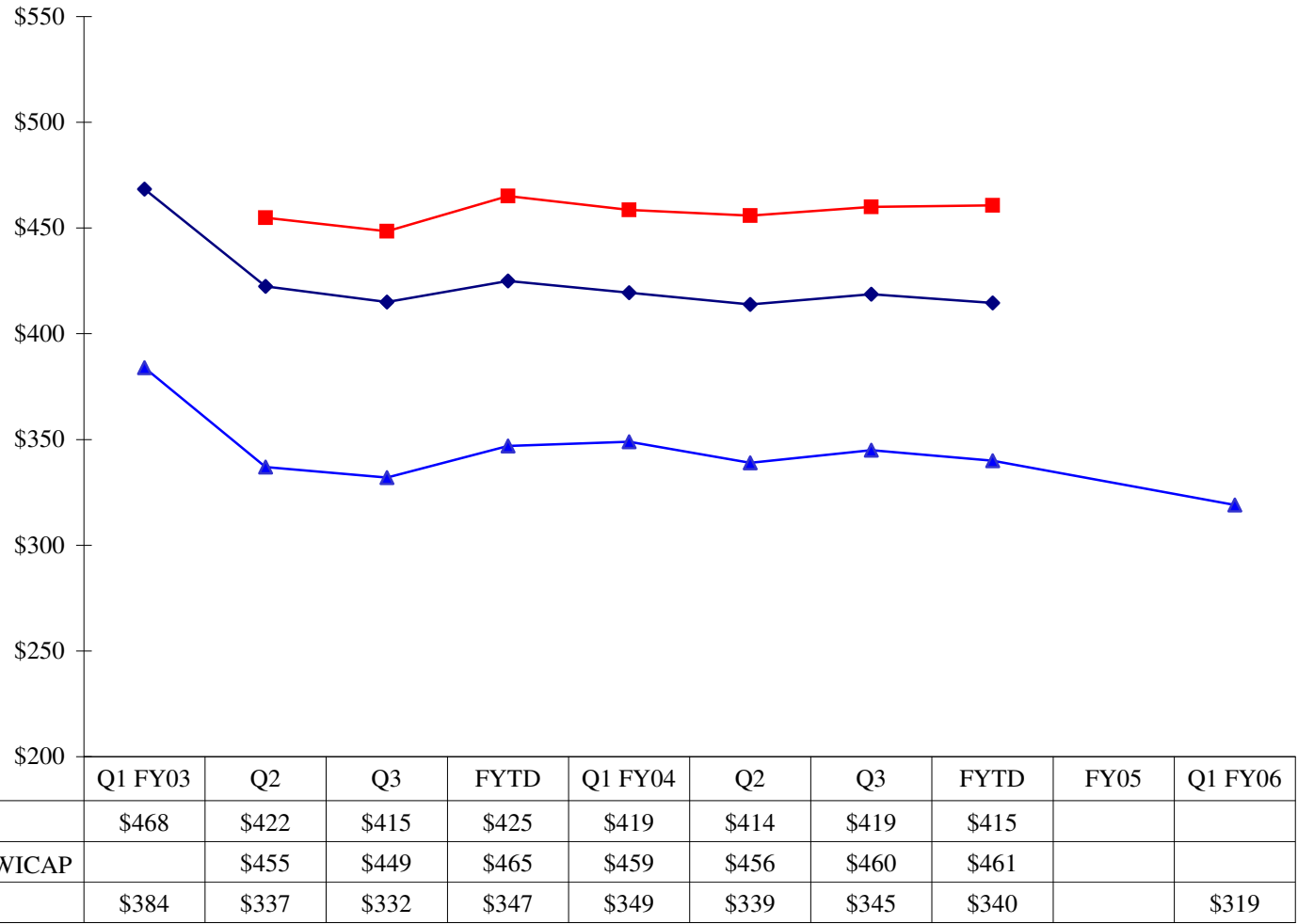
Measure 1B - Cost Per Bed Day
All MH Facilities

Cost Per Bed Day

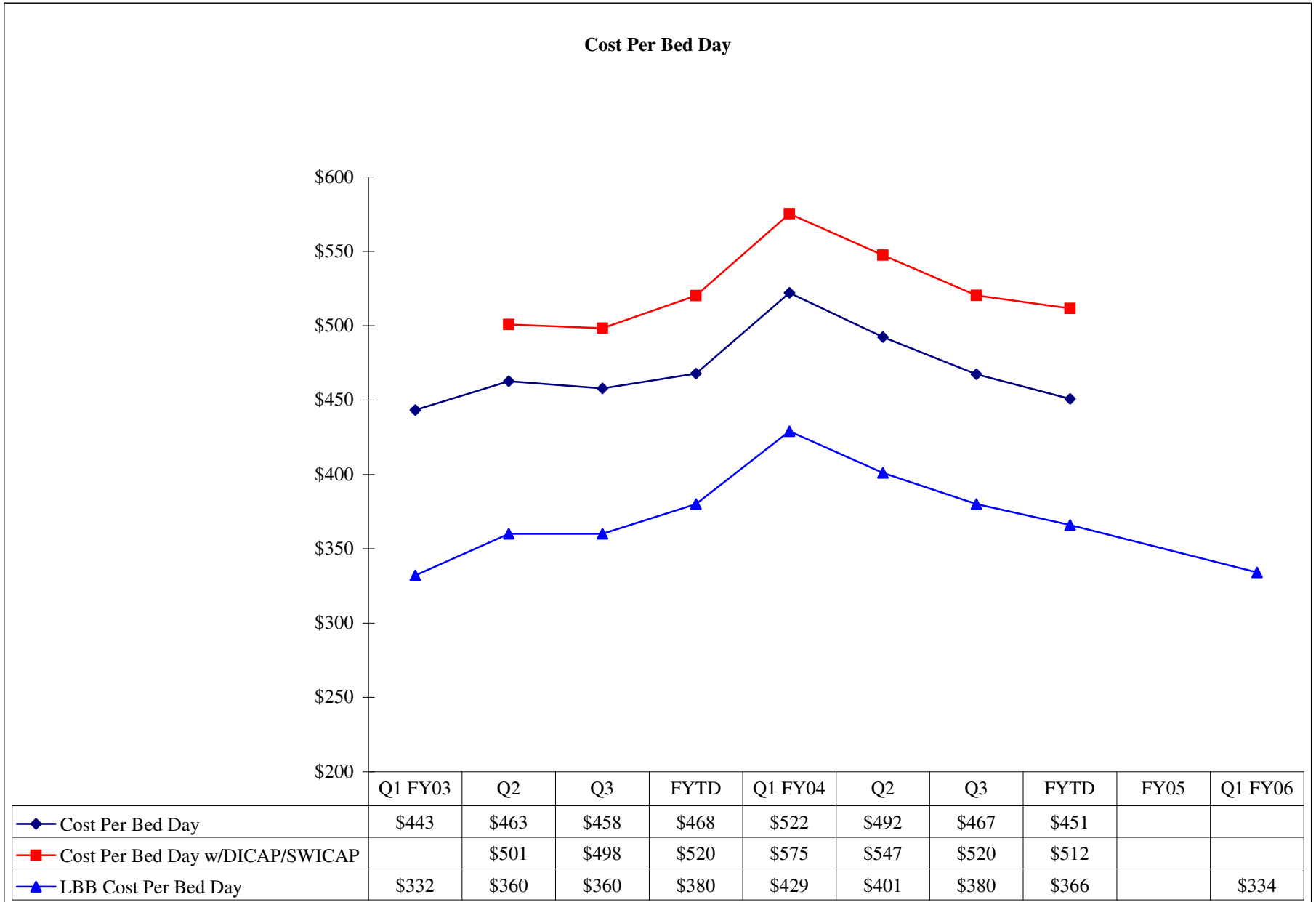


**Measure 1B - Cost Per Bed Day
Austin State Hospital**

Cost Per Bed Day



**Measure 1B - Cost Per Bed Day
Big Spring State Hospital**



Source: Financial Statistical Report - Fiscal Services;
Q1FY06 - Direct Communication from DSHS Budgeting Forecasting Dept.

**Measure 1B - Cost Per Bed Day
El Paso Psychiatric Center**

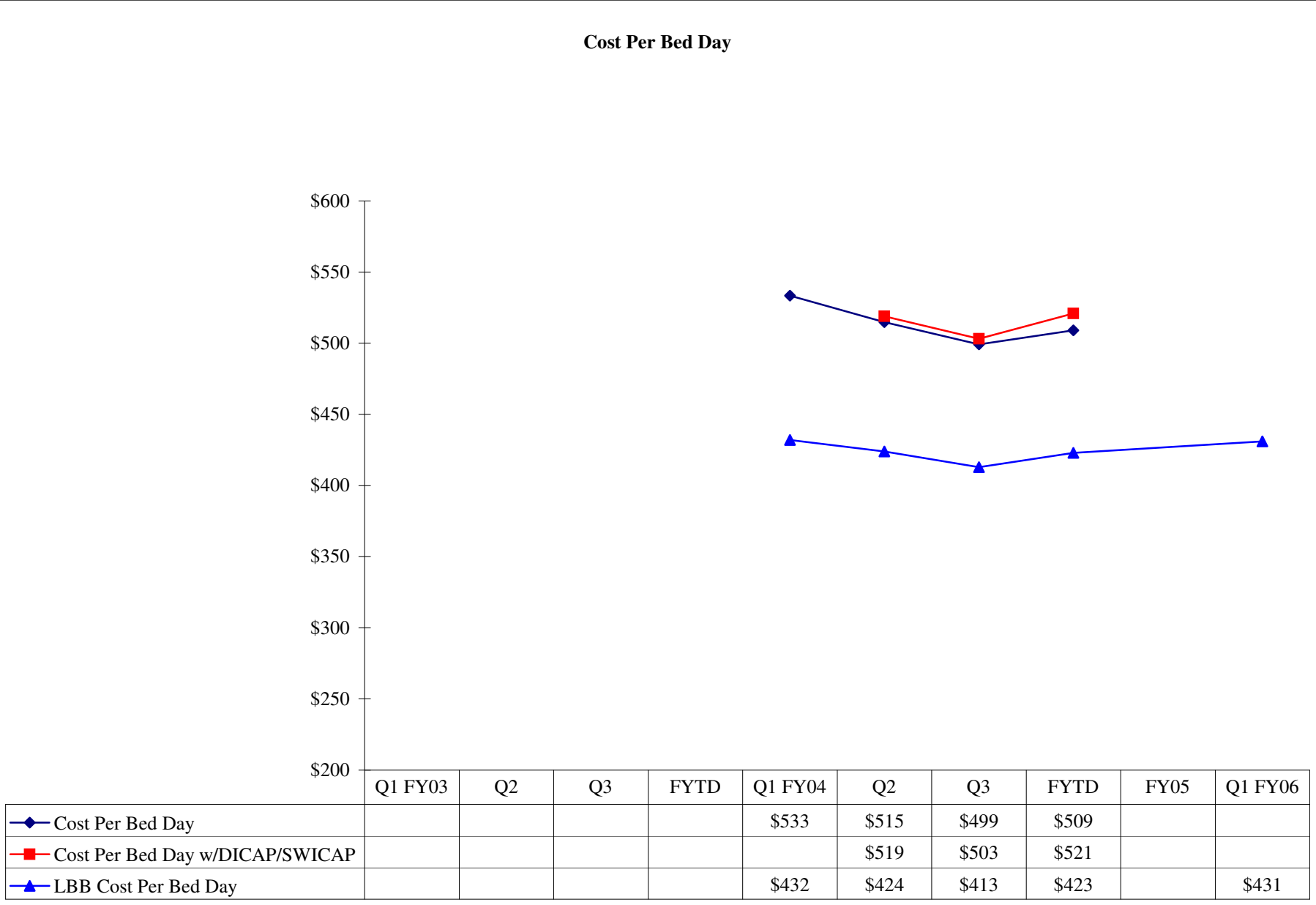
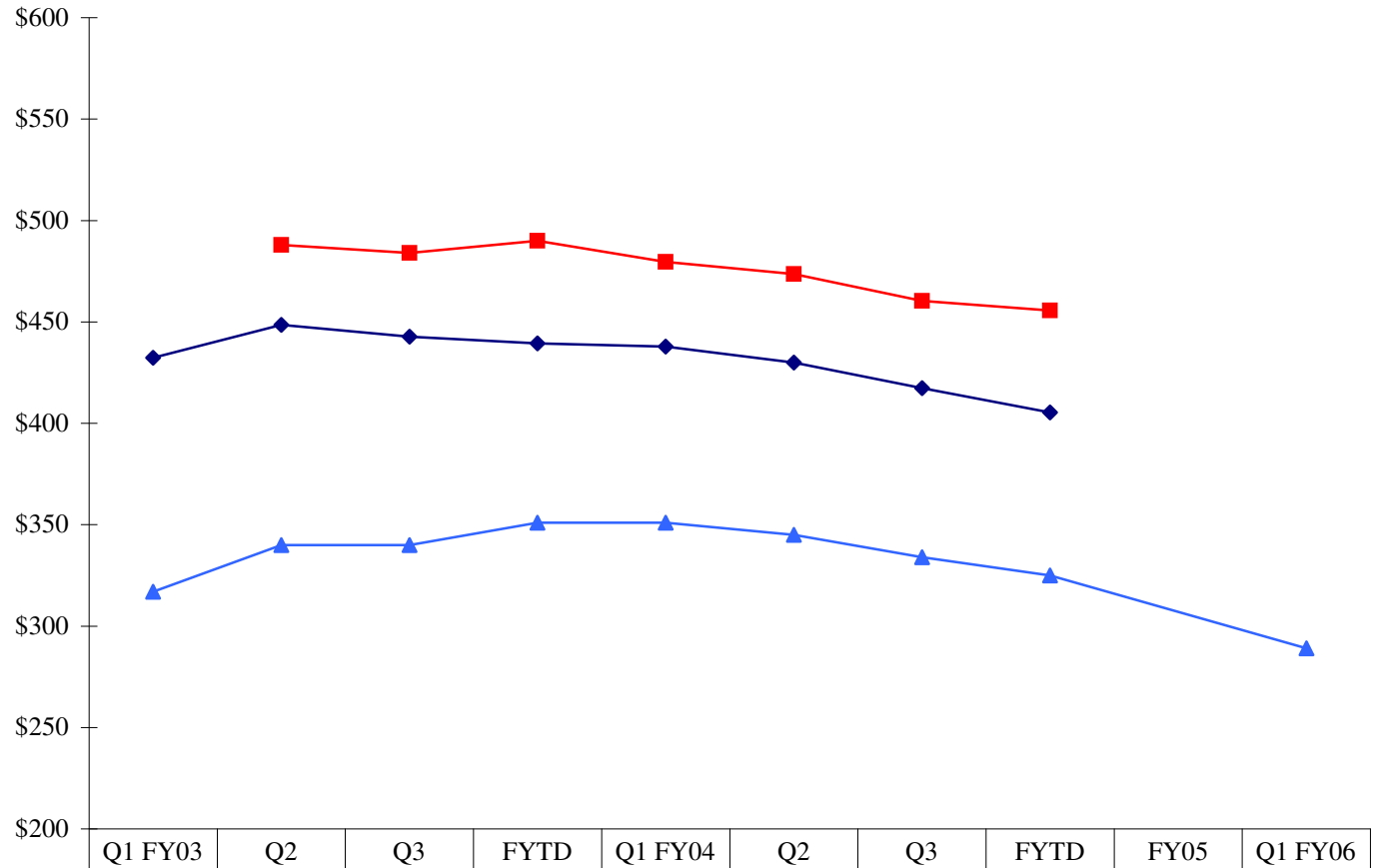


Chart: Hospital Management Data Services

Source: Financial Statistical Report - Fiscal Services;
Q1FY06 - Direct Communication from DSHS Budgeting Forecasting Dept.

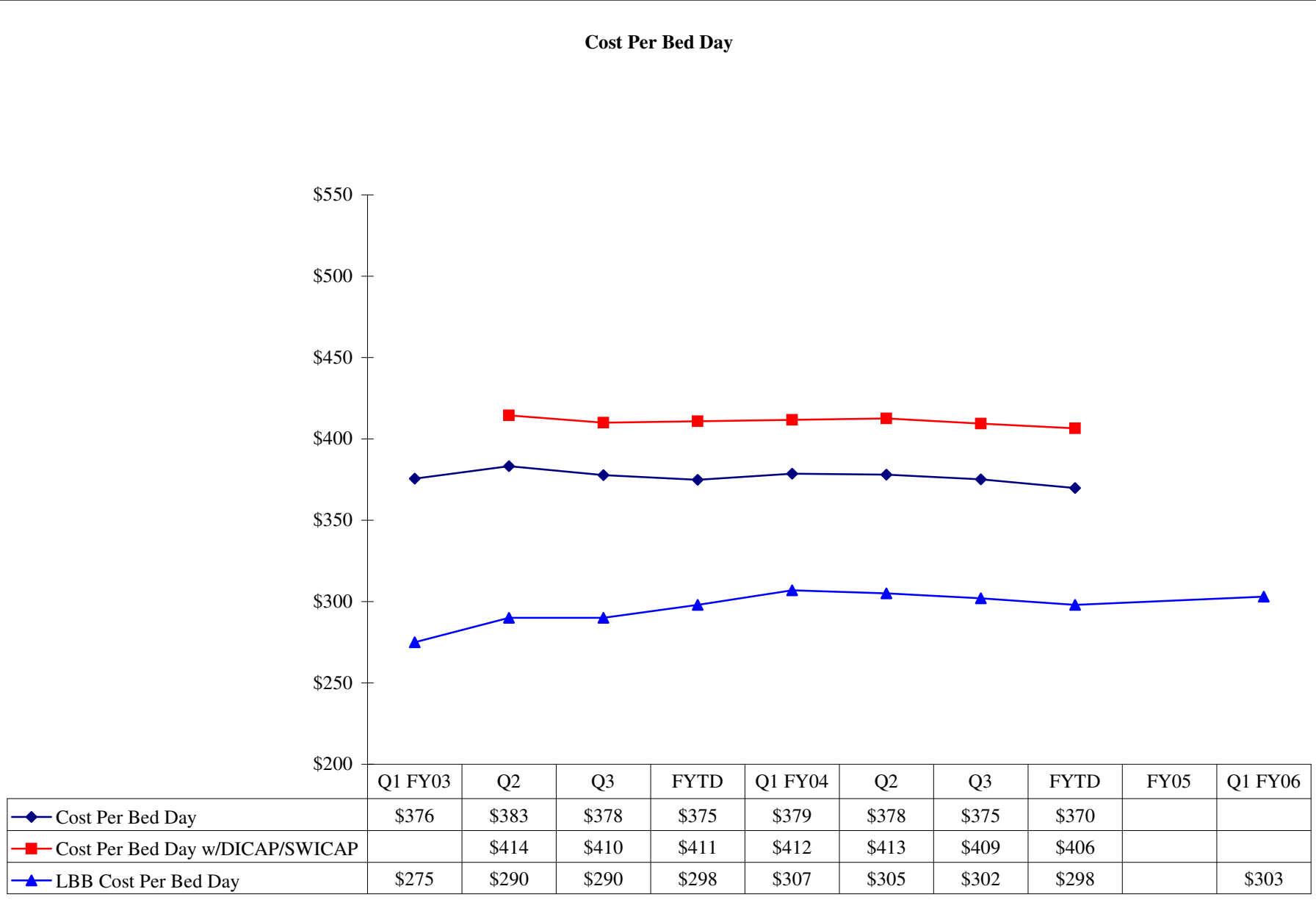
Measure 1B - Cost Per Bed Day
Kerrville State Hospital

Cost Per Bed Day

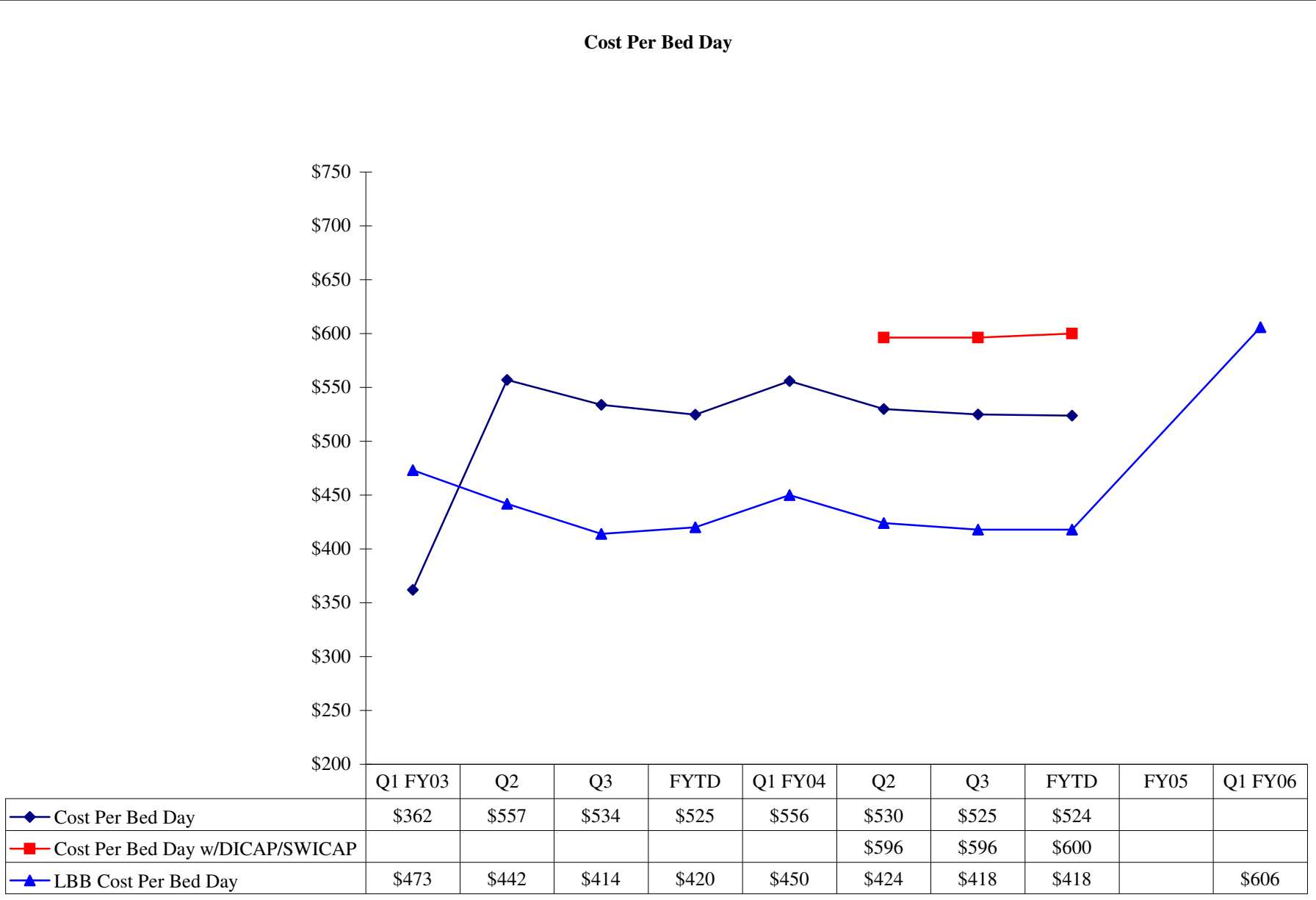


◆ Cost Per Bed Day	\$432	\$449	\$443	\$439	\$438	\$430	\$417	\$405		
■ Cost Per Bed Day w/DICAP/SWICAP		\$488	\$484	\$490	\$480	\$474	\$460	\$456		
▲ LBB Cost Per Bed Day	\$317	\$340	\$340	\$351	\$351	\$345	\$334	\$325		\$289

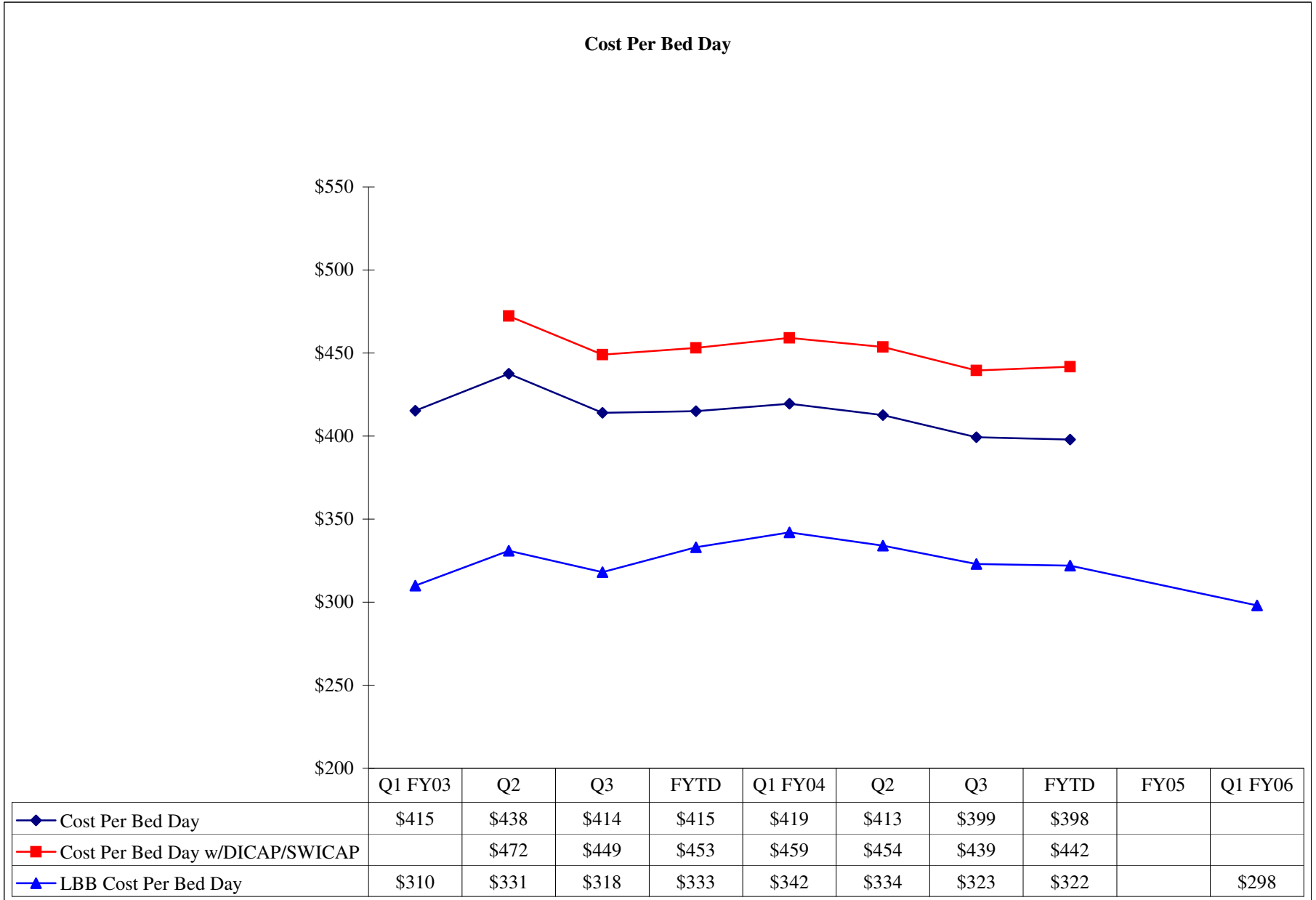
Measure 1B - Cost Per Bed Day
North Texas State Hospital



Measure 1B - Cost Per Bed Day
Rio Grande State Center (MH only)

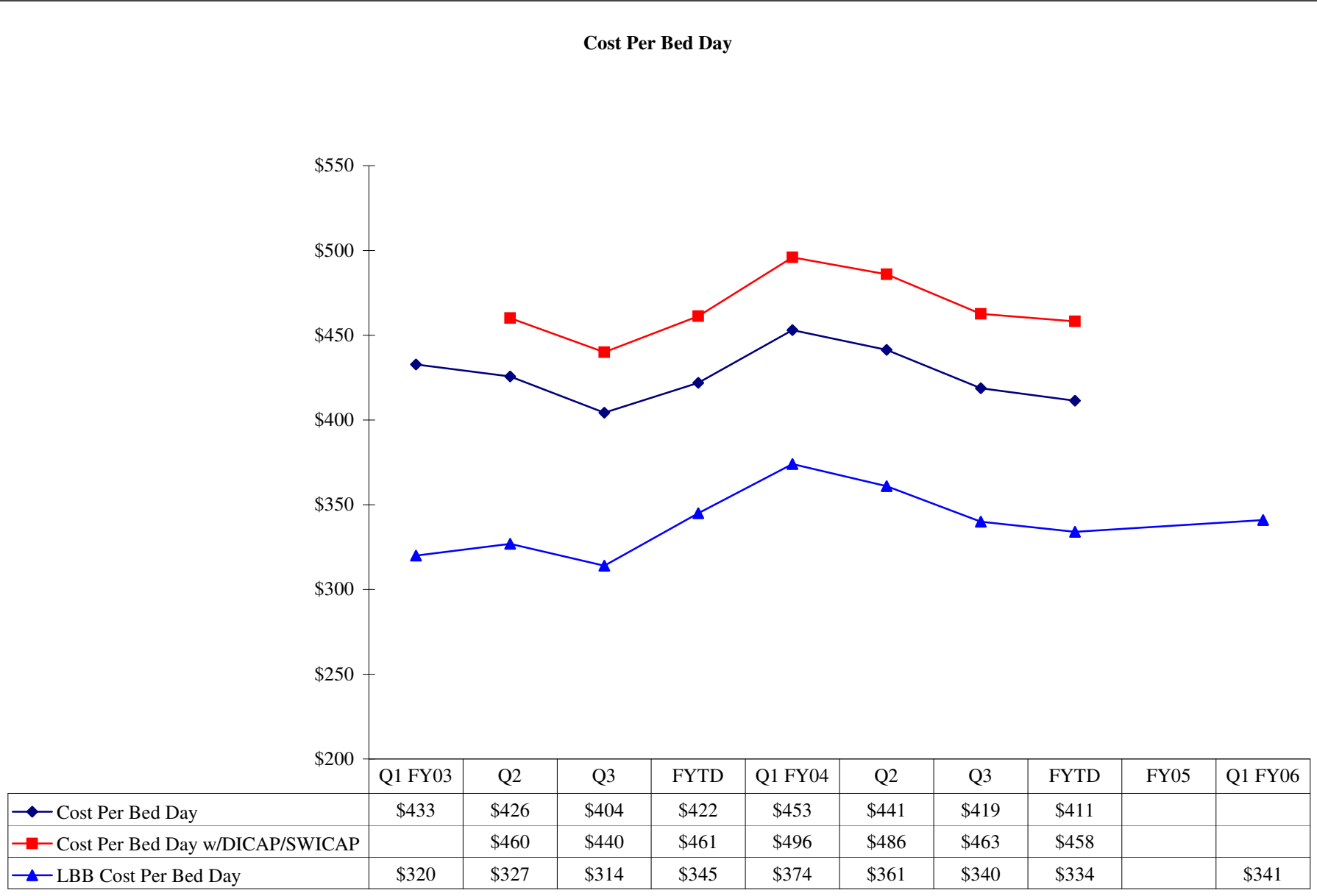


Measure 1B - Cost Per Bed Day
Rusk State Hospital

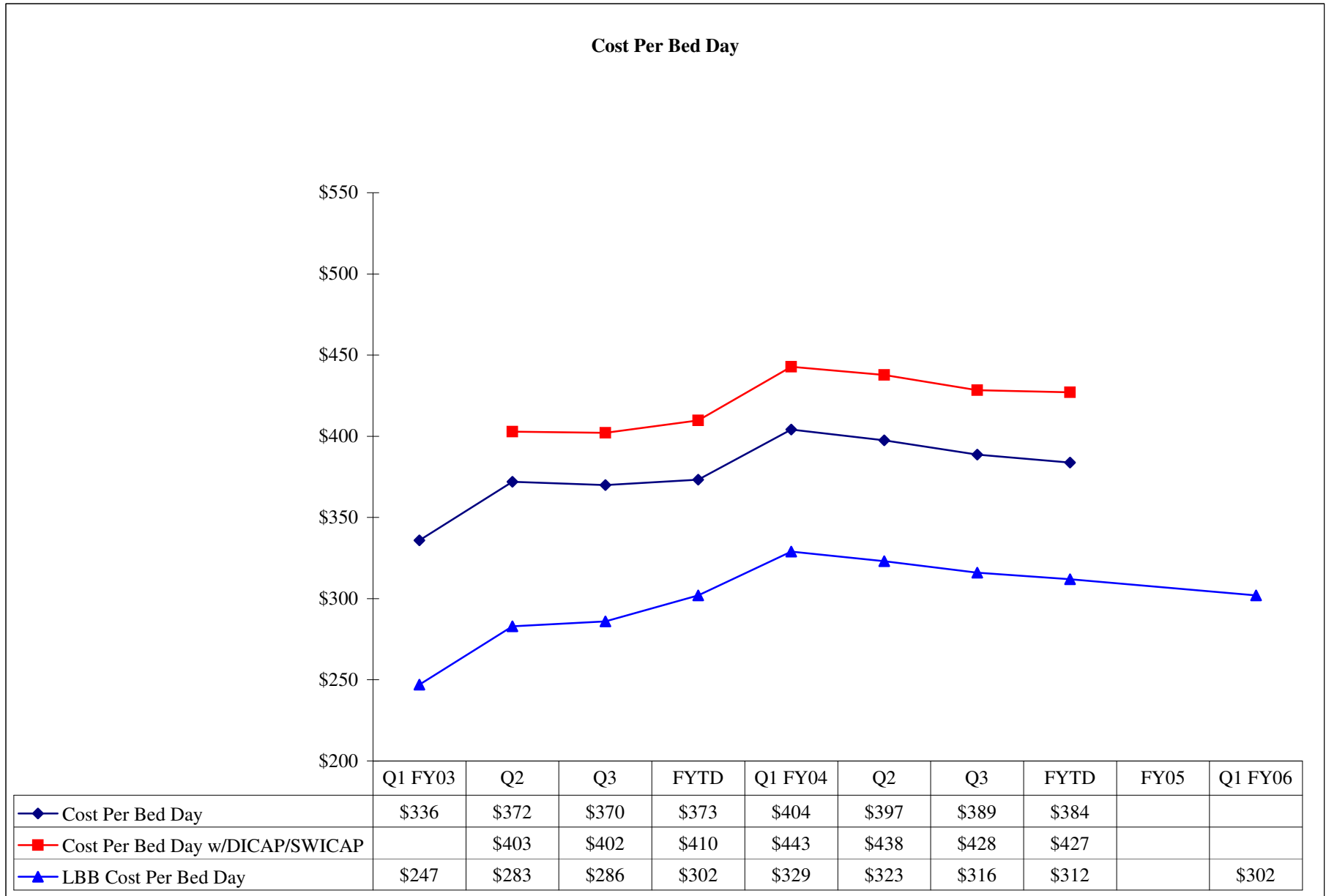


Source: Financial Statistical Report - Fiscal Services;
 Q1FY06 - Direct Communication from DSHS Budgeting Forecasting Dept.

**Measure 1B - Cost Per Bed Day
San Antonio State Hospital**

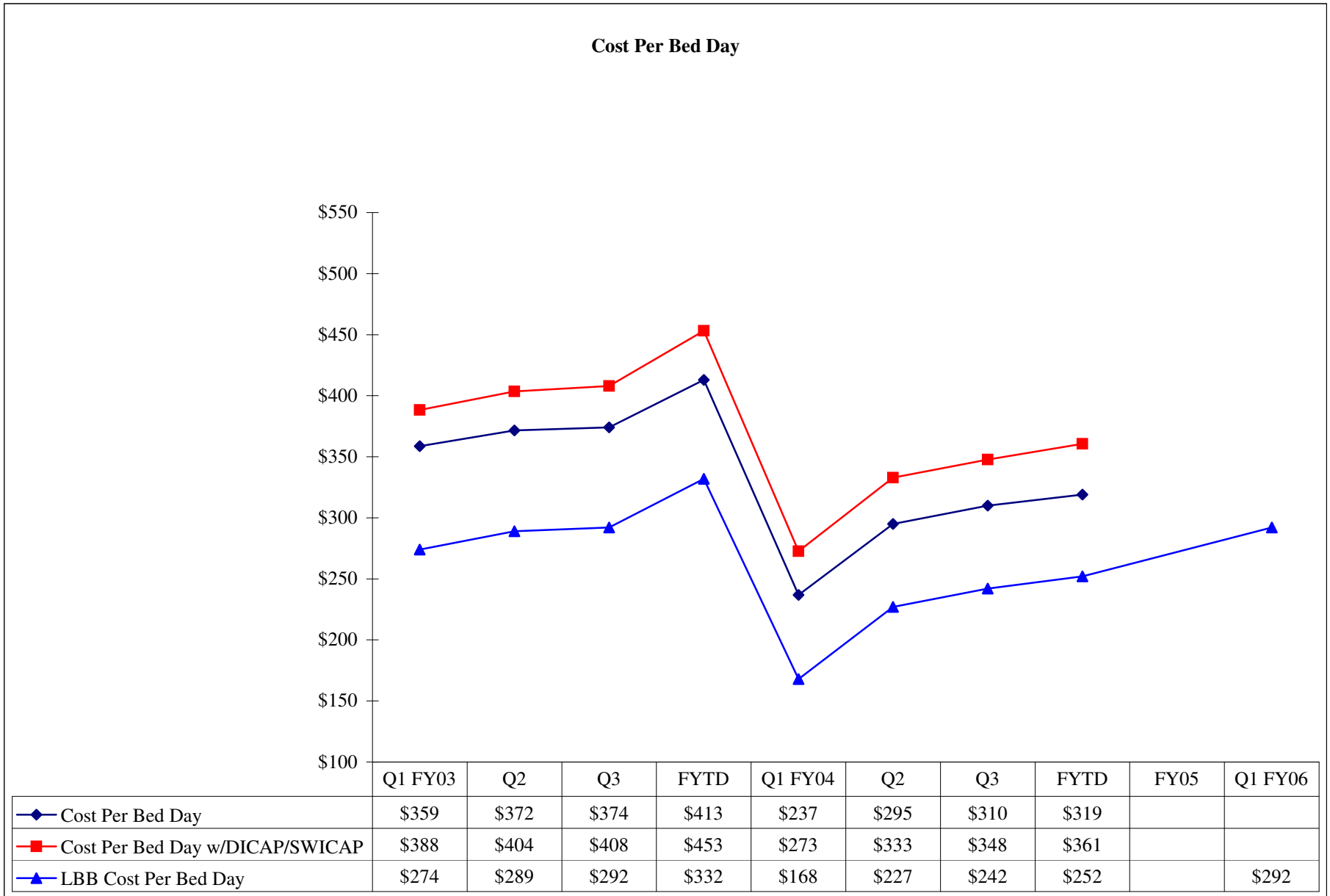


**Measure 1B - Cost Per Bed Day
Terrell State Hospital**



Source: Financial Statistical Report - Fiscal Services;
Q1FY06 - Direct Communication from DSHS Budgeting Forecasting Dept.

**Measure 1B - Cost Per Bed Day
Waco Center for Youth**



Performance Measure 1C:

Average daily census of campus-based services will be calculated and reported for each state hospital on a quarterly basis.

Performance Measure Operational Definition: The state hospital's average daily census will be reported quarterly.

Performance Measure Formula: $C = (N/D)$

C = average daily census

N = number of bed days

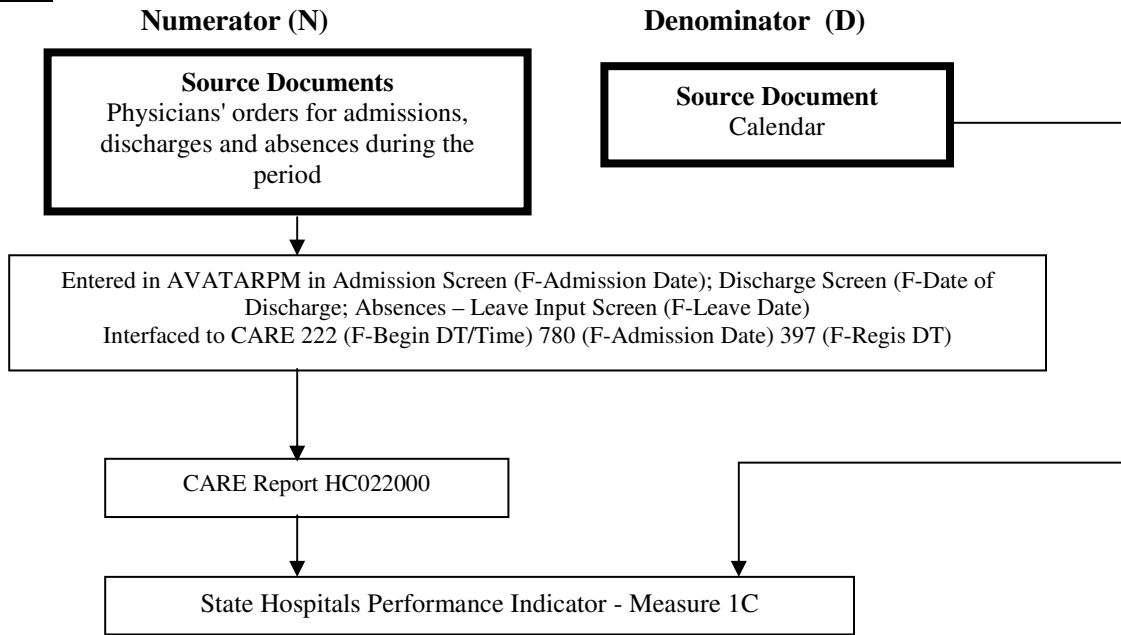
D = number of calendar days in the month

Performance Measure Data Display and Chart Description:

Chart with monthly data points of average daily census and funded census for individual state hospital and system-wide.

See Objective 1F for charts

Data Flow:



Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Note: Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record on the Physician's Order.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including findings and data analysis.

GOAL 2: Recognize and Respect the Rights of Each Patient By Conducting Business In An Ethical Manner

Performance Objective 2A:

State hospitals will demonstrate a downward trend of confirmed abuse or neglect.

Performance Objective Operational Definition: The state hospital rate of confirmed closed abuse and neglect cases as documented on the AN-1-A form per 1,000 bed days per FY.

Performance Objective Formula: $R = (N/D) \times 1,000$

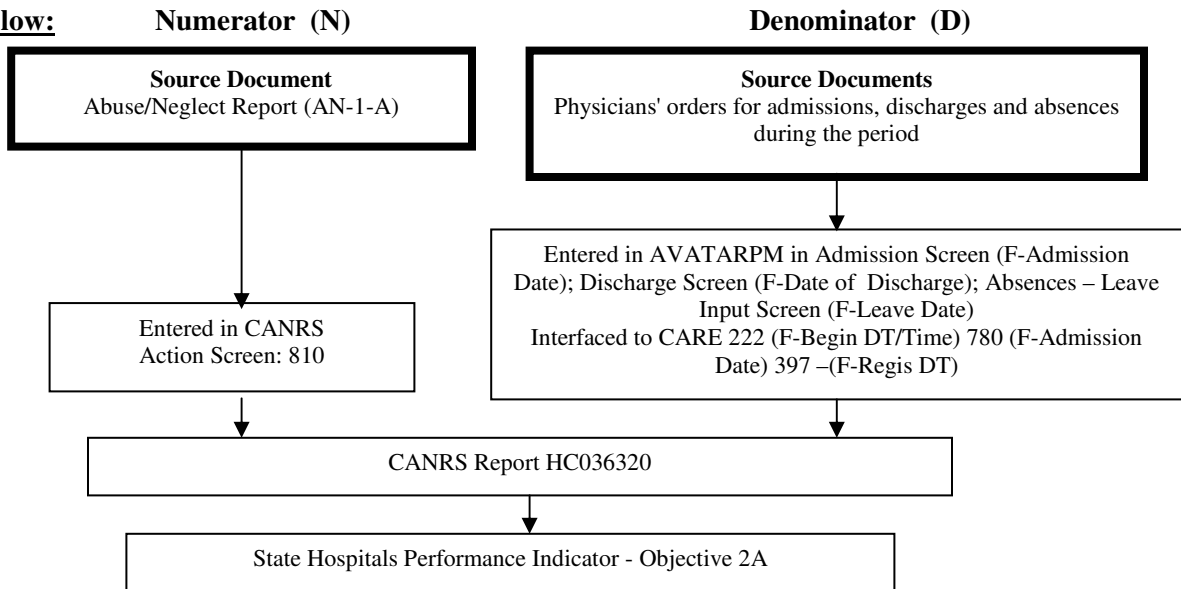
R = rate of confirmed closed abuse and neglect cases per 1,000 bed days per FY

N = number of confirmed closed cases per FY (when multiple confirmations are entered for a single case number on a single day, they are counted only as one in the abuse/neglect category incident (class I, II, verbal) of the most severe incident). D = number of bed days per FY, 1,000 = bed day rate multiplier.

Performance Objective Data Display and Chart Description:

Table shows cases, confirmations and rate by abuse/neglect category for individual state hospital.

Data Flow:



Data Integrity Review Process: (Denominator only)

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Note: Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record on the Physician's Order.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including findings and data analysis.

Objective 2A - Abuse/Neglect Rate

All MH Facilities - As of November 30, 2005

Facility	FY00	FY01	FY02	FY03	FY04	FY05	FY06-FYTD				
	Total	Total	Total	Total	Total	Total	Class I	Class II	Class III	Neglect	Total
ALL MH Facilities											
Total Cases	2419	2260	2387	2188	1476	1536	25	168	61	34	288
Total Confirmed	220	211	193	175	76	117	0	3	0	0	3
Total Confirmed Rate/1000 Bed Days	0.22	0.24	0.23	0.21	0.09	0.13	0	0.01	0	0	0.01

Performance Objective 2B:

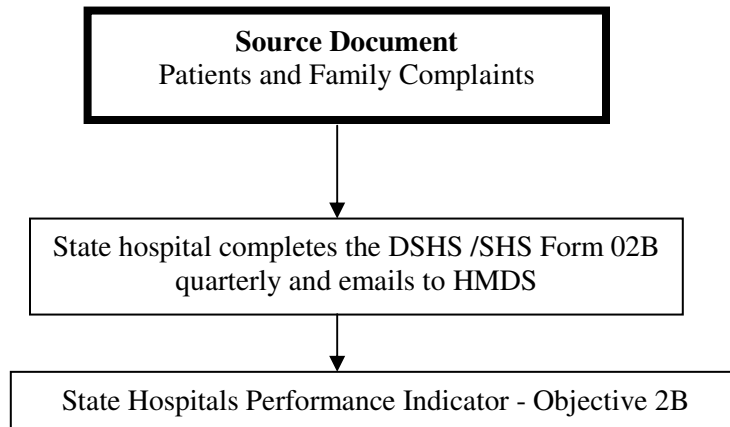
State hospital Client Rights Officers will develop a process for identifying complaints and classify these complaints according to established categories.

Performance Objective Operational Definition: Total number of complaints from state hospitals per monthly regarding property, respect, discharge, medication, treatment team and/or plan and an “other” category will be tracked and analyzed.

Performance Objective Data Display and Chart Description:

Table shows quarterly numbers of complaints by the individual state hospitals and system-wide.

Data Flow:



Data Integrity Review Process:

N/A

**Objective 2B - Patient Complaints
Q1 FY06**

Q1 - FY06

Complaints	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY	System Total
Property	20	24	10	11	54	2	8	14	18	4	165
Per 1,000 Bed Days	0.75	1.51	2.09	0.58	0.94	0.48	0.32	0.54	0.69	0.59	0.78
Respect	15	17	8	7	27	2	20	30	71	8	205
Per 1,000 Bed Days	0.56	1.07	1.67	0.37	0.47	0.48	0.79	1.17	2.73	1.18	0.97
Discharge	13	24	8	2	57	3	3	7	2	0	119
Per 1,000 Bed Days	0.49	1.51	1.67	0.11	1.00	0.72	0.12	0.27	0.08	0.00	0.56
Medication	12	16	4	4	42	2	17	11	9	0	117
Per 1,000 Bed Days	0.45	1.01	0.84	0.21	0.73	0.48	0.67	0.43	0.35	0.00	0.55
Treatment Team/Planning	16	48	8	30	12	0	17	4	24	20	179
Per 1,000 Bed Days	0.60	3.02	1.67	1.59	0.21	0.00	0.67	0.16	0.92	2.95	0.85
Others	43	8	18	30	478	4	41	115	90	15	842
Per 1,000 Bed Days	1.61	0.50	3.77	1.59	8.36	0.96	1.63	4.47	3.46	2.21	3.98
Total	119	137	56	84	670	13	106	181	214	47	1627
Per 1,000 Bed Days	4.44	8.61	11.72	4.45	11.71	3.13	4.21	7.04	8.23	6.93	7.70

GOAL 3: Provide Individualized and Evidence Based Treatment

Performance Objective 3B:

State hospitals will continue to implement plans to reduce the use of behavioral restraint and seclusion based on FY05 performance. Current plans or recommendations from the Restraint and Seclusion Reduction Workgroup will be implemented. Interventions to be monitored are: Personal Restraint, Mechanical Restraint and Seclusion.

Performance Objective Operational Definition: The number of restraint and seclusion incidents as documented on the MHRS 7-4 (or approved substitute) per 1,000 bed days.

Performance Objective Formula: $R = (N/D) \times 1,000$

R = rate of restraint and seclusion incidents per 1,000 bed days per FY quarter

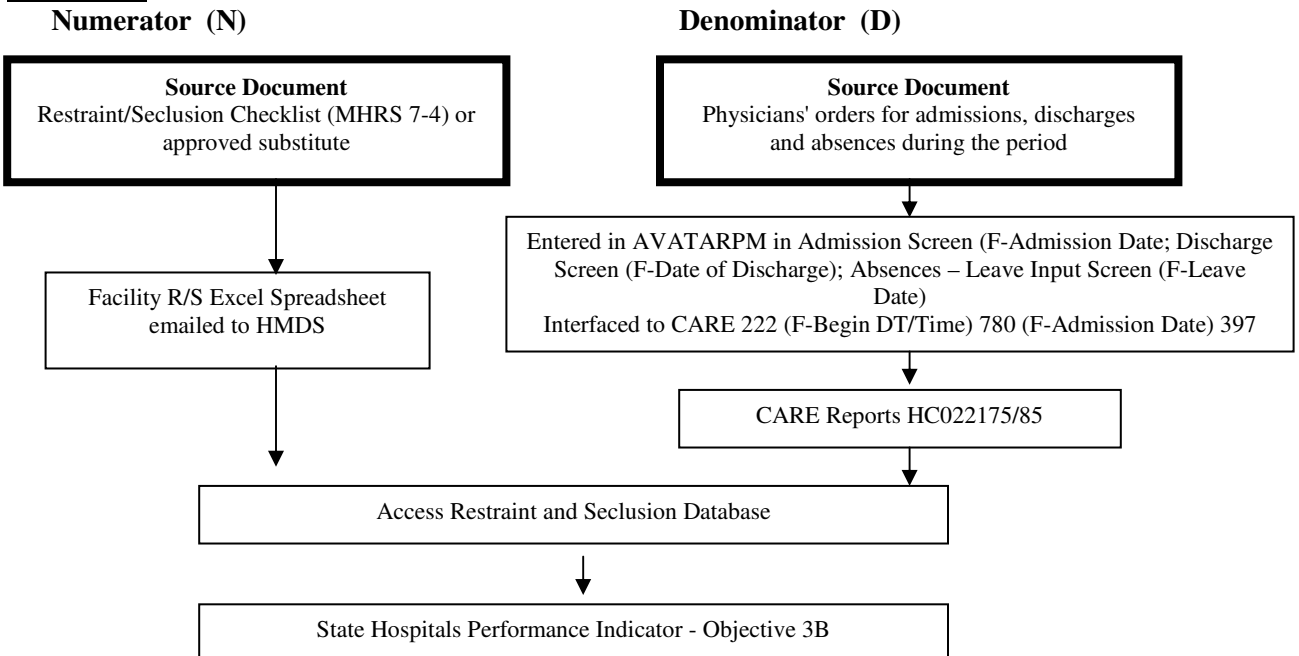
N = number of restraint and seclusion incidents or number of persons involved in restraint/seclusion

D = number of bed days per FY quarter 1,000 = bed day rate multiplier

Performance Objective Data Display and Chart Description:

- ◆ Table shows quarterly numbers of incidents, numbers of persons, and total hours for restraints and seclusions involving children, adolescents and adults for individual state hospitals and system-wide. Also shows child/adolescent bed days and all other units bed days for the quarter for individual state hospitals and system-wide.
- ◆ Table shows quarterly numbers of restraints by type for individual state hospitals and system-wide and table shows quarterly numbers of restraints by type per 1,000 bed days for individual state hospitals and system-wide.
- ◆ Chart with quarterly data points of restraint and seclusion incidents per 1,000 bed days for child/adolescent and adults for individual state hospitals and system-wide.
- ◆ Chart with quarterly data points of average number of hours per restraint/seclusion incident for child/adolescent and adults for individual state hospitals and system-wide.
- ◆ Chart with quarterly data points of number of persons in restraint/seclusion for 1,000 bed days for child/adolescent and adults for individual state hospitals and system-wide.

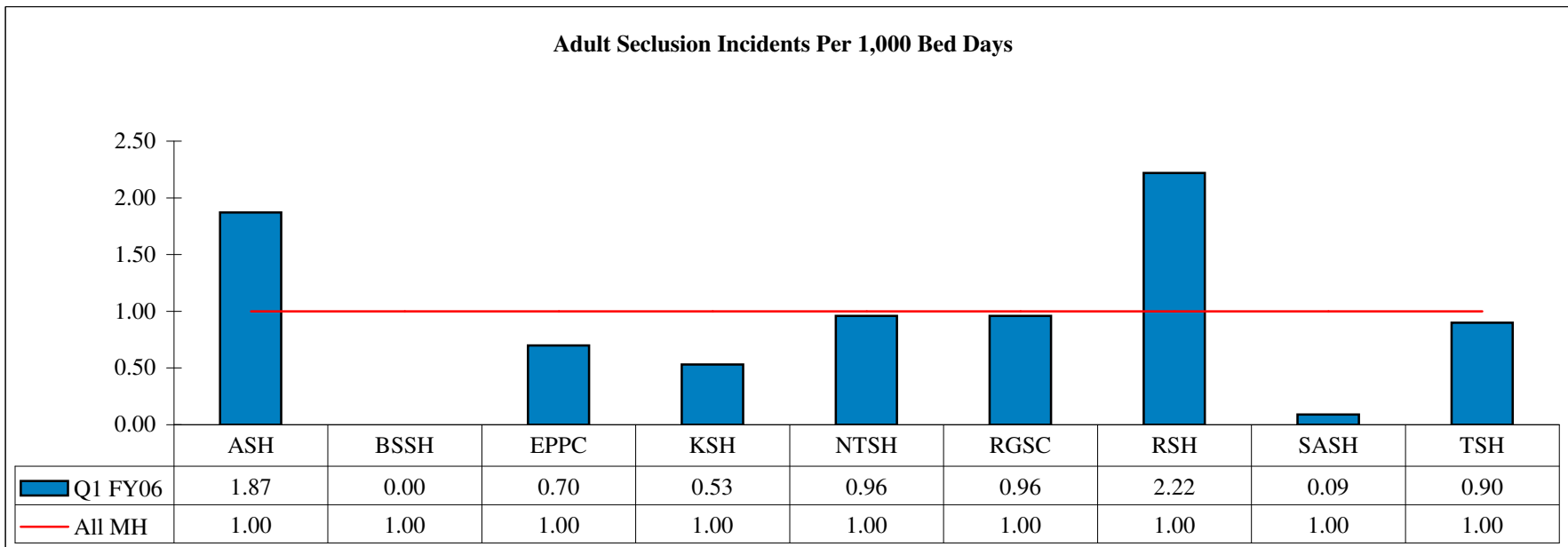
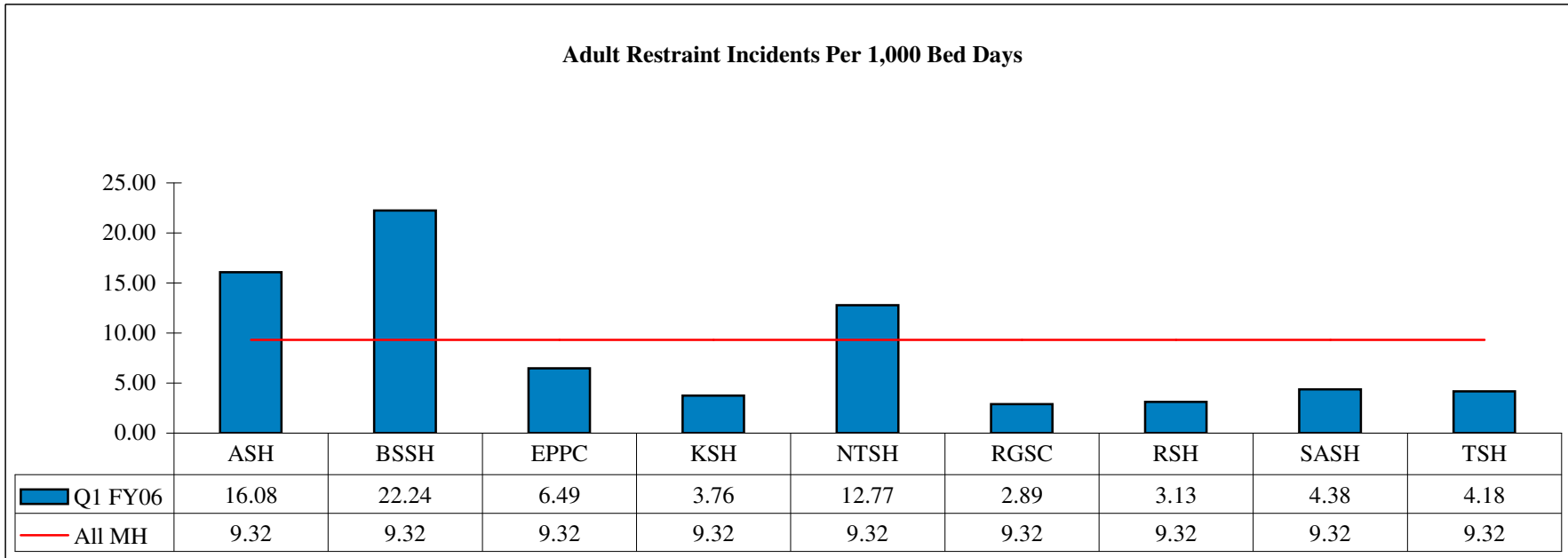
Data Flow:



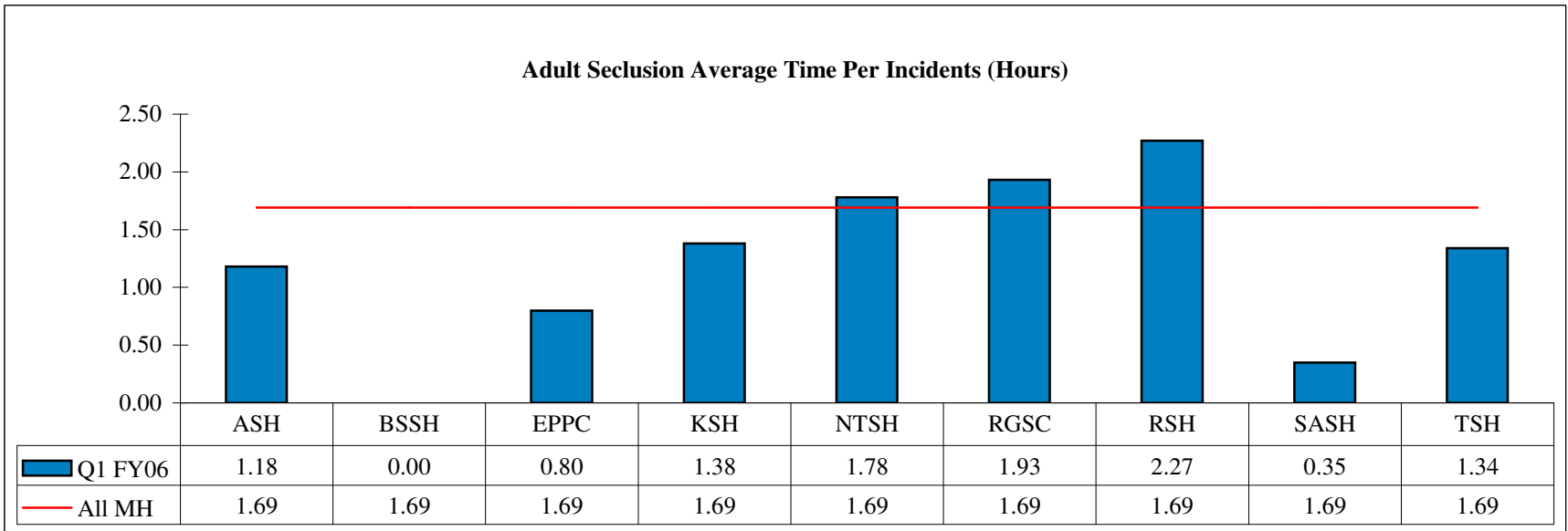
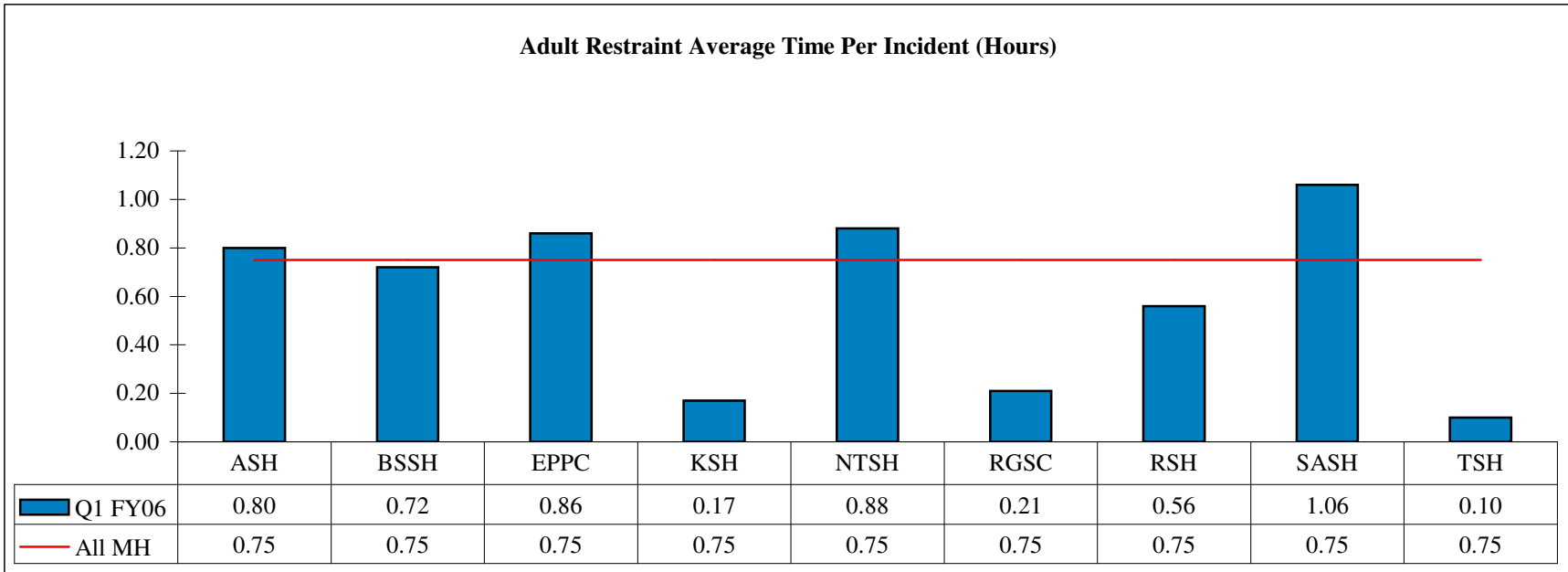
Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files, leave event start/stop dates and the restraint/seclusion event start/stop date/time in the NRI event files as compared to the corresponding information in the medical record.
Sample Size	Use 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and to review only the associated restraint and seclusion events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including percentage accuracy rates, findings and data analysis.

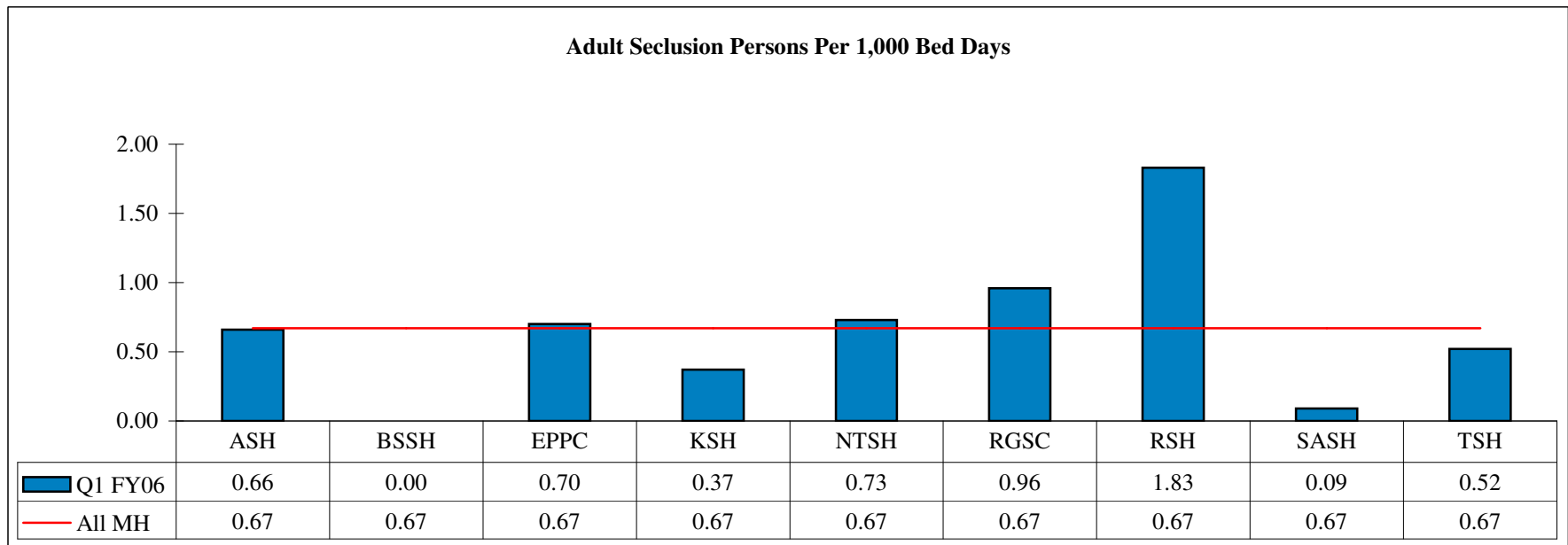
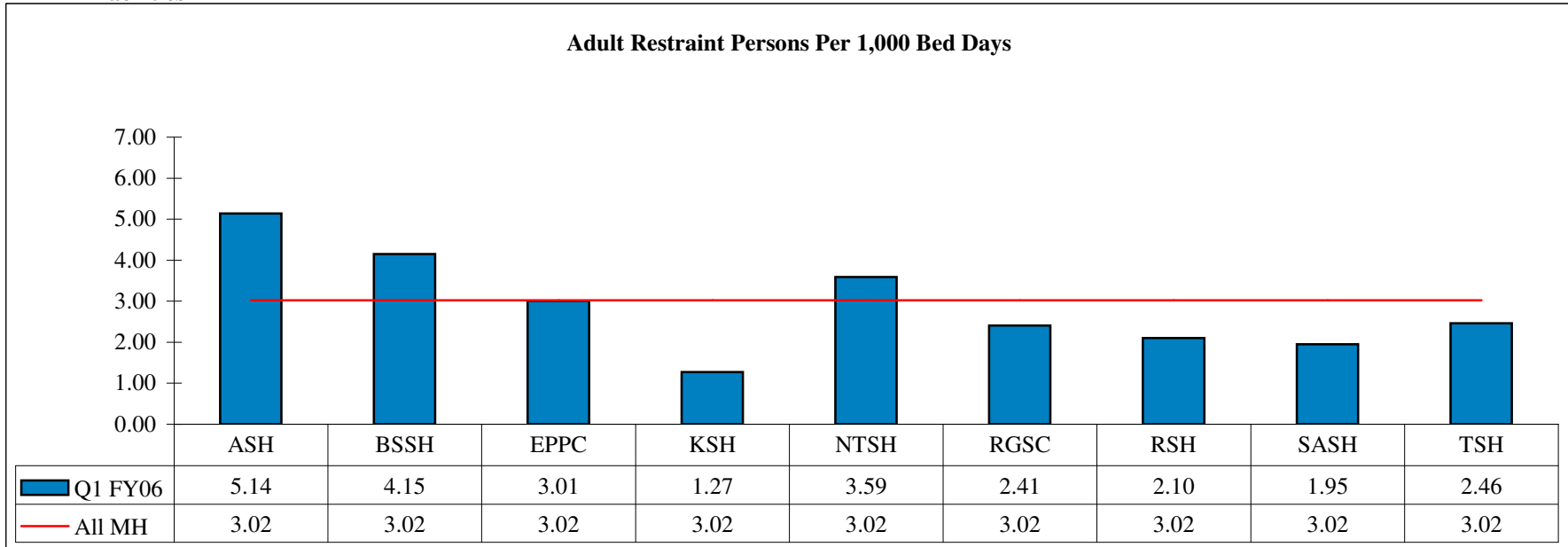
Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities



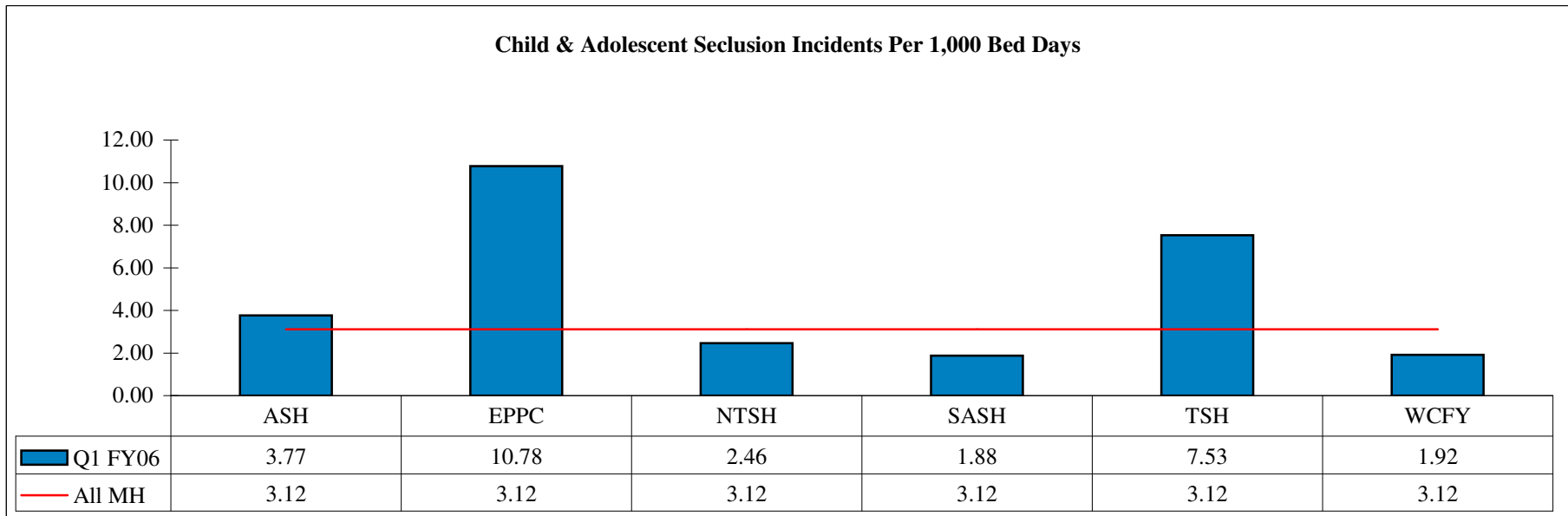
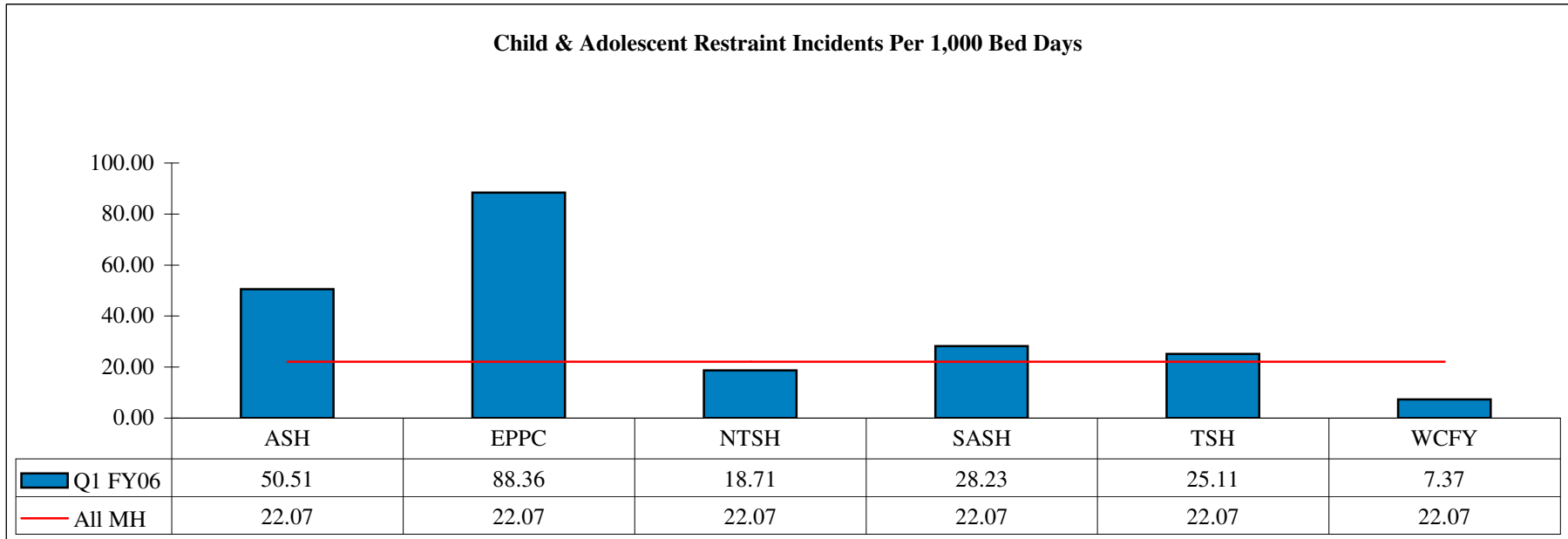
Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities



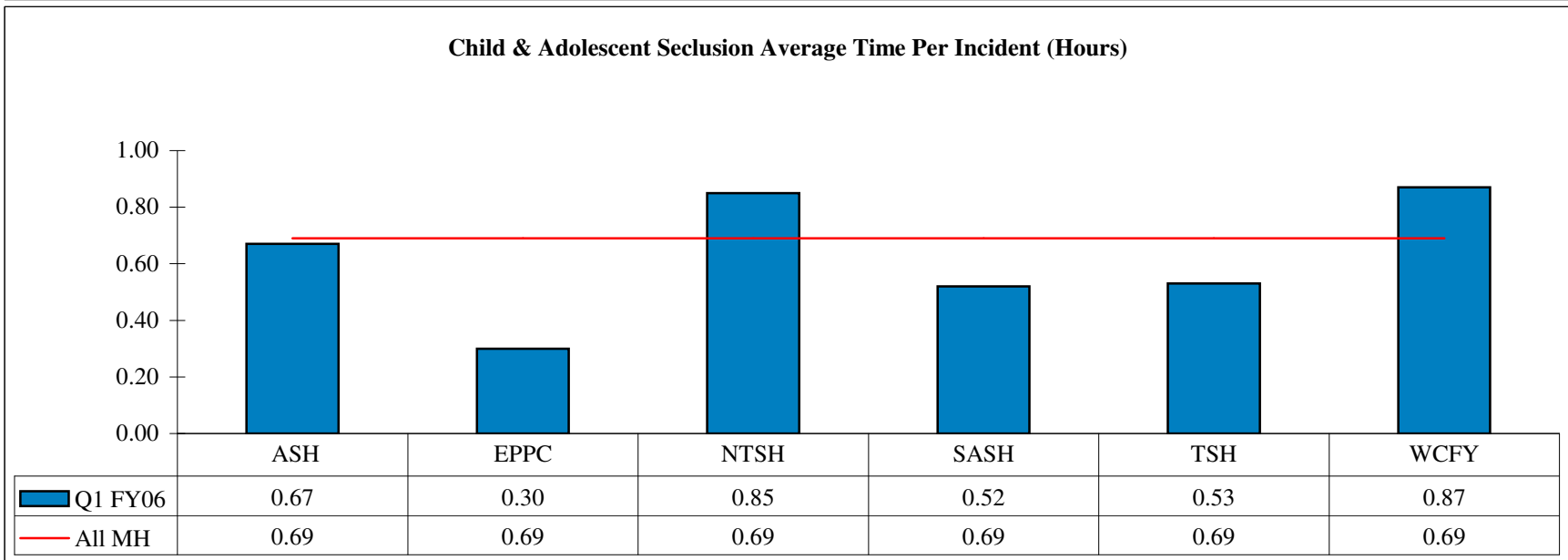
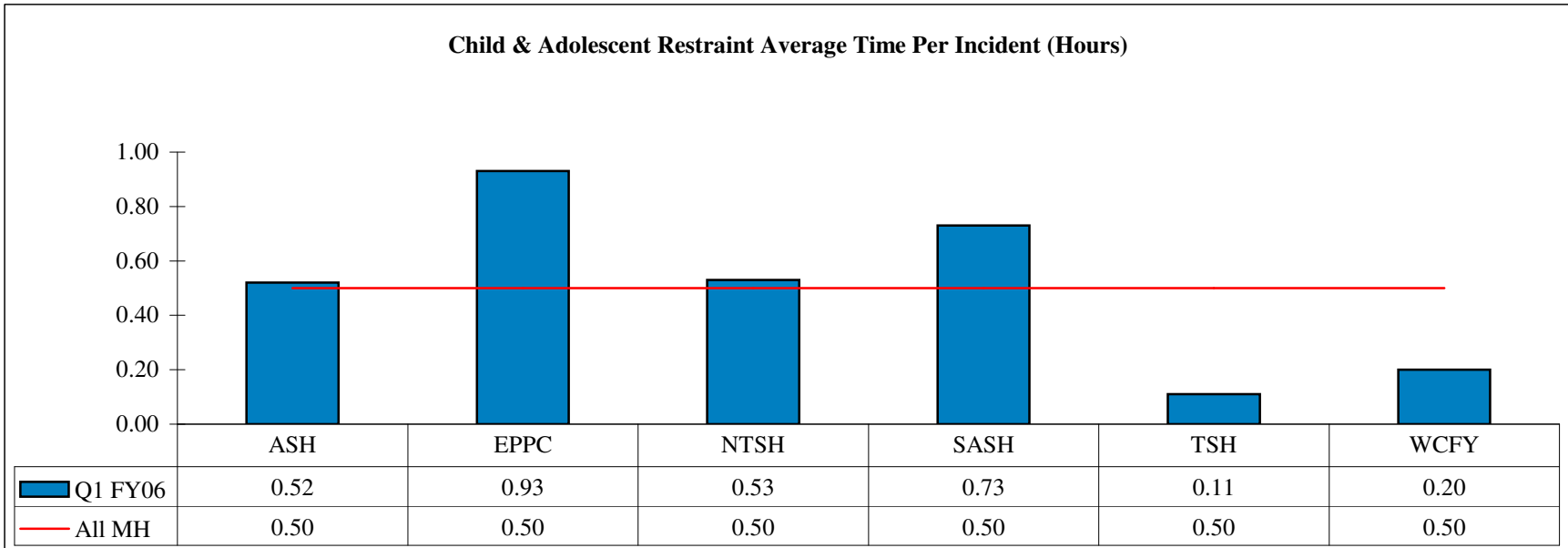
Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities



Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

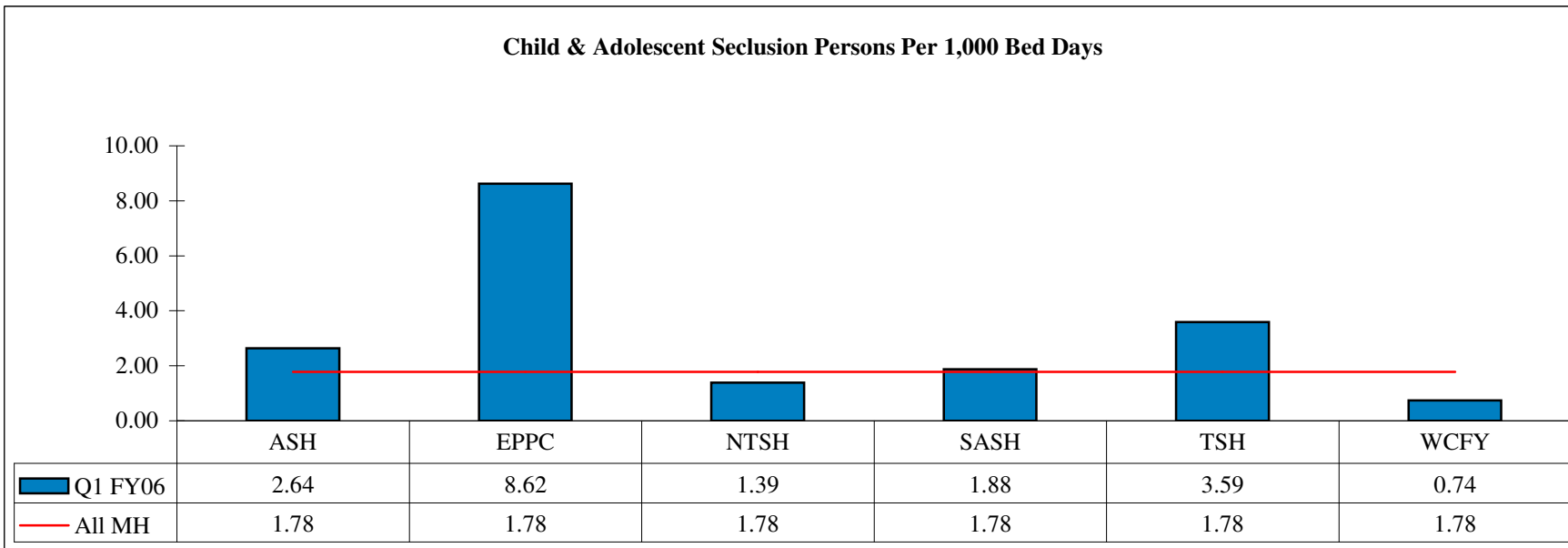
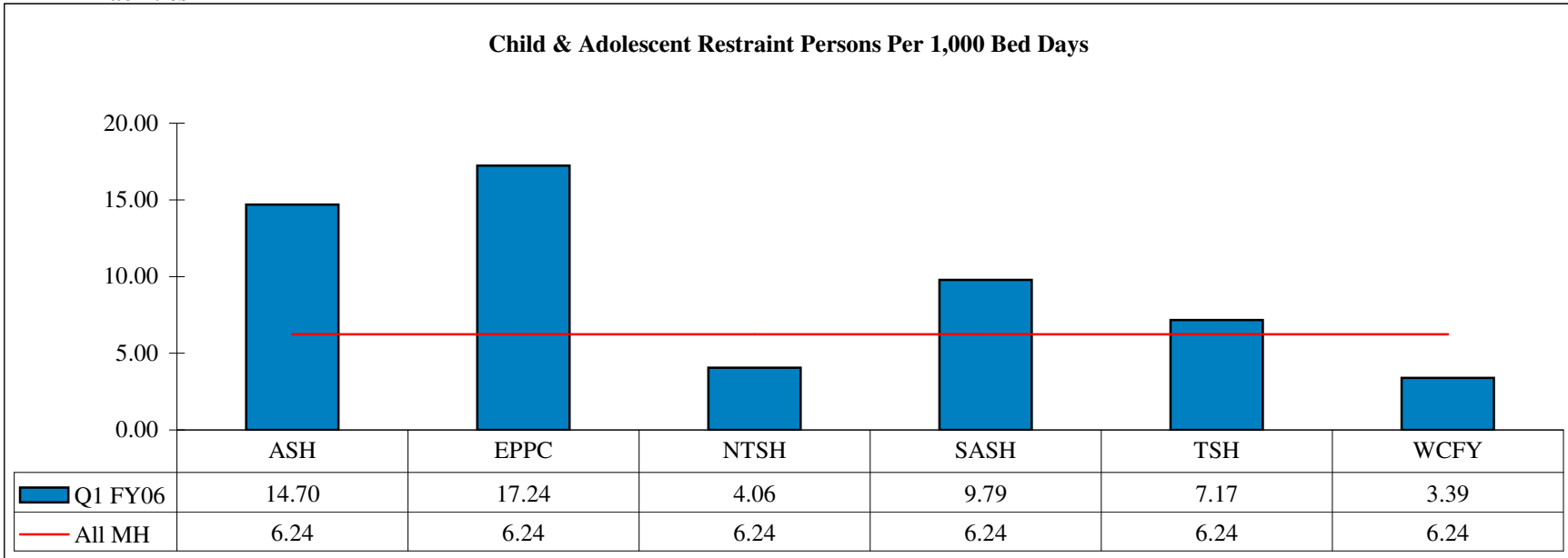


Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities



Objective 3B - Maintain Restraint and Seclusion Data

All MH Facilities



Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

	Fiscal Year 2006											
	Number of Incidents				Number of Persons				Total Hours for Quarter			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Austin State Hospital												
Child/Adolescent Bed Days	2,653				2,653				2,653			
Bed Days in Quarter-All Other Units	24,128				24,128				24,128			
Restraint Involving Children	14				5				2.8			
Restraint Involving Adolescents	120				34				66.9			
Restraint Involving Adults	388				124				312.3			
Seclusion Involving Children	1				1				0.3			
Seclusion Involving Adolescents	9				6				6.4			
Seclusion Involving Adults	45				16				53.2			
Big Spring State Hospital												
Child/Adolescent Bed Days	0				0				0			
Bed Days in Quarter	15,916				15,916				15,916			
Restraint Involving Adolescents												
Restraint Involving Adults	354				66				256.2			
Seclusion Involving Adolescents	0				0				0.0			
Seclusion Involving Adults	0				0				0.0			
El Paso Psychiatric Center												
Child/Adolescent Bed Days	464				464				464			
Bed Days in Quarter-All Other Units	4,315				4,315				4,315			
Restraint Involving Children	5				1				4.6			
Restraint Involving Adolescents	36				7				33.6			
Restraint Involving Adults	28				13				24.0			
Seclusion Involving Children	1				1				0.8			
Seclusion Involving Adolescents	4				3				0.7			
Seclusion Involving Adults	3				3				2.4			
Kerrville State Hospital												
Bed Days in Quarter	18,872				18,872				18,872			
Restraint Involving Adults	71				24				12.1			
Seclusion Involving Adults	10				7				13.8			

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
Access Database

**Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities**

Fiscal Year 2006

	Number of Incidents				Number of Persons				Total Hours for Quarter			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
North Texas State Hospital												
Child/Adolescent Bed Days	9,352				9,352				9,352			
Bed Days in Quarter-All Other Units	47,851				47,851				47,851			
Restraint Involving Children	1				1				0.0			
Restraint Involving Adolescents	174				37				93.1			
Restraint Involving Adults	611				172				539.6			
Seclusion Involving Children	1				1				1.0			
Seclusion Involving Adolescents	22				12				18.5			
Seclusion Involving Adults	46				35				82.1			
Rio Grande State Center												
Child/Adolescent Bed Days in Quarter	0				0				0			
Bed Days in Quarter	4,153				4,153				4,153			
Restraint Involving Adolescents	0				0				0.0			
Restraint Involving Adults	12				10				2.5			
Seclusion Involving Adolescents	0				0				0.0			
Seclusion Involving Adults	4				4				7.7			
Rusk State Hospital												
Bed Days in Quarter	25,203				25,203				25,203			
Restraint Involving Adults	79				53				44.4			
Seclusion Involving Adults	56				46				127.1			
San Antonio State Hospital												
Child/Adolescent Bed Days in Quarter	2,657				2,657				2,657			
Bed Days in Quarter-All Other Units	23,067				23,067				23,067			
Restraint Involving Adolescents	75				26				54.7			
Restraint Involving Adults	101				45				106.7			
Seclusion Involving Adolescents	5				5				2.6			
Seclusion Involving Adults	2				2				0.7			

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
Access Database

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

Fiscal Year 2006

	Number of Incidents				Number of Persons				Total Hours for Quarter			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Terrell State Hospital												
Child/Adolescent Bed Days in Quarter	2,788				2,788				2,788			
Bed Days in Quarter-All Other Units	23,208				23,208				23,208			
Restraint Involving Children	4				1				0.4			
Restraint Involving Adolescents	66				19				7.2			
Restraint Involving Adults	97				57				10.6			
Seclusion Involving Children	0				0				0.0			
Seclusion Involving Adolescents	21				10				11.2			
Seclusion Involving Adults	21				12				28.1			
Waco Center For Youth												
Child/Adolescent Bed Days in Quarter	6,785				6,785				6,785			
Restraint Involving Adolescents	50				23				10.0			
Seclusion Involving Adolescents	13				5				11.3			
All MH Facilities												
Child/Adolescent Bed Days	24,699				24,699				24,699			
Bed Days in Quarter-All Other Units	186,713				186,713				186,713			
Restraint Involving Children	24				8				7.8			
Restraint Involving Adolescents	521				146				265.5			
Restraint Involving Adults	1,741				564				1,308.4			
Seclusion Involving Children	3				3				2.1			
Seclusion Involving Adolescents	74				41				50.7			
Seclusion Involving Adults	187				125				315.1			

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
Access Database

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

Fiscal Year 2006

	Number of Incidents				Number of Persons			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Austin State Hospital								
< 5 Restraint Involving Children	1				1			
< 5 Restraint Involving Adolescents	14				11			
< 5 Restraint Involving Adults	119				46			
Big Spring State Hospital								
< 5 Restraint Involving Adults	37				20			
El Paso Psychiatric Center								
< 5 Restraint Involving Children	0				0			
< 5 Restraint Involving Adolescents	0				0			
< 5 Restraint Involving Adults	2				2			
Kerrville State Hospital								
< 5 Restraint Involving Adults	45				19			
North Texas State Hospital								
< 5 Restraint Involving Children	1				1			
< 5 Restraint Involving Adolescents	12				10			
< 5 Restraint Involving Adults	296				132			
Rio Grande State Center								
< 5 Restraint Involving Adults	2				2			
Rusk State Hospital								
< 5 Restraint Involving Adults	37				29			
San Antonio State Hospital								
< 5 Restraint Involving Adolescents	5				4			
< 5 Restraint Involving Adults	15				13			
Terrell State Hospital								
< 5 Restraint Involving Children	2				1			
< 5 Restraint Involving Adolescents	35				13			
< 5 Restraint Involving Adults	70				41			
Waco Center For Youth								
< 5 Restraint Involving Adolescents	13				8			
All MH Facilities								
< 5 Restraint Involving Children	4				3			
< 5 Restraint Involving Adolescents	79				46			
< 5 Restraint Involving Adults	623				304			

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

Fiscal Year 2006

	Number of Incidents				FY Total
	Q1	Q2	Q3	Q4	
Austin State Hospital					
Personal Restraint	227				227
Mechanical Restraint	295				295
Seclusion	55				55
Big Spring State Hospital					
Personal Restraint	200				200
Mechanical Restraint	154				154
Seclusion	0				0
El Paso Psychiatric Center					
Personal Restraint	12				12
Mechanical Restraint	57				57
Seclusion	8				8
Kerrville State Hospital					
Personal Restraint	63				63
Mechanical Restraint	8				8
Seclusion	10				10
North Texas State Hospital					
Personal Restraint	541				541
Mechanical Restraint	245				245
Seclusion	69				69
Rio Grande State Center					
Personal Restraint	12				12
Mechanical Restraint	0				0
Seclusion	4				4
Rusk State Hospital					
Personal Restraint	61				61
Mechanical Restraint	18				18
Seclusion	57				57
San Antonio State Hospital					
Personal Restraint	80				80
Mechanical Restraint	96				96
Seclusion	7				7

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

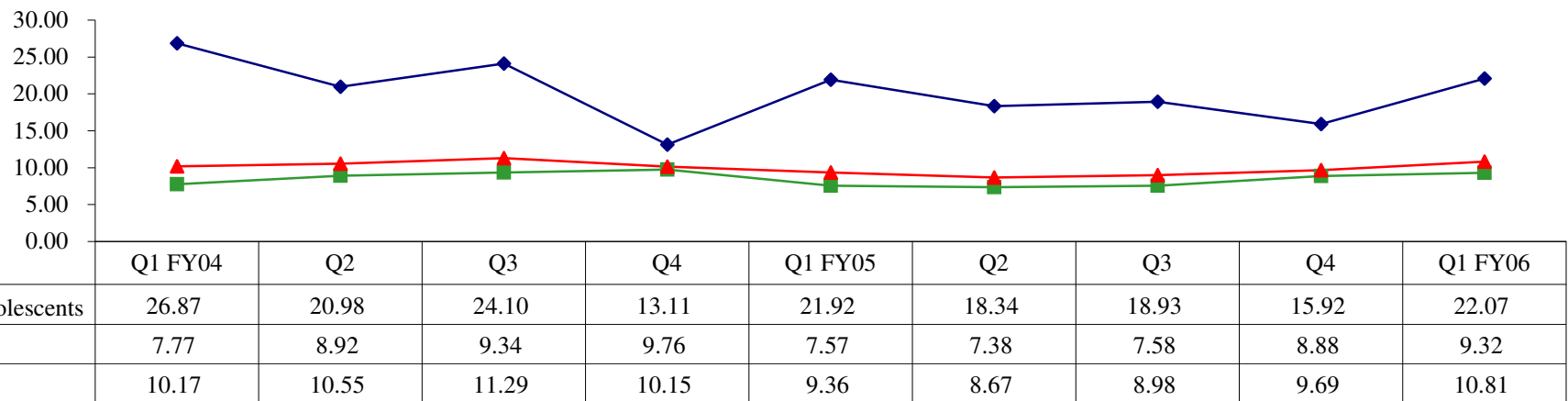
Fiscal Year 2006

	Number of Incidents				FY Total
	Q1	Q2	Q3	Q4	
Terrell State Hospital					
Personal Restraint	164				164
Mechanical Restraint	3				3
Seclusion	42				42
Waco Center For Youth					
Personal Restraint	44				44
Mechanical Restraint	6				6
Seclusion	13				13
All MH Facilities					
Personal Restraint	1,404				1,404
Mechanical Restraint	882				882
Seclusion	265				265

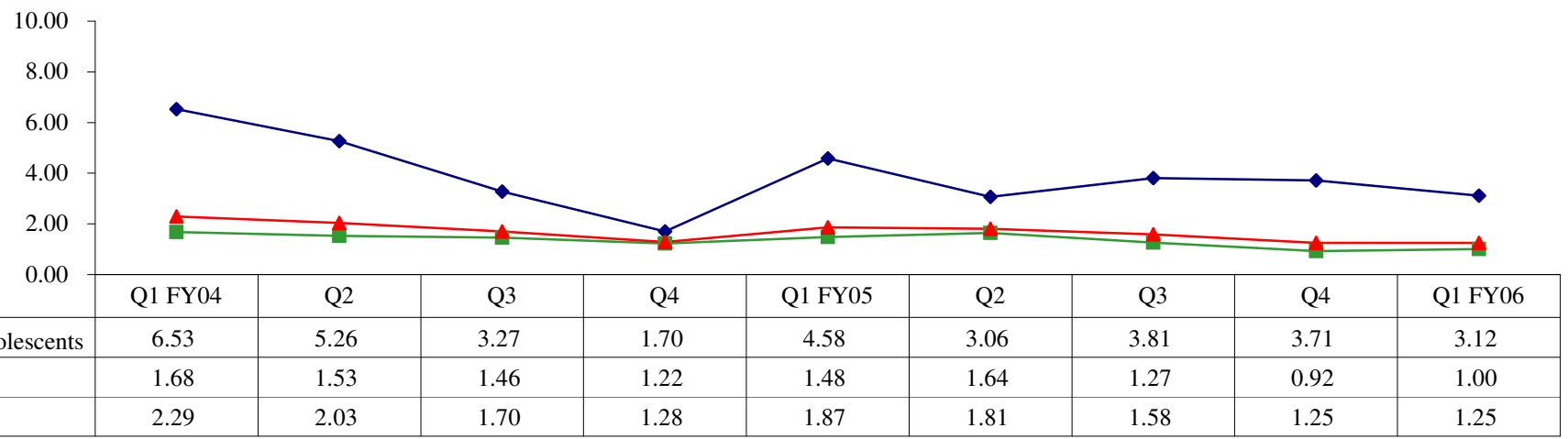
Objective 3B - Maintain Restraint and Seclusion Data

All MH Facilities

Restraint Incidents Per 1,000 Bed Days

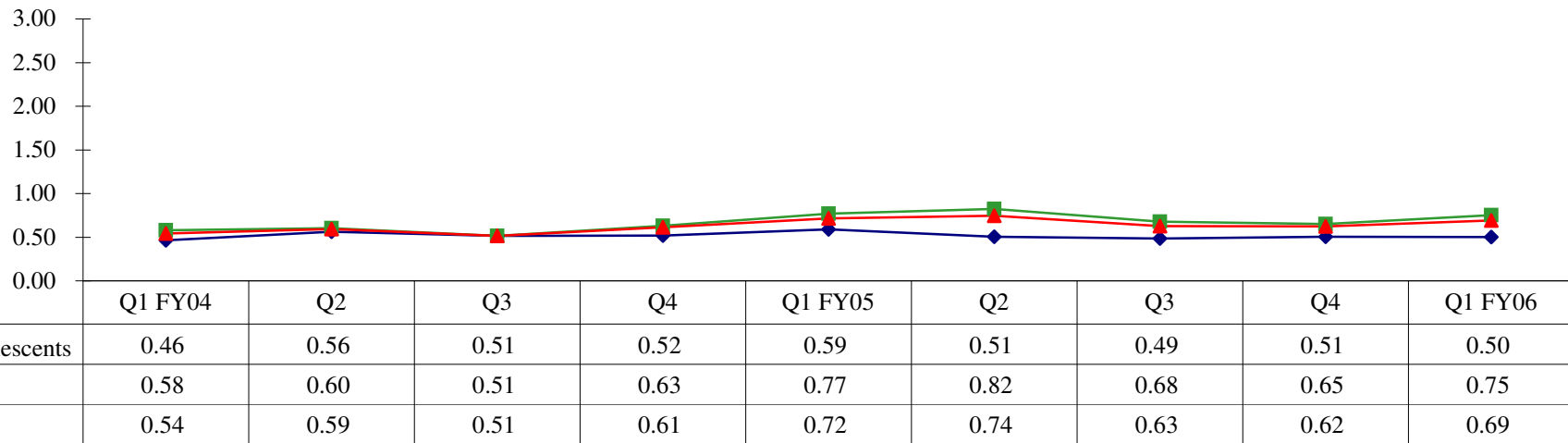


Seclusion Incidents Per 1,000 Bed Days

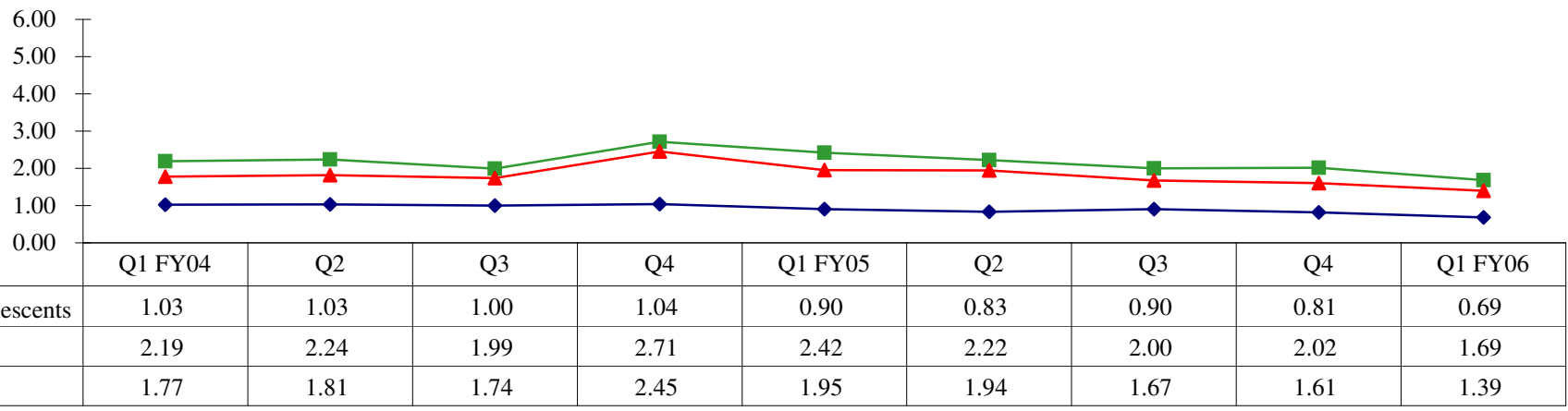


Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

Average Number of Hours Per Incident in Restraints

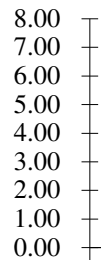


Average Number of Hours Per Incident in Seclusion



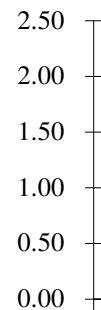
Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

Number of Persons in Restraint/1000 Bed Days



	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
◆ Child/Adolescents	5.97	4.49	6.02	3.85	5.87	5.58	6.04	3.84	6.24
■ Adults	2.89	3.22	3.48	2.44	2.85	2.88	2.92	2.12	3.02
▲ Total	3.27	3.40	3.82	2.60	3.23	3.20	3.30	2.32	3.40

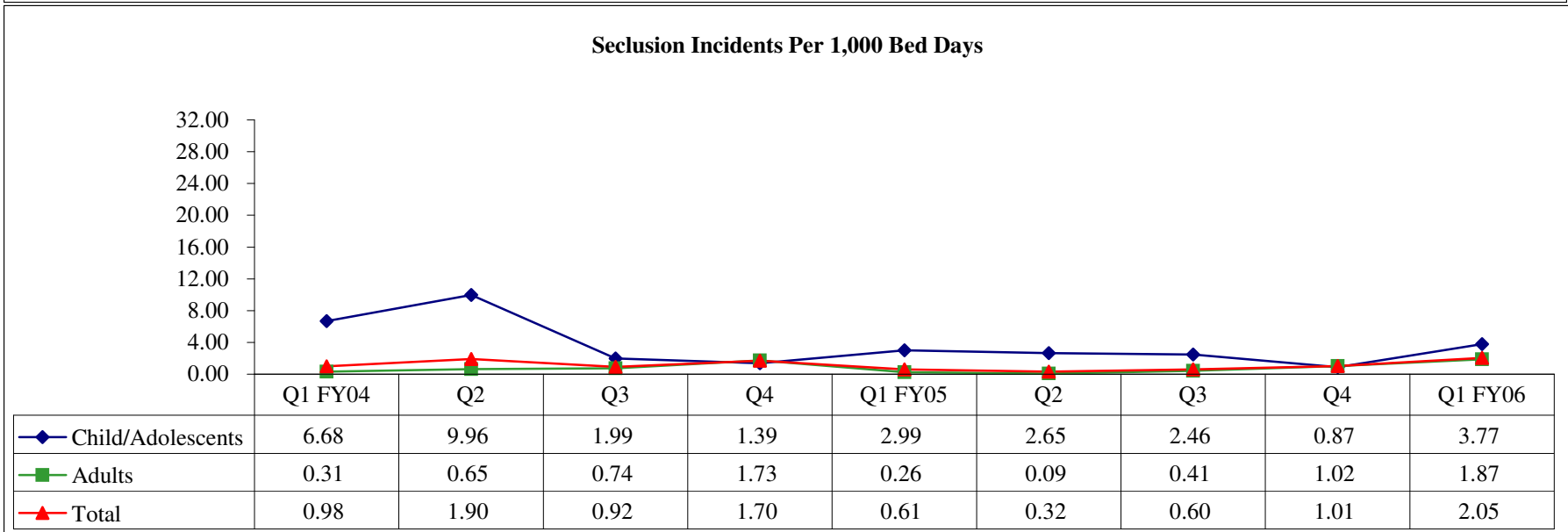
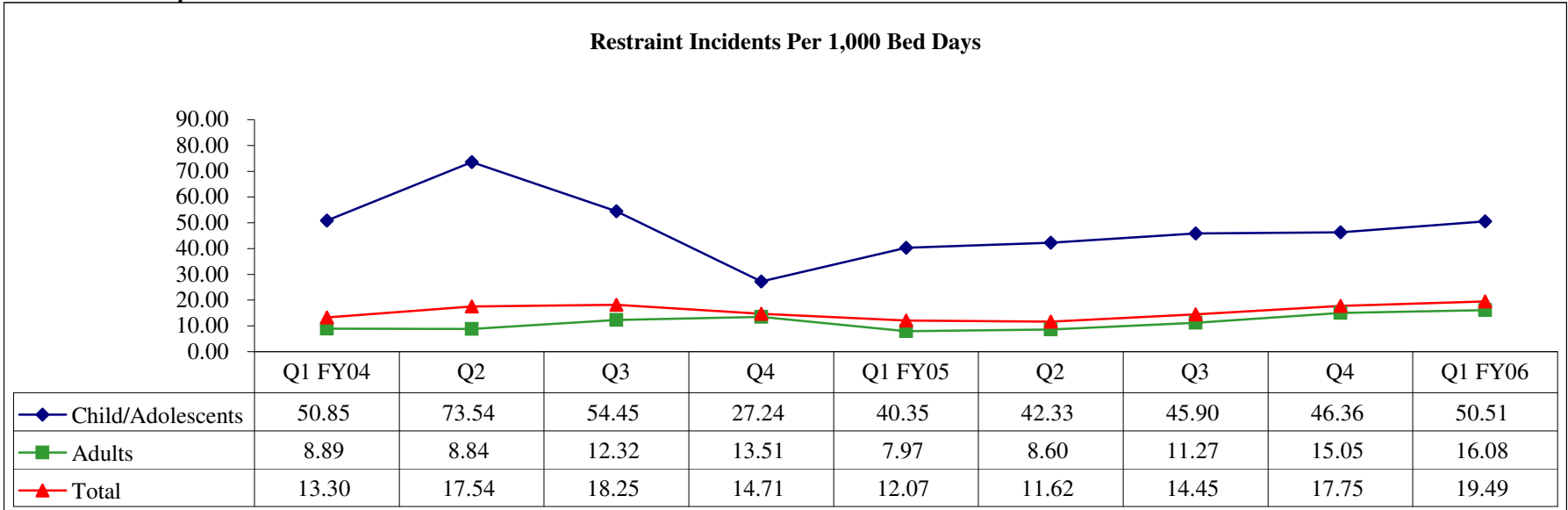
Number of Persons in Seclusion/1000 Bed Days



	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
◆ Child/Adolescents	1.84	2.00	1.64	0.95	2.01	1.72	2.00	1.31	1.78
■ Adults	0.79	0.74	0.69	0.51	0.76	0.73	0.74	0.54	0.67
▲ Total	0.92	0.91	0.81	0.56	0.91	0.84	0.90	0.62	0.80

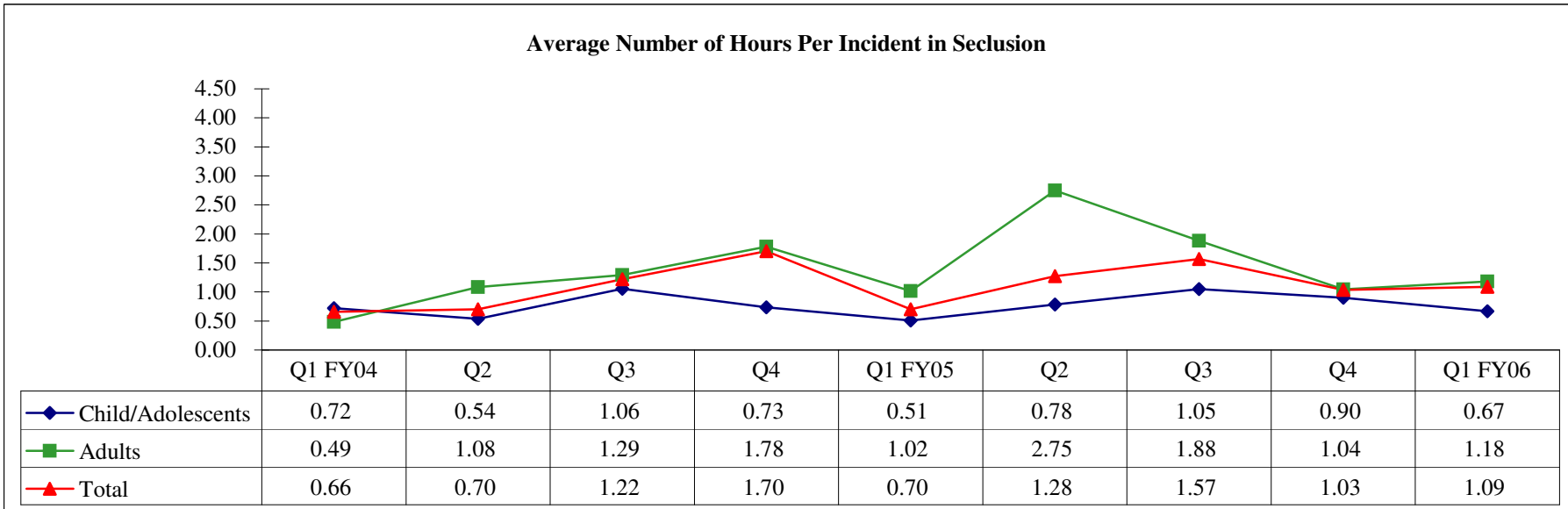
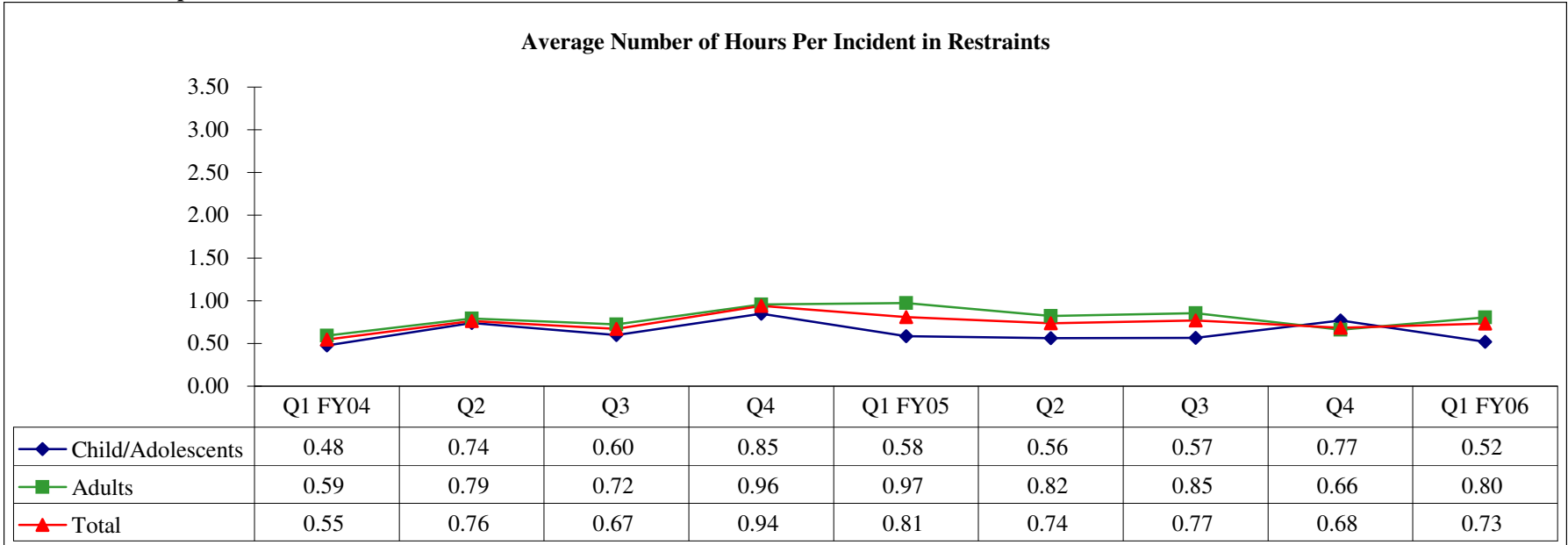
Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
Austin State Hospital



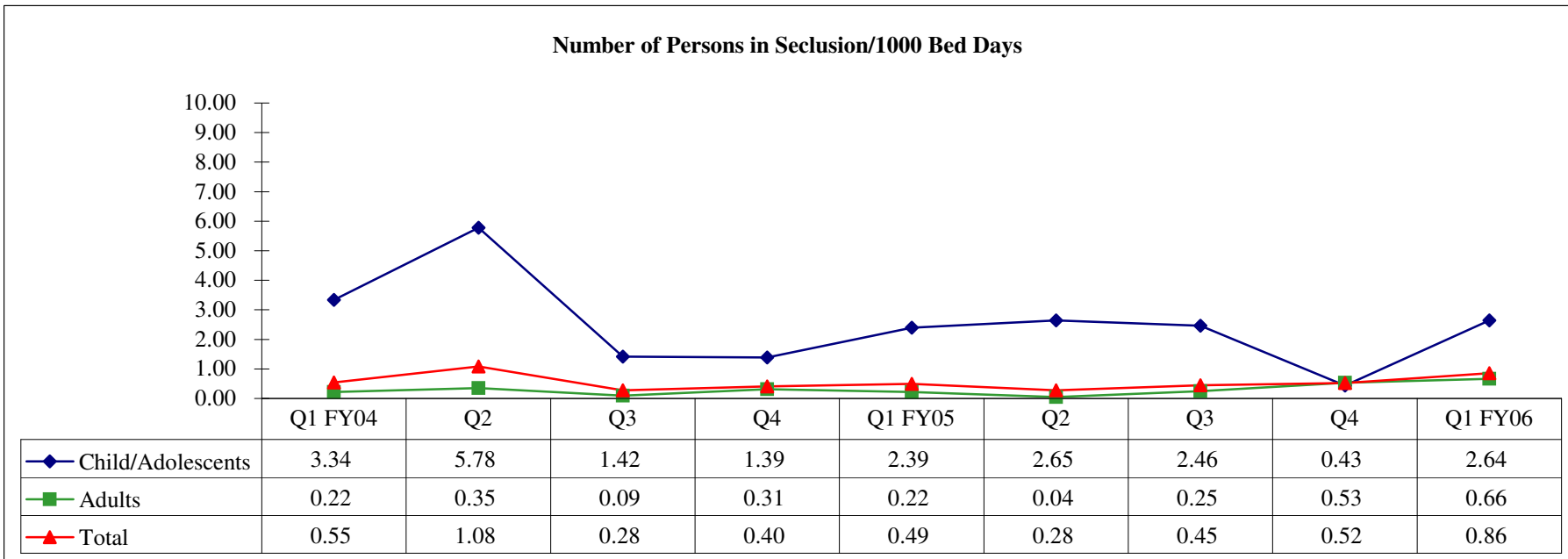
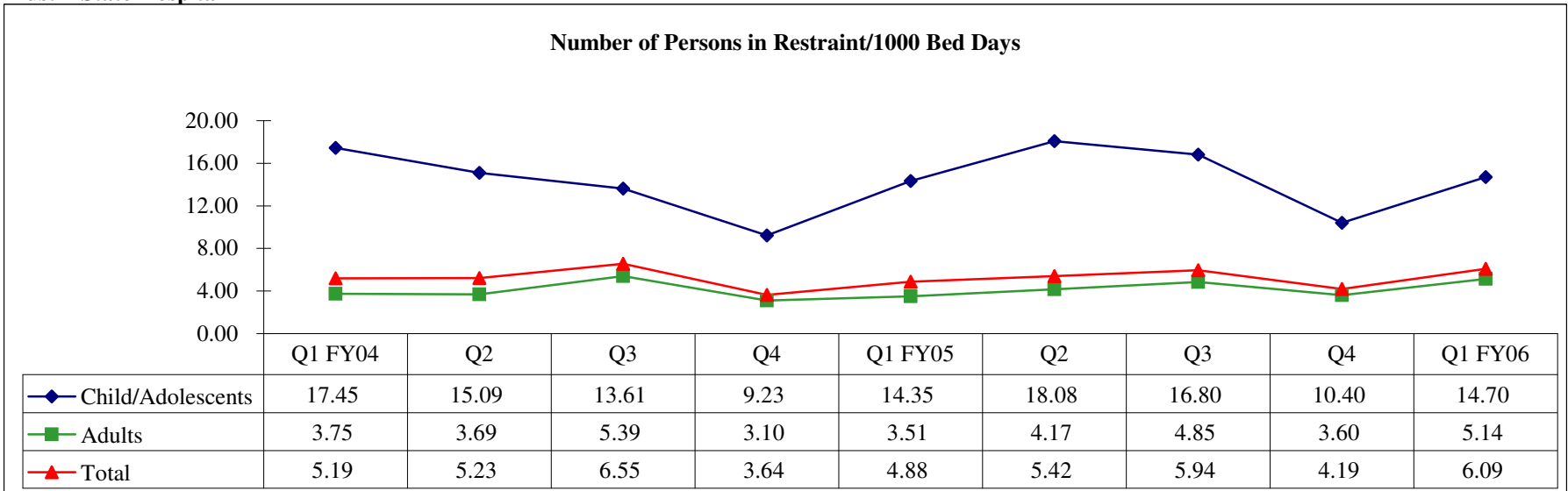
Objective 3B - Maintain Restraint and Seclusion Data

Austin State Hospital



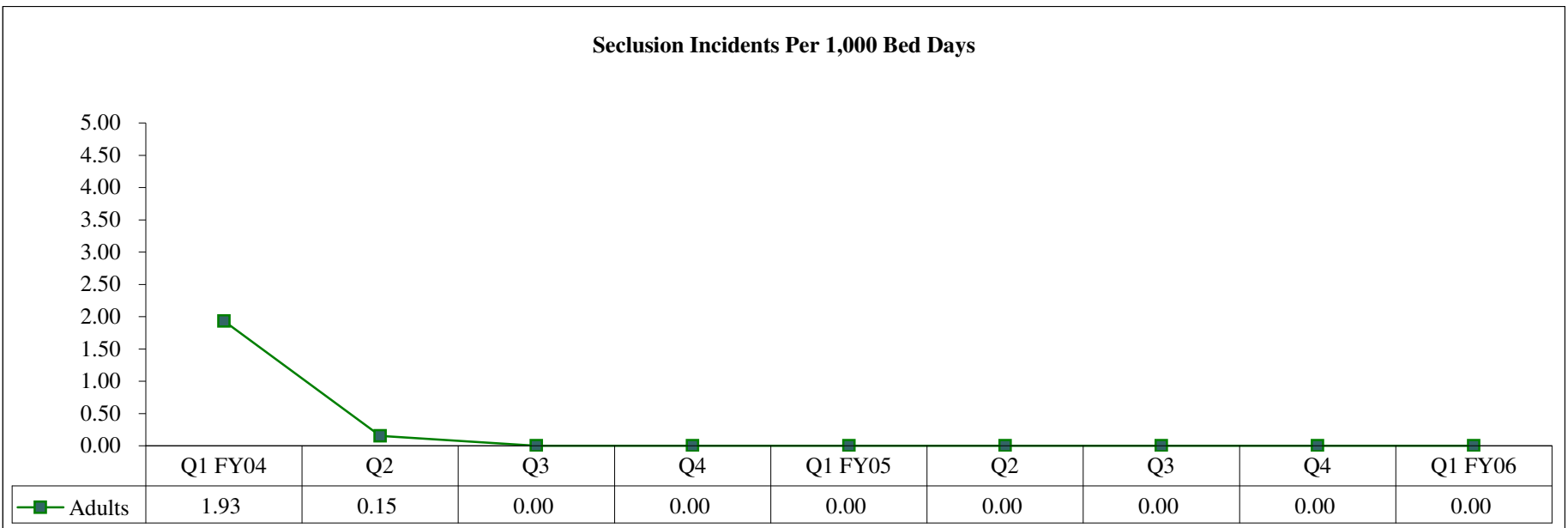
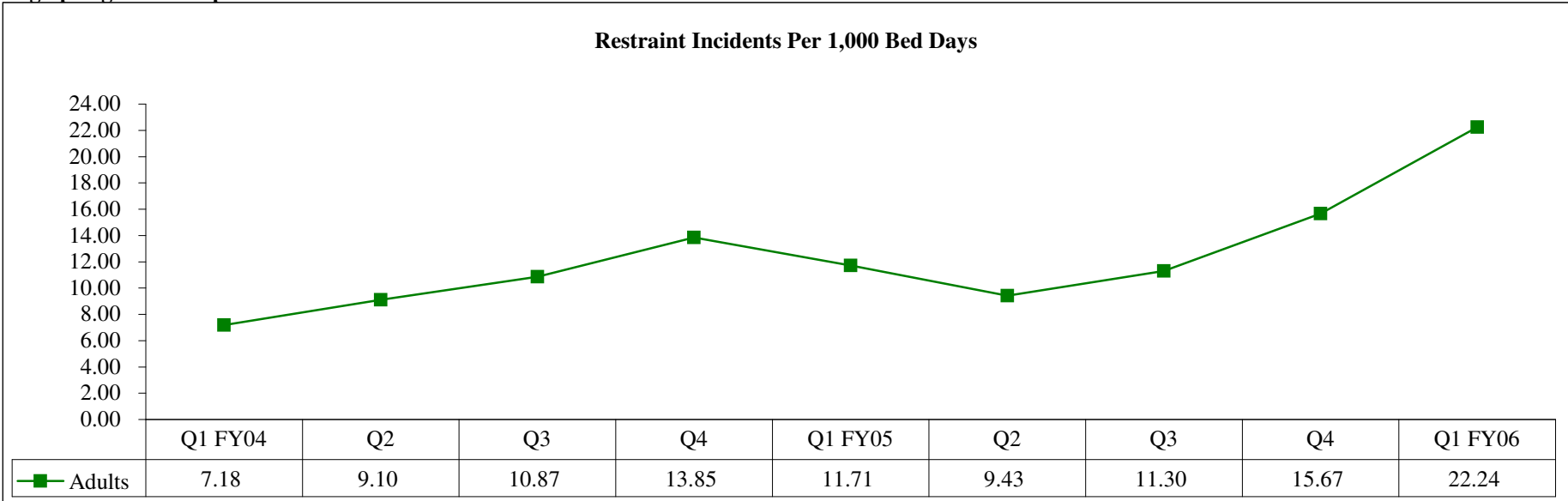
Objective 3B - Maintain Restraint and Seclusion Data

Austin State Hospital



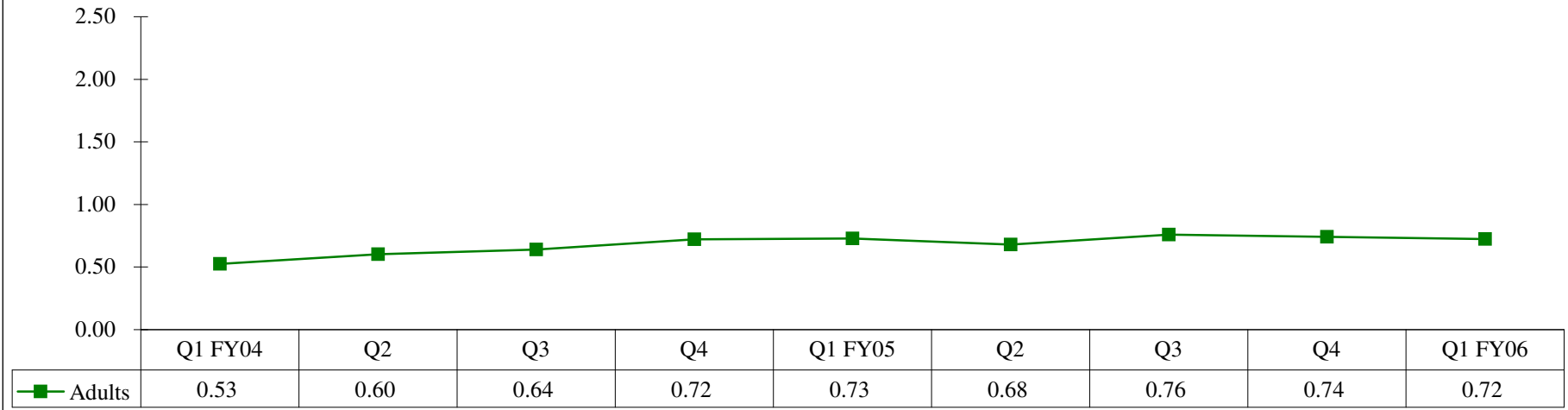
Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85); Access Database

Objective 3B - Maintain Restraint and Seclusion Data
Big Spring State Hospital

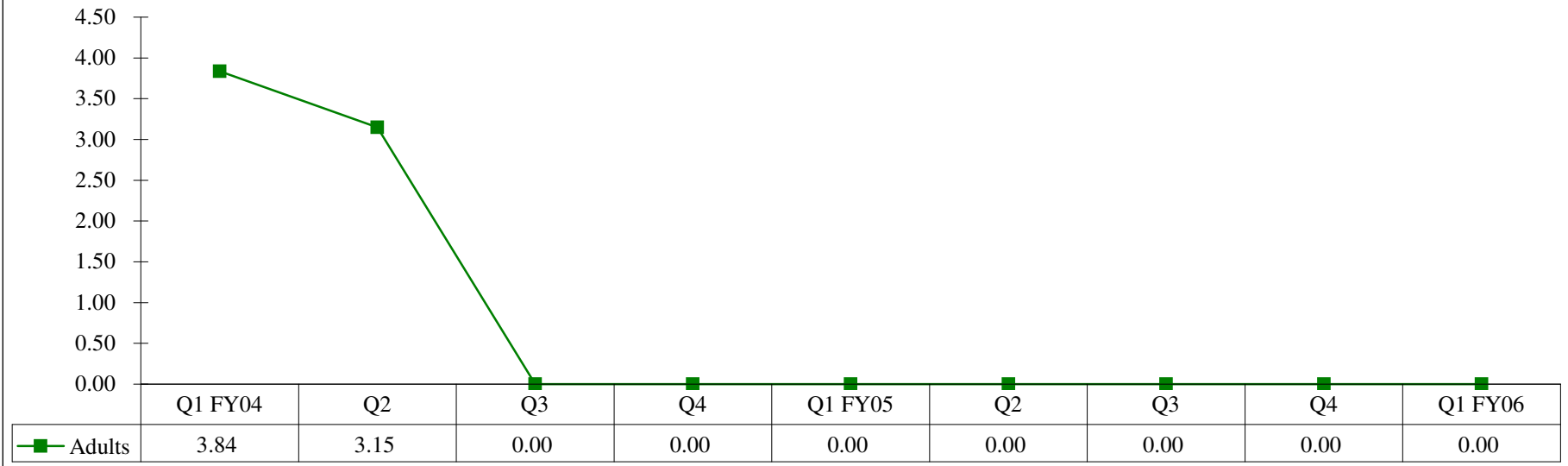


Objective 3B - Maintain Restraint and Seclusion Data
Big Spring State Hospital

Average Number of Hours Per Incident in Restraints

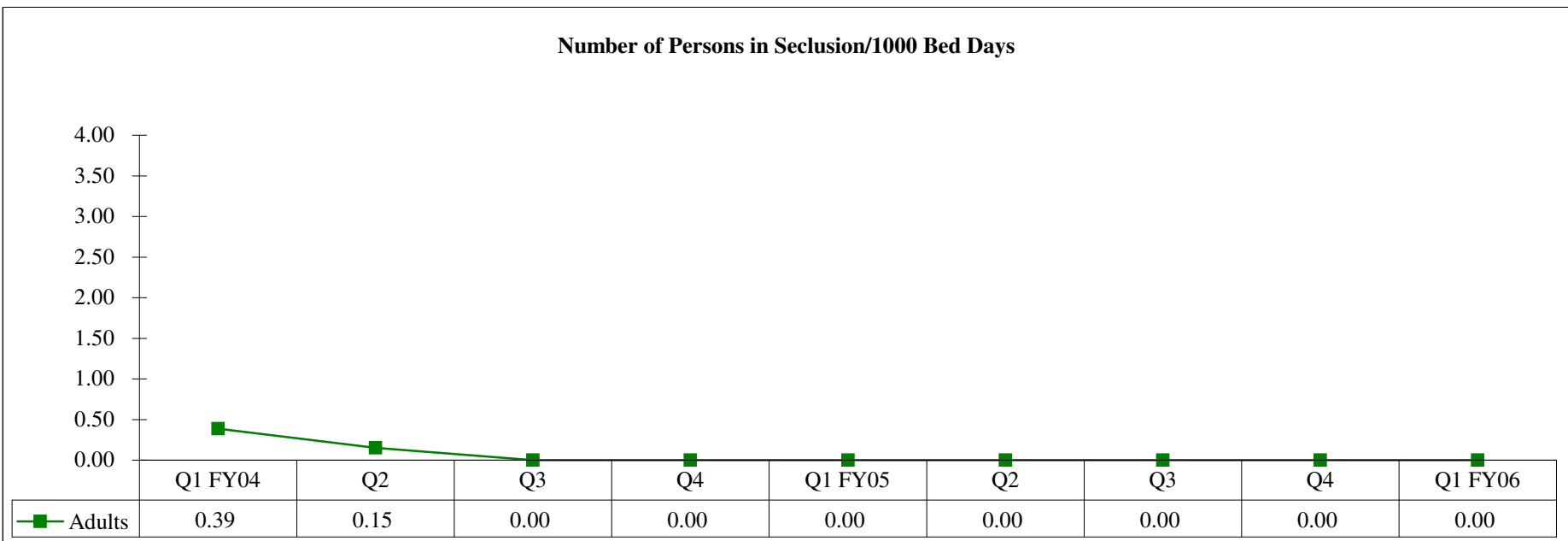
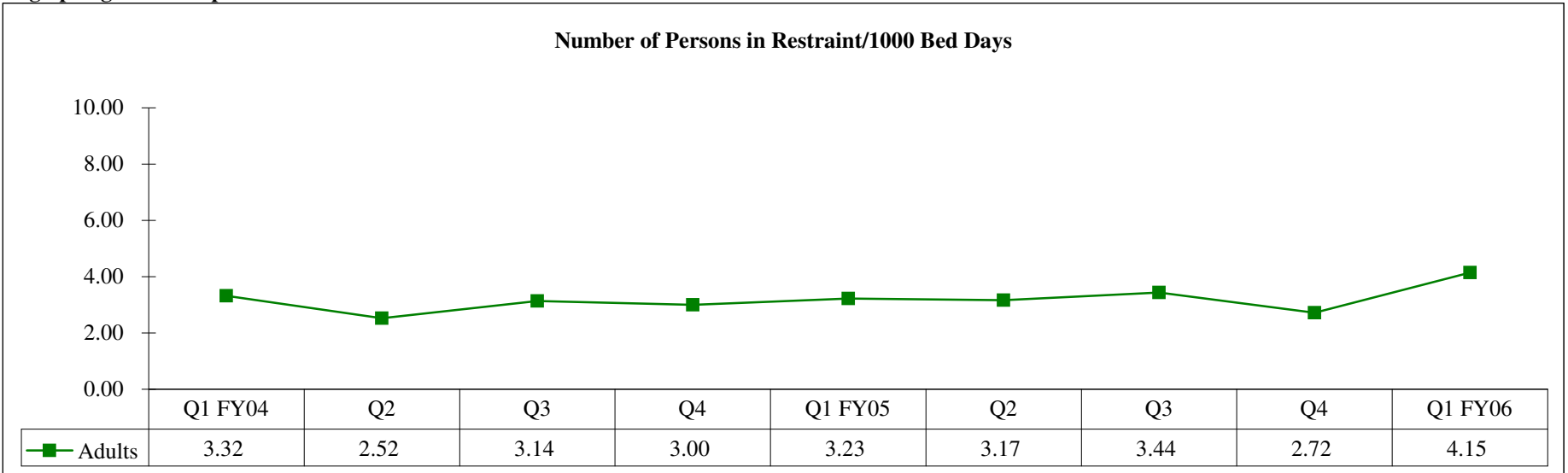


Average Number of Hours Per Incident in Seclusion

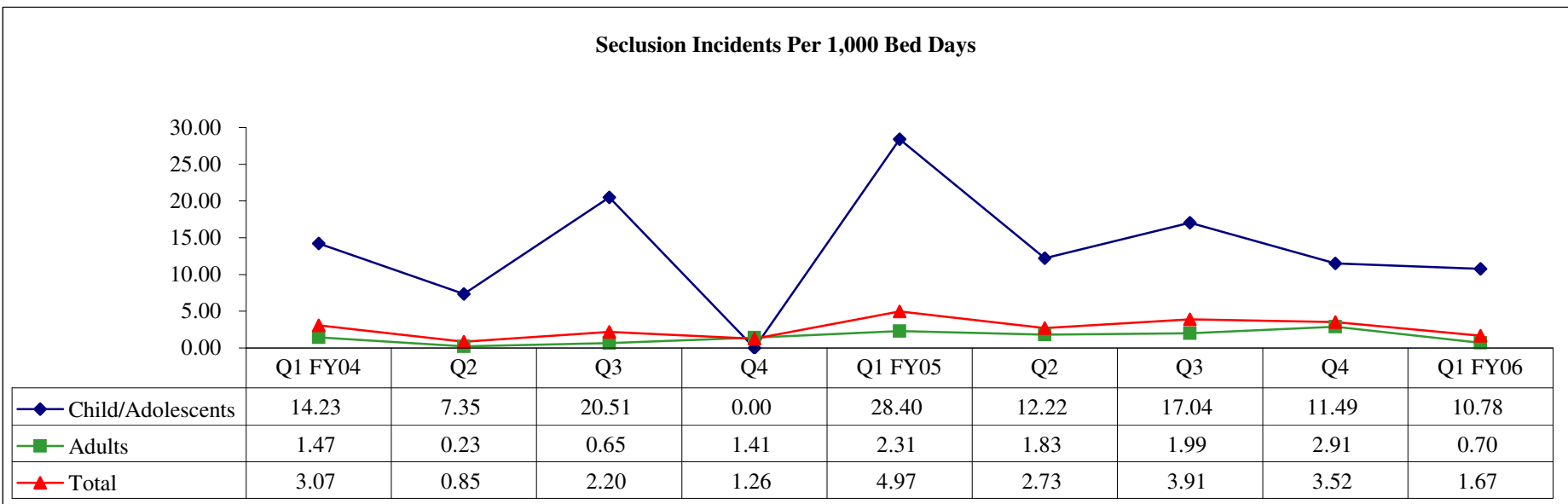
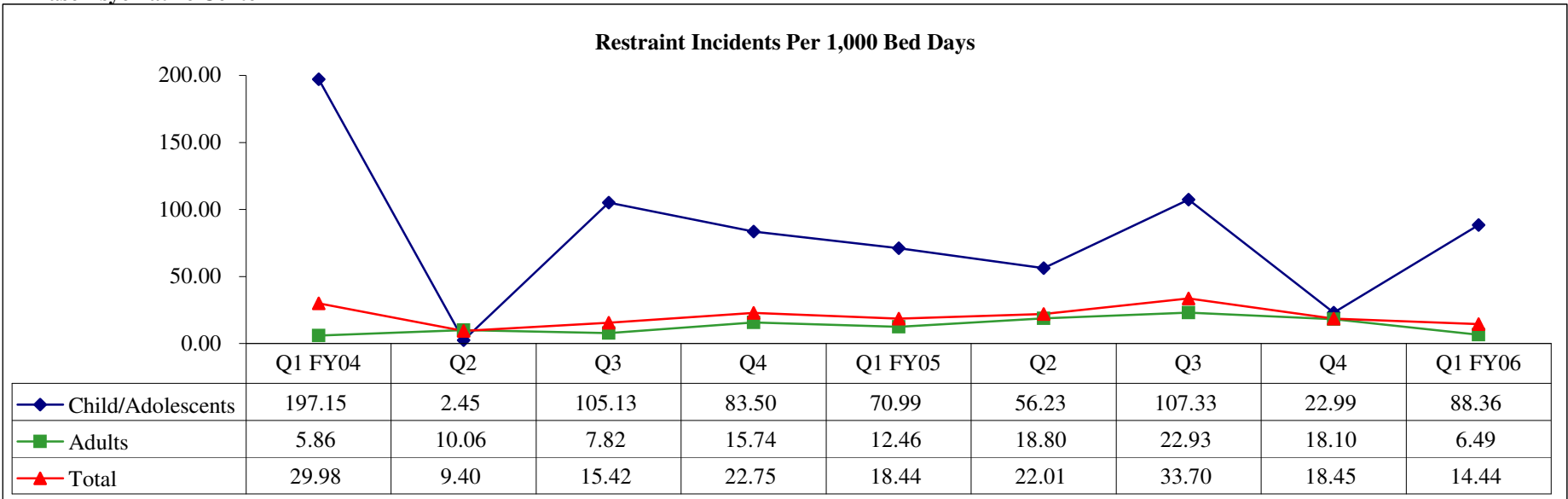


Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

**Objective 3B - Maintain Restraint and Seclusion Data
Big Spring State Hospital**

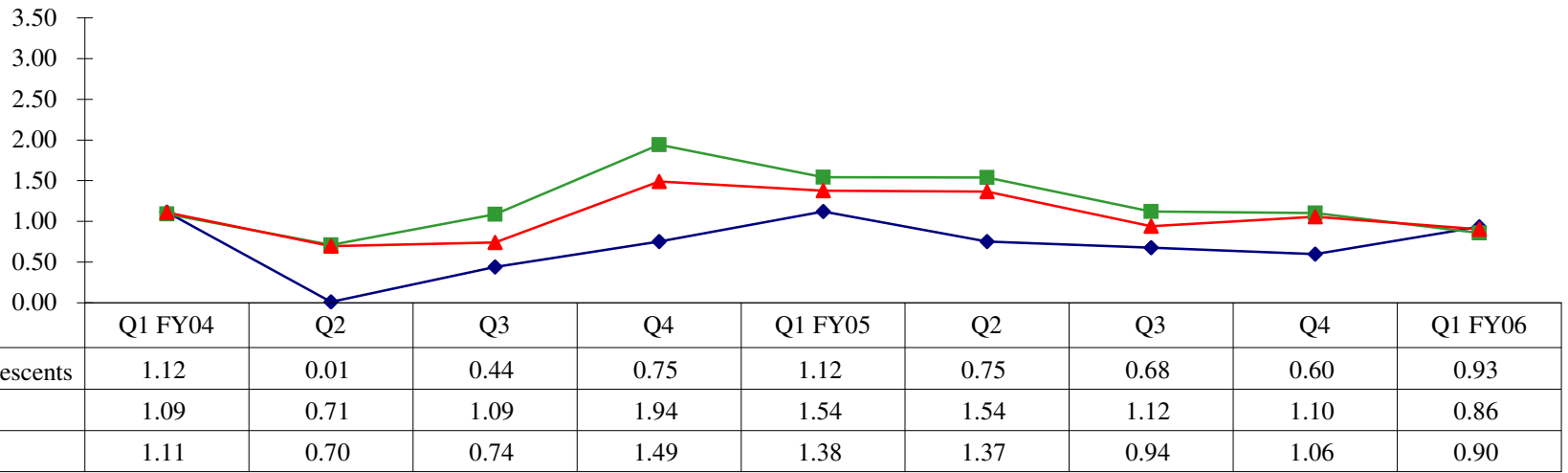


Objective 3B - Maintain Restraint and Seclusion Data
El Paso Psychiatric Center

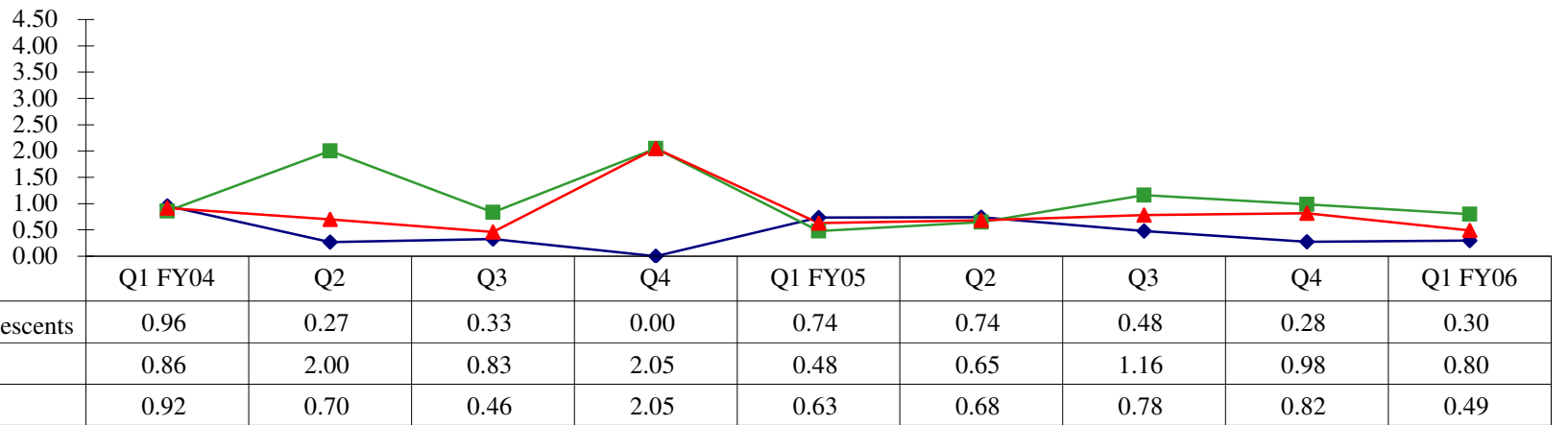


Objective 3B - Maintain Restraint and Seclusion Data
El Paso Psychiatric Center

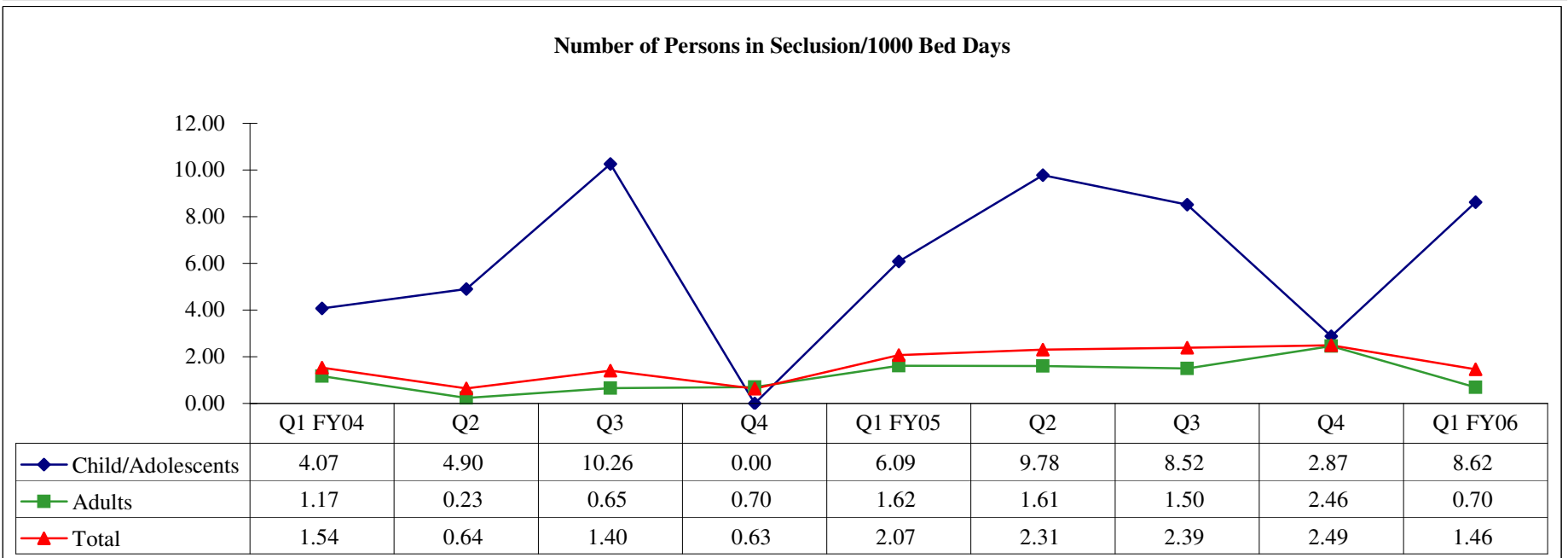
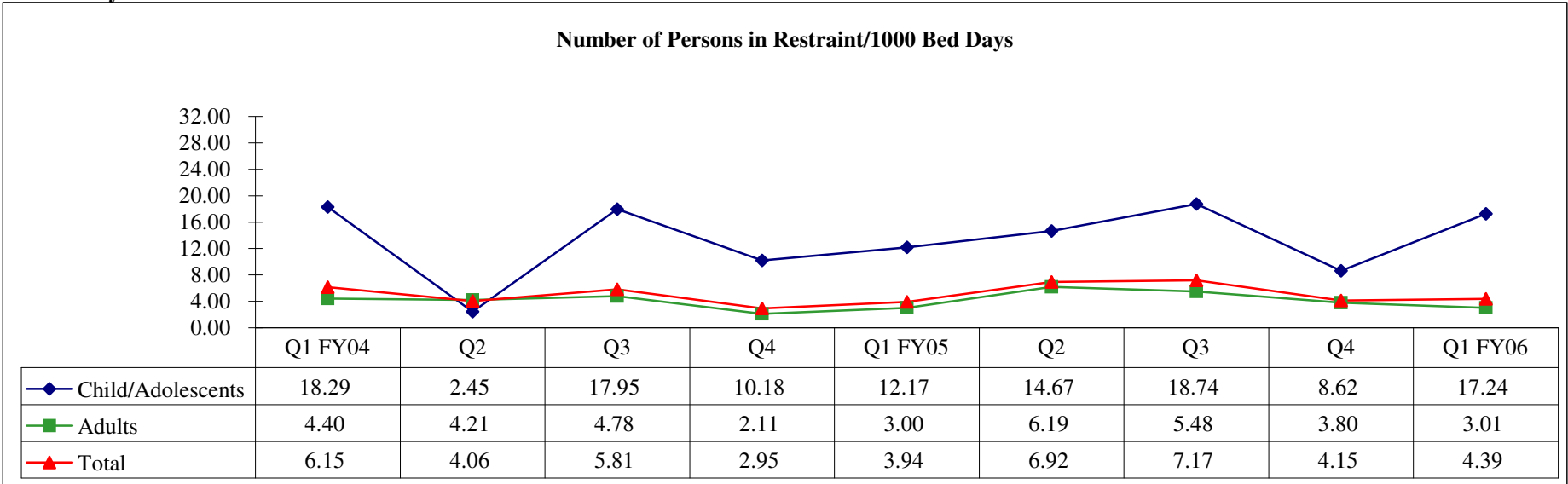
Average Number of Hours Per Incident in Restraints



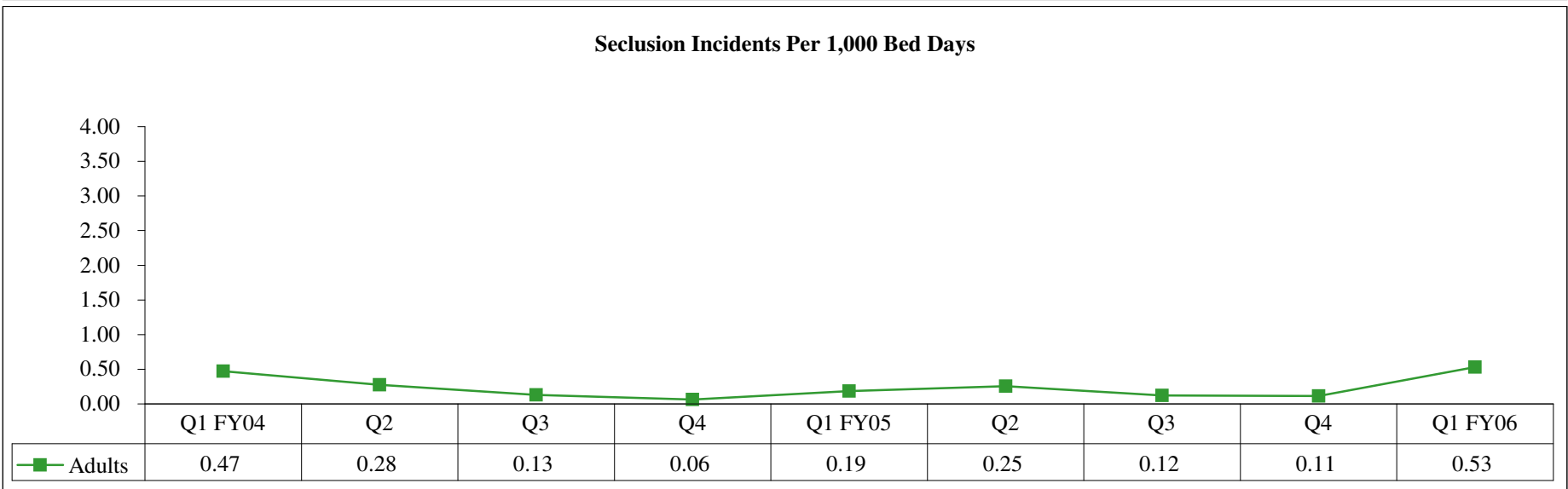
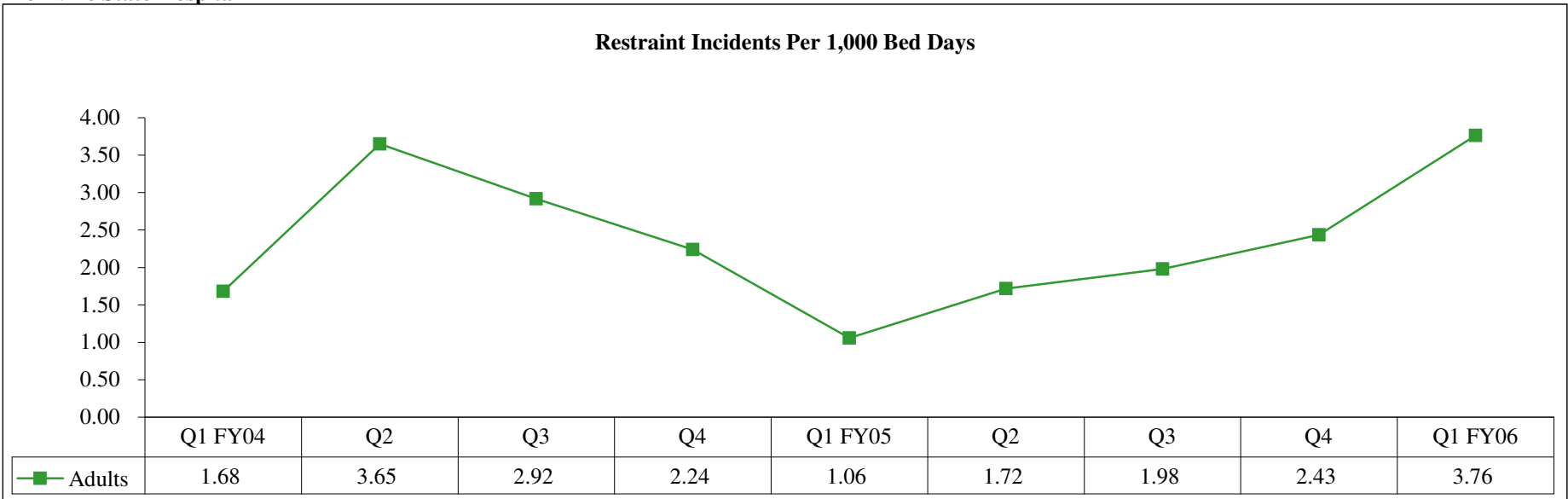
Average Number of Hours Per Incident in Seclusion



Objective 3B - Maintain Restraint and Seclusion Data
El Paso Psychiatric Center

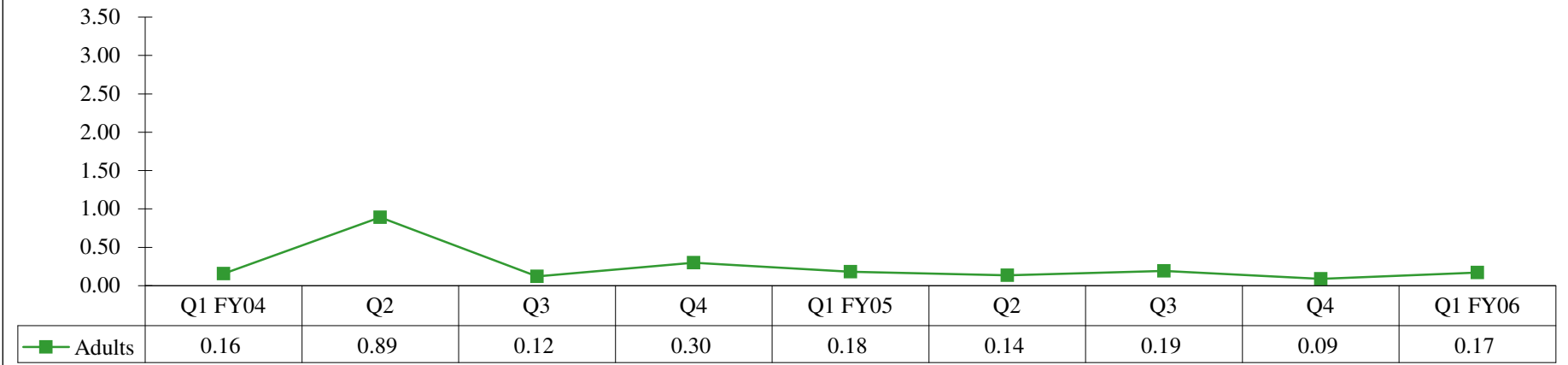


**Objective 3B - Maintain Restraint and Seclusion Data
Kerrville State Hospital**

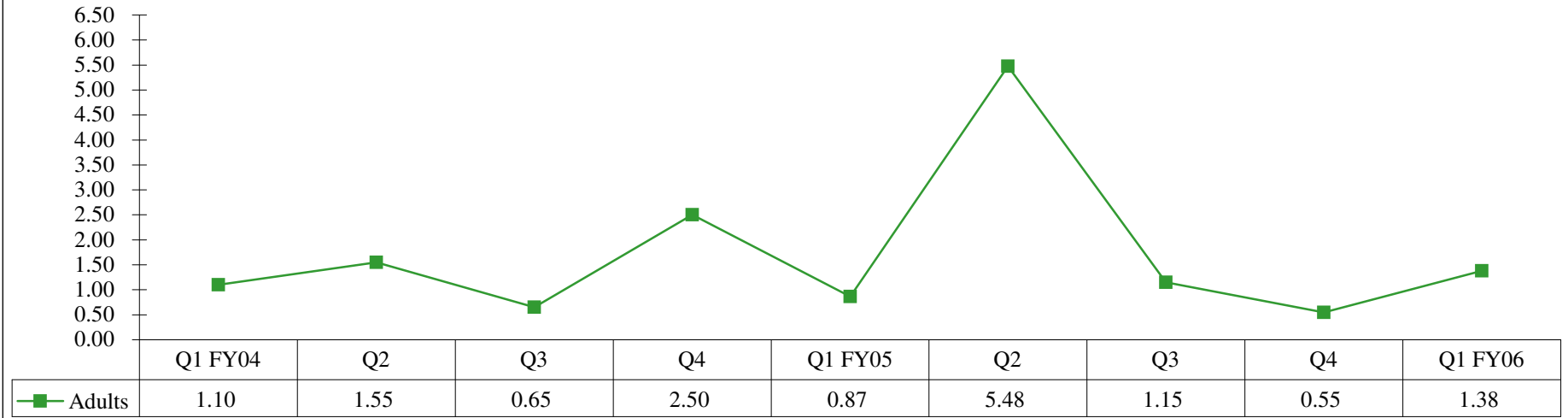


**Objective 3B - Maintain Restraint and Seclusion Data
Kerrville State Hospital**

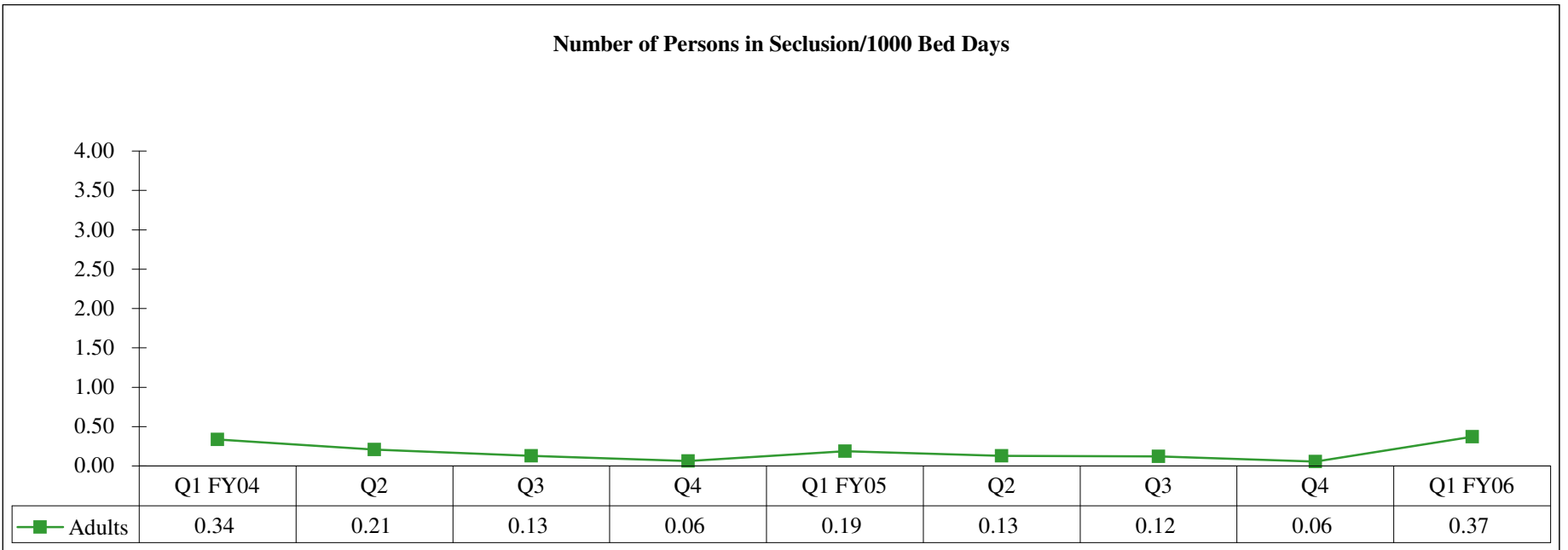
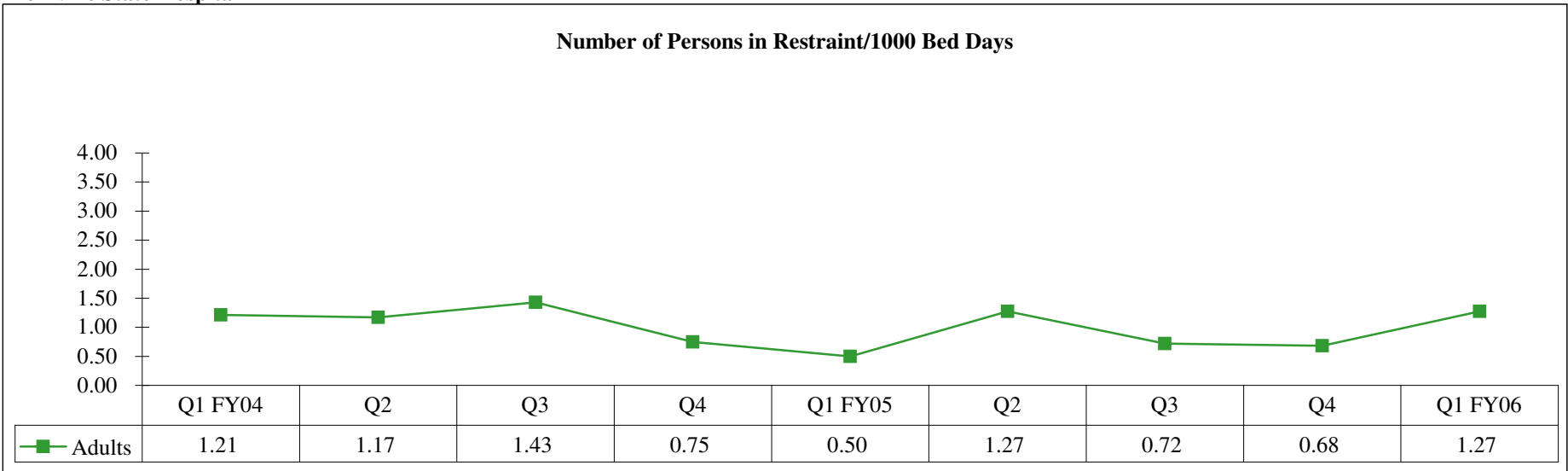
Average Number of Hours Per Incident in Restraints



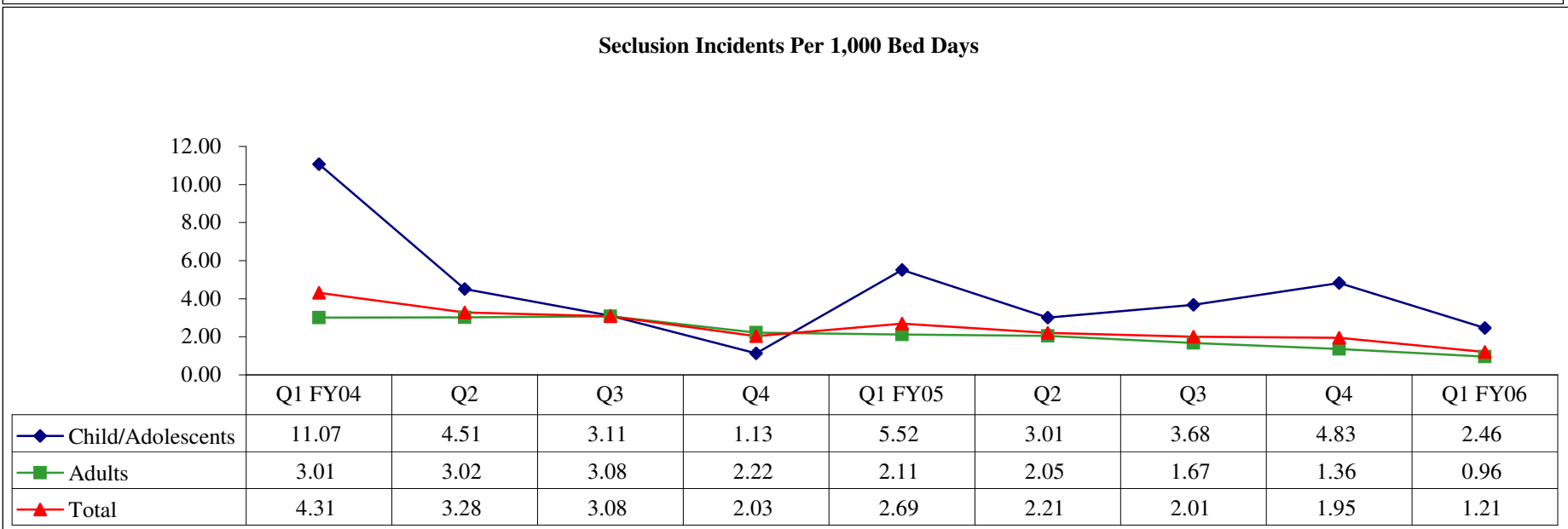
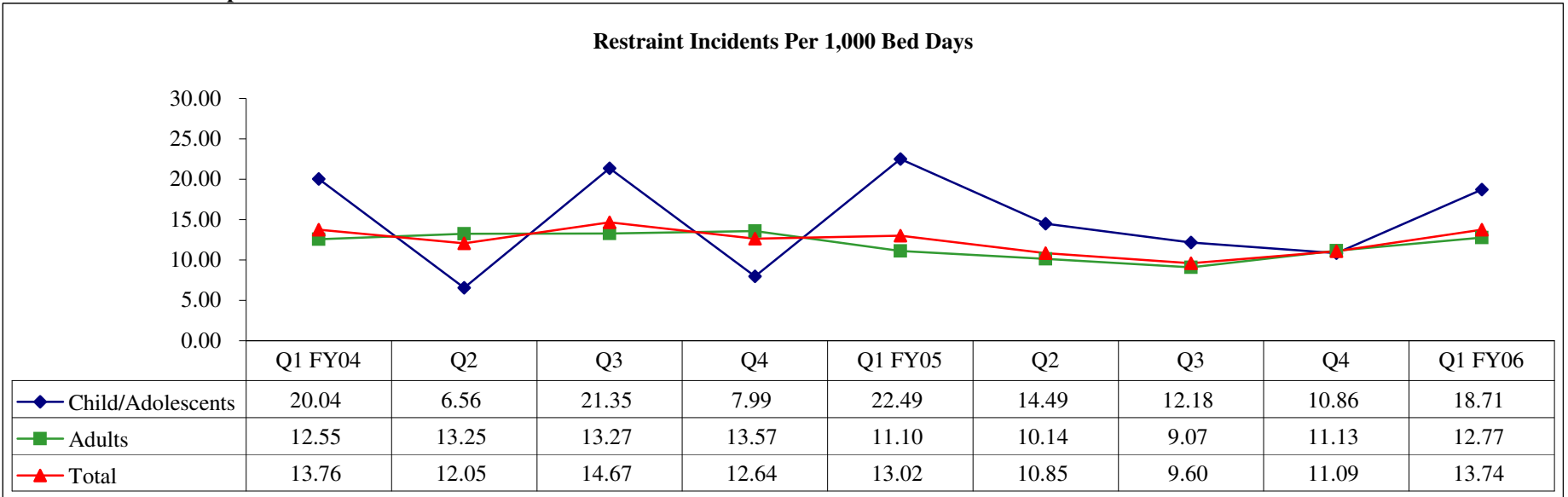
Average Number of Hours Per Incident in Seclusion



**Objective 3B - Maintain Restraint and Seclusion Data
Kerrville State Hospital**

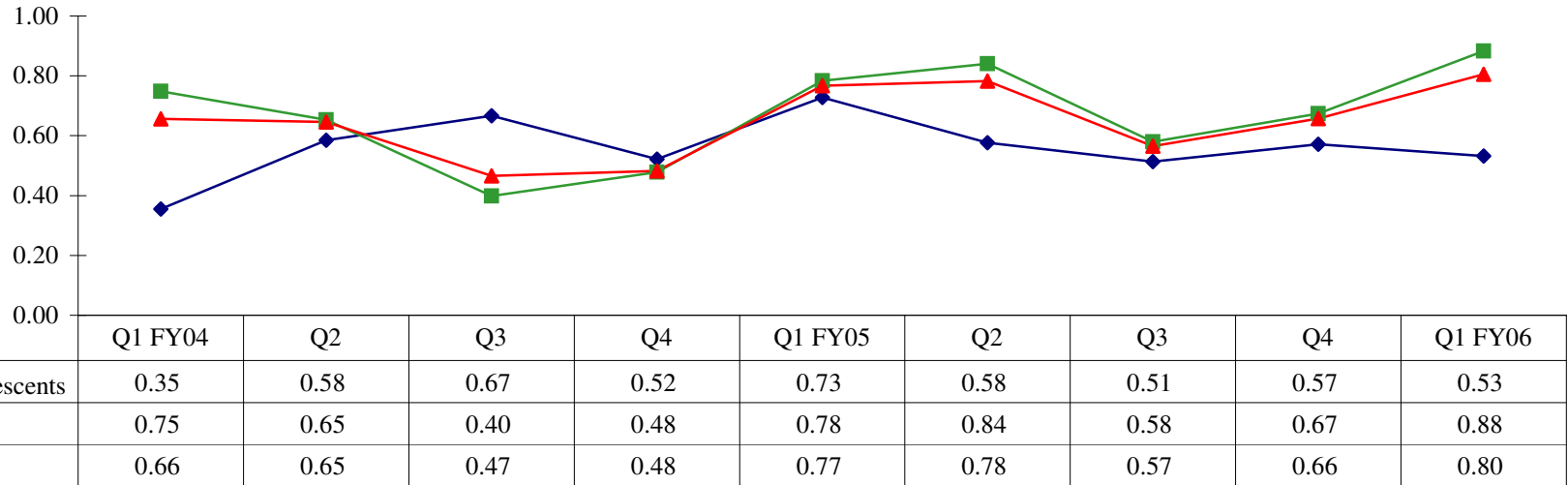


Objective 3B - Maintain Restraint and Seclusion Data
North Texas State Hospital

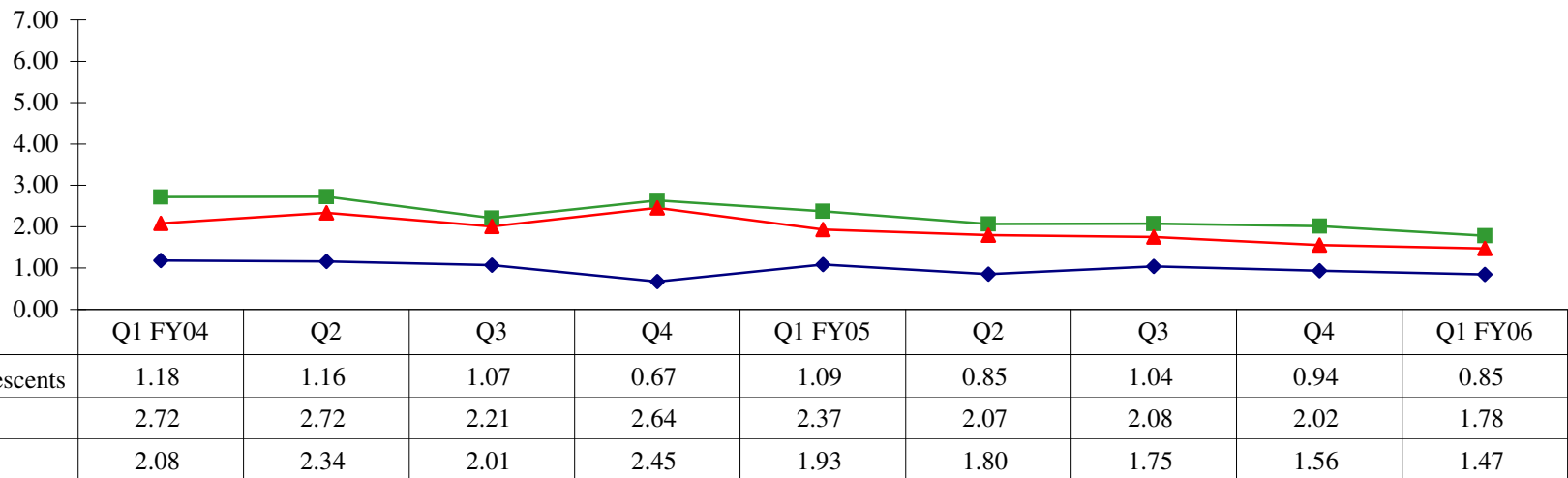


Objective 3B - Maintain Restraint and Seclusion Data
North Texas State Hospital

Average Number of Hours Per Incident in Restraints

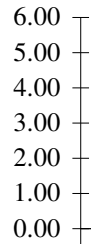


Average Number of Hours Per Incident in Seclusion



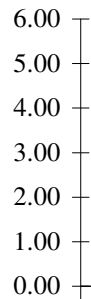
Objective 3B - Maintain Restraint and Seclusion Data
North Texas State Hospital

Number of Persons in Restraint/1000 Bed Days



	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
◆ Child/Adolescents	2.77	2.36	4.46	2.36	3.78	3.34	3.79	2.41	4.06
■ Adults	3.14	3.82	3.71	2.91	3.25	3.06	3.00	2.02	3.59
▲ Total	3.08	3.56	3.84	2.82	3.34	3.11	3.14	2.09	3.67

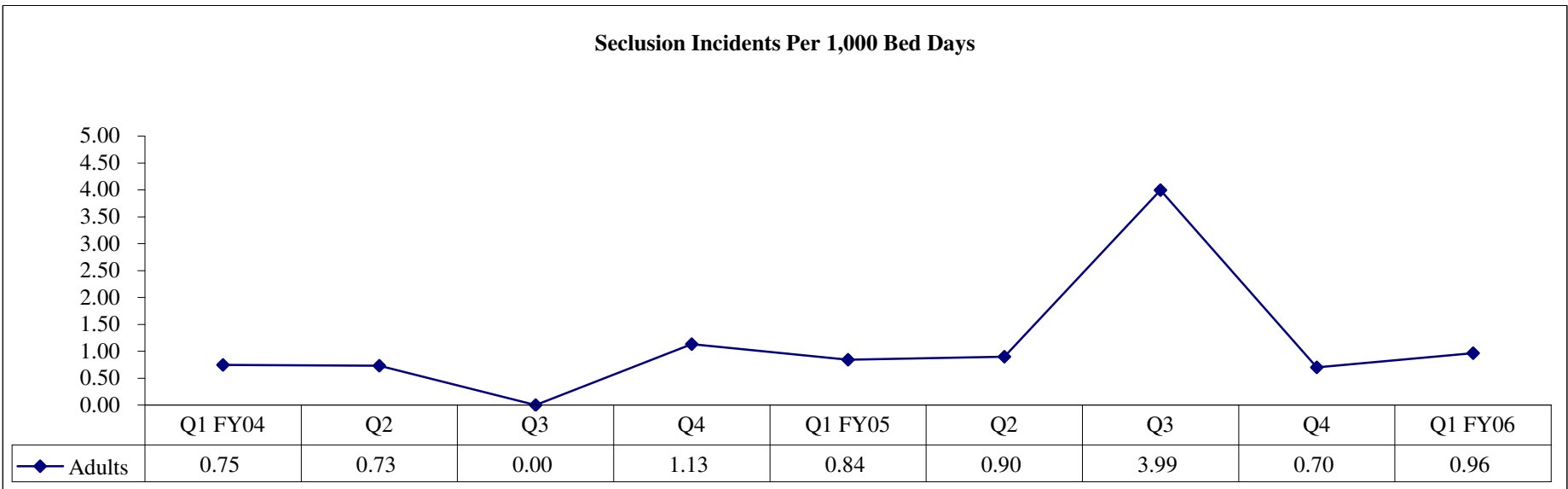
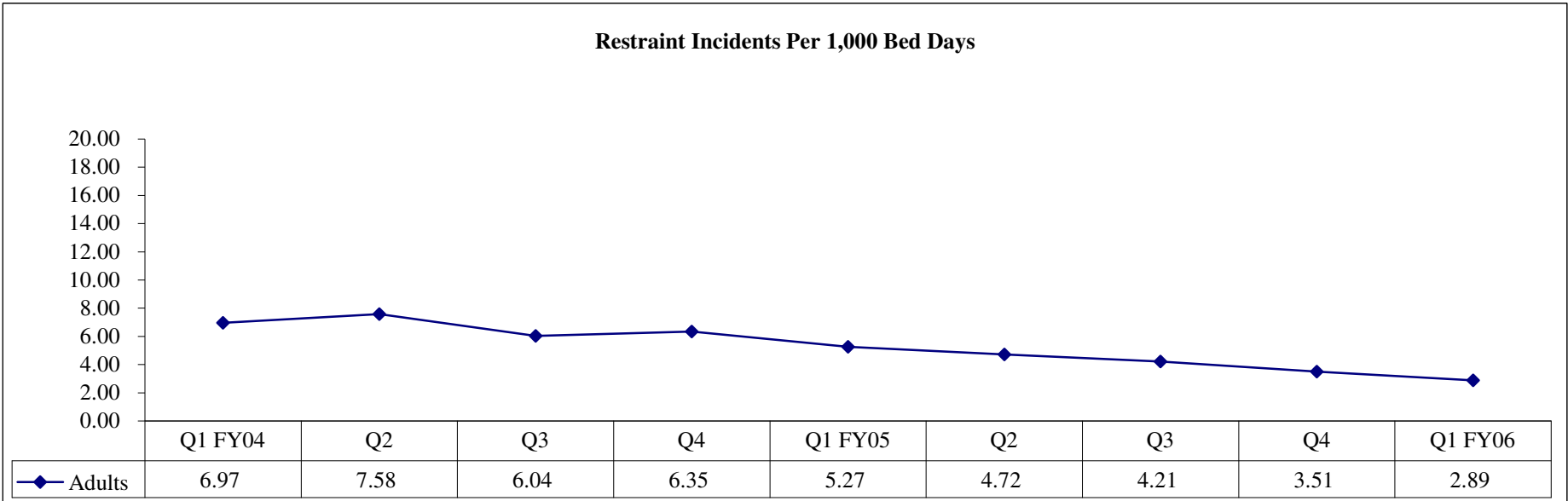
Number of Persons in Seclusion/1000 Bed Days



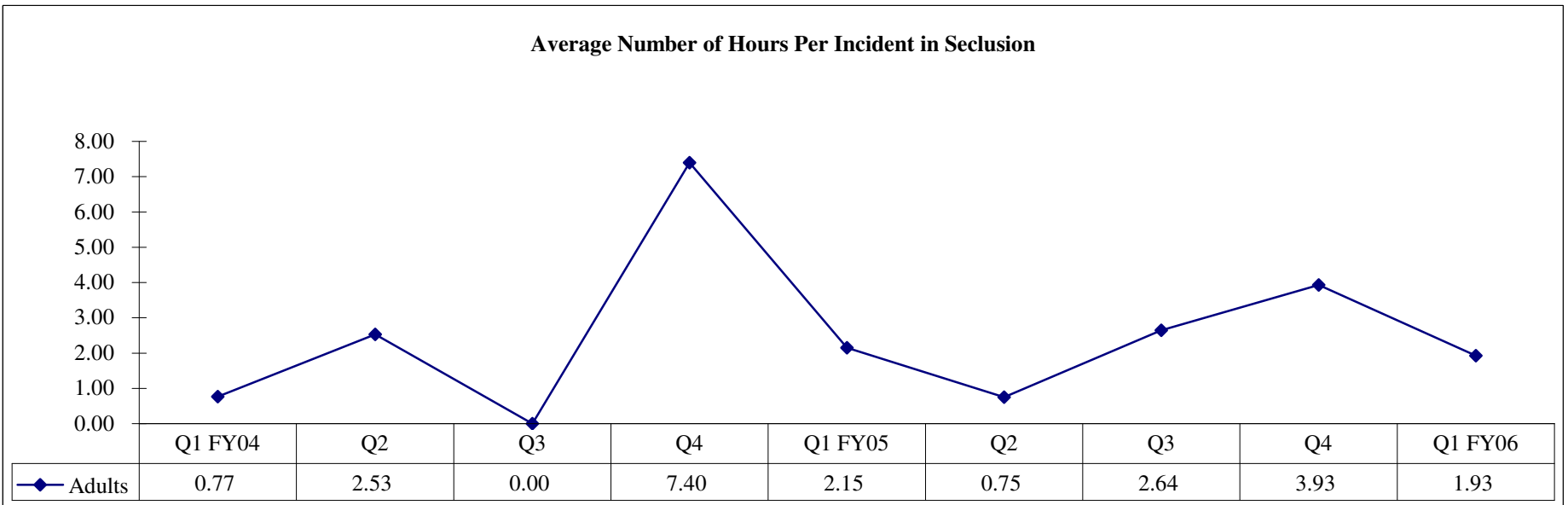
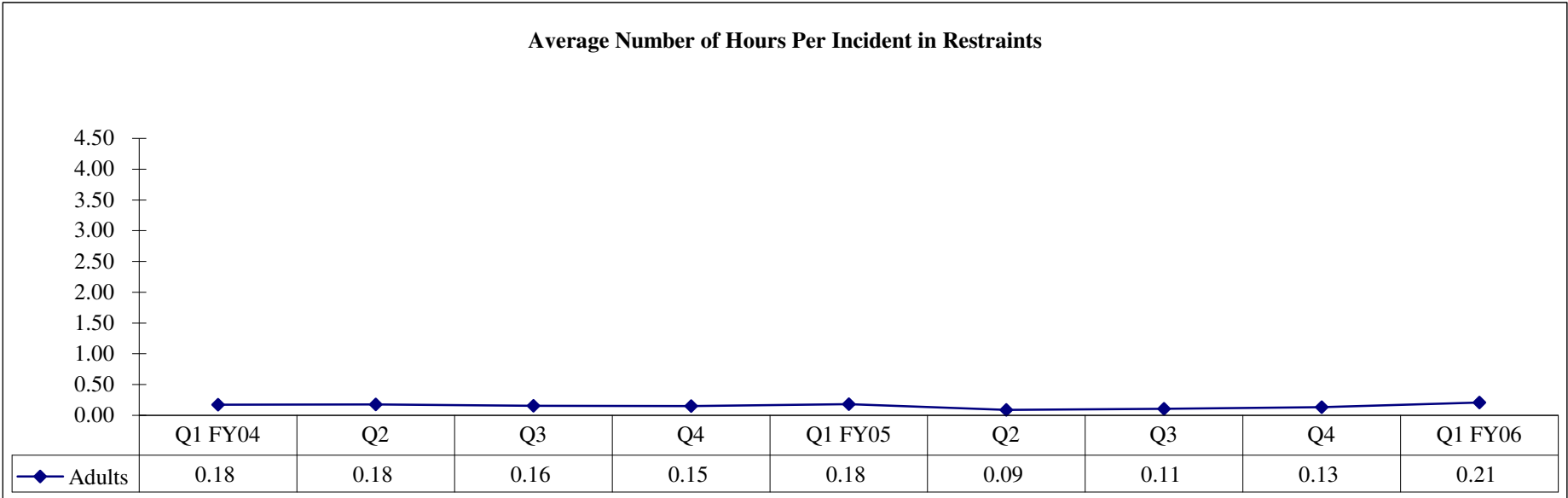
	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
◆ Child/Adolescents	1.99	1.23	1.45	0.51	1.94	1.45	1.74	1.31	1.39
■ Adults	1.04	1.14	1.28	0.90	0.89	0.87	0.81	0.69	0.73
▲ Total	1.19	1.16	1.31	0.84	1.07	0.97	0.97	0.79	0.84

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

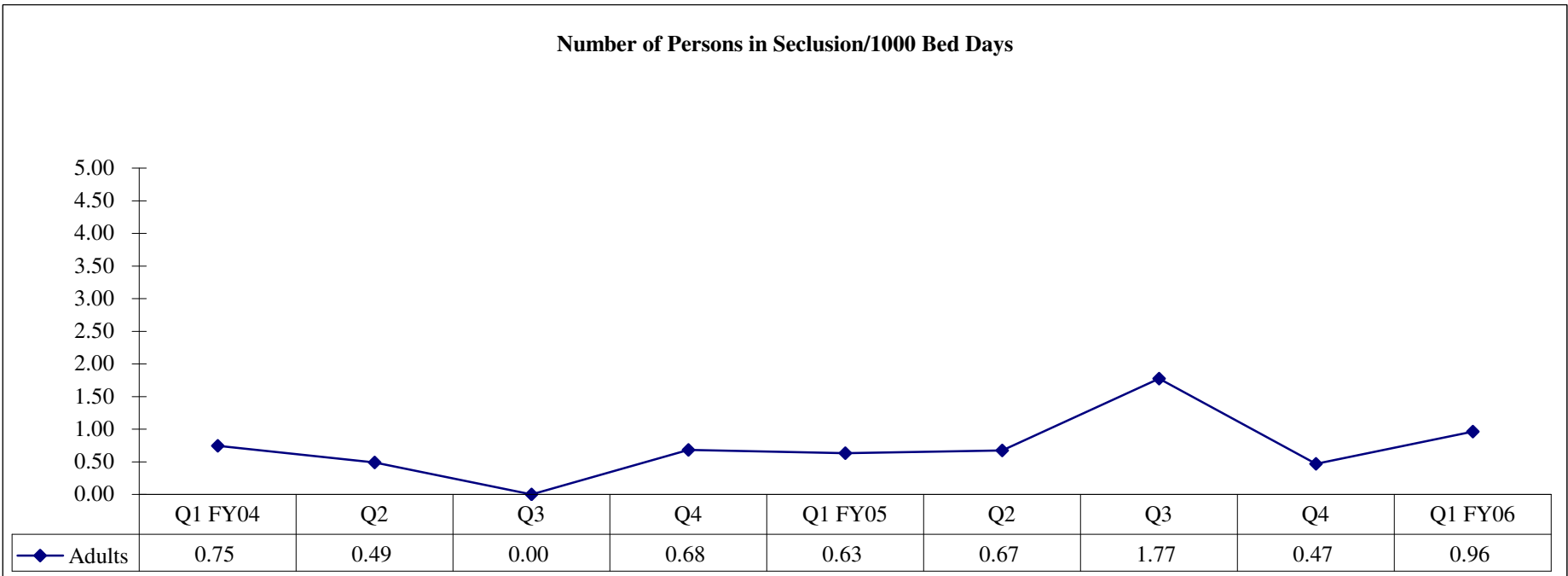
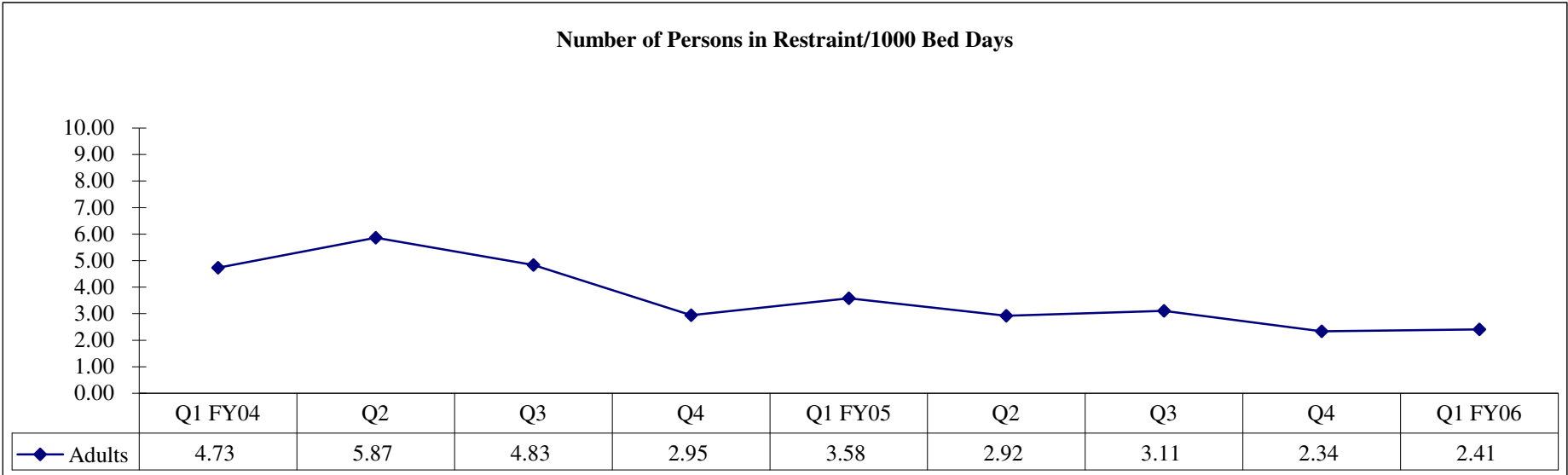
Objective 3B - Maintain Restraint and Seclusion Data
Rio Grande State Center



**Objective 3B - Maintain Restraint and Seclusion Data
Rio Grande State Center**

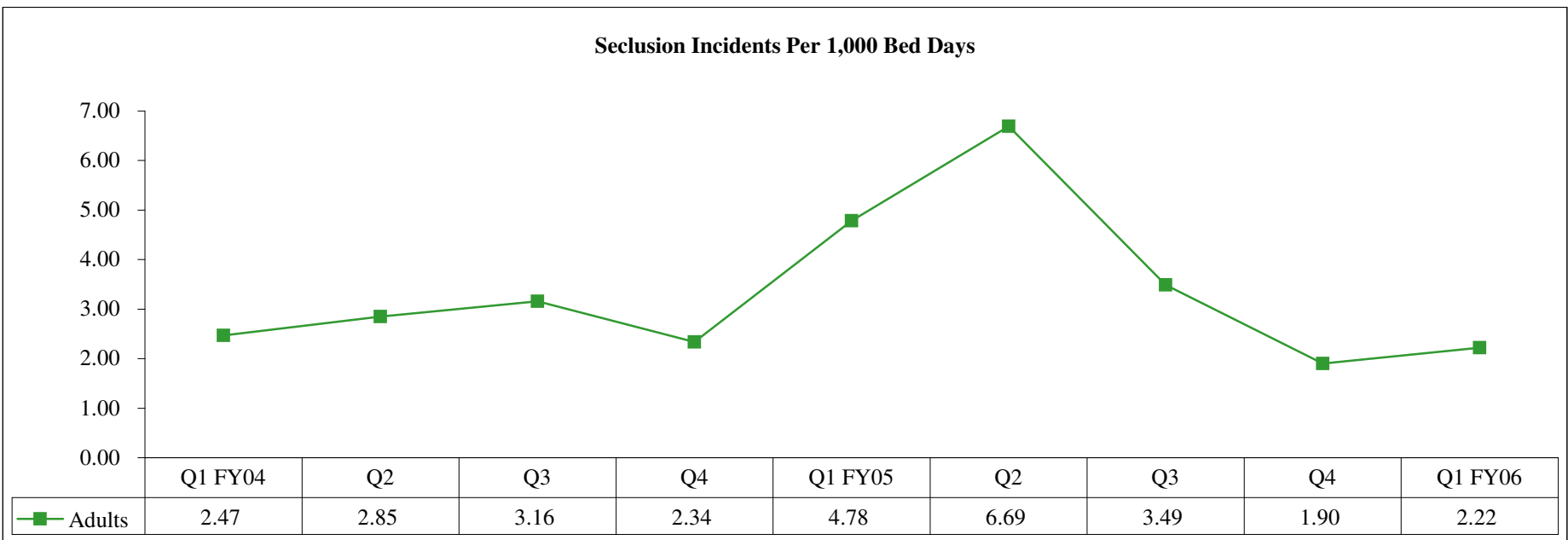
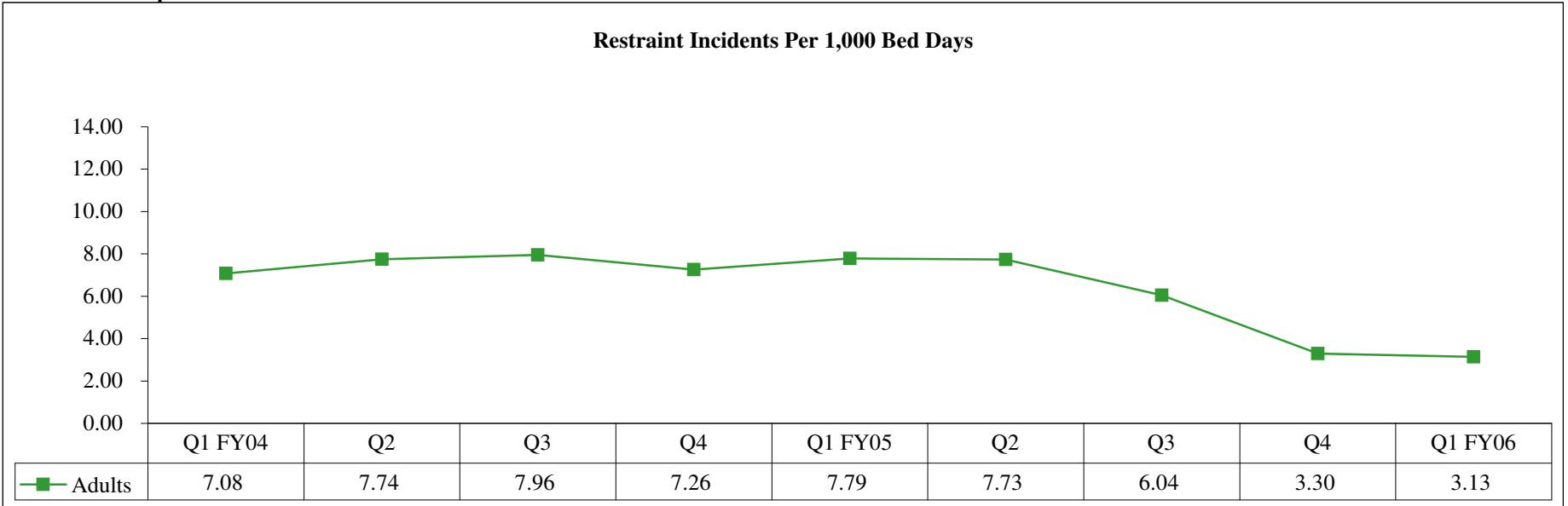


Objective 3B - Maintain Restraint and Seclusion Data
Rio Grande State Center



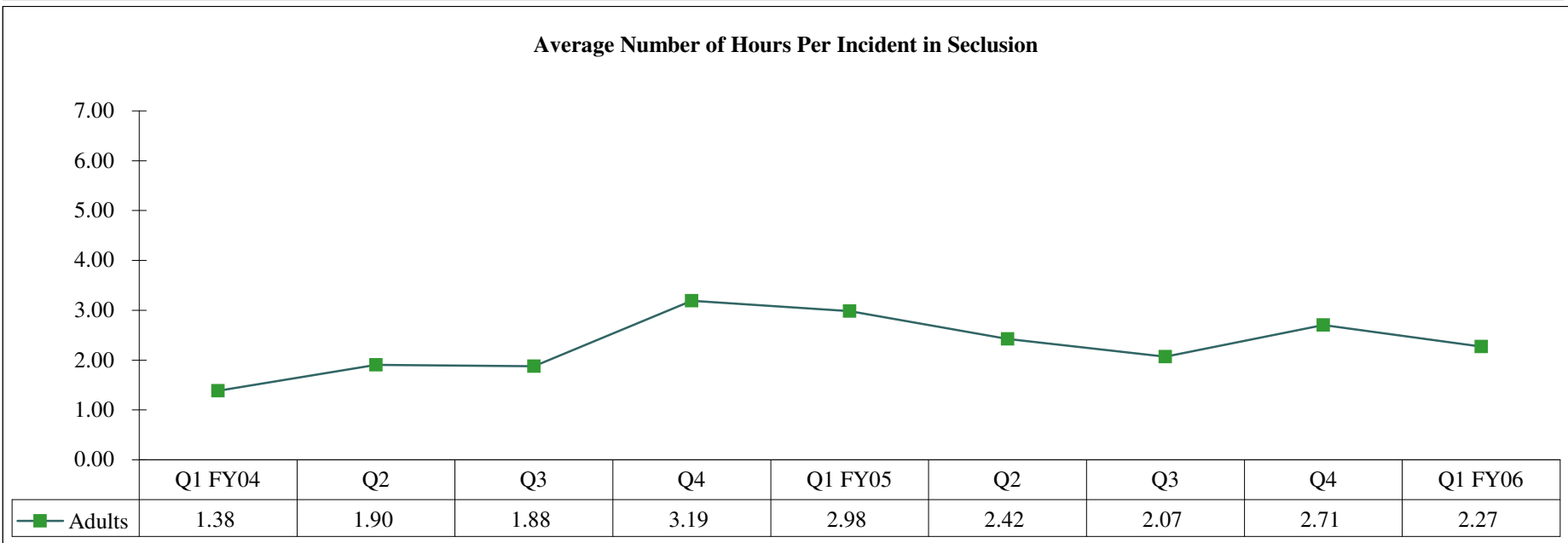
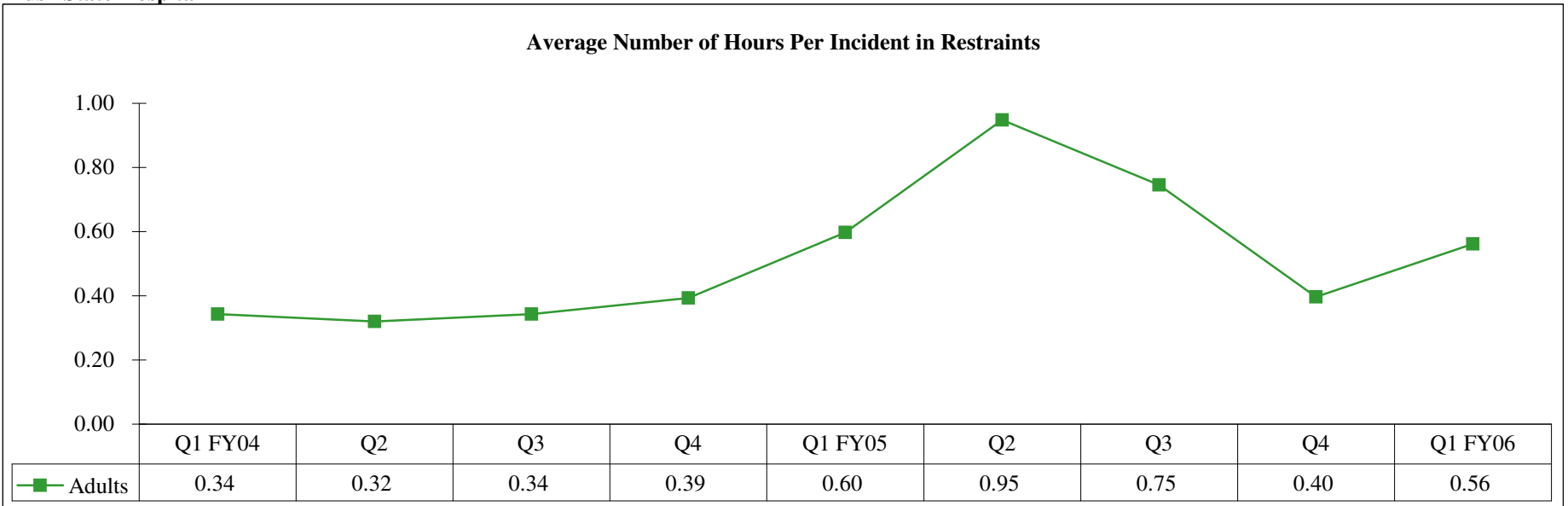
Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
Rusk State Hospital



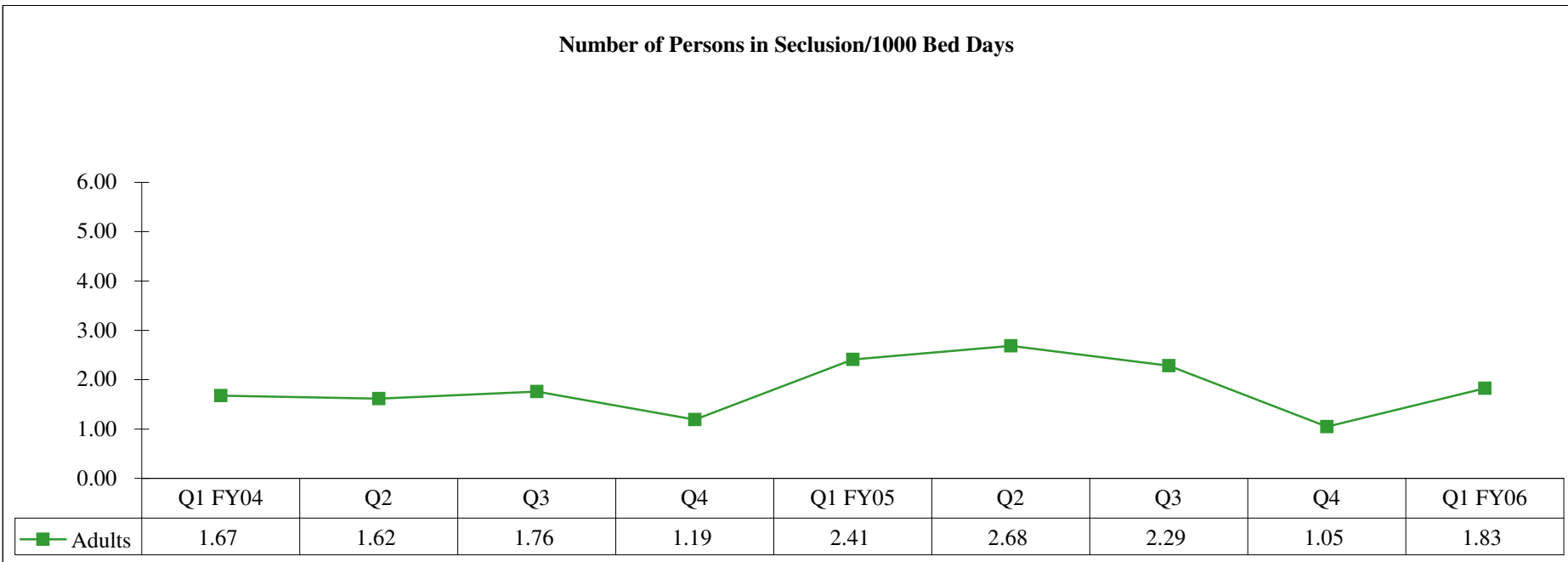
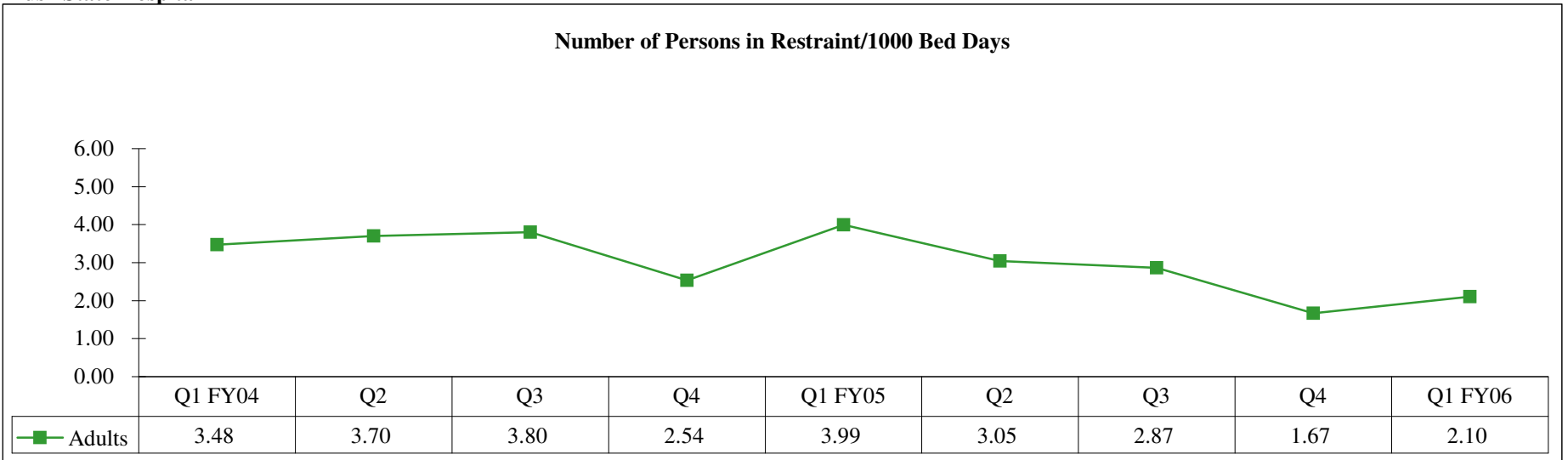
Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
Rusk State Hospital

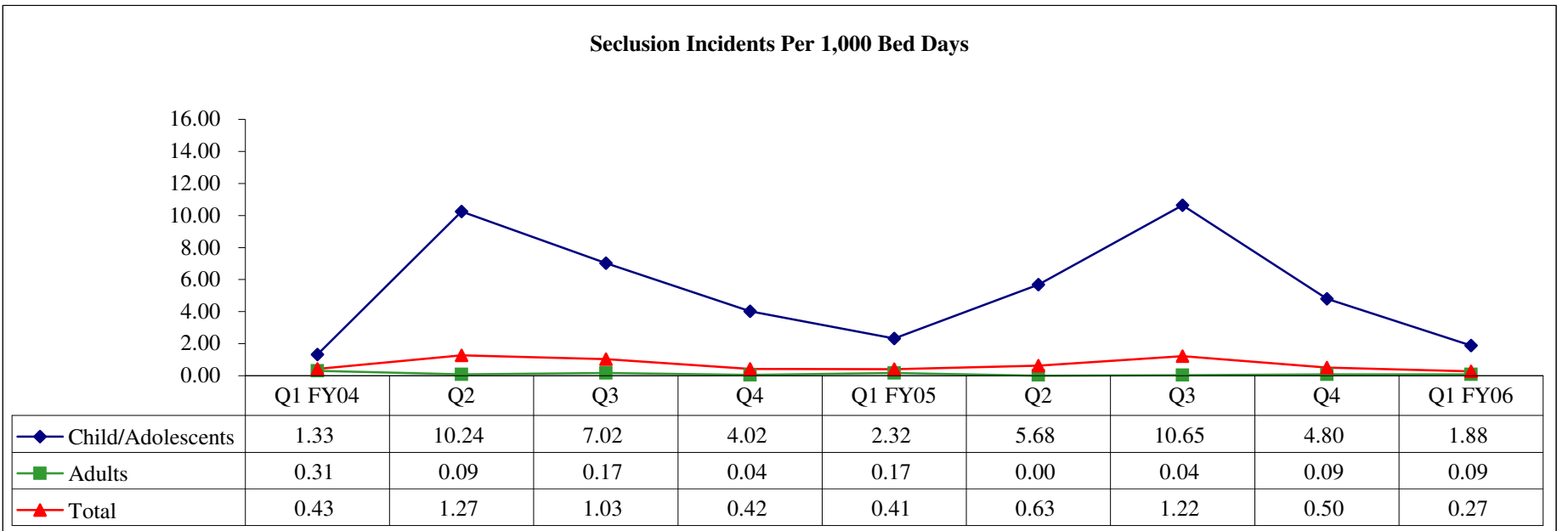
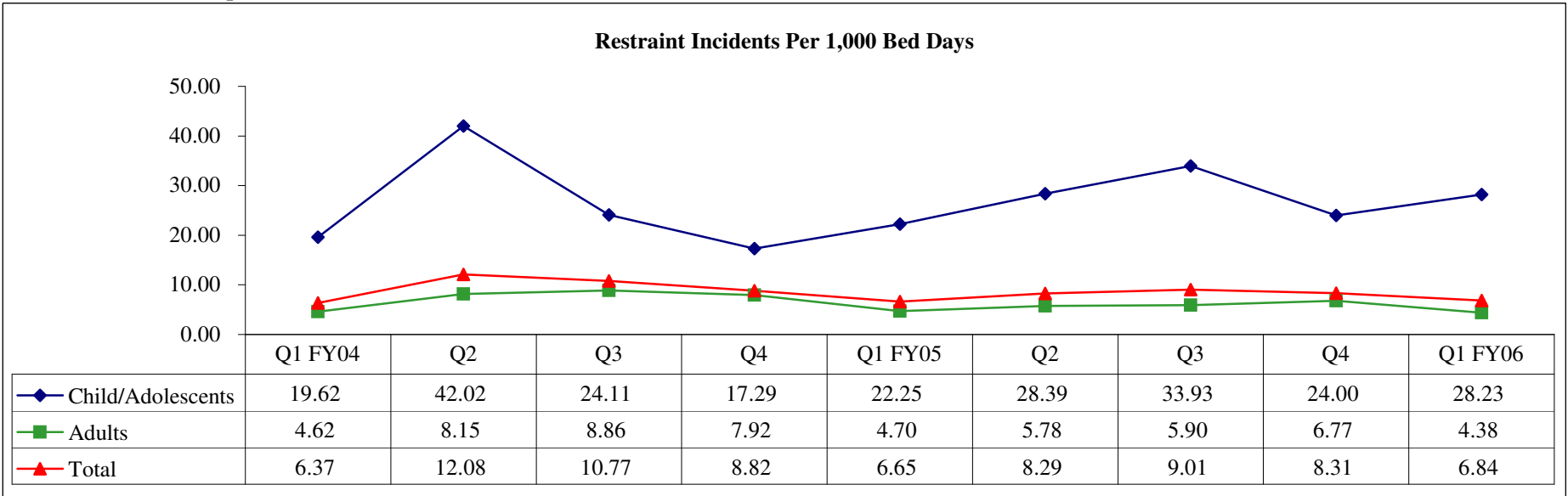


Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
Rusk State Hospital



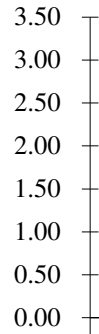
Objective 3B - Maintain Restraint and Seclusion Data
San Antonio State Hospital



Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

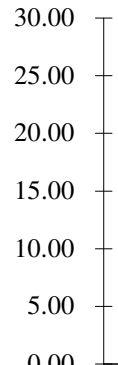
Objective 3B - Maintain Restraint and Seclusion Data
San Antonio State Hospital

Average Number of Hours Per Incident in Restraints



	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
◆ Child/Adolescents	0.78	0.67	0.63	0.69	0.63	0.65	0.57	0.58	0.73
■ Adults	0.64	0.85	0.84	0.67	1.06	0.74	0.82	0.99	1.06
▲ Total	0.69	0.77	0.78	0.68	0.90	0.70	0.71	0.89	0.92

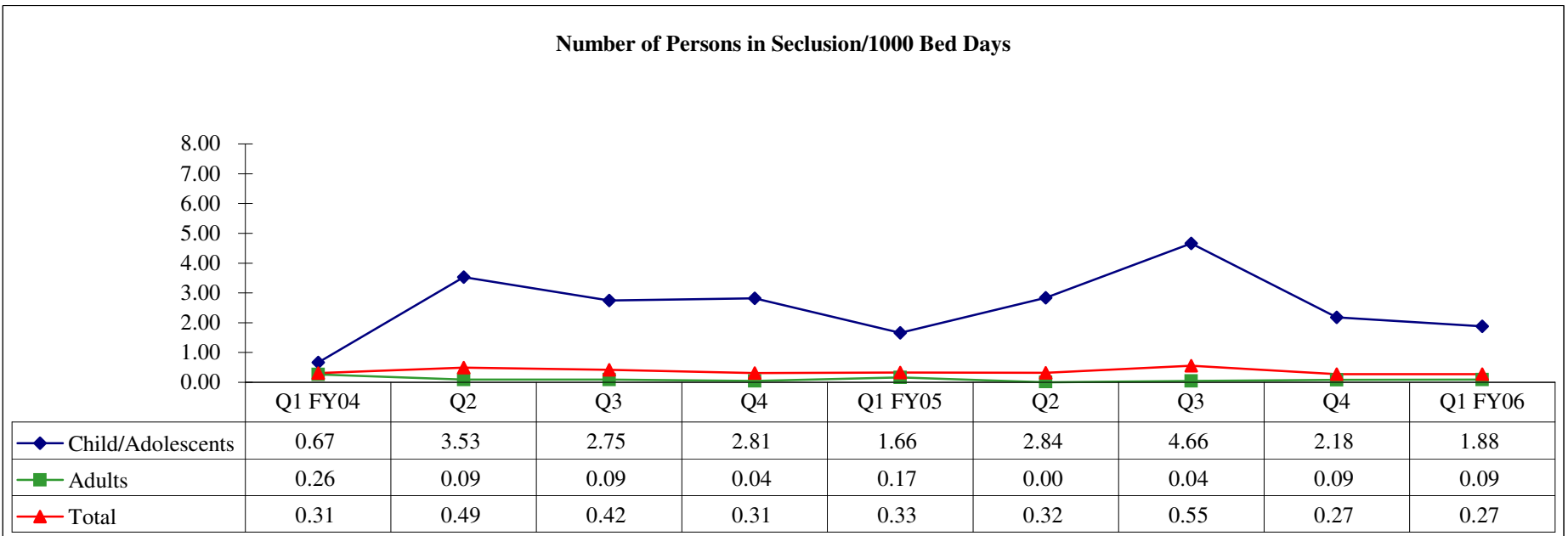
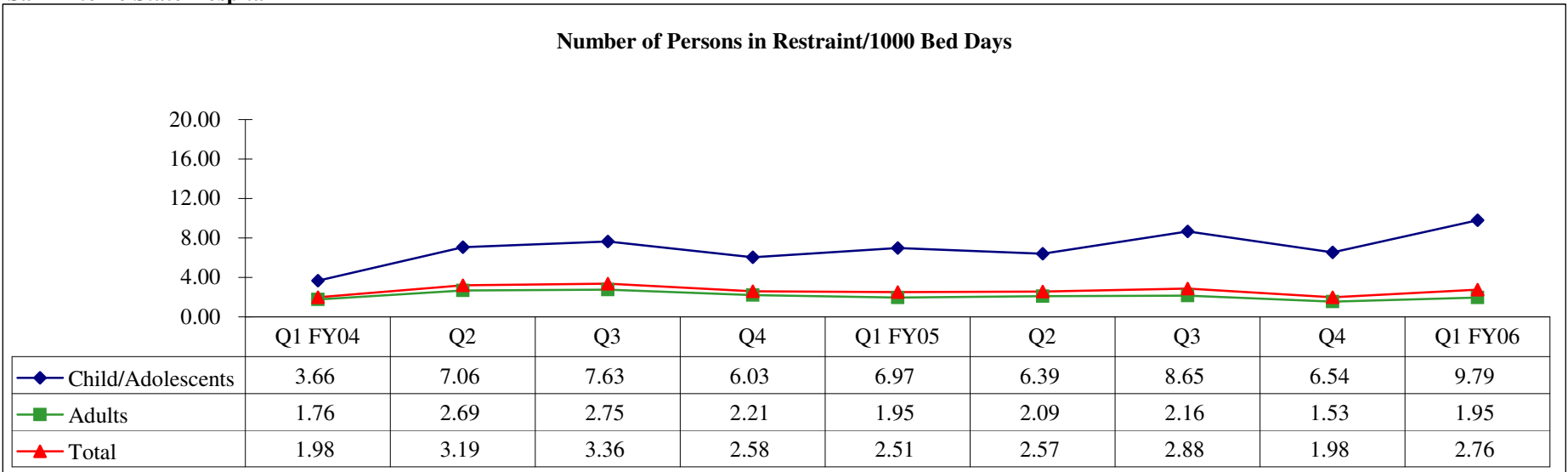
Average Number of Hours Per Incident in Seclusion



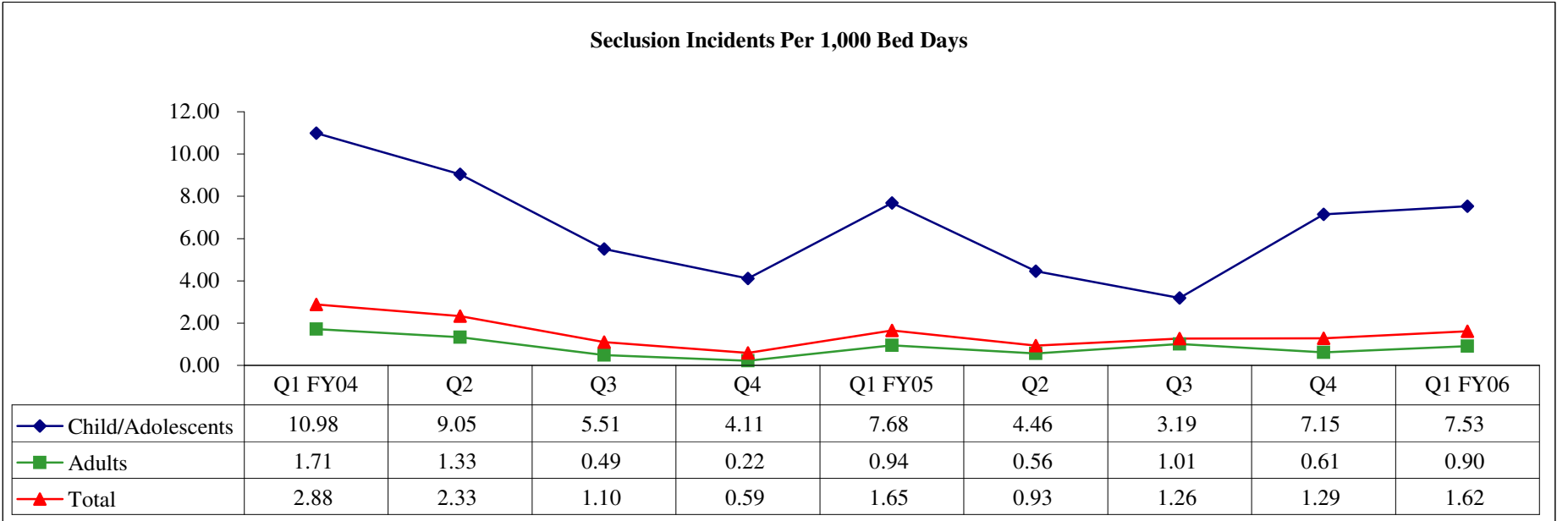
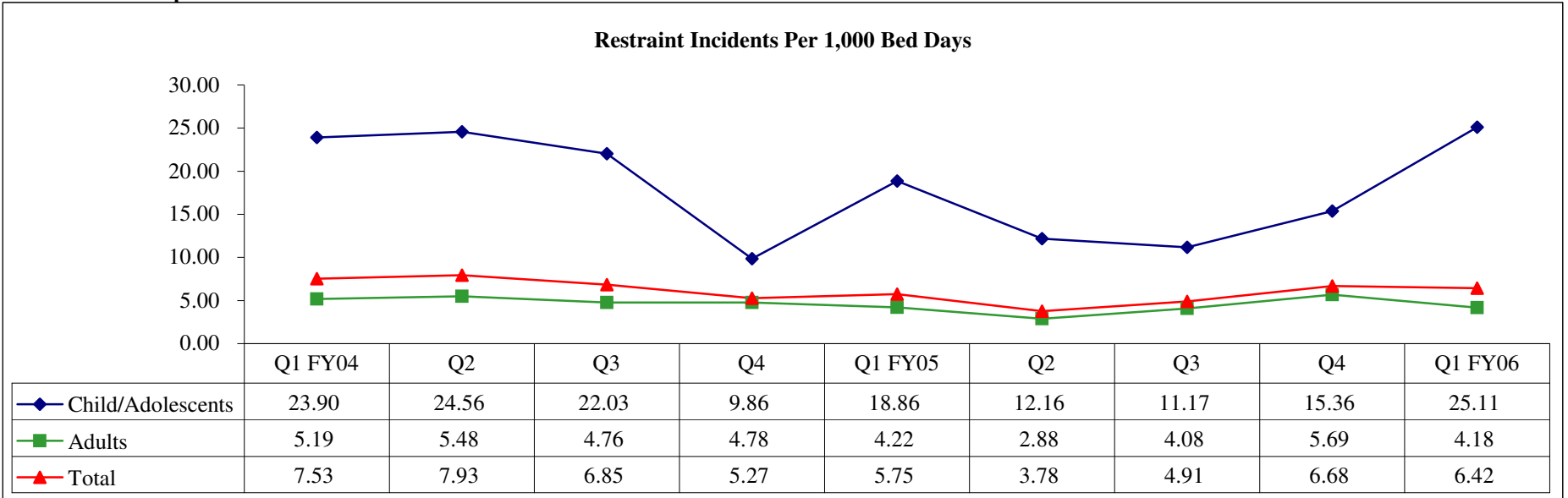
	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
◆ Child/Adolescents	0.60	1.56	1.34	1.51	0.93	0.99	1.07	0.79	0.52
■ Adults	1.64	0.90	2.95	2.50	2.00	0.00	0.30	5.35	0.35
▲ Total	1.26	1.52	1.58	1.60	1.32	0.99	1.04	1.49	0.47

Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

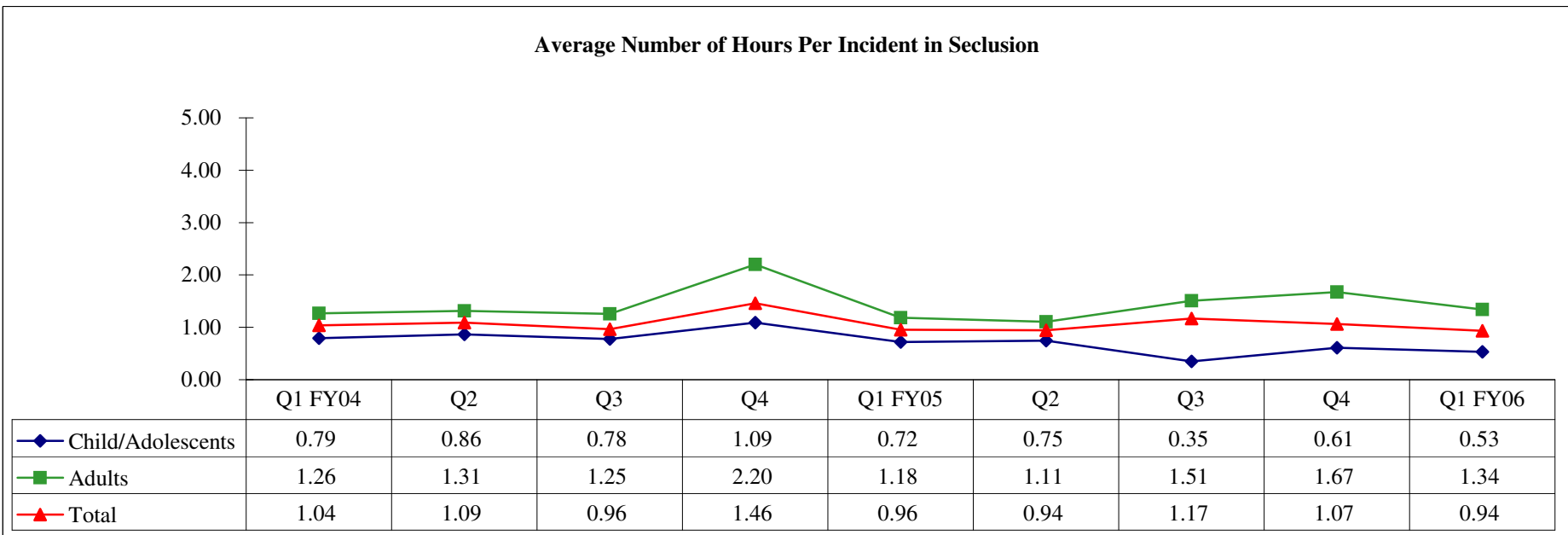
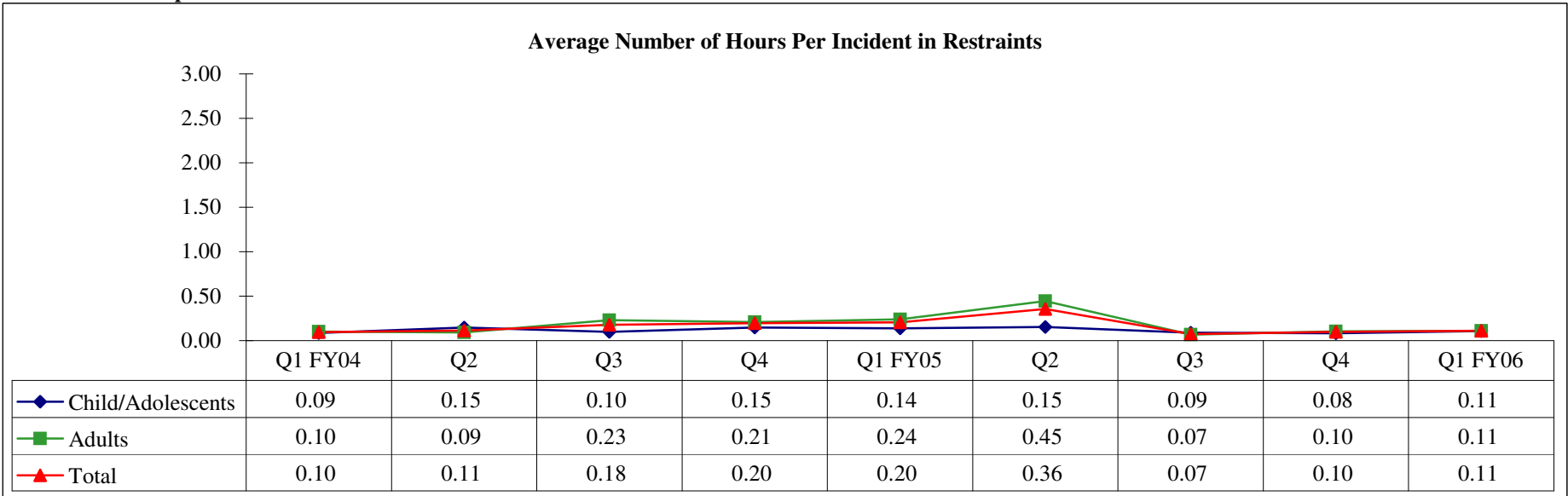
Objective 3B - Maintain Restraint and Seclusion Data
San Antonio State Hospital



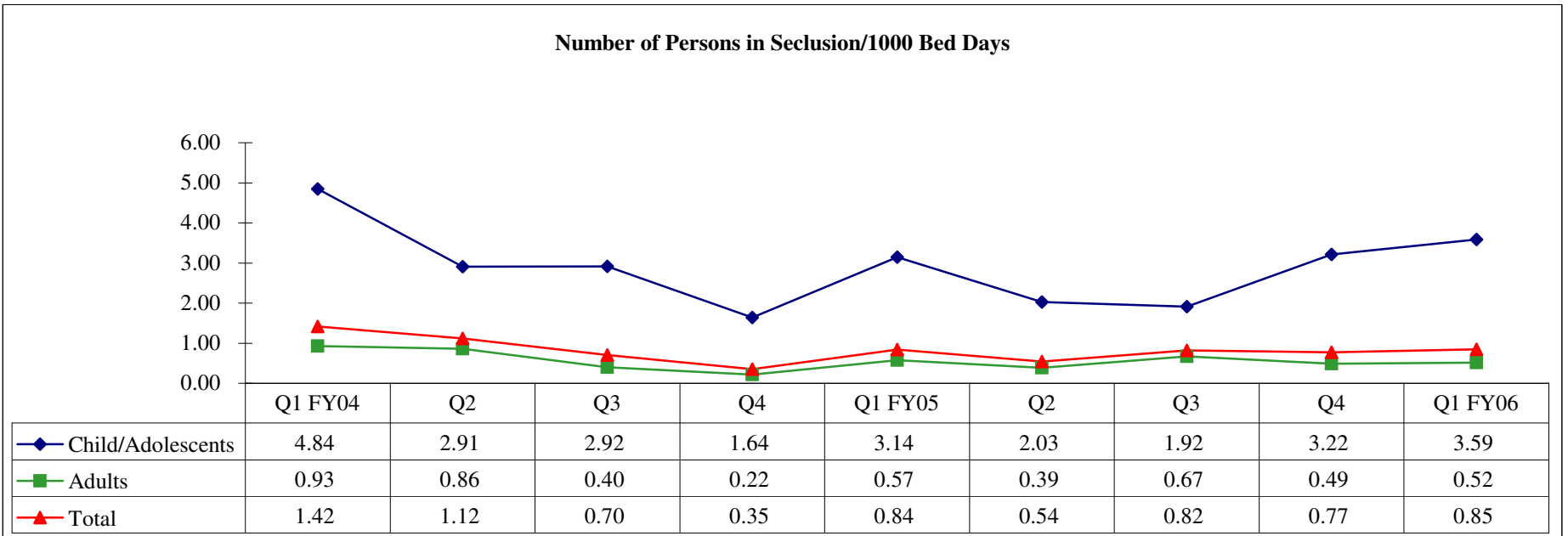
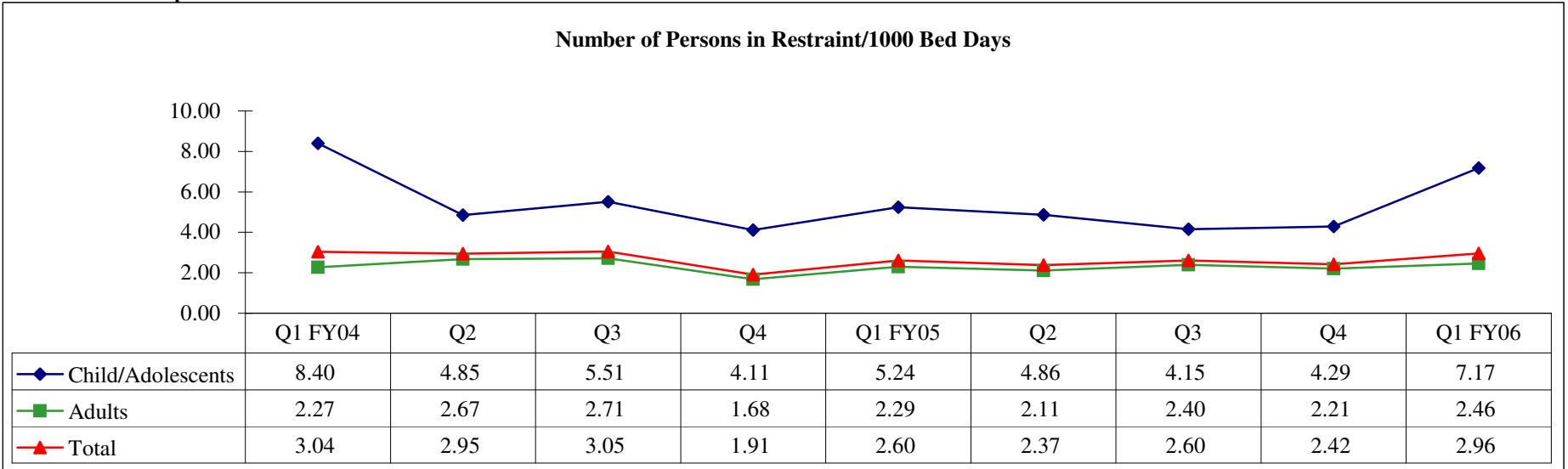
Objective 3B - Maintain Restraint and Seclusion Data
Terrell State Hospital



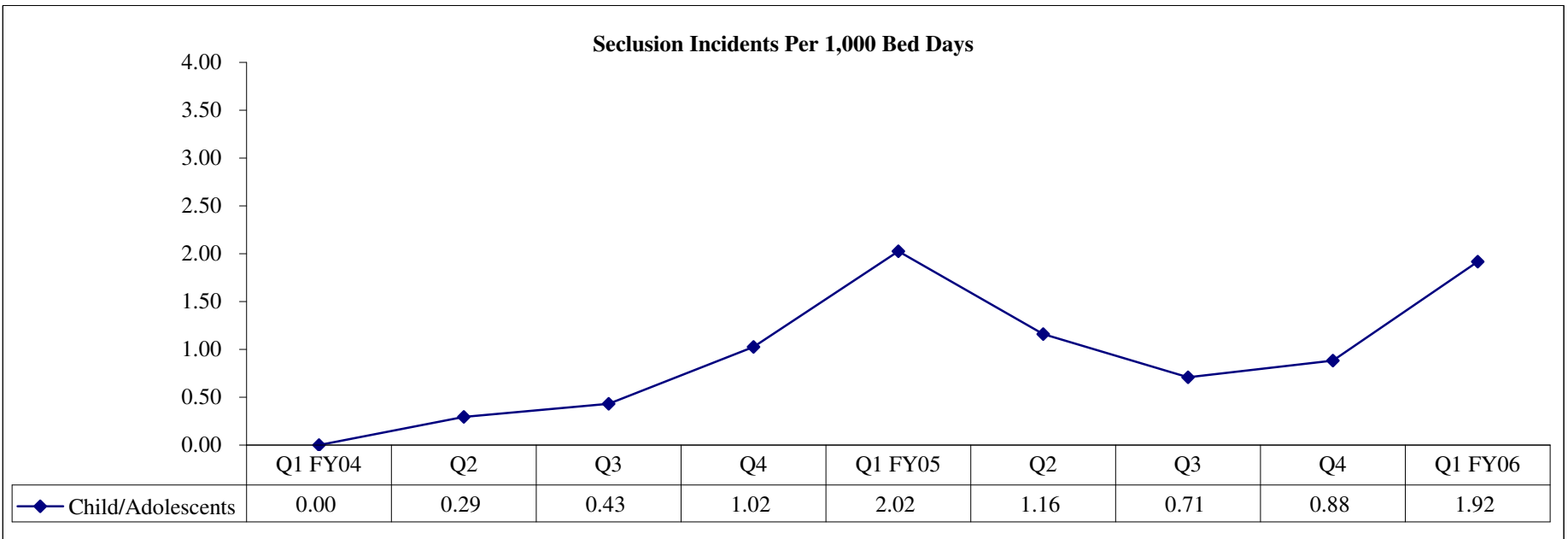
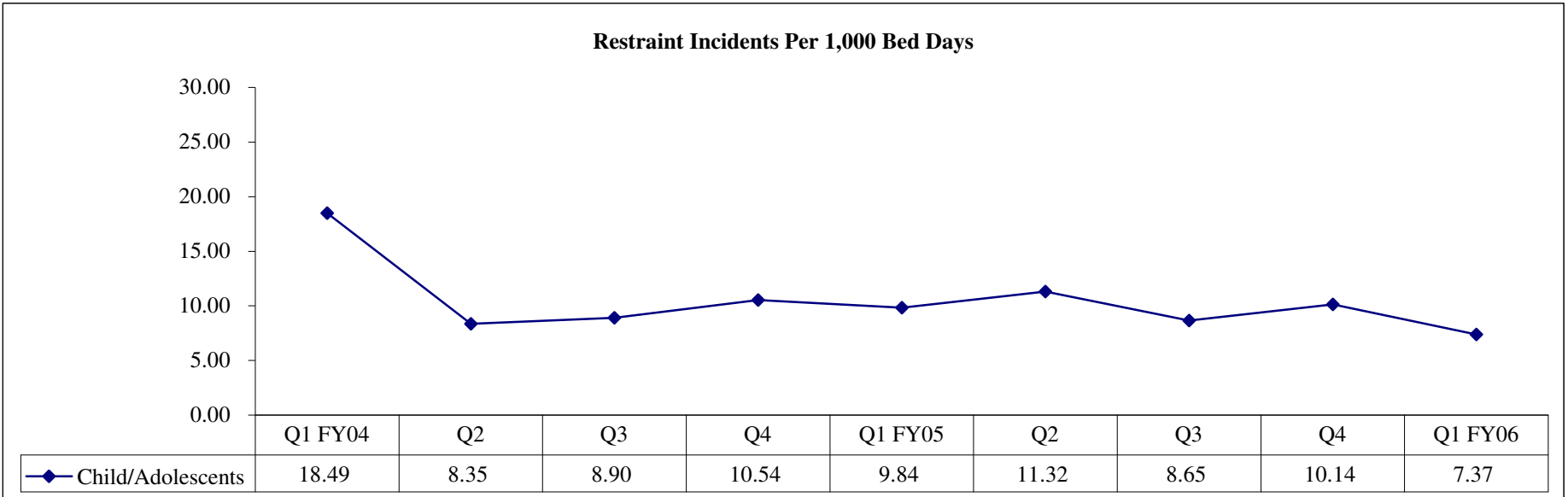
**Objective 3B - Maintain Restraint and Seclusion Data
Terrell State Hospital**



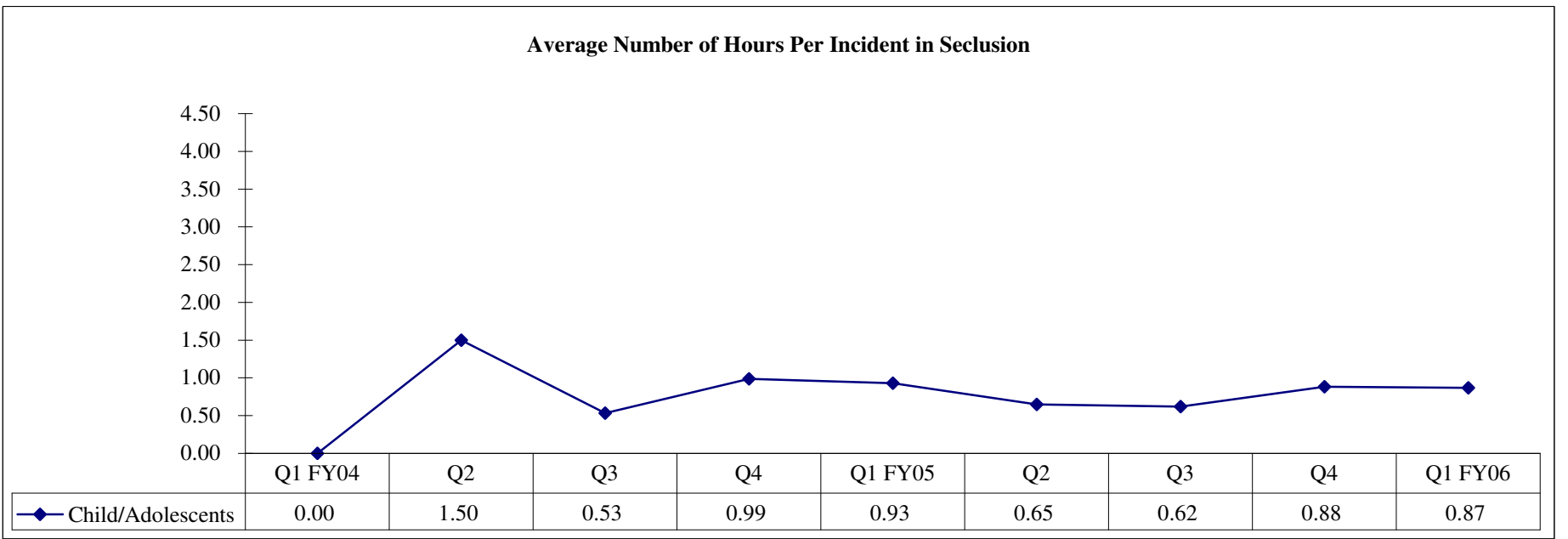
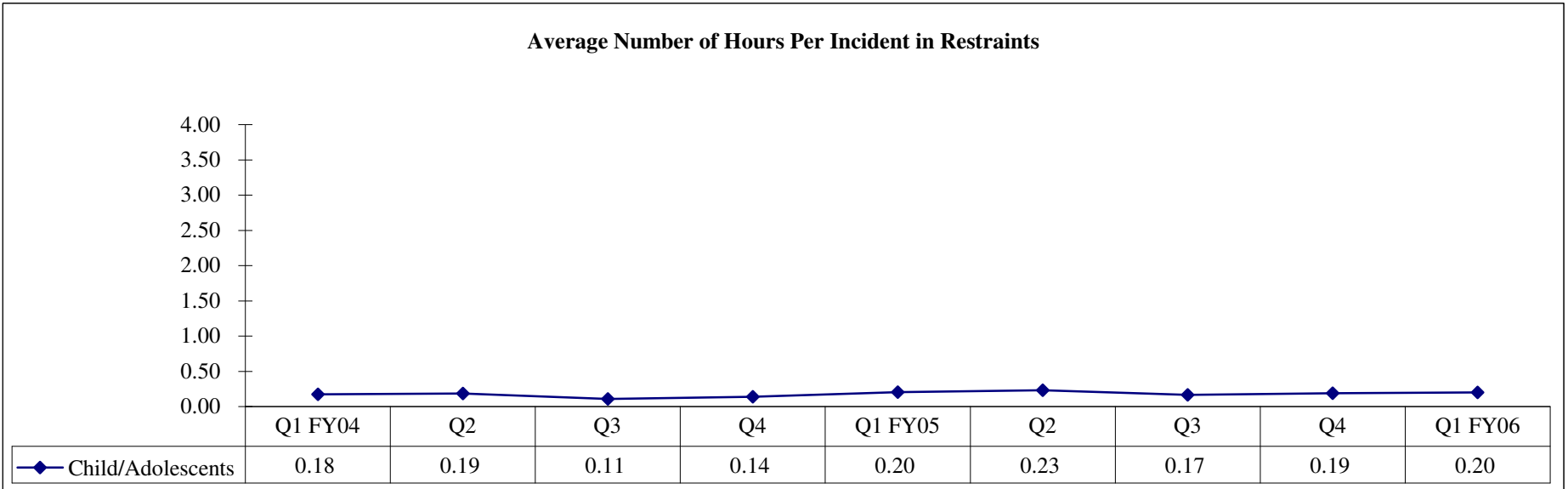
**Objective 3B - Maintain Restraint and Seclusion Data
Terrell State Hospital**



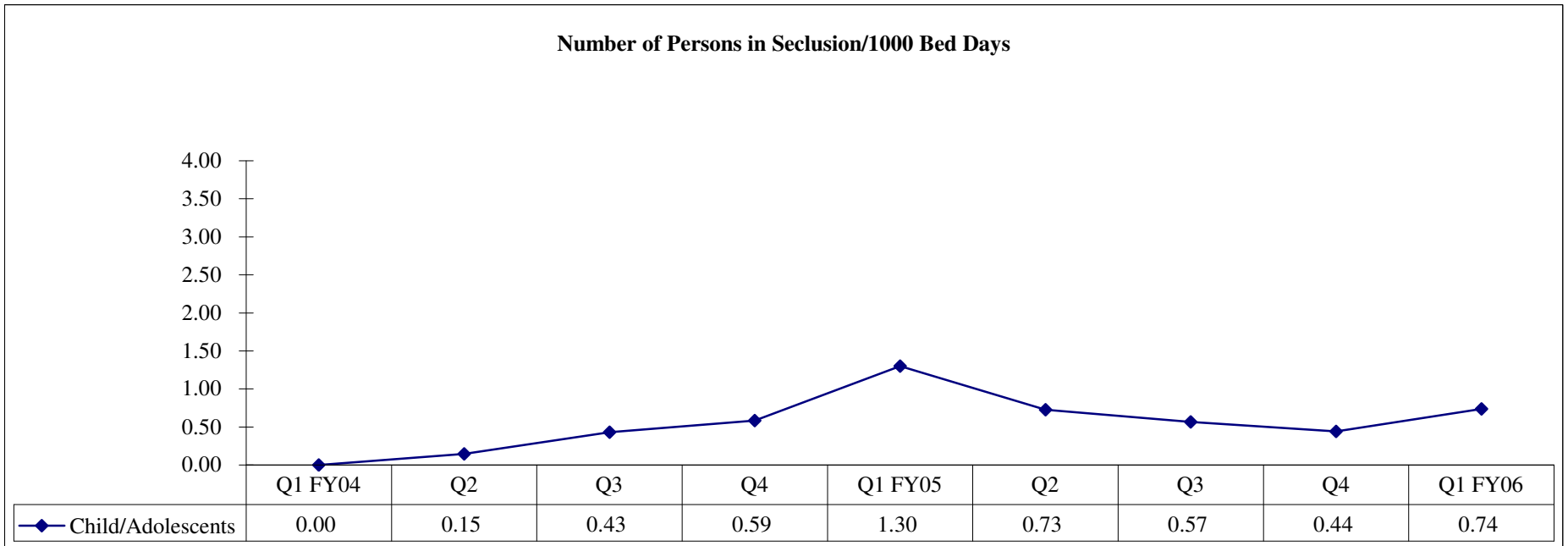
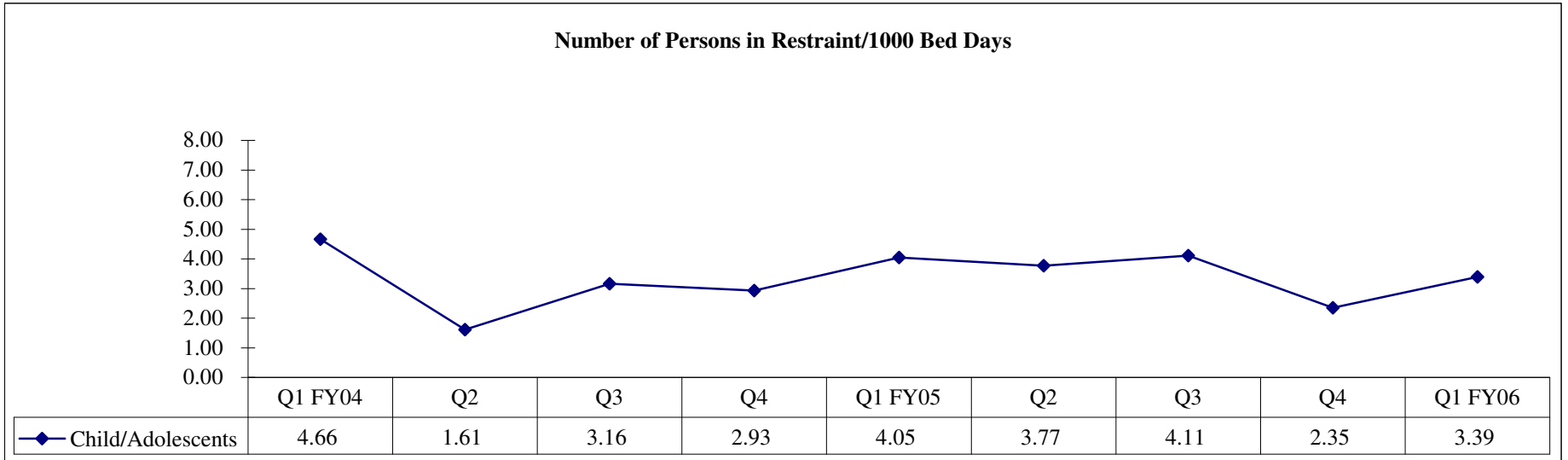
**Objective 3B - Maintain Restraint and Seclusion Data
Waco Center for Youth**



**Objective 3B - Maintain Restraint and Seclusion Data
Waco Center for Youth**



**Objective 3B - Maintain Restraint and Seclusion Data
Waco Center for Youth**



Performance Objective 3C:

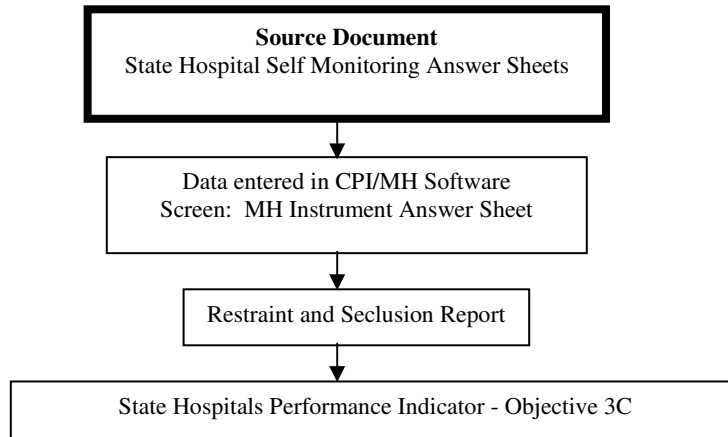
The Behavioral Restraint and Seclusion Monitoring Instrument will be utilized to assure the correct implementation of restraint and seclusion when it is necessary to utilize these procedures.

Performance Objective Operational Definition: Score from the CPI Restraint and Seclusion Monitoring instrument.

Performance Objective Formula: According to the CPI Restraint and Seclusion Monitoring instrument $[(\text{yes} + \text{no with}) / (\text{yes} + \text{no with} + \text{no}) \times 100]$.

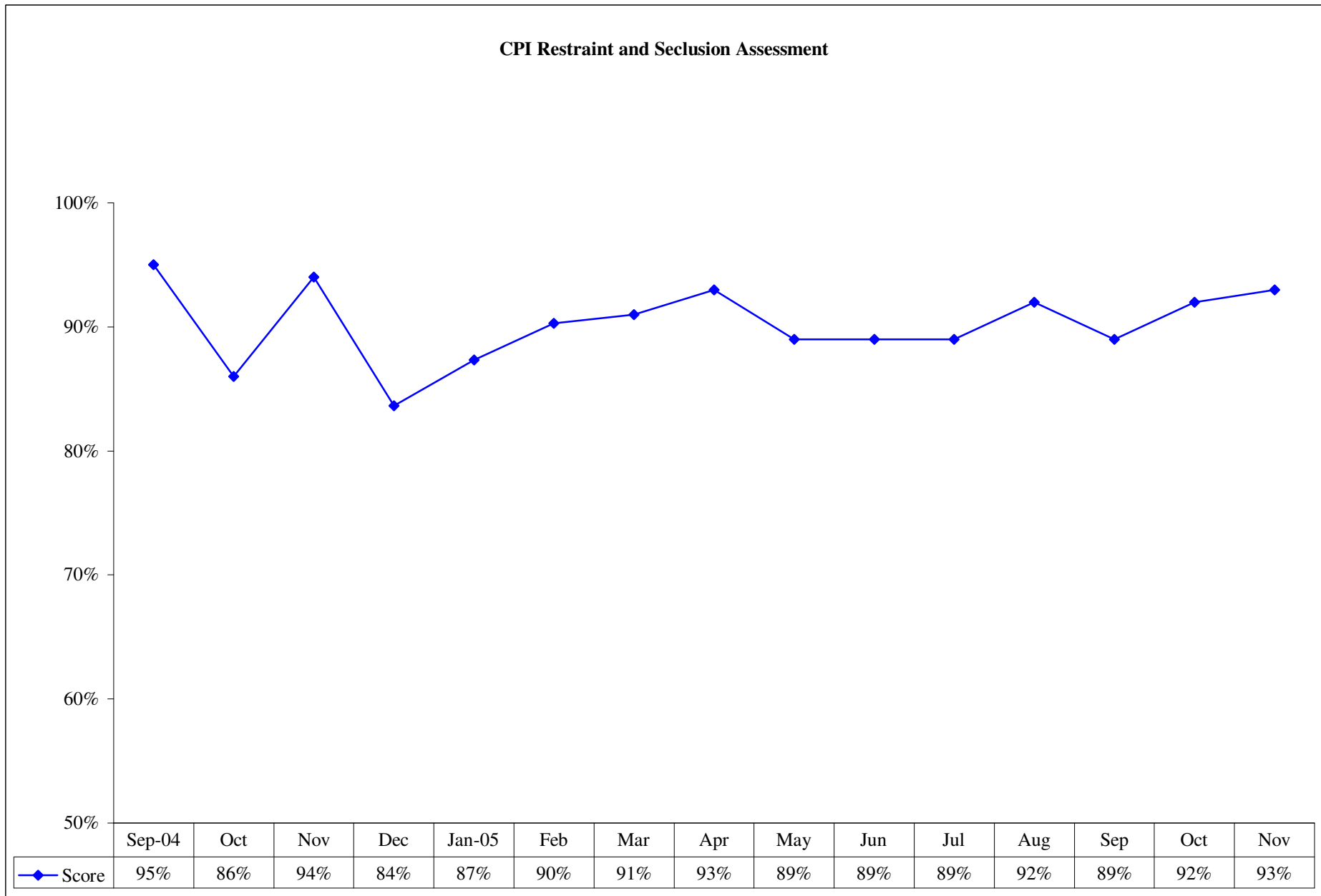
Performance Objective Data Display and Chart Description:
Chart with monthly data points of state hospital scores.

Data Flow:

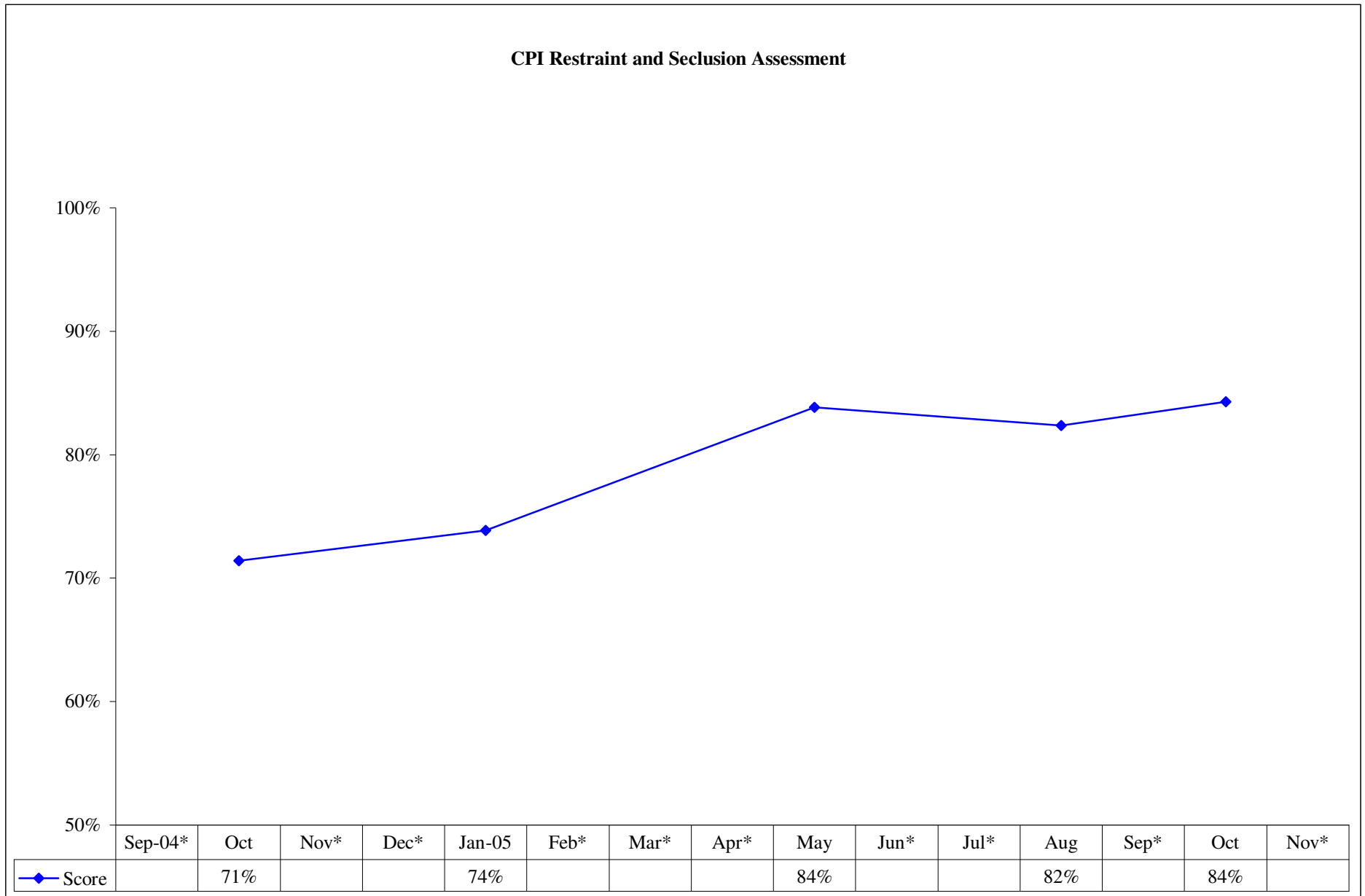


Data Integrity Review Process: (This process ensures the accuracy of data entered into the CPI software from the CPI answer sheets).

Objective 3C - Behavioral Restraint and Seclusion Assessment
All MH Facilities

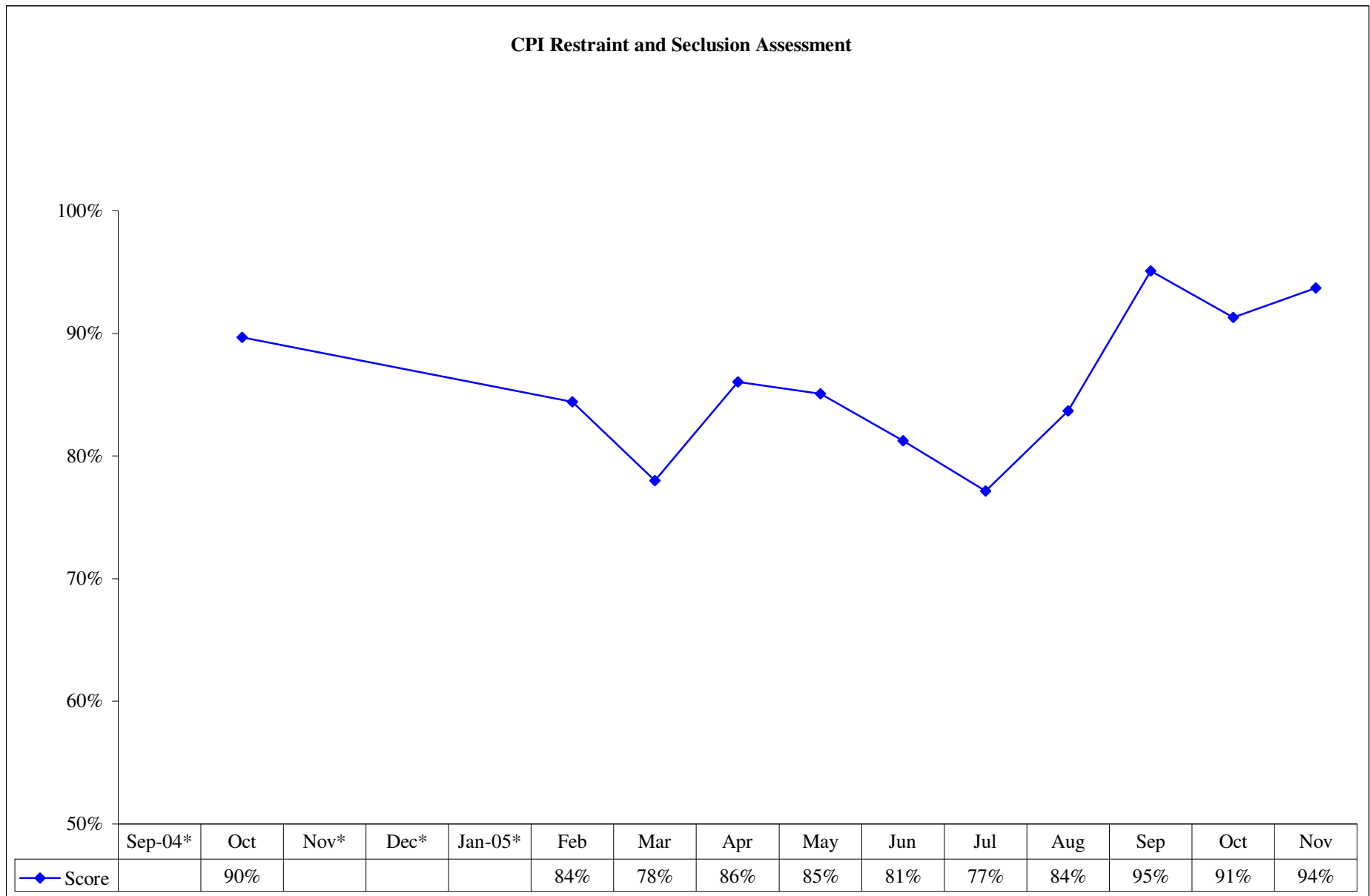


**Objective 3C - Behavioral Restraint and Seclusion Assessment
Austin State Hospital**



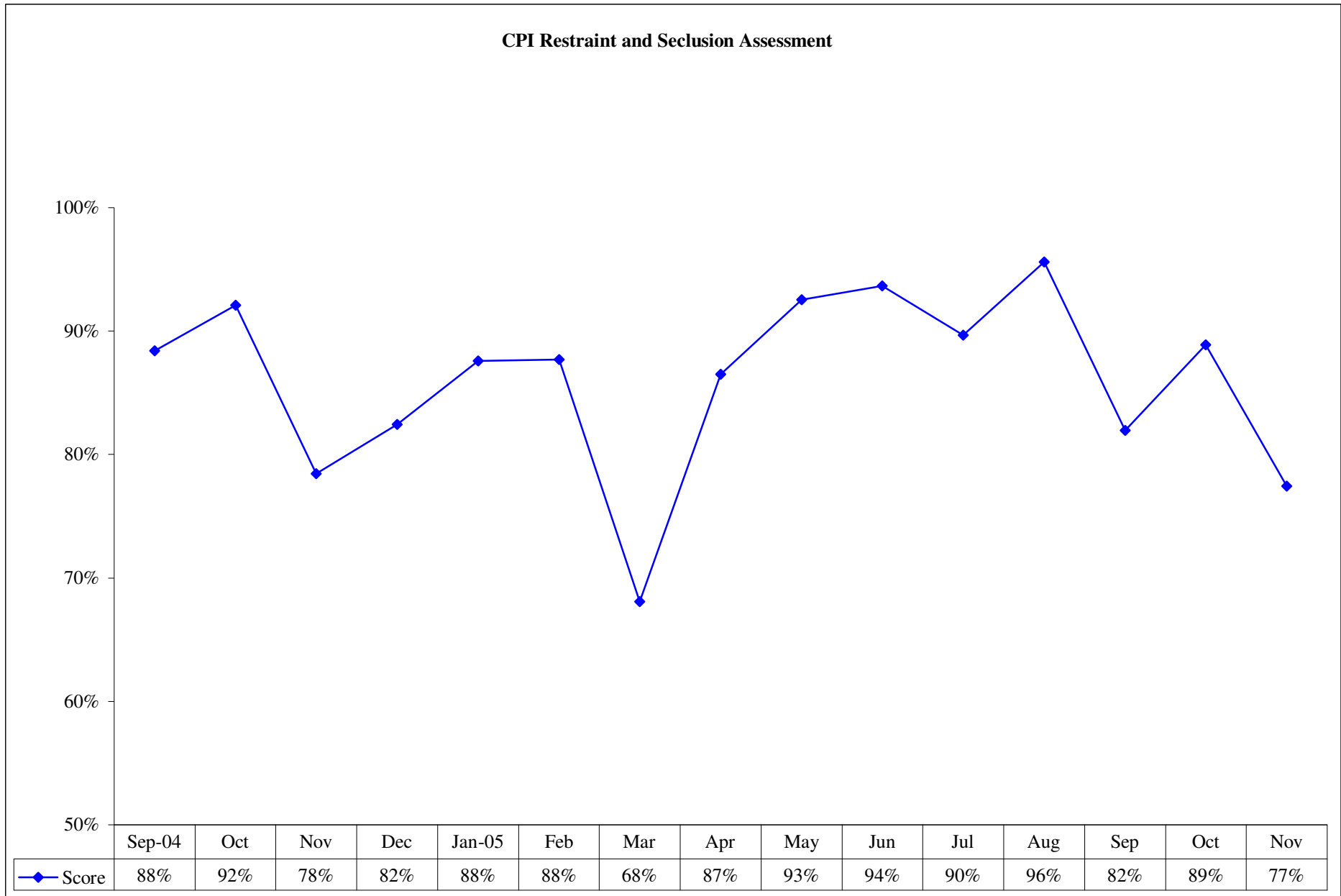
*No scores reported to HMDS.

Objective 3C - Behavioral Restraint and Seclusion Assessment
Big Spring State Hospital

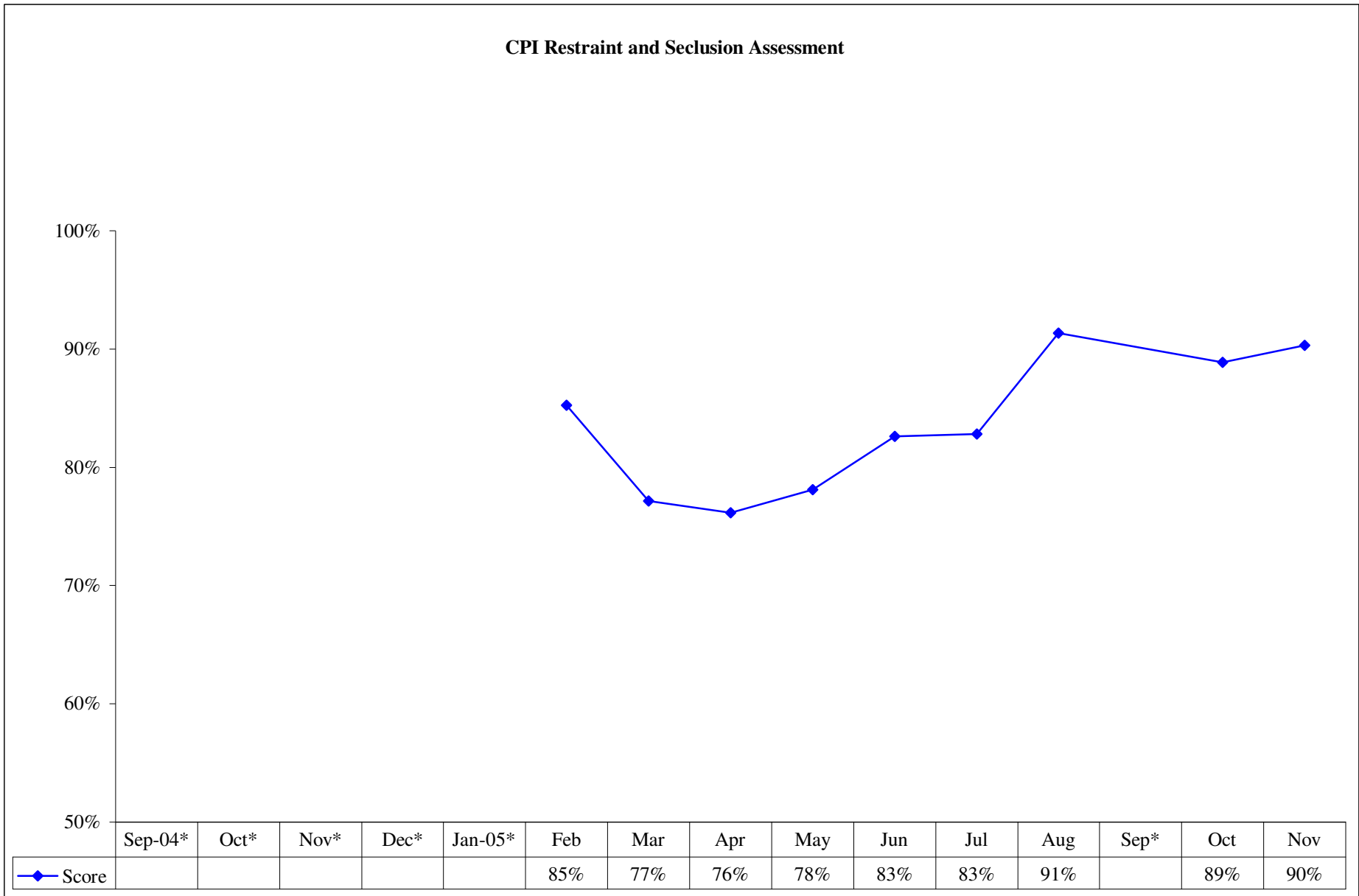


*No scores reported to HMDS.

Objective 3C - Behavioral Restraint and Seclusion Assessment
El Paso Psychiatric Center



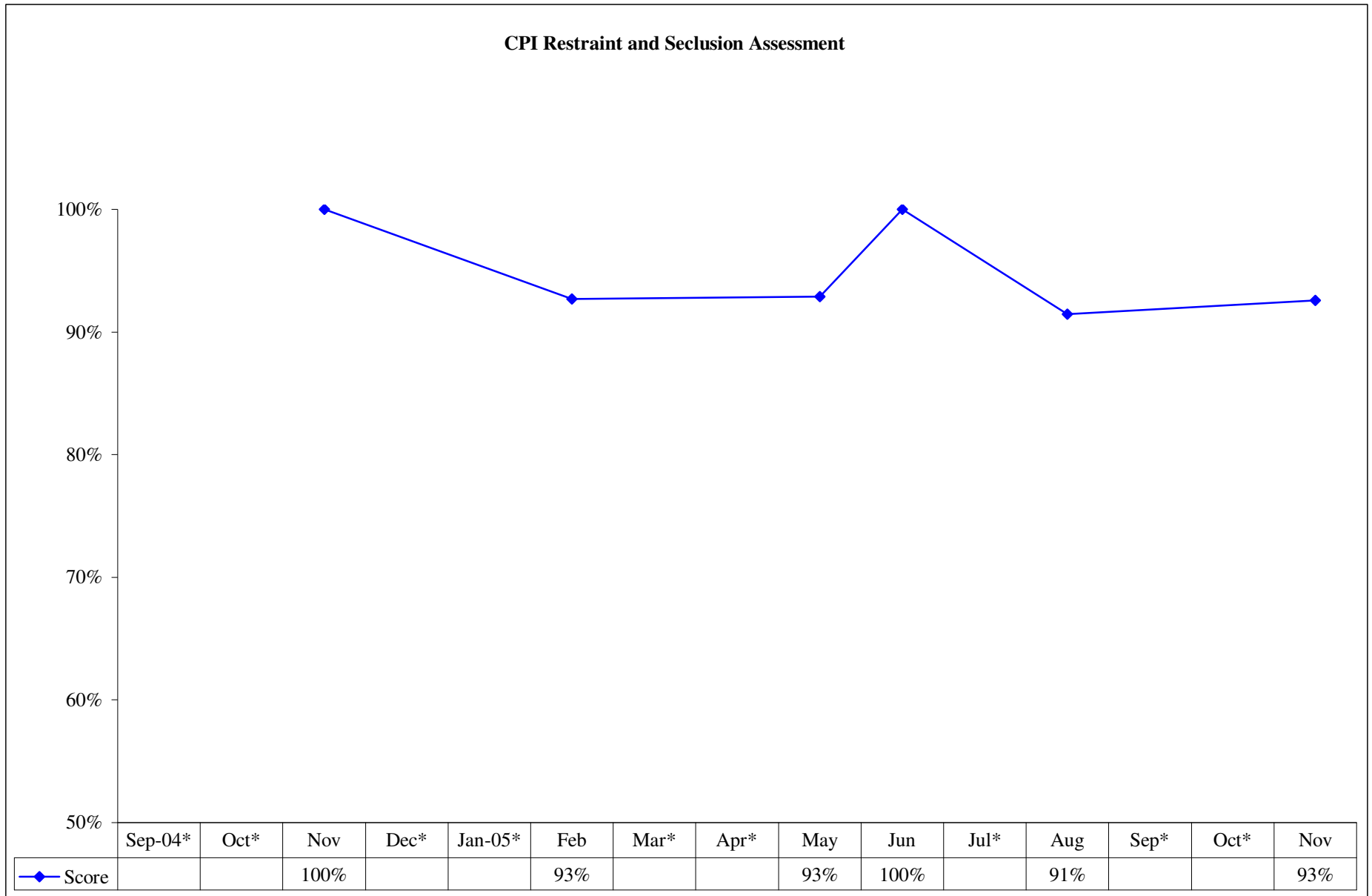
**Objective 3C - Behavioral Restraint and Seclusion Assessment
Kerrville State Hospital**



*No scores reported to HMDS.

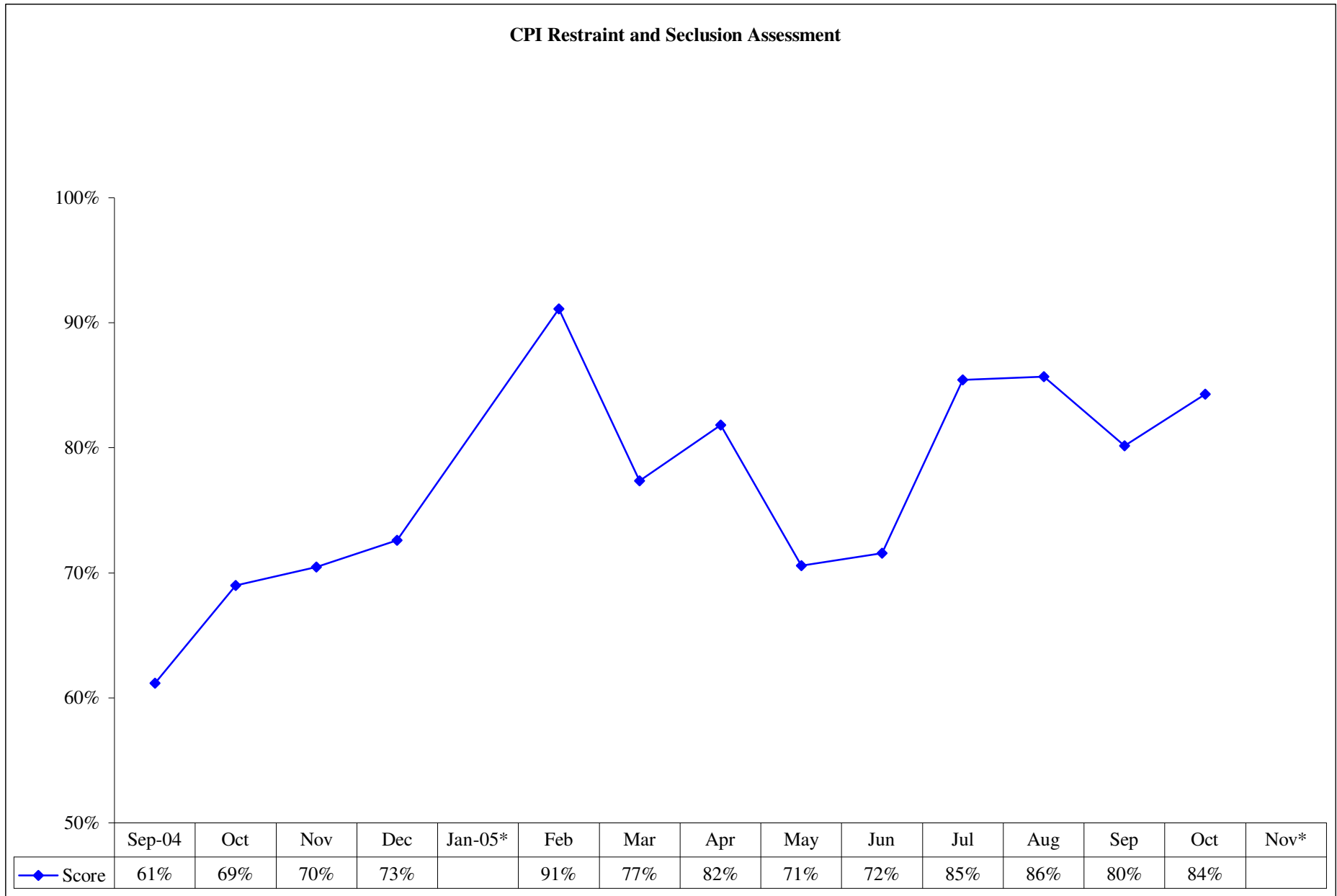
Source: QSO/MDS

Objective 3C - Behavioral Restraint and Seclusion Assessment
North Texas State Hospital

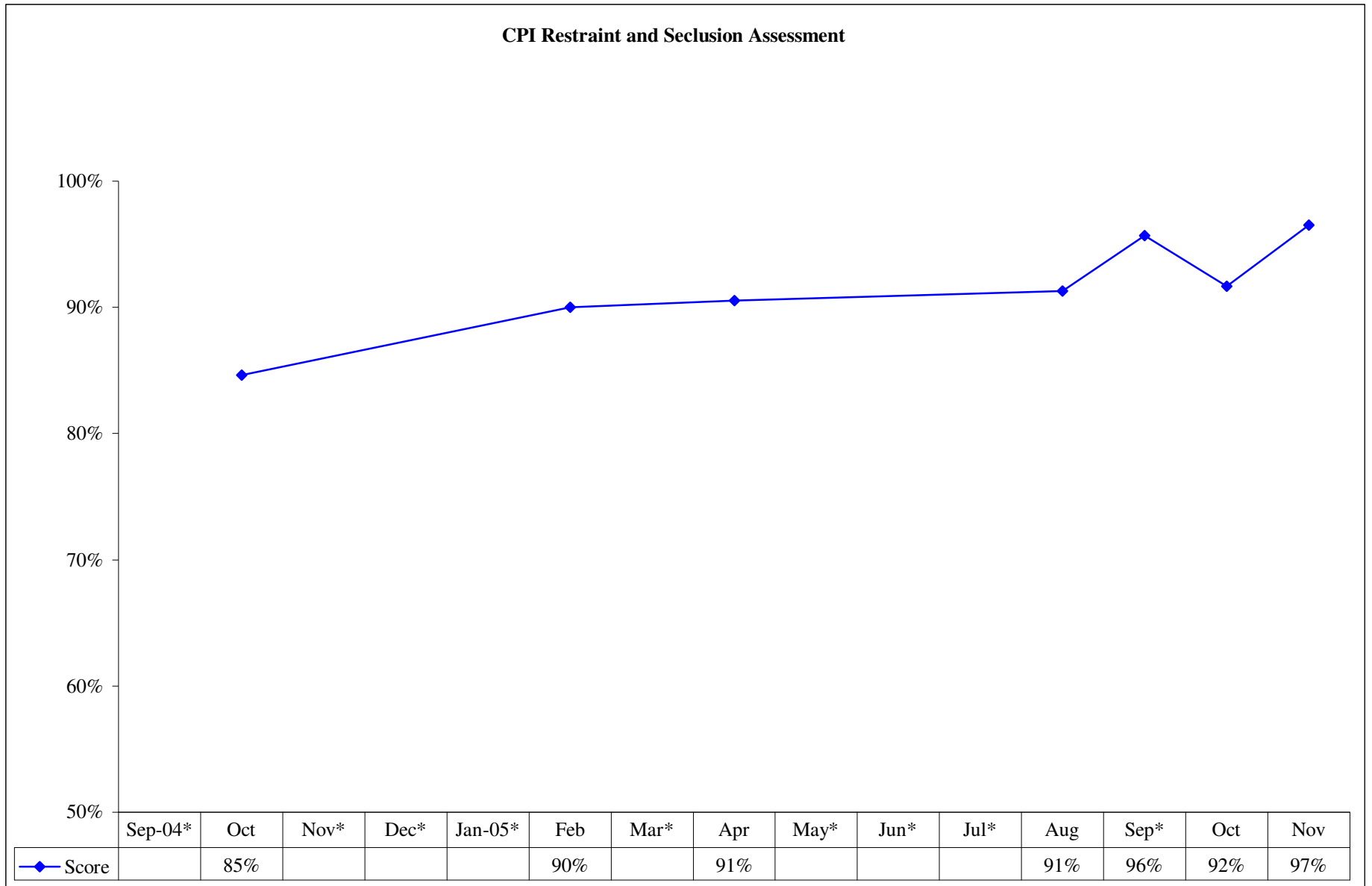


*No scores reported to HMDS.

Objective 3C - Behavioral Restraint and Seclusion Assessment
Rio Grande State Center

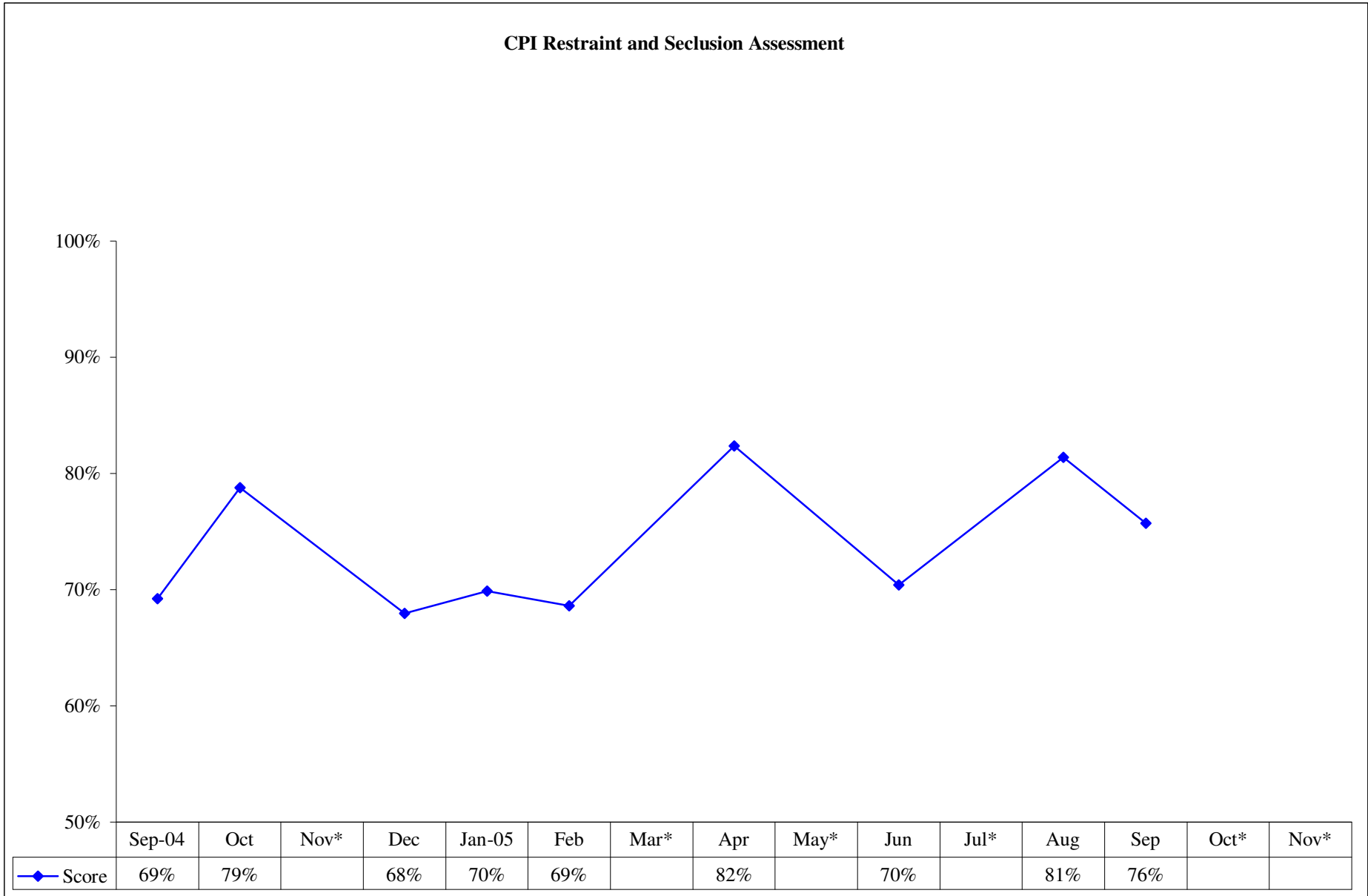


Objective 3C - Behavioral Restraint and Seclusion Assessment
Rusk State Hospital



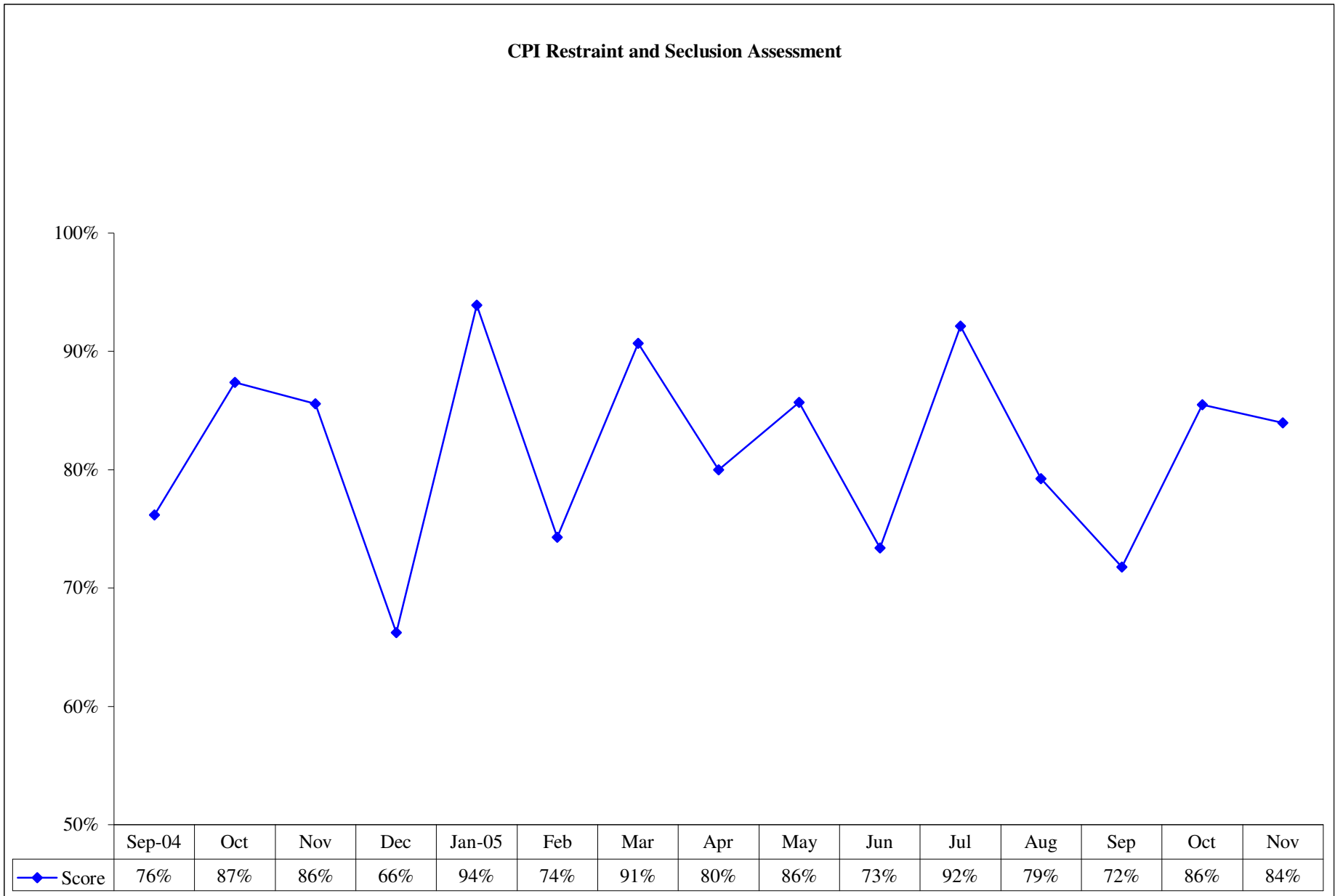
*No scores reported to HMDS.

Objective 3C - Behavioral Restraint and Seclusion Assessment
San Antonio State Hospital

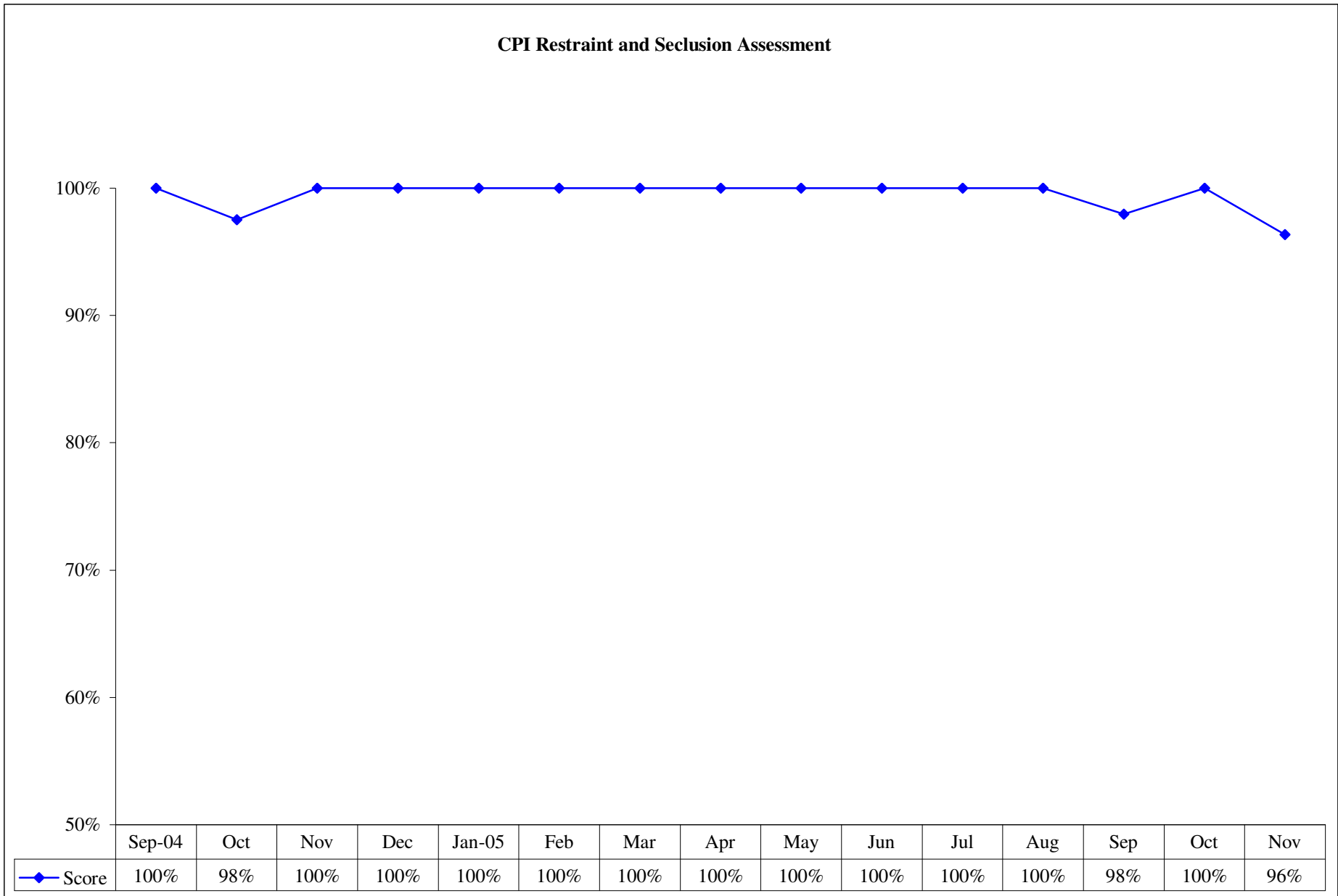


*No scores reported to HMDS.

Objective 3C - Behavioral Restraint and Seclusion Assessment
Terrell State Hospital



**Objective 3C - Behavioral Restraint and Seclusion Assessment
Waco Center for Youth**



Performance Objective 3F:

Patients will be treated in accordance with TIMA guidelines as measured by:

- 1. Assignment of the appropriate algorithm as measured by matching diagnosis to algorithm at the time of discharge.**
- 2. Use of TIMA rating scales as measured by percent of patients with scores from 2 or more different dates.**

Performance Objective Operational Definition: Total of patients with episodes that are tracked by TIMA. The last diagnosis entered into CWS is the diagnosis that will be compared to the TIMA algorithm/stage documented on the Physicians Discharge Order/Note.

Performance Objective Formula: $R = (N/D)$

R = rate of patients that are tracked by TIMA

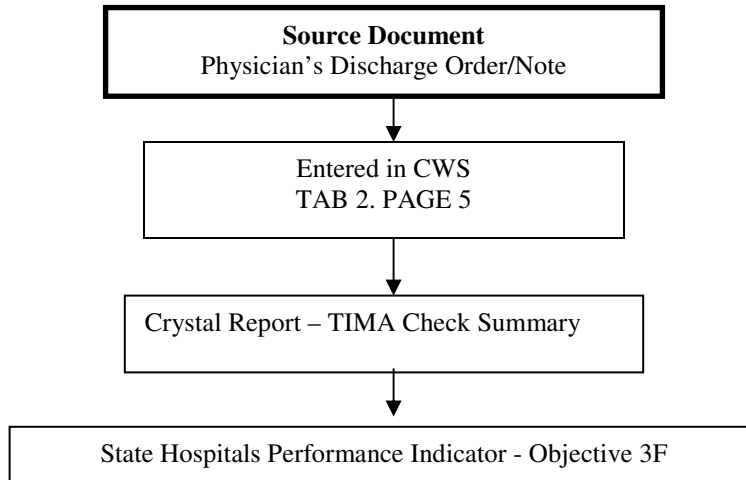
N = patients with episodes that are tracked by TIMA

D = patients with episodes that should be tracked by TIMA

Performance Objective Data Display and Chart Description:

- ◆ Table shows the percent of patients with episodes that are tracked by TIMA for individual state hospitals.
- ◆ Chart with monthly data points of percent of patients with episodes that are tracked by TIMA, number of patients with episodes that should be tracked and number of patients with episodes that are tracked for individual state hospitals and system-wide.

Data Flow:

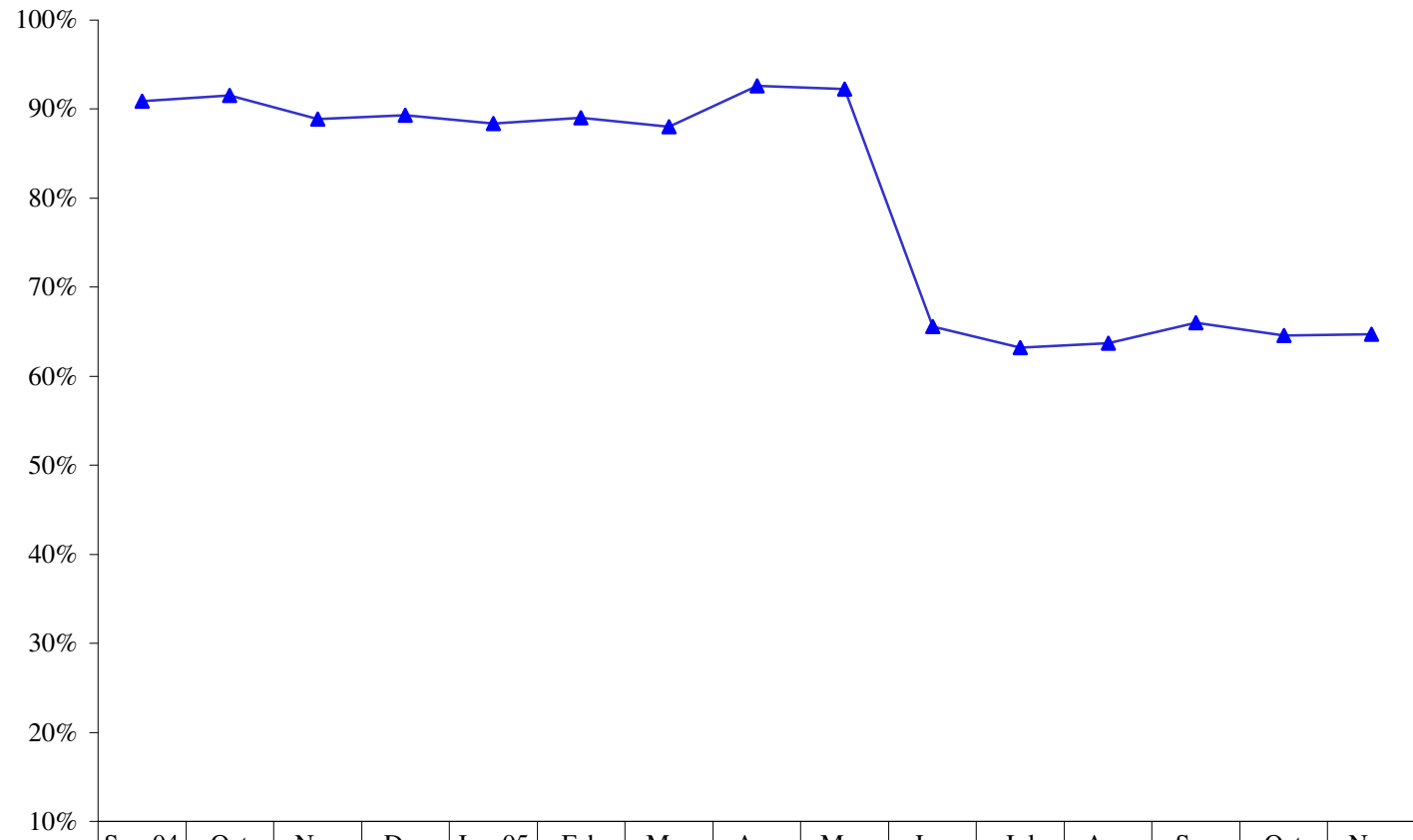


Data Integrity Review Process:

Monitoring Method	Desk and Record Review of applicable TIMA data
Monitoring Instrument/Tool	TIMA Details CWS Report and DIR Tally Sheet
Description of Review Process	Compare the TIMA algorithm and stage in the TIMA Details CWS Report to the corresponding information in the CWS Physician's Discharge Order/Note.
Facility and DIR Sample Size	In a given quarter, 30 randomly selected cases are reviewed.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When there is missing or incorrect data for the quarter reviewed.
DIR/HMDS Report	Summary of review including findings and data analysis

**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
All MH Facilities**

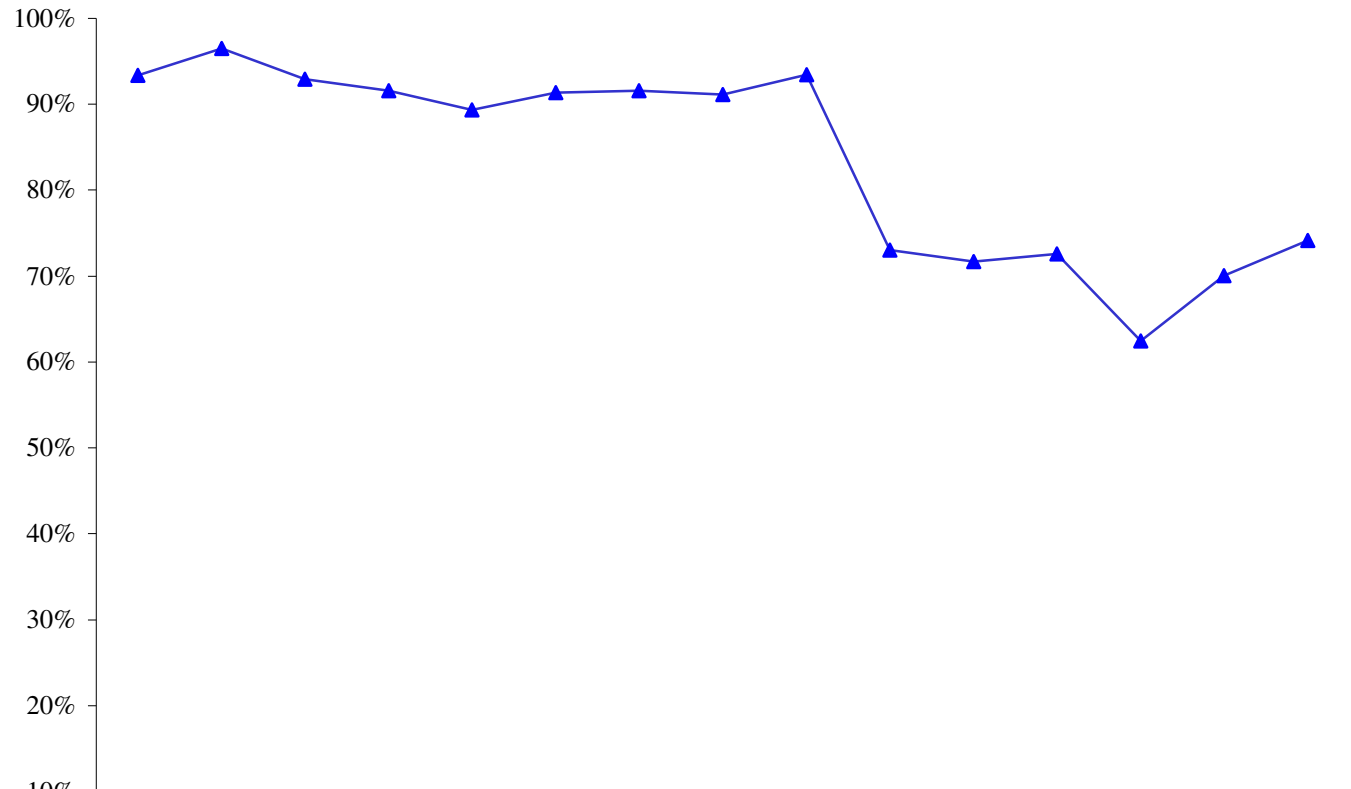
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	1067	1067	908	1017	1014	945	1128	1051	1060	1188	1061	1106	1109	1052	1010
Patients with Episodes that are Tracked	970	977	807	908	896	841	993	973	978	779	671	705	732	679	654
▲ Percent Tracked by TIMA	91%	92%	89%	89%	88%	89%	88%	93%	92%	66%	63%	64%	66%	65%	65%

**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
Austin State Hospital**

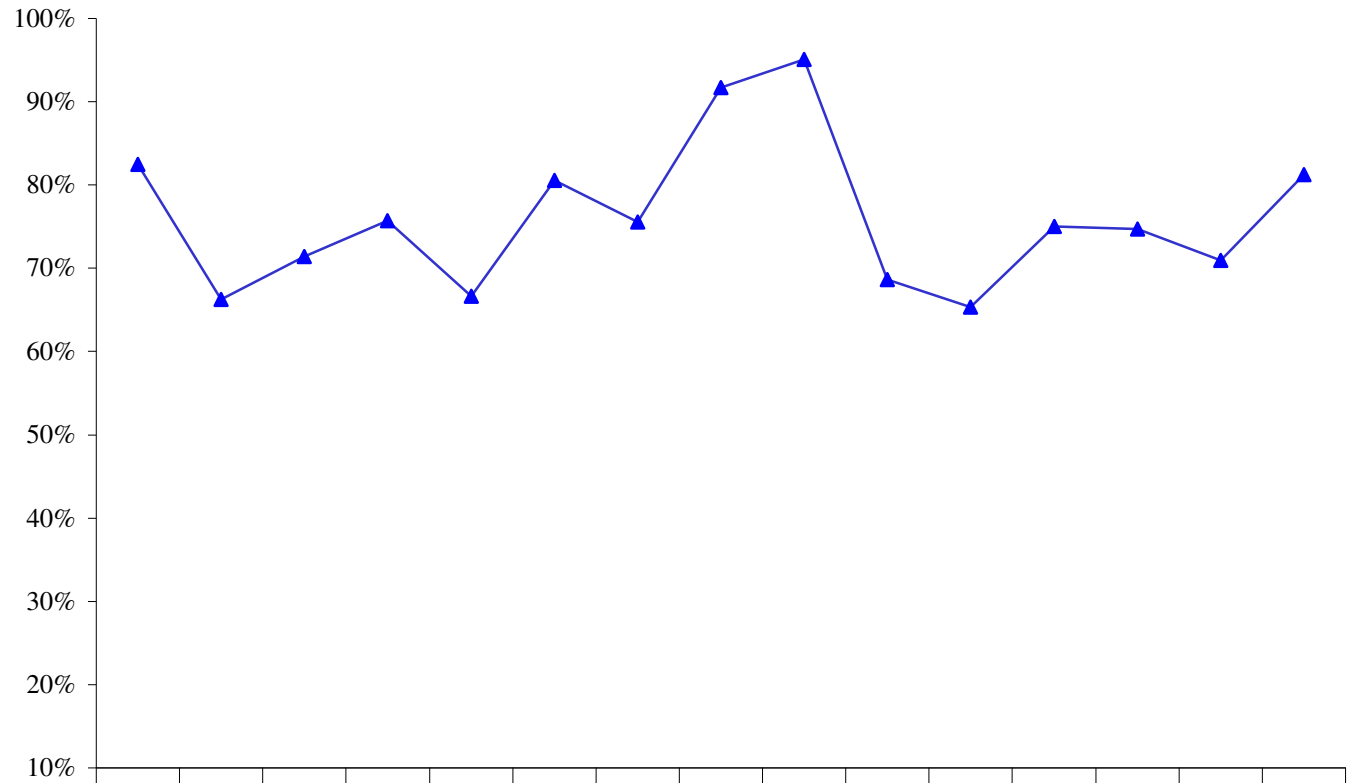
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	255	230	212	226	234	231	285	282	273	282	254	237	245	217	259
Patients with Episodes that are Tracked	238	222	197	207	209	211	261	257	255	206	182	172	153	152	192
▲ Percent Tracked by TIMA	93%	97%	93%	92%	89%	91%	92%	91%	93%	73%	72%	73%	62%	70%	74%

**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
Big Spring State Hospital**

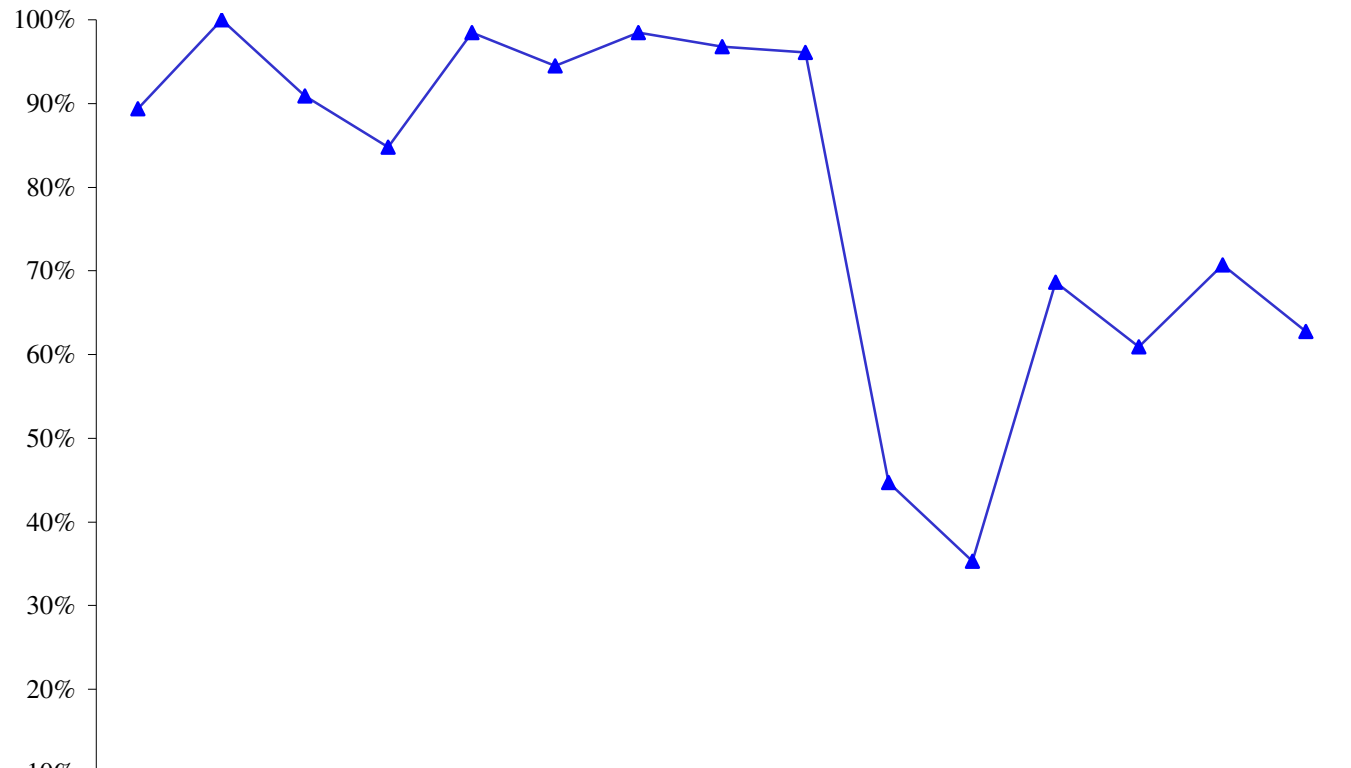
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	80	80	63	74	66	77	86	60	61	67	75	72	83	62	80
Patients with Episodes that are Tracked	66	53	45	56	44	62	65	55	58	46	49	54	62	44	65
▲ Percent Tracked by TIMA	83%	66%	71%	76%	67%	81%	76%	92%	95%	69%	65%	75%	75%	71%	81%

**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
El Paso Psychiatric Center**

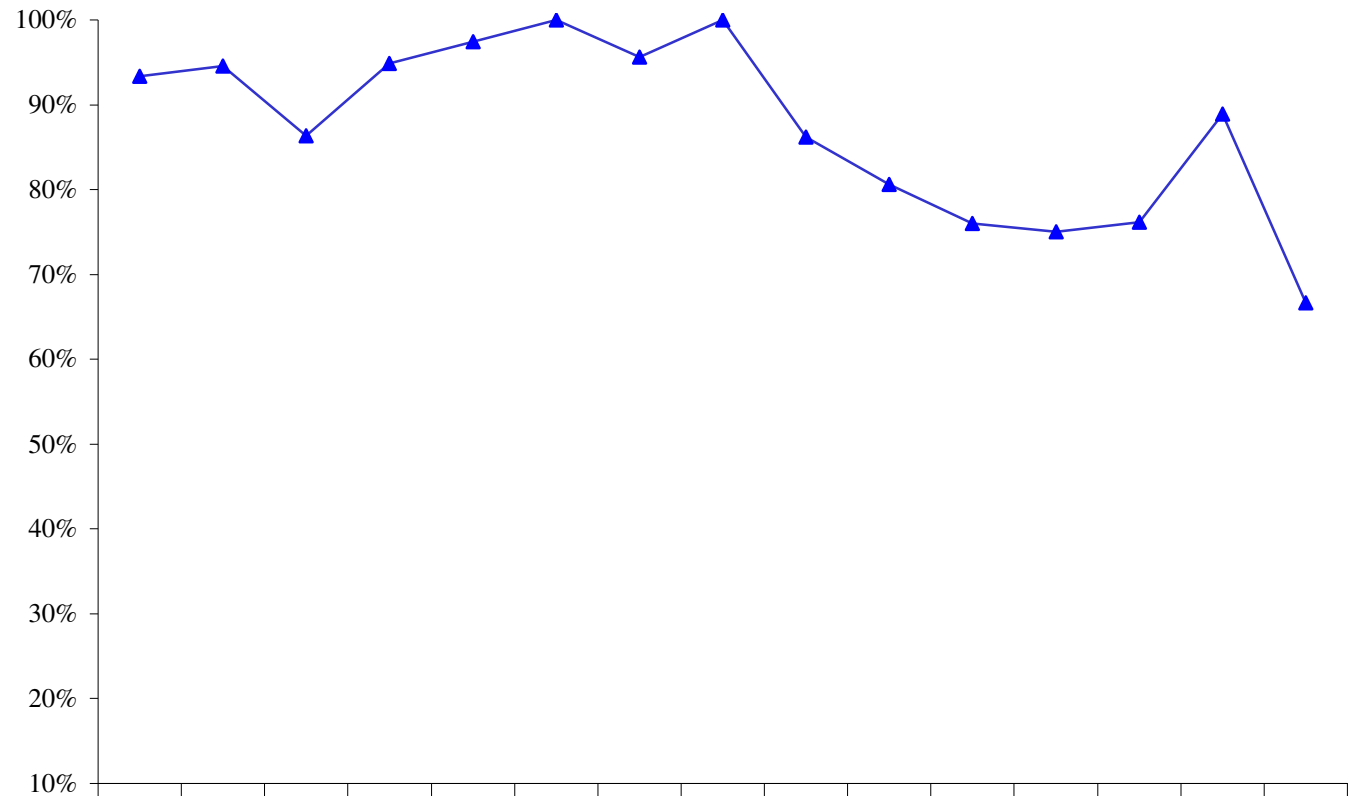
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	66	55	44	46	64	73	64	63	77	76	68	67	64	58	51
Patients with Episodes that are Tracked	59	55	40	39	63	69	63	61	74	34	24	46	39	41	32
▲ Percent Tracked by TIMA	89%	100%	91%	85%	98%	95%	98%	97%	96%	45%	35%	69%	61%	71%	63%

**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
Kerrville State Hospital**

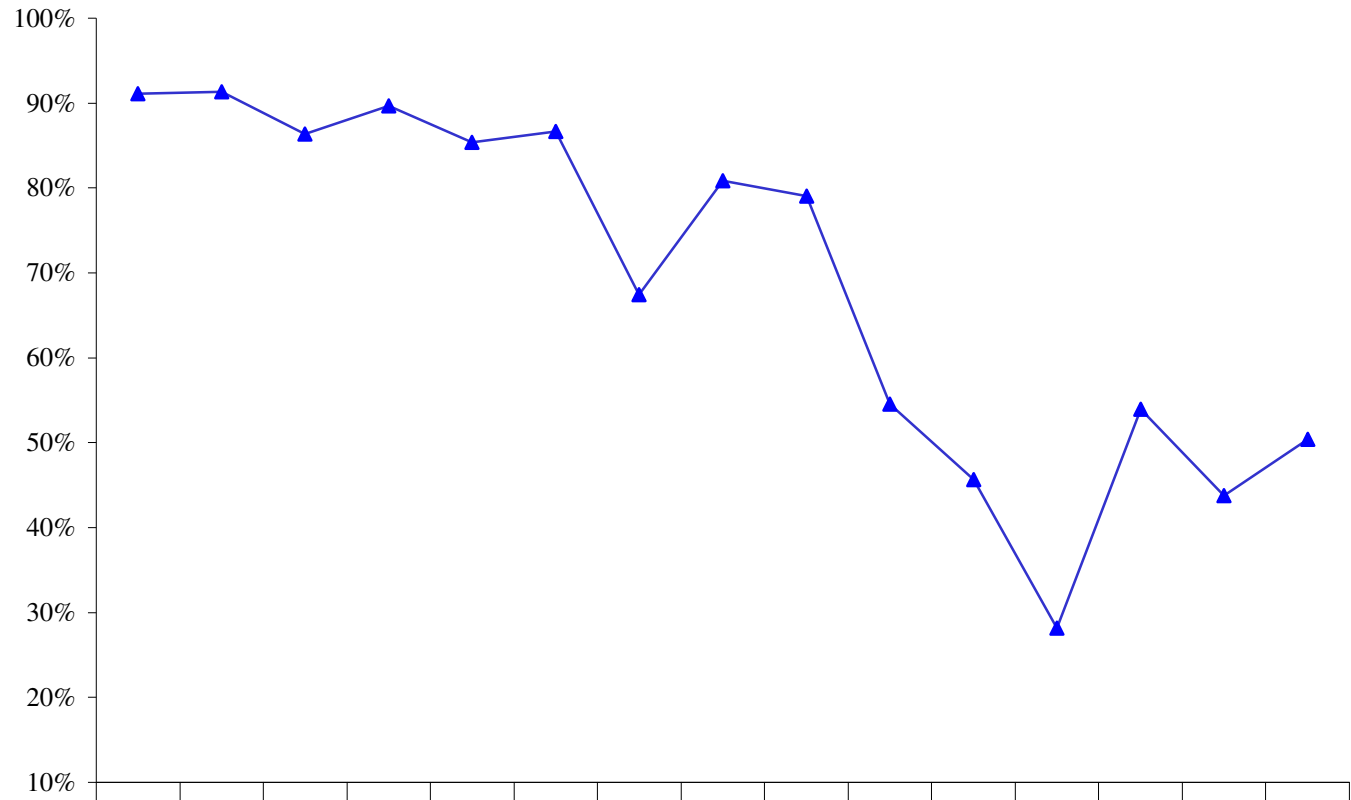
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	45	55	110	39	39	10	23	31	29	31	25	24	21	27	24
Patients with Episodes that are Tracked	42	52	95	37	38	10	22	31	25	25	19	18	16	24	16
—▲— Percent Tracked by TIMA	93%	95%	86%	95%	97%	100%	96%	100%	86%	81%	76%	75%	76%	89%	67%

Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
North Texas State Hospital

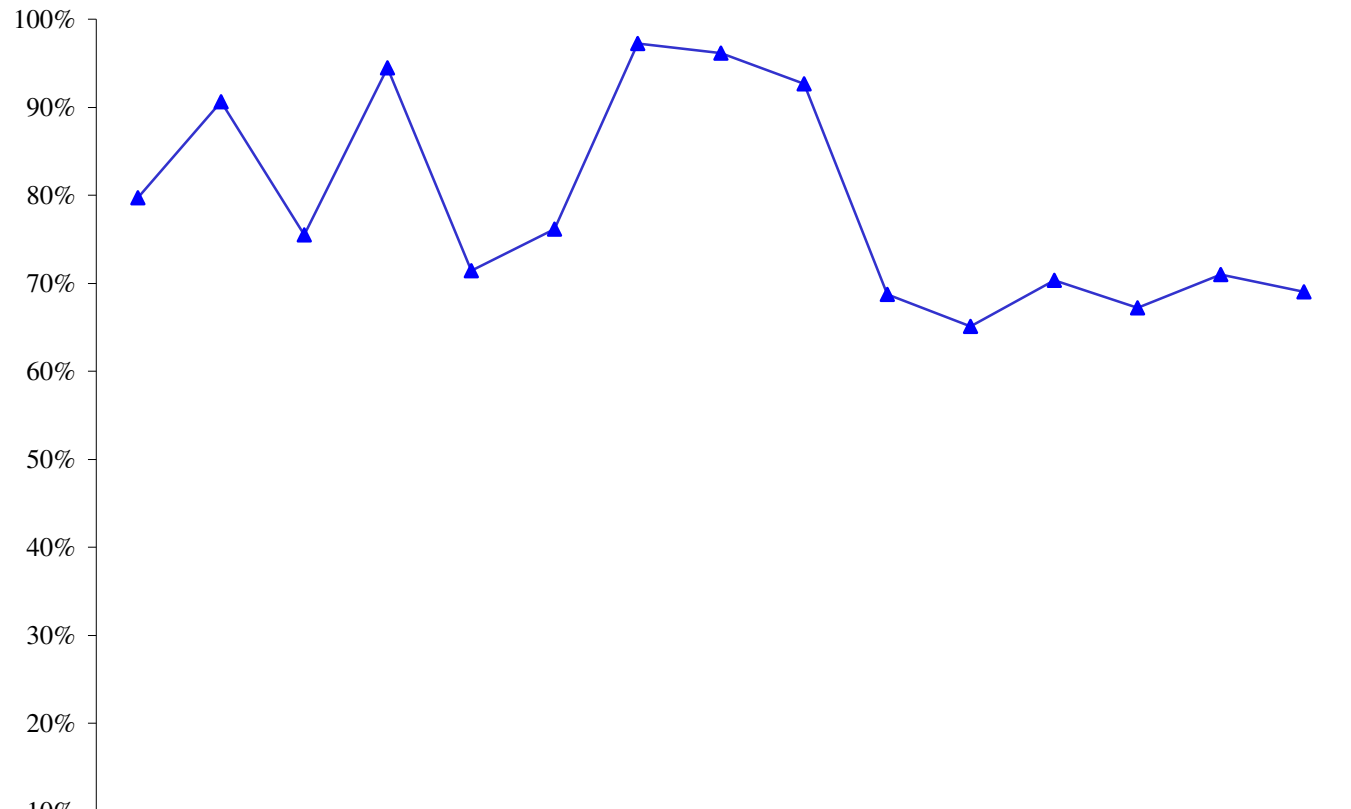
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	124	138	110	145	116	135	126	120	124	132	127	149	115	144	121
Patients with Episodes that are Tracked	113	126	95	130	99	117	85	97	98	72	58	42	62	63	61
▲ Percent Tracked by TIMA	91%	91%	86%	90%	85%	87%	67%	81%	79%	55%	46%	28%	54%	44%	50%

**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
Rio Grande State Center**

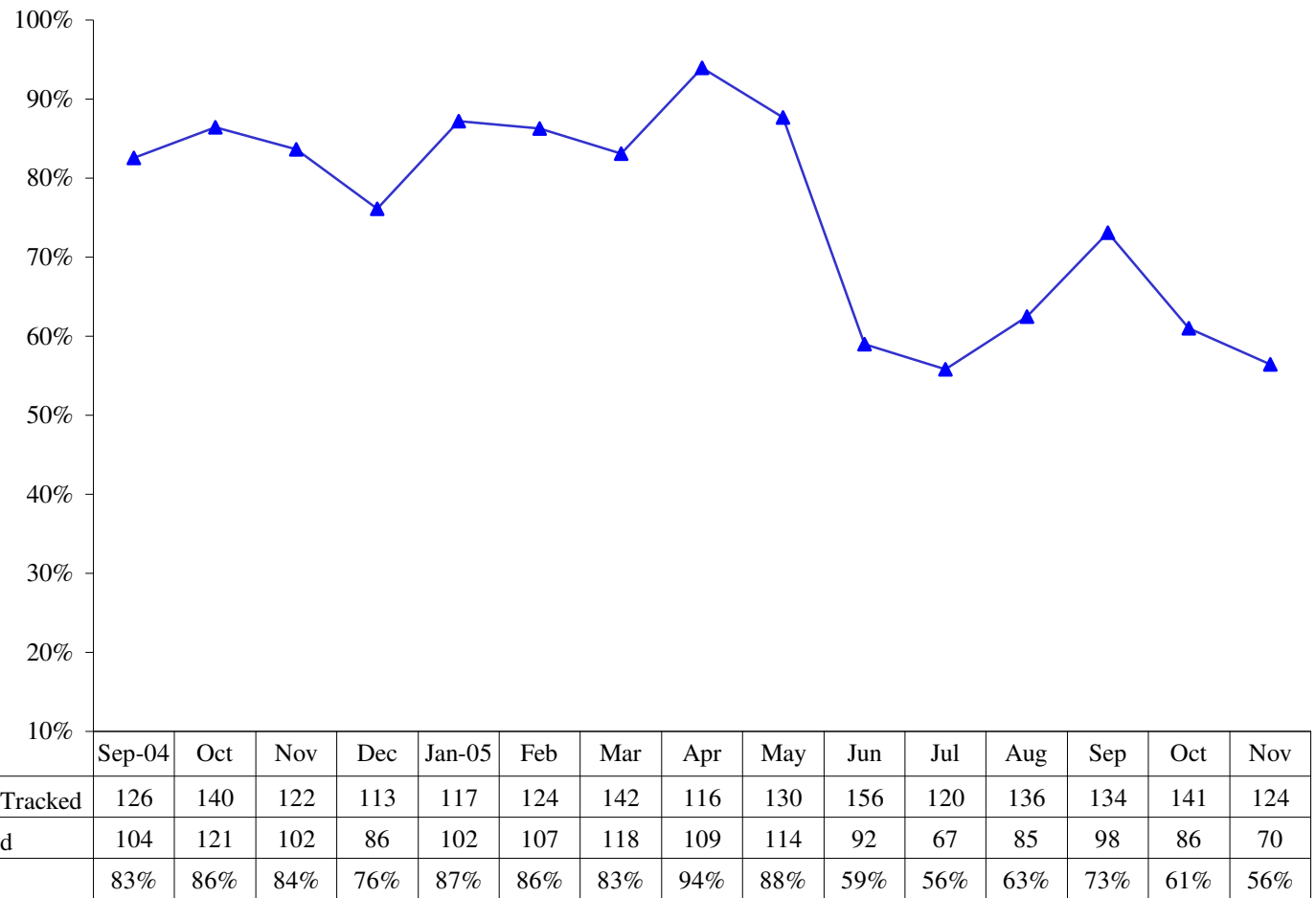
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	64	64	49	54	49	42	72	52	68	80	63	81	64	62	42
Patients with Episodes that are Tracked	51	58	37	51	35	32	70	50	63	55	41	57	43	44	29
▲ Percent Tracked by TIMA	80%	91%	76%	94%	71%	76%	97%	96%	93%	69%	65%	70%	67%	71%	69%

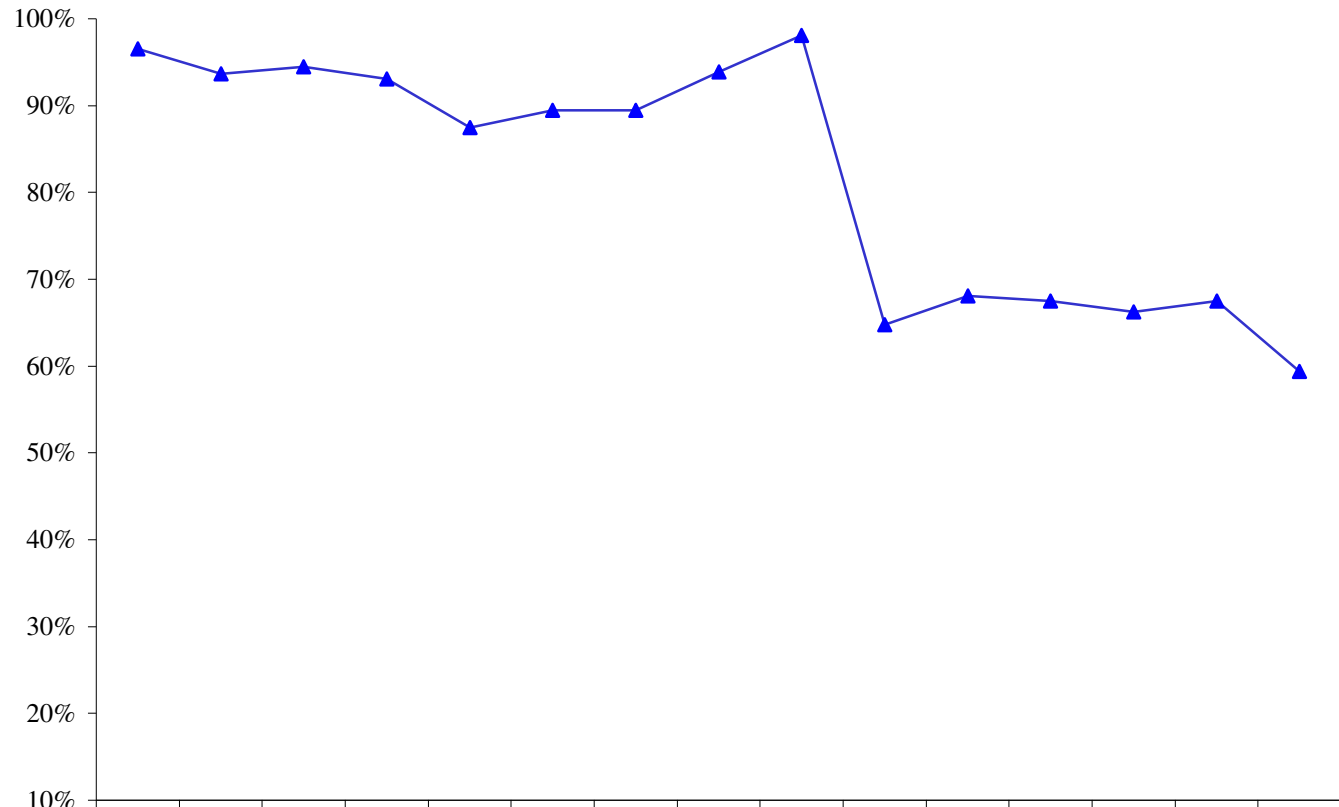
**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
Rusk State Hospital**

Percent of Patients with Episodes that are Tracked by TIMA



**Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
San Antonio State Hospital**

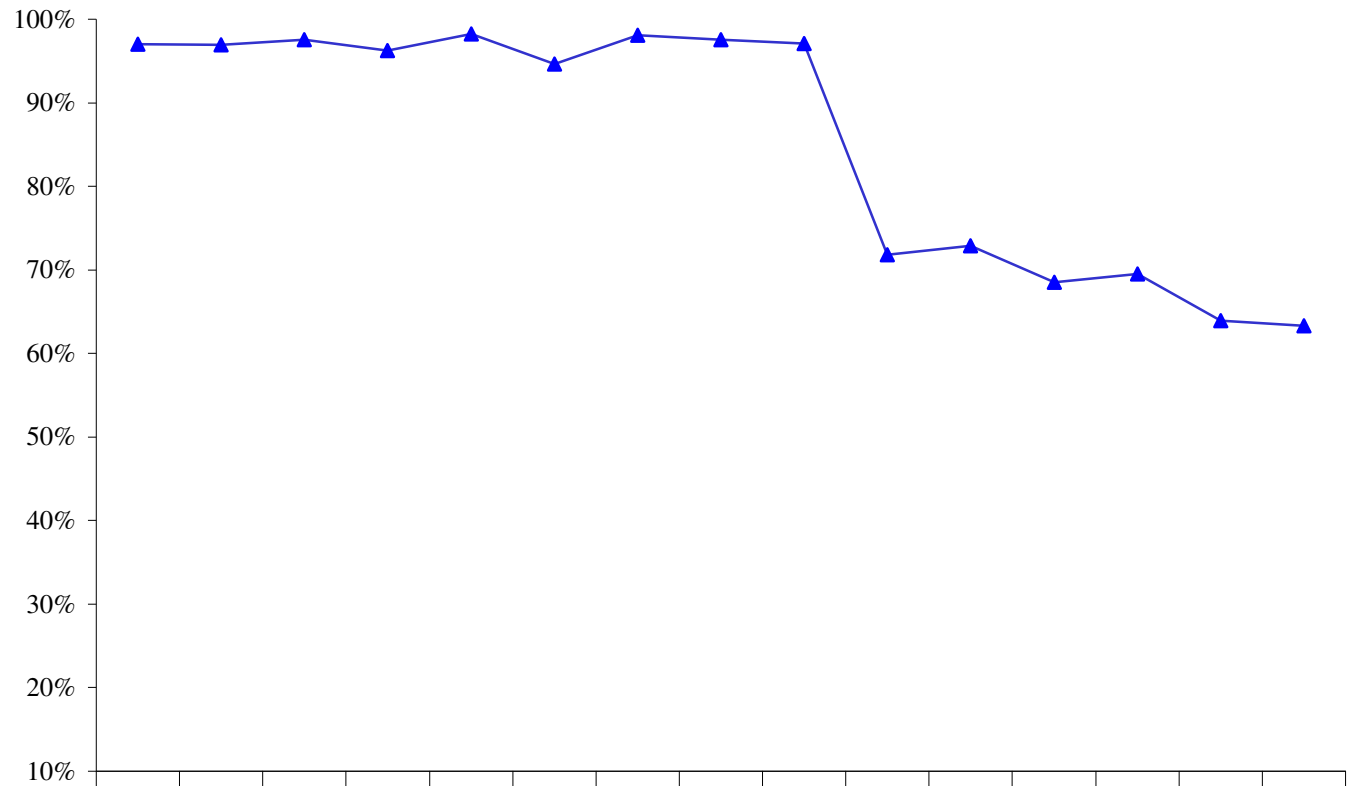
Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	172	173	144	187	160	123	171	163	159	176	185	194	219	197	170
Patients with Episodes that are Tracked	166	162	136	174	140	110	153	153	156	114	126	131	145	133	101
▲ Percent Tracked by TIMA	97%	94%	94%	93%	88%	89%	89%	94%	98%	65%	68%	68%	66%	68%	59%

Objective 3F - Texas Implementation of Medication Algorithm (TIMA)
Terrell State Hospital

Percent of Patients with Episodes that are Tracked by TIMA



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients with Episodes that Should be Tracked	135	132	121	133	169	130	159	164	139	188	144	146	164	144	139
Patients with Episodes that are Tracked	131	128	118	128	166	123	156	160	135	135	105	100	114	92	88
▲ Percent Tracked by TIMA	97%	97%	98%	96%	98%	95%	98%	98%	97%	72%	73%	68%	70%	64%	63%

Performance Measure 3A:

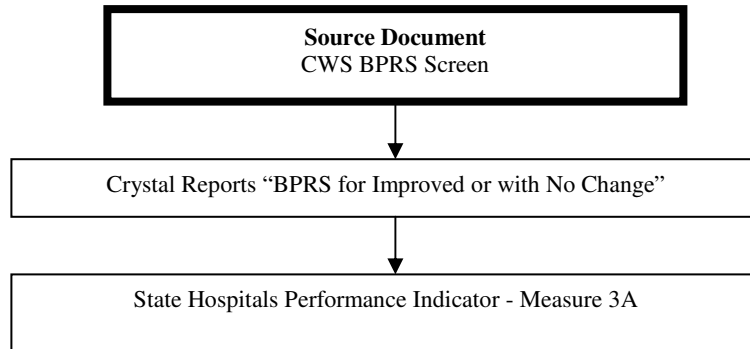
BPRS: Improvement in patient treatment outcomes in state mental health facilities will be measured by showing a significant decrease of clinical symptoms with a reduction of more than twelve (12) points.

Performance Measure Operational Definition: For each quarter, the number of discharged patients in CARE with two BPRS scores that have a change in scores of +12 points or less. BPRS Version 4.0, Expanded Version will be used to rate all patients upon admission and discharge. To be valid, total BPRS score must be between 24 and 168. Higher BPRS scores represent greater symptom problems. The data is entered by the fifteenth of the first month following the quarter.

Performance Measure Formula: The BPRS data is screened to include only patient episodes having two BPRS scores. The discharge BPRS is subtracted from the admission BPRS. Changes of more than ± 12 points are considered to be statistically significant.

Performance Measure Data Display and Chart Description: Table shows the number and percent of improvement, no change and increase symptoms of discharged patients with two BPRS scores for individual state hospitals and system-wide.

Data Flow:



Data Integrity Review Process:

Monitoring Method	Desk and Record Review of applicable BPRS data
Monitoring Instrument/Tool	BPRS Report (located in HMDS/bprs data public folder), CWS BPRS Score Change at Discharge and DIR Tally Sheet
Description of Review Process	Compare the BPRS dates and scores in the BPRS Reports to the CWS BPRS Assessment and/or the MHRS 3-1.2 for discharge patients with two BPRS scores.
Facility and DIR Sample Size	In a given quarter, a random sample of 30 from the BPRS Report.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When there is more than one incorrect date or score for the quarter reviewed.
DIR/HMDS Report	Summary of review including findings and data analysis

Measure 3A - Brief Psychiatric Rating Scale (BPRS) Scores
All MH Facilities

**The Number and Percent of Discharged Patients with
Two BPRS Scores - Q1 FY2006**

Facility	Total	Improvement	%	No Change	%	Increase Symptoms	%
ASH	903	551	61%	300	33%	52	6%
BSSH	280	154	55%	117	42%	9	3%
EPPC	185	159	86%	26	14%	0	0%
KSH	77	60	78%	15	19%	2	3%
NTSH	513	325	63%	177	35%	11	2%
RGSC	268	139	52%	123	46%	6	2%
RSH	479	408	85%	68	14%	3	1%
SASH	695	584	84%	104	15%	7	1%
TSH	536	353	66%	123	23%	60	11%
Totals	3936	2733	69%	1053	27%	150	4%

**Measure 3A - Brief Psychiatric Rating Scale (BPRS) Scores
All MH Facilities**

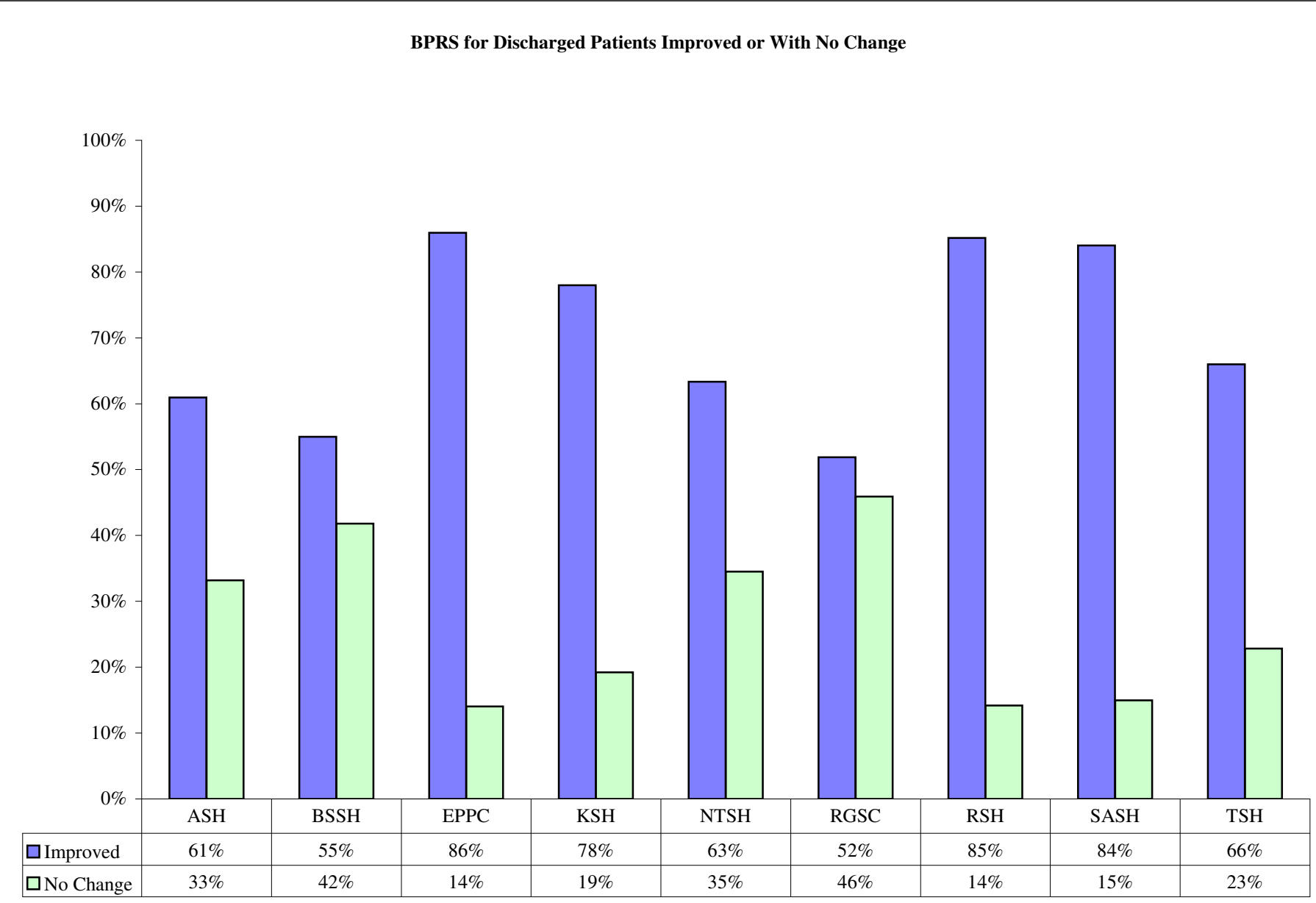


Chart: Hospital Management Data Services

Source: Crystal Report 'BPRS for Discharged Patients Improved or with No Change'

Performance Measure 3B:

GAF: Improvement in patient treatment outcomes in state mental health facilities will be analyzed by showing:

- 1. The percent of patients receiving campus services whose GAF score increased.**
- 2. The percent of patients receiving campus services whose GAF score stabilized.**

Performance Measure Operational Definition: Total of persons with GAF score increased and stabilized. GAF data is collected during the patient’s diagnostic examination at admission and again during the discharge evaluation.

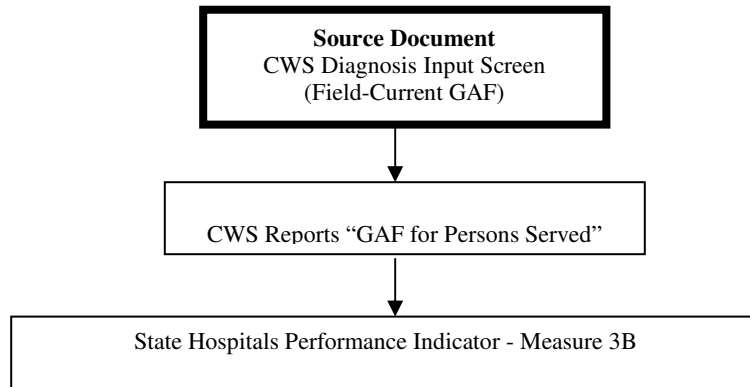
Performance Measure Formula: $R = (N/D)$

R = rate of persons discharged whose GAF stabilized/increased by 10 or more points.
 N = discharged patients with a difference of > 10 points between initial and discharge GAF scores.
 D = number of discharges per month. (Persons who were discharged from the state hospital monthly and FY-to-date who had at least two GAF scores recorded during the episode. If there are not at least two GAF scores for the episode, the person is not counted in either the numerator or denominator for this report).

Performance Measure Data Display and Chart Description:

- ◆ Charts with monthly data points showing percent of persons discharged whose GAF scores stabilized/increased by 10 or more points.
- ◆ Chart with FYTD percent of persons discharged with specific GAF scores.
- ◆ Chart with FYTD percent of persons discharged whose GAF score stabilized/increased by 10 or more points.

Data Flow:

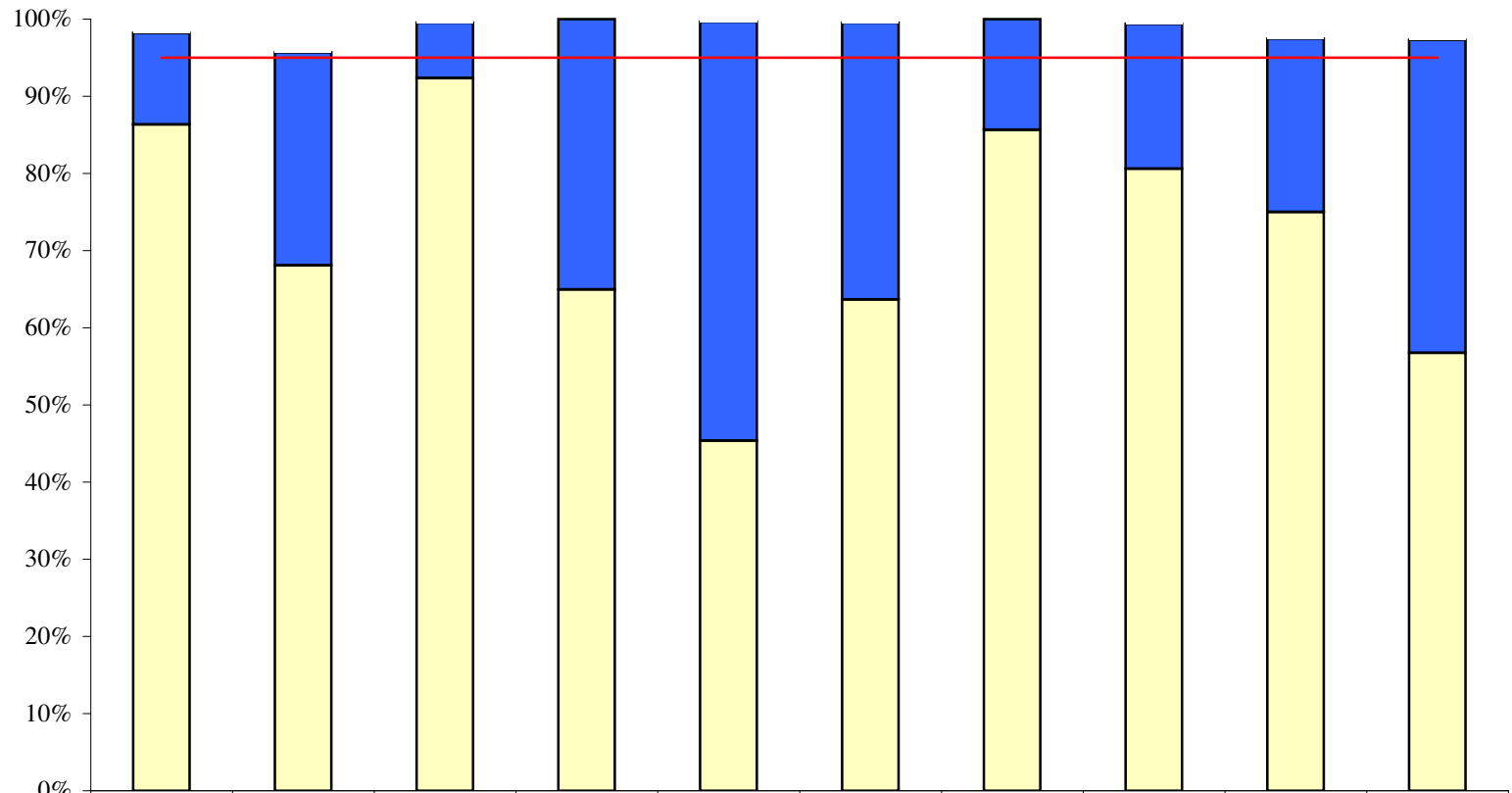


Data Integrity Review Process:

Monitoring Method	Medical record review for GAF scores recorded in psychiatric evaluation and discharge summary/ note (found in CWS Site Specific Diagnosis Report)
Monitoring Instrument/Tool	Care Report HC022830 and DIR Tally Sheet
Description of Review Process	Verification by reviewing patient admission/discharge GAF scores of closed records. (found in CWS Site Specific Diagnosis Report)
Sample Size	Review of 30 randomly selected closed records for the most recent FY Quarter
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When there is more than one incorrect or missing GAF score missing during the quarter reviewed.
DIR/HMDS Report	Summary of review including data accuracy, findings and data analysis.

Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
All MH Facilities - As of November 30, 2005

FYTD Percent of Discharged Whose GAF Score Stabilized/Increased by 10 or More

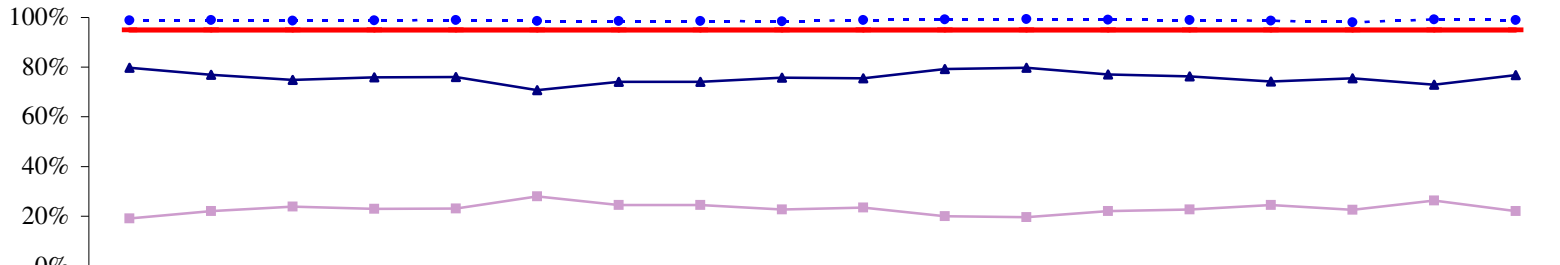


	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY
% Stabilized + Increased	98%	96%	100%	100%	100%	100%	100%	99%	97%	97%
% Stabilized	12%	28%	7%	35%	54%	36%	14%	19%	22%	41%
% Increased by 10 or More	86%	68%	92%	65%	45%	64%	86%	81%	75%	57%
% Expectation	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized

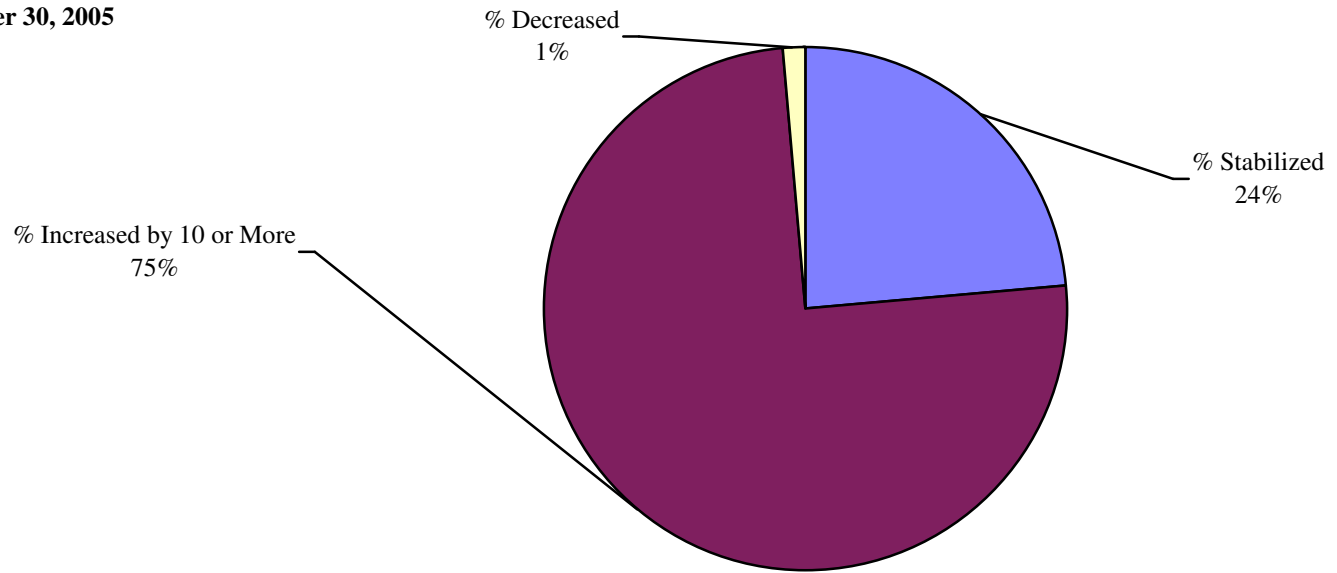
All MH Facilities

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
▲ % Increased by 10 or More	80%	77%	75%	76%	76%	71%	74%	74%	76%	76%	79%	80%	77%	76%	74%	76%	73%	77%
■ % Stabilized	19%	22%	24%	23%	23%	28%	24%	24%	23%	23%	20%	20%	22%	23%	25%	23%	26%	22%
●- - % Stabilized + Increased	99%	99%	99%	99%	99%	99%	99%	99%	98%	99%	99%	99%	99%	99%	99%	98%	99%	99%
— % Statewide Expectation	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005

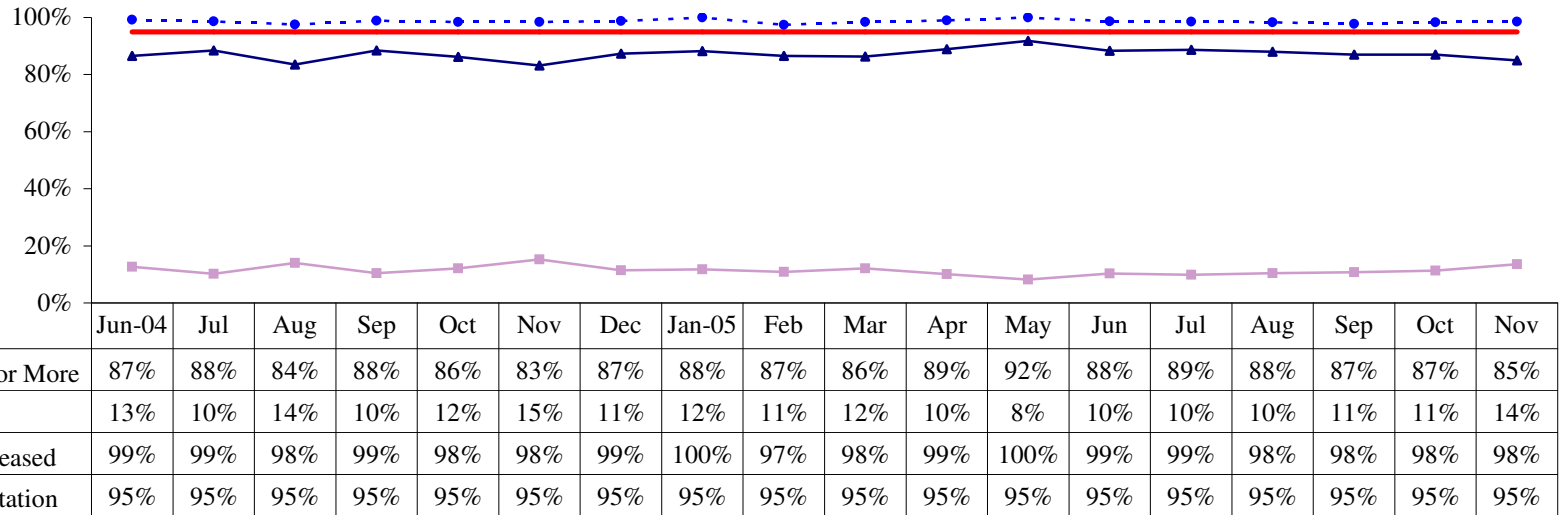


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More

Percent of Discharged Whose GAF Score Stabilized

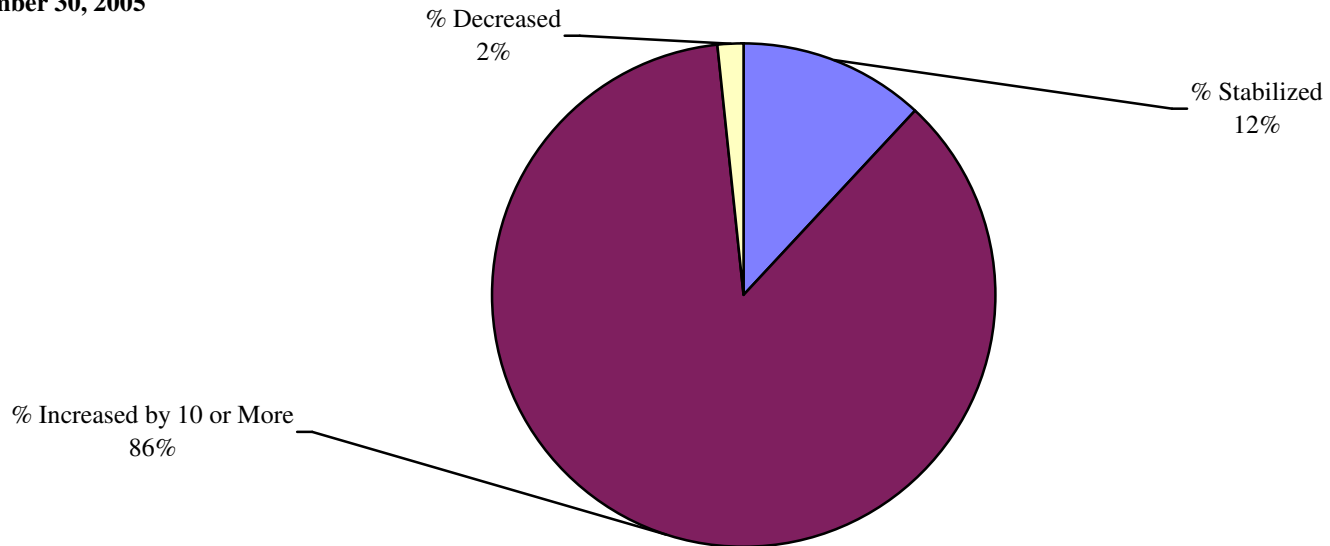
Austin State Hospital

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



Percent of Persons Discharged by GAF Score

FYTD Totals - As of November 30, 2005

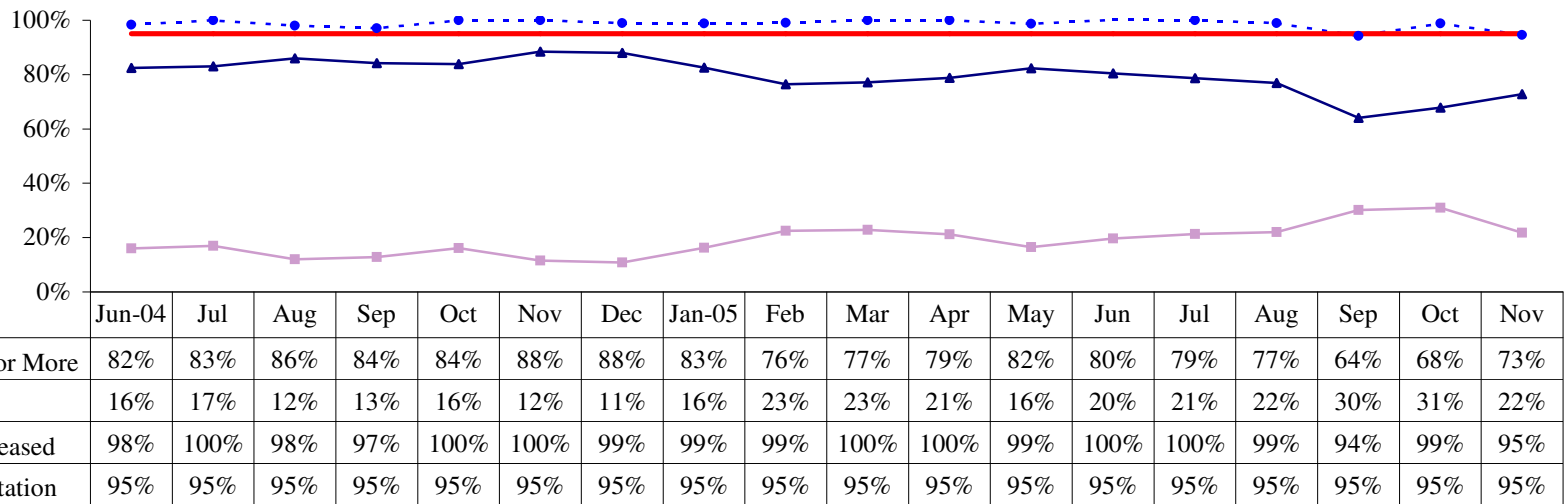


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More

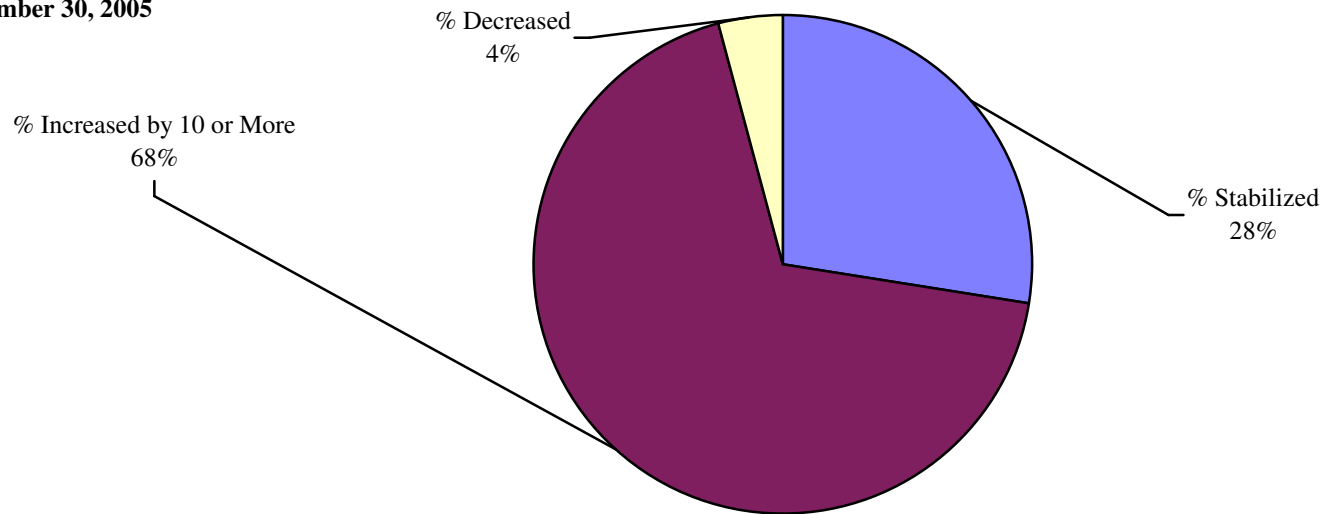
Percent of Discharged Whose GAF Score Stabilized

Big Spring State Hospital

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



**Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005**

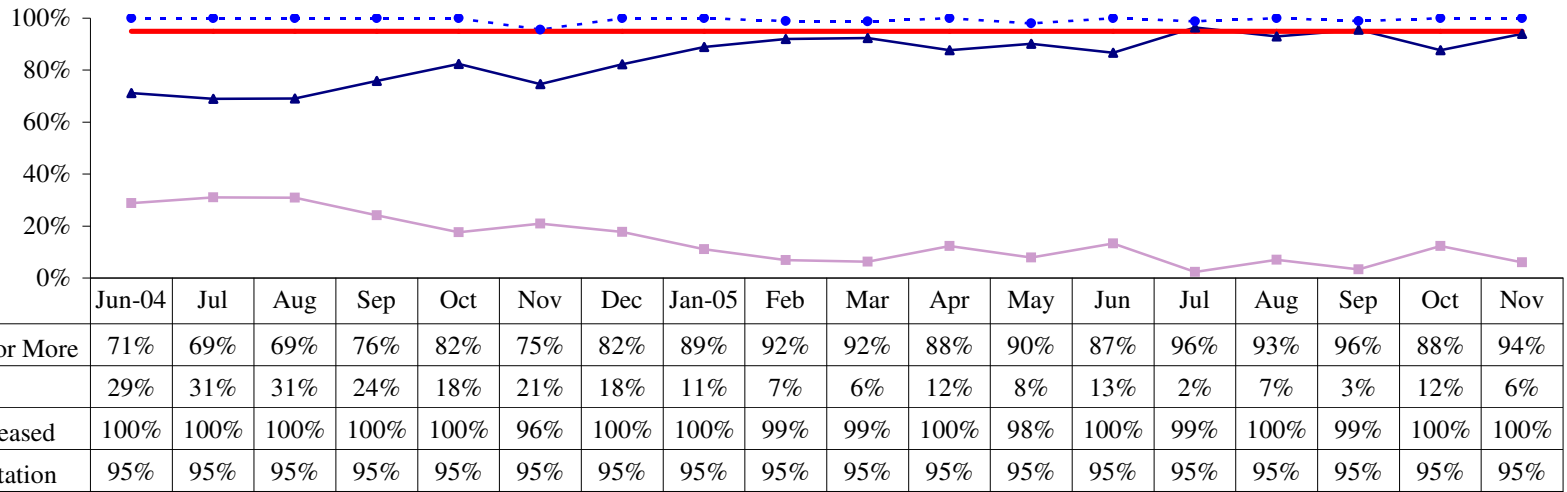


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More

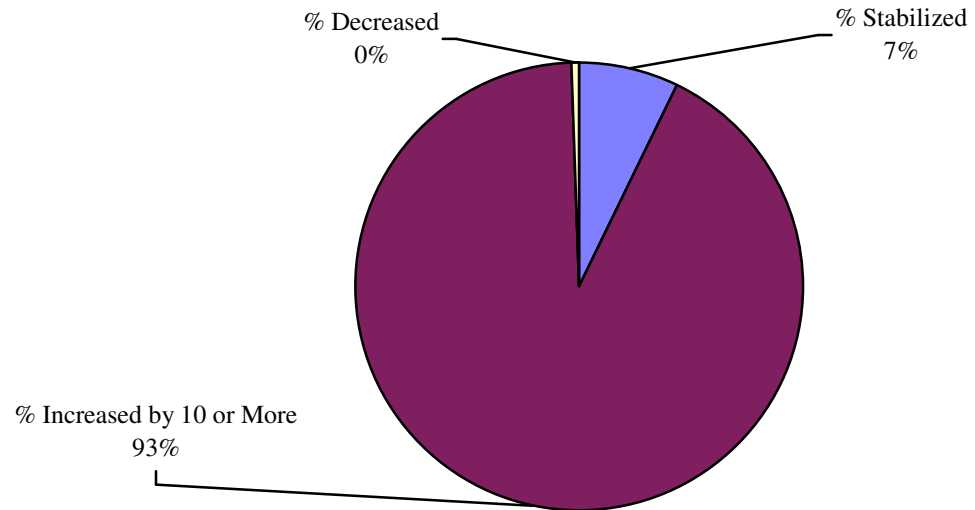
Percent of Discharged Whose GAF Score Stabilized

El Paso Psychiatric Center

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



**Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005**

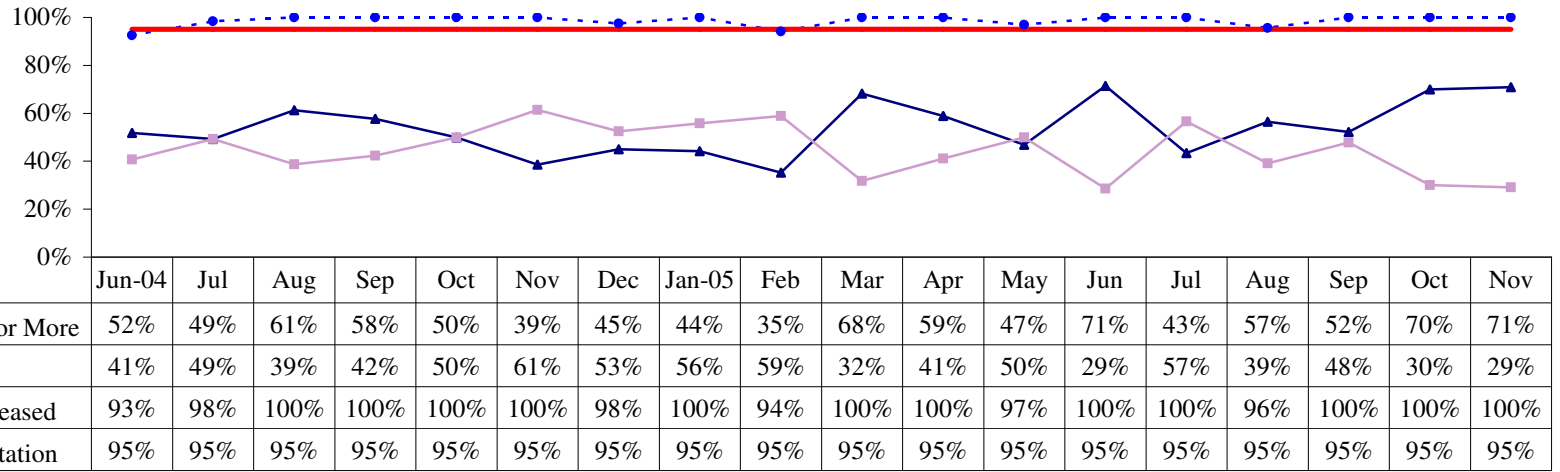


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More

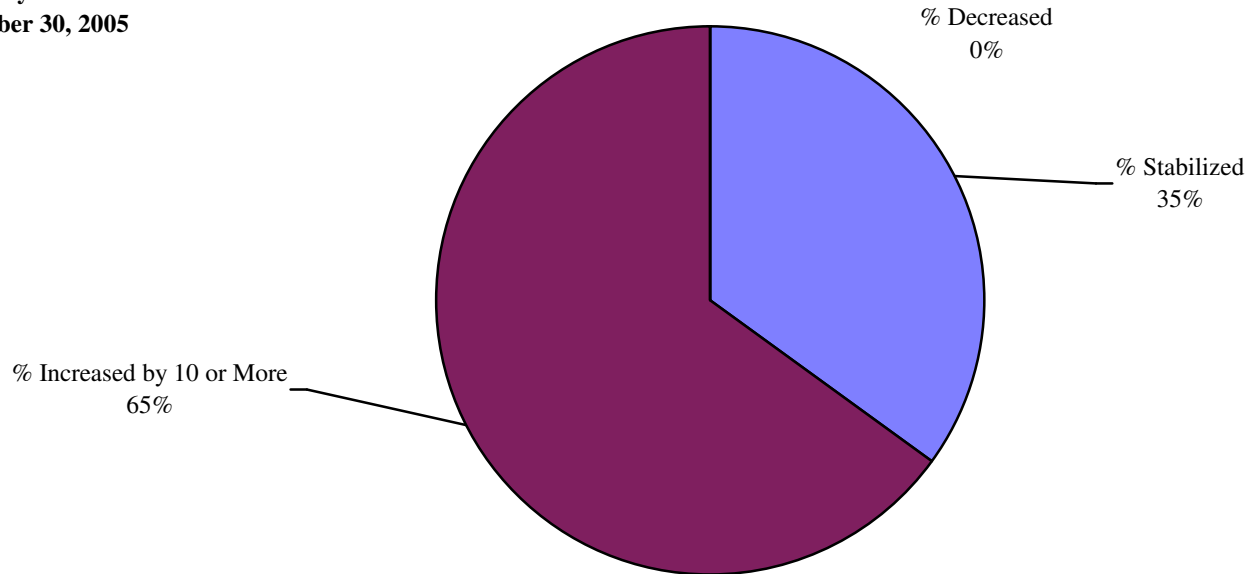
Percent of Discharged Whose GAF Score Stabilized

Kerrville State Hospital

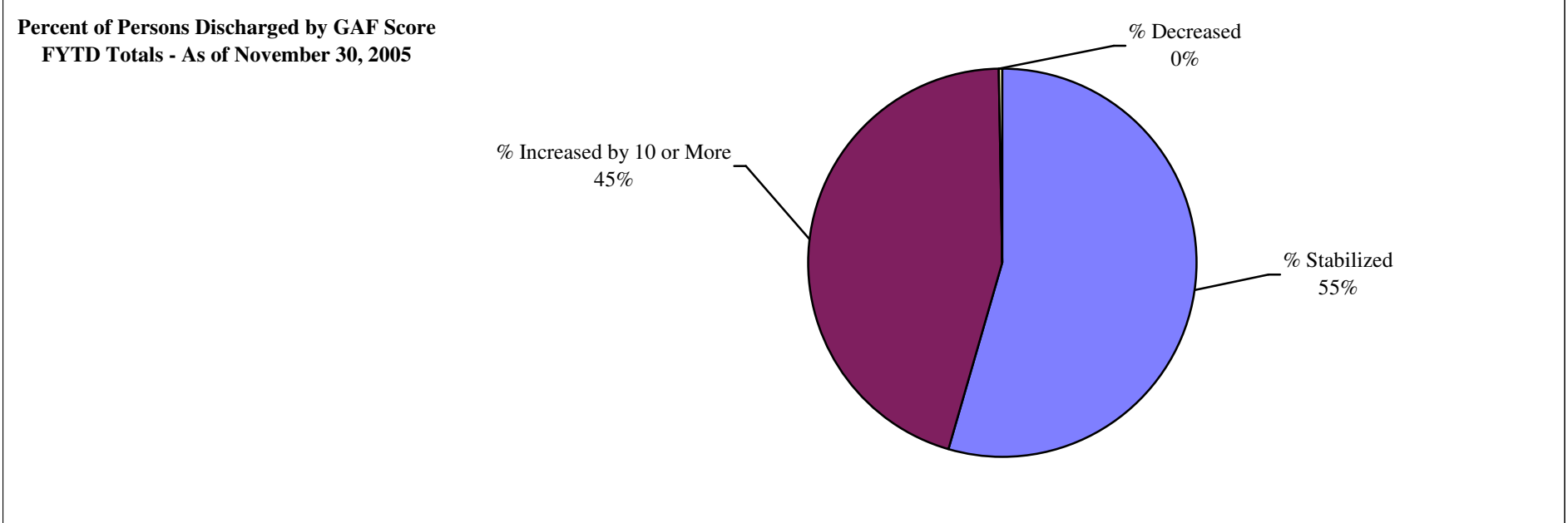
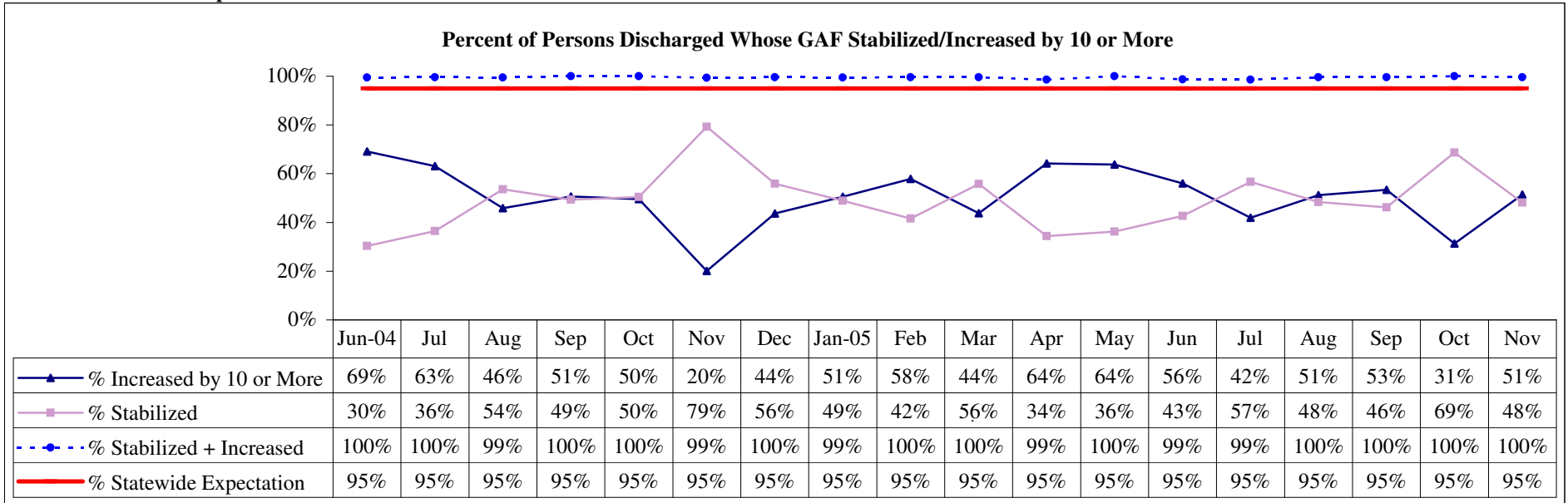
Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



**Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005**

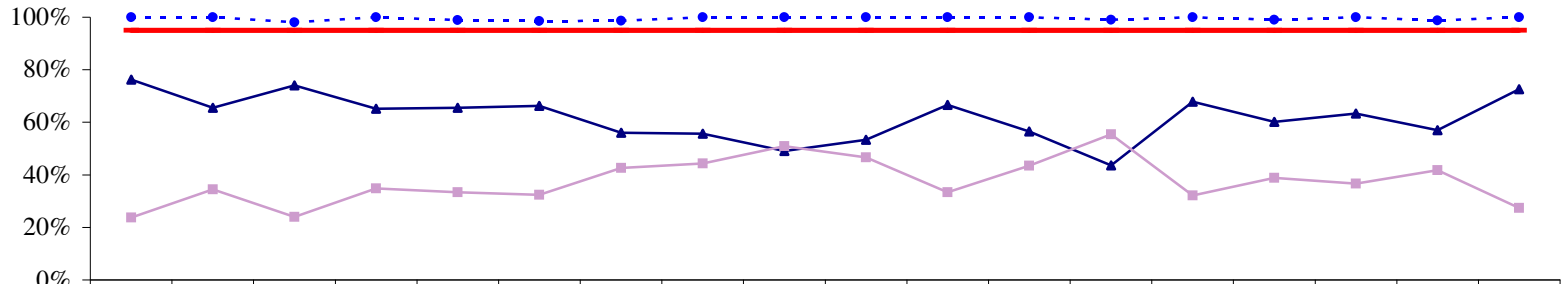


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
North Texas State Hospital



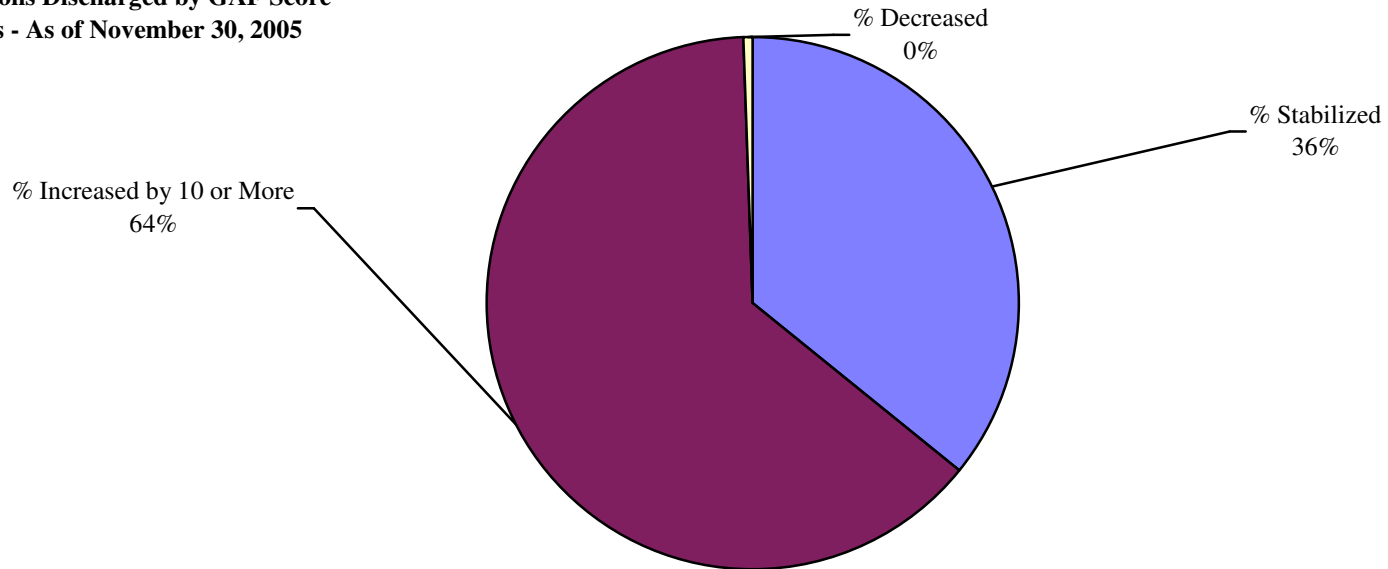
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Rio Grande State Center

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—▲— % Increased by 10 or More	76%	66%	74%	65%	66%	66%	56%	56%	49%	53%	67%	57%	44%	68%	60%	63%	57%	73%
—■— % Stabilized	24%	34%	24%	35%	33%	32%	43%	44%	51%	47%	33%	43%	55%	32%	39%	37%	42%	27%
- - ● - - % Stabilized + Increased	100%	100%	98%	100%	99%	99%	99%	100%	100%	100%	100%	100%	99%	100%	99%	100%	99%	100%
— % Statewide Expectation	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005

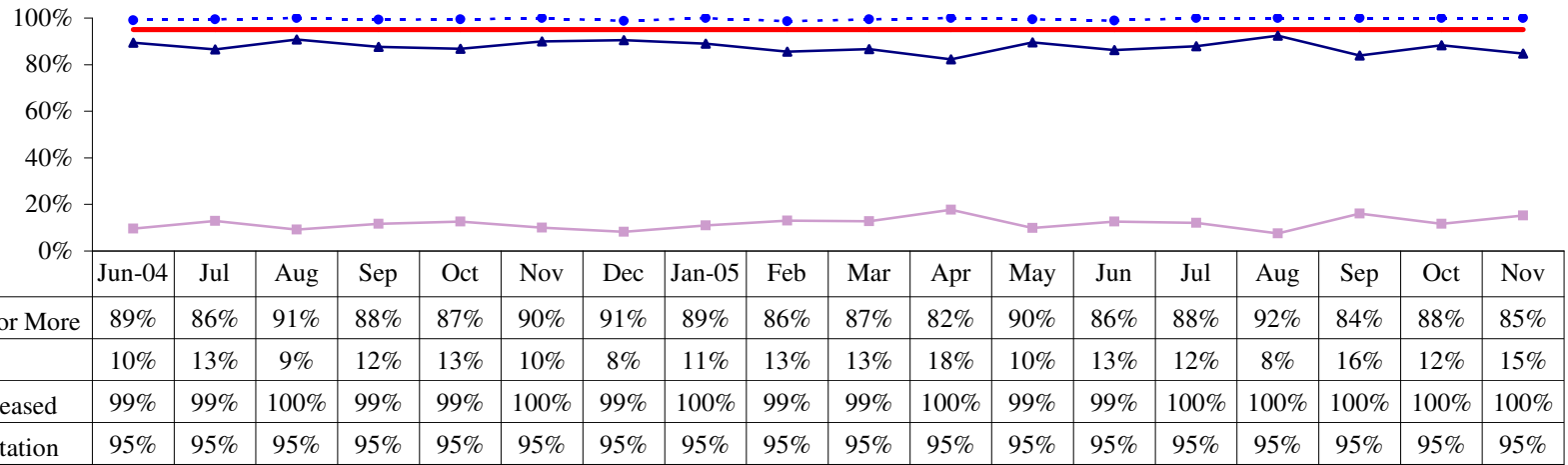


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More

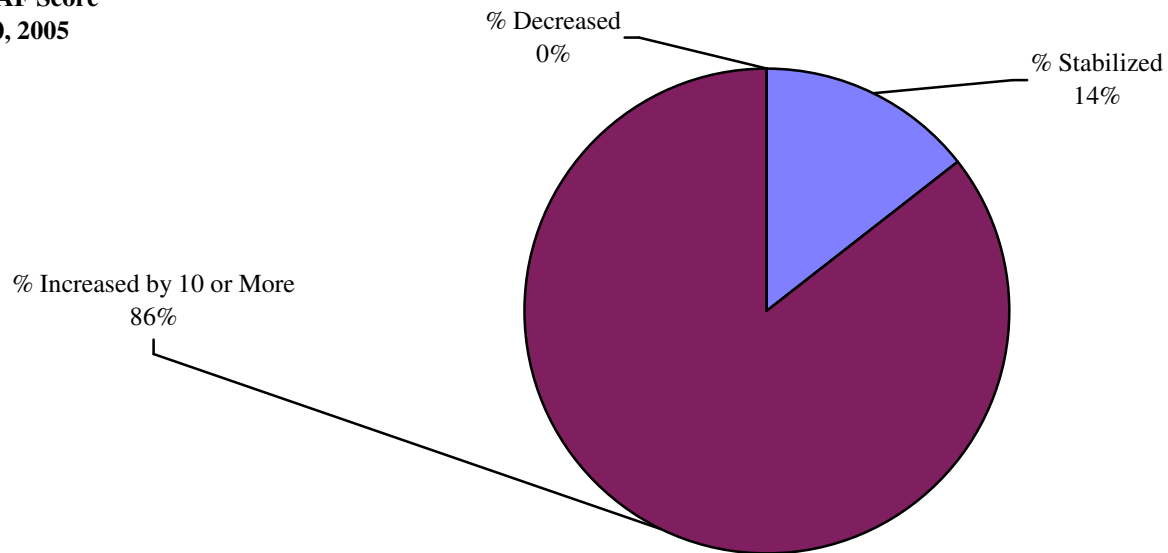
Percent of Discharged Whose GAF Score Stabilized

Rusk State Hospital

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More

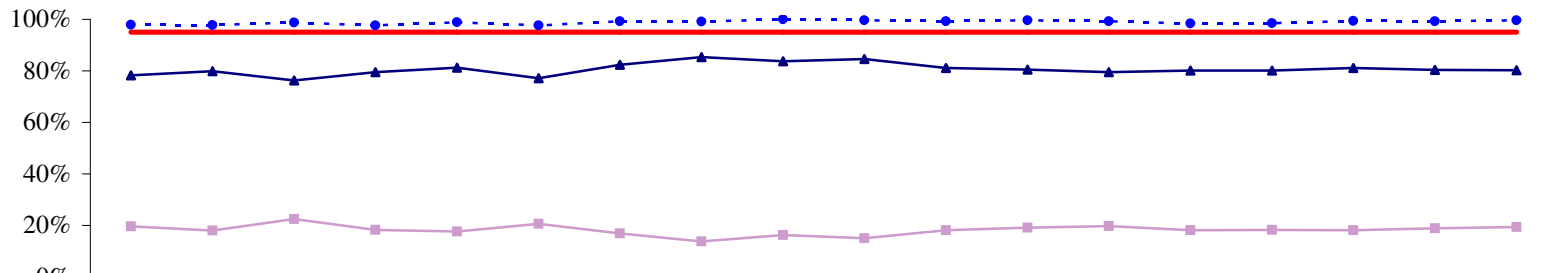


Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005



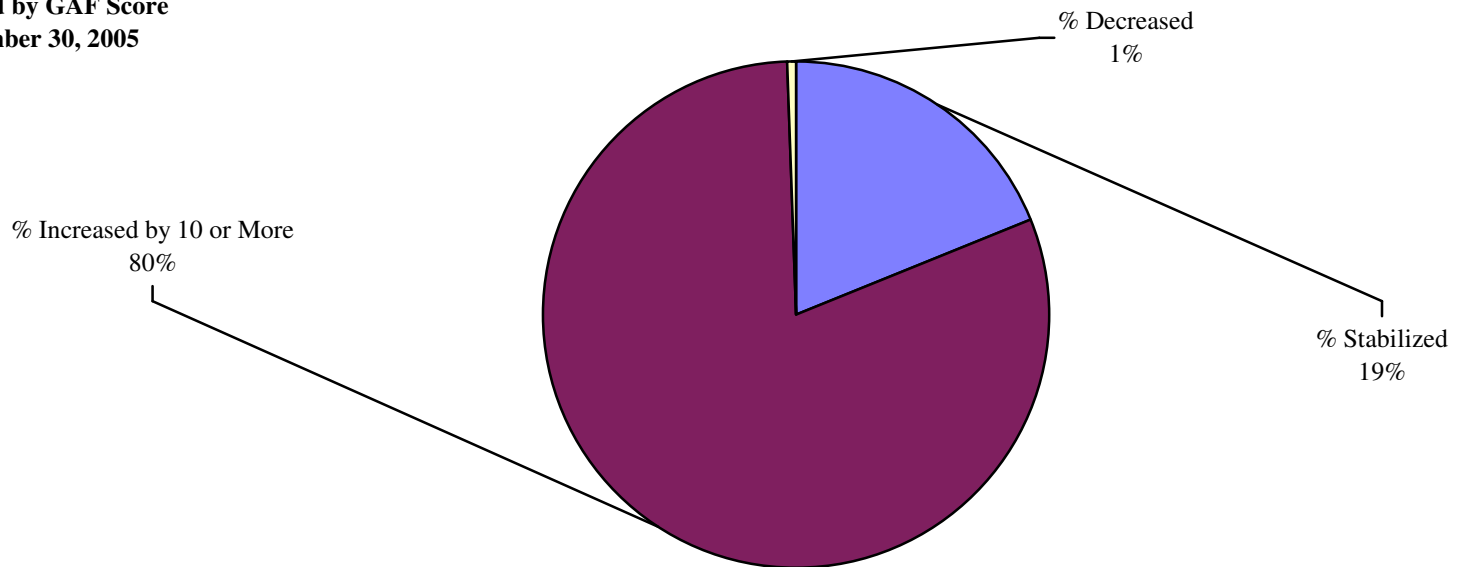
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
San Antonio State Hospital

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



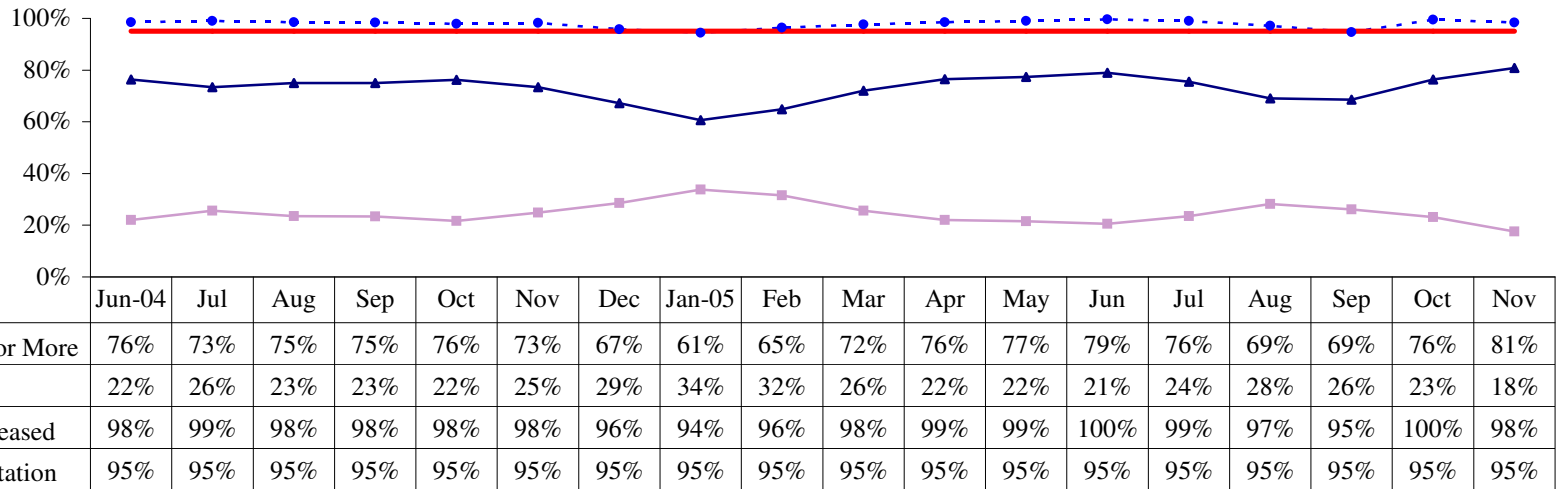
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—▲— % Increased by 10 or More	78%	80%	76%	79%	81%	77%	82%	85%	84%	85%	81%	80%	79%	80%	80%	81%	80%	80%
—■— % Stabilized	20%	18%	22%	18%	18%	21%	17%	14%	16%	15%	18%	19%	20%	18%	18%	18%	19%	19%
- - ● - - % Stabilized + Increased	98%	98%	99%	98%	99%	98%	99%	99%	100%	100%	99%	100%	99%	98%	98%	99%	99%	100%
— % Statewide Expectation	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005

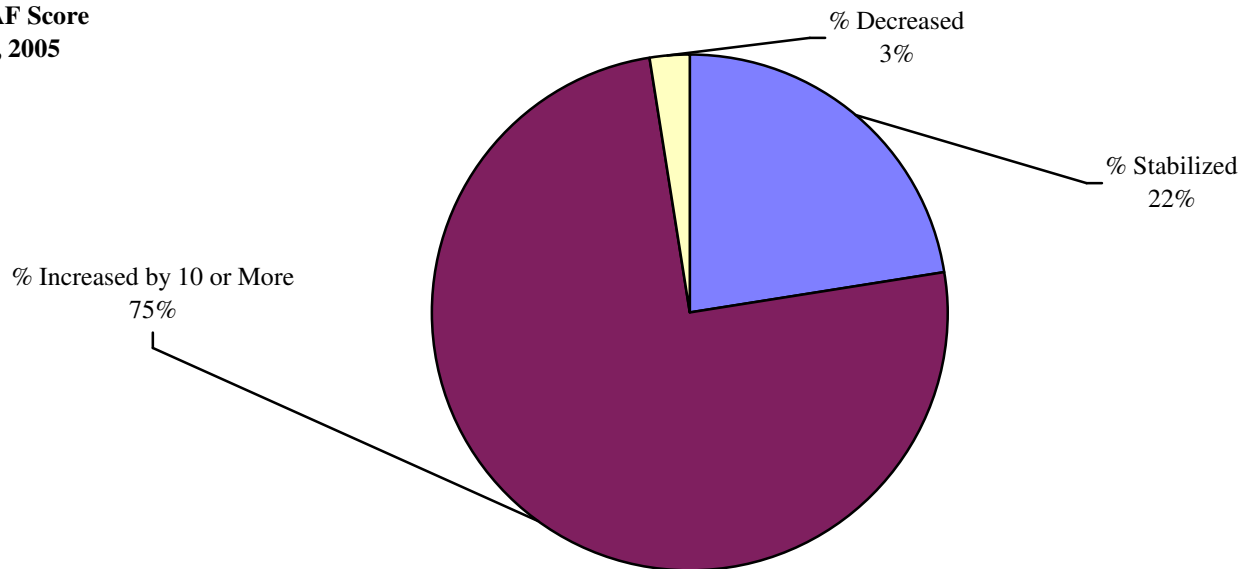


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Terrell State Hospital

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More

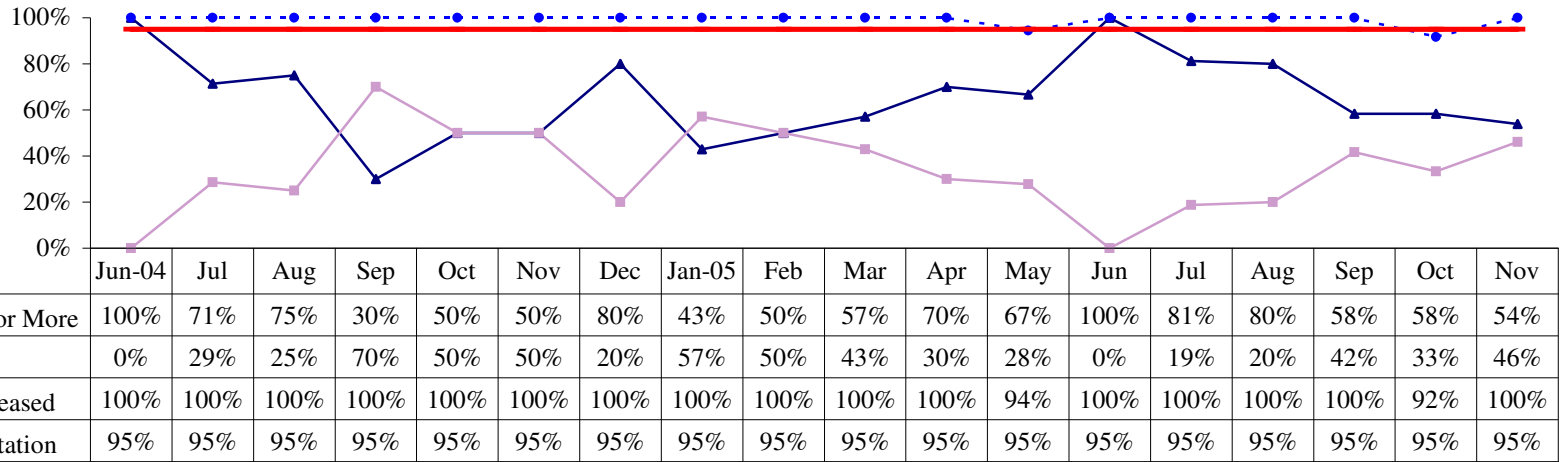


Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005

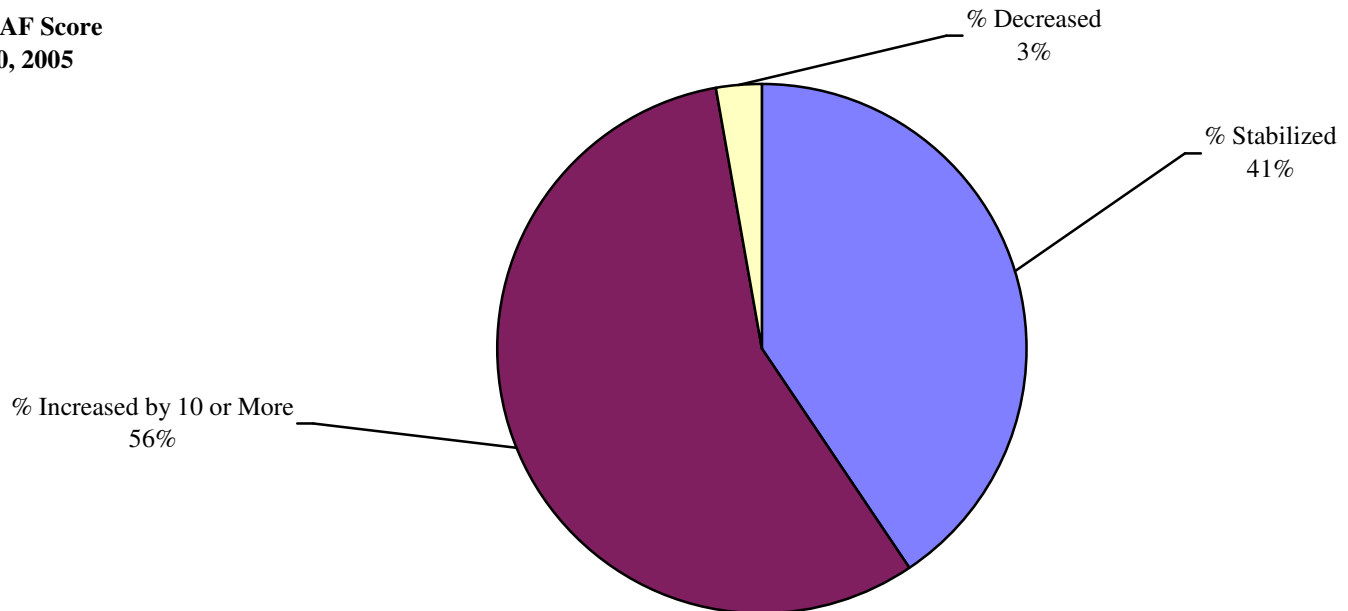


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Waco Center for Youth

Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More



Percent of Persons Discharged by GAF Score
FYTD Totals - As of November 30, 2005



Source: Percent of Persons Discharged Whose GAF Stabilized/Increased by 10 or More (HC022830)

Performance Measure 4A:

The number of patients receiving new generation atypical antipsychotic medication will be tracked and analyzed quarterly.

Performance Measure Operational Definition: The facility count of patients who receive new generation medications (risperidone, clozapine, olanzapine, quetiapine, ziprasidone and aripiprazole).

Performance Measure Formula: $R = (N/D)$

R = rate of persons served receiving new generation medications per FY month

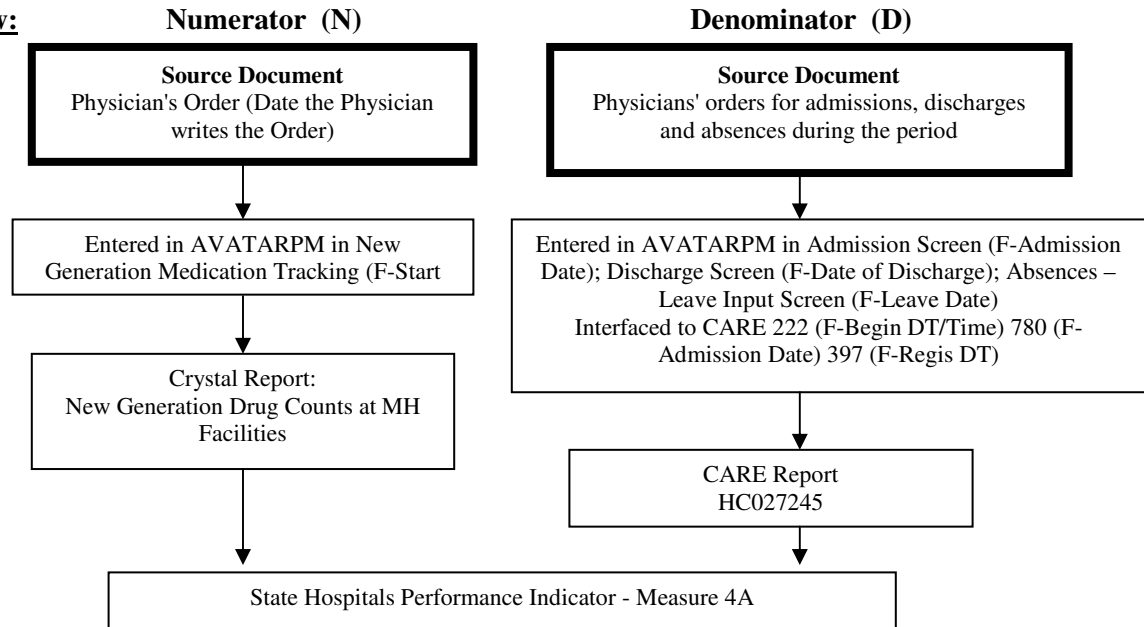
N = patients receiving new generation medications

D = unduplicated person's receiving mental health services

Performance Measure Data Display and Chart Description:

- ◆ Chart of quarterly percentage of patients receiving new generation medication for individual state hospitals and system-wide.
- ◆ Chart with monthly data points of number of patients receiving new generation medication for individual state hospitals and system-wide.
- ◆ Chart with monthly data points of percentage of patients receiving new generation medication for individual state hospitals and system-wide.

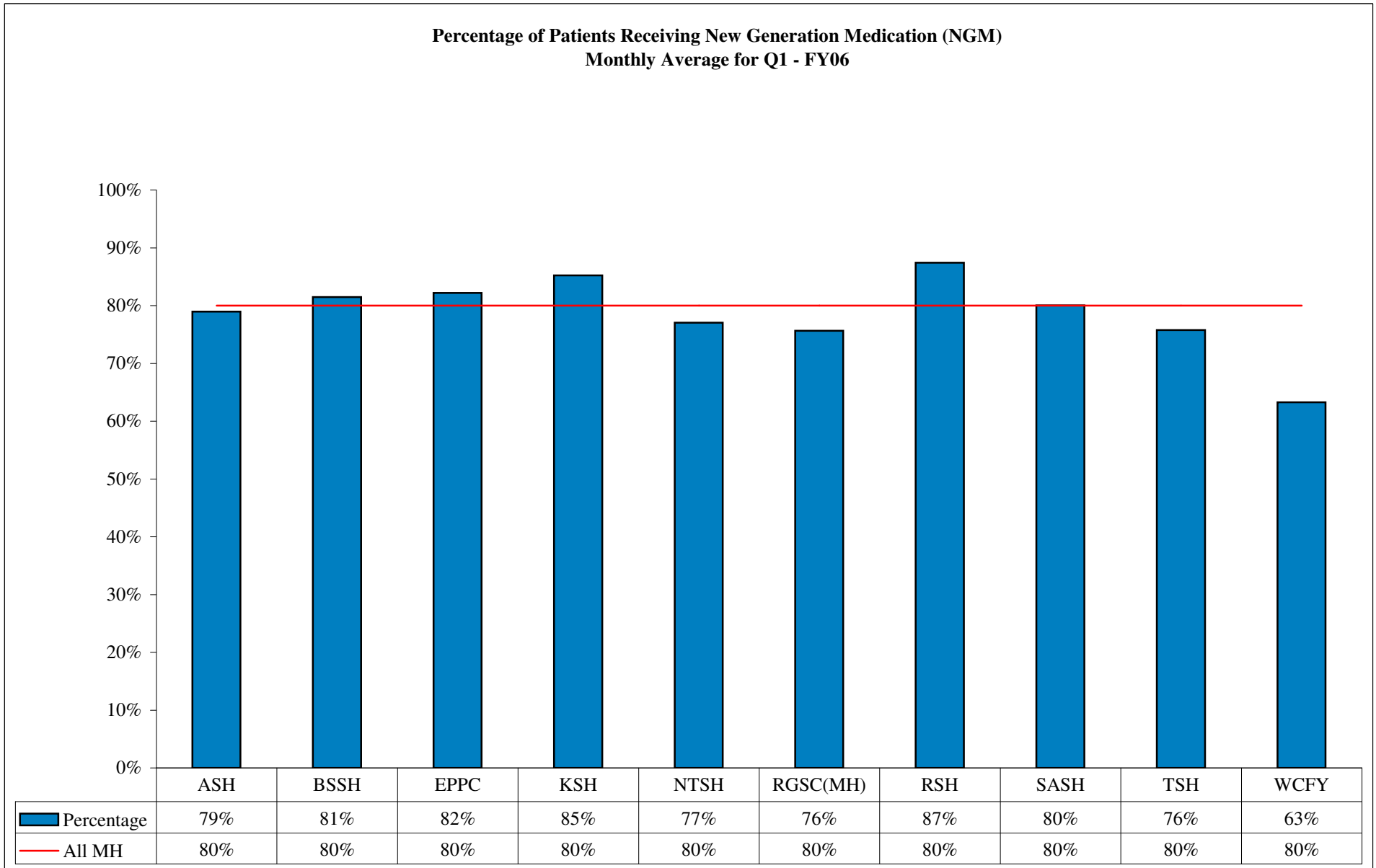
Data Flow:



Data Integrity Review Process:

Monitoring Method	Review of physician's orders for a new generation medication that has been ordered by the physician during the review period.
Monitoring Instrument/Tool	Physician orders and DIR Tally Sheet
Description of Review Process	Verification by reviewing physician orders for "new generation" medications prescribed for patients on the CWS crystal report "New Generation Medications" covering the review period.
Sample Size	Review of 30 randomly selected closed records for a selected FY Quarter
Monitoring Frequency	Facility: Semiannually; HMDS: Annually

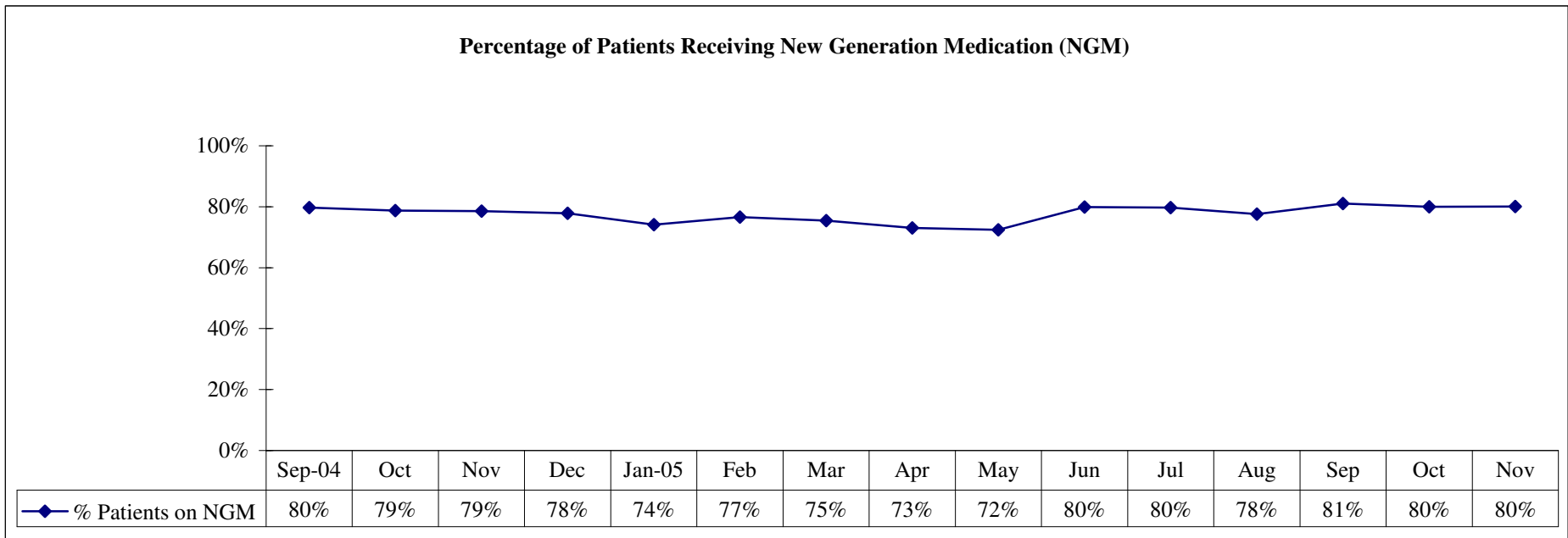
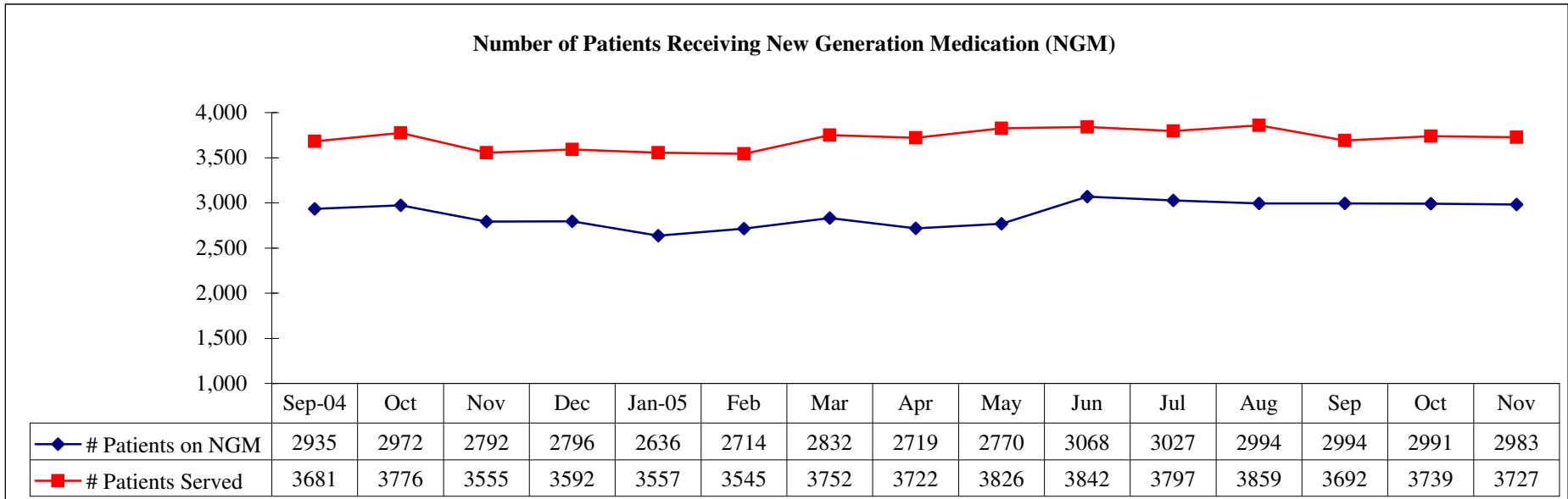
Measure 4A - Patients Receiving New Generation Medication (NGM)
All MH Facilities



Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

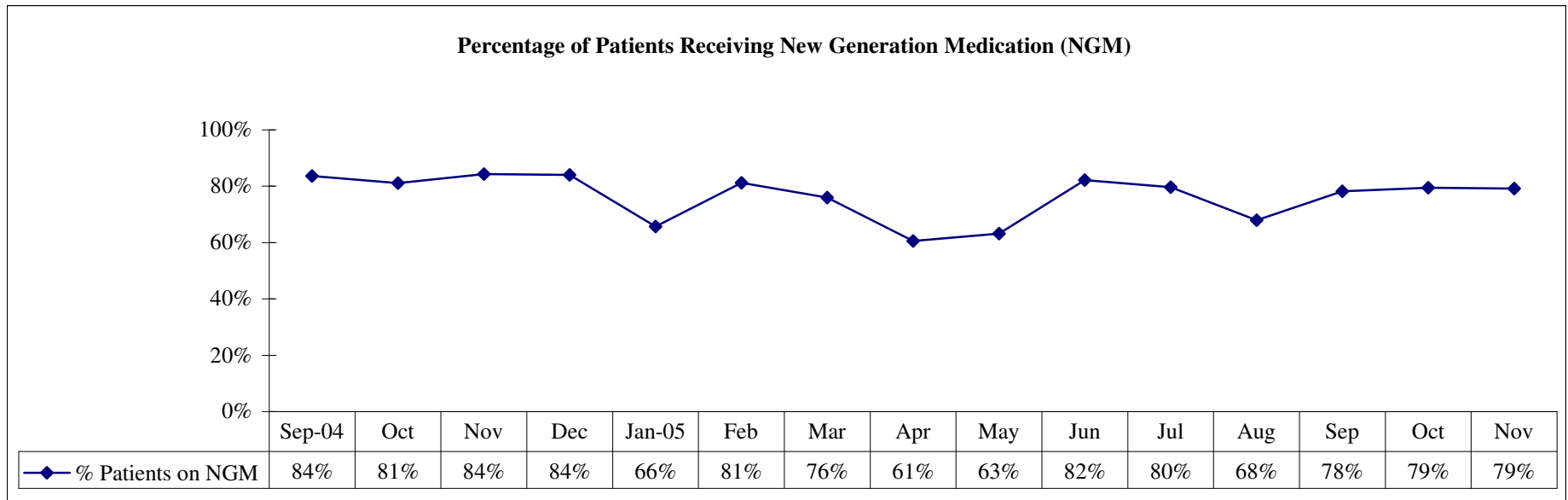
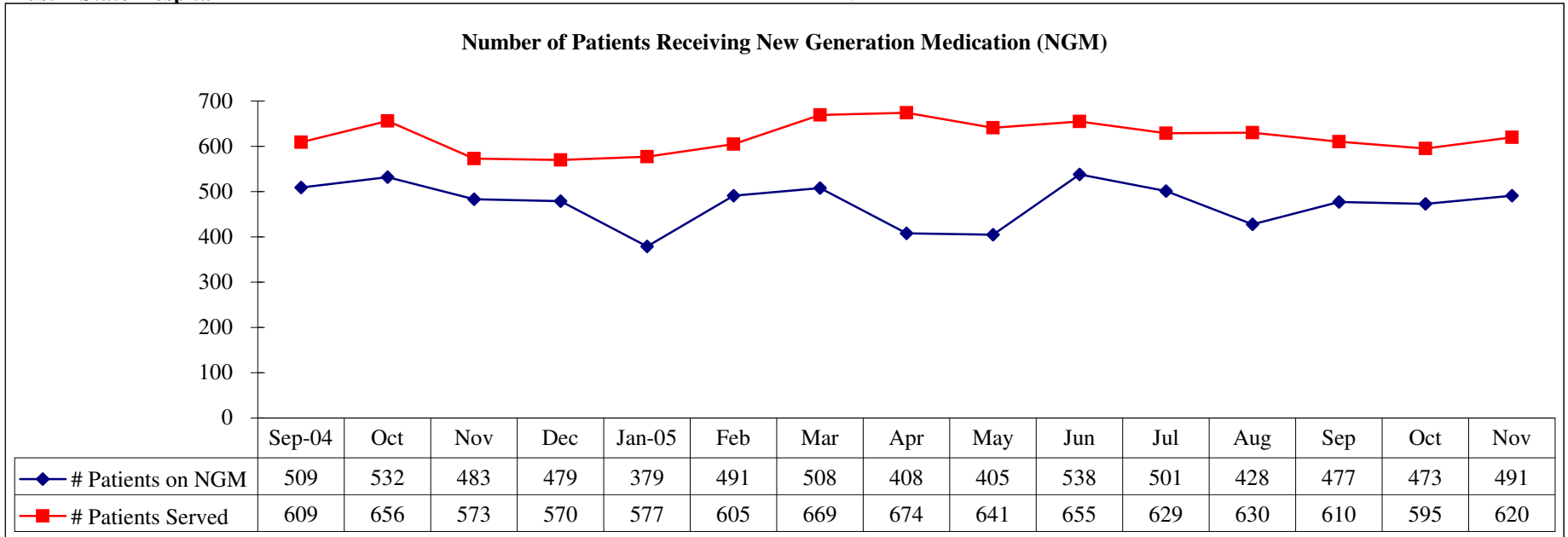
Measure 4A - Patients Receiving New Generation Medication (NGM)

All MH Facilities



Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
Counts of Persons Receiving MH Services (HC027245)

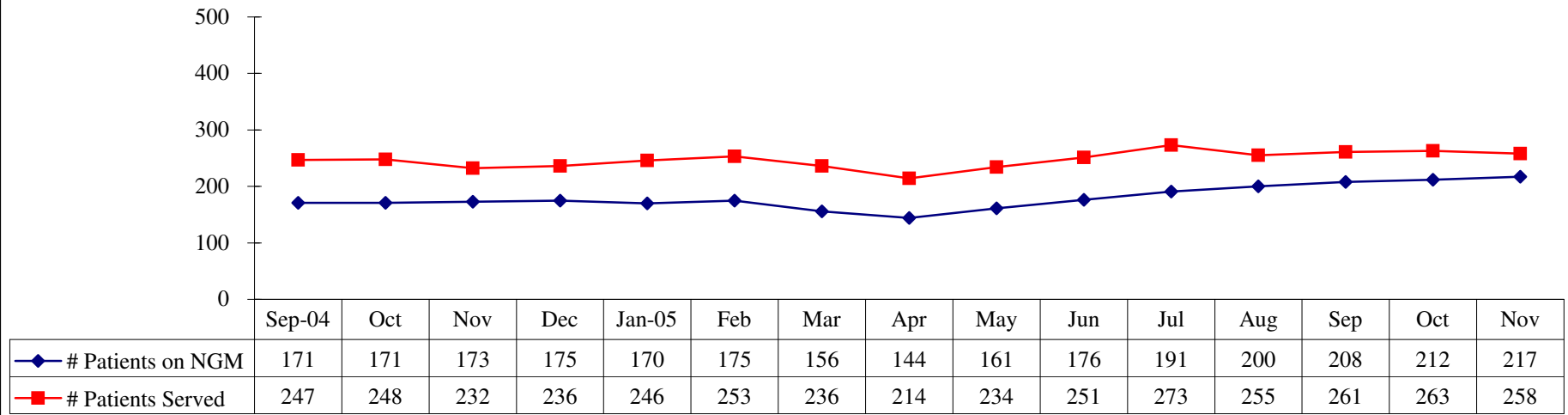
Measure 4A - Patients Receiving New Generation Medication (NGM)
Austin State Hospital



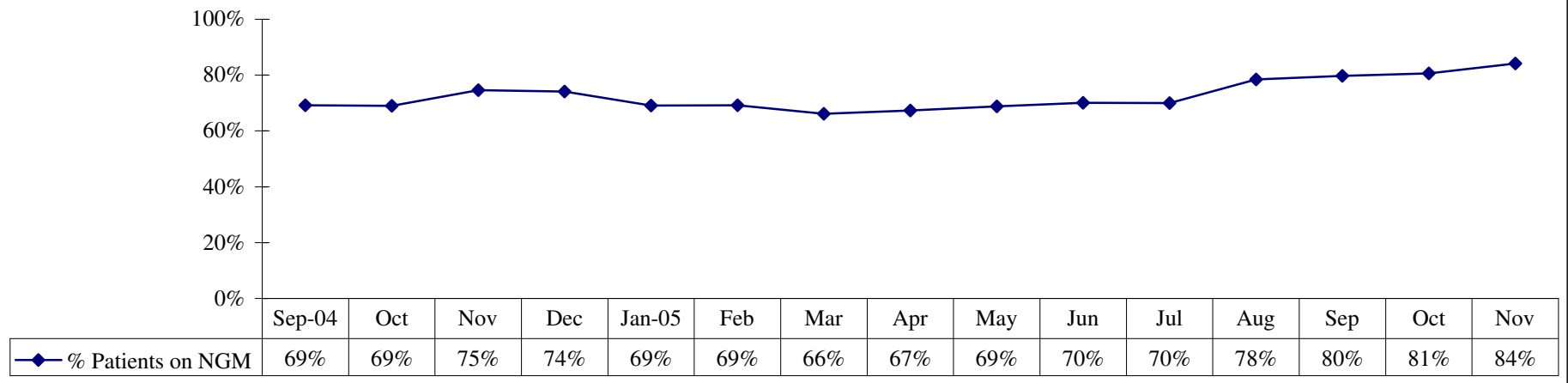
Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
Big Spring State Hospital

Number of Patients Receiving New Generation Medication (NGM)

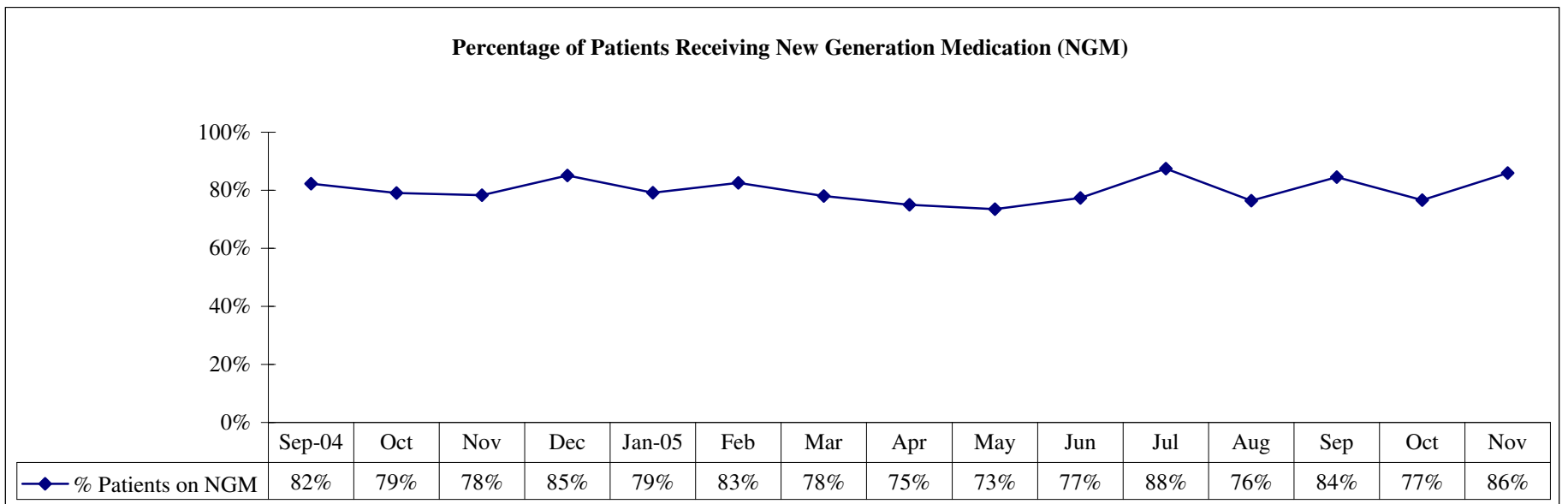
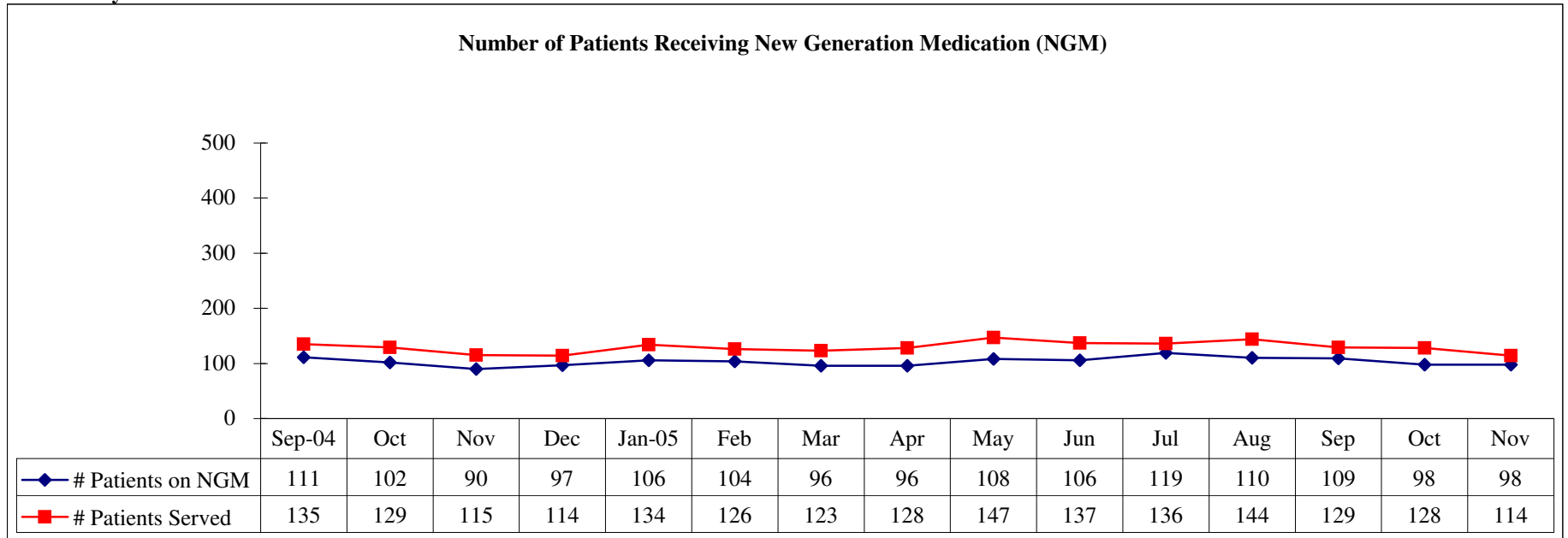


Percentage of Patients Receiving New Generation Medication (NGM)



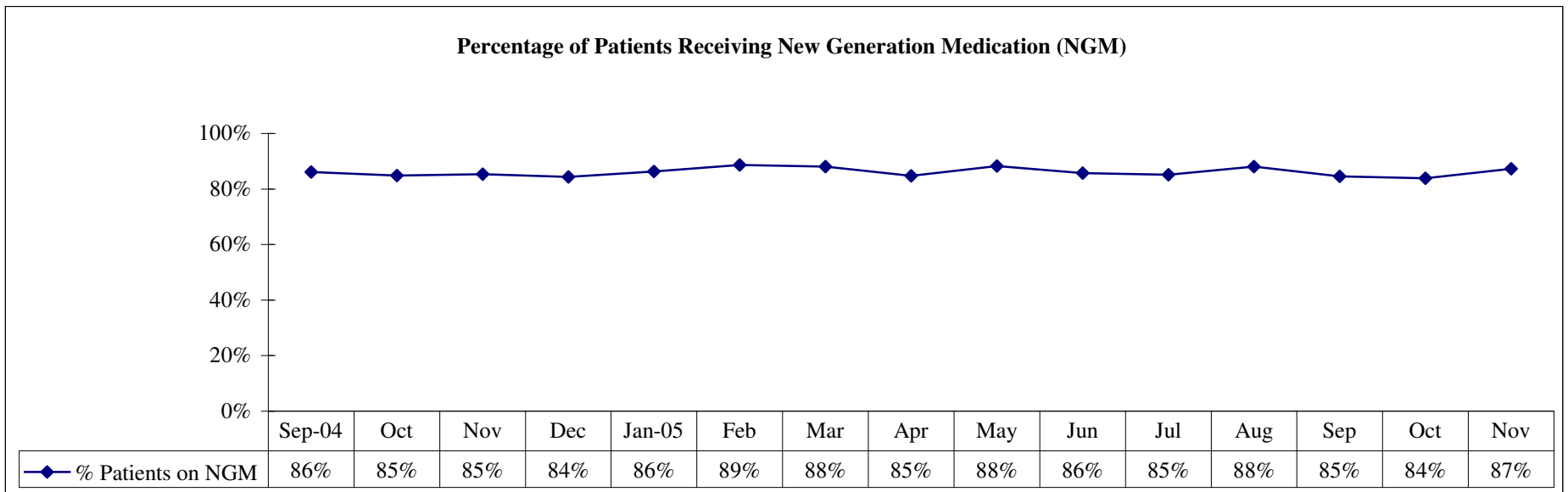
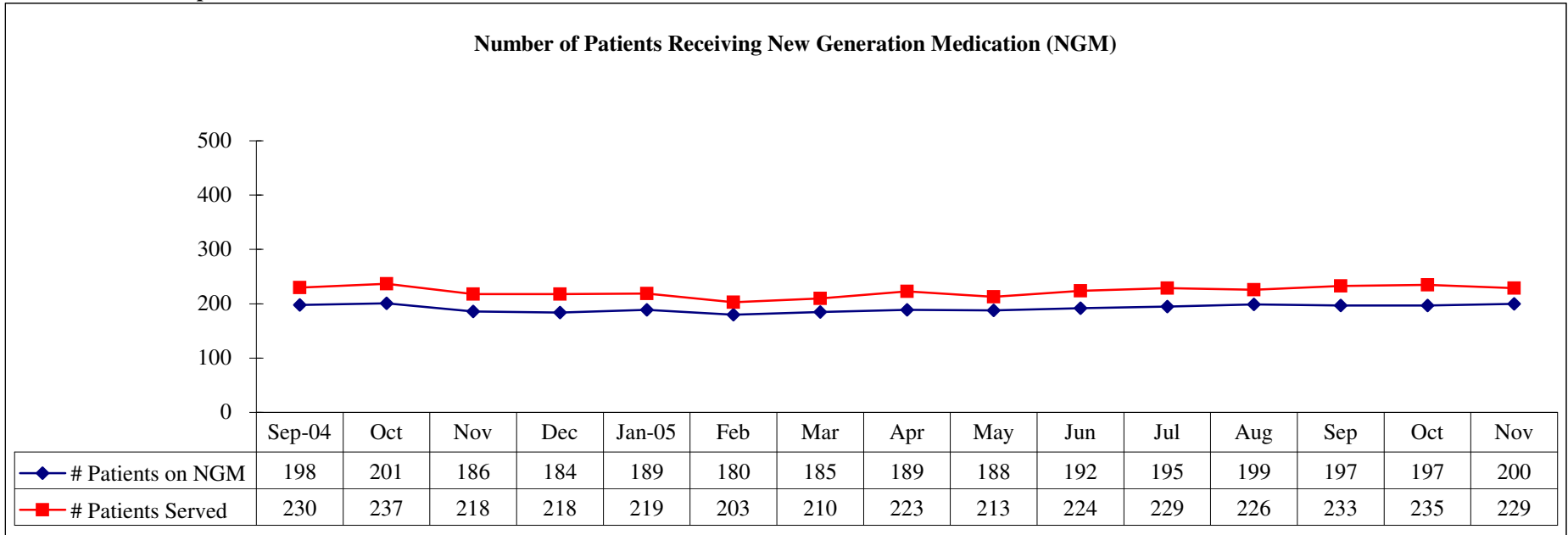
Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
El Paso Psychiatric Center



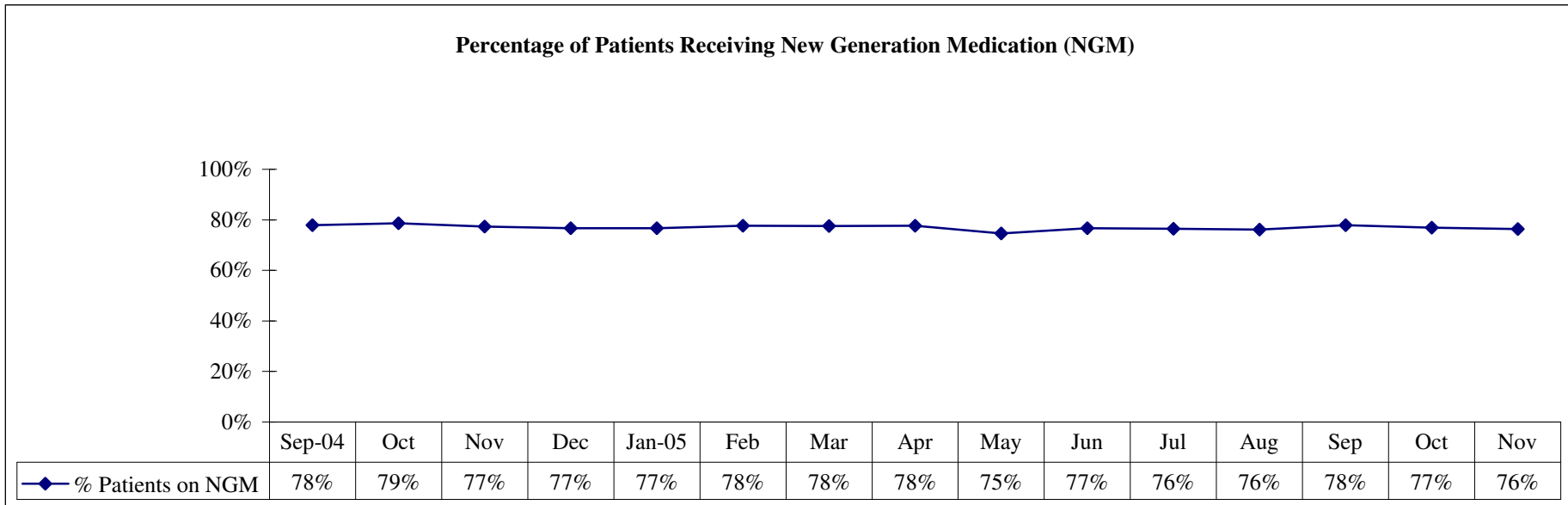
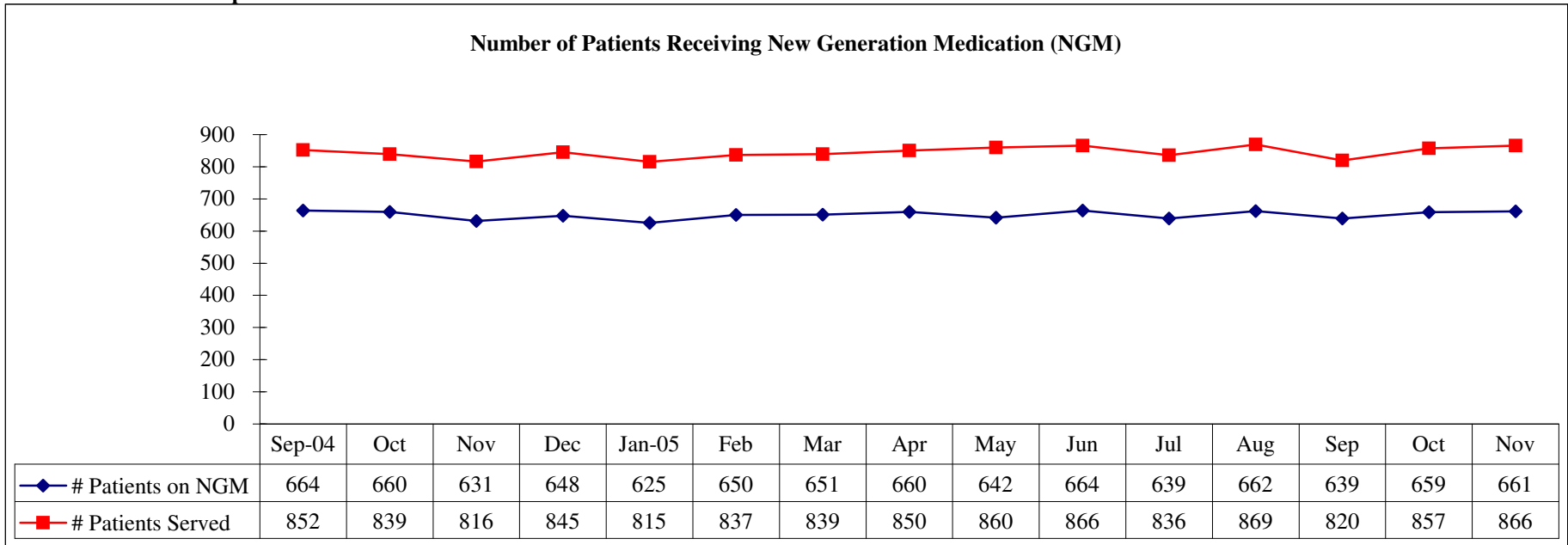
Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
Kerrville State Hospital



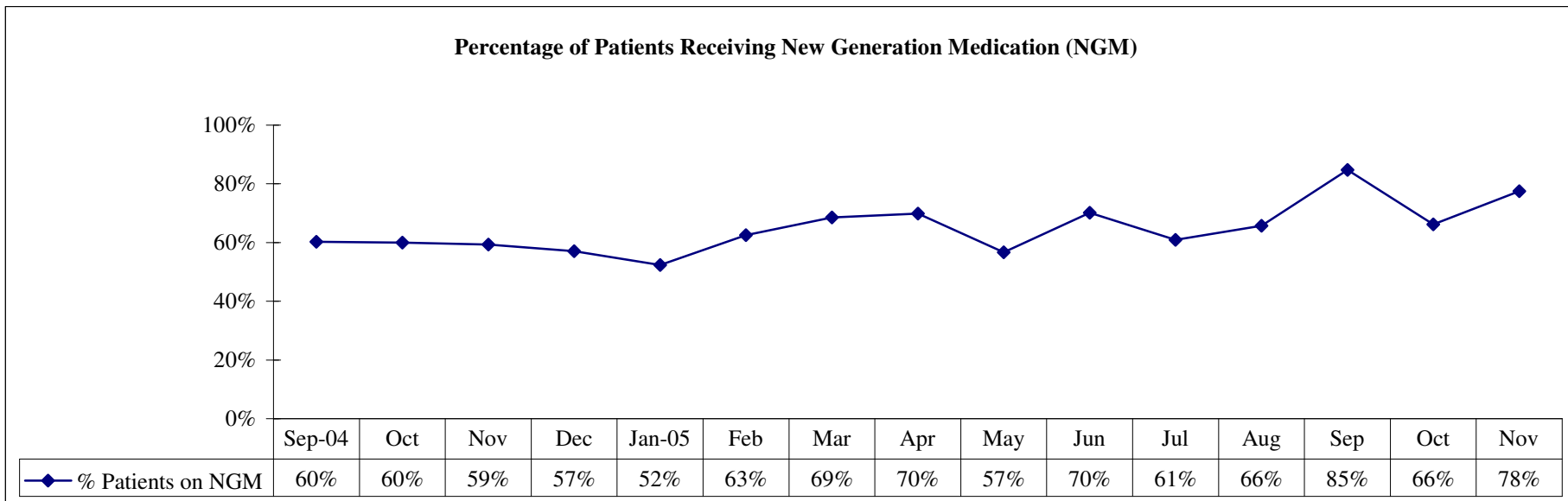
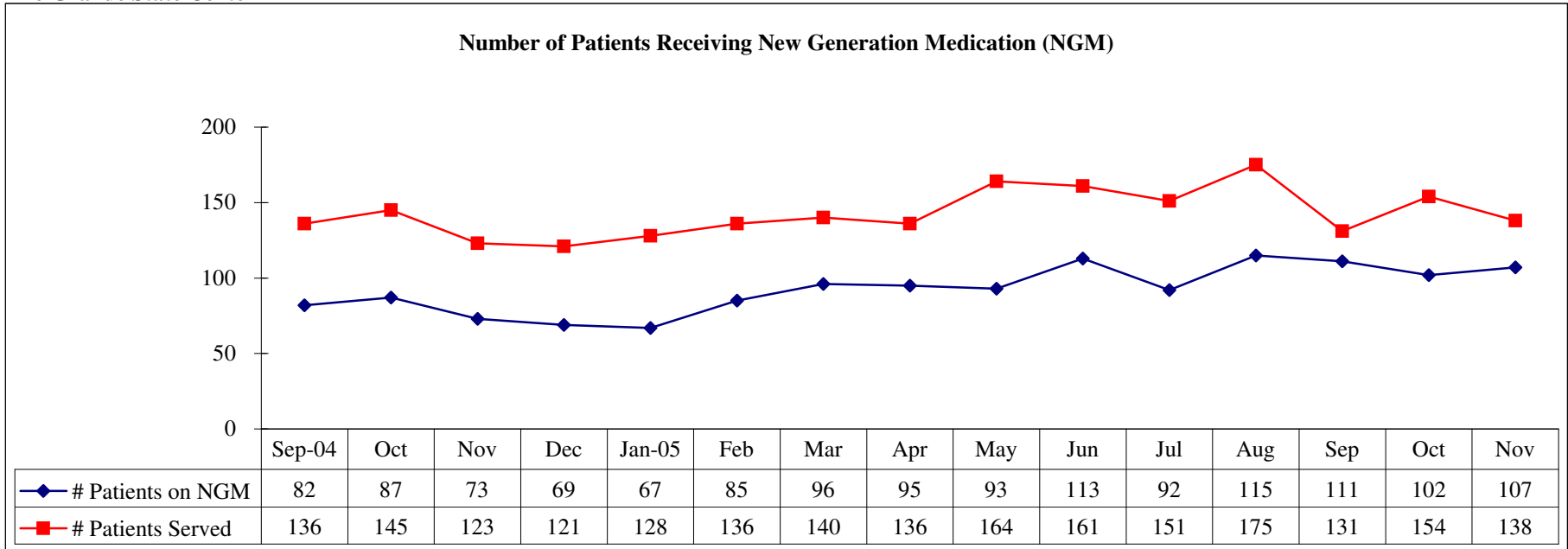
Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
North Texas State Hospital



Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

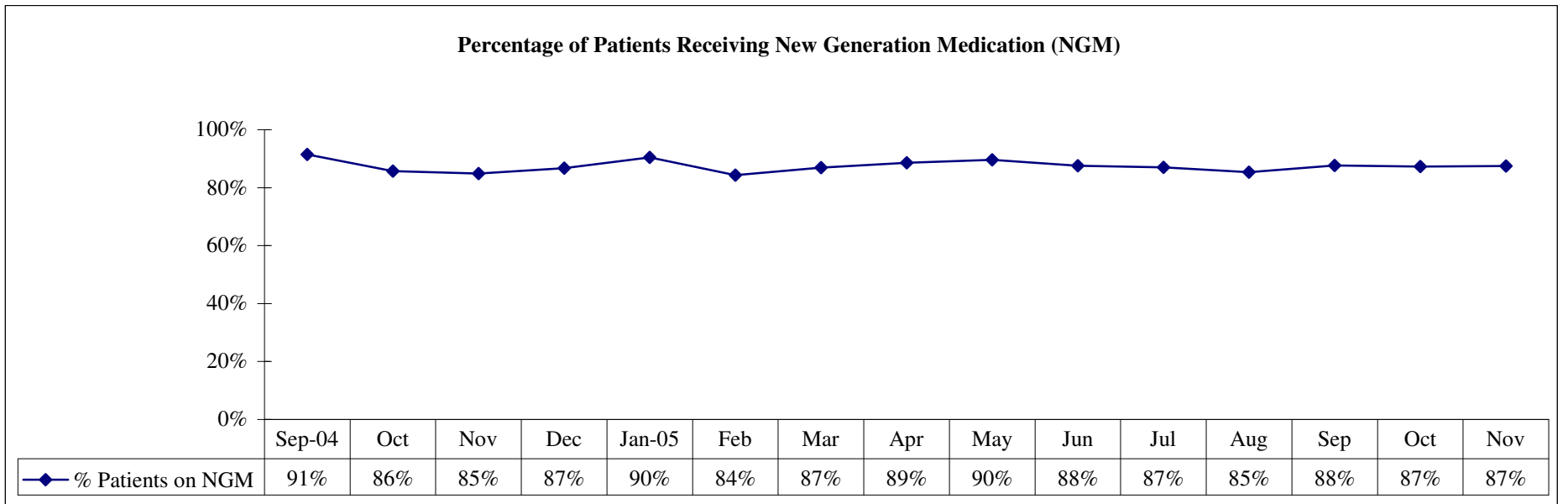
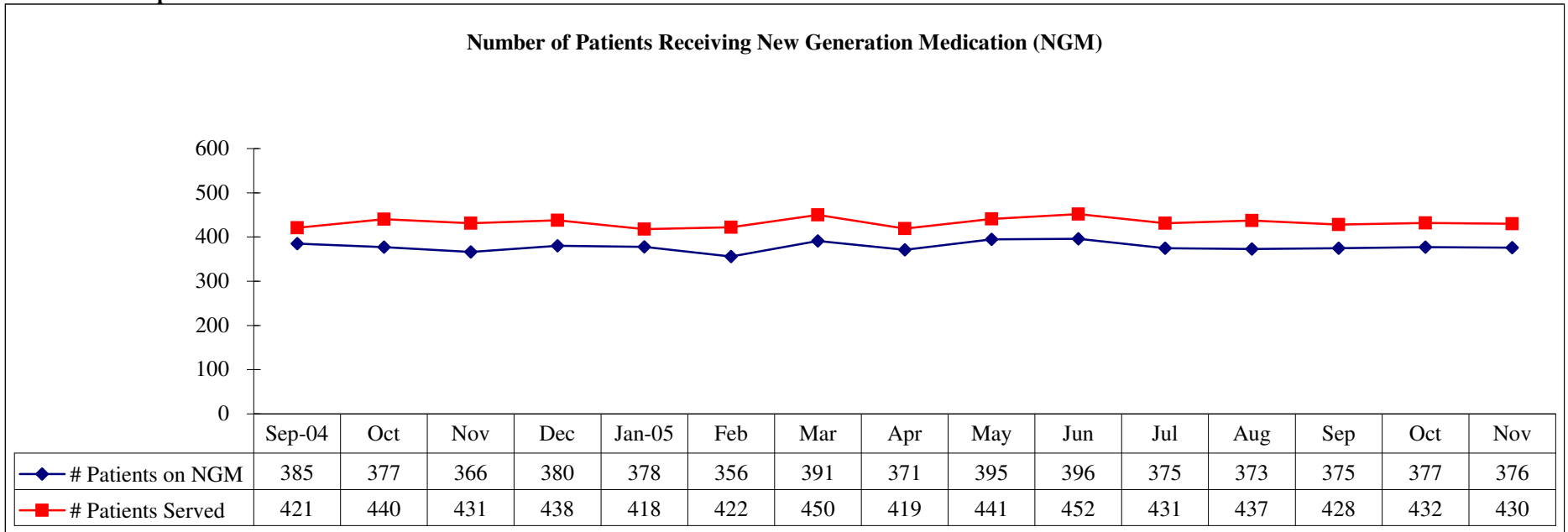
Measure 4A - Patients Receiving New Generation Medication (NGM)
Rio Grande State Center



Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

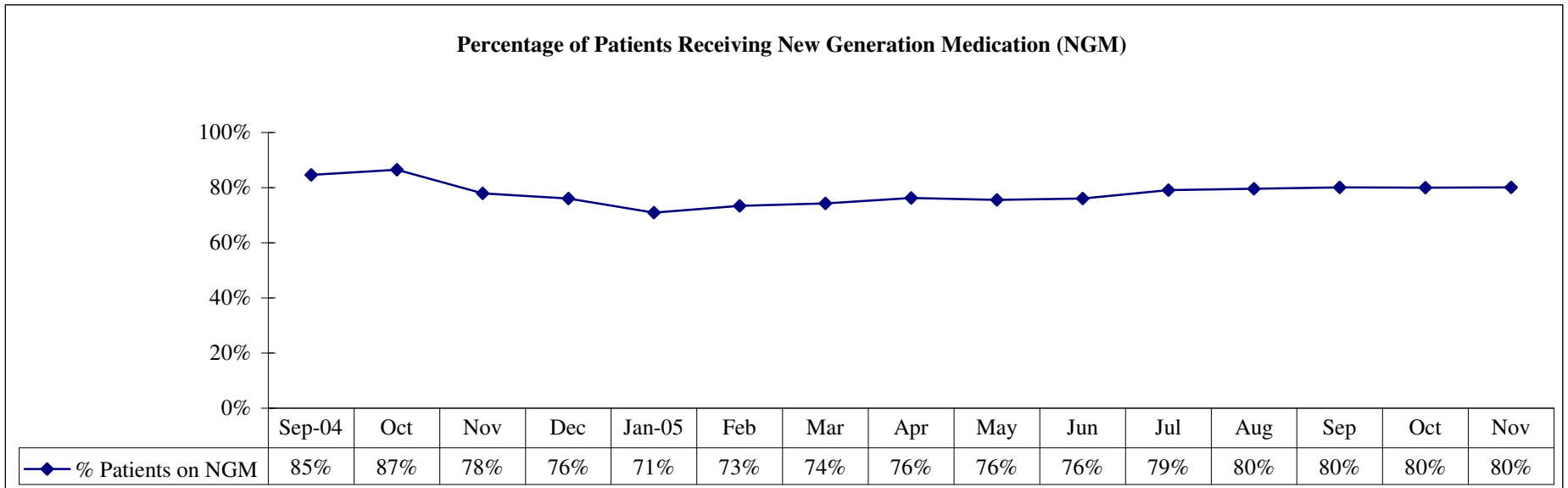
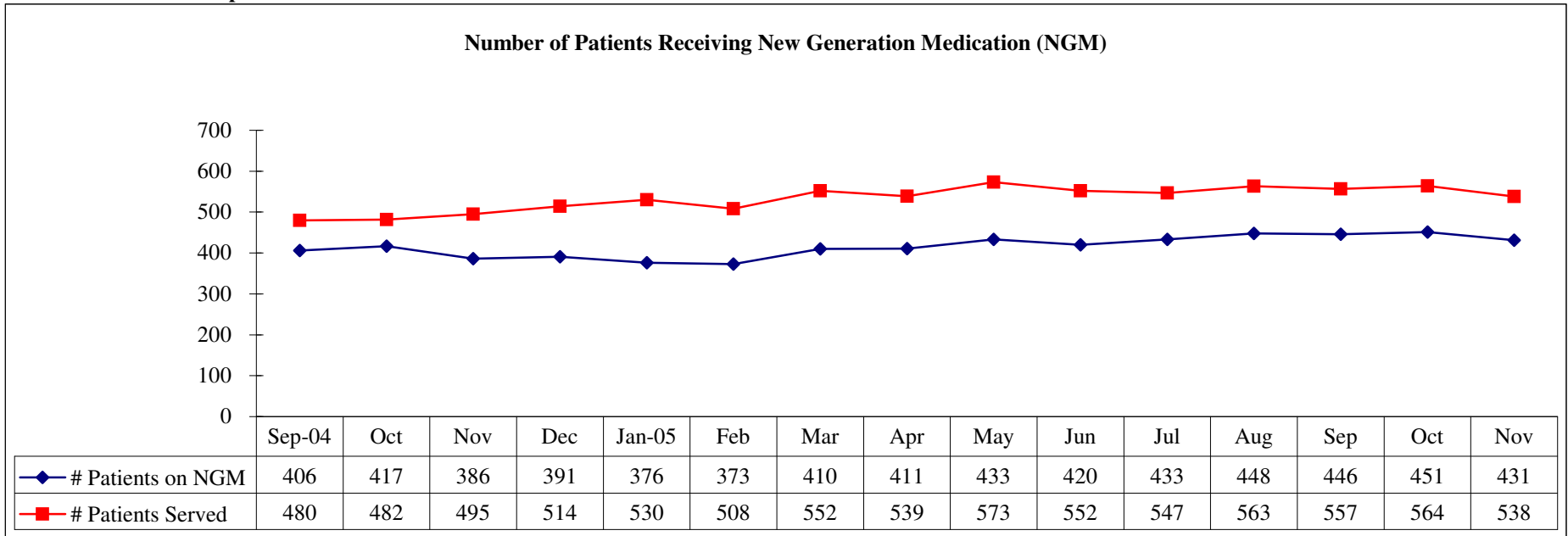
Measure 4A - Patients Receiving New Generation Medication (NGM)

Rusk State Hospital



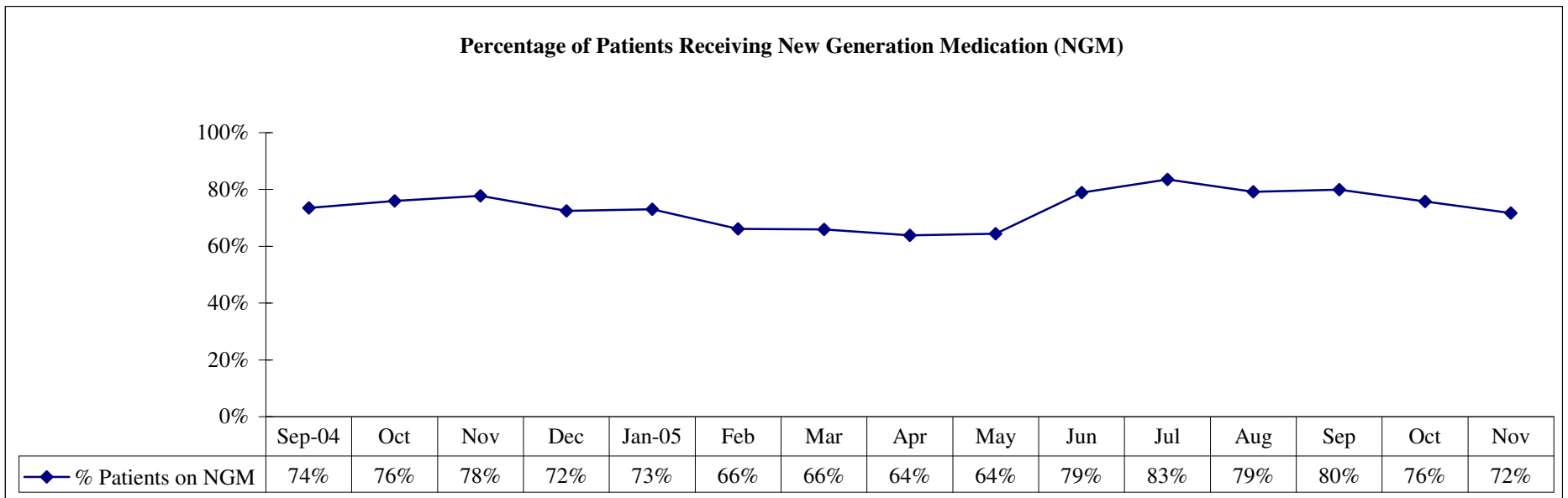
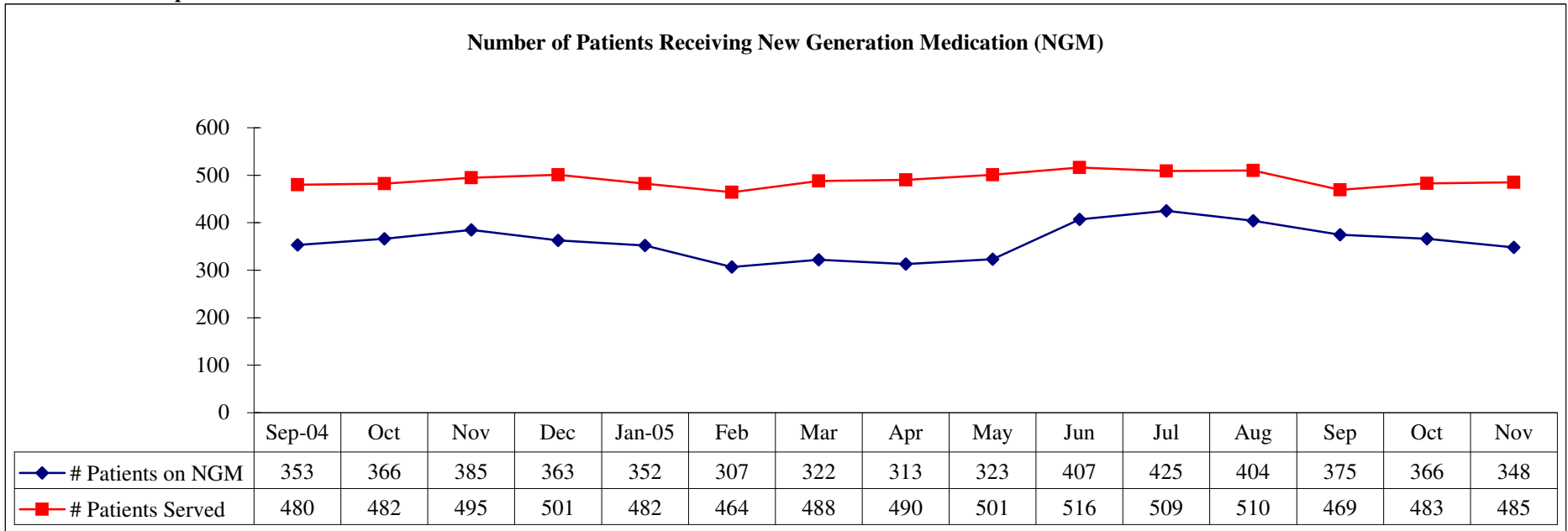
Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
San Antonio State Hospital



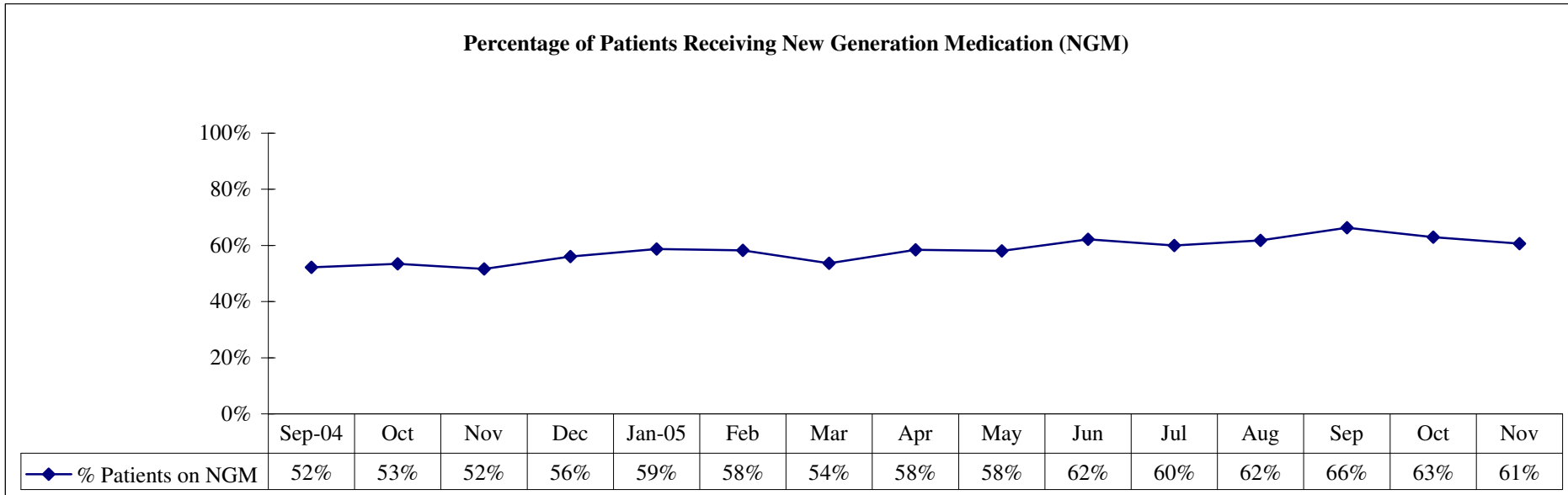
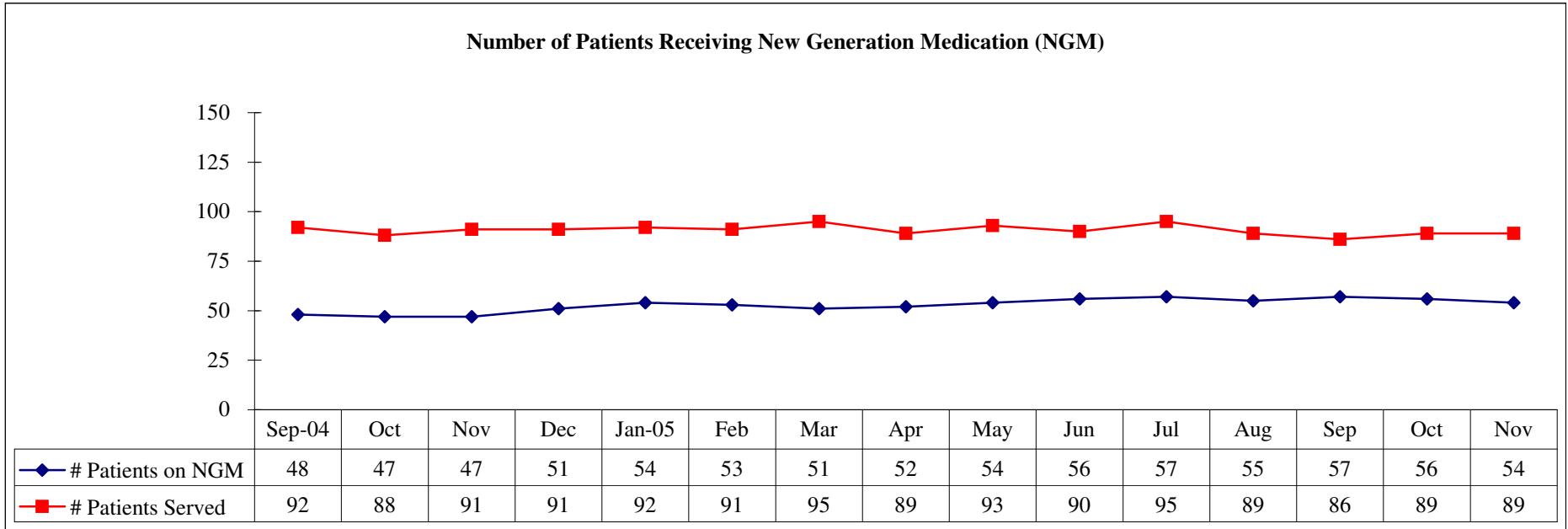
Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
Terrell State Hospital



Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Measure 4A - Patients Receiving New Generation Medication (NGM)
Waco Center for Youth



Source: New Generation Drug Counts (BHIS Report); HMDS # of Pts on NGM Report
 Counts of Persons Receiving MH Services (HC027245)

Performance Measure 4B:

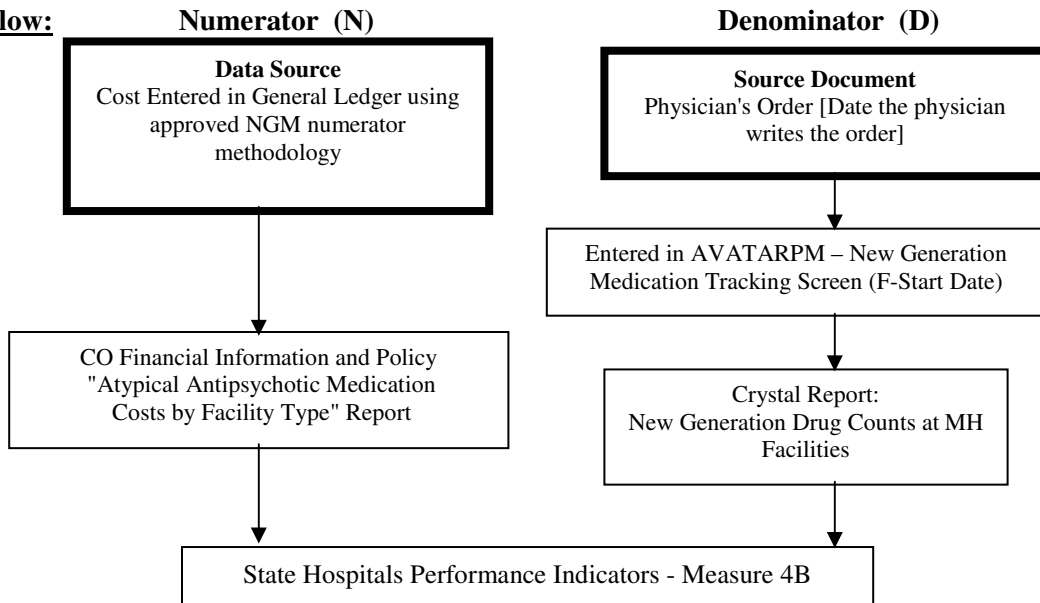
After the full implementation of the pharmacy distribution and accounting system, WORx , the costs of medications, including psychiatric medications, medications for medical issues, and discharge medications will be tracked and analyzed quarterly.

Performance Measure Operational Definition: The state hospitals average monthly cost for medications per patient.

Performance Measure Formula: Average Cost Per Patient Receiving NGM = NGM Cost / Number of Unique Patients Taking NGM. Formula to calculate NGM numerator equals: beginning NGM balance, plus current monthly NGM purchases/receipts, minus NGM ending balance equals NGM drug issues (costs). The source is Pharmakon. Note: State hospitals that are exempted from this formula are SASH, KSH and EPPC. SASH and KSH will track individual patients for NGM cost and EPPC will use their own pharmacy system rather than Pharmakon.

Performance Measure Data Display and Chart Description: Chart with monthly data points of average cost of new generation medication per patient for individual state hospitals and system-wide.

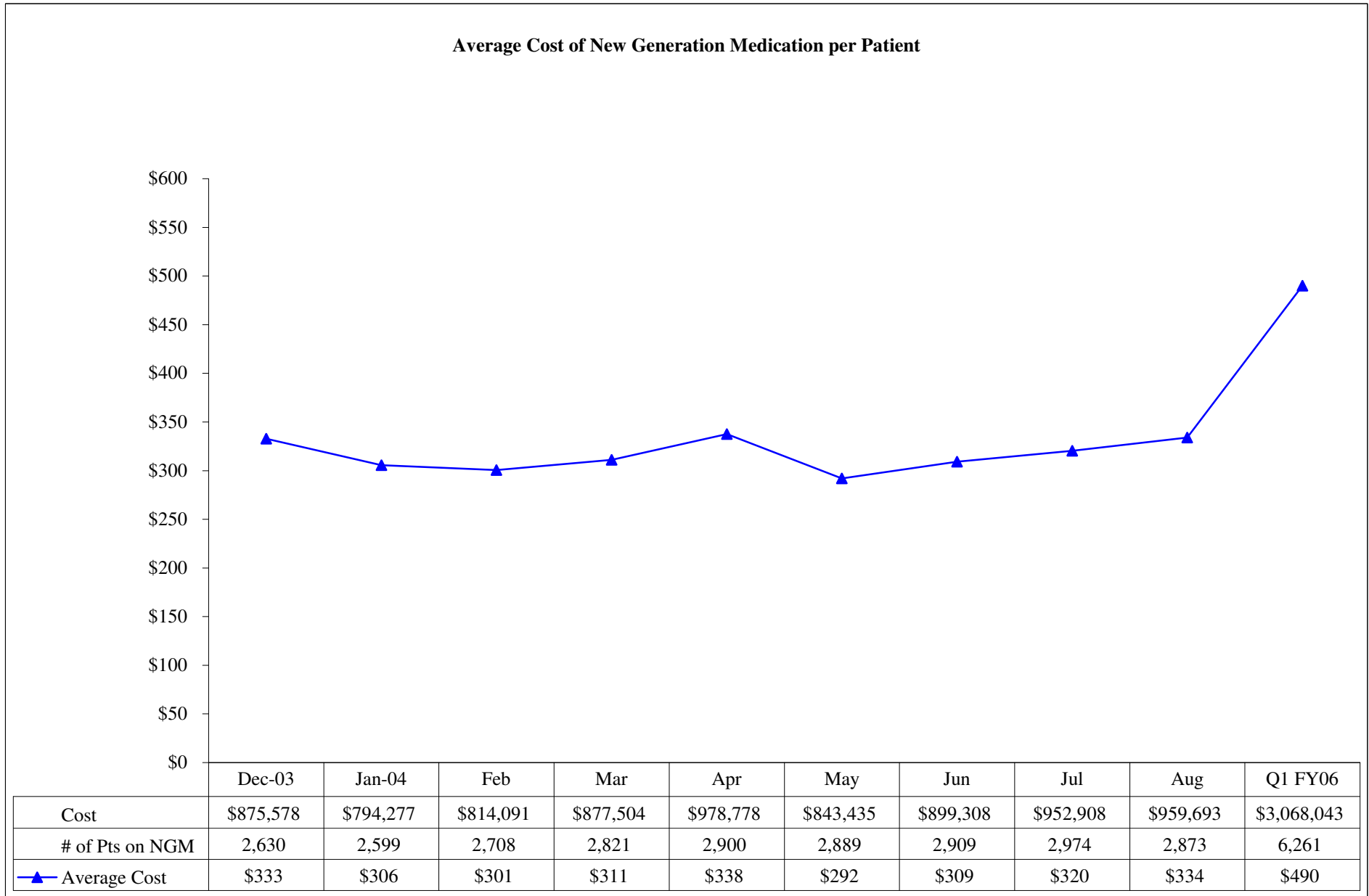
Data Flow:



Data Integrity Review Process:

N/A

**Measure 4B - Average Cost Per Patient Receiving New Generation Medication
All MH Facilities**



GOAL 5: Assure Continuum of Care

Performance Measure 5A:

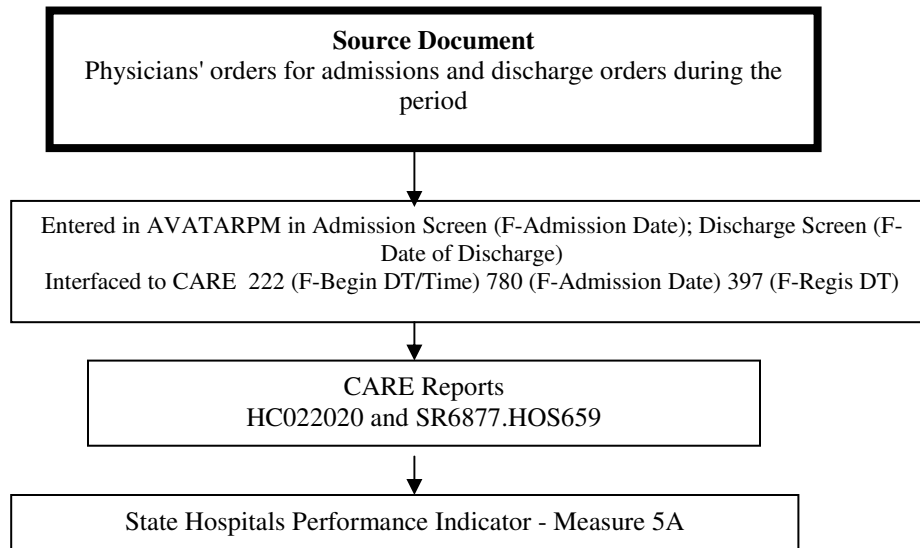
Number and type of all admissions, discharges, and the percentage of patients new to the system will be calculated and reported for each state hospital on a quarterly basis.

Performance Measure Operational Definition: The state hospital number of admissions and discharges to the same SMHF per mandated FYTD as calculated by CARE using data daily entered by each state hospital. The readmission rate is calculated by CARE using readmission to any SMHF.

Performance Measure Data Display and Chart Description:

- ◆ Chart with monthly data points of total admissions, discharges and percent of readmissions for individual state hospitals and system-wide.
- ◆ Chart with monthly data points of total year-to-date admissions and discharges for individual state hospitals and system-wide.
- ◆ Table shows total admissions (voluntary, involuntary [OPC, Emergency, Temporary, Extended, 46.02/03 and Other]), discharge and percent of readmissions per month for individual state hospitals and system-wide.

Data Flow:



Data Integrity Review Process:

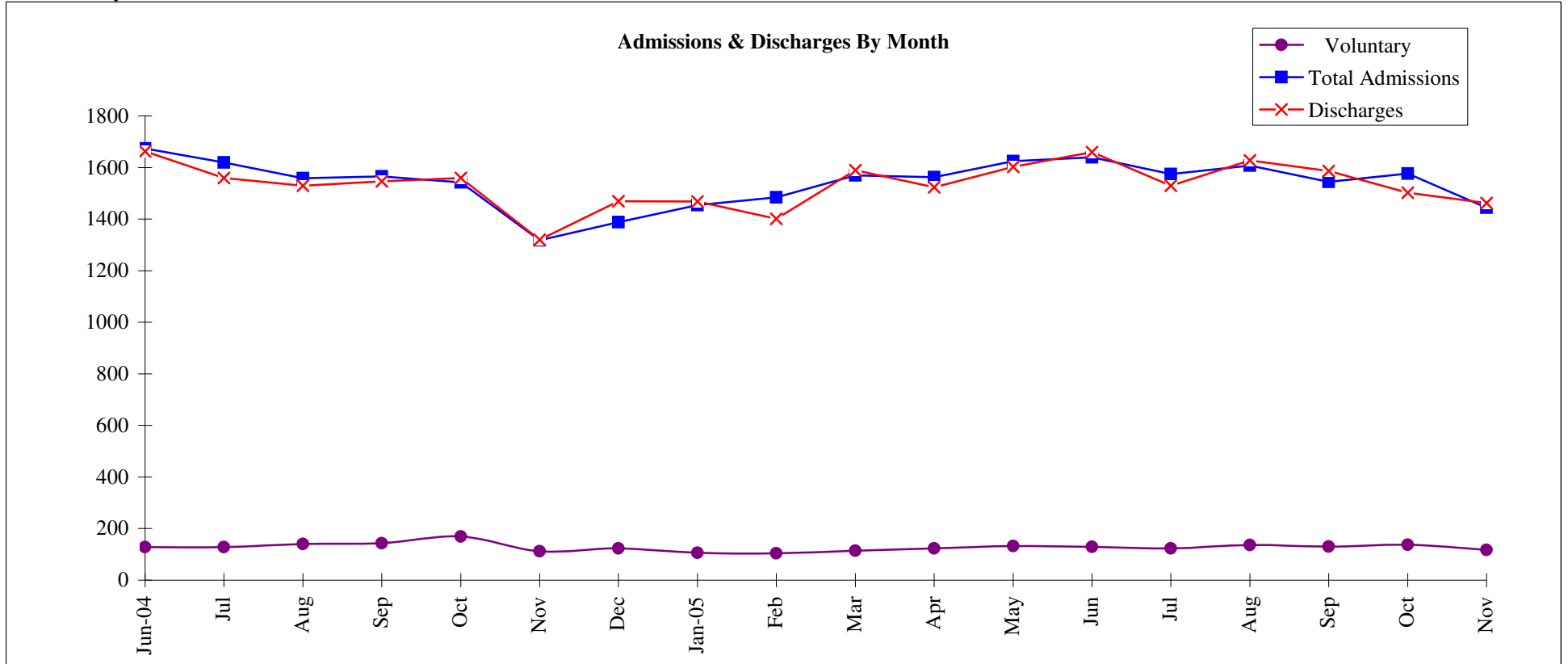
Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including data accuracy, findings and data analysis.

Measure 5A - Number/Type of Admissions and Readmissions

All MH Facilities

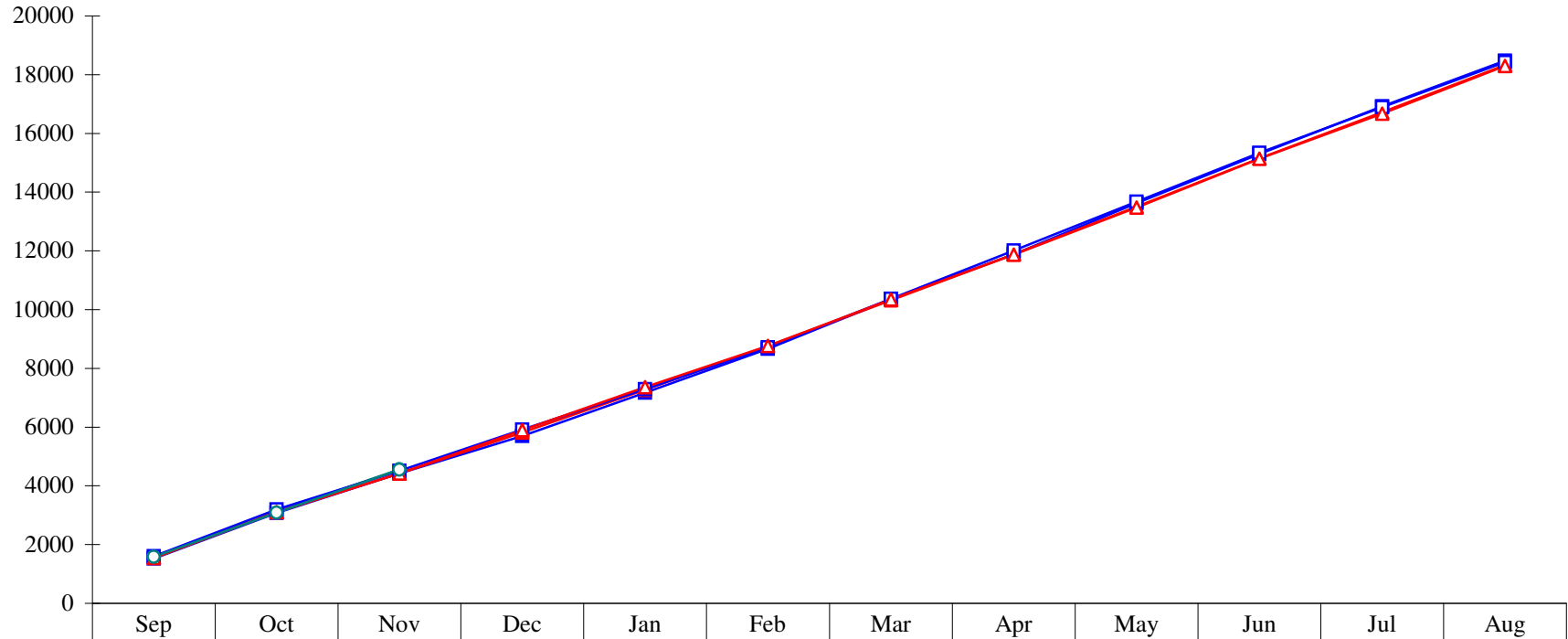
Admissions by Month

	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	1674	1620	1558	1565	1542	1318	1388	1454	1484	1569	1562	1625	1640	1574	1608	1544	1577	1444
Voluntary	128	128	140	143	169	112	123	106	104	114	123	132	129	123	136	130	137	117
Involuntary	1546	1492	1417	1422	1373	1206	1265	1348	1380	1455	1439	1493	1511	1451	1472	1414	1440	1327
OPC	351	372	359	363	305	318	313	325	297	371	390	386	339	365	388	367	388	371
Emergency	807	791	713	712	759	573	613	690	704	719	739	817	797	737	746	735	702	652
Temporary	215	172	185	182	153	170	178	171	186	174	161	149	183	172	173	134	152	140
Extended	4	7	5	7	12	3	11	5	19	10	6	5	6	10	6	6	9	5
46.02/46.03	153	124	135	131	130	124	142	143	151	164	121	117	162	106	101	157	169	142
Order for MR S'	16	26	20	27	14	18	8	14	23	17	22	19	24	61	58	15	20	17
Discharges	1663	1559	1529	1546	1559	1320	1469	1468	1401	1590	1523	1603	1660	1529	1628	1587	1502	1462
% New to System	43%	44%	43%	44%	46%	44%	45%	44%	42%	43%	45%	46%	43%	44%	43%	46%	44%	45%



Measure 5A - Number/Type of Admissions and Readmissions
All MH Facilities
FYTD Admissions & Discharges

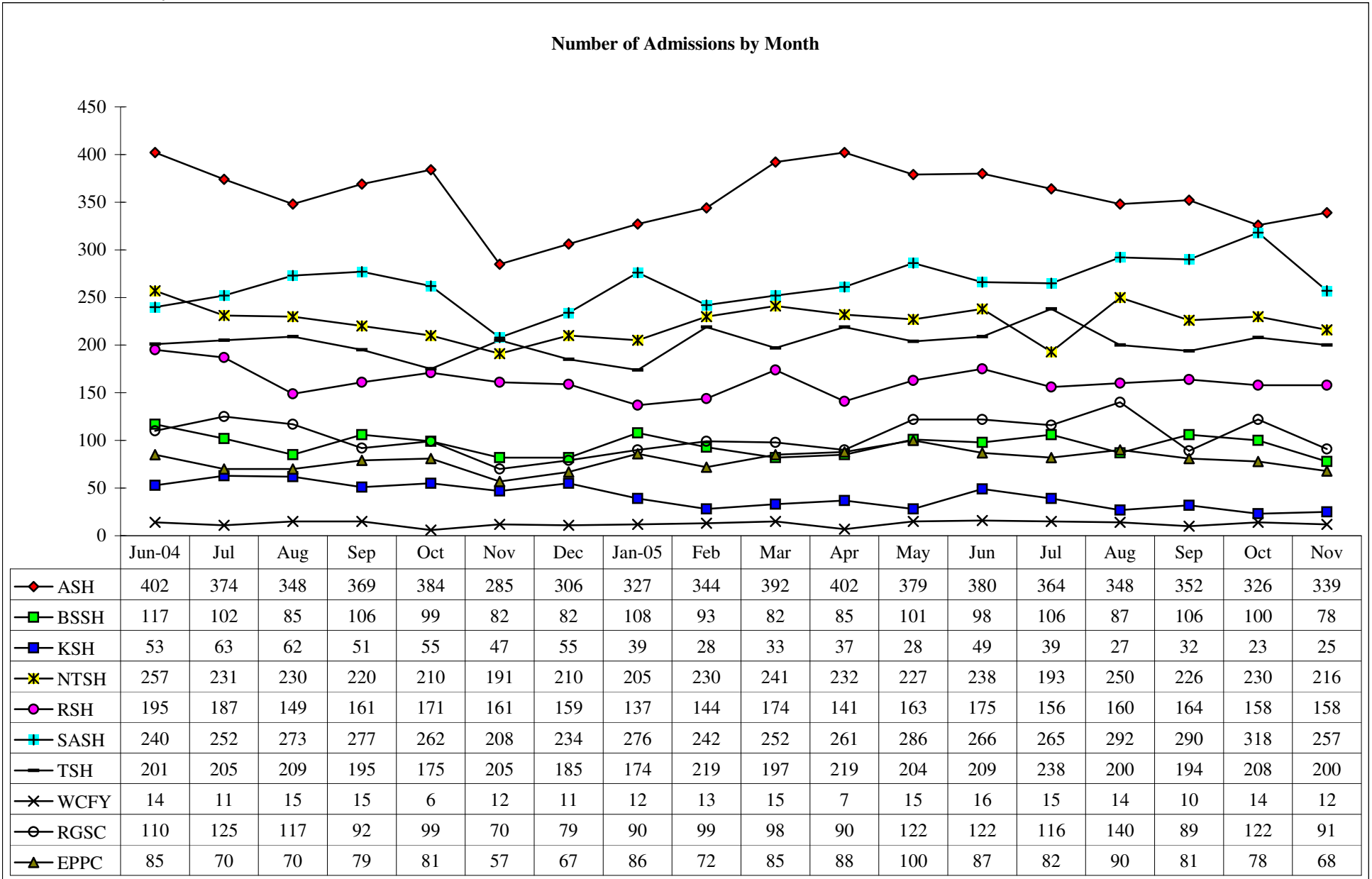
Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
—■— FY04 Admissions	1523	3077	4427	5697	7170	8667	10359	11881	13627	15301	16921	18479
—▲— FY05 Admissions	1565	3107	4425	5813	7267	8751	10319	11881	13506	15146	16720	18328
—●— FY06 Admissions	1544	3121	4565									
—■— FY04 Discharges	1604	3197	4509	5915	7294	8711	10367	12014	13675	15338	16897	18426
—▲— FY05 Discharges	1546	3105	4425	5894	7362	8763	10353	11876	13479	15140	16669	18297
—●— FY06 Discharges	1587	3089	4551									

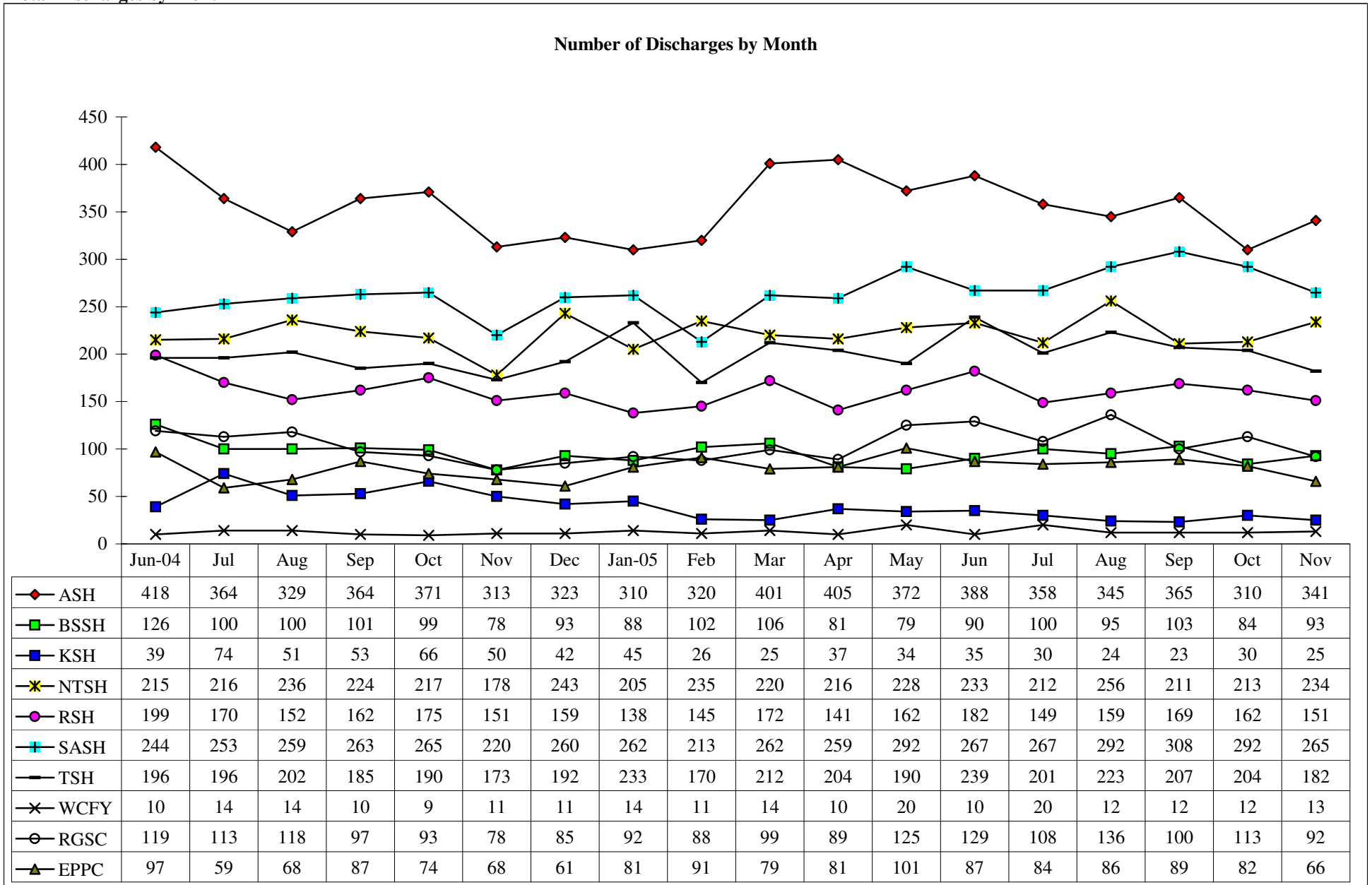
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
All MH Facilities
Total Admissions by Month



Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
All MH Facilities
Total Discharges by Month



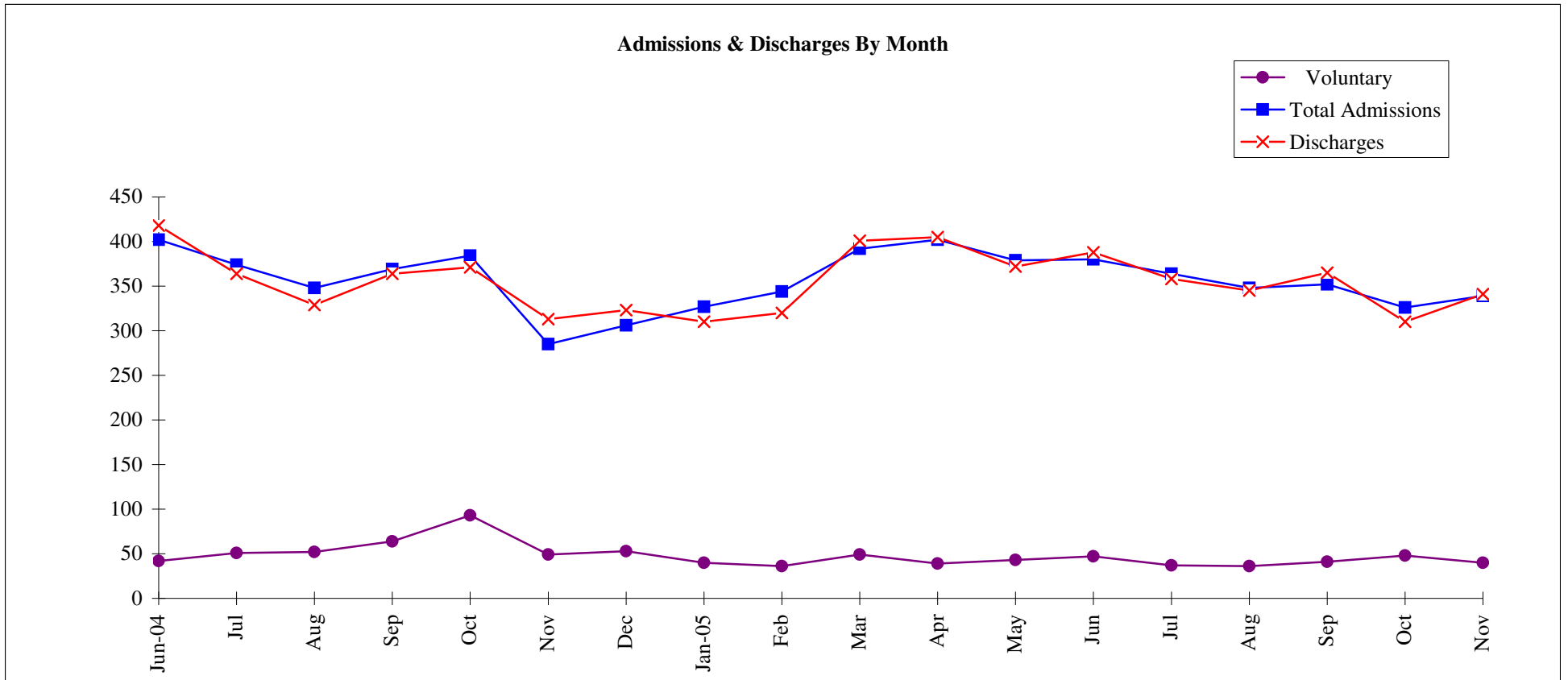
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Austin State Hospital

Admissions by Month

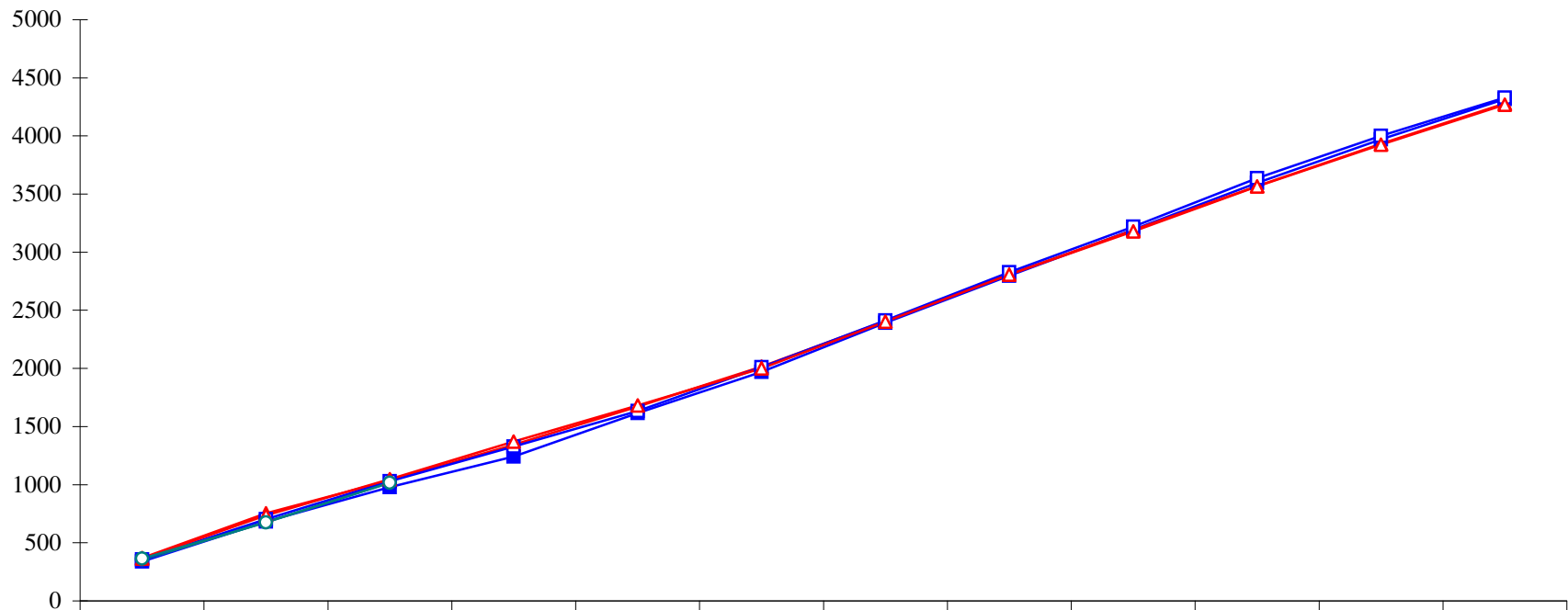
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	402	374	348	369	384	285	306	327	344	392	402	379	380	364	348	352	326	339
Voluntary	42	51	52	64	93	49	53	40	36	49	39	43	47	37	36	41	48	40
Involuntary	360	323	296	305	291	236	253	287	308	343	363	336	333	327	312	311	278	299
OPC	29	27	31	29	25	18	23	27	30	38	33	23	28	35	33	32	35	31
Emergency	277	244	224	225	231	177	178	223	238	249	283	265	252	250	233	244	195	231
Temporary	33	32	33	29	23	27	40	31	26	40	33	38	30	24	25	23	30	23
Extended	1	1	0	0	0	0	0	0	1	0	0	0	1	0	2	0	2	1
46.02/46.03	20	17	7	21	12	14	12	6	13	15	14	10	20	17	19	9	16	13
Order for MR S	0	2	1	1	0	0	0	0	0	1	0	0	2	1	0	3	0	0
Discharges	418	364	329	364	371	313	323	310	320	401	405	372	388	358	345	365	310	341
% New to System	38%	42%	43%	45%	45%	42%	46%	46%	44%	43%	52%	43%	38%	42%	43%	51%	43%	46%



Source: Admis./Disch./Pop. by Month (HC022020/22), Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
Austin State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	340	683	978	1241	1616	1969	2392	2796	3194	3596	3970	4318
▲ FY05 Admissions	369	753	1038	1344	1671	2015	2407	2809	3188	3568	3932	4280
● FY06 Admissions	352	678	1017									
■ FY04 Discharges	357	703	1029	1329	1634	2010	2412	2827	3219	3637	4001	4330
▲ FY05 Discharges	364	735	1048	1371	1681	2001	2402	2807	3179	3567	3925	4270
● FY06 Discharges	365	675	1016									

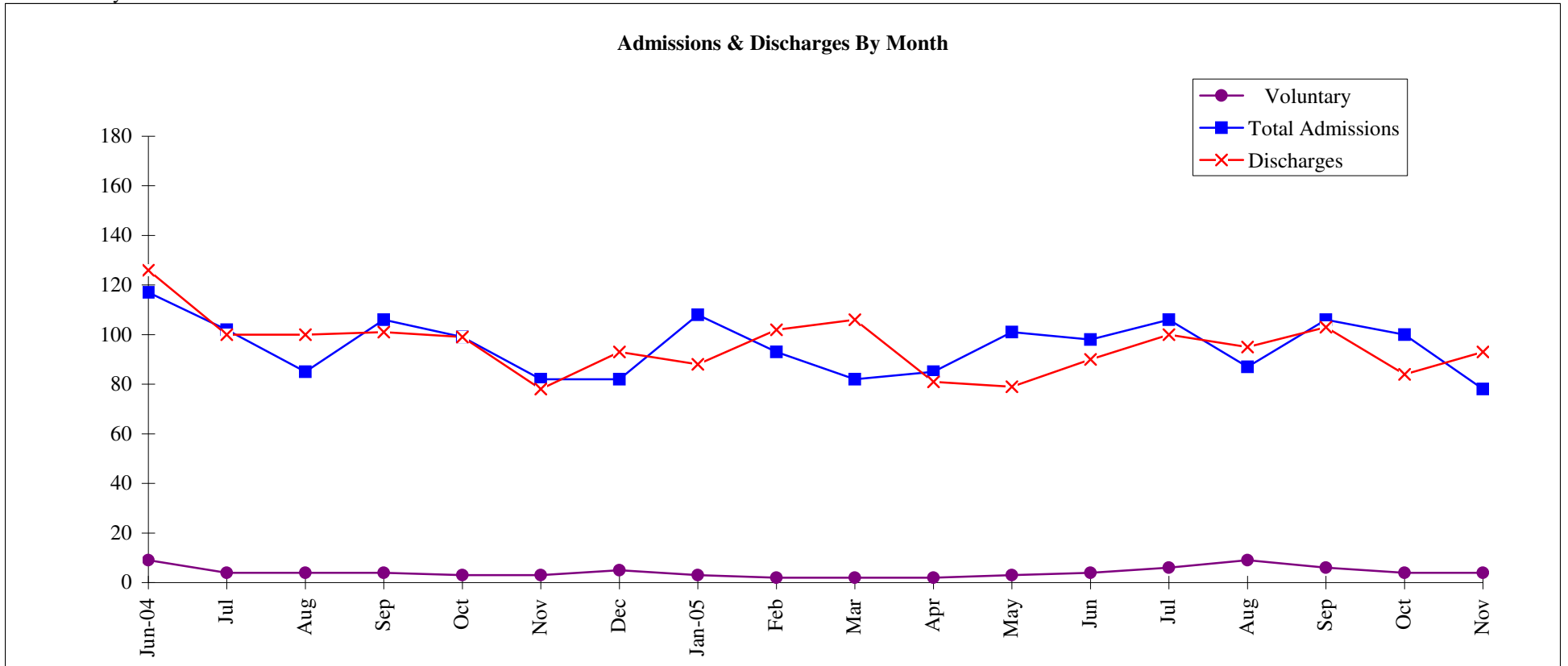
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Big Spring State Hospital

Admissions by Month

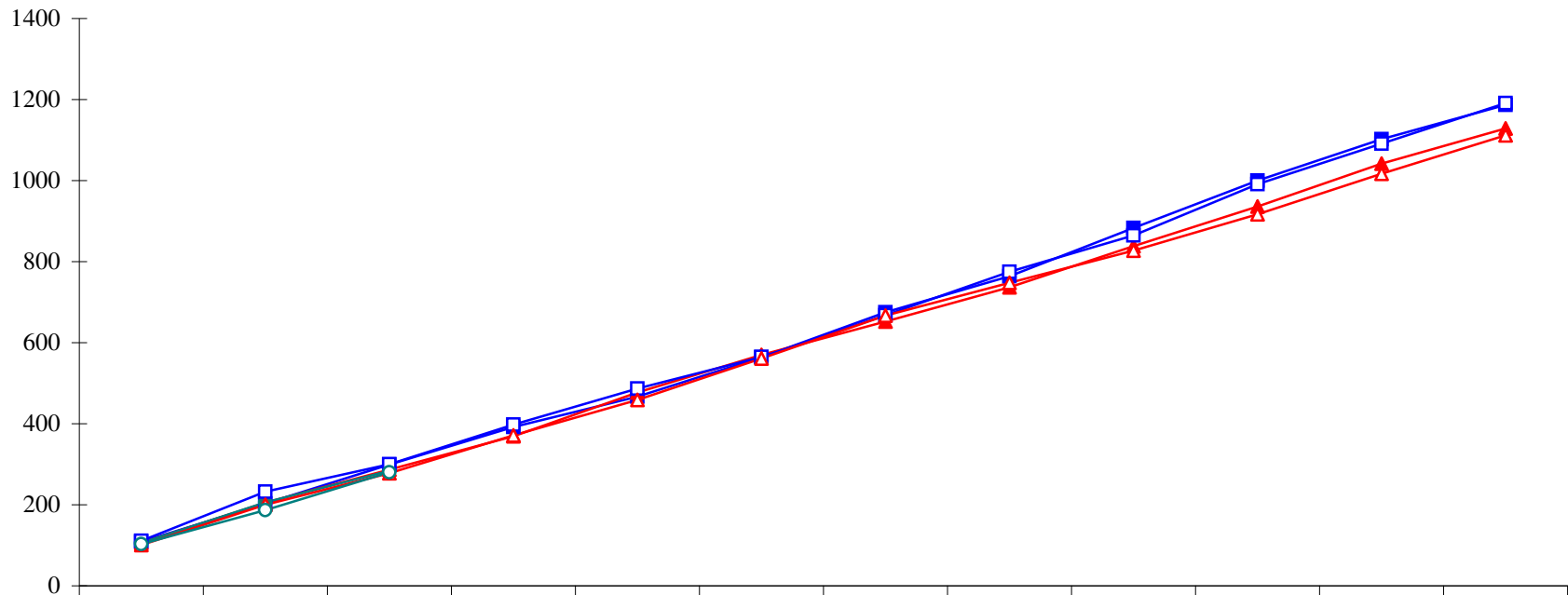
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	117	102	85	106	99	82	82	108	93	82	85	101	98	106	87	106	100	78
Voluntary	9	4	4	4	3	3	5	3	2	2	2	3	4	6	9	6	4	4
Involuntary	108	98	81	102	96	79	77	105	91	80	83	98	94	100	78	100	96	74
OPC	18	23	13	20	18	19	10	15	14	18	19	16	12	25	19	17	7	16
Emergency	75	65	60	57	63	48	61	68	74	54	58	55	55	57	47	56	47	38
Temporary	11	2	3	8	11	4	0	0	0	1	1	0	1	0	3	1	1	0
Extended	1	2	0	2	0	0	1	1	0	1	1	0	0	1	0	0	1	0
46.02/46.03	2	4	4	12	3	5	4	21	2	4	2	23	23	12	7	24	38	18
Order for MR S	1	2	1	3	1	3	1	0	1	2	2	4	3	5	2	2	2	2
Discharges	126	100	100	101	99	78	93	88	102	106	81	79	90	100	95	103	84	93
% New to System	38%	38%	31%	31%	37%	45%	39%	31%	39%	43%	39%	43%	38%	38%	31%	31%	28%	33%



Source: Admis./Disch./Pop. by Month (HC022020/22), Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
Big Spring State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	109	203	299	392	467	564	675	764	883	1000	1102	1187
▲ FY05 Admissions	106	205	287	369	477	570	652	737	838	936	1042	1129
● FY06 Admissions	106	206	284									
□ FY04 Discharges	111	232	300	398	487	565	668	775	865	991	1091	1191
▲ FY05 Discharges	101	200	278	371	459	561	667	748	827	917	1017	1112
○ FY06 Discharges	103	187	280									

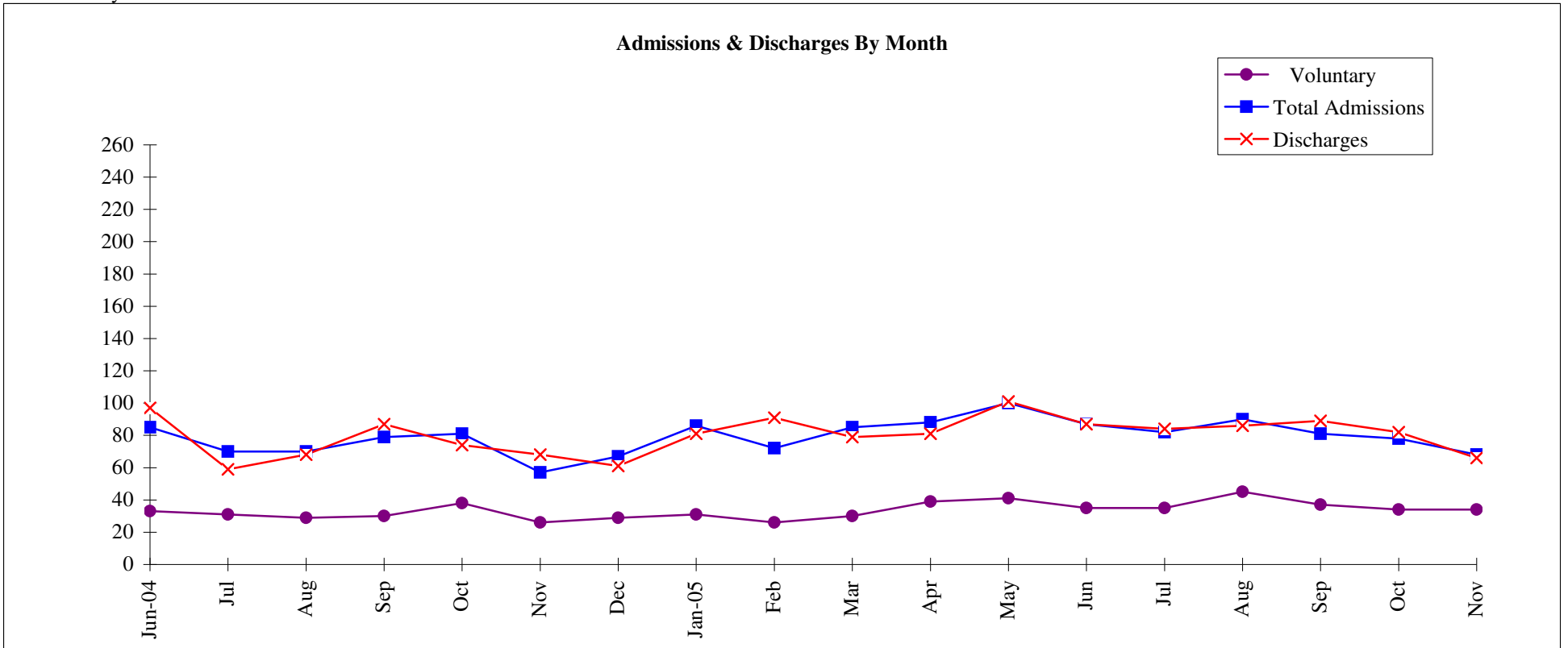
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

El Paso Psychiatric Center

Admissions by Month

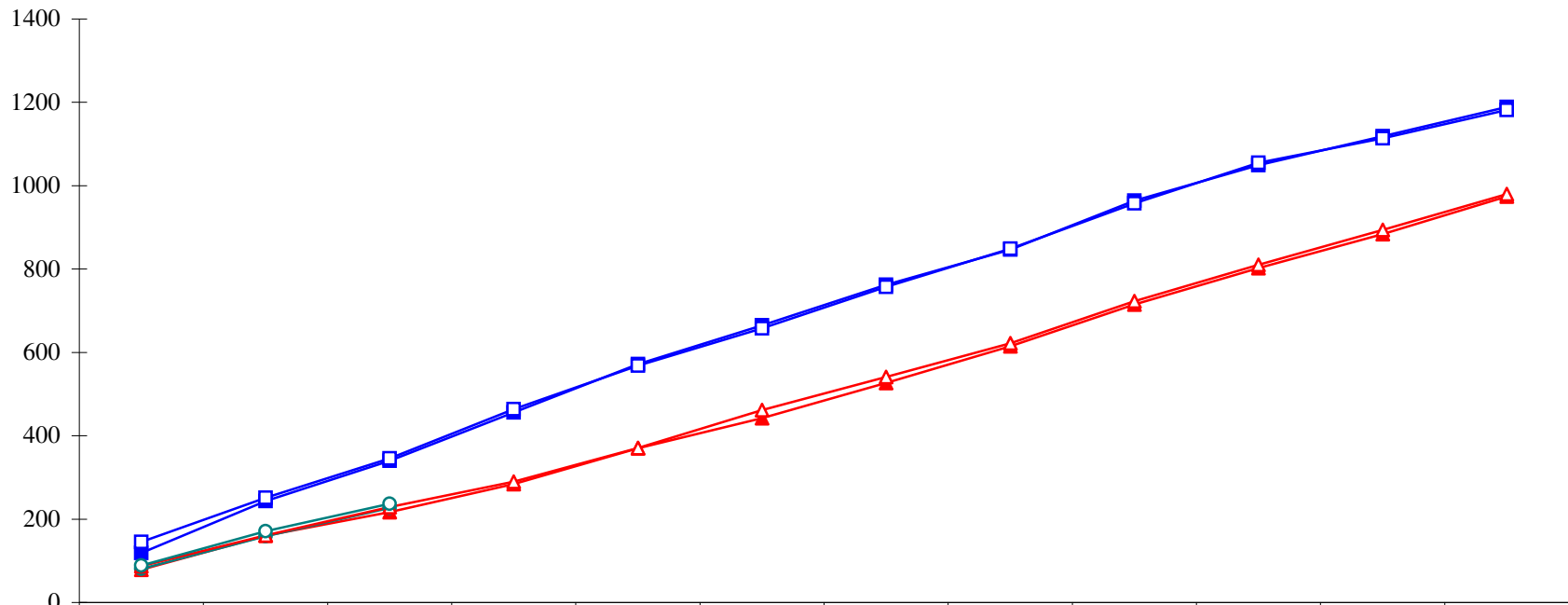
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	85	70	70	79	81	57	67	86	72	85	88	100	87	82	90	81	78	68
Voluntary	33	31	29	30	38	26	29	31	26	30	39	41	35	35	45	37	34	34
Involuntary	52	39	41	49	43	31	38	55	46	55	49	59	52	47	45	44	44	34
OPC	9	3	2	3	2	3	4	4	1	3	0	3	3	1	0	1	4	3
Emergency	42	36	34	45	40	26	29	48	44	51	45	53	49	45	45	43	40	29
Temporary	1	0	2	1	1	2	3	3	1	1	3	2	0	1	0	0	0	0
Extended	0	0	1	0	0	0	2	0	0	0	1	1	0	0	0	0	0	0
46.02/46.03	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Order for MR S	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	97	59	68	87	74	68	61	81	91	79	81	101	87	84	86	89	82	66
% New to System	41%	39%	47%	49%	53%	56%	63%	52%	44%	48%	48%	54%	41%	39%	47%	51%	51%	50%



Source: Admis./Disch./Pop. by Month (HC022020/22), Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
El Paso Psychiatric Center
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



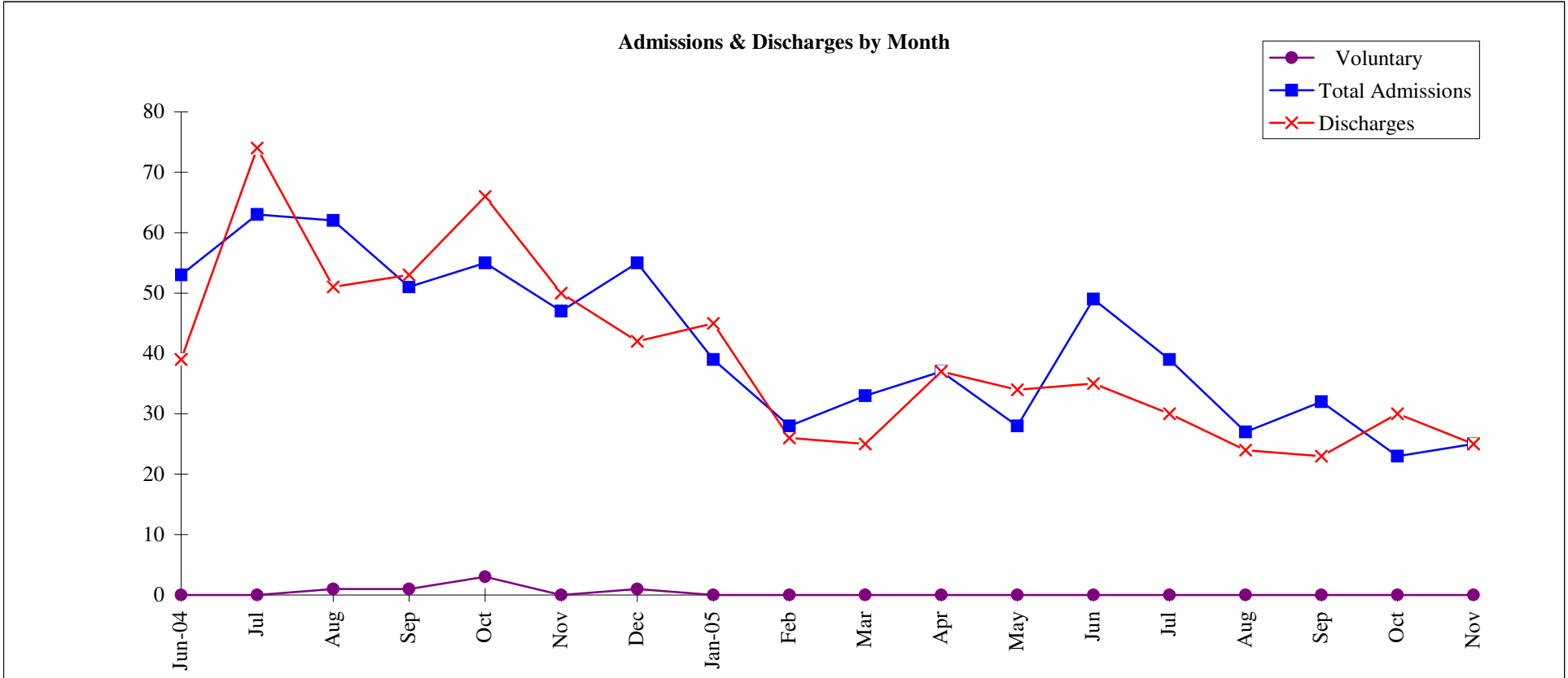
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	119	243	340	456	572	665	762	847	964	1049	1119	1189
▲ FY05 Admissions	79	160	217	284	370	442	527	615	715	802	884	974
● FY06 Admissions	81	159	227									
□ FY04 Discharges	145	251	346	464	568	658	757	849	958	1055	1114	1182
▲ FY05 Discharges	87	161	229	290	371	462	541	622	723	810	894	980
○ FY06 Discharges	89	171	237									

Measure 5A - Number/Type of Admissions and Readmissions

Kerrville State Hospital

Admissions by Month

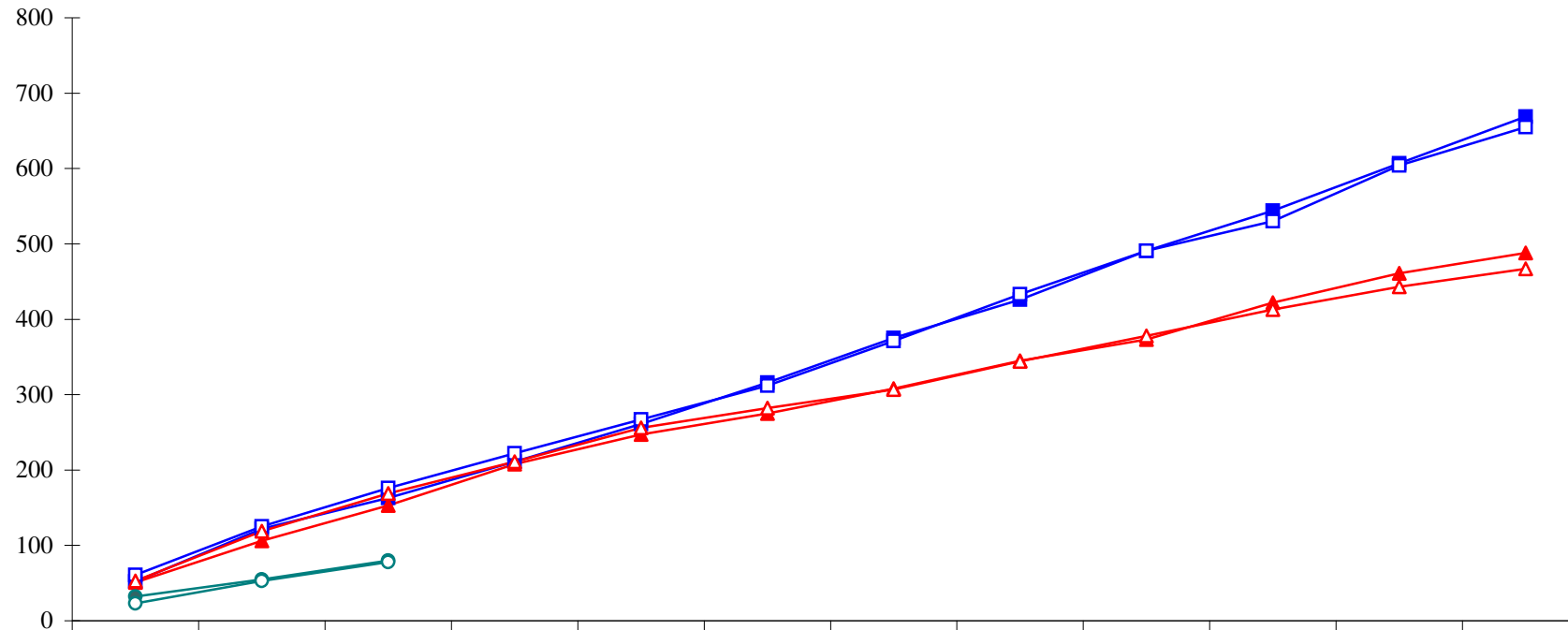
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	53	63	62	51	55	47	55	39	28	33	37	28	49	39	27	32	23	25
Voluntary	0	0	1	1	3	0	1	0	0	0	0	0	0	0	0	0	0	0
Involuntary	53	63	61	50	52	47	54	39	28	33	37	28	49	39	27	32	23	25
OPC	7	8	5	5	3	3	2	1	0	1	3	1	3	1	2	4	0	1
Emergency	34	42	38	41	39	34	31	12	1	20	17	19	22	16	15	15	20	15
Temporary	2	0	1	0	0	4	8	0	0	0	0	0	1	0	0	0	0	0
Extended	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
46.02/46.03	10	11	17	2	9	6	13	26	27	12	17	8	22	21	10	13	3	9
Order for MR S	0	2	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	39	74	51	53	66	50	42	45	26	25	37	34	35	30	24	23	30	25
% New to System	26%	35%	32%	49%	42%	30%	29%	15%	0%	27%	22%	43%	26%	35%	32%	22%	43%	20%



Source: Admis./Disch./Pop. by Month (HC022020/22), Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
Kerrville State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date

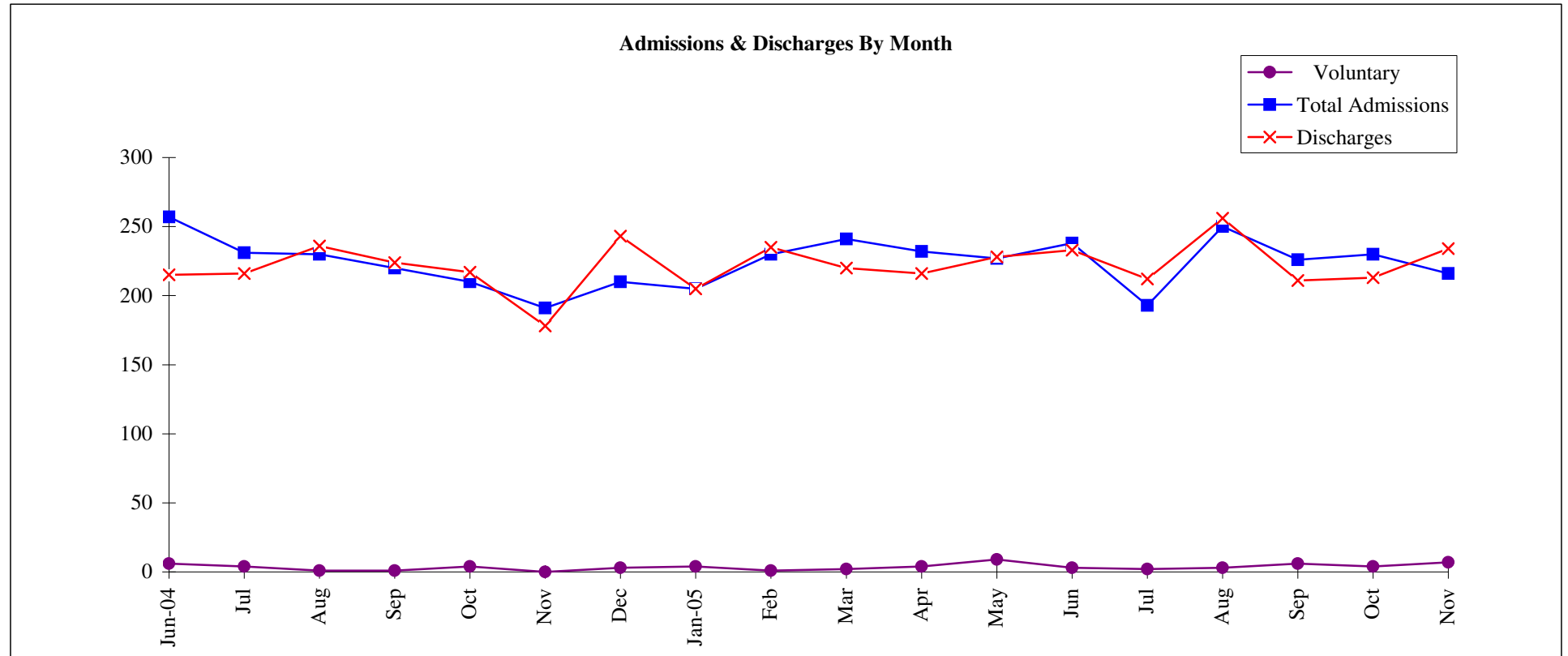


	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	52	122	163	211	261	316	375	426	491	544	607	669
▲ FY05 Admissions	51	106	153	208	247	275	308	345	373	422	461	488
● FY06 Admissions	32	55	80									
□ FY04 Discharges	61	125	176	222	267	312	371	433	491	530	604	655
△ FY05 Discharges	53	119	169	211	256	282	307	344	378	413	443	467
○ FY06 Discharges	23	53	78									

Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

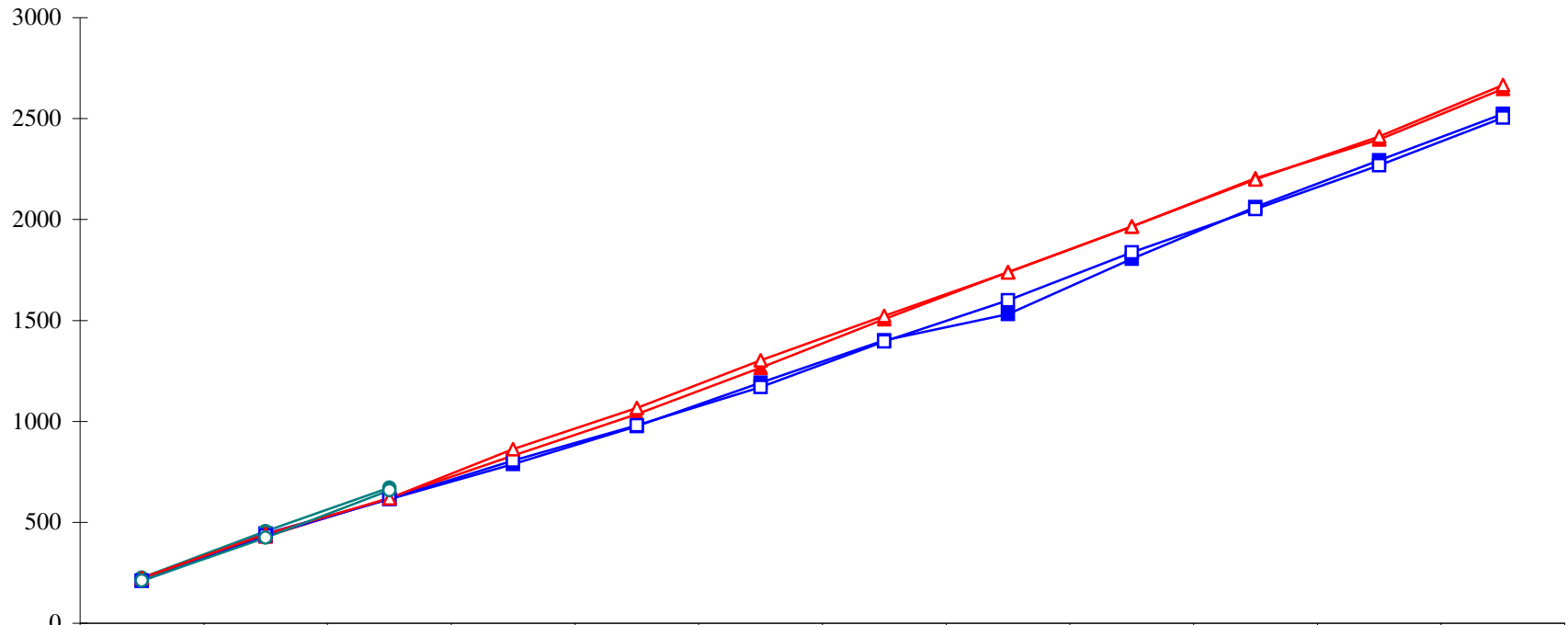
Measure 5A - Number/Type of Admissions and Readmissions
North Texas State Hospital
Admissions by Month

	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	257	231	230	220	210	191	210	205	230	241	232	227	238	193	250	226	230	216
Voluntary	6	4	1	1	4	0	3	4	1	2	4	9	3	2	3	6	4	7
Involuntary	251	227	229	219	206	191	207	201	229	239	228	218	235	191	247	220	226	209
OPC	27	41	43	32	27	27	31	41	28	31	21	39	23	23	32	24	39	30
Emergency	46	41	44	44	36	34	38	44	37	39	48	65	55	39	45	41	34	43
Temporary	77	71	57	62	64	59	61	55	64	52	65	45	68	52	69	60	49	51
Extended	1	4	1	1	6	3	2	1	7	2	1	2	1	0	2	3	0	1
46.02/46.03	86	53	69	64	63	58	68	47	71	103	76	54	72	40	44	82	88	69
Order for MR S	14	17	15	16	10	10	7	13	22	12	17	13	16	37	55	10	16	15
Discharges	215	216	236	224	217	178	243	205	235	220	216	228	233	212	256	211	213	234
% New to System	46%	47%	47%	46%	49%	41%	47%	50%	46%	41%	45%	52%	46%	47%	47%	48%	47%	50%



Measure 5A - Number/Type of Admissions and Readmissions
North Texas State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	211	445	615	788	976	1192	1401	1531	1805	2062	2293	2523
▲ FY05 Admissions	220	430	621	831	1036	1266	1507	1739	1966	2204	2397	2647
● FY06 Admissions	226	456	672									
□ FY04 Discharges	210	434	616	806	980	1170	1396	1600	1837	2052	2268	2504
▲ FY05 Discharges	224	441	619	862	1067	1302	1522	1738	1966	2199	2411	2667
○ FY06 Discharges	211	424	658									

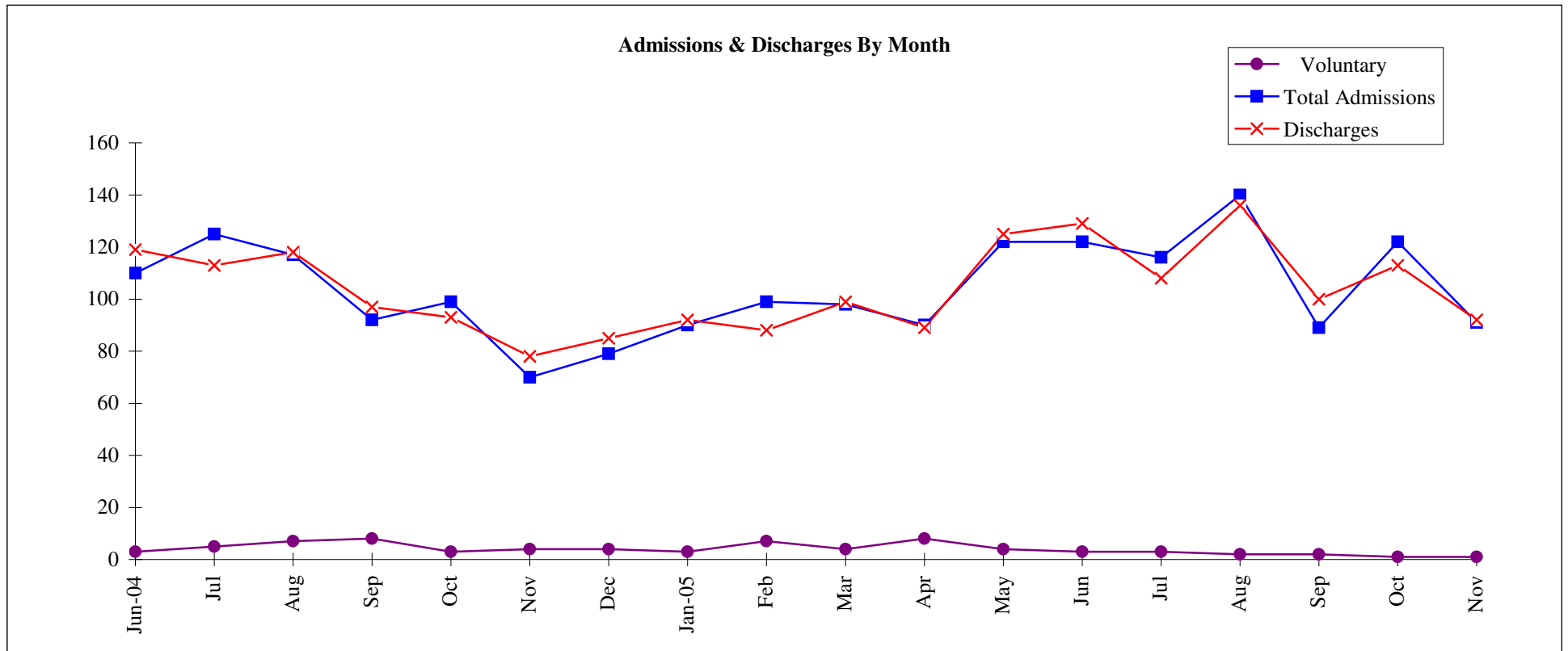
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Rio Grande State Center

Admissions by Month

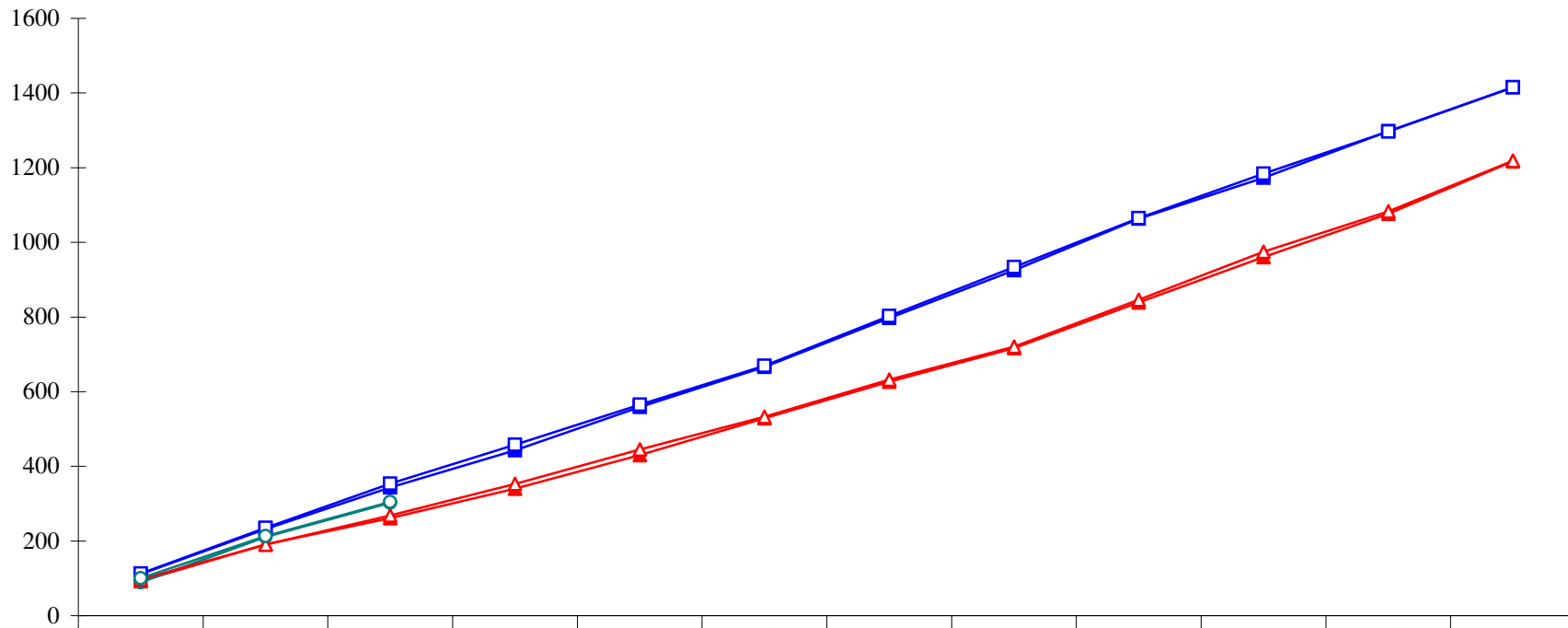
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	110	125	117	92	99	70	79	90	99	98	90	122	122	116	140	89	122	91
Voluntary	3	5	7	8	3	4	4	3	7	4	8	4	3	3	2	2	1	1
Involuntary	107	120	109	84	96	66	75	87	92	94	82	118	119	113	138	87	121	90
OPC	1	2	1	0	1	0	3	1	1	3	1	4	2	1	0	2	0	1
Emergency	105	118	108	83	95	66	71	86	91	91	80	114	117	112	137	85	120	89
Temporary	0	0	0	1	0	0	1	0	0	0	1	0	0	0	1	0	0	0
Extended	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
46.02/46.03	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Order for MR S	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	119	113	118	97	93	78	85	92	88	99	89	125	129	108	136	100	113	92
% New to System	56%	37%	48%	45%	47%	39%	38%	47%	37%	35%	44%	44%	56%	37%	48%	51%	55%	44%



Source: Admis./Disch./Pop. by Month (HC022020/22), Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
Rio Grande State Center
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
FY04 Admissions	111	232	343	443	559	666	797	925	1063	1173	1298	1415
FY05 Admissions	92	191	261	340	430	529	627	717	839	961	1077	1217
FY06 Admissions	89	211	302									
FY04 Discharges	113	235	354	458	565	669	803	934	1065	1184	1297	1415
FY05 Discharges	97	190	268	353	445	533	632	721	846	975	1083	1219
FY06 Discharges	100	213	305									

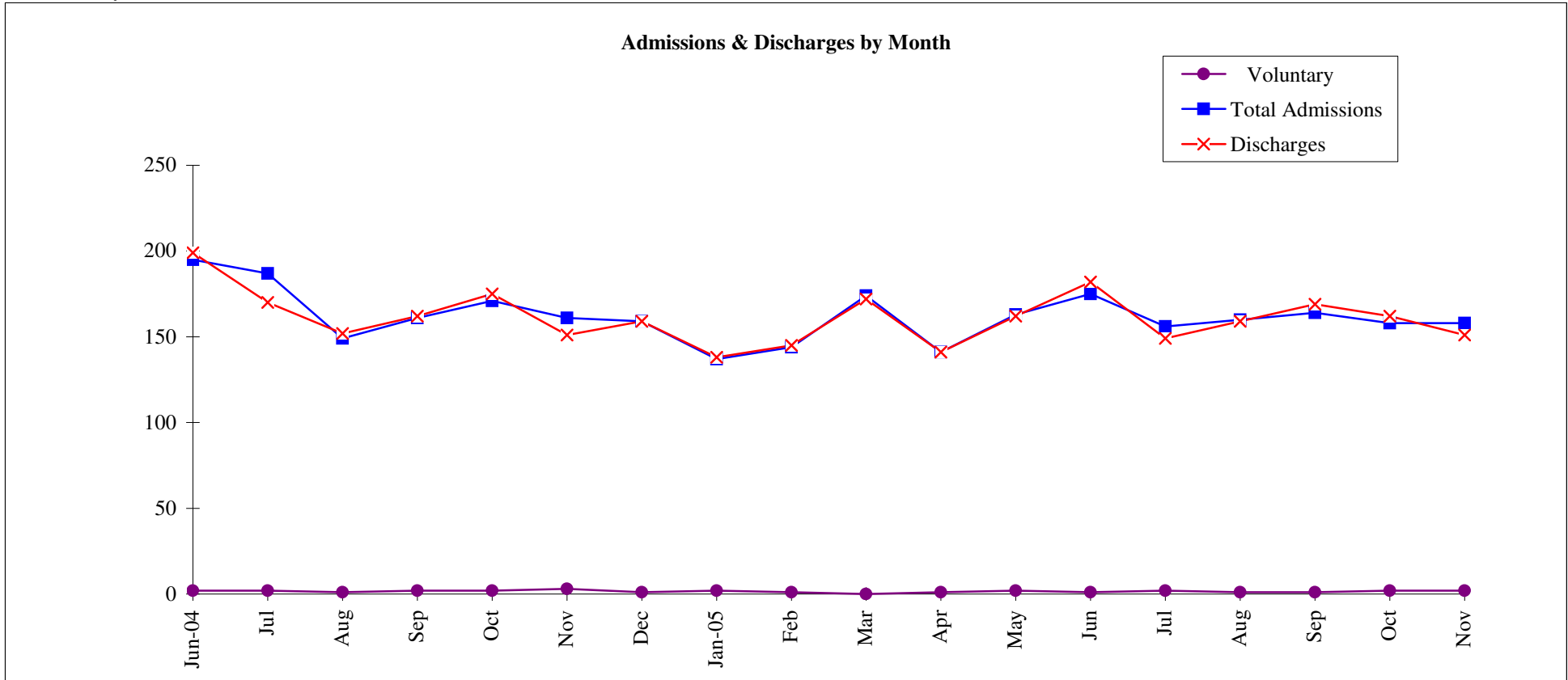
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Rusk State Hospital

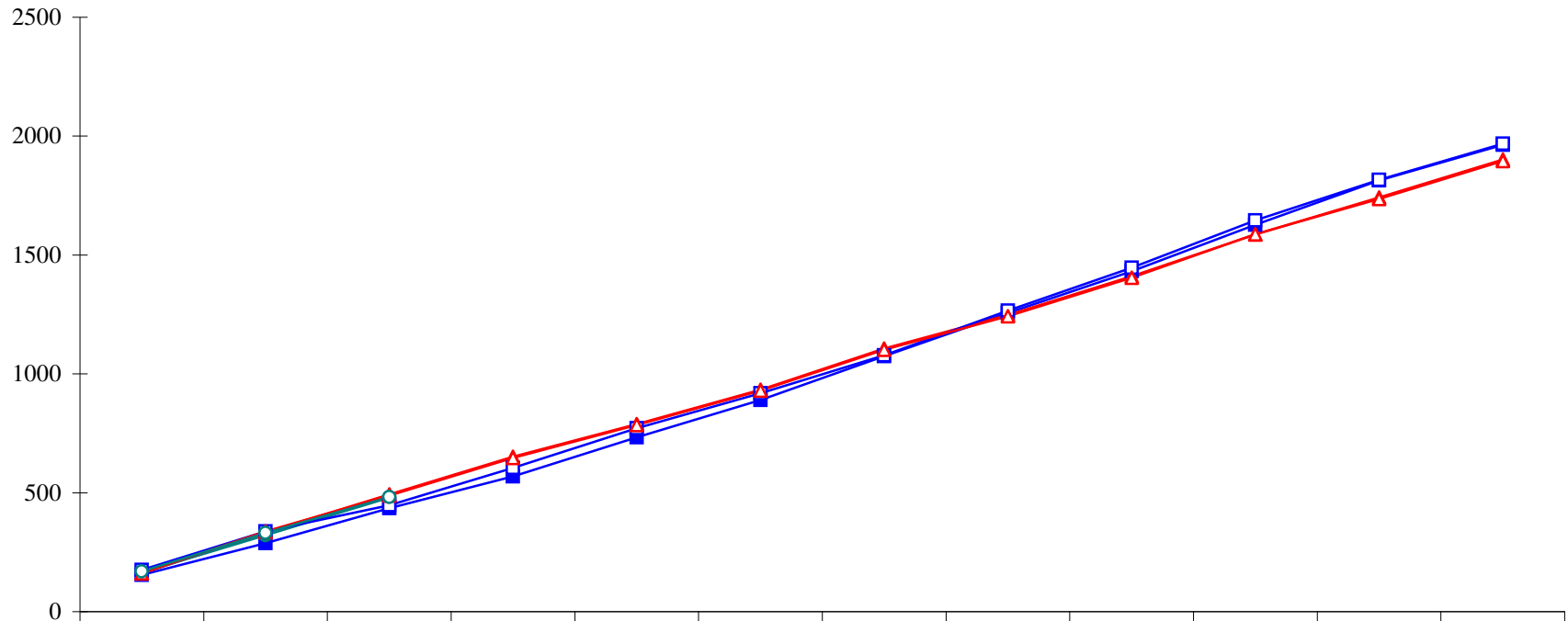
Admissions by Month

	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	195	187	149	161	171	161	159	137	144	174	141	163	175	156	160	164	158	158
Voluntary	2	2	1	2	2	3	1	2	1	0	1	2	1	2	1	1	2	2
Involuntary	193	185	148	159	169	158	158	135	143	174	140	161	174	154	159	163	156	156
OPC	36	38	42	34	39	41	36	39	42	59	56	63	51	36	65	61	58	55
Emergency	106	107	65	82	95	72	83	57	60	63	58	69	80	61	53	75	66	56
Temporary	37	30	29	26	19	28	18	27	30	29	18	14	18	31	25	5	13	19
Extended	1	0	0	0	0	0	2	1	0	2	0	0	0	2	0	0	1	1
46.02/46.03	13	10	11	17	16	17	19	11	11	21	8	15	23	11	16	22	18	25
Order for MR S	0	0	1	0	0	0	0	0	0	0	0	0	2	13	0	0	0	0
Discharges	199	170	152	162	175	151	159	138	145	172	141	162	182	149	159	169	162	151
% New to System	49%	49%	41%	43%	47%	43%	38%	35%	42%	43%	45%	44%	49%	49%	41%	47%	36%	44%



Measure 5A - Number/Type of Admissions and Readmissions
Rusk State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date

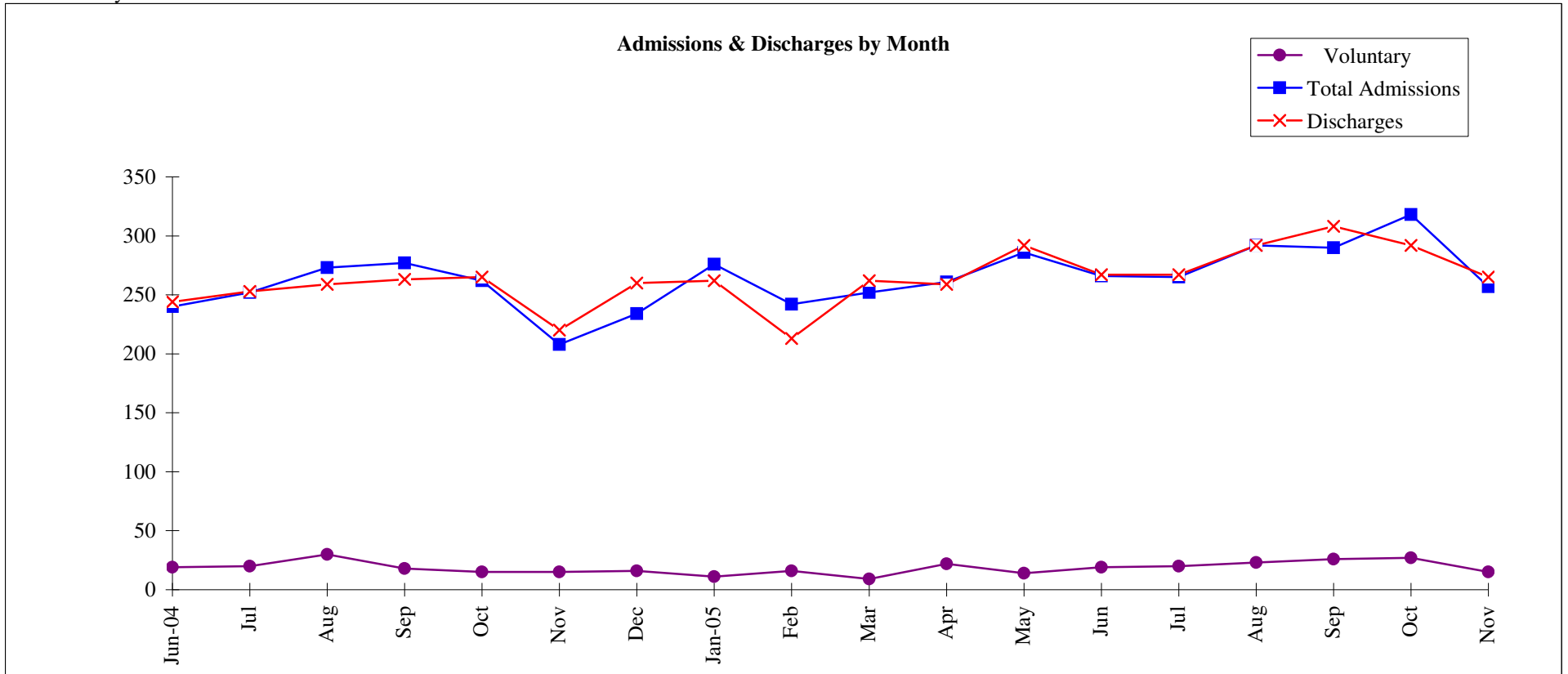


	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	155	288	435	569	733	890	1074	1256	1432	1627	1814	1963
▲ FY05 Admissions	161	332	493	652	789	933	1107	1248	1411	1586	1742	1902
● FY06 Admissions	164	322	480									
□ FY04 Discharges	176	337	447	605	771	919	1078	1266	1447	1646	1816	1968
▲ FY05 Discharges	162	337	488	647	785	930	1102	1243	1405	1587	1736	1895
○ FY06 Discharges	169	331	482									

Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

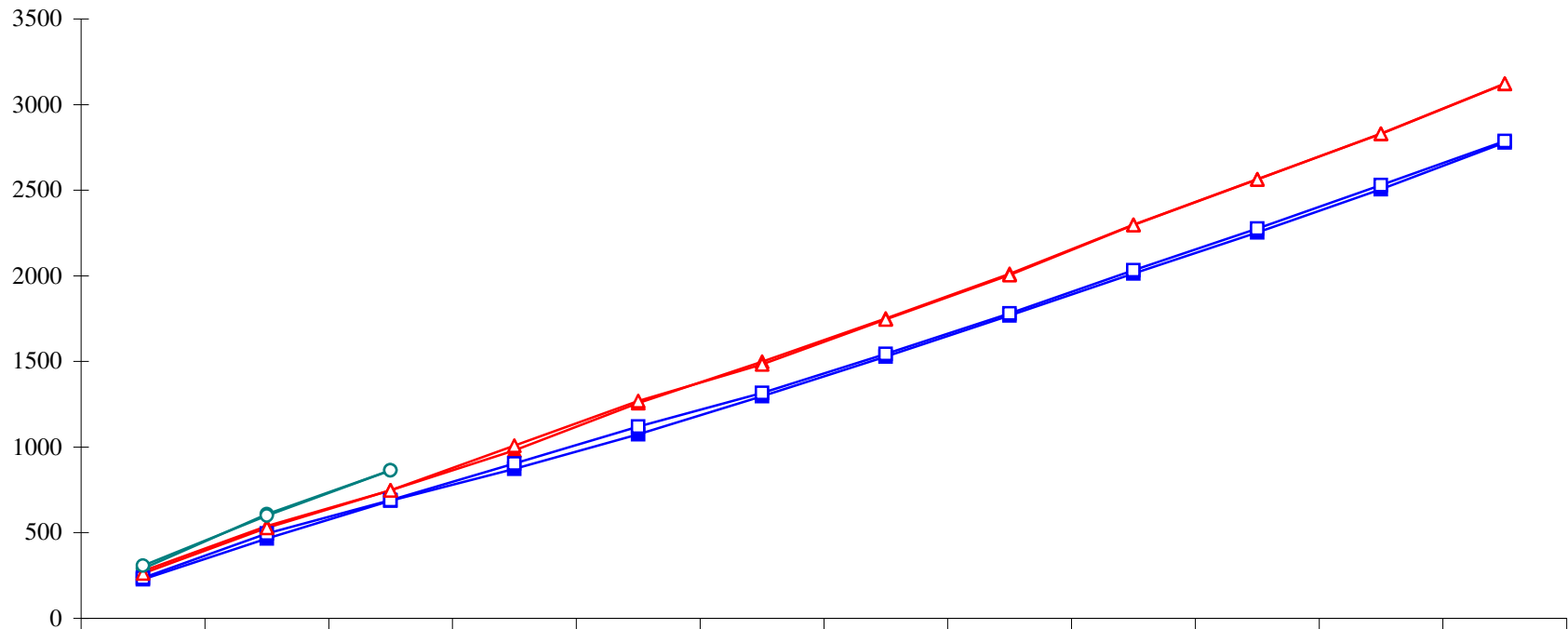
Measure 5A - Number/Type of Admissions and Readmissions
San Antonio State Hospital
Admissions by Month

	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	240	252	273	277	262	208	234	276	242	252	261	286	266	265	292	290	318	257
Voluntary	19	20	30	18	15	15	16	11	16	9	22	14	19	20	23	26	27	15
Involuntary	221	232	243	259	247	193	218	265	226	243	239	272	247	245	269	264	291	242
OPC	71	81	81	90	64	53	71	76	61	71	80	78	85	65	79	78	80	72
Emergency	111	117	123	116	149	102	109	146	127	133	125	152	120	131	156	155	169	141
Temporary	32	23	28	37	19	29	33	32	25	27	27	32	40	37	27	24	33	22
Extended	0	0	0	3	2	0	1	1	3	2	0	1	0	2	1	0	1	1
46.02/46.03	7	9	10	8	12	5	4	9	10	9	4	7	2	5	5	7	6	6
Order for MR S	0	2	1	5	1	4	0	1	0	1	3	2	0	5	1	0	2	0
Discharges	244	253	259	263	265	220	260	262	213	262	259	292	267	267	292	308	292	265
% New to System	50%	48%	41%	46%	50%	48%	53%	51%	50%	48%	45%	45%	50%	48%	41%	47%	46%	47%



Measure 5A - Number/Type of Admissions and Readmissions
San Antonio State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
FY04 Admissions	227	466	687	873	1075	1297	1528	1769	2014	2254	2506	2779
FY05 Admissions	277	539	747	981	1257	1499	1751	2012	2298	2564	2829	3121
FY06 Admissions	290	608	865									
FY04 Discharges	236	496	691	904	1119	1316	1544	1780	2032	2276	2529	2788
FY05 Discharges	263	528	748	1008	1270	1483	1745	2004	2296	2563	2830	3122
FY06 Discharges	308	600	865									

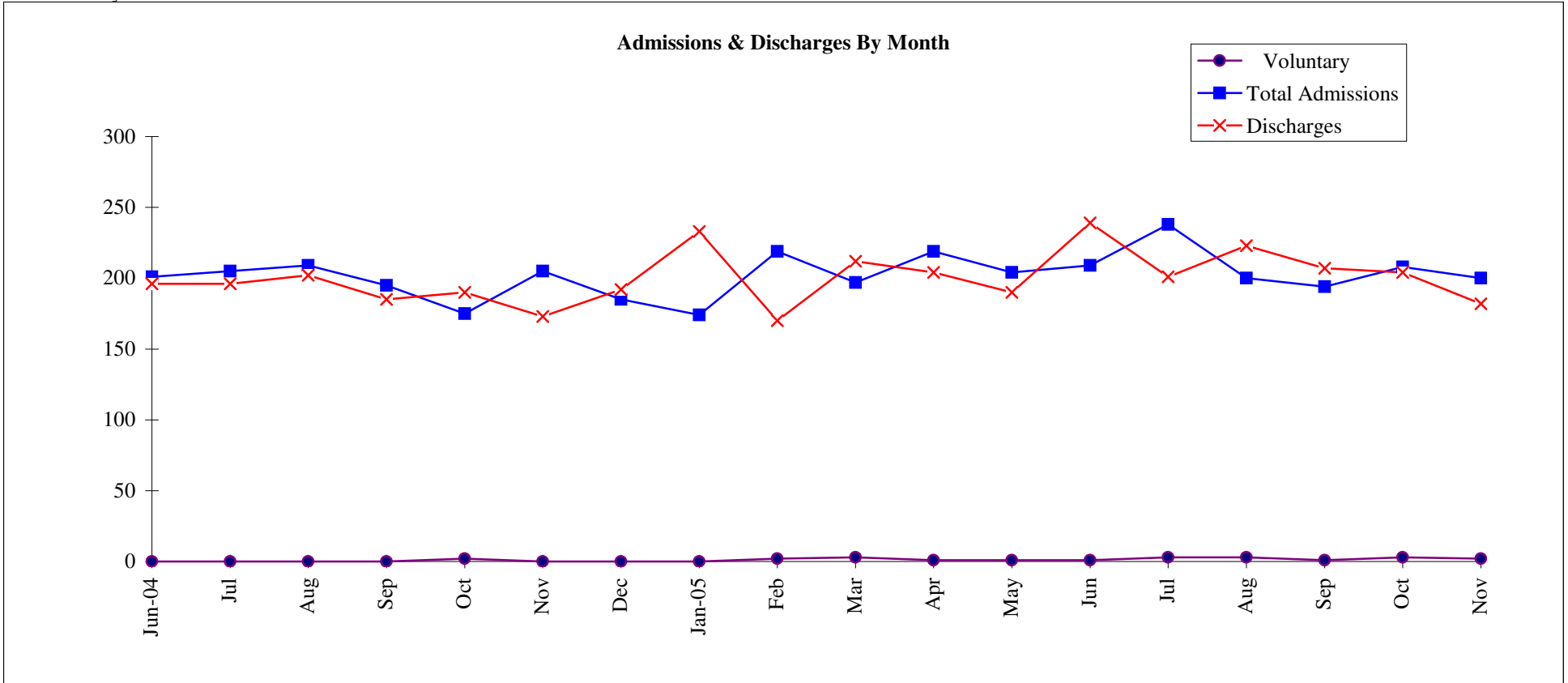
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Terrell State Hospital

Admissions by Month

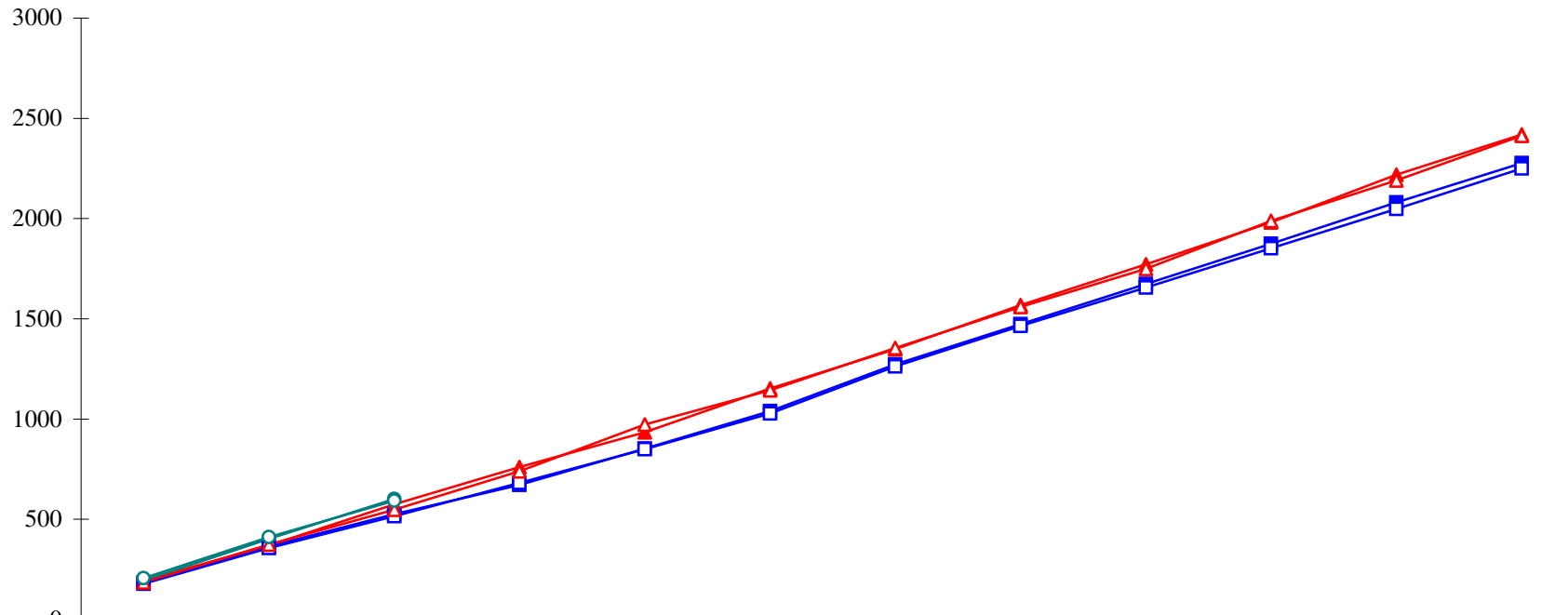
	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	201	205	209	195	175	205	185	174	219	197	219	204	209	238	200	194	208	200
Voluntary	0	0	0	0	2	0	0	0	2	3	1	1	1	3	3	1	3	2
Involuntary	201	205	209	195	173	205	185	174	217	194	218	203	208	235	197	193	205	198
OPC	153	149	141	150	126	154	133	121	120	147	177	159	132	178	158	148	165	162
Emergency	11	21	17	19	11	14	13	6	32	19	25	25	47	26	15	21	11	10
Temporary	22	14	32	18	16	17	14	23	40	24	13	18	25	27	23	21	26	25
Extended	0	0	3	1	4	0	3	1	8	3	3	1	3	4	1	3	3	1
46.02/46.03	15	20	15	7	15	19	22	23	17	0	0	0	0	0	0	0	0	0
Order for MR S	0	1	1	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0
Discharges	196	196	202	185	190	173	192	233	170	212	204	190	239	201	223	207	204	182
% New to System	36%	43%	41%	42%	42%	45%	43%	39%	30%	40%	36%	44%	36%	43%	41%	40%	45%	43%



Source: Admis./Disch./Pop. by Month (HC022020/22), Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions
Terrell State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY04 Admissions	183	366	526	671	853	1040	1273	1473	1674	1875	2080	2277
▲ FY05 Admissions	195	370	575	760	934	1153	1349	1568	1772	1981	2219	2419
● FY06 Admissions	194	402	602									
□ FY04 Discharges	178	357	515	682	850	1028	1262	1465	1656	1852	2048	2250
△ FY05 Discharges	185	375	548	740	973	1143	1355	1559	1749	1989	2190	2413
○ FY06 Discharges	207	411	593									

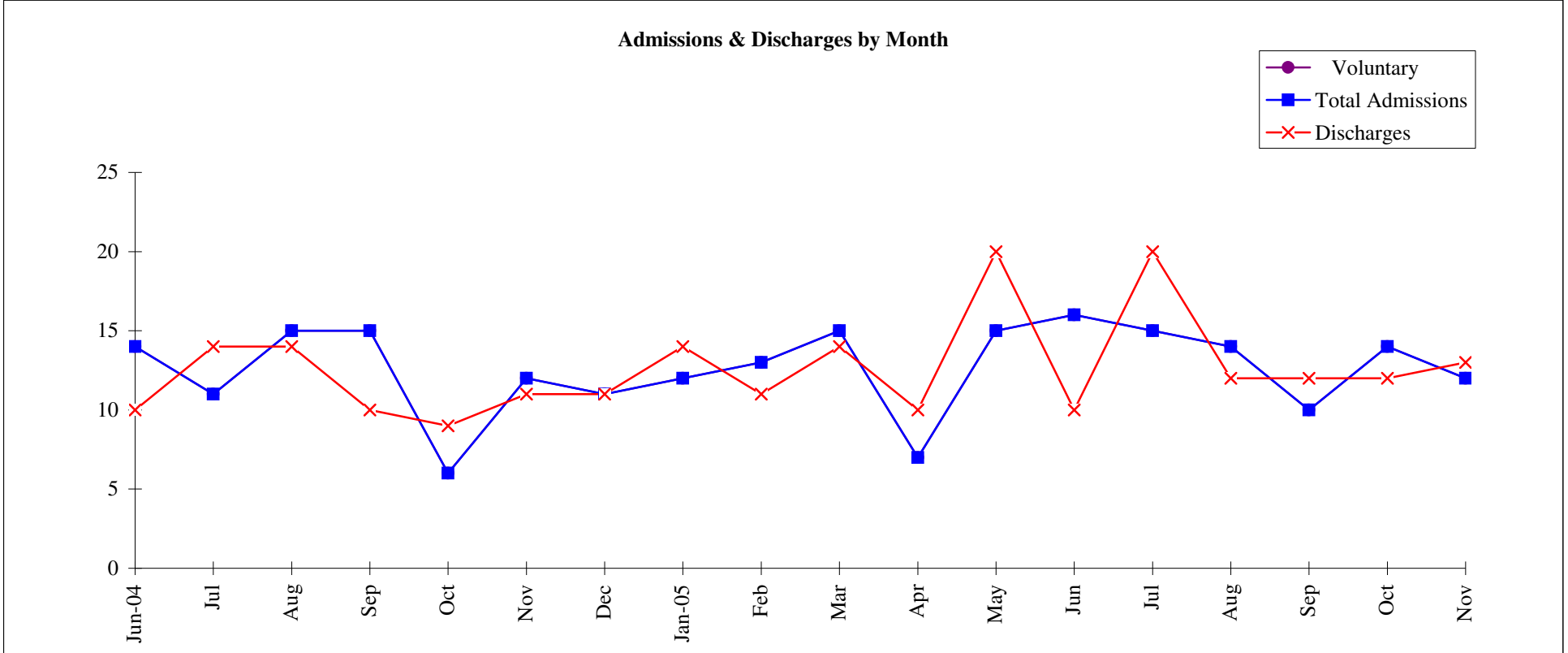
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Waco Center for Youth

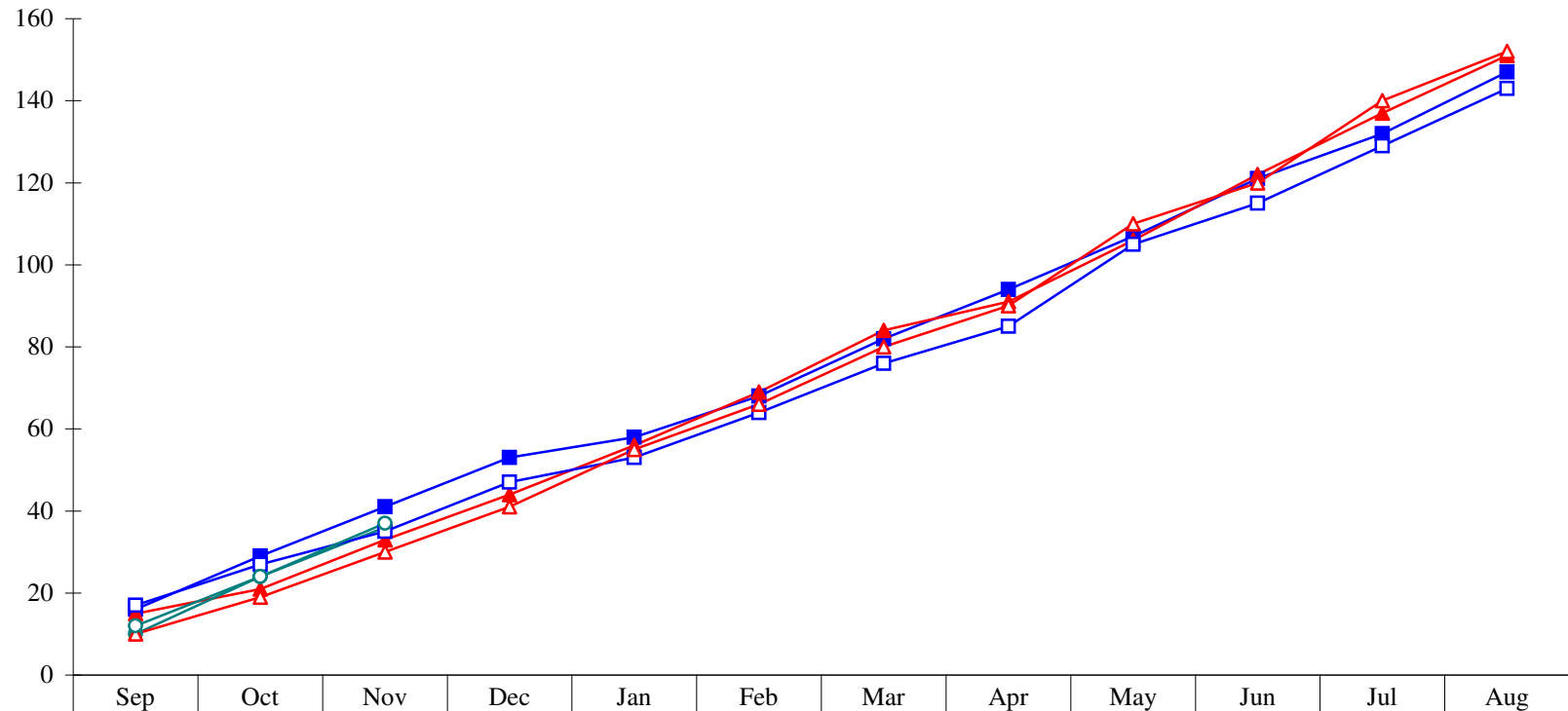
Admissions by Month

	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Admissions	14	11	15	15	6	12	11	12	13	15	7	15	16	15	14	10	14	12
Voluntary	14	11	15	15	6	12	11	12	13	15	7	15	16	15	14	10	14	12
Involuntary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OPC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Emergency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Temporary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Extended	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
46.02/46.03	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Order for MR S'	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	10	14	14	10	9	11	11	14	11	14	10	20	10	20	12	12	12	13
% New to System	50%	55%	60%	47%	50%	58%	27%	42%	38%	47%	43%	47%	50%	55%	60%	40%	50%	33%



Measure 5A - Number/Type of Admissions and Readmissions
Waco Center for Youth
FYTD Admissions & Discharges

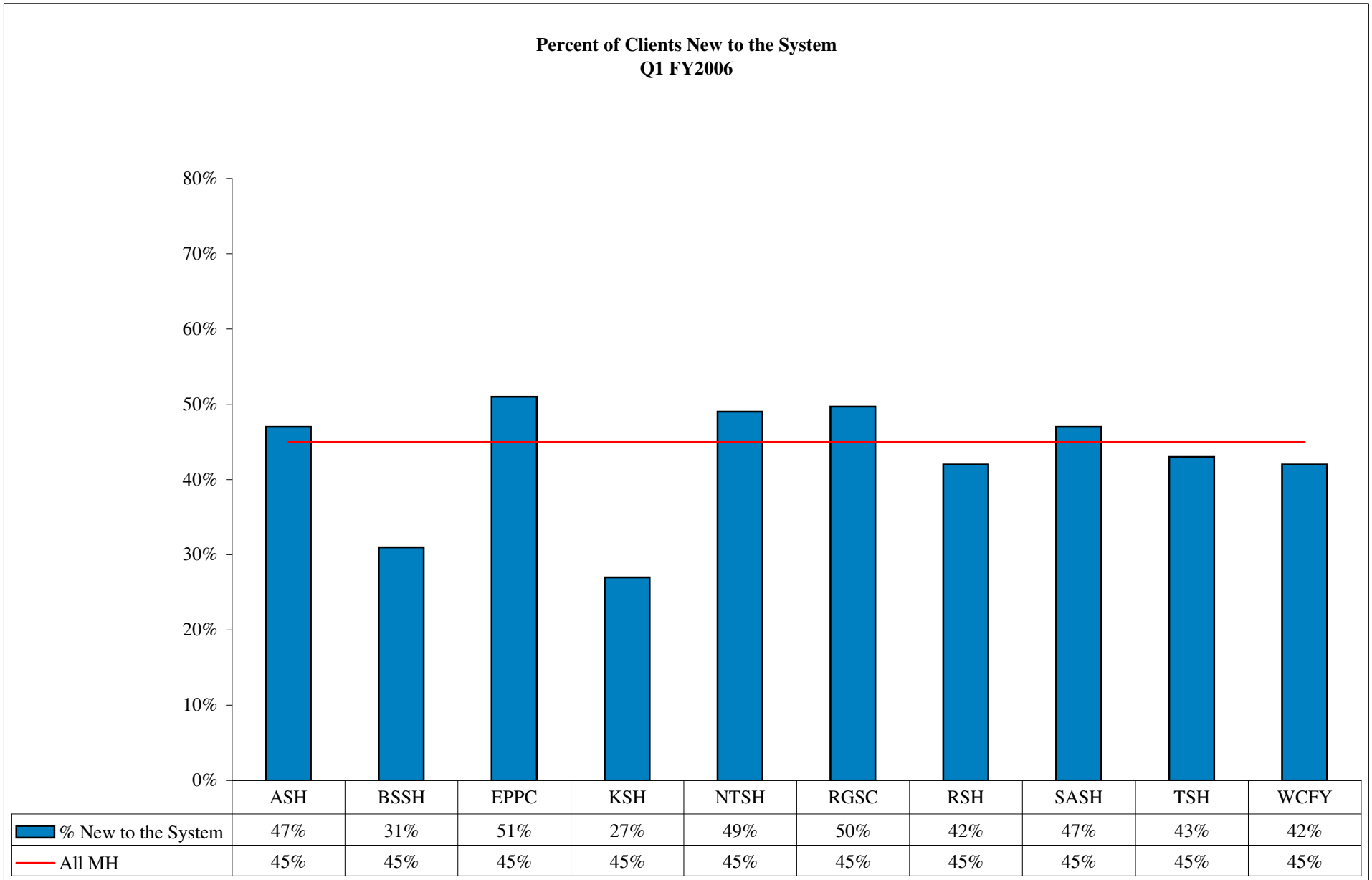
Total Admissions & Discharges Year-To-Date



■ FY04 Admissions	16	29	41	53	58	68	82	94	107	121	132	147
▲ FY05 Admissions	15	21	33	44	56	69	84	91	106	122	137	151
● FY06 Admissions	10	24	36									
□ FY04 Discharges	17	27	35	47	53	64	76	85	105	115	129	143
▲ FY05 Discharges	10	19	30	41	55	66	80	90	110	120	140	152
○ FY06 Discharges	12	24	37									

Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

**Measure 5A - Number/Type of Admissions and Readmissions
All MH Facilities**



Performance Measure 5B:

Percent of forensic/non forensic discharges returned to the community will be calculated on a quarterly basis for: 7 days or less; 8 to 30 days; 31 to 90 days; and greater than 90 days.

Performance Measure Operational Definition: Percent of discharges returned to the community will be calculated on a quarterly basis for: 7 days or less; 8 to 30 days; 31 to 90 days; and greater than 90 days.

Performance Measure Formula:

Rate = (N/D) x 100

N = # persons discharged during time frame

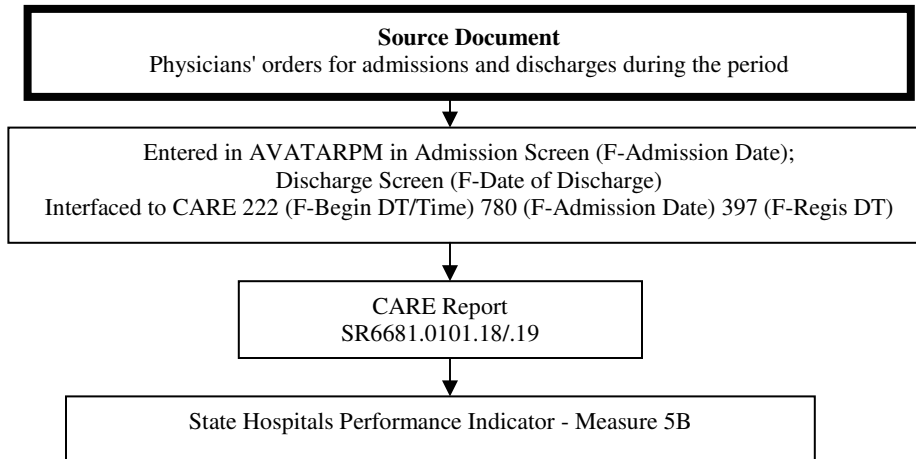
D = total persons discharged during the quarter

Net length of stay for persons who were discharged using codes (DRE) Discharge with Reassignment) or (DNS) Discharge No More Services, or sent on Absence Trial Placement (ATP), unless they were referred to another campus-based program. (It eliminates persons who were discharged during the period and who were counted because of an ATP in a prior reporting period. It does not include persons who were discharged against medical advice (DMA) or who died (DED) during the quarter. The report uses net length of stay, which is the number of days an individual was resident on campus, not including days absent).

Performance Measure Data Display and Chart Description:

- ◆ Chart with quarterly data points of percent of discharges returned to the community for individual state hospitals and system-wide
- ◆ Table shows total discharges for the quarter for individual state hospitals and system-wide.

Data Flow:

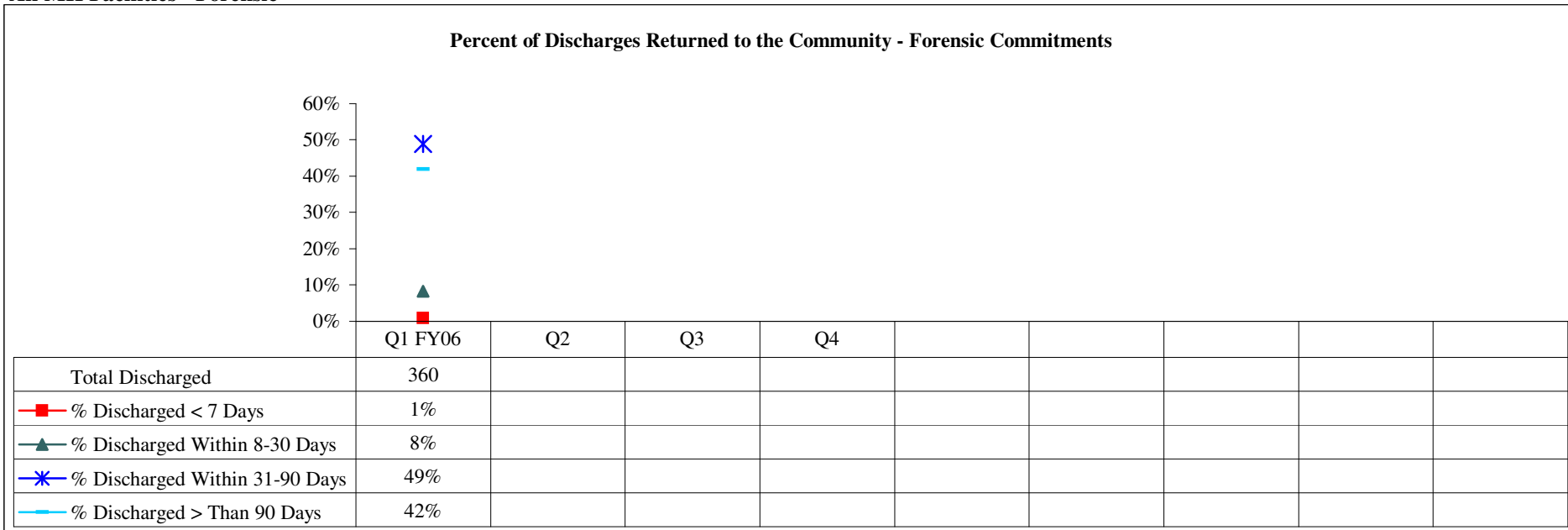


Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.

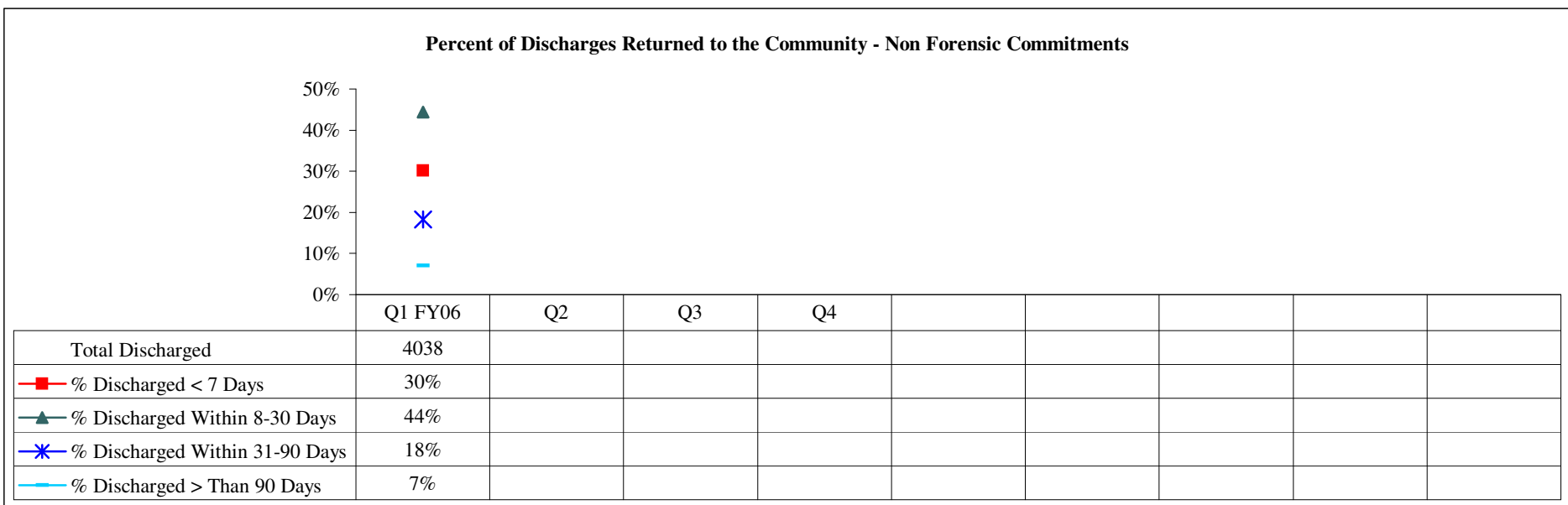
Measure 5B - Percent of Discharges Returned to the Community

All MH Facilities - Forensic



Measure 5B - Percent of Discharges Returned to the Community

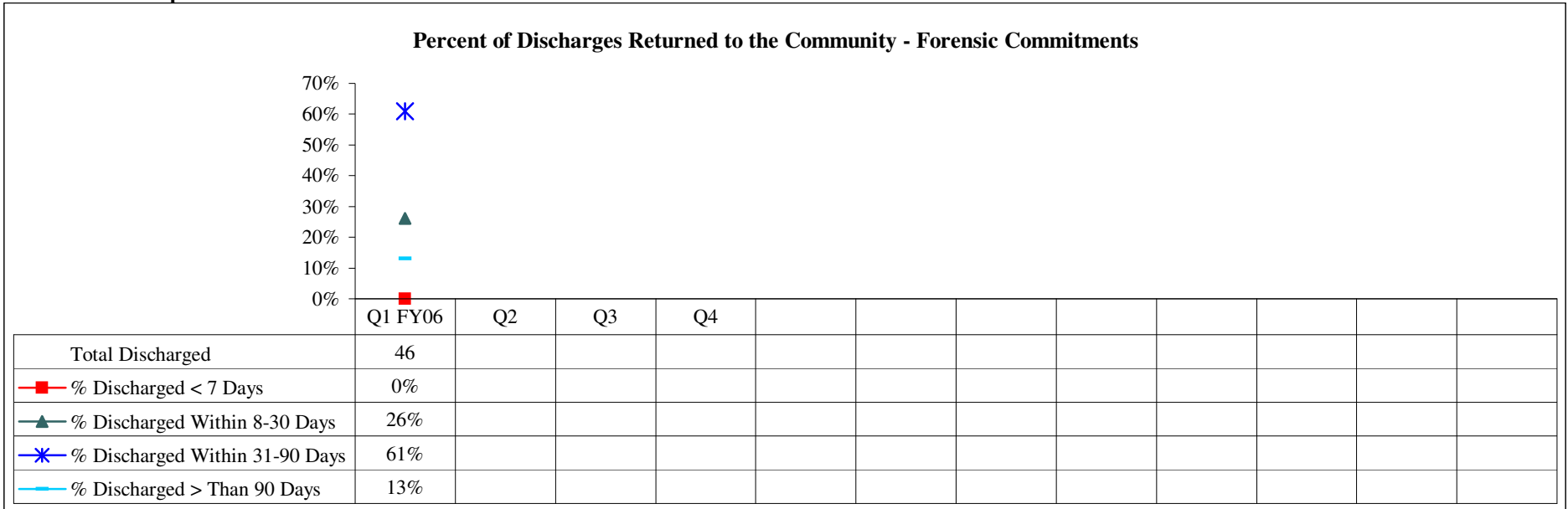
All MH Facilities - Non Forensic



Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

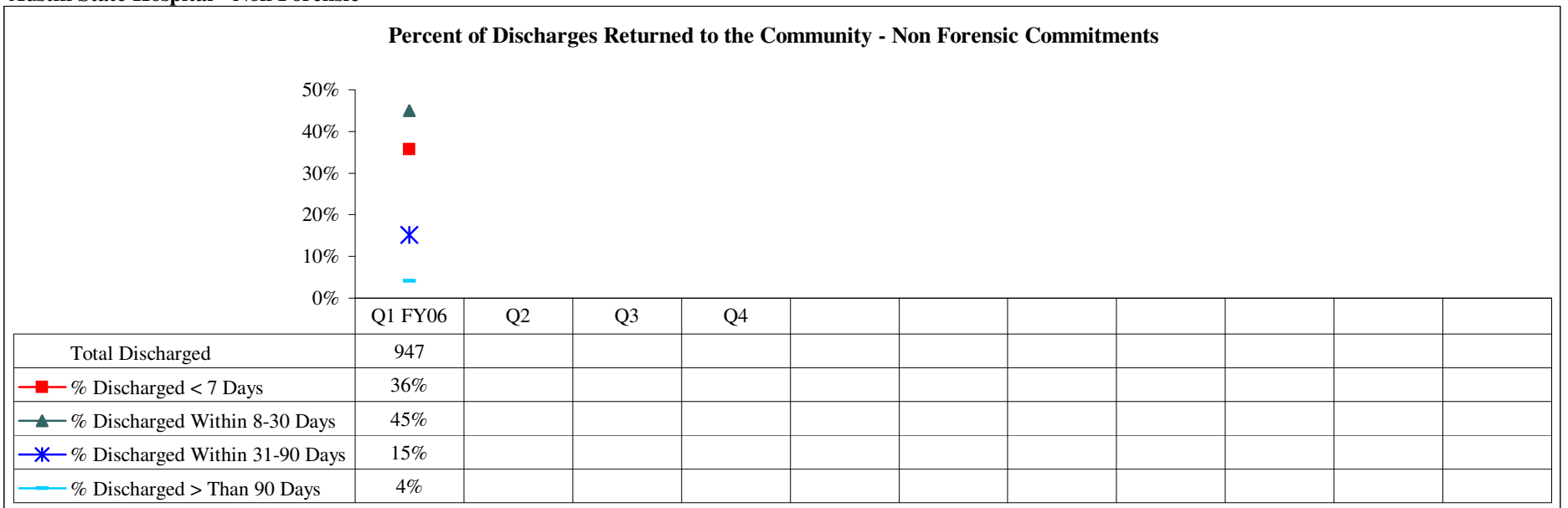
Measure 5B - Percent of Discharges Returned to the Community

Austin State Hospital - Forensic



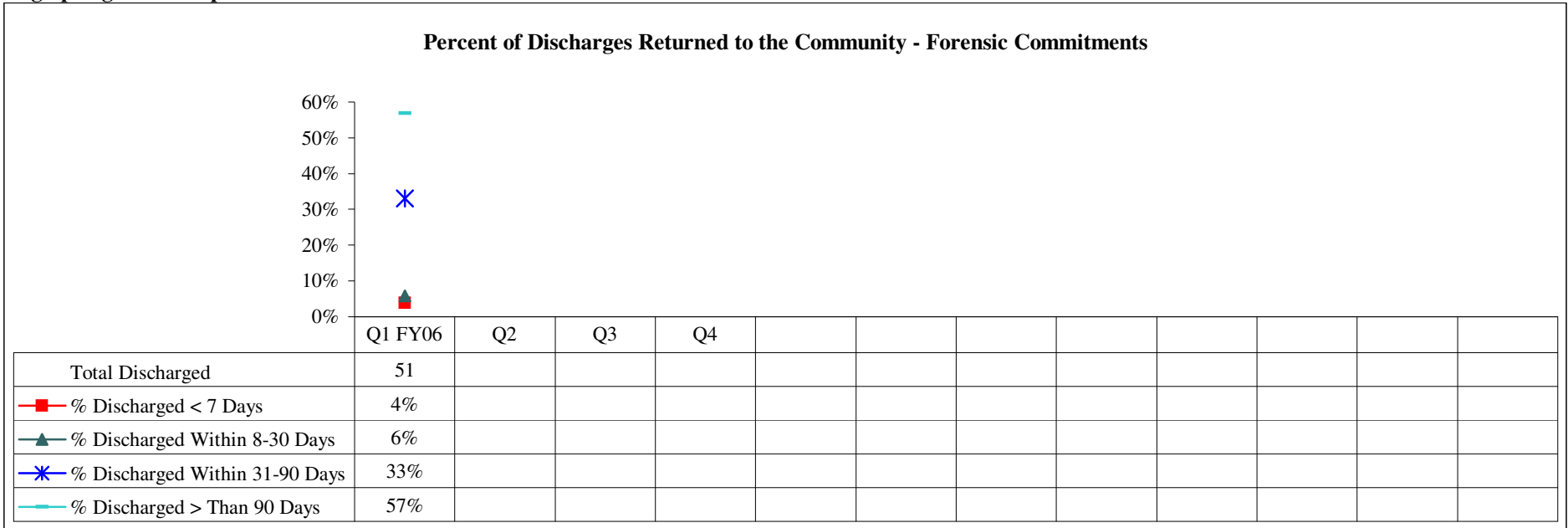
Measure 5B - Percent of Discharges Returned to the Community

Austin State Hospital - Non Forensic

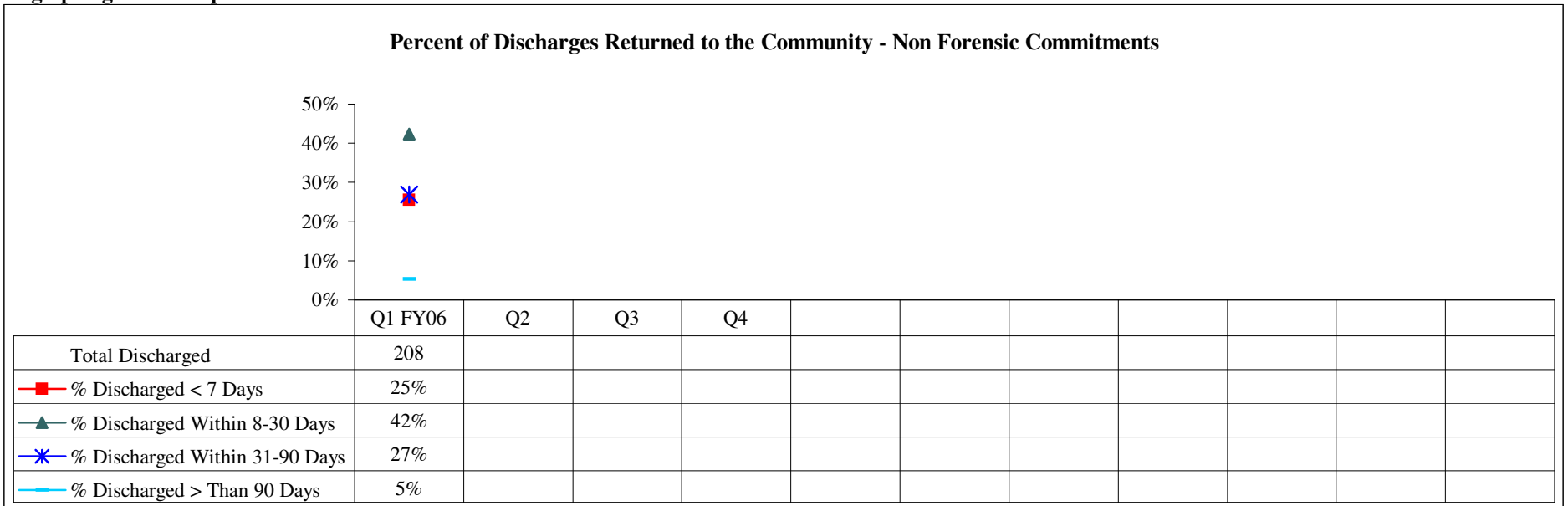


Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

Measure 5B - Percent of Discharges Returned to the Community
Big Spring State Hospital - Forensic



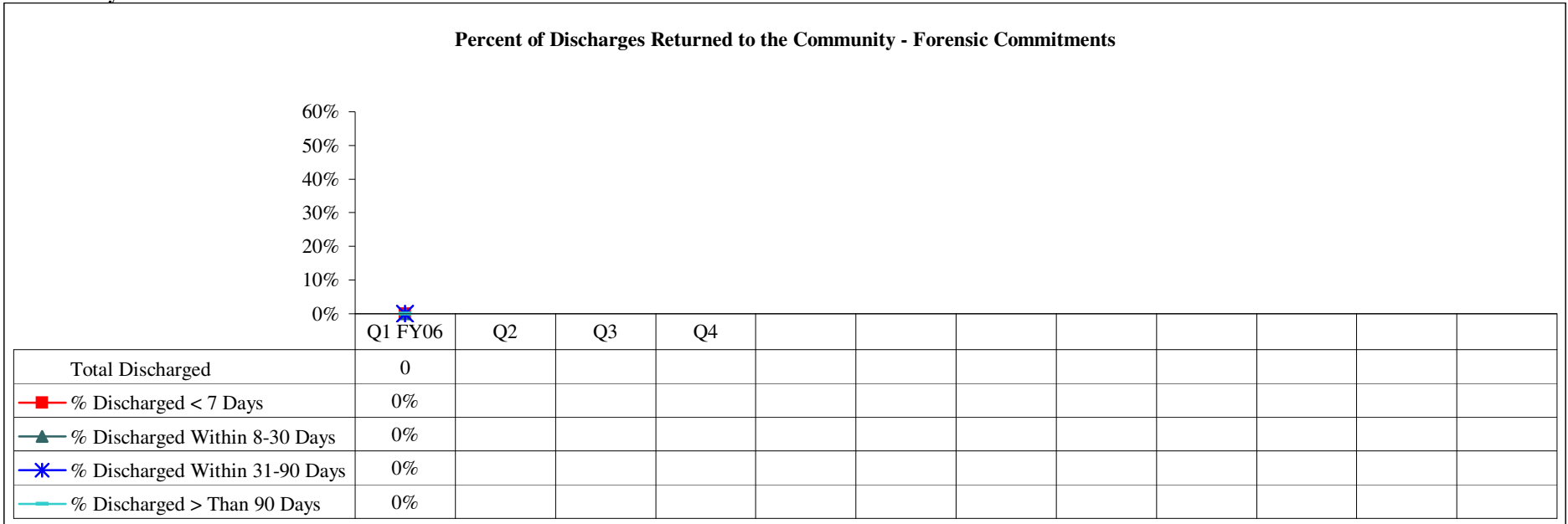
Measure 5B - Percent of Discharges Returned to the Community
Big Spring State Hospital - Non Forensic



Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

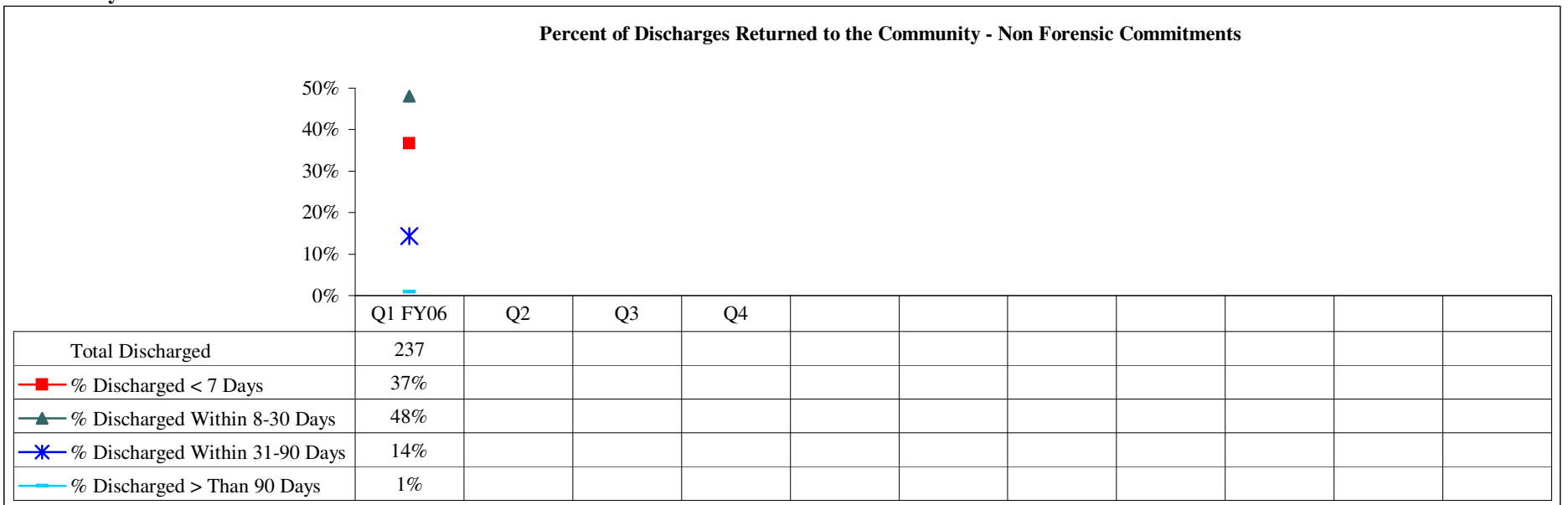
Measure 5B - Percent of Discharges Returned to the Community

El Paso Psychiatric Center - Forensic



Measure 5B - Percent of Discharges Returned to the Community

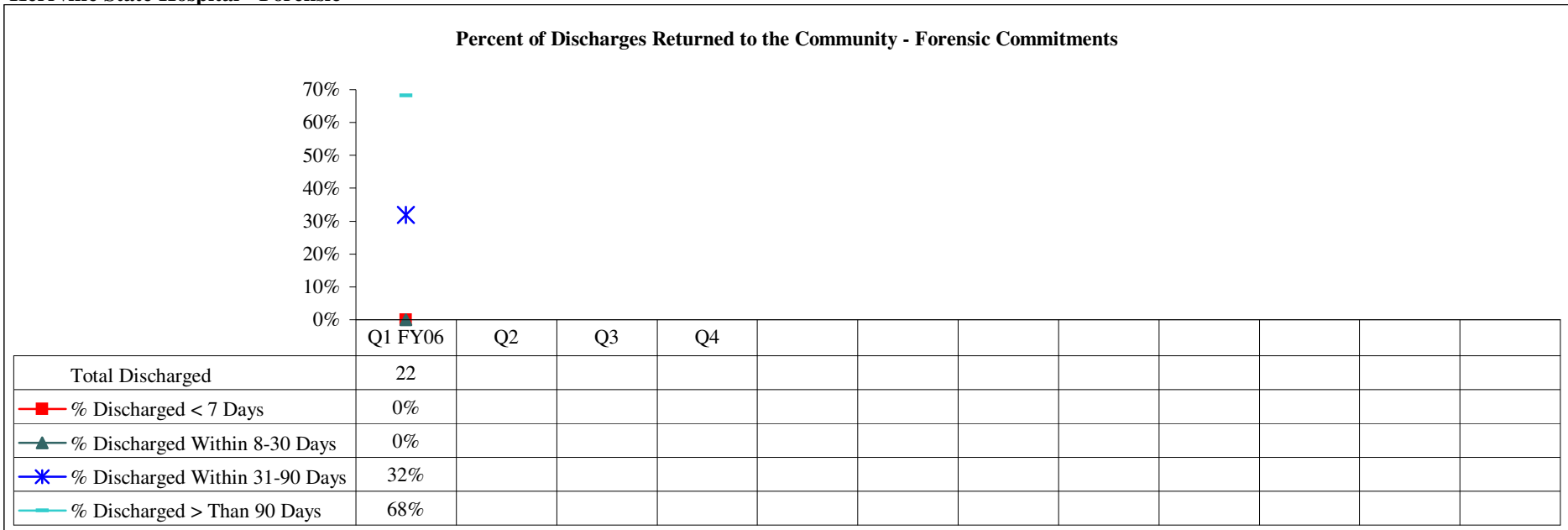
El Paso Psychiatric Center - Non Forensic



Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

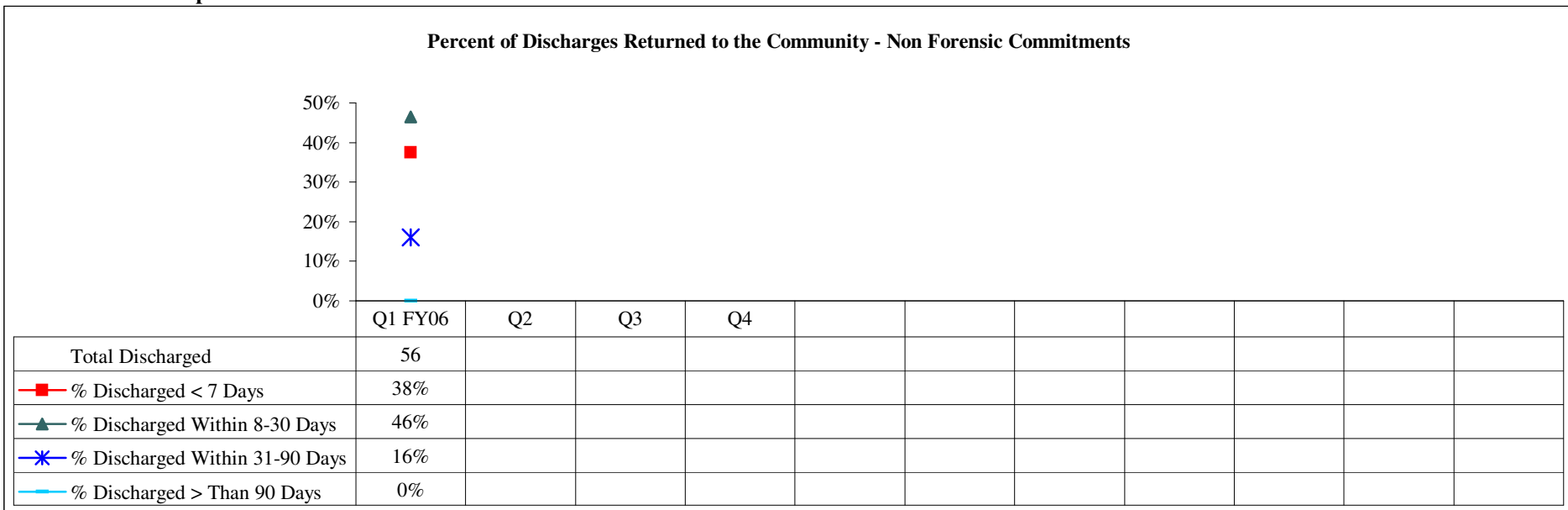
Measure 5B - Percent of Discharges Returned to the Community

Kerrville State Hospital - Forensic



Measure 5B - Percent of Discharges Returned to the Community

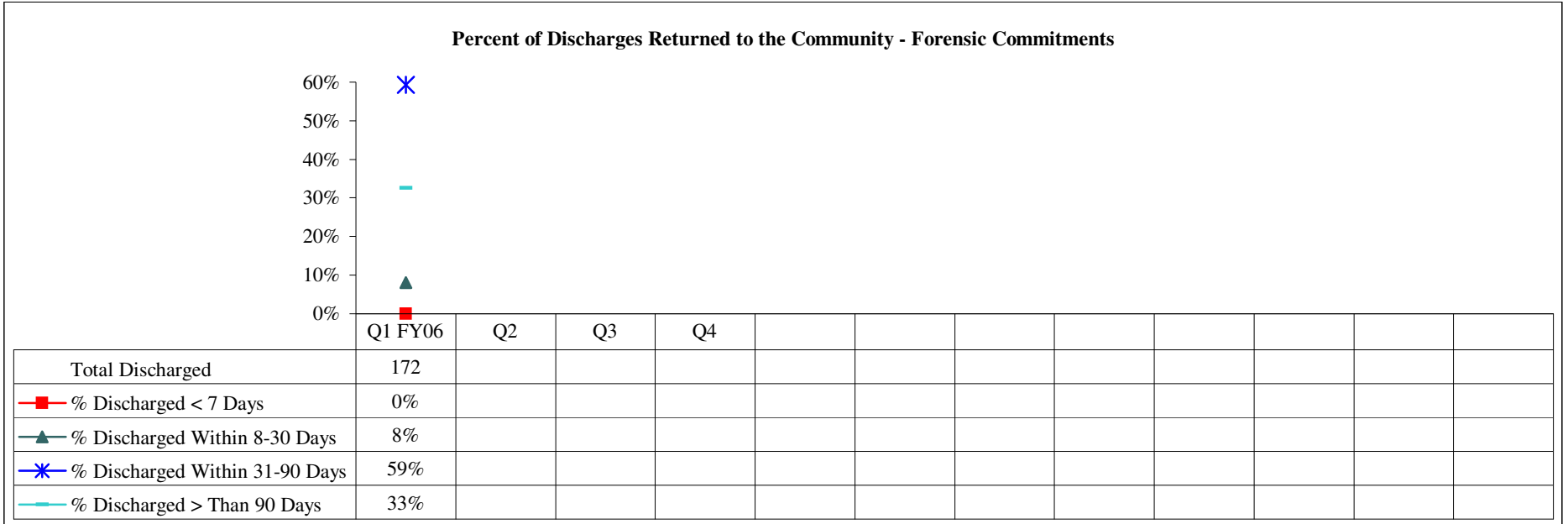
Kerrville State Hospital - Non Forensic



Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

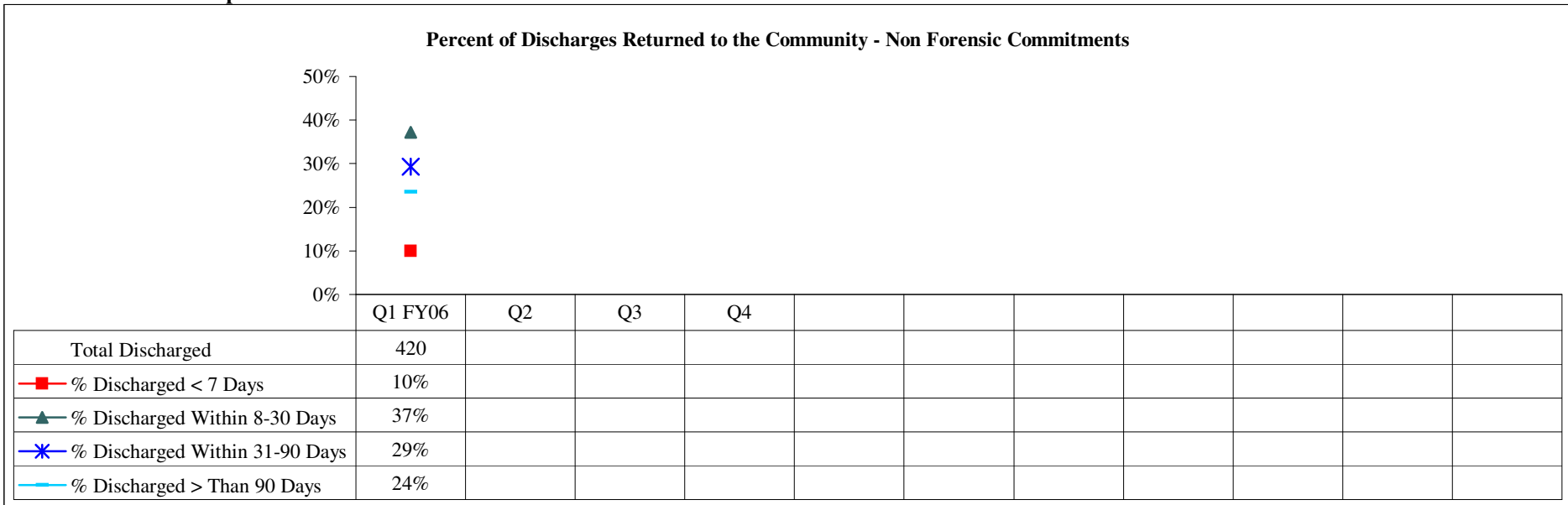
Measure 5B - Percent of Discharges Returned to the Community

North Texas State Hospital - Forensic



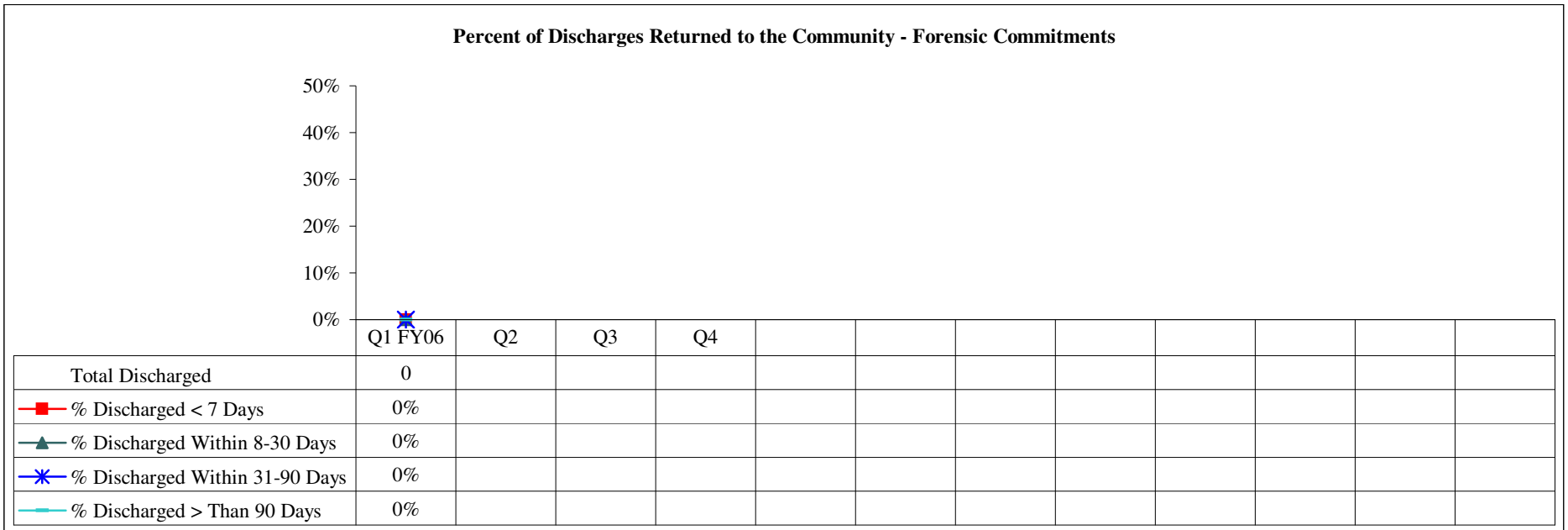
Measure 5B - Percent of Discharges Returned to the Community

North Texas State Hospital - Non Forensic

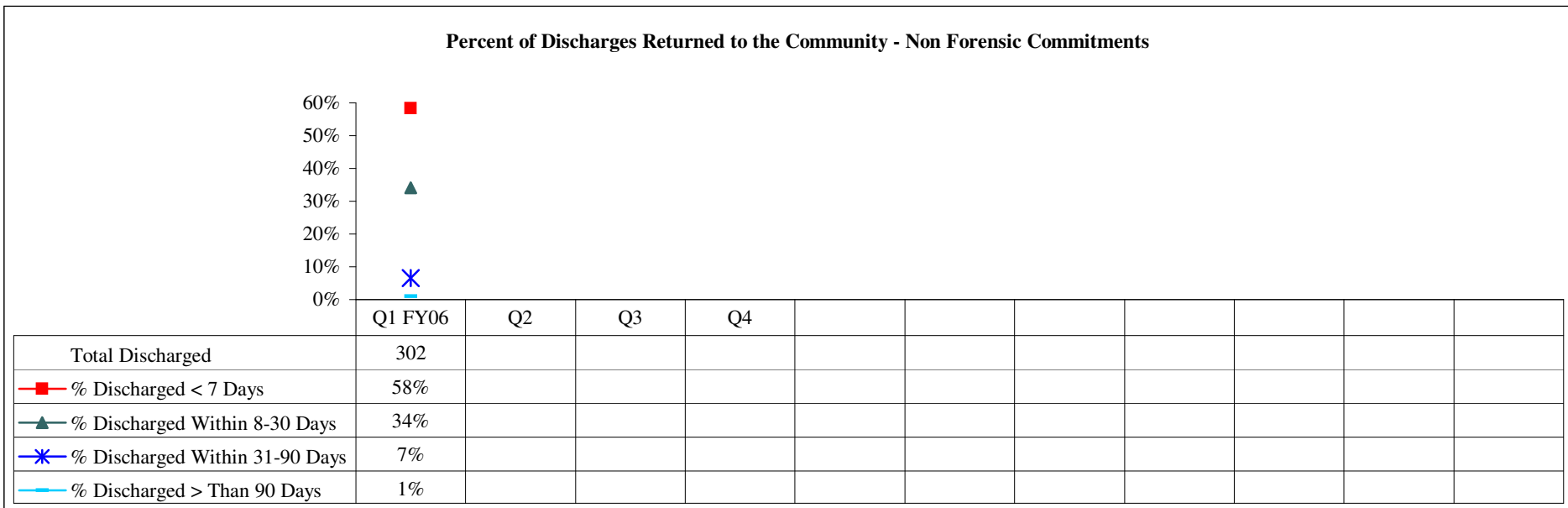


Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

**Measure 5B - Percent of Discharges Returned to the Community
Rio Grande State Center - Forensic**



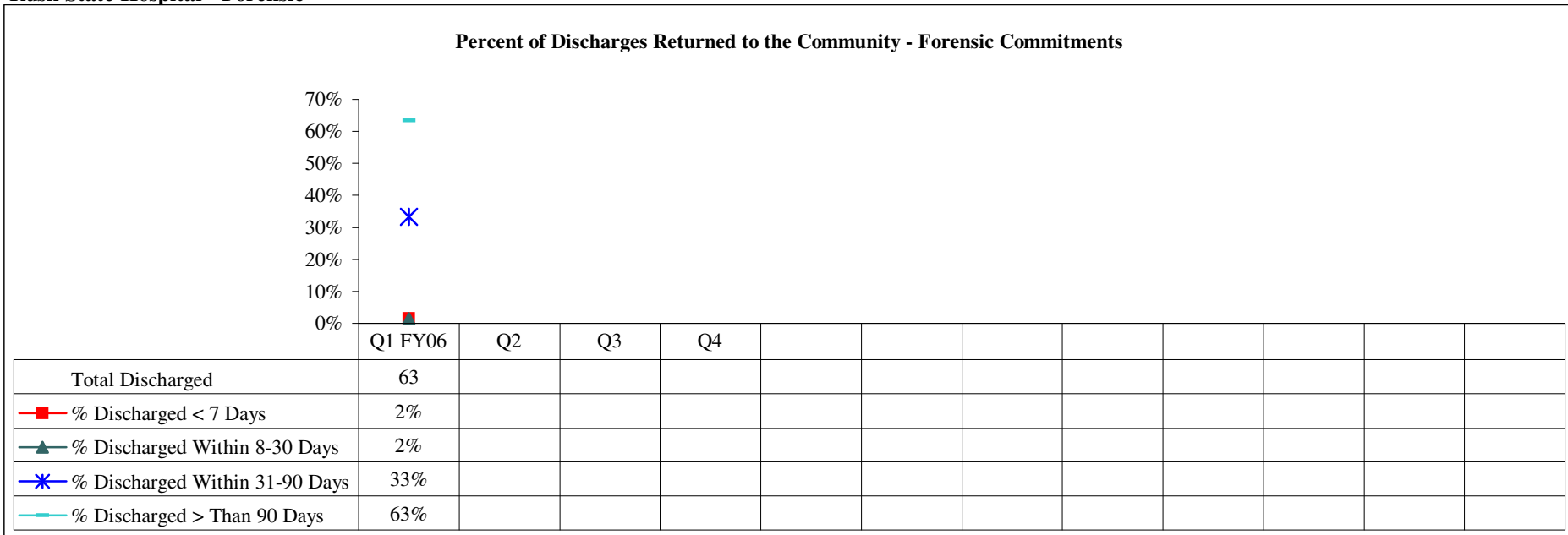
**Measure 5B - Percent of Discharges Returned to the Community
Rio Grande State Center - Non Forensic**



Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

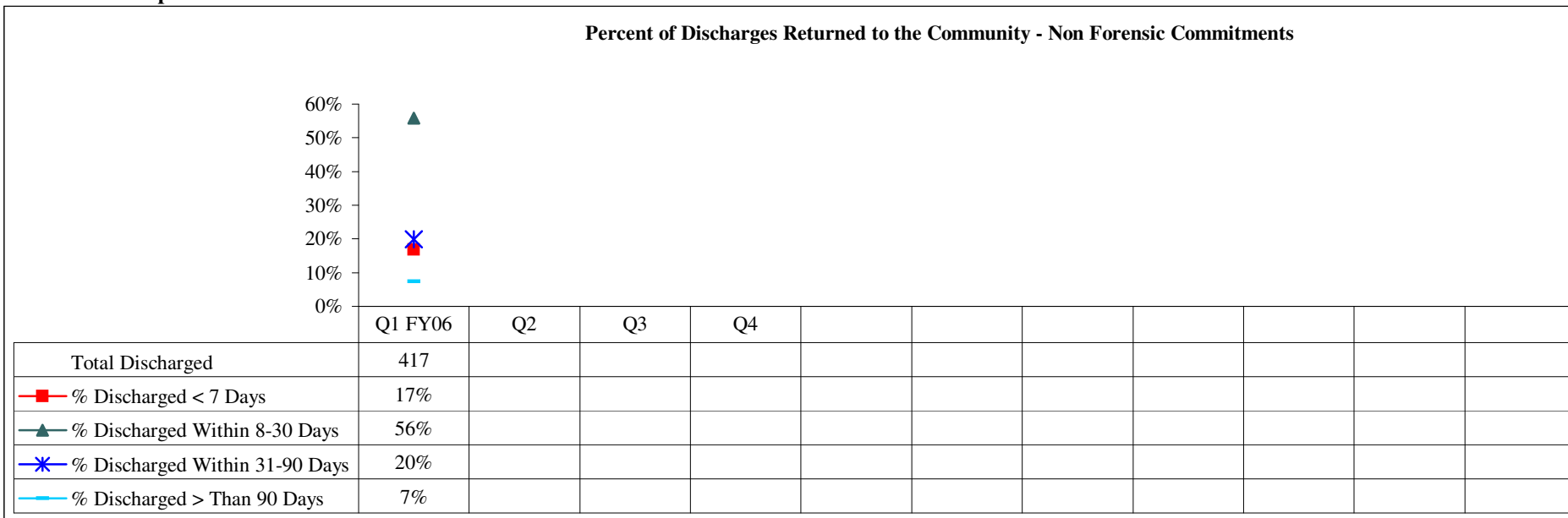
Measure 5B - Percent of Discharges Returned to the Community

Rusk State Hospital - Forensic



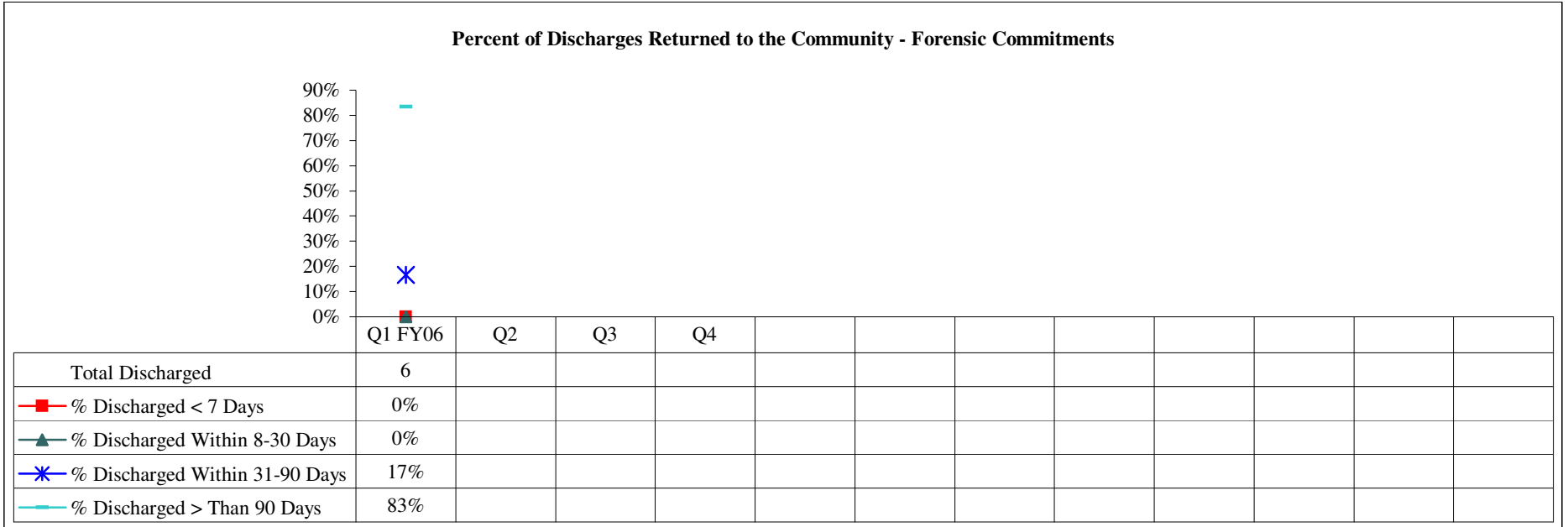
Measure 5B - Percent of Discharges Returned to the Community

Rusk State Hospital - Non Forensic



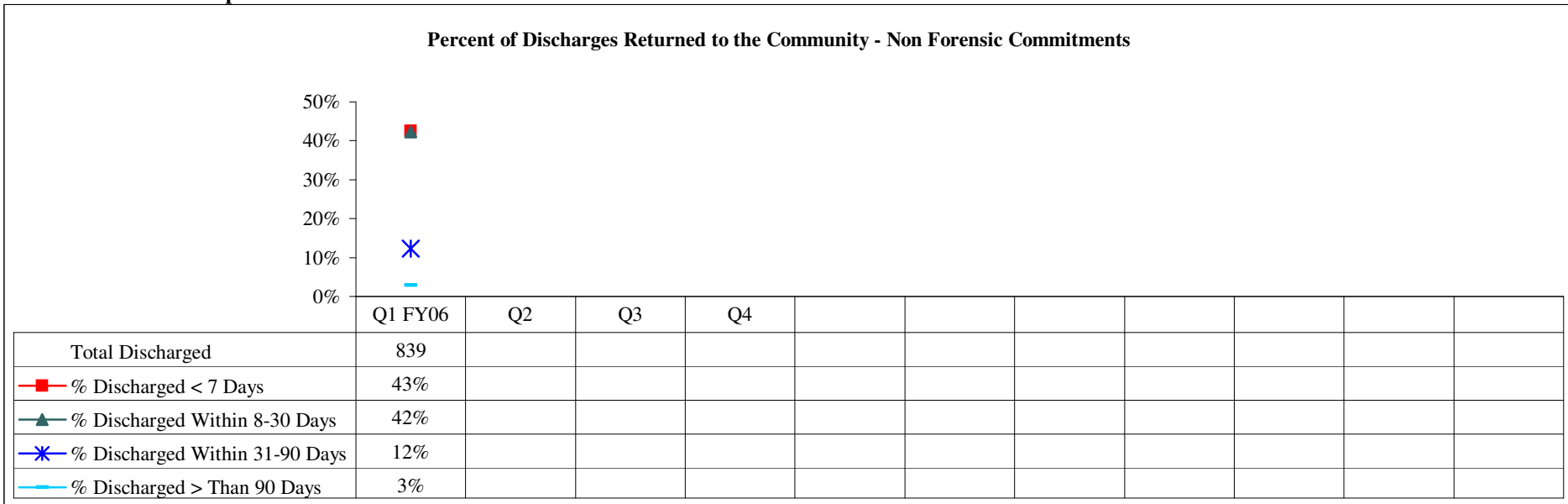
Measure 5B - Percent of Discharges Returned to the Community

San Antonio State Hospital - Forensic



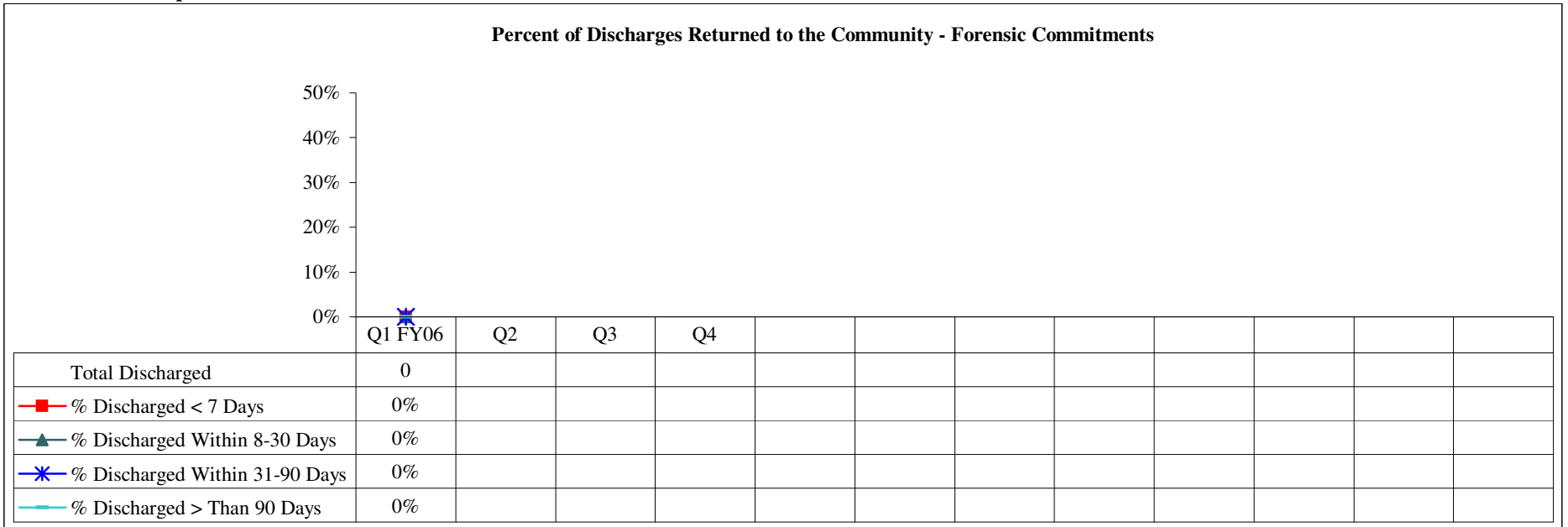
Measure 5B - Percent of Discharges Returned to the Community

San Antonio State Hospital - Non Forensic

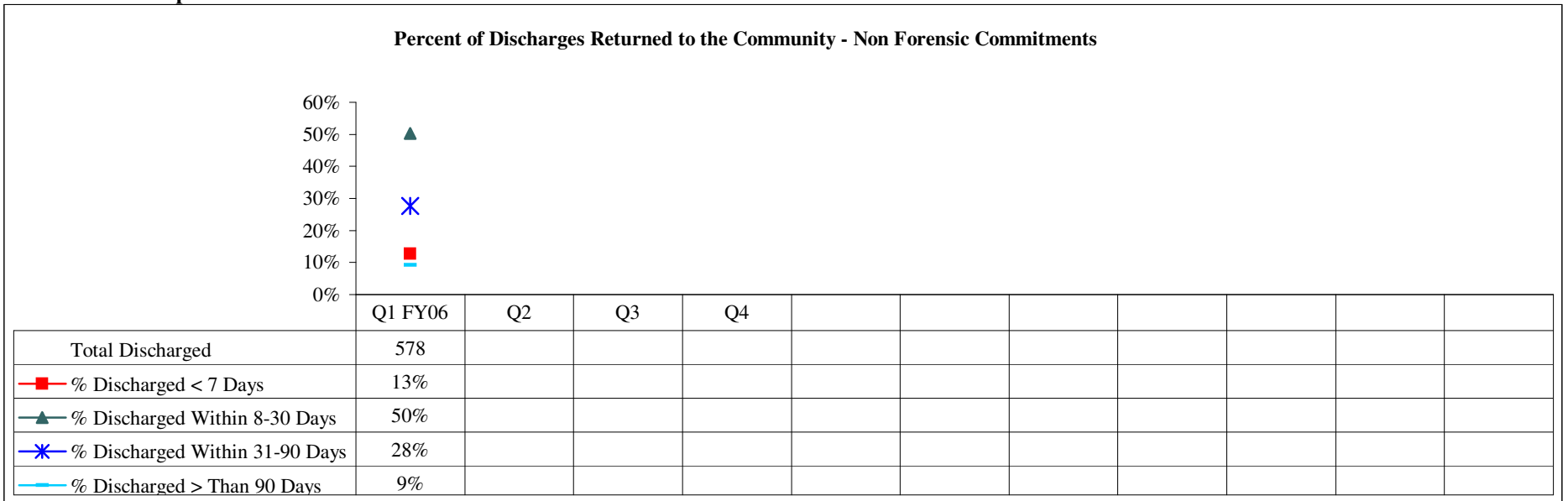


Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

**Measure 5B - Percent of Discharges Returned to the Community
Terrell State Hospital - Forensic**

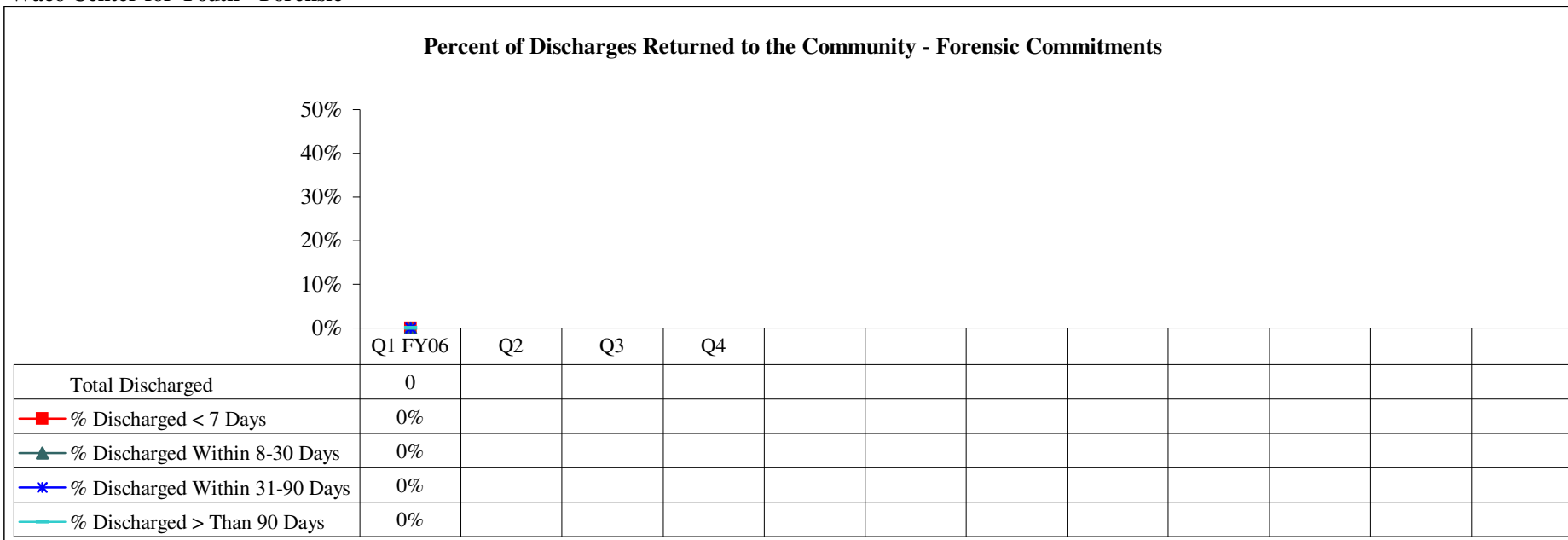


**Measure 5B - Percent of Discharges Returned to the Community
Terrell State Hospital - Non Forensic**

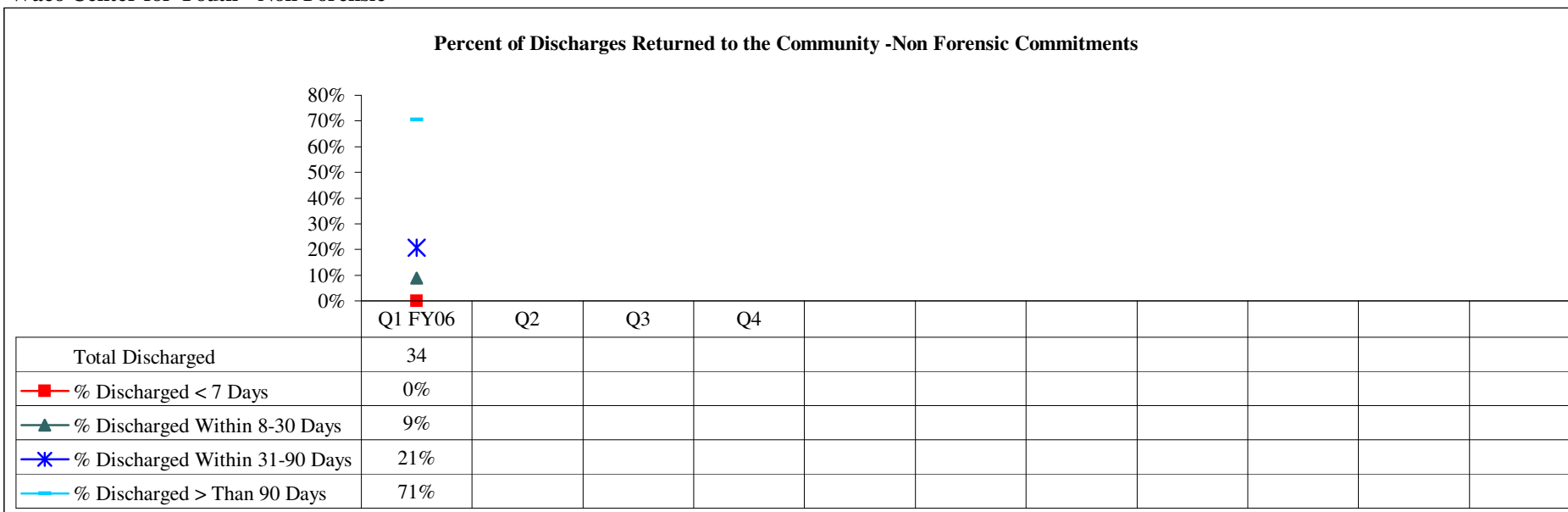


Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

**Measure 5B - Percent of Discharges Returned to the Community
Waco Center for Youth - Forensic**



**Measure 5B - Percent of Discharges Returned to the Community
Waco Center for Youth - Non Forensic**



Source: Percent of Forensic/Non-Forensic Discharges Returned to Community (SR4206)

Performance Measure 5C:

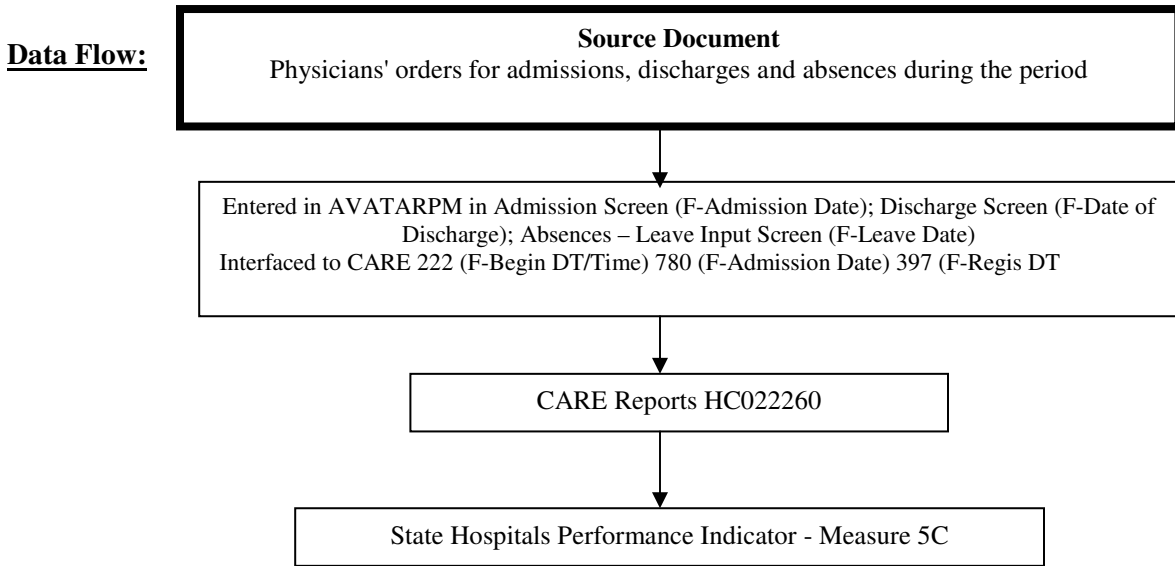
Average length of stay in a state hospital will be calculated on a quarterly basis for those patients: Admitted and discharged within 12 months, and all discharges.

Performance Measure Operational Definition: The state hospital average length of stay at discharged using admissions, absence and discharge data.

Performance Measure Formula: Net length of stay calculated by subtracting the date of admission from the date of discharge, and then subtracting days absent. Length of Stay for Admitted and Discharged During Prior Twelve Months shows how many people were both admitted and discharged during the prior twelve months.

Performance Measure Data Display and Chart Description:

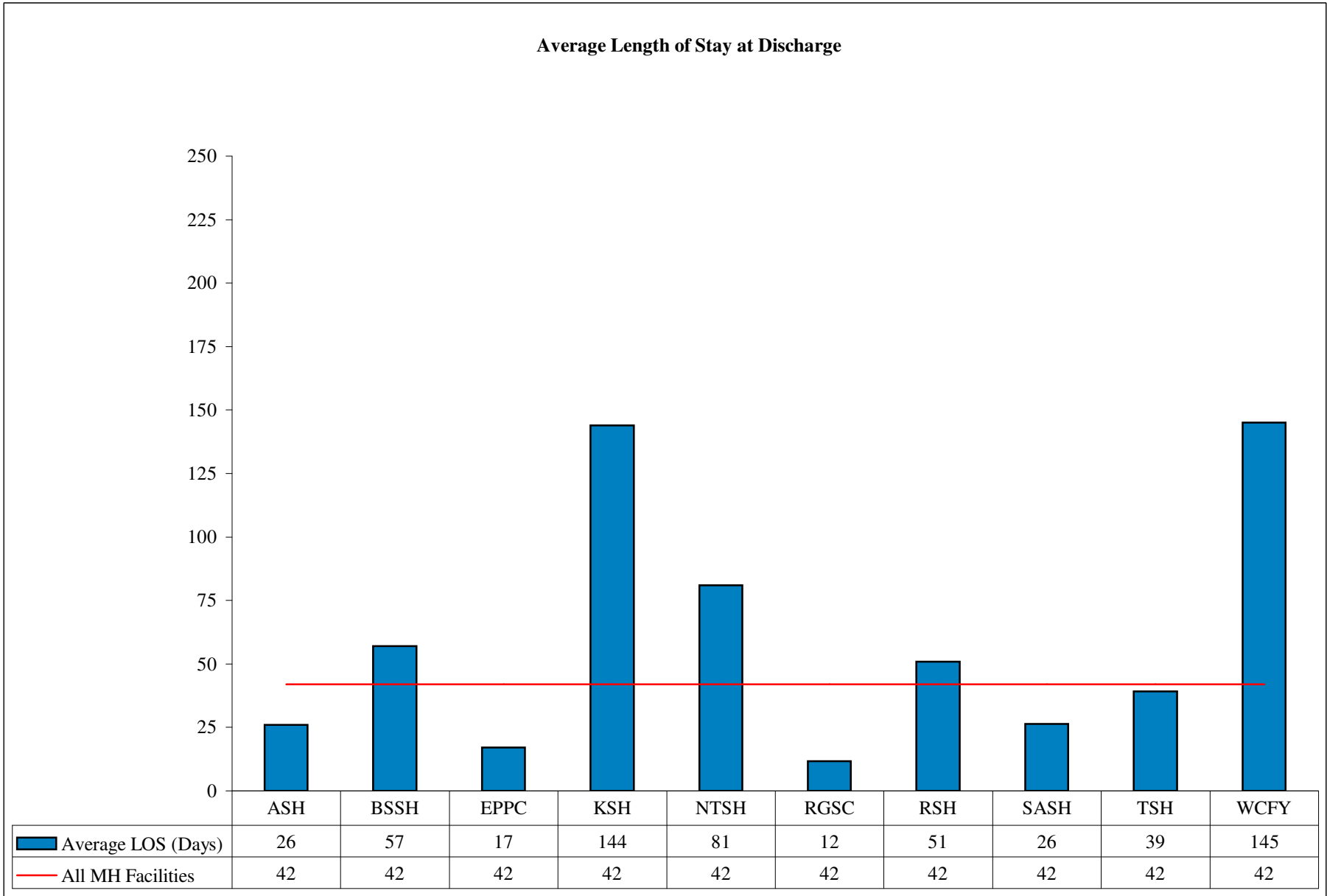
- ◆ Chart with quarterly data points showing average length of stay at discharge by category for individual state hospitals and system-wide.
- ◆ Chart with average length of stay for admitted and discharged during prior 12 months by category for individual state hospitals and system-wide.



Data Integrity Review Process:

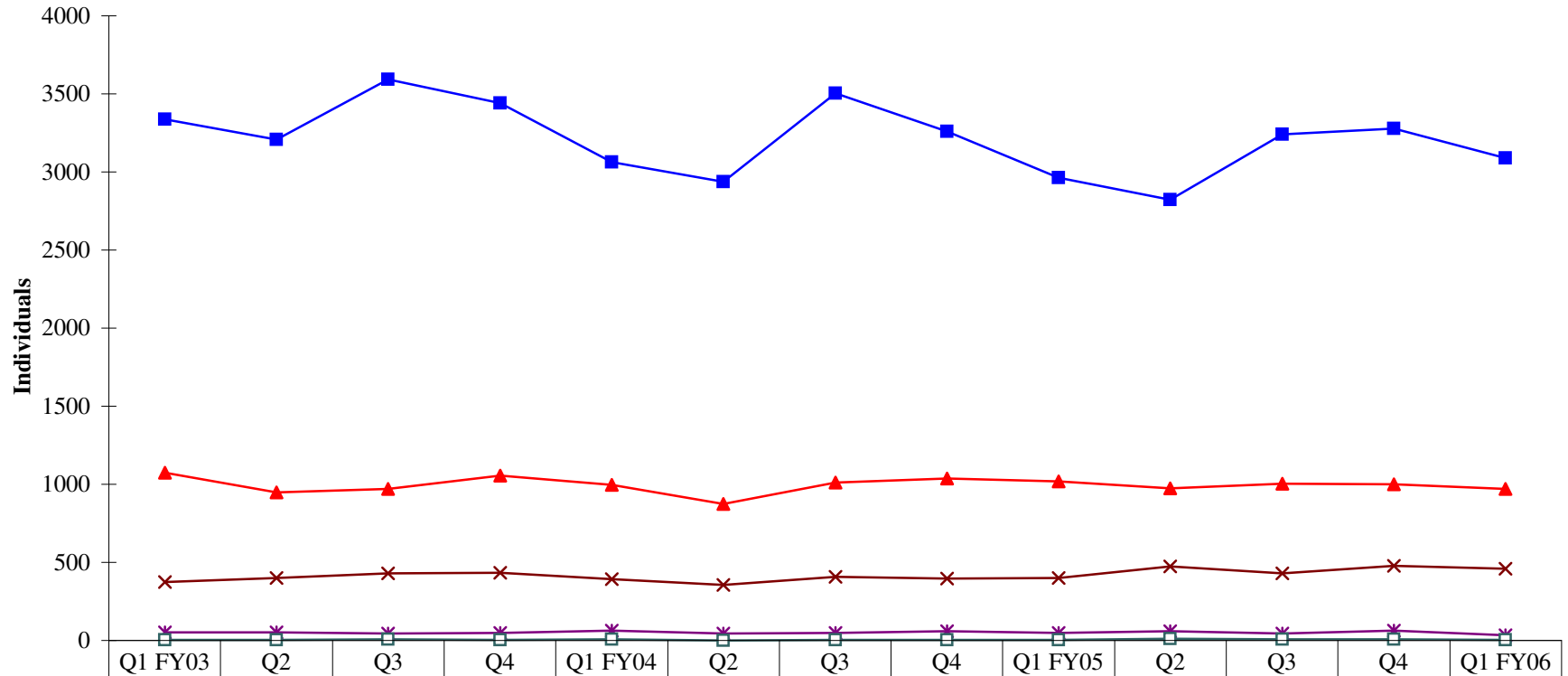
Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time when a leave, restraint/seclusion, injury or elopement started and stopped.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record.
Sample Size	Review of 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data and associated events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.
DIR/HMDS Report	Summary of review including data accuracy, findings and data analysis.

**Measure 5C - Average Length of Stay at Discharge
All MH Facilities**



**Measure 5C - Average Length of Stay at Discharge
All MH Facilities**

Average Length of Stay at Discharge by Category

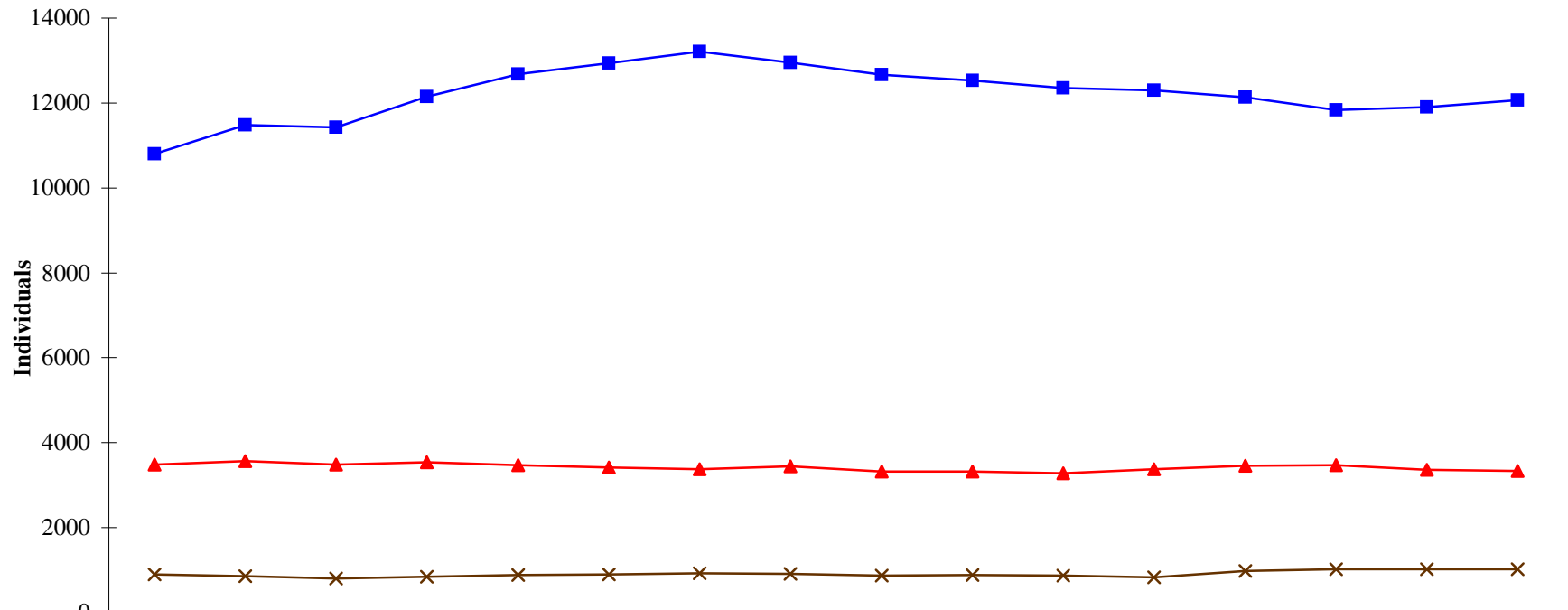


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	40	44	41	43	49	39	45	45	47	59	43	49	42
30 Days or Less	3336	3209	3592	3439	3064	2936	3502	3261	2963	2824	3240	3277	3089
31 - 90 Days	1074	950	969	1057	998	874	1011	1038	1017	975	1004	999	969
91 - 365 Days	374	399	430	433	392	357	407	397	400	474	428	479	458
1 - 5 Years	51	52	43	50	64	45	49	58	47	61	43	63	35
Over 5 Years	3	5	6	3	7	0	5	5	4	12	6	6	2

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
All MH Facilities

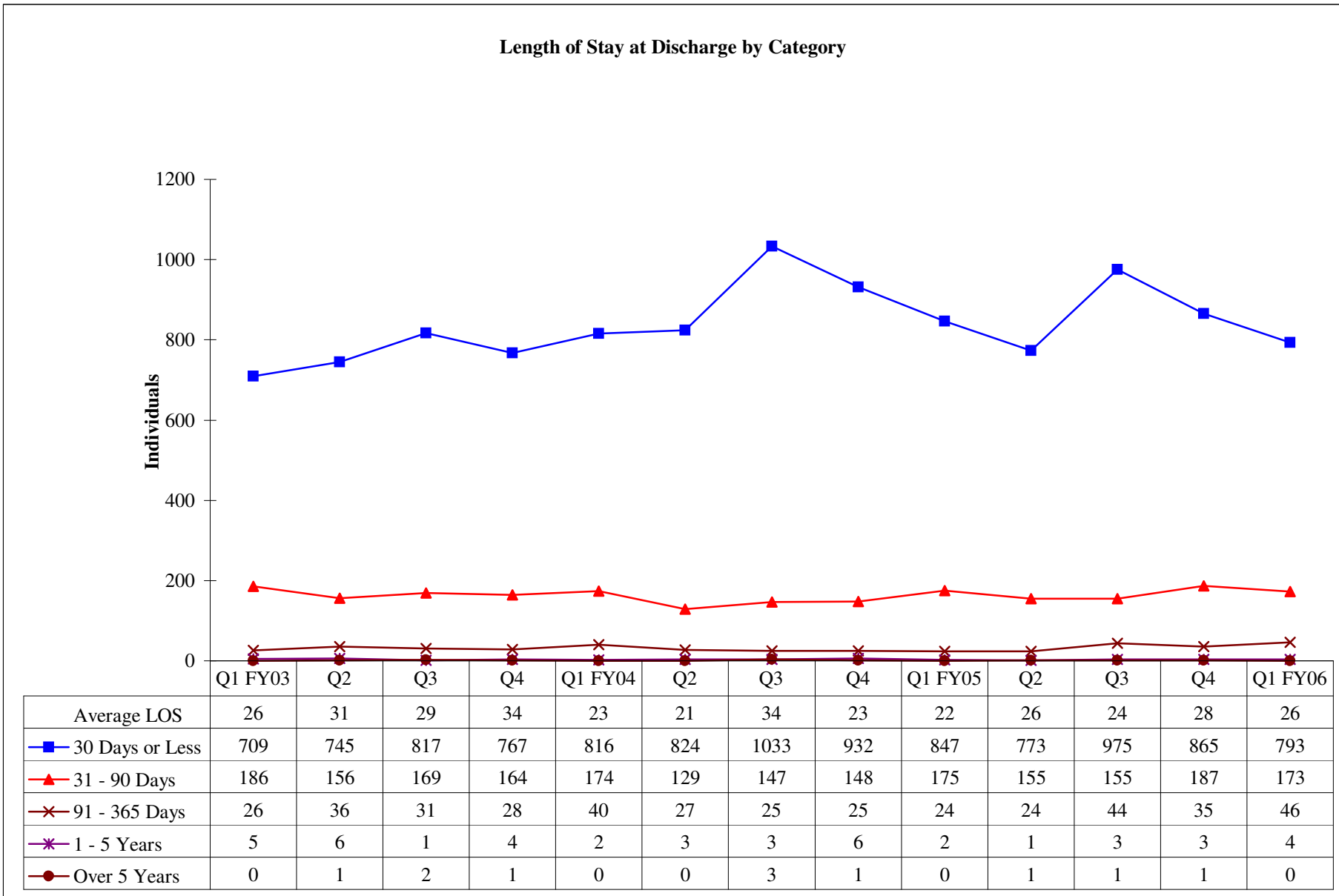
Average Length of Stay for Admitted and Discharged During Prior 12 Months



	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	28	28	27	26	26	25	25	25	25	26	26	26	27	28	27	27
30 Days or Less	10801	11479	11431	12148	12685	12933	13204	12948	12661	12529	12348	12301	12141	11837	11899	12067
31-90 Days	3492	3567	3483	3535	3468	3419	3378	3442	3324	3325	3285	3381	3462	3475	3361	3332
91-365 Days	895	854	806	842	884	897	926	906	867	885	871	833	974	1016	1020	1021

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

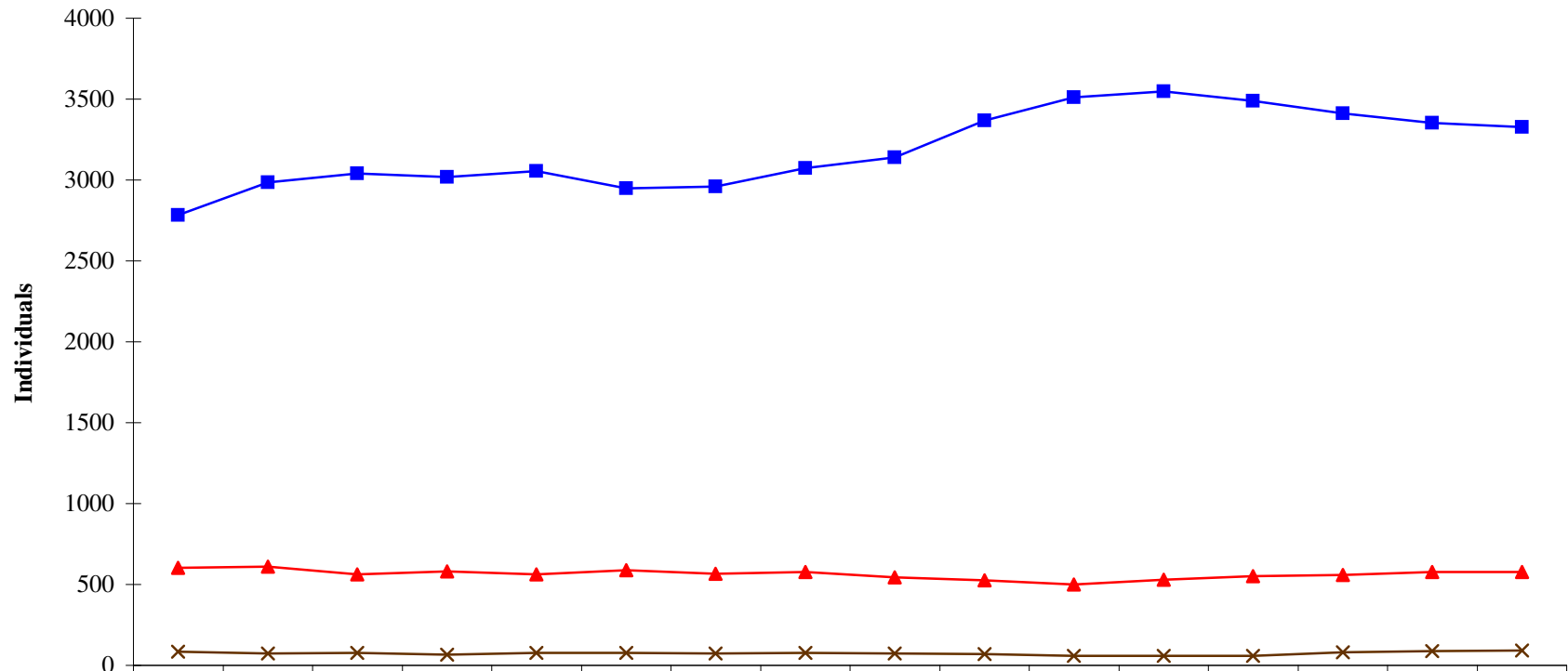
**Measure 5C - Average Length of Stay at Discharge
Austin State Hospital**



Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

**Measure 5C - Average Length of Stay at Discharge
Austin State Hospital**

Average Length of Stay For Admitted and Discharged During Prior 12 Months

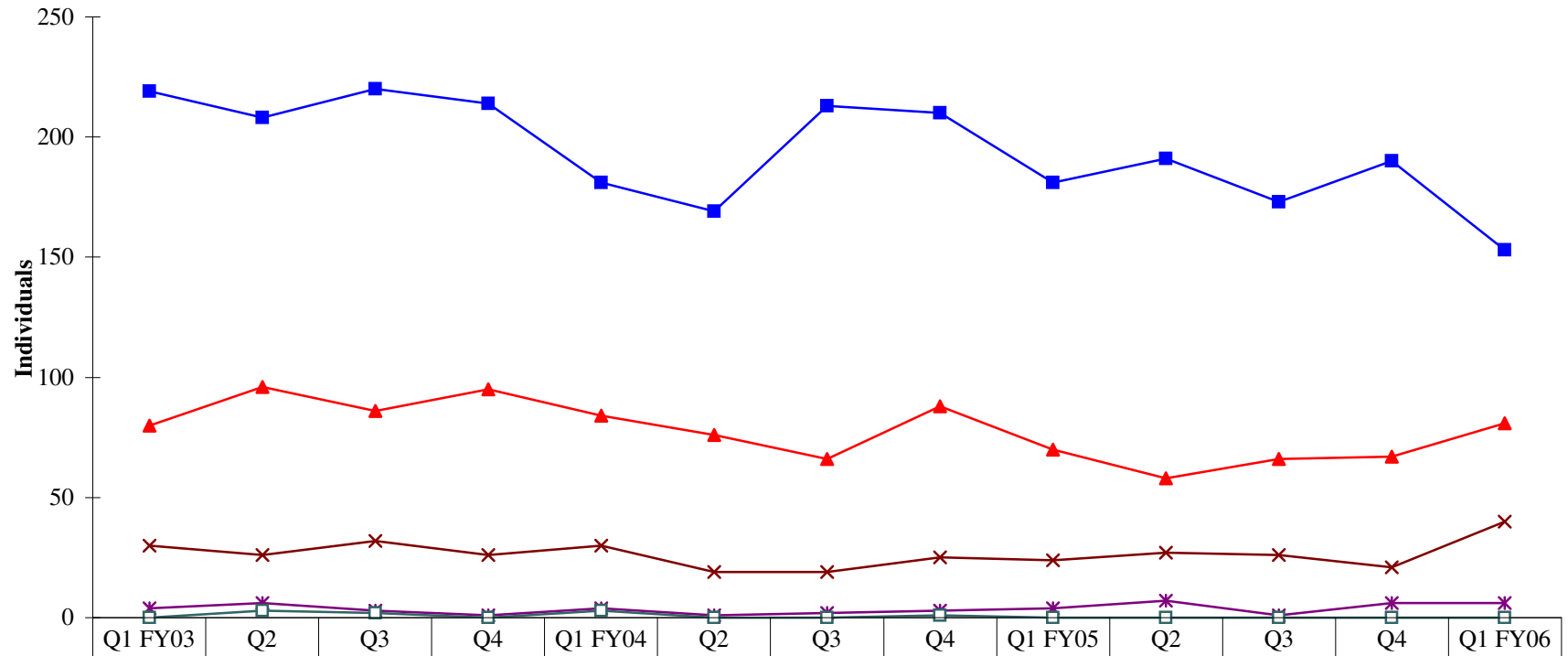


	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	20	19	18	18	19	19	18	18	18	17	16	16	17	18	18	18
30 Days or Less	2783	2987	3040	3019	3056	2947	2958	3073	3139	3369	3511	3548	3490	3412	3354	3326
31-90 Days	602	612	564	582	564	587	566	578	543	526	499	529	550	557	577	577
91-365 Days	83	72	76	66	79	79	75	79	73	71	58	60	59	82	87	92

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
Big Spring State Hospital

Length of Stay at Discharge by Category

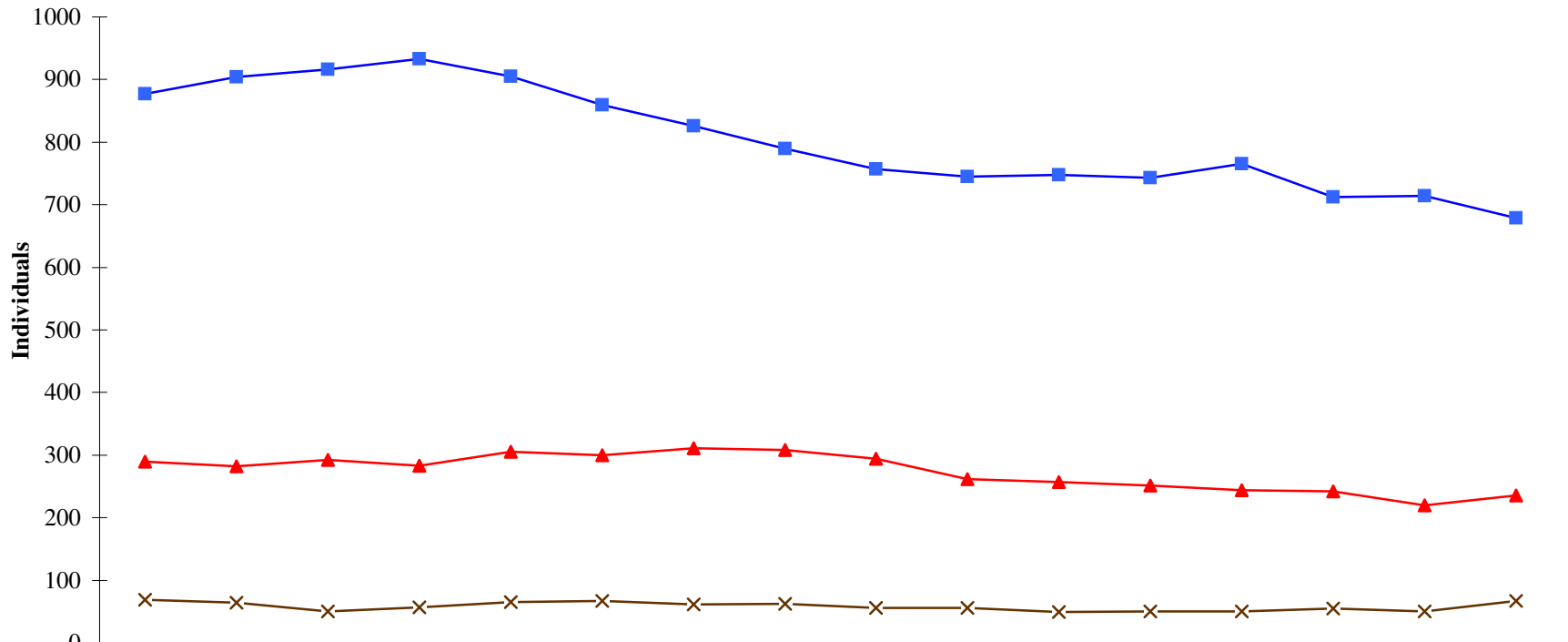


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	43	86	64	42	93	35	35	61	48	57	38	43	57
30 Days or Less	219	208	220	214	181	169	213	210	181	191	173	190	153
31 - 90 Days	80	96	86	95	84	76	66	88	70	58	66	67	81
91 - 365 Days	30	26	32	26	30	19	19	25	24	27	26	21	40
1 - 5 Years	4	6	3	1	4	1	2	3	4	7	1	6	6
Over 5 Years	0	3	2	0	3	0	0	1	0	0	0	0	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
Big Spring State Hospital

Average Length of Stay for Admitted and Discharged During Prior 12 Months

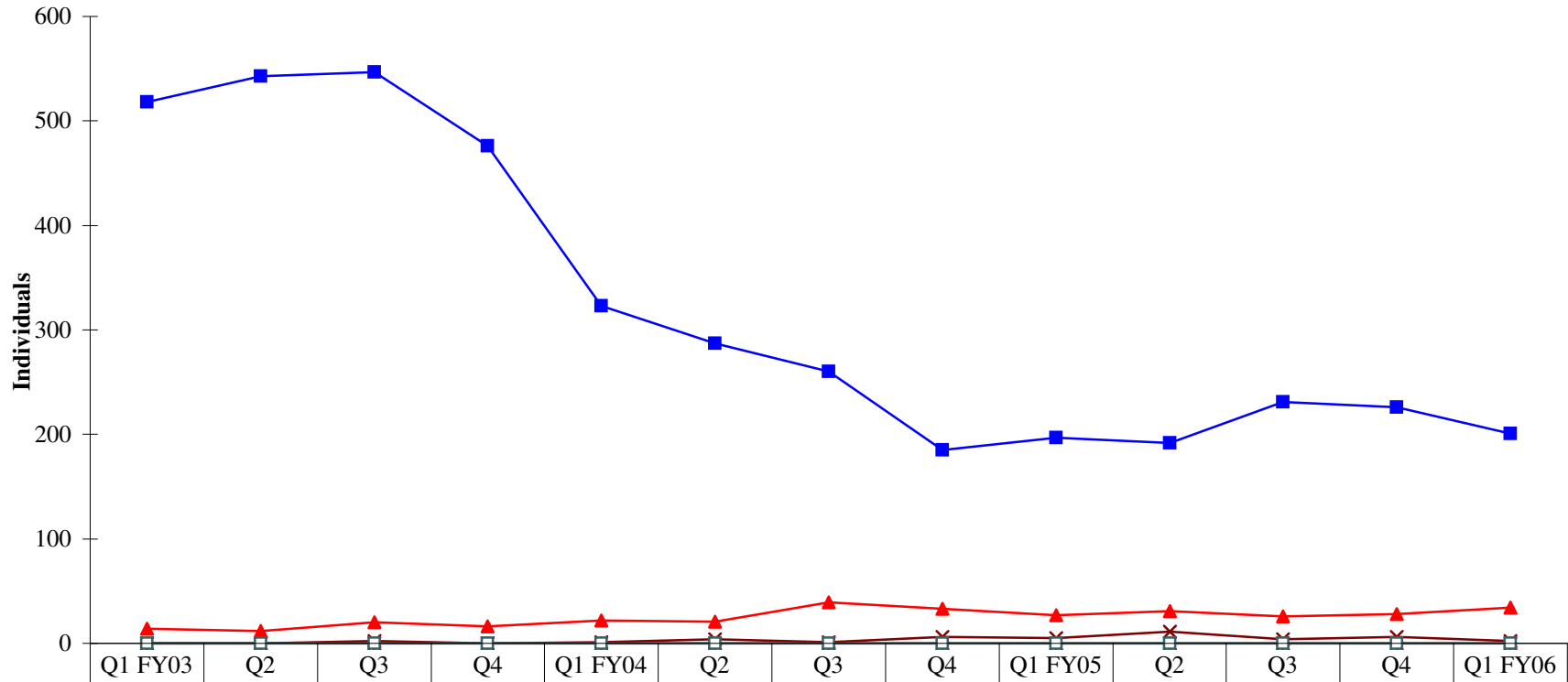


	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	29	29	27	27	29	29	30	30	29	29	28	28	28	28	27	30
■ 30 Days or Less	877	904	916	933	905	859	826	790	757	745	748	743	765	712	714	679
▲ 31-90 Days	290	282	292	283	305	300	311	308	294	262	257	251	244	242	220	236
× 91-365 Days	69	64	50	57	65	67	61	62	56	56	49	50	50	55	50	67

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
El Paso Psychiatric Center

Length of Stay at Discharge by Category

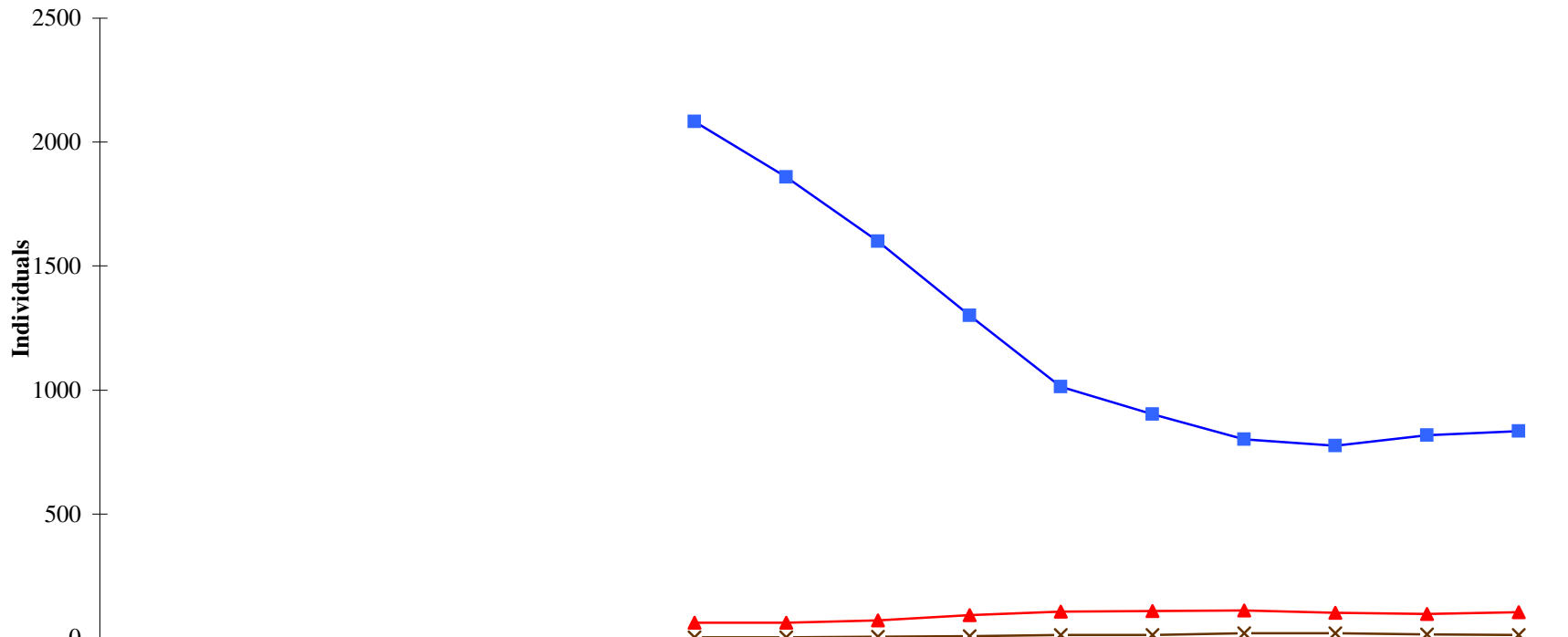


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	7	7	8	8	10	13	14	19	18	22	15	17	17
30 Days or Less	518	543	547	476	323	287	260	185	197	192	231	226	201
31 - 90 Days	14	12	20	16	22	21	39	33	27	31	26	28	34
91 - 365 Days	0	0	2	0	1	4	1	6	5	11	4	6	2
1 - 5 Years	0	0	0	0	0	0	0	0	0	0	0	0	0
Over 5 Years	0	0	0	0	0	0	0	0	0	0	0	0	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
El Paso Psychiatric Center

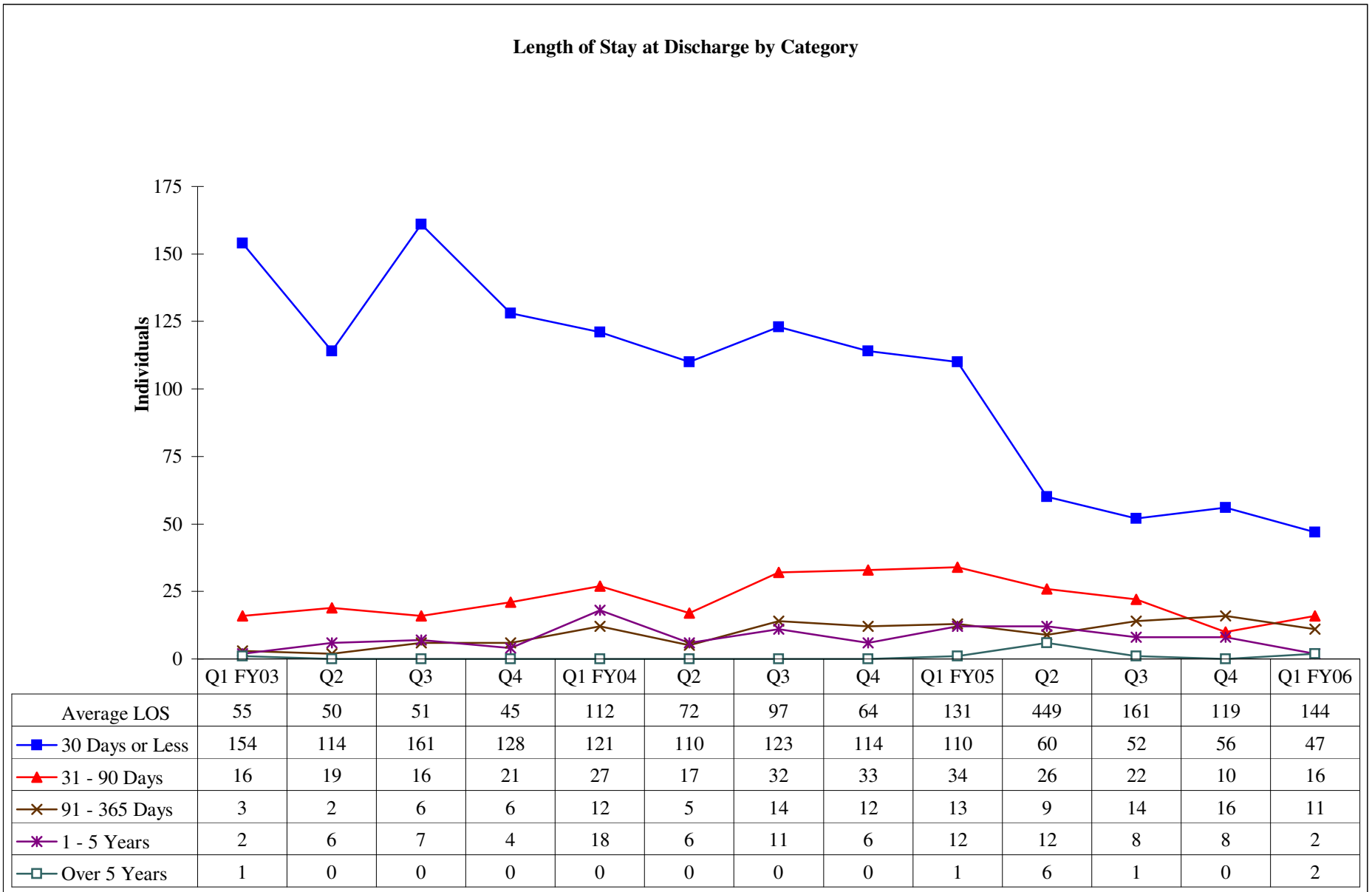
Average Length of Stay for Admitted and Discharged During Prior 12 Months



	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS							7	8	9	11	13	14	17	17	16	15
■ 30 Days or Less							2084	1858	1601	1300	1013	903	802	775	817	834
▲ 31-90 Days							62	62	71	93	105	109	111	101	97	104
× 91-365 Days							2	2	5	6	11	11	19	18	15	11

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

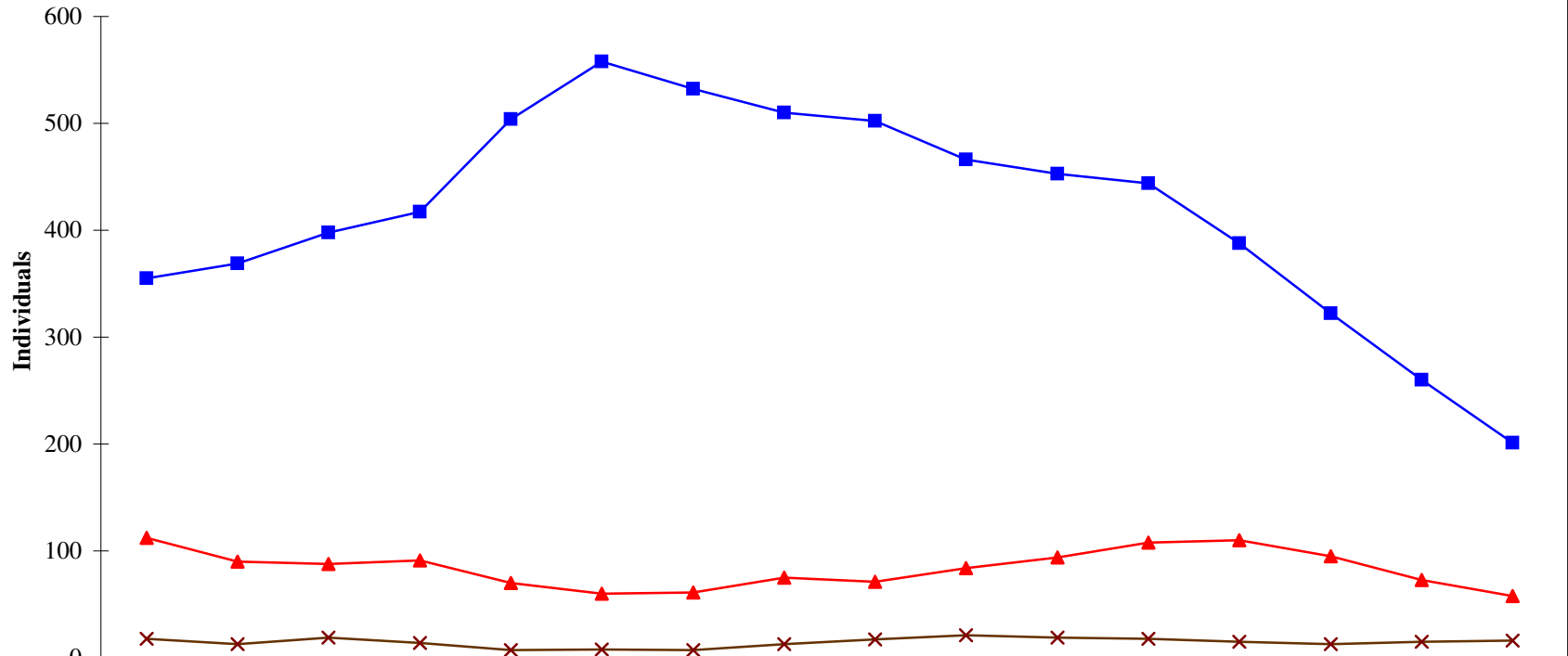
**Measure 5C - Average Length of Stay at Discharge
Kerrville State Hospital**



Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

**Measure 5C - Average Length of Stay at Discharge
Kerrville State Hospital**

Average Length of Stay for Admitted and Discharged During Prior 12 Months

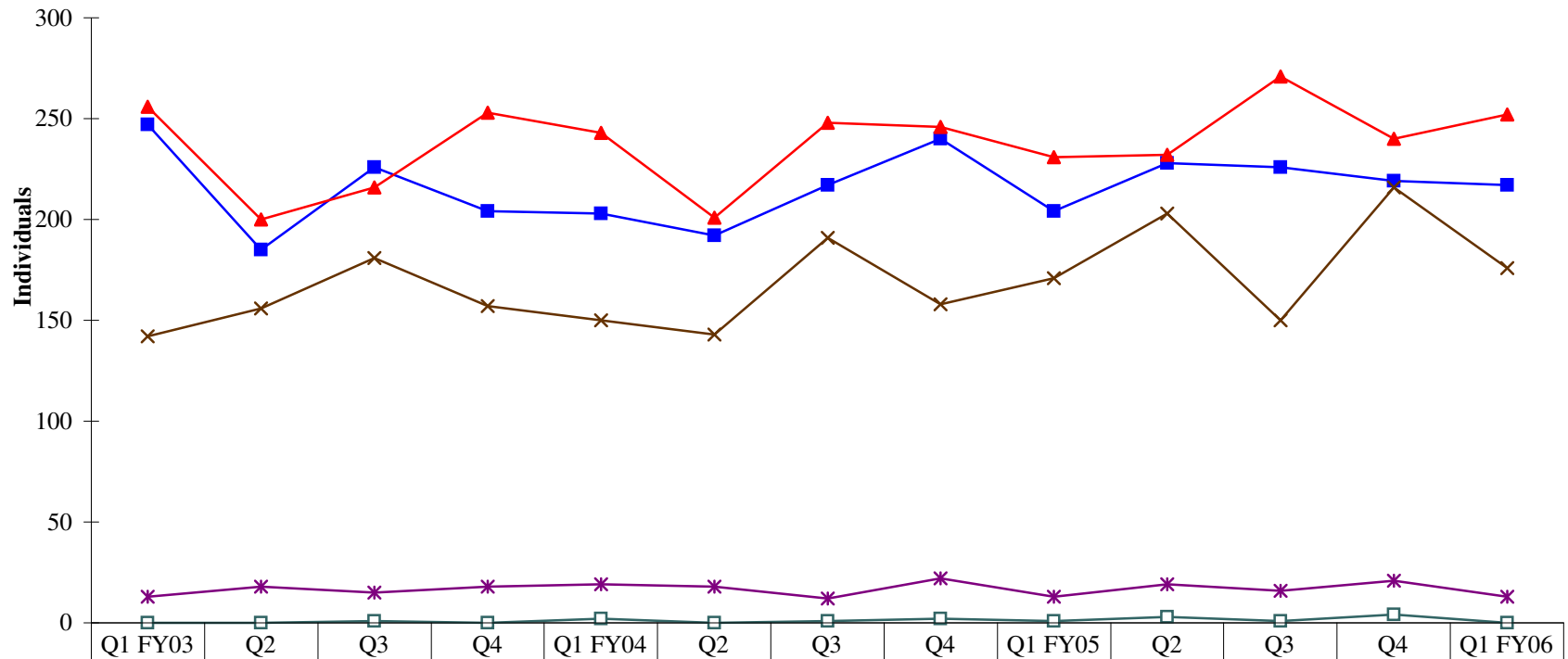


	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	28	23	25	22	17	16	16	18	19	23	24	26	27	29	30	33
■ 30 Days or Less	355	369	398	417	504	558	532	510	502	466	453	444	388	322	260	201
▲ 31-90 Days	112	90	88	91	70	60	61	75	71	84	94	108	110	95	73	58
× 91-365 Days	18	13	19	14	7	8	7	13	17	21	19	18	15	13	15	16

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
North Texas State Hospital

Length of Stay at Discharge by Category

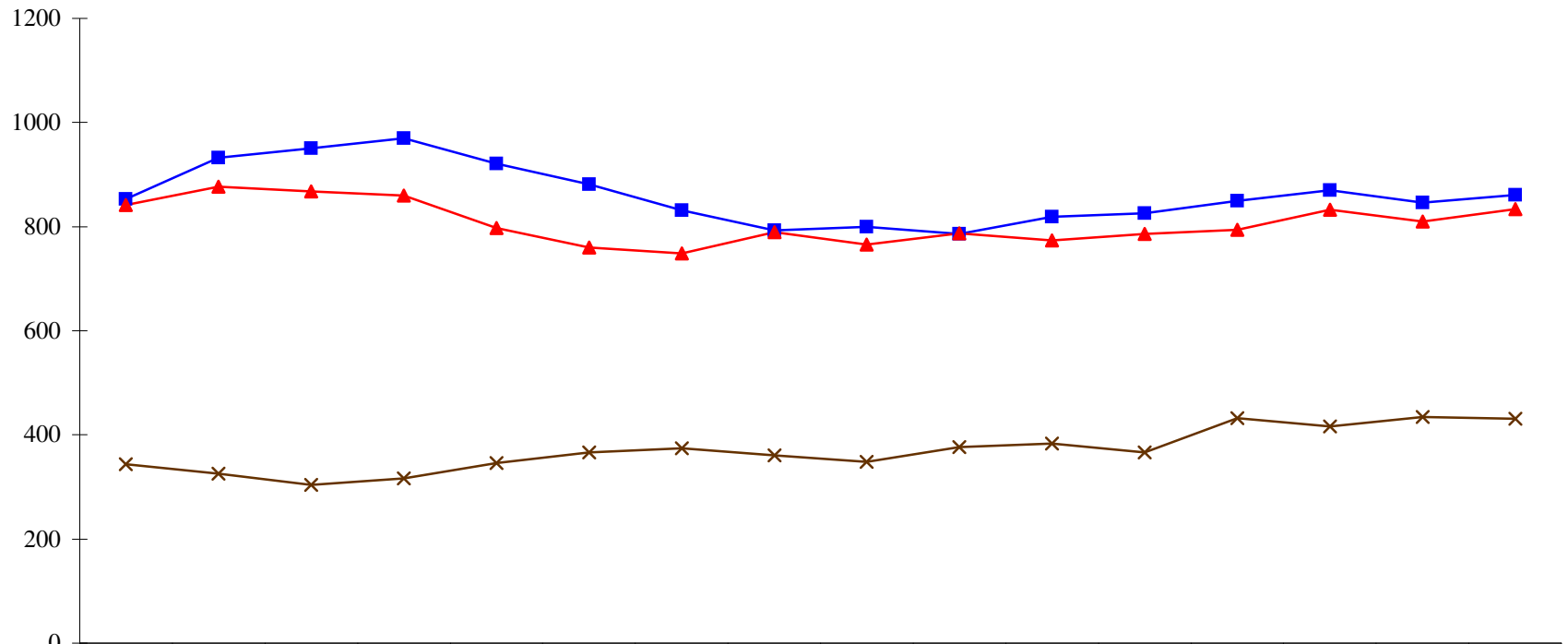


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	72	93	89	80	101	83	89	98	86	97	84	110	81
30 Days or Less	247	185	226	204	203	192	217	240	204	228	226	219	217
31 - 90 Days	256	200	216	253	243	201	248	246	231	232	271	240	252
91 - 365 Days	142	156	181	157	150	143	191	158	171	203	150	216	176
1 - 5 Years	13	18	15	18	19	18	12	22	13	19	16	21	13
Over 5 Years	0	0	1	0	2	0	1	2	1	3	1	4	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
North Texas State Hospital

Average Length of Stay for Admitted and Discharged During Prior 12 Months

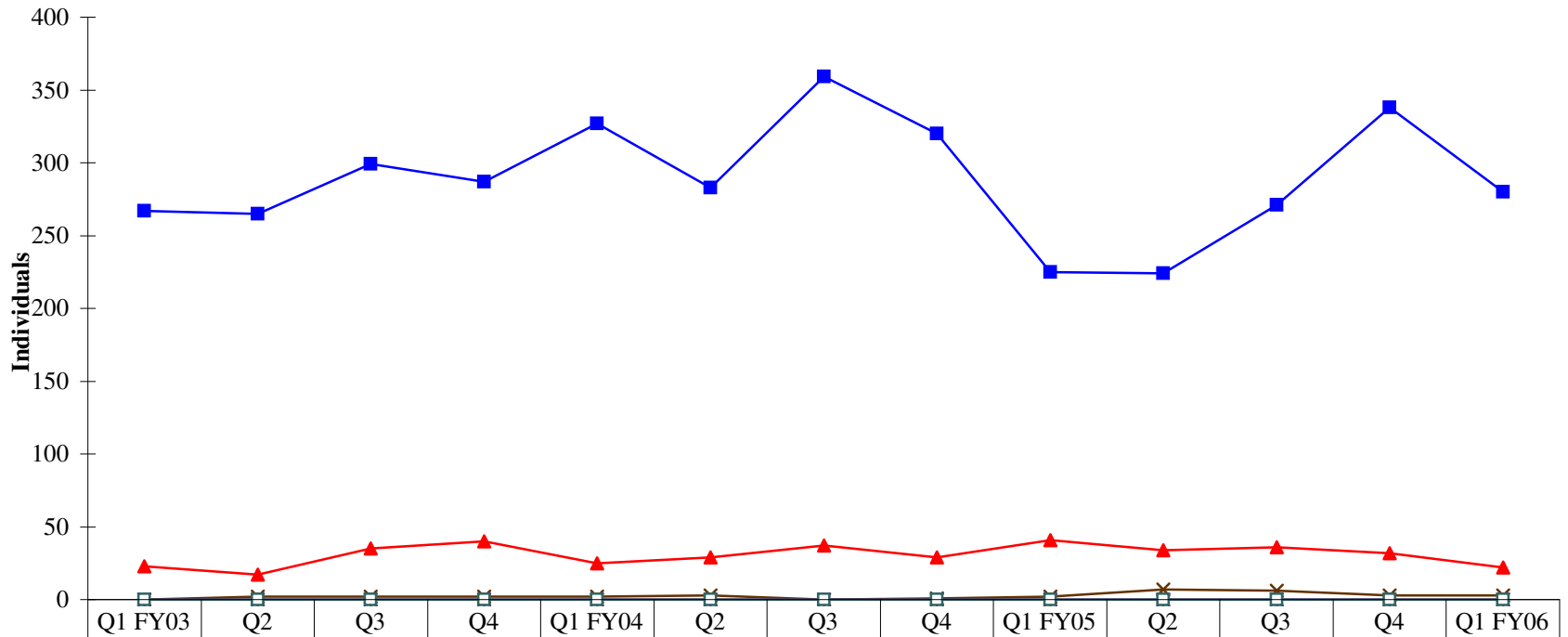


	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	53	51	49	49	50	52	53	54	53	56	54	53	56	55	54	56
■ 30 Days or Less	853	932	951	970	921	881	831	793	800	786	819	826	849	870	846	861
▲ 31-90 Days	842	877	868	860	797	760	749	789	766	787	774	786	794	832	810	834
✕ 91-365 Days	344	326	304	317	346	366	374	361	348	377	383	366	432	416	434	431

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

**Measure 5C - Average Length of Stay at Discharge
Rio Grande State Center**

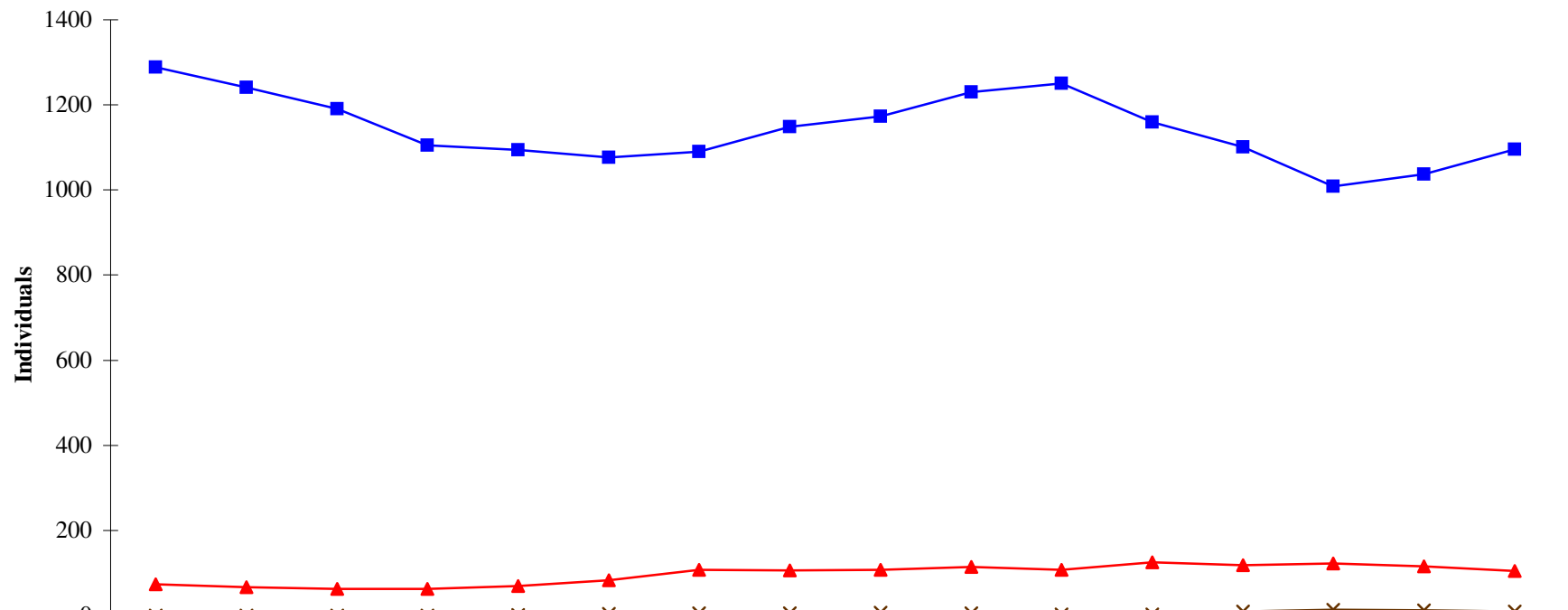
Average Length of Stay at Discharge by Category



	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	13	12	13	15	11	13	11	11	16	18	16	11	12
30 Days or Less	267	265	299	287	327	283	359	320	225	224	271	338	280
31 - 90 Days	23	17	35	40	25	29	37	29	41	34	36	32	22
91 - 365 Days	0	2	2	2	2	3	0	1	2	7	6	3	3
1 - 5 Years	0	0	0	0	0	0	0	0	0	0	0	0	0
Over 5 Years	0	0	0	0	0	0	0	0	0	0	0	0	0

**Measure 5C - Average Length of Stay at Discharge
Rio Grande State Center**

Average Length of Stay for Admitted and Discharged During Prior 12 Months

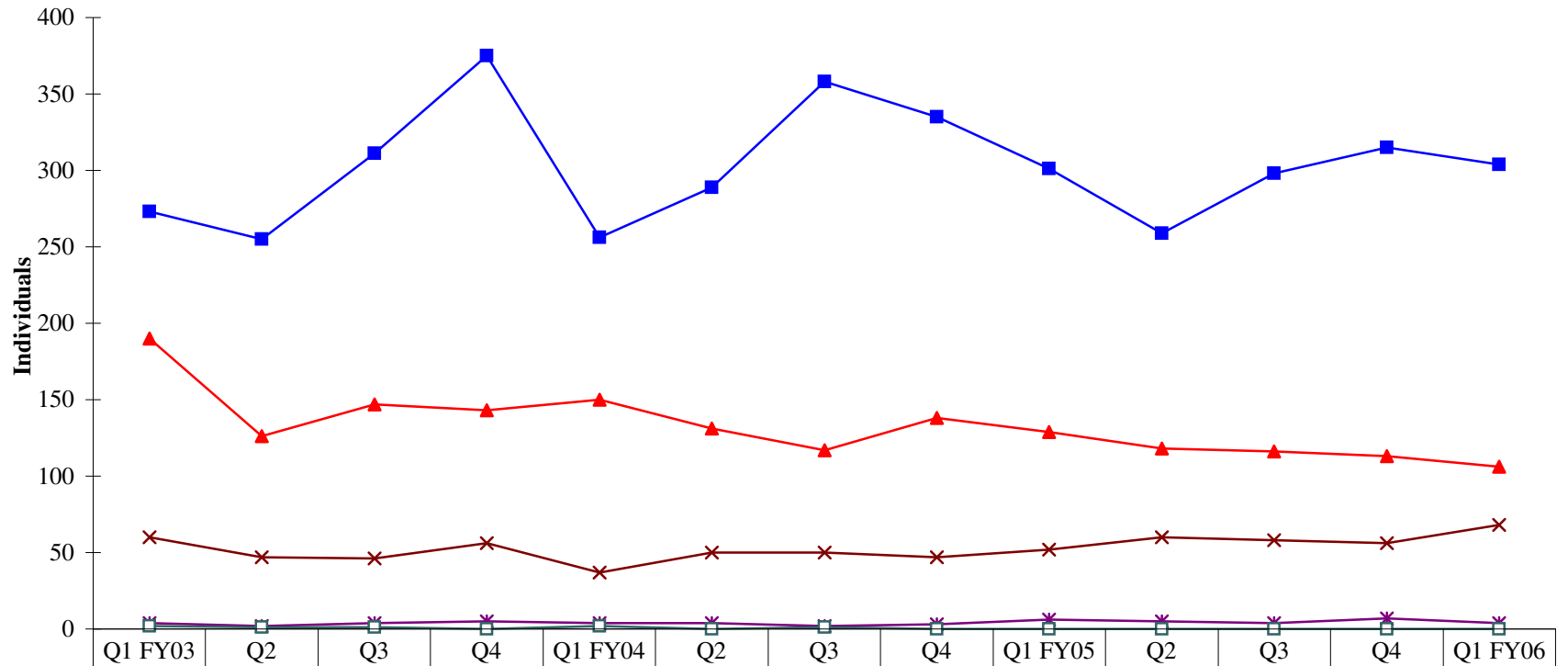


	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	9	9	9	10	11	12	12	12	12	11	11	12	13	14	13	12
■ 30 Days or Less	1289	1241	1191	1105	1094	1076	1090	1149	1173	1230	1251	1159	1101	1008	1037	1096
▲ 31-90 Days	74	67	62	63	69	83	107	106	108	114	108	125	118	123	116	104
× 91-365 Days	0	0	0	0	2	4	5	6	7	5	3	3	10	13	12	9

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
Rusk State Hospital

Length of Stay at Discharge by Category

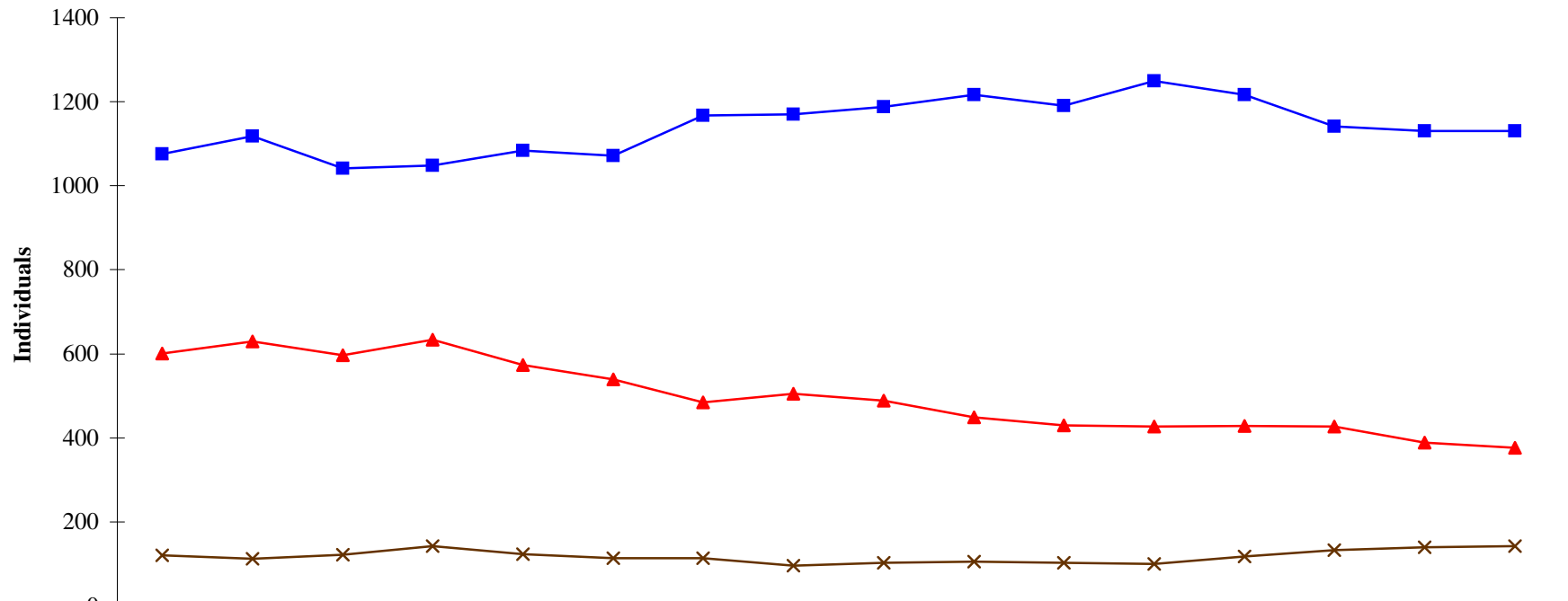


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	60	52	51	45	64	44	46	41	52	49	45	49	51
30 Days or Less	273	255	311	375	256	289	358	335	301	259	298	315	304
31 - 90 Days	190	126	147	143	150	131	117	138	129	118	116	113	106
91 - 365 Days	60	47	46	56	37	50	50	47	52	60	58	56	68
1 - 5 Years	4	2	4	5	4	4	2	3	6	5	4	7	4
Over 5 Years	2	1	1	0	2	0	1	0	0	0	0	0	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

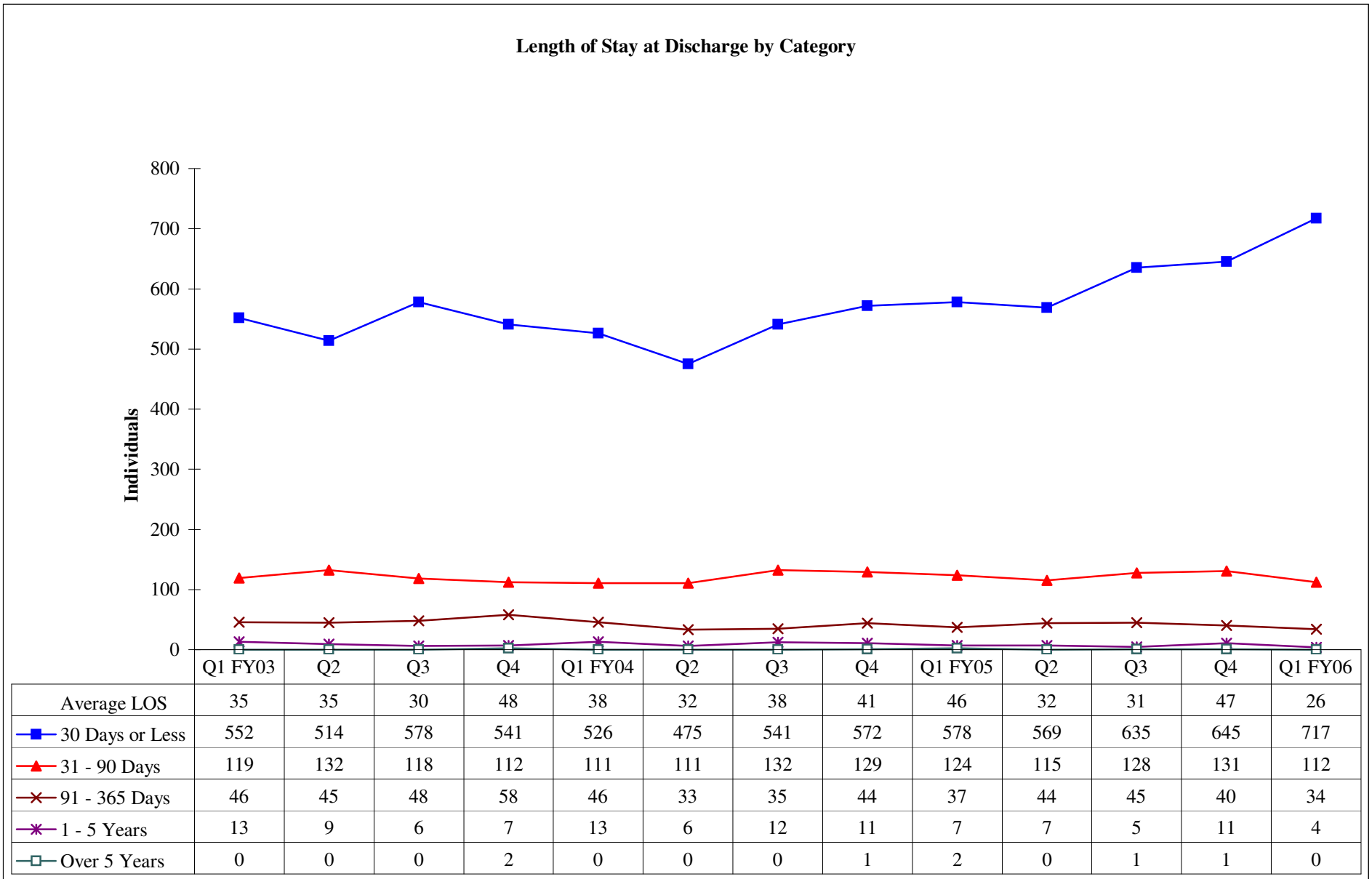
Measure 5C - Average Length of Stay at Discharge
Rusk State Hospital

Average Length of Stay for Admitted and Discharged During Prior 12 Months



	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	37	35	36	37	34	34	32	31	32	31	30	30	31	33	33	33
■ 30 Days or Less	1076	1118	1041	1048	1084	1072	1167	1170	1188	1216	1190	1250	1216	1141	1131	1130
▲ 31-90 Days	601	630	596	633	573	539	485	505	489	449	430	427	428	427	388	377
× 91-365 Days	121	112	122	142	123	113	114	96	103	105	102	100	118	133	140	143

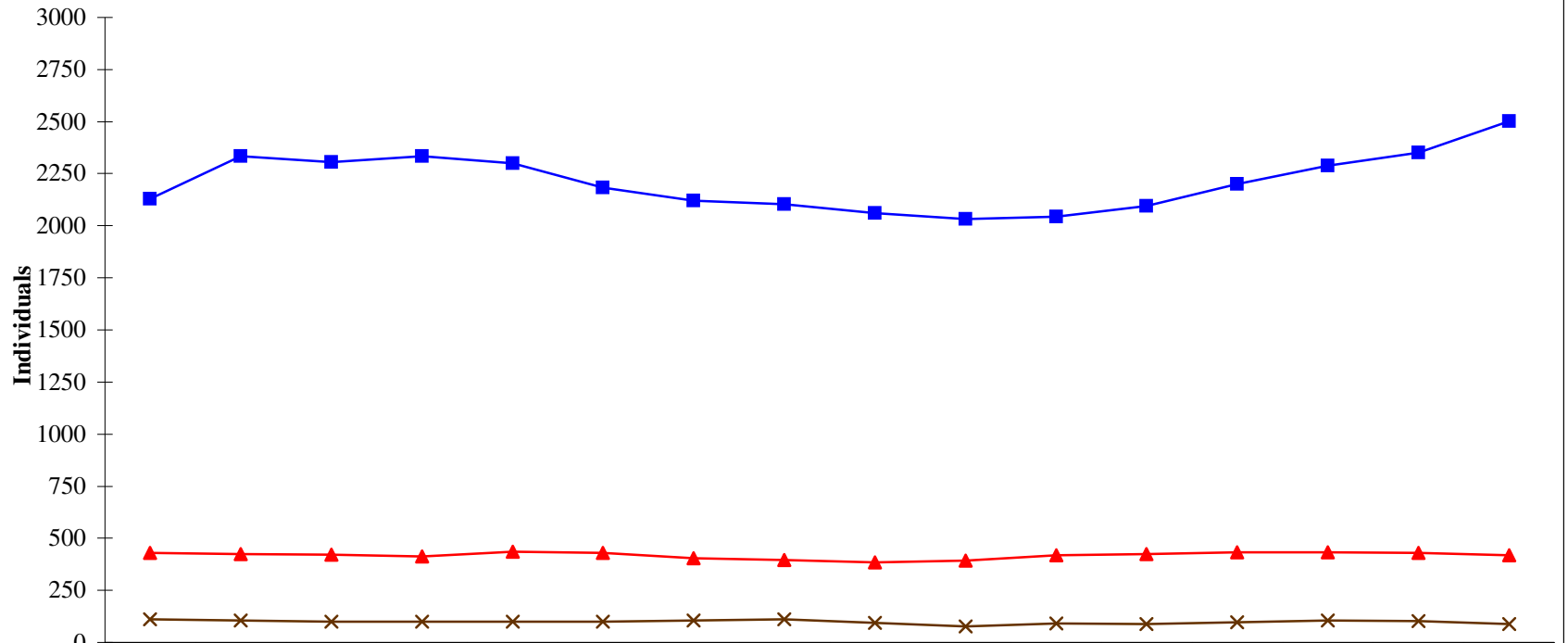
**Measure 5C - Average Length of Stay at Discharge
San Antonio State Hospital**



Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

Measure 5C - Average Length of Stay at Discharge
San Antonio State Hospital

Average Length of Stay for Admitted and Discharged During Prior 12 Months

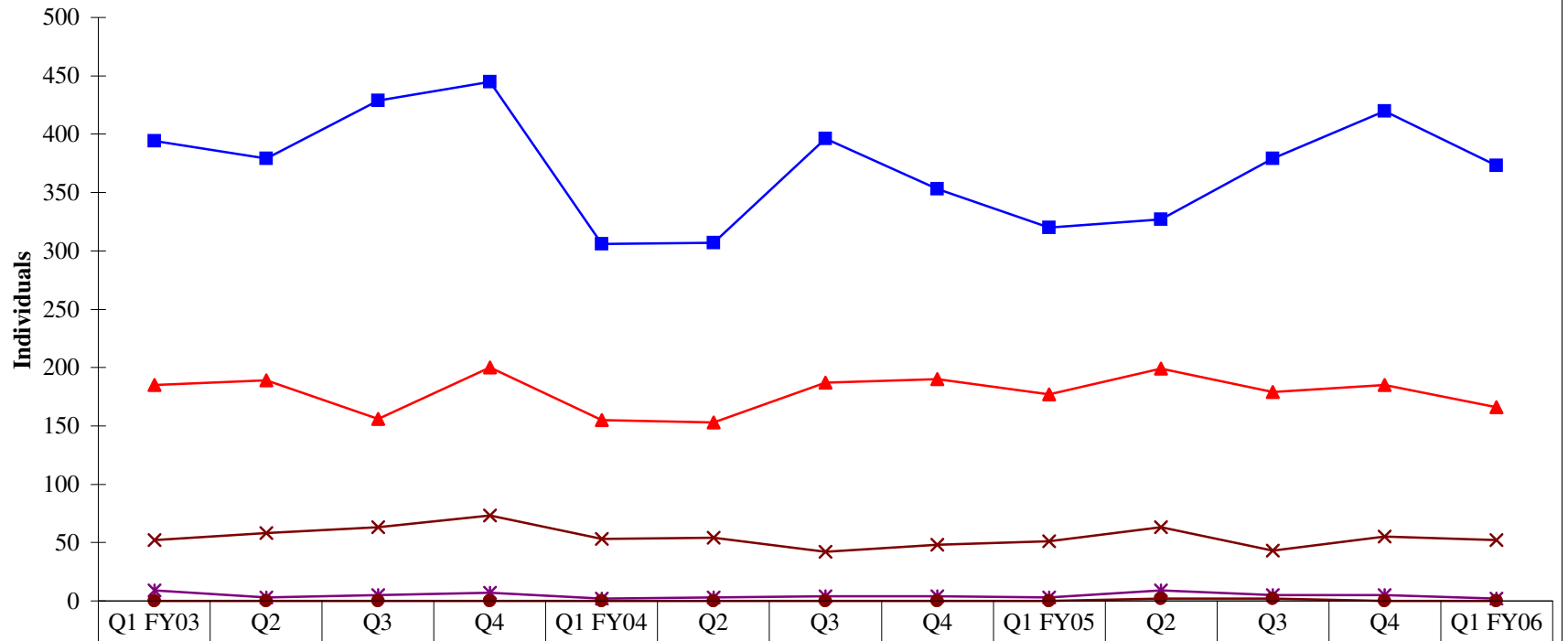


	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	21	21	21	20	20	21	21	21	20	20	21	20	20	20	20	19
■ 30 Days or Less	2129	2333	2305	2333	2301	2184	2120	2104	2061	2032	2043	2096	2199	2289	2351	2501
▲ 31-90 Days	429	424	420	413	436	430	404	396	384	394	417	423	432	432	429	418
✕ 91-365 Days	111	106	99	100	99	100	106	111	93	76	90	87	98	105	102	88

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
 Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

**Measure 5C - Average Length of Stay at Discharge
Terrell State Hospital**

Average Length of Stay at Discharge by Category

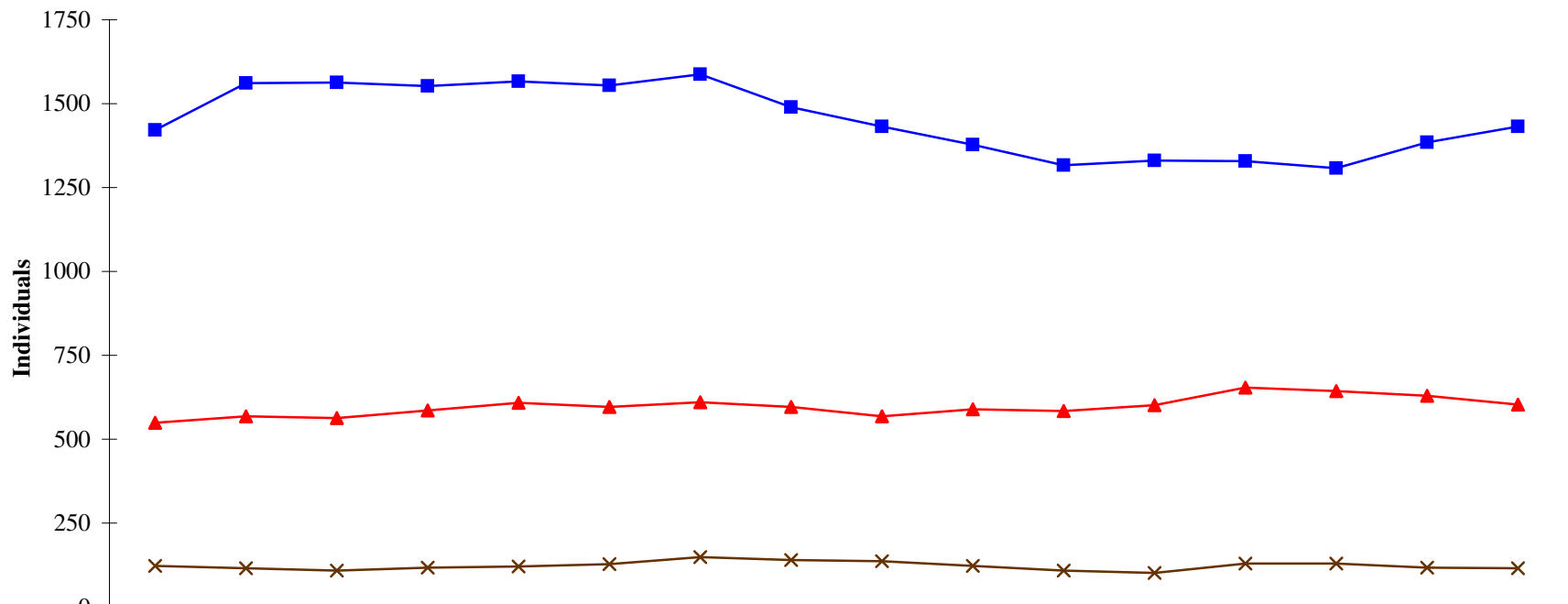


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	47	41	41	46	40	44	40	44	43	64	51	41	39
30 Days or Less	394	379	429	445	306	307	396	353	320	327	379	420	373
31 - 90 Days	185	189	156	200	155	153	187	190	177	199	179	185	166
91 - 365 Days	52	58	63	73	53	54	42	48	51	63	43	55	52
1 - 5 Years	9	3	5	7	2	3	4	4	3	9	5	5	2
Over 5 Years	0	0	0	0	0	0	0	0	0	2	2	0	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

**Measure 5C - Average Length of Stay at Discharge
Terrell State Hospital**

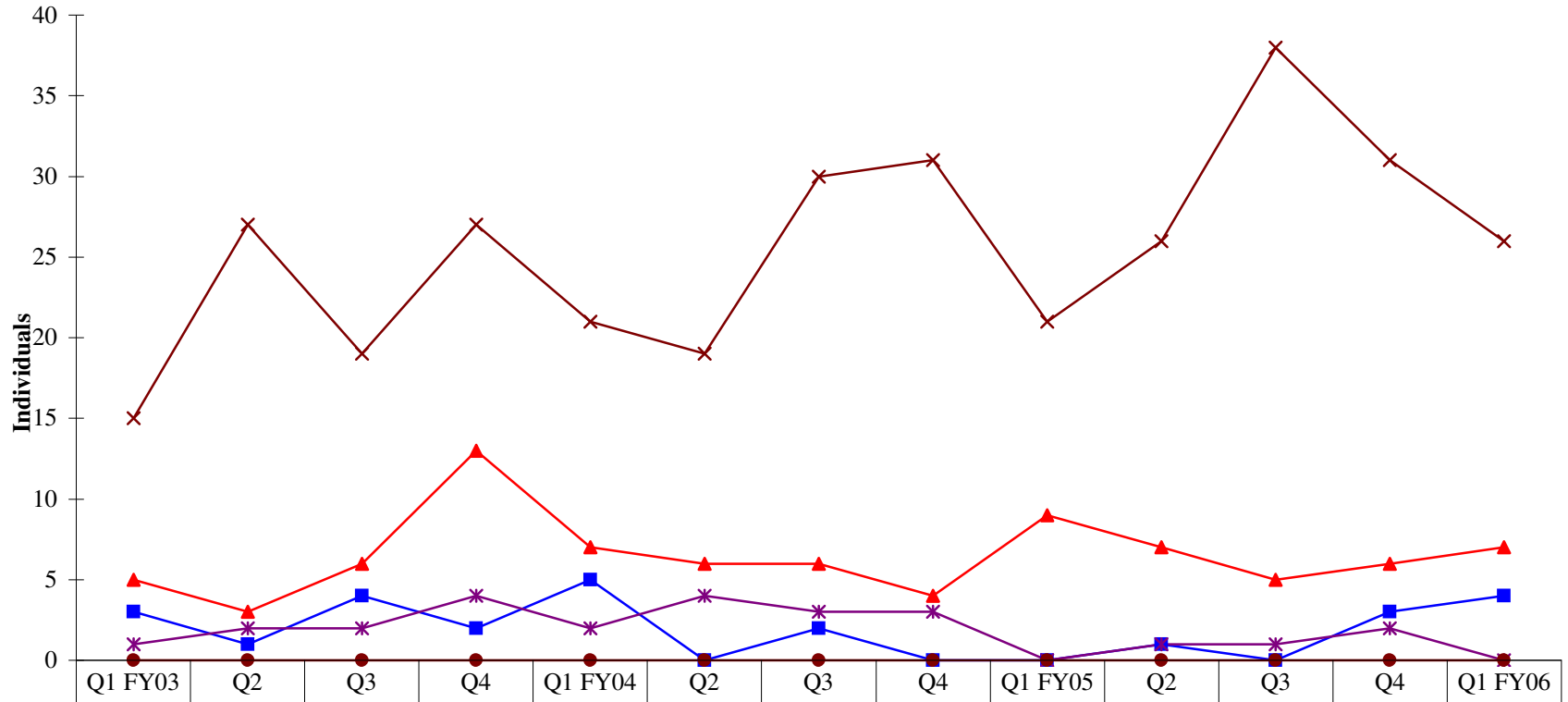
Average Length of Stay for Admitted and Discharged During Prior 12 Months



	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	31	29	29	30	30	30	31	31	32	32	32	31	33	33	32	31
■ 30 Days or Less	1421	1562	1563	1553	1566	1554	1587	1490	1431	1377	1316	1330	1328	1307	1385	1431
▲ 31-90 Days	549	569	563	586	609	596	610	597	569	590	584	602	653	644	629	603
× 91-365 Days	123	115	108	117	120	127	149	140	136	123	108	101	130	130	117	115

**Measure 5C - Average Length of Stay at Discharge
Waco Center for Youth**

Average Length of Stay at Discharge by Category

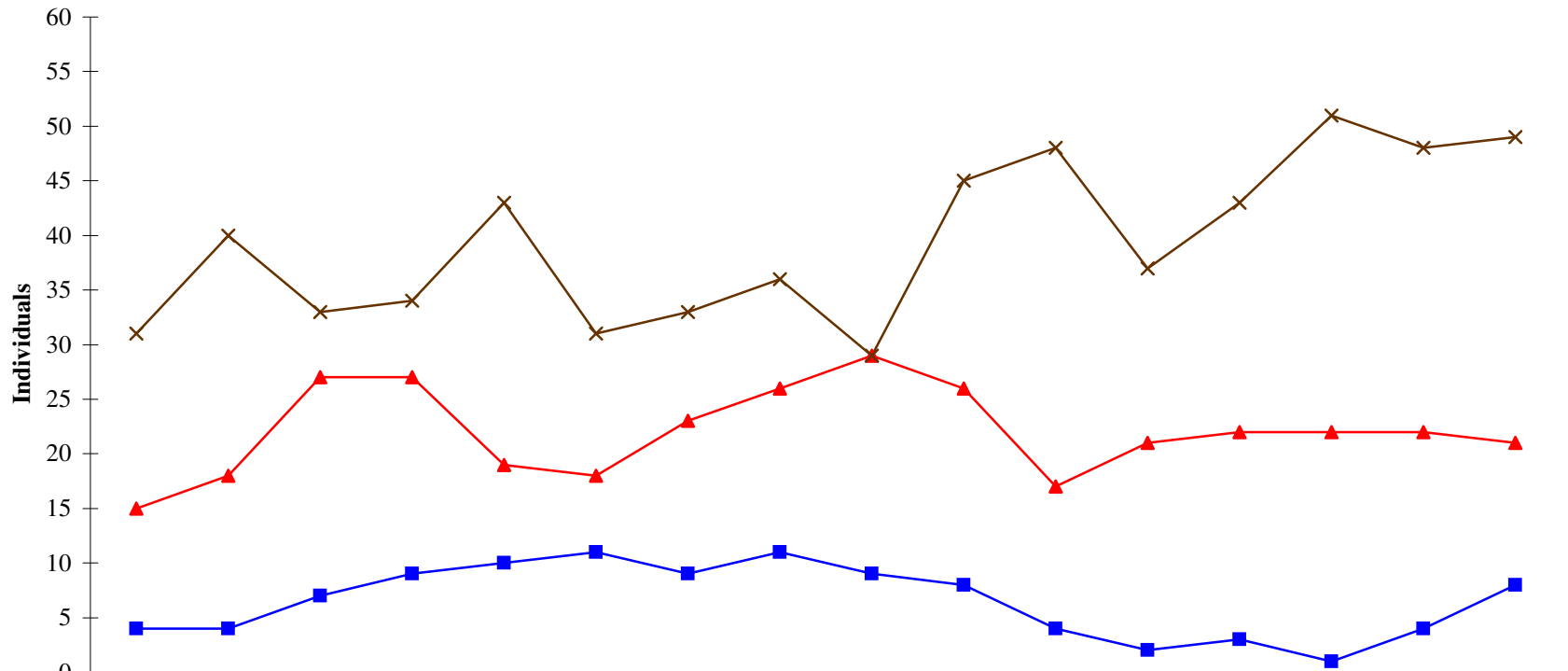


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2	Q3	Q4	Q1 FY06
Average LOS	158	201	182	188	153	207	212	213	163	182	205	183	145
30 Days or Less	3	1	4	2	5	0	2	0	0	1	0	3	4
31 - 90 Days	5	3	6	13	7	6	6	4	9	7	5	6	7
91 - 365 Days	15	27	19	27	21	19	30	31	21	26	38	31	26
1 - 5 Years	1	2	2	4	2	4	3	3	0	1	1	2	0
Over 5 Years	0	0	0	0	0	0	0	0	0	0	0	0	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

**Measure 5C - Average Length of Stay at Discharge
Waco Center for Youth**

Average Length of Stay for Admitted and Discharged During Prior 12 Months



	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05	6/04-5/05	9/04-8/05	12/04-11/05
Average LOS	123	147	105	100	116	109	113	109	98	124	151	131	131	152	129	123
■ 30 Days or Less	4	4	7	9	10	11	9	11	9	8	4	2	3	1	4	8
▲ 31-90 Days	15	18	27	27	19	18	23	26	29	26	17	21	22	22	22	21
✕ 91-365 Days	31	40	33	34	43	31	33	36	29	45	48	37	43	51	48	49

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC022260)

GOAL 6: Implement An Integrated Patient Safety Program

Performance Objective 6B:

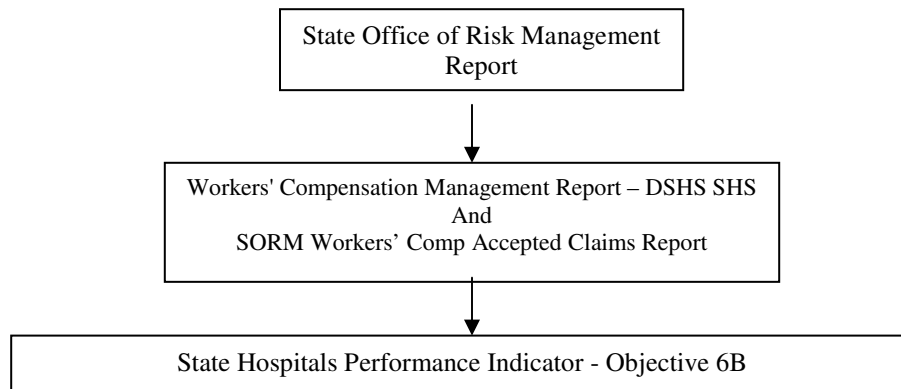
State hospitals will manage workers' compensation claim expenses so that an individual hospital total FY 2006 claims expense will be at or below the dollar target amount established for that hospital.

Performance Objective Operational Definition: Total workers compensation claim expenses filed for FY 2006 will not exceed the target amounts specified for each state hospital by System Risk Management.

Performance Objective Data Display and Chart Description:

- ◆ Chart with monthly data points of claim expenses with targets for individual state hospitals and system-wide.
- ◆ Chart with monthly data points of FYTD claim expenses with targets for individual state hospitals and system-wide.

Data Flow:



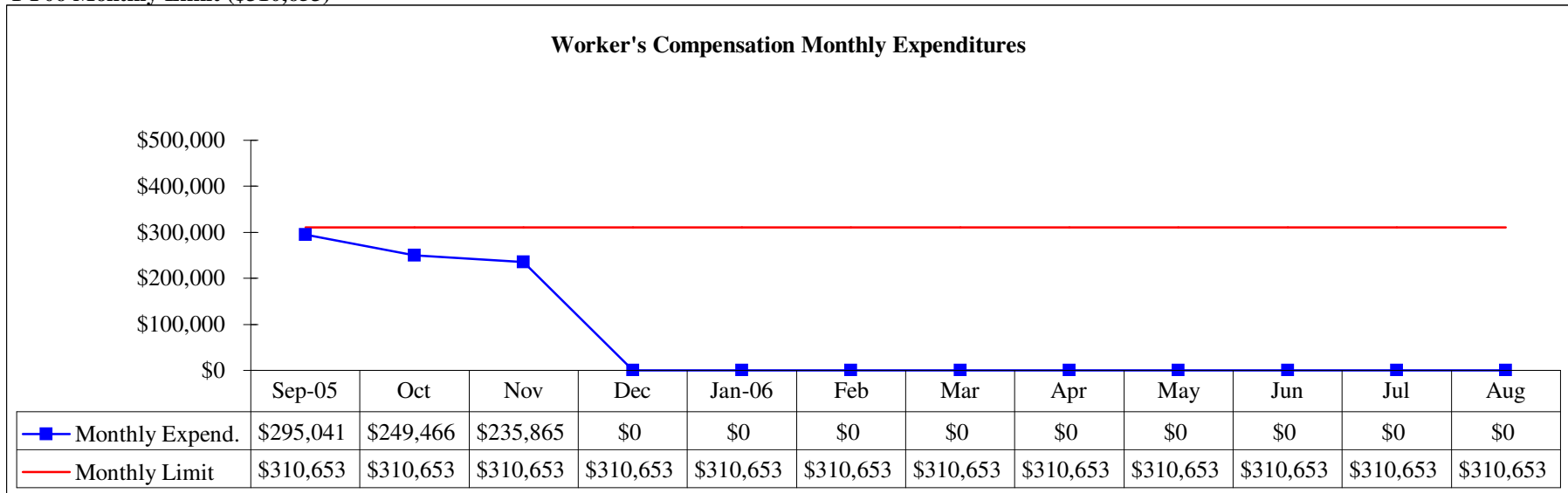
Data Integrity Review Process:

Not subject to DIR. This data is calculated and reported to DSHS Hospitals Section by the Office of the Attorney General.

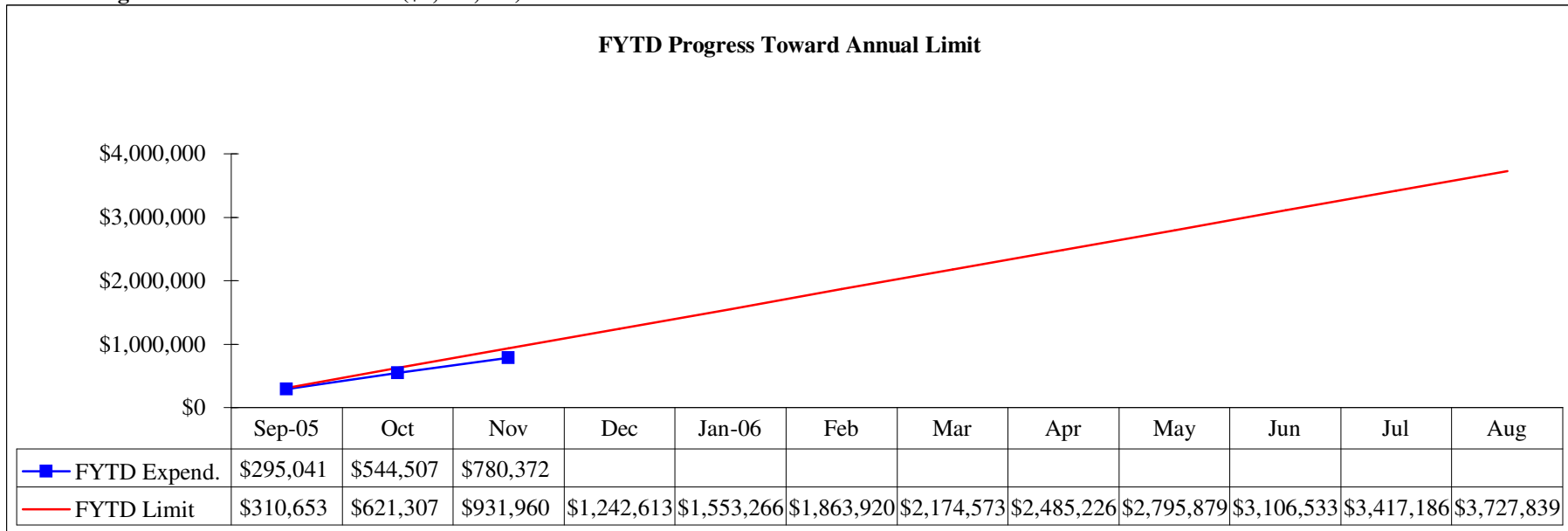
Objective 6B - Workers Compensation

All MH Facilities

FY06 Monthly Limit (\$310,653)



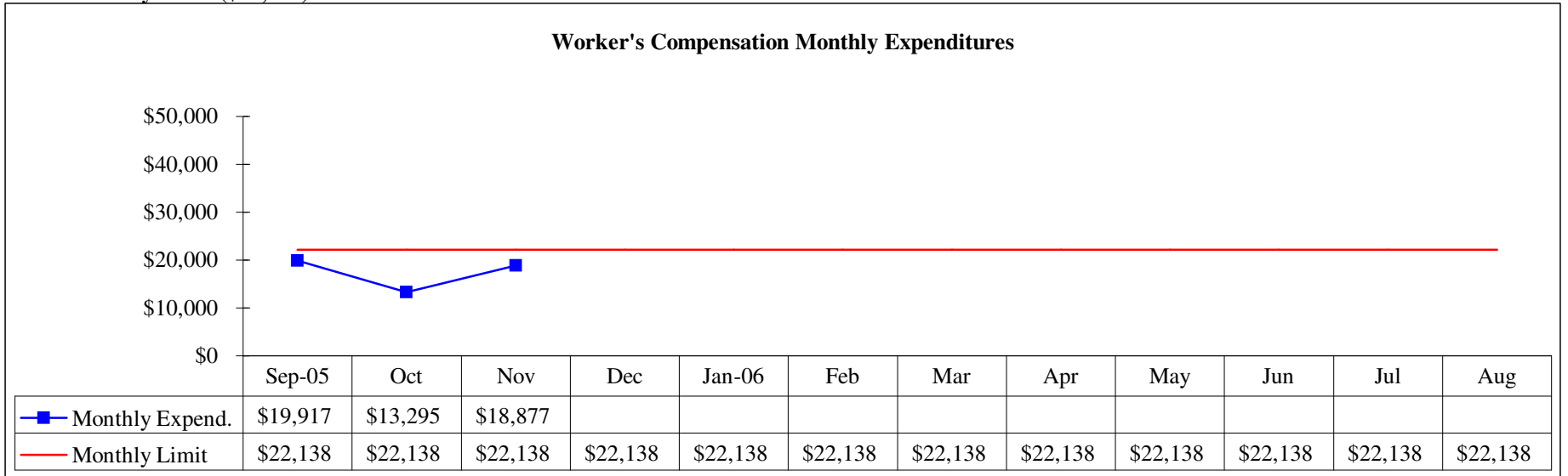
FYTD Progress Toward Annual Limit (\$3,727,839)



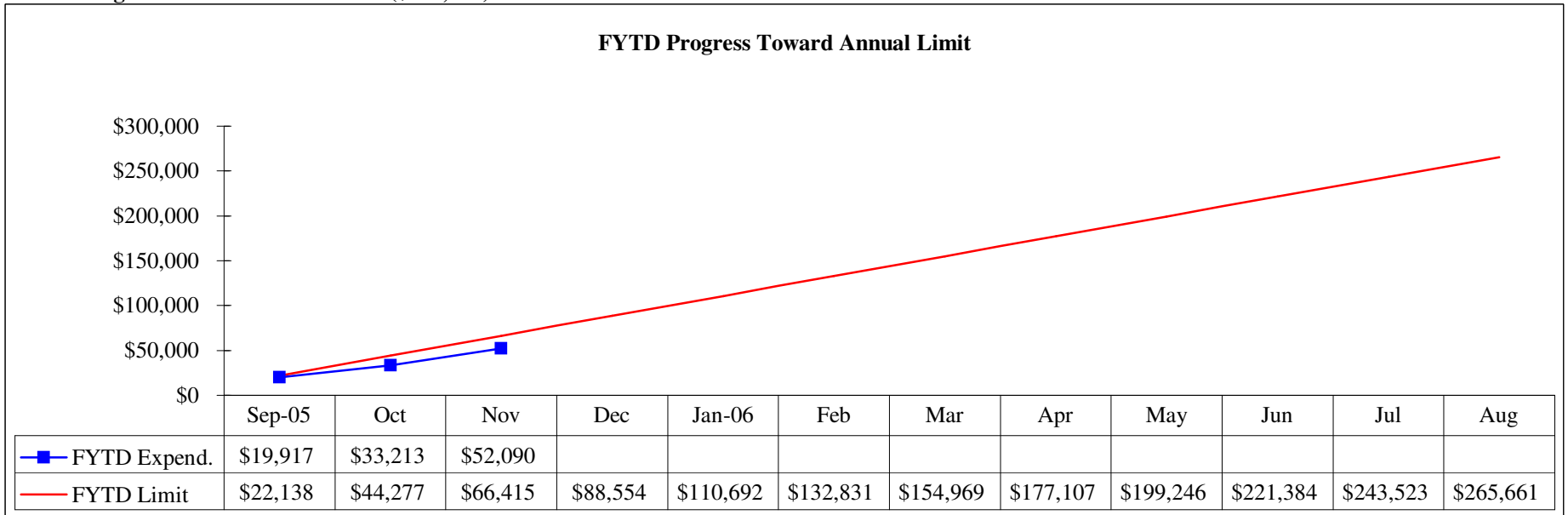
Objective 6B - Workers Compensation

Austin State Hospital

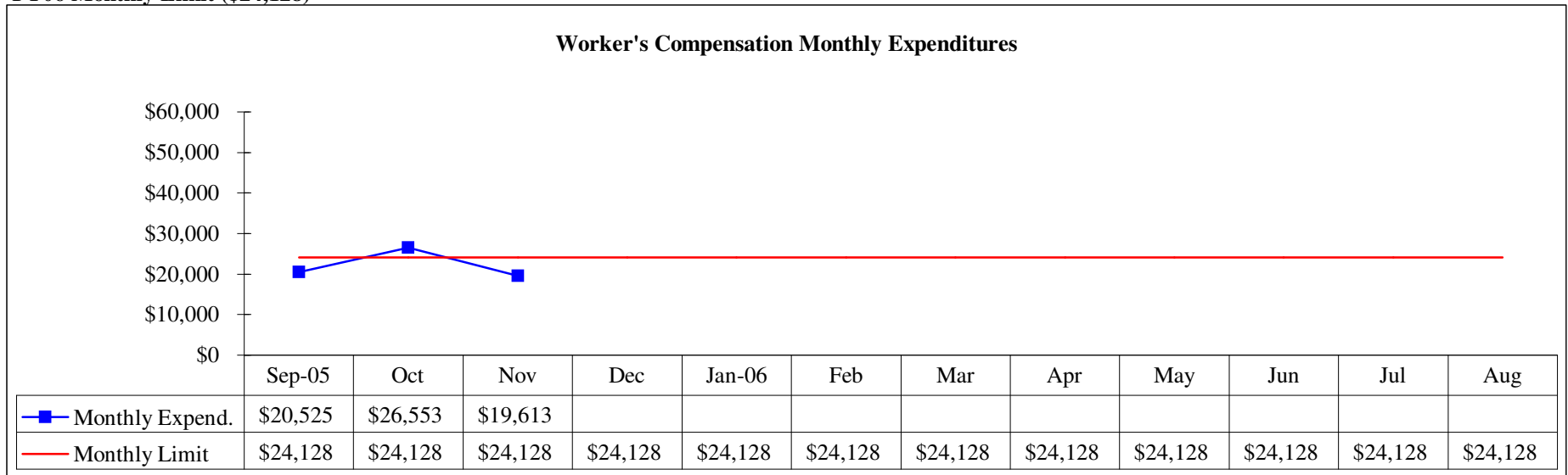
FY06 Monthly Limit (\$22,138)



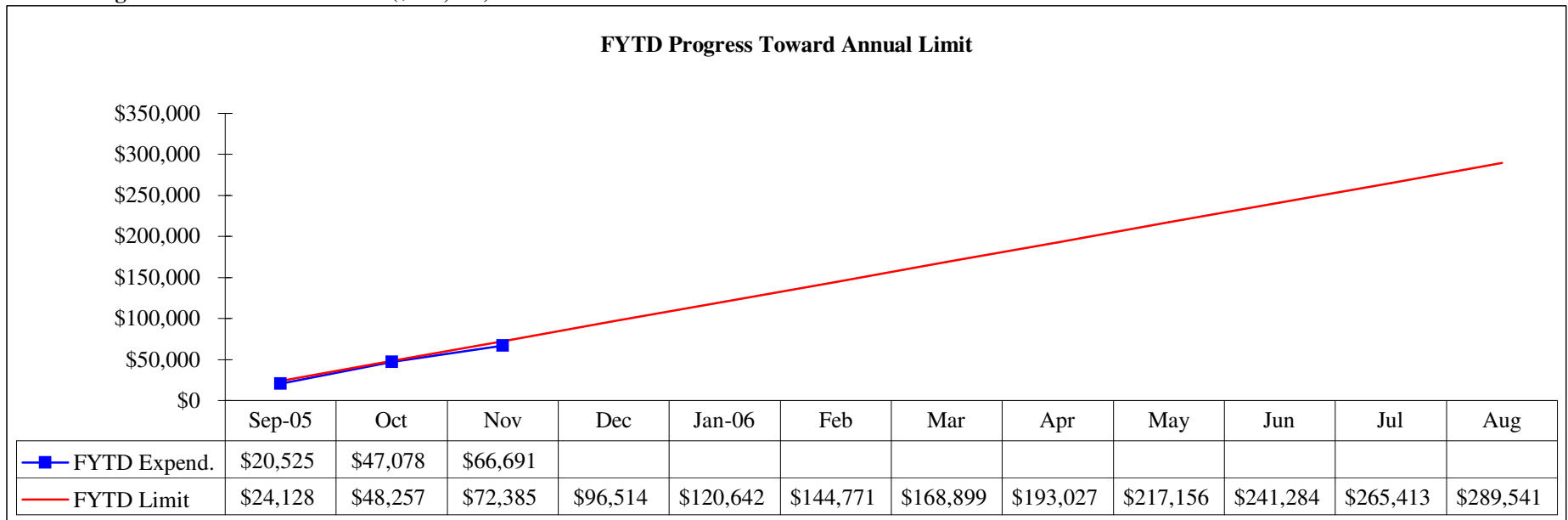
FYTD Progress Toward Annual Limit (\$265,661)



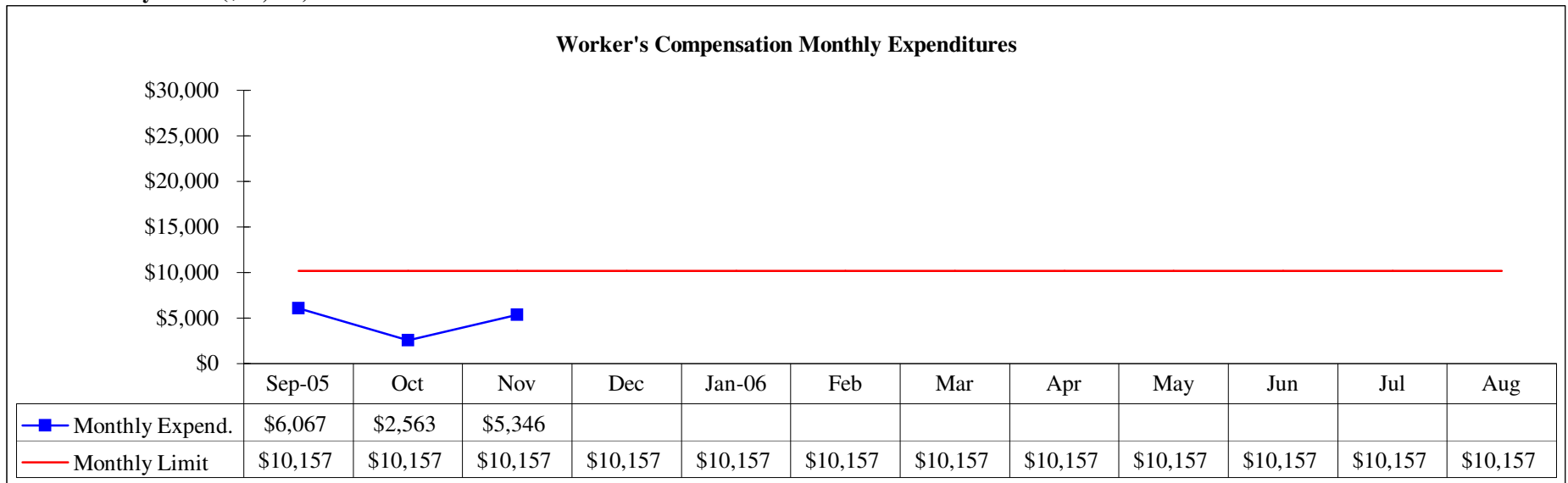
**Objective 6B - Workers Compensation
Big Spring State Hospital
FY06 Monthly Limit (\$24,128)**



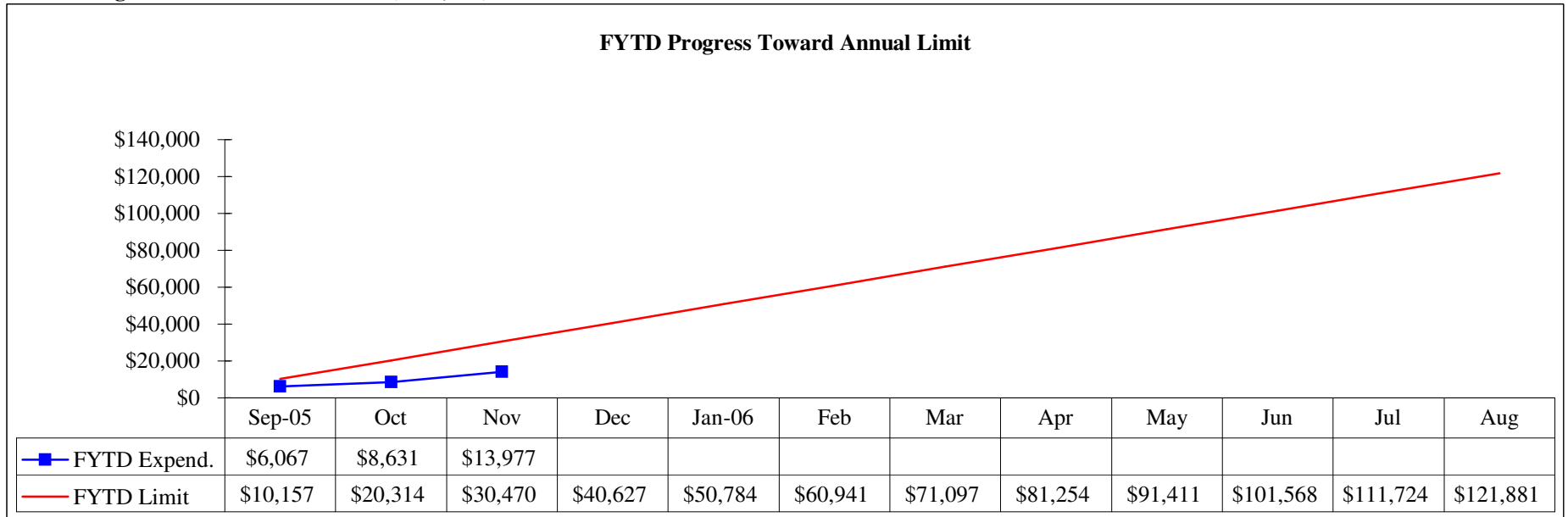
FYTD Progress Toward Annual Limit (\$289,541)



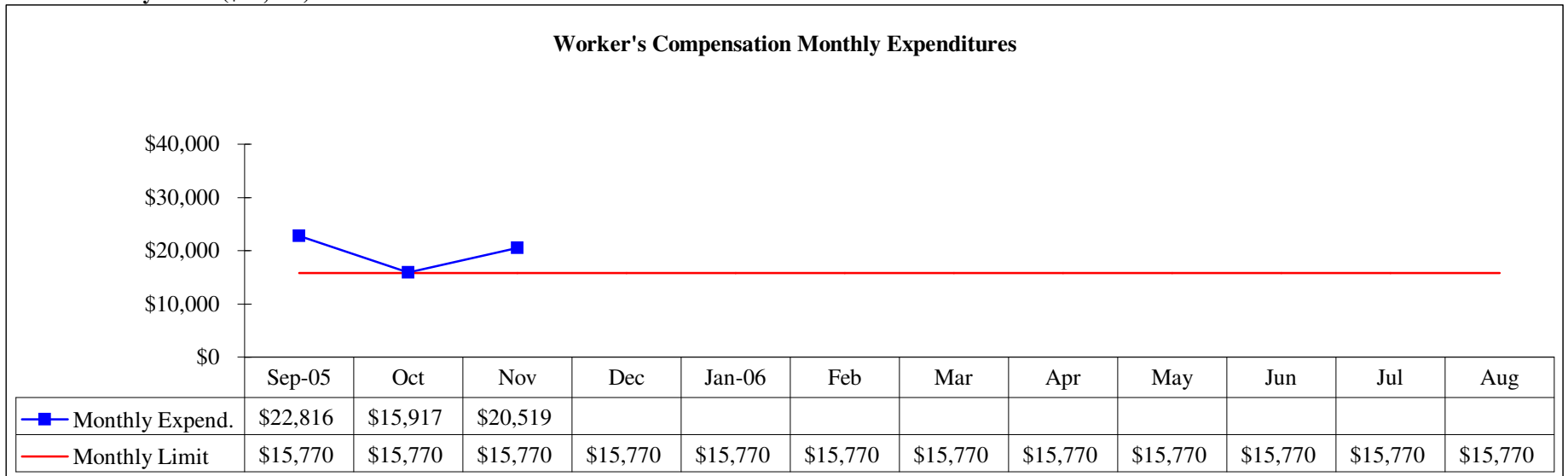
**Objective 6B - Workers Compensation
 El Paso Psychiatric Center
 FY06 Monthly Limit (\$10,157)**



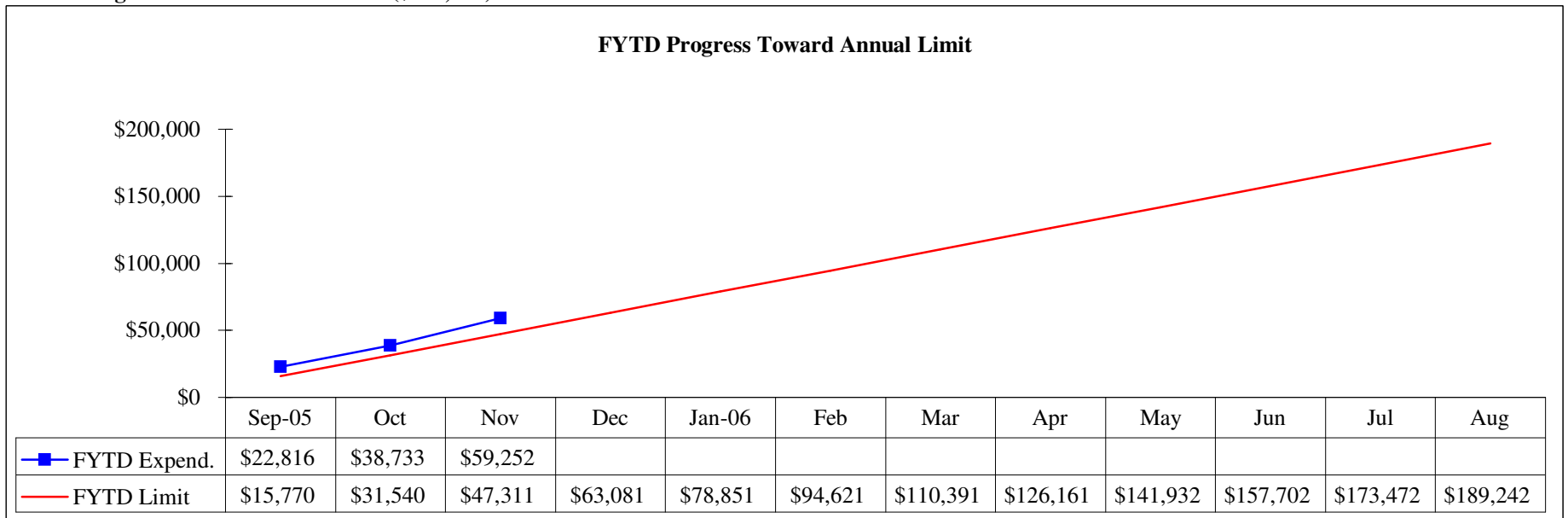
FYTD Progress Toward Annual Limit (\$121,881)



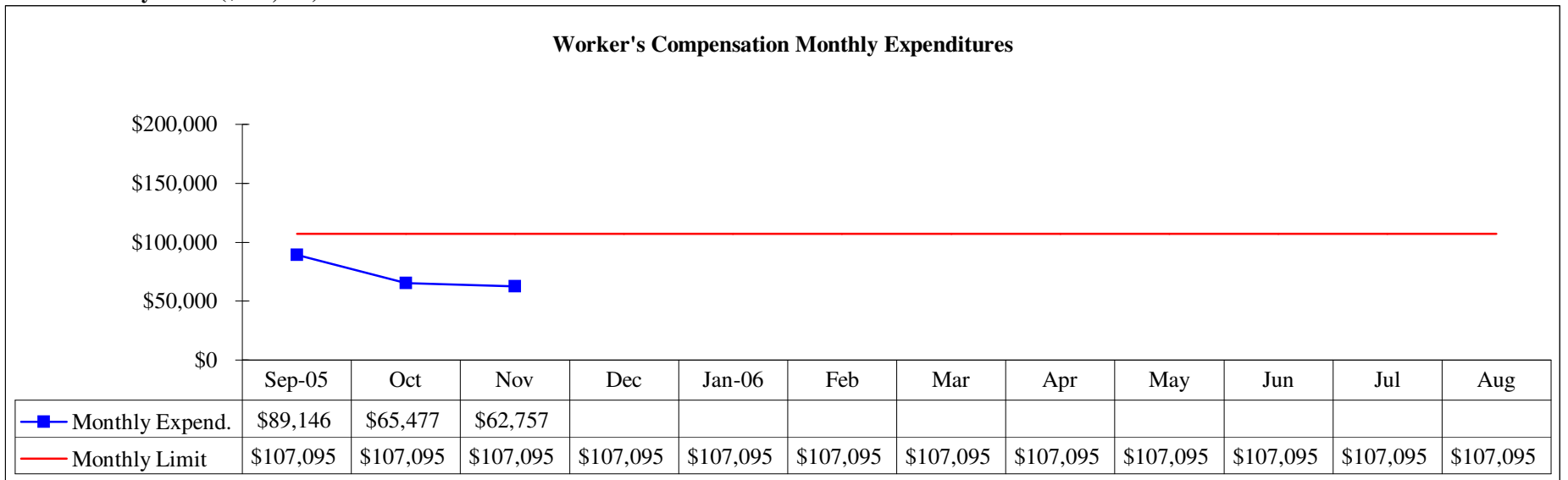
**Objective 6B - Workers Compensation
Kerrville State Hospital
FY06 Monthly Limit (\$15,770)**



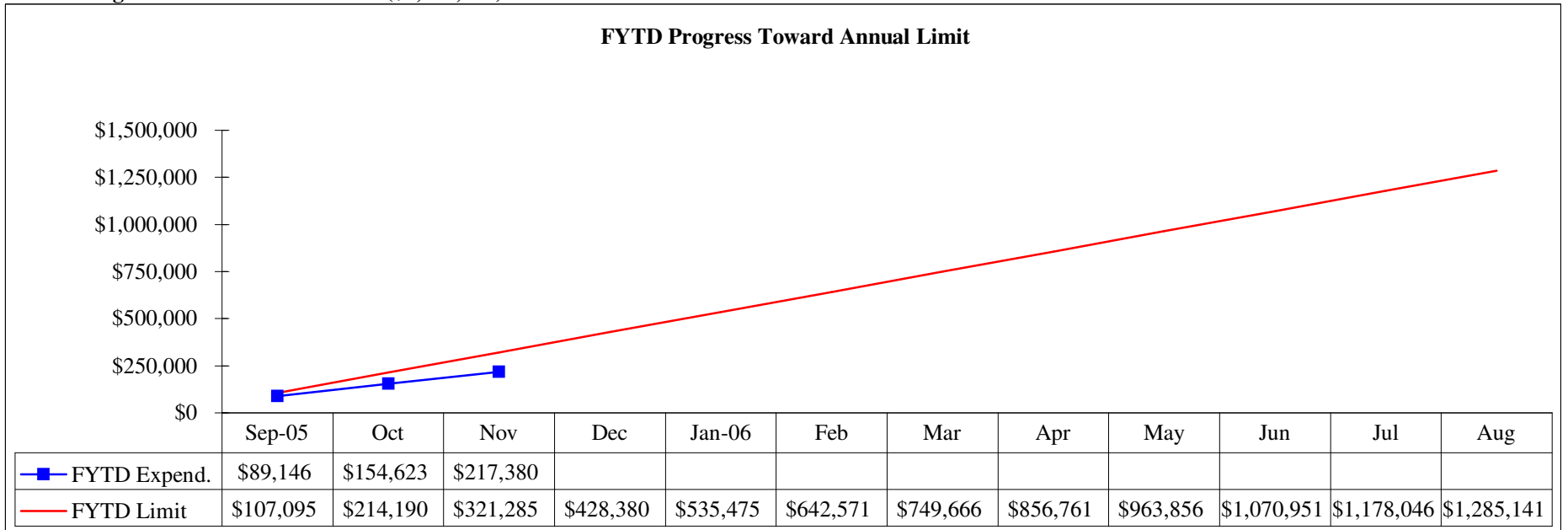
FYTD Progress Toward Annual Limit (\$189,242)



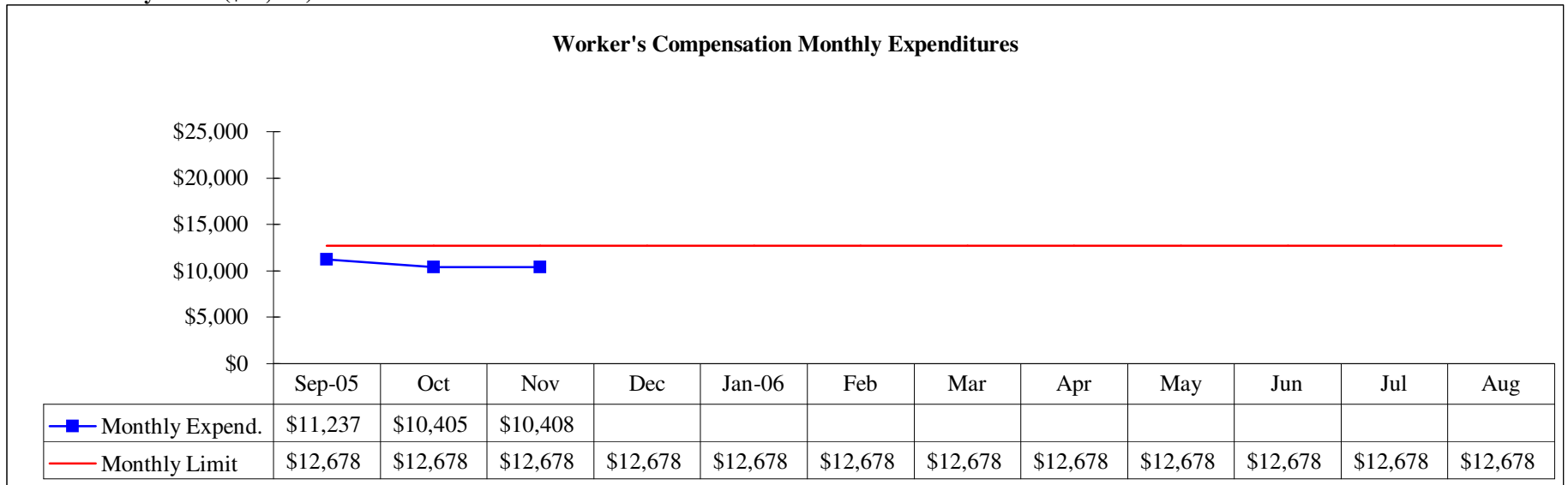
Objective 6B - Workers Compensation
North Texas State Hospital
FY06 Monthly Limit (\$107,095)



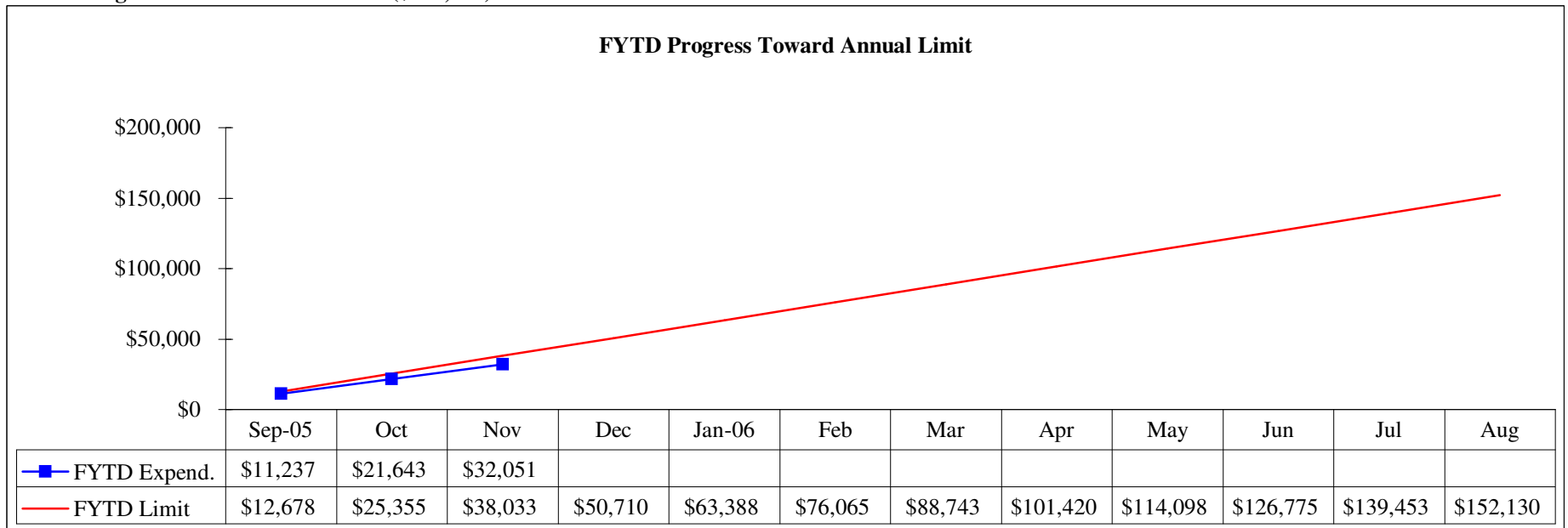
FYTD Progress Toward Annual Limit (\$1,285,141)



Objective 6B - Workers Compensation
Rio Grande State Center
FY06 Monthly Limit (\$12,678)



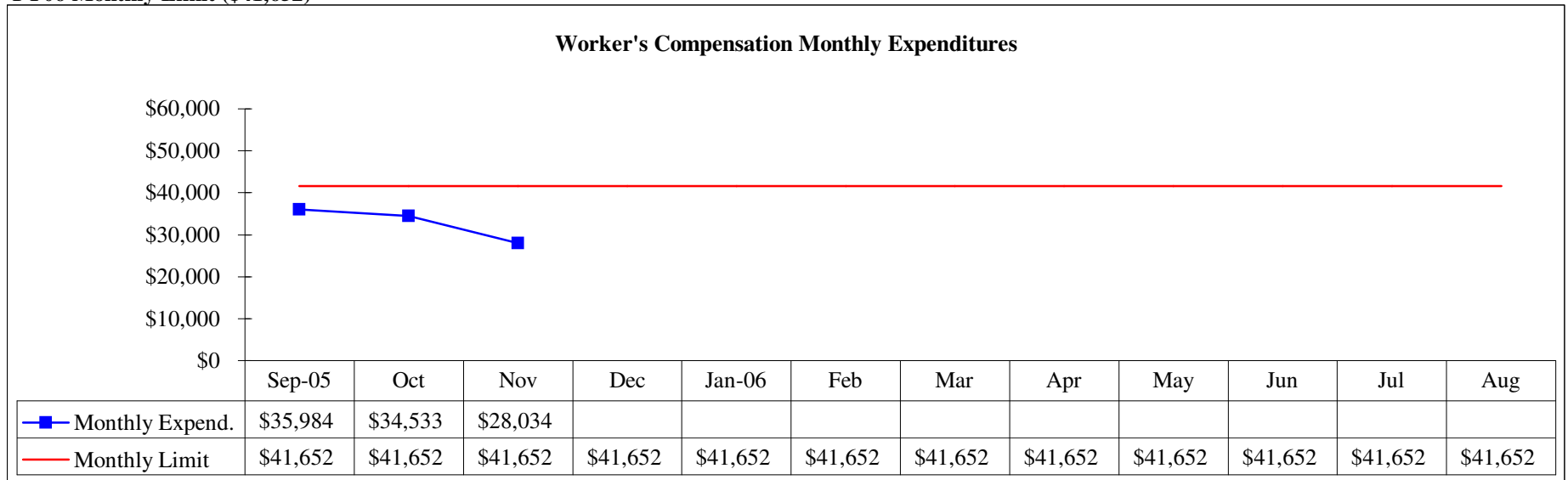
FYTD Progress Toward Annual Limit (\$152,130)



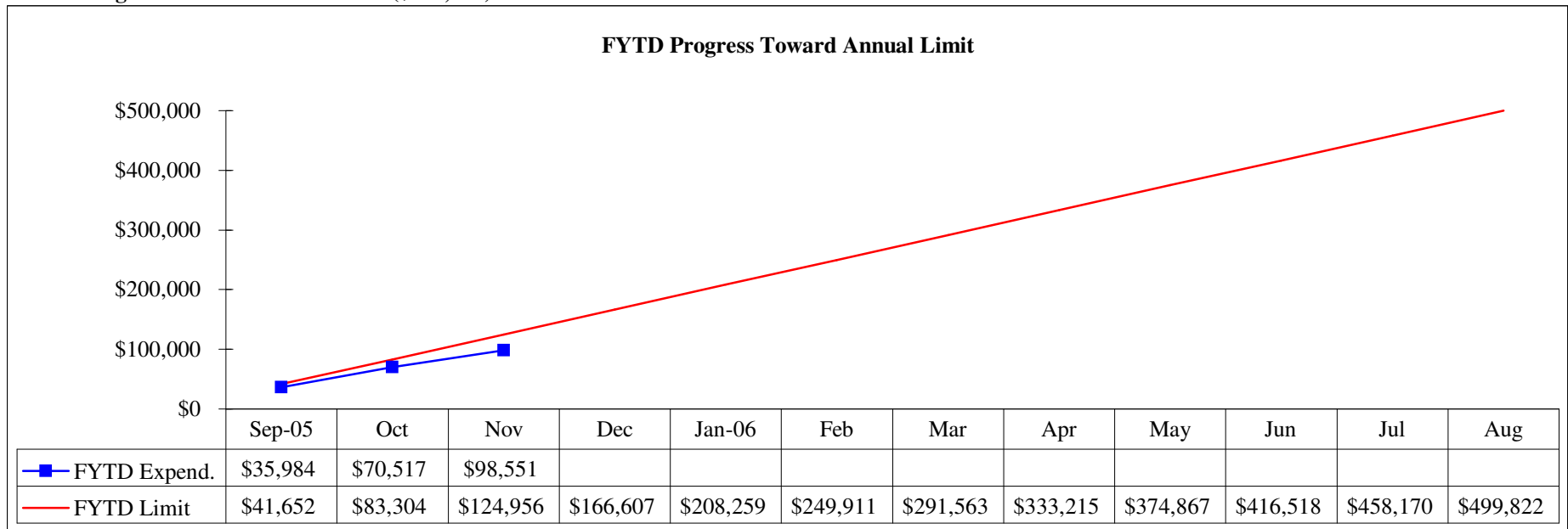
Objective 6B - Workers Compensation

Rusk State Hospital

FY06 Monthly Limit (\$41,652)



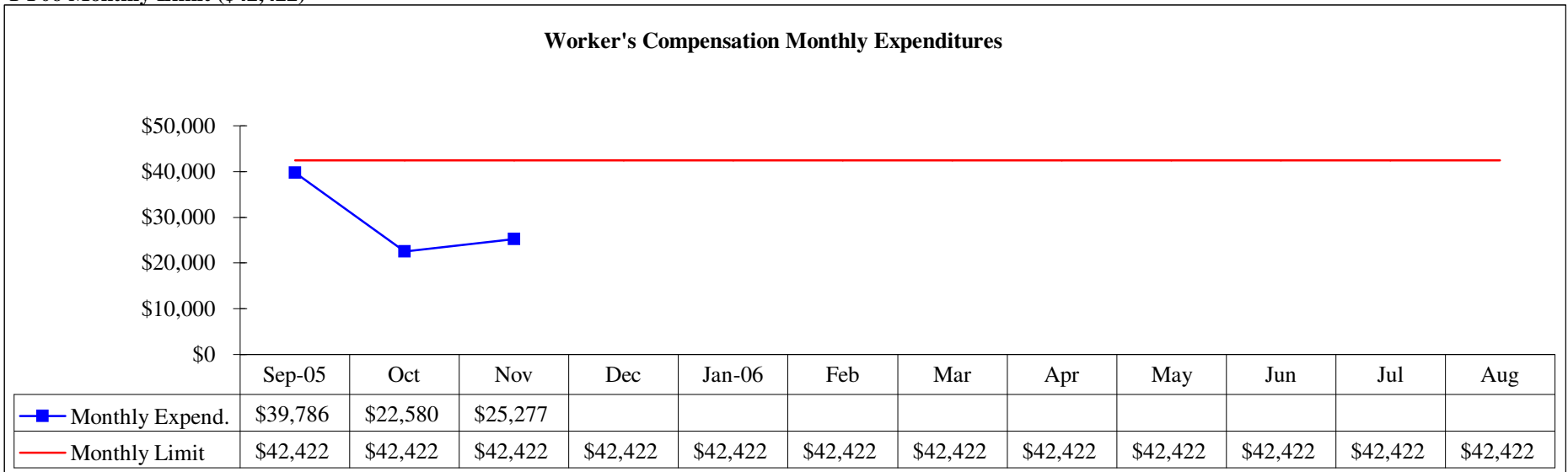
FYTD Progress Toward Annual Limit (\$499,822)



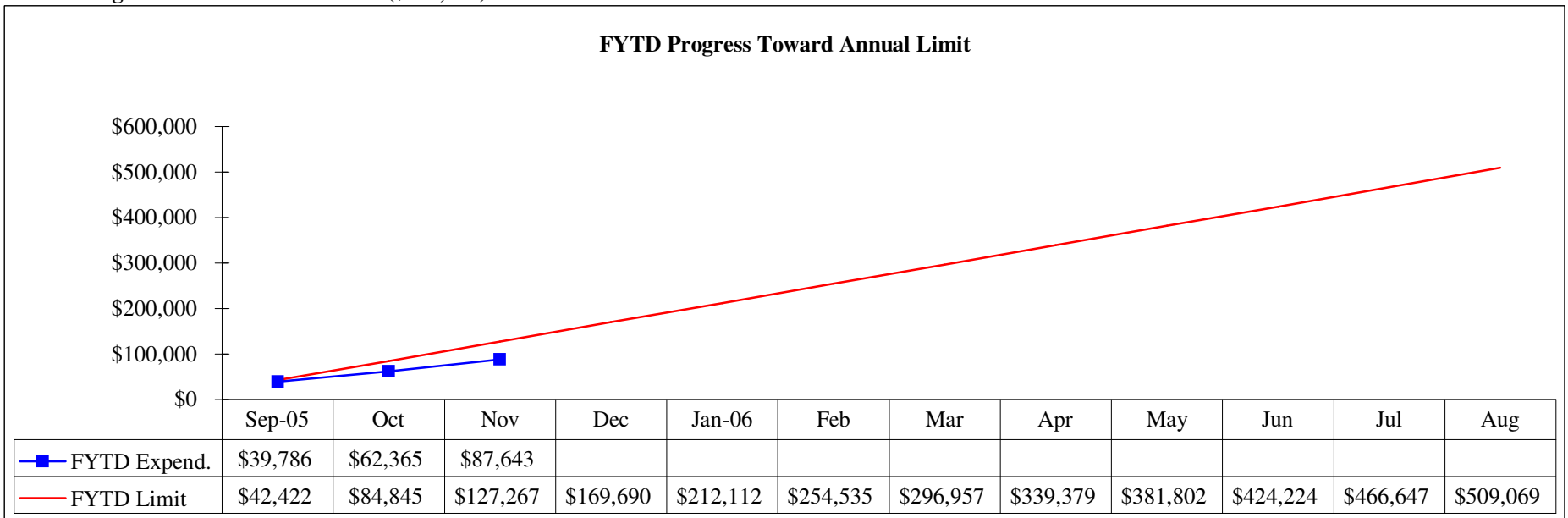
Objective 6B - Workers Compensation

San Antonio State Hospital

FY06 Monthly Limit (\$42,422)



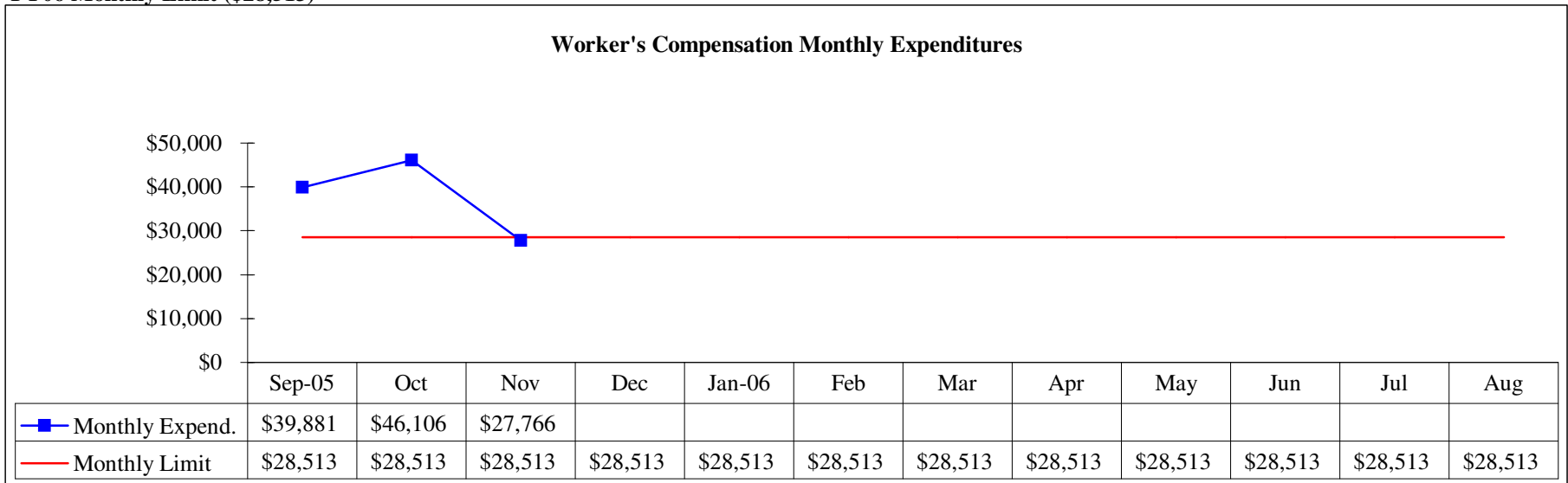
FYTD Progress Toward Annual Limit (\$509,069)



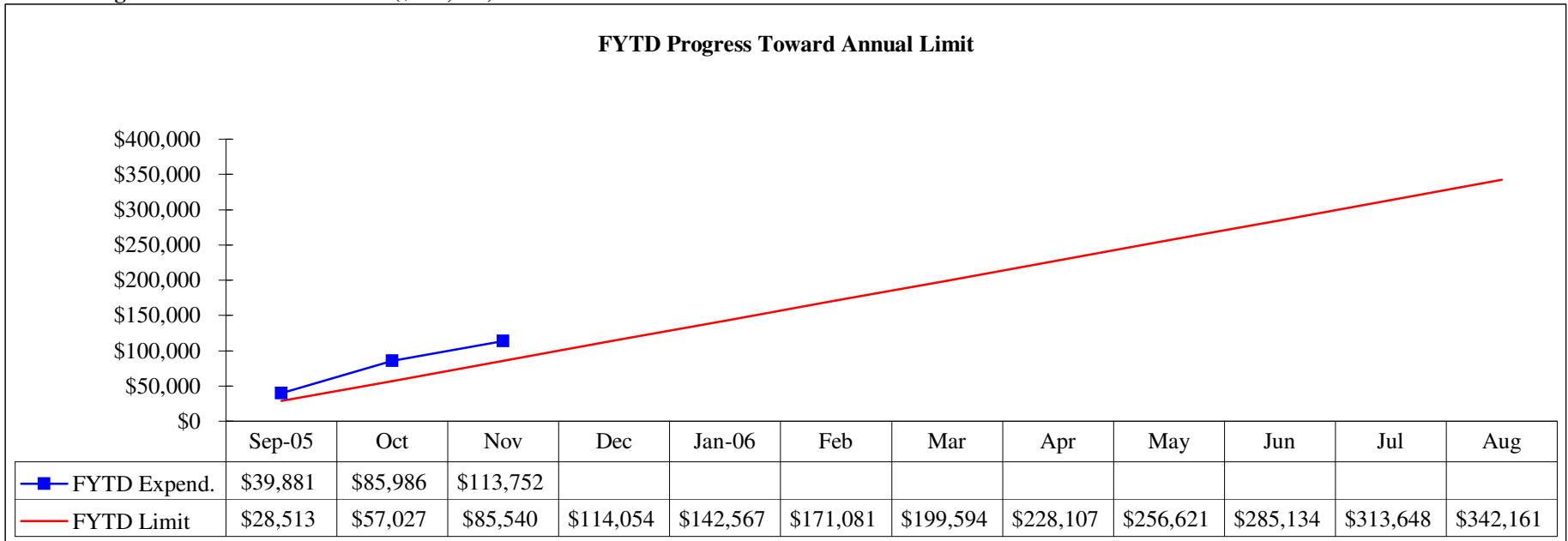
Objective 6B - Workers Compensation

Terrell State Hospital

FY06 Monthly Limit (\$28,513)



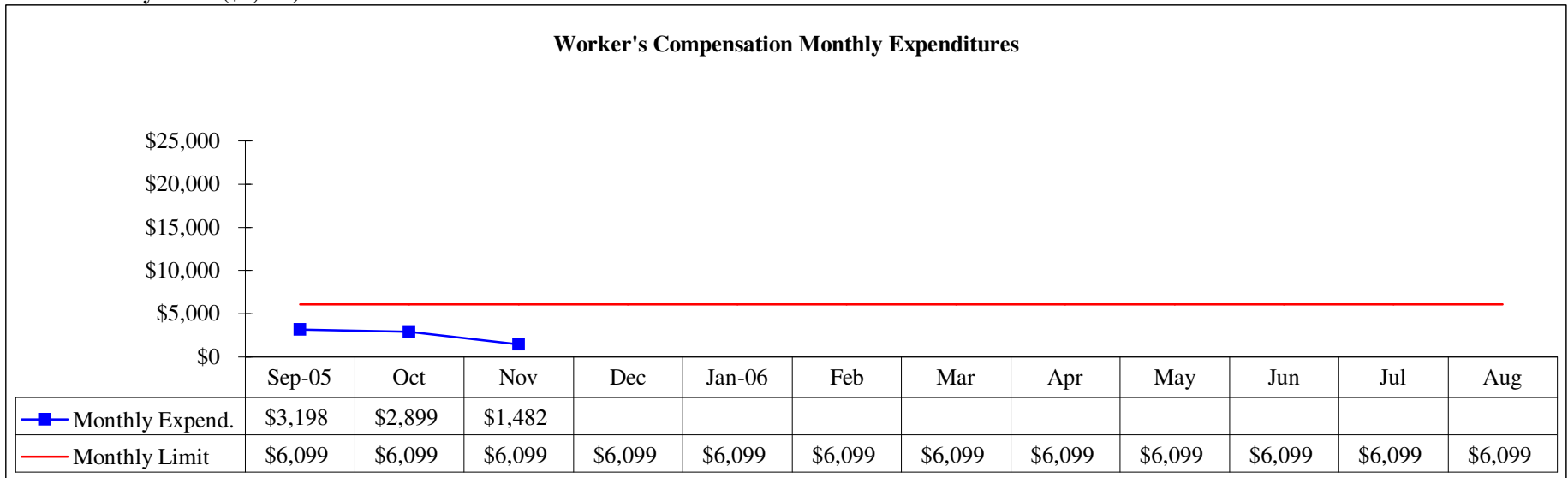
FYTD Progress Toward Annual Limit (\$342,161)



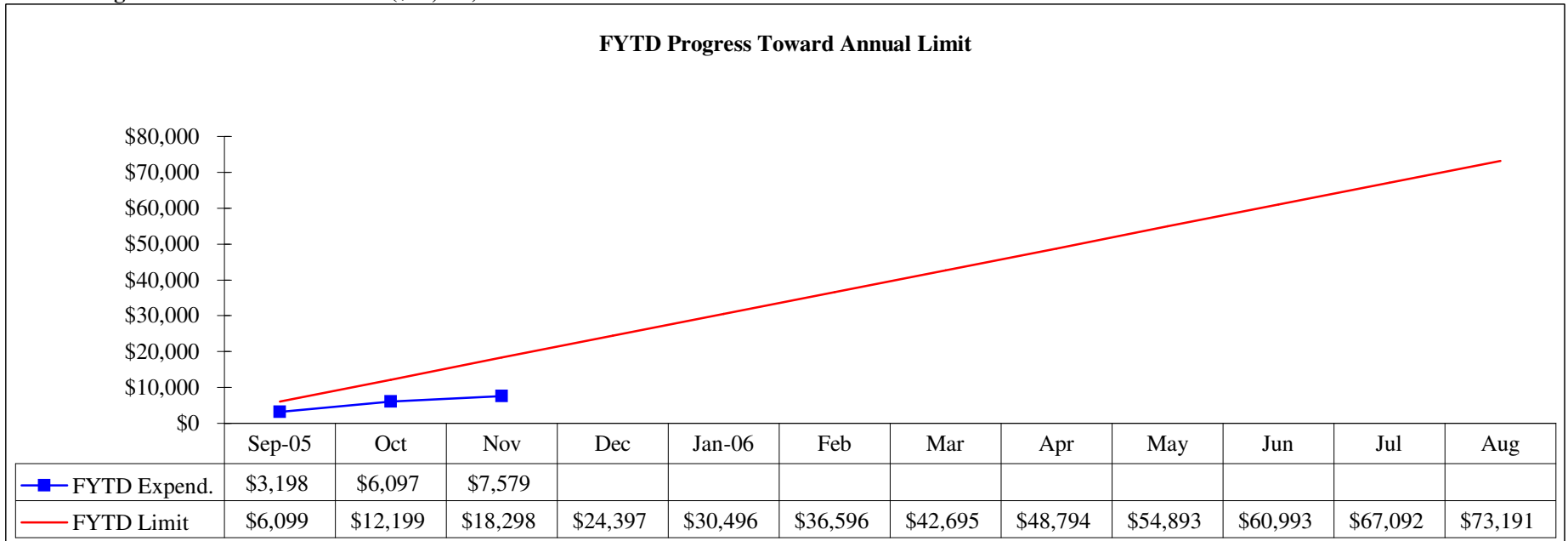
Objective 6B - Workers Compensation

Waco Center for Youth

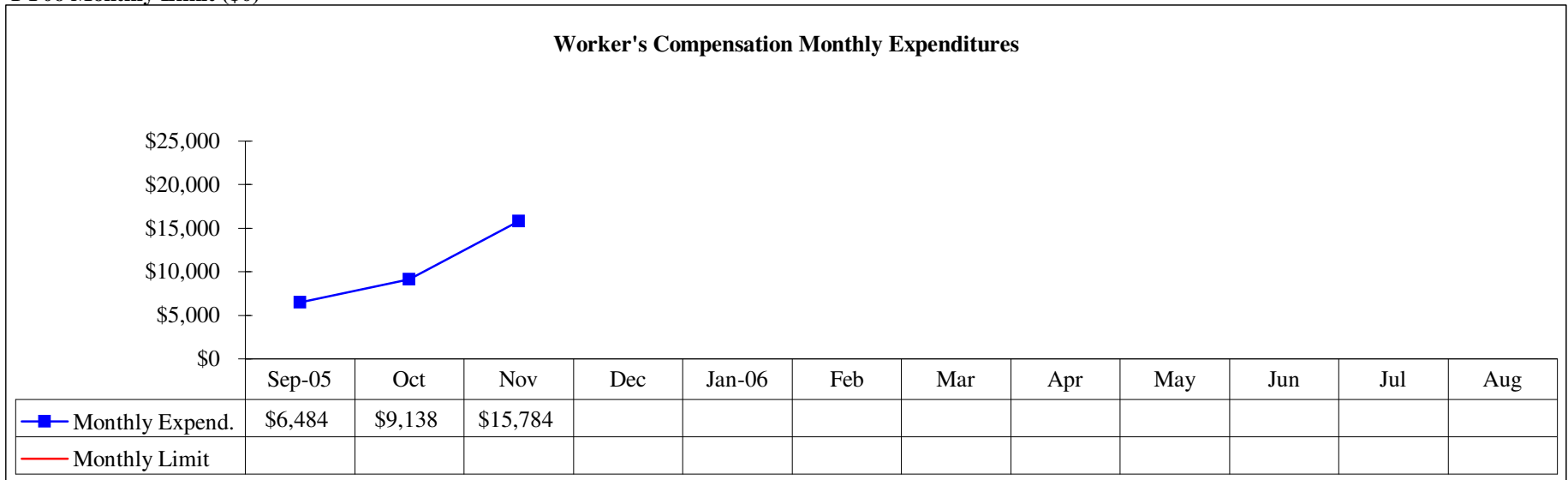
FY06 Monthly Limit (\$6,099)



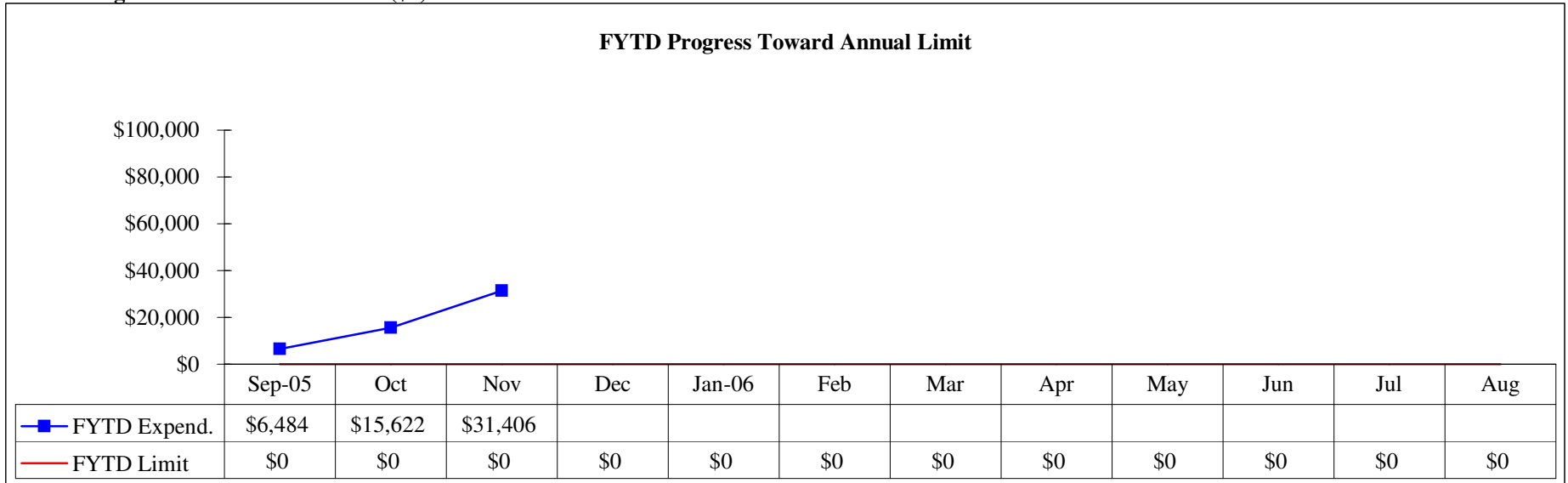
FYTD Progress Toward Annual Limit (\$73,191)



Objective 6B - Workers Compensation
Texas Center for Infectious Disease
FY06 Monthly Limit (\$0)



FYTD Progress Toward Annual Limit (\$0)



FYTD Limit to be determined at a later date

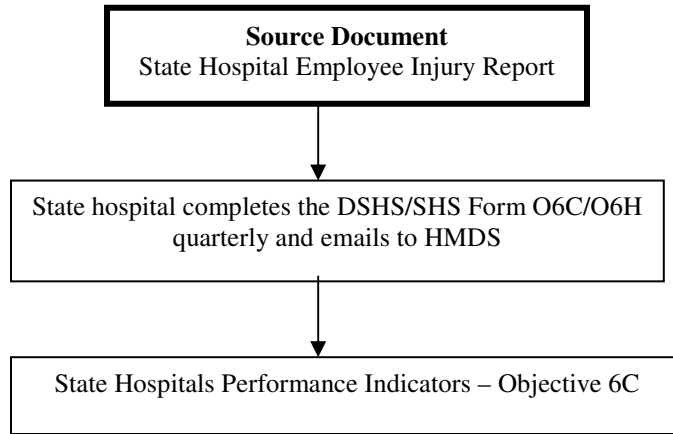
Performance Objective 6C:

Employee injuries resulting in a worker compensation claim will not exceed 1.11 per 1000 bed days.

Performance Objective Operational Definition: The state hospital rate of employee injuries resulting in a worker compensation claim filed.

Performance Objective Data Display and Chart Description:
Chart with monthly data points showing total employee injuries, injuries resulting in a workers compensation claim and rate per 1000 bed days.

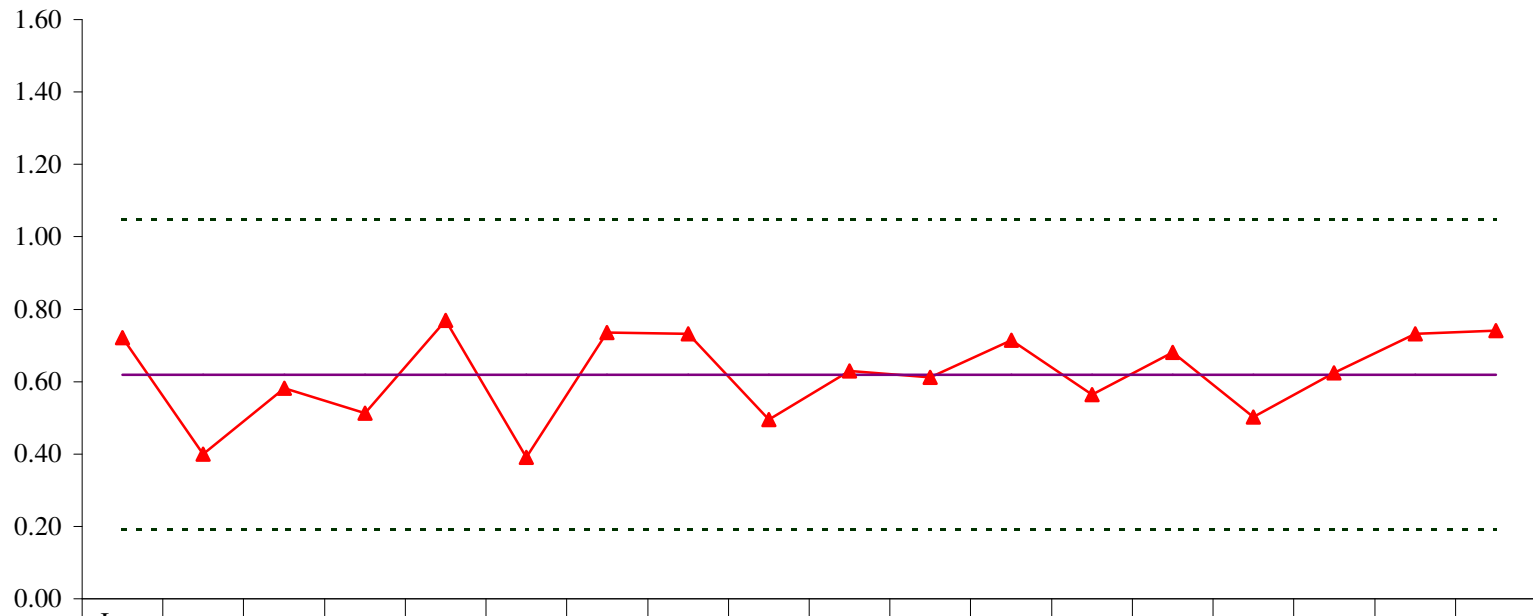
Data Flow:



Data Integrity Review Process:
Not subject to DIR. This data is calculated and reported to DSHS-Hospitals Section by the Office of the Attorney General.

Objective 6C & 6I - Employee Injuries
All MH Facilities

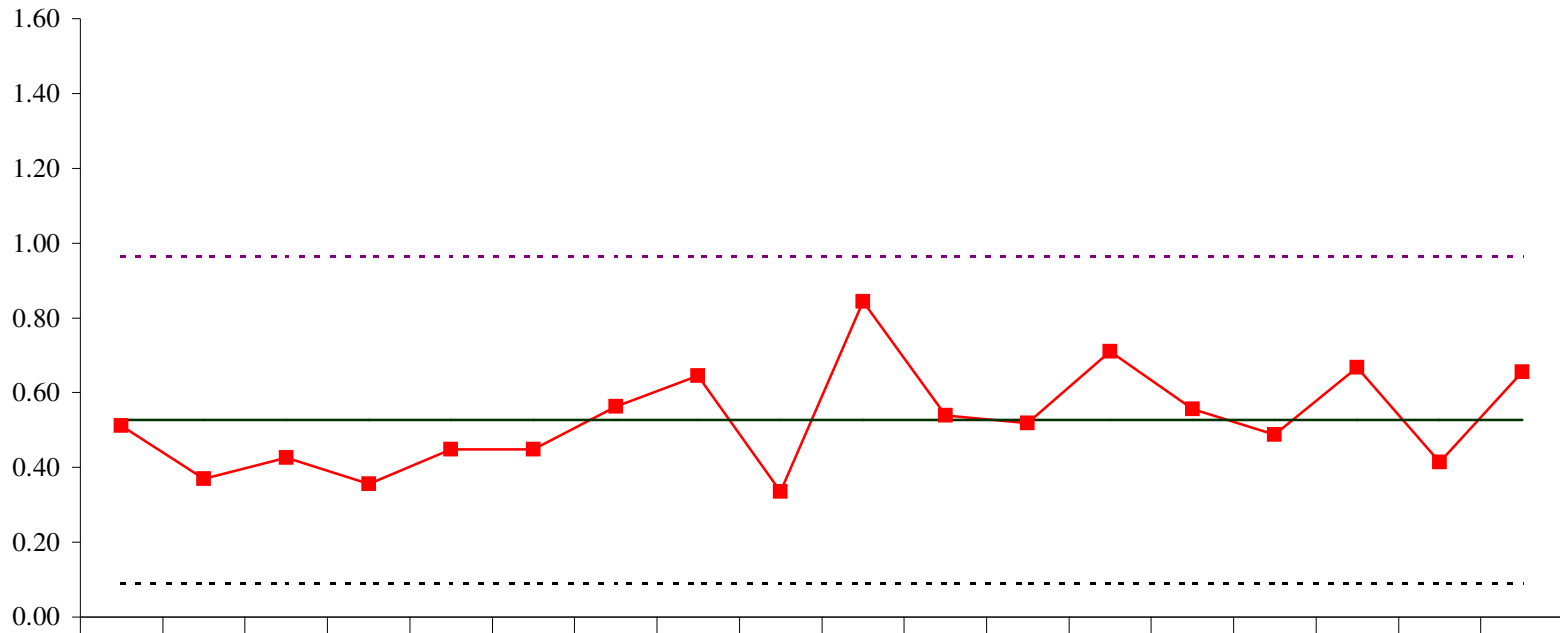
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	162	165	168	170	160	132	150	156	92	202	192	157	179	195	212	204	195	174
Injuries Resulting in a WCC	48	28	41	36	55	27	51	51	31	44	42	51	39	49	36	43	53	52
▲ Emp. Inj.(WCC)/1000 Bed Days	0.72	0.40	0.58	0.51	0.77	0.39	0.74	0.73	0.49	0.63	0.61	0.71	0.56	0.68	0.50	0.62	0.73	0.74
-----UCL	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05
— Avg	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62
-----LCL	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19

Objective 6C & 6I - Employee Injuries
All MH Facilities

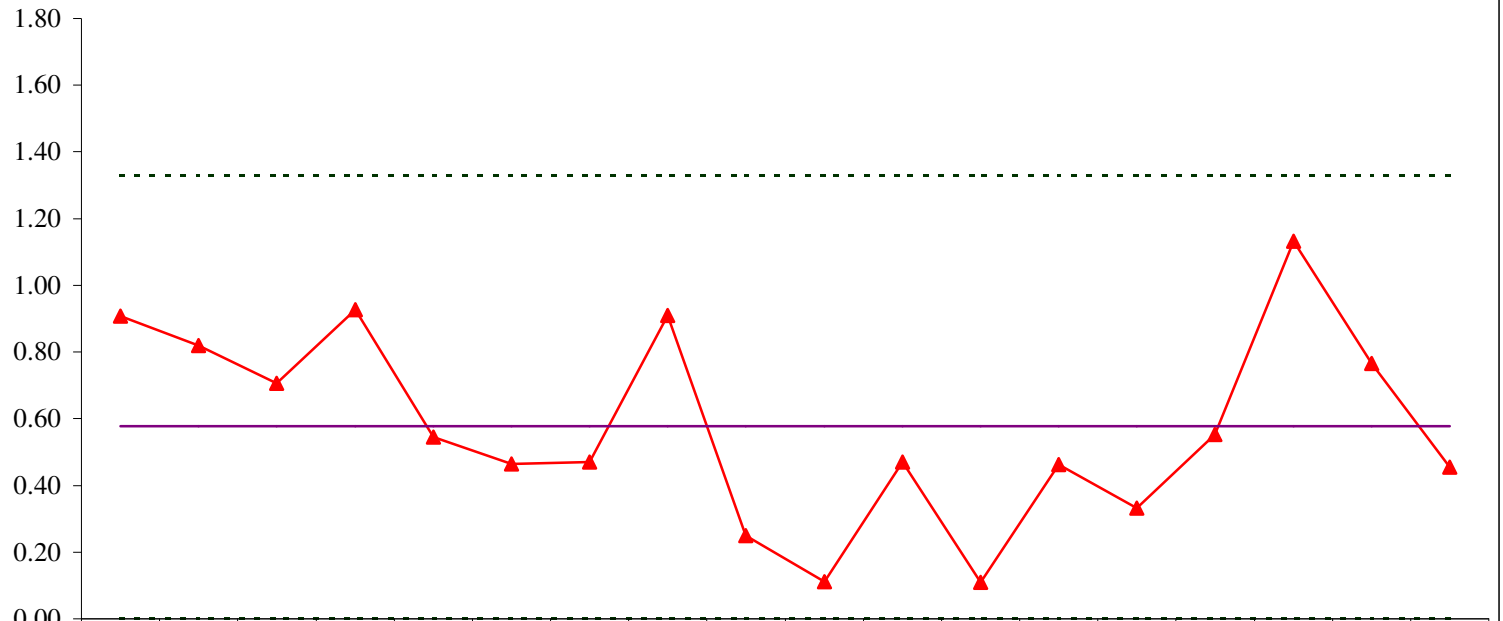
Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	162	165	168	170	160	132	150	156	92	202	192	157	179	195	212	204	195	174
Injuries Associated with R/S	34	26	30	25	32	31	39	45	21	59	37	37	49	40	35	46	30	46
Emp. Inj.(RS)/1000 Bed Days	0.51	0.37	0.43	0.36	0.45	0.45	0.56	0.65	0.33	0.84	0.54	0.52	0.71	0.56	0.49	0.67	0.41	0.66
UCL	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96
Avg	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53
LCL	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09

Objective 6C & 6I - Employee Injuries
Austin State Hospital

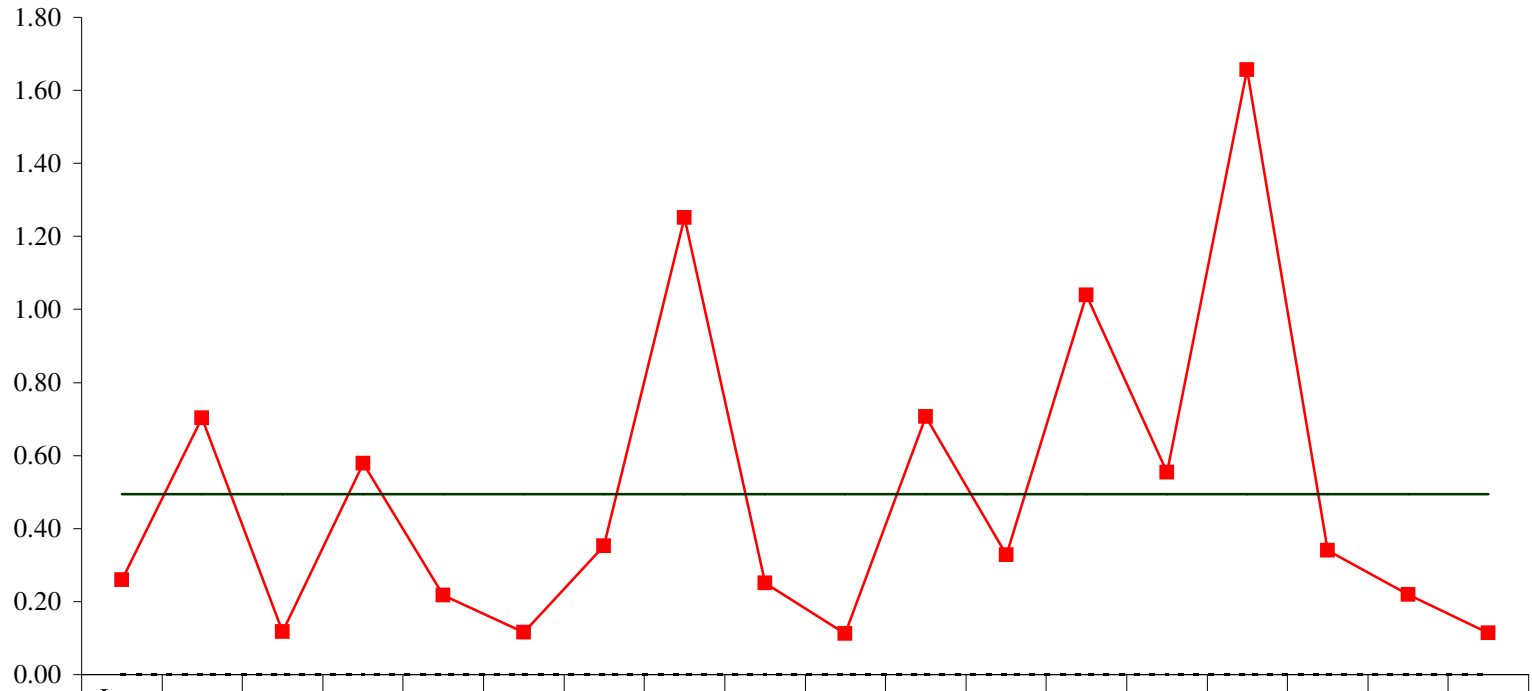
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	7	14	4	9	7	4	6	17	6	3	16	12	18	30	37	10	7	5
Injuries Resulting in a WCC	7	7	6	8	5	4	4	8	2	1	4	1	4	3	5	10	7	4
▲ Emp. Inj.(WCC)/1000 Bed Days	0.91	0.82	0.71	0.93	0.54	0.46	0.47	0.91	0.25	0.11	0.47	0.11	0.46	0.33	0.55	1.13	0.76	0.46
-----UCL	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33
— Avg	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58	0.58
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Austin State Hospital

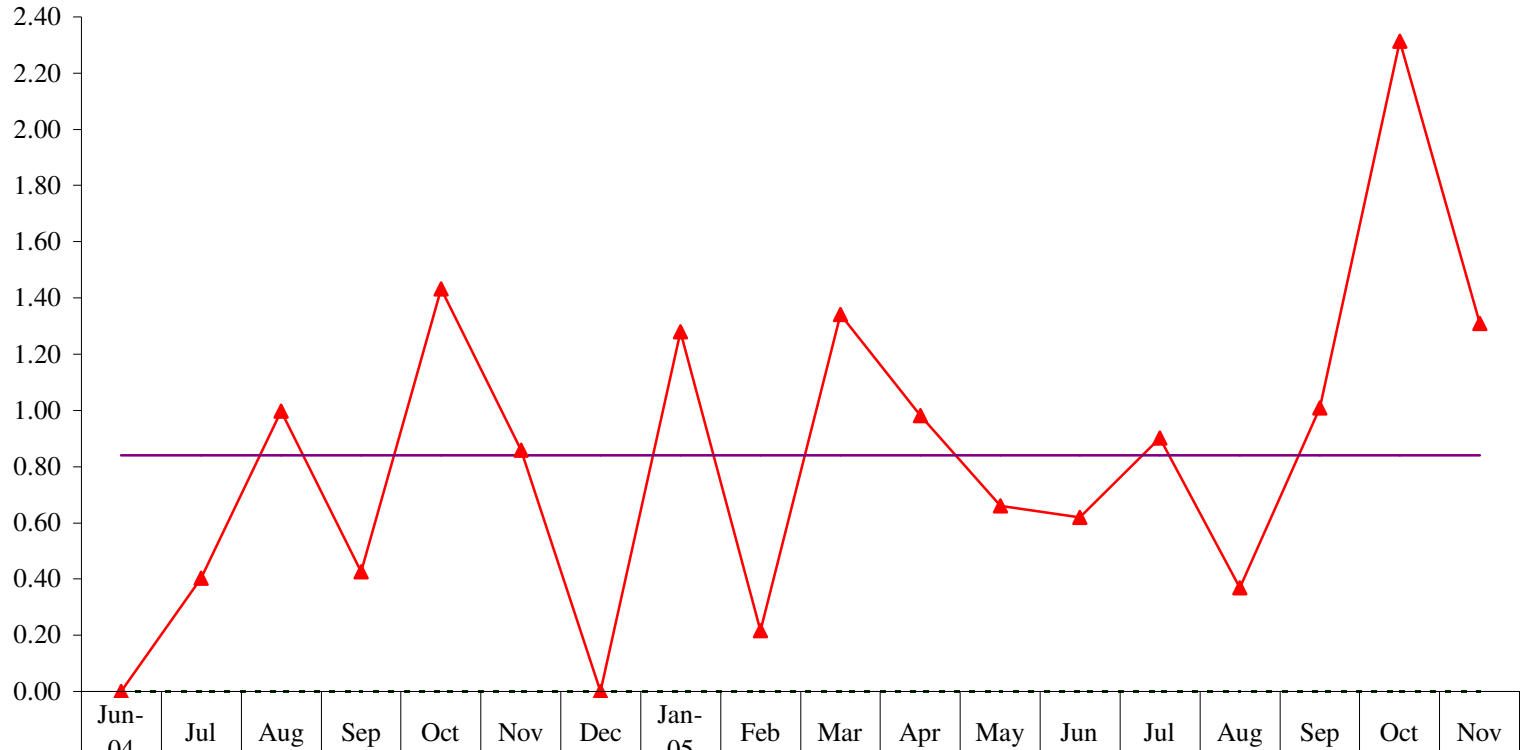
Employee Injuries During Restraint or Seclusion
 (Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	7	14	4	9	7	4	6	17	6	3	16	12	18	30	37	10	7	5
Injuries Associated with R/S	2	6	1	5	2	1	3	11	2	1	6	3	9	5	15	3	2	1
■ Emp. Inj.(RS)/1000 Bed Days	0.26	0.70	0.12	0.58	0.22	0.12	0.35	1.25	0.25	0.11	0.71	0.33	1.04	0.55	1.66	0.34	0.22	0.11
--- UCL	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91	1.91
— Avg	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
- - - - - LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Big Spring State Hospital

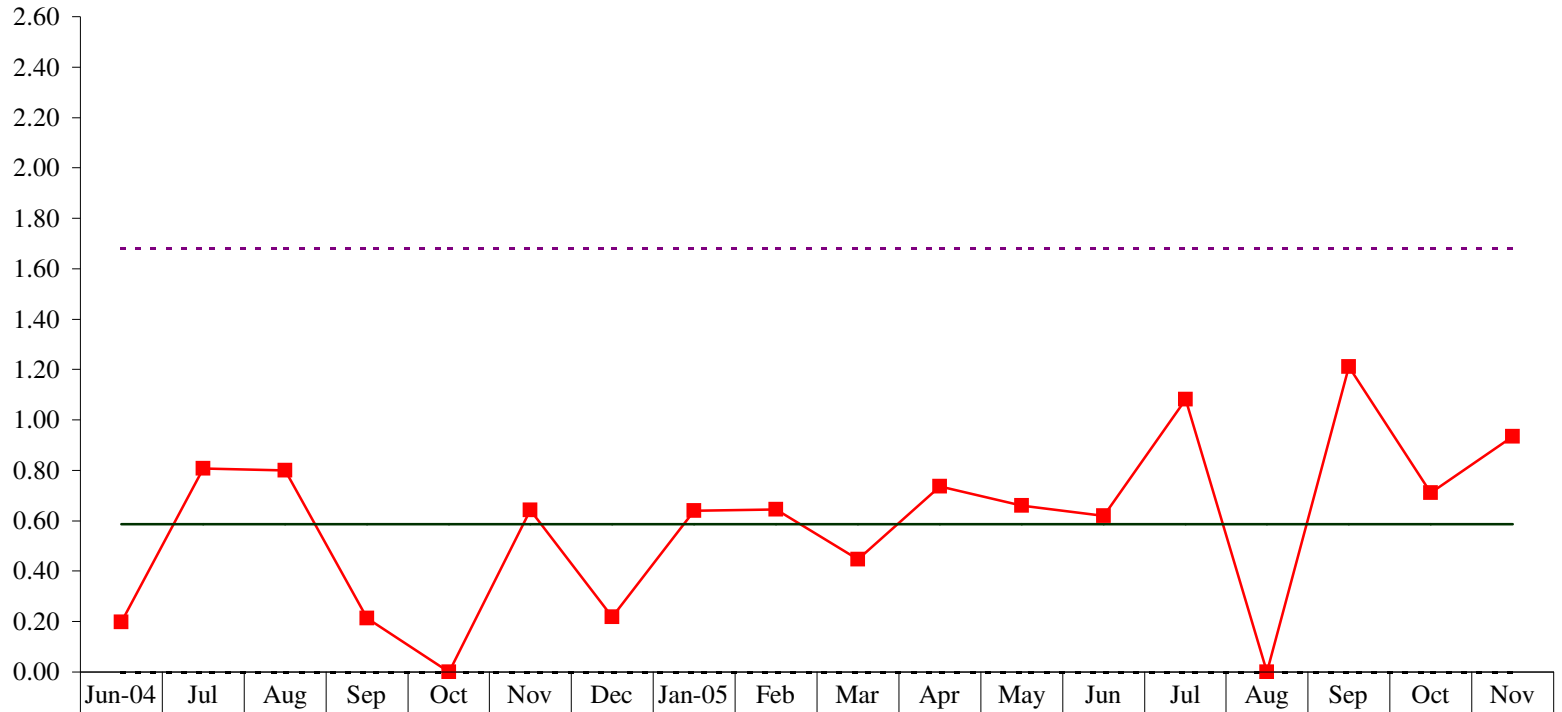
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	12	11	17	9	12	15	9	16	7	13	17	11	10	21	3	31	25	19
Injuries Resulting in a WCC	0	2	5	2	7	4	0	6	1	6	4	3	3	5	2	5	13	7
▲ Emp. Inj.(WCC)/1000 Bed Days	0.00	0.40	1.00	0.42	1.43	0.86	0.00	1.28	0.22	1.34	0.98	0.66	0.62	0.90	0.37	1.01	2.31	1.31
-----UCL	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71	2.71
— Avg	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Big Spring State Hospital

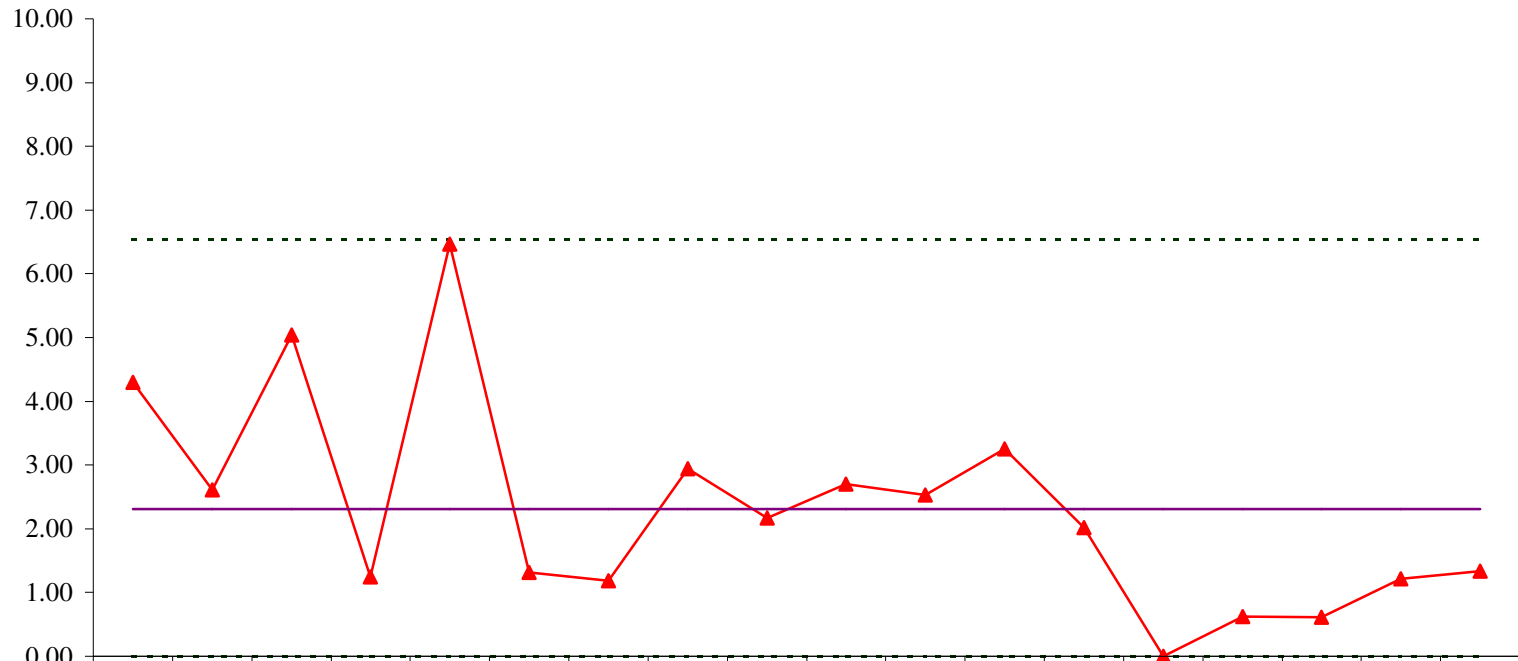
Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	12	11	17	9	12	15	9	16	7	13	17	11	10	21	3	31	25	19
Injuries Associated with R/S	1	4	4	1	0	3	1	3	3	2	3	3	3	6	0	6	4	5
■— Emp. Inj.(RS)/1000 Bed Days	0.20	0.81	0.80	0.21	0.00	0.64	0.22	0.64	0.65	0.45	0.74	0.66	0.62	1.08	0.00	1.21	0.71	0.94
- - - - - UCL	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68
— Avg	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59	0.59
- - - - - LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
El Paso Psychiatric Center

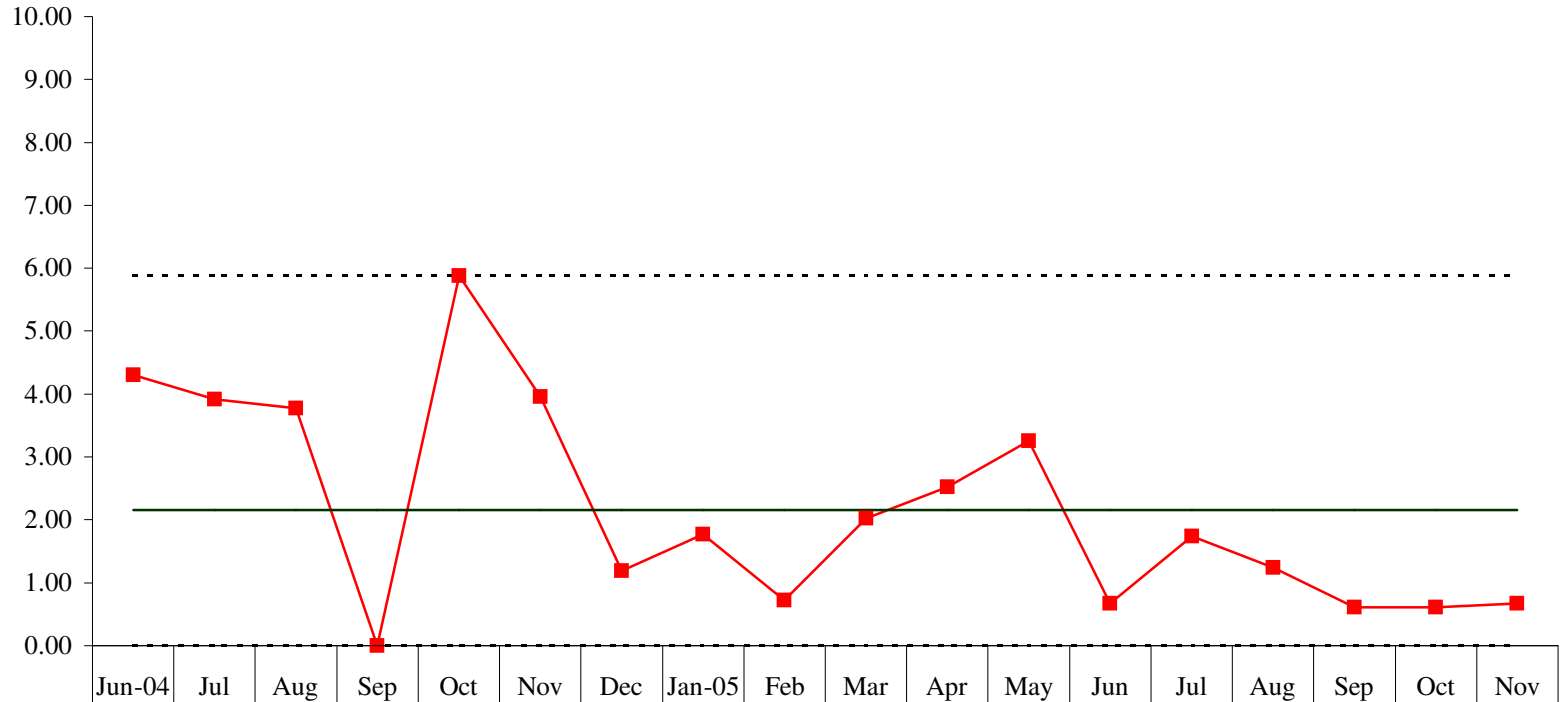
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	12	14	19	2	18	7	2	5	3	10	11	10	4	4	6	6	4	5
Injuries Resulting in a WCC	7	4	8	2	11	2	2	5	3	4	4	5	3	0	1	1	2	2
▲ Emp. Inj.(WCC)/1000 Bed Days	4.30	2.61	5.04	1.24	6.46	1.32	1.19	2.94	2.16	2.70	2.53	3.25	2.02	0.00	0.62	0.61	1.22	1.34
-----UCL	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53	6.53
— Avg	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31	2.31
.....LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
El Paso Psychiatric Center

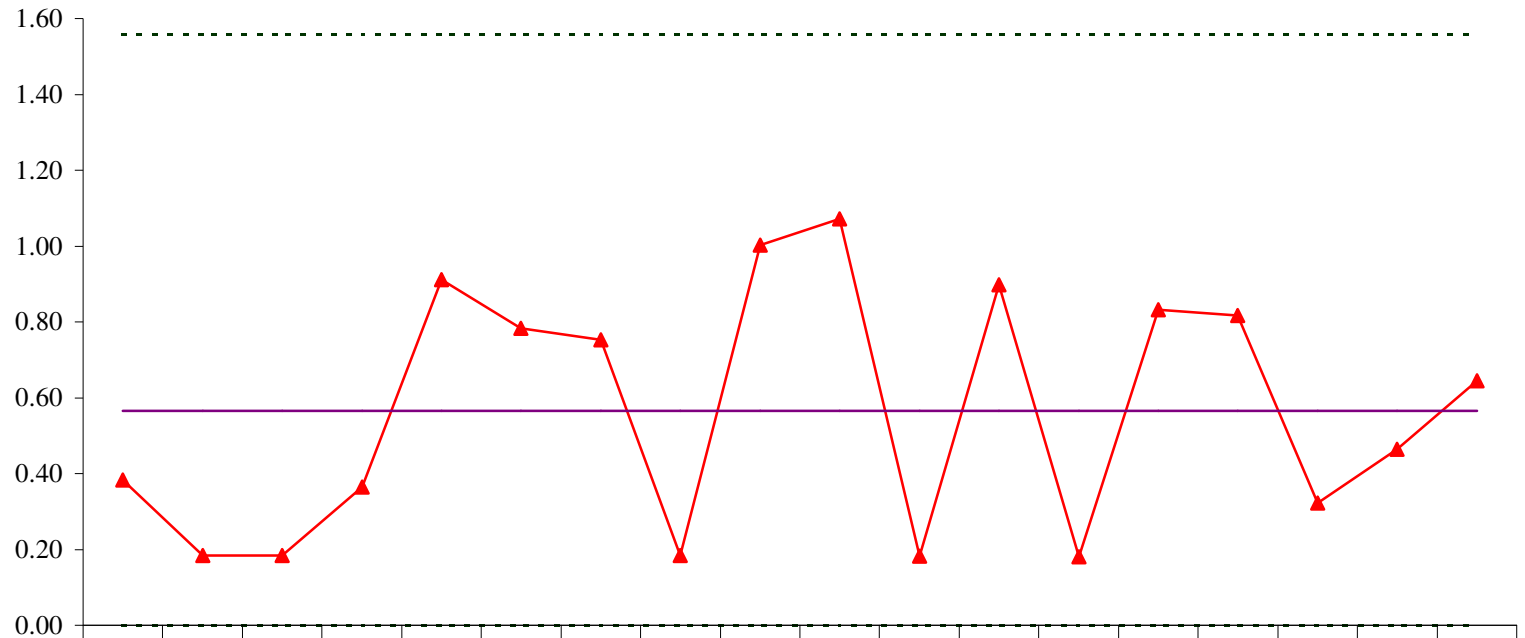
Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	12	14	19	2	18	7	2	5	3	10	11	10	4	4	6	6	4	5
Injuries Associated with R/S	7	6	6	0	10	6	2	3	1	3	4	5	1	3	2	1	1	1
■ Emp. Inj.(RS)/1000 Bed Days	4.30	3.92	3.78	0.00	5.88	3.96	1.19	1.77	0.72	2.03	2.53	3.25	0.67	1.74	1.24	0.61	0.61	0.67
-----UCL	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89	5.89
— Avg	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Kerrville State Hospital

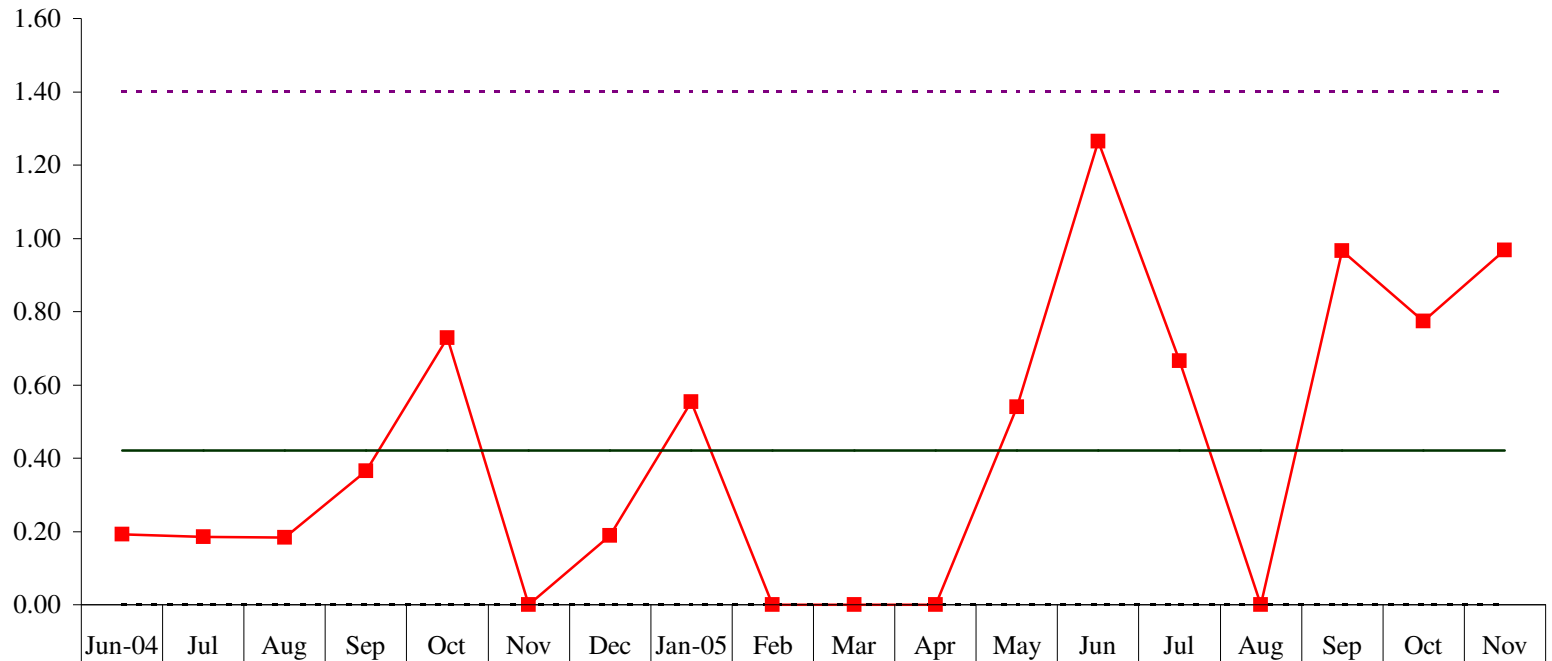
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	6	10	11	7	8	8	8	17	5	7	6	13	17	10	16	10	17	12
Injuries Resulting in a WCC	2	1	1	2	5	4	4	1	5	6	1	5	1	5	5	2	3	4
▲ Emp. Inj.(WCC)/1000 Bed Days	0.38	0.18	0.18	0.37	0.91	0.78	0.75	0.18	1.00	1.07	0.18	0.90	0.18	0.83	0.82	0.32	0.46	0.65
-----UCL	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56	1.56
— Avg	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Kerrville State Hospital

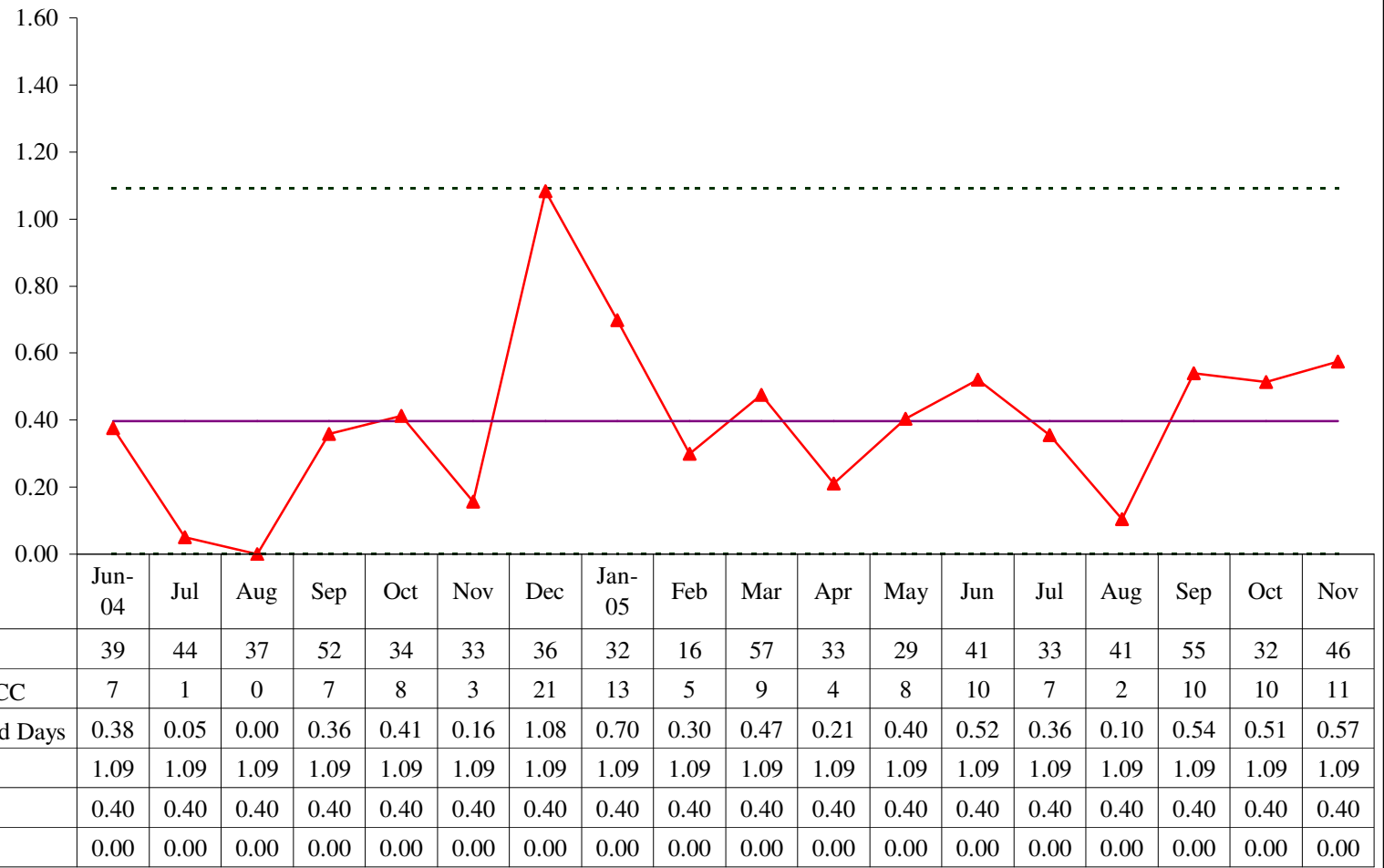
Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	6	10	11	7	8	8	8	17	5	7	6	13	17	10	16	10	17	12
Injuries Associated with R/S	1	1	1	2	4	0	1	3	0	0	0	3	7	4	0	6	5	6
Emp. Inj.(RS)/1000 Bed Days	0.19	0.18	0.18	0.37	0.73	0.00	0.19	0.55	0.00	0.00	0.00	0.54	1.26	0.67	0.00	0.97	0.77	0.97
UCL	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40
Avg	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42
LCL	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	0.00	0.00	0.00	0.00	0.00

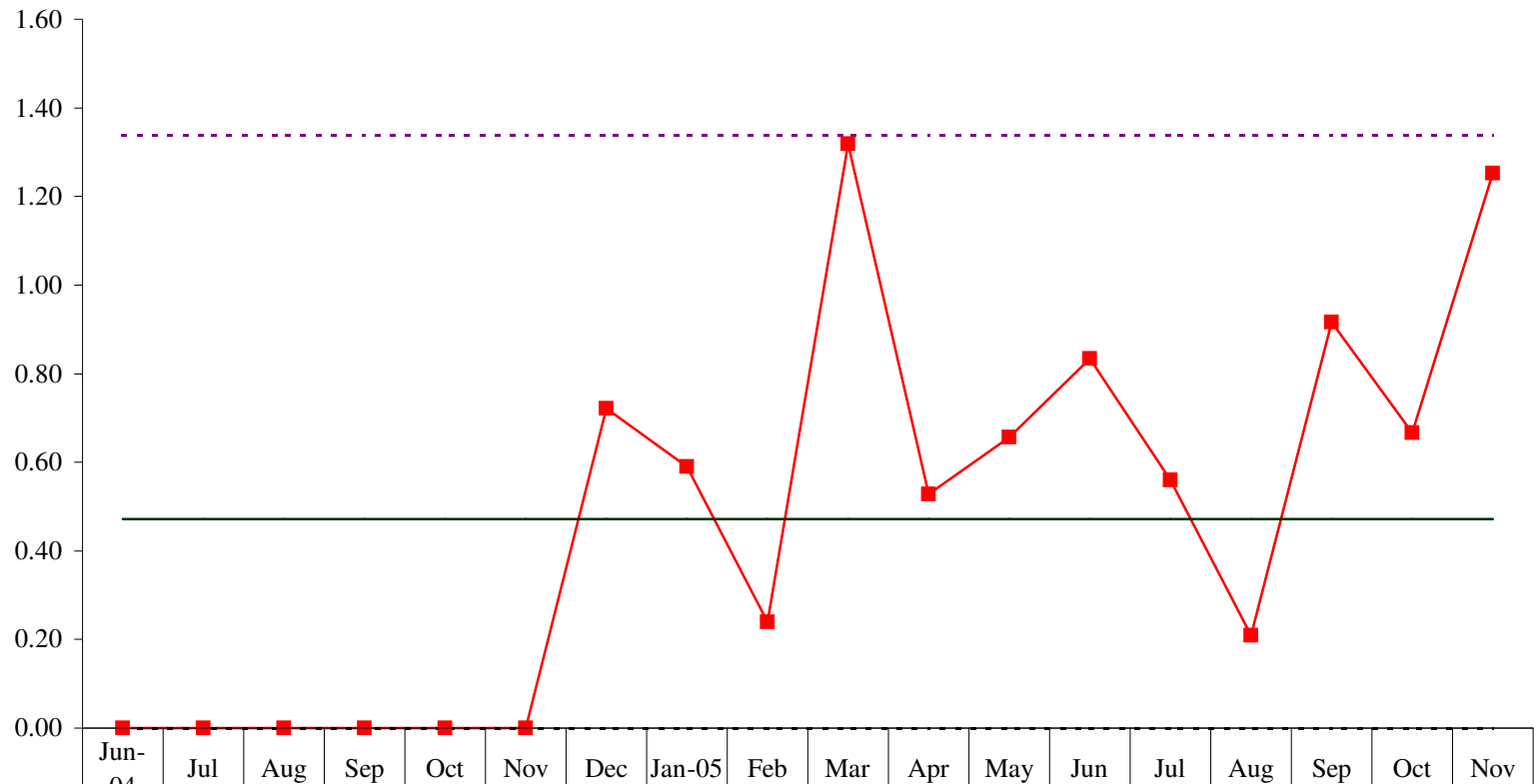
Objective 6C & 6I - Employee Injuries
North Texas State Hospital

Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



Objective 6C & 6I - Employee Injuries
North Texas State Hospital

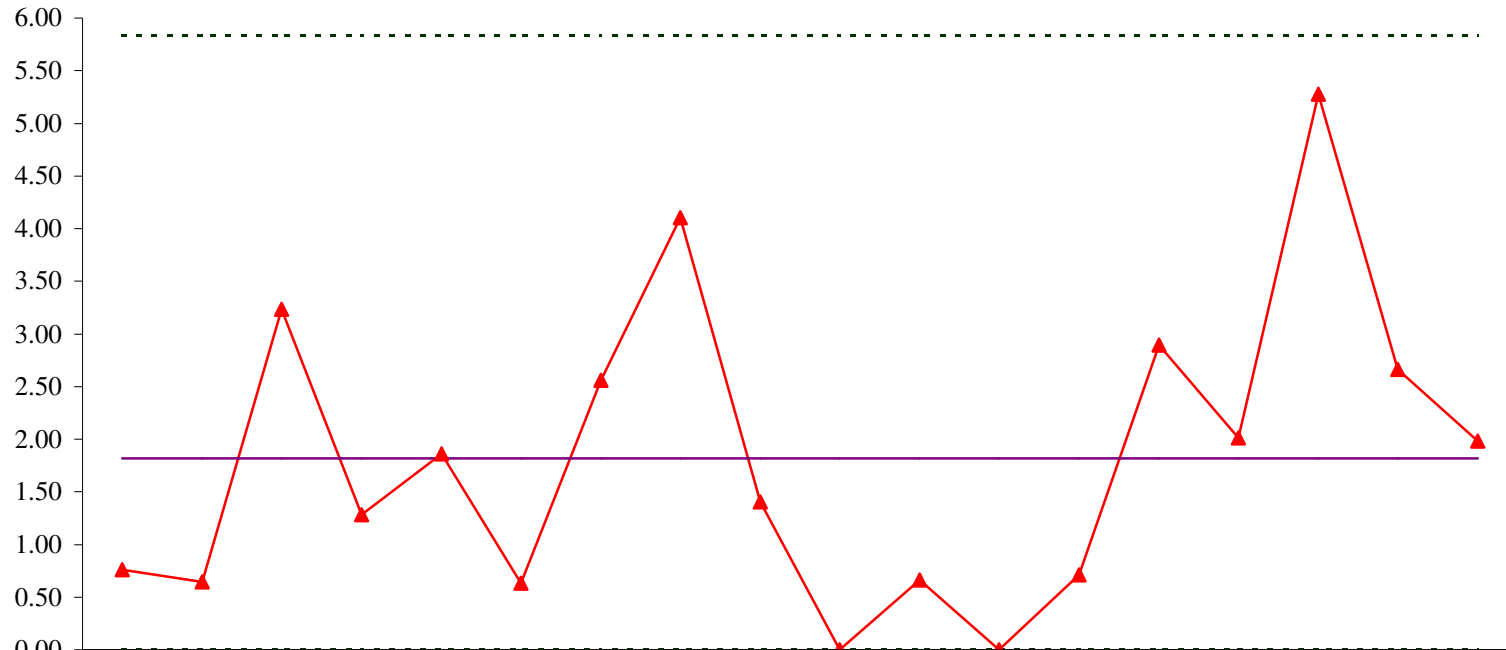
Employee Injuries During Restraint or Seclusion
 (Expectation is ≤ 0.92 per 1,000 Bed Days)



Total Employee Injuries	39	44	37	52	34	33	36	32	16	57	33	29	41	33	41	55	32	46
Injuries Associated with R/S	0	0	0	0	0	0	14	11	4	25	10	13	16	11	4	17	13	24
Emp. Inj.(RS)/1000 Bed Days	0.00	0.00	0.00	0.00	0.00	0.00	0.72	0.59	0.24	1.32	0.53	0.66	0.83	0.56	0.21	0.92	0.67	1.25
UCL	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34	1.34
Avg	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47
LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Rio Grande State Center

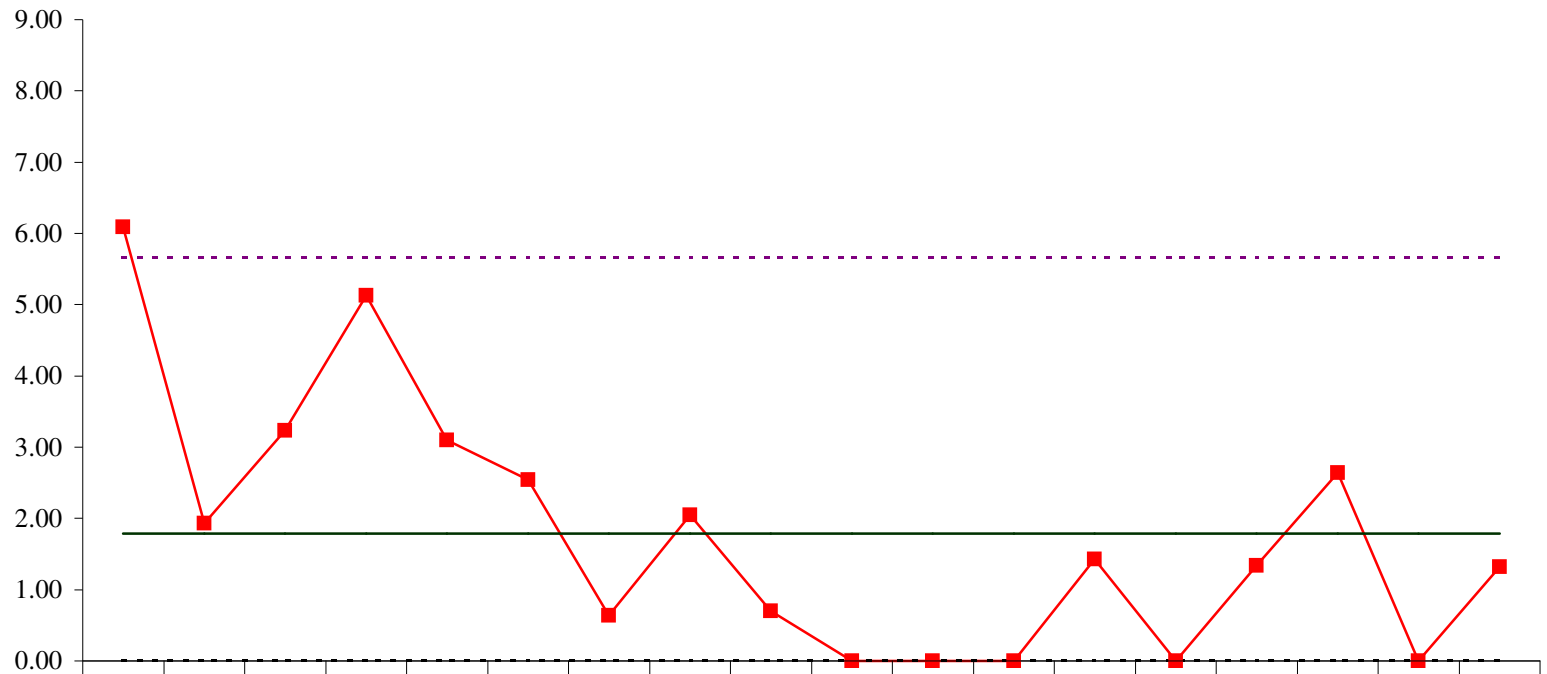
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	11	3	8	10	12	5	19	10	3	6	6	2	4	6	7	12	10	8
Injuries Resulting in a WCC	1	1	5	2	3	1	4	6	2	0	1	0	1	4	3	6	4	3
▲ Emp. Inj.(WCC)/1000 Bed Days	0.76	0.65	3.23	1.28	1.86	0.63	2.56	4.10	1.41	0.00	0.67	0.00	0.71	2.90	2.01	5.28	2.66	1.98
----- UCL	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84	5.84
———— Avg	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82	1.82
----- LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Rio Grande State Center

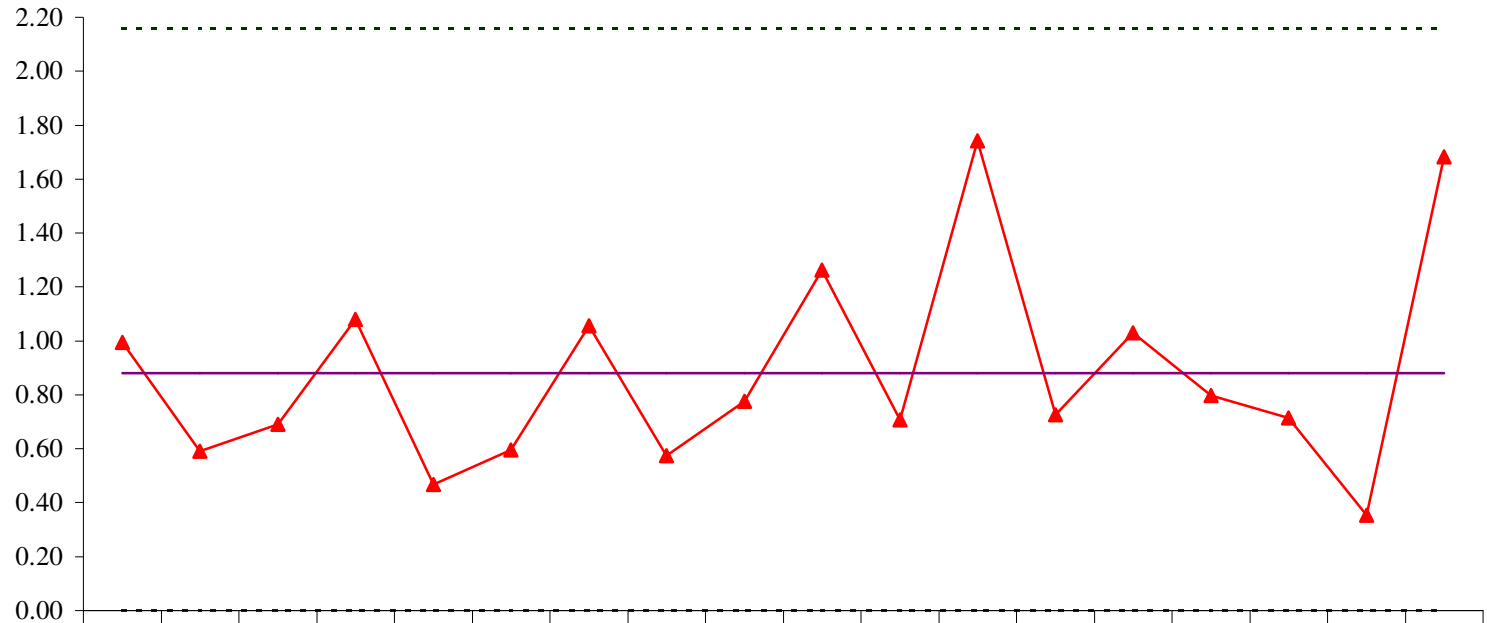
Employee Injuries During Restraint or Seclusion
 (Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	11	3	8	10	12	5	19	10	3	6	6	2	4	6	7	12	10	8
Injuries Associated with R/S	8	3	5	8	5	4	1	3	1	0	0	0	2	0	2	3	0	2
■ Emp. Inj.(RS)/1000 Bed Days	6.09	1.94	3.23	5.13	3.10	2.54	0.64	2.05	0.70	0.00	0.00	0.00	1.43	0.00	1.34	2.64	0.00	1.32
- - - - - UCL	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66	5.66
— Avg	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79
- - - - - LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Rusk State Hospital

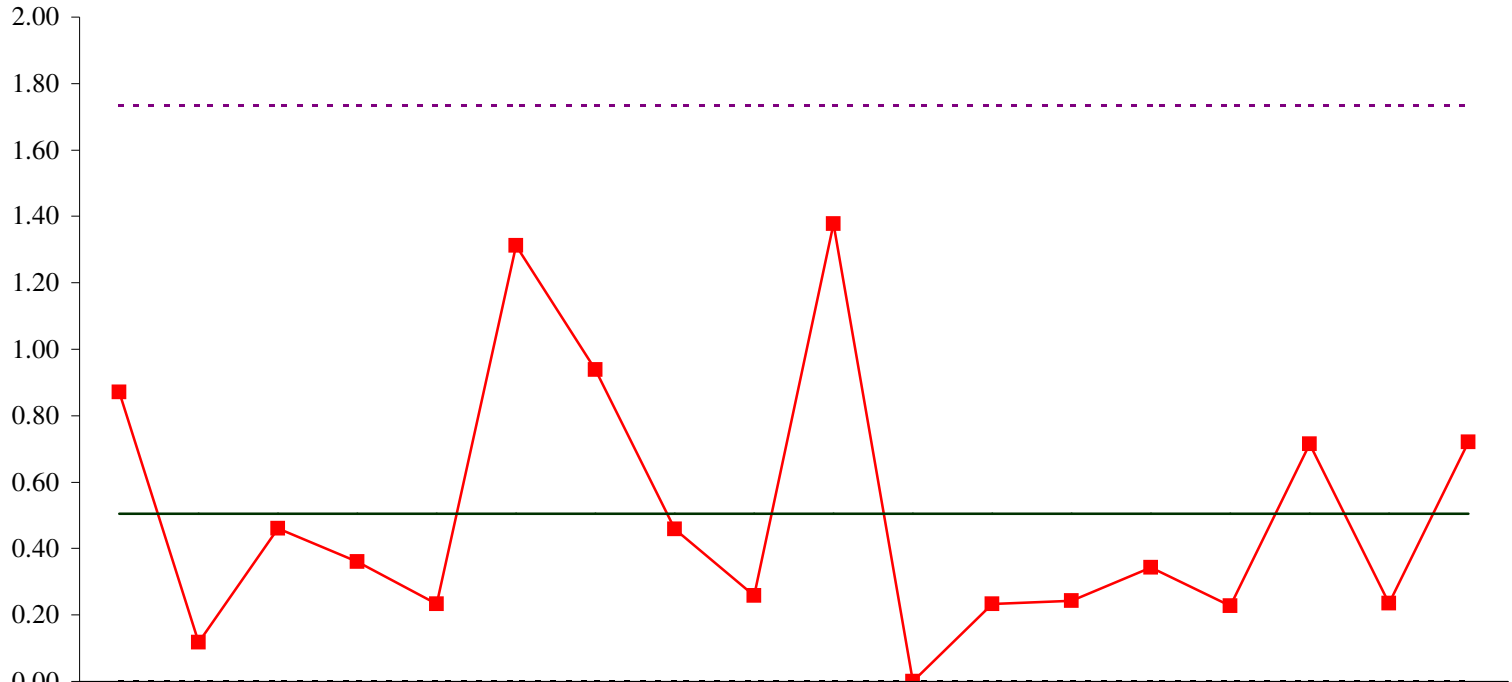
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	20	15	12	28	11	17	21	18	15	26	14	33	26	27	30	28	21	34
Injuries Resulting in a WCC	8	5	6	9	4	5	9	5	6	11	6	15	6	9	7	6	3	14
▲ Emp. Inj.(WCC)/1000 Bed Days	0.99	0.59	0.69	1.08	0.47	0.60	1.06	0.57	0.78	1.26	0.71	1.74	0.73	1.03	0.80	0.71	0.35	1.68
-----UCL	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16
— Avg	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Rusk State Hospital

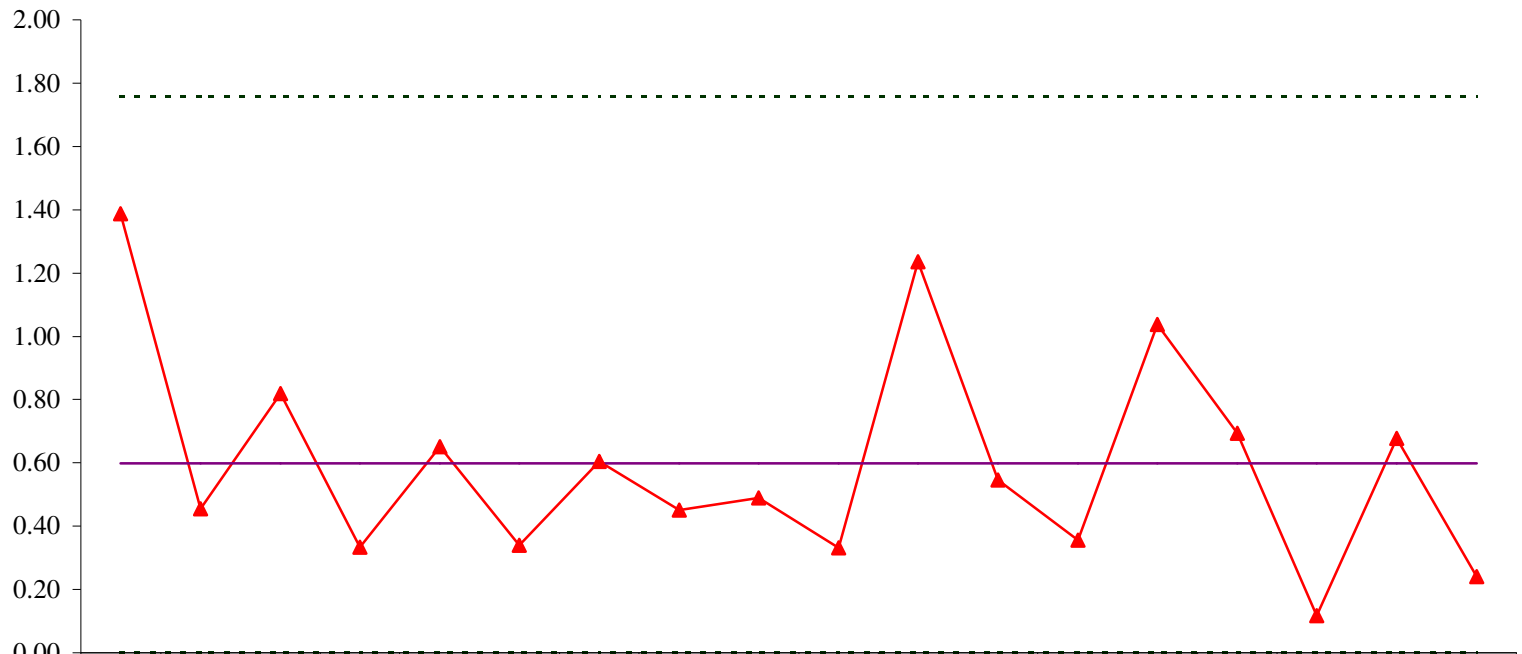
Employee Injuries During Restraint or Seclusion
 (Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	20	15	12	28	11	17	21	18	15	26	14	33	26	27	30	28	21	34
Injuries Associated with R/S	7	1	4	3	2	11	8	4	2	12	0	2	2	3	2	6	2	6
Emp. Inj.(RS)/1000 Bed Days	0.87	0.12	0.46	0.36	0.23	1.31	0.94	0.46	0.26	1.38	0.00	0.23	0.24	0.34	0.23	0.71	0.24	0.72
UCL	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74	1.74
Avg	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51
LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
San Antonio State Hospital

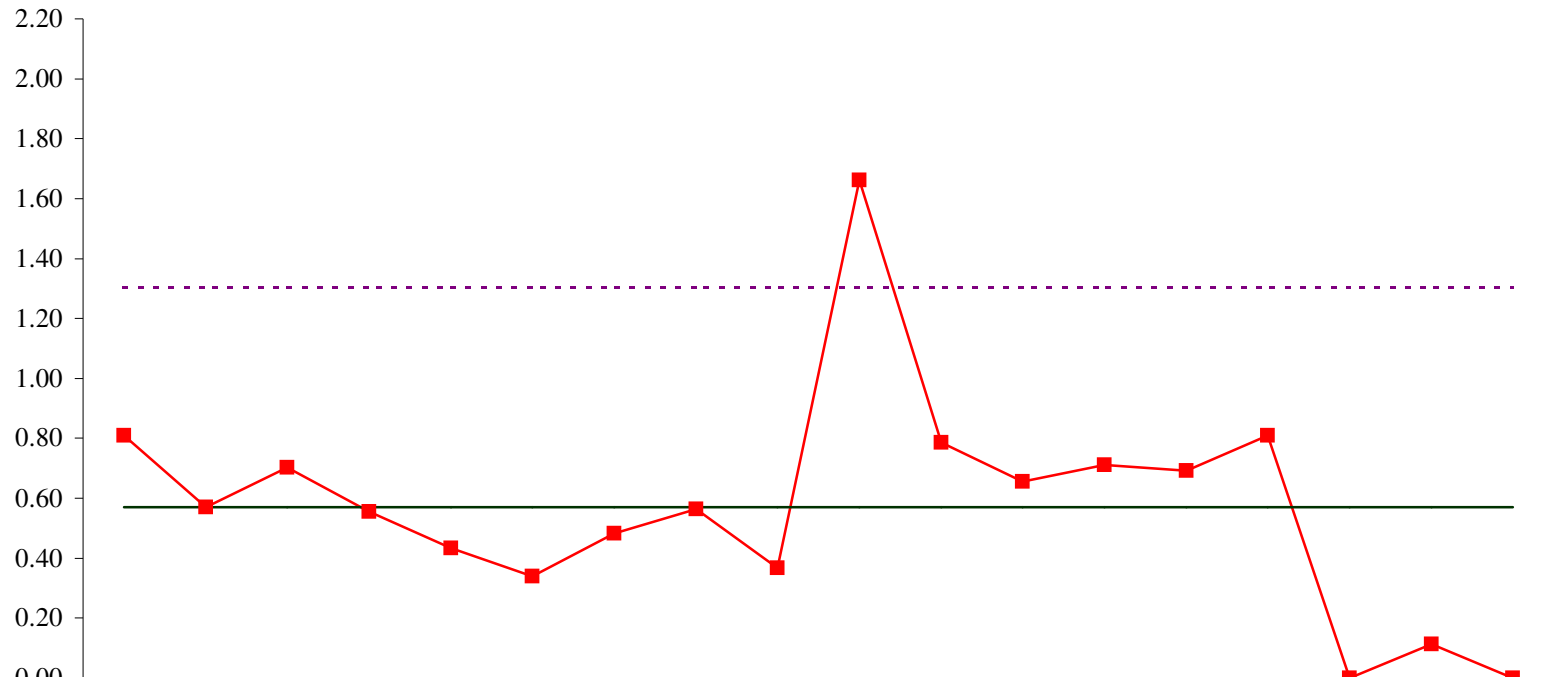
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	33	30	30	31	32	24	27	21	18	36	46	19	21	41	30	24	33	22
Injuries Resulting in a WCC	12	4	7	3	6	3	5	4	4	3	11	5	3	9	6	1	6	2
▲ Emp. Inj.(WCC)/1000 Bed Days	1.39	0.46	0.82	0.33	0.65	0.34	0.60	0.45	0.49	0.33	1.24	0.55	0.36	1.04	0.69	0.12	0.68	0.24
-----UCL	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76	1.76
— Avg	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
San Antonio State Hospital

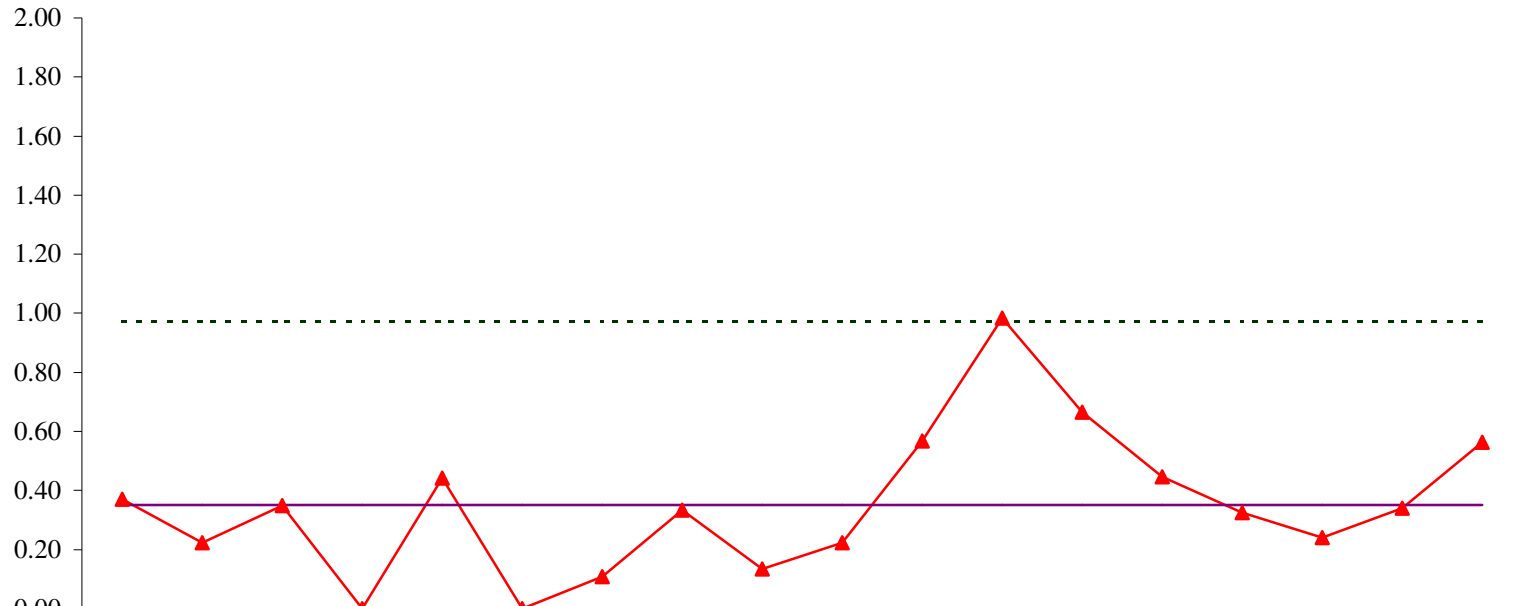
Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	33	30	30	31	32	24	27	21	18	36	46	19	21	41	30	24	33	22
Injuries Associated with R/S	7	5	6	5	4	3	4	5	3	15	7	6	6	6	7	0	1	0
Emp. Inj.(RS)/1000 Bed Days	0.81	0.57	0.70	0.55	0.43	0.34	0.48	0.56	0.37	1.66	0.79	0.66	0.71	0.69	0.81	0.00	0.11	0.00
UCL	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30
Avg	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57
LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Terrell State Hospital

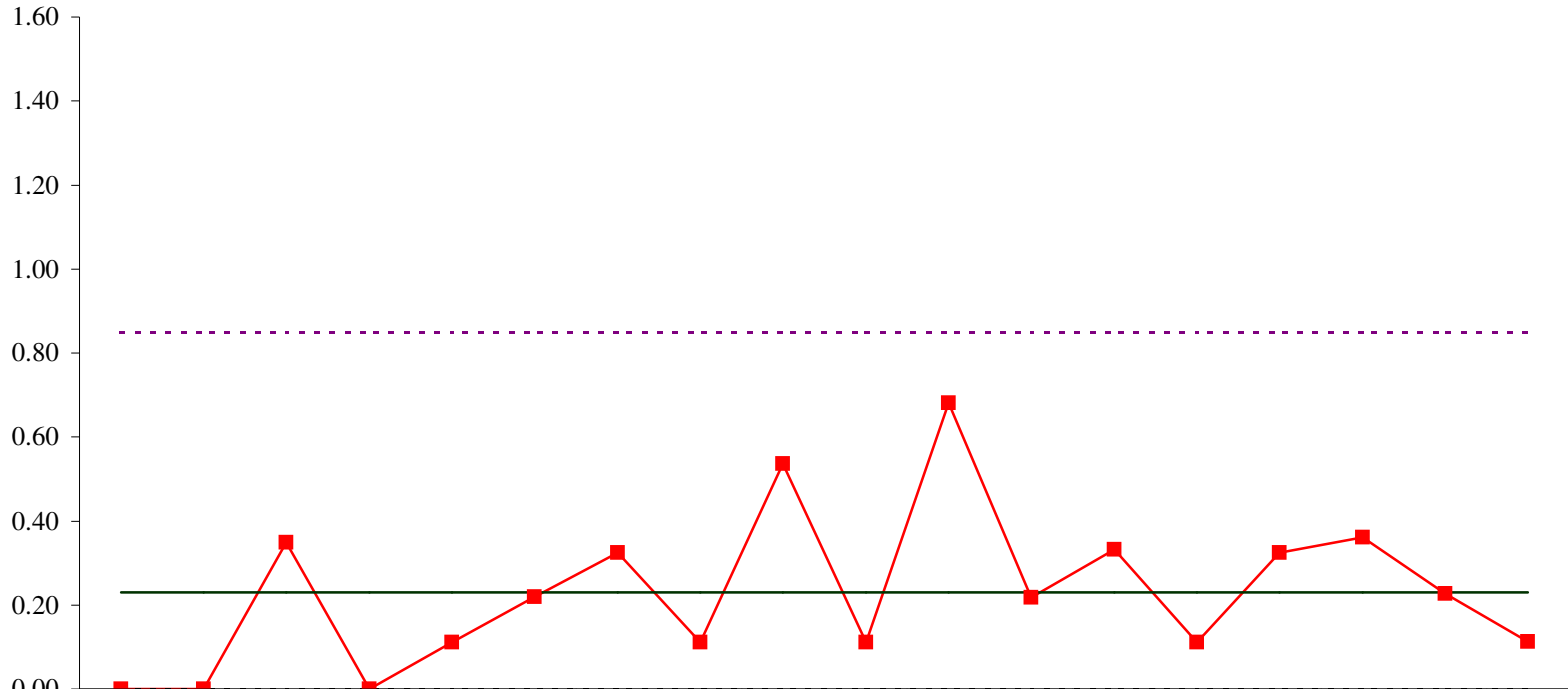
Employee Injuries Resulting in a Workers' Compensation Claim
 (Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	21	21	29	20	18	16	17	18	14	40	39	28	34	17	40	27	43	23
Injuries Resulting in a WCC	3	2	3	0	4	0	1	3	1	2	5	9	6	4	3	2	3	5
▲ Emp. Inj.(WCC)/1000 Bed Days	0.37	0.22	0.35	0.00	0.44	0.00	0.11	0.33	0.13	0.22	0.57	0.98	0.67	0.45	0.32	0.24	0.34	0.56
----- UCL	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97
— Avg	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35
----- LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Terrell State Hospital

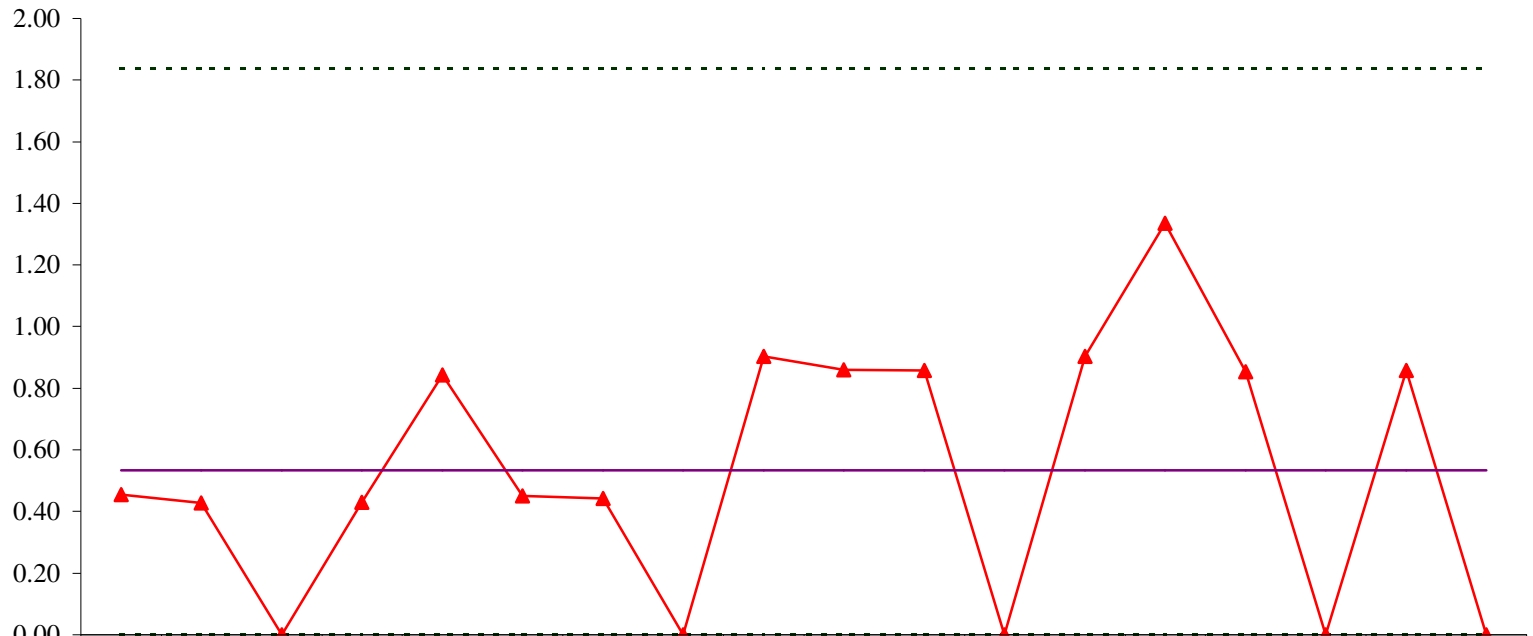
Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	21	21	29	20	18	16	17	18	14	40	39	28	34	17	40	27	43	23
Injuries Associated with R/S	0	0	3	0	1	2	3	1	4	1	6	2	3	1	3	3	2	1
■ Emp. Inj.(RS)/1000 Bed Days	0.00	0.00	0.35	0.00	0.11	0.22	0.32	0.11	0.54	0.11	0.68	0.22	0.33	0.11	0.32	0.36	0.23	0.11
- - - UCL	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85
— Avg	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23
- - - - LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Waco Center for Youth

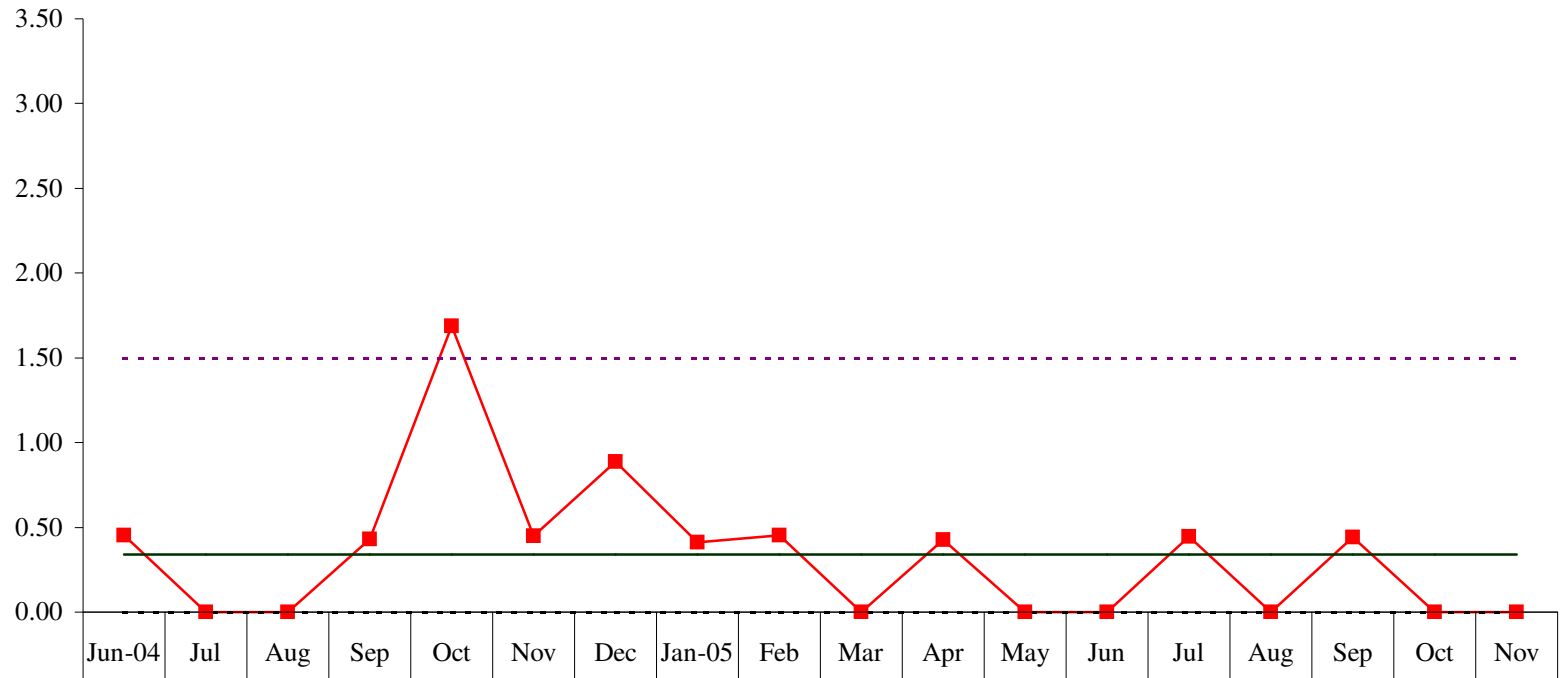
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is ≤ 1.11 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	1	3	1	2	8	3	5	2	5	4	4	0	4	6	2	1	3	0
Injuries Resulting in a WCC	1	1	0	1	2	1	1	0	2	2	2	0	2	3	2	0	2	0
▲ Emp. Inj.(WCC)/1000 Bed Days	0.45	0.43	0.00	0.43	0.84	0.45	0.44	0.00	0.90	0.86	0.86	0.00	0.90	1.34	0.85	0.00	0.86	0.00
-----UCL	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84
— Avg	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53
-----LCL	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	0.00	0.00	0.00	0.00	0.00

Objective 6C & 6I - Employee Injuries
Waco Center for Youth

Employee Injuries During Restraint or Seclusion
(Expectation is ≤ 0.92 per 1,000 Bed Days)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Total Employee Injuries	1	3	1	2	8	3	5	2	5	4	4	0	4	6	2	1	3	0
Injuries Associated with R/S	1	0	0	1	4	1	2	1	1	0	1	0	0	1	0	1	0	0
■ Emp. Inj.(RS)/1000 Bed Days	0.45	0.00	0.00	0.43	1.69	0.45	0.89	0.41	0.45	0.00	0.43	0.00	0.00	0.45	0.00	0.44	0.00	0.00
- - - - - UCL	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50
— Avg	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34
- - - - - LCL	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	0.00	0.00	0.00	0.00	0.00

Performance Objective 6F:

Rate of patient injuries will be calculated, trended and reviewed for quality improvement opportunities. Injuries will be reported by age categories as follows: Ages 0-17; 18-64; and 65-older.

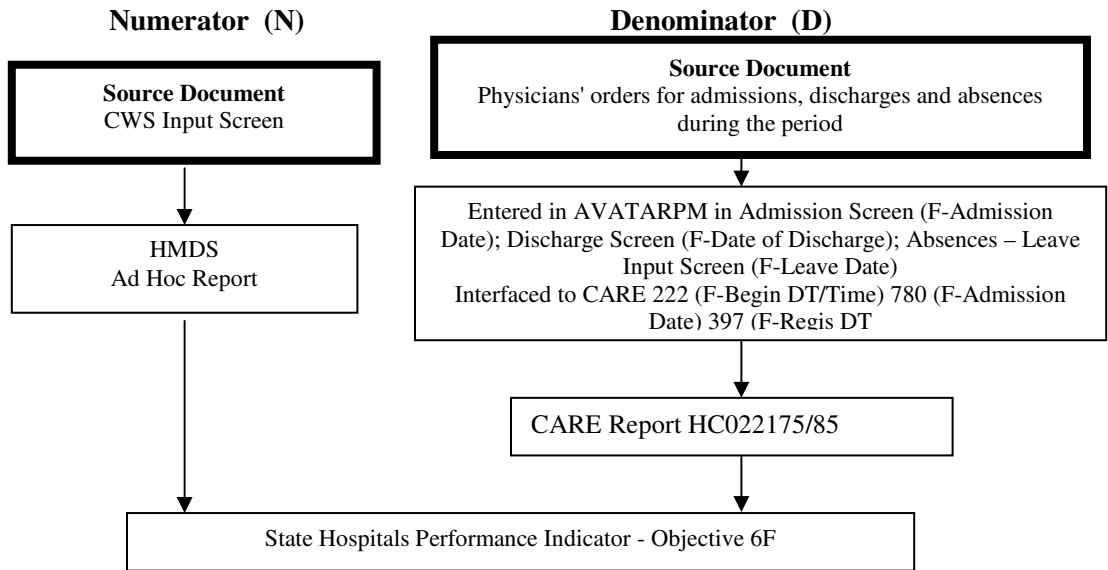
Performance Objective Operational Definition: The state hospital rate of patient injuries documented on the Client Injury Assessment per FY quarter.
 Number of injuries incurred by age group category per FY quarter (age will be calculated at the beginning of the reporting period).

Performance Objective Formula: $R = (N/D) \times 1000$
 R = rate of injuries per 1000 bed days per FY quarter
 N = number of injuries D = number of bed days per FY quarter
 1000 = bed day rate multiplier

Performance Objective Data Display and Chart Description:

- ◆ Table shows number of injuries by probable cause and rate (per 1000 bed days) of injuries by treatment for individual state hospitals and system-wide.
- ◆ Bar chart with fiscal year to date of total NRI Categories 3,4 and 5 injuries per 1000 bed days for individual state hospitals and system-wide.
- ◆ Table showing number of injuries by age category per quarter.

Data Flow:



Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time of injury and type.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates and injury event date and type data field as compared to the corresponding information in the medical record.
Sample Size	Use 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data to review only associated injury events.

Objective 6F - Client Injuries

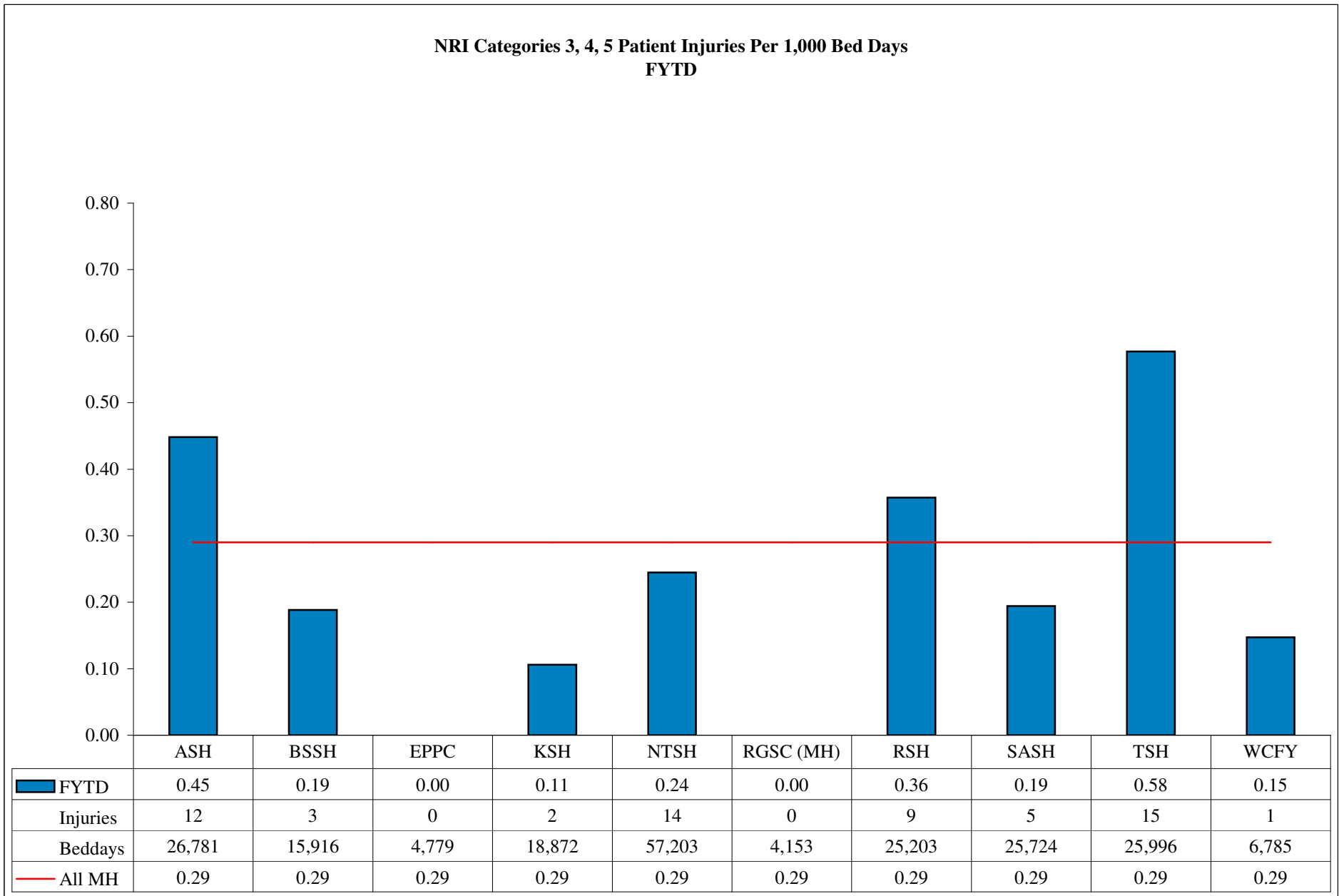
All MH Facilities

Facility	Q1 FY06							Q2							Q3							FYTD						
	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total
ALL MH																												
Age 0-17	2	60	133	11	1	0	207																					
Age 18-64	37	520	430	48	2	0	1037																					
Age 65-older	2	64	36	1	0	0	103																					
Total	41	644	599	60	3	0	1347																					

N/A = Not Available

Objective 6F - Patient Injuries

All MH Facilities - As of November 30, 2005



Objective 6F - Patient Injuries

All MH Facilities - FY06

Facility	Q1							Q2							Q3							Q4							
		No	First	Med	Hospital-		*		No	First	Med	Hospital-		*		No	First	Med	Hospital-		*		No	First	Med	Hospital-		*	
	N/A	Tx	Aid	Tx	ization	Fatal	Total	N/A	Tx	Aid	Tx	ization	Fatal	Total	N/A	Tx	Aid	Tx	ization	Fatal	Total	N/A	Tx	Aid	Tx	ization	Fatal	Total	
ALL MH																													
Accident	7	233	239	25	2	0	506																						
Another Client	3	158	160	19	0	0	340																						
Employee/Accident	0	6	6	1	0	0	13																						
Medical Condition	0	15	5	0	0	0	20																						
Self Inflicted	3	86	133	10	0	0	232																						
Undetermined	28	122	53	3	1	0	207																						
Visitor	0	0	0	0	0	0	0																						
Total	41	620	596	58	3	0	1318																						
Rate/1000 Bed Days	0.2	2.9	2.8	0.27	0.0	0	0.3																						

N/A = Not Available

*Total Rate/1000 Bed Days for NRI Category 3, 4,5

Performance Objective 6H:

The rate of patient injury related to behavioral seclusion and restraint for FY06 will not exceed 0.49 per 1000 bed days for FY05.

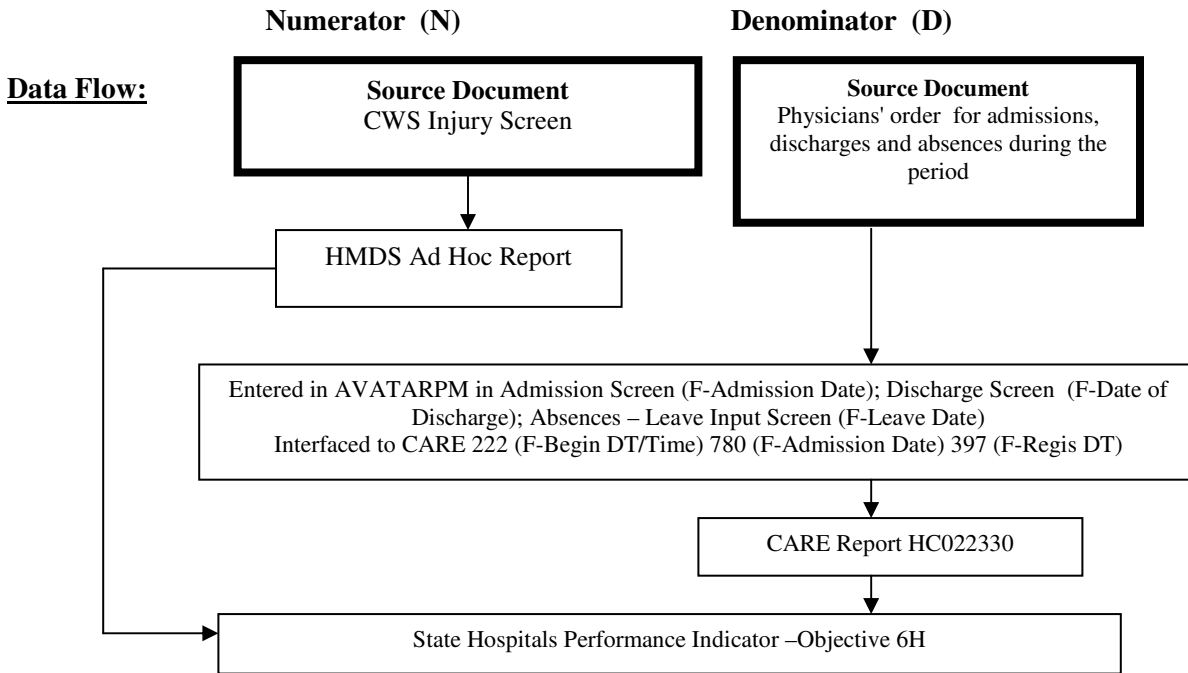
Performance Objective Operational Definition: Patient injuries documented on the Client Injury Assessment per FY quarter resulted from restraint or seclusion (per 1000 bed days).

Performance Measure Formula: $R=(N/D) \times 1000$

R = rate of patients injured during restraint or seclusion per 1000 bed days per quarter
 N = number of patients injured during restraint or seclusion per quarter
 D = number of bed days per quarter 1000 = bed day rate multiplier

Performance Objective Data Display and Chart Description:

- ◆ Table shows quarterly number of injuries by restraint or seclusion by treatment for individual state hospitals and system-wide.
- ◆ Bar chart with total FYTD client injuries resulted from restraint and seclusion per 1000 bed days.



Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date or date/time of injury and type.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates and injury event date and type data field as compared to the corresponding information in the medical record.
Sample Size	Use 15 randomly selected patient records for the most recently reported NRI PMS quarterly episode file data to review only associated injury events.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When any admission/discharge dates and/or events found on the most recent NRI PMS quarterly report do not correspond to the information in the medical record.

Objective 6H - Client Injuries Resulted From Restraint and Seclusion

All MH Facilities - FY2006

Facility	Q1							Q2							Q3							Q4							
	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	Total	
ALL MH																													
Restraint	5	38	34	4	1	0	82																						
Seclusion	0	0	2	2	0	0	4																						
Total	5	38	36	6	1	0	86																						
Per 1000 Beddays							0.4																						

Performance Objective 6I:

Employees injured during restraint or seclusion will not exceed .92 per 1000 bed days across all state hospitals in FY 2006.

Performance Objective Operational Definition: The state hospital rate of employees injured during restraint or seclusion per 1000 bed days.

Performance Objective Formula: $R = (N/D) \times 1000$

R = rate of employees injured during restraint or seclusion per 1000 bed days per month

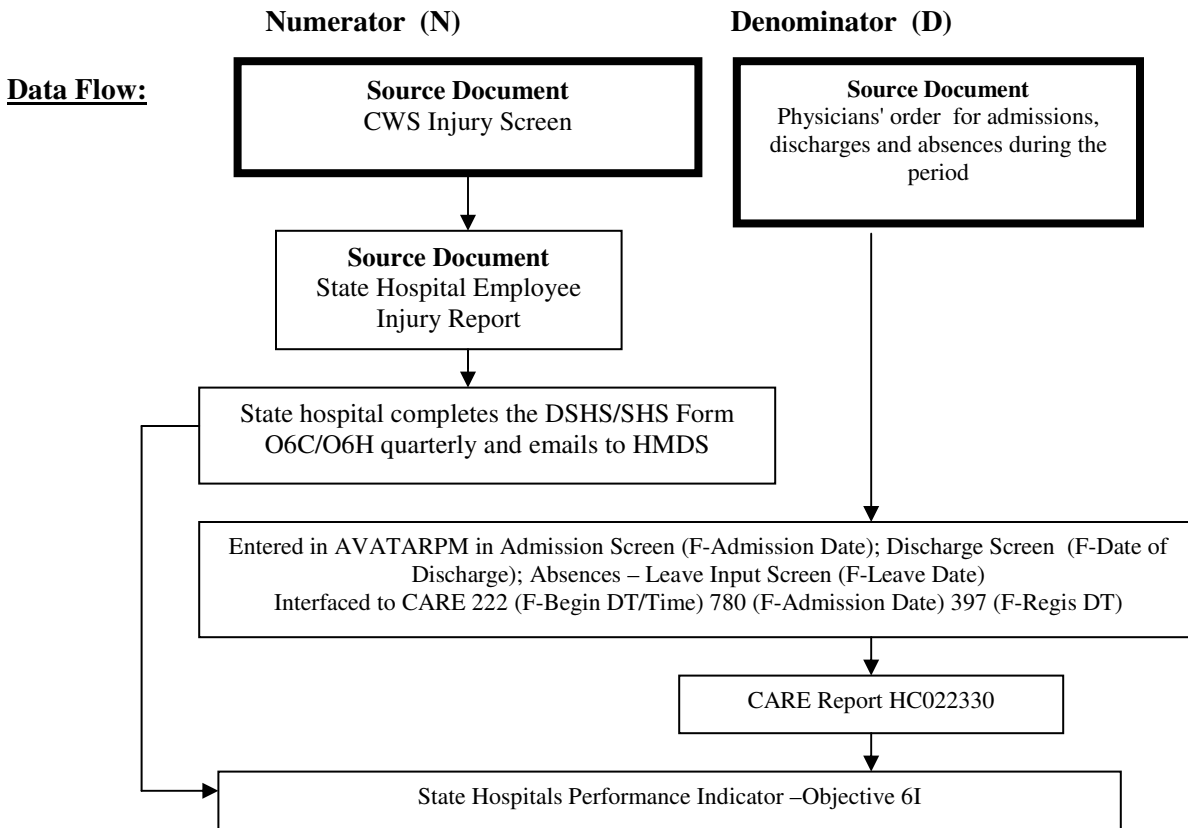
N = number of employees injured during restraint or seclusion per month

D = number of bed days per month 1000 = bed day rate multiplier

Performance Objective Data Display and Chart Description:

Chart with monthly data points showing total employee injuries, injuries associated with restraint or seclusion and rate per 1000 bed days.

See Objective 6C for charts.



Data Integrity Review Process:

Not subject to DIR. This data is calculated and reported to DSHS-Hospitals Section by each state hospital.

See Objective 6C for charts.

Performance Objective 6J:

The rate of Unauthorized Departures will not exceed 0.42 per 1000 bed days across all state hospitals during FY2006.

Performance Objective Operational Definition: The state hospital rate of unauthorized departures assignments documented on the state hospital elopement report form per 1000 bed days per month.

Performance Objective Formula: $R = (N/D) \times 1000$

R = rate of elopement assignments per 1000 bed days per month

N = number of elopement assignments per month (Each UD is counted only once, in the month it is begun, even if it extends into subsequent months. Number of persons means the number of persons for whom assignments were begun during the month)

D = number of bed days per month 1000 = bed day rate multiplier

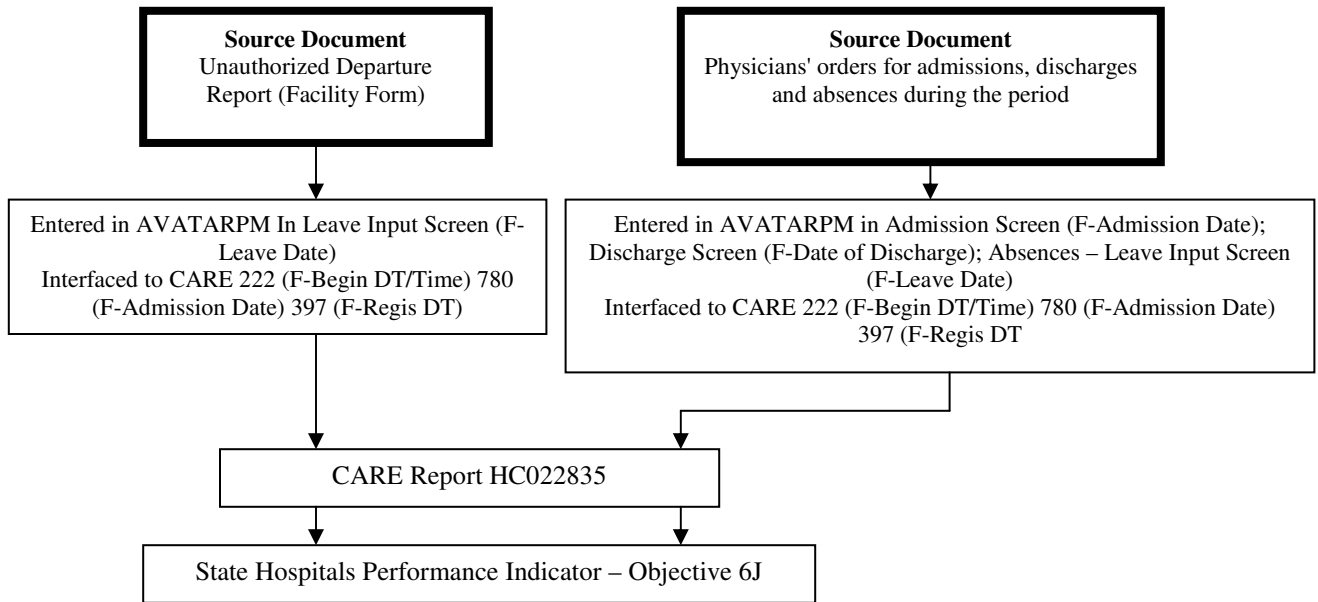
Performance Objective Data Display and Chart Description:

- ◆ Table shows UD incidents, UD persons and bed days in a month for individual state hospitals and system-wide.
- ◆ Control chart with monthly data points of UDs per 1000 bed days for individual state hospitals and system-wide and NRI national public rates.

Data Flow:

Numerator (N)

Denominator (D)



Data Integrity Review Process:

Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates. Event files include date when elopement started and stopped and location.
Monitoring Instrument/Tool	NRI PMS Episode and/or Event DIR Worksheet
Description of Review Process	Verification of the admission and discharge data fields of the NRI episode files and leave event start/stop dates as compared to the corresponding information in the medical record. Verify elopement start/stop dates, location and type of the NRI elopement event file with corresponding information on the UD form.

GOAL 8: Assure A Competent Workforce

Performance Objective 8A:

95 percent of all staff will be current with required training at all times.

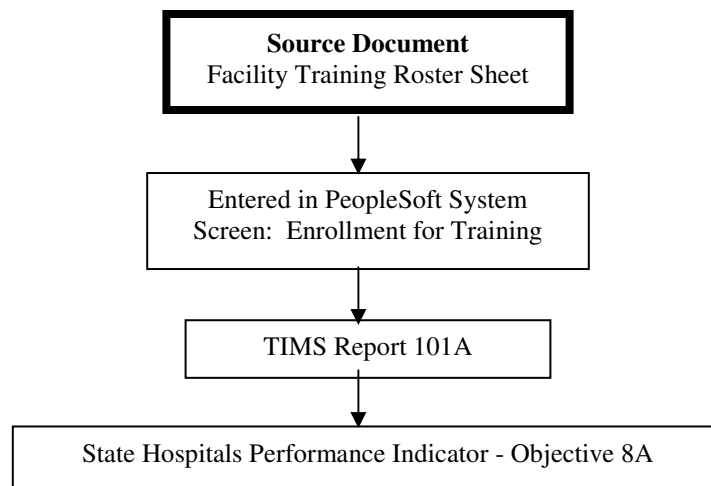
Performance Objective Operational Definition: The state hospital percentage of employees with active training statuses who have completed all courses related to their position type training program within specified time frame. Monthly data (based on data entered up until 5 p.m. on the day the report is run) will be reported in TIMS Report 101A.

Performance Objective Formula: Rate = number of employees with active training statuses who have completed their training/number of current employees at the state hospital.

Performance Objective Data Display and Chart Description:

- ◆ Control chart with monthly data points of percentage of training completed for individual state hospitals and system-wide.
- ◆ Bar chart with all state hospital scores for the last month of the quarter.

Data Flow:

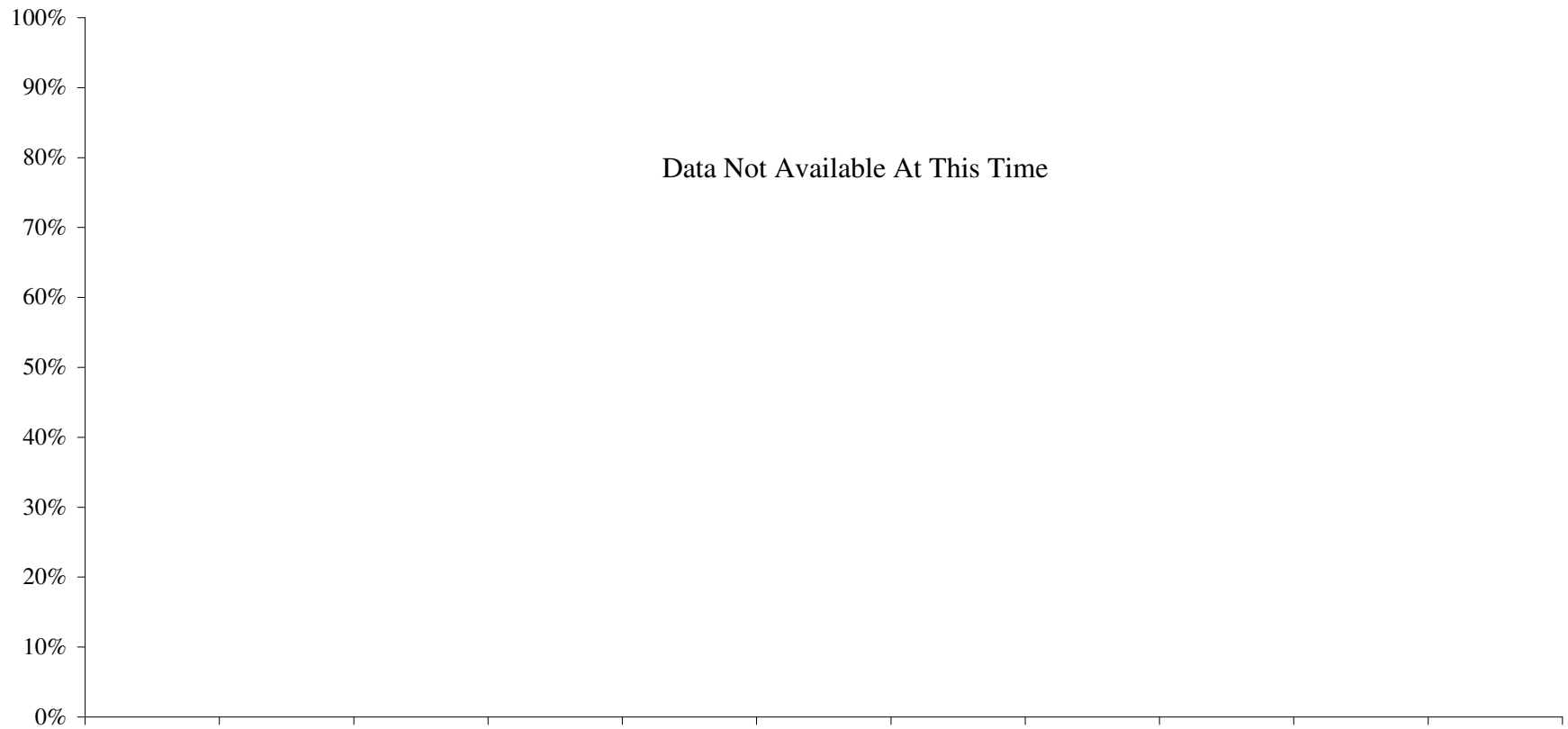


Data Integrity Review Process:

Data integrity review done through the Administrative Performance Indicators (API) Validation Audit Process.

Objective 8A - Staff Current With Required Training
All MH Facilities

Required Training
(As of November 30, 2005)



Q1 FY06												
Required Rate												

Performance Objective 8B:

97 percent of all staff will have current date performance evaluations on file at all times.

Performance Objective Operational Definition: The state hospital rate of up-to-date annual performance evaluations documented on the HR5.2 per month. (Performance evaluations are due 12 months following the date of the last evaluation as entered in PeopleSoft and are considered late when they are more than 30 days past due). PeopleSoft Report HSAS1102 includes all employees on leave, transferred employees and retired employees using up their time.

Performance Objective Formula: $R = (N/D)$

Rate = rate of staff up-to-date with annual performance evaluations

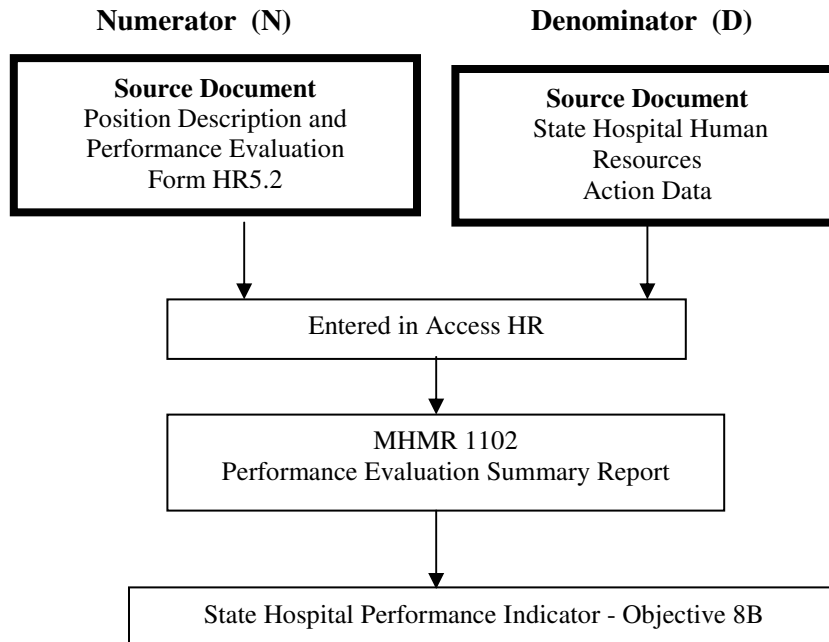
N = number of employees with current evaluations on the last day of the month

D = number of active employees (people, not FTEs) on the last day of the month

Performance Objective Data Display and Chart Description:

- ◆ Control chart with monthly data points of percentage of performance evaluations up-to-date for individual state hospitals and system-wide.

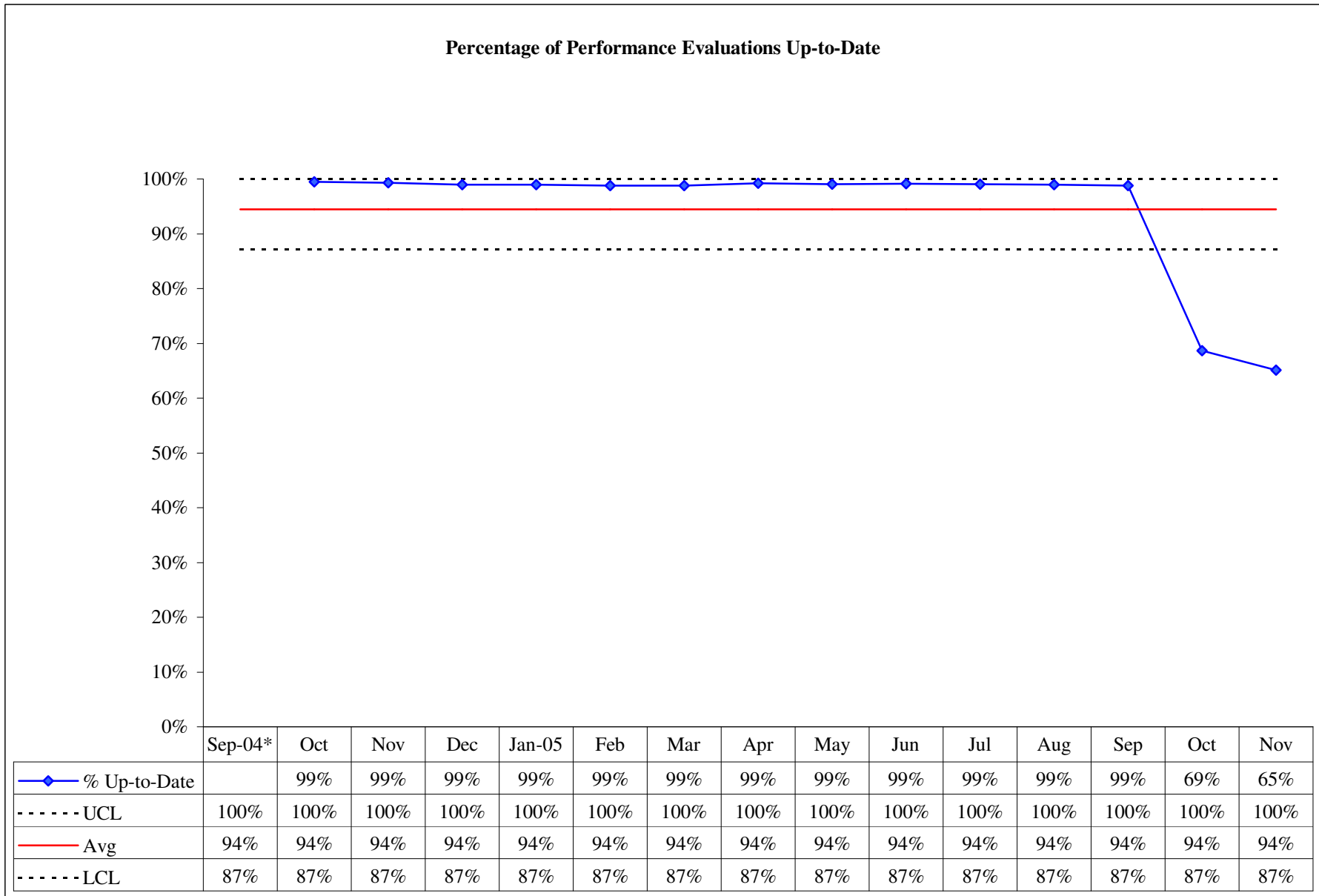
Data Flow:



Data Integrity Review Process:

Data integrity review done through the Administrative Performance Indicators (API) Validation Audit Process.

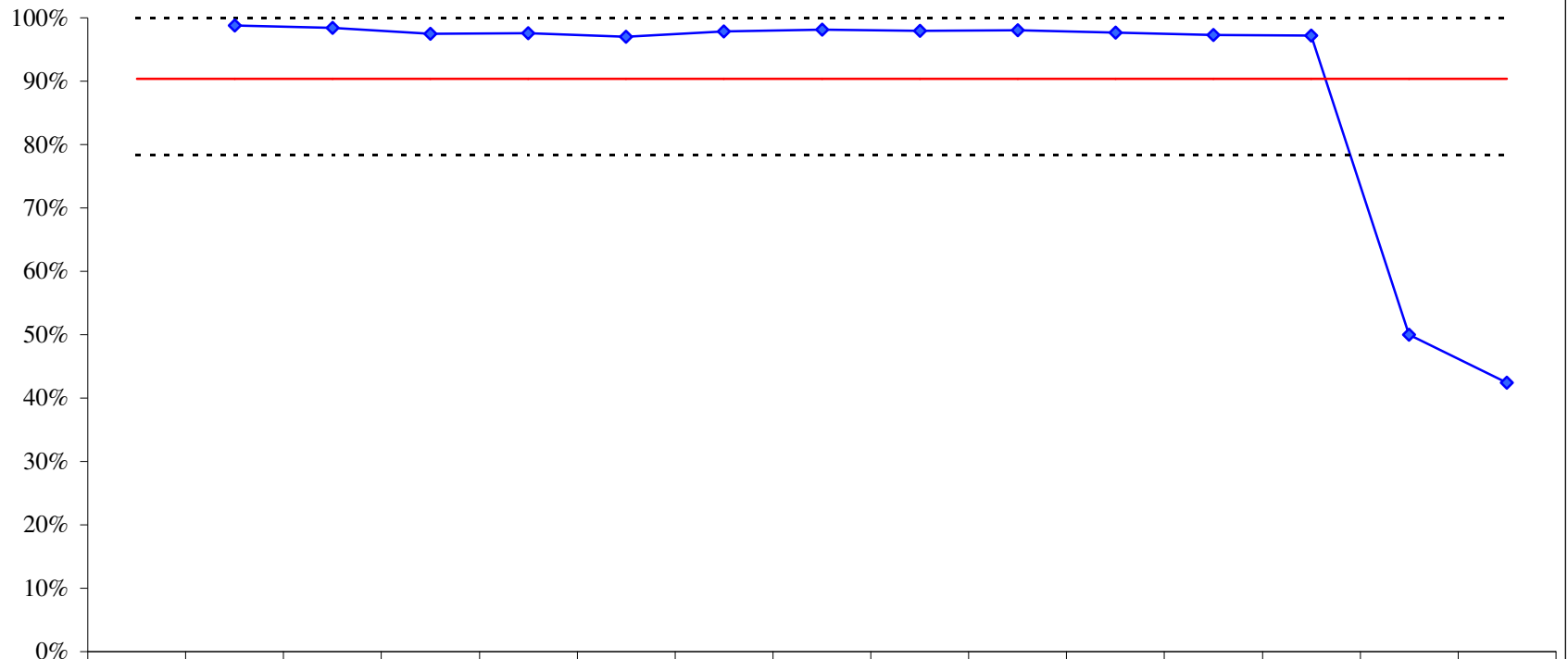
Objective 8B - Staff Have Current Performance Evaluations
All MH Facilities



*Data not available

Objective 8B - Staff Have Current Performance Evaluations
Austin State Hospital

Percentage of Performance Evaluations Up-to-Date

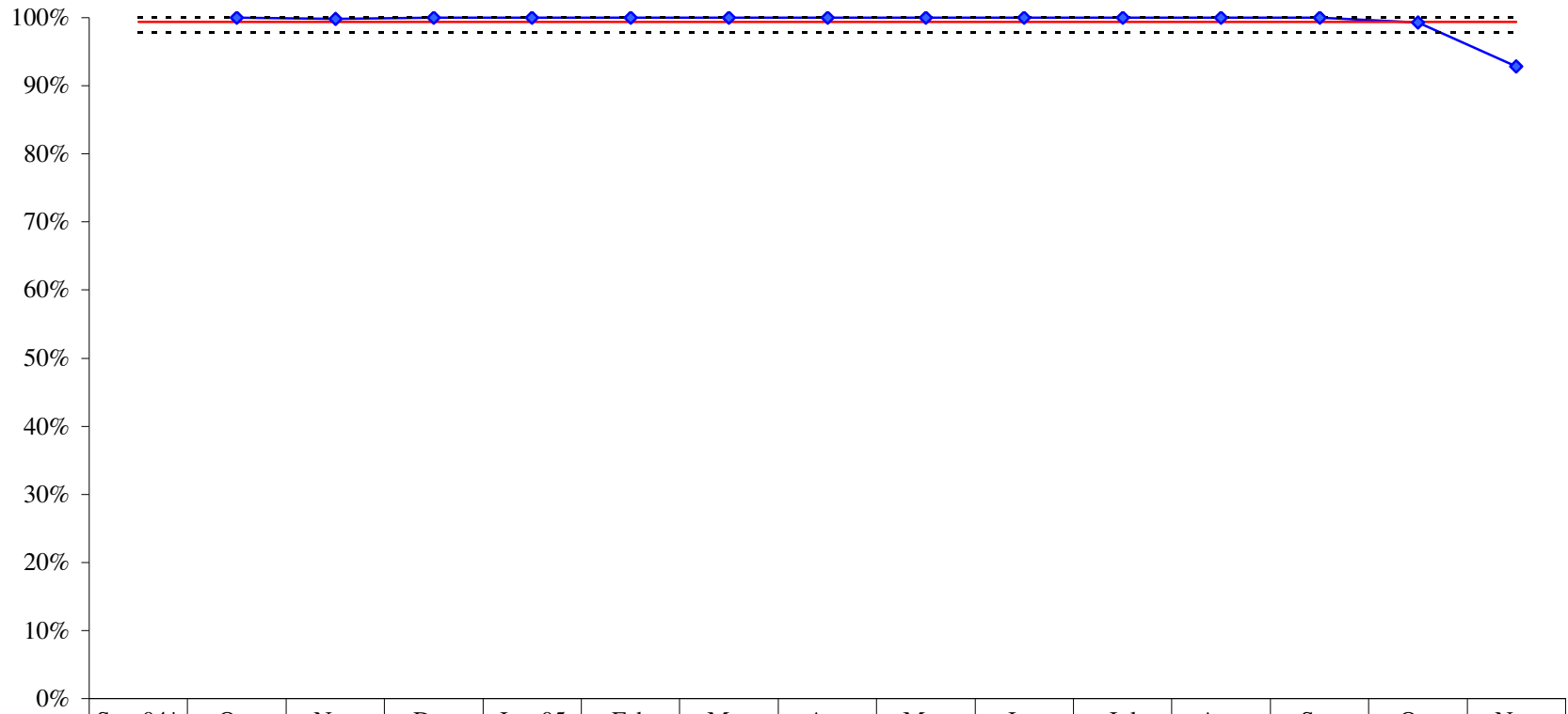


	Sep-04*	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ % Up-to-Date		99%	98%	98%	98%	97%	98%	98%	98%	98%	98%	97%	97%	50%	42%
----- UCL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
— Avg	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
----- LCL	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%

*Data not available

Objective 8B - Staff Have Current Performance Evaluations
Big Spring State Hospital

Percentage of Performance Evaluations Up-to-Date



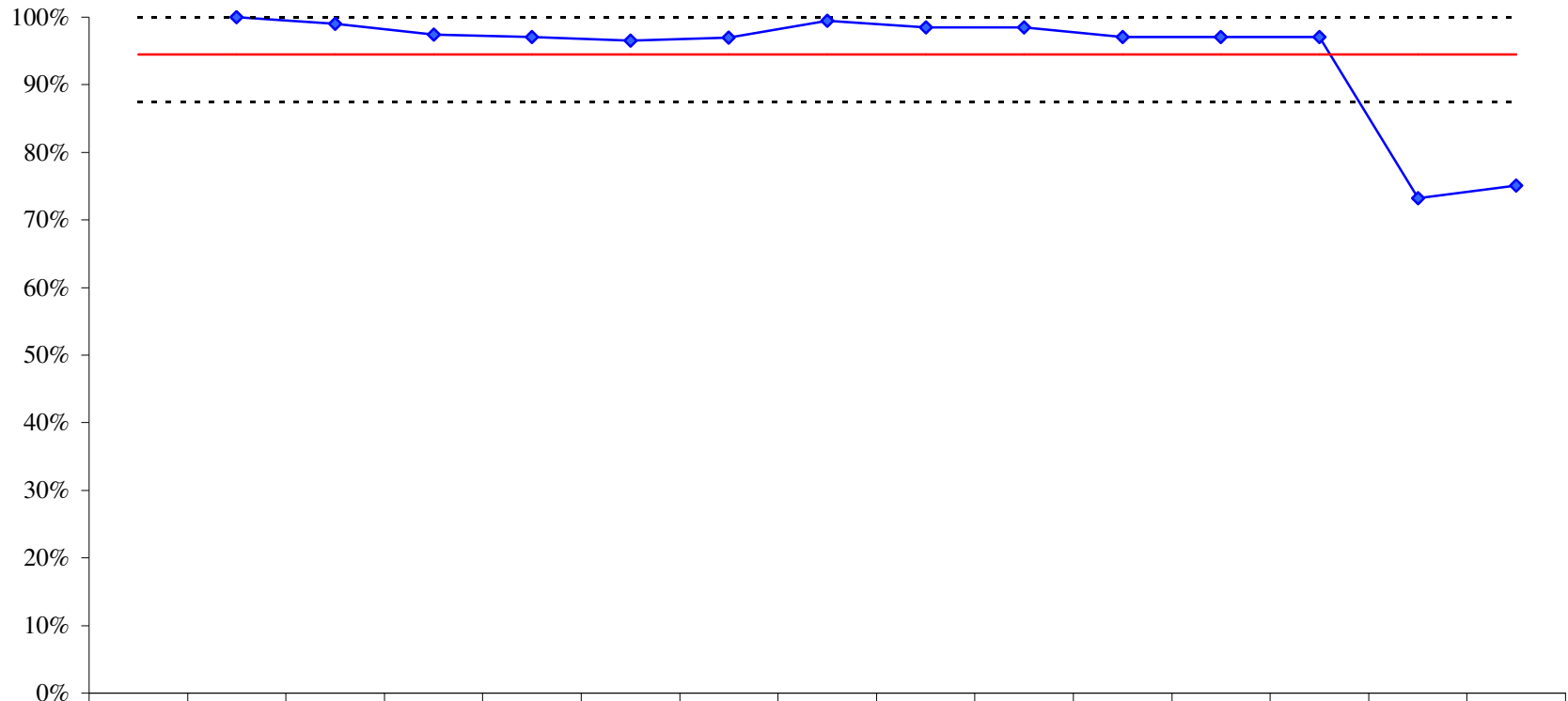
*Data not available

Chart: Hospital Management Data Services

Source: PeopleSoft MHMR1102

Objective 8B - Staff Have Current Performance Evaluations
El Paso Psychiatric Center

Percentage of Performance Evaluations Up-to-Date



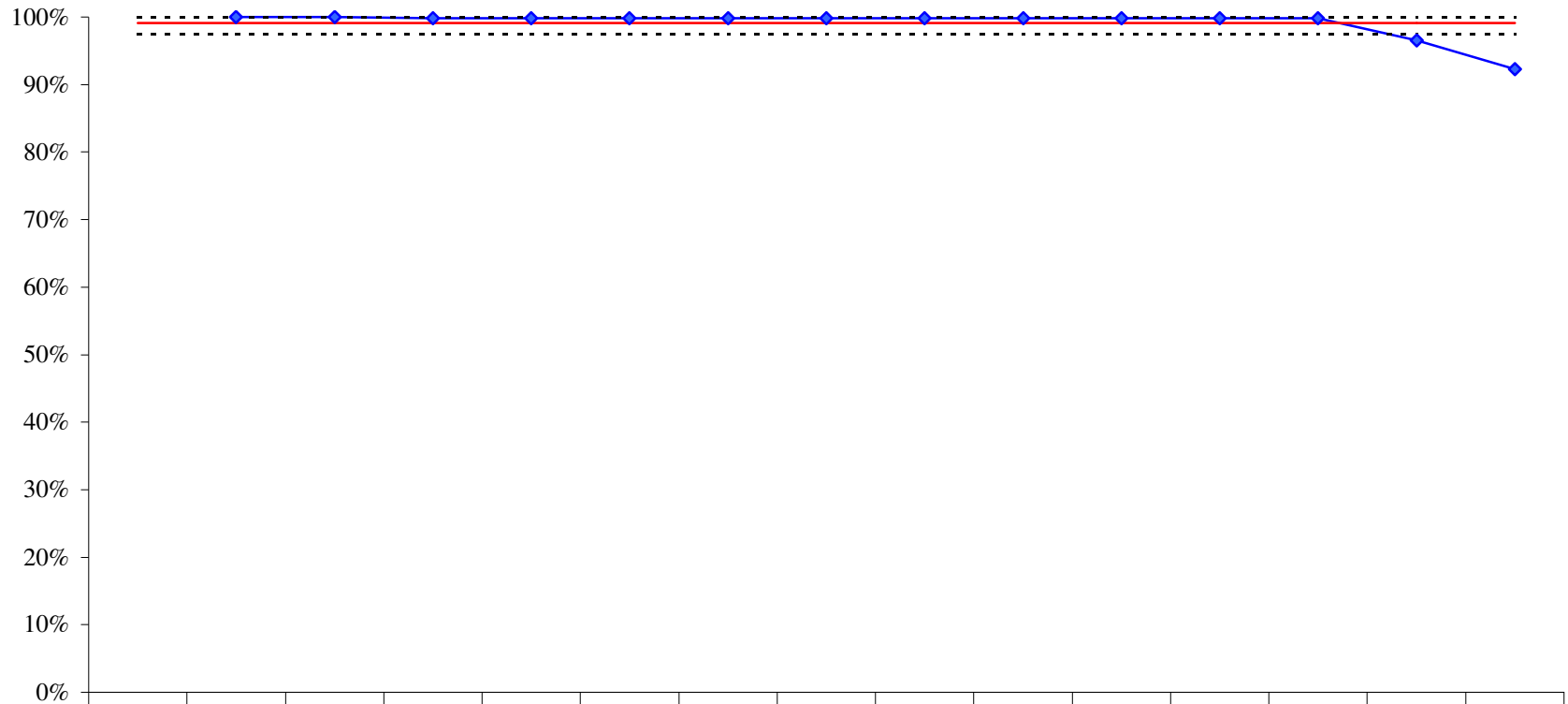
*Data not available

Chart: Hospital Management Data Services

Source: PeopleSoft MHMR1102

Objective 8B - Staff Have Current Performance Evaluations
Kerrville State Hospital

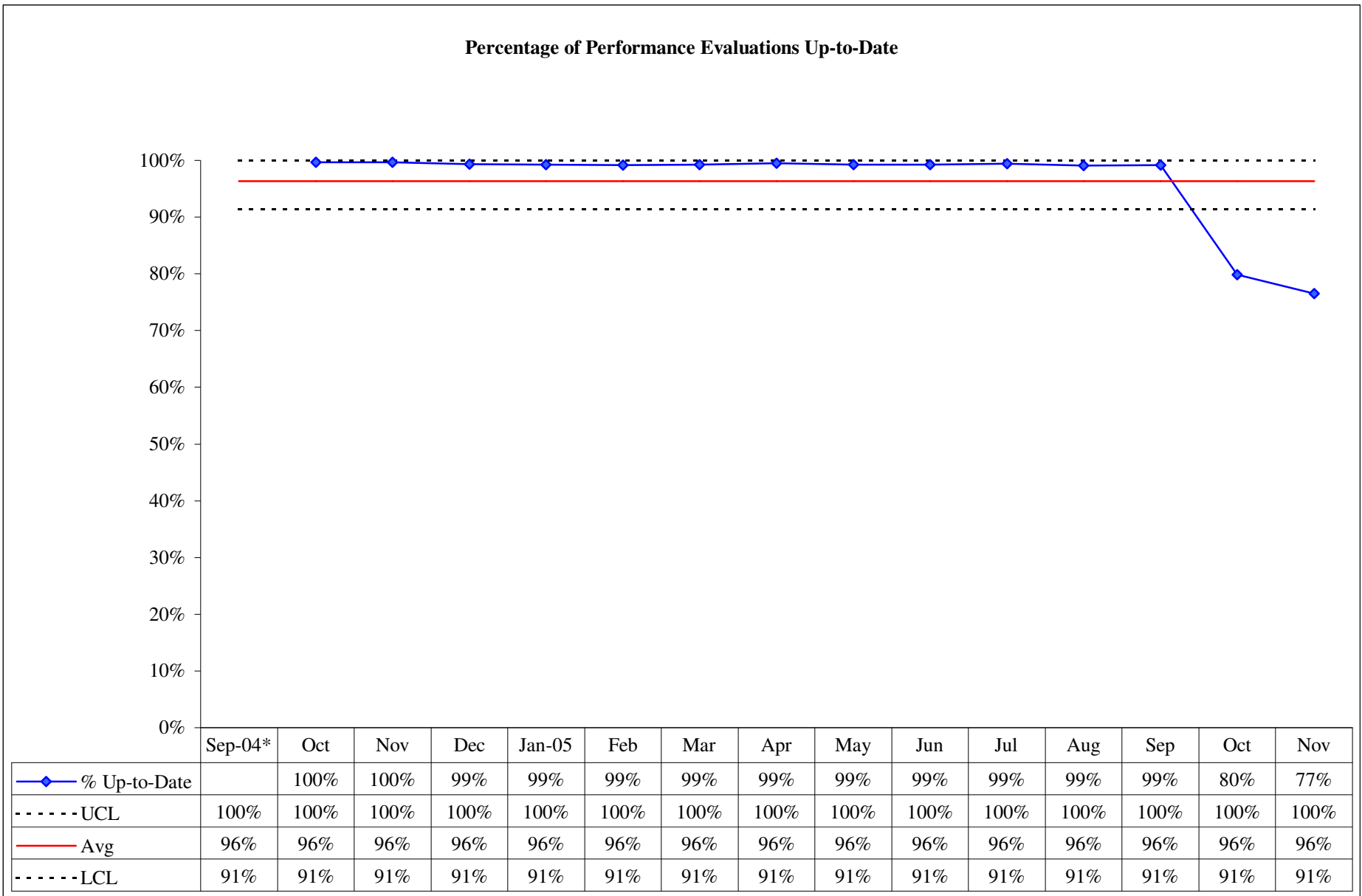
Percentage of Performance Evaluations Up-to-Date



	Sep-04*	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ % Up-to-Date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	92%
-----UCL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
— Avg	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
.....LCL	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

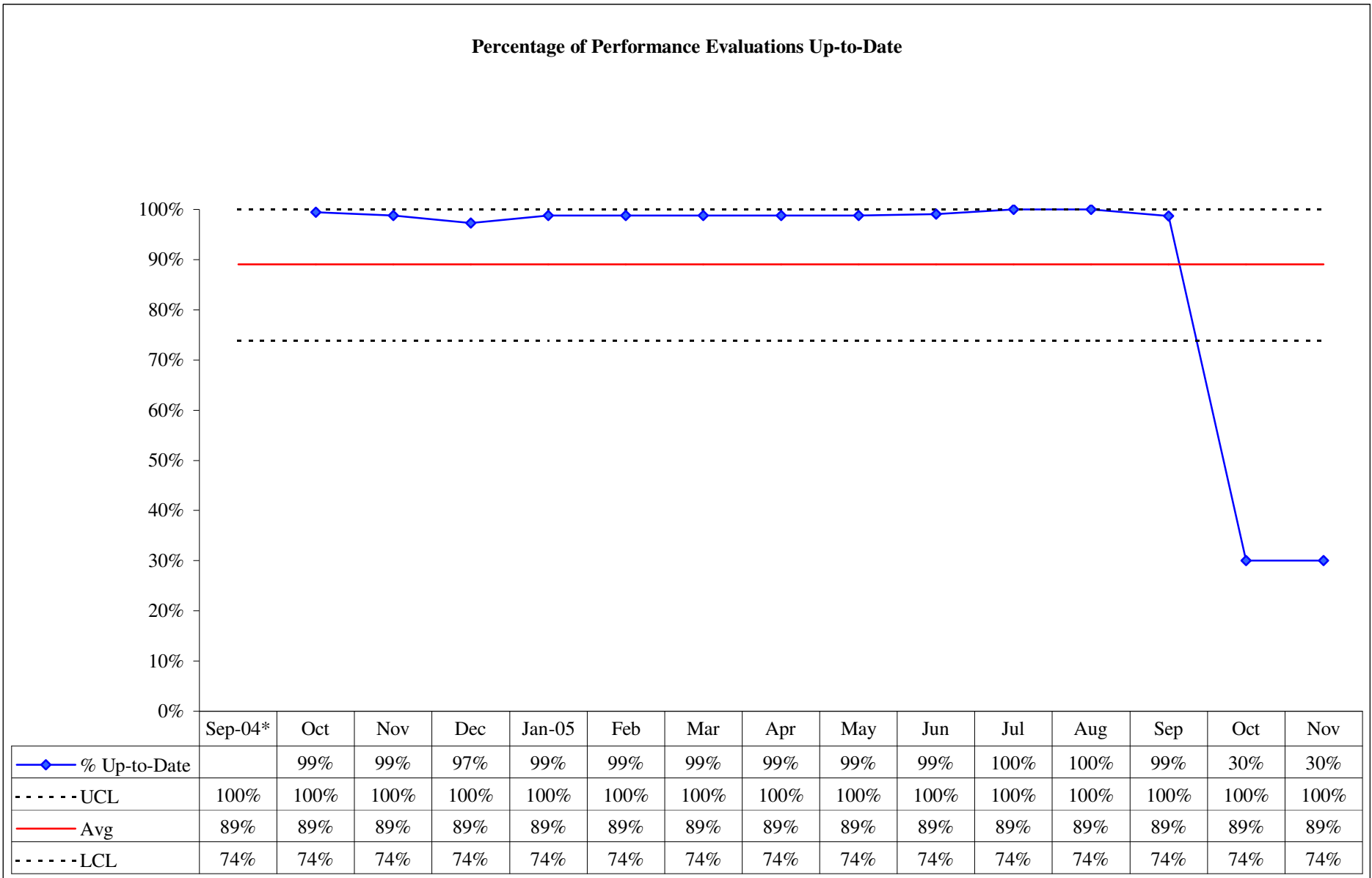
*Data not available
 Chart: Hospital Management Data Services

Objective 8B - Staff Have Current Performance Evaluations
North Texas State Hospital



*Data not available

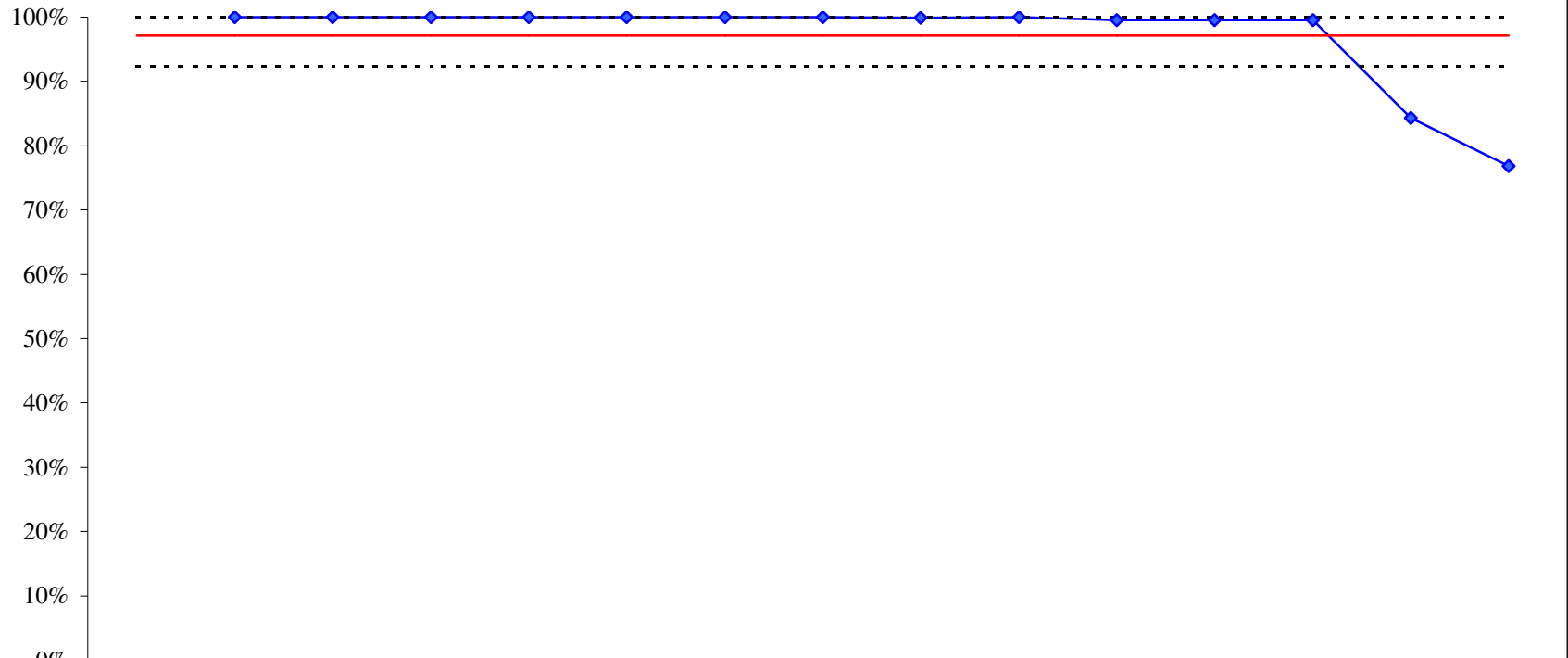
Objective 8B - Staff Have Current Performance Evaluations
Rio Grande State Center



*Data not available

Objective 8B - Staff Have Current Performance Evaluations
Rusk State Hospital

Percentage of Performance Evaluations Up-to-Date

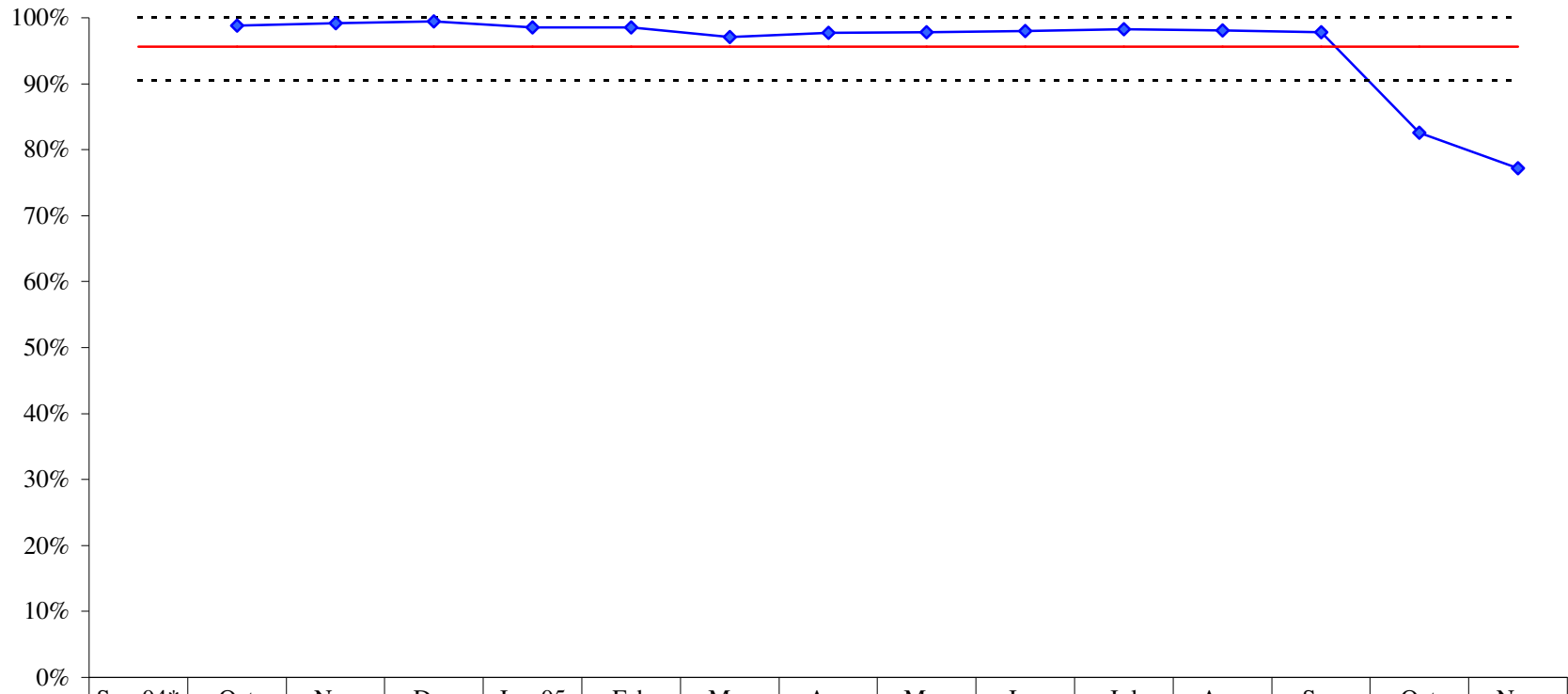


	Sep-04*	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ % Up-to-Date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	84%	77%
----- UCL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
— Avg	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
----- LCL	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

*Data not available

Objective 8B - Staff Have Current Performance Evaluations
San Antonio State Hospital

Percentage of Performance Evaluations Up-to-Date

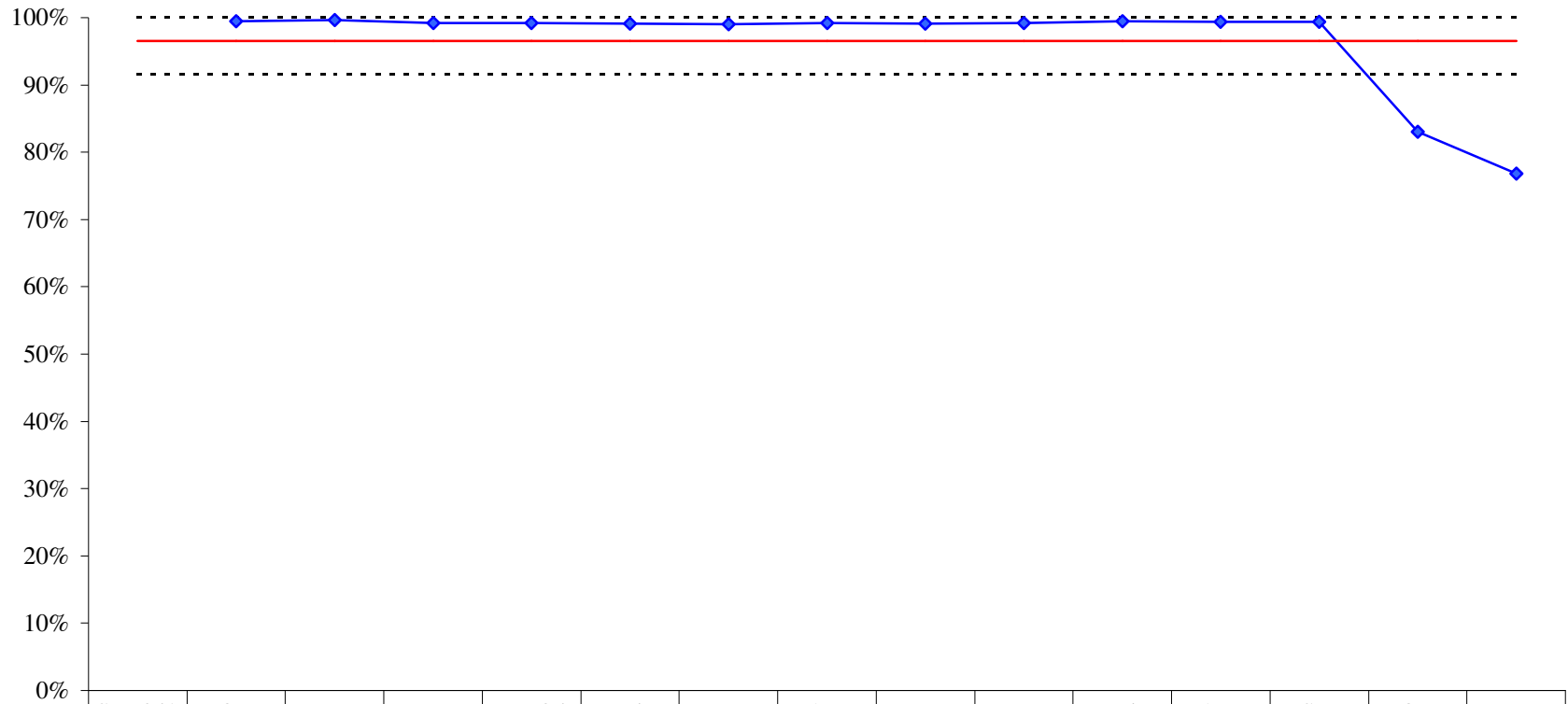


	Sep-04*	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
◆ % Up-to-Date		99%	99%	99%	99%	99%	97%	98%	98%	98%	98%	98%	98%	83%	77%
----- UCL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
— Avg	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
----- LCL	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

*Data not available

Objective 8B - Staff Have Current Performance Evaluations
Terrell State Hospital

Percentage of Performance Evaluations Up-to-Date



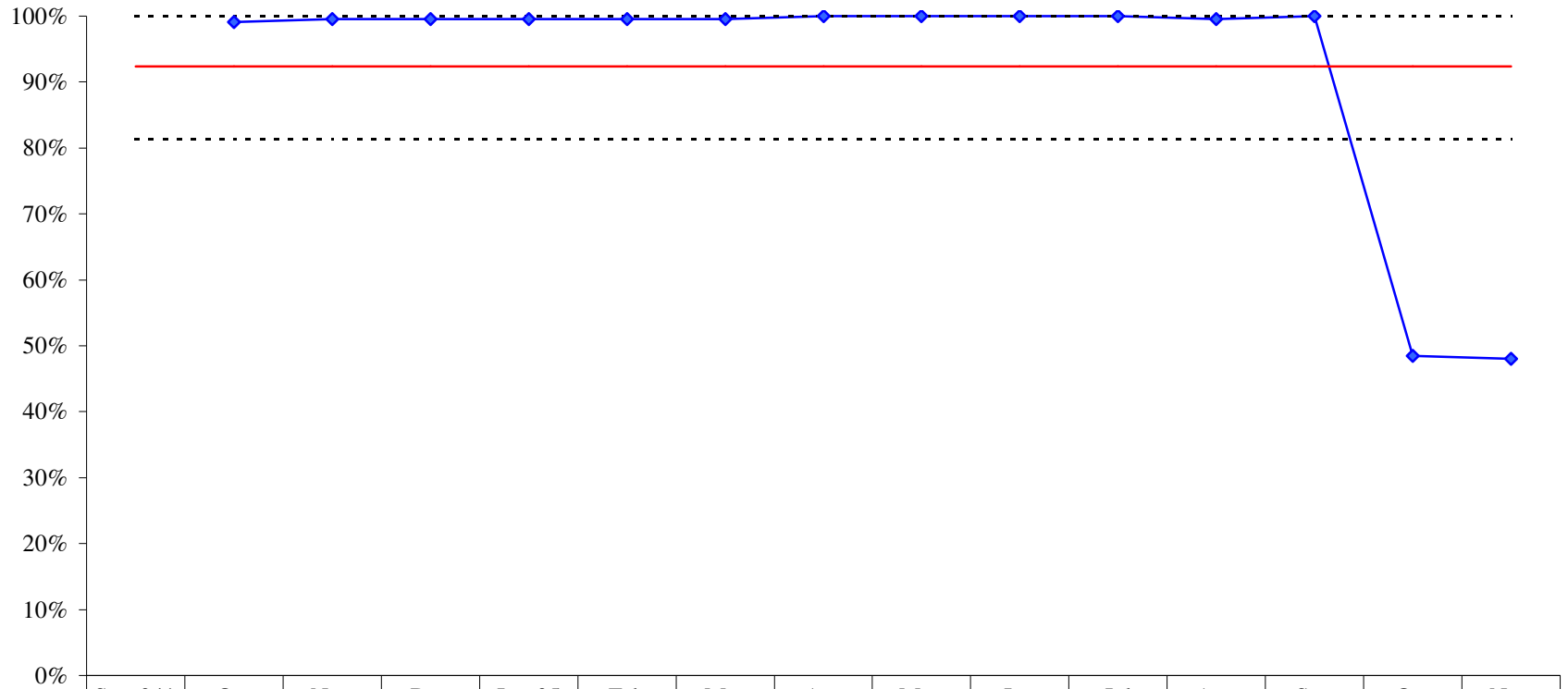
*Data not available

Chart: Hospital Management Data Services

Source: PeopleSoft MHMR1102

Objective 8B - Staff Have Current Performance Evaluations
Waco Center For Youth

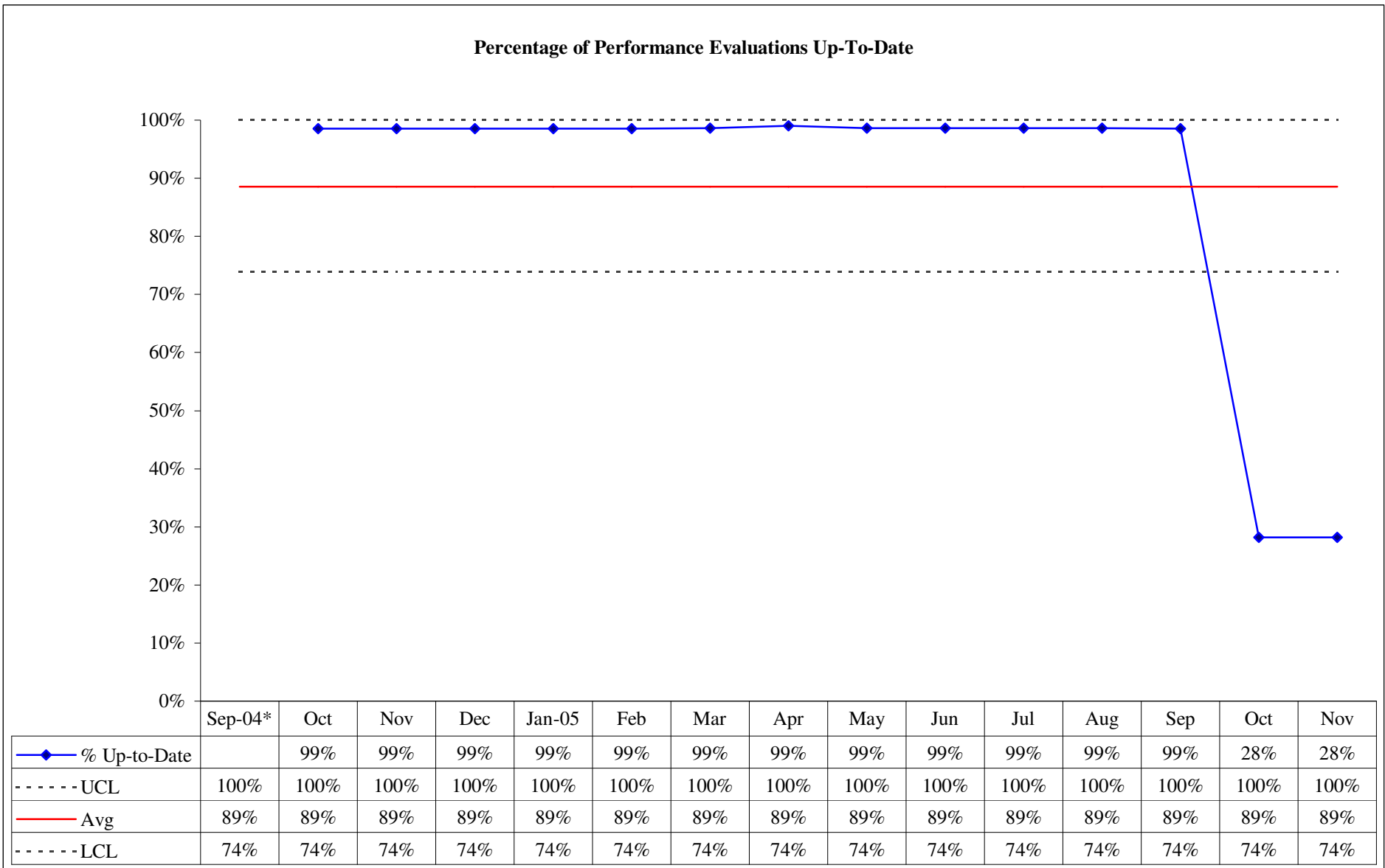
Percentage of Performance Evaluations Up-to-Date



◆ % Up-to-Date		99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	48%	48%
----- UCL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
— Avg	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
----- LCL	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%

*Data not available

Objective 8B - Staff Have Current Performance Evaluations
Texas Center for Infectious Disease



*Data not available

Performance Measure 8A:

“Staff Turnover” rates for critical shortage staff will be maintained and reported quarterly.

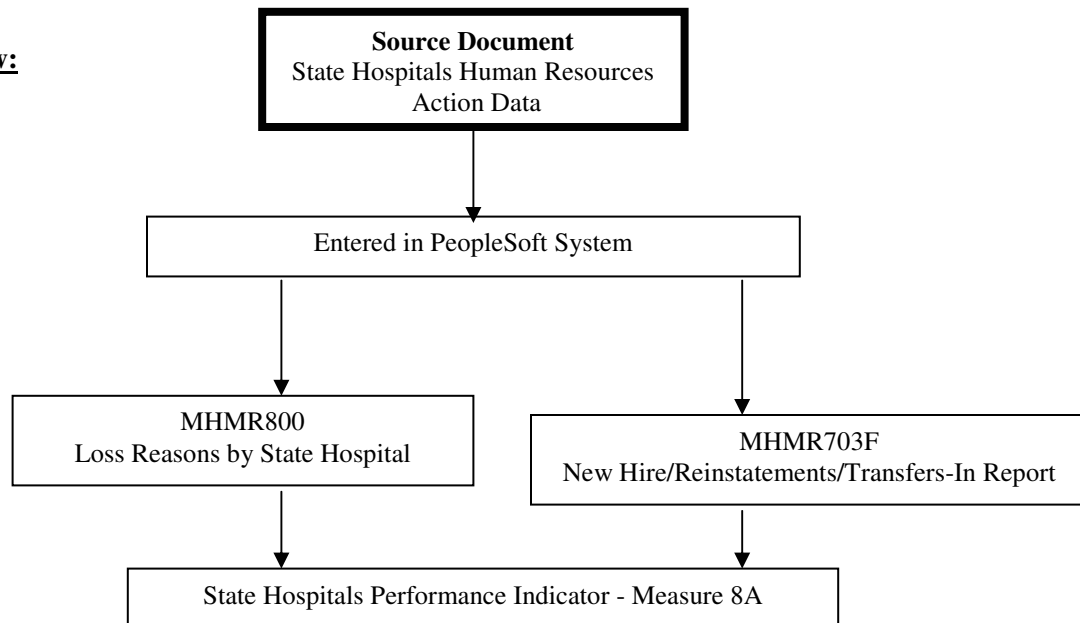
Performance Measure Operational Definition: The state hospital rate of staff turnover relating to “new hires” and “losses” will be available to the board.

Performance Measure Formula: Two formulas are used to calculate turnover for this report. The first formula for calculating turnover is [(number of losses/average strength for reporting period) x 100]. (Number of losses is not reported in full-time equivalents). The second formula for calculating turnover is [(number of new hires, transfers-in and reinstatements/average strength for reporting period) x 100]. Average daily strength is calculated by adding the total number of filled positions for each day in the reporting period, and dividing by the total number of days in the reporting period.

Performance Measure Data Display and Chart Description:

- ◆ Table shows new hires, losses and average daily strength for individual state hospitals and system-wide.
- ◆ Chart with monthly data points of turnover rate and annualized turnover (twelve month rolling average) for individual state hospitals and system-wide.

Data Flow:



Data Integrity Review Process:

Staff turnover rates are not subject to a data integrity review at this time.

Measure 8A - Staff Turnover Rates
All MH Facilities

Annualized Turnover
(Twelve Month Rolling Average)

70%
60%
50%
40%
30%
20%
10%
0%

Data Not Available At This Time

	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY
■ Turnover (New Hires/Strength)										
■ Turnover (Losses/Strength)										

Source: Loss Reasons by Business Unit (MHMR800-PeopleSoft)
 New Hires/Reinstatements/Transfers In (MHMR703F-PeopleSoft)

Performance Measure 8B:

Number of statewide vacancies for critical shortage staff will be maintained and reported quarterly.

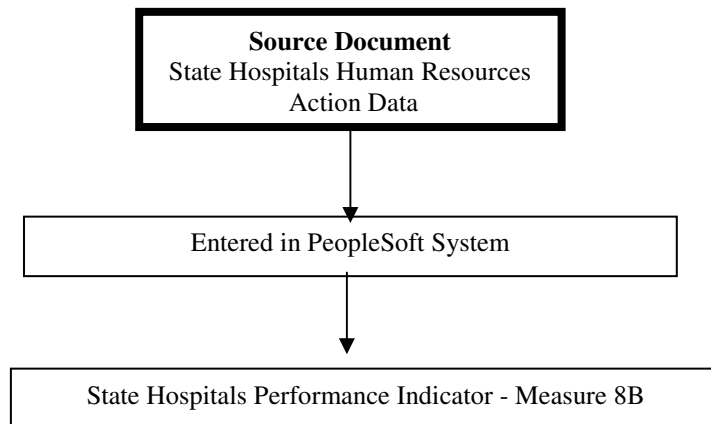
Performance Measure Operational Definition: The statewide vacancies rate for critical shortage staff will be maintained.

Performance Measure Formula:

Performance Measure Data Display and Chart Description:

- ◆ Table shows vacancies rate for individual state hospitals and system-wide.

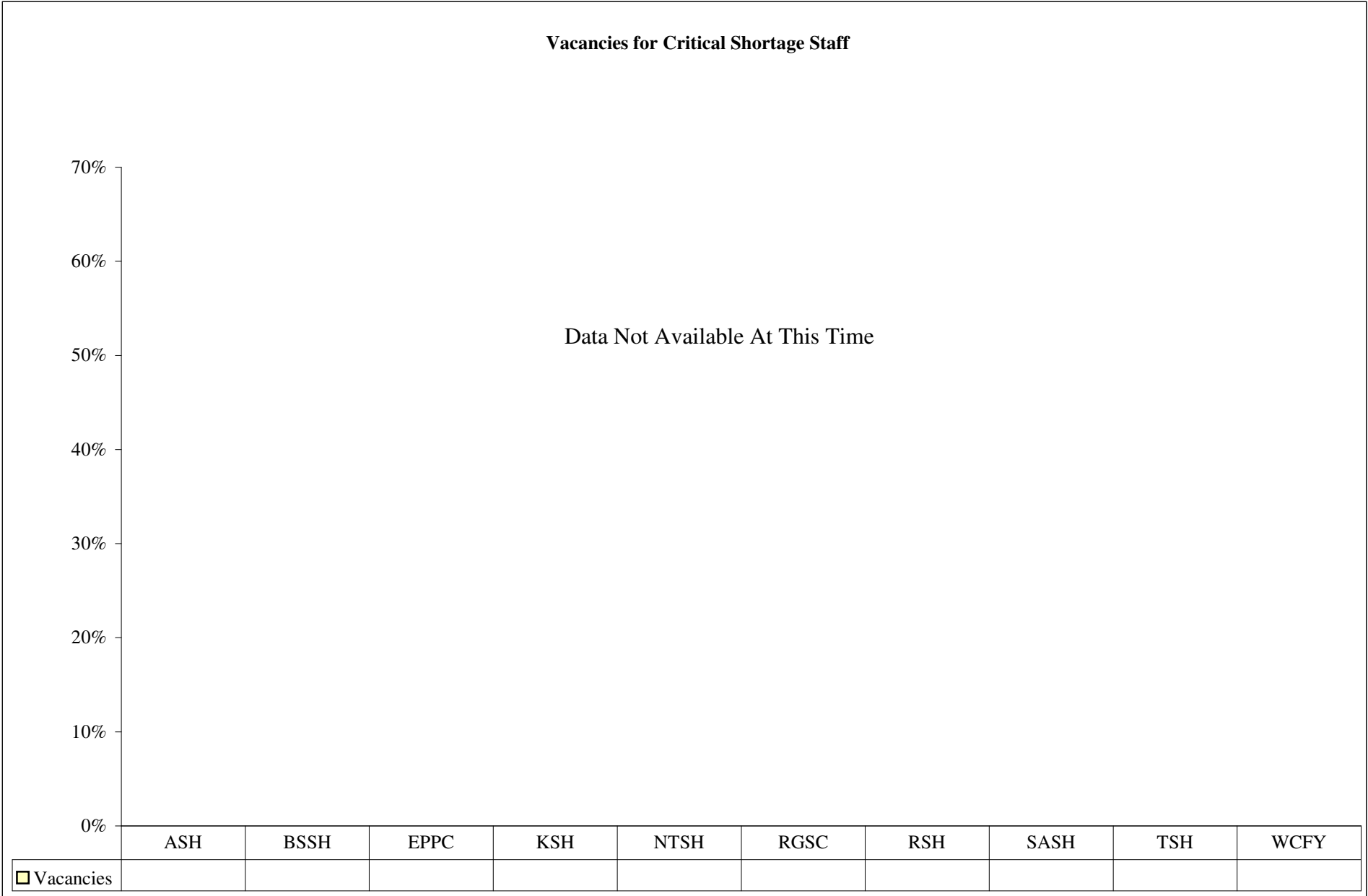
Data Flow:



Data Integrity Review Process:

Vacancies for critical shortage staff rates are not subject to a data integrity review at this time.

Measure 8B - Vacancies for Critical Shortage Staff
All MH Facilities



Source: Loss Reasons by Business Unit (MHMR800-PeopleSoft)
 New Hires/Reinstatements/Transfers In (MHMR703F-PeopleSoft)

GOAL 9: Improve Organizational Performance

Performance Objective 9A:

Children and parent(s) or the legally authorized representative will be satisfied with the treatment and safe milieu provided by in state mental health hospitals by achieving the following average response on the Patient Satisfaction Surveys (PSAT).

- 1. An average score of “4” on the Parent Satisfaction Survey**
- 2. An average score of “1.698” on the Children Satisfaction Survey**

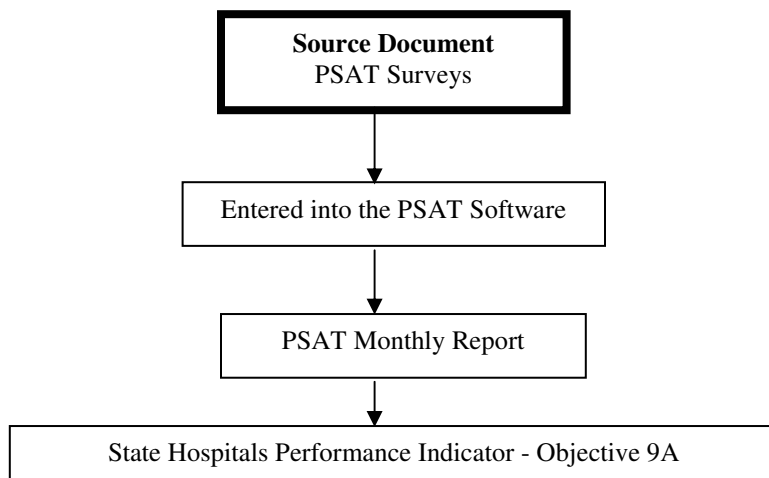
Performance Objective Operational Definition: At least 20% of discharges should be sampled each month for children (age 5-12) and for parents.

Performance Objective Formula: PSAT System gives the frequency of response and the percent of total sample on the 5-point Likert scale for the overall score.

Performance Objective Data Display and Chart Description:

- ◆ Bar chart showing scores for individual state hospitals.
- ◆ Line chart with monthly data points of children scores and parent scores for individual state hospitals and system-wide.

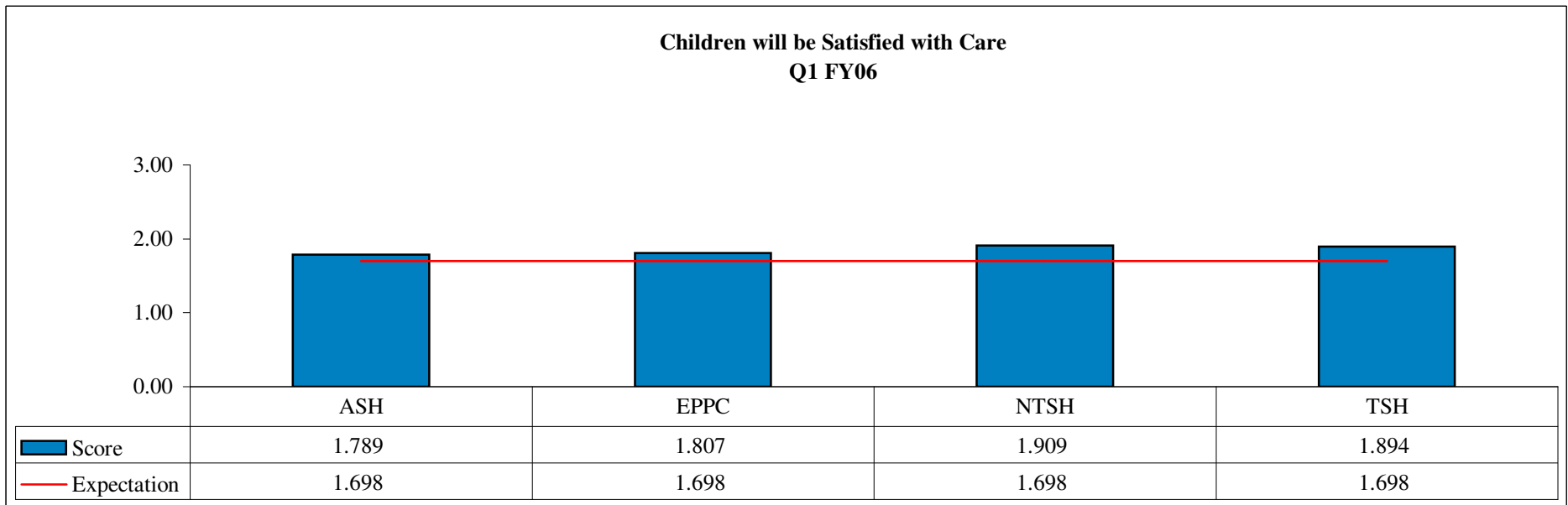
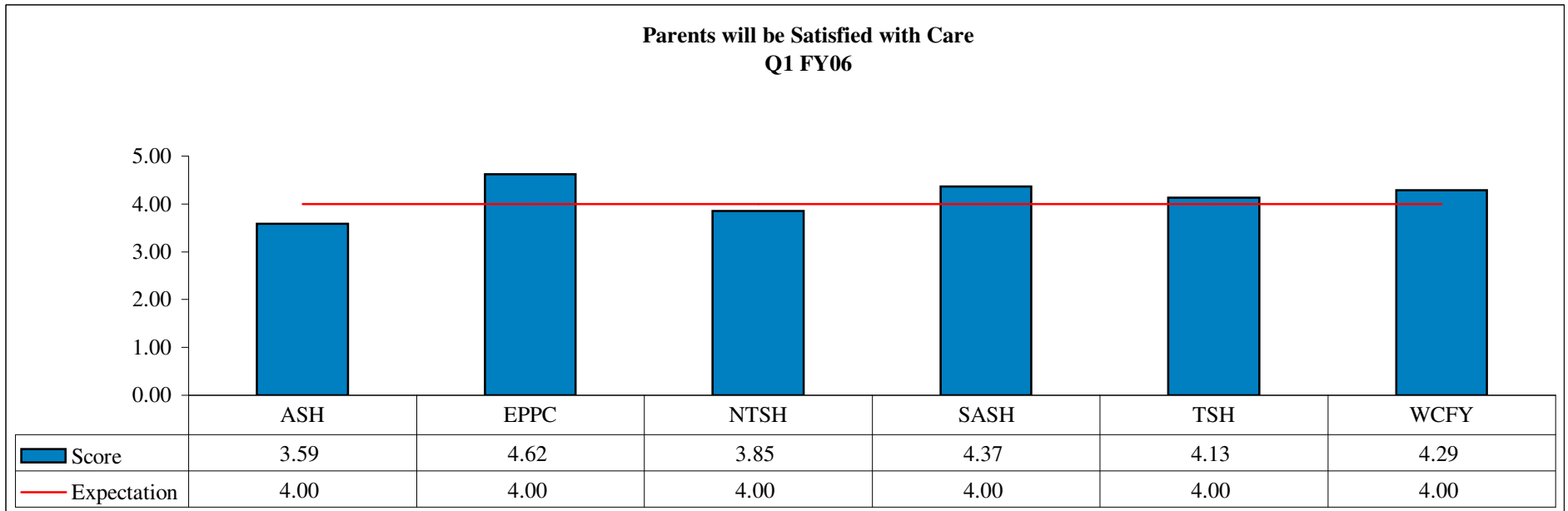
Data Flow:



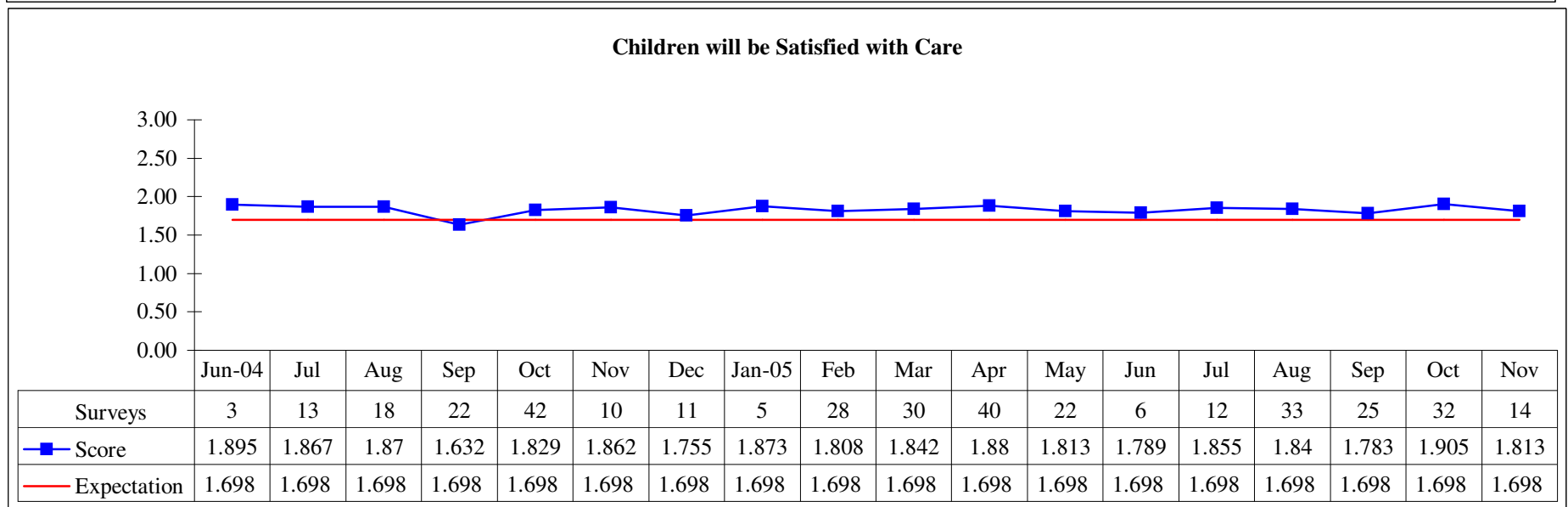
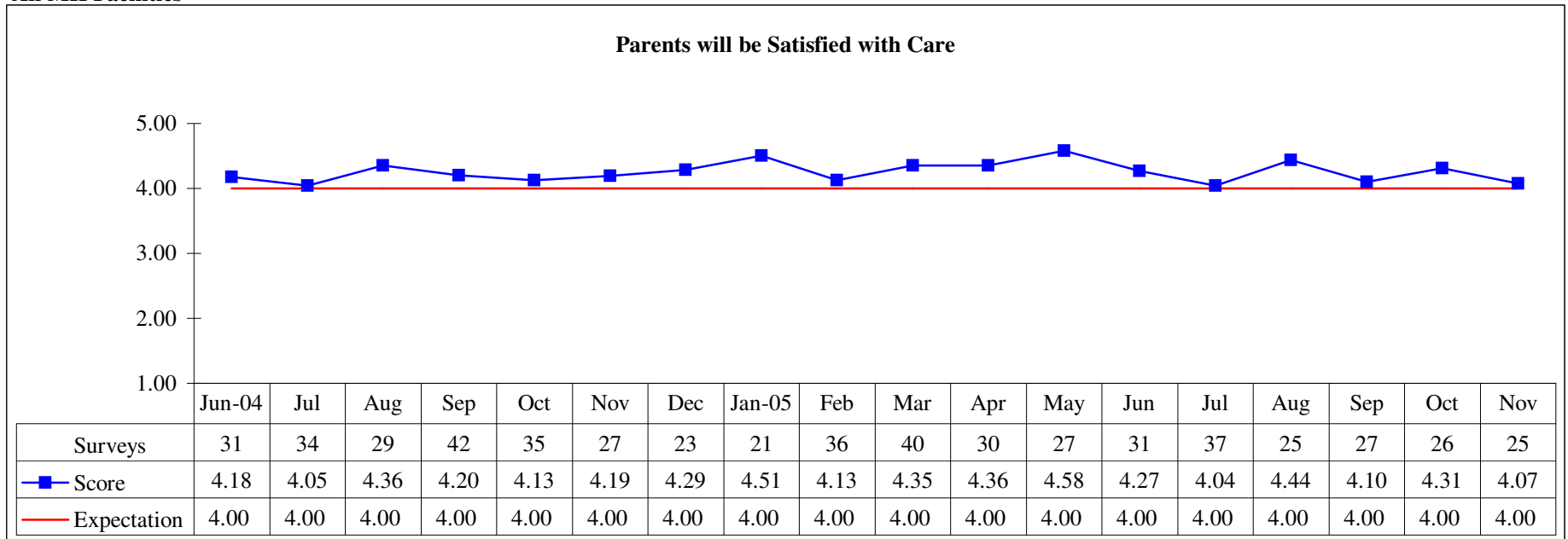
Data Integrity Review Process:

Children and parent satisfaction surveys are not subject to a data integrity review at this time.

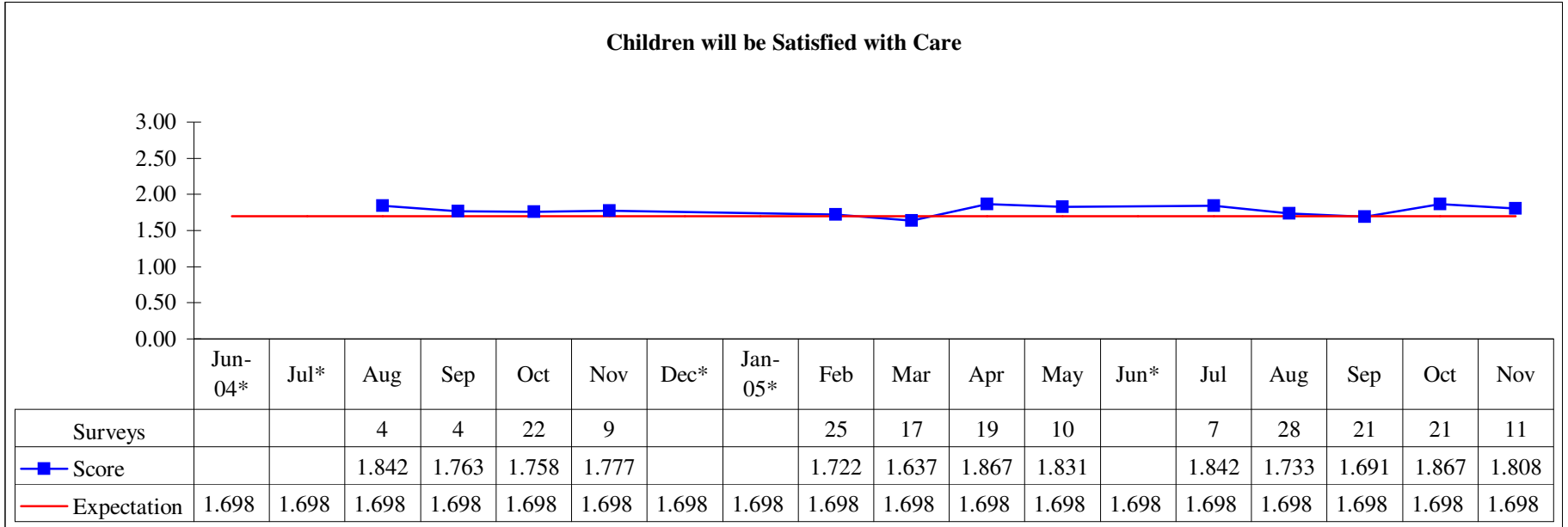
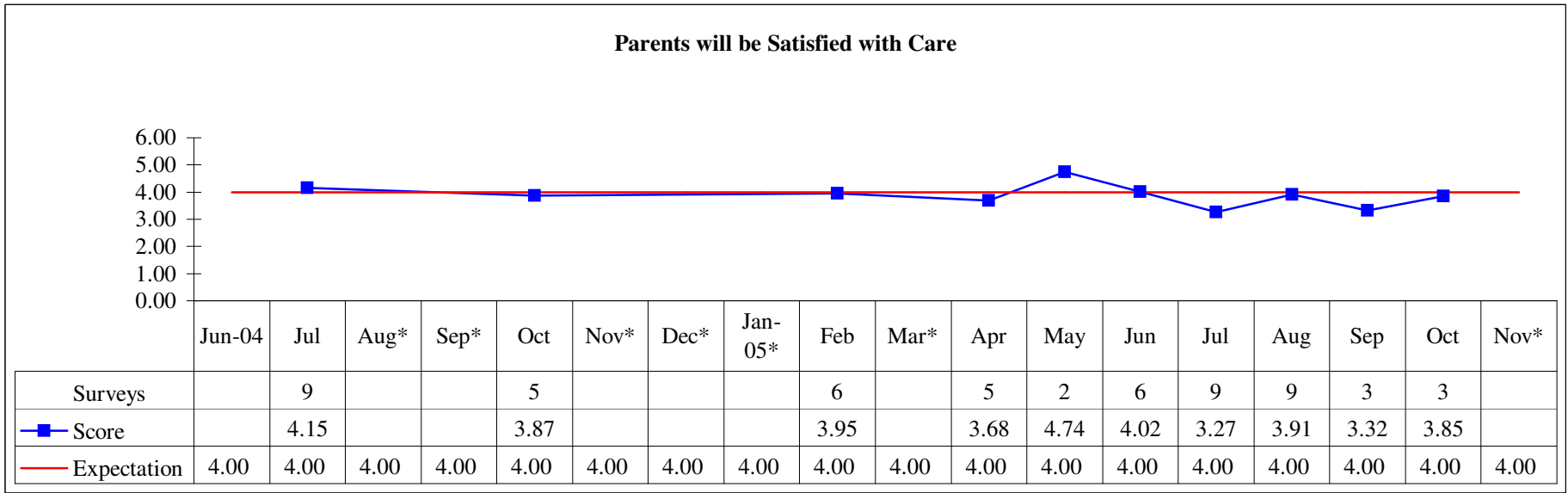
Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
All MH Facilities



Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
All MH Facilities

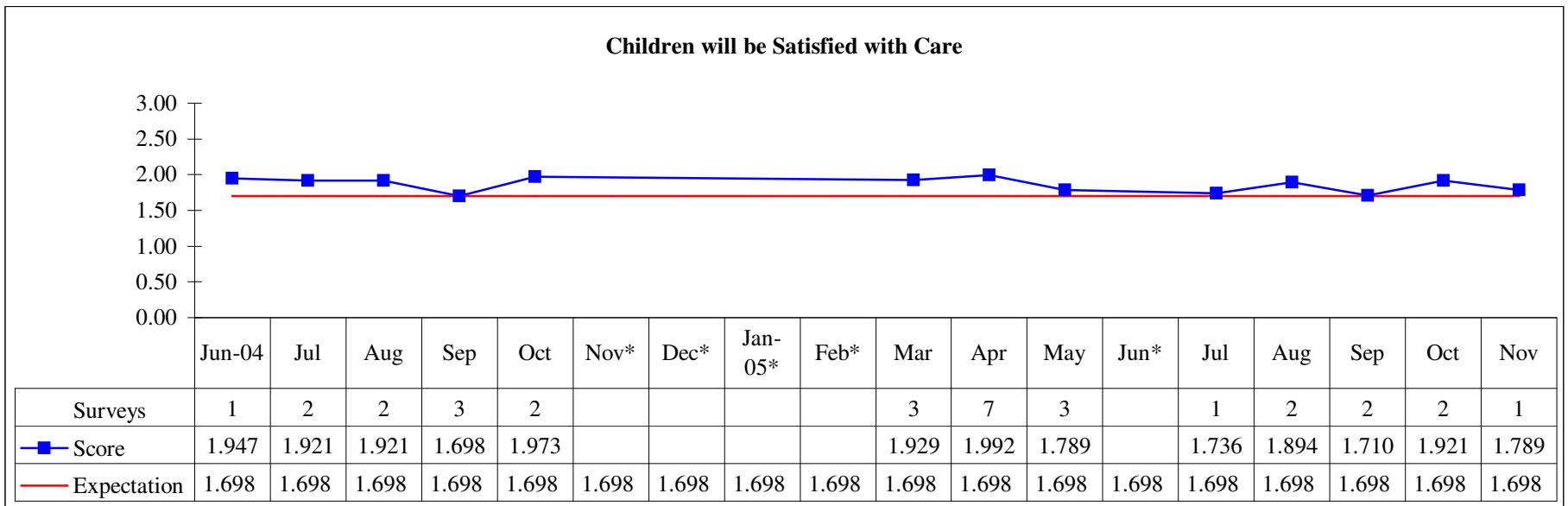
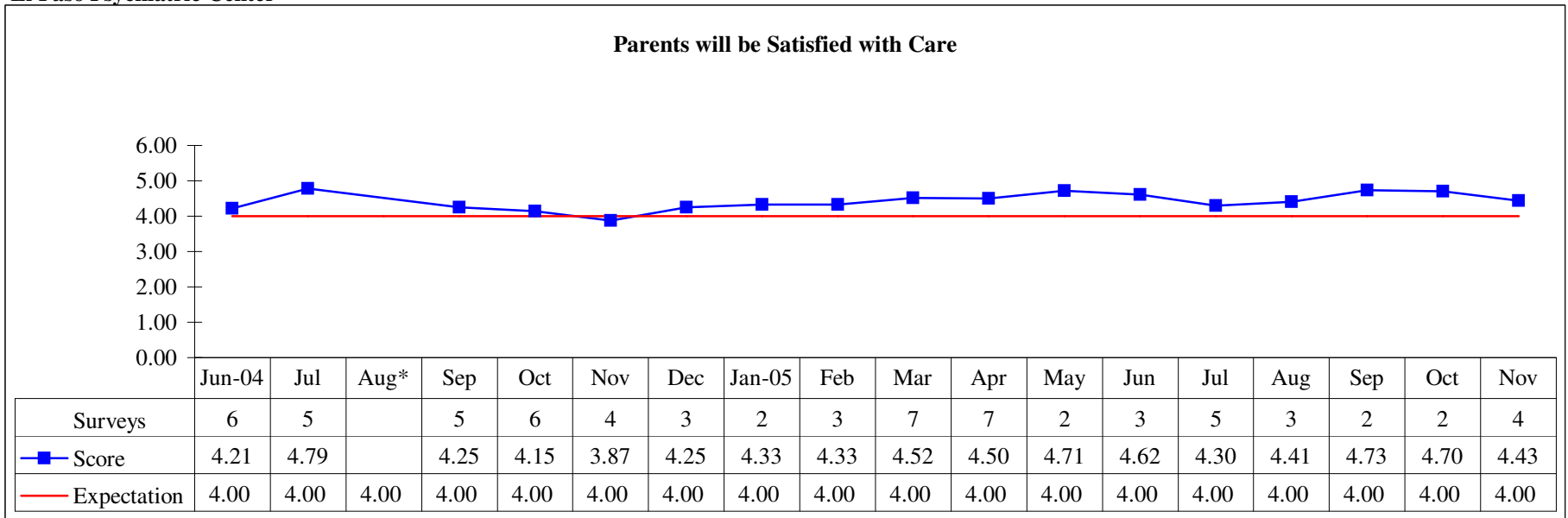


Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
Austin State Hospital



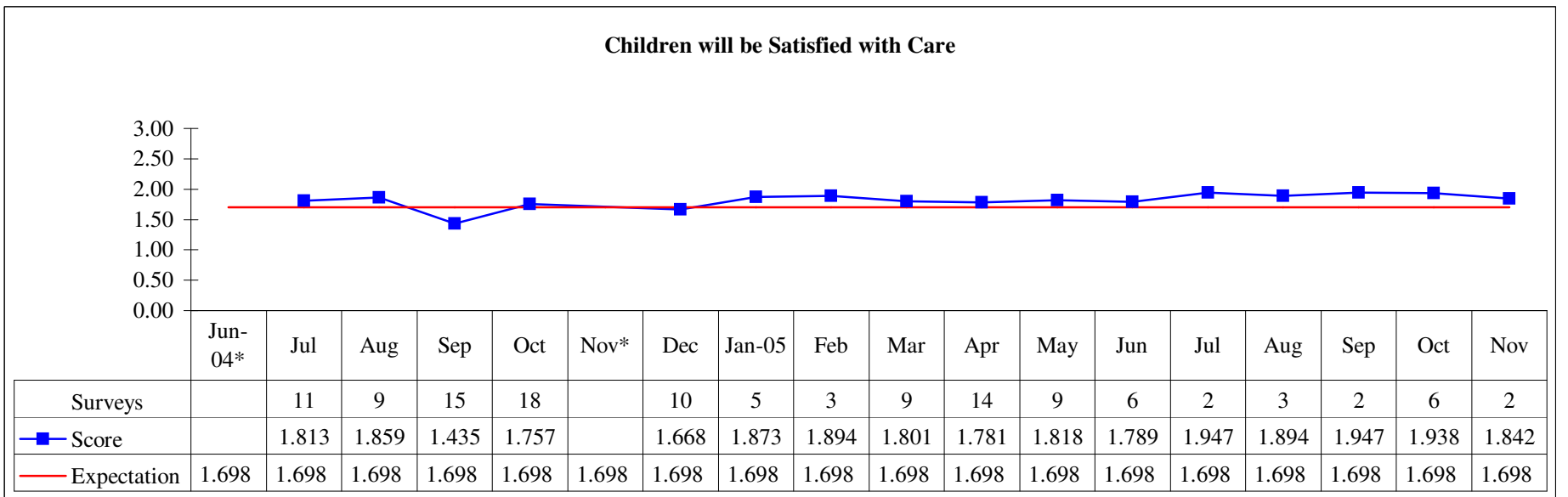
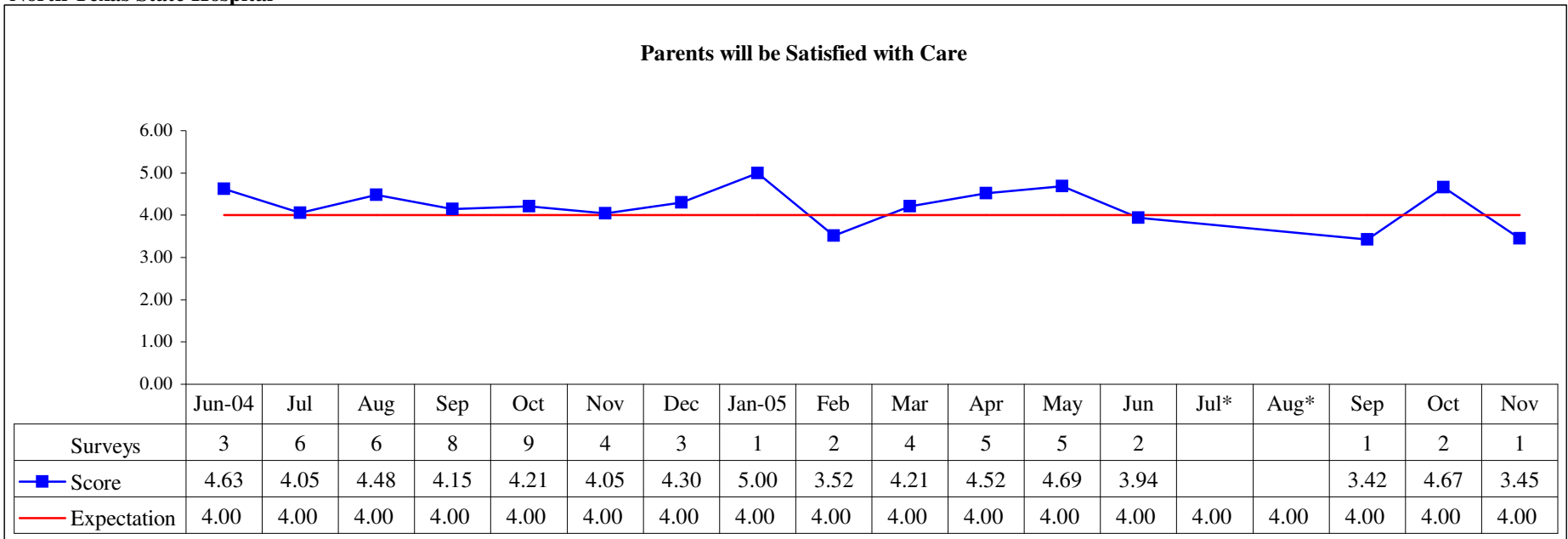
*No surveys submitted

Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
El Paso Psychiatric Center



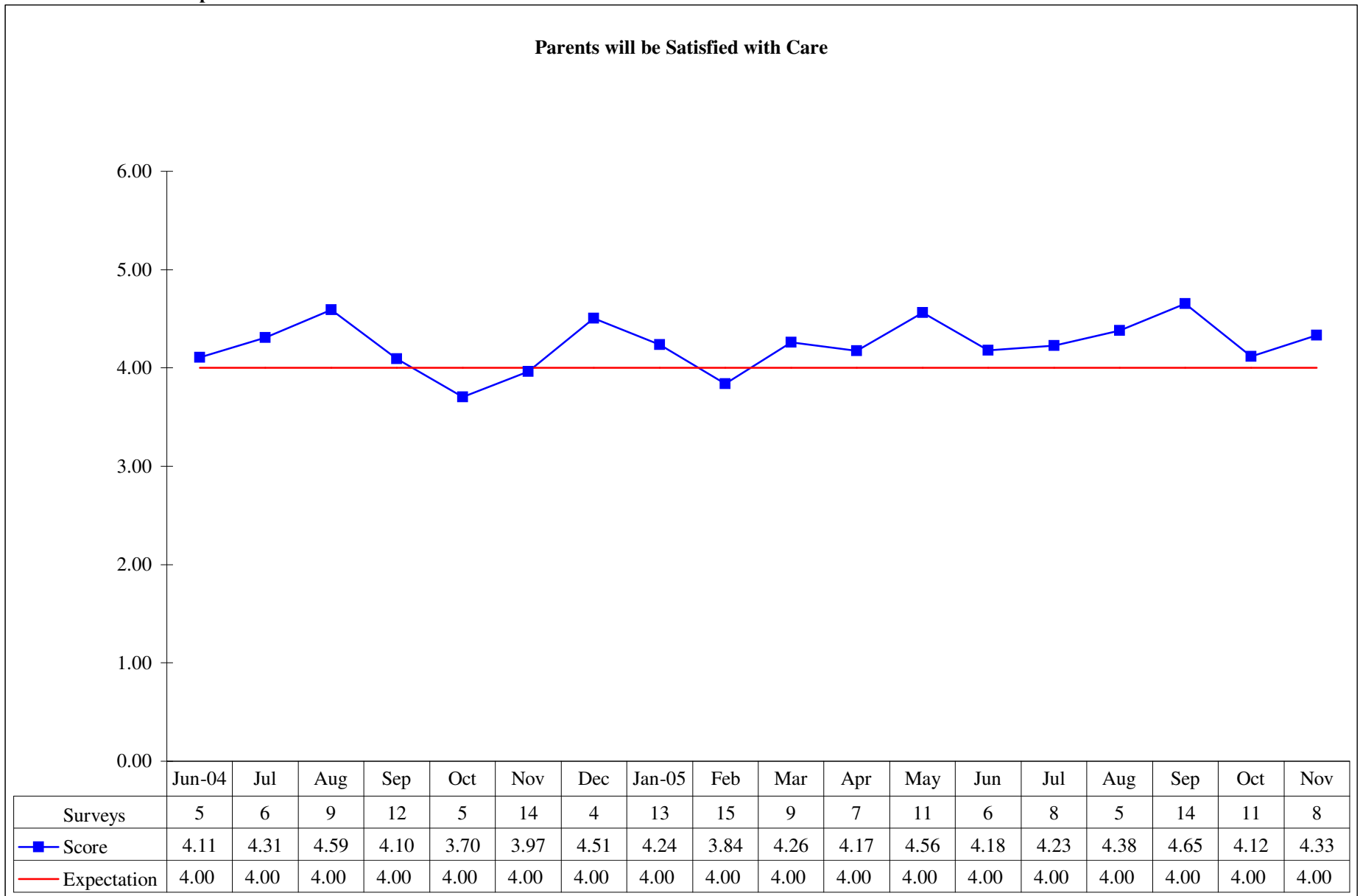
*No surveys submitted

Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
North Texas State Hospital

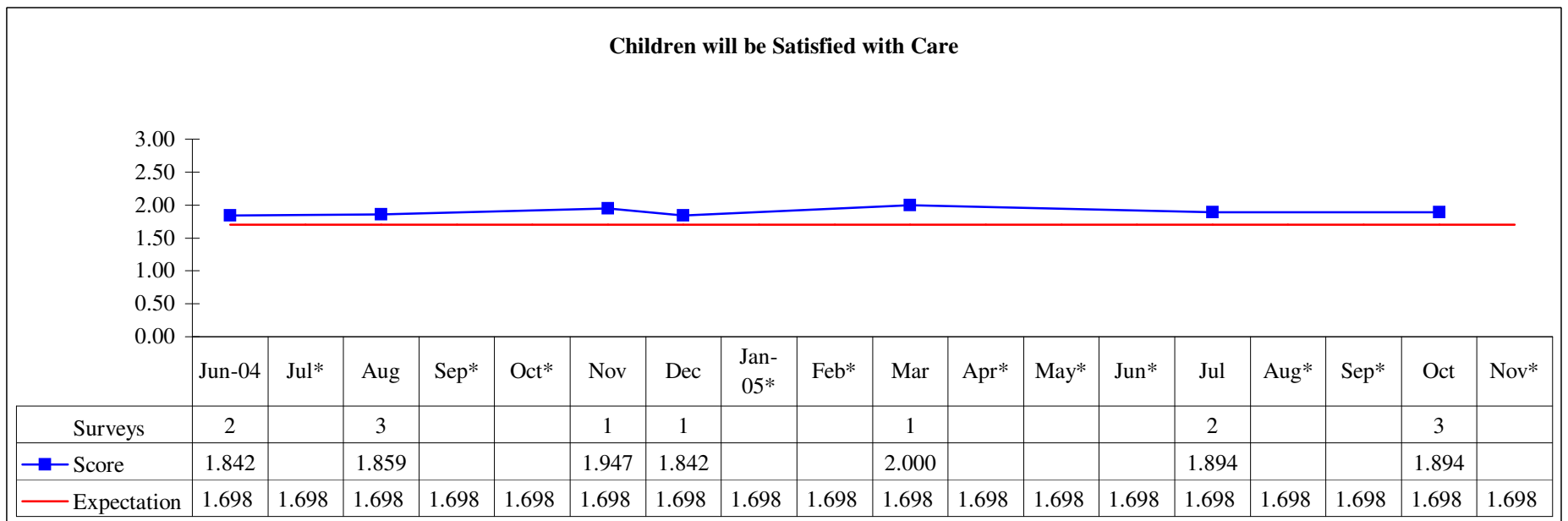
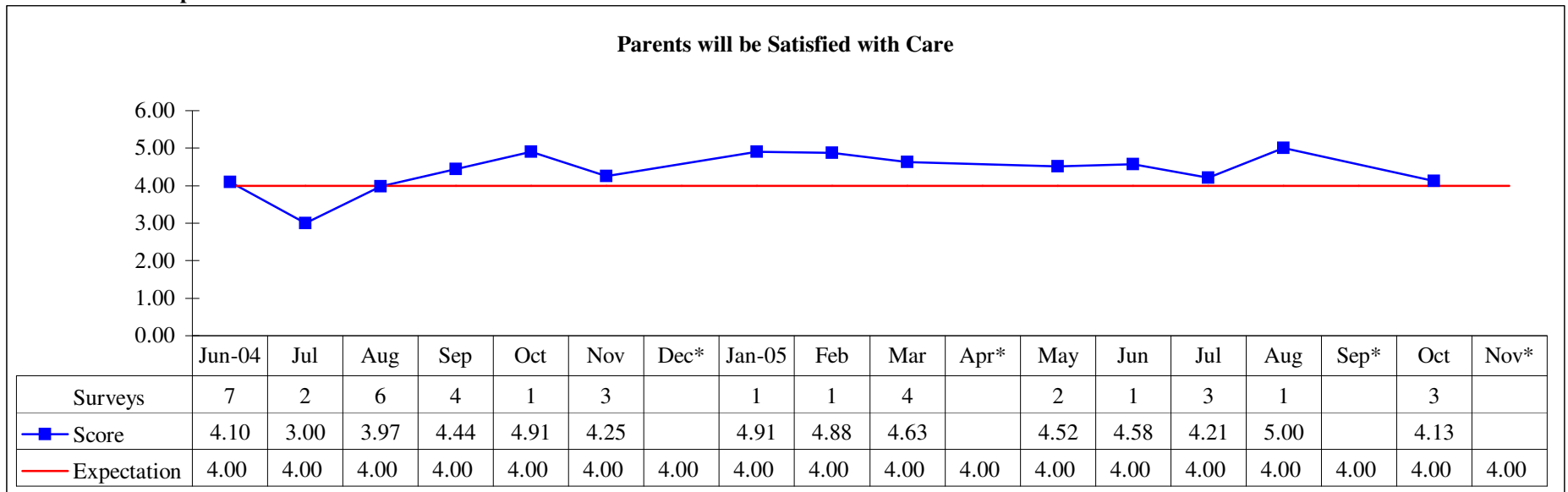


*No surveys submitted

Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
San Antonio State Hospital

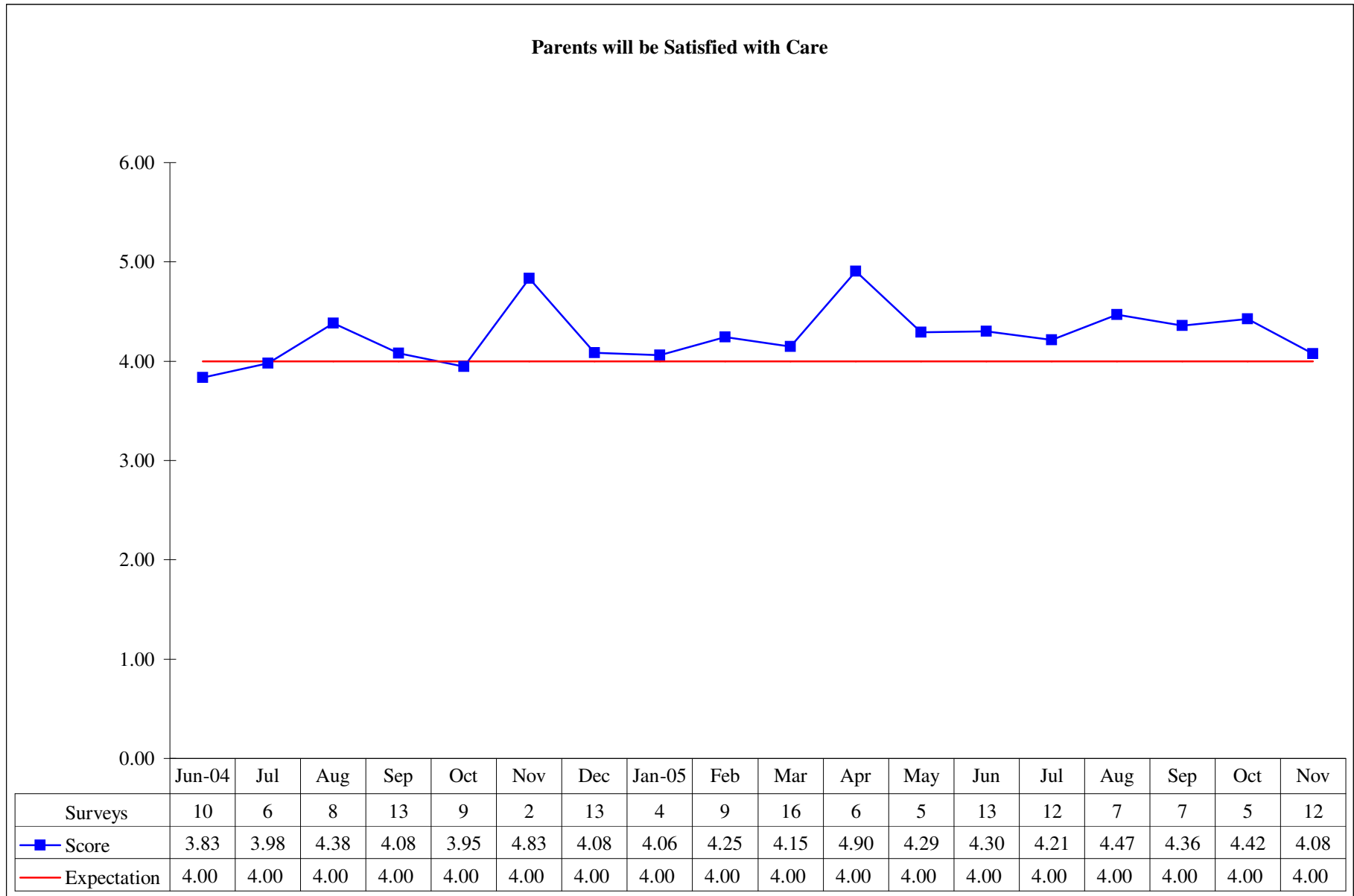


Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
Terrell State Hospital



*No surveys submitted

Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
Waco Center for Youth



Performance Objective 9B:

Adults and adolescents will be satisfied with their care at state mental health hospitals as represented by achieving an average score of 3.60 on the NRI Inpatient Consumer Survey (NRI-ICS).

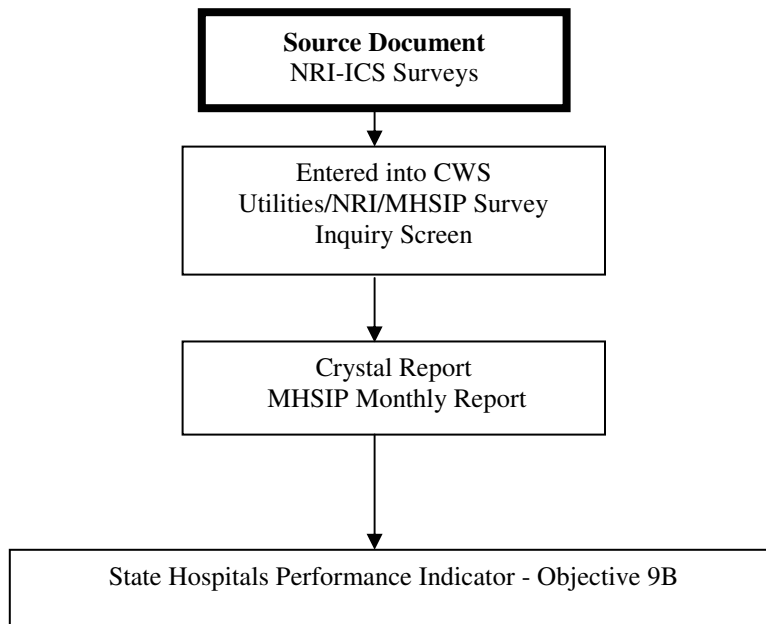
Performance Objective Operational Definition: At least 25% of discharges should be sampled each month for adult and adolescent patients.

Performance Objective Formula: NRI-ICS gives the frequency of response and the percent of total sample on the 5-point Likert scale for the overall score.

Performance Objective Data Display and Chart Description:

- ◆ Bar chart showing scores for individual state hospitals.
- ◆ Bar chart showing percentages of discharges surveyed for individual state hospitals.
- ◆ Control chart with monthly data points of scores for individual state hospitals and system-wide. Chart shows number of surveys, number of discharges and the percentage of discharges surveyed for individual state hospitals.

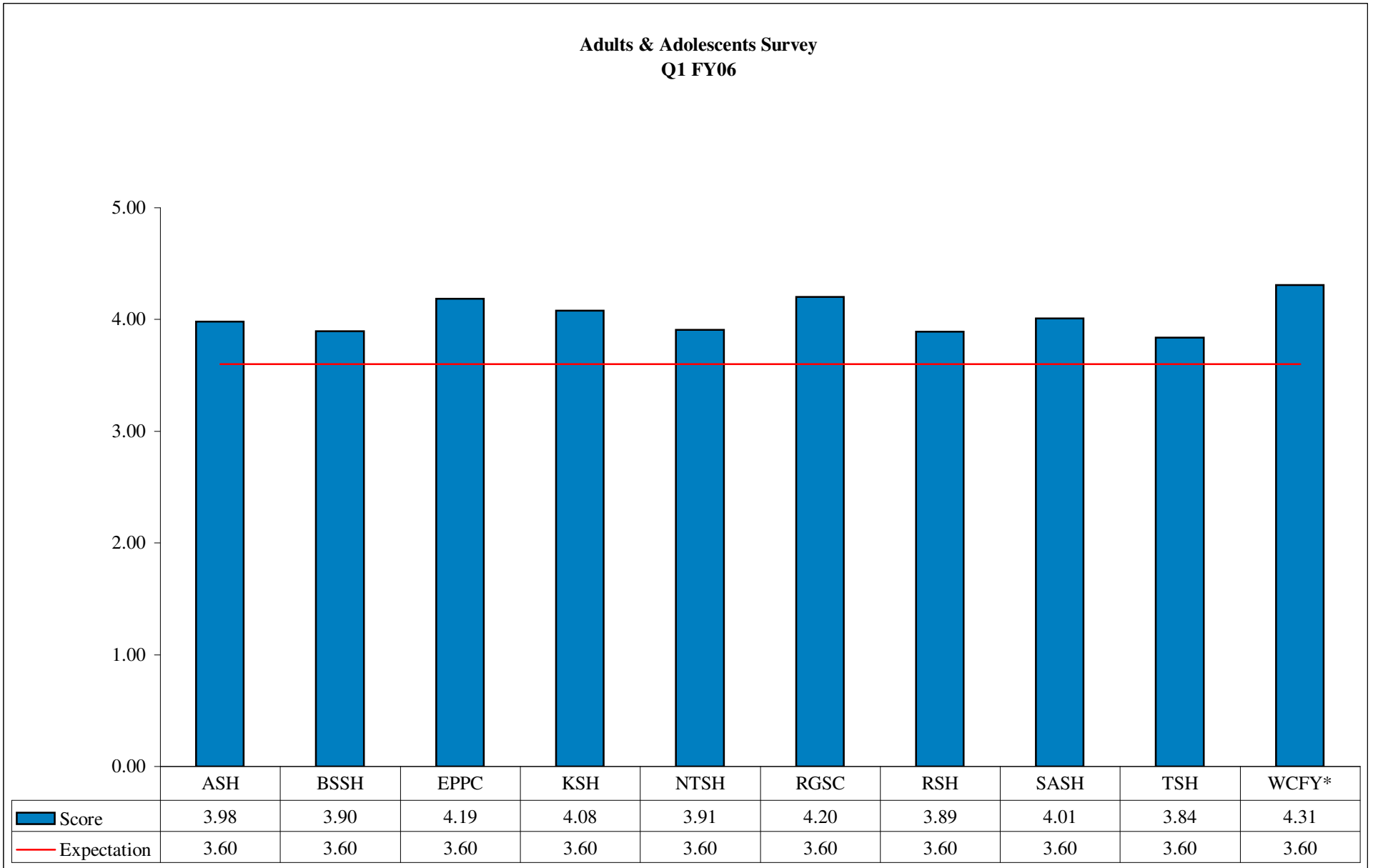
Data Flow:



Data Integrity Review Process:

Monitoring Method	Adult patient satisfaction survey review using the most recent NRI PMS quarterly episode file data to select sample.
Monitoring Instrument/Tool	NRI Inpatient Consumer Survey sample list, audit sheet and facility hard copy surveys
Description of Review Process	Copies of the original patient surveys are audited to see if the data (survey responses and demographic information) matches the corresponding information found in CWS NRI ICS (MHSIP) Reports
Sample Size	15 randomly selected surveys completed at the facility during the review period
Monitoring Frequency	Facility: Semiannually HMDS: Annually
Performance Improvement Trigger	When at least 3 of 15 surveys have data errors
DIR/HMDS Report	Summary of review including data accuracy, findings and data analysis.

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
All MH Facilities

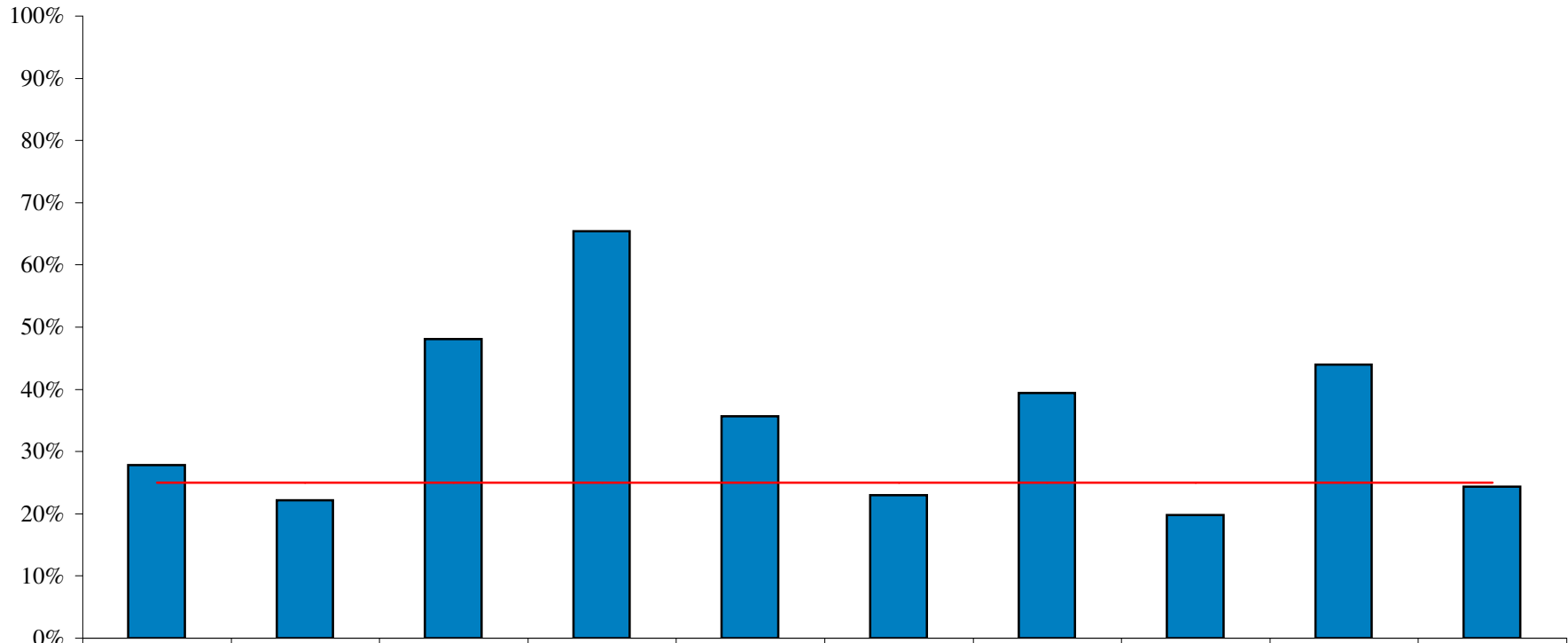


*WCFY - Adolescent Surveys Only

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
All MH Facilities

Percentage of Adult & Adolescent Surveys Completed
Q1 FY06



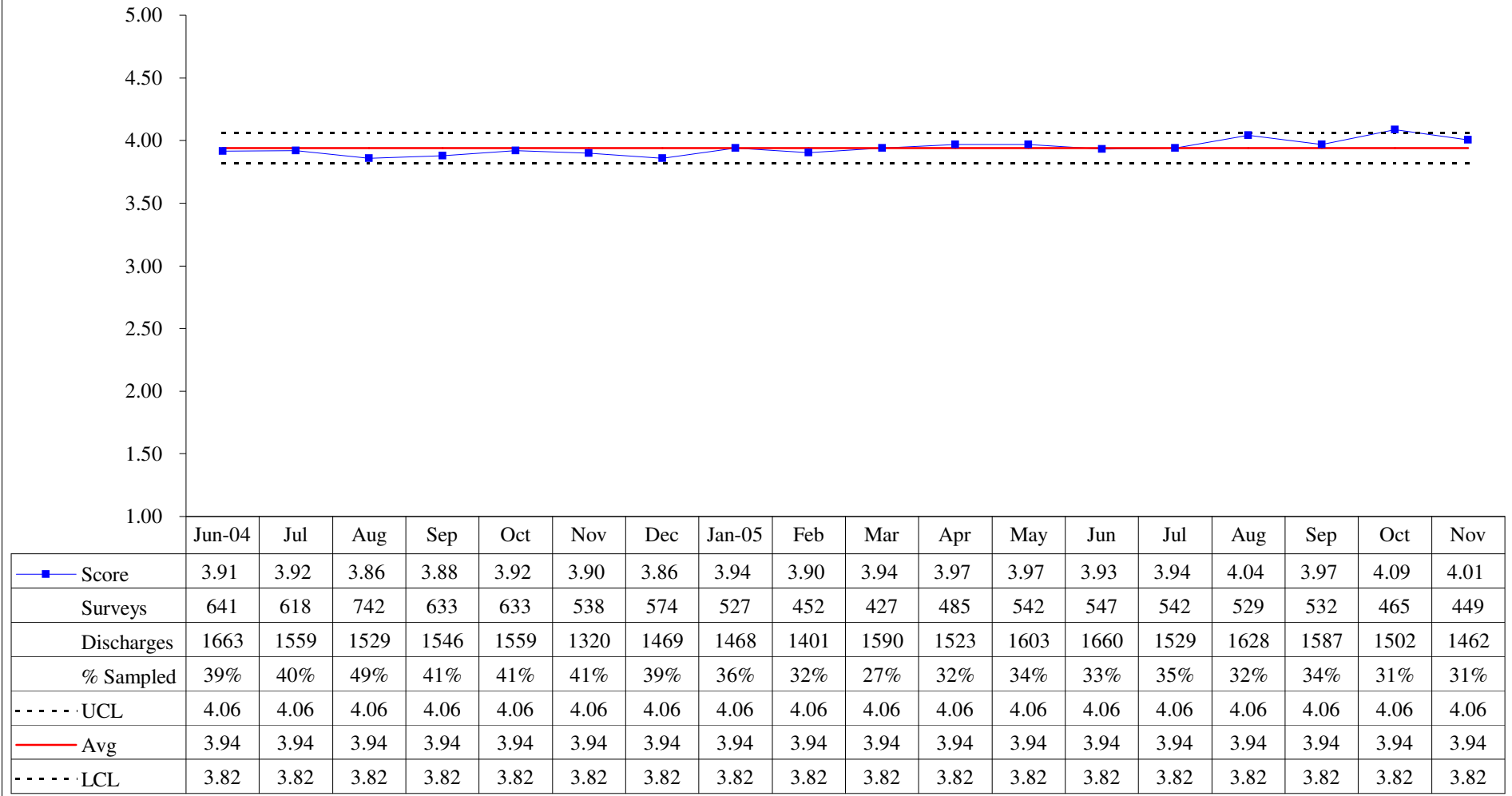
	ASH	BSSH	EPPC	KSH	NTSB	RGSC	RSH	SASH	TSH	WCFY*
Discharges	1016	280	237	78	658	305	482	865	593	37
Surveys	283	62	114	51	235	70	190	171	261	9
% Surveyed	28%	22%	48%	65%	36%	23%	39%	20%	44%	24%
Expectation	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%

*WCFY - Adolescent Surveys Only

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
All MH Facilities

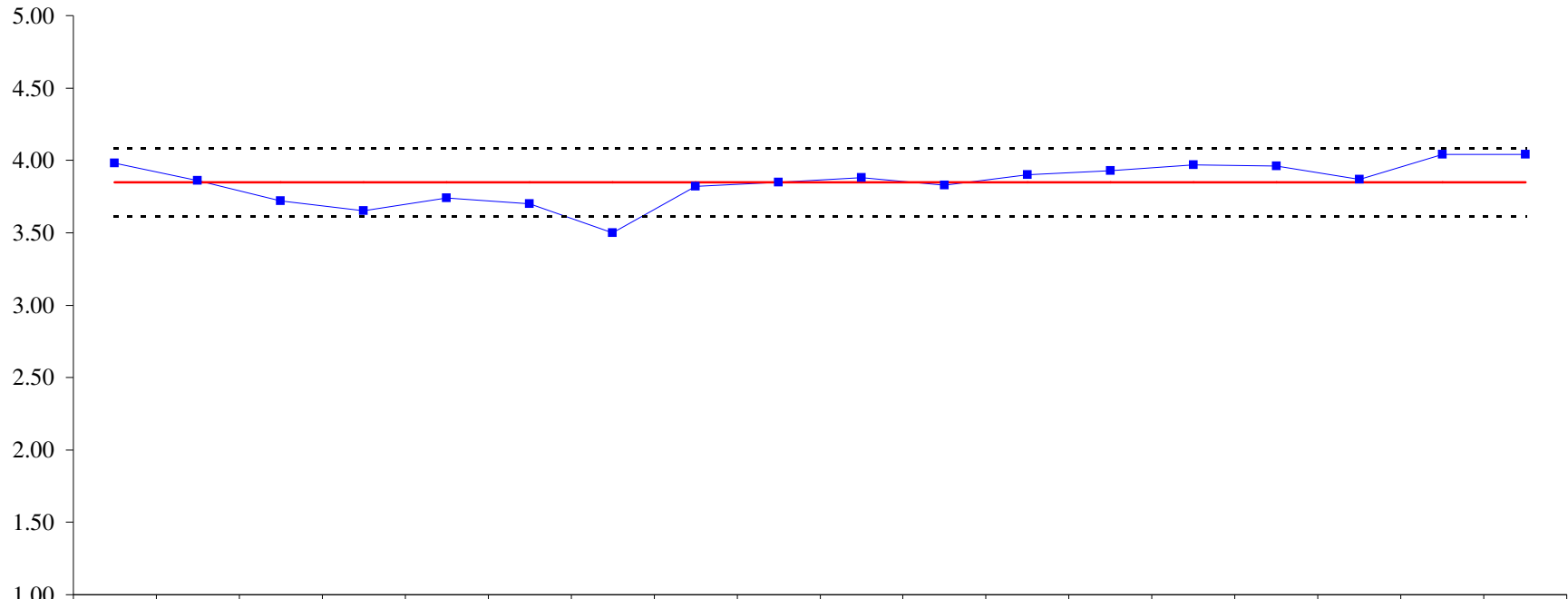
Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)



Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Austin State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

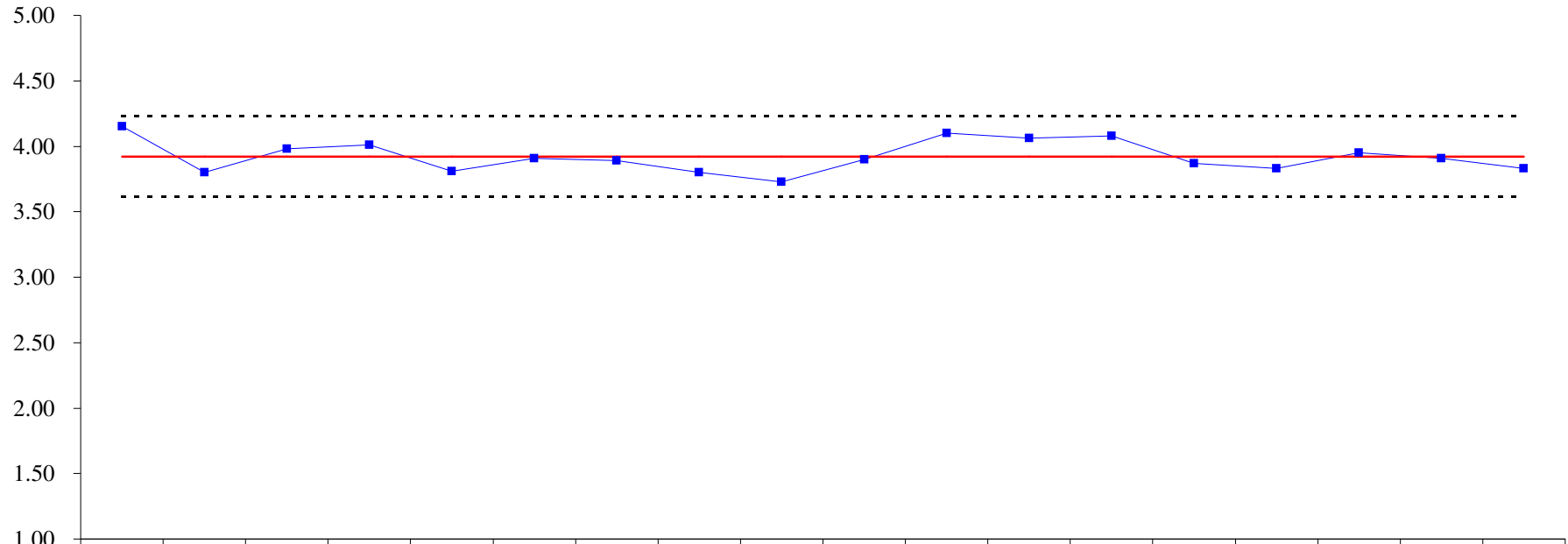


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	3.98	3.86	3.72	3.65	3.74	3.70	3.50	3.82	3.85	3.88	3.83	3.90	3.93	3.97	3.96	3.87	4.04	4.04
Surveys	67	70	200	161	137	113	132	87	101	22	76	55	58	77	118	102	86	95
Discharges	418	364	329	364	371	313	323	310	320	401	405	372	388	358	345	365	310	341
% Sampled	16%	19%	61%	44%	37%	36%	41%	28%	32%	5%	19%	15%	15%	22%	34%	28%	28%	28%
----- UCL	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08
— Avg	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85	3.85
----- LCL	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61	3.61

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Big Spring State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

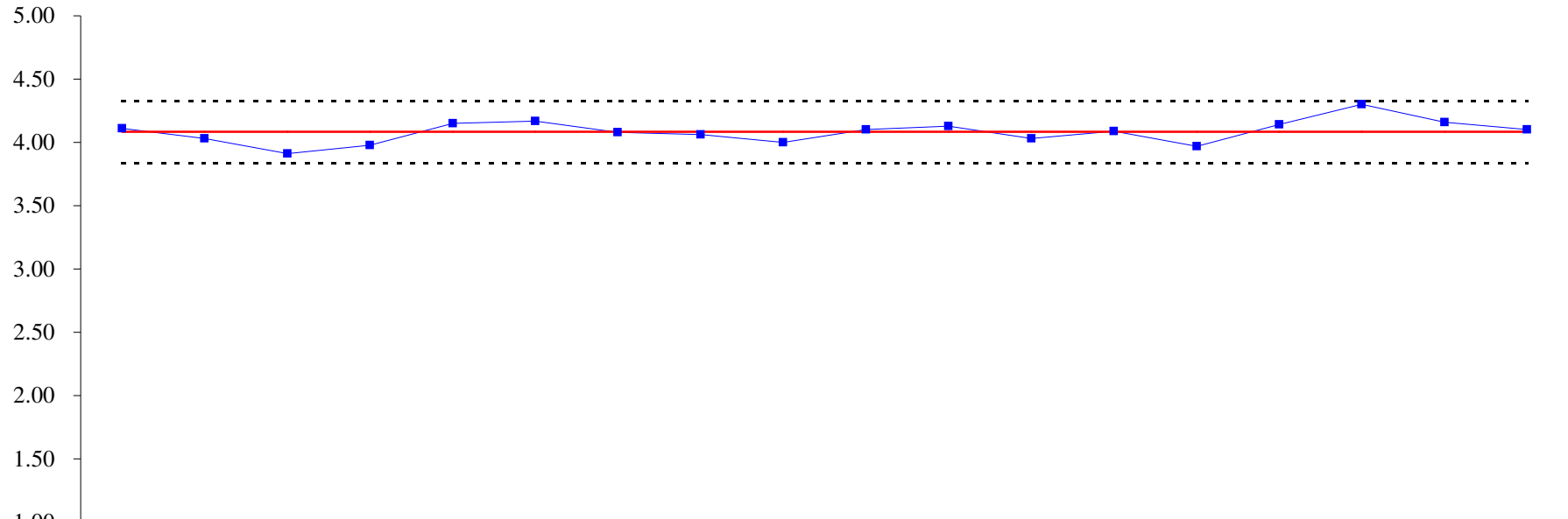


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	4.15	3.80	3.98	4.01	3.81	3.91	3.89	3.80	3.73	3.90	4.10	4.06	4.08	3.87	3.83	3.95	3.91	3.83
Surveys	28	31	45	48	44	28	36	28	28	45	29	35	28	22	34	21	24	17
Discharges	126	100	100	101	99	78	93	88	102	106	81	79	90	100	95	103	84	93
% Sampled	22%	31%	45%	48%	44%	36%	39%	32%	27%	42%	36%	44%	31%	22%	36%	20%	29%	18%
----- UCL	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23	4.23
— Avg	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92
----- LCL	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62	3.62

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
El Paso Psychiatric Center

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

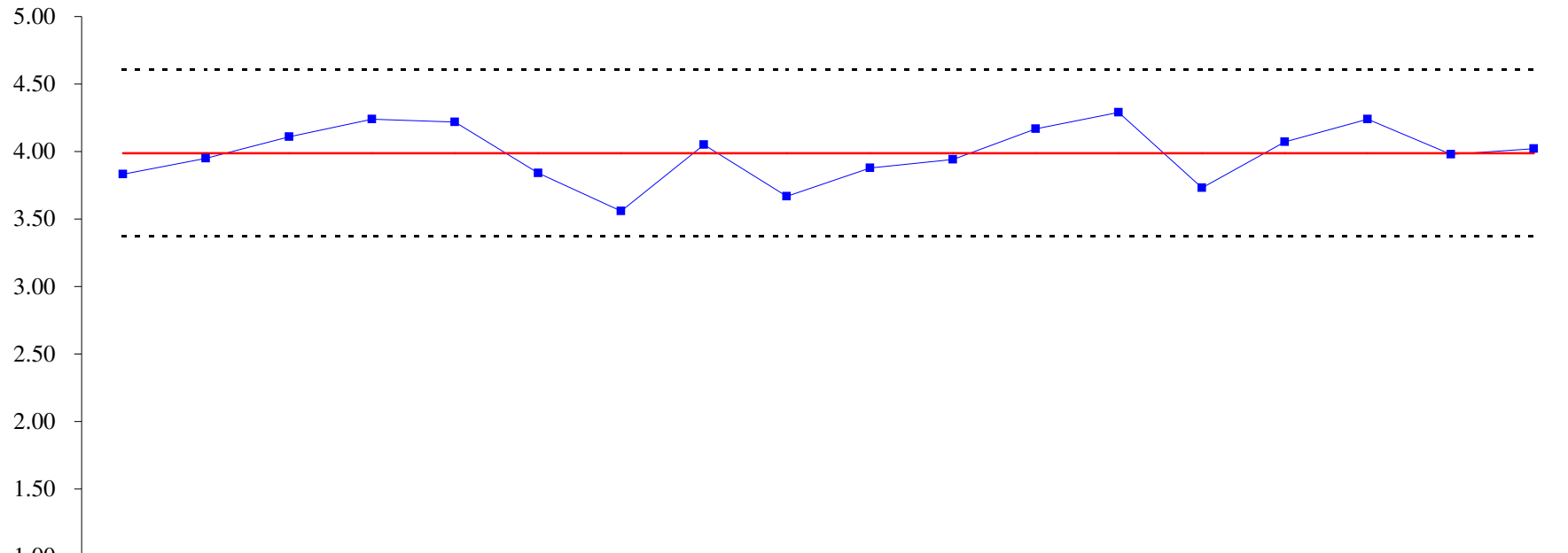


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Score	4.11	4.03	3.91	3.98	4.15	4.17	4.08	4.06	4.00	4.10	4.13	4.03	4.09	3.97	4.14	4.30	4.16	4.10
Surveys	58	29	27	49	40	44	36	55	40	32	41	59	55	49	37	36	38	40
Discharges	97	59	68	87	74	68	61	81	91	79	81	101	87	84	86	89	82	66
% Sampled	60%	49%	40%	56%	54%	65%	59%	68%	44%	41%	51%	58%	63%	58%	43%	40%	46%	61%
UCL	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33	4.33
Avg	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08	4.08
LCL	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Kerrville State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

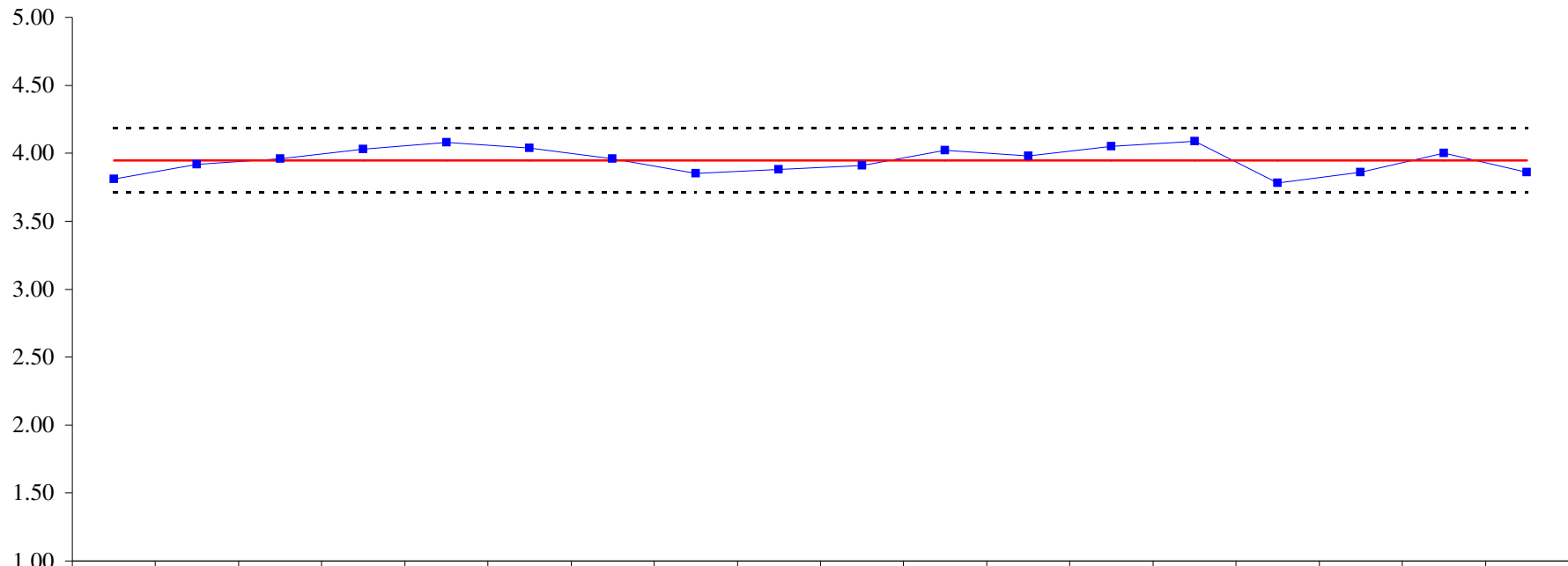


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	3.83	3.95	4.11	4.24	4.22	3.84	3.56	4.05	3.67	3.88	3.94	4.17	4.29	3.73	4.07	4.24	3.98	4.02
Surveys	18	47	27	14	31	21	20	13	2	13	21	22	15	20	11	15	11	25
Discharges	39	74	51	53	66	50	42	45	26	25	37	34	35	30	24	23	30	25
% Sampled	46%	64%	53%	26%	47%	42%	48%	29%	8%	52%	57%	65%	43%	67%	46%	65%	37%	100%
----- UCL	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61	4.61
— Avg	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99	3.99
----- LCL	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37	3.37

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
North Texas State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

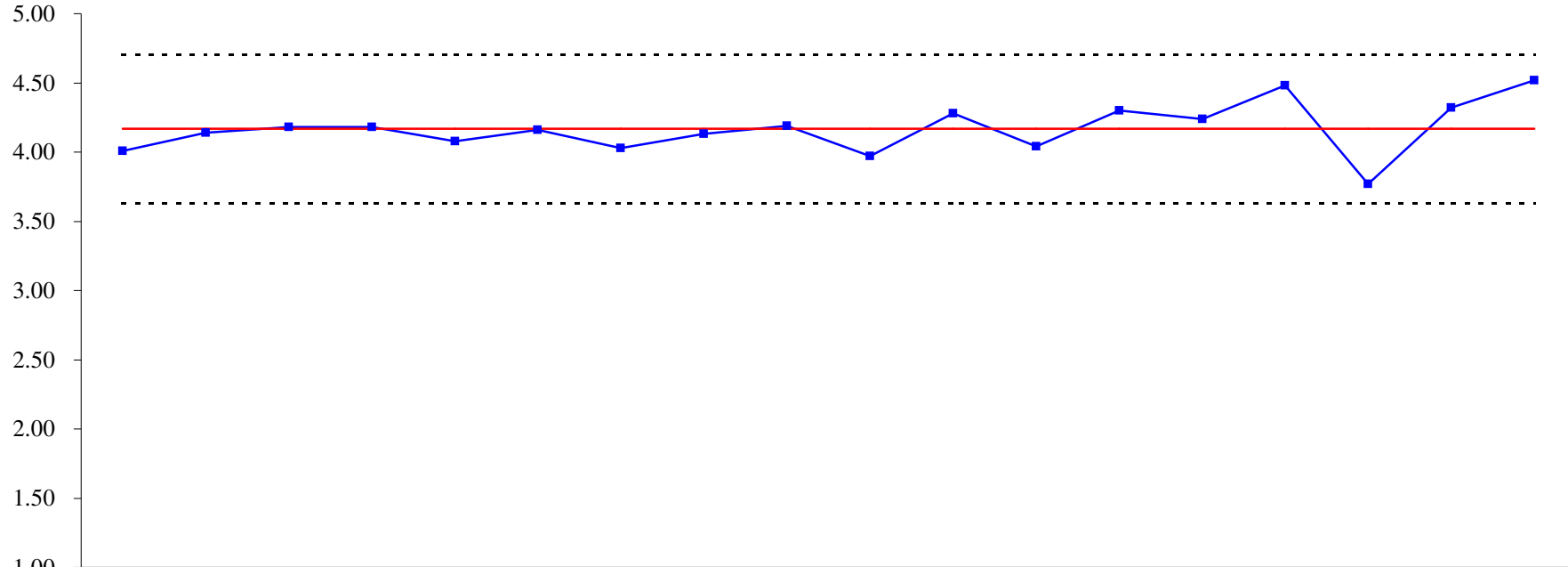


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Score	3.81	3.92	3.96	4.03	4.08	4.04	3.96	3.85	3.88	3.91	4.02	3.98	4.05	4.09	3.78	3.86	4.00	3.86
Surveys	67	80	62	77	81	56	82	87	59	62	87	80	81	61	80	79	70	86
Discharges	215	216	236	224	217	178	243	205	235	220	216	228	233	212	256	211	213	234
% Sampled	31%	37%	26%	34%	37%	31%	34%	42%	25%	28%	40%	35%	35%	29%	31%	37%	33%	37%
UCL	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18	4.18
Avg	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95	3.95
LCL	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72	3.72

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Rio Grande State Center

Adults & Adolescents will be Satisfied With Care
(FY2006 Expectation is Average Score ≥ 3.60)

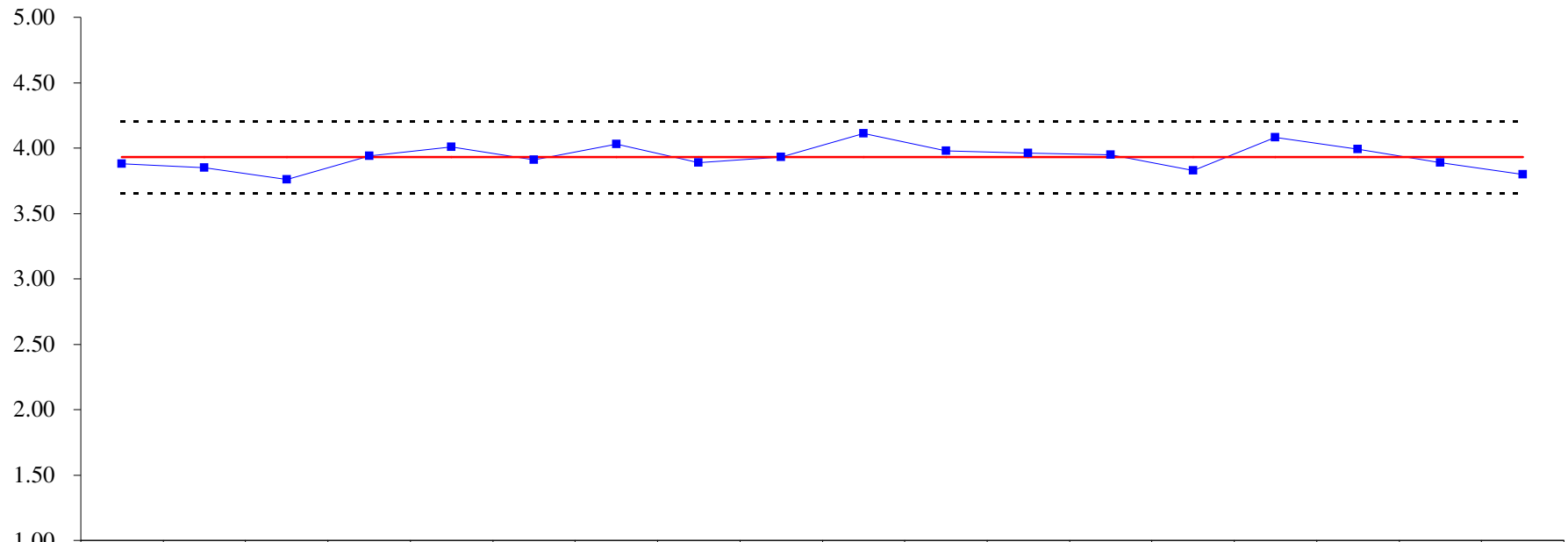


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	4.01	4.14	4.18	4.18	4.08	4.16	4.03	4.13	4.19	3.97	4.28	4.04	4.30	4.24	4.48	3.77	4.32	4.52
Surveys	59	46	46	36	28	22	28	29	31	30	40	43	28	25	13	13	29	28
Discharges	119	113	118	97	93	78	85	92	88	99	89	125	129	108	136	100	113	92
% Sampled	50%	41%	39%	37%	30%	28%	33%	32%	35%	30%	45%	34%	22%	23%	10%	13%	26%	30%
-----UCL	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
— Avg	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17
-----LCL	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63	3.63

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Rusk State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

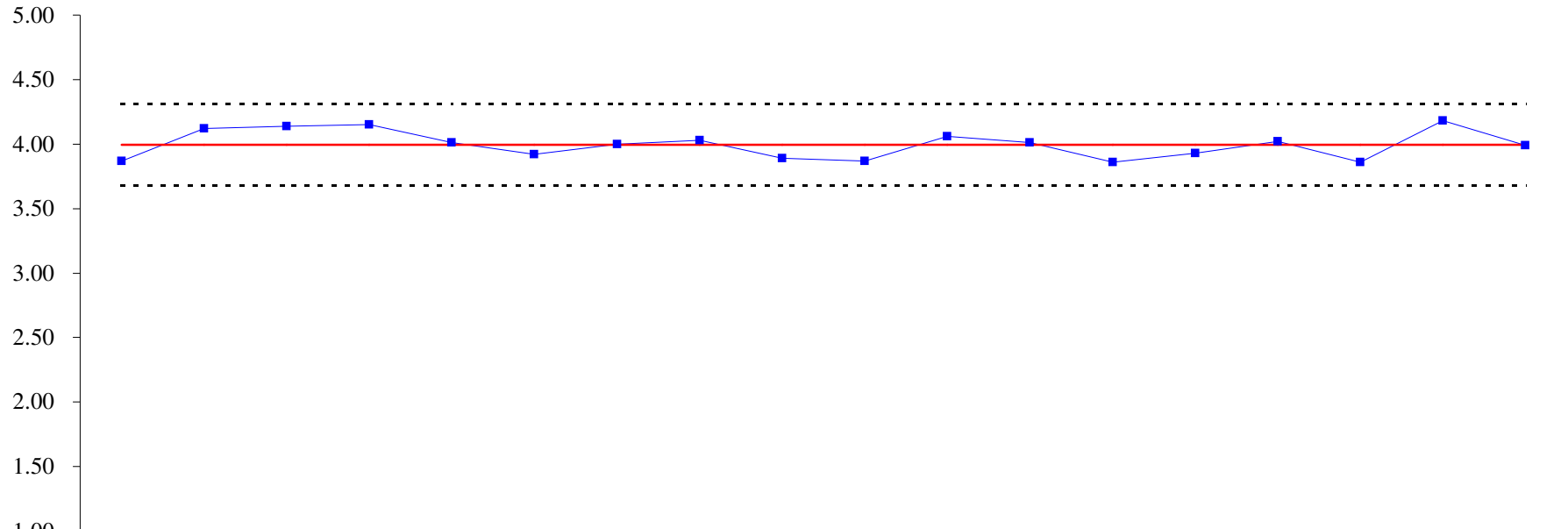


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	3.88	3.85	3.76	3.94	4.01	3.91	4.03	3.89	3.93	4.11	3.98	3.96	3.95	3.83	4.08	3.99	3.89	3.80
Surveys	137	107	177	81	87	90	70	57	65	65	54	49	68	73	61	53	80	57
Discharges	199	170	152	162	175	151	159	138	145	172	141	162	182	149	159	169	162	151
% Sampled	69%	63%	116%	50%	50%	60%	44%	41%	45%	38%	38%	30%	37%	49%	38%	31%	49%	38%
- - - - - UCL	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21	4.21
— Avg	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93
- - - - - LCL	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66	3.66

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
San Antonio State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

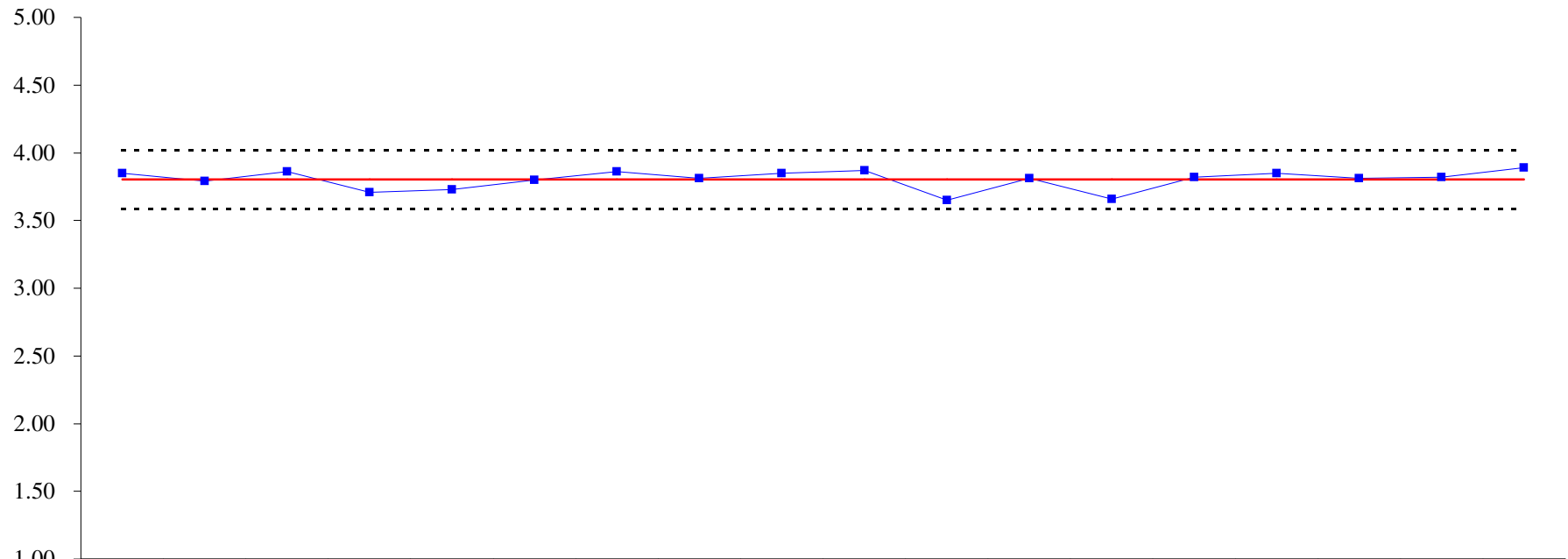


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Score	3.87	4.12	4.14	4.15	4.01	3.92	4.00	4.03	3.89	3.87	4.06	4.01	3.86	3.93	4.02	3.86	4.18	3.99
Surveys	46	74	27	46	46	57	70	61	49	54	64	99	86	119	106	124	23	24
Discharges	244	253	259	263	265	220	260	262	213	262	259	292	267	267	292	308	292	265
% Sampled	19%	29%	10%	17%	17%	26%	27%	23%	23%	21%	25%	34%	32%	45%	36%	40%	8%	9%
UCL	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31	4.31
Avg	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
LCL	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Terrell State Hospital

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)

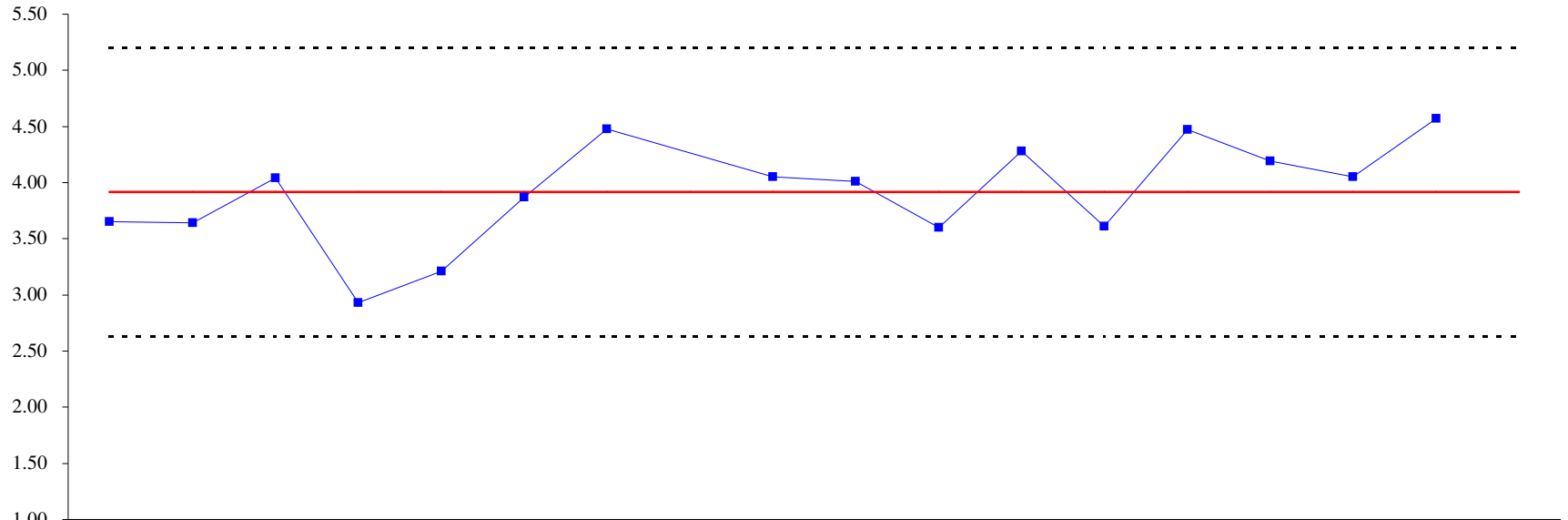


	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	3.85	3.79	3.86	3.71	3.73	3.80	3.86	3.81	3.85	3.87	3.65	3.81	3.66	3.82	3.85	3.81	3.82	3.89
Surveys	157	127	124	120	136	103	97	110	73	100	68	99	123	89	63	81	103	77
Discharges	196	196	202	185	190	173	192	233	170	212	204	190	239	201	223	207	204	182
% Sampled	80%	65%	61%	65%	72%	60%	51%	47%	43%	47%	33%	52%	51%	44%	28%	39%	50%	42%
----- UCL	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02	4.02
— Avg	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80	3.80
----- LCL	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59	3.59

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
Waco Center for Youth

Adults & Adolescents will be Satisfied with Care
(FY2006 Expectation is Average Score ≥ 3.60)



	Jun-04	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05*	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
—■— Score	3.65	3.64	4.04	2.93	3.21	3.87	4.48		4.05	4.01	3.60	4.28	3.61	4.47	4.19	4.05	4.57	
Surveys	4	7	7	1	3	4	3	0	4	4	5	1	5	7	6	8	1	0
Discharges	10	14	14	10	9	11	11	14	11	14	10	20	10	20	12	12	12	13
% Sampled	40%	50%	50%	10%	33%	36%	27%	0%	36%	29%	50%	5%	50%	35%	50%	67%	8%	0%
----- UCL	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20
----- Avg	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92	3.92
----- LCL	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63

Source: HC022020;
 Crystal Reports: Facility MHSIP ICS Score Analysis by Domain
 and MHSIP ICS Summary

Performance Objective 9E:

Regularly scheduled assessments will be conducted using established criteria and improvement opportunities identified by each state hospital on the following

1st Quarter:

- Pharmacy Inventory Controls
- Medication Room Controls
- HRD

2nd Quarter

- Facility CMM
- Procurement Card Controls
- Warehousing

3rd Quarter

- Accounting
- Facility Personnel Actions

4th Quarter

- CAFM
- Information/LAN Security

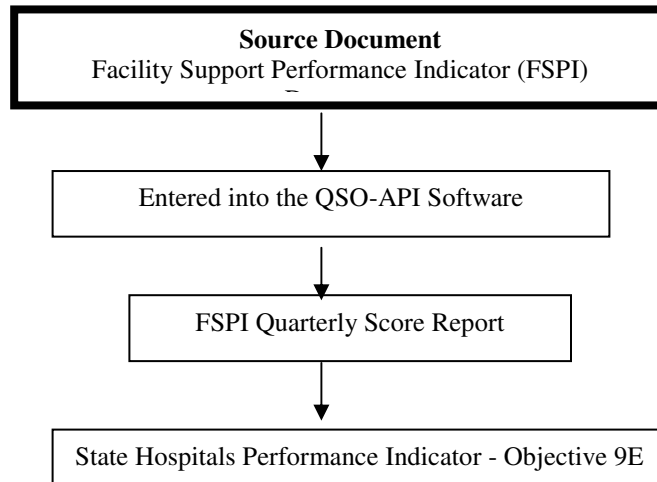
Performance Objective Operational Definition: The state hospital performs the self-assessment once per fiscal year according to the schedule.

Performance Objective Formula: Compliance scores for each instrument are computed as follows: $[(\# \text{ of yes} + \# \text{ of no with justification}) / (\# \text{ of NA} - \text{Contract Facility})] \times 100$.

Performance Objective Data Display and Chart Description:

- ◆ Table shows the assessment score for individual state hospitals and system-wide
- ◆ Chart shows the assessment score for individual state hospitals.

Data Flow:



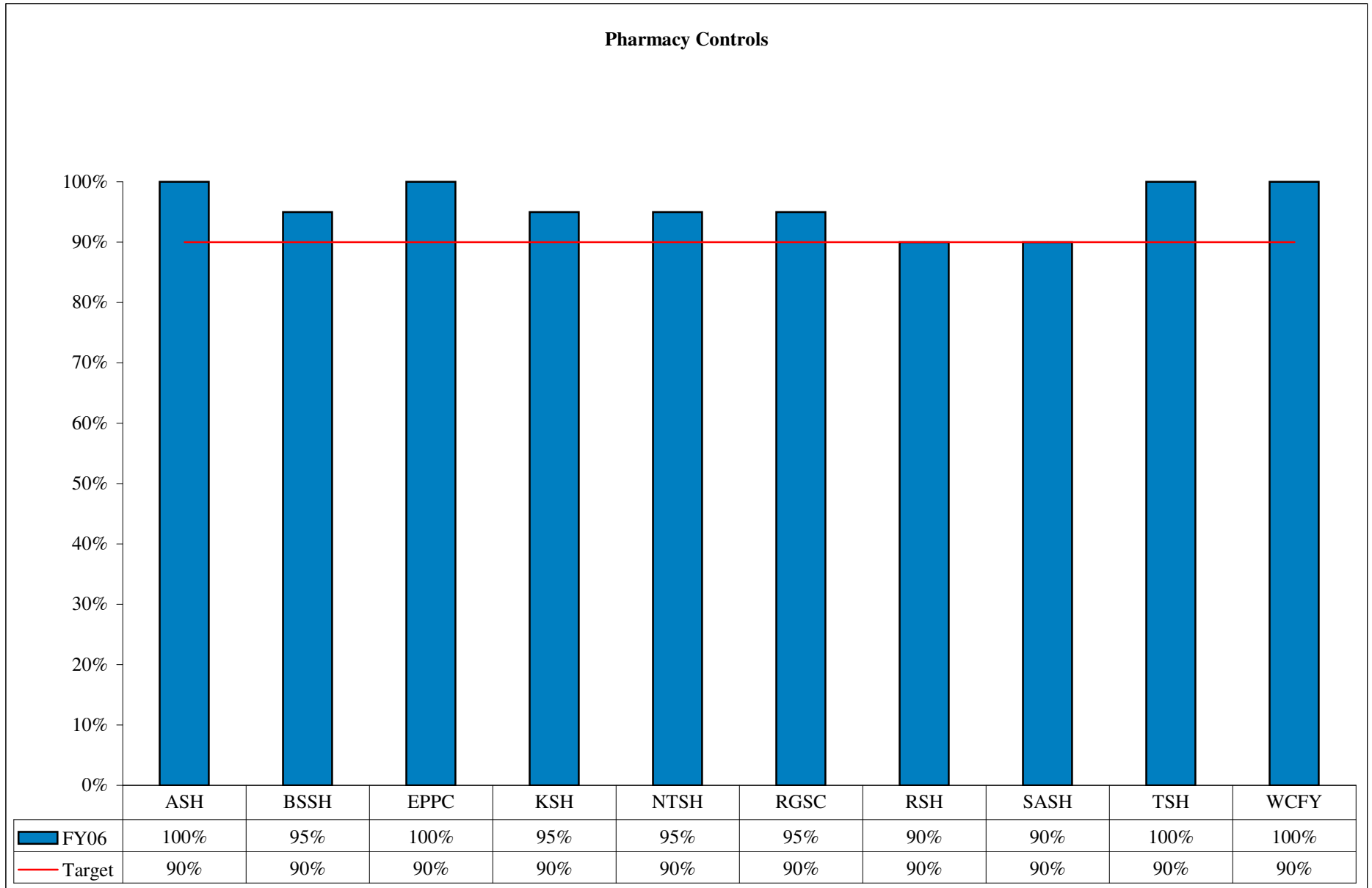
Data Integrity Review Process:

Data integrity review done through the Administrative Performance Indicators (API) Validation Audit Process.

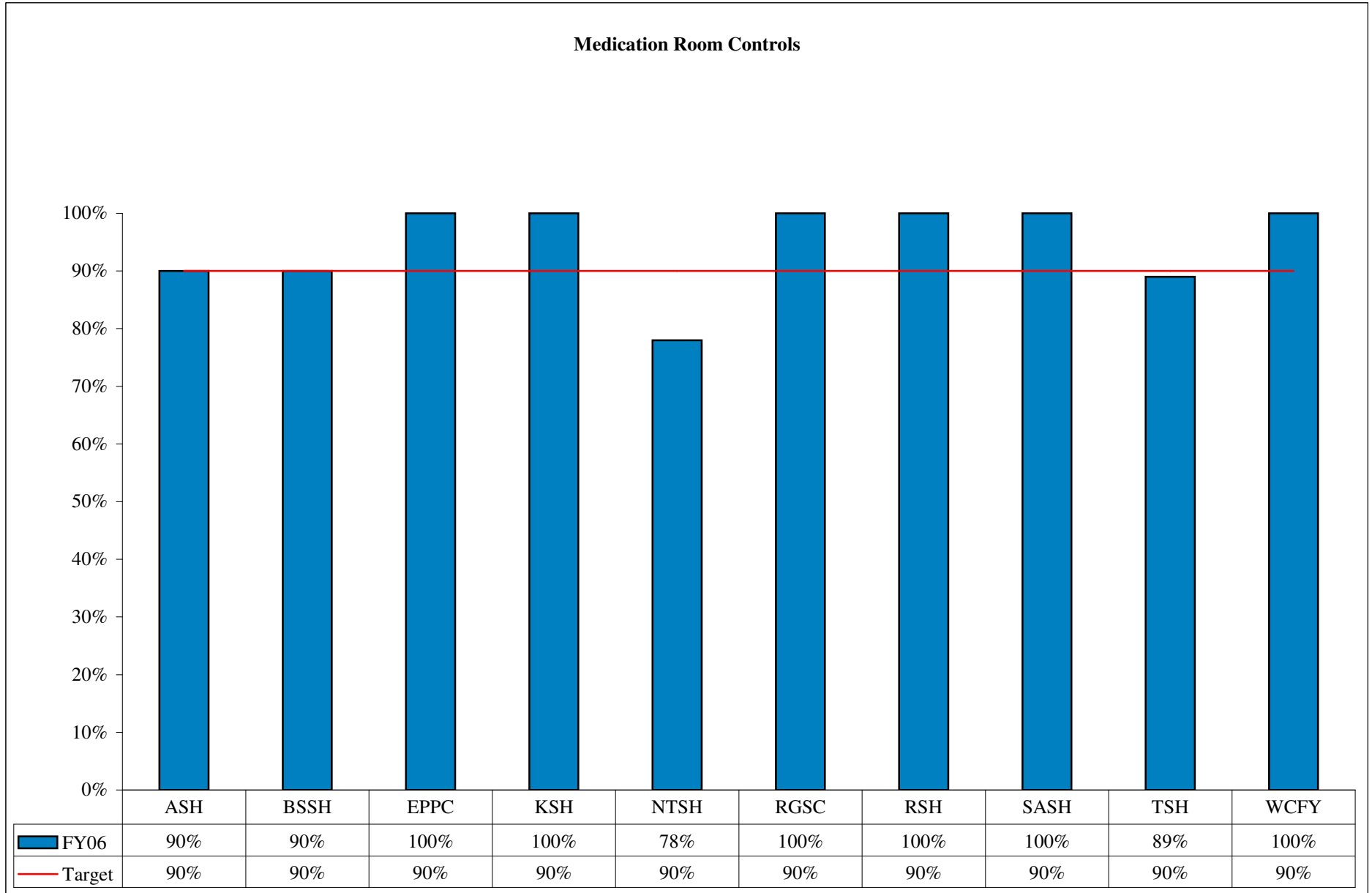
Objective 9E - Facility Support Performance Indicators
All MH Facilities - FY2006

	Q1			Q2			Q3		Q4	
	Pharmacy Controls	Medication Room Controls	Competency Training & Development	Facility CMM	Procurement Card Controls	Warehousing	Accounting	Facility Personnel Actions	CAFM	Information/LAN Security
Compliance Target	90%	90%	90%							
MH Totals	96%	95%	92%							
Austin State Hospital	100%	90%	100%							
Big Spring State Hospital	95%	90%	83%							
El Paso Psychiatric Center	100%	100%	92%							
Kerrville State Hospital	95%	100%	92%							
North Texas State Hospital	95%	78%	92%							
Rio Grande State Center	95%	100%	83%							
Rusk State Hospital	90%	100%	100%							
San Antonio State Hospital	90%	100%	92%							
Terrell State Hospital	100%	89%	100%							
Waco Center For Youth	100%	100%	82%							

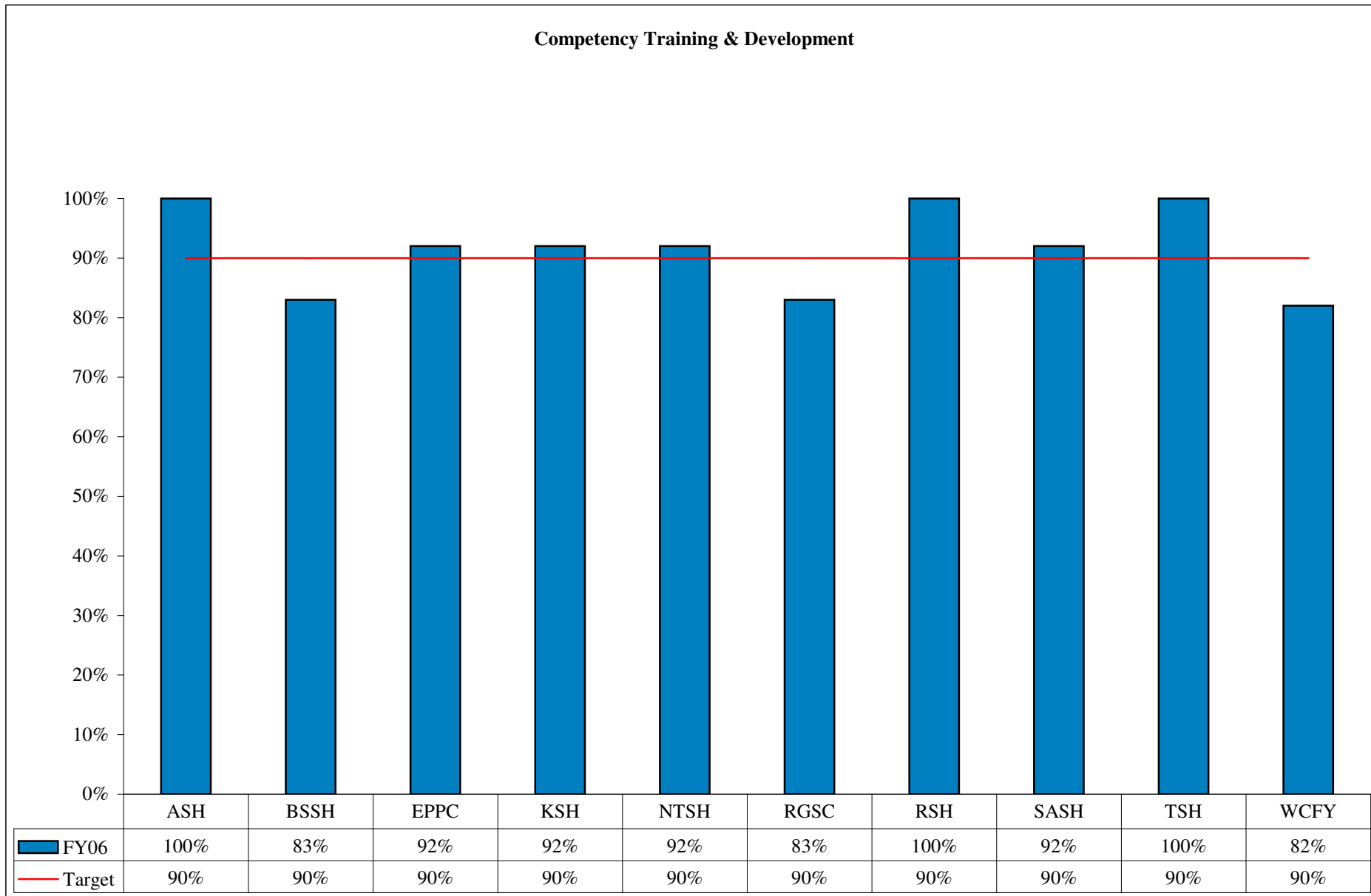
Objective 9E - Facility Support Performance Indicators
All MH Facilities
Pharmacy Controls



Objective 9E - Facility Support Performance Indicators
All MH Facilities
Medication Room Controls



Objective 9E - Facility Support Performance Indicators
All MH Facilities
Competency Training & Development



Appendix A - Control Chart Analysis

Starting with the 1st Quarter FY99 Performance Indicator Books, control chart upper and lower control limits are being included in some of the performance indicator graphs. The purpose of this paper is to answer the following questions:

- Why use control charts?
- What information does control charts provide?
- What kind of control chart is used and what is the formula?
- Can control chart analysis be applied to other data as well?

Why use control charts?

One reason to start using control charts is because the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is going to use that methodology to analyze our data. Through the ORYX initiative, the JCAHO will use two types of analysis on the data we will be transmitting to them; control chart analysis and comparative analysis. JCAHO will apply control chart analysis starting with the two initial indicators we will be transmitting to them by the 1st calendar quarter of 1999 for data collected during the 3rd calendar quarter 1998. That gives us a six month advantage on analyzing our data using control charts, before JCAHO does the same. We need to be prepared. Also, during recent JCAHO site visits, we have been "encouraged" to provide more analysis of the data we present. Control chart interpretations and analysis provides a good framework for doing exactly that.

Another reason for analyzing data with control charts is because it is the right thing to do in order to understand variation in data. Even more important, if action is to be taken because of what signals the data is sending, then we need to be prepared to take the RIGHT action.

No matter what the process, no matter what the data, *all* data display variation. Any measure that is of interest to governing body will vary from time period to time period. The reasons for the variation are many. There are all sorts of causes that have an impact on the process measured. For example, how many causes or reasons can be thought of for client injuries? How many causes for client abuse and neglect? The processes and systems we measure could be subject to dozens, even hundreds, of cause-and-effect relationships. This means it is easy to come up with a reason for the current value (or any value), but it also means it is very difficult to know if the explanation is even close to being right. If you ask for an explanation for any one incident, you will receive at least one of the possibly hundreds of causes. Even if you are successful in correcting that one cause, there is a very good chance you will have negligible impact on the system. In fact, you run a high risk of making things worse.

A major issue is that we may be uncertain of our explanation or cause. But what is there to do about it? How can we interpret the current value when the previous values are so variable? One good proven approach is using statistical process control or control charts. We must use them to insure correct explanation and therefore improve our chances of choosing the correct remedy or course of action.

What information does control charts provide?

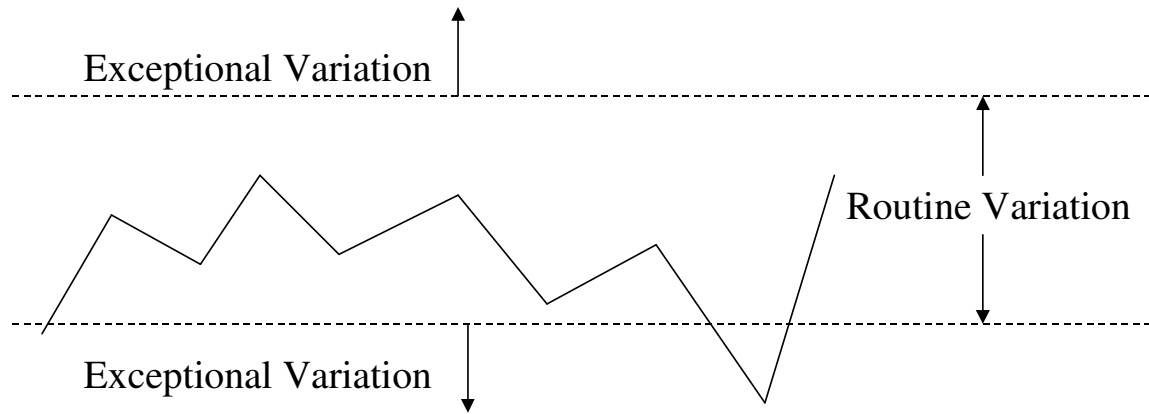
The key to understanding what information control charts provide is to make a distinction between two types of variation. The first type of variation is routine variation. It is always present. It is unavoidable. It is inherent in the process. Because this type of variation is routine, it is also predictable. The second type of variation is exceptional variation. It is not always present. It is not routine. It comes and goes. Because this type of variation is exceptional variation, it is unpredictable.

The first benefit of this distinction is that it provides a way to know what to expect in the future, which is the essence of management.

While every process displays variation, some processes display predictable variation, while others display unpredictable variation.

Don Wheeler, Building Continual Improvement.

So how do we put these concepts into practice? We need a way to detect the presence of exceptional variation. Then we can characterize our processes as being predictable or unpredictable. In order to obtain signals of exceptional variation we will compute limits for the running record of our data. As shown below, the idea is to establish limits that will allow us to distinguish between routine variation and exceptional variation.



If we compute values that place the limits too close together we will get false alarms (or false signals) when routine variation causes a point to fall outside the lines by chance. This is the first type of mistake we could make. We could avoid this mistake entirely by computing the limits that are too far apart.

But if we have the limits too far apart we will miss some signals of exceptional variation. This is the second type of mistake we could make. We can minimize the occurrence of this mistake only by having the limits close together.

The trick is to strike a balance between the consequences of these two mistakes, and this is exactly what Walter Shewhart did when he created the control chart. Shewhart's choice of limits will bracket approximately 99% to 100% of the routine variation. As a result, whenever you have a value outside the limits you can be reasonably sure that the value is the result of exceptional variation.

The variation within the control limits will be predictable and have many cause-and-effect relationships. When a process displays unpredictable variation, then the variation must be due to the many predictable common causes *plus* some *additional* causes. Since the sum is unpredictable, we must conclude the unpredictable causes dominate the common cause variation. What this means is, **we must investigate the unpredictable causes first**. Shewhart called these unpredictable dominant causes assignable causes. Deming and others call them special causes and the predictable common cause variation as being systemic causes. Systemic in the sense that the causes are inherent and predictable in the process under scrutiny and that they will remain as causes producing the predictable variation as long as the system goes unchanged.

Therefore, with this knowledge of what produces the measure or process variation, the correct actions can be taken. Actions should address unpredictable or special causes first. This is usually referred to as problem solving or "fighting fires". It is necessary and is important to understand and "fix" the special causes first. If unpredictable or special causes are not corrected first, there is a very high probability that the wrong actions will be taken. Changing a major portion of the process would be premature and could even make things worse (a.k.a. tampering). For example, suppose that one person on a living unit makes a mistake that produces a sudden rise in medication errors. The action taken is a reprimand is issued to everyone to pay close attention to medication errors and prevent them in the future. Many people who have been doing a good job, become demoralized or upset over being indirectly accused of errors. The action was taken on the system as a whole instead of uncovering the exceptional cause of the sudden increase in medication errors.

If no evidence of exceptional or unpredictable or special cause is seen in the control chart, then what action should be taken? The process is predictable or "in control". Should no action be taken? If, for example, the control chart shows that the system is predictably producing 20 injuries a month and that there is no special causes evident, then should nothing be done? Of course something should be done. Action or remedies to reducing and preventing injuries should concentrate on systemic causes, that is, causes inherent in the system producing the injuries. The injuries are not wanted, but nevertheless, are being produced consistently and predictably. The injuries that will be produced predictably in the future, unless action is taken in first finding the significant systemic causes and then taking action on those causes and finally measuring the effect of the actions in relation to reducing or eliminating the problem, in this case injuries.

Thus the path to process improvement depends upon what type of variation is present. This is the essence and value of using control chart to understand and analyze the variation present.

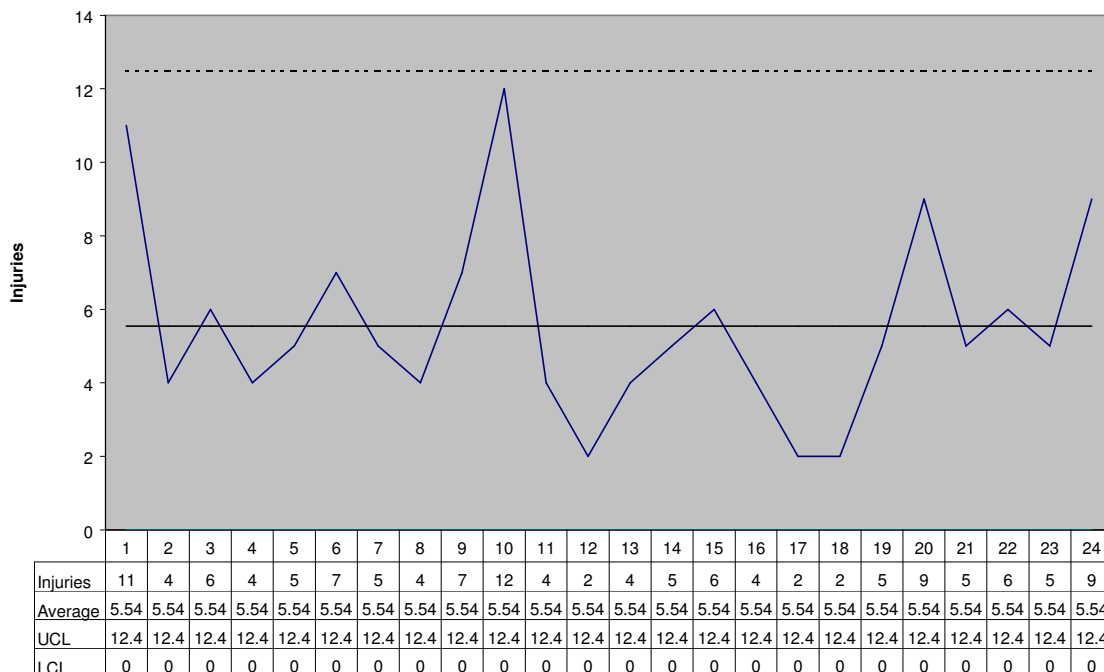
- If a process displays predictable variation, then the variation is the result of many common causes and it will be a waste of time to look for assignable causes. Improvement will only come by changing a major portion of the process.
- If a process displays unpredictable variation, then in addition to the common cause variation there is an extra amount of variation that is the result of one or more assignable causes. Improvement will come by finding and removing the assignable causes. Changing a major portion of the process will be premature.

One additional point about control charts is vital. Control charts *do not show specifications* for a process. They do not show targets or goals. They do not show the voice of the customer. Control charts show the voice of the process. They let us see how the process or system is currently working and detect signals that guide us in improving the process or system. They do not show how the process or system *should be* working. For example, the customer may want client injuries below last year's injuries. Maybe management wants injuries to be reduced 20 percent. These two examples are goals or statements related to the voice of the customer. The control chart shows what the system is currently capable of producing if it stays unchanged. The current system can be compared to what the customer wants. To meet the voice of the customer, a plan of action is necessary with measurements to indicate how the voice of the process is meeting or moving towards the voice of the customer.

What kind of control chart is used and what is the formula?

The control limits in the control charts in the performance measurement book will use a basic process behavior chart called the XmR chart. The XmR chart is also known as the chart for individual values and a moving range. Let us look at some example monthly injury data plotted in a XmR chart. Here is how the chart looks.

The XmR Chart for Monthly Injuries



Below the chart is a table showing the example injury data by month. There are 24 months of injuries shown and the average number of injuries is 5.54. We show this value as a central line for the plot. The use of a central line provides a visual reference to use in looking for trends in the values. No trend is seen in these injury values. In order to compute the upper control limits (UCL) and the lower control limits (LCL) which will filter out the noise of the routine variation, we will need to measure the routine variation. To do this we will compute moving ranges for the injury data. The moving ranges are the differences between successive values. The following table shows the moving range values for each of the 23 months. Note that the first month's moving range cannot be calculated so it is left blank. The number of moving range values is always N-1.

Month	Injuries	Moving Ranges	UCL	LCL	LCL
1	11		12.48	-1.40	0
2	4	7	12.48	-1.40	0
3	6	2	12.48	-1.40	0
4	4	2	12.48	-1.40	0
5	5	1	12.48	-1.40	0
6	7	2	12.48	-1.40	0
7	5	2	12.48	-1.40	0
8	4	1	12.48	-1.40	0
9	7	3	12.48	-1.40	0
10	12	5	12.48	-1.40	0
11	4	8	12.48	-1.40	0
12	2	2	12.48	-1.40	0
13	4	2	12.48	-1.40	0
14	5	1	12.48	-1.40	0
15	6	1	12.48	-1.40	0
16	4	2	12.48	-1.40	0
17	2	2	12.48	-1.40	0
18	2	0	12.48	-1.40	0
19	5	3	12.48	-1.40	0
20	9	4	12.48	-1.40	0
21	5	4	12.48	-1.40	0
22	6	1	12.48	-1.40	0
23	5	1	12.48	-1.40	0
24	9	4	12.48	-1.40	0
Average	5.54	2.61			

Since moving ranges are used to measure variation, we do not care what the sign if the difference might be. Thus, if you get a negative value for a moving range, you change the sign and record a positive value, as in the example above. Moving ranges are always zero or positive.

The upper and lower limits for the individual data (e.g. monthly injury data) are called *Natural Process Limits*. They are centered on the central or average line. The distance from the central line to either of these limits is computed by multiplying the average moving range by a scaling factor of 2.66. The value of 2.66 is a constant for this type of process behavior chart, and is the value required to convert the average moving range into the appropriate amount of spread for the individual values. The *Upper Process Limit* is found by multiplying the average moving range by 2.66, and then adding the product to the central line of the X chart. The *Lower Process Limit* is found by multiplying the average moving range by 2.66, and then subtracting the product from the central line of the X chart.

In the table above, you see the computed upper control limit (UCL) and lower control limit (LCL). Since the injury data is counts of injuries, a negative LCL is meaningless - counts cannot be negative. Therefore, we have a one-sided X chart with a boundary condition on the bottom (zero) and a Natural Process Limit on the top.

The UCL and LCL are usually plotted on the graph as a dashed line and the average is usually a solid line as in the example plot above. The example data's limits define bands of routine variation for the individual injury data. As long as the number of injuries stay between 0 and 12.5, there is no evidence of exceptional variation. The variation here can be explained as pure noise. There is no evidence of any signals. When a process is predictable the Natural Process Limits define what to expect in the future. From the graph above, we should expect this process to continue to produce counts that cluster around 5.5, and vary from 0 to 12.5. Unless something is done to change the system that is producing these injuries, we can predict that this average number of injuries will continue.

Thus the process behavior chart allows you to:

- Characterize a process as predictable or unpredictable
- Identify points that represent exceptional variation

- Predict the average level to expect from a predictable process in the future
- Characterize the amount of routine variation to expect from a predictable process in the future

It must be noted at this point that there are actually three ways to detect assignable causes: points outside the limits (the most common method and the one discussed above), runs near the limits, and runs about the central line.

Three Rules for Detecting Assignable Causes

Detection Rule One: Points Outside the Limits

A single point outside the computed limits will be taken as an indication of the presence of an assignable cause which has a dominant effect.

Detection Rule Two: Runs Near the Limits

Three out of three, or three out of four successive values in the upper (or lower) 25% of the region between the limits will be taken as an indication of the presence of an assignable cause which has a *moderate* but sustained effect.

Detection Rule Three: Runs About the Central Line

Eight successive values on the same side of the central line will be taken as an indication of the presence of an assignable cause which has a *weak* but sustained effect.

Can control chart analysis be applied to other data as well?

The majority of trend data that we collect within the MHMR system is single point or individual data points. For example, daily, weekly, monthly or quarterly data having one data point per point in time. For this reason, the XmR chart is the most appropriate control chart to use. You are encouraged to plot your own local data on a trend line and apply control limits as described above. Simply plotting the data, even without control limits added, can be very enlightening. Of course, the addition of the control limits gives guidance to the type of action that is needed to continuously improve the process under scrutiny. Also, there are other types of control charts to pick from, depending on the data and how it is collected. Please refer to the sources at the end of this paper, or contact Management Data Service in Central Office.

Too often we produce faulty interpretation of numbers. Sometimes, this faulty interpretation can lead to commendations or reprimands. The faulty interpretations, invariably, are a result of the premise that "two numbers which are not the same are different." This concept is simple, straightforward and WRONG. In, fact, it is wrong on several levels. Even if we measure the same thing with precision, we commonly obtain different values. Even in accounting this is true because every accounting figure is dependent upon the assumptions or categorizations that were required for the computation. There is also the problem of measuring something at different points in time. Raw inputs change such as the people doing the work or measurements, the way things are counted, the delays of getting inputs entered into the system and a myriad of other possible factors. In practice, there is a certain amount of variation *over time* in every measure.

Another very important consideration to keep in mind is related to the problem of comparing measures of different things. When different regions are compared using common measures there is the problem of whether or not the measures were collected and computed in the same way. If the assumptions and decisions necessary to collect the raw data and to compute the measures are not all exactly the same, then it is unrealistic to assume that the measures for the different regions are comparable. Even if the two regions performed exactly the same, they would not necessarily get the same values on a given measure. Thus, in practice, there is a certain amount of variation from *place to place* in every measure.

Given these multiple sources of variation in our measures, we should always make a distinction between the numbers themselves and the properties which the numbers represent. Of course, this is precisely what is not done when numbers are used to create rankings. The rank ordering of the values is transferred over to the items represented by those values, regardless of whether or not the items being ranked actually differ. No allowance is made for variation.

Whenever actions are taken based upon the assumption that any numerical difference is a real difference, those actions will ultimately be arbitrary and capricious. This is an inevitable consequence of the fact that the assumption ignores the effects of variation. Variation is random and miscellaneous, and it undermines all simple and naïve

attempts to interpret numbers. And yet our lives are governed by such interpretations of numbers. Any time the value of some measure changes, people are required to identify the source of that change, and then to take steps to keep it from happening again. We hear calls of "What happened?" or similar "accountability" questions, the explanation for "variances", and "tighter" control. The result is man-made chaos. This is why you should always look at how your data varies over time, plot control limits, then make a more informed decision of what action to take or not take. Analysis focuses on "why" there are differences. Descriptive summaries are inadequate. They may be used as part of the analysis, but you cannot interpret the descriptive summaries at face value. Use control charts!

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