

Department of State Health Services
State Hospitals Section
**Mission, Vision, Goals and
2005 Work Plan**

**Statewide Performance Indicators
2nd Quarter FY 2005**

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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 	<ul style="list-style-type: none"> - Medicare - JCAHO - Medicaid - ICF/MR - CAP - Agency clinical and administrative performance indicator compliance 	<p 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 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 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 2005 MANAGEMENT PLAN**

The State Hospitals Section FY 2005 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 FY2006 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 2005. | 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) and will identify an alternative proposal which has the state MH hospitals operating as a provider in a "Fee for Service" system. | 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 06 Governing Body Bylaws Template will be revised and approved by August 1, 2005. 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 times Over Capacity Plan was activated at MH hospital,**
 - 3. **Number of patients who were transferred to another state MH hospital,**
 - 4. **Number of patients each MH hospital received as transfers or diversions,**
 - 5. **Number of patients the MH hospital assisted the local authority in diverting to another state hospital, and**
 - 6. **Number of times all MH hospitals were over capacity for adults and child/adolescents.**
 - 7. **Number of patients by month awaiting admission to TCID.**
 - 8. **Length of time on waiting list for TCID.** B1
- J. Hospitals will monitor and evaluate the JCAHO priority focus area of Communication through the clinical performance improvement process. The aggregate information will be evaluated through the Clinical Performance Improvement Committee (CPIC) and reported to the Executive Committee. B1,B5
- K. 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. B1

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 hospitals will benchmark complaint data among state hospitals in order to identify opportunities to improve performance in upholding patient rights.**
- 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. **Every state hospital will have a plan developed and approved by the Director of Hospitals Section that will reduce and eventually eliminate the use of behavioral restraint and seclusion.** A1,A2

- B. **In keeping with Goal A, state hospitals will reduce the use of behavioral restraint and seclusion based on FY04 performance. Episodes will be reported by:** 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. **State Hospitals will monitor and evaluate the JCAHO priority focus area of assessment/care/and services through the Clinical Performance Improvement Process. The aggregate information will be evaluated by the CPIC and reported to the Executive Committee.** A2

- E. **In order to help clinicians determine whether a patient should be referred for a formalized dangerousness risk assessment upon admission, the Clinical Oversight Committee will coordinate the development of a dangerousness risk screening instrument.** A2

- F. **According to the National Patient Safety Goal 9A each state hospital will assess and periodically reassess each patient’s risk for falling, including the potential risk associated with the patients medication regime, and take action to address any identified risks.**

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

- H. **EVERY PATIENT WITH A DIAGNOSIS OF MAJOR DEPRESSION, SCHIZOPHRENIA, OR BIPOLAR DISORDER WILL BE STAGED ON THE APPROPRIATE ALGORITHM AT LEAST AT DISCHARGE.** A4

- I. **State Mental Health Hospitals will adopt Resiliency and Disease Management as guiding principles for service delivery philosophy and integration with community services.** 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 decide on a new system for reporting medications errors in all categories and each hospital will ensure successful implementation of the system.** 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.**

Performance Measures

- A. THE NUMBER OF PATIENTS RECEIVING NEW GENERATION ATYPICAL ANTIPSYCHOTIC MEDICATION WILL BE TRACKED AND ANALYZED QUARTERLY. B1,A4**
- B. THE COSTS OF NEW GENERATION ATYPICAL ANTIPSYCHOTIC MEDICATION WILL BE TRACKED AND ANALYZED QUARTERLY. B1,A4**

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 patients 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. A.**
- B. Each state MH hospital will maintain a current Utilization Management Agreement with all the local health authorities in their service area. A.**
- 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. A.**
- 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 ADMISSIONS, DISCHARGES, AND READMISSIONS WILL BE CALCULATED AND REPORTED FOR EACH HOSPITAL ON A QUARTERLY BASIS.** **A3**

- B. **PERCENT OF DISCHARGES RETURNED TO THE COMMUNITY WILL BE CALCULATED ON A QUARTERLY BASIS.** **A3**
 - 7 days or less,
 - 8 to 15 days,
 - 16 to 30 days,
 - 30 to 45 days, and
 - 45 to 90 days,
 - 91 to 180 days,
 - 181 to 365 days and,
 - greater than 365 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.

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**

- D. State Hospital Infection Control Practitioners (ICP) will develop a system-wide definition for “healthcare acquired (nosocomial) infections” and begin to collect and compare data on facility healthcare acquired infection rates. B4
- E. 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-older B4
- G. **WHEN THE USE OF RESTRAINT OR SECLUSION IN A BEHAVIORAL EMERGENCY IS NECESSARY AS A LAST RESORT, THE PROCEDURES WILL BE PERFORMED APPROPRIATELY TO REDUCE THE RISK OF PATIENT INJURY. THE RATE OF PATIENT INJURY FOR FY 05 WILL NOT EXCEED .66 PER 1000 BED DAYS FOR FY 04.** B4
- H. **Employees injured during restraint or seclusion will not exceed 1.34 per 1000 bed days across all state hospitals in FY 2005.** B4
- I. **THE RATE OF UNAUTHORIZED DEPARTURES WILL NOT EXCEED .42 PER 1000 BED DAYS ACROSS ALL STATE HOSPITALS DURING FY 2005.** B4
- J. State Hospitals will monitor and evaluate the JCAHO priority focus area of patient safety through the Clinical Performance Improvement Process. The aggregate information will be evaluated by CPIC and reported to Executive Committee.

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 Q1 FY05. B2

- B. Service level agreements with Statewide Information Services will be completed and implemented on September 30, 2004. B2
- C. **Each Mental Health hospital will work towards 95% implementation of the Clinical Record System.** B2
- D. **State Hospitals will monitor medical records delinquency rates. The average of the total number of delinquent records calculated form 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

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 identify, track, and analyze two clinical/service-screening indicators in combination with two human resource-screening indicators to assess staffing effectiveness. At least one of the human resources and one of the clinical/service screening indicators must be selected from a list of Joint Commission identified screening indicators.** B3

Performance Measures

“STAFF TURNOVER” RATES 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. The Clinical Performance Improvement Committee (CPIC) will implement the Tracer Methodology System for monitoring patient care, aggregate the findings from the tracer review and evaluate the system. Findings will be reported to the Executive Committee of the Governing Body.**
- D. Each State Hospital will prepare a status report on the implementation of the CPIC Plan for FY 05 by June 2005. CPIC will review and incorporate recommendation into the CPIC Plan for FY 06.**
- 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**
- Fleet Management
 - Fixed Assets
 - Maintenance
 - Consumer Monies
 - Vocational Services
 - Community Relations
 - Food Service
 - Risk Management
 - Cash Receipts

- Petty Cash
- Pharmacy Inventory Controls
- Medication Room Controls
- HRD
- Facility CMM
- Procurement Card Controls
- Warehousing
- Accounting
- Facility Personnel Actions
- CAFM
- Information/LAN Security

GOAL 1: Provide Leadership

Performance Objective 1C:

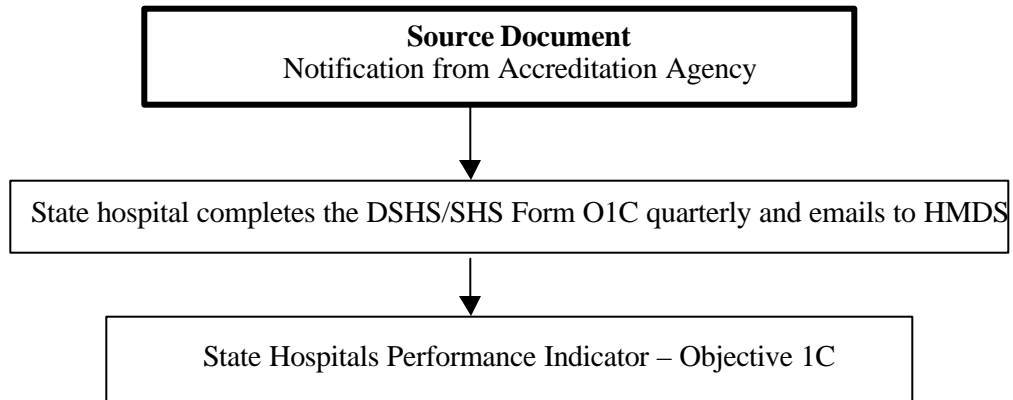
State hospitals will maintain Joint Commission on Accreditation of Healthcare Organization (JCAHO) accreditation, Medicare certification, Institute of Mental Diseases (IMD) certification and Intermediate Care Facility-Mental Retardation (ICF-MR) where appropriate during FY 2005.

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 February 28, 2005)**

	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY
JCAHO Accreditation										
Date of accreditation:	Jun-03	Jan-03	Aug-03	Jul-03	Mar-04	Apr-02	Mar-04	Aug-04	Aug-04	Jul-04
Years accredited:	3	3	3	3	3	3	3	3	3	3
Medicare Certification										
No. certified beds:	201	104	40	80	100	27	106	160	94	N/A
No. of Complaint Visits for Q2	1	1	0	0	0	0	1	2	0	N/A
No. of Complaint Visits for FYTD	2	2	0	0	1	1	1	4	1	N/A
Date of last IMD Review:	May-04	Jul-03	N/A	Dec-03	Jul-04	N/A	Oct-03	Oct-03	May-04	N/A
ICF-MR Certification										
Last date certified:	N/A	N/A	N/A	N/A	N/A	Nov-04	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

*Based on the Behavioral Health Care Accreditation Standards

Performance Objective 1D:

FY2005 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.

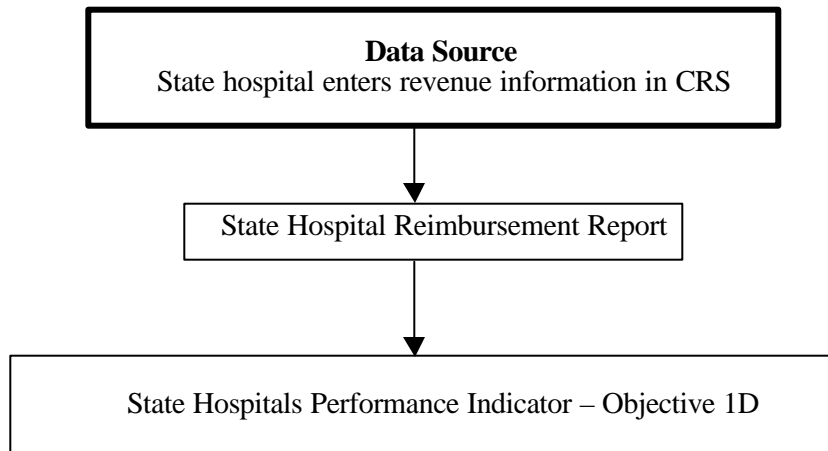
Performance Objective Operational Definition: The state hospital collections for Medicare, THSteps, Private Source, and IMD per month.

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.

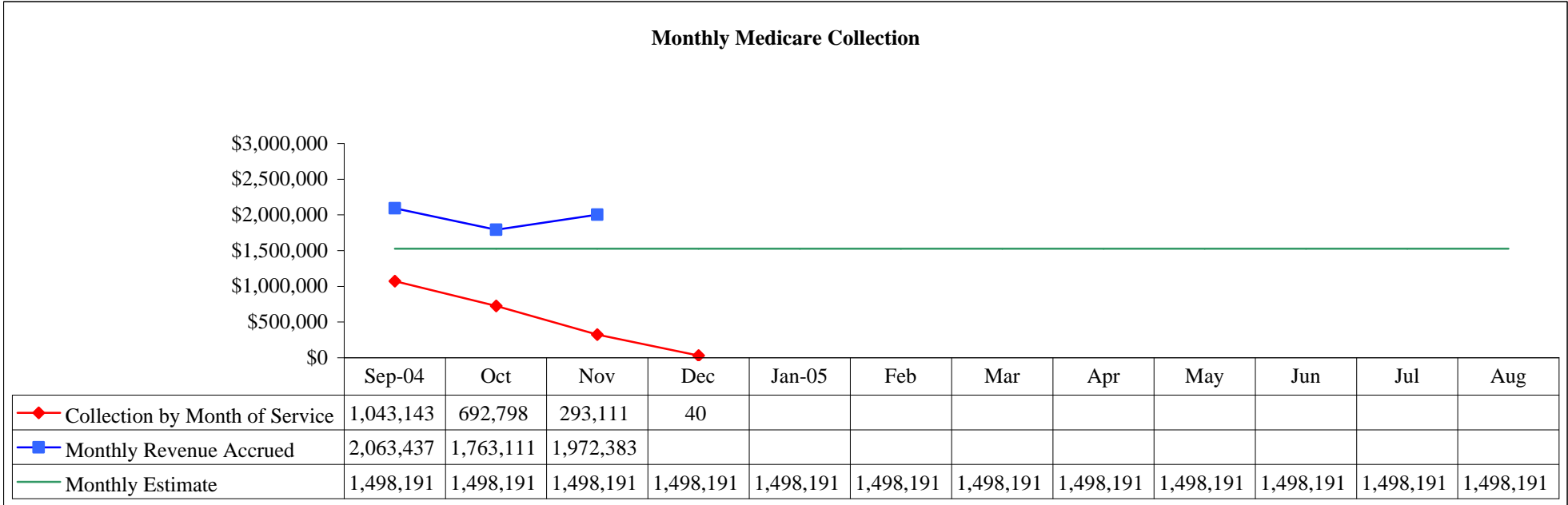
Data Flow:



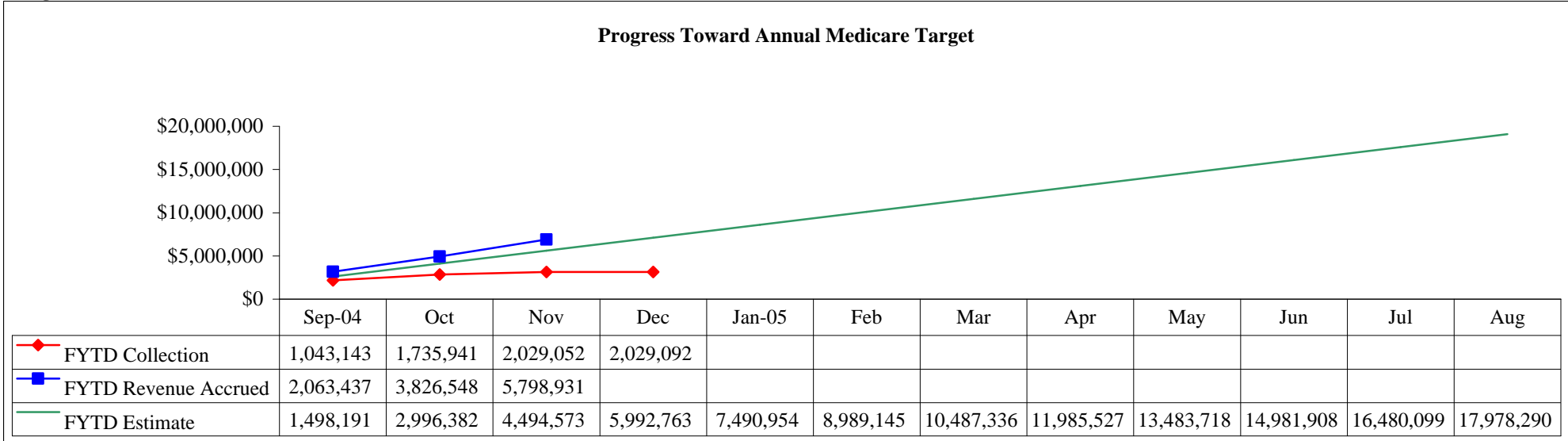
Data Integrity Review Process:

N/A

Objective 1D - FY 2005 Revenue Estimates
All Mental Health Facilities
Monthly Medicare Estimate (\$1,498,191)



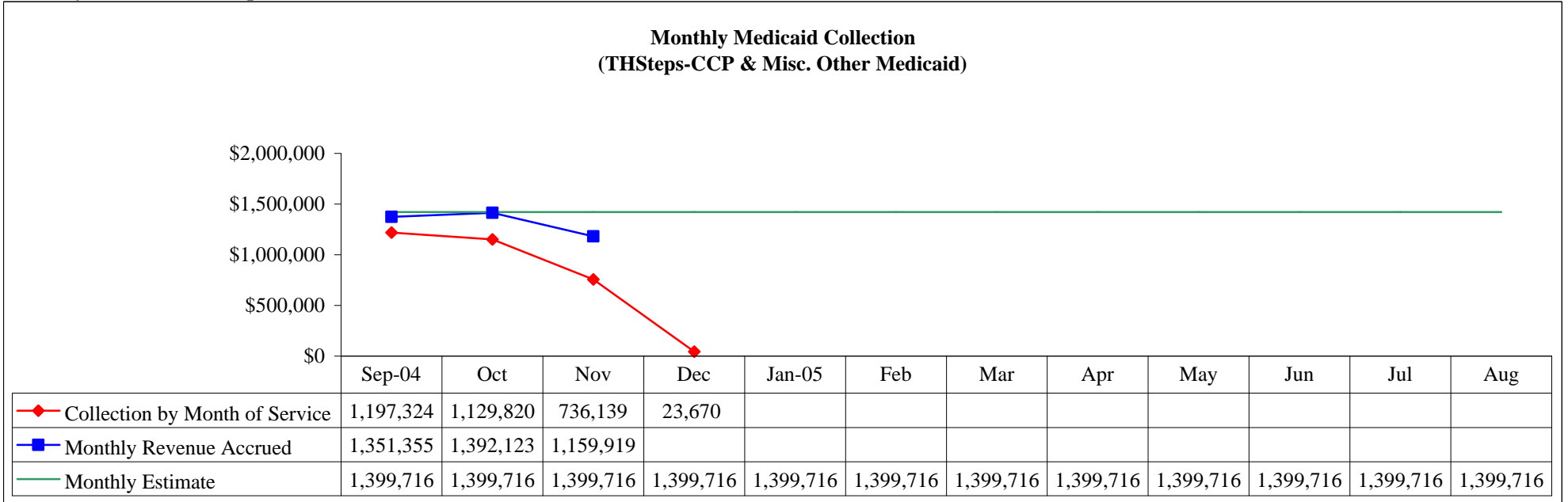
Progress Toward Annual Medicare Estimate (\$17,978,290)



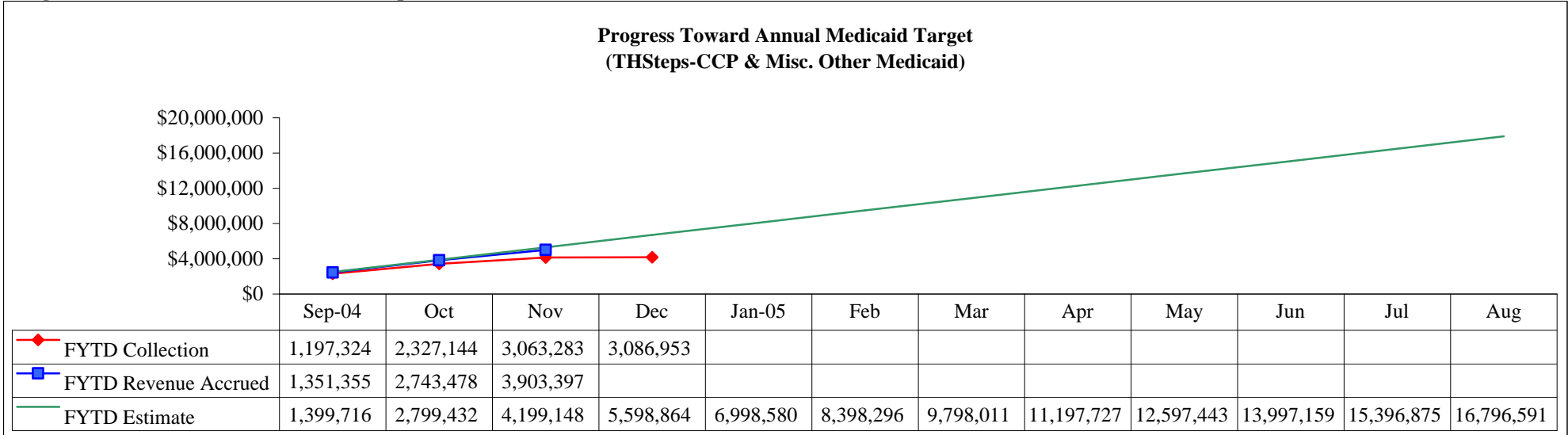
Objective 1D - FY 2005 Revenue Estimates

All Mental Health Facilities

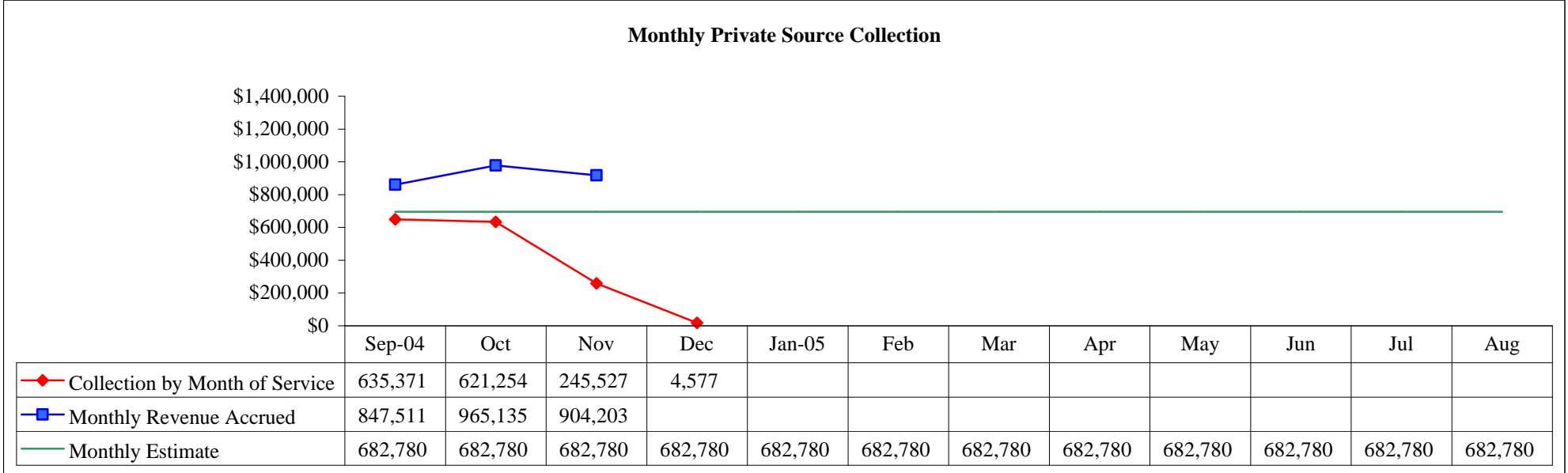
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$1,399,716)



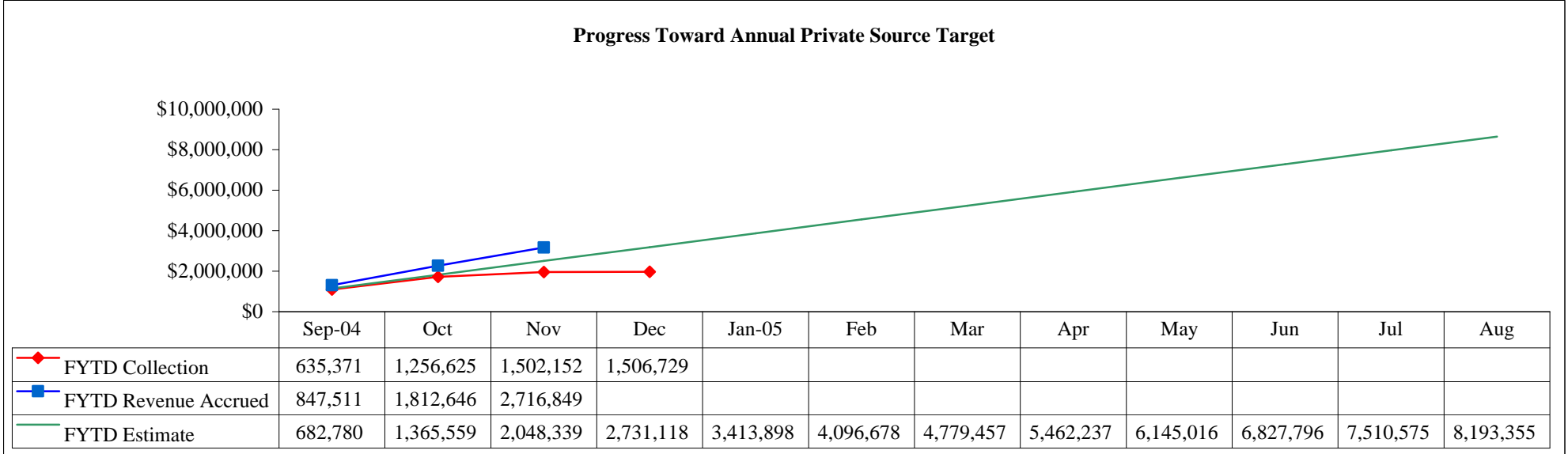
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$16,796,591)



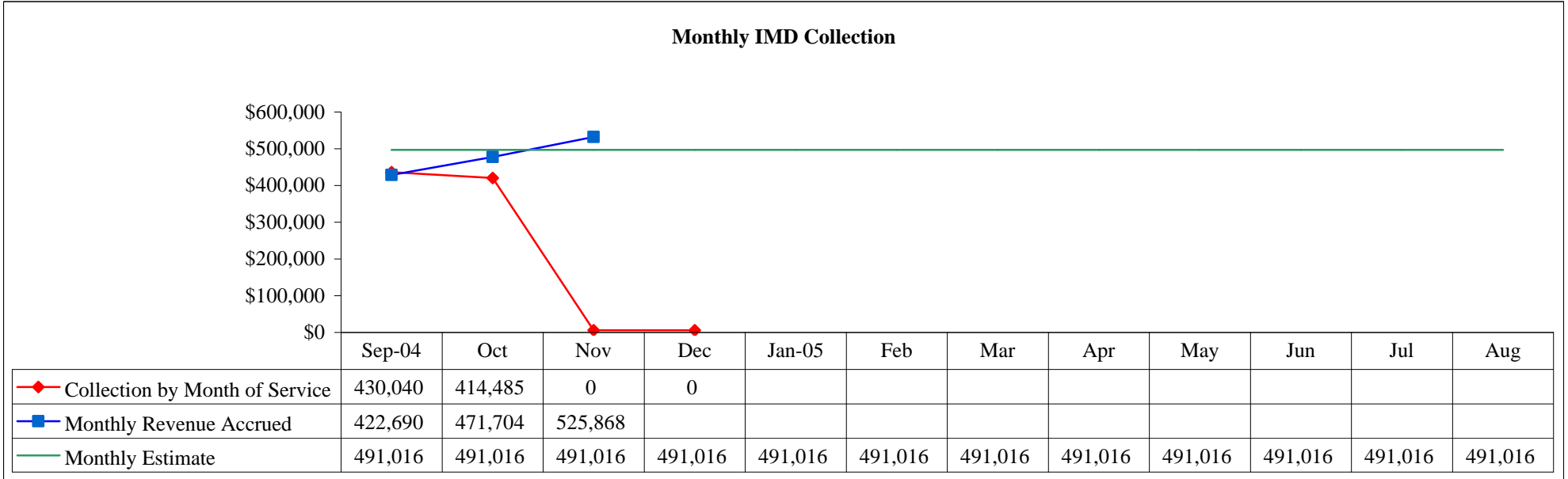
Objective 1D - FY 2005 Revenue Estimates
All Mental Health Facilities
Monthly Private Source Estimate (\$682,780)



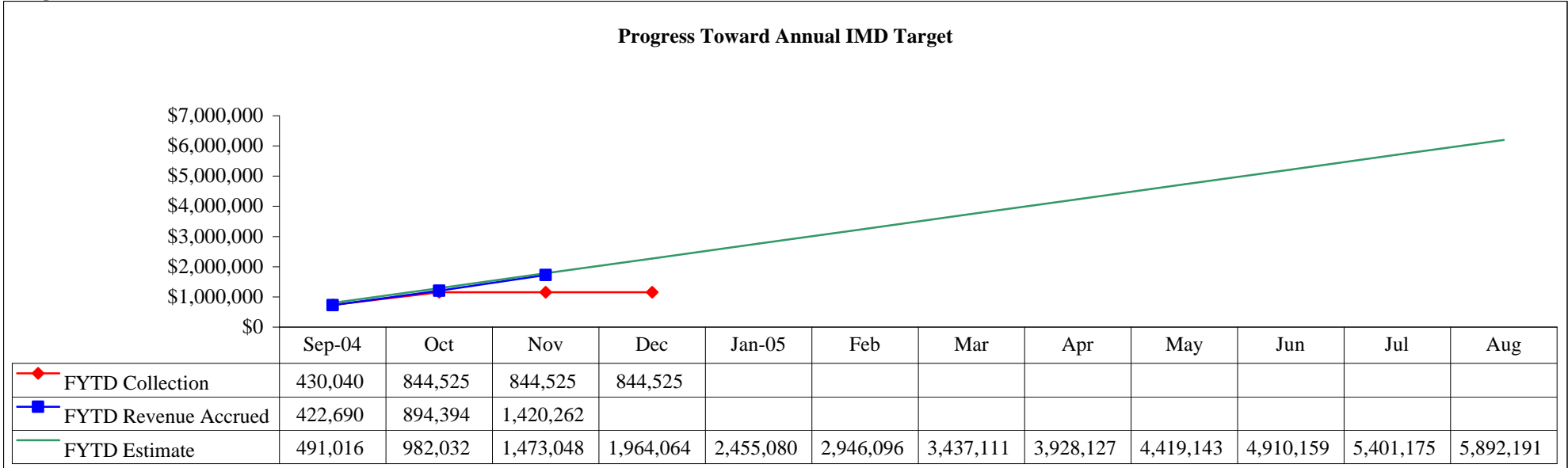
Progress Toward Annual Private Source Estimate (\$8,193,355)



Objective 1D - FY 2005 Revenue Estimates
All Mental Health Facilities
Monthly IMD Estimate (\$491,016)



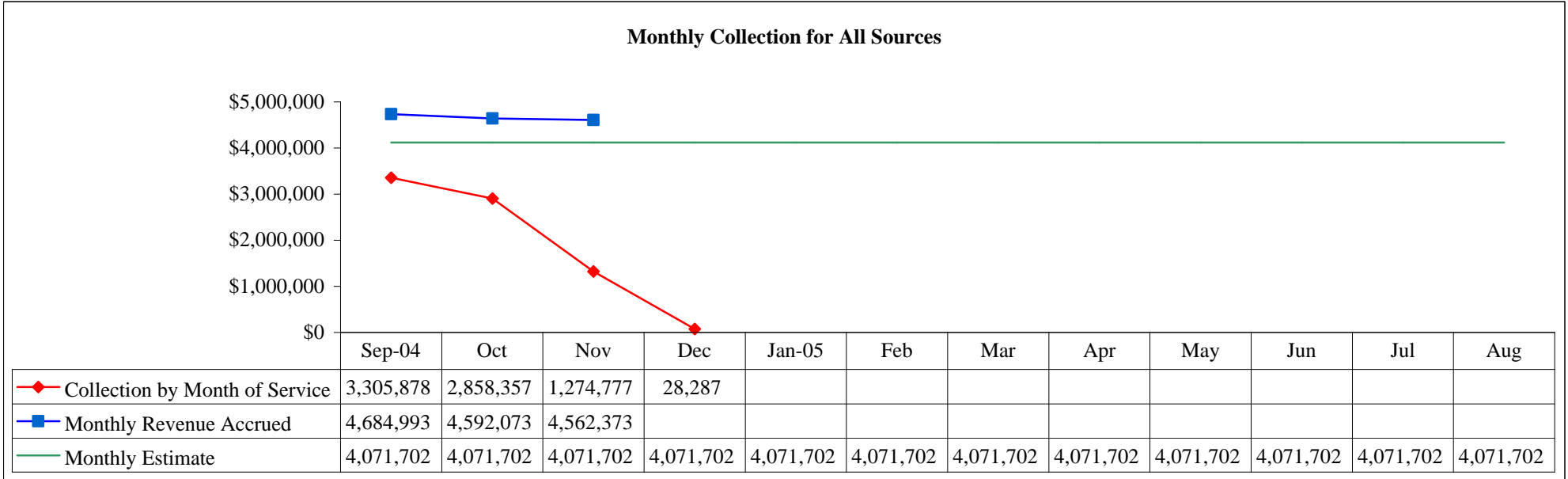
Progress Toward Annual IMD Estimate (\$5,892,191)



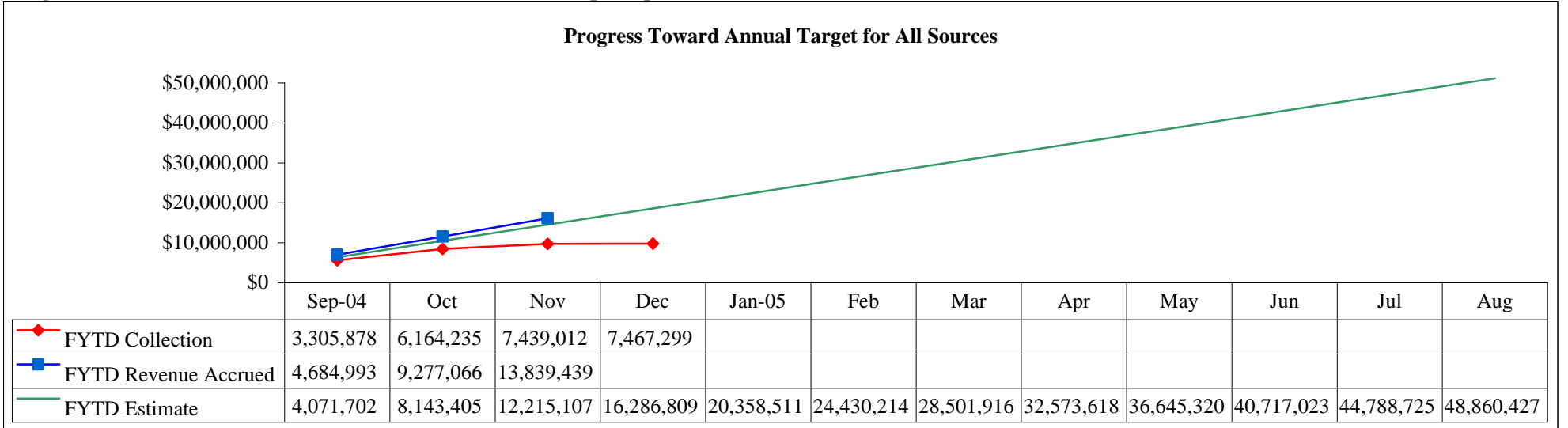
Objective 1D - FY 2005 Revenue Estimates

All Mental Health Facilities

Monthly Estimate for All Sources (except Dispro) (\$4,071,702)

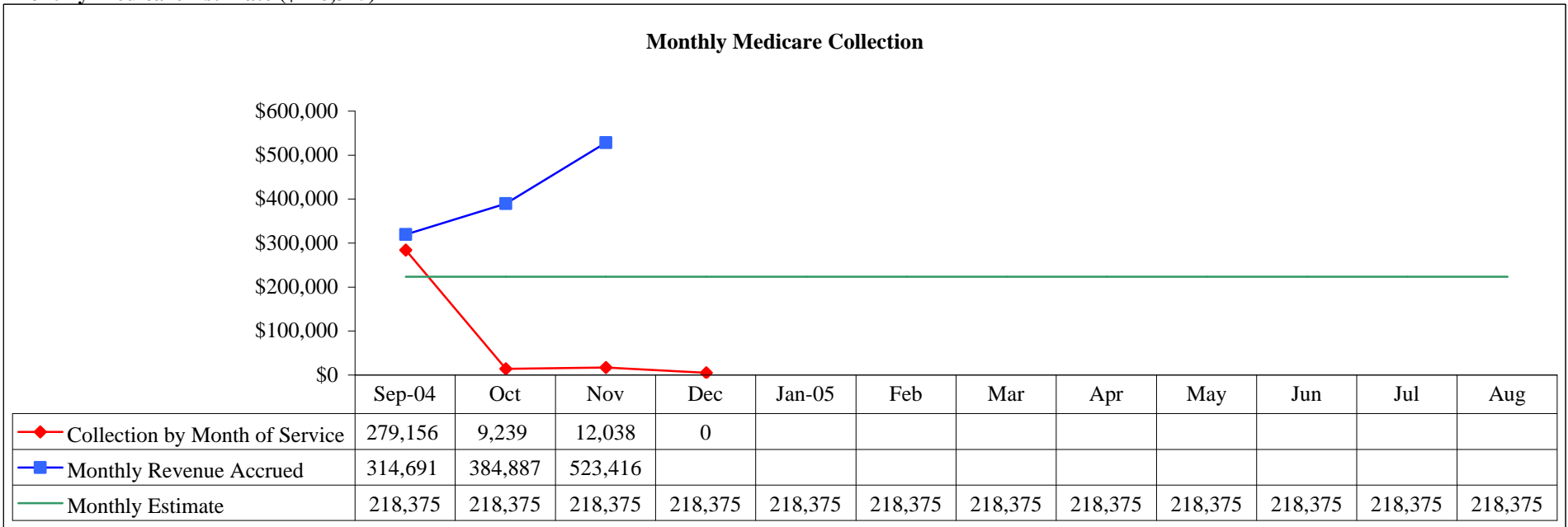


Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$48,860,427)

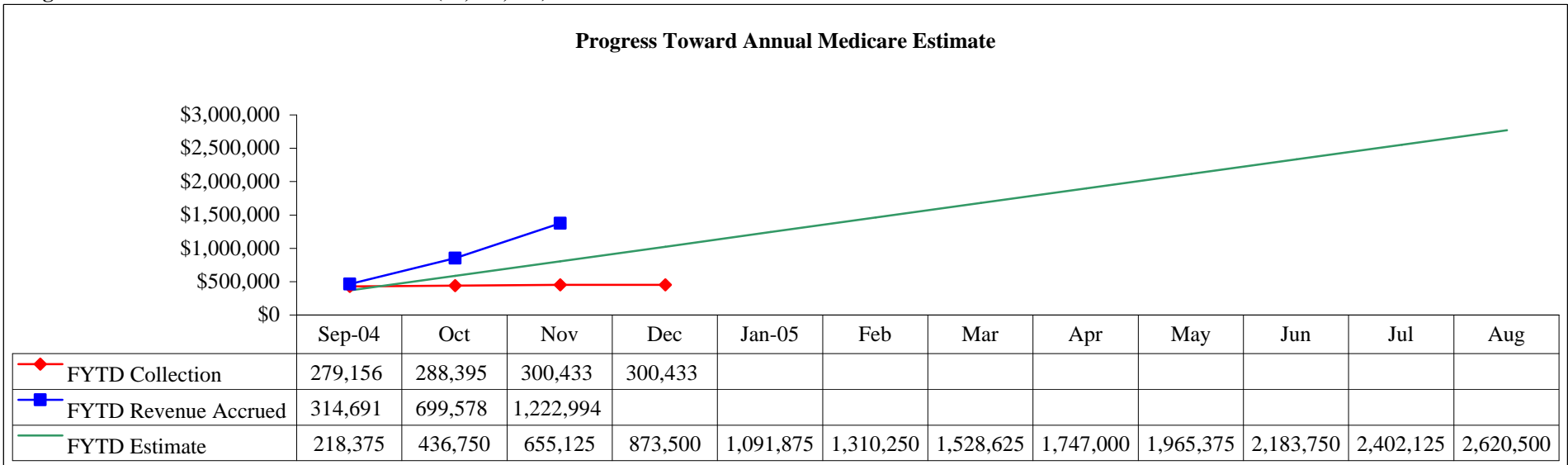


December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimates
Austin State Hospital
Monthly Medicare Estimate (\$218,375)



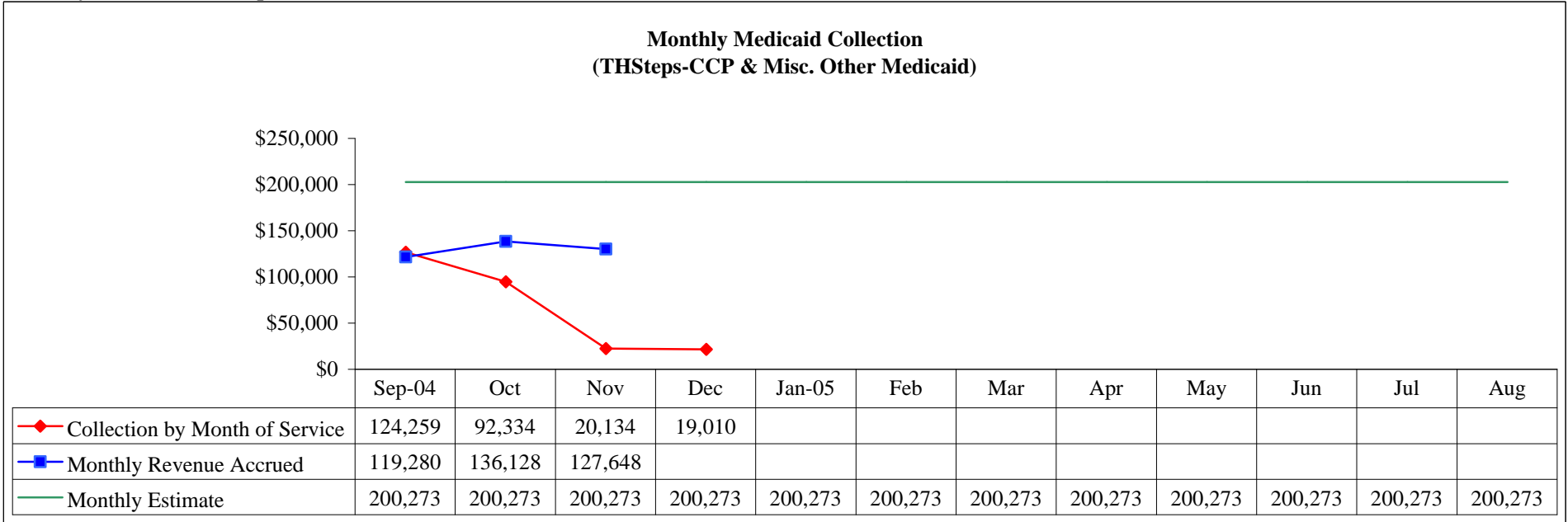
Progress Toward Annual Medicare Estimate (\$2,620,500)



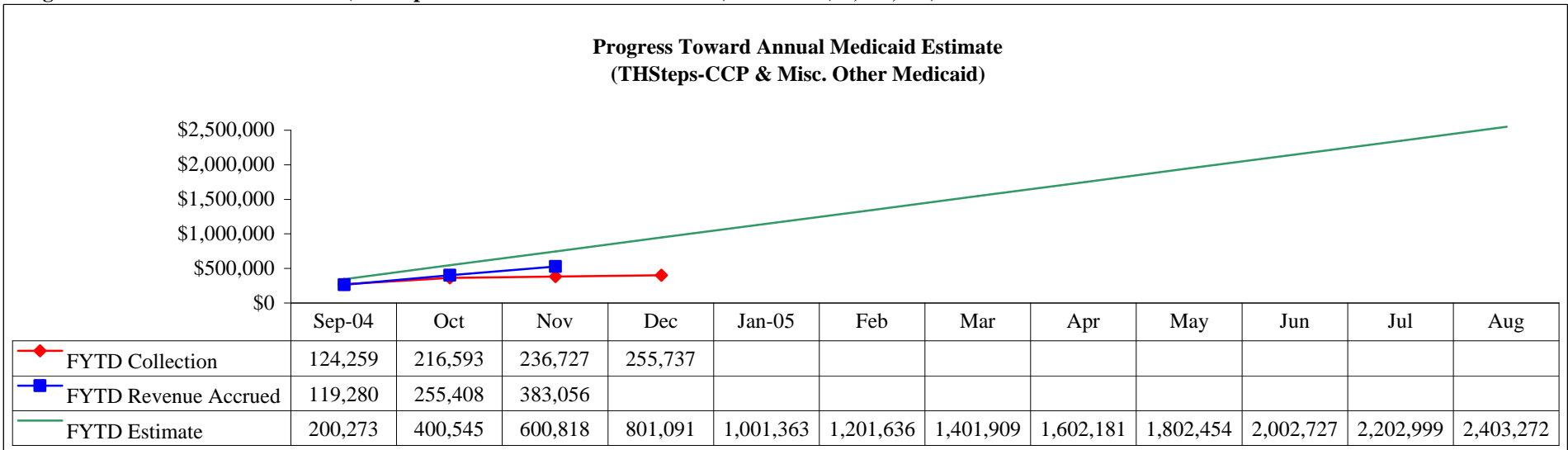
Objective 1D - FY 2005 Revenue Estimates

Austin State Hospital

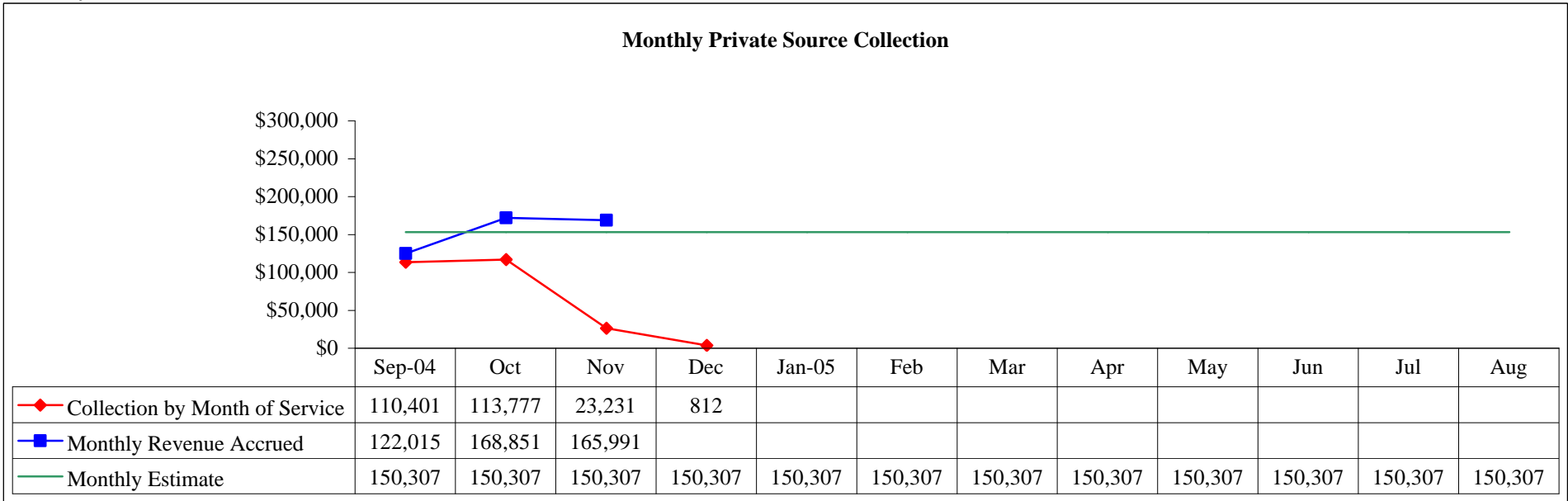
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$200,273)



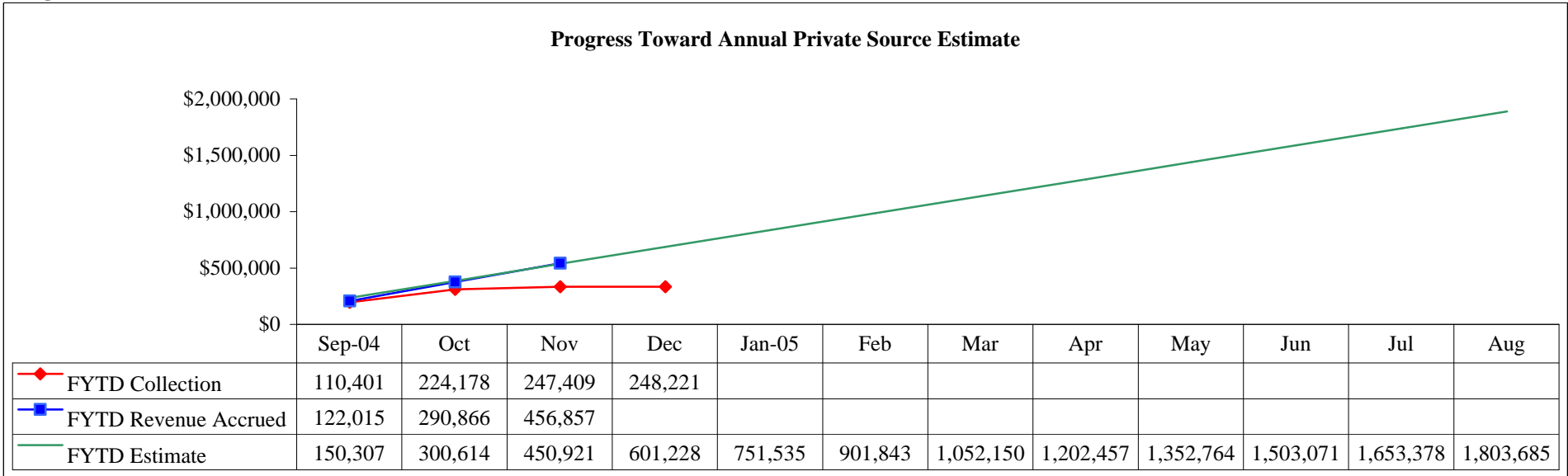
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$2,403,272)



Objective 1D - FY 2005 Revenue Estimates
Austin State Hospital
Monthly Private Source Estimate (\$150,307)

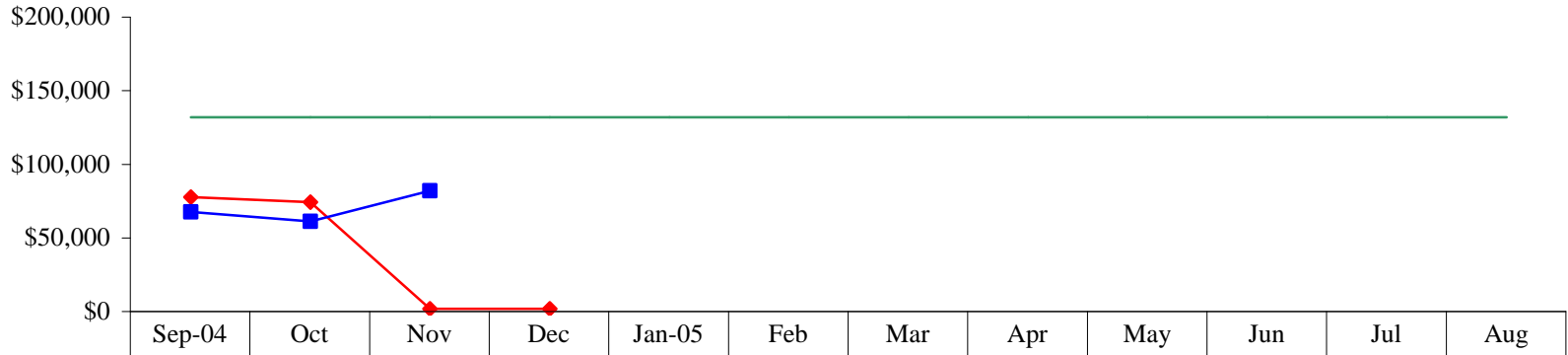


Progress Toward Annual Private Source Estimate (\$1,803,685)



Objective 1D - FY 2005 Revenue Estimates
Austin State Hospital
Monthly IMD Estimate (\$130,045)

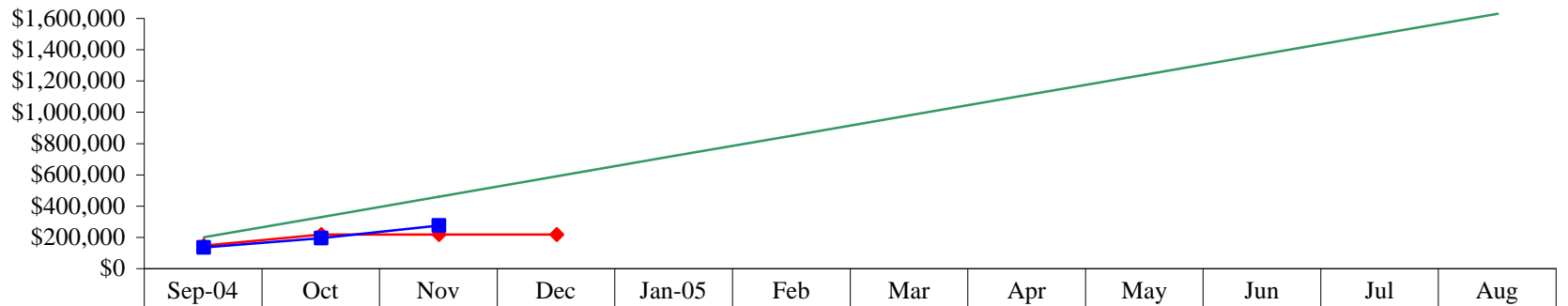
Monthly IMD Collection



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
Collection by Month of Service	75,873	72,457	0	0								
Monthly Revenue Accrued	65,721	59,353	80,174									
Monthly Estimate	130,045	130,045	130,045	130,045	130,045	130,045	130,045	130,045	130,045	130,045	130,045	130,045

Progress Toward Annual IMD Estimate (\$1,560,537)

Progress Toward Annual IMD Estimate

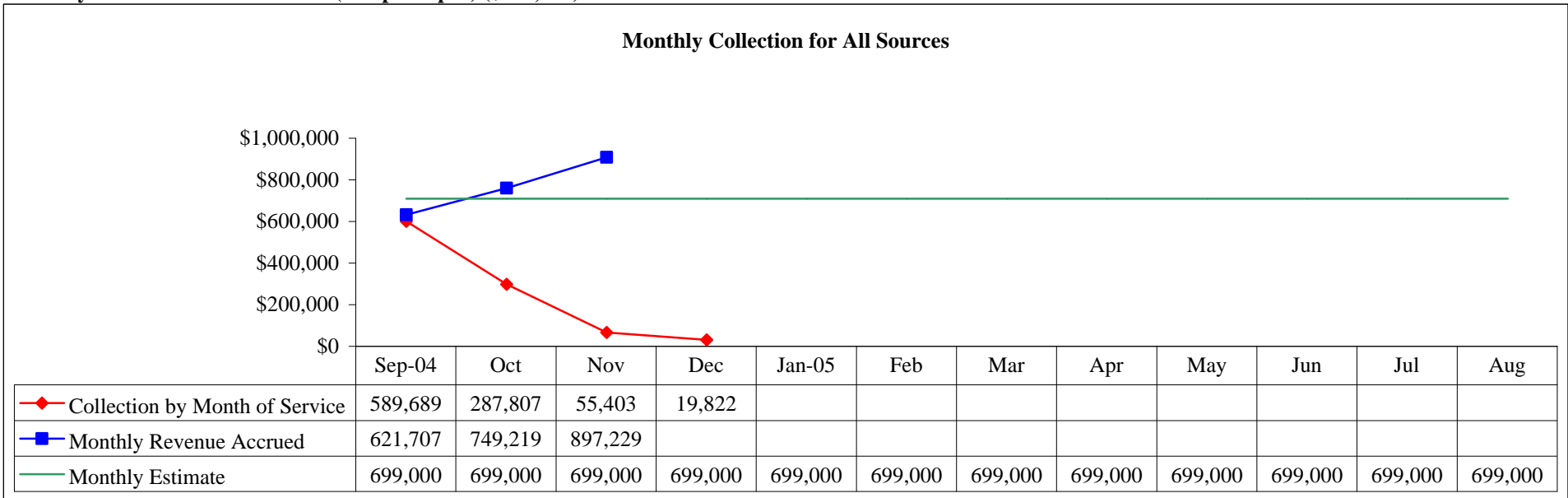


	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
FYTD Collection	75,873	148,330	148,330	148,330								
FYTD Revenue Accrued	65,721	125,074	205,248									
FYTD Estimate	130,045	260,090	390,134	520,179	650,224	780,269	910,313	1,040,358	1,170,403	1,300,448	1,430,492	1,560,537

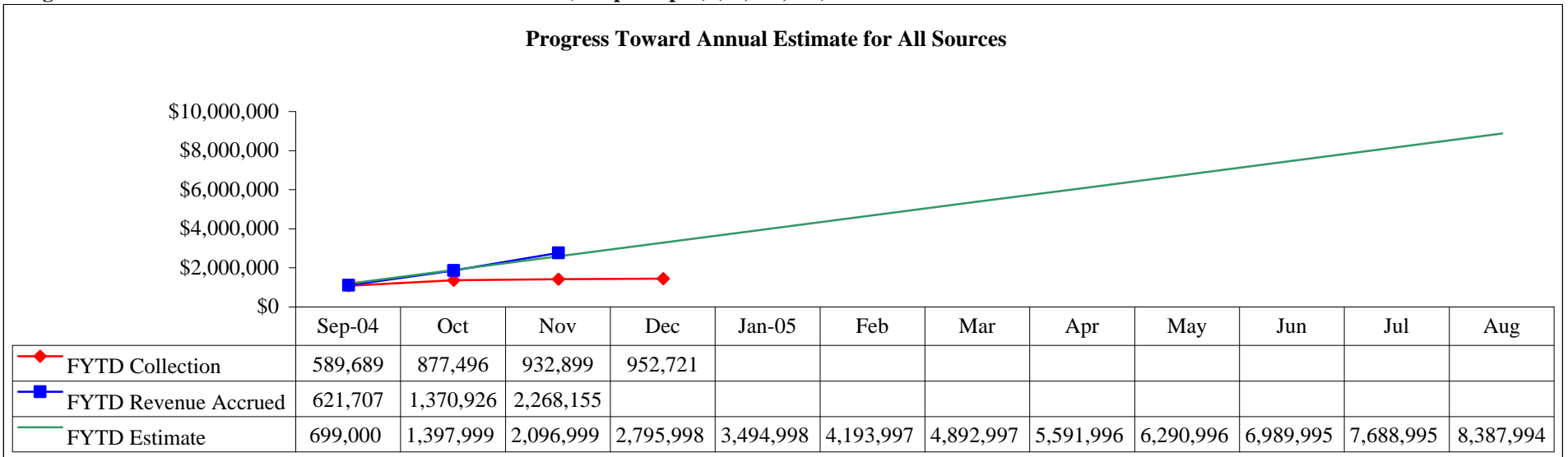
Objective 1D - FY 2005 Revenue Estimates

Austin State Hospital

Monthly Estimate For All Sources (except Dispro) (\$699,000)



Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$8,387,994)

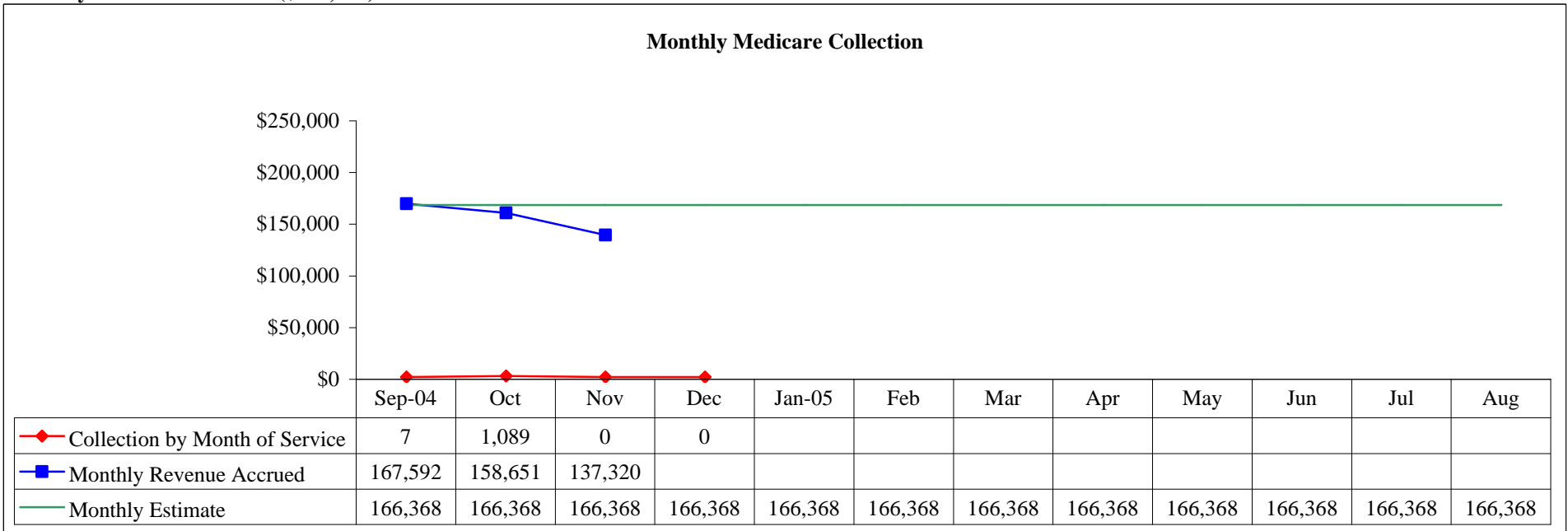


December Revenue Accrued information not available at this time.

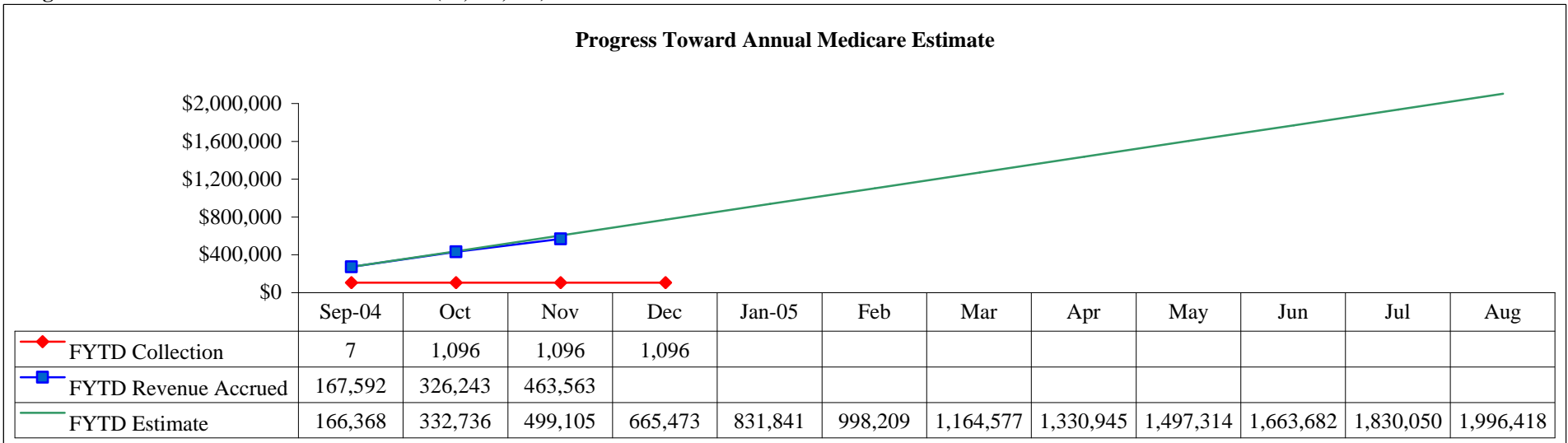
Chart: Hospital Management Data Services

Source: MH Monthly Reimbursement Report

Objective 1D - FY 2005 Revenue Estimates
Big Spring State Hospital
Monthly Medicare Estimate (\$166,368)



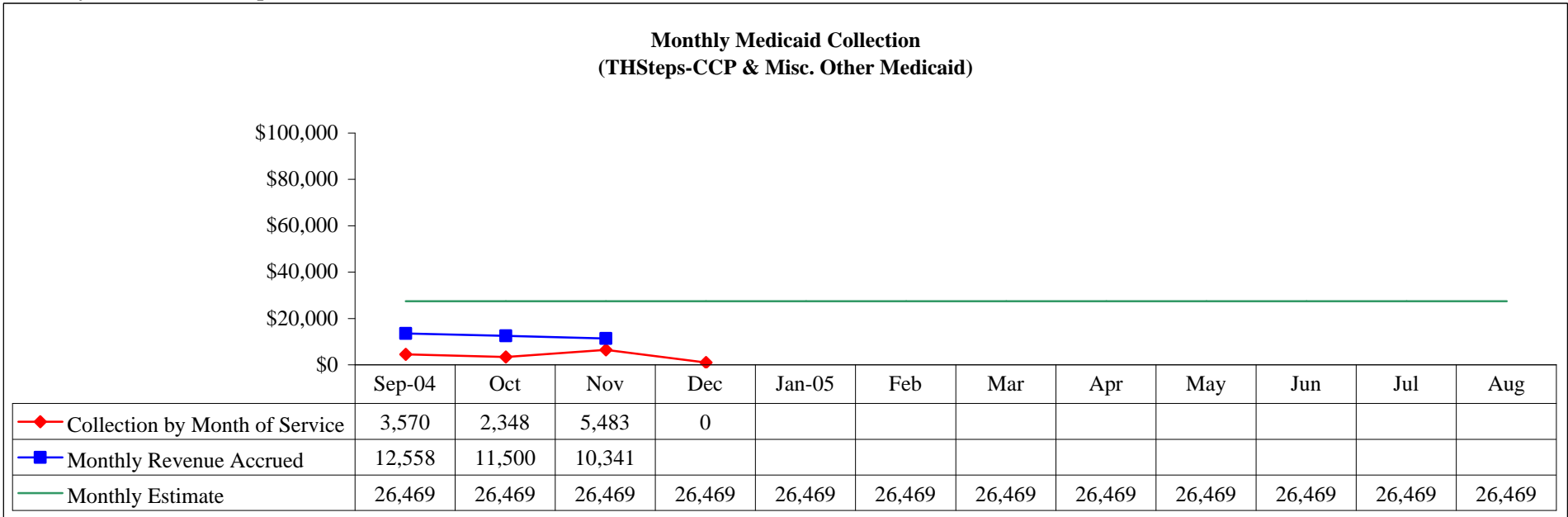
Progress Toward Annual Medicare Estimate (\$1,996,418)



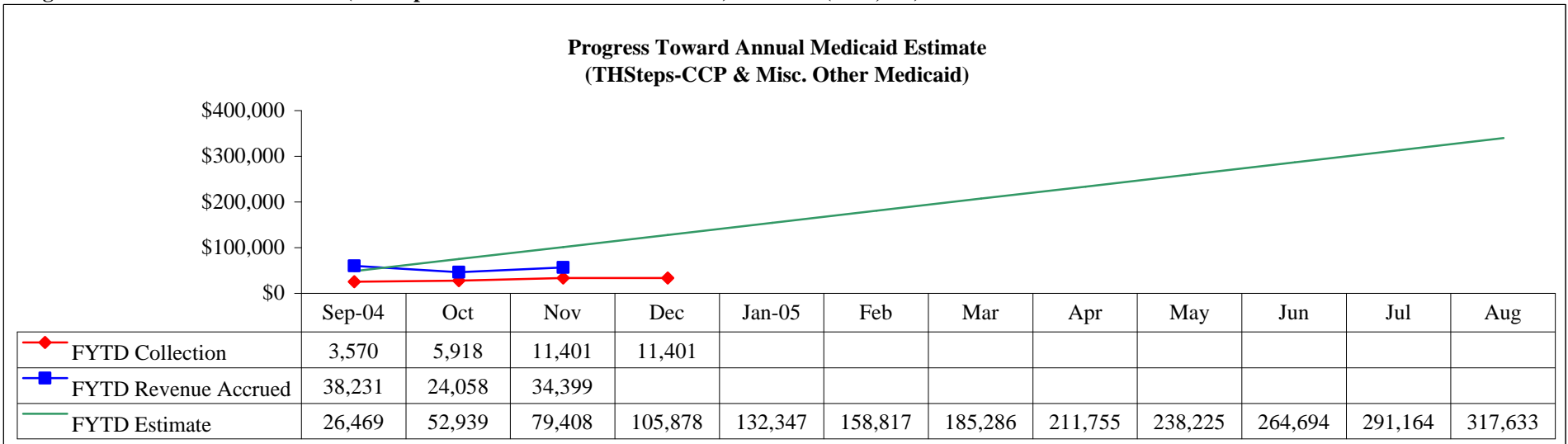
Objective 1D - FY 2005 Revenue Estimates

Big Spring State Hospital

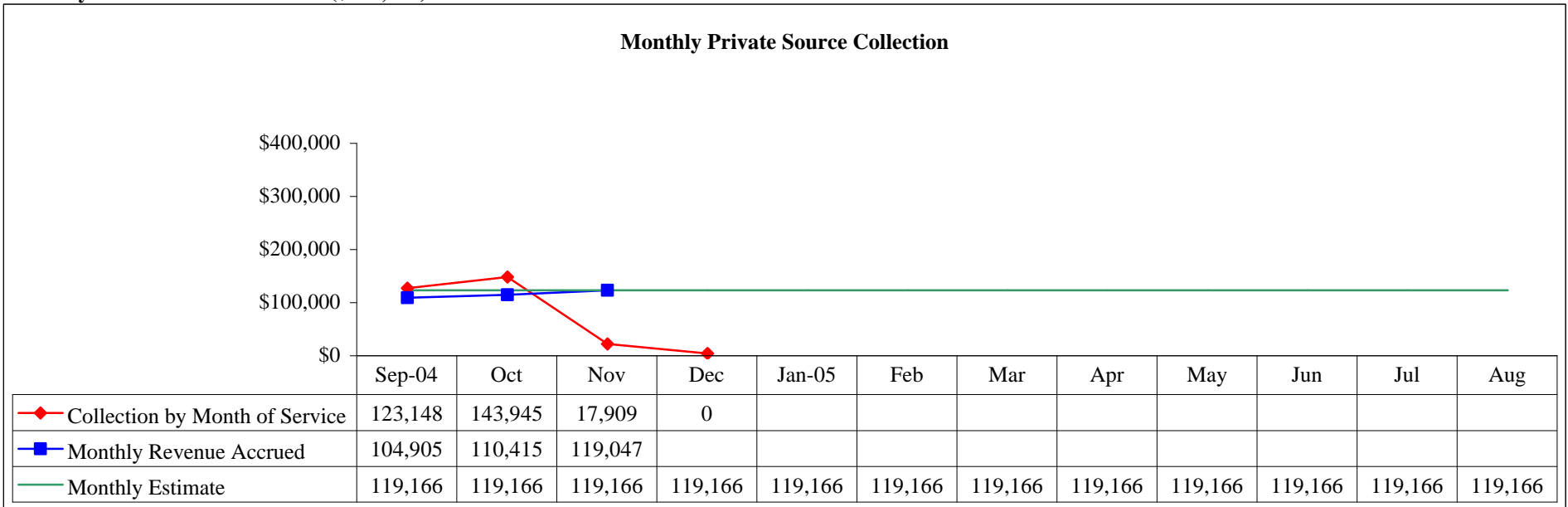
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$26,469)



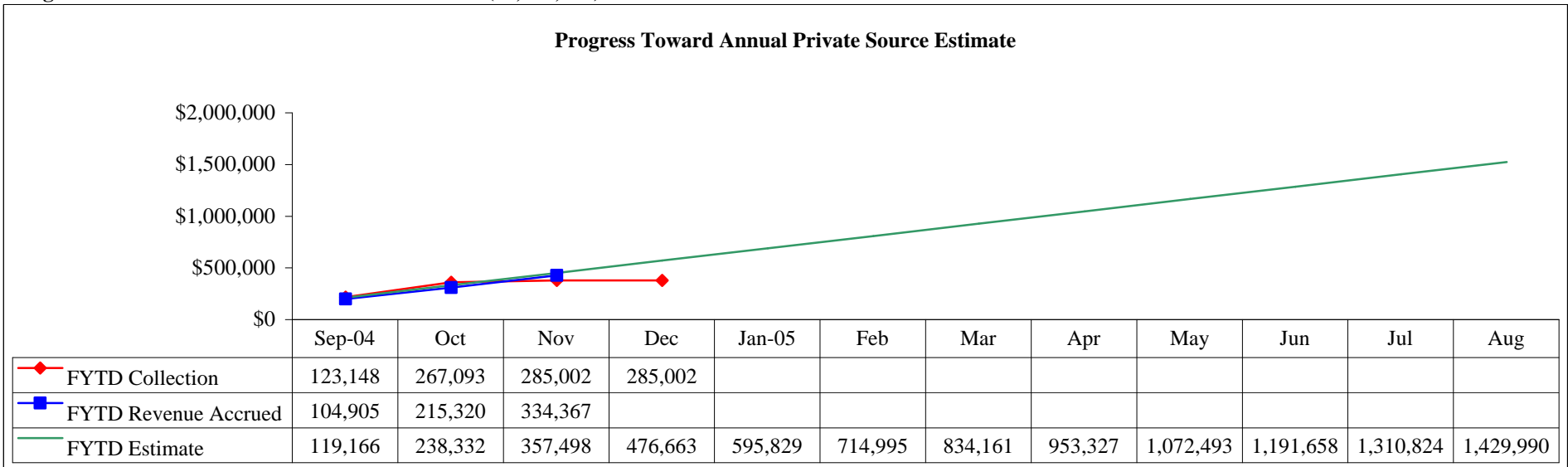
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$317,633)



Objective 1D - FY 2005 Revenue Estimates
Big Spring State Hospital
Monthly Private Source Estimate (\$119,166)

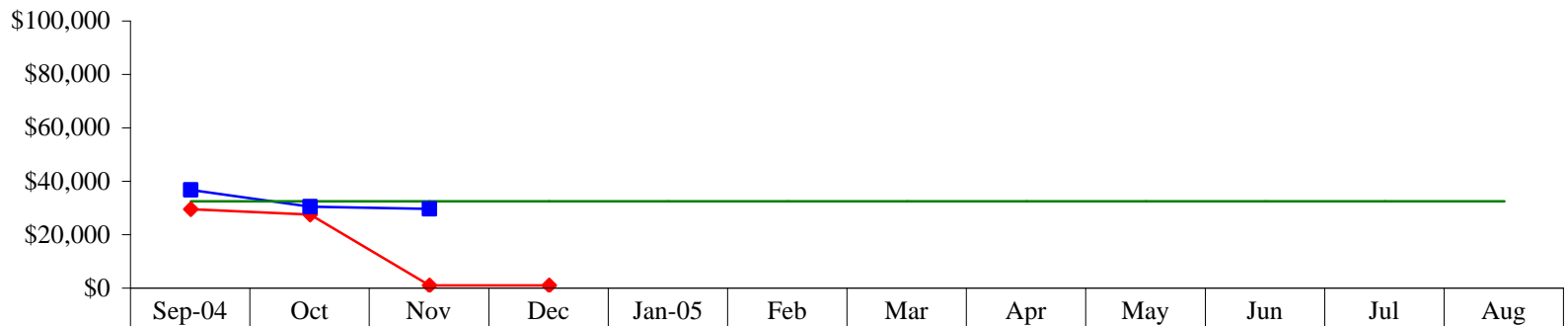


Progress Toward Annual Private Source Estimate (\$1,429,990)



Objective 1D - FY 2005 Revenue Estimates
Big Spring State Hospital
Monthly IMD Estimate (\$31,488)

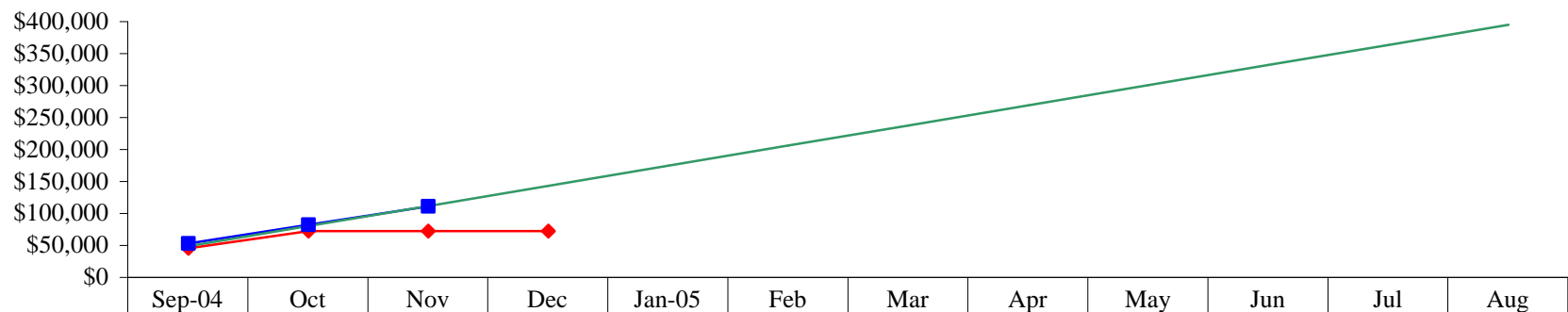
Monthly IMD Collection



Collection by Month of Service	28,489	26,479	0	0								
Monthly Revenue Accrued	35,790	29,489	28,647									
Monthly Estimate	31,488	31,488	31,488	31,488	31,488	31,488	31,488	31,488	31,488	31,488	31,488	31,488

Progress Toward Annual IMD Estimate (\$377,857)

Progress Toward Annual IMD Estimate

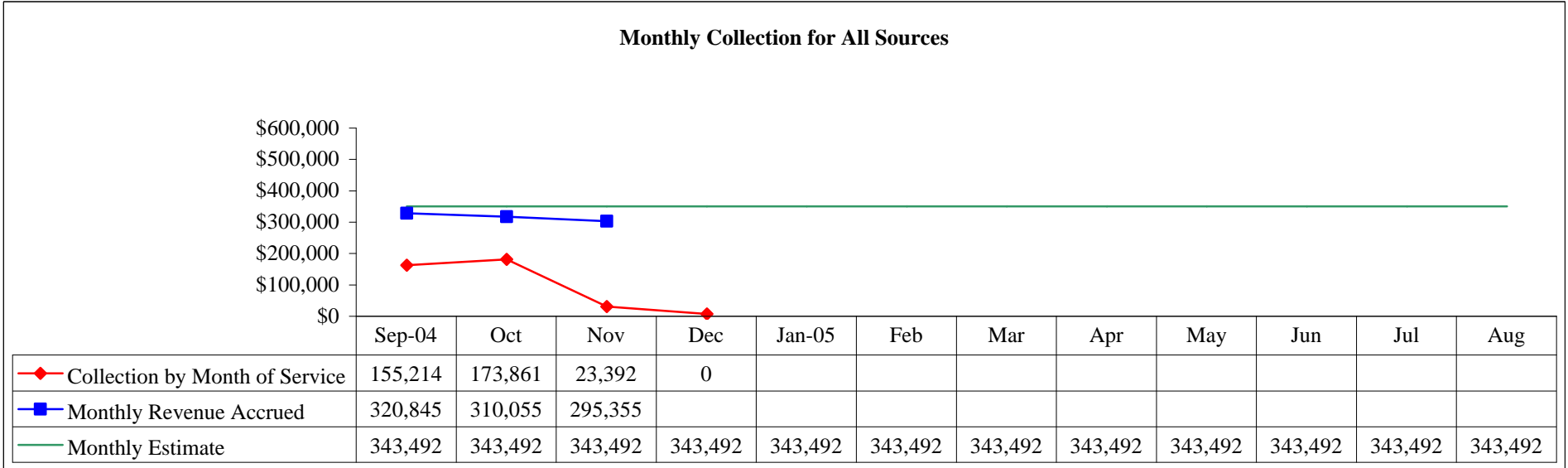


FYTD Collection	28,489	54,968	54,968	54,968								
FYTD Revenue Accrued	35,790	65,279	93,926									
FYTD Estimate	31,488	62,976	94,464	125,952	157,440	188,929	220,417	251,905	283,393	314,881	346,369	377,857

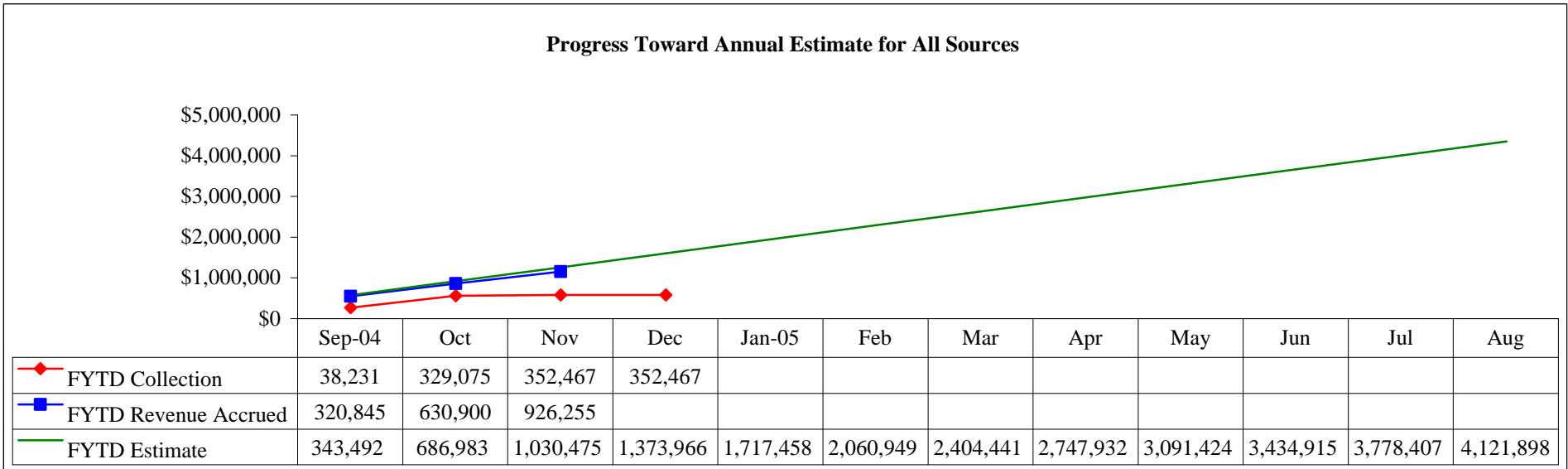
Objective 1D - FY 2005 Revenue Estimates

Big Spring State Hospital

Monthly Estimate For All Sources (except Dispro) (\$343,492)



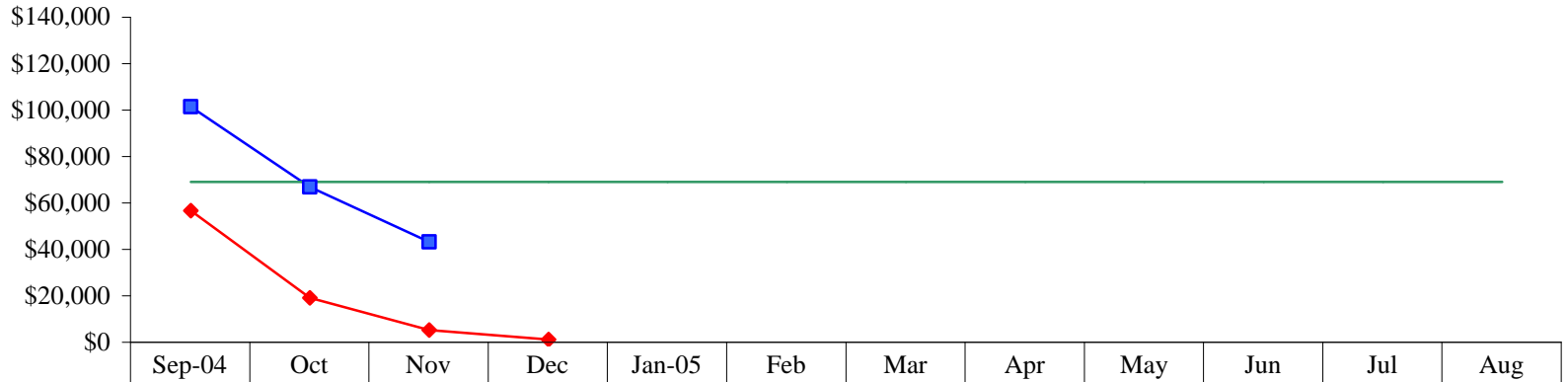
Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$4,121,898)



December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimates
El Paso Psychiatric Center
Monthly Medicare Estimate (\$67,839)

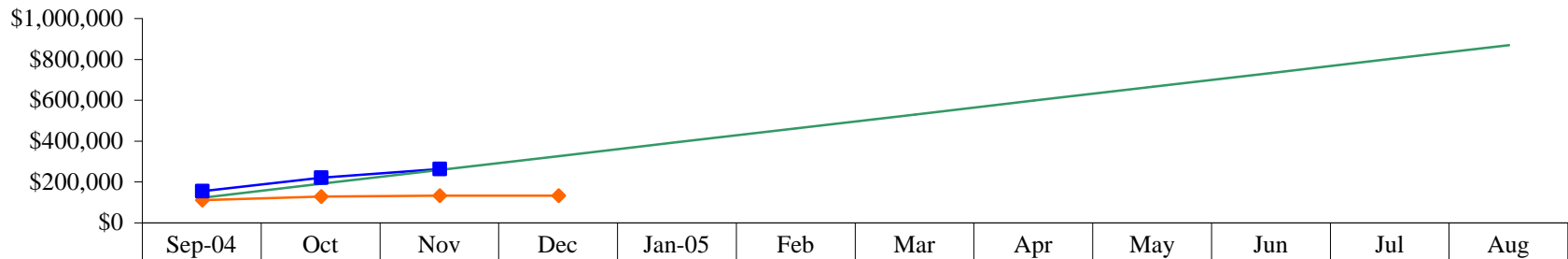
Monthly Medicare Collection



Collection by Month of Service	55,524	17,980	4,133	0								
Monthly Revenue Accrued	100,218	65,742	42,032									
Monthly Estimate	67,839	67,839	67,839	67,839	67,839	67,839	67,839	67,839	67,839	67,839	67,839	67,839

Progress Toward Annual Medicare Estimate (\$814,067)

Progress Toward Annual Medicare Estimate

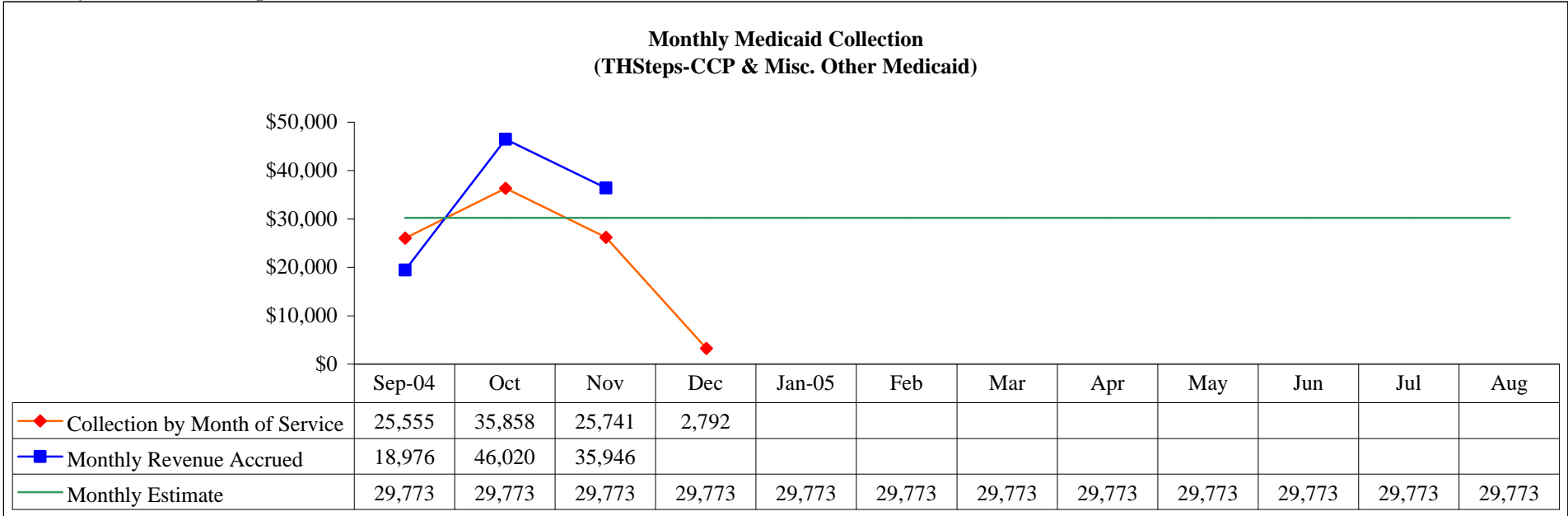


FYTD Collection	55,524	73,504	77,637	77,637								
FYTD Revenue Accrued	100,218	165,960	207,992									
FYTD Estimate	67,839	135,678	203,517	271,356	339,195	407,034	474,872	542,711	610,550	678,389	746,228	814,067

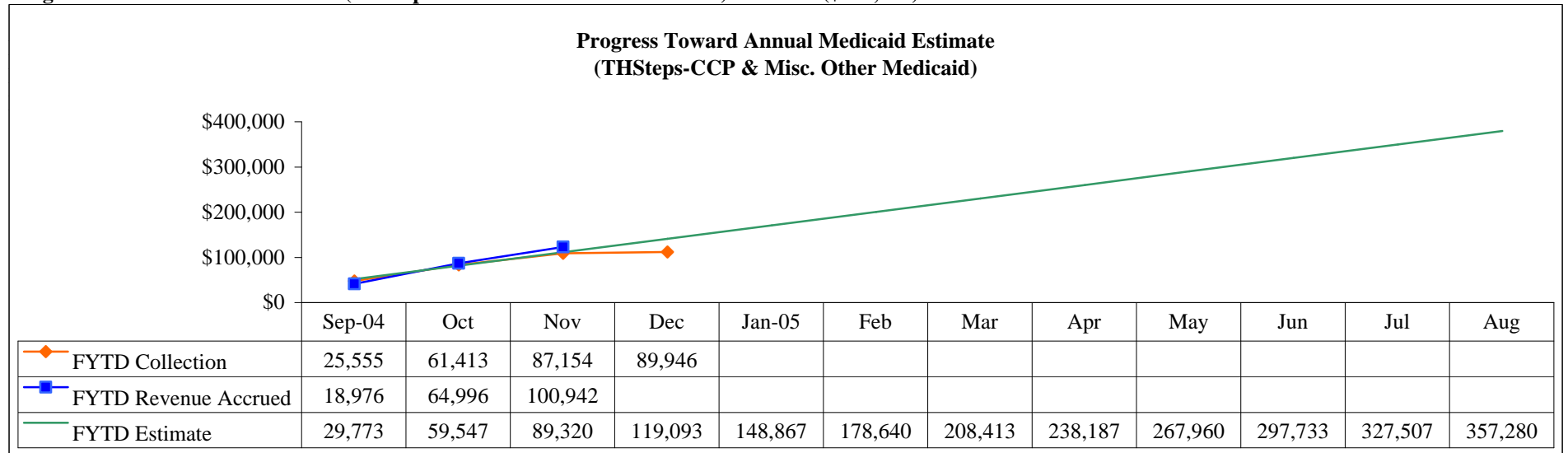
Objective 1D - FY 2005 Revenue Estimates

El Paso Psychiatric Center

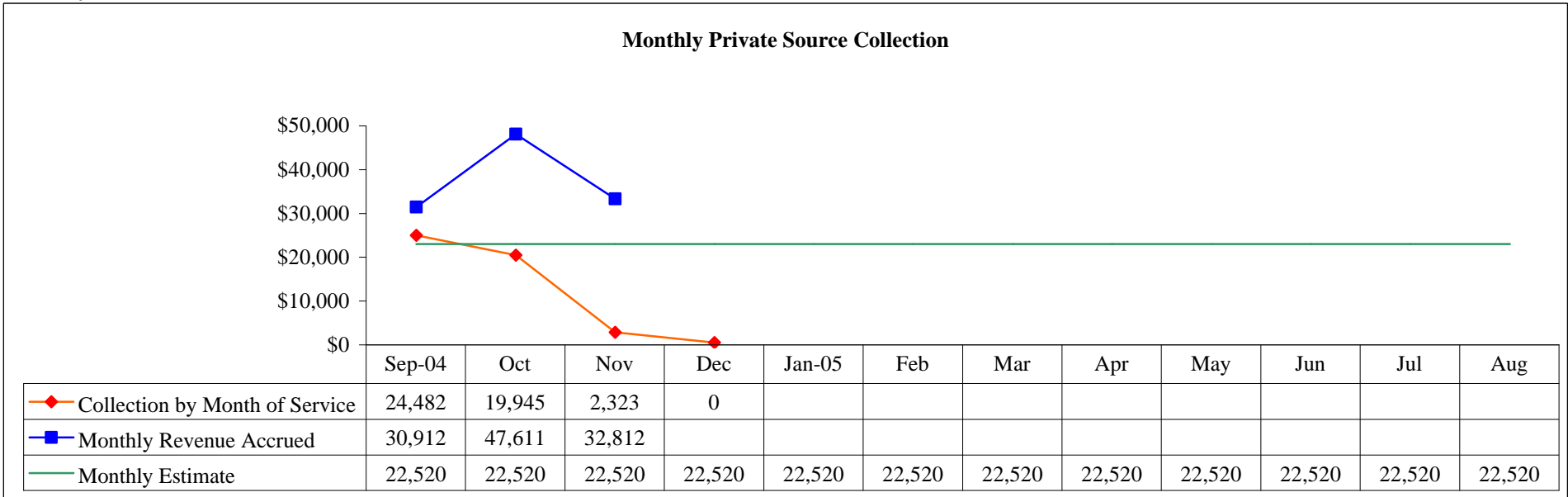
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$29,773)



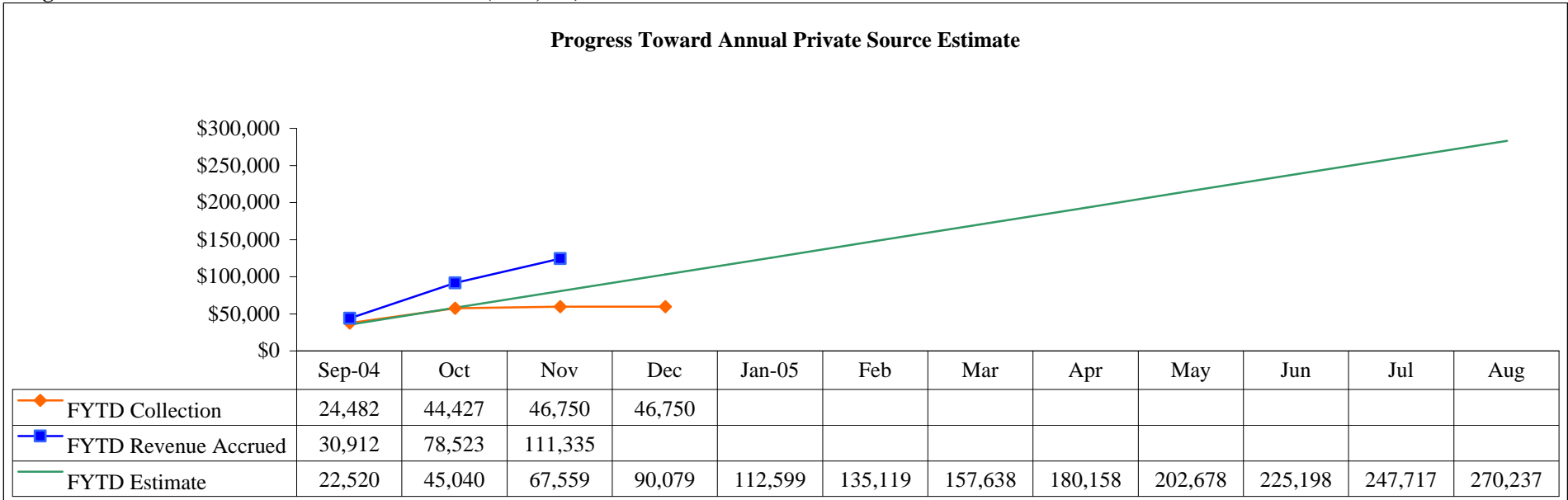
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$357,280)



Objective 1D - FY 2005 Revenue Estimates
El Paso Psychiatric Center
Monthly Private Source Estimate (\$22,520)



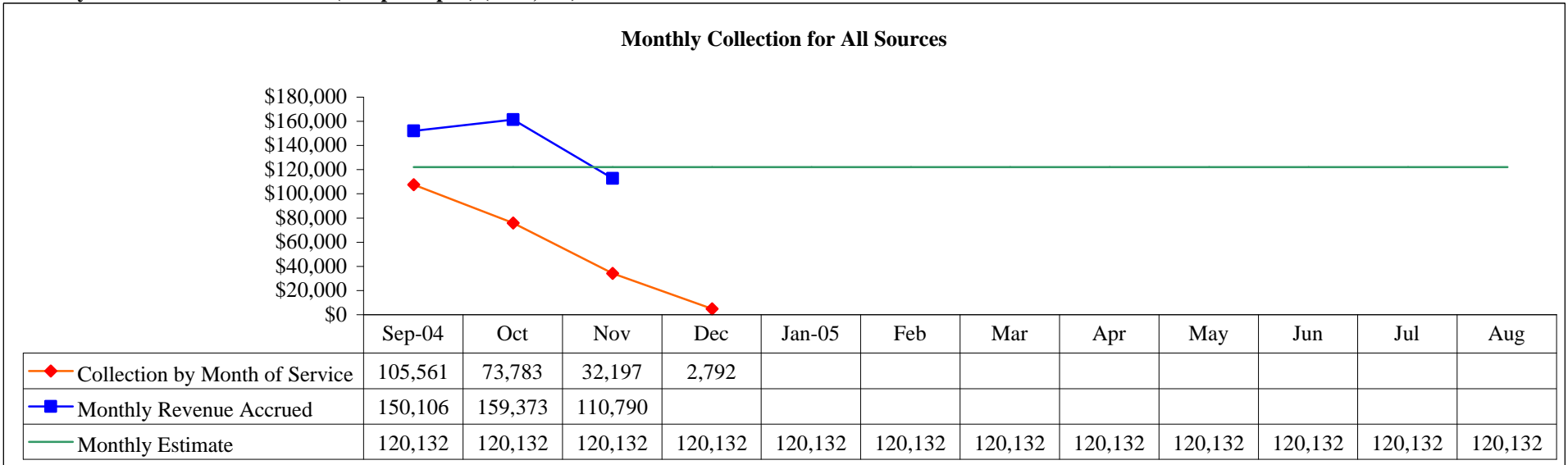
Progress Toward Annual Private Source Estimate (\$270,237)



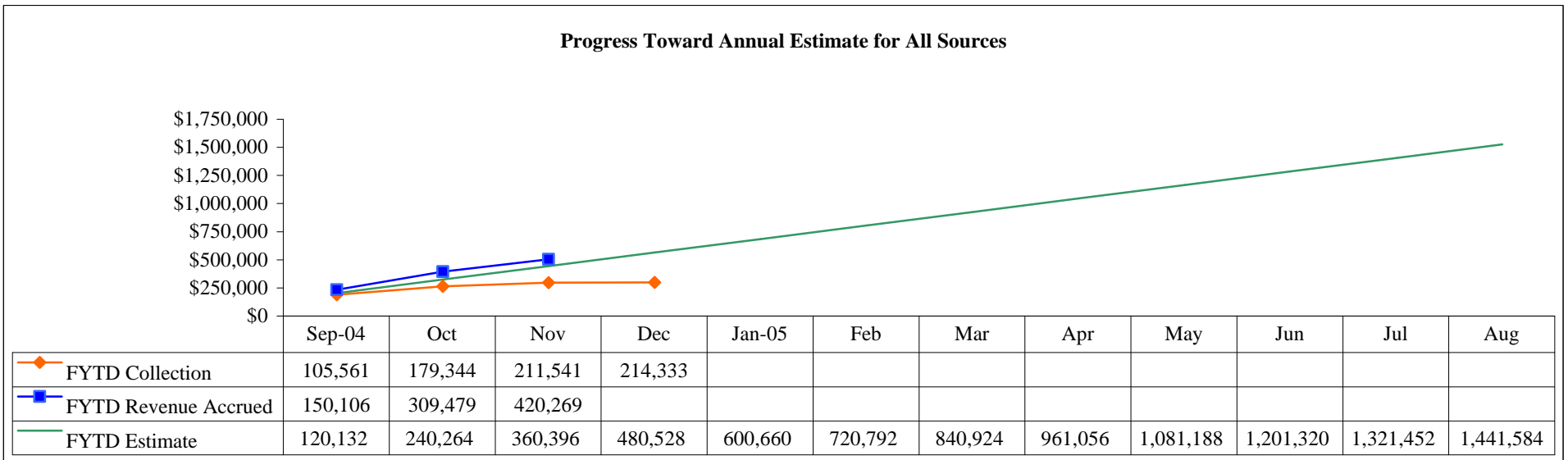
Objective 1D - FY 2005 Revenue Estimates

El Paso Psychiatric Center

Monthly Estimate For All Sources (except Dispro) (\$120,132)



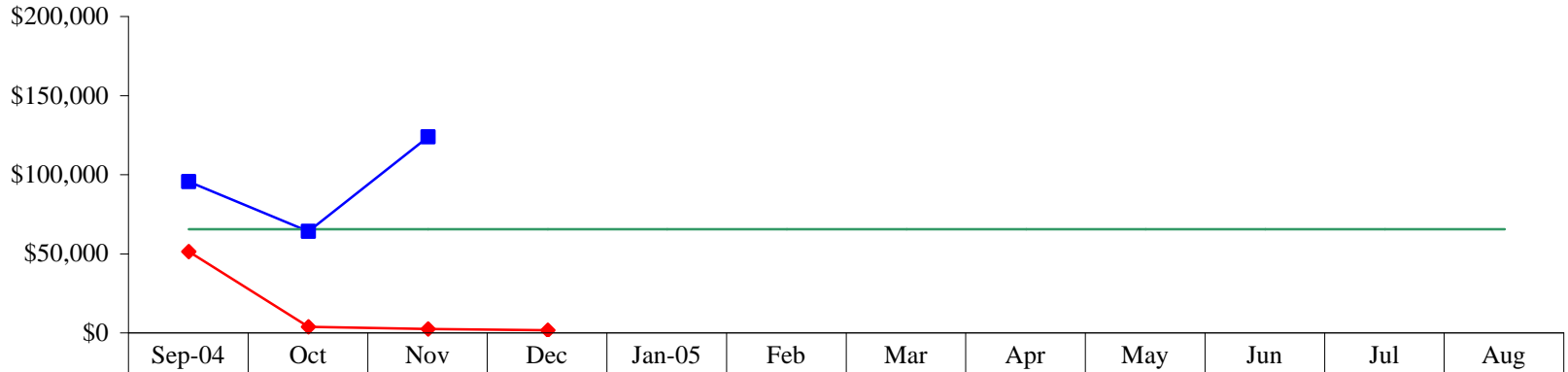
Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$1,441,584)



December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimate
Kerrville State Hospital
Monthly Medicare Estimate (\$63,846)

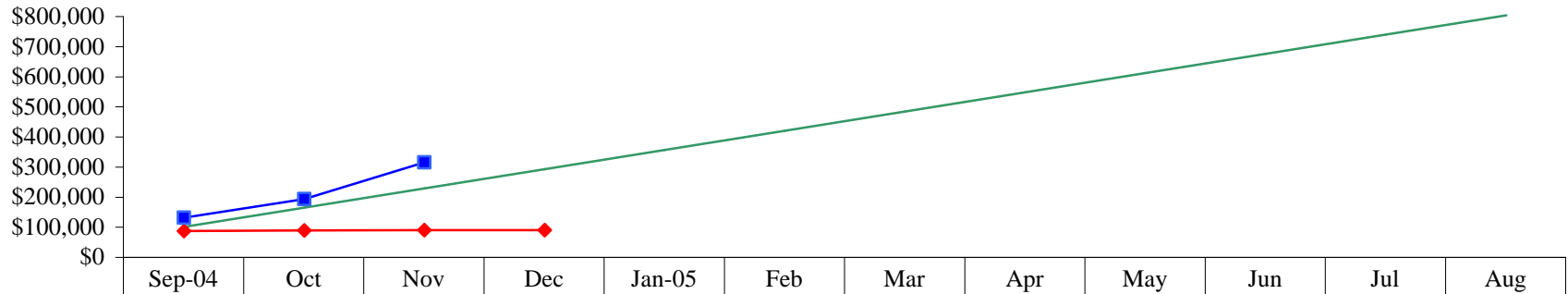
Monthly Medicare Collection



Collection by Month of Service	49,762	2,194	735	0								
Monthly Revenue Accrued	93,907	62,453	122,135									
Monthly Estimate	63,846	63,846	63,846	63,846	63,846	63,846	63,846	63,846	63,846	63,846	63,846	63,846

Progress Toward Annual Medicare Estimate (\$766,146)

Progress Toward Annual Medicare Estimate

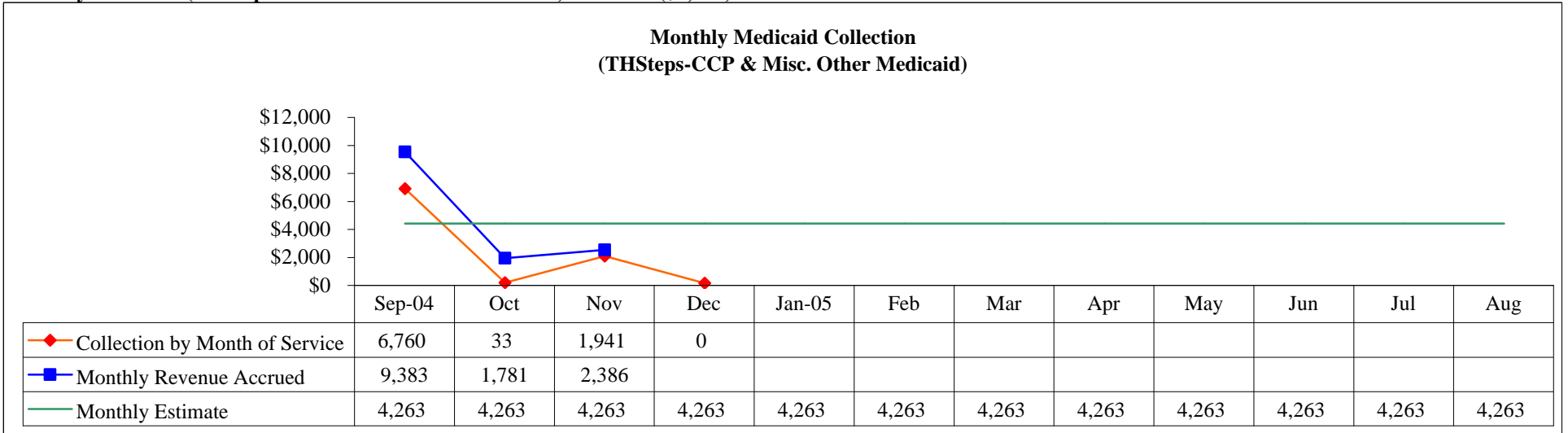


FYTD Collection	49,762	51,956	52,691	52,691								
FYTD Revenue Accrued	93,907	156,360	278,495									
FYTD Estimate	63,846	127,691	191,537	255,382	319,228	383,073	446,919	510,764	574,610	638,455	702,301	766,146

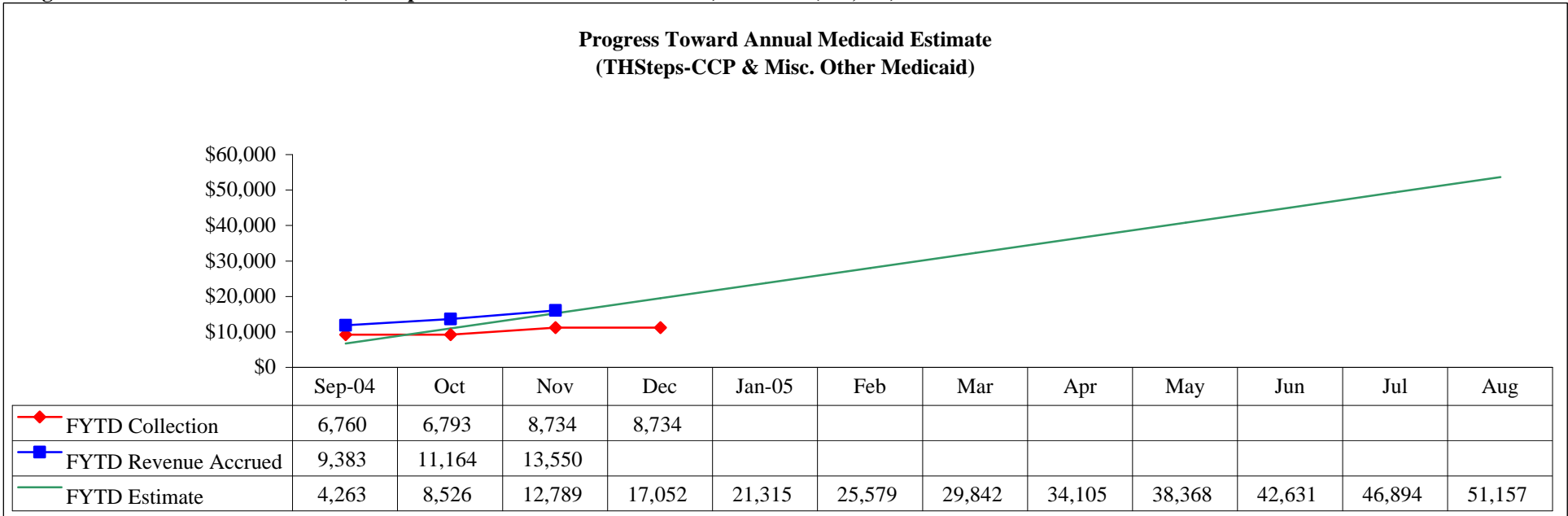
Objective 1D - FY 2005 Revenue Estimate

Kerrville State Hospital

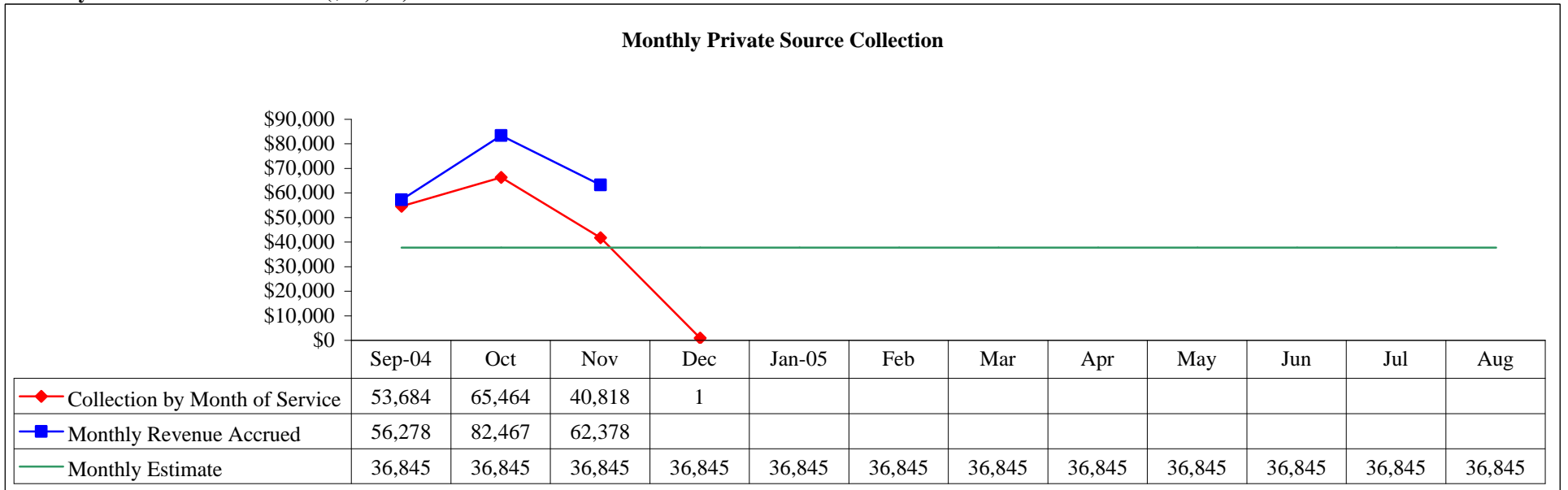
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$4,263)



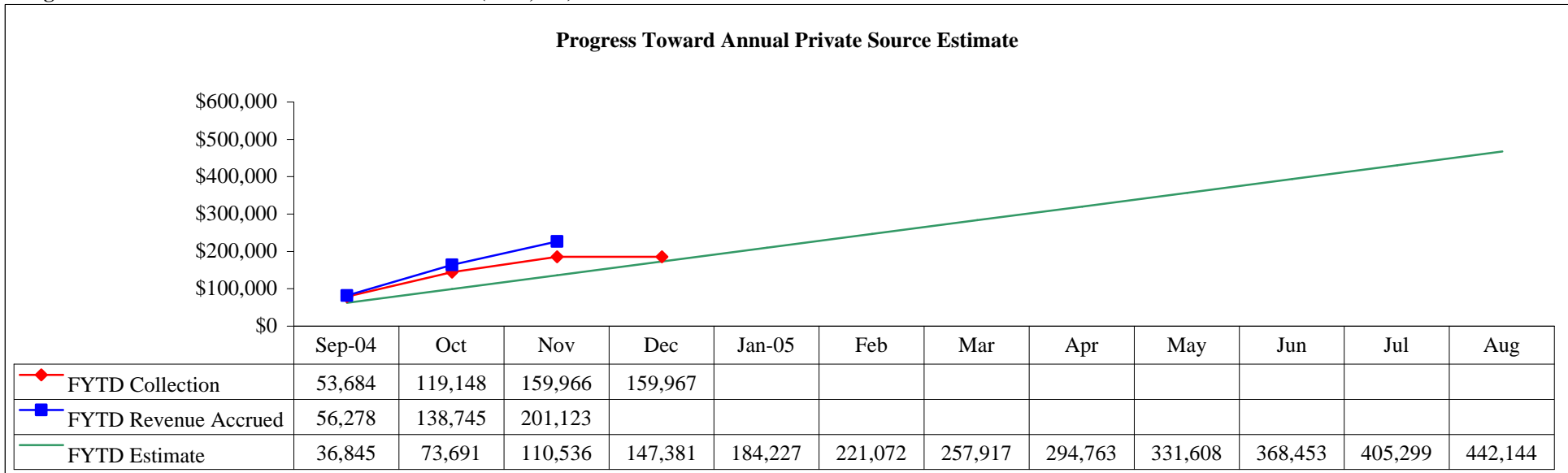
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$51,157)



Objective 1D - FY 2005 Revenue Estimate
Kerrville State Hospital
Monthly Private Source Estimate (\$36,845)

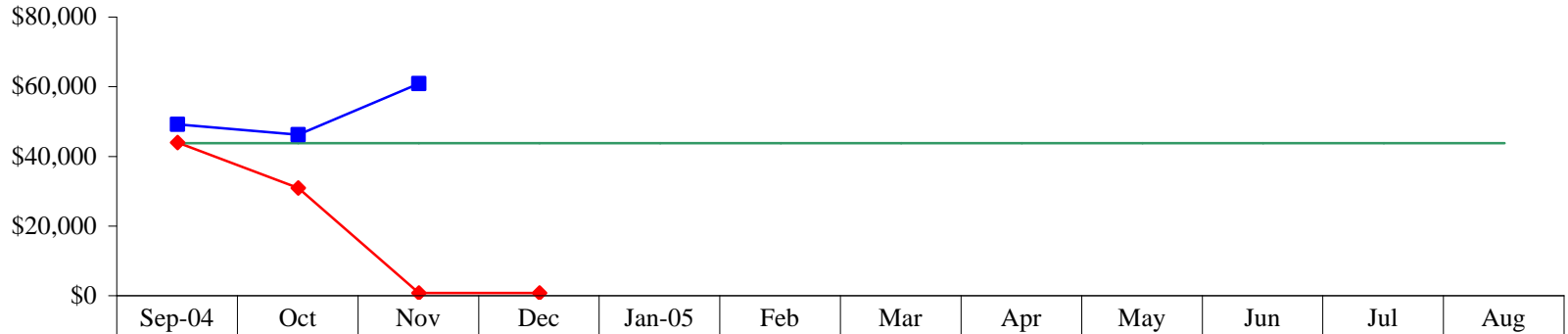


Progress Toward Annual Private Source Estimate (\$442,144)



Objective 1D - FY 2005 Revenue Estimate
Kerrville State Hospital
Monthly IMD Estimate (\$43,026)

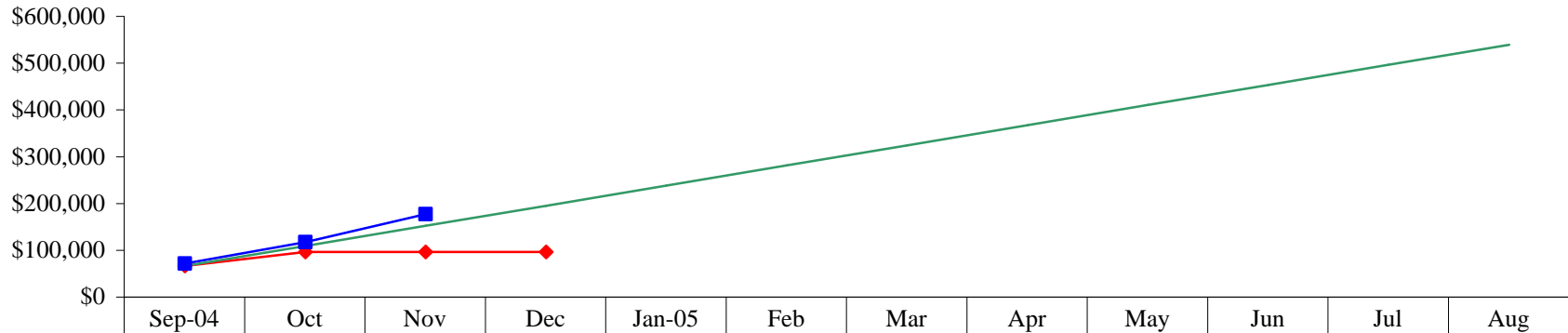
Monthly IMD Collection



Collection by Month of Service	43,216	30,162	0	0								
Monthly Revenue Accrued	48,396	45,466	60,116									
Monthly Estimate	43,026	43,026	43,026	43,026	43,026	43,026	43,026	43,026	43,026	43,026	43,026	43,026

Progress Toward Annual IMD Estimate (\$516,311)

Progress Toward Annual IMD Estimate

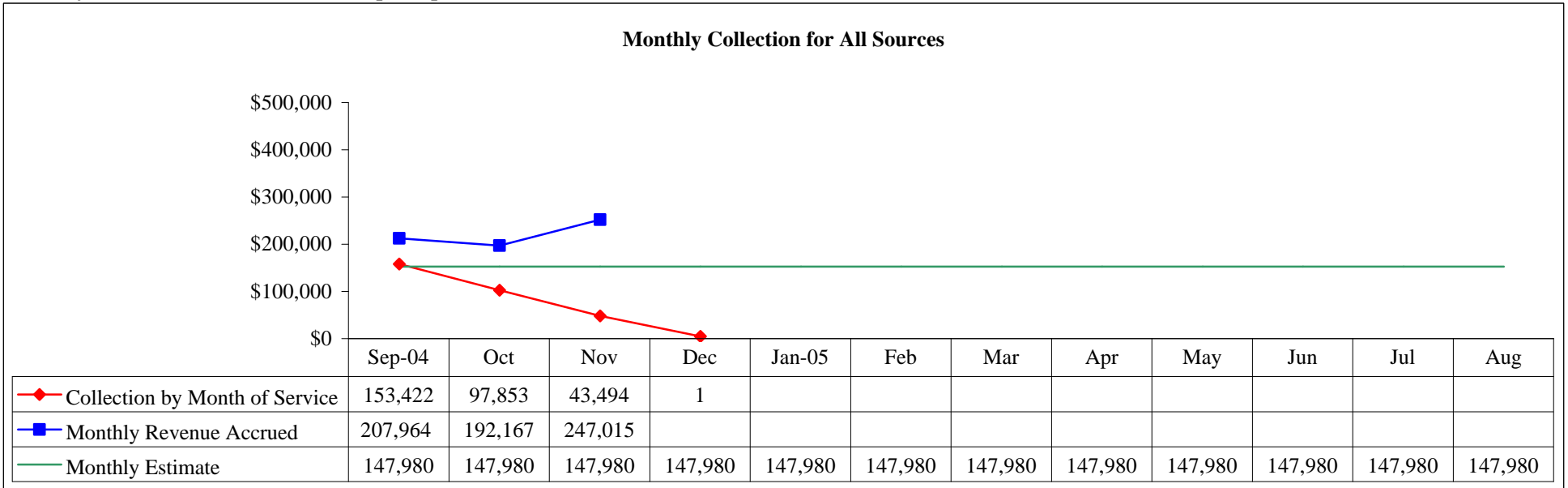


FYTD Collection	43,216	73,378	73,378	73,378								
FYTD Revenue Accrued	48,396	93,862	153,978									
FYTD Estimate	43,026	86,052	129,078	172,104	215,130	258,156	301,181	344,207	387,233	430,259	473,285	516,311

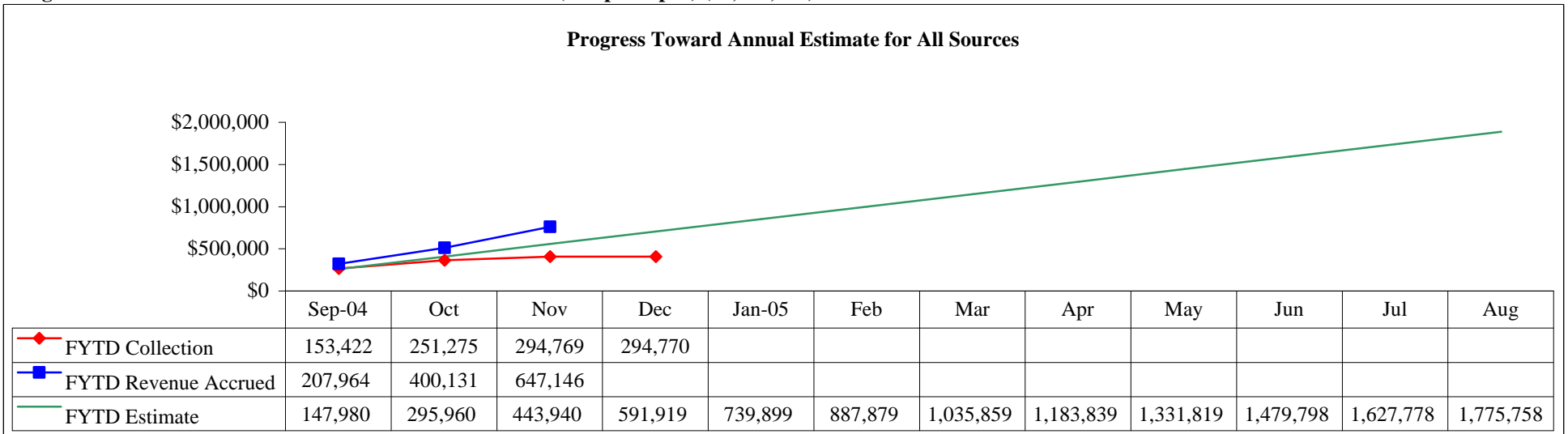
Objective 1D - FY 2005 Revenue Estimate

Kerrville State Hospital

Monthly Estimate For All Sources (except Dispro) (\$147,980)



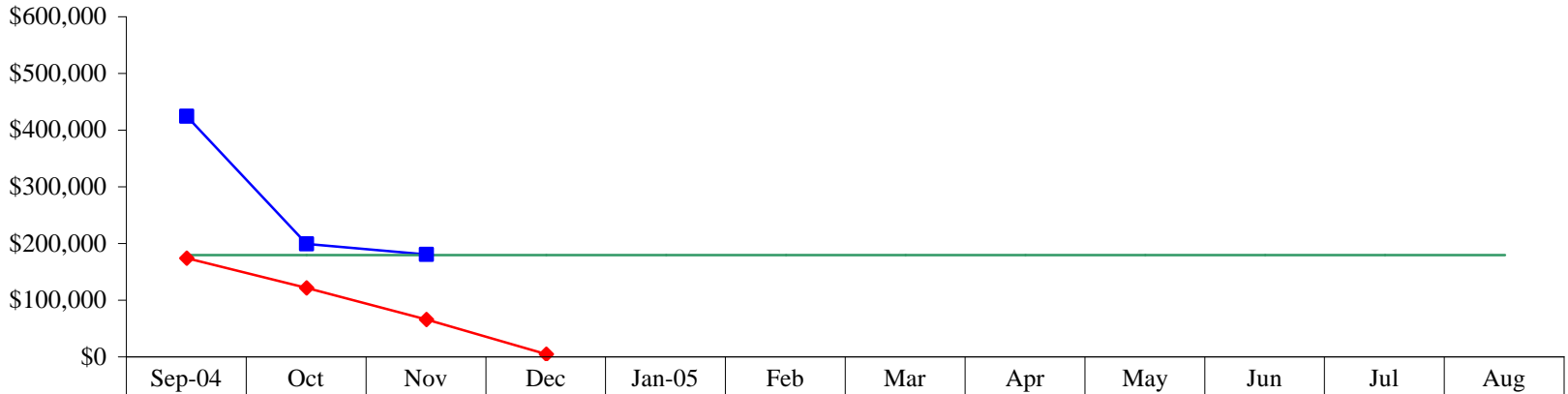
Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$1,775,758)



December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimate
North Texas State Hospital
Monthly Medicare Estimate (\$174,809)

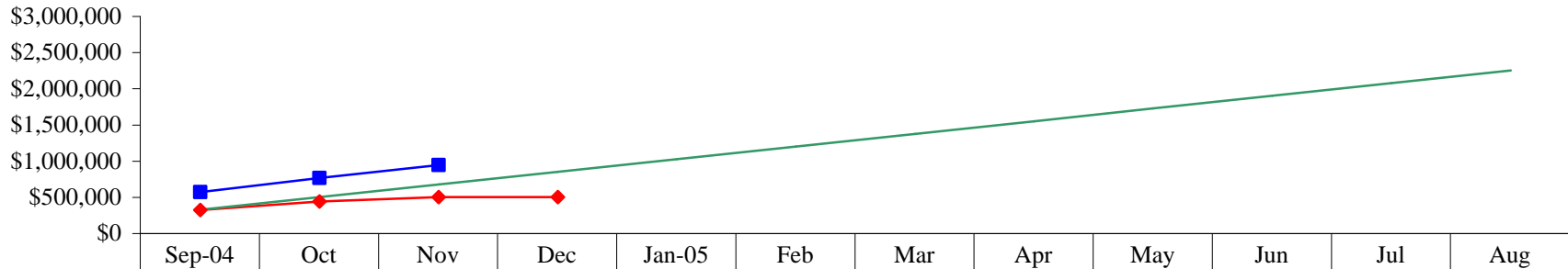
Monthly Medicare Collection



Collection by Month of Service	169,440	116,956	61,242	1								
Monthly Revenue Accrued	419,720	194,376	175,694									
Monthly Estimate	174,809	174,809	174,809	174,809	174,809	174,809	174,809	174,809	174,809	174,809	174,809	174,809

Progress Toward Annual Medicare Estimate (\$2,097,702)

Progress Toward Annual Medicare Estimate

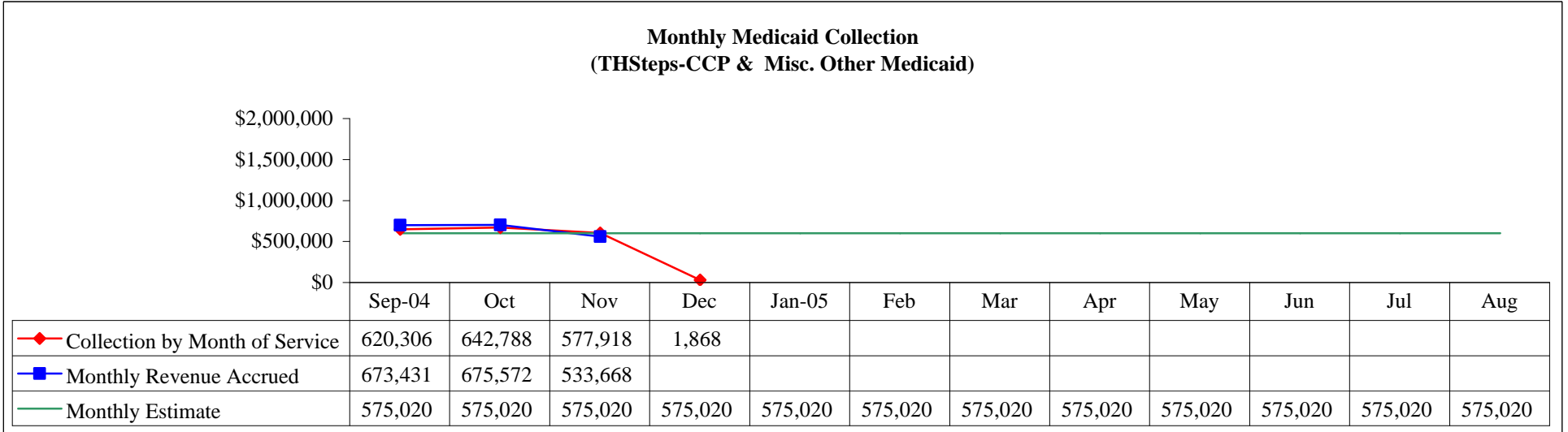


FYTD Collection	169,440	286,396	347,638	347,639								
FYTD Revenue Accrued	419,720	614,096	789,790									
FYTD Estimate	174,809	349,617	524,426	699,234	874,043	1,048,851	1,223,660	1,398,468	1,573,277	1,748,085	1,922,894	2,097,702

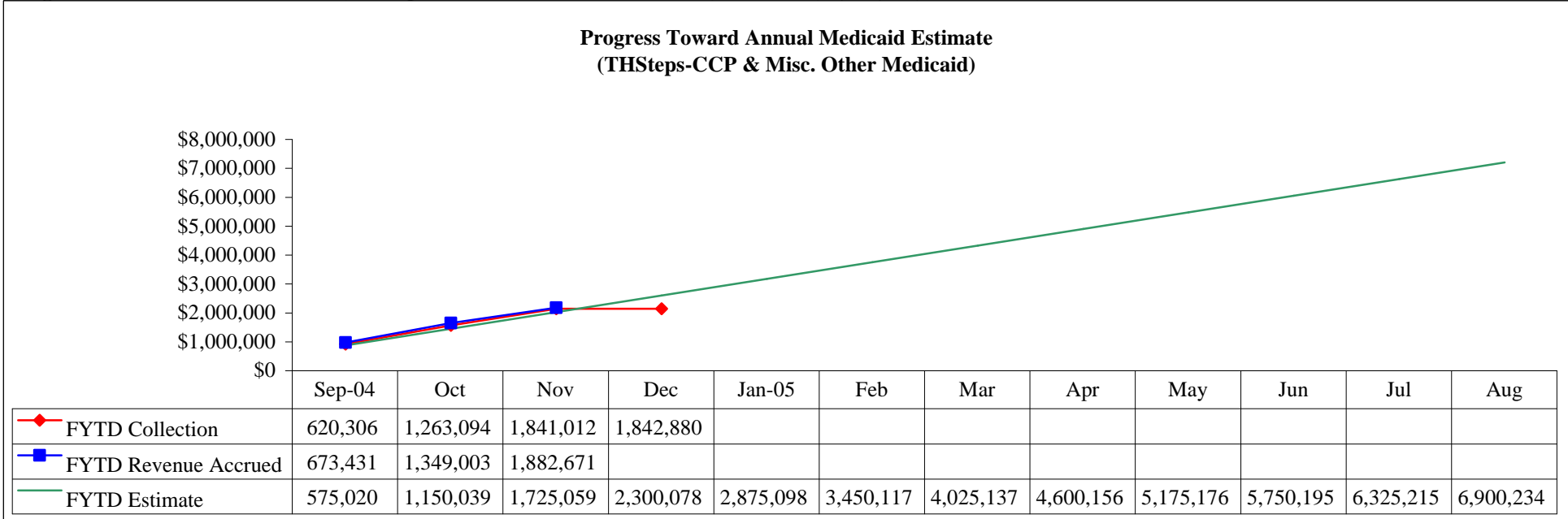
Objective 1D - FY 2005 Revenue Estimate

North Texas State Hospital

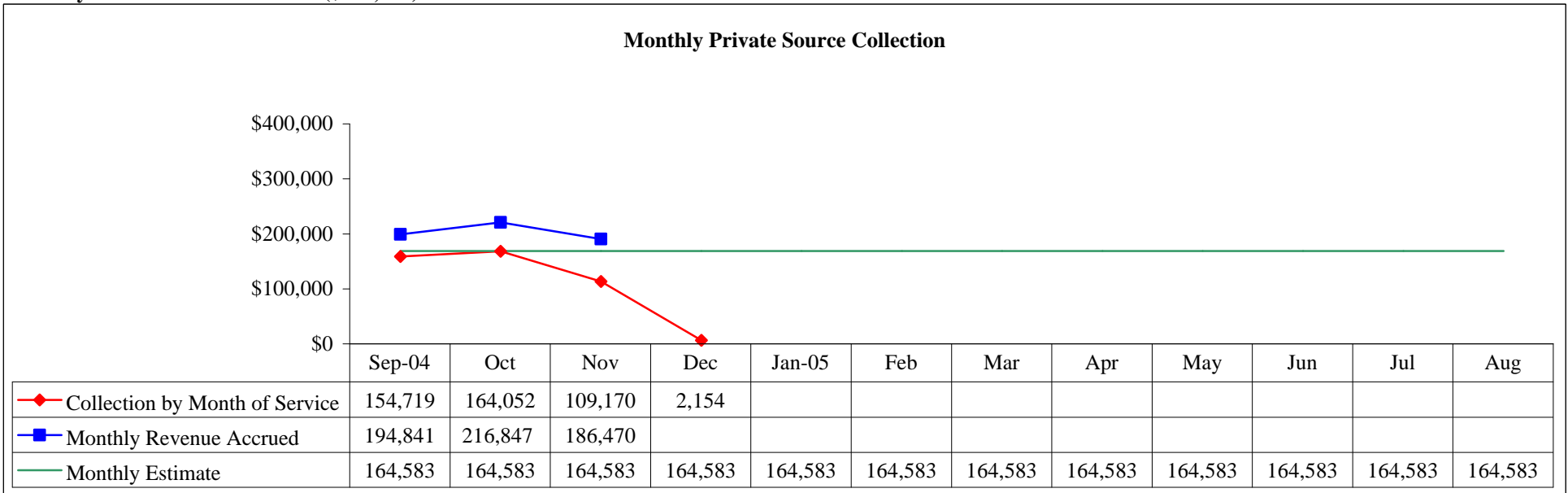
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$575,020)



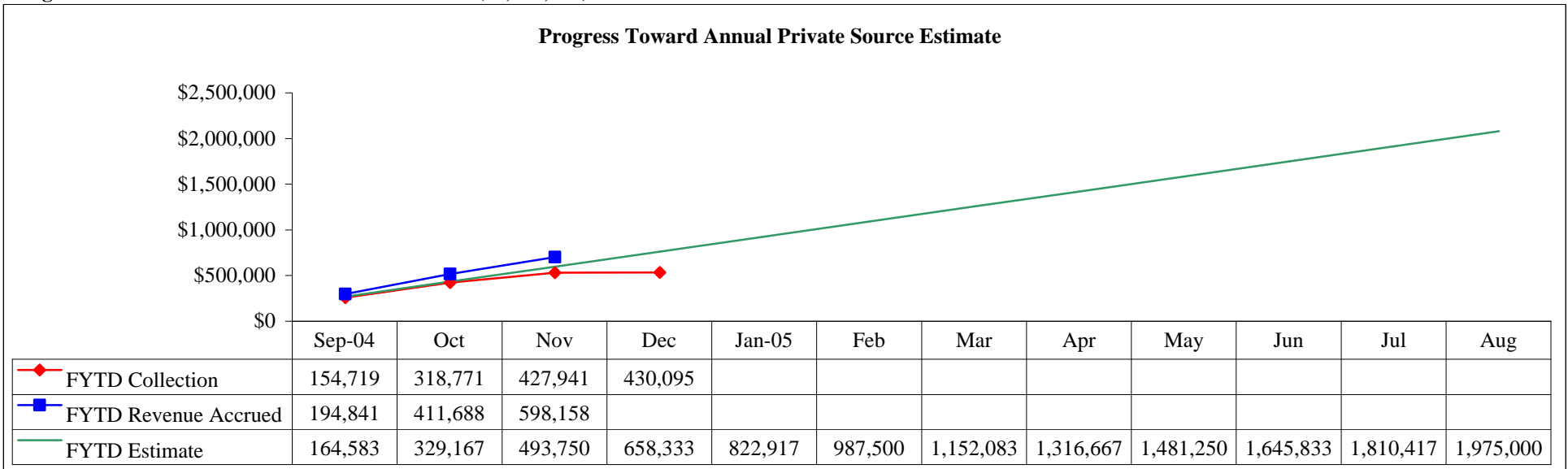
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$6,900,234)



Objective 1D - FY 2005 Revenue Estimate
North Texas State Hospital
Monthly Private Source Estimate (\$164,583)

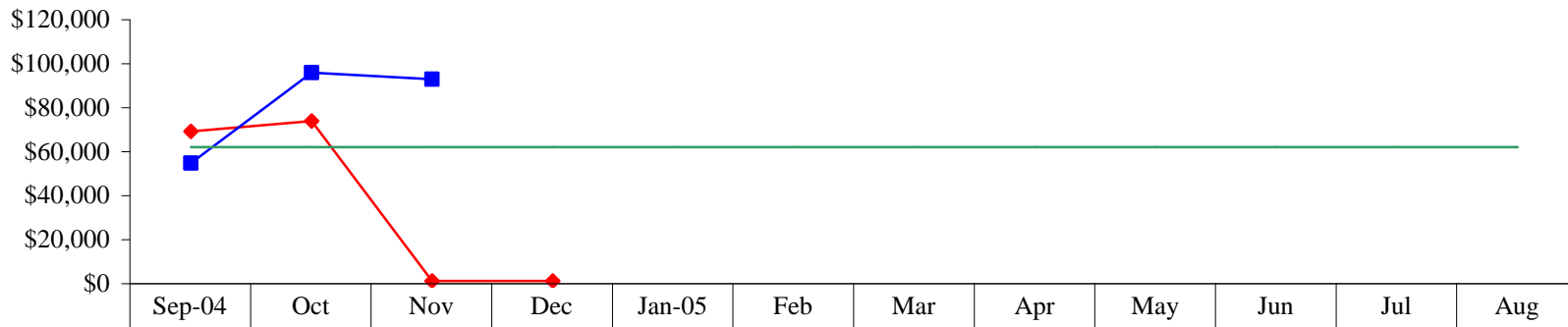


Progress Toward Annual Private Source Estimate (\$1,975,000)



Objective 1D - FY 2005 Revenue Estimate
North Texas State Hospital
Monthly IMD Estimate (\$60,833)

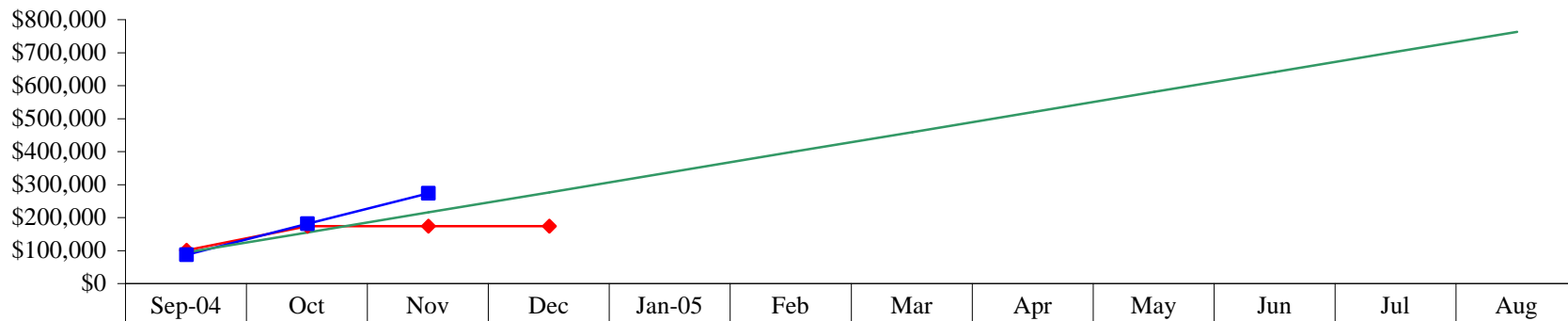
Monthly IMD Collection



Collection by Month of Service	68,012	72,659	0	0								
Monthly Revenue Accrued	53,619	94,755	91,698									
Monthly Estimate	60,833	60,833	60,833	60,833	60,833	60,833	60,833	60,833	60,833	60,833	60,833	60,833

Progress Toward Annual IMD Estimate (\$730,000)

Progress Toward Annual IMD Estimate

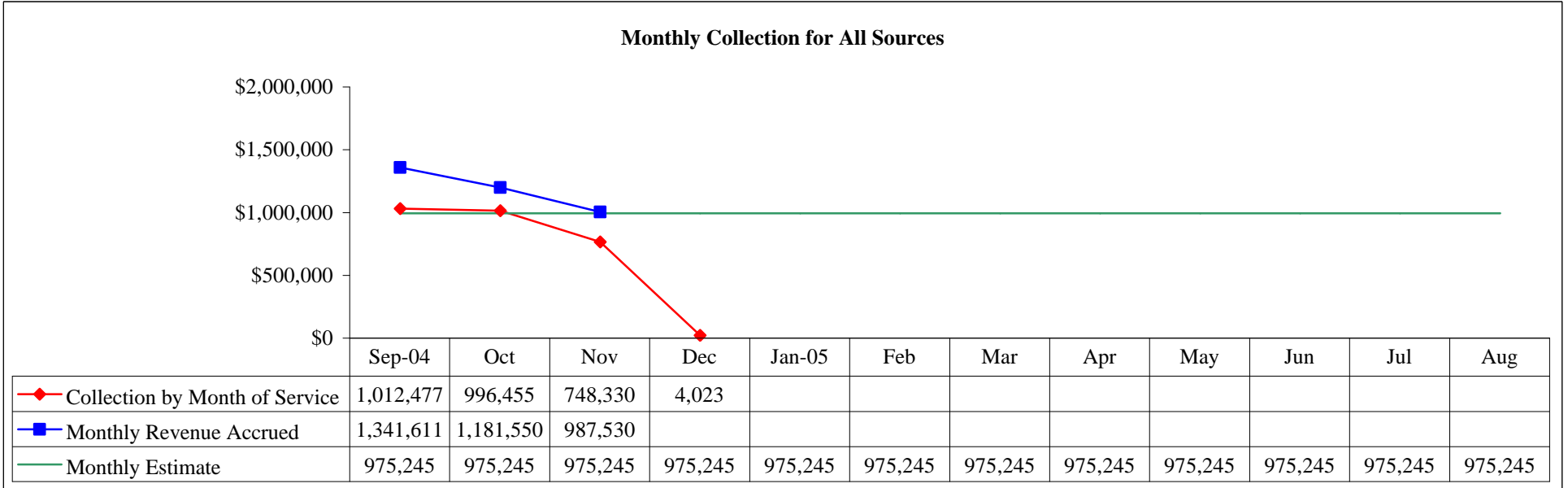


FYTD Collection	68,012	140,671	140,671	140,671								
FYTD Revenue Accrued	53,619	148,374	240,072									
FYTD Estimate	60,833	121,667	182,500	243,333	304,167	365,000	425,833	486,667	547,500	608,333	669,167	730,000

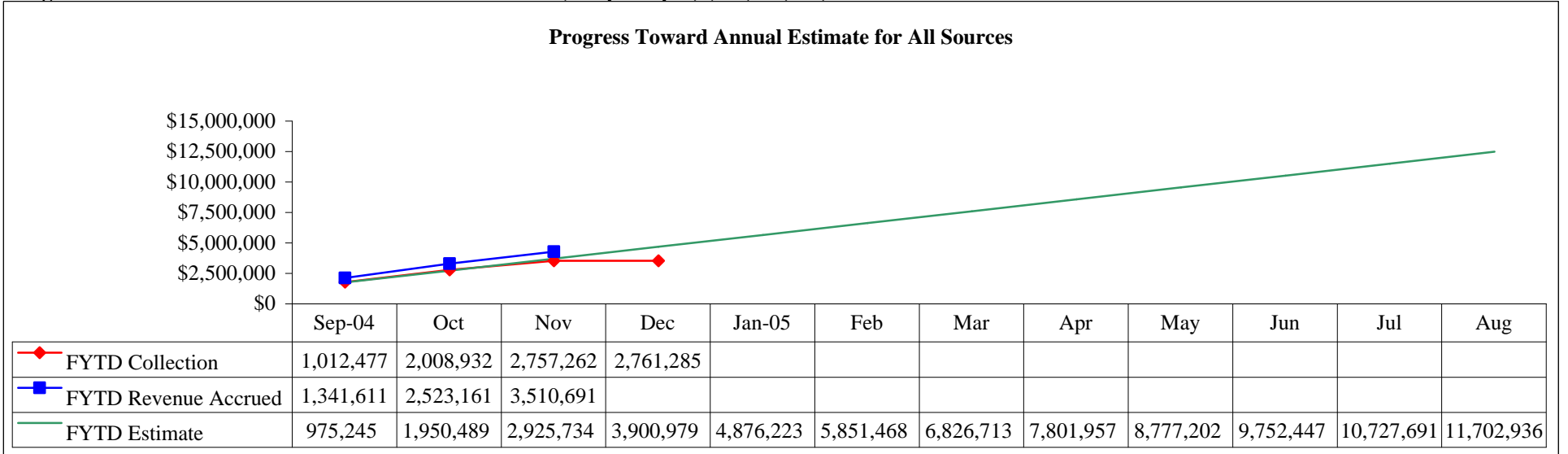
Objective 1D - FY 2005 Revenue Estimate

North Texas State Hospital

Monthly Estimate For All Sources (except Dispro) (\$975,245)



Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$11,702,936)



December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimate
Rusk State Hospital
Monthly Medicare Estimate (\$245,062)

Monthly Medicare Collection



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
Collection by Month of Service	210,767	264,940	214,963	0								
Monthly Revenue Accrued	327,391	274,991	400,928									
Monthly Estimate	245,062	245,062	245,062	245,062	245,062	245,062	245,062	245,062	245,062	245,062	245,062	245,062

Progress Toward Annual Medicare Estimate (\$2,940,739)

Progress Toward Annual Medicare Estimate

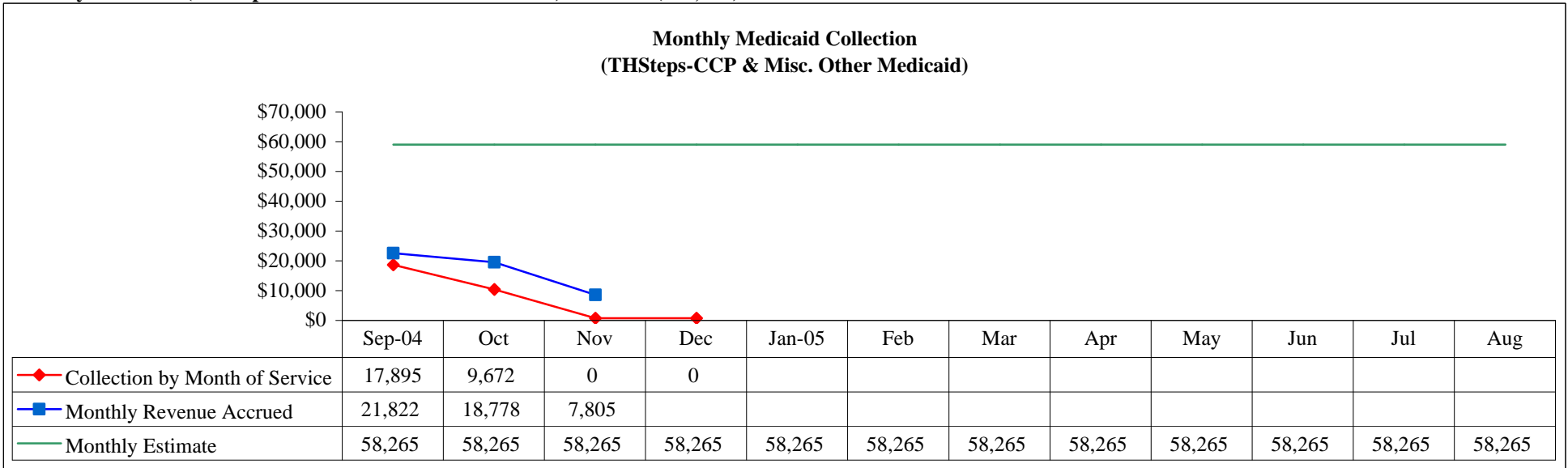


	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
FYTD Collection	210,767	475,707	690,670	690,670								
FYTD Revenue Accrued	327,391	602,382	1,003,310									
FYTD Estimate	245,062	490,123	735,185	980,246	1,225,308	1,470,370	1,715,431	1,960,493	2,205,554	2,450,616	2,695,677	2,940,739

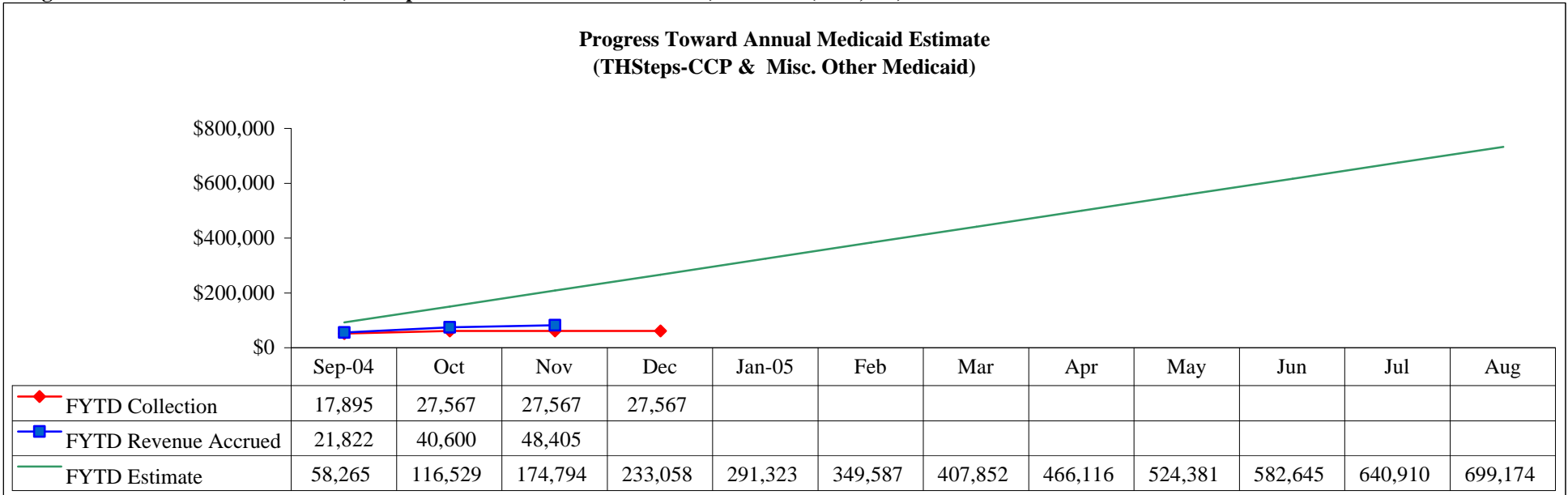
Objective 1D - FY 2005 Revenue Estimate

Rusk State Hospital

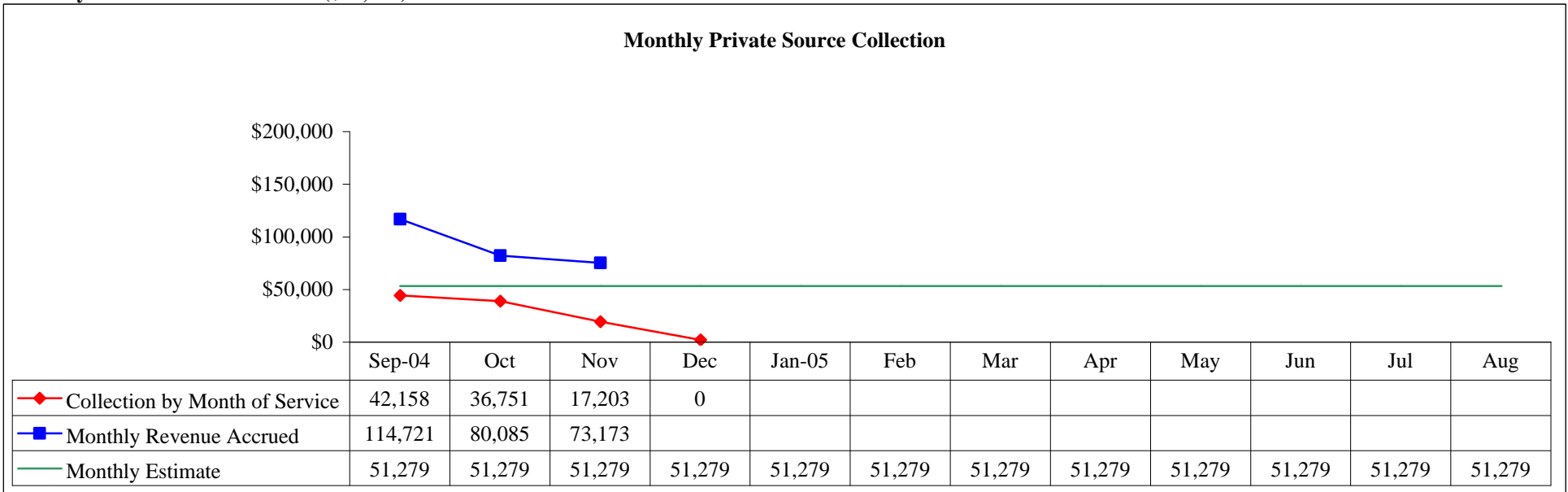
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$58,265)



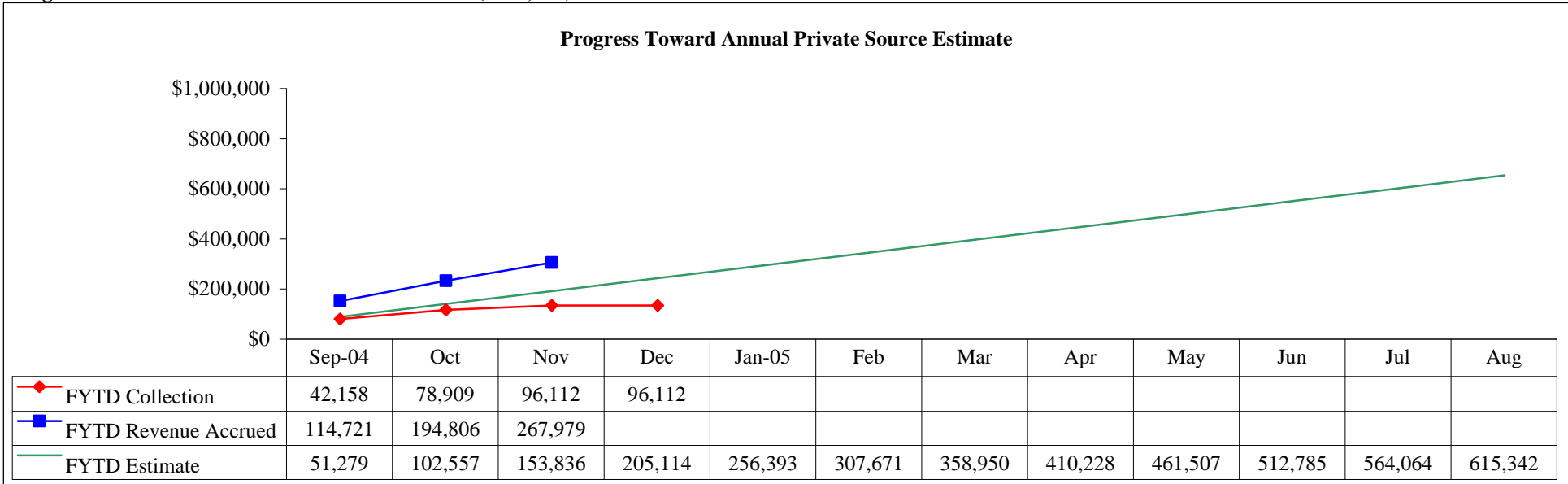
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$699,174)



Objective 1D - FY 2005 Revenue Estimate
Rusk State Hospital
Monthly Private Source Estimate (\$51,279)



Progress Toward Annual Private Source Estimate (\$615,342)

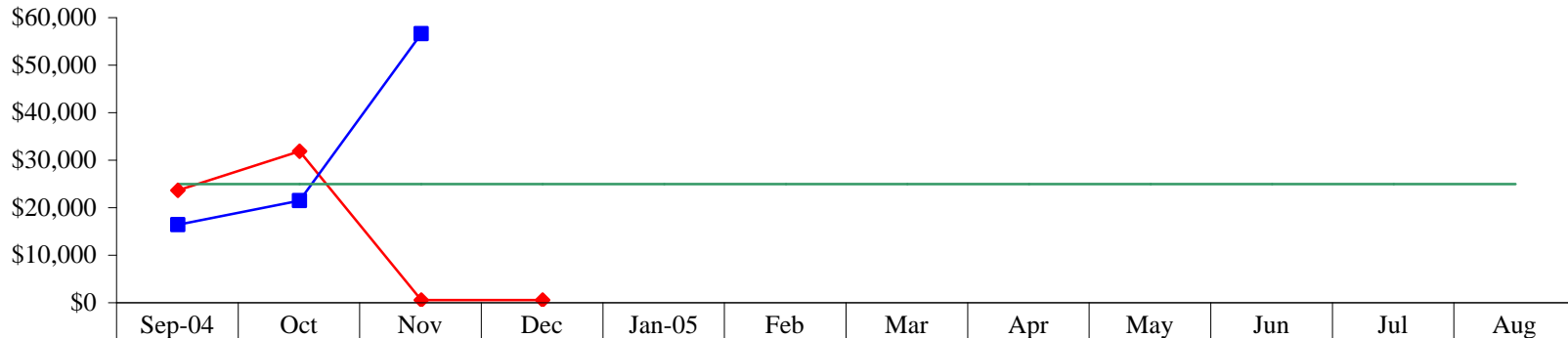


Objective 1D - FY 2005 Revenue Estimate

Rusk State Hospital

Monthly IMD Estimate (\$24,411)

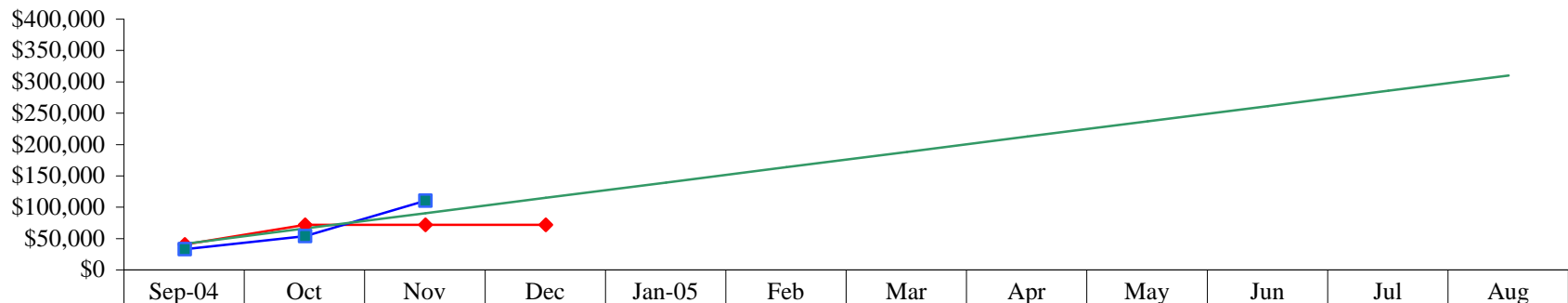
Monthly IMD Collection



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
Collection by Month of Service	23,077	31,347	0	0								
Monthly Revenue Accrued	15,845	20,918	56,074									
Monthly Estimate	24,411	24,411	24,411	24,411	24,411	24,411	24,411	24,411	24,411	24,411	24,411	24,411

Progress Toward Annual IMD Estimate (\$292,926)

Progress Toward Annual IMD Estimate

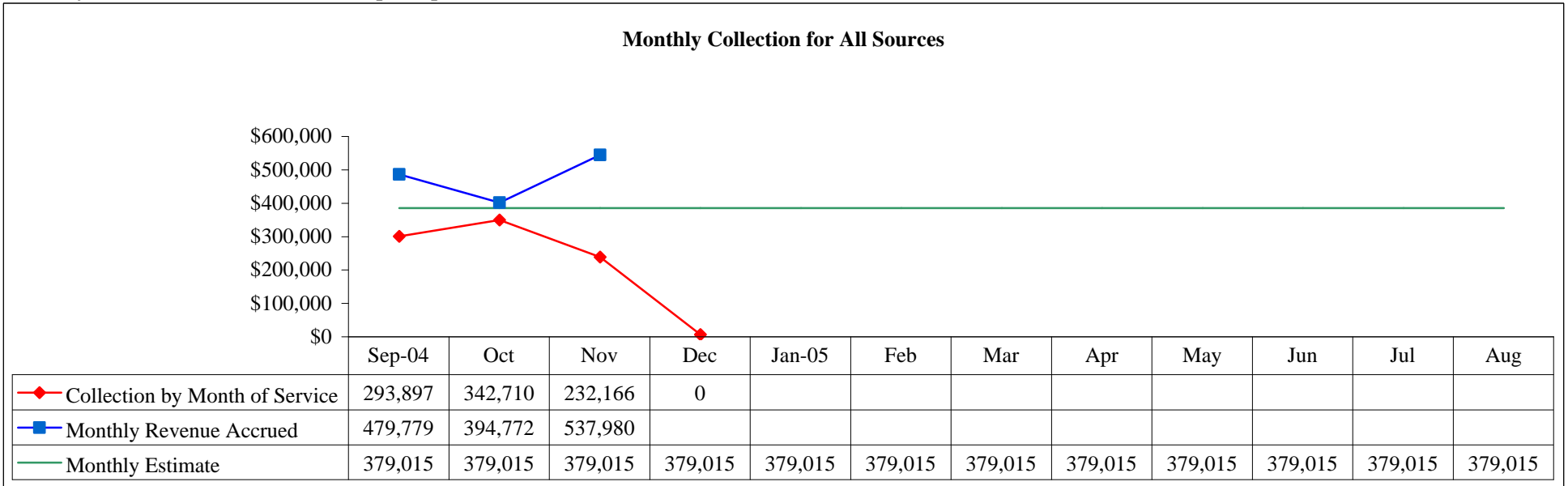


	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
FYTD Collection	23,077	54,424	54,424	54,424								
FYTD Revenue Accrued	15,845	36,763	92,837									
FYTD Estimate	24,411	48,821	73,232	97,642	122,053	146,463	170,874	195,284	219,695	244,105	268,516	292,926

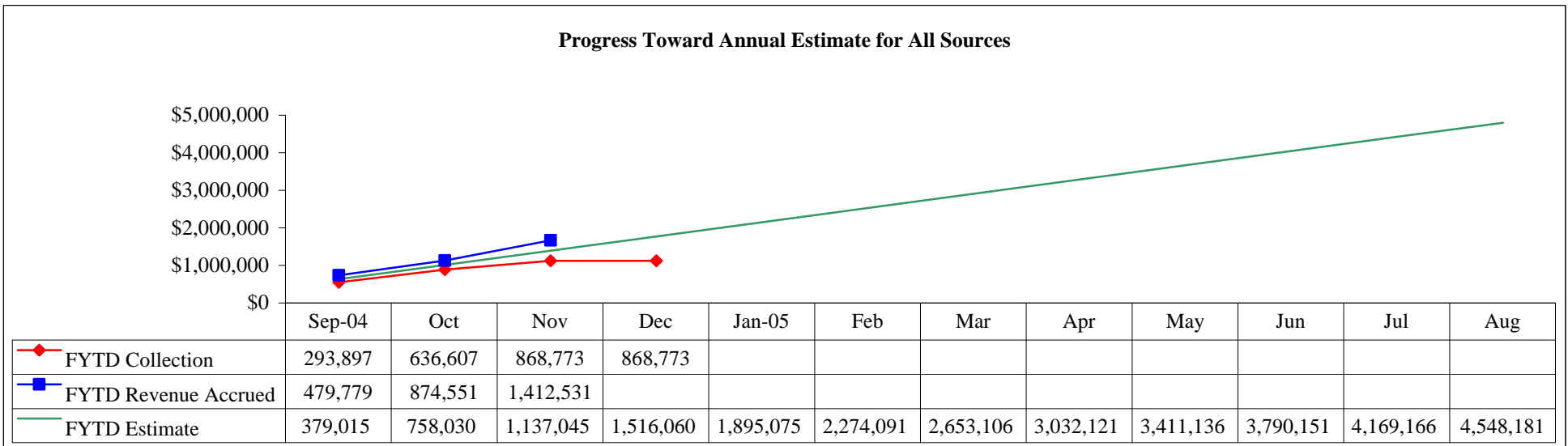
Objective 1D - FY 2005 Revenue Estimate

Rusk State Hospital

Monthly Estimate For All Sources (except Dispro) (\$379,015)

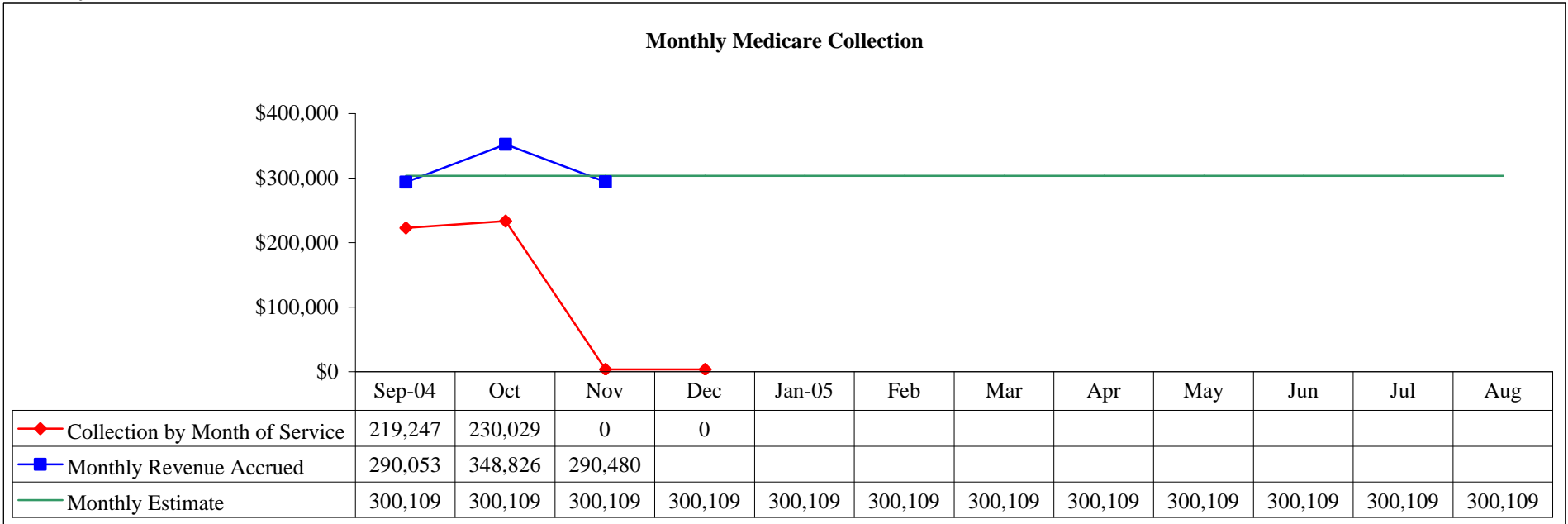


Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$4,548,181)

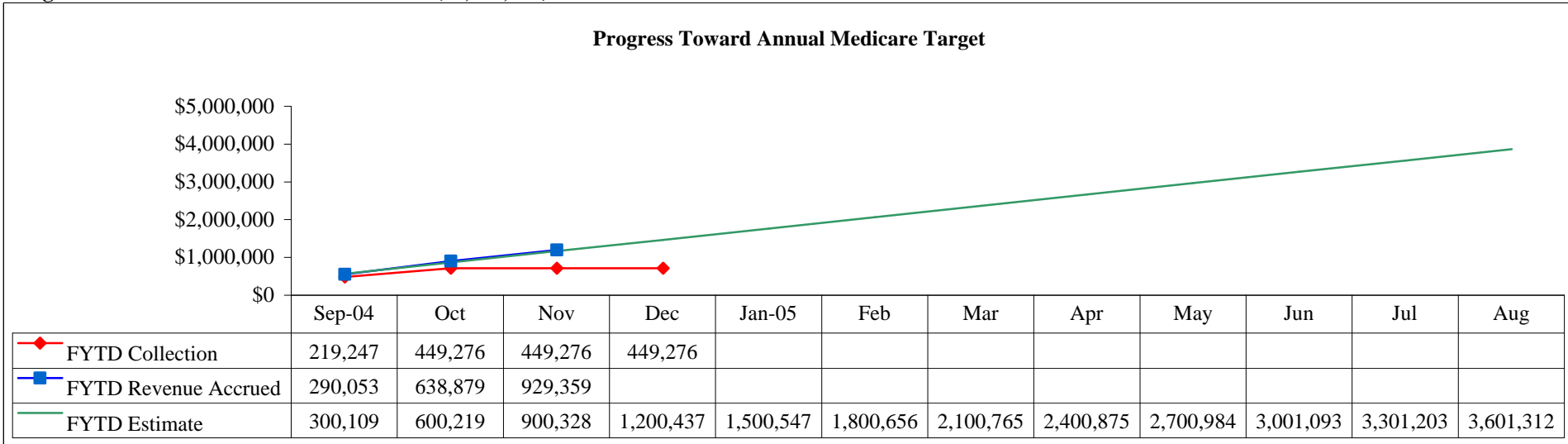


December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimate
San Antonio State Hospital
Monthly Medicare Estimate (\$300,109)



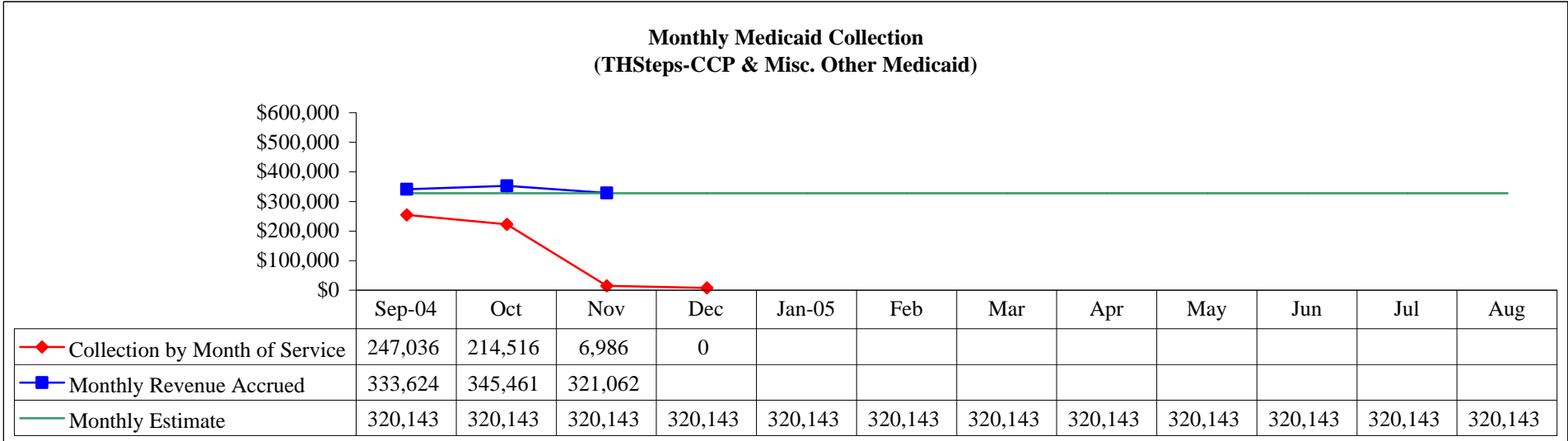
Progress Toward Annual Medicare Estimate (\$3,601,312)



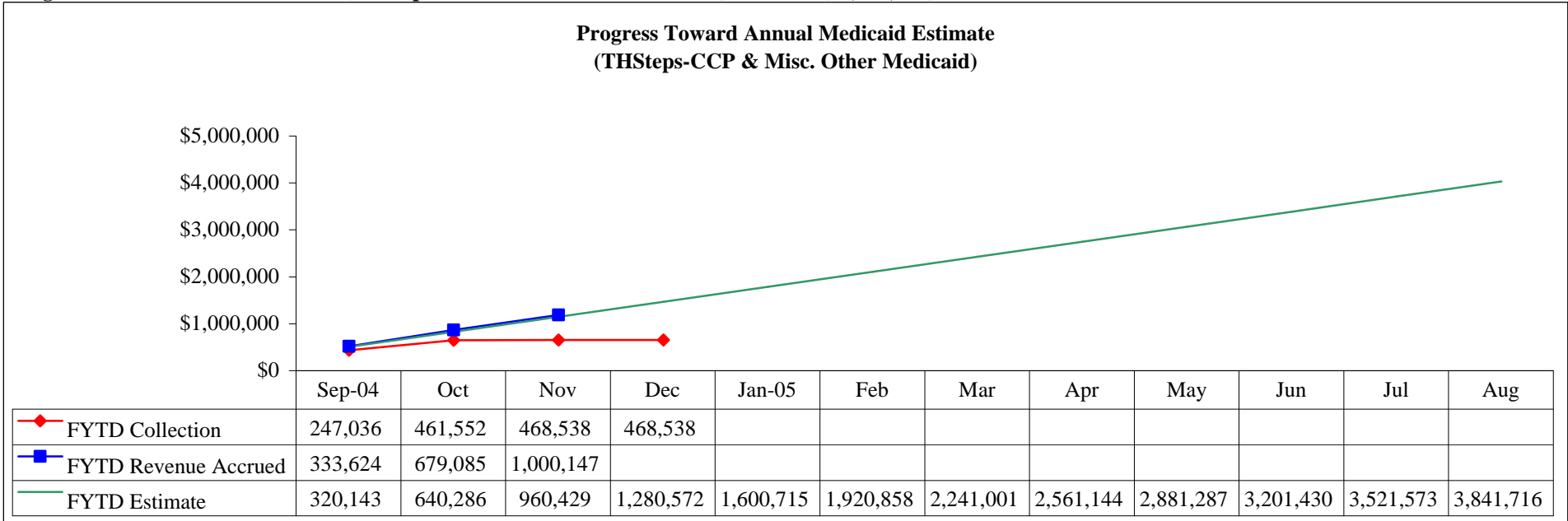
Objective 1D - FY 2005 Revenue Estimate

San Antonio State Hospital

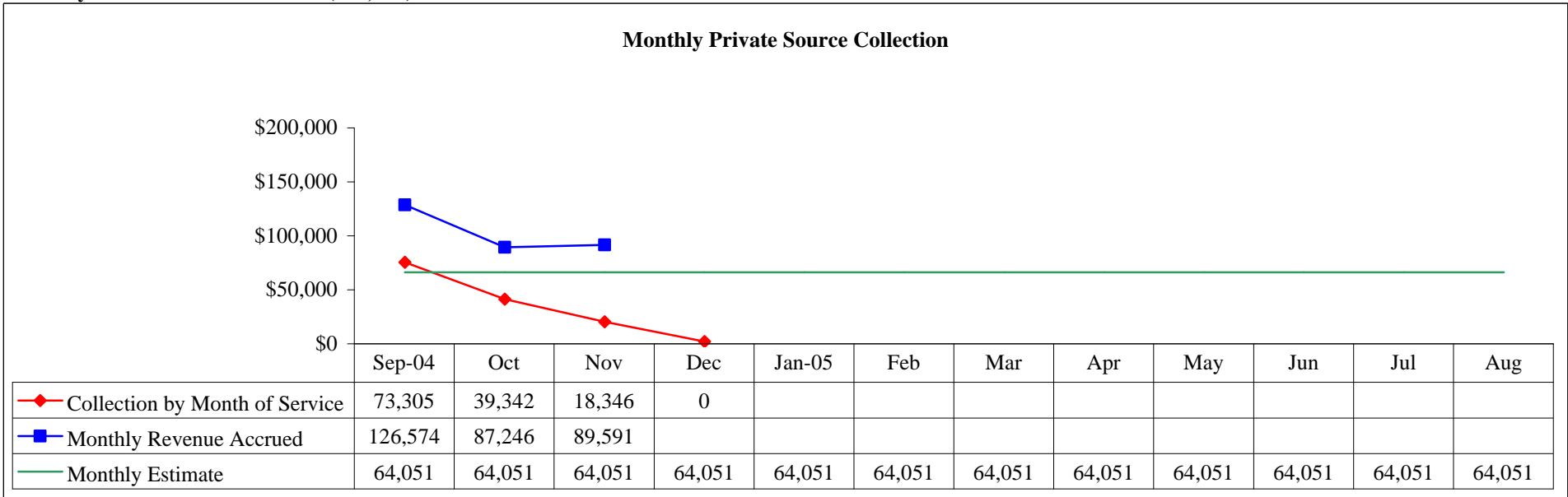
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$320,143)



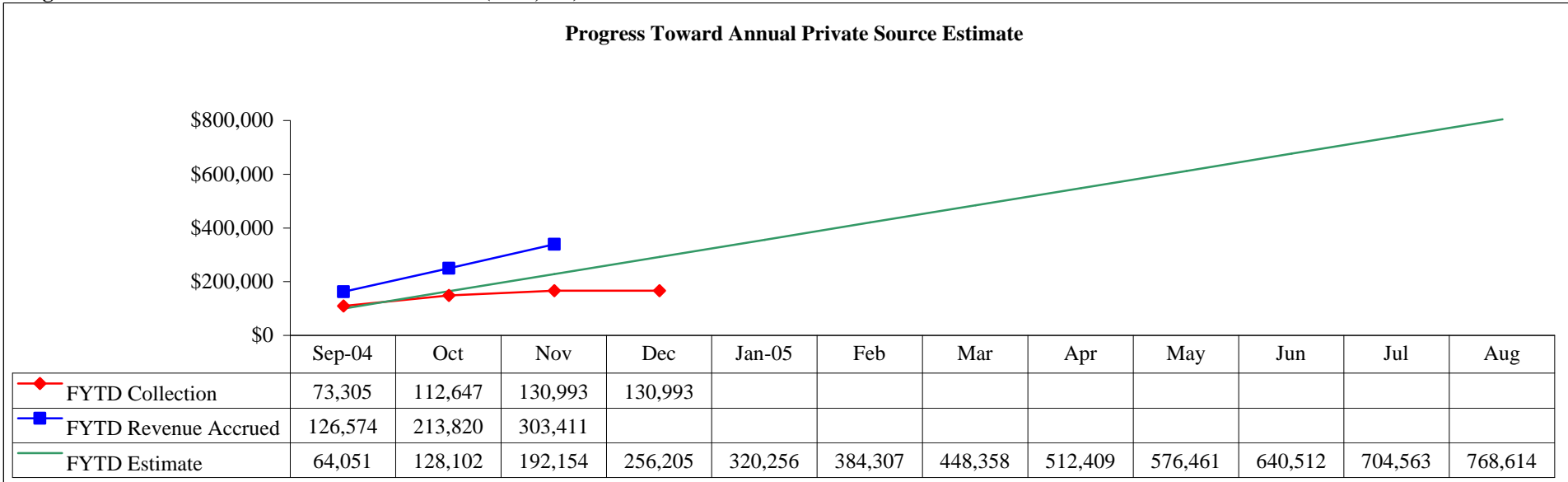
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$3,841,716)



Objective 1D - FY 2005 Revenue Estimate
San Antonio State Hospital
Monthly Private Source Estimate (\$64,051)

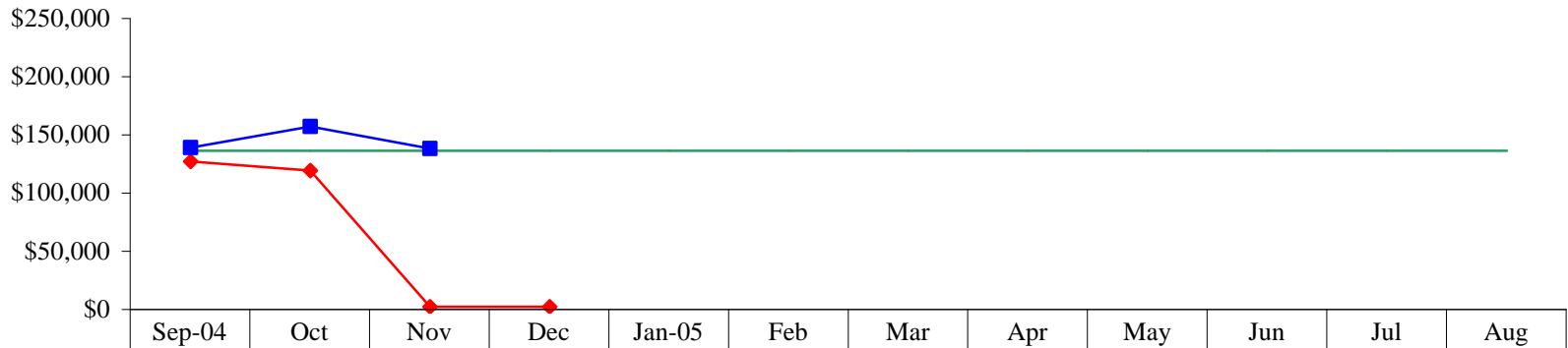


Progress Toward Annual Private Source Estimate (\$768,614)



Objective 1D - FY 2005 Revenue Estimate
San Antonio State Hospital
Monthly IMD Estimate (\$134,039)

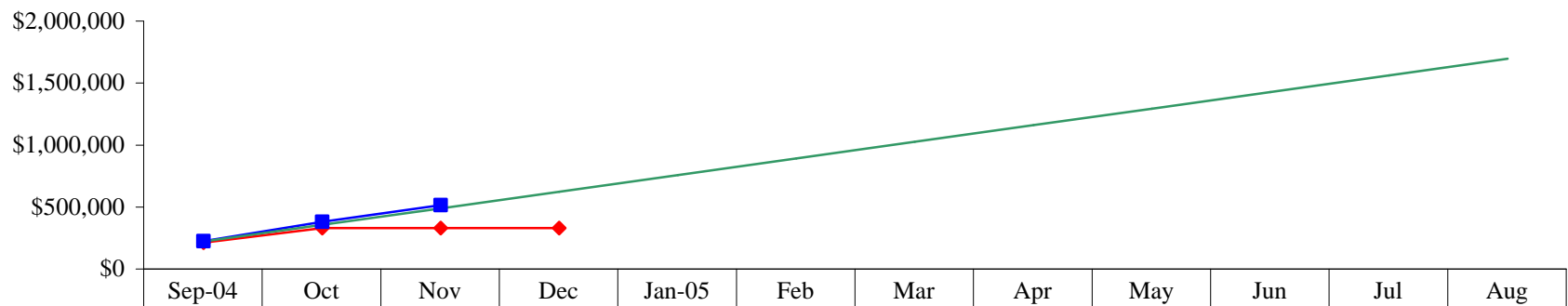
Monthly IMD Collection



Collection by Month of Service	124,789	117,146	0	0								
Monthly Revenue Accrued	136,734	154,988	135,880									
Monthly Estimate	134,039	134,039	134,039	134,039	134,039	134,039	134,039	134,039	134,039	134,039	134,039	134,039

Progress Toward Annual IMD Estimate (\$1,608,467)

Progress Toward Annual IMD Estimate

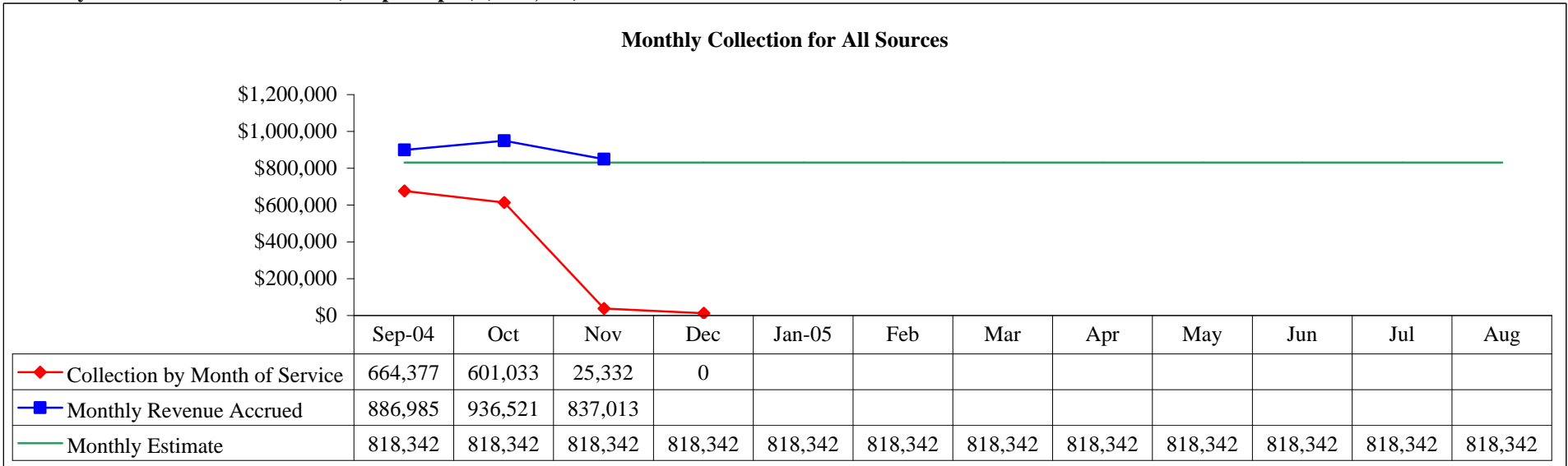


FYTD Collection	124,789	241,935	241,935	241,935								
FYTD Revenue Accrued	136,734	291,722	427,602									
FYTD Estimate	134,039	268,078	402,117	536,156	670,195	804,234	938,272	1,072,311	1,206,350	1,340,389	1,474,428	1,608,467

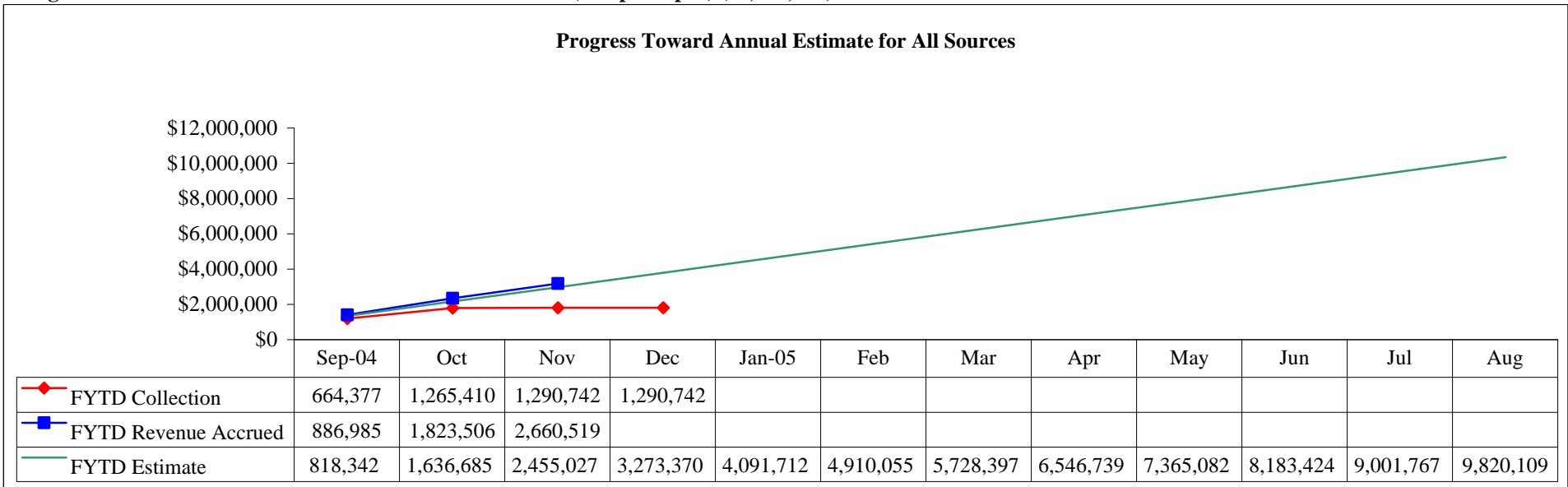
Objective 1D - FY 2005 Revenue Estimate

San Antonio State Hospital

Monthly Estimate For All Sources (except Dispro) (\$818,342)

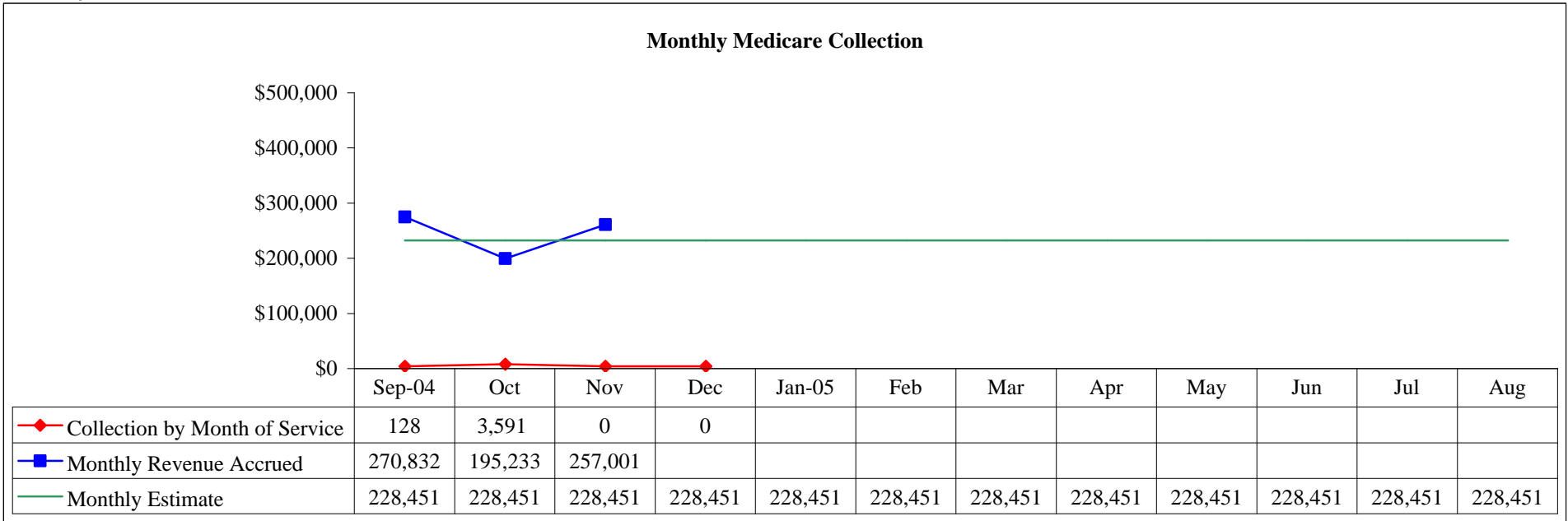


Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$9,820,109)

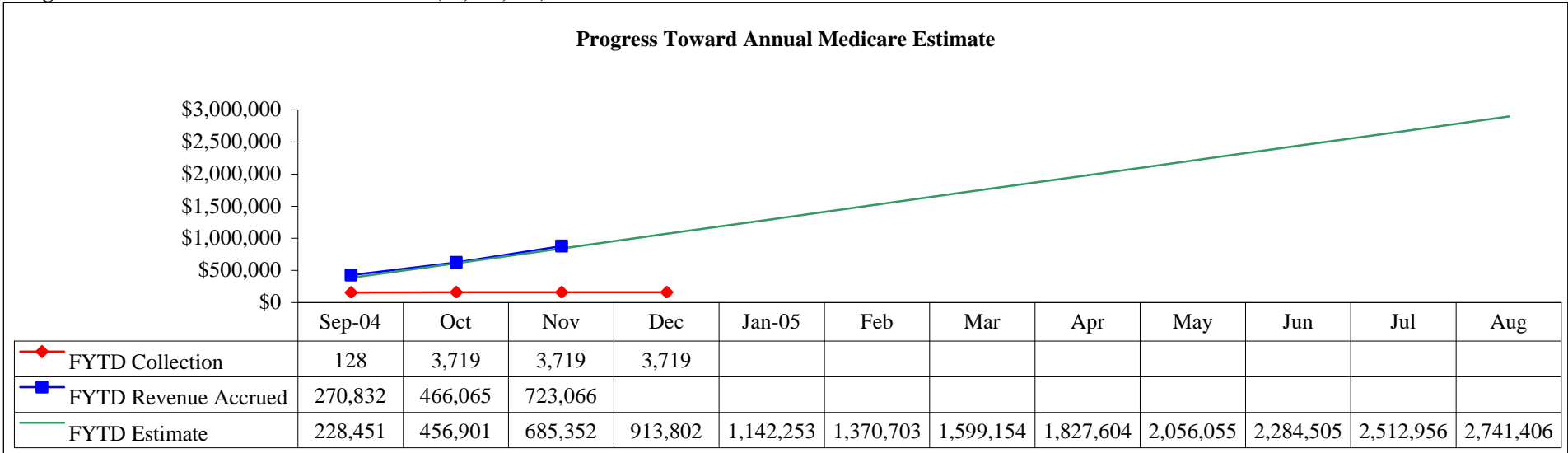


December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimate
Terrell State Hospital
Monthly Medicare Estimate (\$228,451)



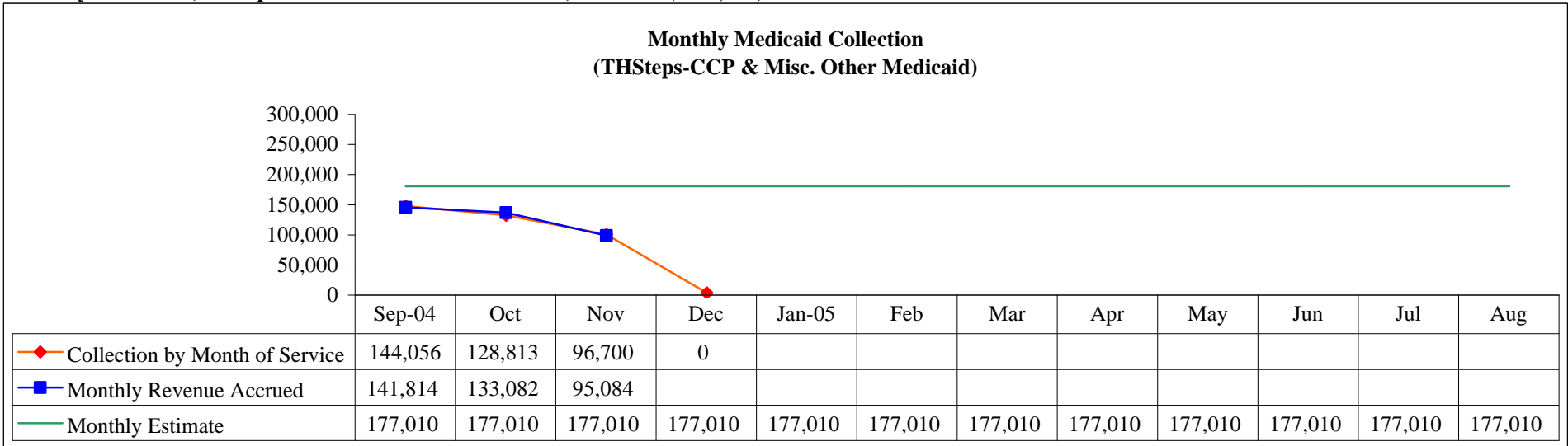
Progress Toward Annual Medicare Estimate (\$2,741,406)



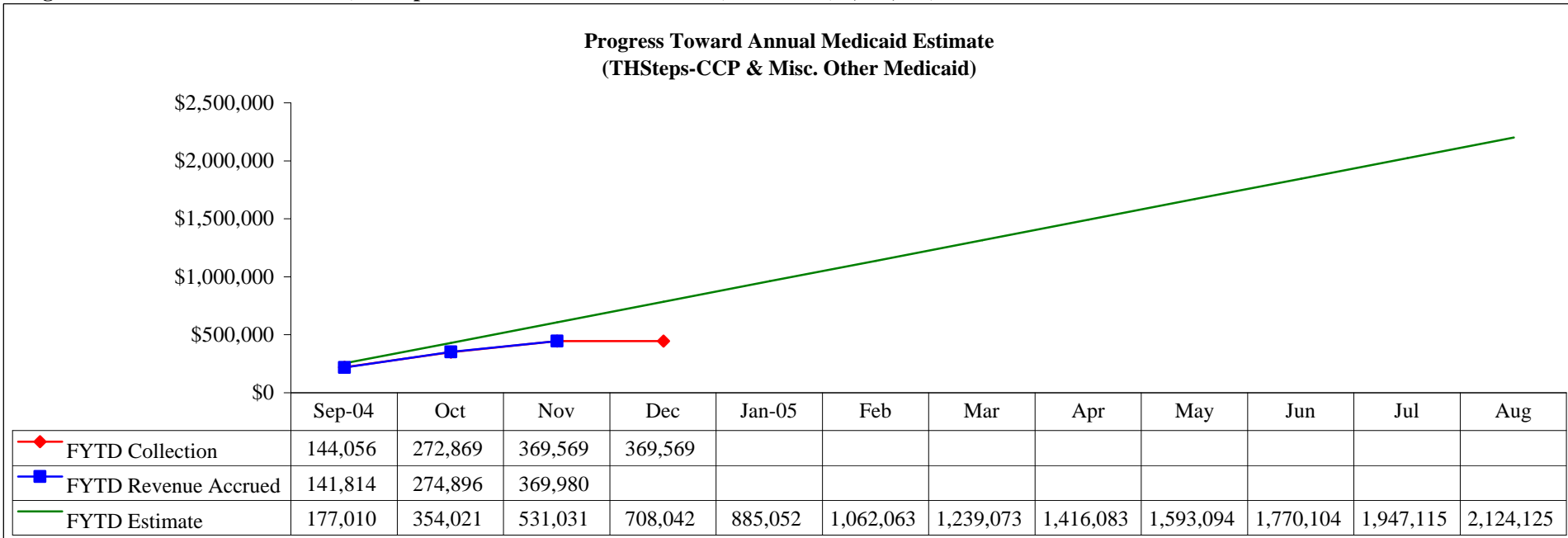
Objective 1D - FY 2005 Revenue Estimate

Terrell State Hospital

Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$177,010)

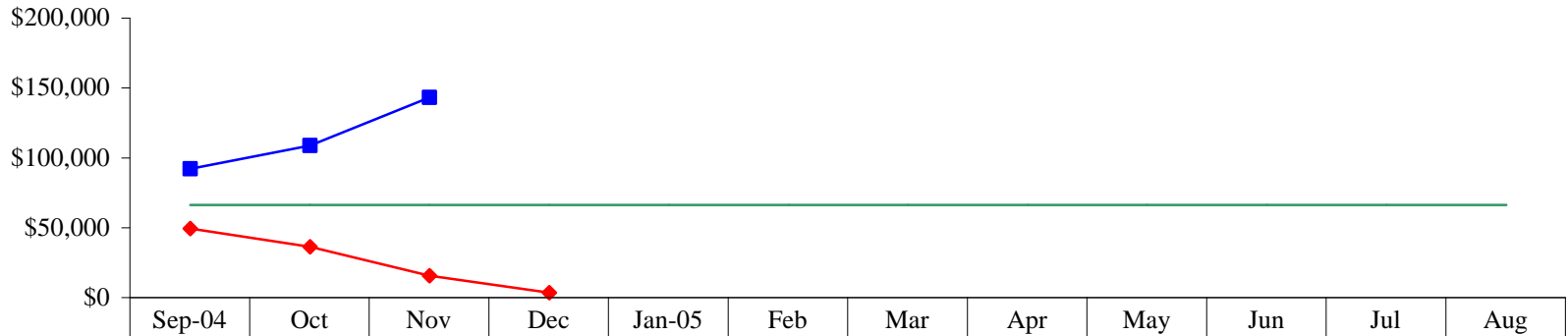


Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$2,124,125)



Objective 1D - FY 2005 Revenue Estimate
Terrell State Hospital
Monthly Private Source Estimate (\$64,279)

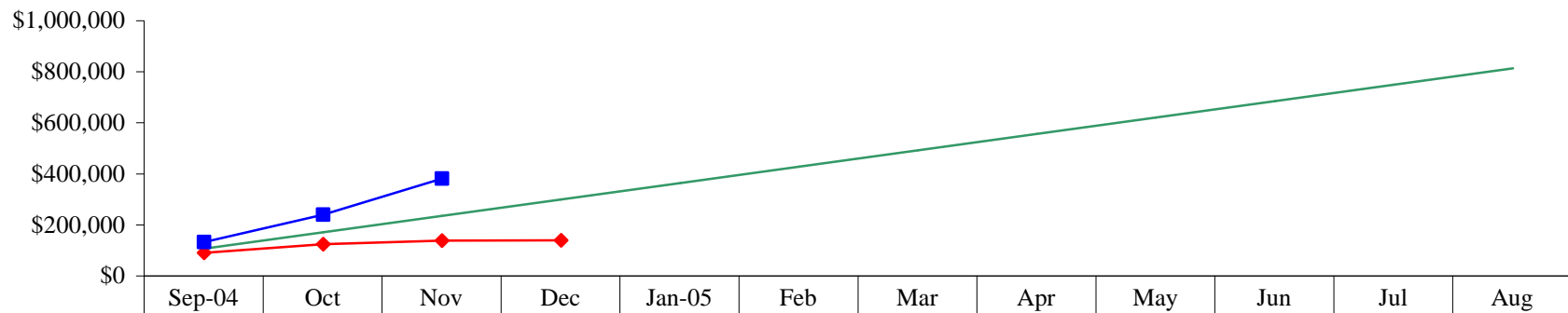
Monthly Private Source Collection



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
◆ Collection by Month of Service	47,573	34,492	13,708	1,646								
■ Monthly Revenue Accrued	90,158	106,877	141,245									
— Monthly Estimate	64,279	64,279	64,279	64,279	64,279	64,279	64,279	64,279	64,279	64,279	64,279	64,279

Progress Toward Annual Private Source Estimate (\$771,343)

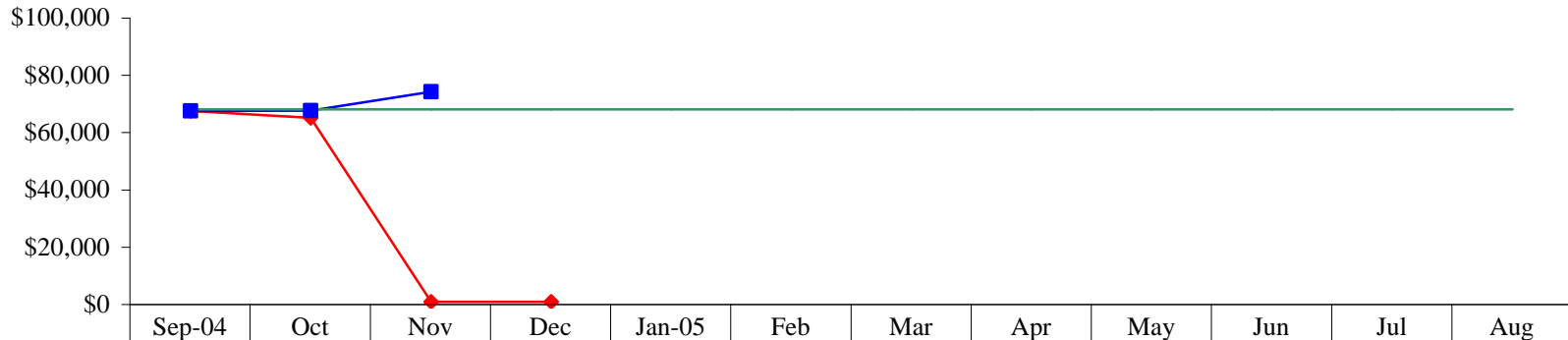
Progress Toward Annual Private Source Estimate



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
◆ FYTD Collection	47,573	82,065	95,773	97,419								
■ FYTD Revenue Accrued	90,158	197,035	338,280									
— FYTD Estimate	64,279	128,557	192,836	257,114	321,393	385,672	449,950	514,229	578,507	642,786	707,064	771,343

Objective 1D - FY 2005 Revenue Estimate
Terrell State Hospital
Monthly IMD Estimate (\$67,174)

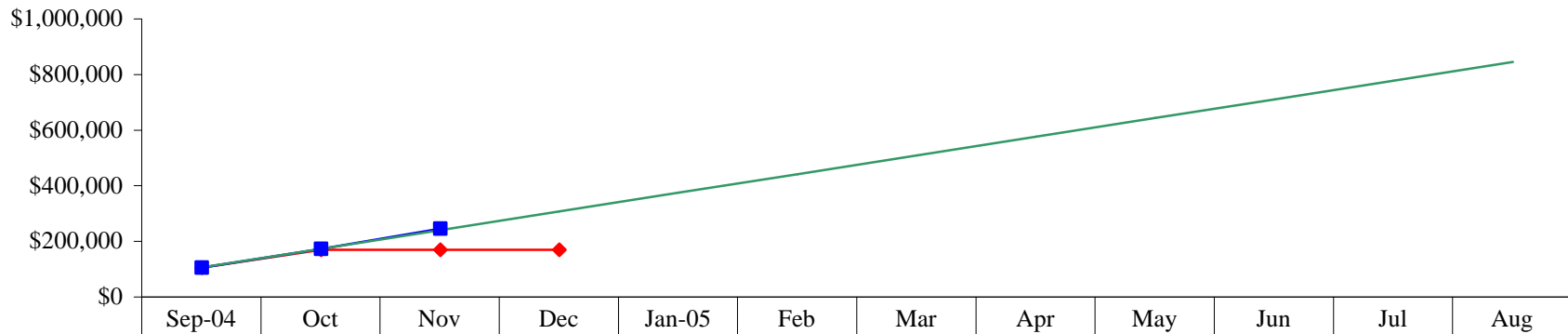
Monthly IMD Collection



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
Collection by Month of Service	66,584	64,235	0	0								
Monthly Revenue Accrued	66,585	66,735	73,279									
Monthly Estimate	67,174	67,174	67,174	67,174	67,174	67,174	67,174	67,174	67,174	67,174	67,174	67,174

Progress Toward Annual IMD Estimate (\$806,093)

Progress Toward Annual IMD Estimate

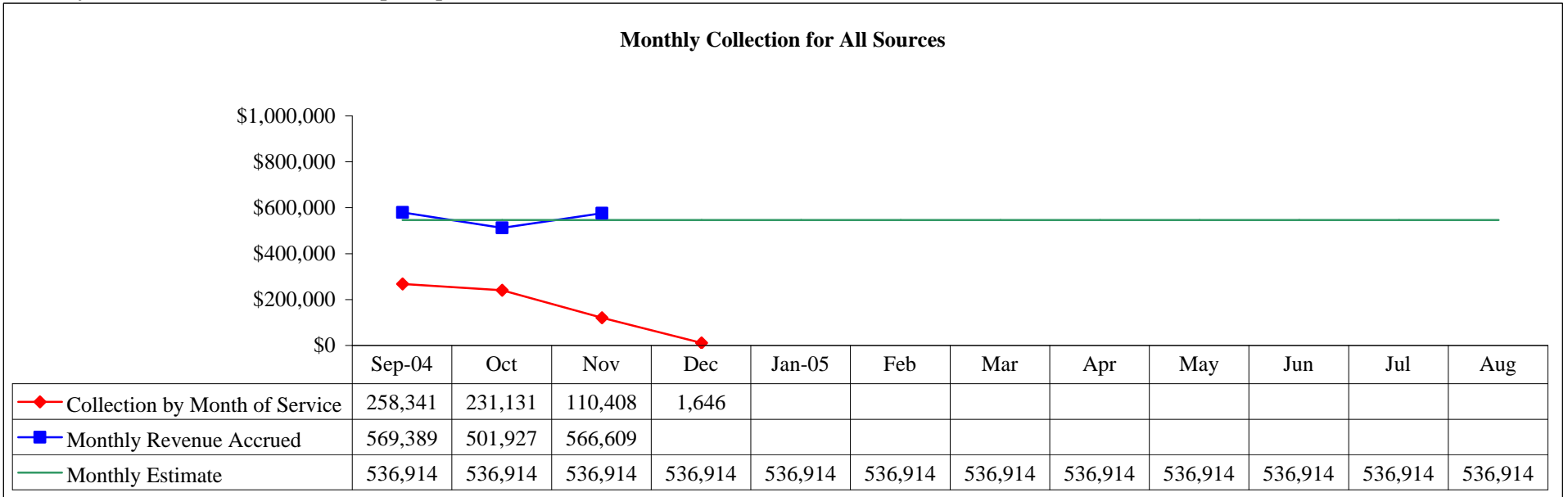


	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
FYTD Collection	66,584	130,819	130,819	130,819								
FYTD Revenue Accrued	66,585	133,320	206,599									
FYTD Estimate	67,174	134,349	201,523	268,698	335,872	403,047	470,221	537,395	604,570	671,744	738,919	806,093

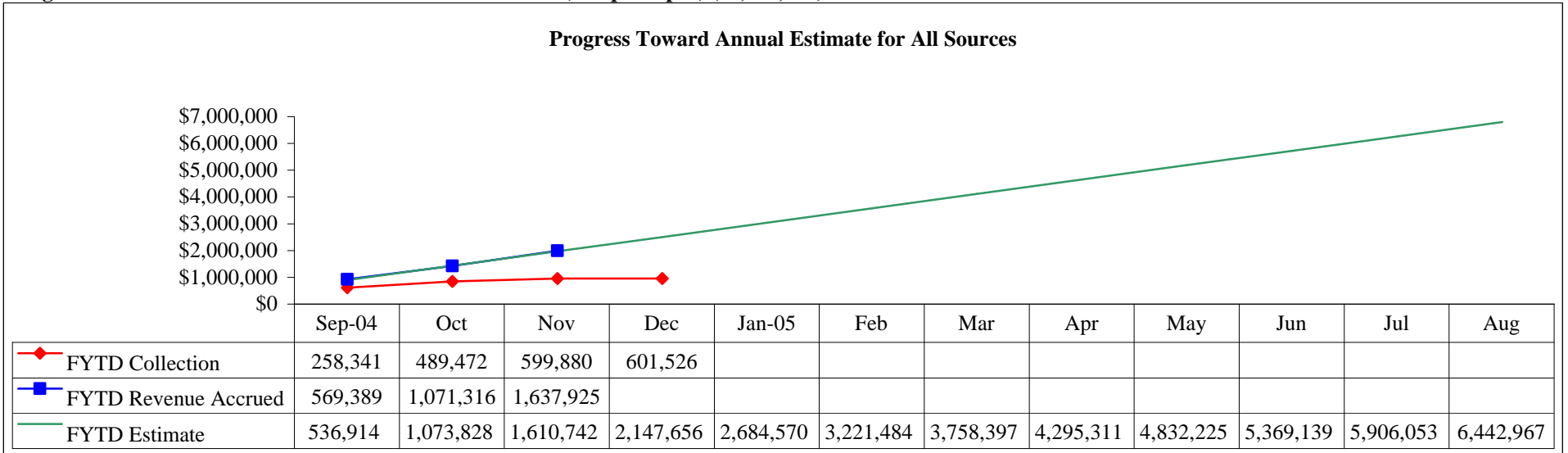
Objective 1D - FY 2005 Revenue Estimate

Terrell State Hospital

Monthly Estimate For All Sources (except Dispro) (\$536,914)



Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$6,442,967)

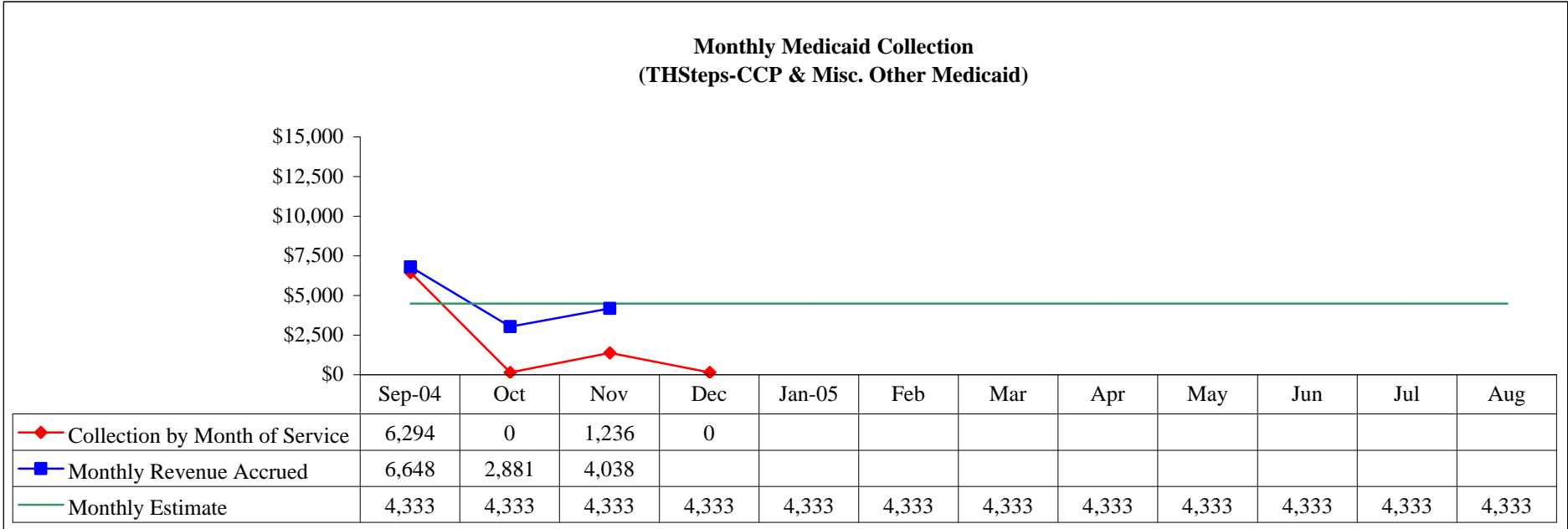


December Revenue Accrued information not available at this time.

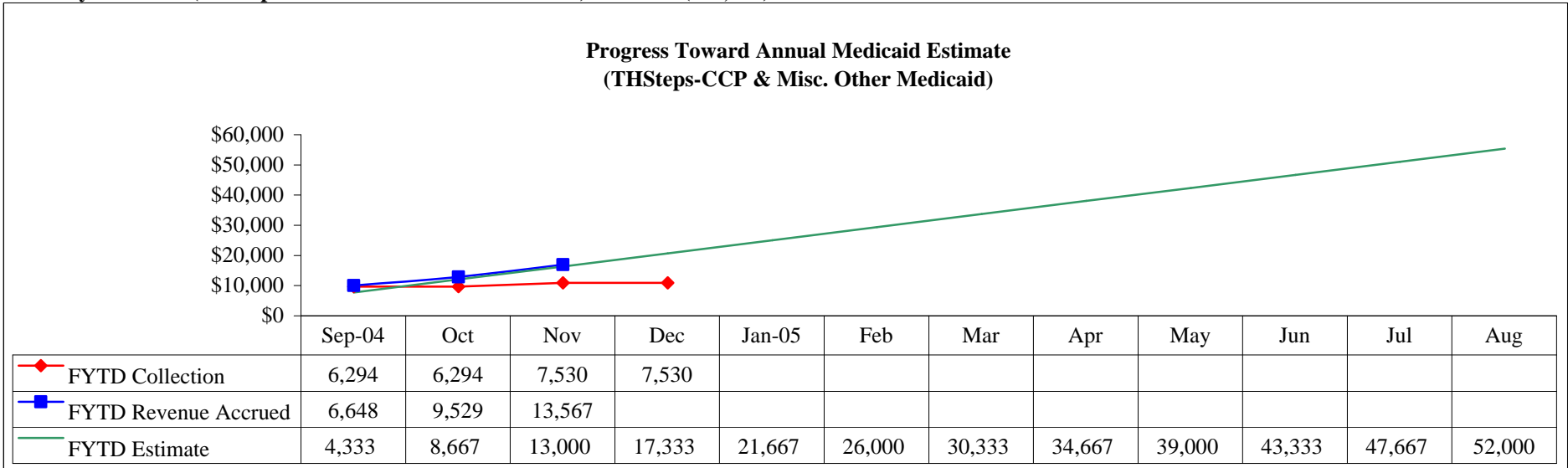
Objective 1D - FY 2005 Revenue Estimate

Waco Center for Youth

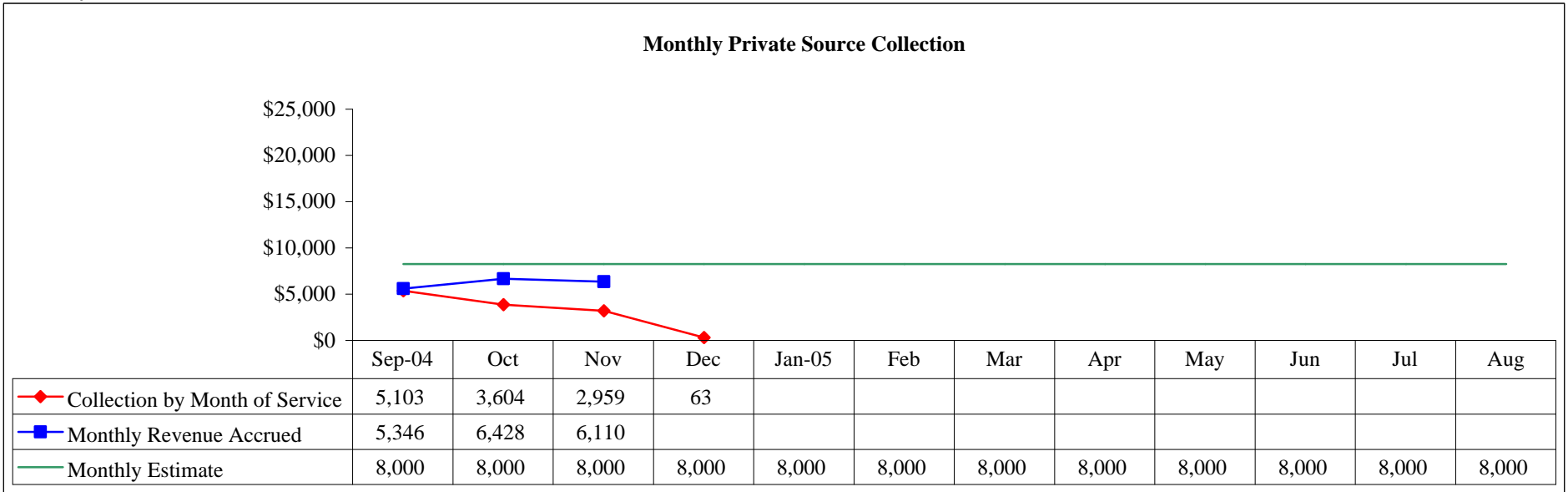
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$4,333)



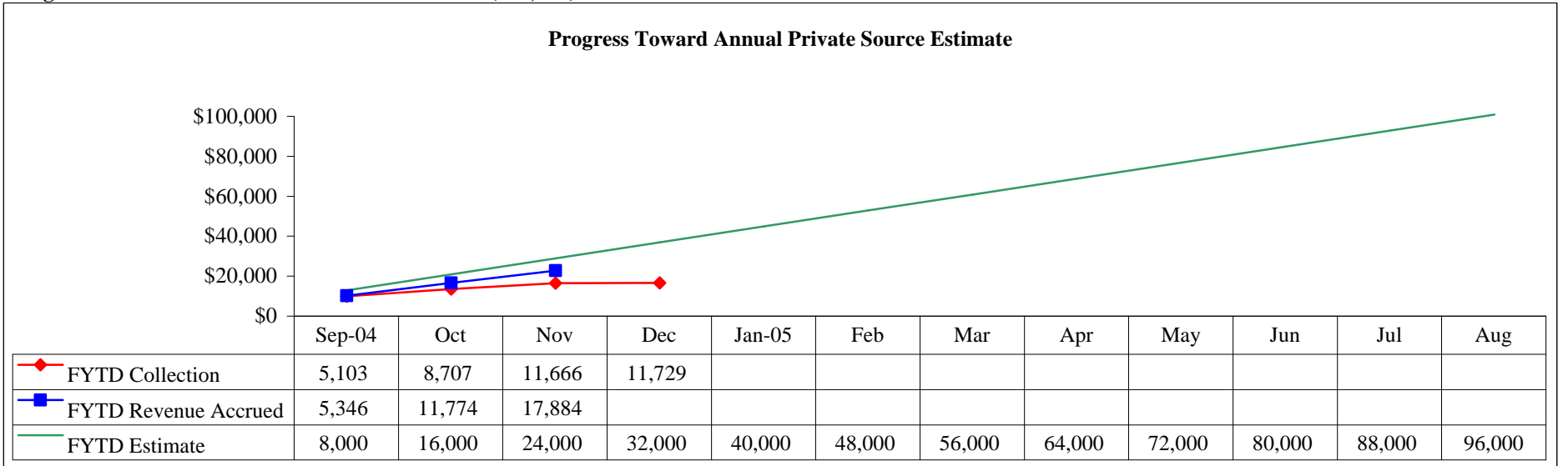
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$52,000)



Objective 1D - FY 2005 Revenue Estimate
Waco Center for Youth
Monthly Private Source Estimate (\$8,000)



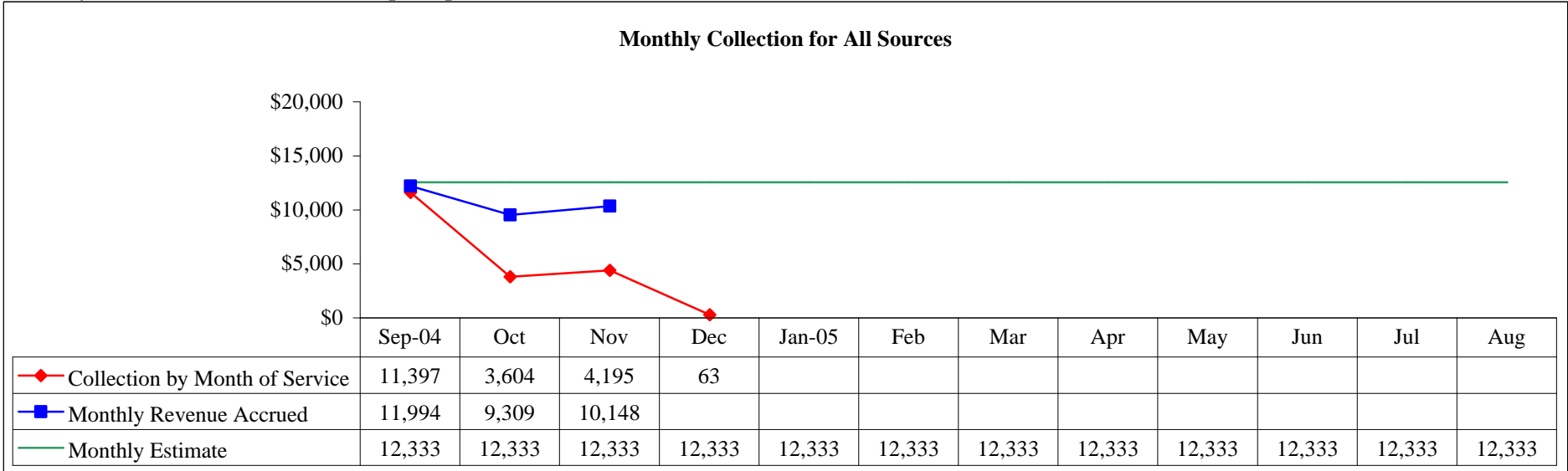
Progress Toward Annual Private Source Estimate (\$96,000)



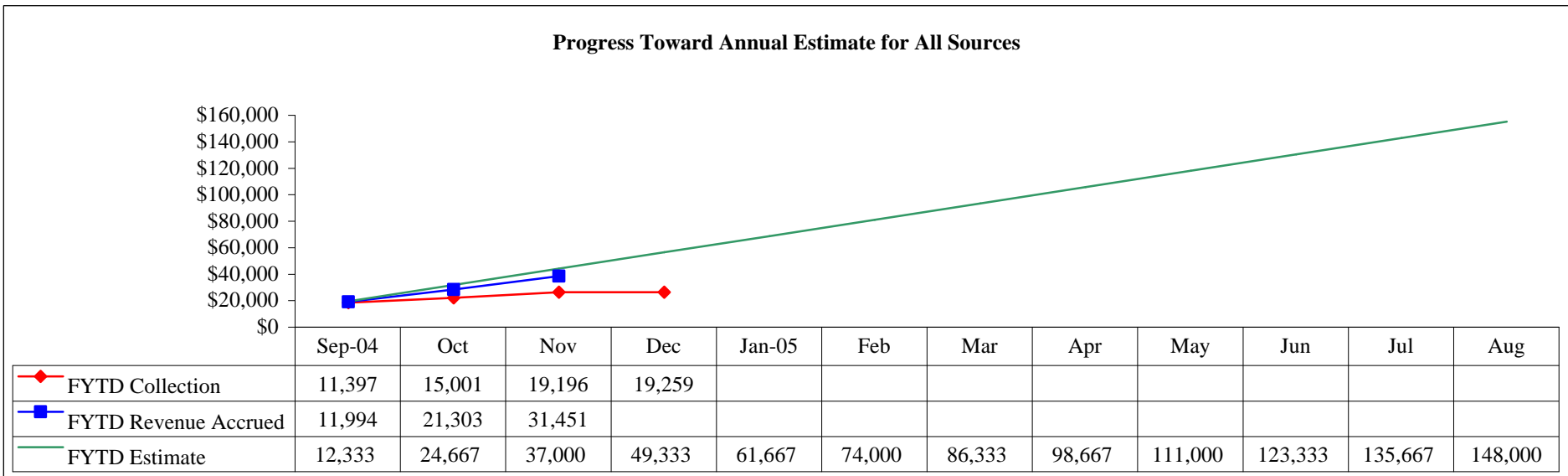
Objective 1D - FY 2005 Revenue Estimate

Waco Center for Youth

Monthly Estimate For All Sources (except Dispro) (\$12,333)



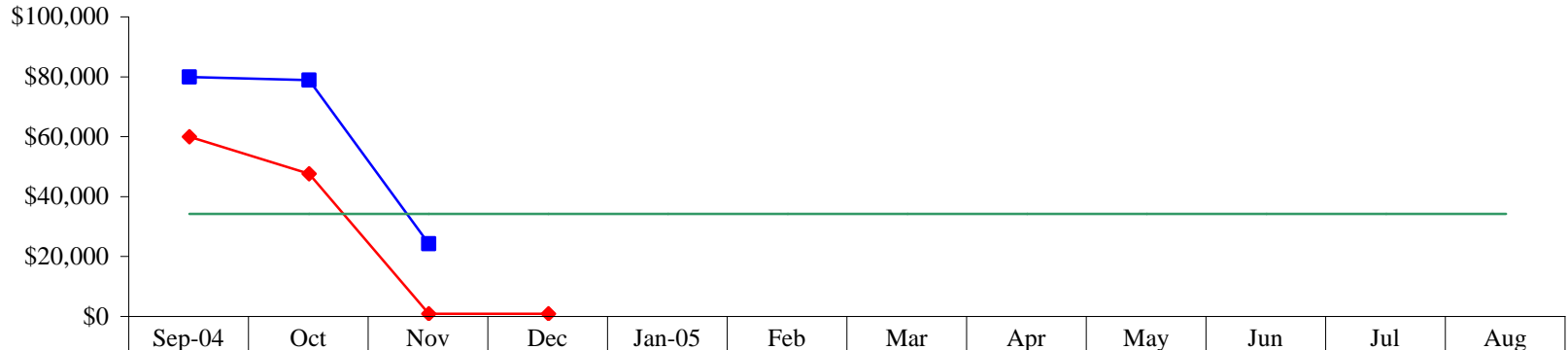
Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$148,000)



December Revenue Accrued information not available at this time.

Objective 1D - FY 2005 Revenue Estimate
Rio Grande State Center-MH
Monthly Medicare Estimate (\$33,333)

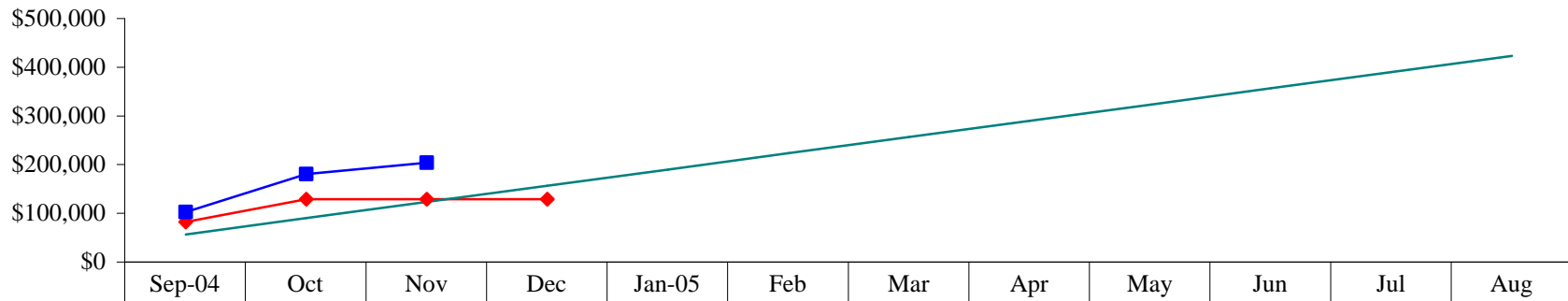
Monthly Medicare Collection



	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
Collection by Month of Service	59,112	46,780	0	39								
Monthly Revenue Accrued	79,033	77,952	23,377									
Monthly Estimate	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333

Progress Toward Annual Medicare Estimate (\$400,000)

Progress Toward Annual Medicare Estimate

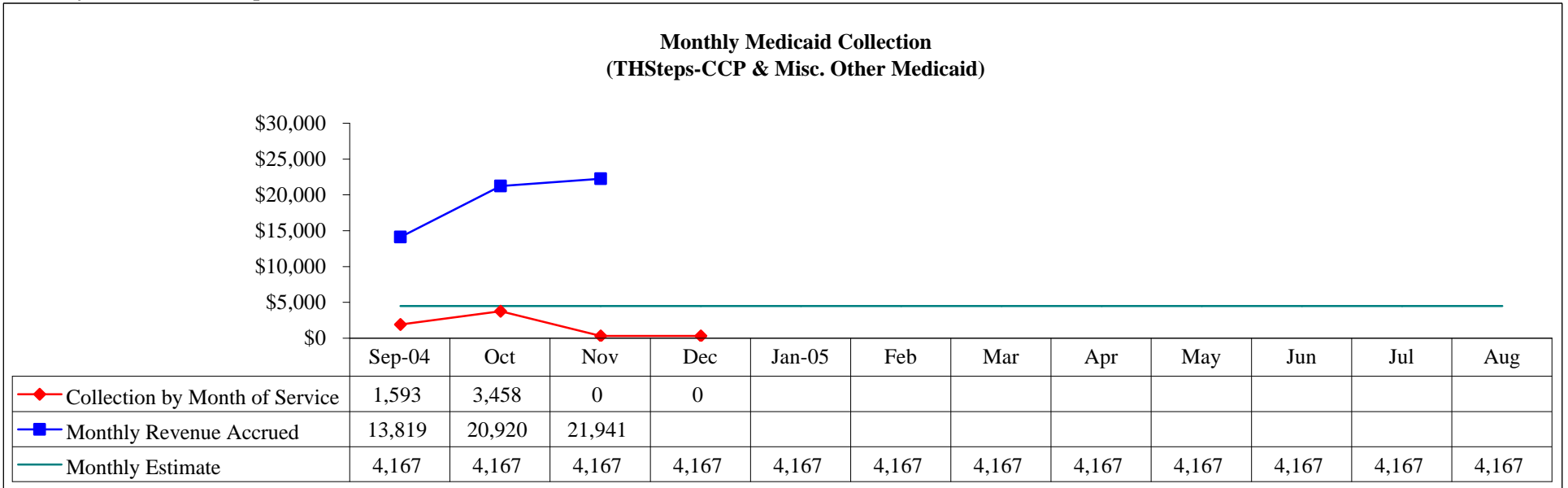


	Sep-04	Oct	Nov	Dec	Jan-05	Feb	Mar	Apr	May	Jun	Jul	Aug
FYTD Collection	59,112	105,892	105,892	105,931								
FYTD Revenue Accrued	79,033	156,985	180,362									
FYTD Estimate	33,333	66,667	100,000	133,333	166,667	200,000	233,333	266,667	300,000	333,333	366,667	400,000

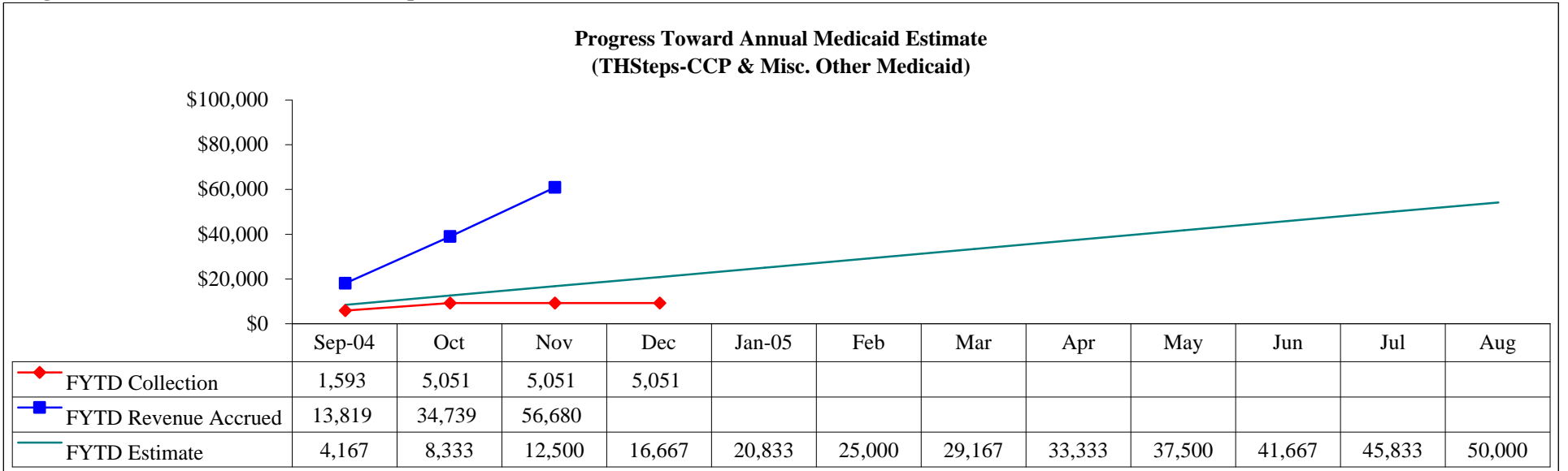
Objective 1D - FY 2005 Revenue Estimate

Rio Grande State Center-MH

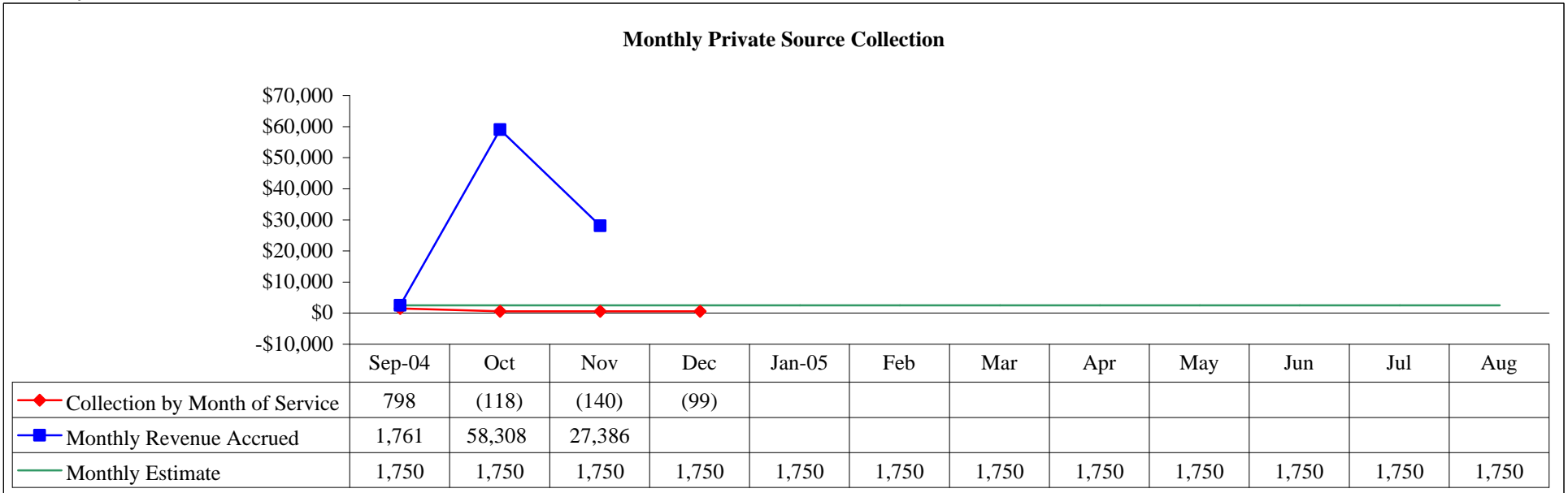
Monthly Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$4,167)



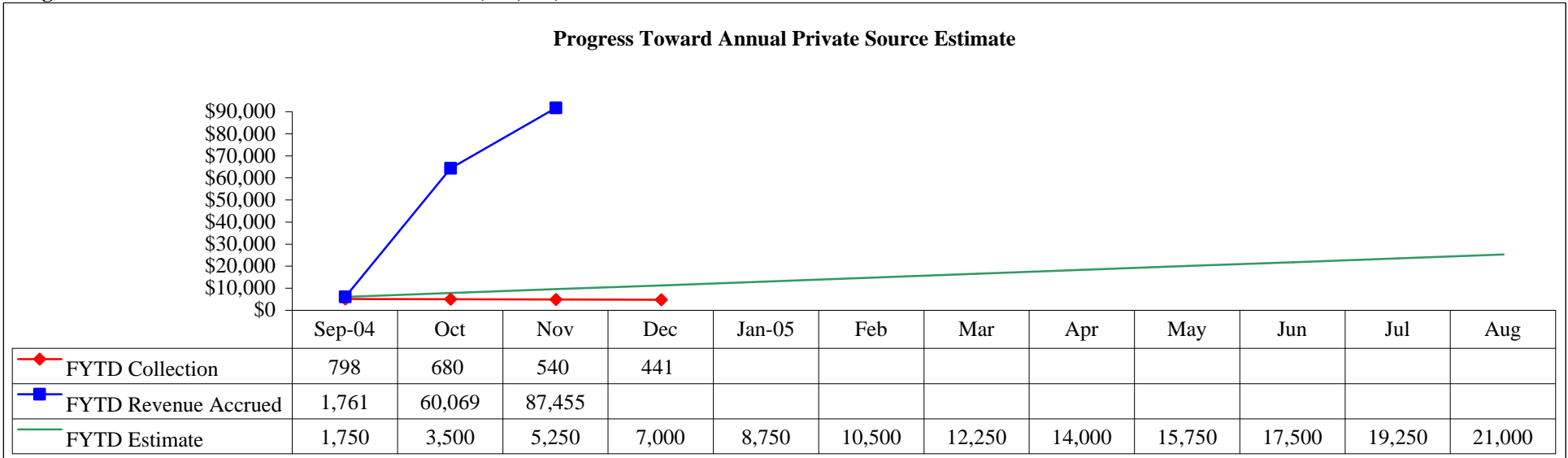
Progress Toward Annual Medicaid (THSteps-CCP & Misc. Other Medicaid) Estimate (\$50,000)



Objective 1D - FY 2005 Revenue Estimate
Rio Grande State Center-MH
Monthly Private Source Estimate (\$1,750)



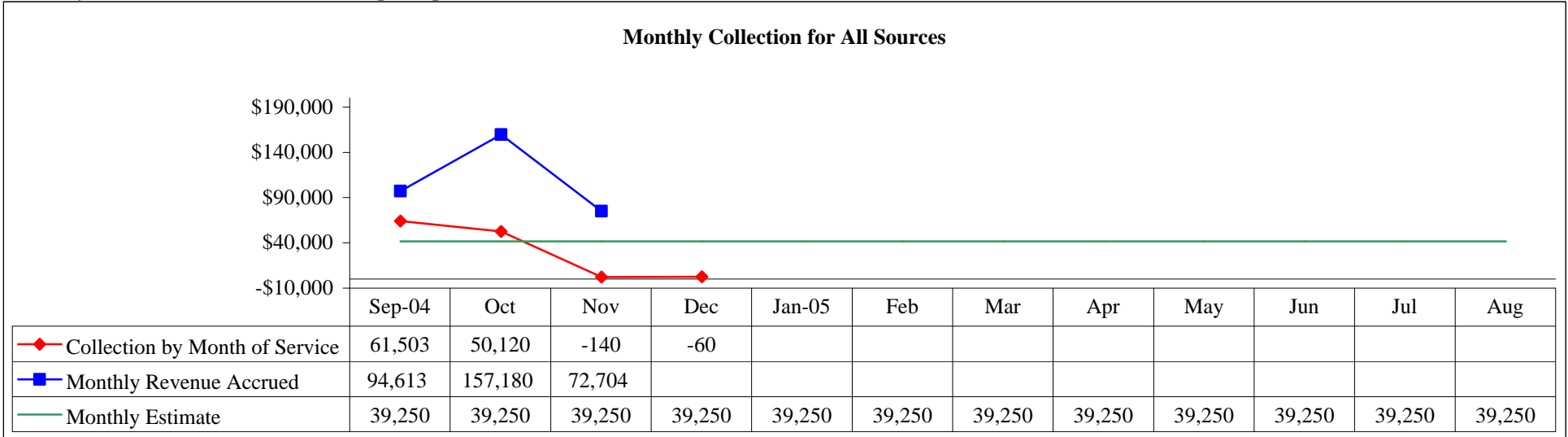
Progress Toward Annual Private Source Estimate (\$21,000)



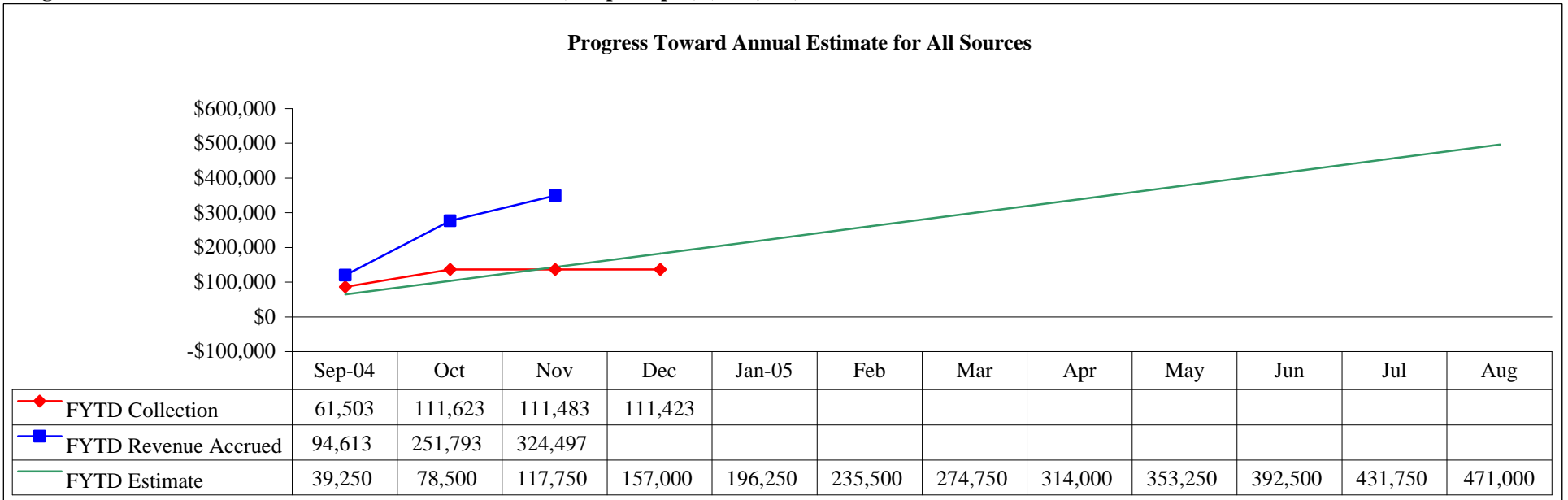
Objective 1D - FY 2005 Revenue Estimate

Rio Grande State Center-MH

Monthly Estimate For All Sources (except Dispro) (\$39,250)



Progress Toward Annual Estimate Amount for All Sources (except Dispro) (\$471,000)



December Revenue Accrued information not available at this time.

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.

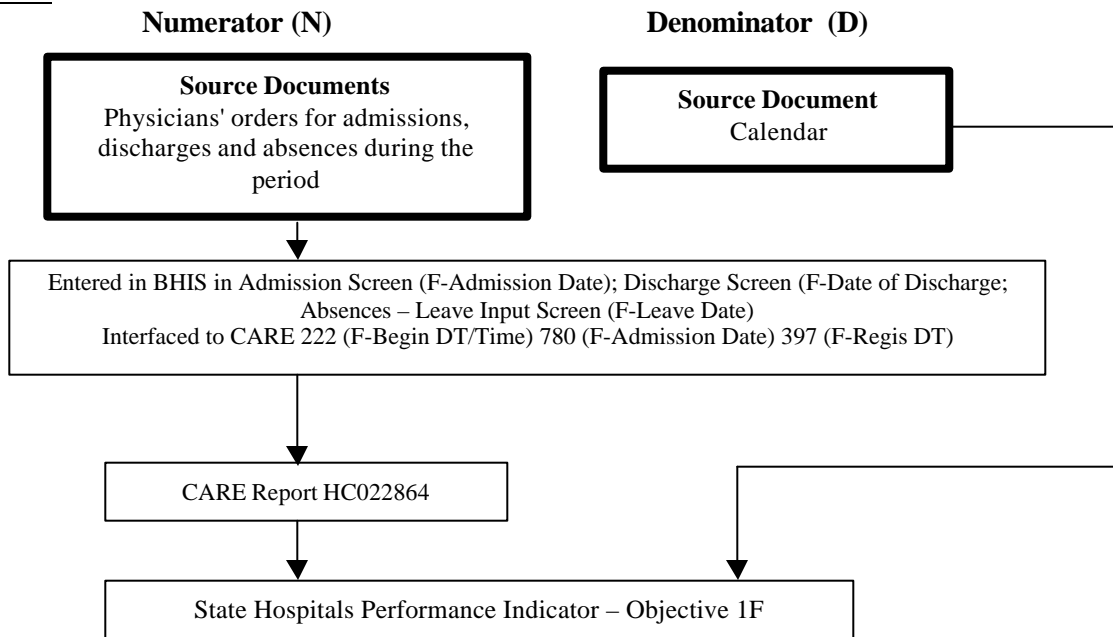
Performance Objective Operational Definition: DSHS Hospital Section will project total ADC, GR ADC and 3rd Party ADC for FY05. Extract report will divide episodes into 3rd Party episodes and GR episodes and calculate monthly ADC, monthly GR ADC and monthly 3rd Party ADC.

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.

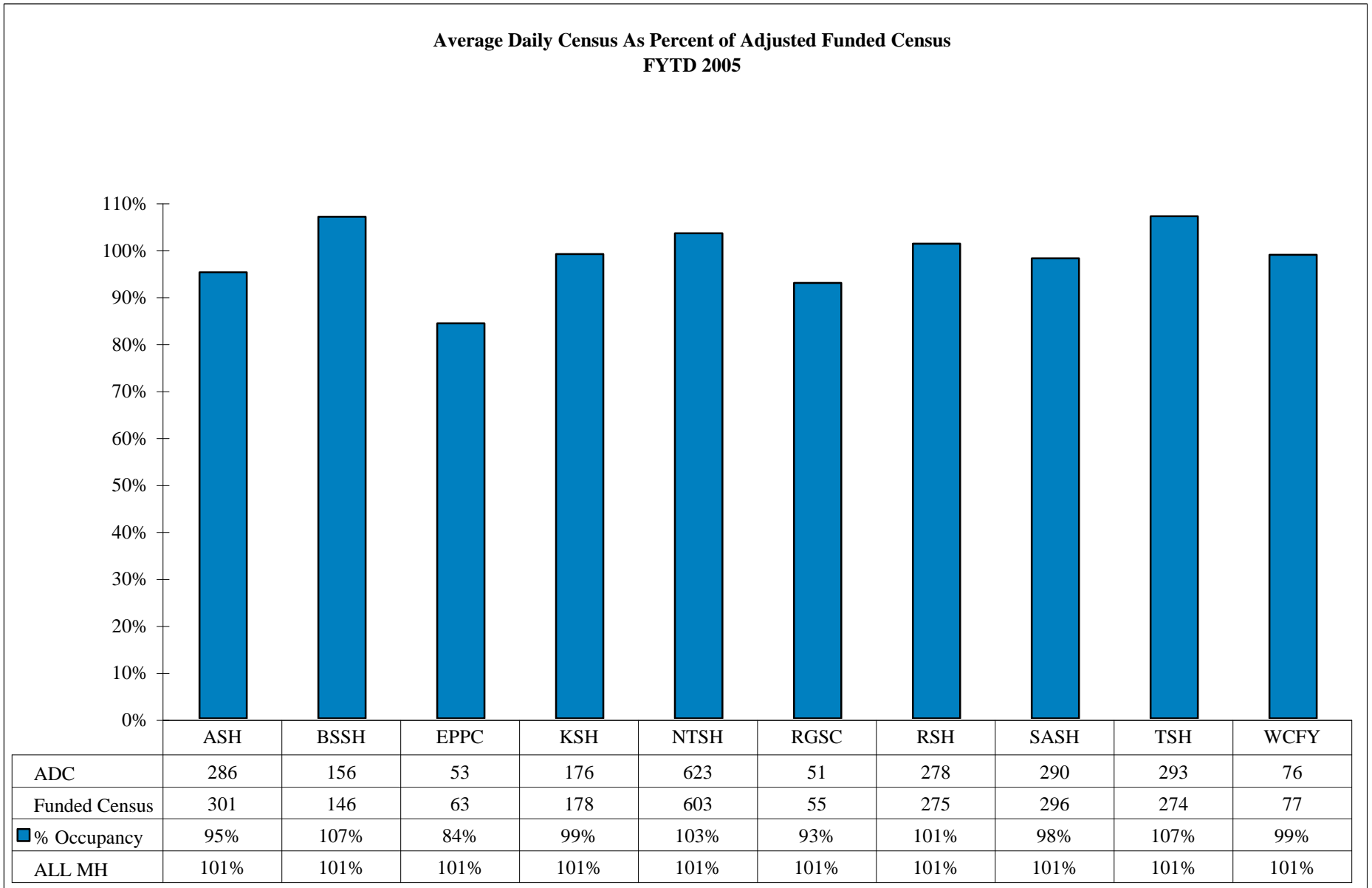
Data Flow:



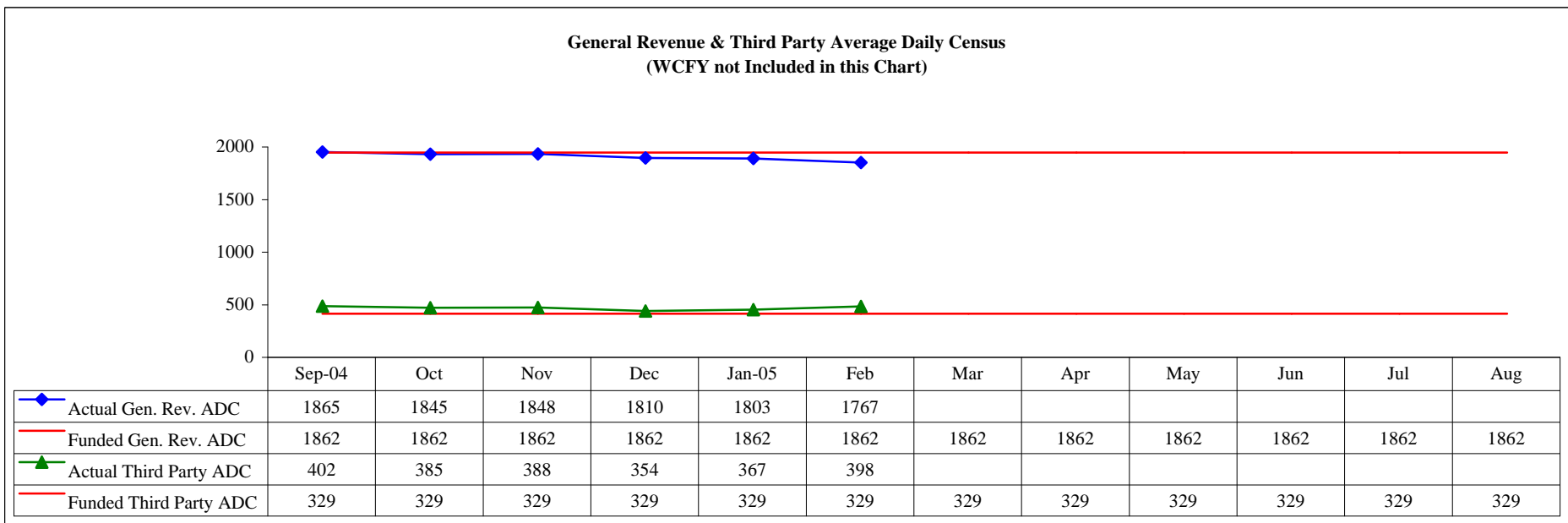
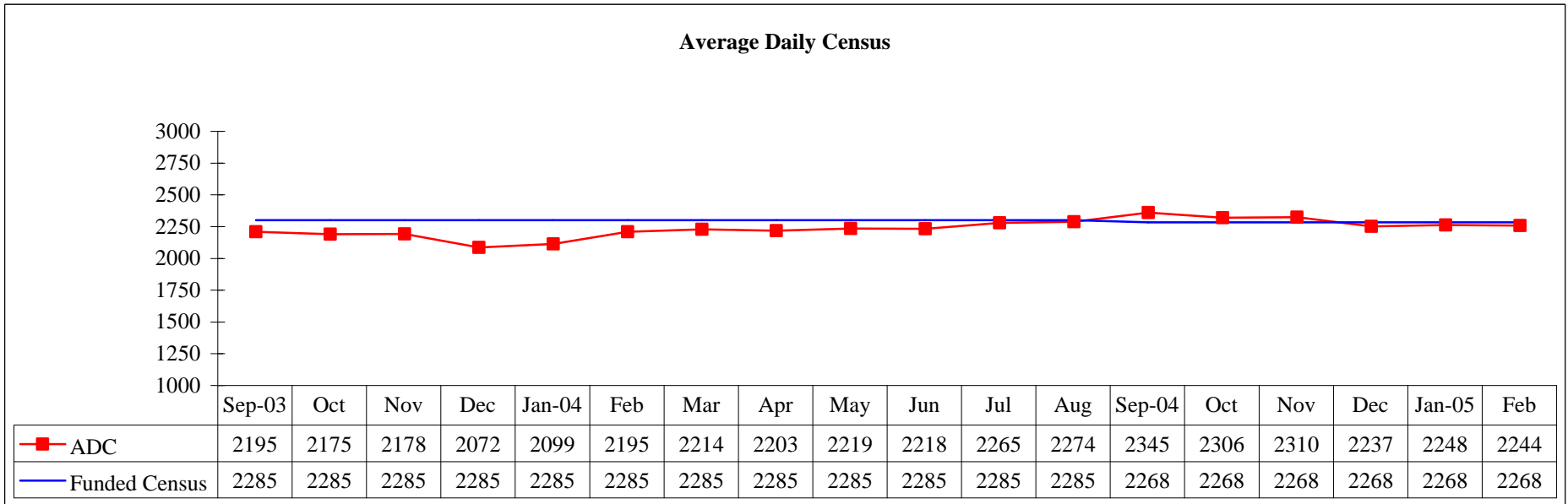
Data Integrity Review Process:

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 February 28, 2005

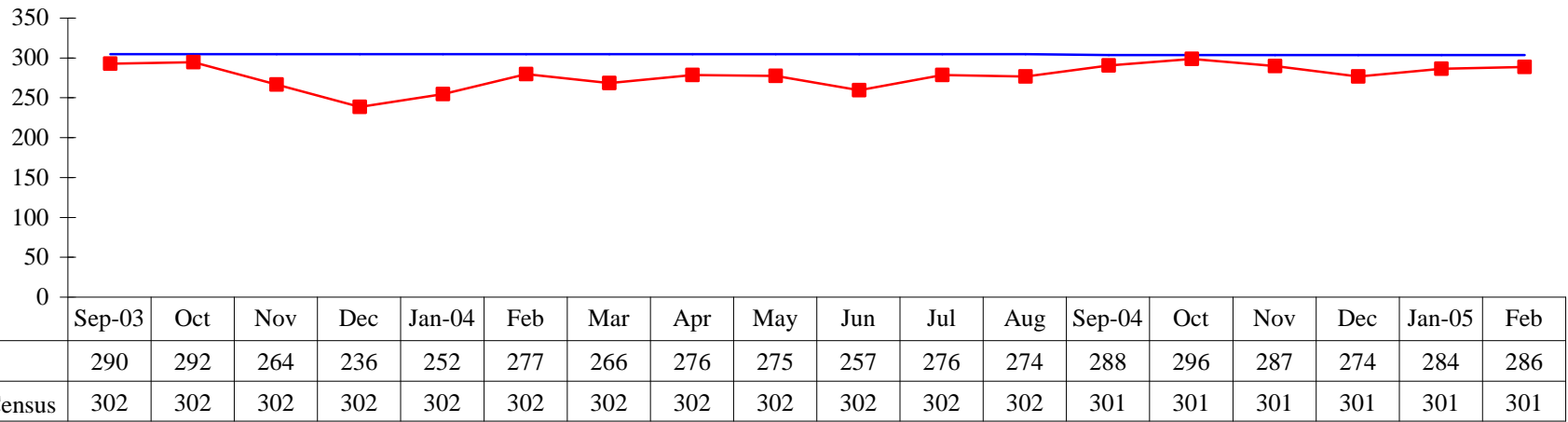


Objective 1F & Measure 1C - Average Daily Census
All MH Facilities

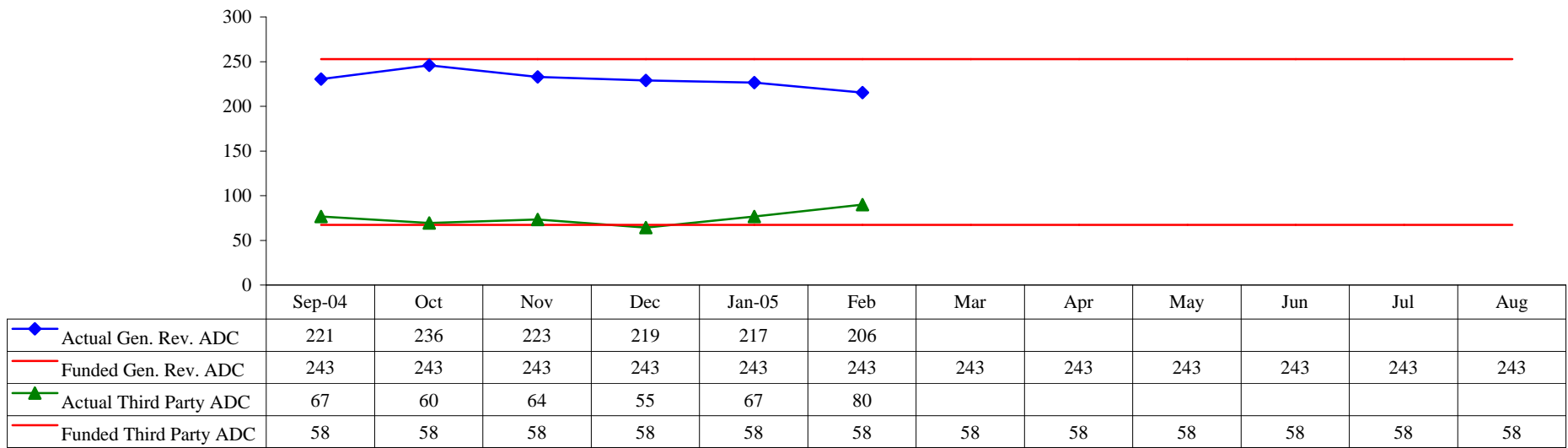


**Objective 1F & Measure 1C - Average Daily Census
Austin State Hospital**

Average Daily Census

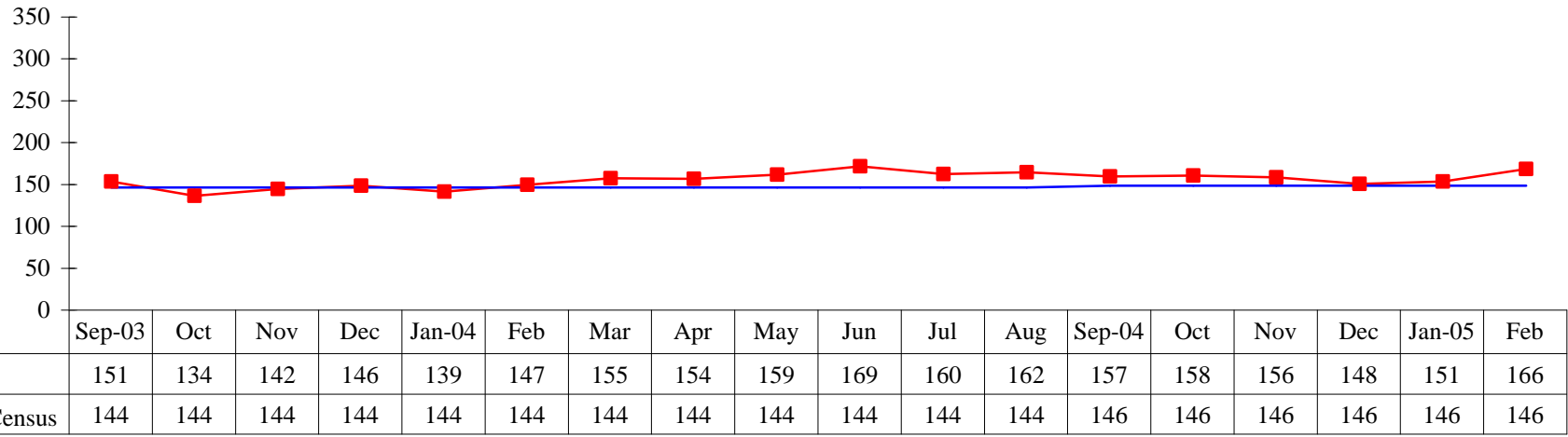


General Revenue & Third Party Average Daily Census

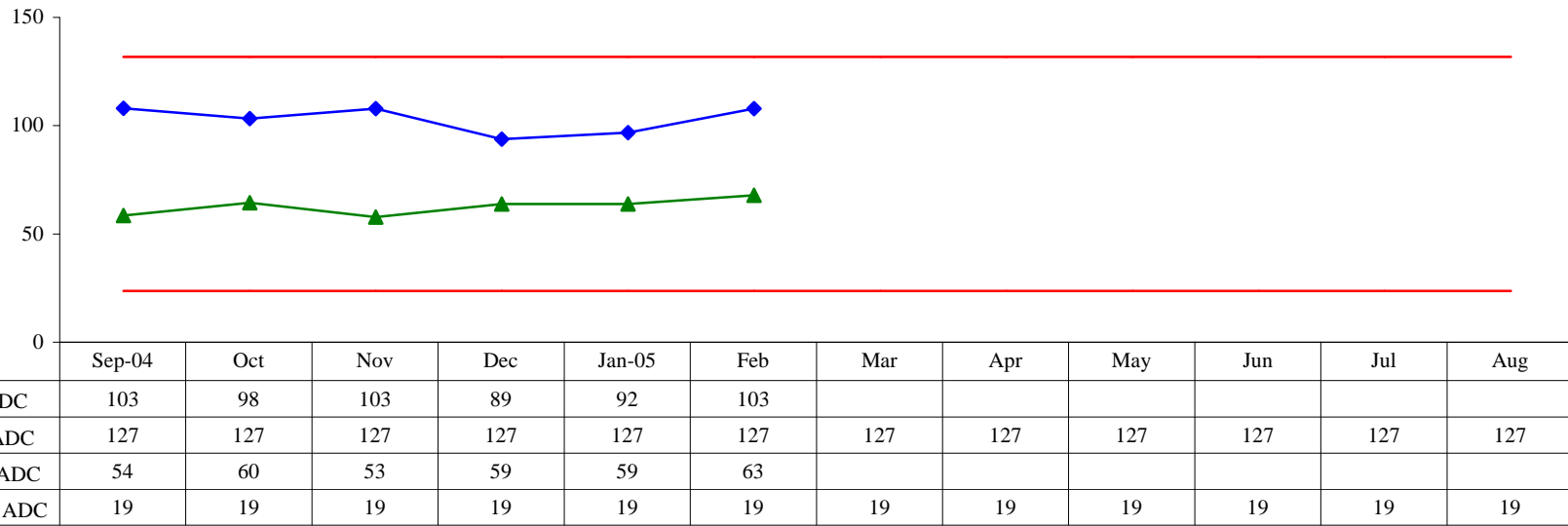


Objective 1F & Measure 1C - Average Daily Census
Big Spring State Hospital

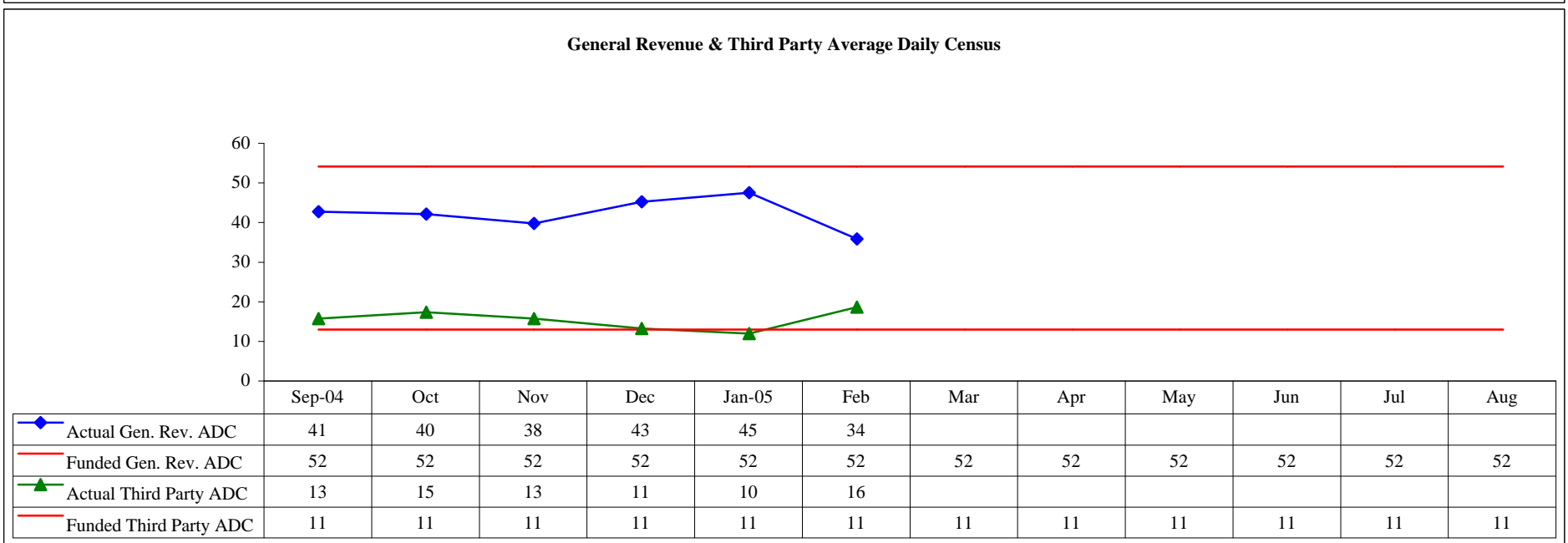
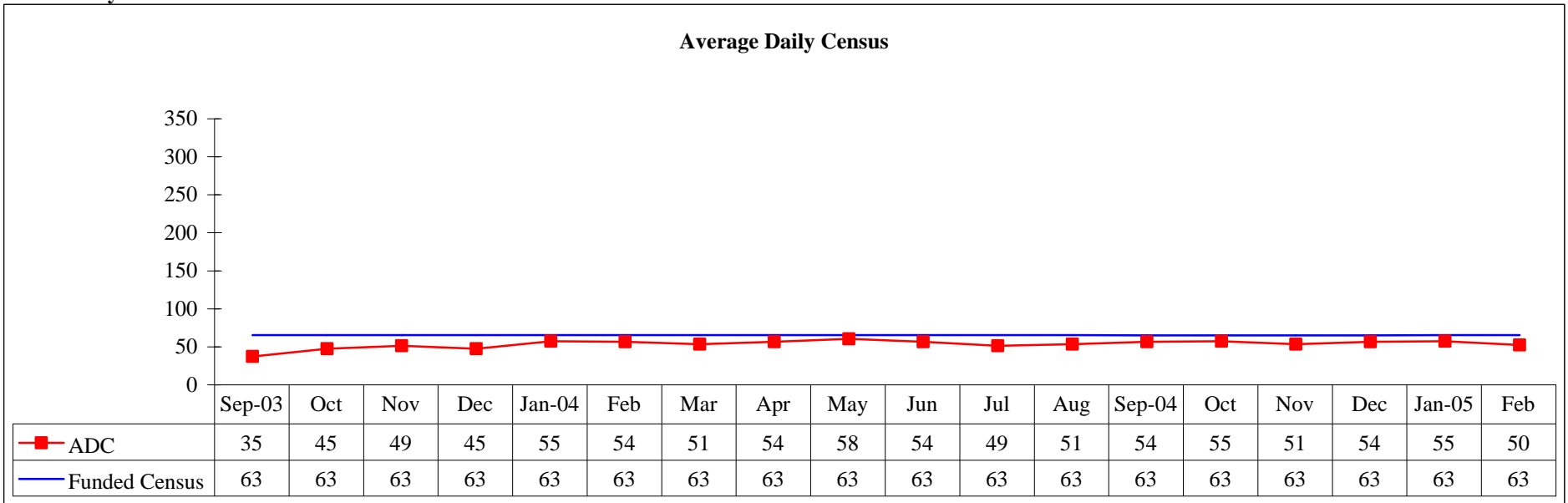
Average Daily Census



General Revenue & Third Party Average Daily Census

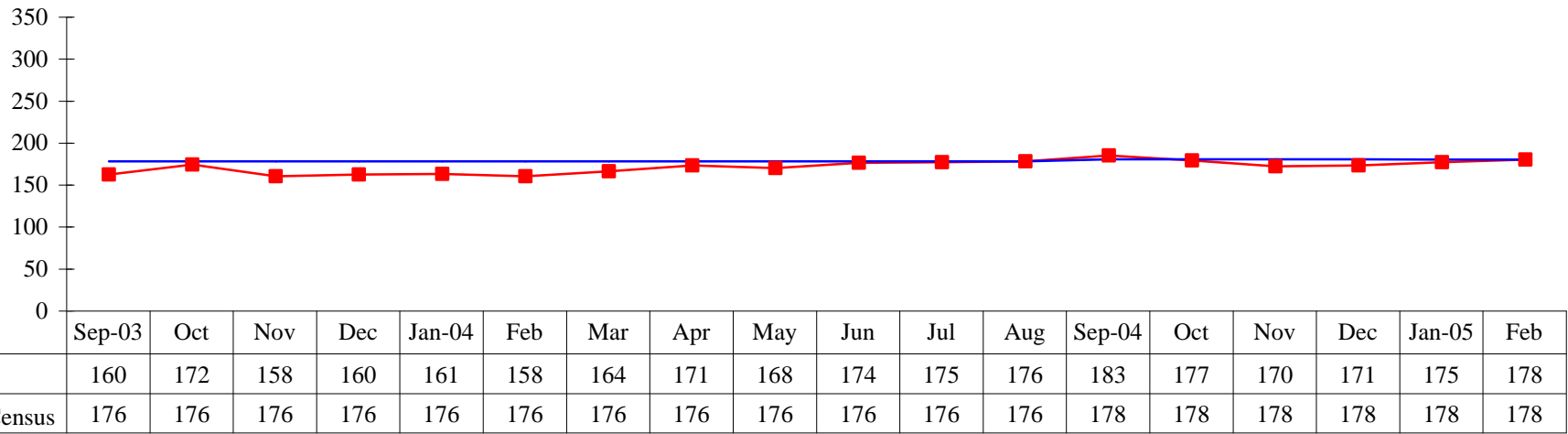


Objective 1F & Measure 1C - Average Daily Census
El Paso Psychiatric Center

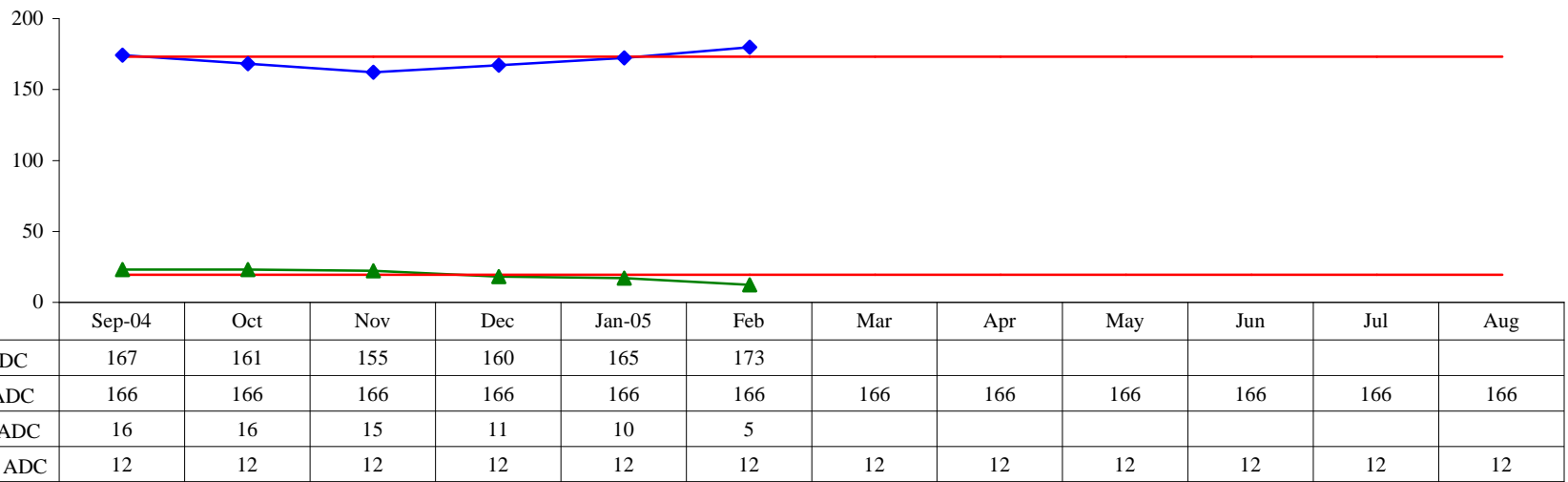


Objective 1F & Measure 1C - Average Daily Census
Kerrville State Hospital

Average Daily Census

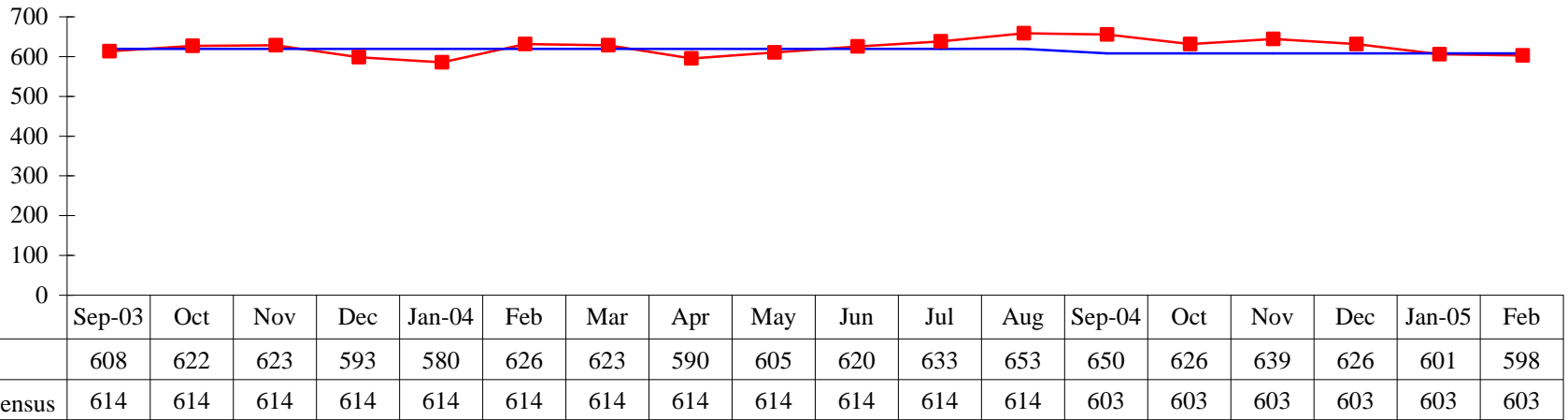


General Revenue & Third Party Average Daily Census

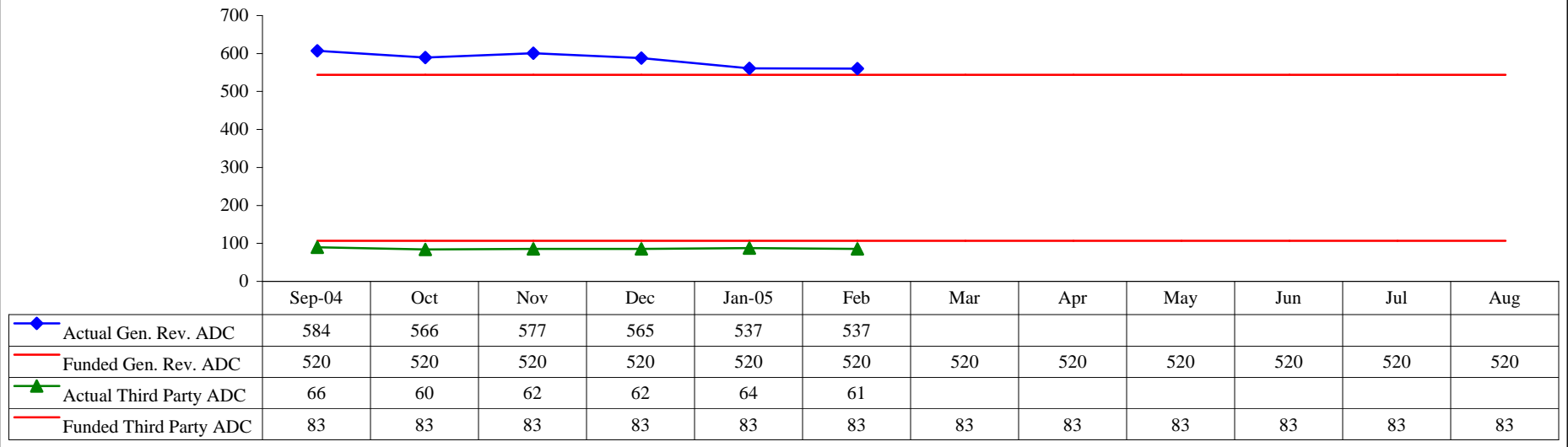


Objective 1F & Measure 1C - Average Daily Census
North Texas State Hospital

Average Daily Census

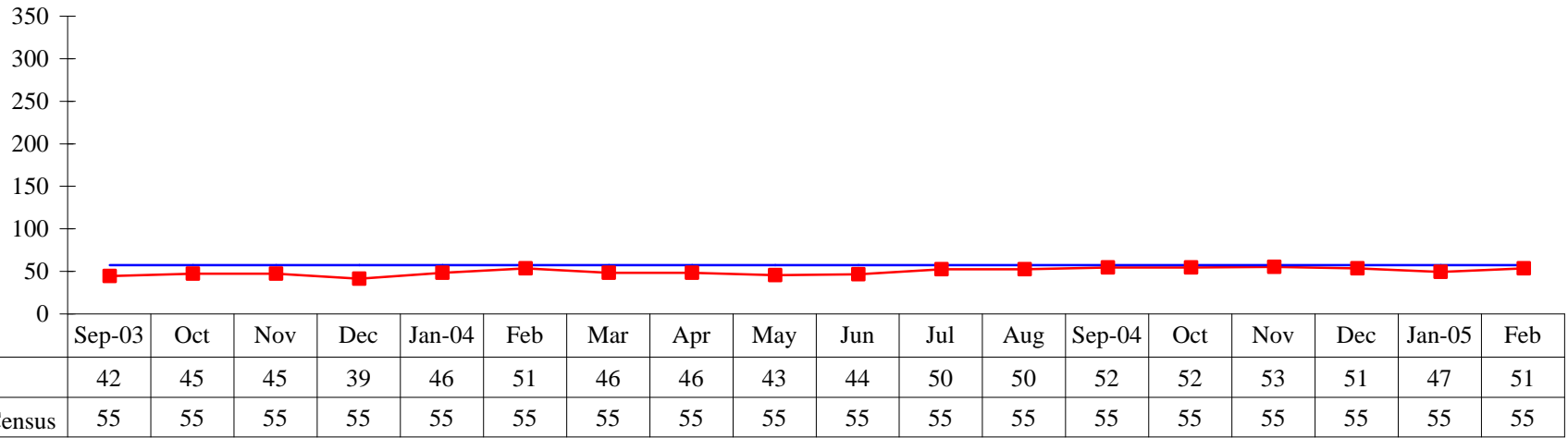


General Revenue & Third Party Average Daily Census

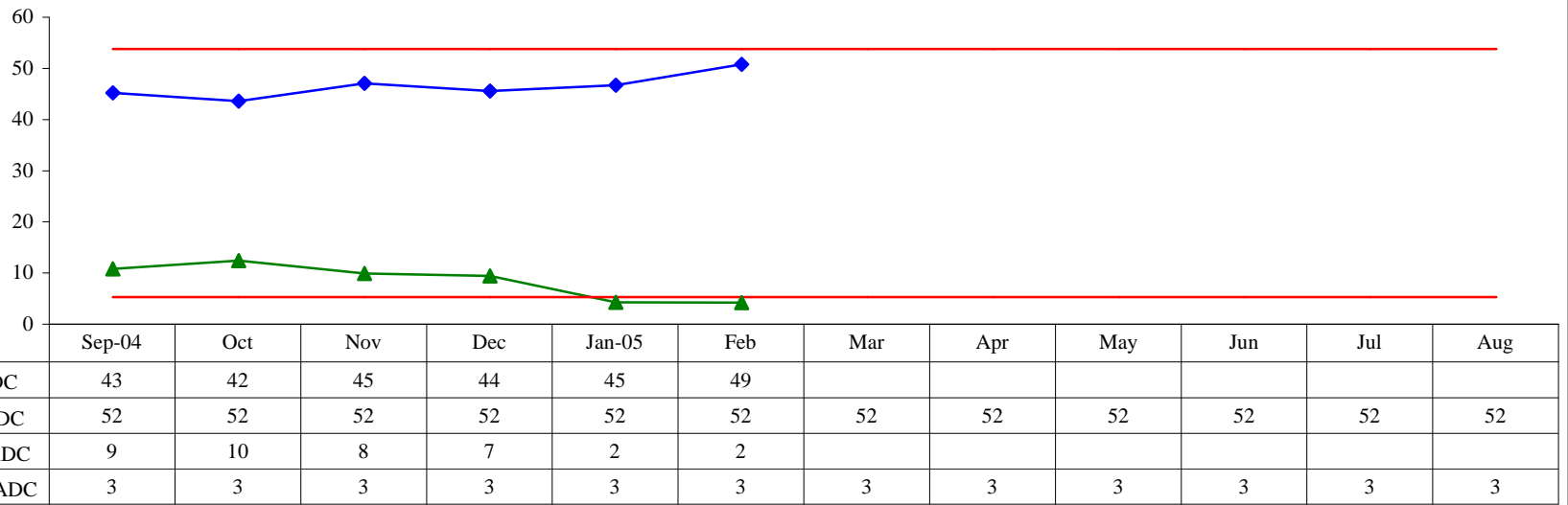


Objective 1F & Measure 1C - Average Daily Census
Rio Grande State Center-MH

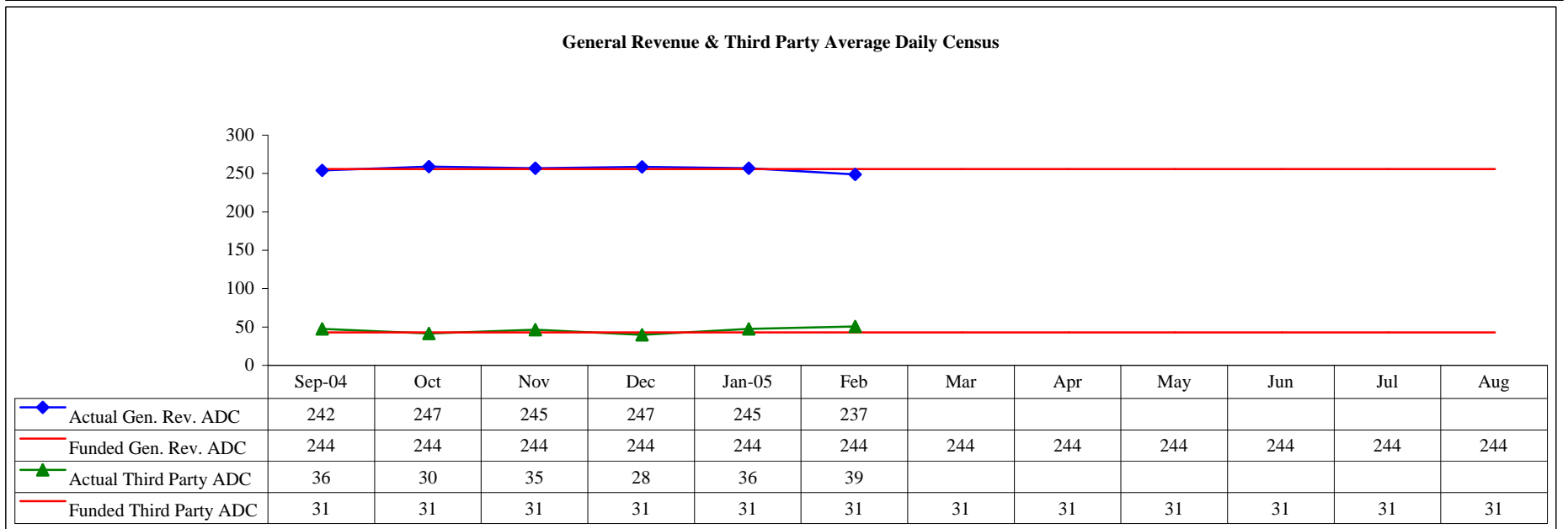
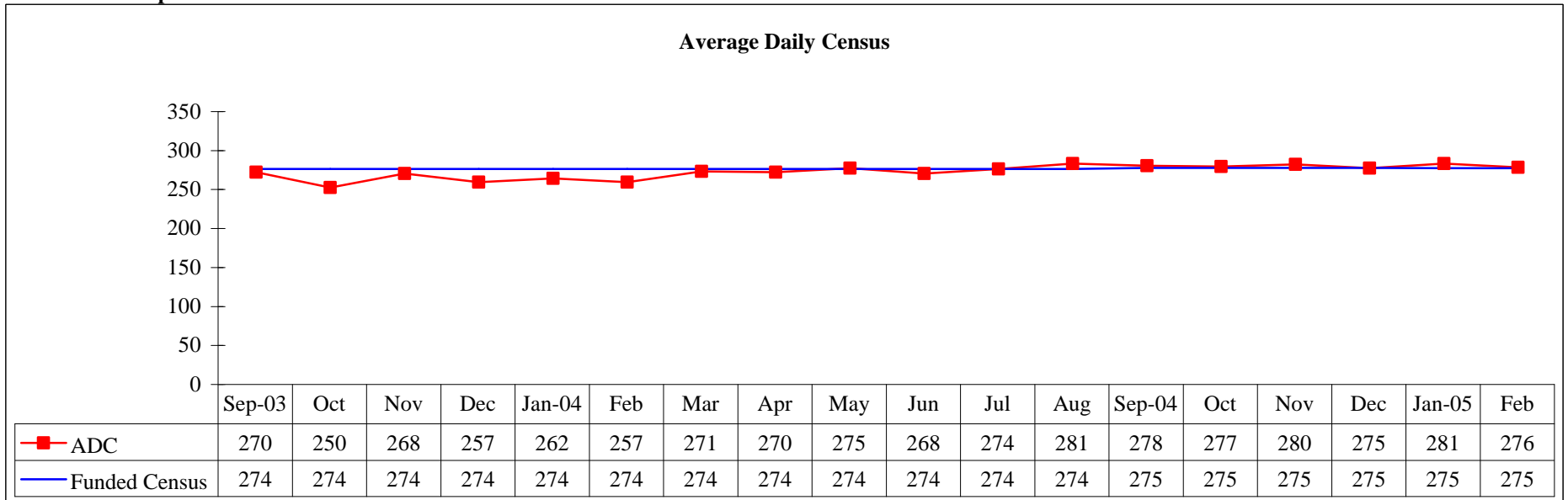
Average Daily Census



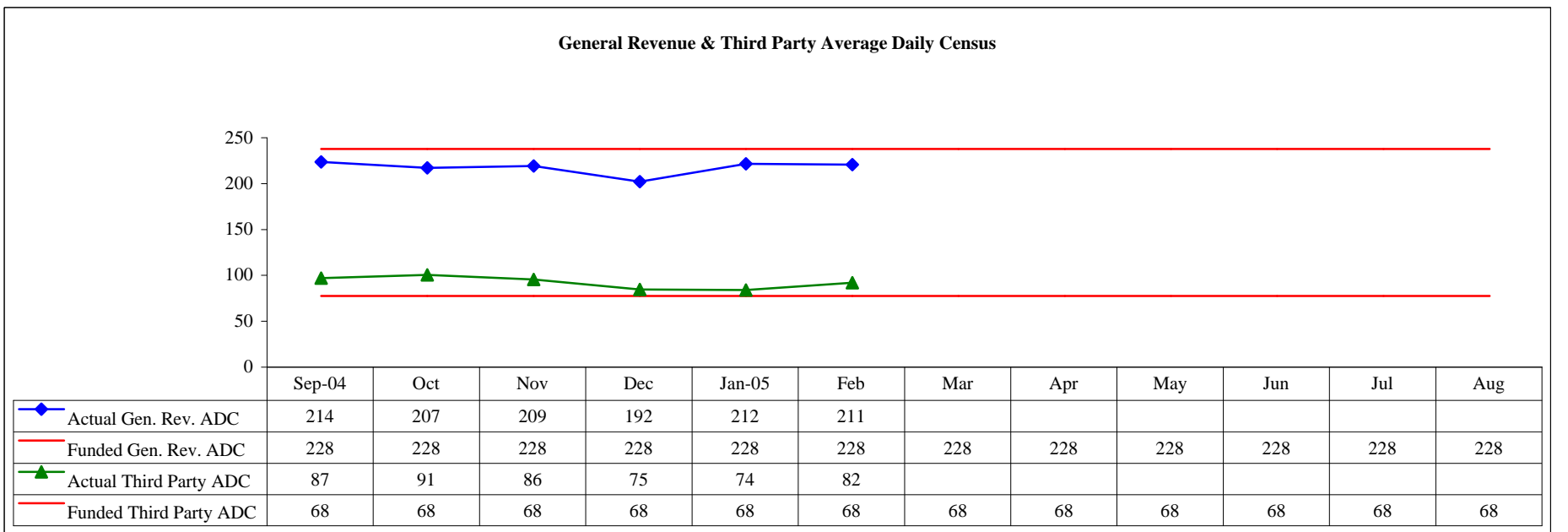
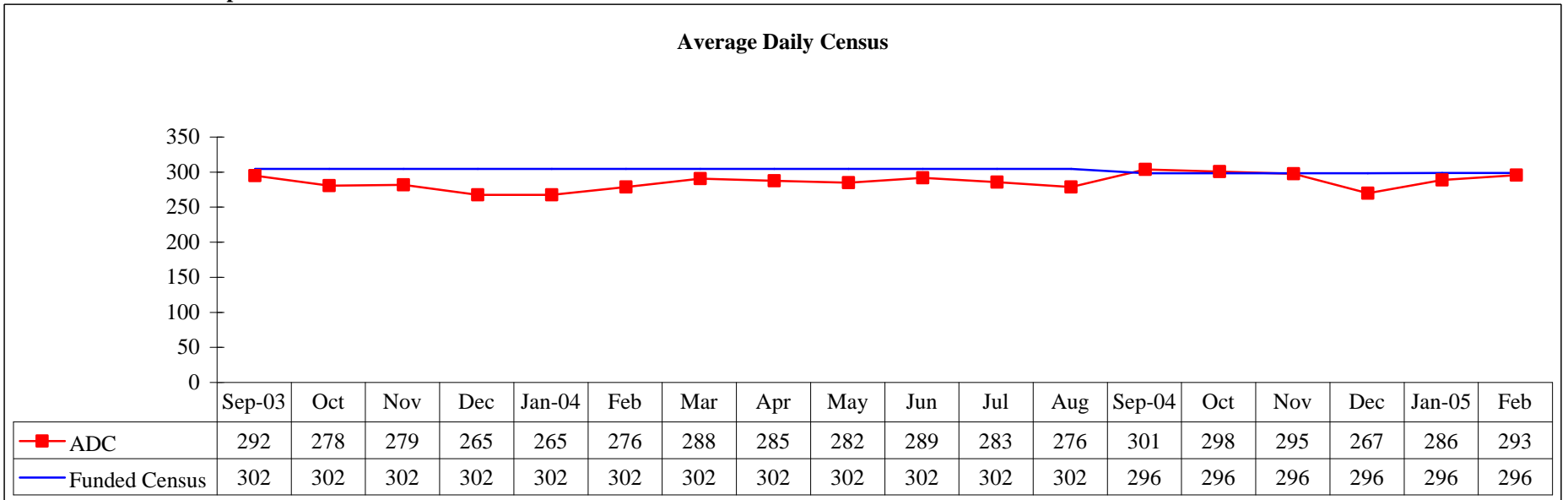
General Revenue & Third Party Average Daily Census



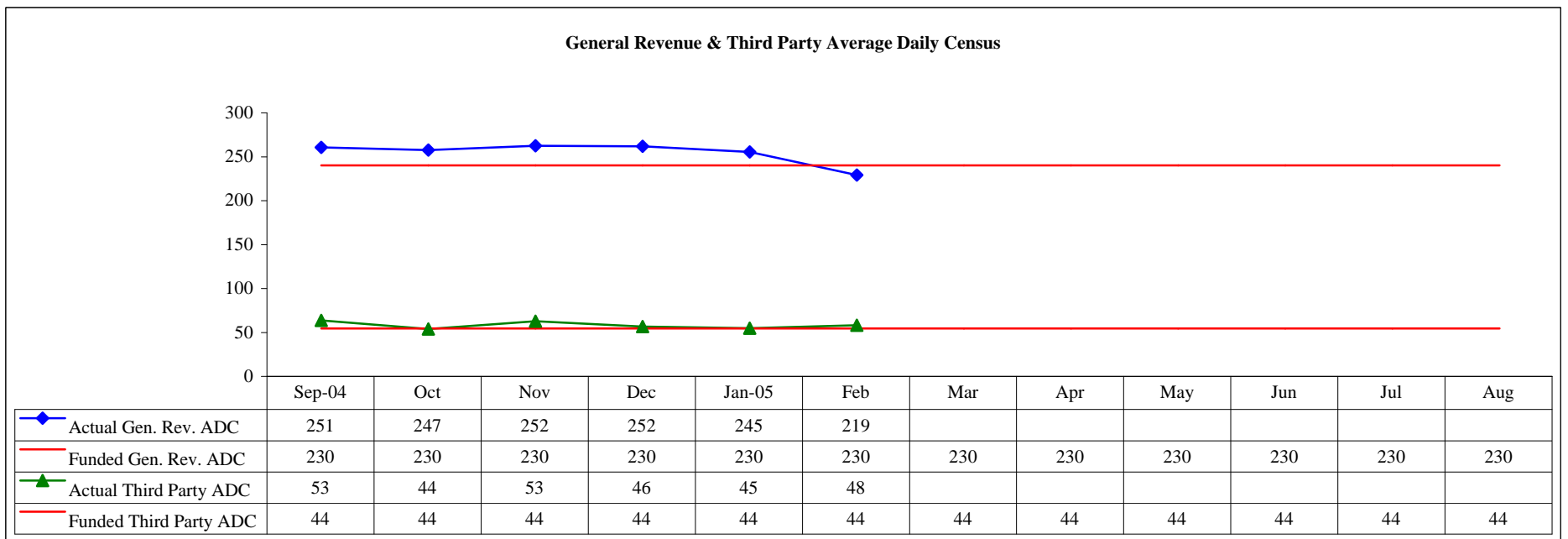
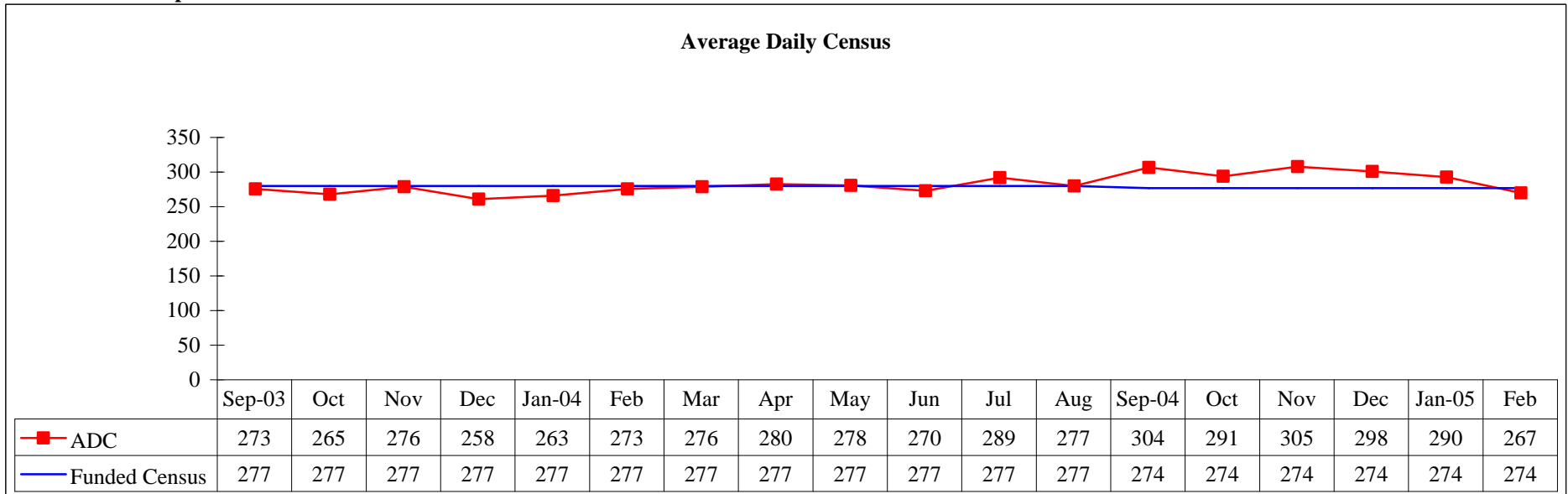
Objective 1F & Measure 1C - Average Daily Census
Rusk State Hospital



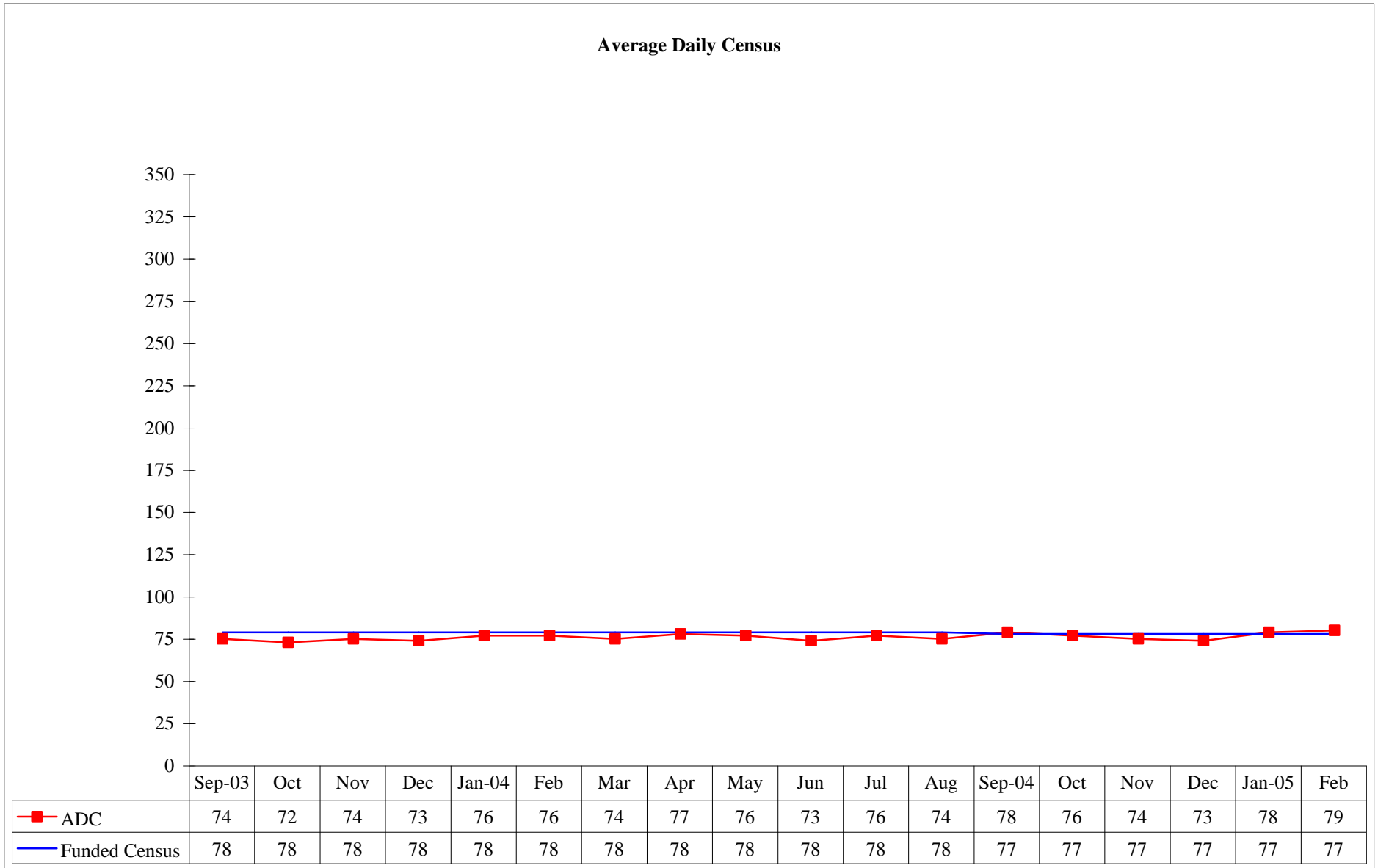
Objective 1F & Measure 1C - Average Daily Census
San Antonio State Hospital



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



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



Performance Measure 1A:

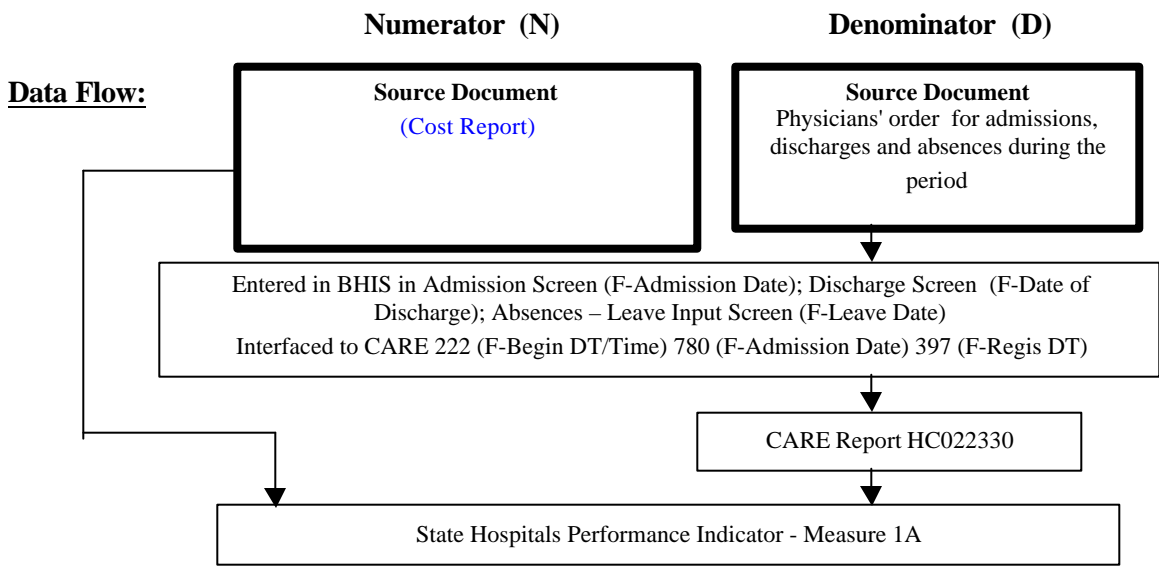
Average cost per patient served will be calculated and reported for each state hospital in the following categories: LBB Cost; State Cost; and Total State Cost.

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:

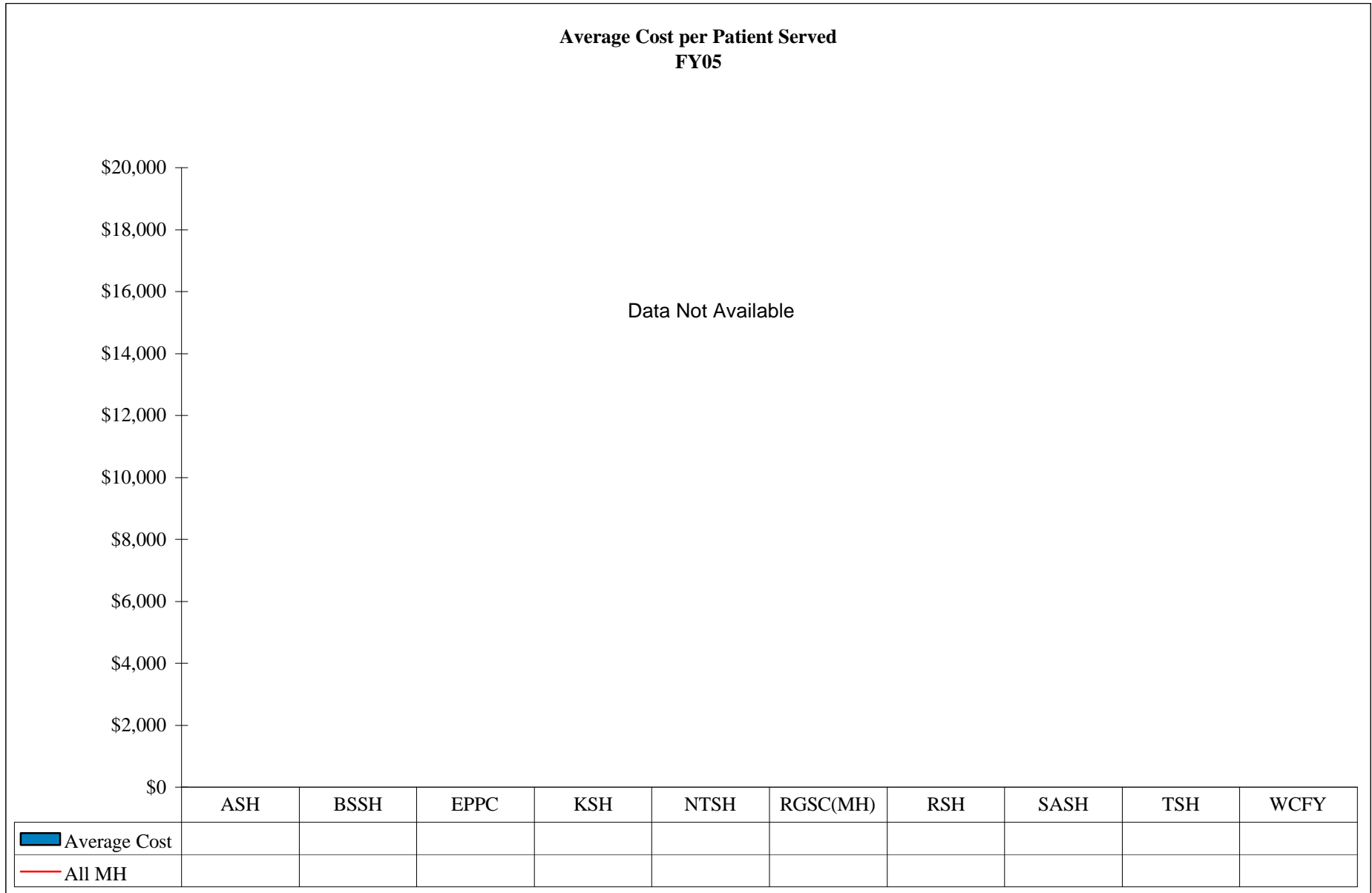
- ◆ Table shows average patient days, cost per bed day and average cost for FY quarter for individual state hospitals and system-wide.
- ◆ Chart with accumulated quarterly data points of average cost per persons served for individual state hospitals and system-wide.



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



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.

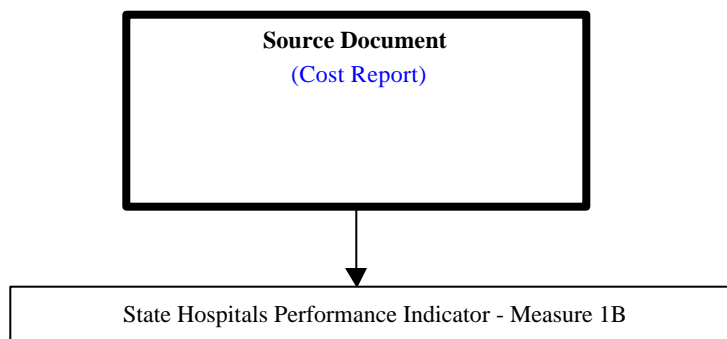
Performance Measure Formula: The state hospital's average cost per occupied bed day per FY quarter is calculated three ways.

- 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.

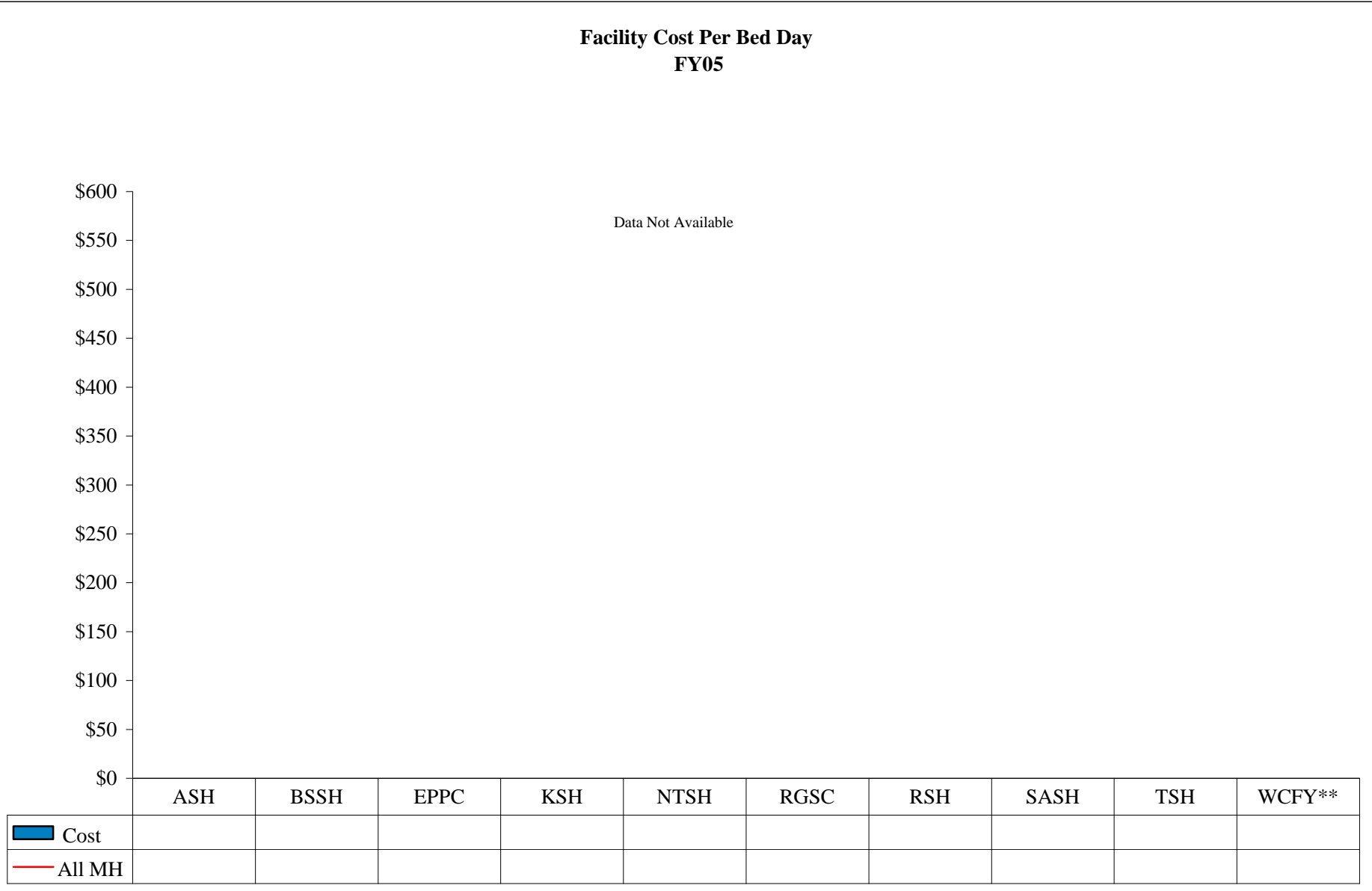
Data Flow:



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



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

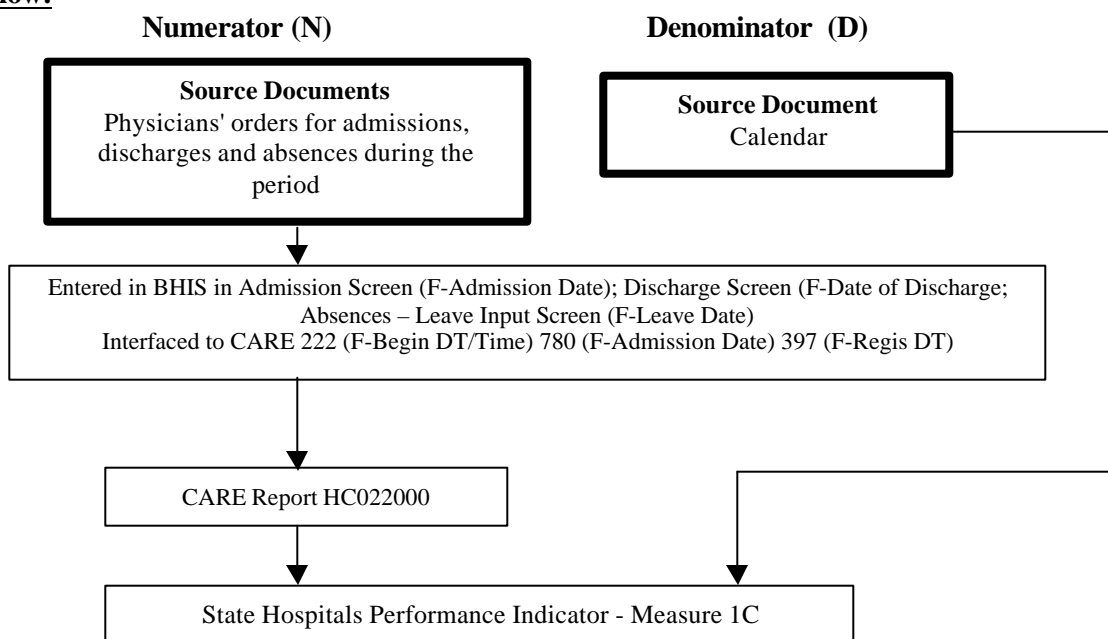
D = number of calendar days in the month

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

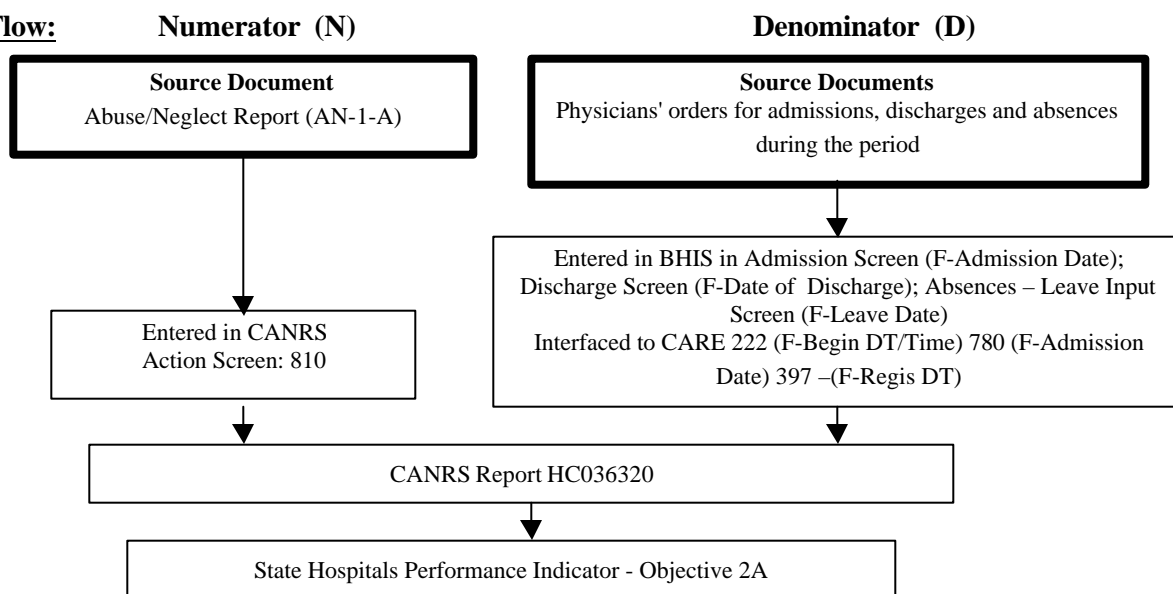
R = rate of confirmed closed abuse and neglect cases per 1,000 bed days per FY

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 February 28, 2005

Facility	FY99	FY00	FY01	FY02	FY03	FY04*	FY05-FYTD					
	Total	Total	Total	Total	Total	Total	Class I	Class II	Class III	Neglect	Total	
ALL MH Facilities												
Total Cases	2844	2419	2260	2387	2188	1476	57	356	148	99	660	
Total Confirmed	277	220	211	193	175	76	2	18	10	15	45	
Total Confirmed Rate/1000 Bed Days	0.31	0.22	0.24	0.23	0.21	0.09	0.00	0.04	0.02	0.03	0.1	

*FY04 Updated

Performance Objective 2B:

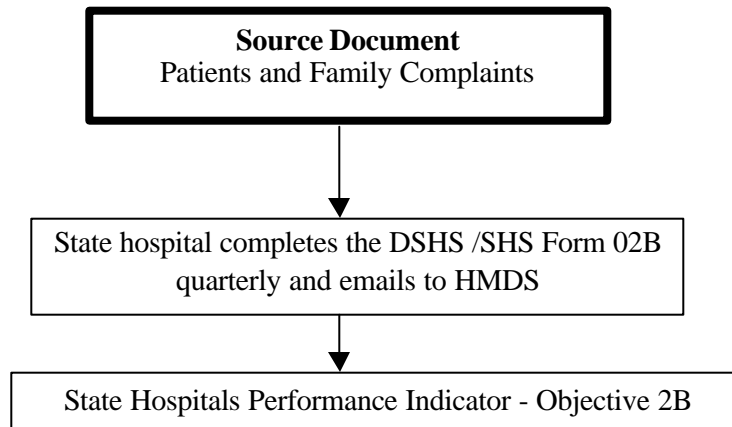
State hospitals will baseline complaint data among state hospitals in order to identify opportunities to improve performance in upholding patient rights.

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.

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
 (As of November 30, 2004)

Q1 - FY05

Complaints	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY	System Total
Property	17	15	13	30	43	2	11	7	33	8	179
Per 1,000 Bed Days	0.64	1.05	2.69	1.87	0.74	0.42	0.43	0.26	1.21	1.16	0.85
Respect	32	14	14	13	15	5	13	12	72	5	195
Per 1,000 Bed Days	1.21	0.98	2.90	0.81	0.26	1.05	0.51	0.44	2.64	0.72	0.92
Discharge	19	13	12	0	17	9	2	8	3	0	83
Per 1,000 Bed Days	0.72	0.91	2.49	0.00	0.29	1.90	0.08	0.30	0.11	0.00	0.39
Medication	10	5	7	9	12	1	9	5	9	1	68
Per 1,000 Bed Days	0.38	0.35	1.45	0.56	0.21	0.21	0.36	0.18	0.33	0.14	0.32
Treatment Team/Planning	23	12	12	41	30	3	16	4	22	27	190
Per 1,000 Bed Days	0.87	0.84	2.49	2.55	0.52	0.63	0.63	0.15	0.81	3.91	0.90
Others	69	5	32	9	215	4	15	55	65	13	482
Per 1,000 Bed Days	2.61	0.35	6.63	0.56	3.70	0.84	0.59	2.03	2.38	1.88	2.28
Total	170	64	90	102	332	24	66	91	204	54	1197
Per 1,000 Bed Days	6.43	4.49	18.65	6.35	5.72	5.06	2.61	3.36	7.48	7.81	5.67

Objective 2B - Patient Complaints
(As of February 28, 2005)

Q2 - FY05

Complaints	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY	System Total
Property	26	13	8	16	36	4	5	18	55	6	187
Per 1,000 Bed Days	1.03	0.94	1.68	1.02	0.66	0.90	0.20	0.71	2.14	0.87	0.93
Respect	18	12	8	3	23	1	13	18	91	9	196
Per 1,000 Bed Days	0.71	0.86	1.68	0.19	0.42	0.22	0.52	0.71	3.54	1.31	0.97
Discharge	15	23	13	1	23	4	0	12	15	0	106
Per 1,000 Bed Days	0.59	1.65	2.73	0.06	0.42	0.90	0.00	0.47	0.58	0.00	0.53
Medication	5	13	5	3	25	2	8	6	10	0	77
Per 1,000 Bed Days	0.20	0.94	1.05	0.19	0.46	0.45	0.32	0.24	0.39	0.00	0.38
Treatment Team/Planning	20	22	11	24	37	0	0	9	21	39	183
Per 1,000 Bed Days	0.79	1.58	2.31	1.53	0.68	0.00	0.00	0.36	0.82	5.66	0.91
Others	36	15	15	4	298	10	44	91	99	34	646
Per 1,000 Bed Days	1.42	1.08	3.14	0.25	5.45	2.25	1.76	3.59	3.85	4.93	3.20
Total	120	98	60	51	442	21	70	154	291	88	1395
Per 1,000 Bed Days	4.74	7.05	12.58	3.24	8.08	4.72	2.81	6.08	11.33	12.77	6.92

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 - FY05

Fiscal Year 2005

	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	3,346	2,268			3,346	2,268			3,346	2,268		
Bed Days in Quarter-All Other Units	23,080	23,032			23,080	23,032			23,080	23,032		
Restraint Involving Children	2	3			2	2			0.1	1.0		
Restraint Involving Adolescents	133	93			46	39			78.7	52.9		
Restraint Involving Adults	184	198			81	96			179.2	162.9		
Seclusion Involving Children	1	1			1	1			0.3	0.6		
Seclusion Involving Adolescents	9	5			7	5			4.8	4.1		
Seclusion Involving Adults	6	2			5	1			6.1	5.5		
Big Spring State Hospital												
Bed Days in Quarter	14,257	13,898			14,257	13,898			14,257	13,898		
Restraint Involving Adults	167	131			46	44			121.7	89.1		
Seclusion Involving Adults	0	0			0	0			0.0	0.0		
El Paso Psychiatric Center												
Child/Adolescent Bed Days	493	409			493	409			493	409		
Bed Days in Quarter-All Other Units	4,333	4,361			4,333	4,361			4,333	4,361		
Restraint Involving Children	0	0			0	0			0.0	0.00		
Restraint Involving Adolescents	35	23			6	6			39.3	17.3		
Restraint Involving Adults	54	82			13	27			83.4	126.1		
Seclusion Involving Children	0	0			0	0			0.0	0.0		
Seclusion Involving Adolescents	14	5			3	4			10.3	3.7		
Seclusion Involving Adults	10	8			7	7			4.8	5.2		
Kerrville State Hospital												
Bed Days in Quarter	16,072	15,722			16,072	15,722			16,072	15,722		
Restraint Involving Adults	17	27			8	20			3.1	3.7		
Seclusion Involving Adults	3	4			3	2			2.6	21.9		

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities - FY05

	Fiscal Year 2005											
	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	9,783	8,972			9,783	8,972			9,783	8,972		
Bed Days in Quarter-All Other Units	48,272	45,757			48,272	45,757			48,272	45,757		
Restraint Involving Children	1	0			1	0			0.1	0.0		
Restraint Involving Adolescents	219	130			36	30			160.1	75.0		
Restraint Involving Adults	536	464			157	140			420.1	390.1		
Seclusion Involving Children	4	2			2	1			2.3	1.4		
Seclusion Involving Adolescents	50	25			17	12			56.5	21.6		
Seclusion Involving Adults	102	94			43	40			242.2	194.4		
Rio Grande State Center												
Bed Days in Quarter	4,747	4,447			4,747	4,447			4,747	4,447		
Restraint Involving Adults	25	21			17	13			4.5	1.9		
Seclusion Involving Adults	4	4			3	3			8.6	3.0		
Rusk State Hospital												
Bed Days in Quarter	25,295	24,955			25,295	24,955			25,295	24,955		
Restraint Involving Adults	197	193			101	76			117.7	183.0		
Seclusion Involving Adults	121	167			61	67			361.0	404.5		
San Antonio State Hospital												
Child/Adolescent Bed Days in Quarter	3,011	2,818			3,011	2,818			3,011	2,818		
Bed Days in Quarter-All Other Units	24,053	22,509			24,053	22,509			24,053	22,509		
Restraint Involving Adolescents	67	80			21	18			42.1	52.0		
Restraint Involving Adults	113	130			47	47			119.8	95.9		
Seclusion Involving Adolescents	7	16			5	8			6.5	15.9		
Seclusion Involving Adults	4	0			4	0			8.0	0.0		

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

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities - FY05

	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	2,863	2,467			2,863	2,467			2,863	2,467		
Bed Days in Quarter-All Other Units	24,422	23,224			24,422	23,224			24,422	23,224		
Restraint Involving Children	0	0			0	0			0.0	0.0		
Restraint Involving Adolescents	54	30			15	12			7.5	4.6		
Restraint Involving Adults	103	67			56	49			24.6	29.9		
Seclusion Involving Children	3	0			1	0			1.6	0.0		
Seclusion Involving Adolescents	19	11			8	5			14.2	8.2		
Seclusion Involving Adults	23	13			14	9			27.2	14.4		
Waco Center For Youth												
Child/Adolescent Bed Days in Quarter	6,914	6,893			6,914	6,893			6,914	6,893		
Restraint Involving Adolescents	68	78			28	26			13.8	18.0		
Seclusion Involving Adolescents	14	8			9	5			13.0	5.2		
All MH Facilities												
Child/Adolescent Bed Days	26,410	23,827			26,410	23,827			26,410	23,827		
Bed Days in Quarter-All Other Units	184,531	177,905			184,531	177,905			184,531	177,905		
Restraint Involving Children	3	3			3	2			0.2	1.0		
Restraint Involving Adolescents	576	434			152	131			341.5	219.8		
Restraint Involving Adults	1,396	1,313			526	512			1,074.1	1,082.6		
Seclusion Involving Children	8	3			4	2			4.2	2.0		
Seclusion Involving Adolescents	113	70			49	39			105.3	58.7		
Seclusion Involving Adults	273	292			140	129			660.5	648.9		

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities - FY05

Fiscal Year 2005

	Number of Incidents				Number of Persons			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Austin State Hospital								
< 5 Restraint Involving Children	1	0			1	0		
< 5 Restraint Involving Adolescents	10	14			8	12		
< 5 Restraint Involving Adults	23	31			18	24		
Big Spring State Hospital								
< 5 Restraint Involving Adults	22	20			15	15		
El Paso Psychiatric Center								
< 5 Restraint Involving Children	0	0			0	0		
< 5 Restraint Involving Adolescents	1	0			1	0		
< 5 Restraint Involving Adults	5	2			4	2		
Kerrville State Hospital								
< 5 Restraint Involving Adults	8	16			5	14		
North Texas State Hospital								
< 5 Restraint Involving Children	1	0			1	0		
< 5 Restraint Involving Adolescents	25	18			13	12		
< 5 Restraint Involving Adults	305	211			121	98		
Rio Grande State Center								
< 5 Restraint Involving Adults	7	11			5	9		
Rusk State Hospital								
< 5 Restraint Involving Adults	115	72			74	41		
San Antonio State Hospital								
< 5 Restraint Involving Adolescents	4	4			4	4		
< 5 Restraint Involving Adults	7	19			7	10		
Terrell State Hospital								
< 5 Restraint Involving Children	0	0			0	0		
< 5 Restraint Involving Adolescents	13	10			7	4		
< 5 Restraint Involving Adults	67	52			43	41		
Waco Center For Youth								
< 5 Restraint Involving Adolescents	22	15			15	12		
All MH Facilities								
< 5 Restraint Involving Children	2	0			2	0		
< 5 Restraint Involving Adolescents	75	61			48	44		
< 5 Restraint Involving Adults	559	434			292	254		

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

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities - FY05

Fiscal Year 2005

	Number of Incidents			
	Q1	Q2	Q3	Q4
Austin State Hospital				
Personal Restraint	167	85		
Mechanical Restraint	446	209		
Seclusion	24	8		
Big Spring State Hospital				
Personal Restraint	179	85		
Mechanical Restraint	119	46		
Seclusion	0	0		
El Paso Psychiatric Center				
Personal Restraint	0	0		
Mechanical Restraint	194	105		
Seclusion	37	13		
Kerrville State Hospital				
Personal Restraint	40	25		
Mechanical Restraint	4	2		
Seclusion	7	4		
North Texas State Hospital				
Personal Restraint	951	415		
Mechanical Restraint	399	179		
Seclusion	277	121		
Rio Grande State Center				
Personal Restraint	45	21		
Mechanical Restraint	1	0		
Seclusion	8	4		
Rusk State Hospital				
Personal Restraint	281	126		
Mechanical Restraint	109	67		
Seclusion	289	167		
San Antonio State Hospital				
Personal Restraint	187	101		
Mechanical Restraint	203	109		
Seclusion	27	16		

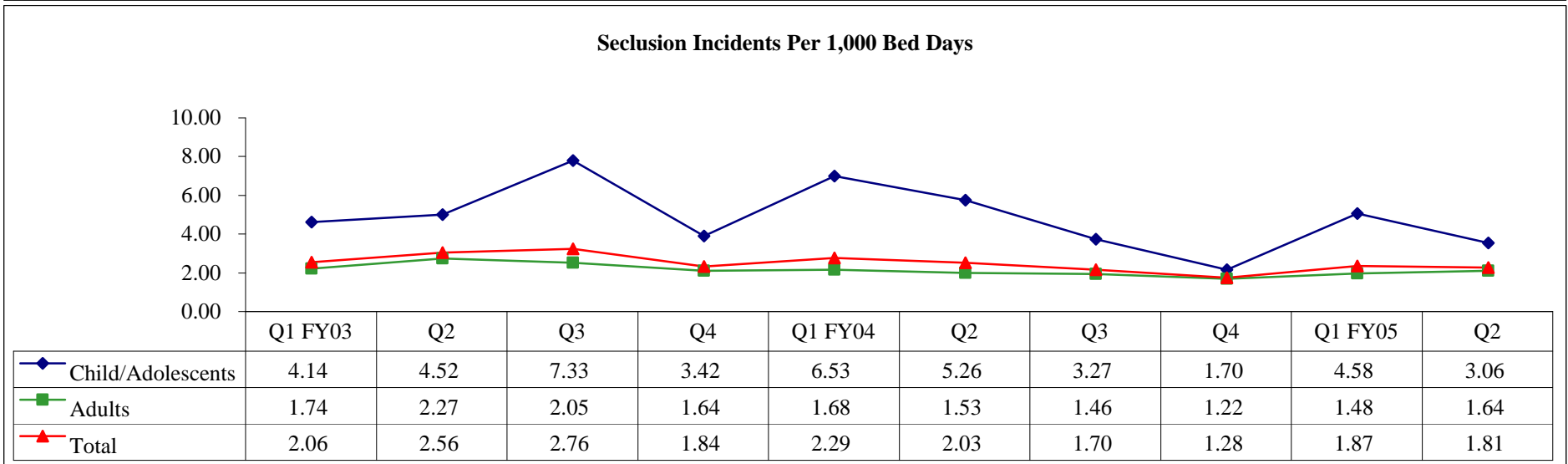
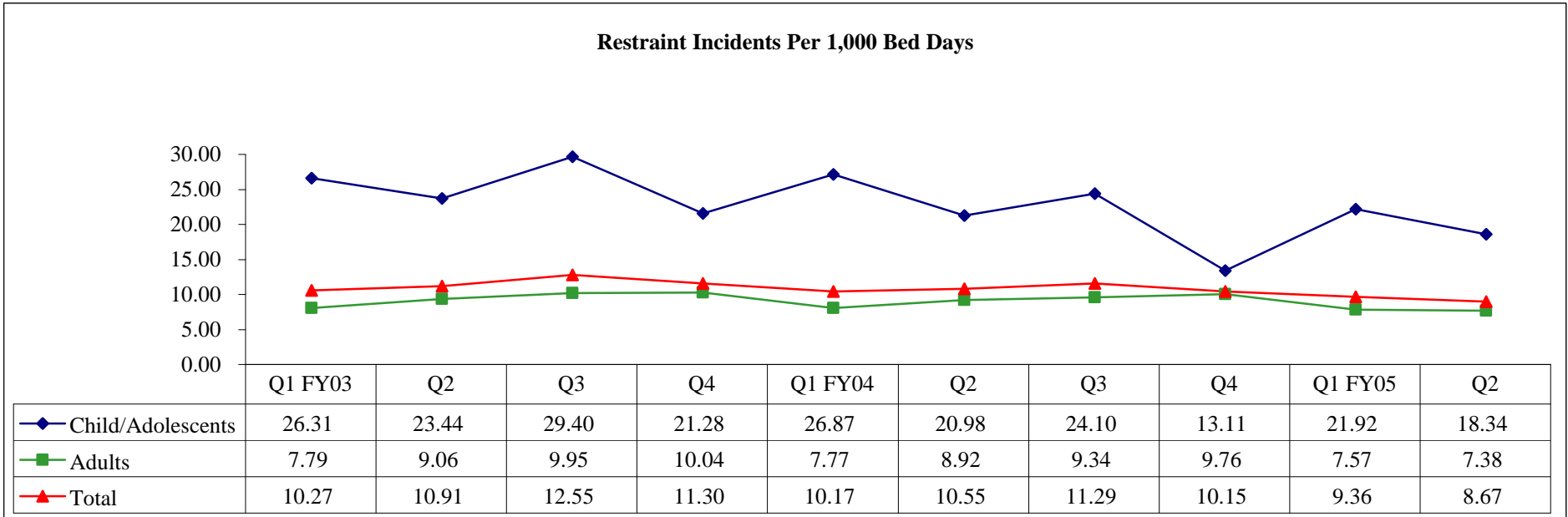
Source: Unduplicated Client Days by Unit-Hospital/Center (HC022175/85);
 Access Database

Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities - FY05

Fiscal Year 2005

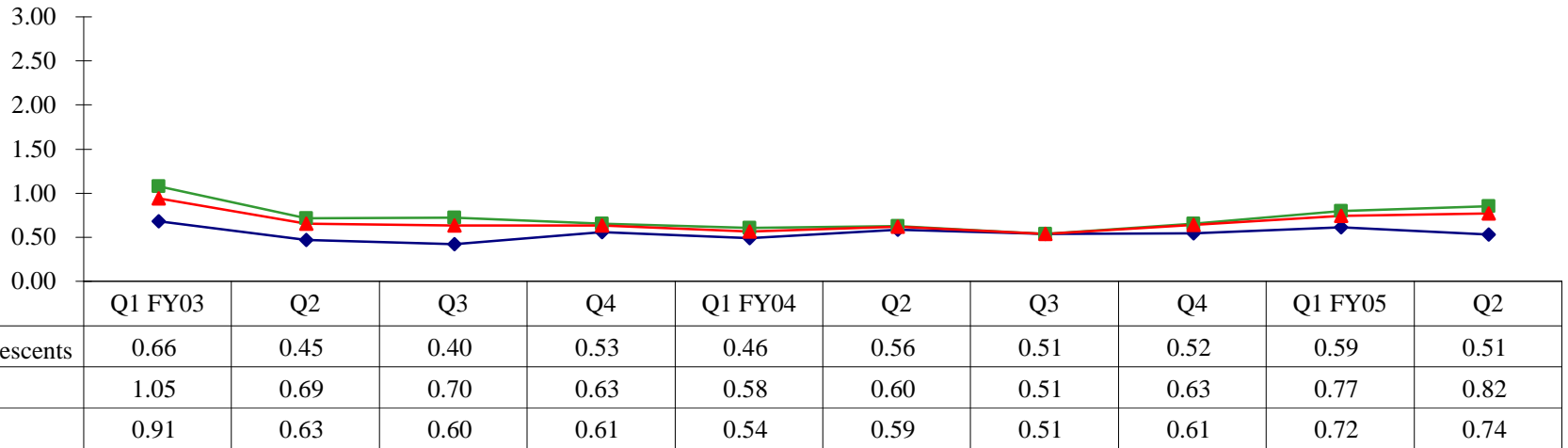
	Number of Incidents			
	Q1	Q2	Q3	Q4
Terrell State Hospital				
Personal Restraint	246	94		
Mechanical Restraint	8	3		
Seclusion	69	24		
Waco Center For Youth				
Personal Restraint	128	68		
Mechanical Restraint	18	10		
Seclusion	23	8		
All MH Facilities				
Personal Restraint	2,224	1,020		
Mechanical Restraint	1,501	730		
Seclusion	761	365		

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

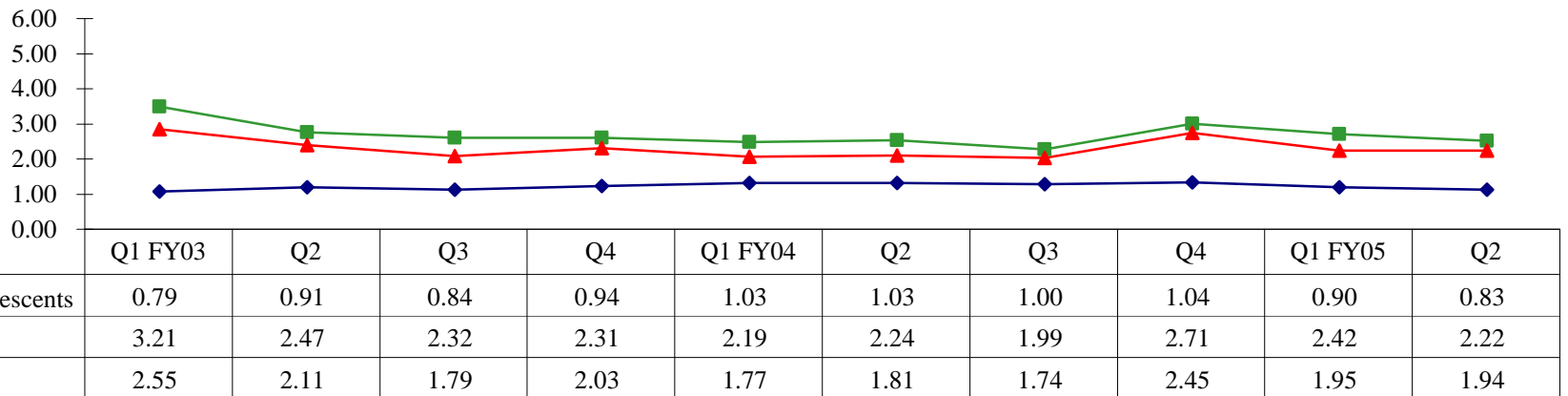


Objective 3B - Maintain Restraint and Seclusion Data
All MH Facilities

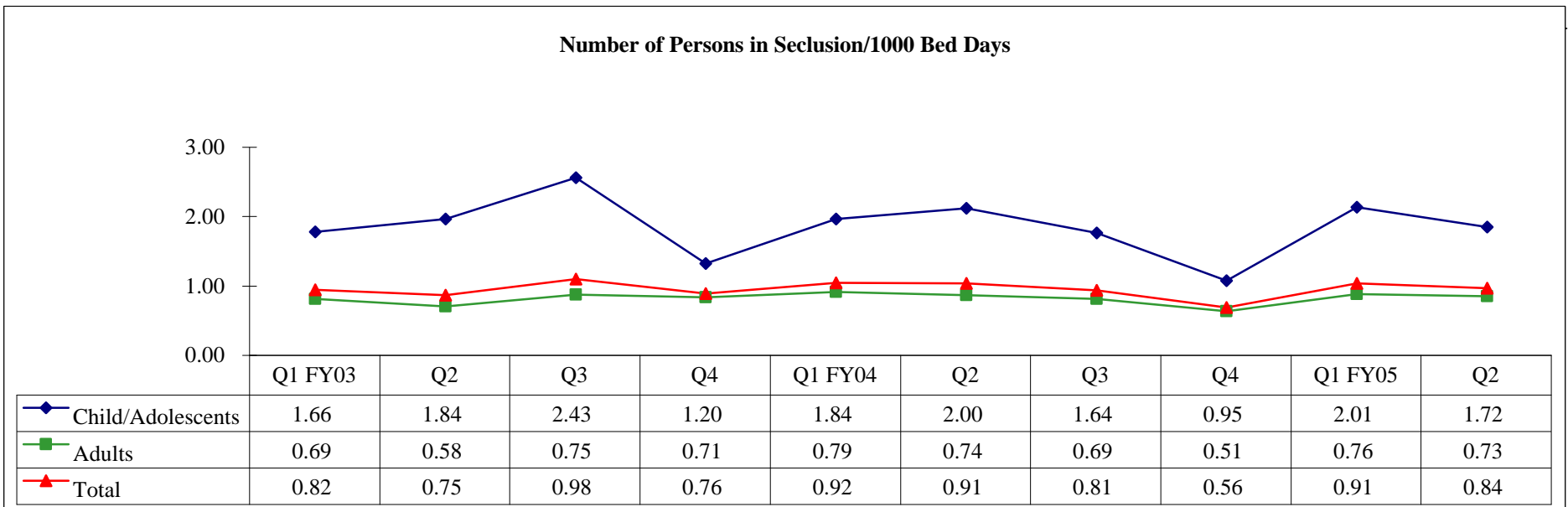
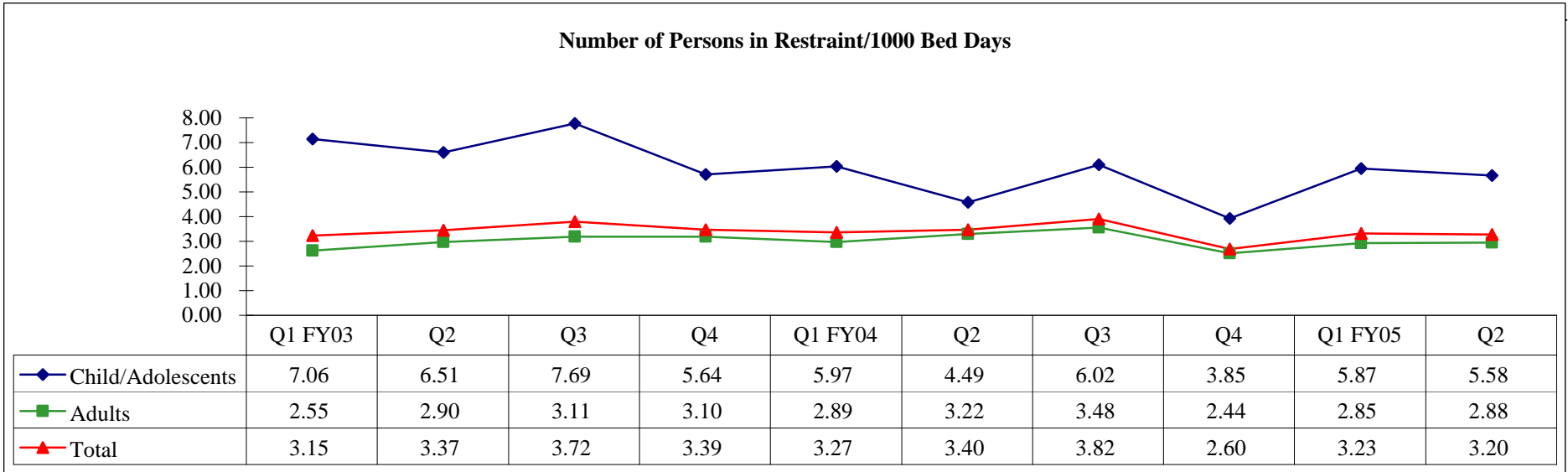
Average Number of Hours Per Incident in Restraints



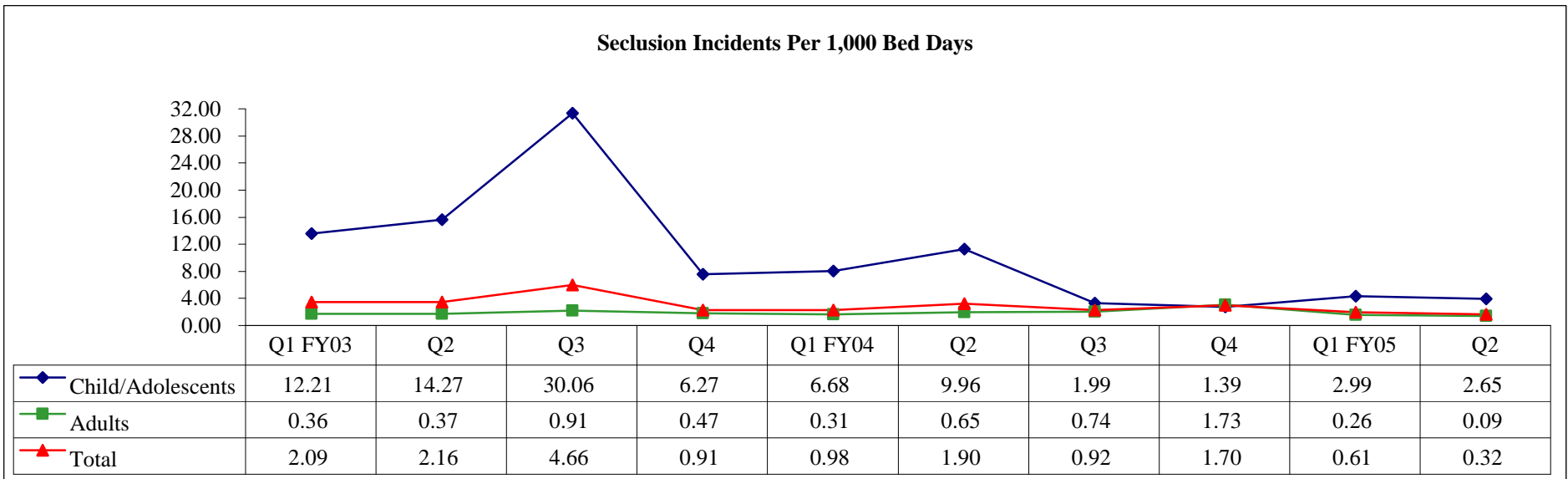
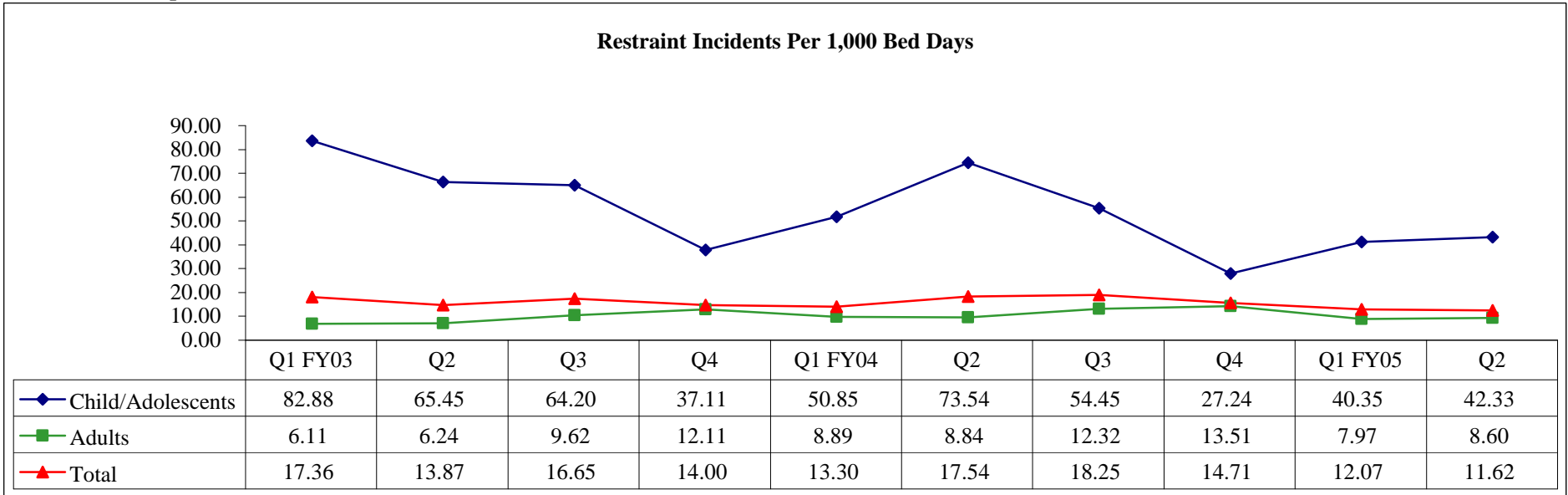
Average Number of Hours Per Incident in Seclusion



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

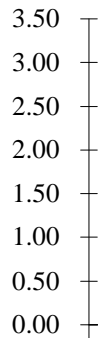


Objective 3B - Maintain Restraint and Seclusion Data
Austin State Hospital



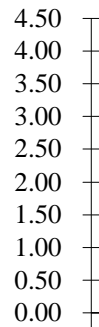
Objective 3B - Maintain Restraint and Seclusion Data
Austin State Hospital

Average Number of Hours Per Incident in Restraints



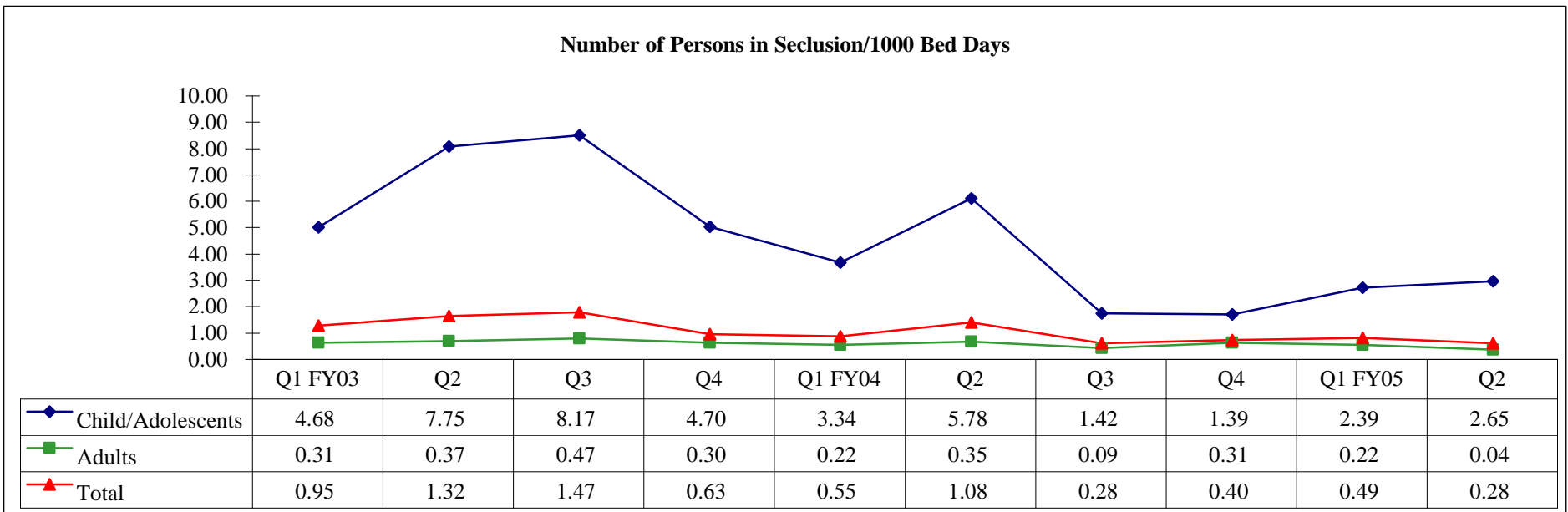
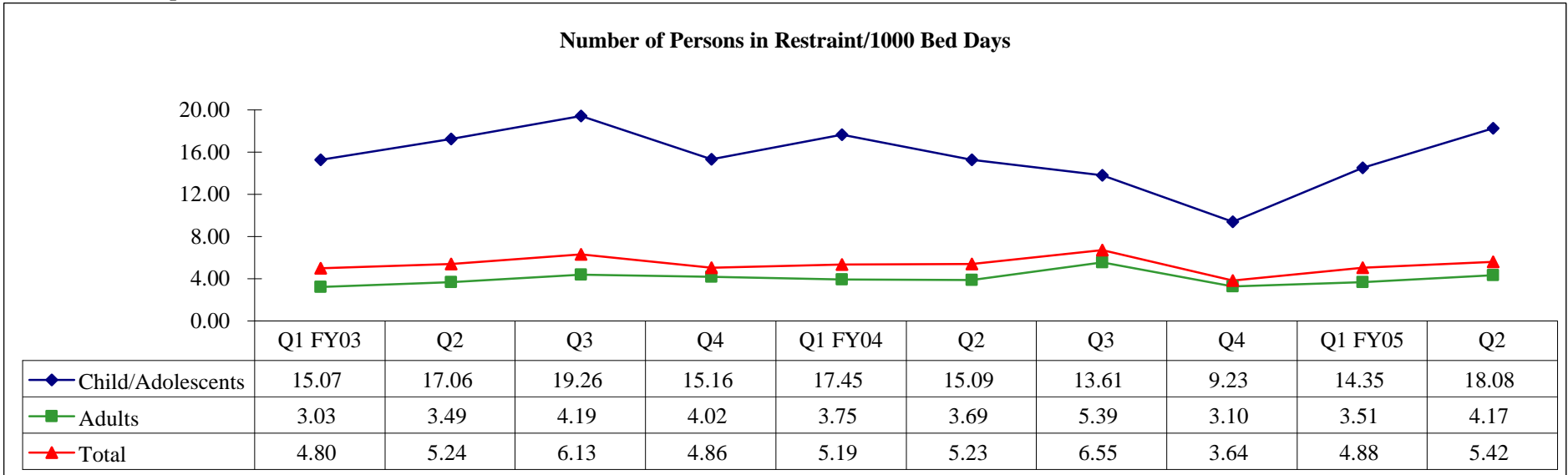
	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
◆ Child/Adolescents	0.61	0.50	0.50	0.60	0.48	0.74	0.60	0.85	0.58	0.56
■ Adults	1.00	0.84	0.79	0.66	0.59	0.79	0.72	0.96	0.97	0.82
▲ Total	0.73	0.63	0.64	0.65	0.55	0.76	0.67	0.94	0.81	0.74

Average Number of Hours Per Incident in Seclusion



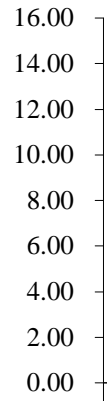
	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
◆ Child/Adolescents	0.55	0.70	0.68	0.54	0.72	0.54	1.06	0.73	0.51	0.54
■ Adults	1.04	1.10	1.15	0.89	0.49	1.08	1.29	1.78	1.02	1.08
▲ Total	0.62	0.76	0.76	0.71	0.66	0.70	1.22	1.70	0.70	1.28

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



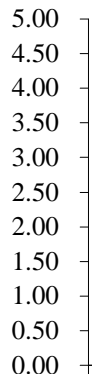
Objective 3B - Maintain Restraint and Seclusion Data
Big Spring State Hospital

Restraint Incidents Per 1,000 Bed Days



	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
■ Adults	8.59	6.63	11.51	9.22	7.18	9.10	10.87	13.85	11.71	9.43

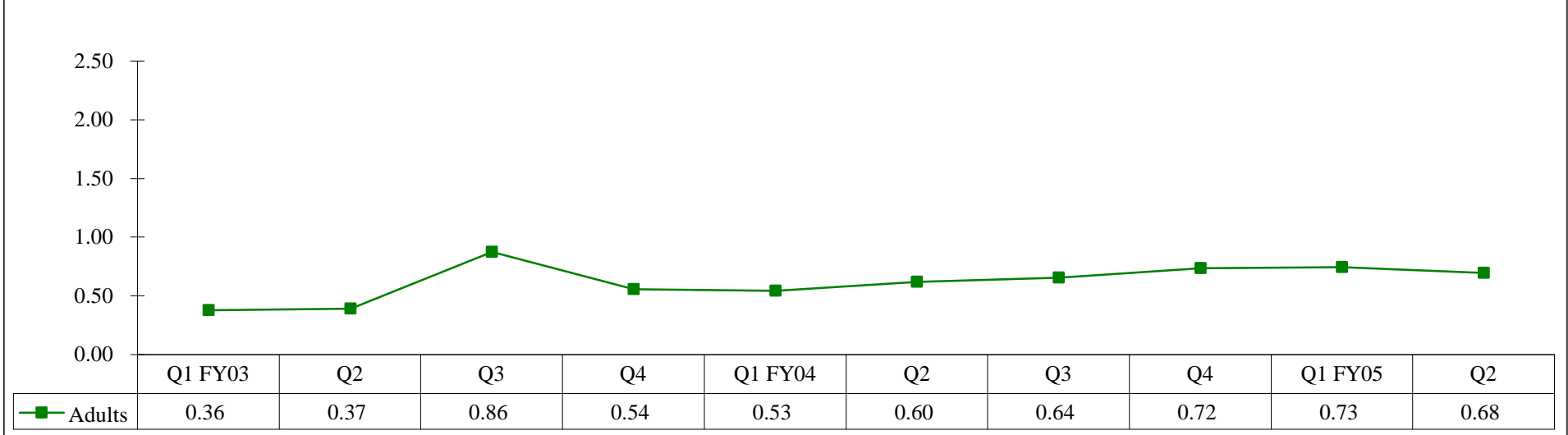
Seclusion Incidents Per 1,000 Bed Days



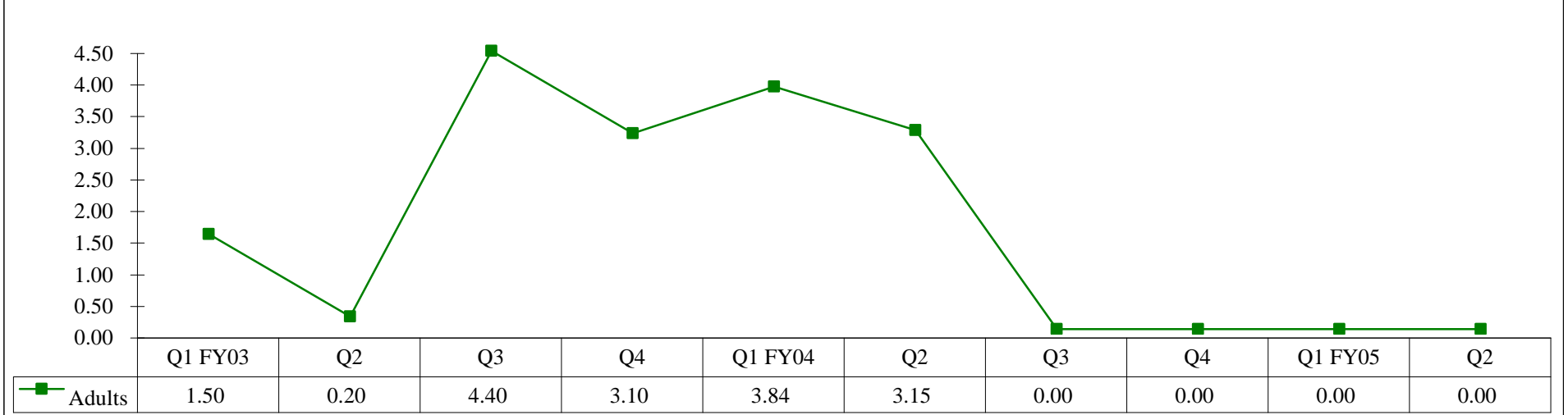
	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
■ Adults	0.14	0.07	0.14	0.14	1.93	0.15	0.00	0.00	0.00	0.00

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

Average Number of Hours Per Incident in Restraints

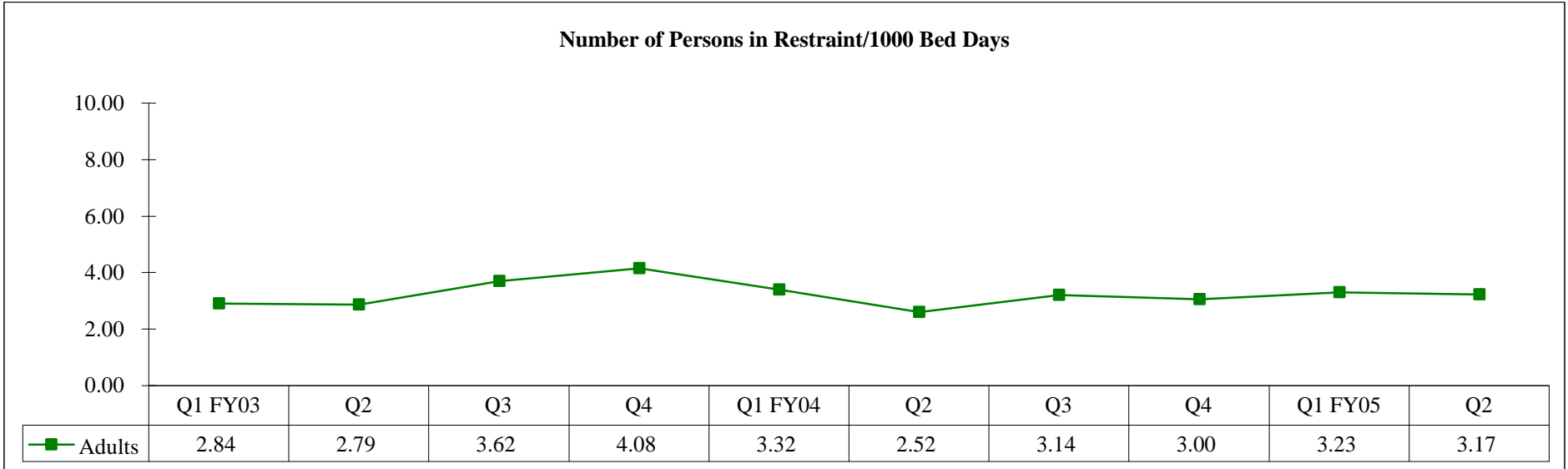


Average Number of Hours Per Incident in Seclusion

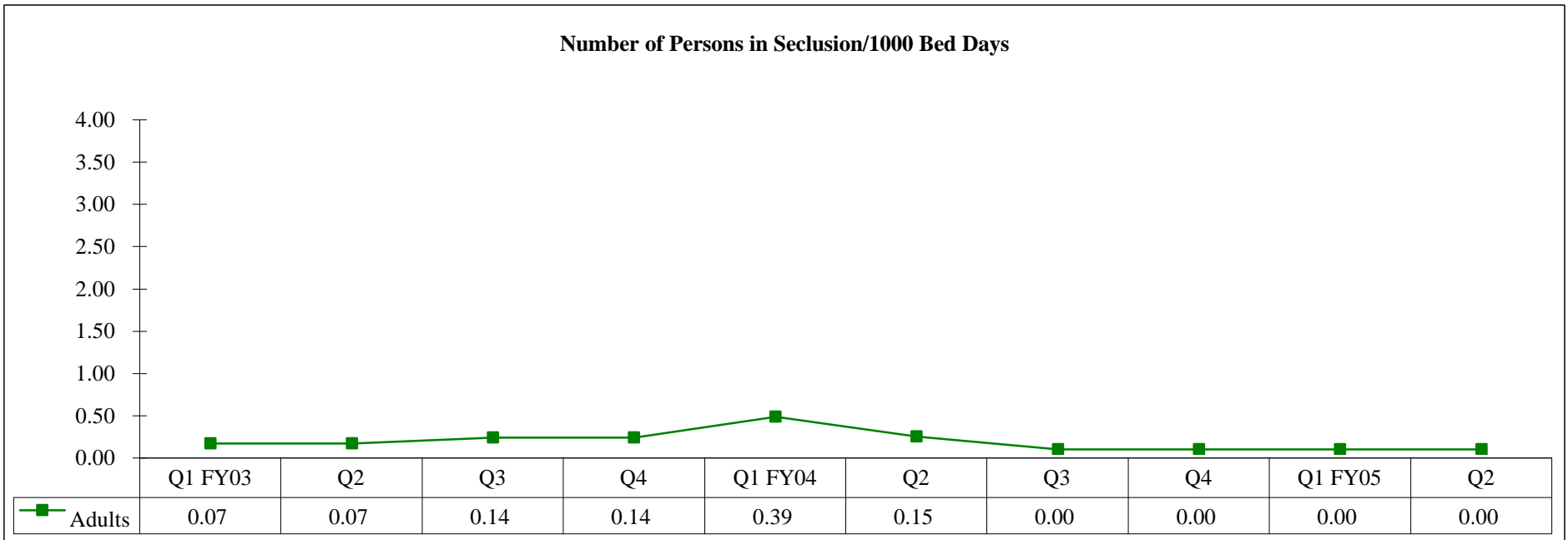


**Objective 3B - Maintain Restraint and Seclusion Data
Big Spring State Hospital**

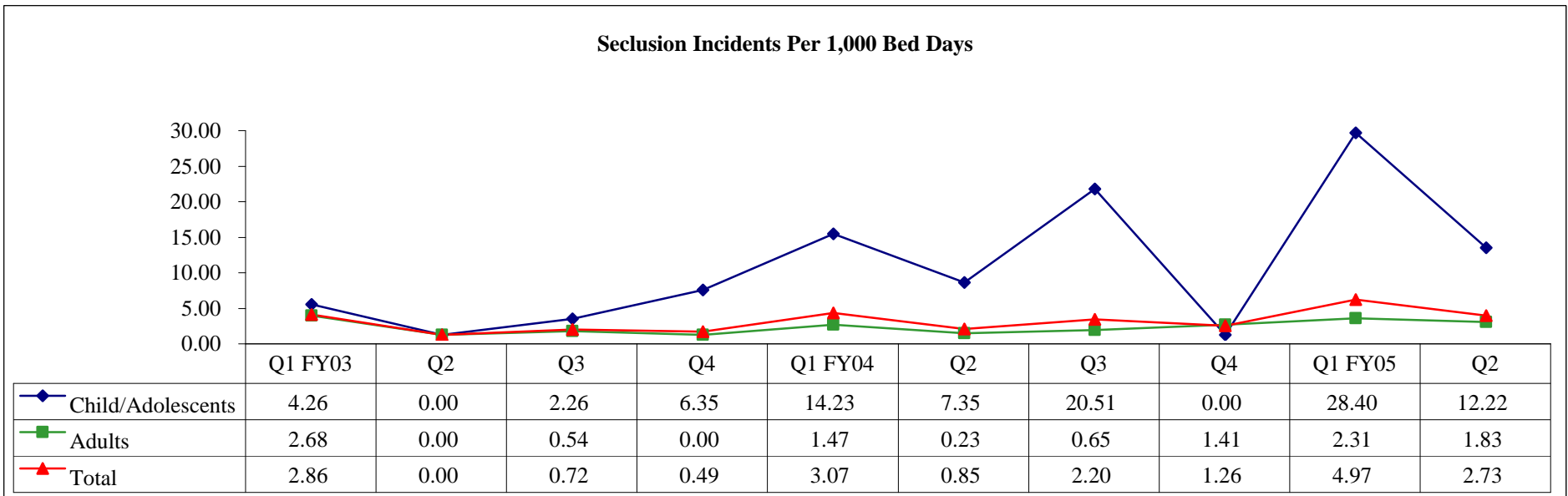
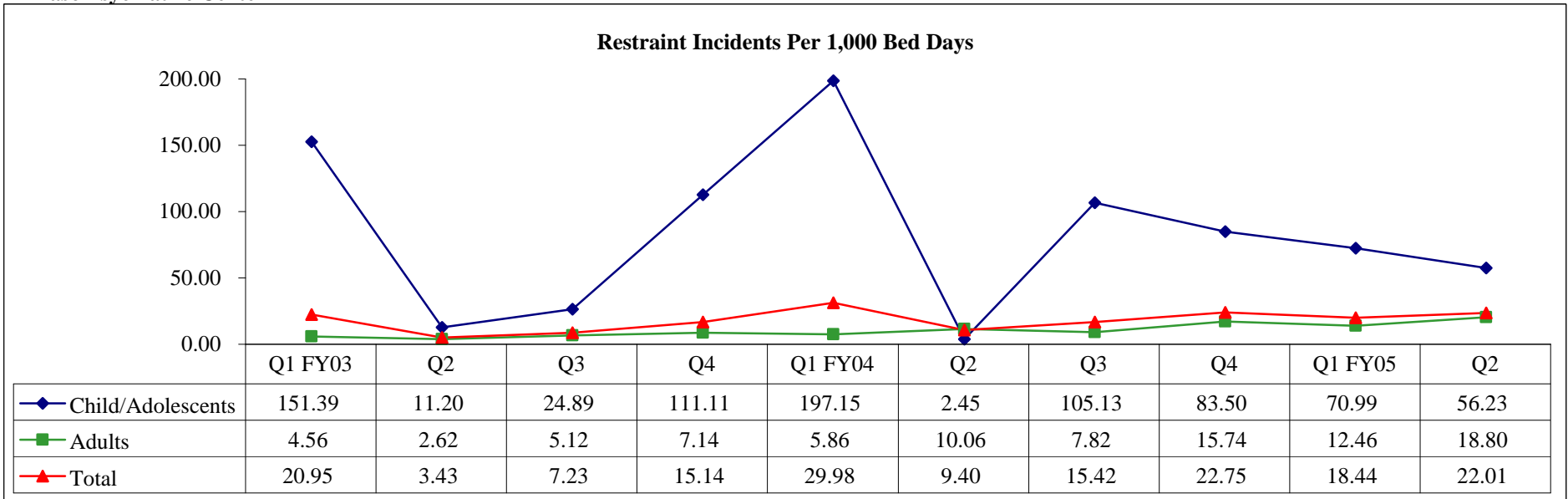
Number of Persons in Restraint/1000 Bed Days



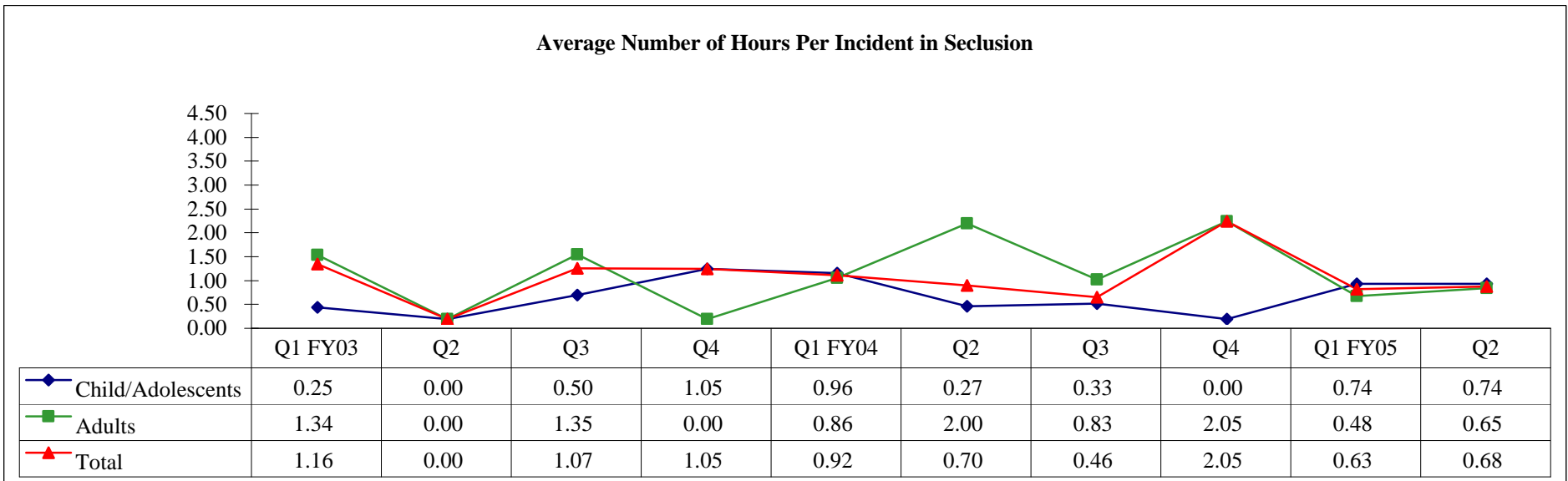
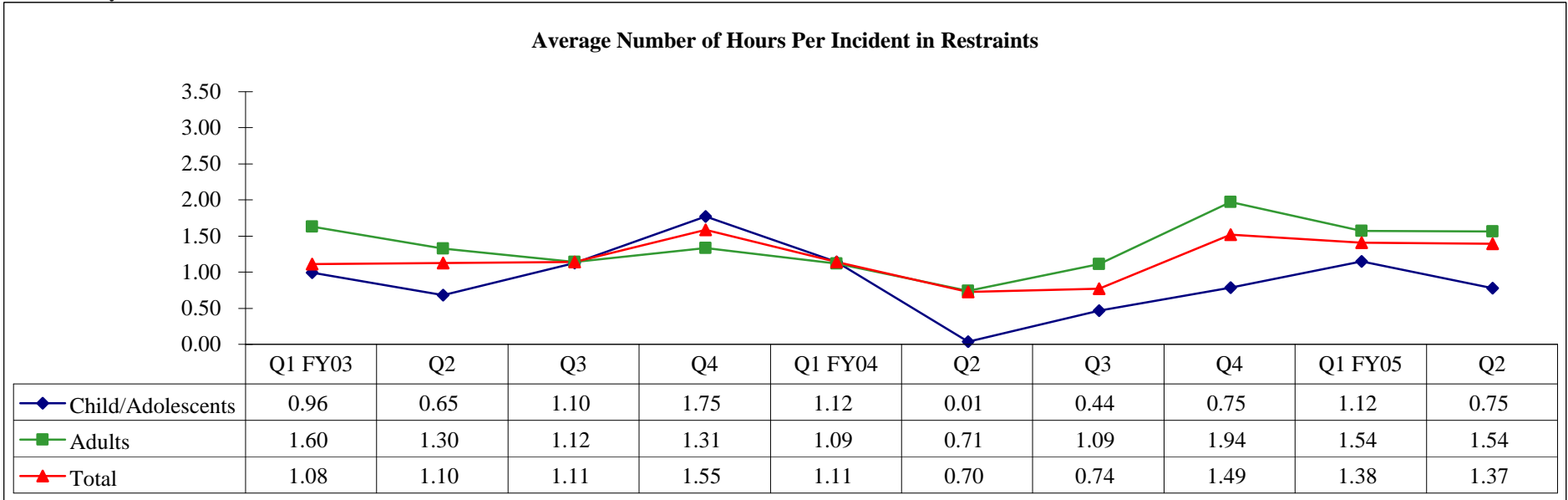
Number of Persons in Seclusion/1000 Bed Days



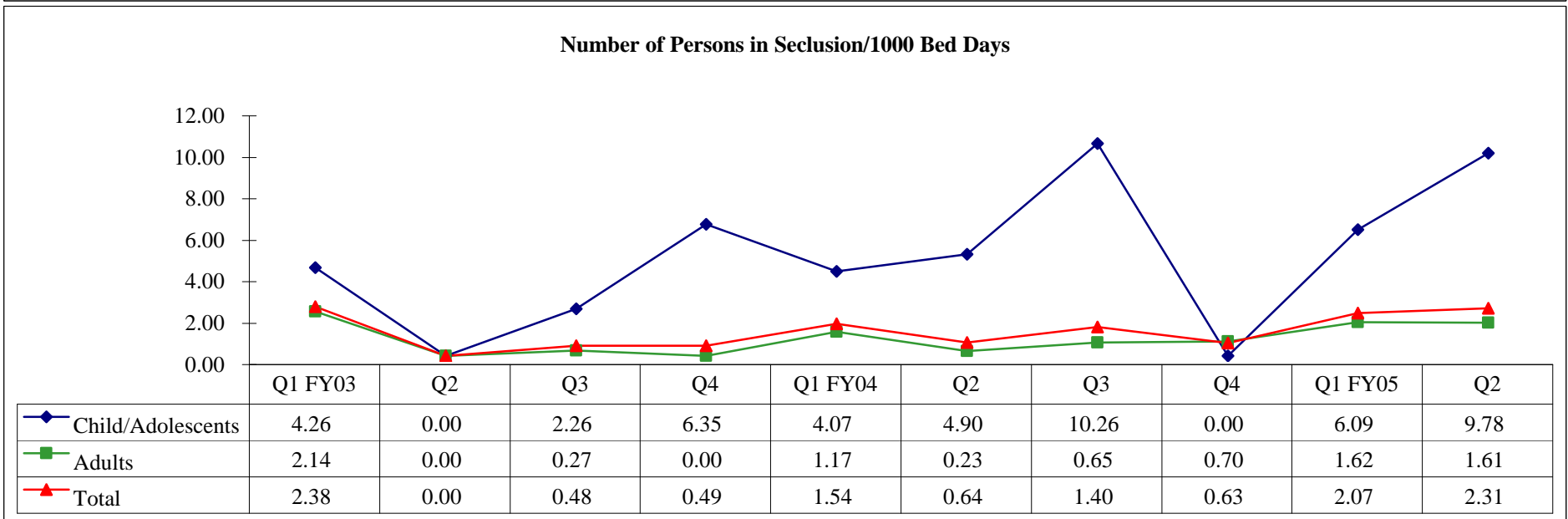
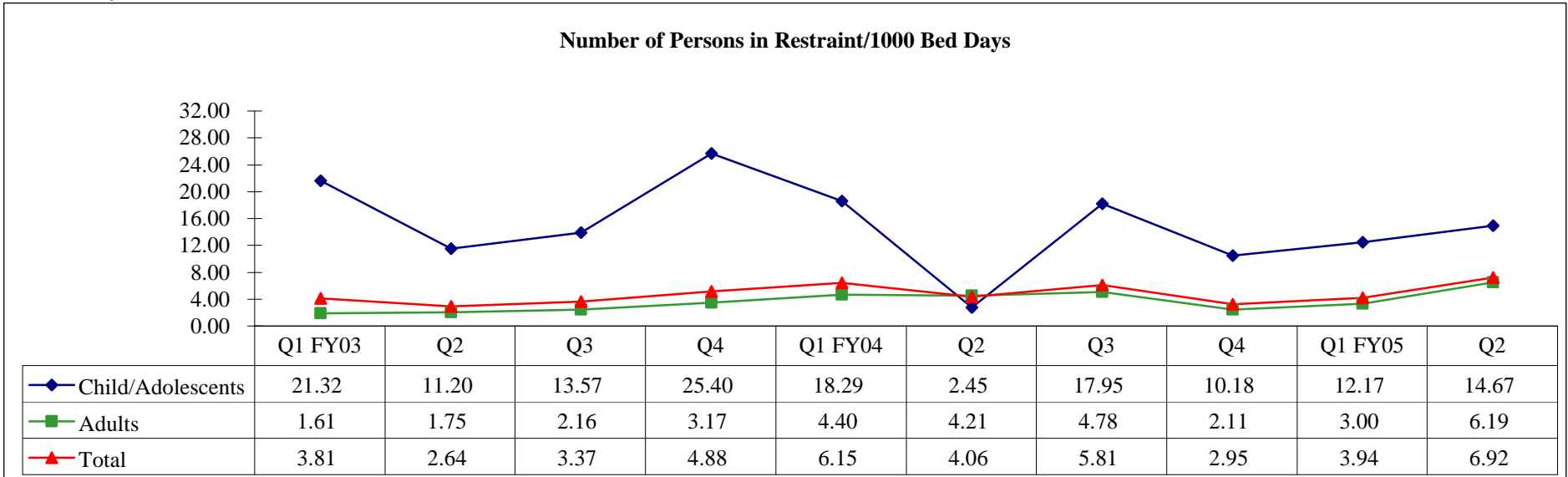
Objective 3B - Maintain Restraint and Seclusion Data
El Paso Psychiatric Center



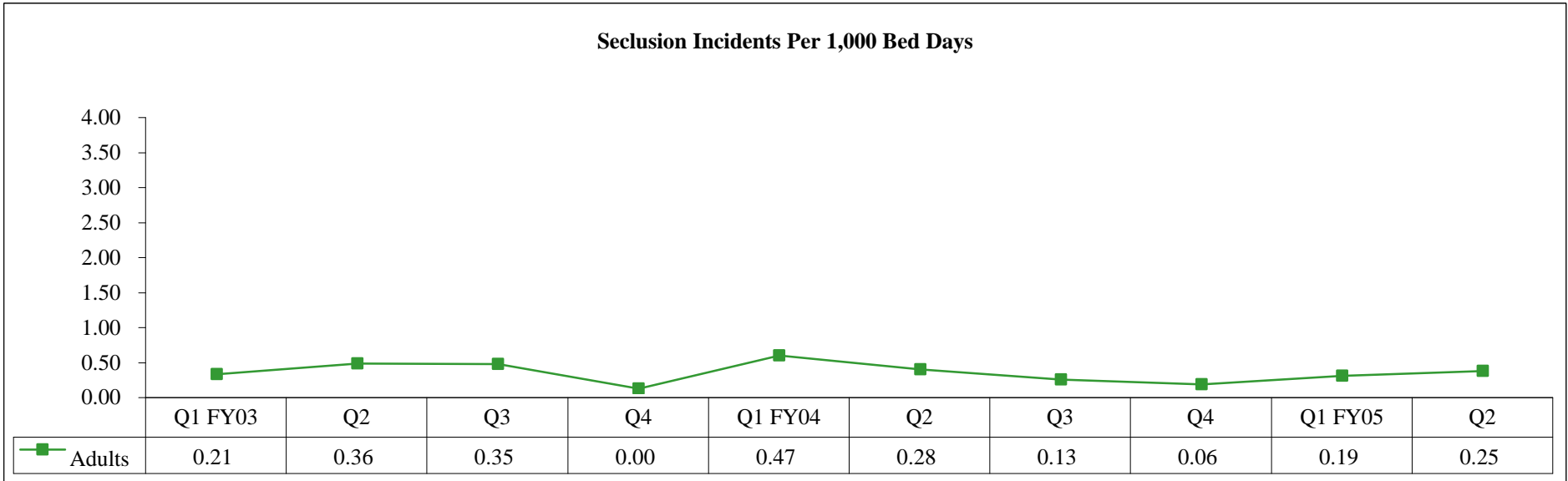
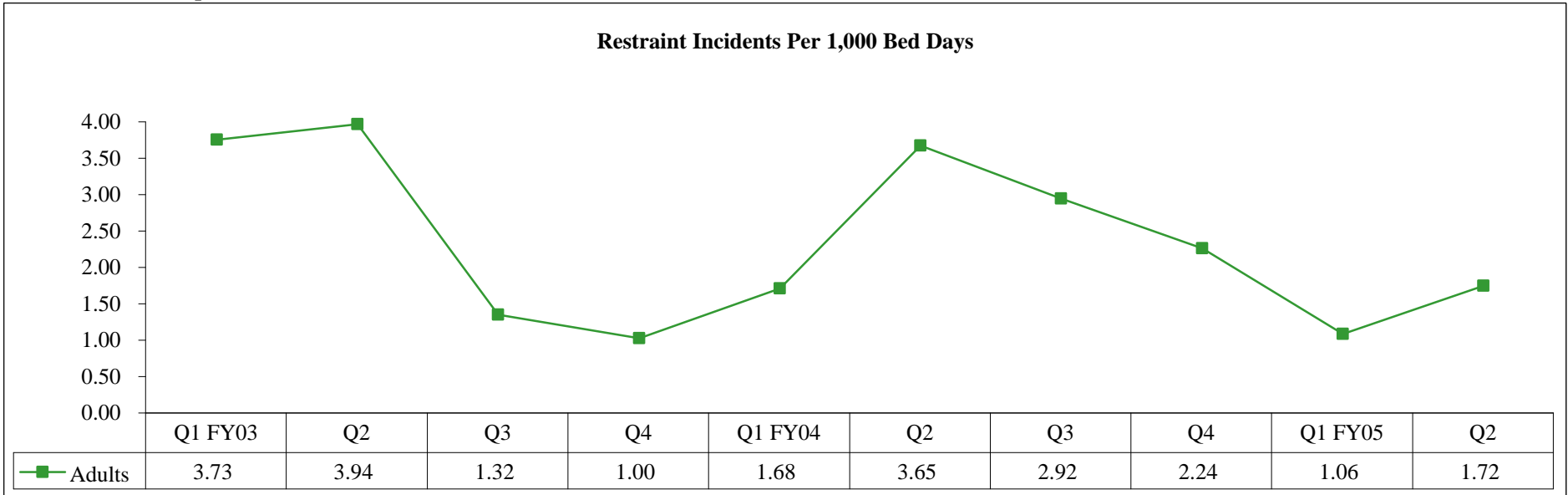
Objective 3B - Maintain Restraint and Seclusion Data
El Paso Psychiatric Center



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

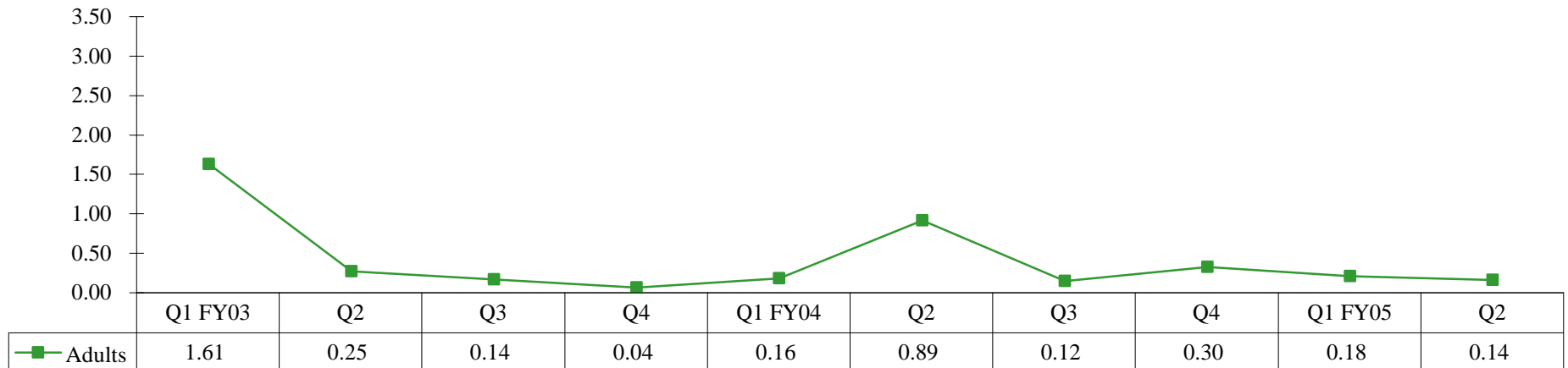


Objective 3B - Maintain Restraint and Seclusion Data
Kerrville State Hospital

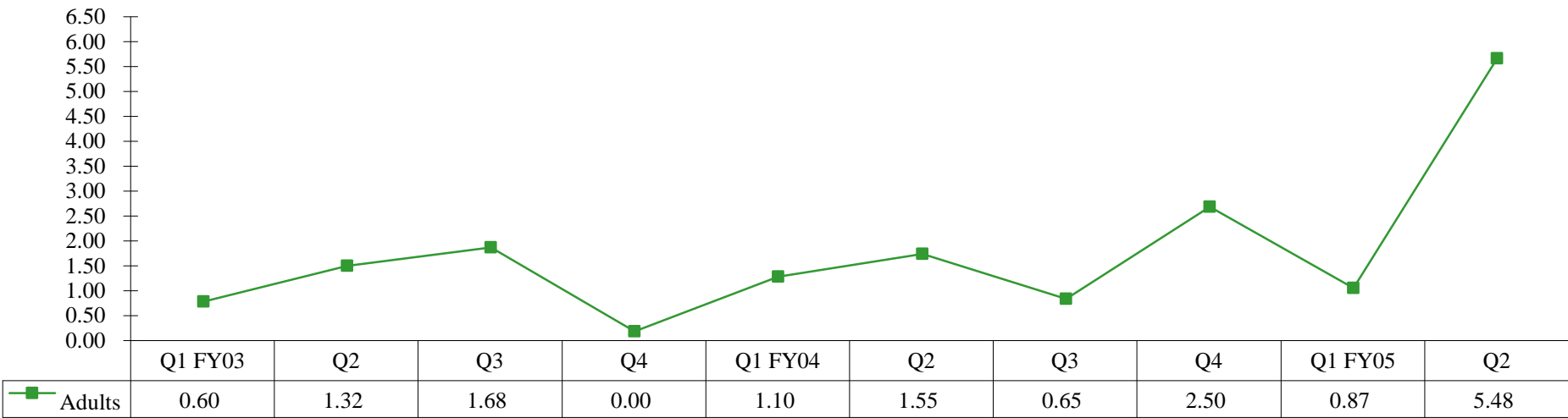


**Objective 3B - Maintain Restraint and Seclusion Data
Kerrville State Hospital**

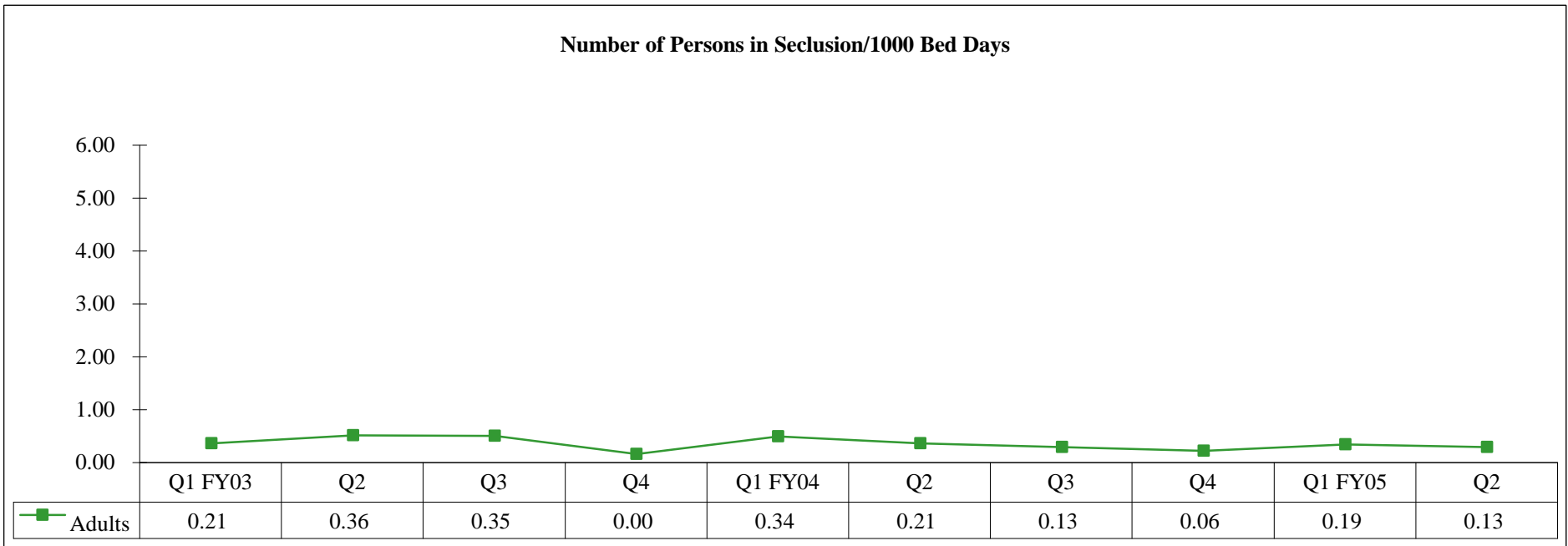
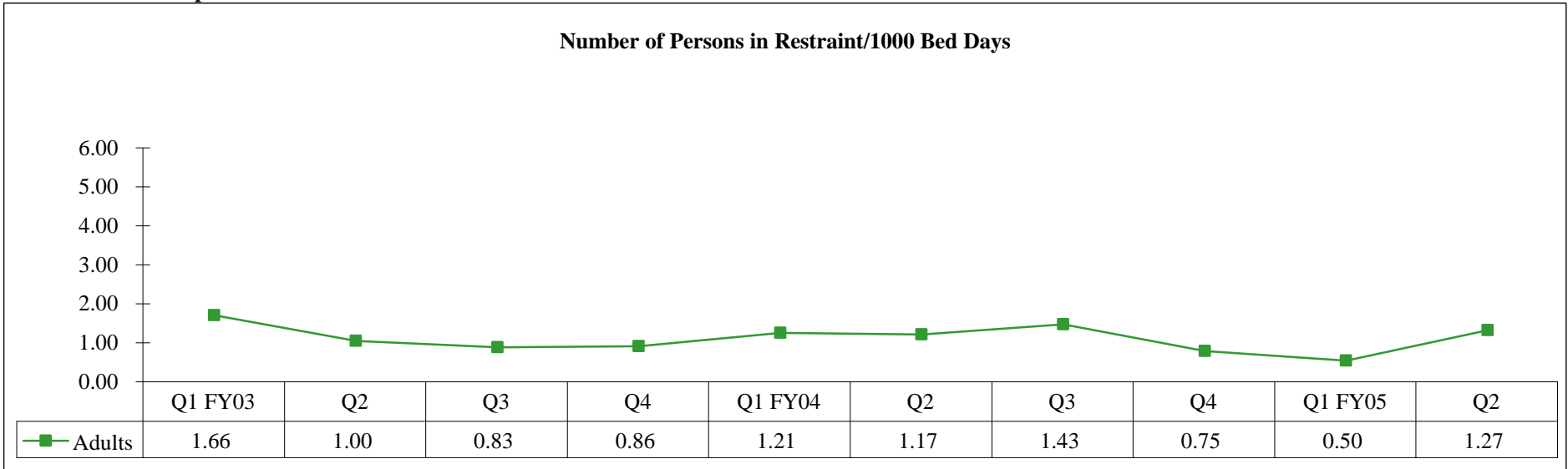
Average Number of Hours Per Incident in Restraints



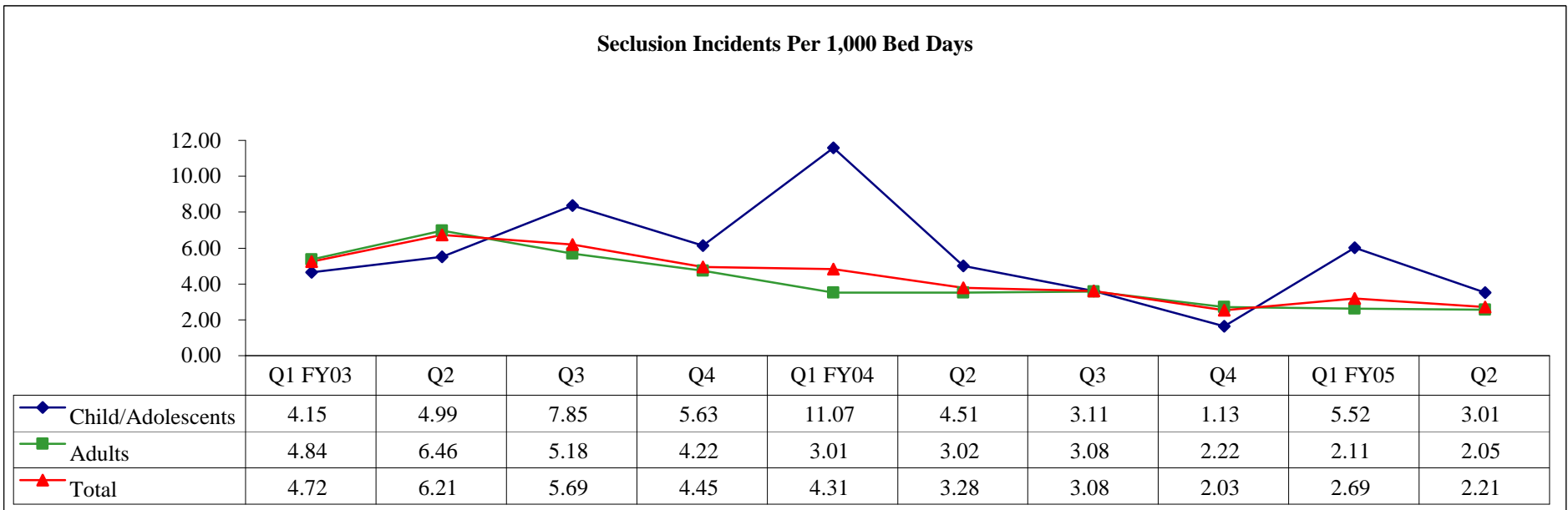
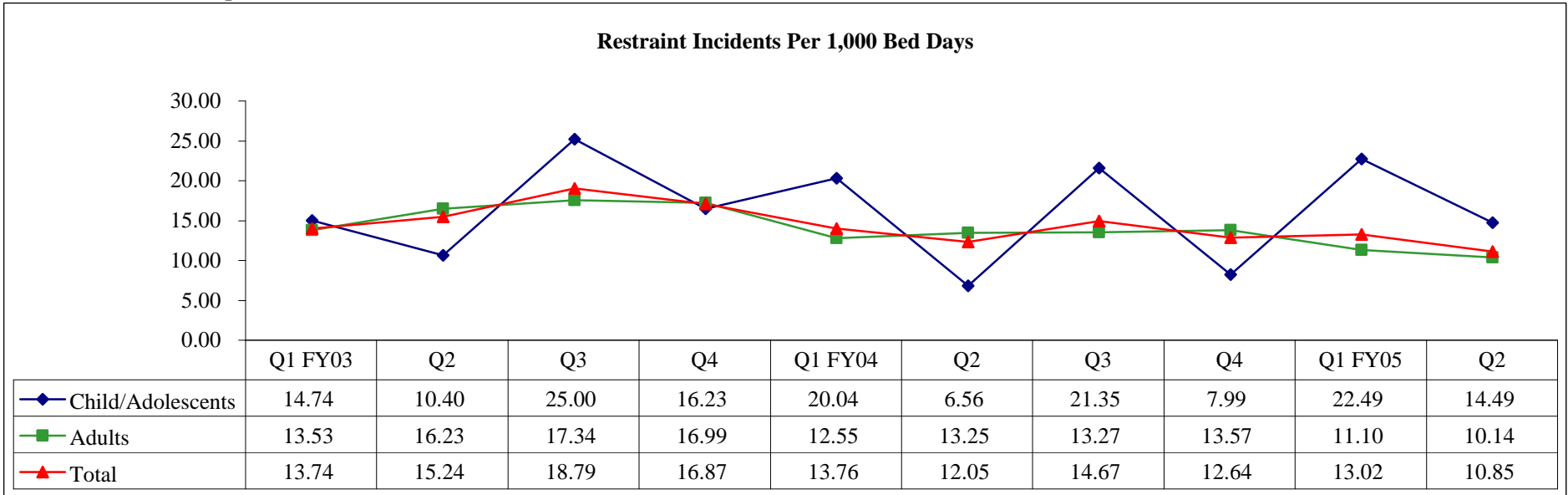
Average Number of Hours Per Incident in Seclusion



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

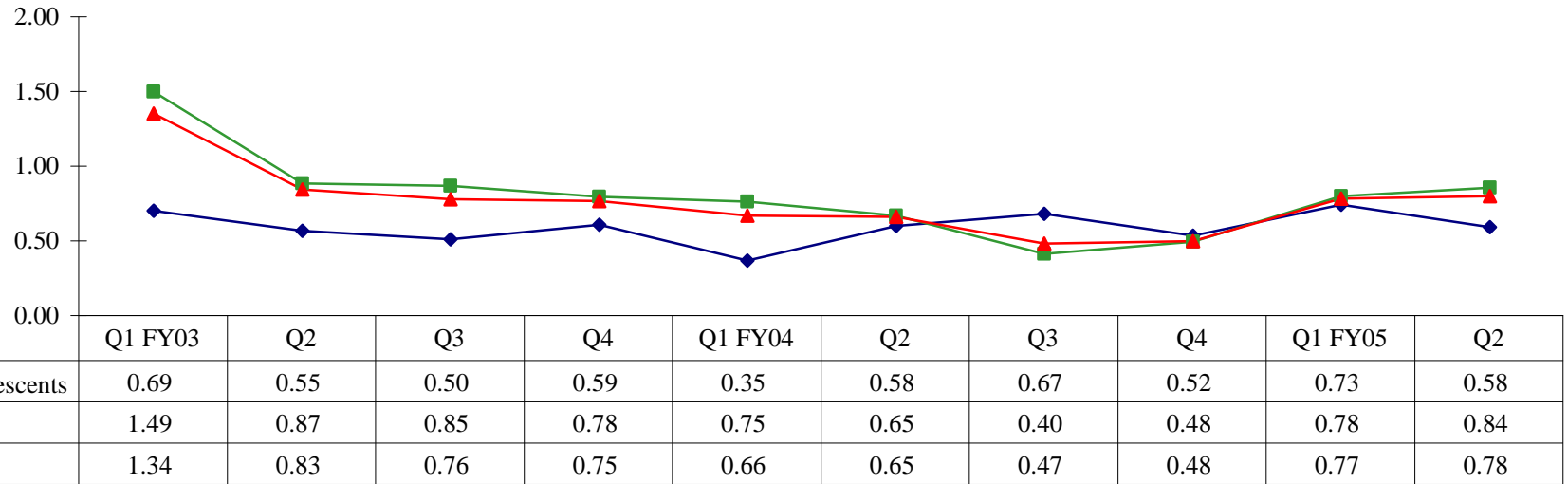


Objective 3B - Maintain Restraint and Seclusion Data
North Texas State Hospital

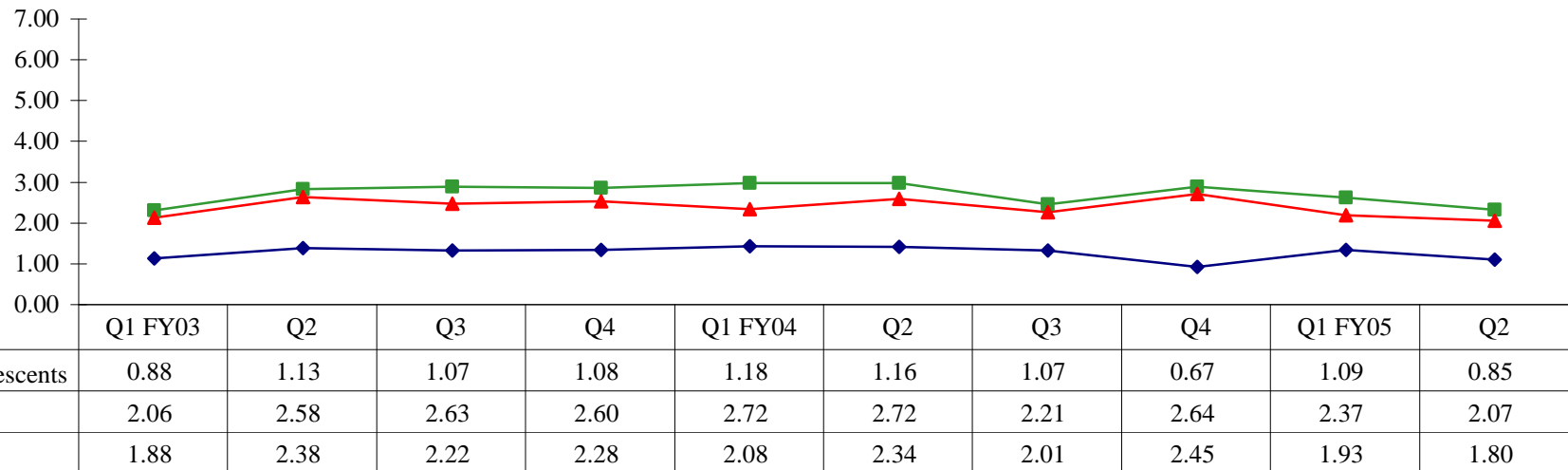


Objective 3B - Maintain Restraint and Seclusion Data
North Texas State Hospital

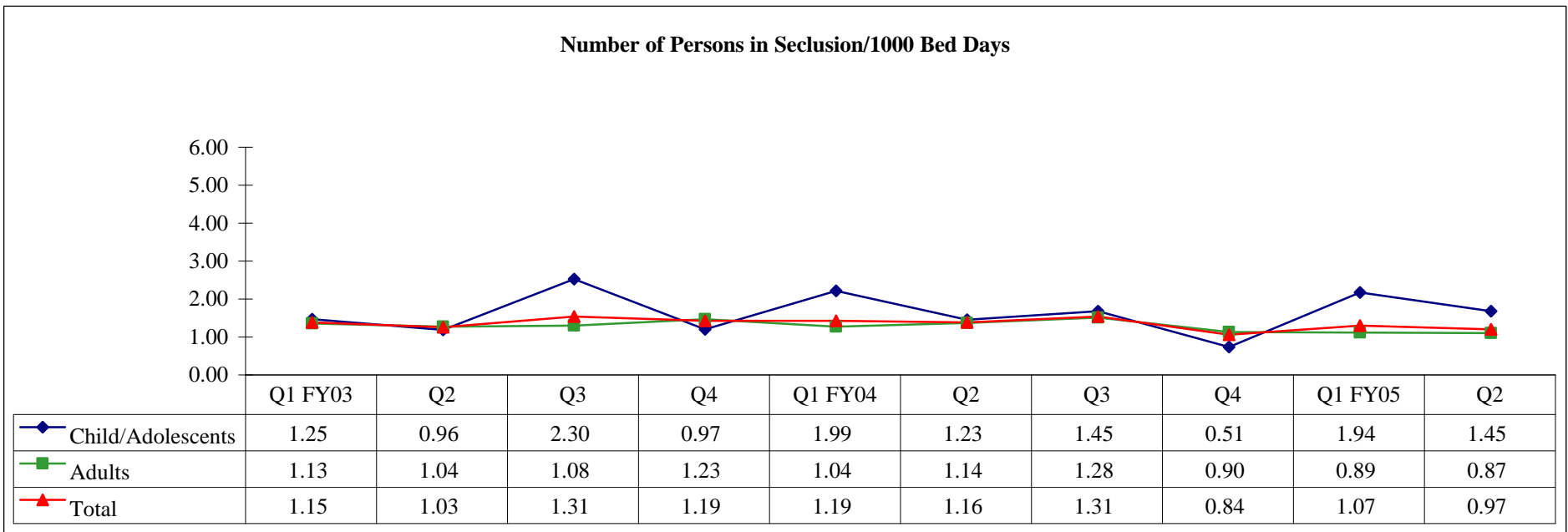
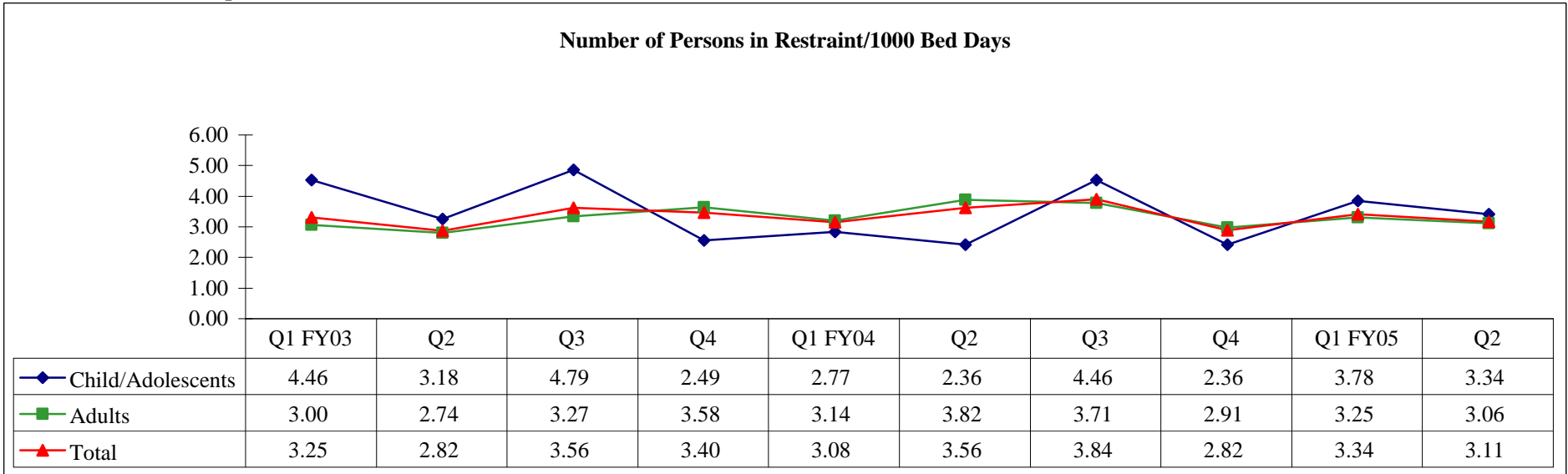
Average Number of Hours Per Incident in Restraints



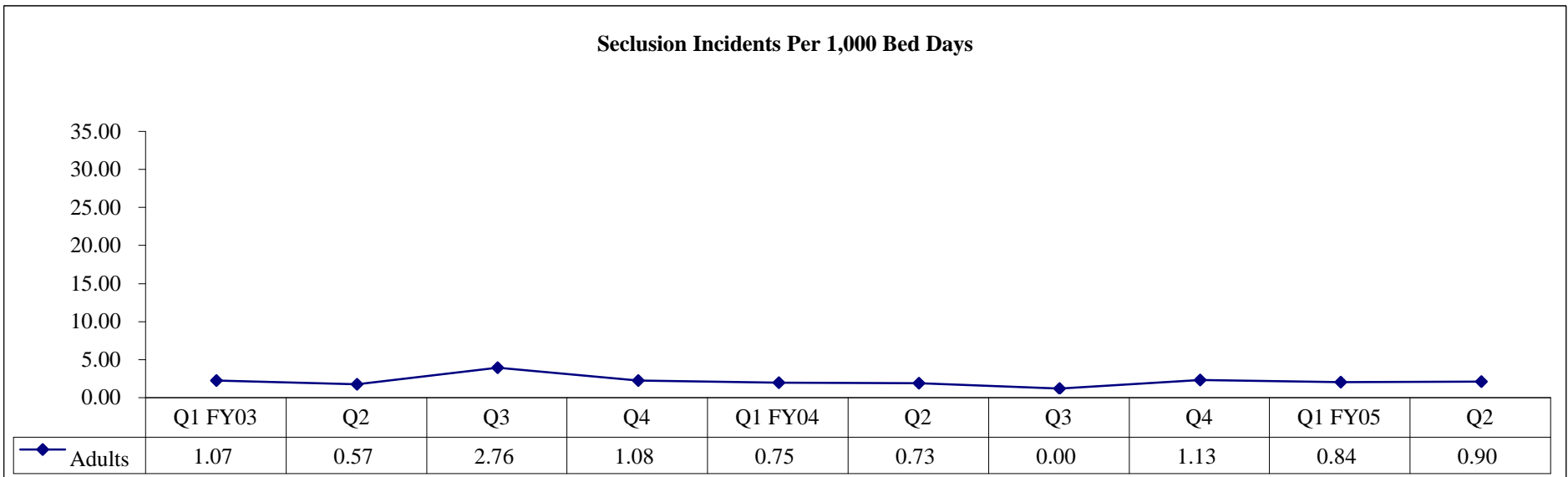
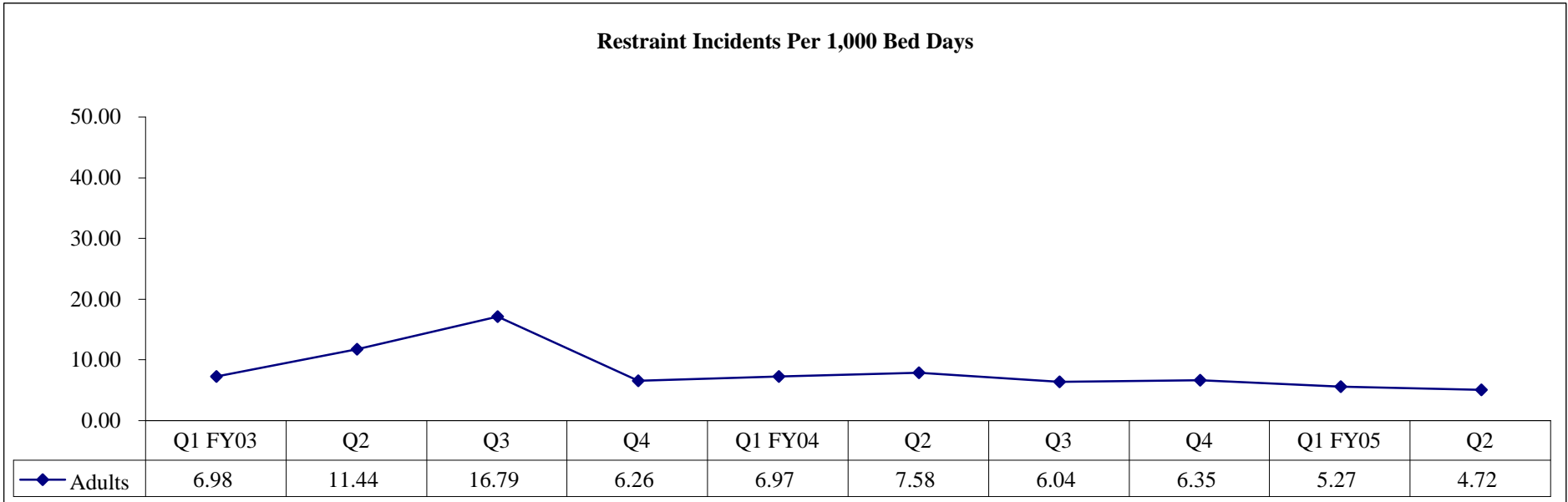
Average Number of Hours Per Incident in Seclusion



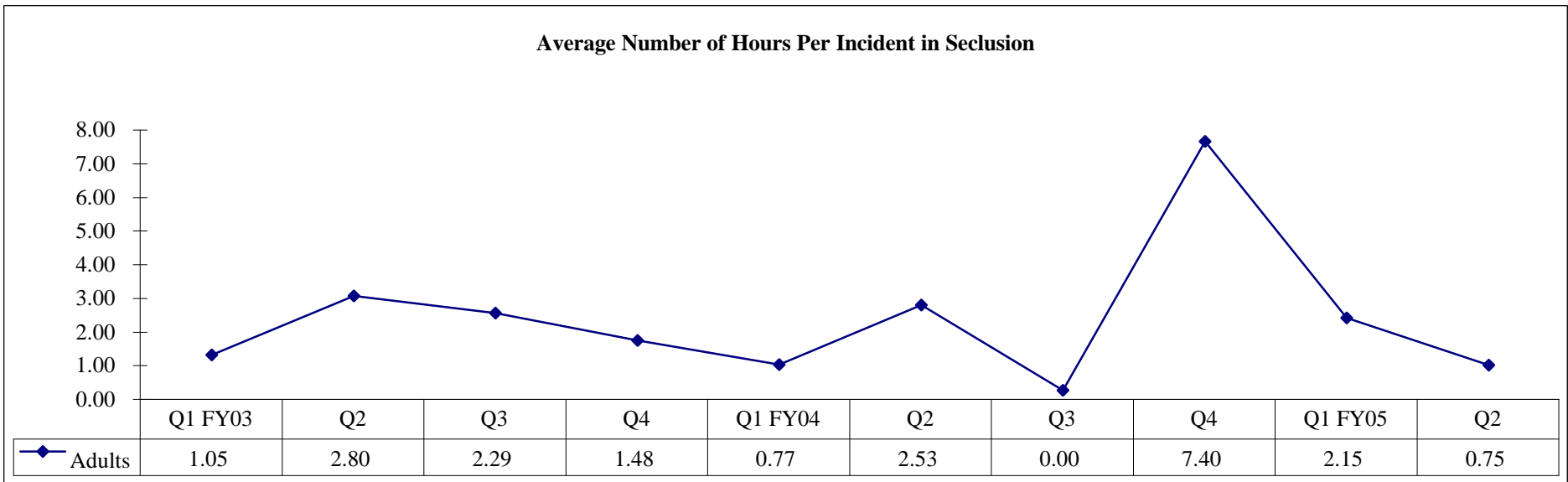
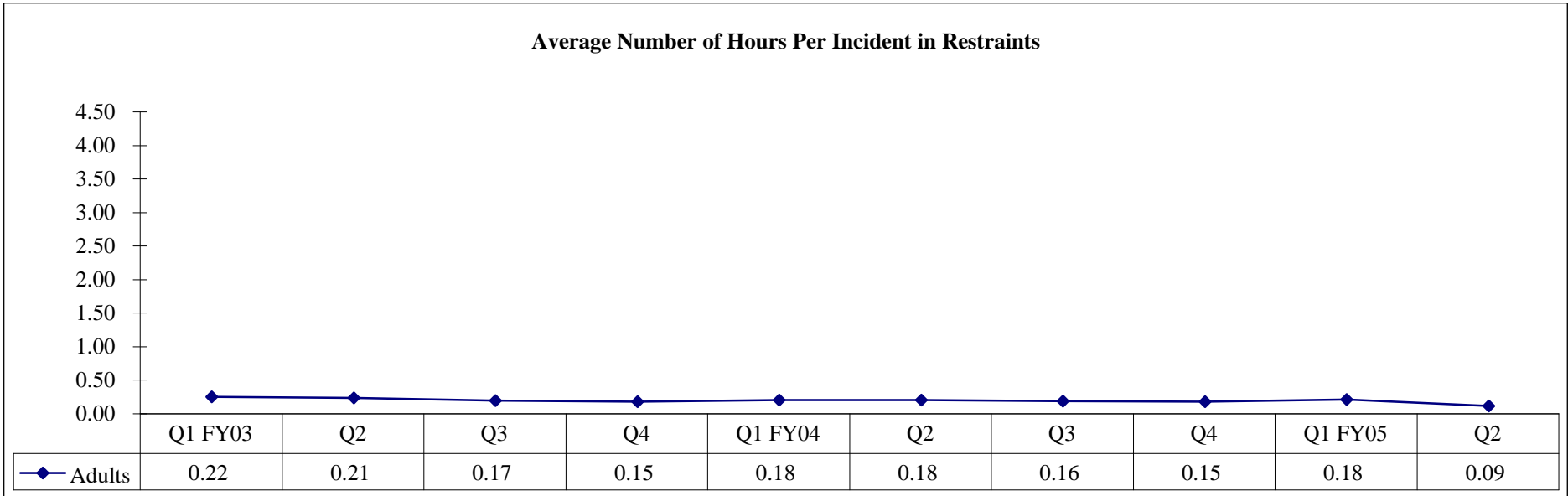
Objective 3B - Maintain Restraint and Seclusion Data
North Texas State Hospital



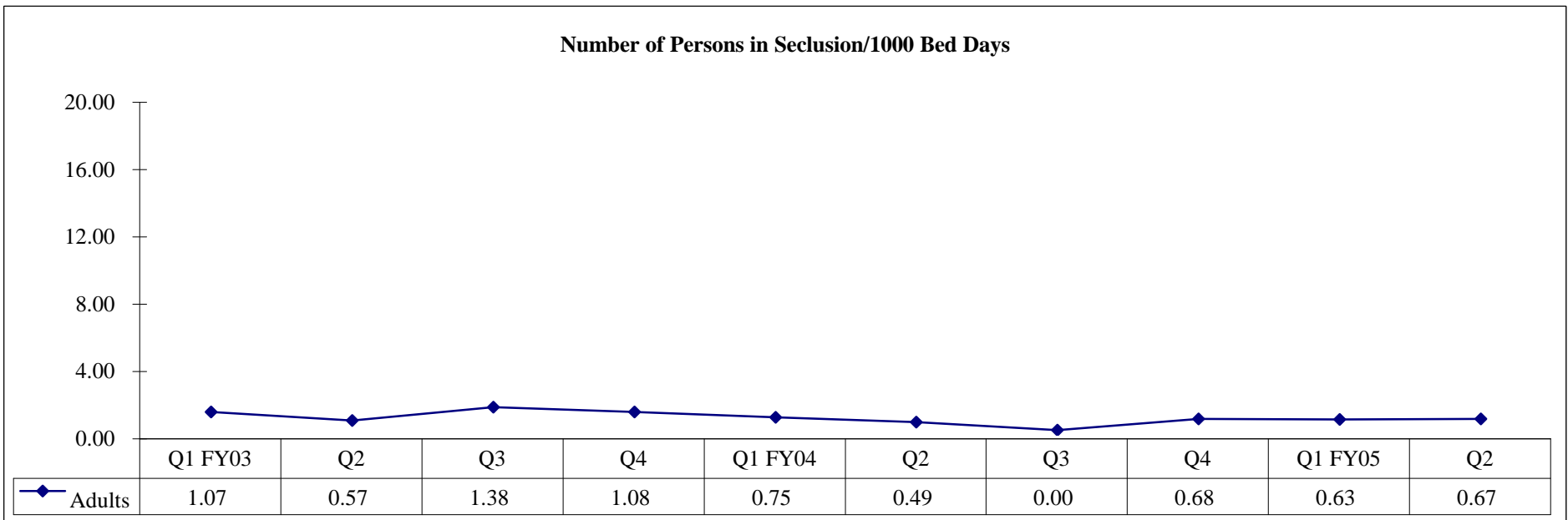
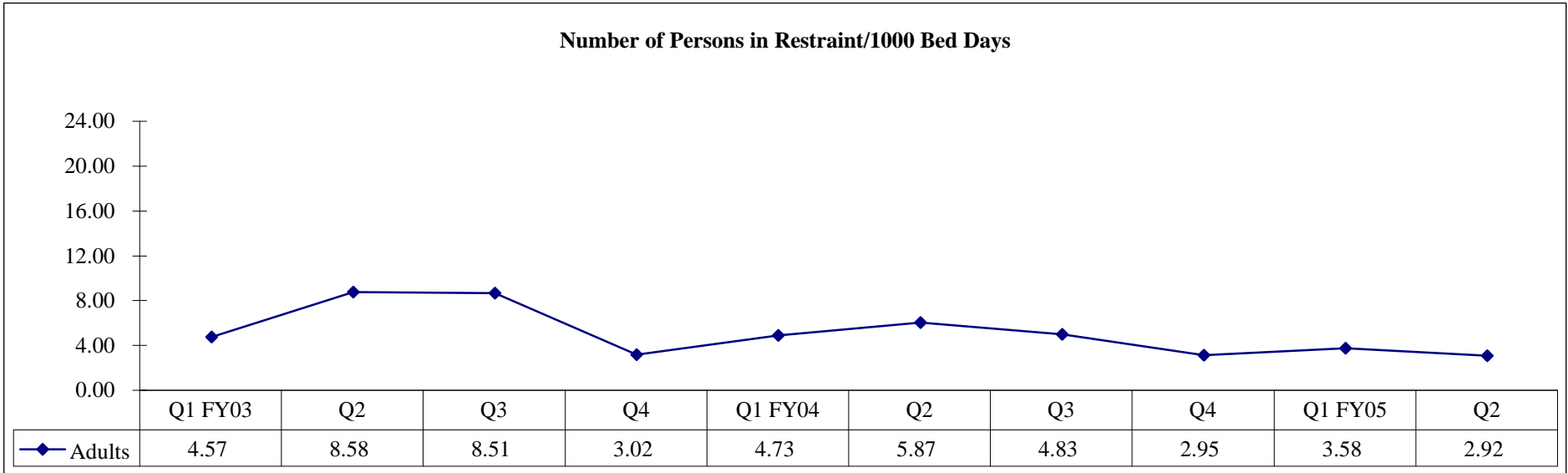
Objective 3B - Maintain Restraint and Seclusion Data
Rio Grande State Center



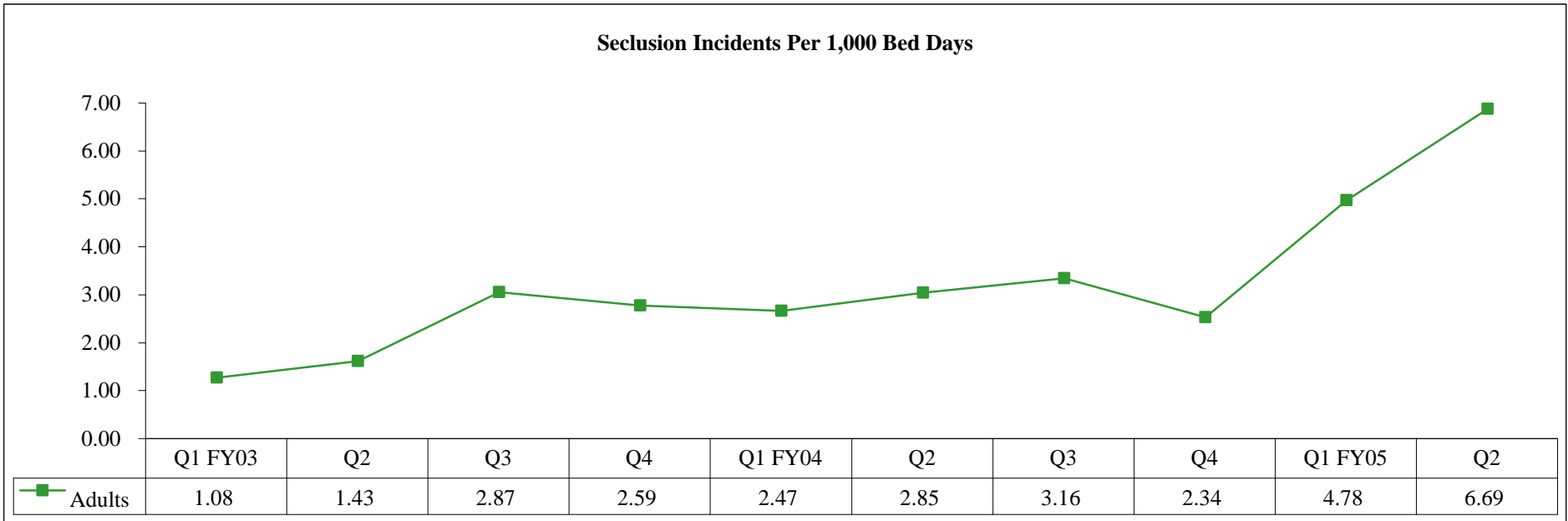
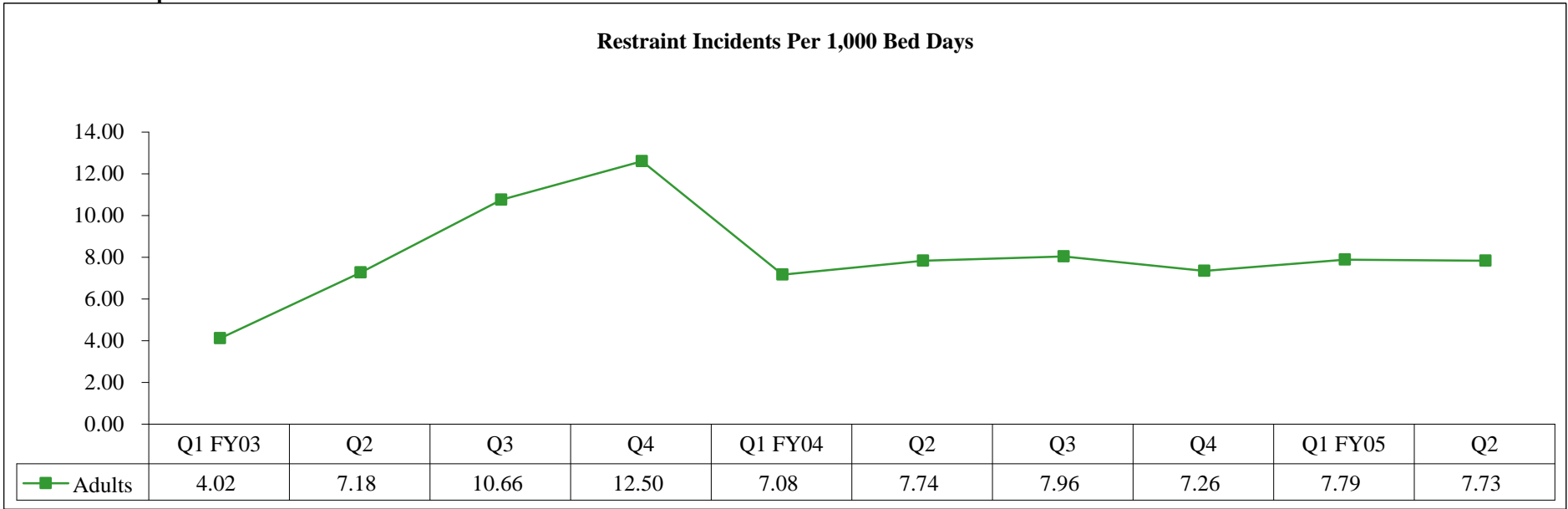
Objective 3B - Maintain Restraint and Seclusion Data
Rio Grande State Center



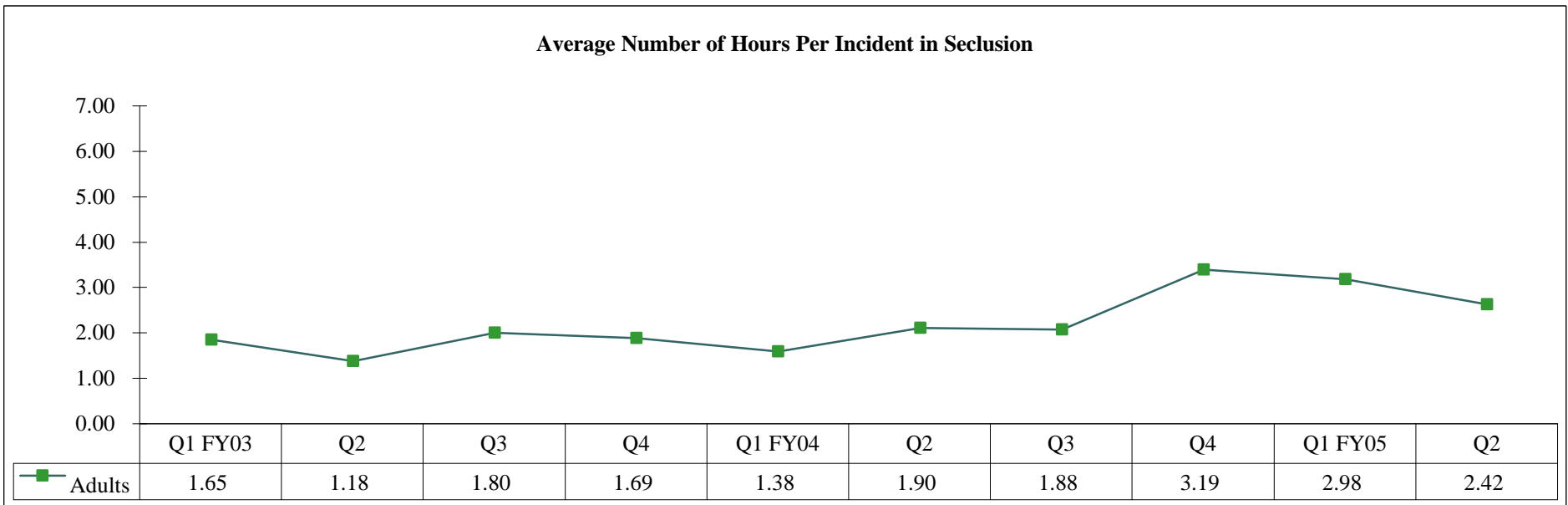
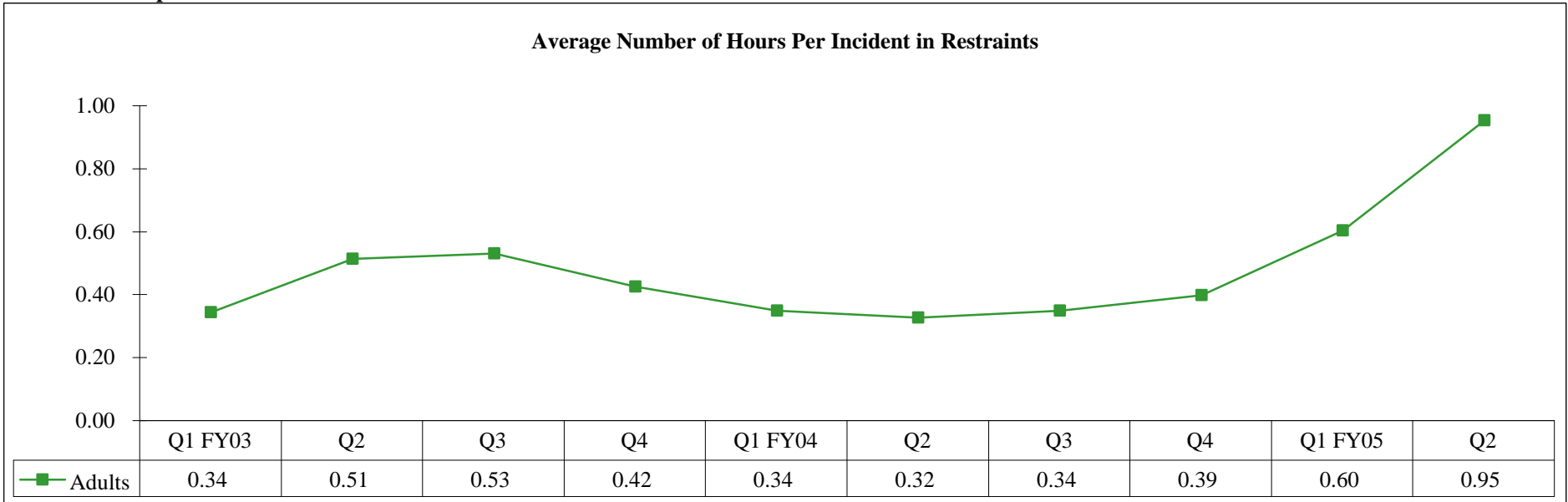
Objective 3B - Maintain Restraint and Seclusion Data
Rio Grande State Center



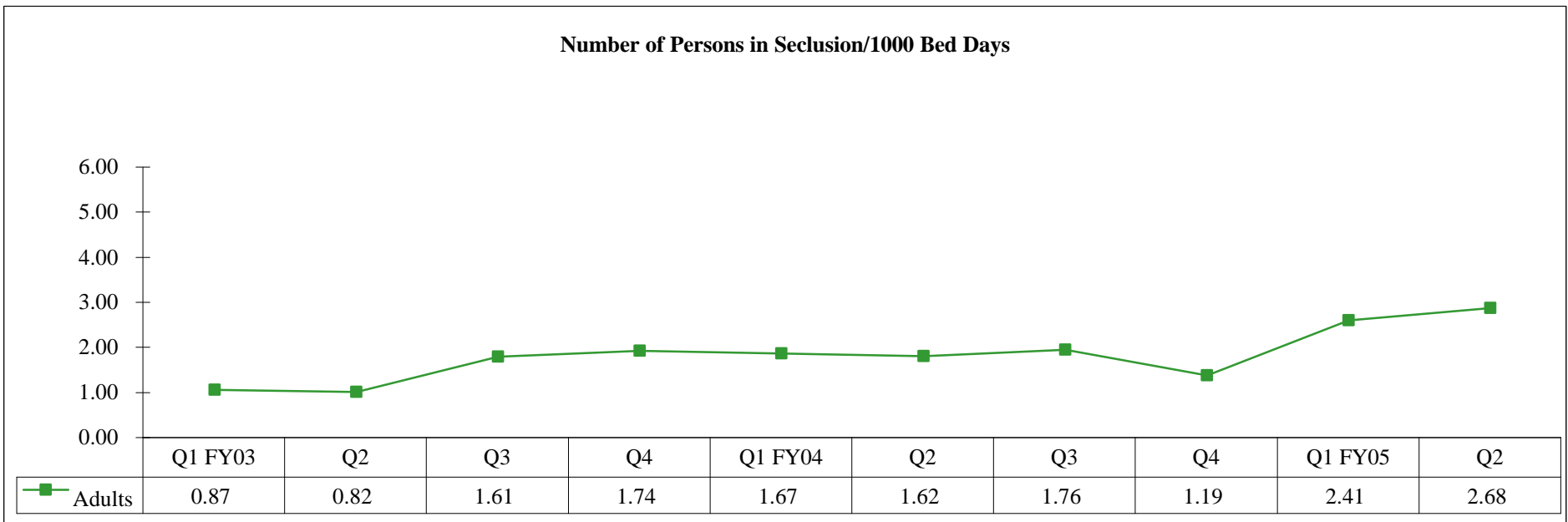
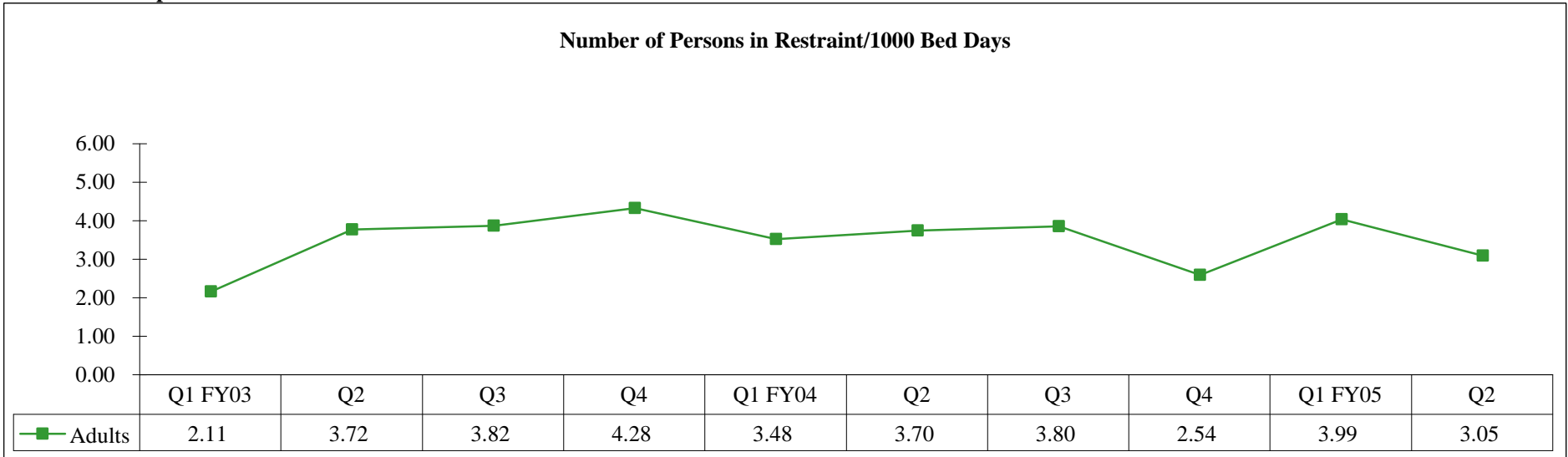
Objective 3B - Maintain Restraint and Seclusion Data
Rusk State Hospital



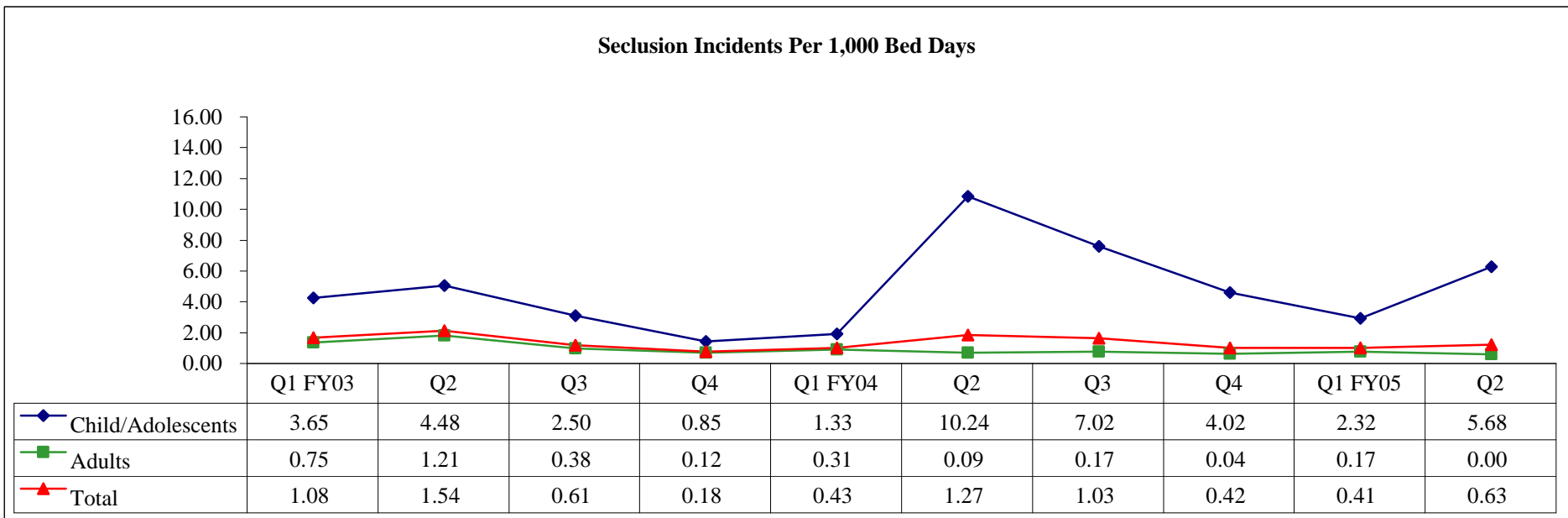
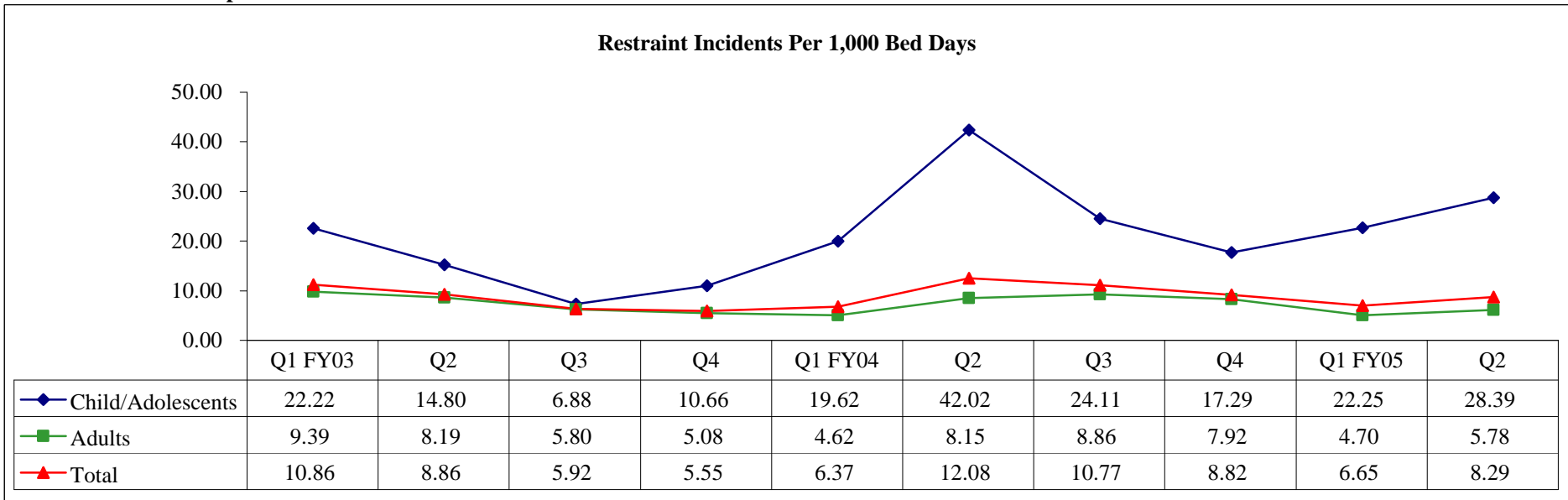
Objective 3B - Maintain Restraint and Seclusion Data
Rusk State Hospital



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

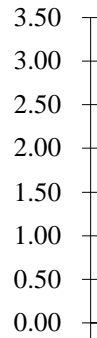


Objective 3B - Maintain Restraint and Seclusion Data
San Antonio State Hospital



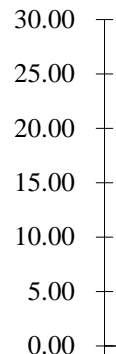
Objective 3B - Maintain Restraint and Seclusion Data
San Antonio State Hospital

Average Number of Hours Per Incident in Restraints



	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
◆ Child/Adolescents	0.96	0.58	0.23	1.49	0.78	0.67	0.63	0.69	0.63	0.65
■ Adults	0.83	0.77	0.64	0.72	0.64	0.85	0.84	0.67	1.06	0.74
▲ Total	0.86	0.74	0.59	0.84	0.69	0.77	0.78	0.68	0.90	0.70

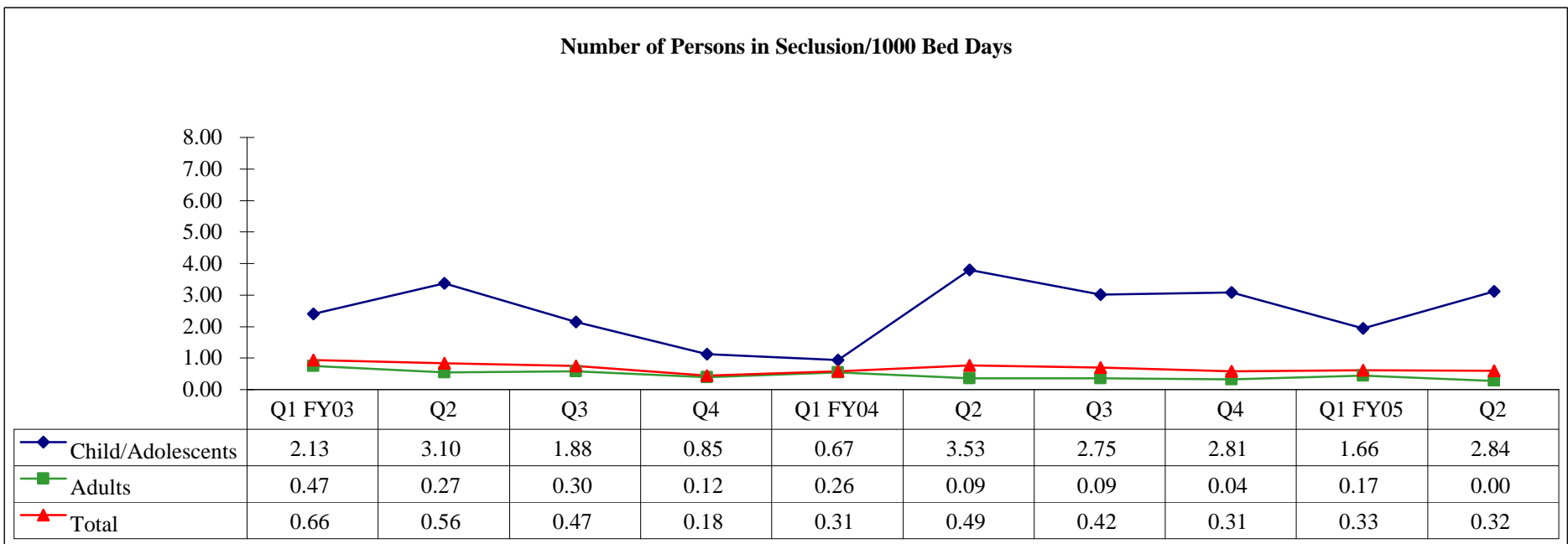
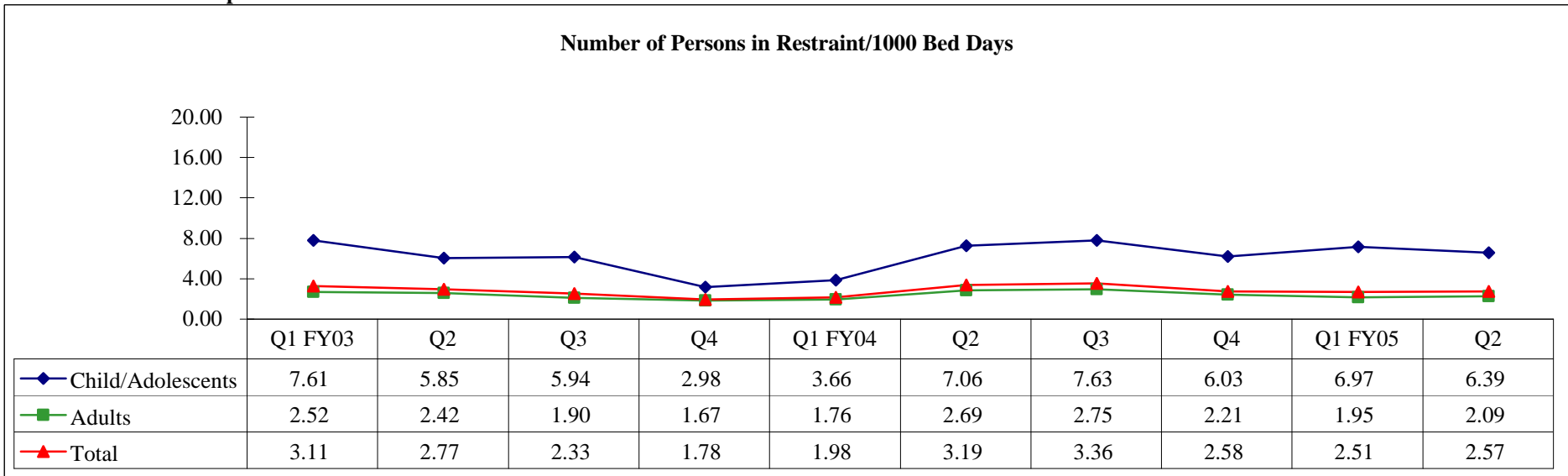
Average Number of Hours Per Incident in Seclusion



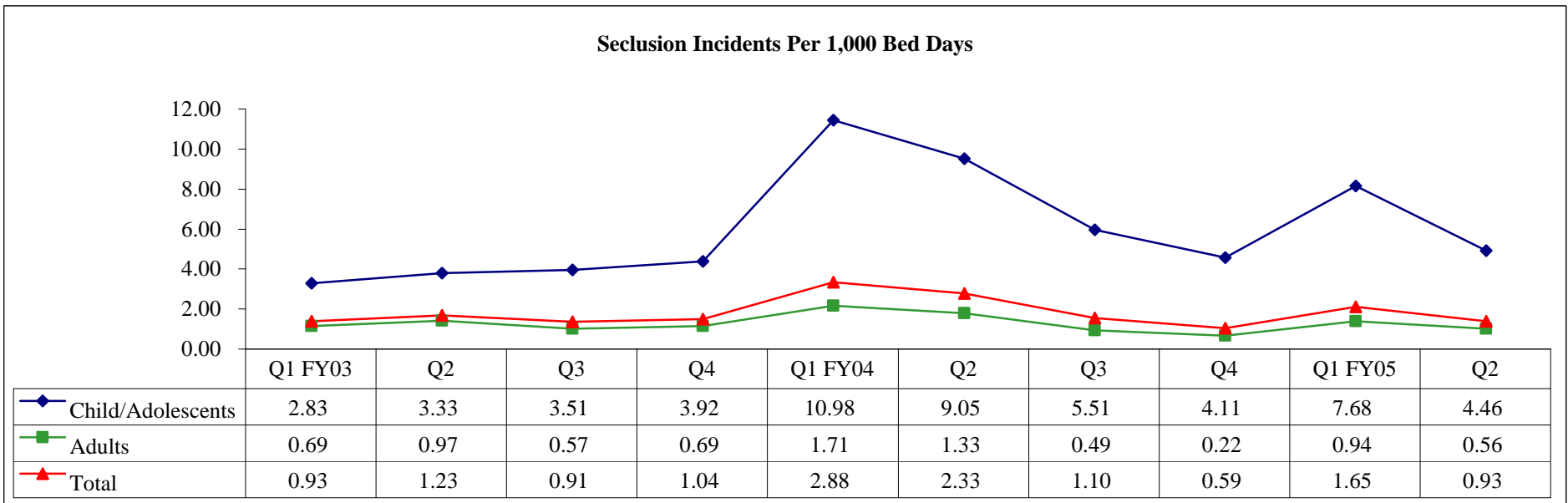
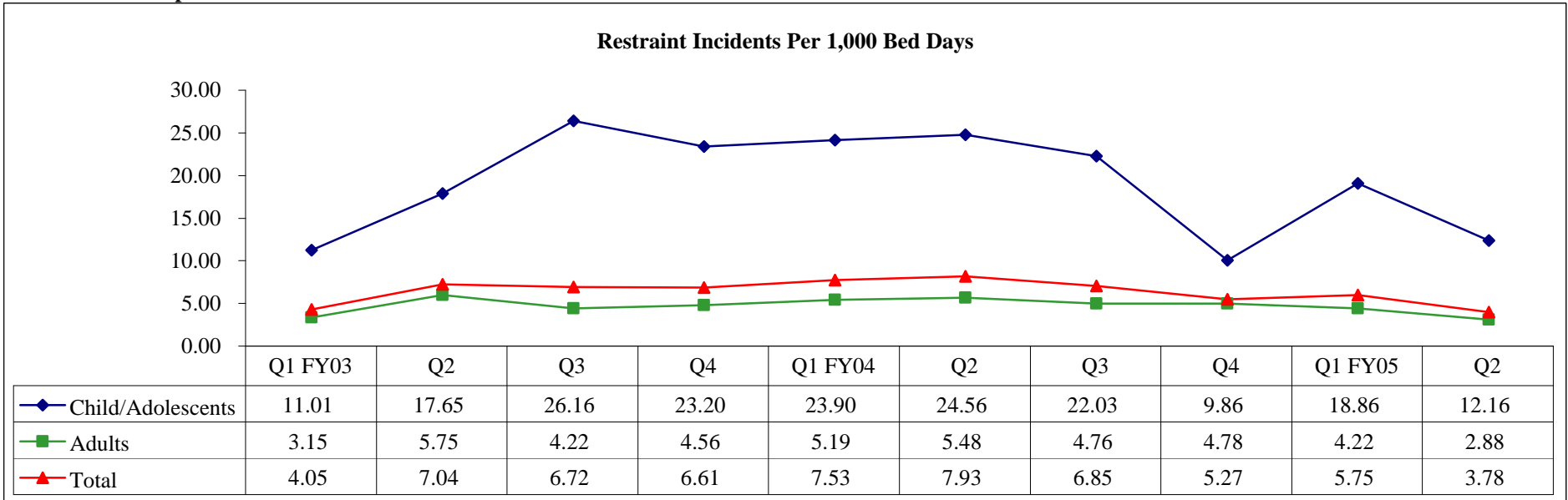
	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
◆ Child/Adolescents	1.14	0.75	1.01	1.40	0.60	1.56	1.34	1.51	0.93	0.99
■ Adults	22.95	2.30	2.77	2.53	1.64	0.90	2.95	2.50	2.00	0.00
▲ Total	14.51	1.84	1.99	2.08	1.26	1.52	1.58	1.60	1.32	0.99

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

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

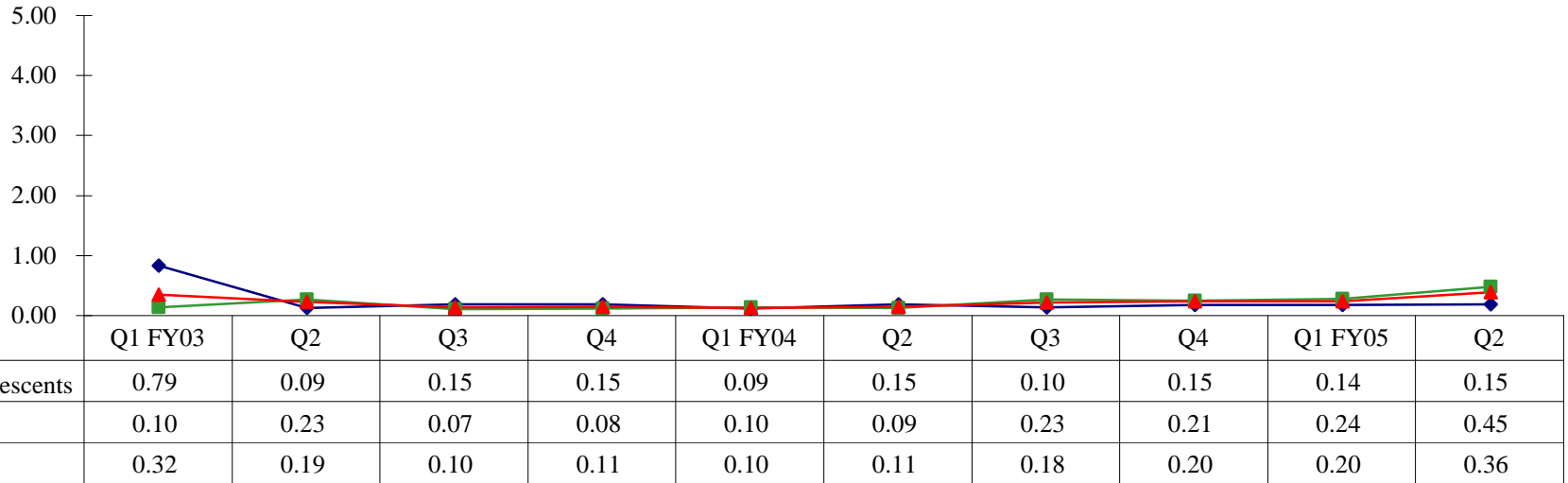


Objective 3B - Maintain Restraint and Seclusion Data
Terrell State Hospital

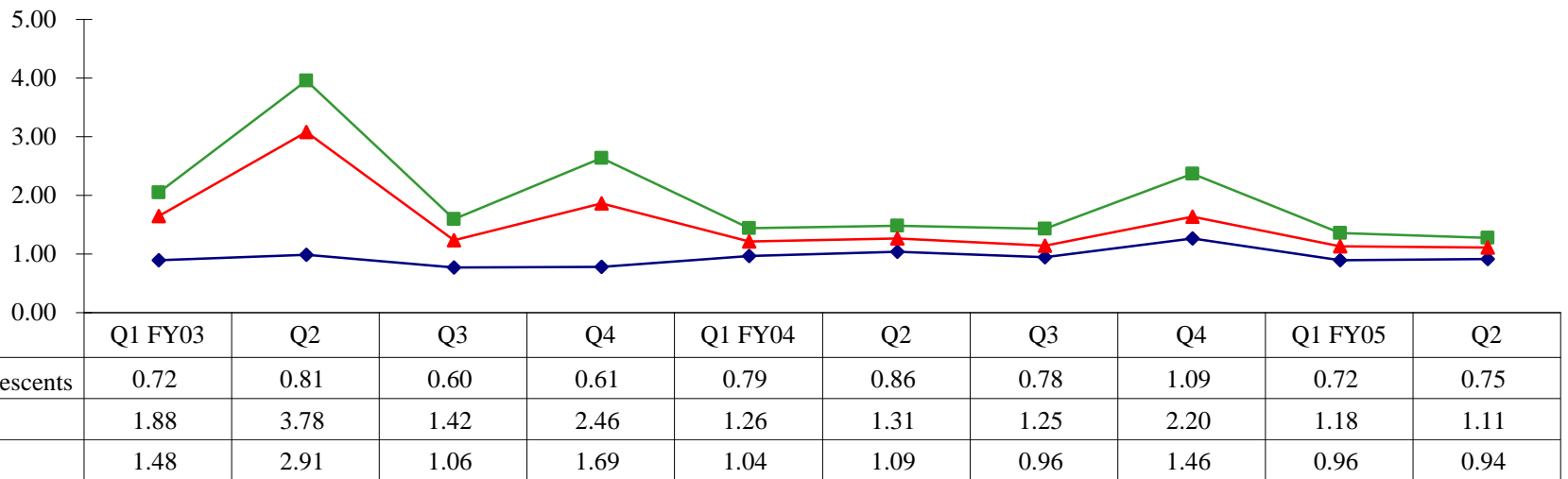


Objective 3B - Maintain Restraint and Seclusion Data
Terrell State Hospital

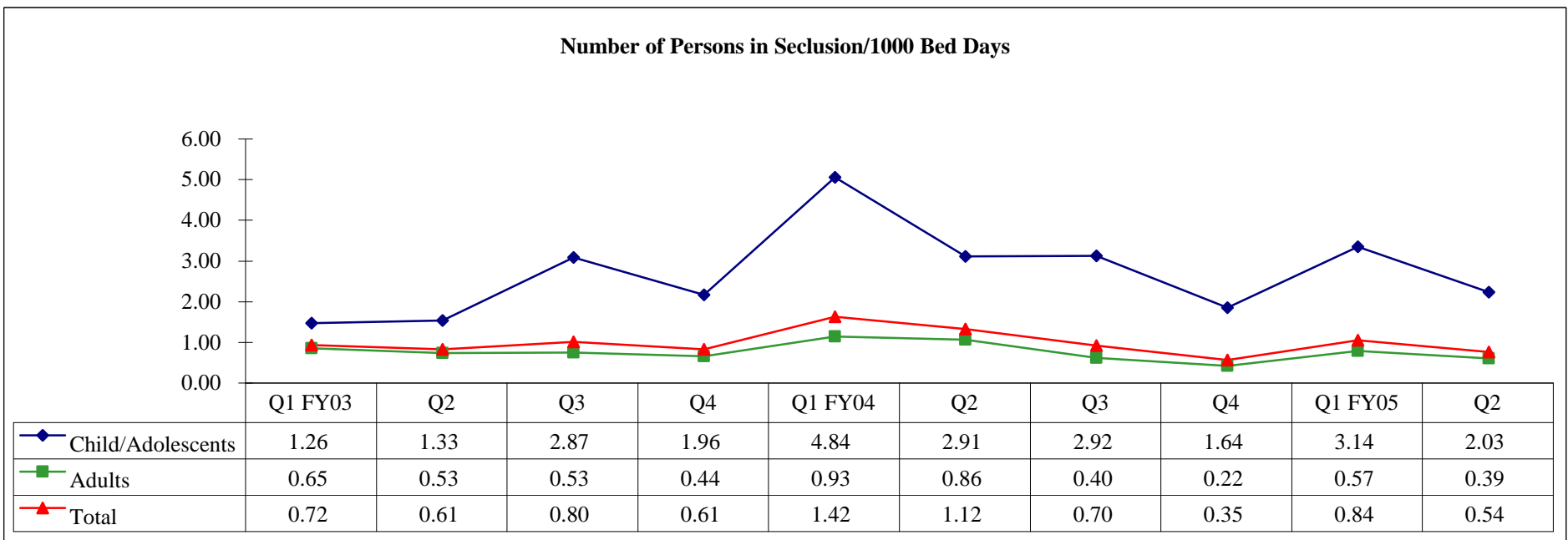
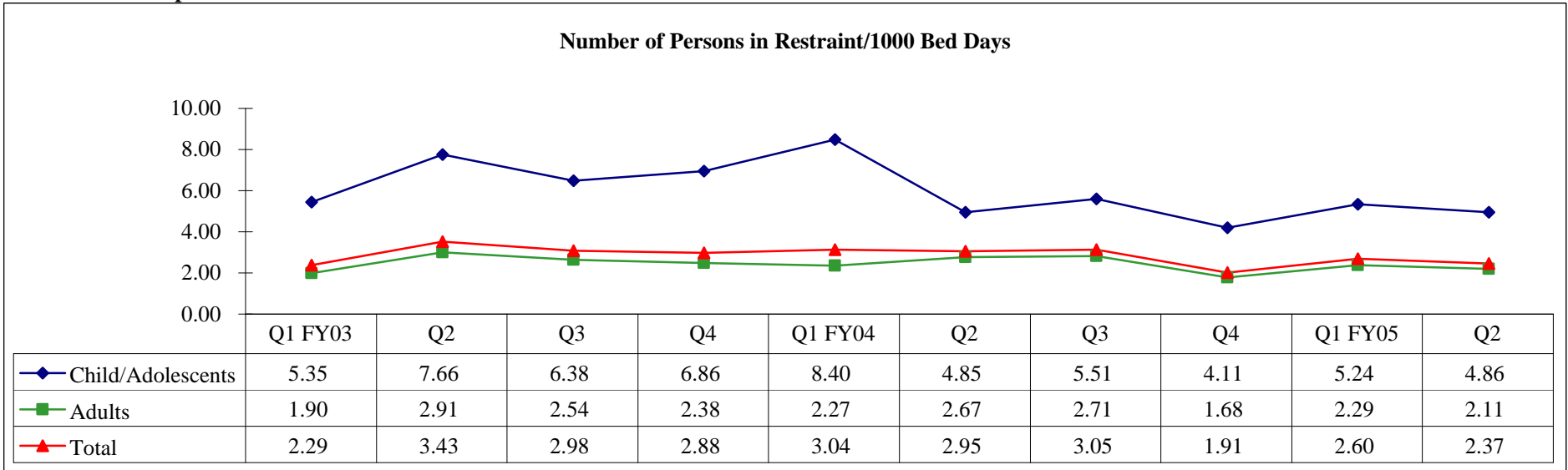
Average Number of Hours Per Incident in Restraints



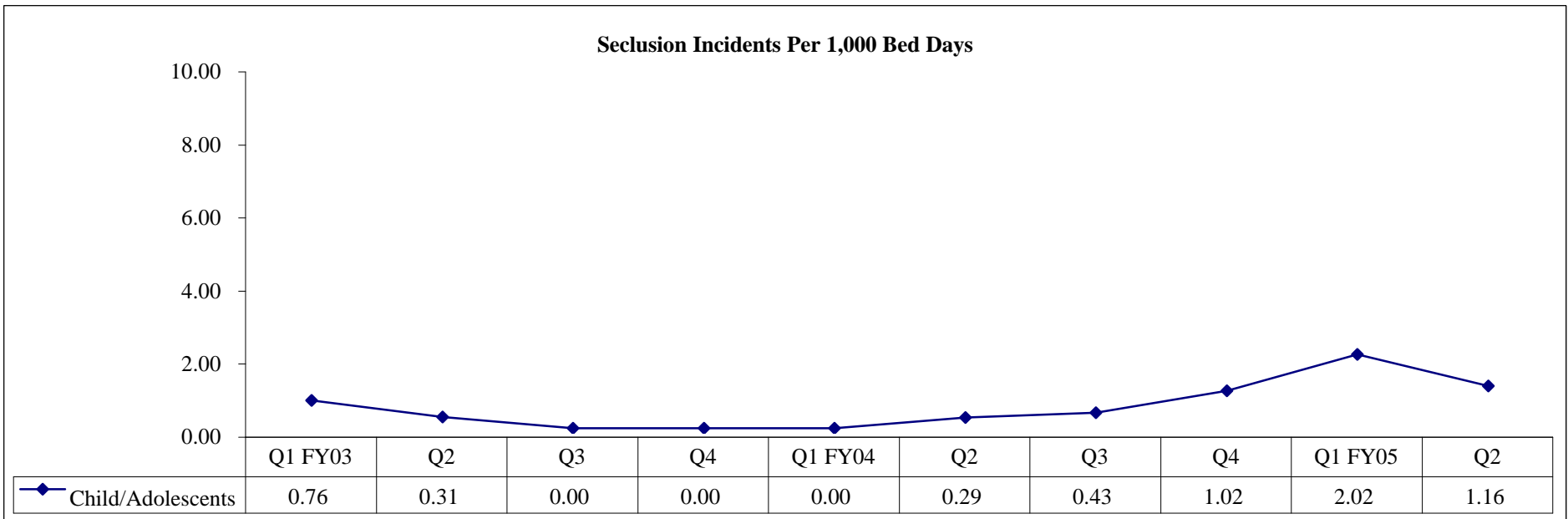
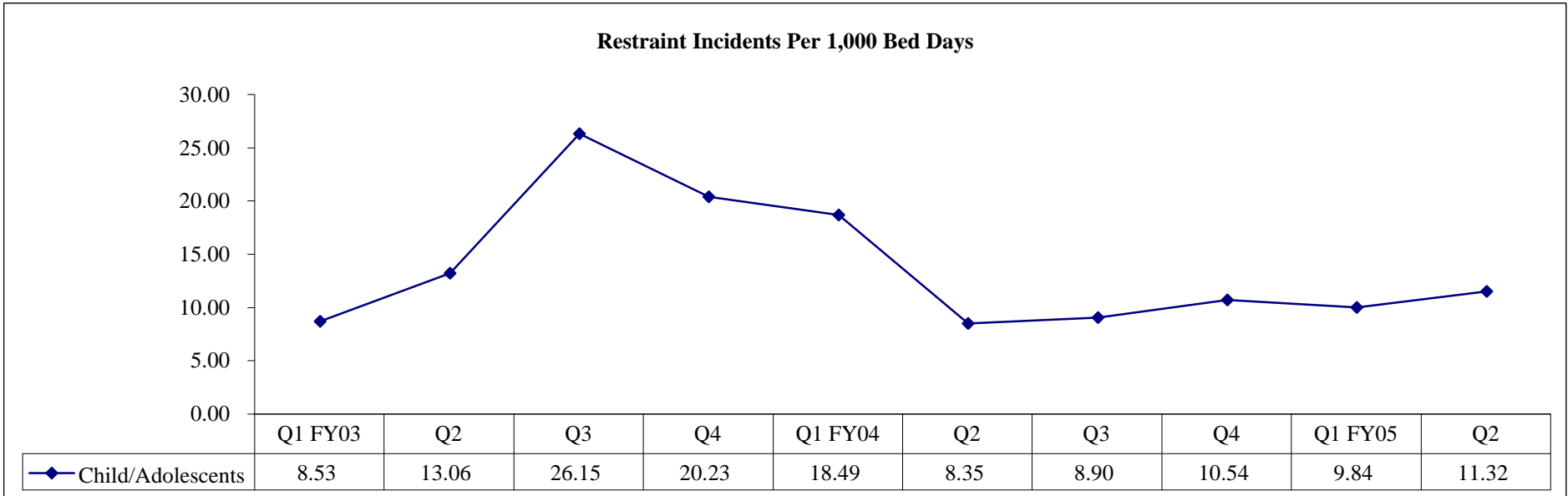
Average Number of Hours Per Incident in Seclusion



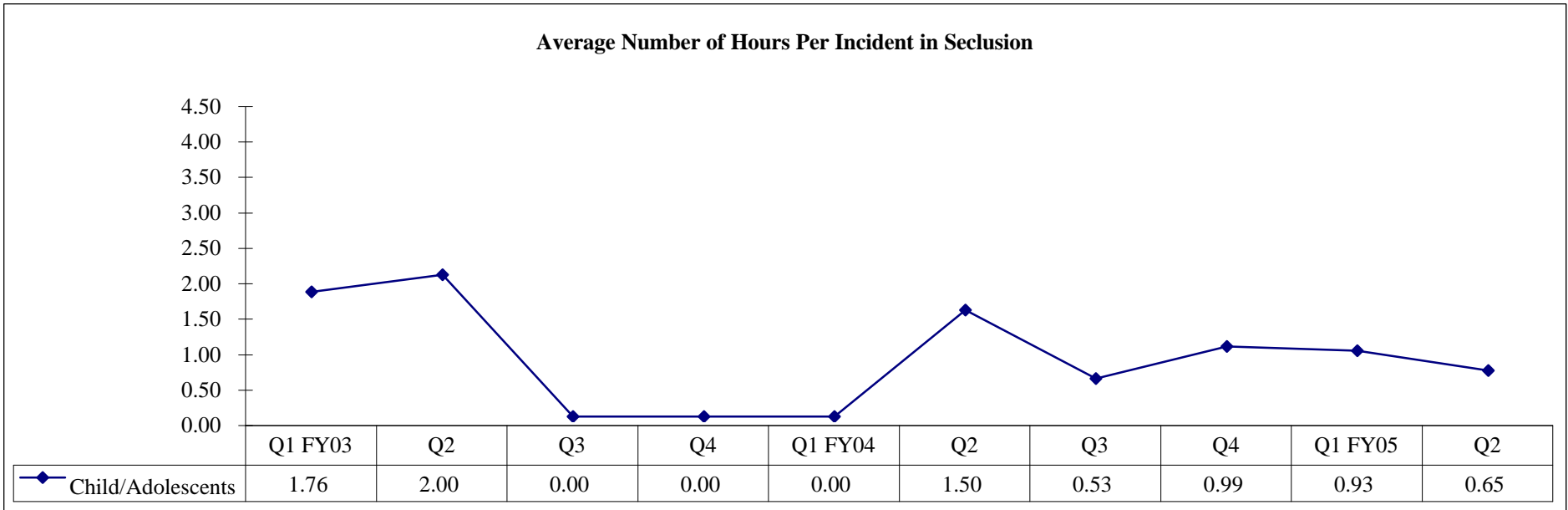
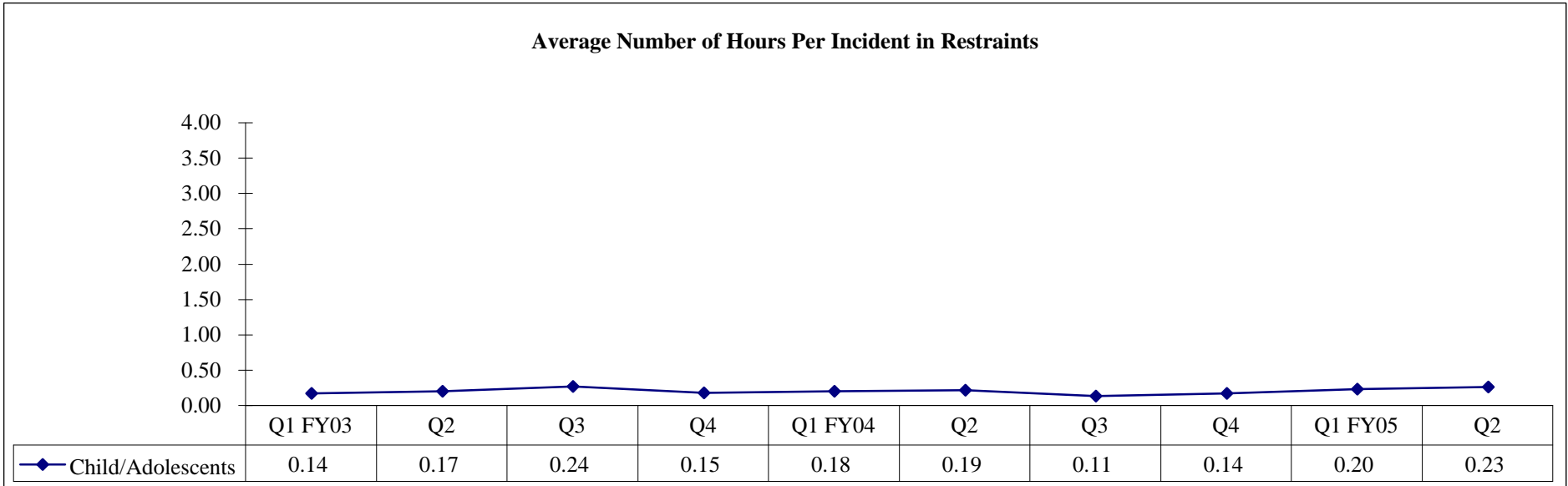
Objective 3B - Maintain Restraint and Seclusion Data
Terrell State Hospital



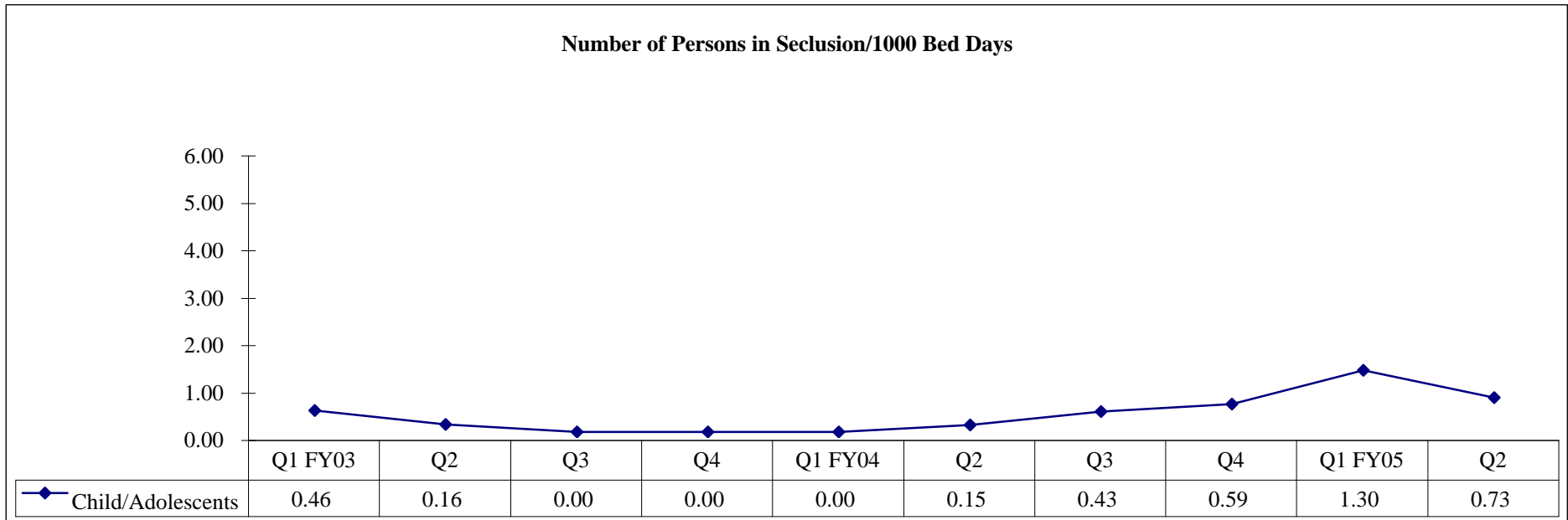
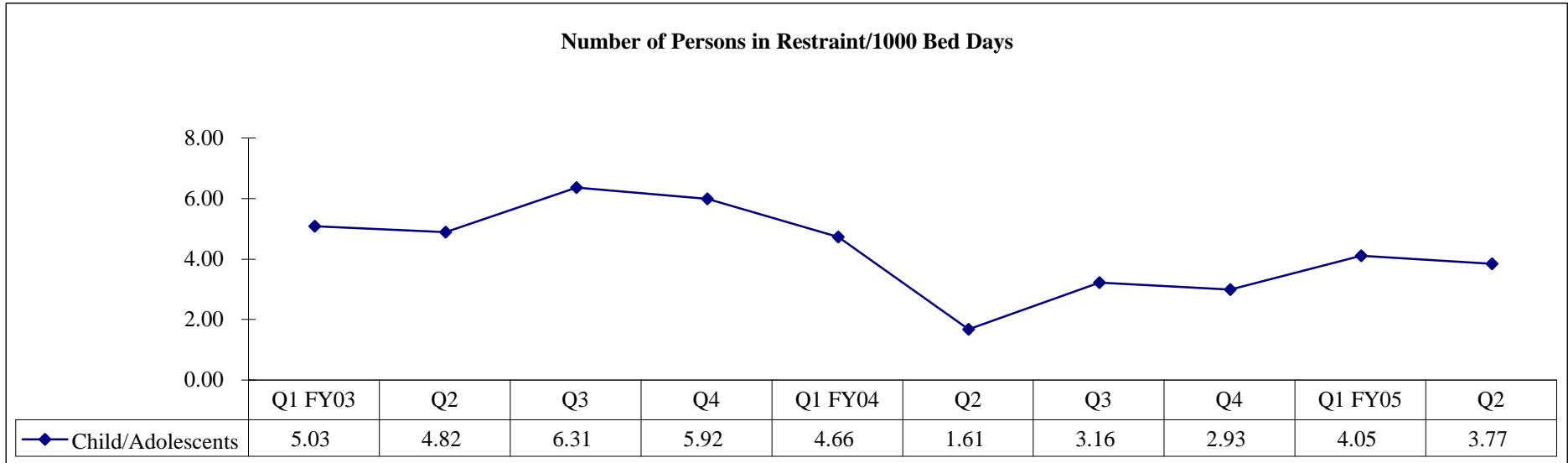
Objective 3B - Maintain Restraint and Seclusion Data
Waco Center for Youth



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:

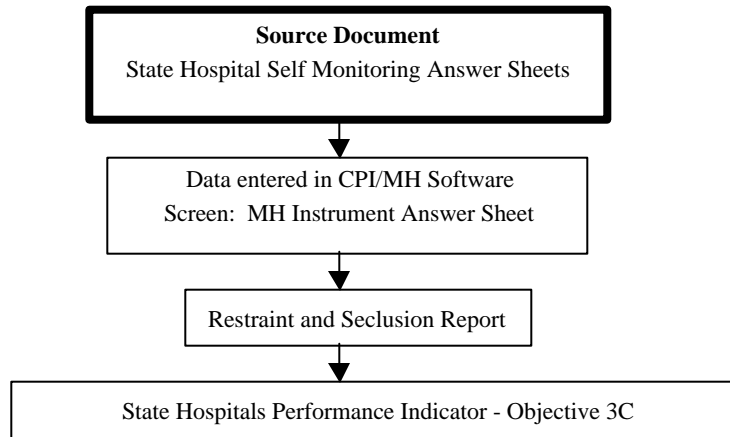
The Behavioral Restraint and Seclusion Monitoring Instrument will be utilized to assure the correct implementation of restraint and seclusion when it is necessary to utilize these procedures.

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 $[(\text{yes} + \text{no with}) / (\text{yes} + \text{no with} + \text{no}) \times 100]$.

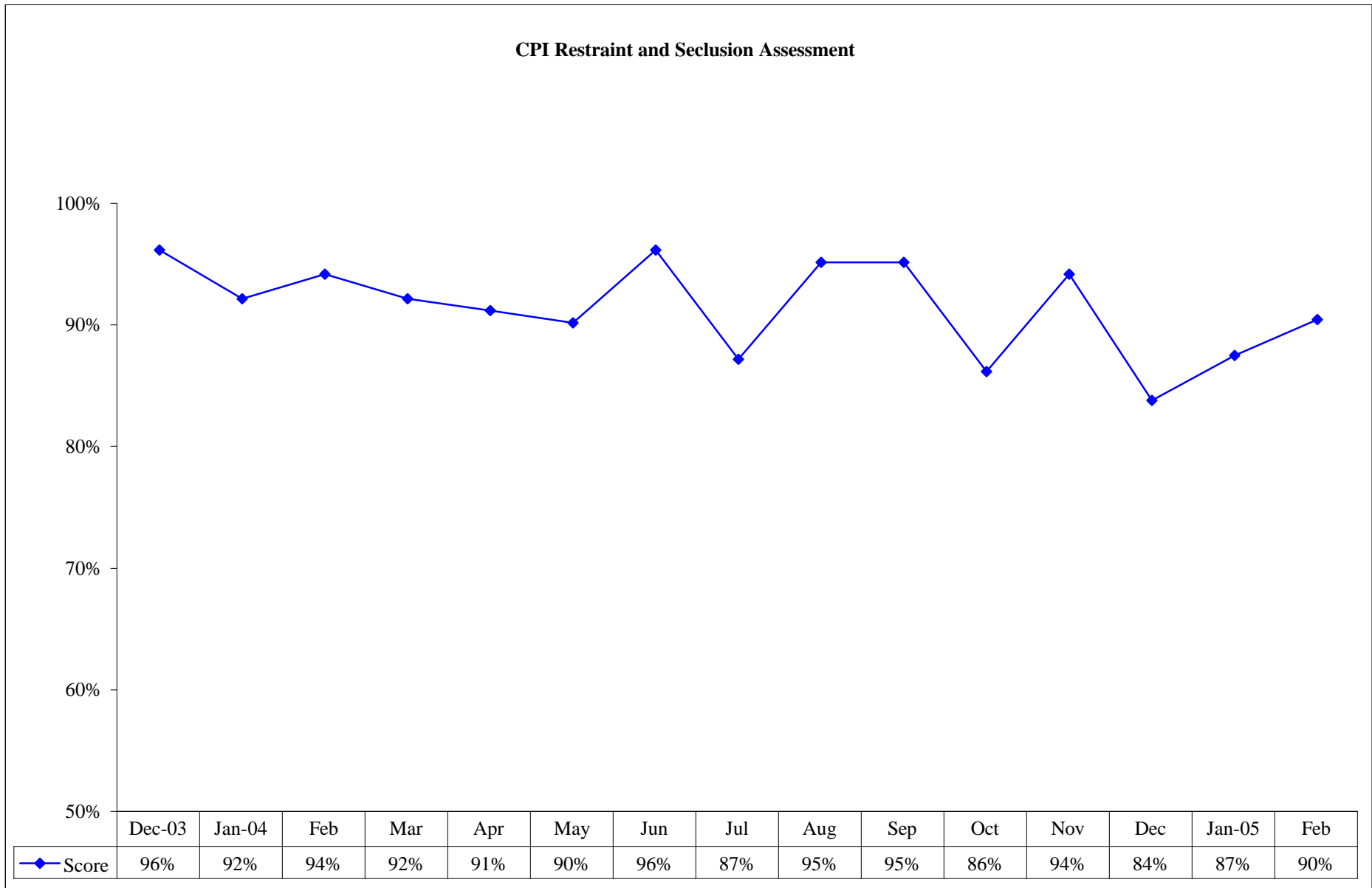
Performance Objective Data Display and Chart Description: Chart with monthly data points of state hospital scores.

Data Flow:

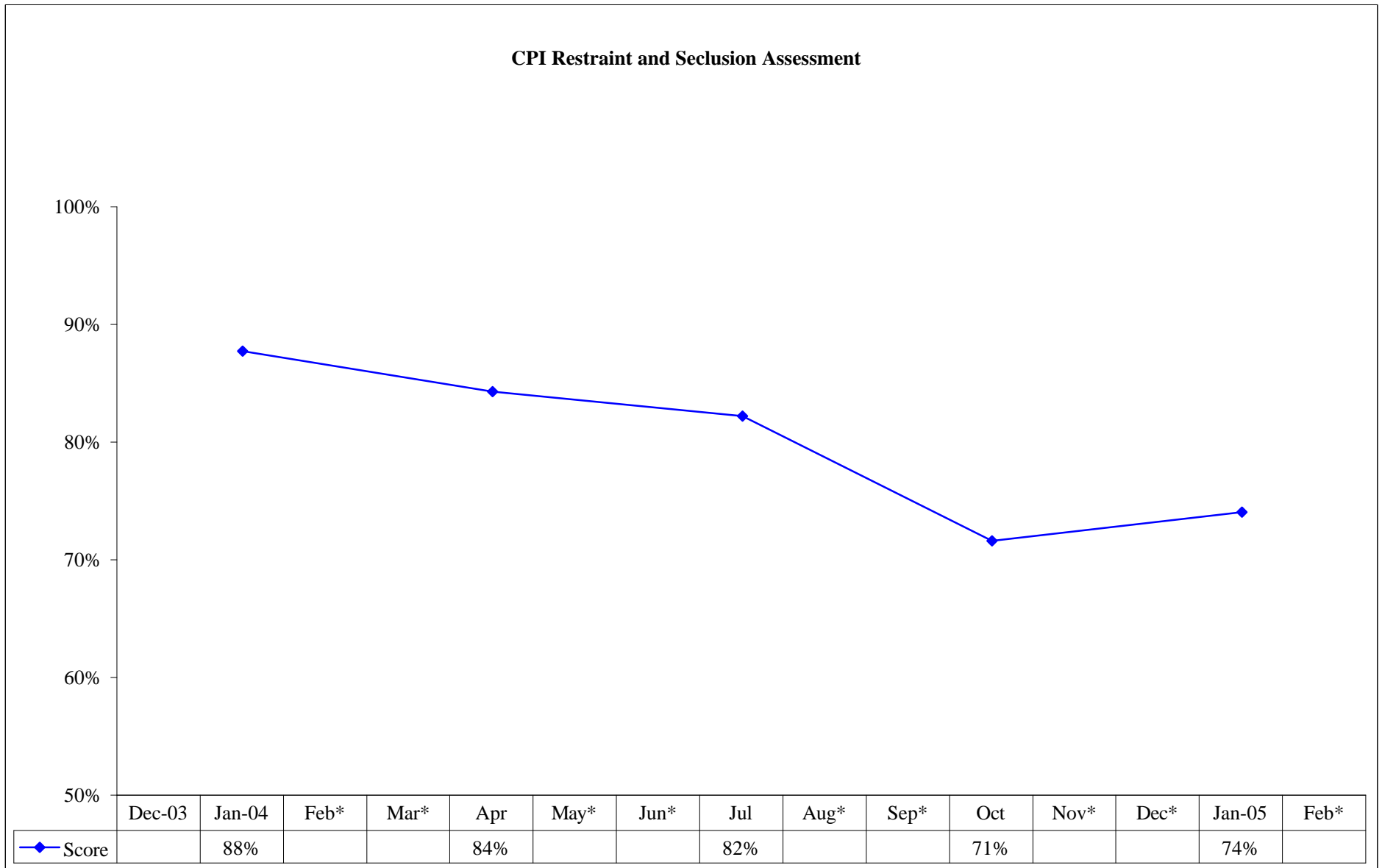


Data Integrity Review Process: (This process ensures the accuracy of data entered into the CPI software from the CPI answer sheets).

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

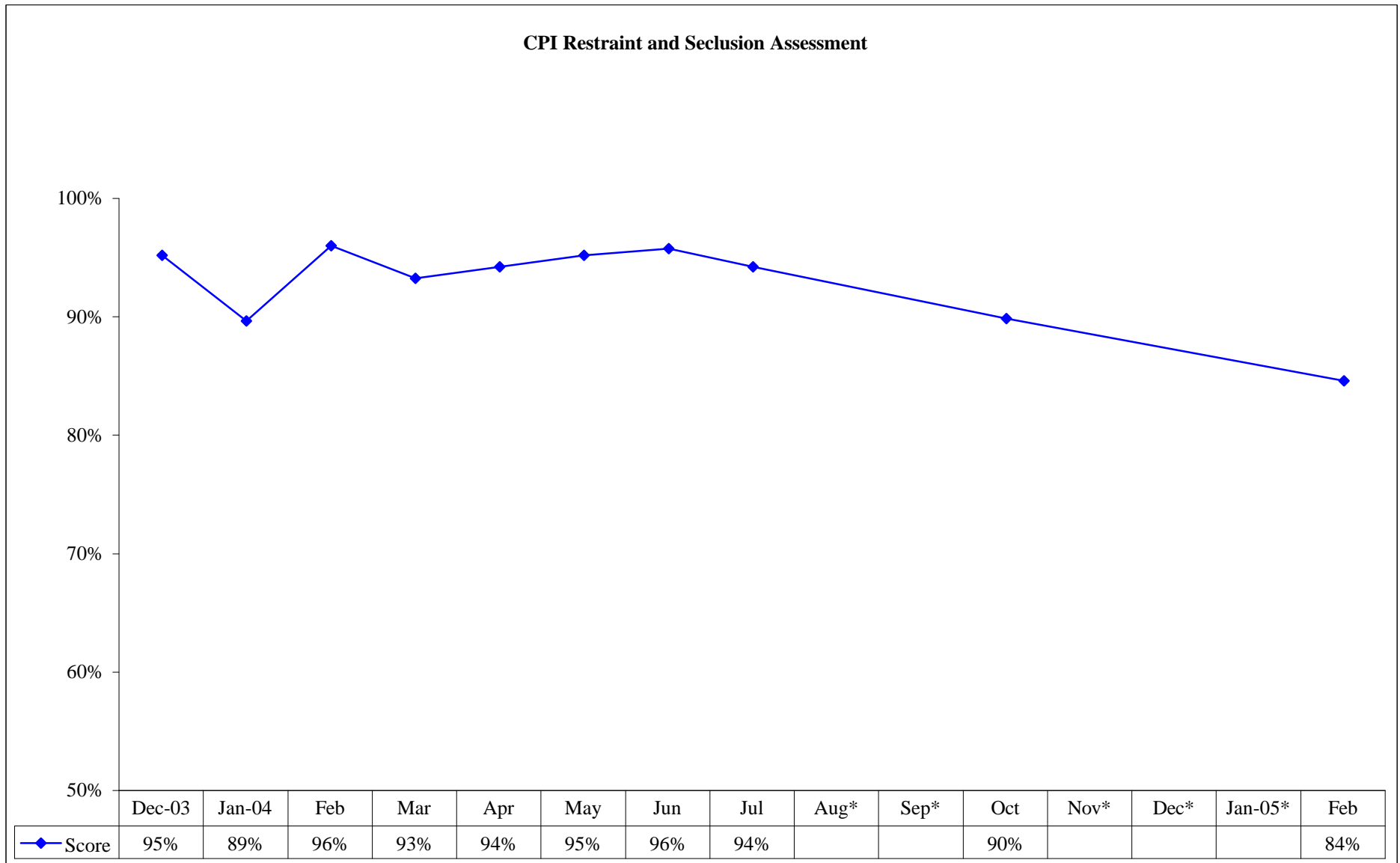


**Objective 3C - Behavioral Restraint and Seclusion Assessment
Austin State Hospital**



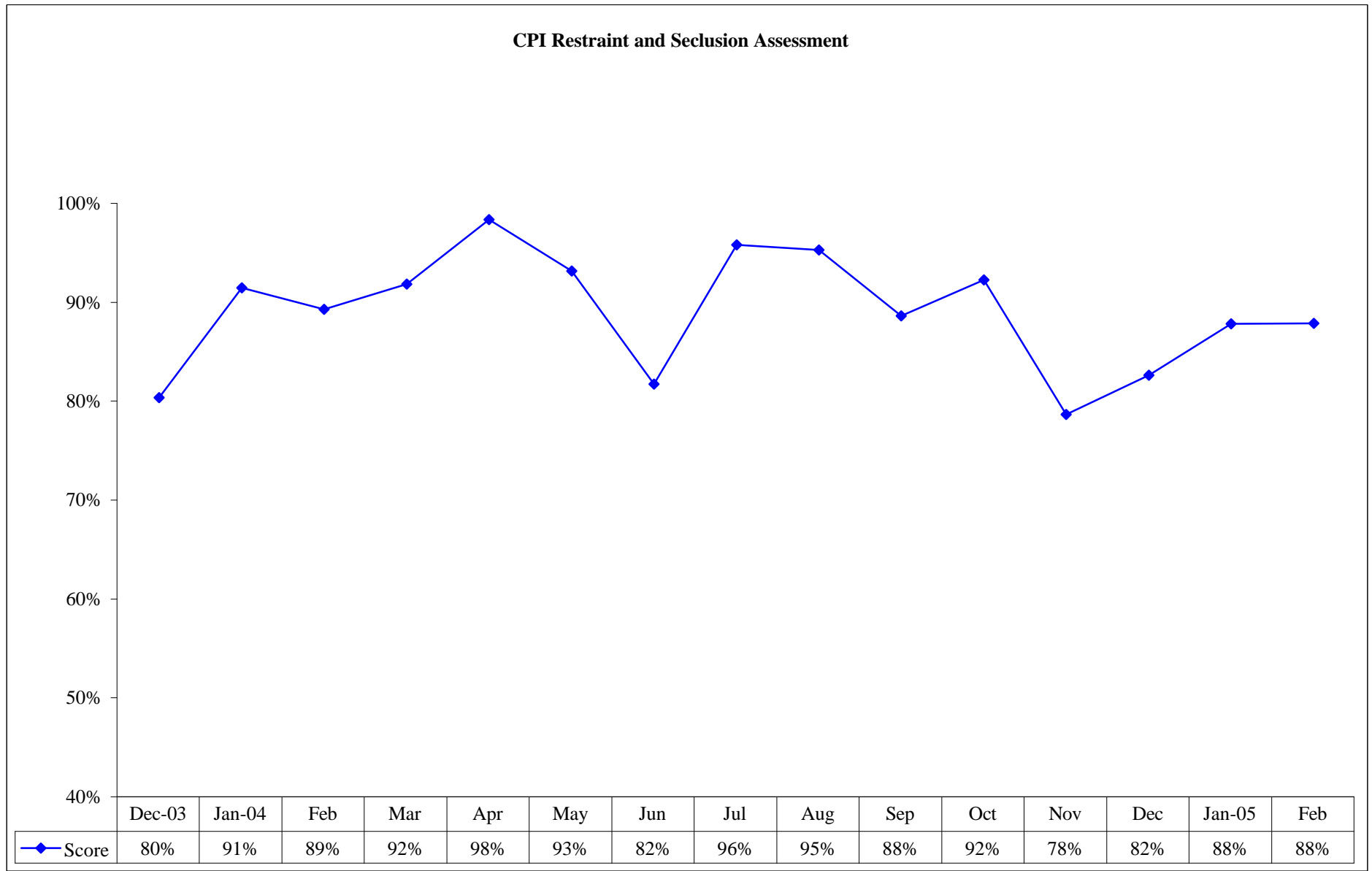
*No scores reported to HMDS.

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

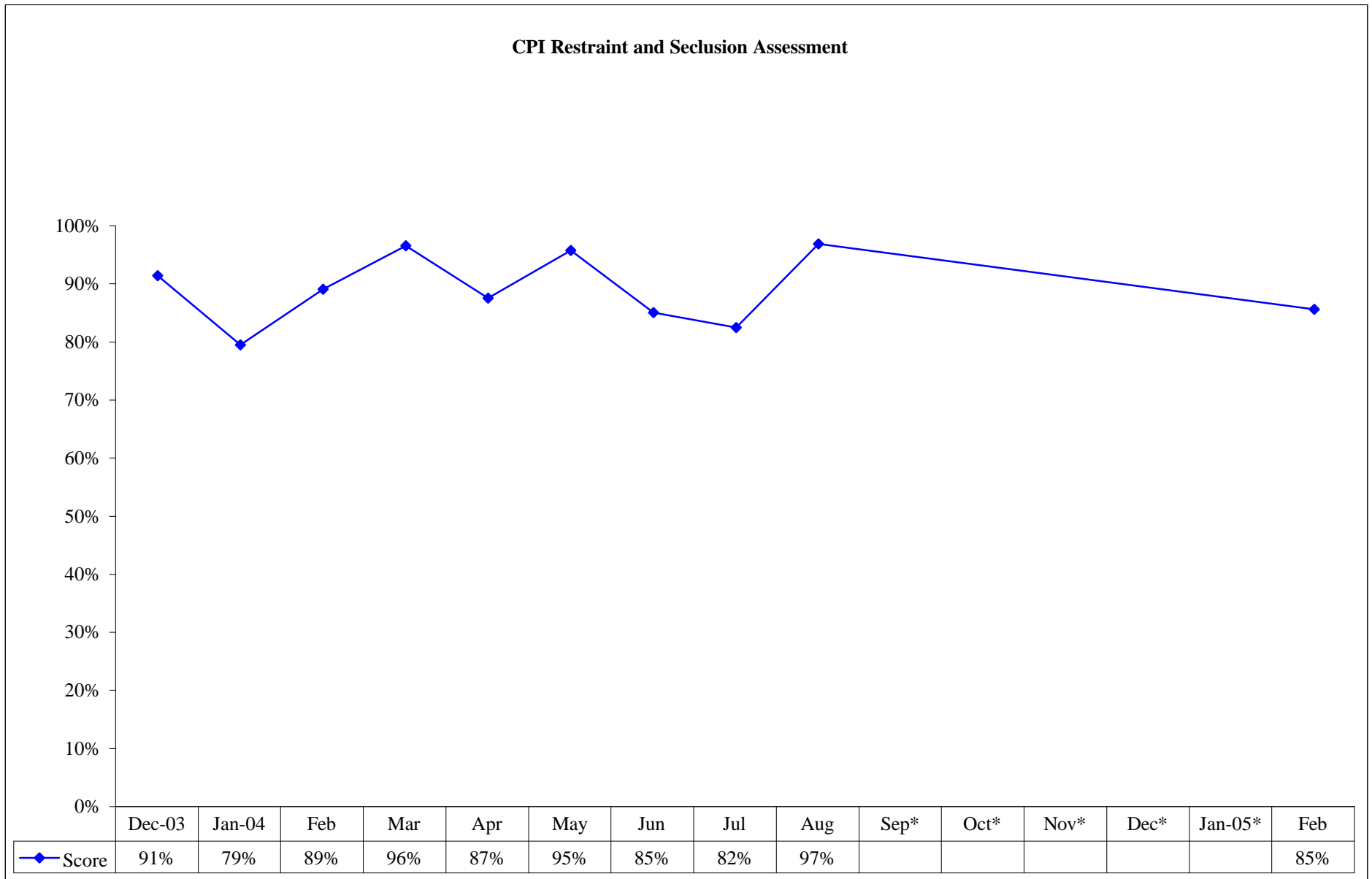


*No scores reported to HMDS.

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

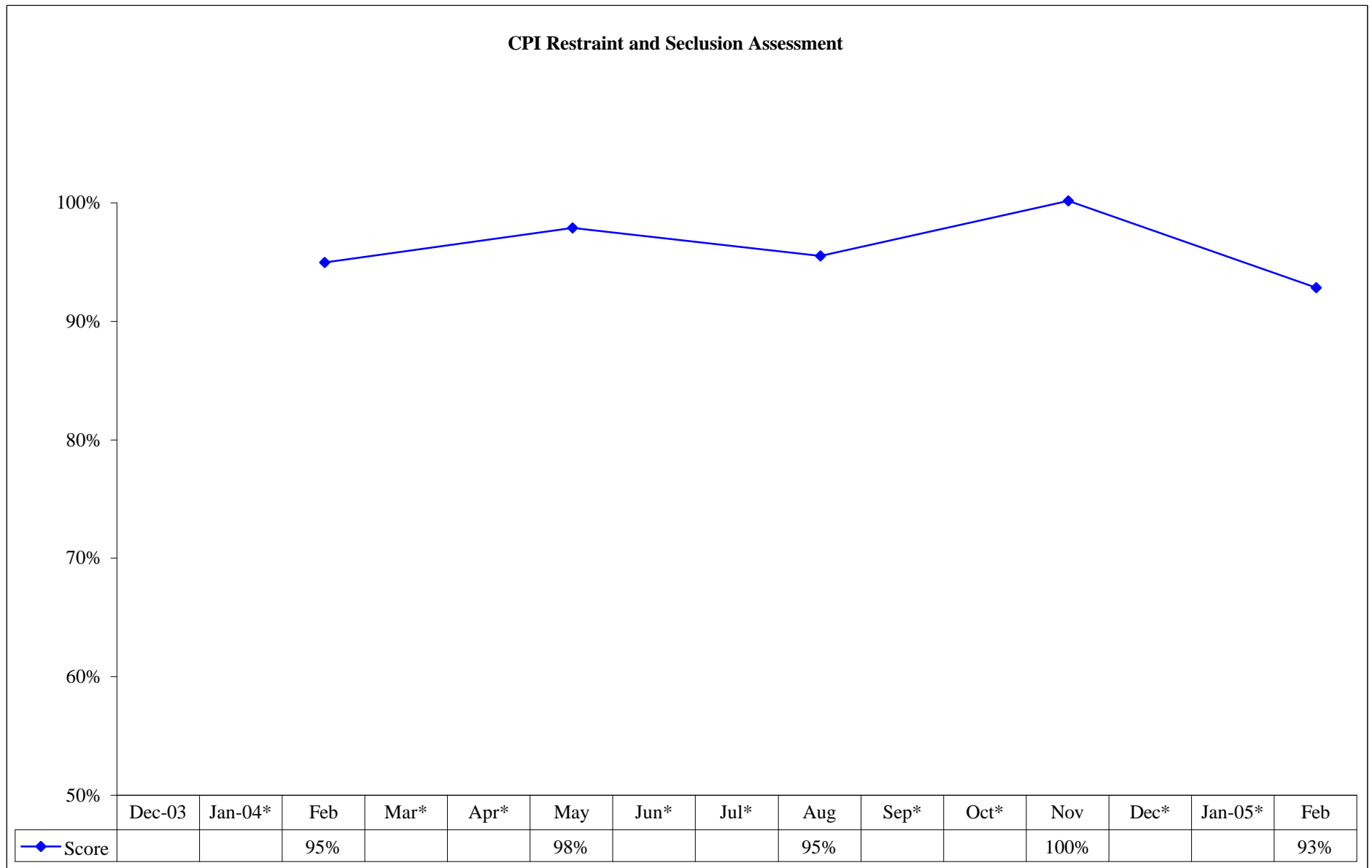


**Objective 3C - Behavioral Restraint and Seclusion Assessment
Kerrville State Hospital**



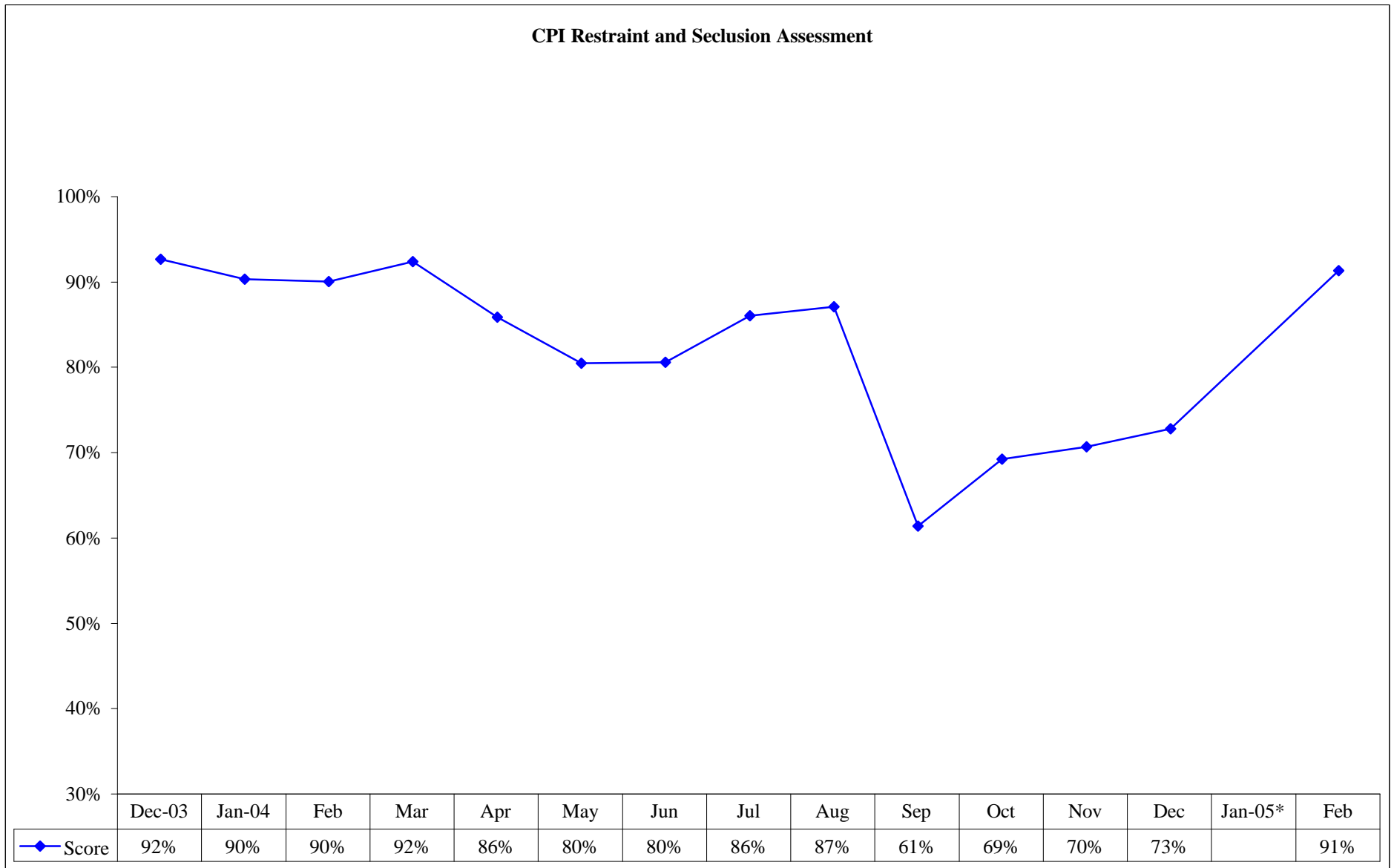
*No scores reported to HMDS.

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



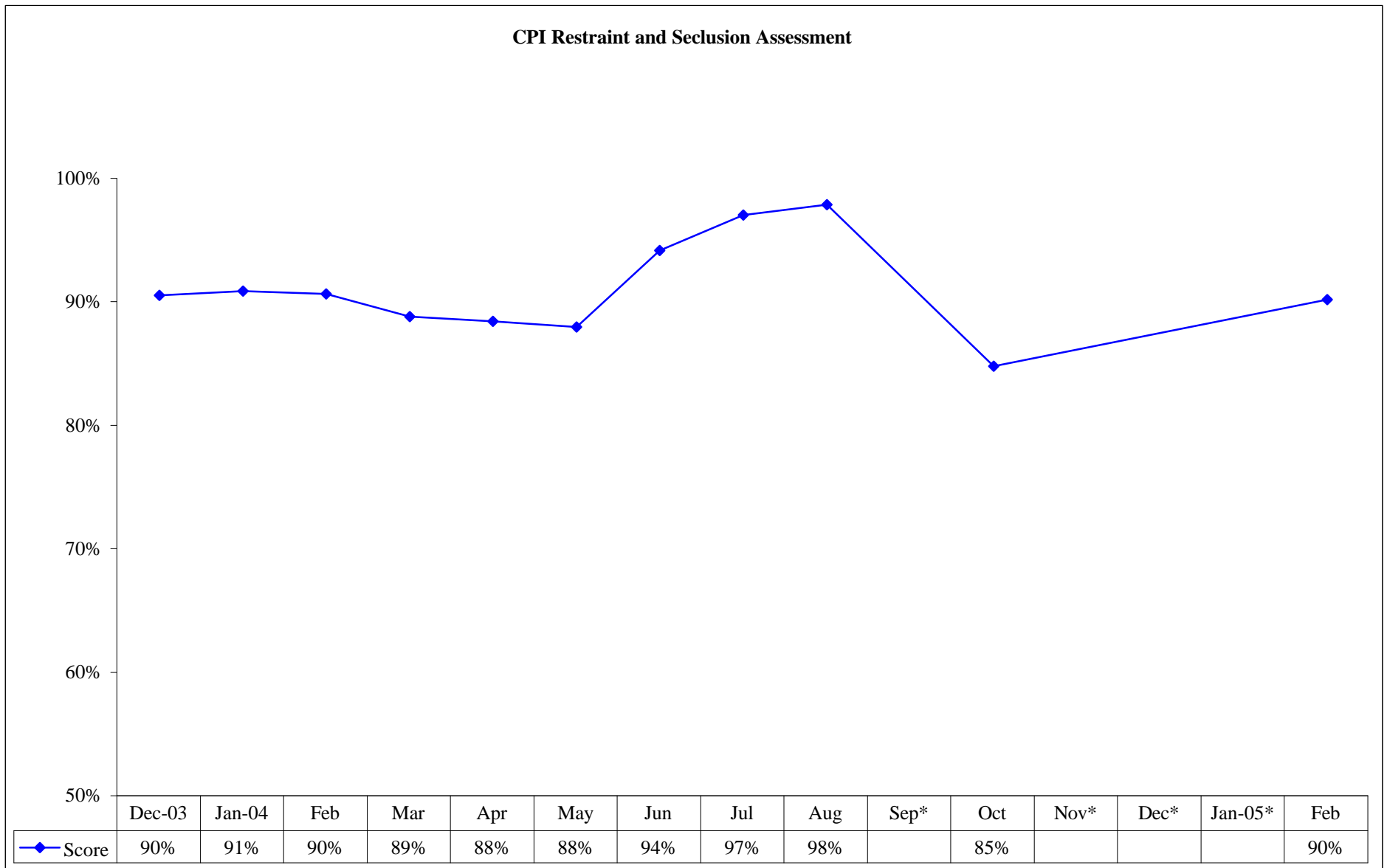
*No scores reported to HMDS.

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



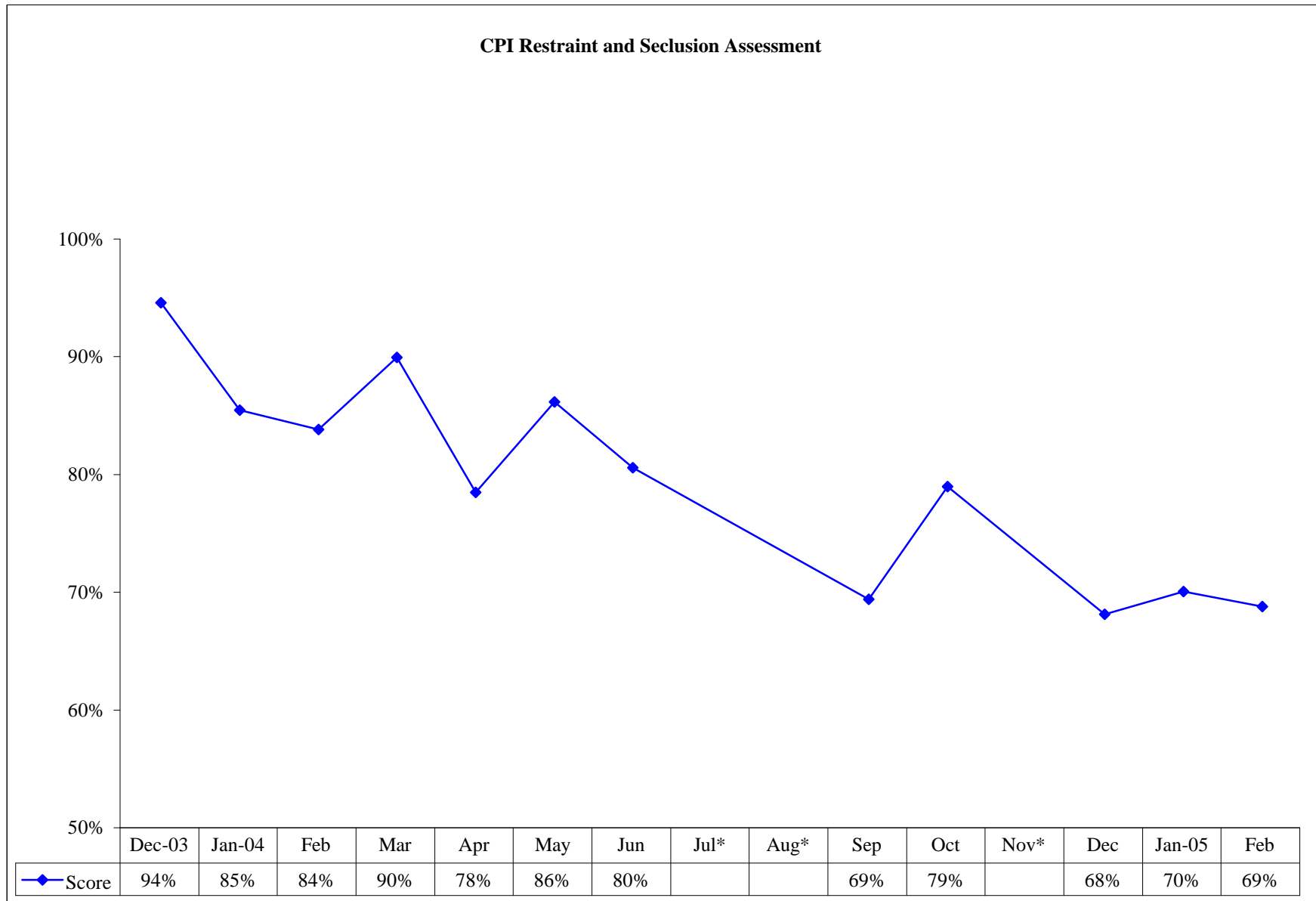
*No scores reported to HMDS.

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



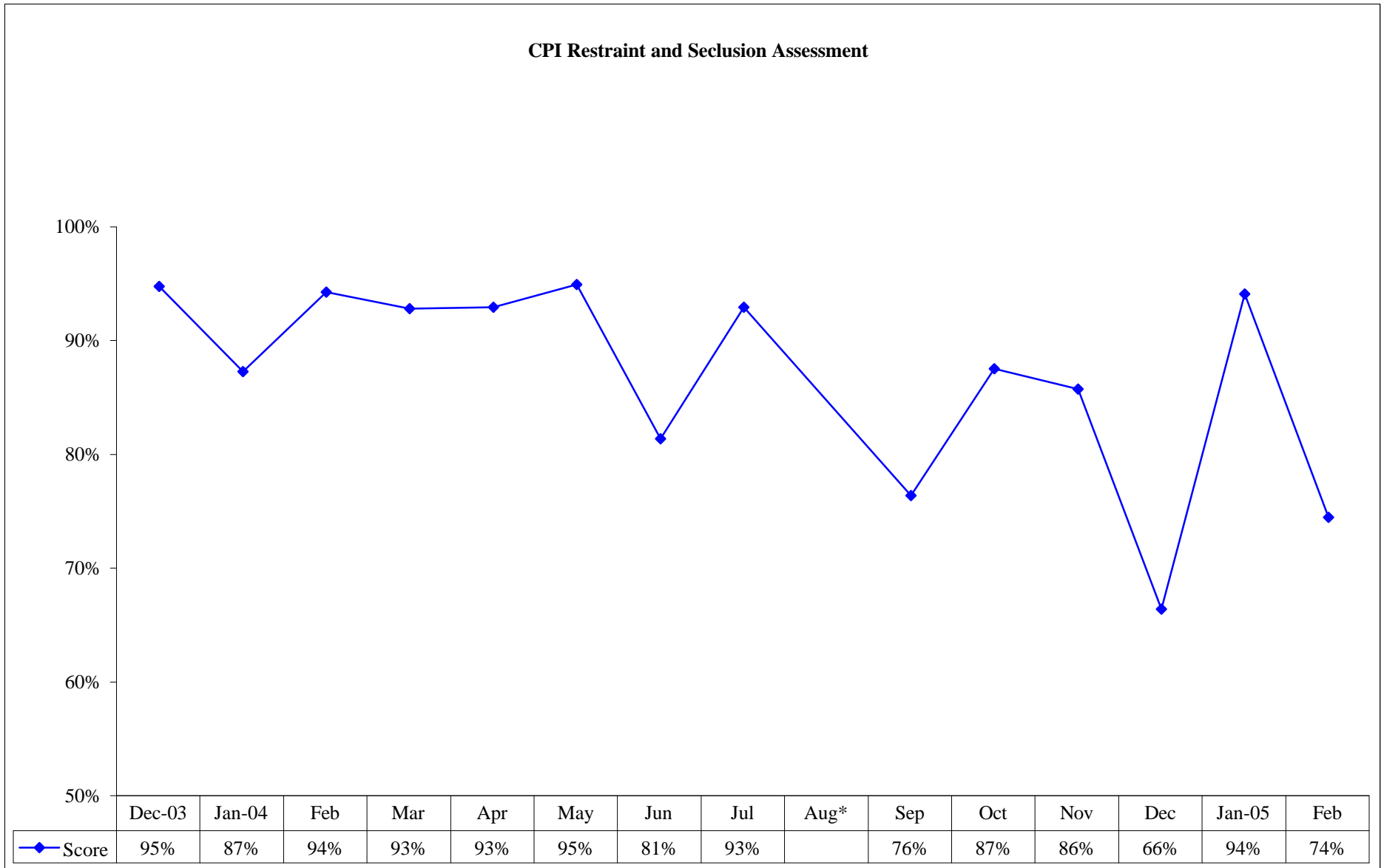
*No scores reported to HMDS.

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



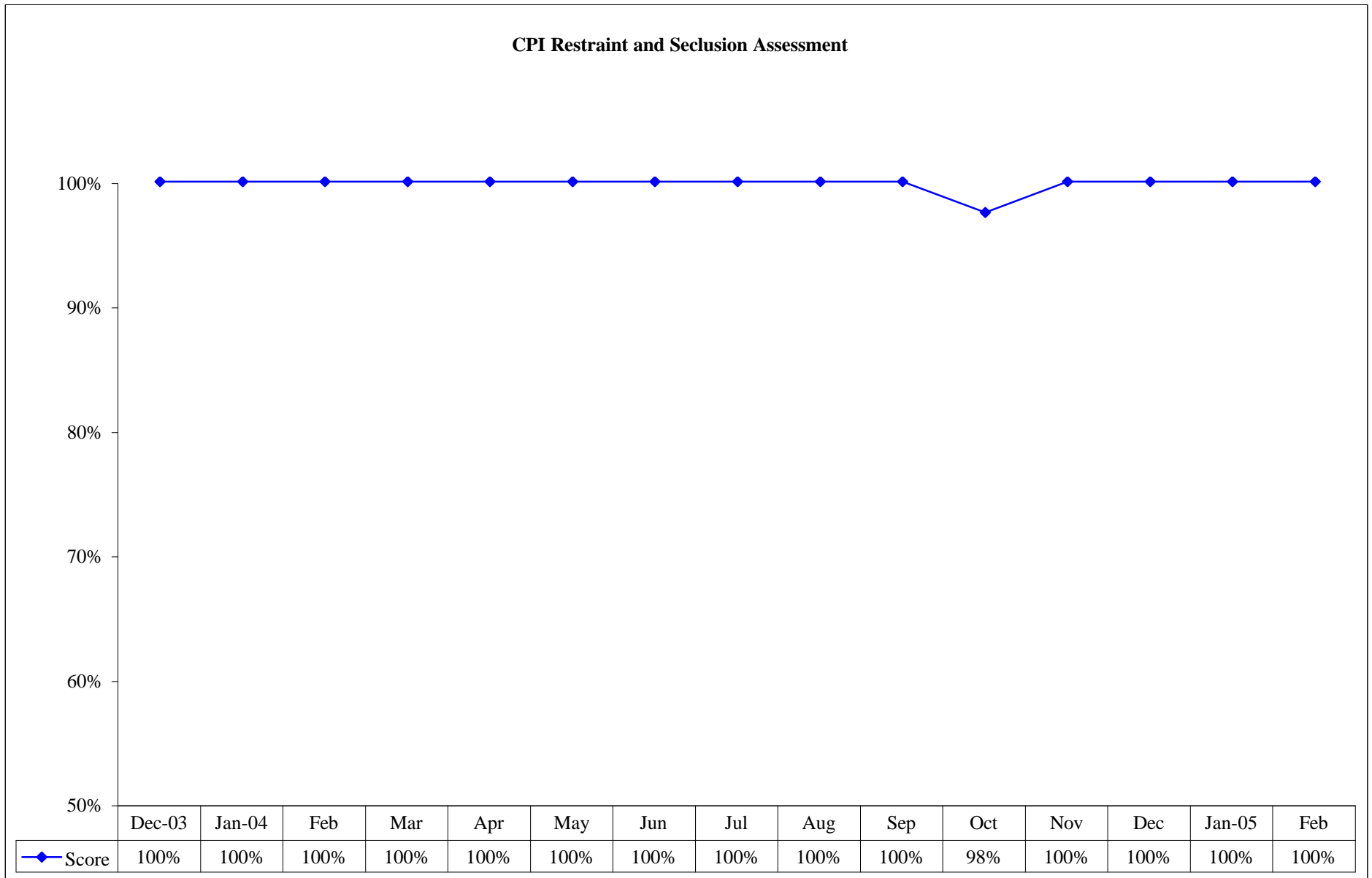
*No scores reported to HMDS.

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



*No scores reported to HMDS.

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



Performance Objective 3H:

Every patient with a diagnosis of Major Depression, Schizophrenia, or Bipolar disorder will be staged on the appropriate algorithm at least at discharge.

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

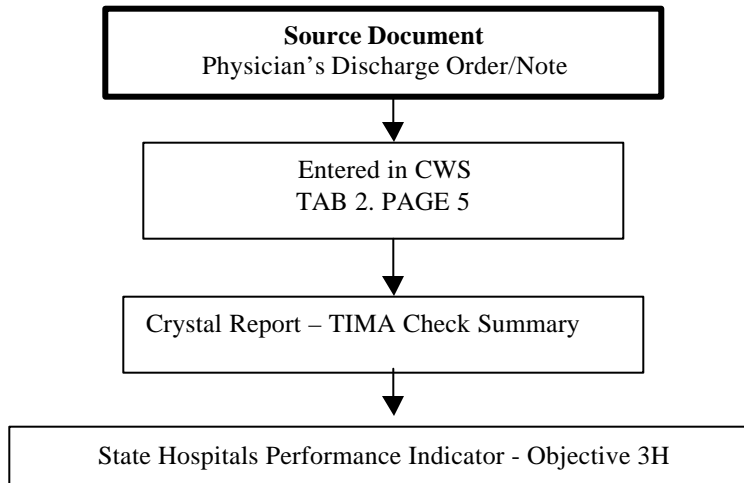
N = patients with episodes that are tracked by TIMA

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

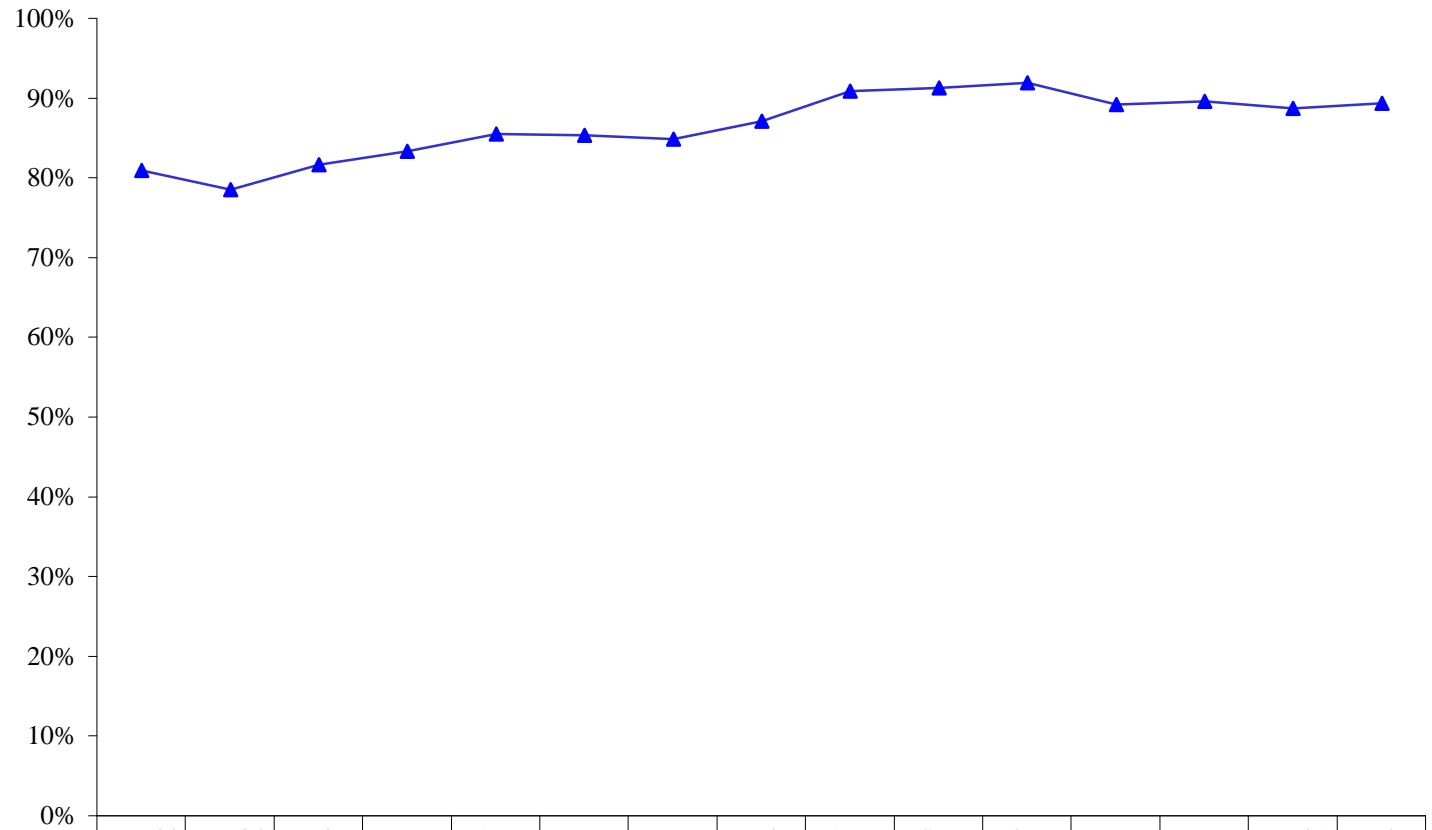
Percent of Patients with Episodes that are Tracked by TIMA

Facility	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
ASH	80%	79%	91%	89%	94%	95%	93%	88%	91%	93%	97%	93%	92%	89%	91%
BSSH	76%	73%	79%	81%	83%	70%	73%	69%	80%	83%	66%	71%	76%	67%	81%
EPPC	56%	66%	65%	66%	68%	85%	77%	76%	84%	89%	100%	91%	85%	98%	95%
KSH	88%	89%	100%	98%	95%	80%	68%	73%	91%	93%	95%	86%	95%	97%	100%
NTSH	95%	99%	94%	93%	83%	85%	79%	85%	93%	91%	91%	86%	90%	85%	87%
RGSC	97%	100%	96%	91%	87%	82%	84%	84%	83%	80%	91%	76%	94%	71%	76%
RSH	86%	82%	82%	87%	95%	95%	92%	88%	91%	83%	86%	84%	76%	87%	86%
SASH	89%	77%	78%	85%	92%	88%	97%	97%	97%	97%	94%	94%	93%	88%	89%
TSH	50%	44%	43%	57%	56%	60%	66%	92%	91%	97%	97%	98%	96%	98%	95%
All MH	81%	78%	81%	83%	85%	85%	85%	87%	91%	91%	92%	89%	89%	88%	89%

WCFY is exempted - There are no algorithm/scores for children at this time.

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

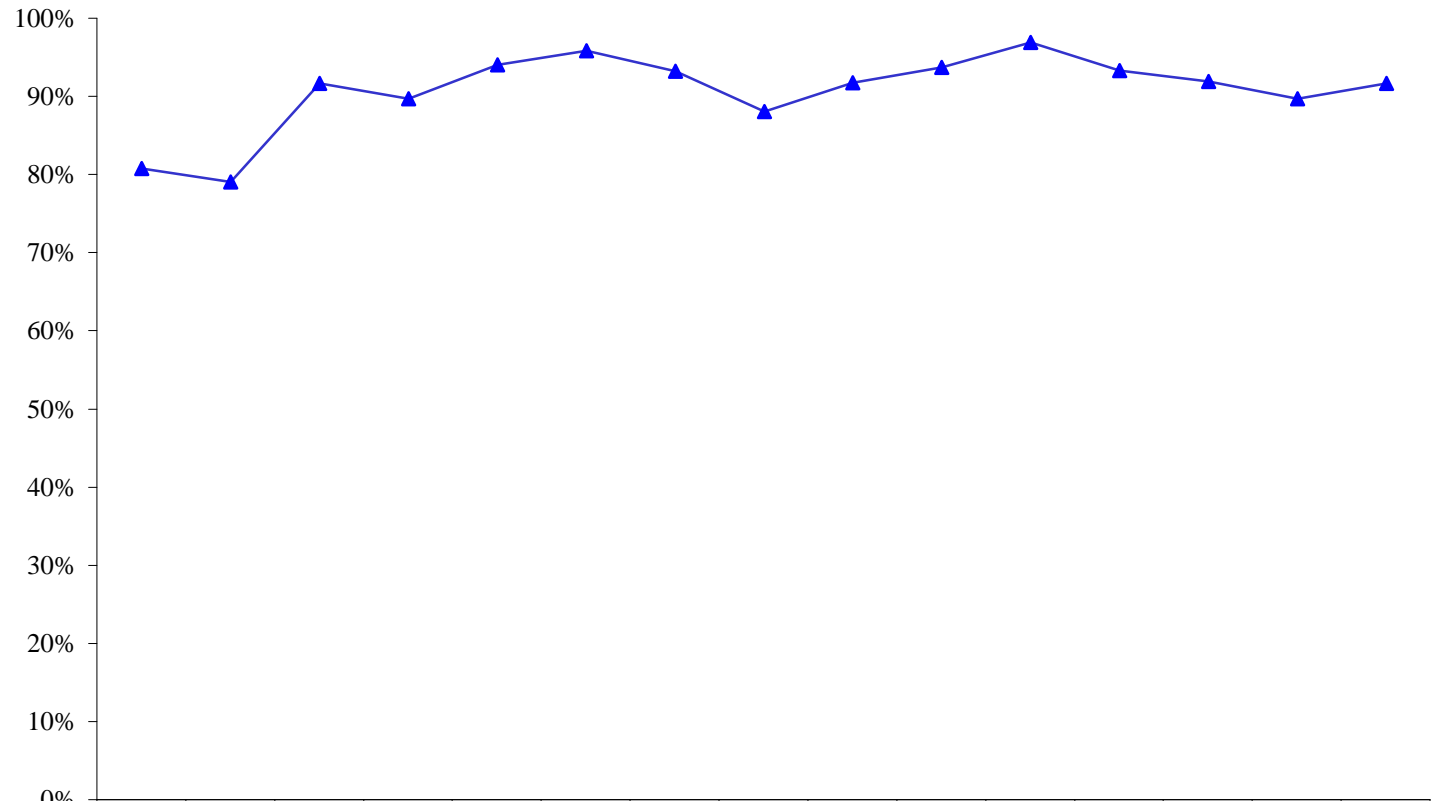
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	901	879	857	1052	1119	1044	1157	1042	1067	1067	1067	908	1017	1014	945
Patients with Episodes that are Tracked	726	687	697	873	953	887	978	904	966	970	977	807	908	896	841
▲ Percent Tracked by TIMA	81%	78%	81%	83%	85%	85%	85%	87%	91%	91%	92%	89%	89%	88%	89%

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

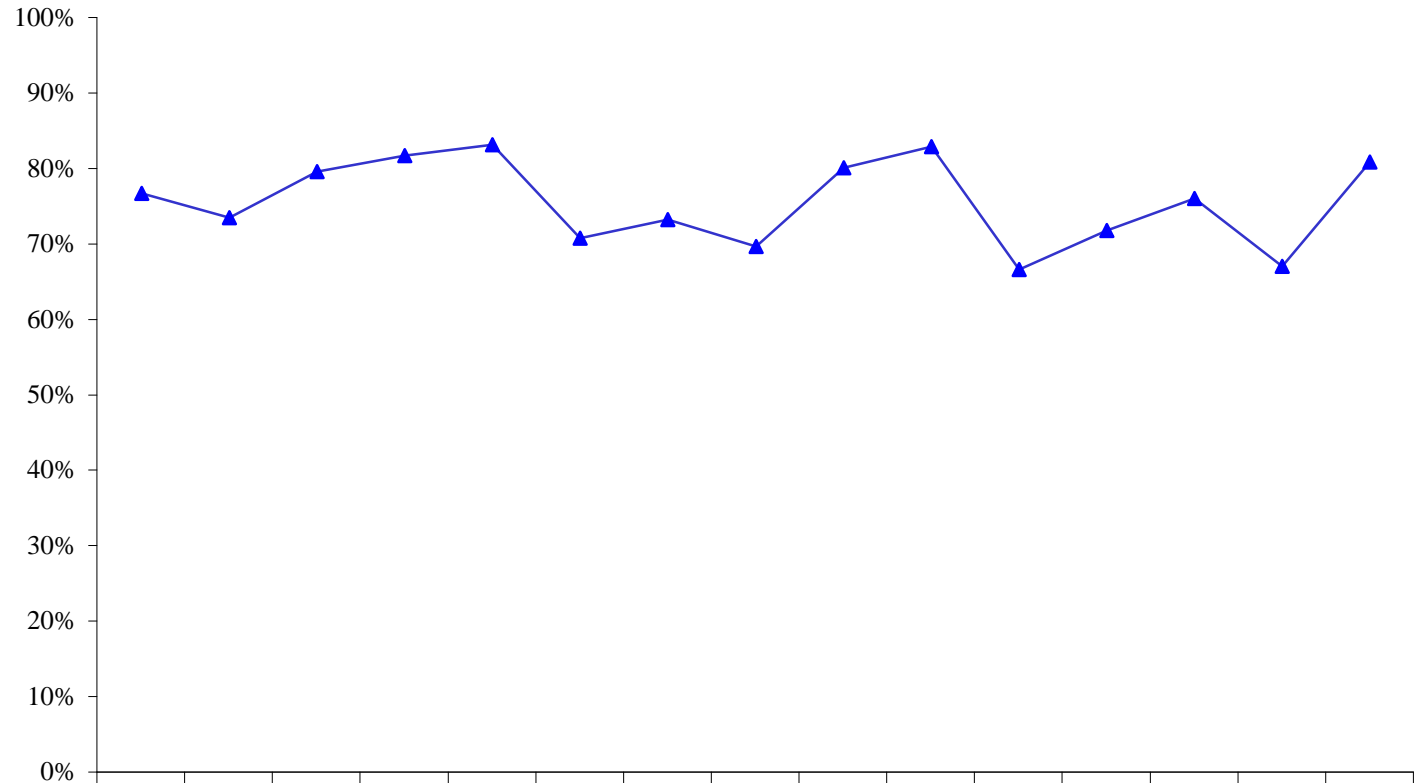
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	174	174	219	254	284	243	309	244	221	255	230	212	226	234	231
Patients with Episodes that are Tracked	140	137	200	227	266	232	287	214	202	238	222	197	207	209	211
▲ Percent Tracked by TIMA	80%	79%	91%	89%	94%	95%	93%	88%	91%	93%	97%	93%	92%	89%	91%

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

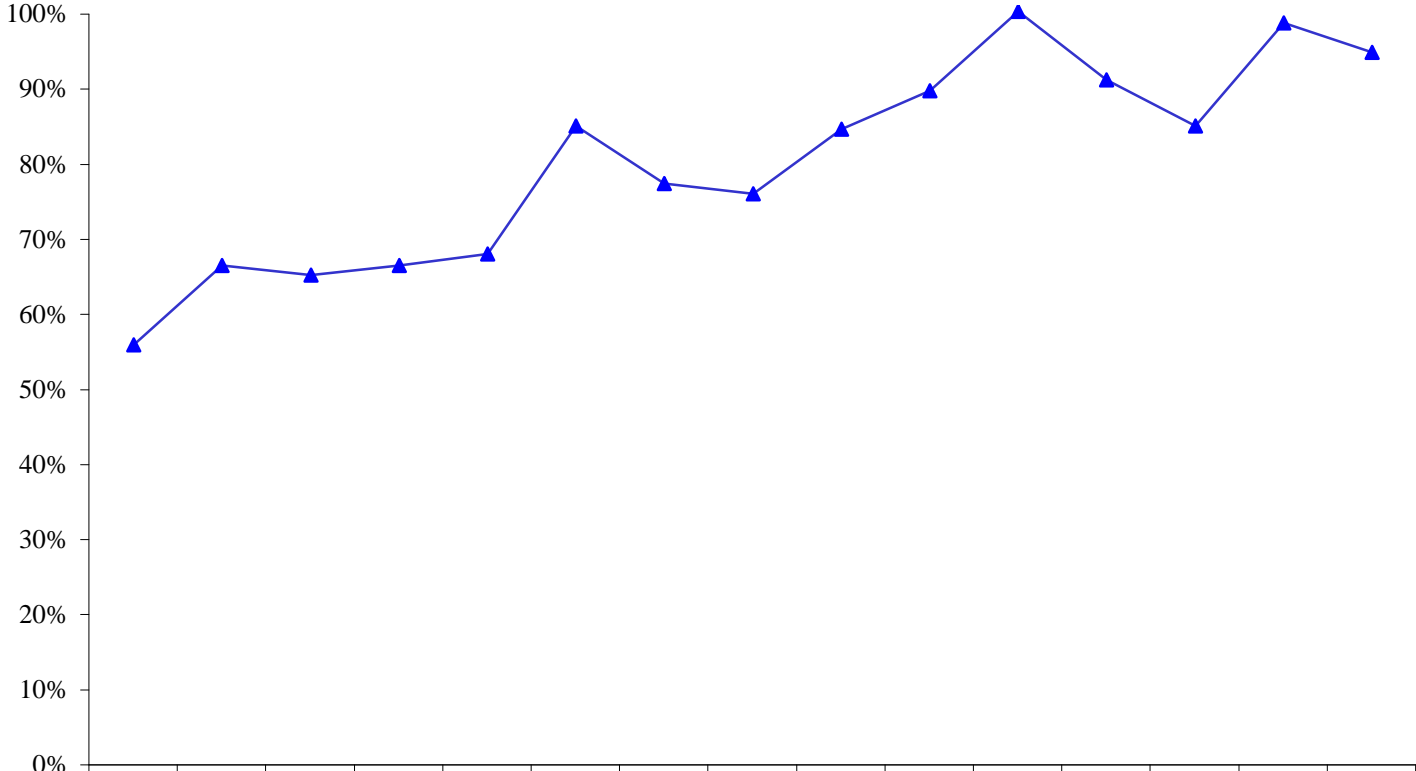
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	76	67	53	75	87	71	92	75	84	80	80	63	74	66	77
Patients with Episodes that are Tracked	58	49	42	61	72	50	67	52	67	66	53	45	56	44	62
▲ Percent Tracked by TIMA	76%	73%	79%	81%	83%	70%	73%	69%	80%	83%	66%	71%	76%	67%	81%

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

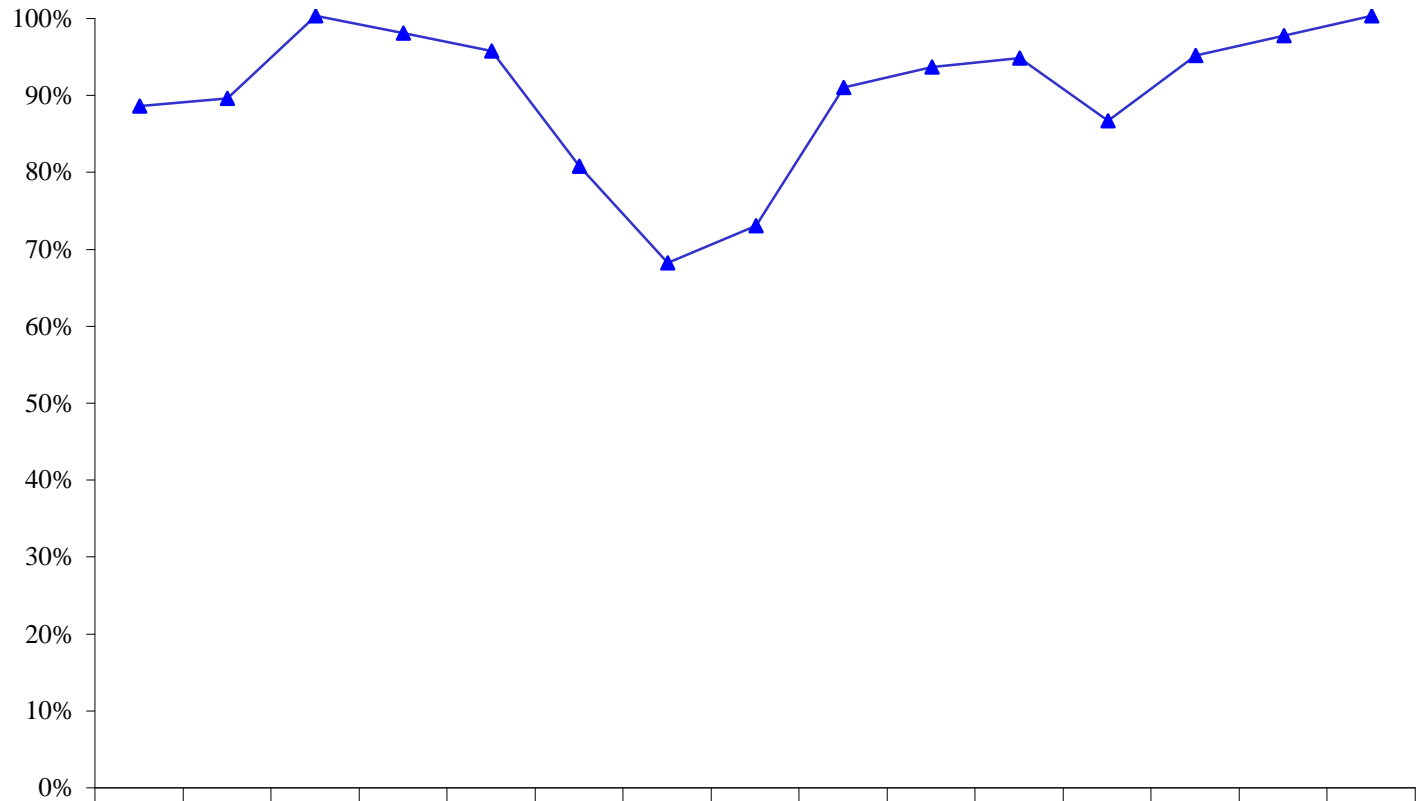
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	63	65	57	65	65	72	74	37	51	66	55	44	46	64	73
Patients with Episodes that are Tracked	35	43	37	43	44	61	57	28	43	59	55	40	39	63	69
▲ Percent Tracked by TIMA	56%	66%	65%	66%	68%	85%	77%	76%	84%	89%	100%	91%	85%	98%	95%

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

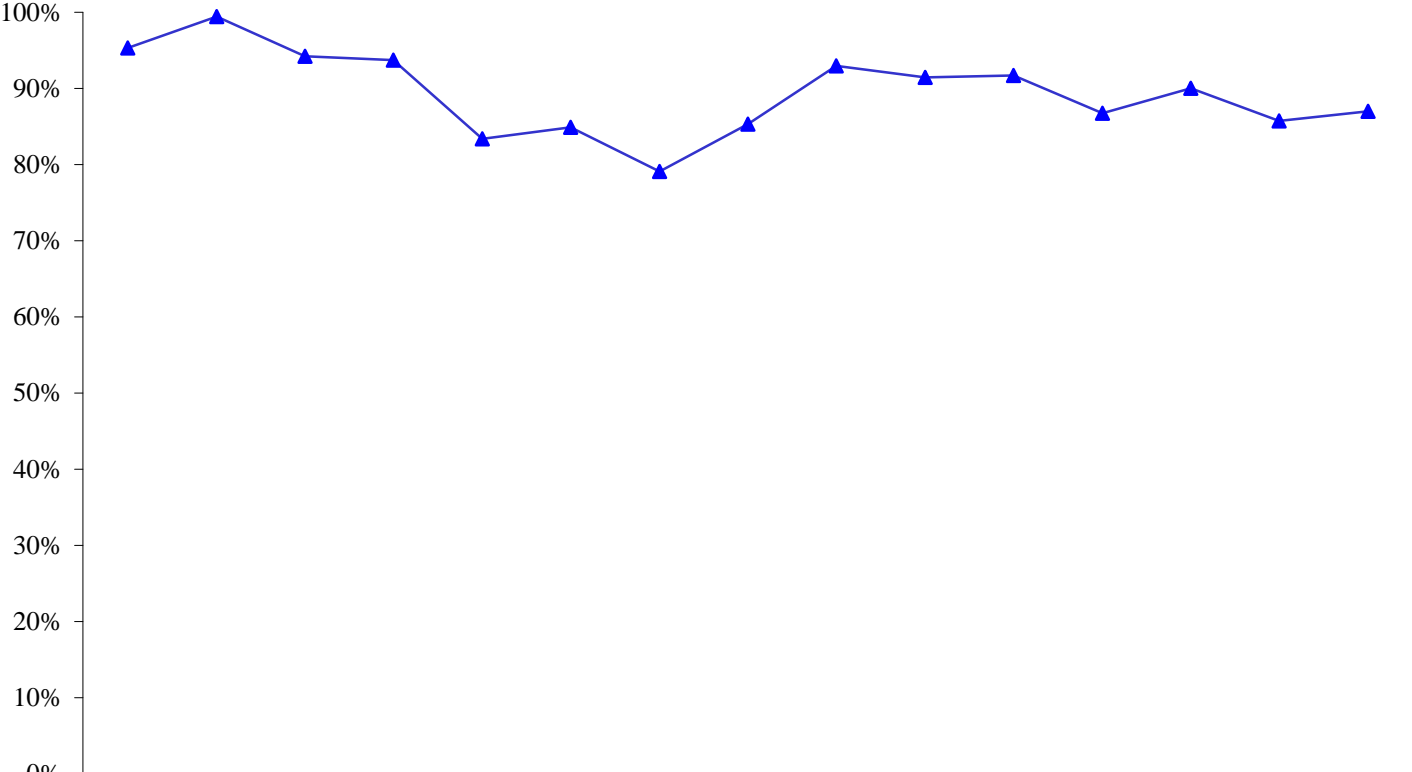
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	34	28	17	44	44	46	28	55	43	45	55	110	39	39	10
Patients with Episodes that are Tracked	30	25	17	43	42	37	19	40	39	42	52	95	37	38	10
▲ Percent Tracked by TIMA	88%	89%	100%	98%	95%	80%	68%	73%	91%	93%	95%	86%	95%	97%	100%

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

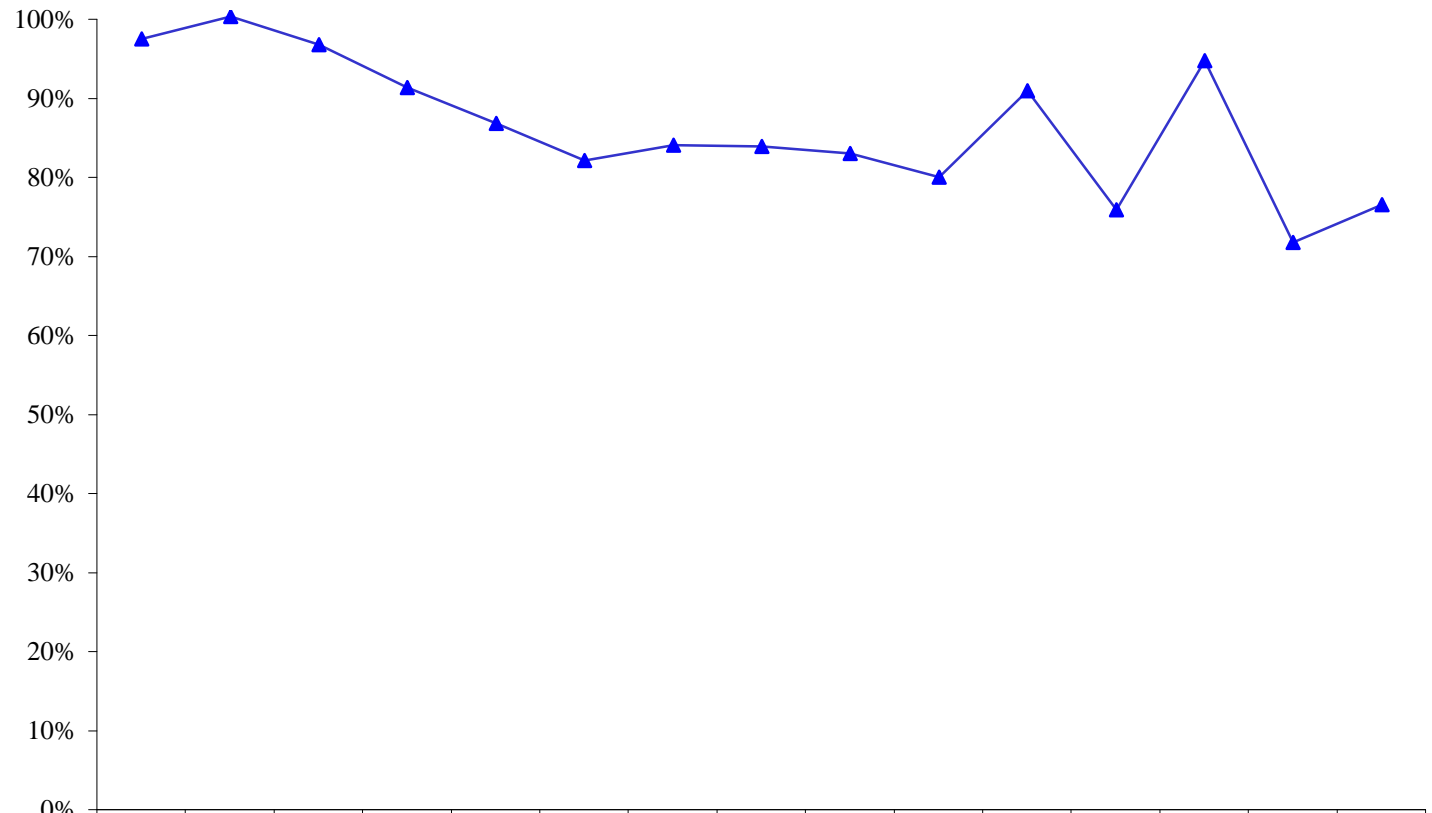
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	119	111	131	136	118	136	141	120	148	124	138	110	145	116	135
Patients with Episodes that are Tracked	113	110	123	127	98	115	111	102	137	113	126	95	130	99	117
▲ Percent Tracked by TIMA	95%	99%	94%	93%	83%	85%	79%	85%	93%	91%	91%	86%	90%	85%	87%

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

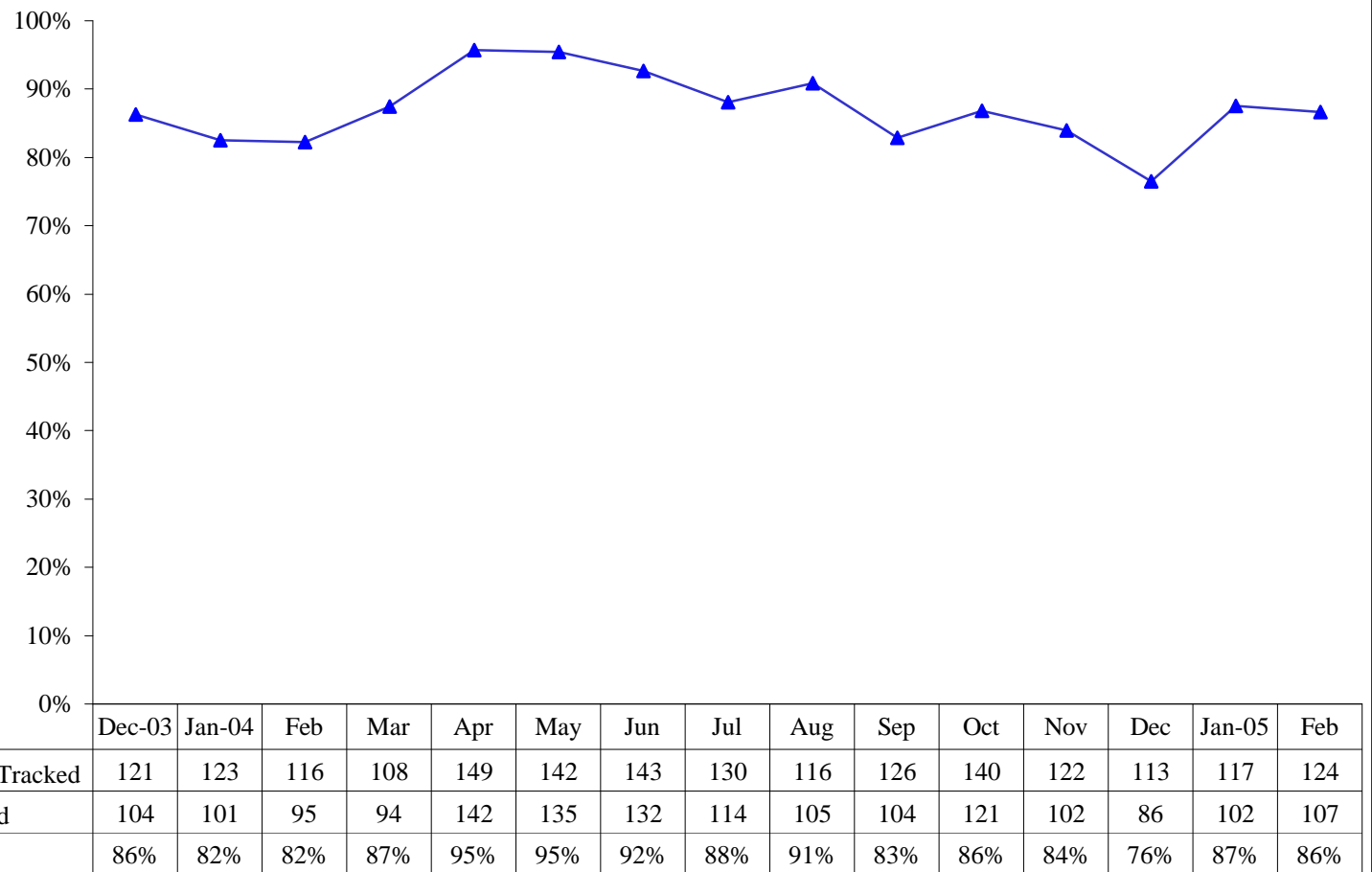
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	70	76	56	78	89	66	80	67	75	64	64	49	54	49	42
Patients with Episodes that are Tracked	68	76	54	71	77	54	67	56	62	51	58	37	51	35	32
▲ Percent Tracked by TIMA	97%	100%	96%	91%	87%	82%	84%	84%	83%	80%	91%	76%	94%	71%	76%

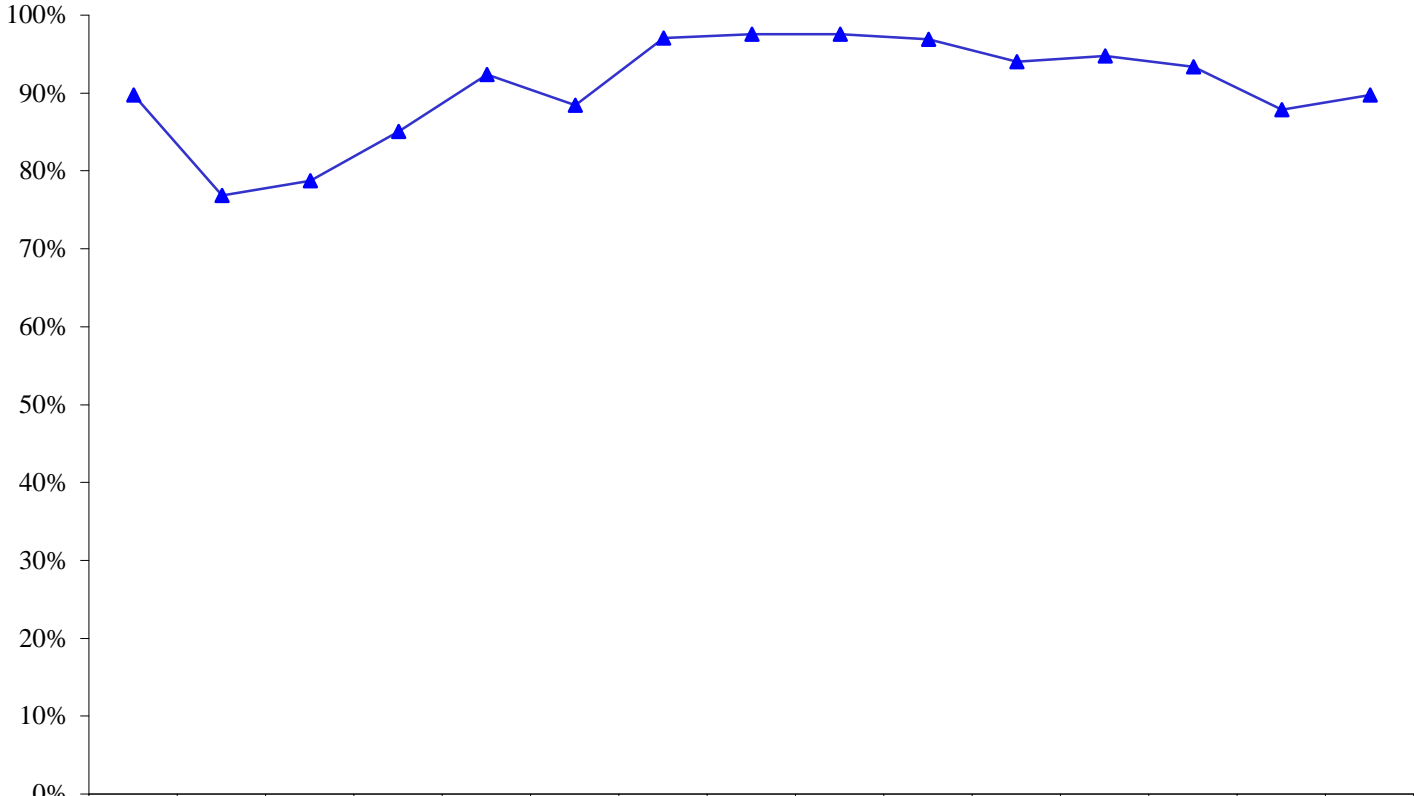
Objective 3H - Texas Implementation of Medication Algorithm (TIMA)
Rusk State Hospital

Percent of Patients with Episodes that are Tracked by TIMA



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

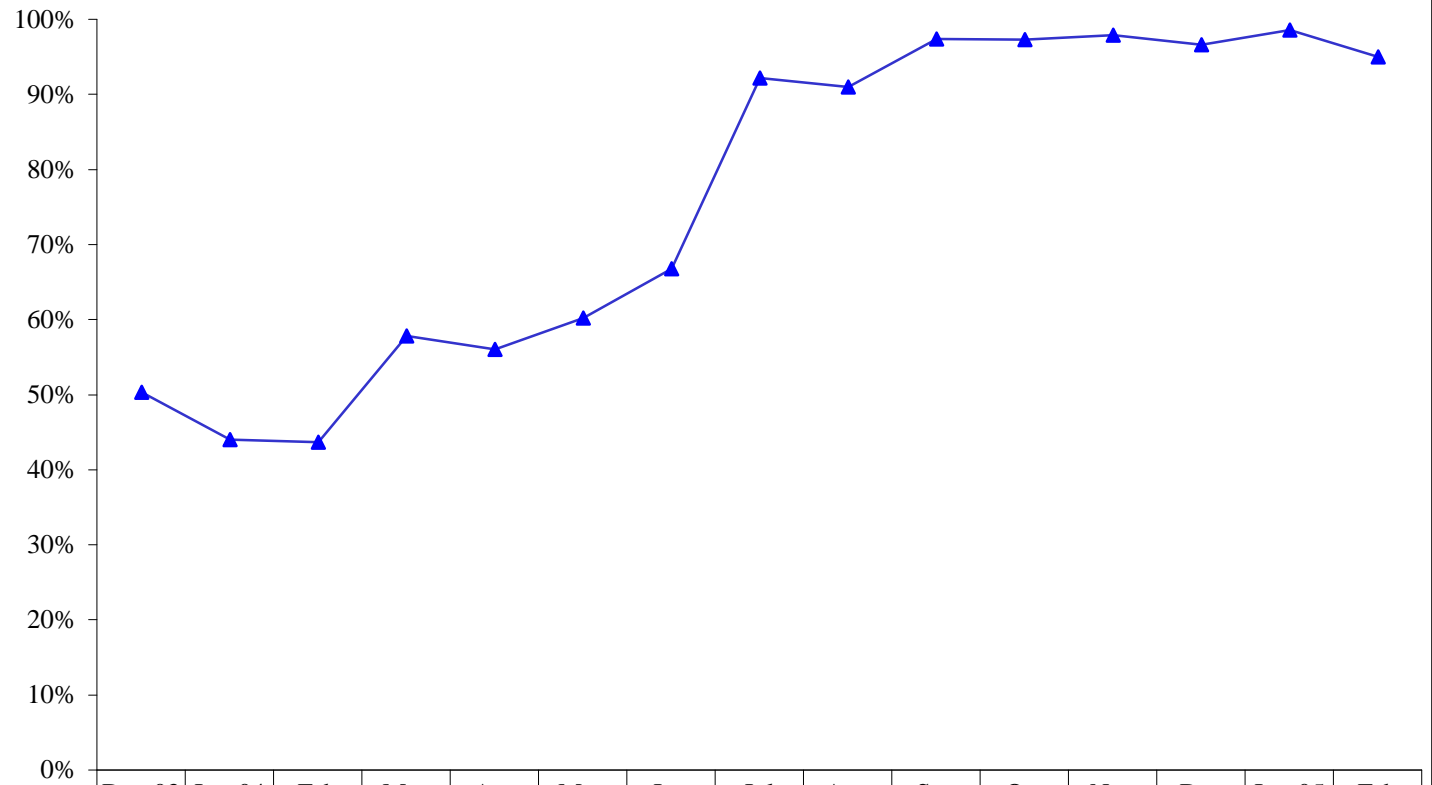
Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	142	132	111	144	150	151	152	179	181	172	173	144	187	160	123
Patients with Episodes that are Tracked	127	101	87	122	138	133	147	174	176	166	162	136	174	140	110
▲ Percent Tracked by TIMA	89%	77%	78%	85%	92%	88%	97%	97%	97%	97%	94%	94%	93%	88%	89%

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

Percent of Patients with Episodes that are Tracked by TIMA



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Patients with Episodes that Should be Tracked	102	103	97	148	133	117	137	135	149	135	132	121	133	169	130
Patients with Episodes that are Tracked	51	45	42	85	74	70	91	124	135	131	128	118	128	166	123
▲ Percent Tracked by TIMA	50%	44%	43%	57%	56%	60%	66%	92%	91%	97%	97%	98%	96%	98%	95%

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.

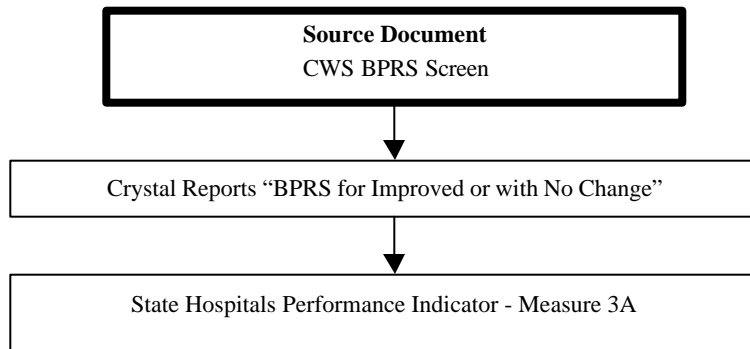
Performance Measure Operational Definition: For each quarter, the number of discharged patients in CARE with two BPRS scores that have a change in scores of +12 points or less. BPRS Version 4.0, Expanded Version will be used to rate all patients upon admission and discharge. To be valid, total BPRS score 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 - Q2 FY2005**

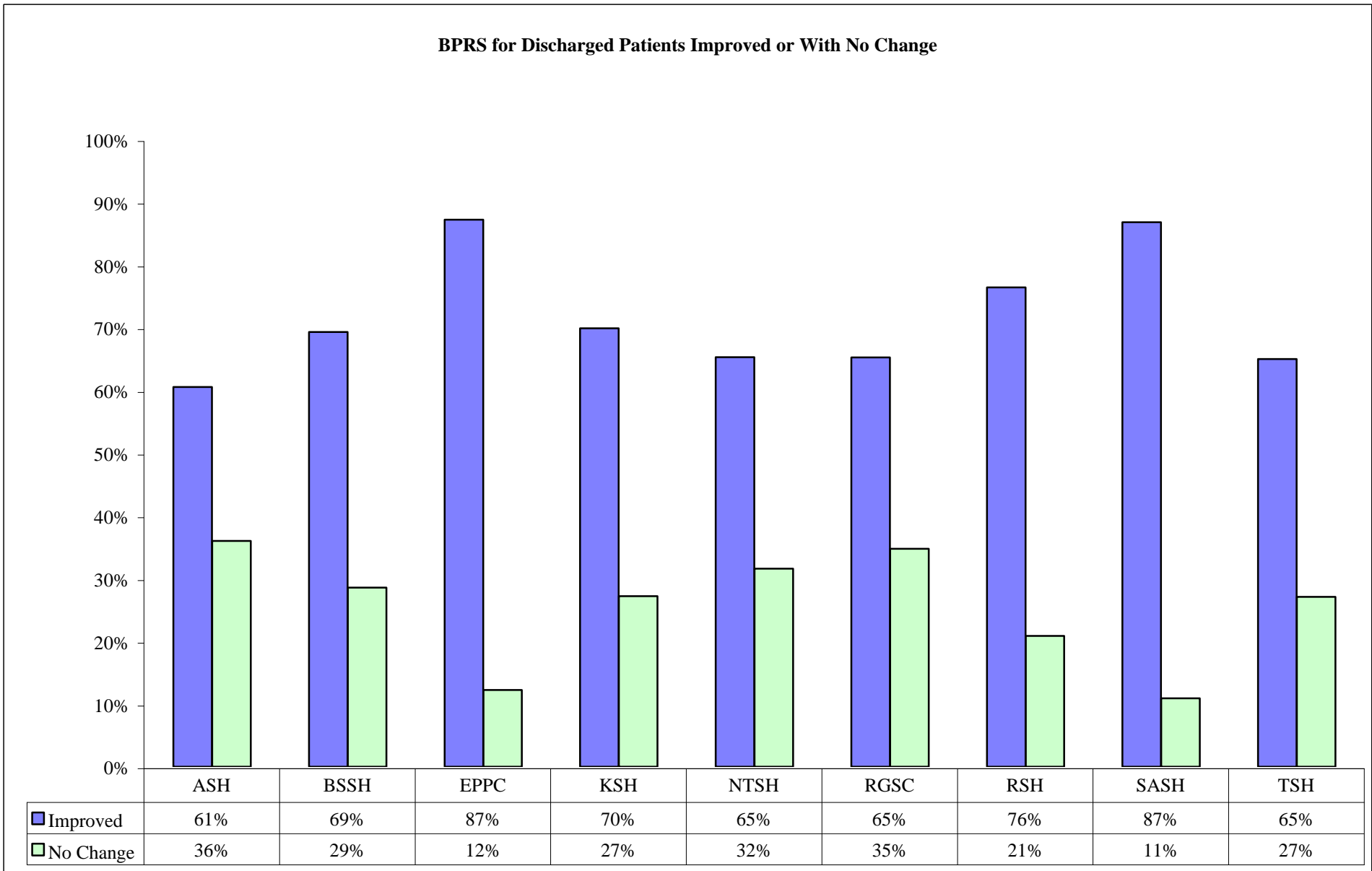
Facility	Total	Improvement	%	No Change	%	Increase Symptoms	%
ASH	808	489	61%	291	36%	28	3%
BSSH	280	194	69%	80	29%	6	2%
EPPC	188	164	87%	23	12%	1	1%
KSH	103	72	70%	28	27%	3	3%
NTSH	513	335	65%	162	32%	16	3%
RGSC	141	92	65%	49	35%	0	0%
RSH	441	337	76%	92	21%	12	3%
SASH	569	494	87%	62	11%	13	2%
TSH	542	350	65%	147	27%	45	8%
Totals	3585	2527	71%	934	26%	124	3%

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

**The Number and Percent of Discharged Patients with
Two BPRS Scores - Q1 FY2005**

Facility	Total	Improvement	%	No Change	%	Increase Symptoms	%
ASH	829	534	64%	274	33%	21	3%
BSSH	278	174	63%	97	34%	7	3%
EPPC	97	77	79%	19	20%	1	1%
KSH	159	125	79%	32	20%	2	1%
NTSH	482	302	63%	167	34%	13	3%
RGSC	156	97	62%	57	37%	2	1%
RSH	486	346	71%	128	27%	12	2%
SASH	569	480	84%	75	14%	14	2%
TSH	480	319	66%	109	23%	52	11%
Totals	3536	2454	69%	958	27%	124	4%

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



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.

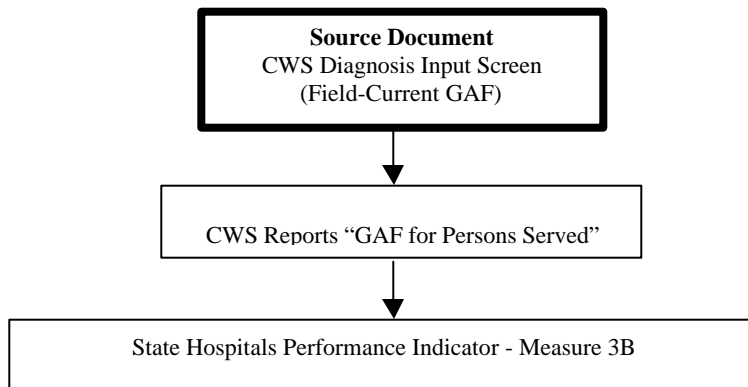
Performance Measure Formula: $R = (N/D)$

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:

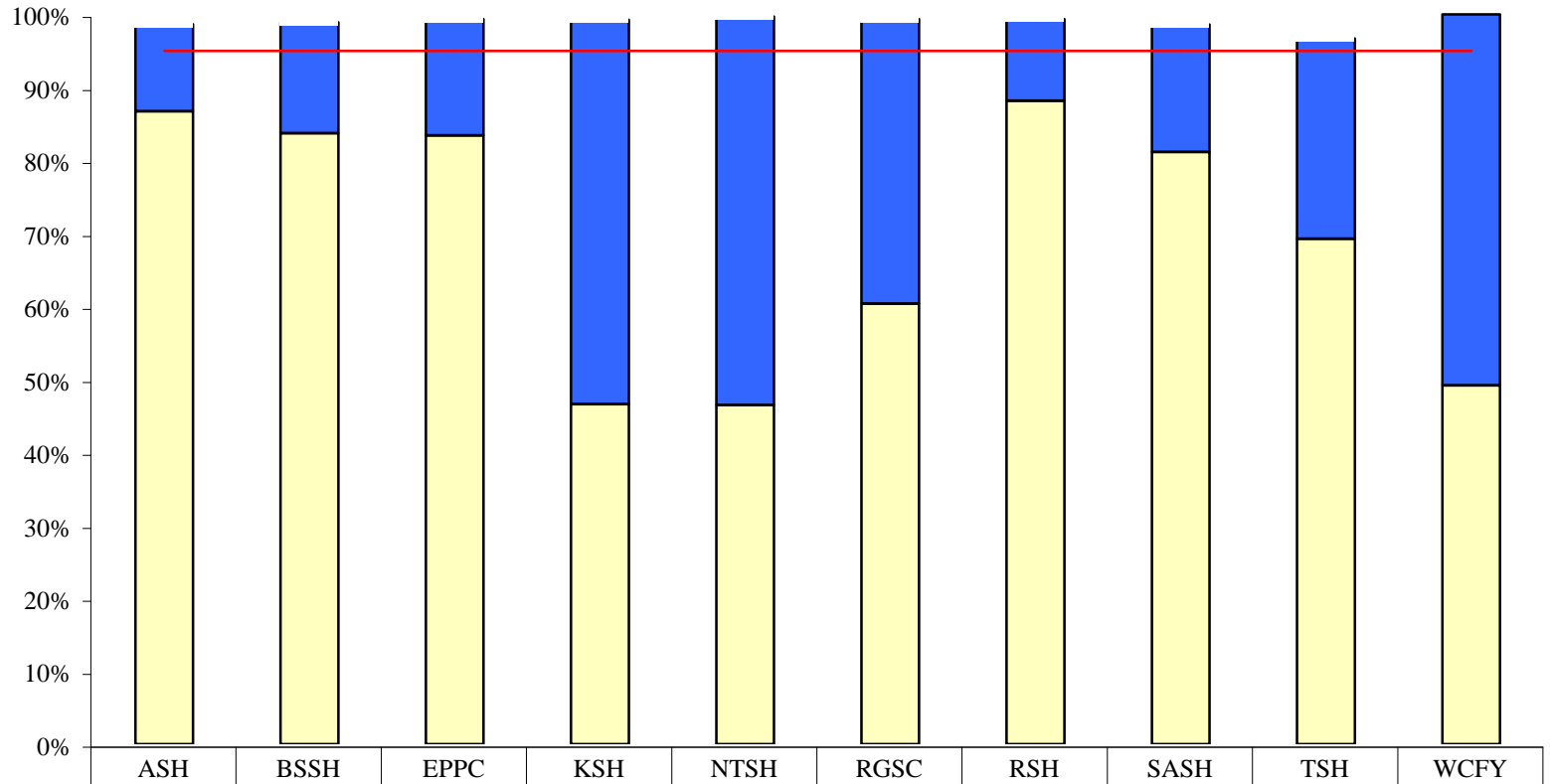


Data Integrity Review Process:

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 February 28, 2005

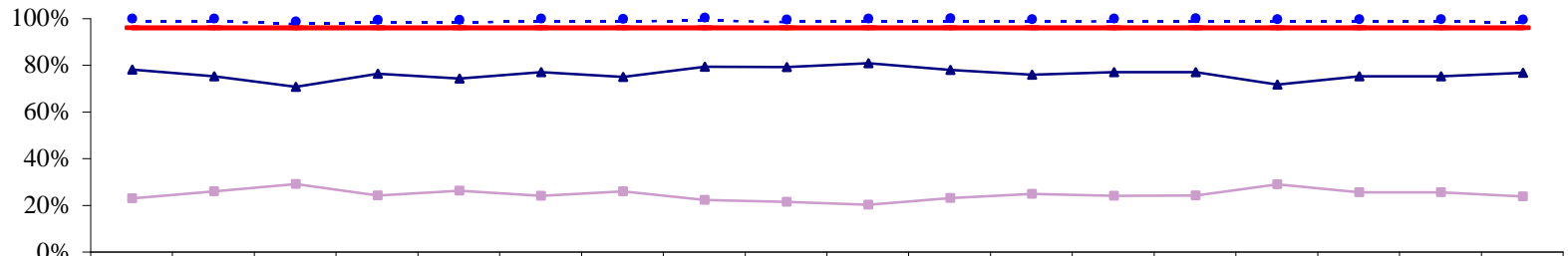
FYTD Percent of Discharged Whose GAF Score Stabilized/Increased by 10 or More



	ASH	BSSH	EPPC	KSH	NTSH	RGSC	RSH	SASH	TSH	WCFY
% Stabilized + Increased	99%	99%	99%	99%	100%	99%	99%	99%	97%	100%
% Stabilized	12%	15%	16%	53%	53%	39%	11%	17%	27%	51%
% Increased by 10 or More	87%	84%	83%	47%	46%	60%	88%	81%	69%	49%
% Expectation	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

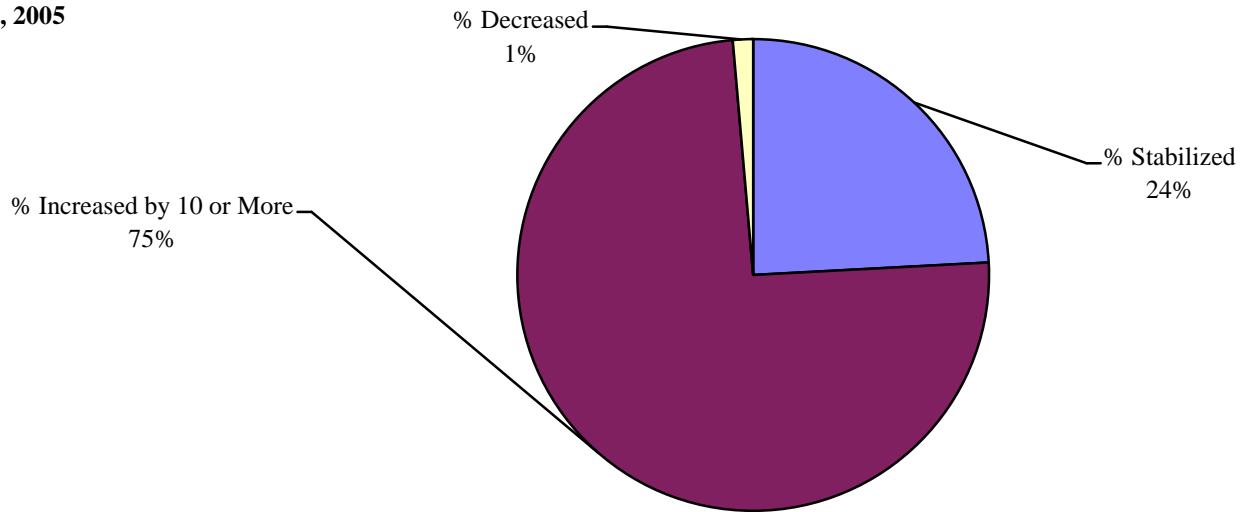
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
All MH Facilities

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



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	77%	74%	70%	75%	73%	76%	74%	78%	78%	80%	77%	75%	76%	76%	71%	74%	74%	76%
—■— % Stabilized	22%	25%	28%	23%	25%	23%	25%	21%	20%	19%	22%	24%	23%	23%	28%	24%	24%	23%
- - ● - - % Stabilized + Increased	99%	99%	98%	98%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	98%
— % 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 February 28, 2005

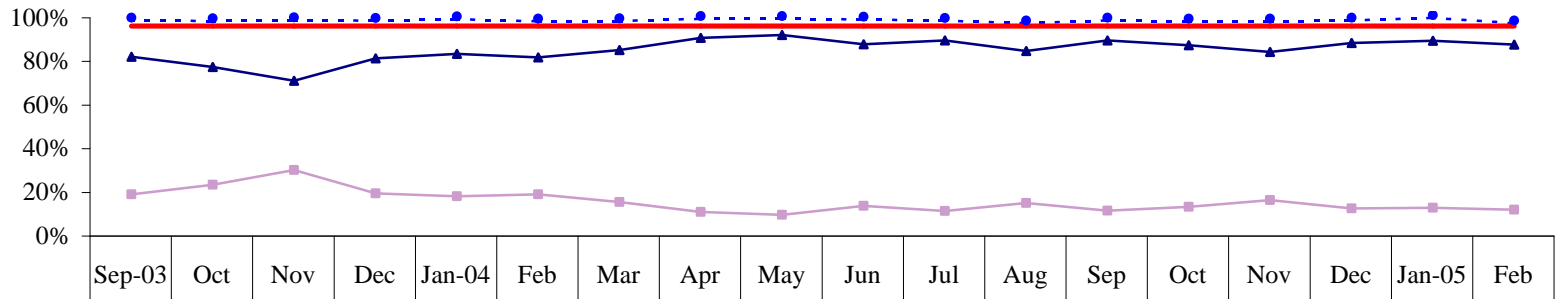


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More

Percent of Discharged Whose GAF Score Stabilized

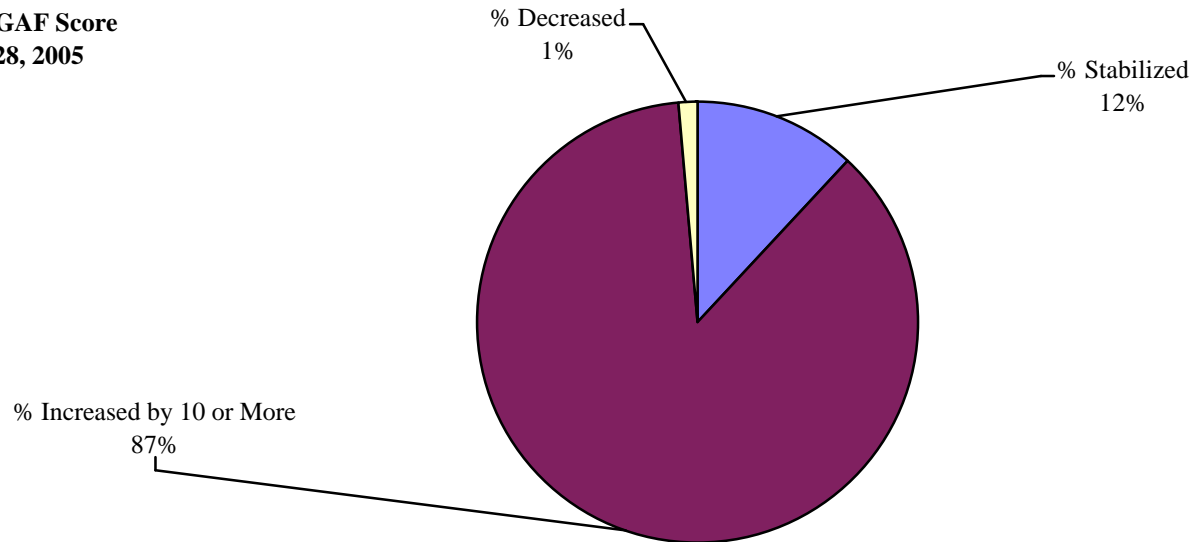
Austin State Hospital

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



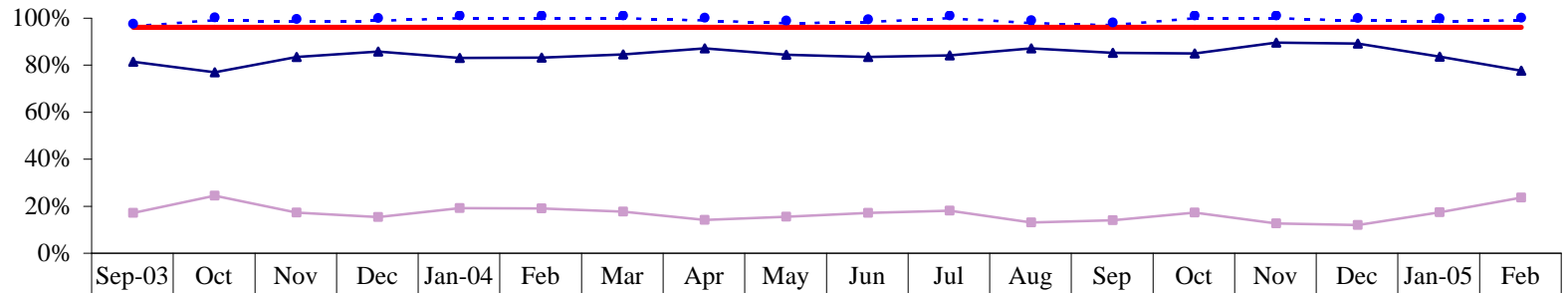
—▲— % Increased by 10 or More	81%	76%	70%	80%	82%	81%	84%	90%	91%	87%	88%	84%	88%	86%	83%	87%	88%	87%
—■— % Stabilized	18%	22%	29%	18%	17%	18%	14%	10%	9%	13%	10%	14%	10%	12%	15%	11%	12%	11%
- - ● - - % Stabilized + Increased	99%	99%	99%	99%	99%	98%	99%	100%	99%	99%	99%	98%	99%	98%	98%	99%	100%	97%
— % 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 February 28, 2005**



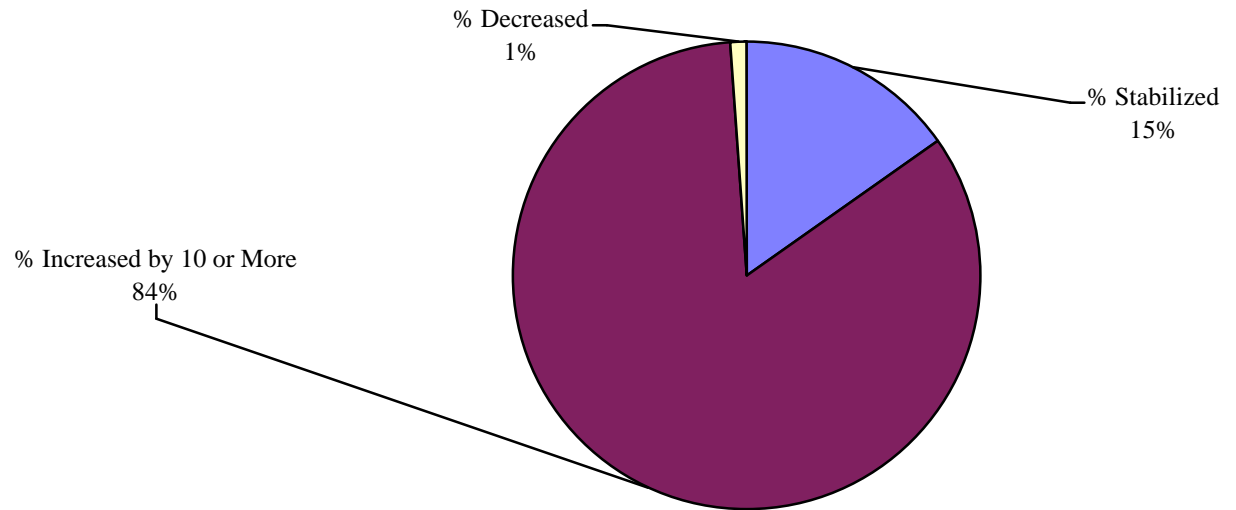
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Big Spring State Hospital

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



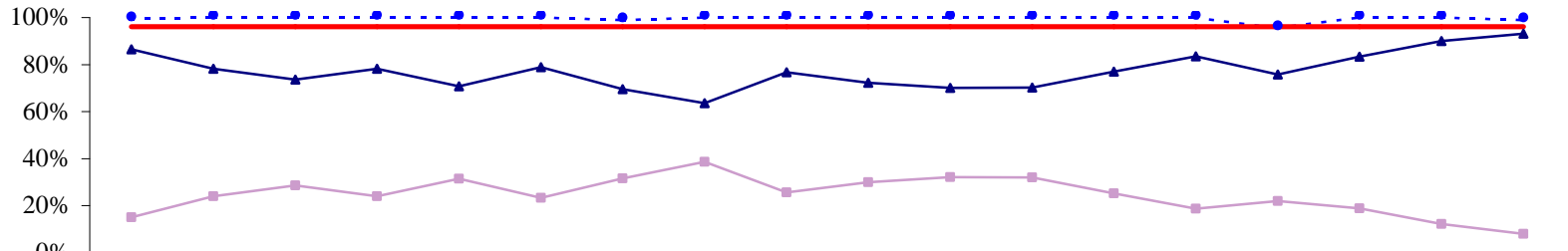
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	80%	76%	82%	85%	82%	82%	84%	86%	83%	82%	83%	86%	84%	84%	88%	88%	83%	76%
—■— % Stabilized	16%	23%	16%	14%	18%	18%	17%	13%	14%	16%	17%	12%	13%	16%	12%	11%	16%	23%
- - -▲- - - % Stabilized + Increased	96%	99%	99%	99%	100%	100%	100%	99%	98%	98%	100%	98%	97%	100%	100%	99%	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 February 28, 2005



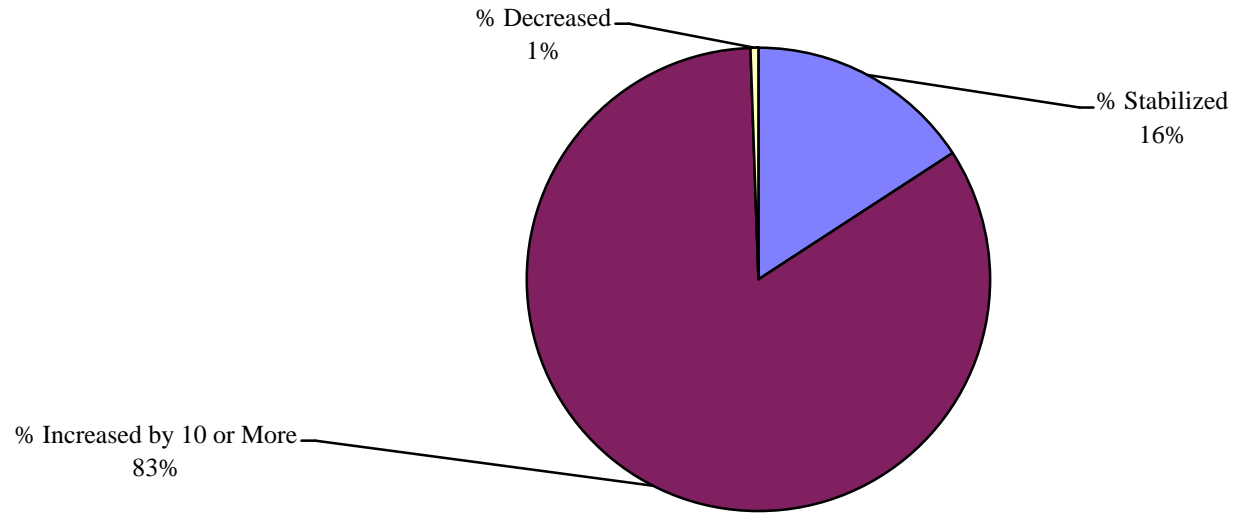
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
El Paso Psychiatric Center

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



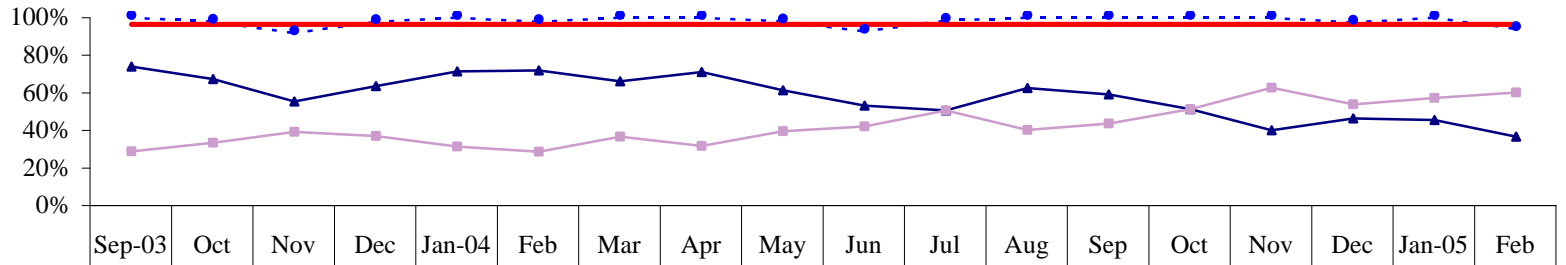
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	85%	77%	73%	77%	70%	78%	68%	63%	76%	71%	69%	69%	76%	82%	75%	82%	89%	92%
—■— % Stabilized	14%	23%	27%	23%	30%	22%	31%	38%	24%	29%	31%	31%	24%	18%	21%	18%	11%	7%
- - ● - - % Stabilized + Increased	99%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	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 February 28, 2005



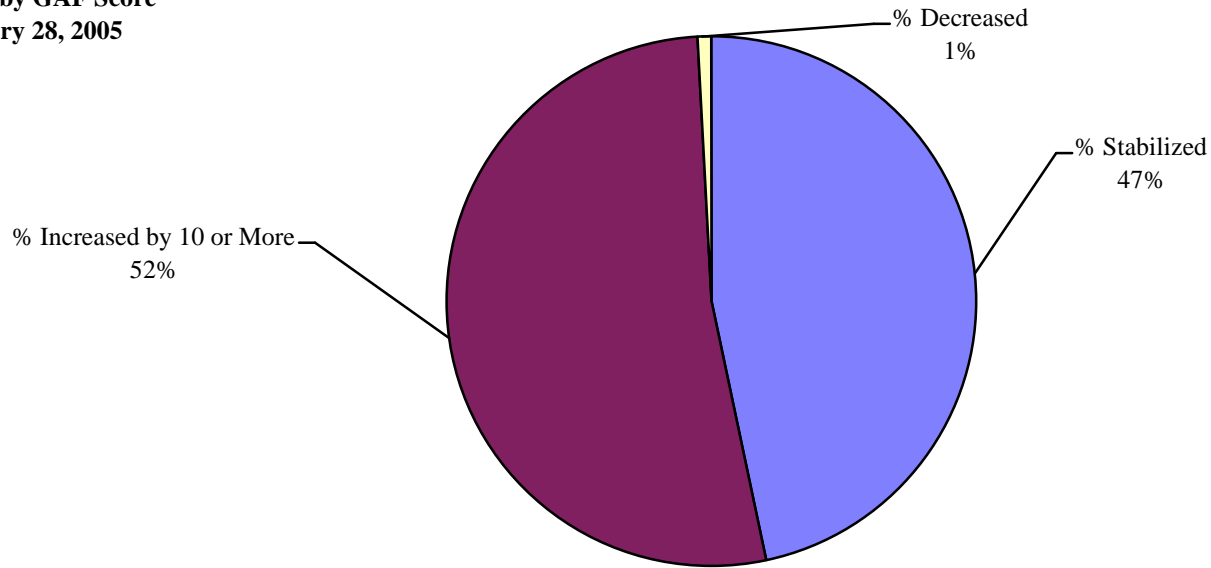
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Kerrville State Hospital

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

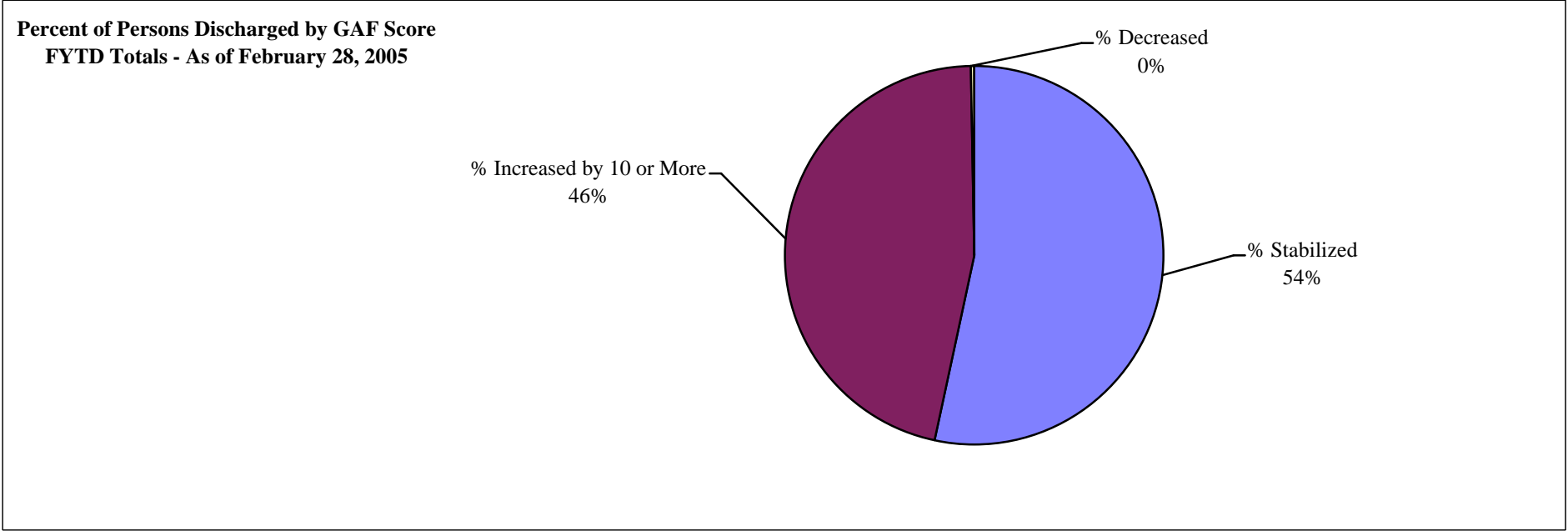
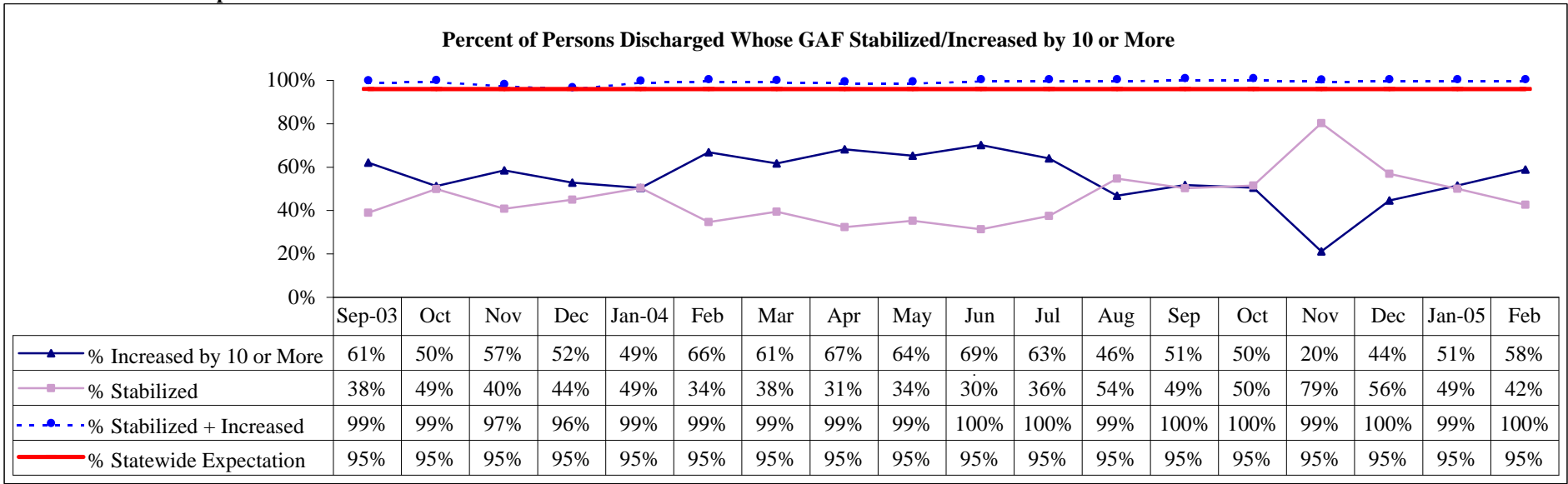


	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	73%	66%	54%	62%	70%	70%	65%	70%	60%	52%	49%	61%	58%	50%	39%	45%	44%	35%
—■— % Stabilized	27%	32%	38%	36%	30%	27%	35%	30%	38%	41%	49%	39%	42%	50%	61%	53%	56%	59%
- - ● - - % Stabilized + Increased	100%	98%	92%	98%	100%	98%	100%	100%	98%	93%	98%	100%	100%	100%	100%	98%	100%	94%
— % 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 February 28, 2005

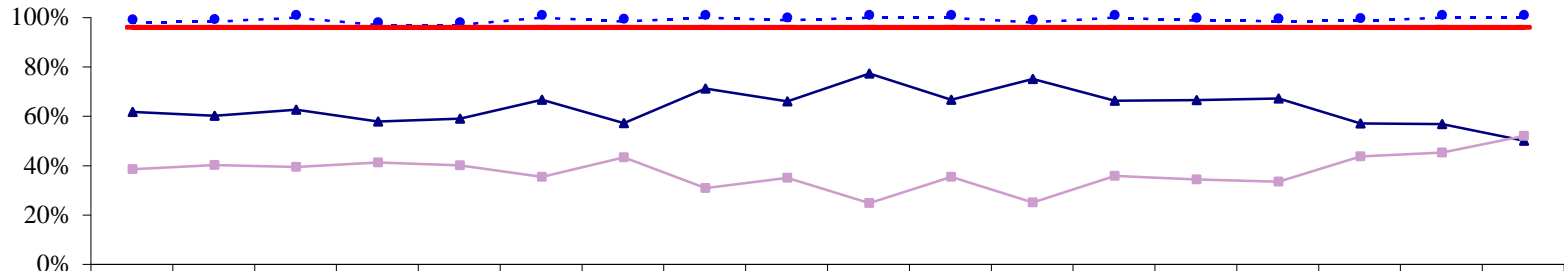


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
North Texas State Hospital



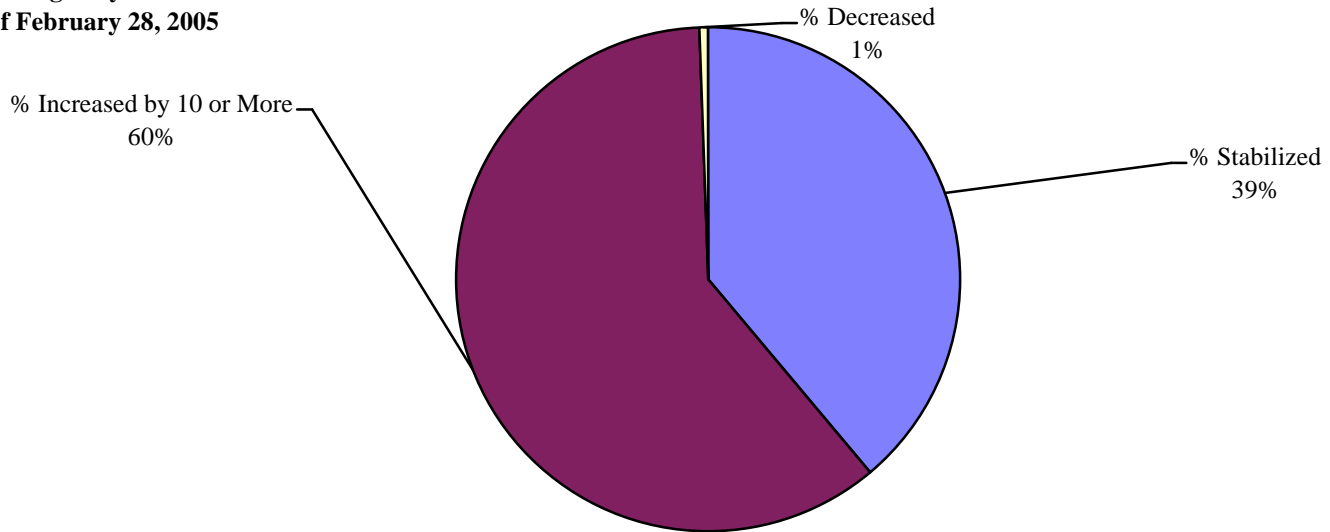
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Rio Grande State Center

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



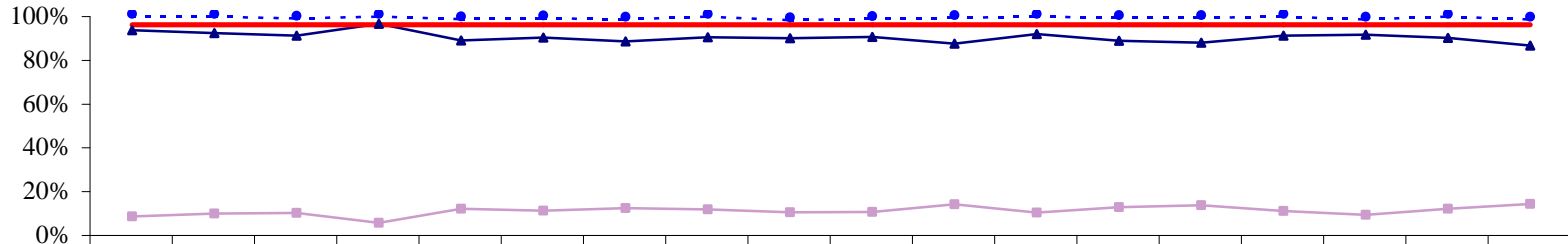
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	61%	59%	62%	57%	58%	66%	56%	70%	65%	76%	66%	74%	65%	66%	66%	56%	56%	49%
—■— % Stabilized	38%	39%	38%	40%	39%	34%	42%	30%	34%	24%	34%	24%	35%	33%	32%	43%	44%	51%
- - ● - - % Stabilized + Increased	98%	98%	100%	97%	97%	100%	98%	100%	99%	100%	100%	98%	100%	99%	99%	99%	100%	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 February 28, 2005



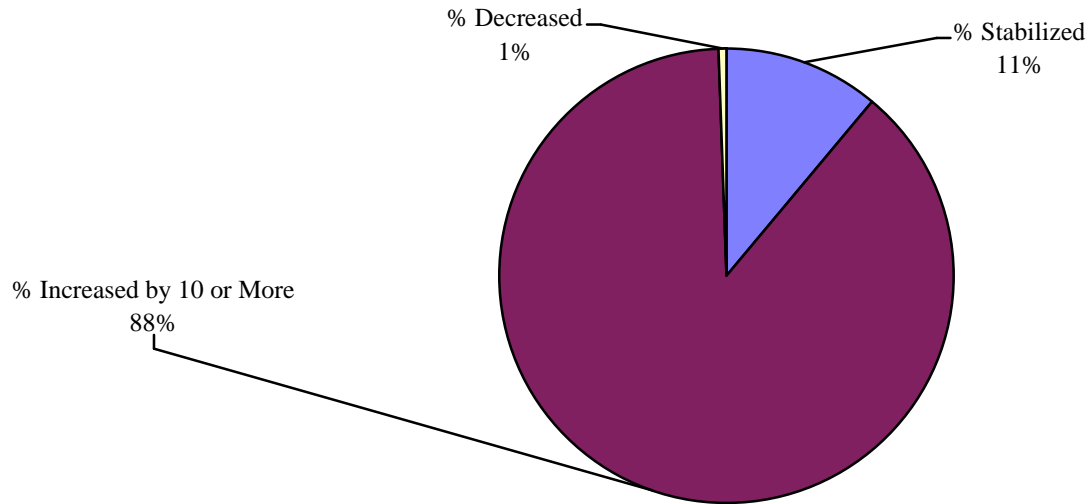
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Rusk State Hospital

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



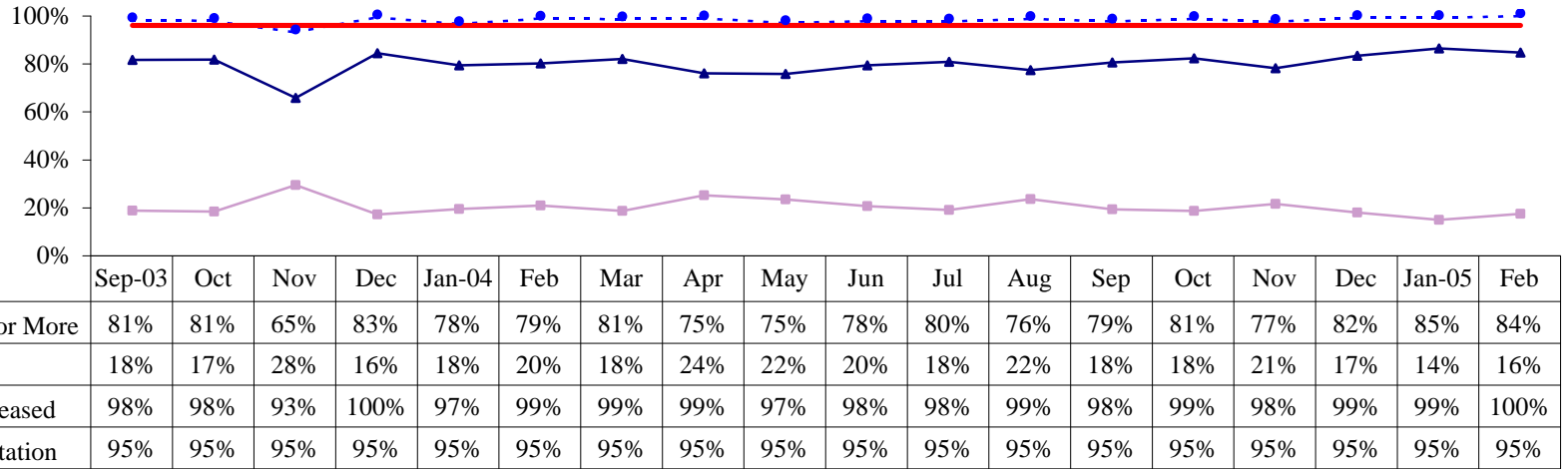
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	93%	91%	90%	96%	88%	89%	87%	89%	89%	89%	86%	91%	88%	87%	90%	91%	89%	86%
—■— % Stabilized	7%	9%	9%	4%	11%	10%	11%	11%	9%	10%	13%	9%	12%	13%	10%	8%	11%	13%
- - -▲- - - % Stabilized + Increased	100%	100%	99%	100%	99%	99%	99%	100%	98%	99%	99%	100%	99%	99%	100%	99%	100%	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 February 28, 2005

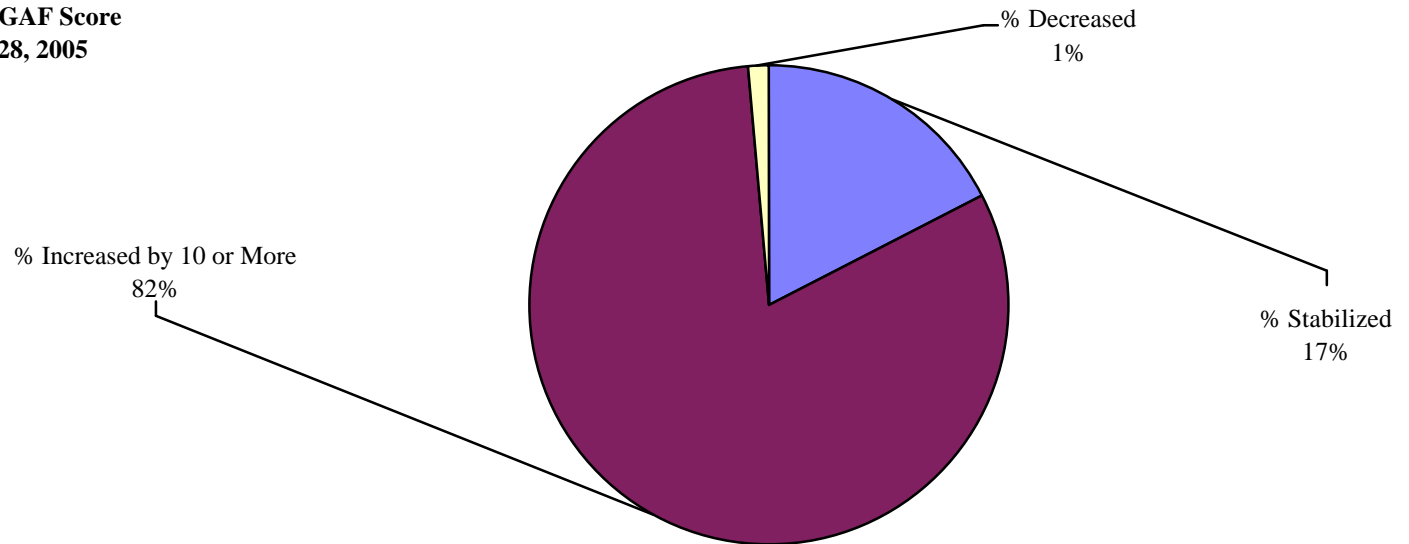


Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
San Antonio State Hospital

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

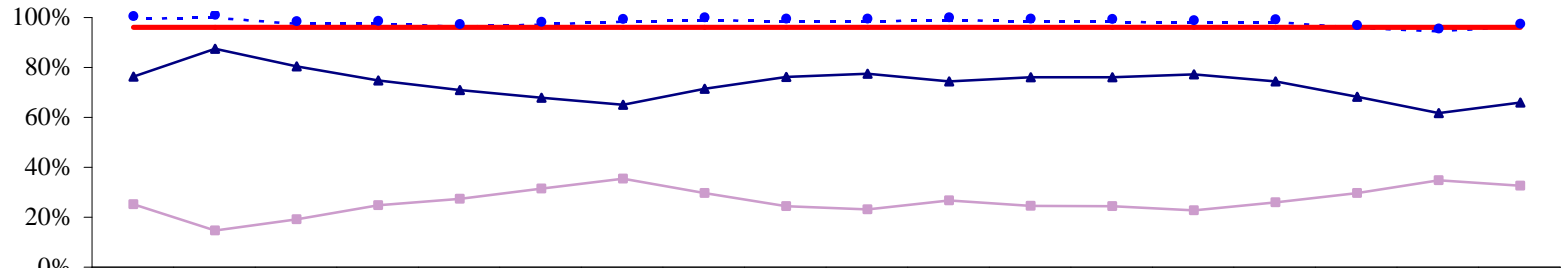


Percent of Persons Discharged by GAF Score
FYTD Totals - As of February 28, 2005



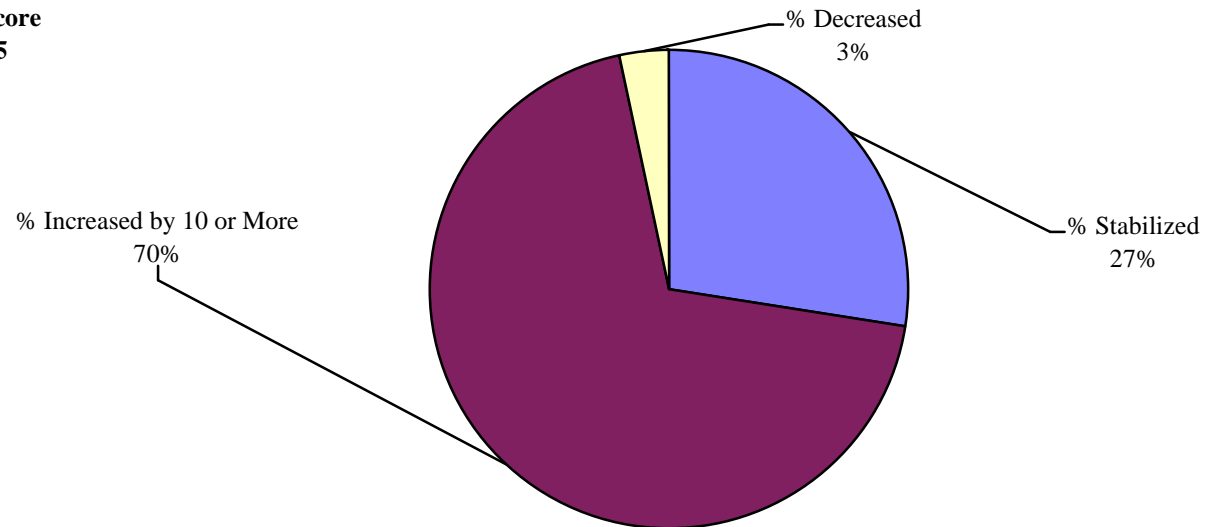
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Terrell State Hospital

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



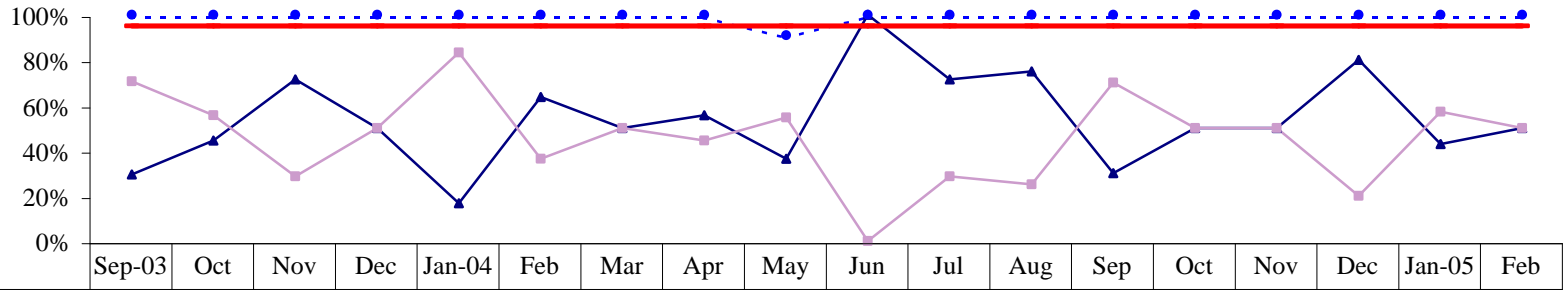
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— % Increased by 10 or More	75%	86%	79%	74%	70%	67%	64%	70%	75%	76%	73%	75%	75%	76%	73%	67%	61%	65%
—■— % Stabilized	24%	14%	18%	24%	26%	30%	34%	29%	23%	22%	26%	23%	23%	22%	25%	29%	34%	32%
- - ● - - % Stabilized + Increased	99%	100%	97%	98%	96%	97%	98%	99%	98%	98%	99%	98%	98%	98%	98%	96%	94%	96%
— % 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 February 28, 2005



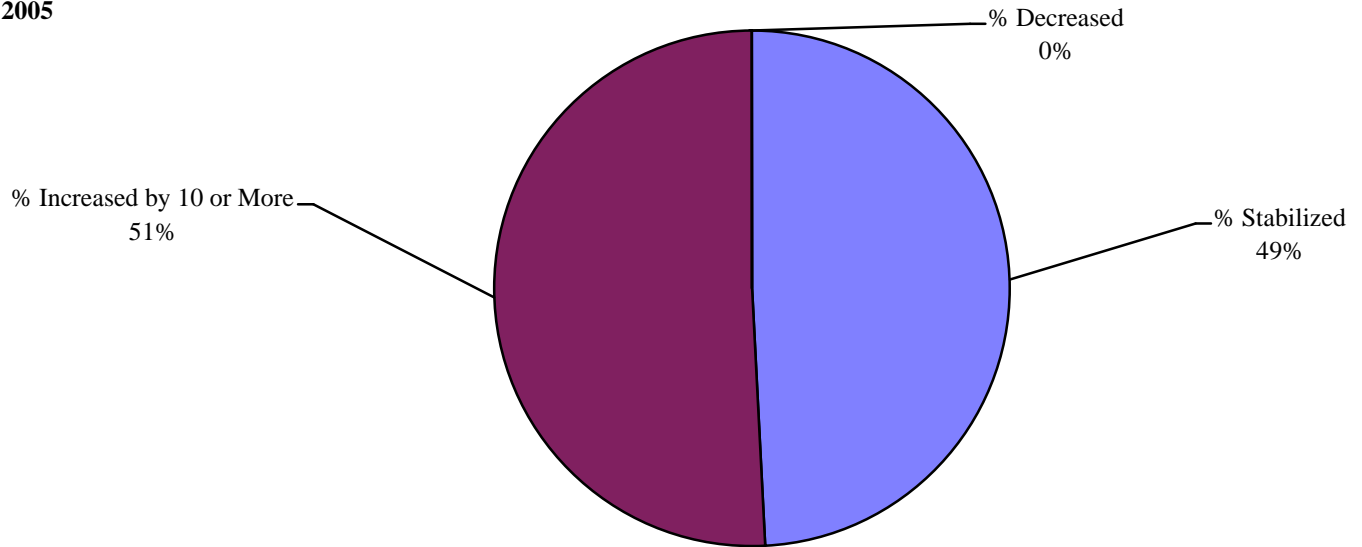
Measure 3B - Percent of Discharged Whose GAF Score Increased by 10 or More
Percent of Discharged Whose GAF Score Stabilized
Waco Center for Youth

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



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
% Increased by 10 or More	29%	44%	71%	50%	17%	64%	50%	56%	36%	100%	71%	75%	30%	50%	50%	80%	43%	50%
% Stabilized	71%	56%	29%	50%	83%	36%	50%	44%	55%	0%	29%	25%	70%	50%	50%	20%	57%	50%
% Stabilized + Increased	100%	100%	100%	100%	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%	100%	100%	100%	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 February 28, 2005



GOAL 4: Implement an Effective and Safe Medication Management System That Improves the Quality of Care, Treatment, and Services.

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

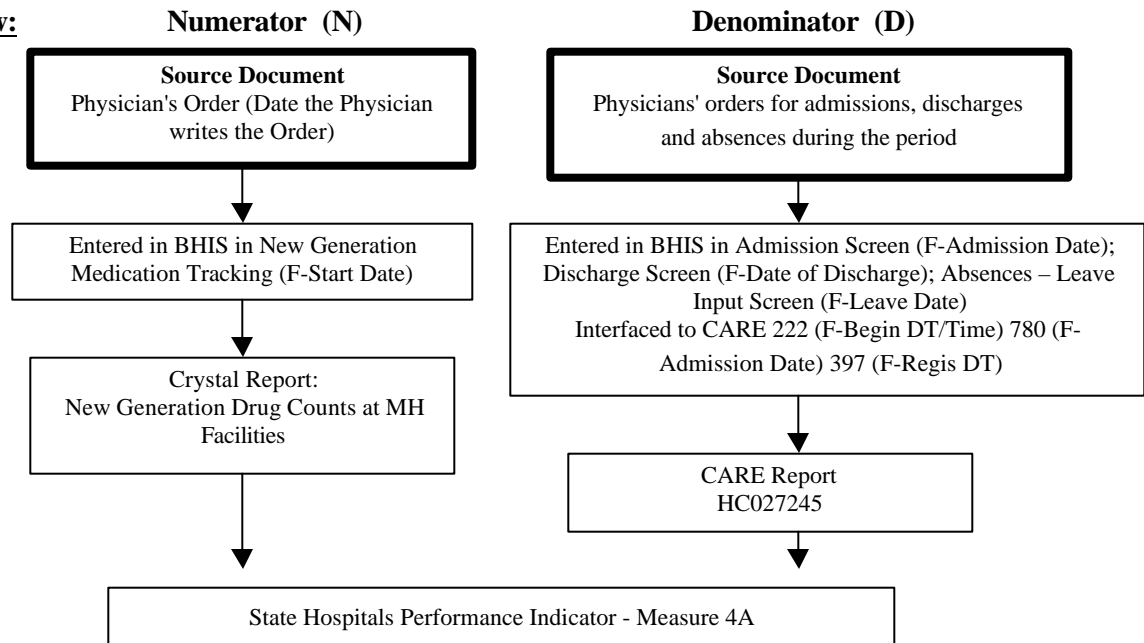
N = patients receiving new generation medications

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.

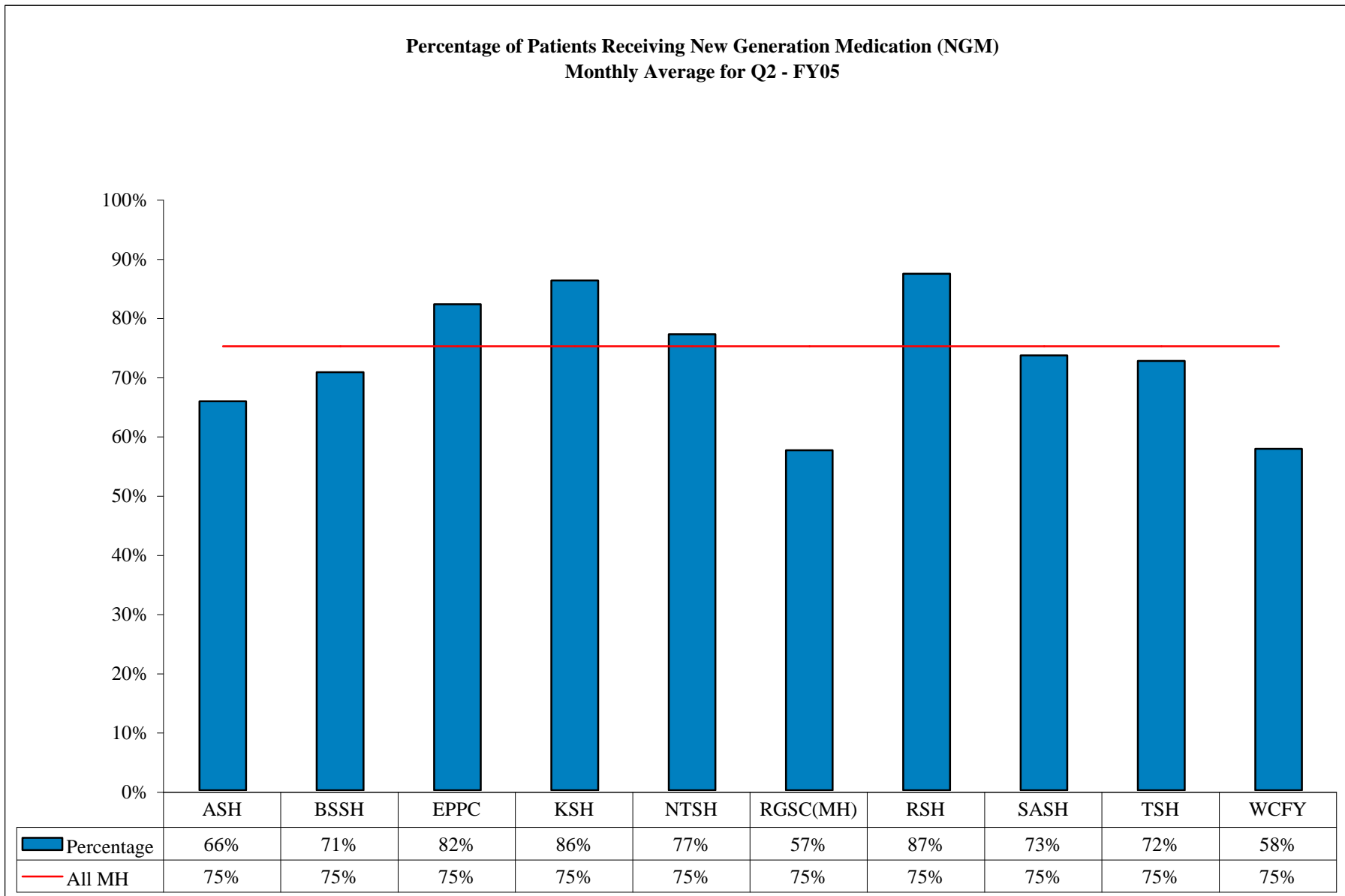
Data Flow:



Data Integrity Review Process:

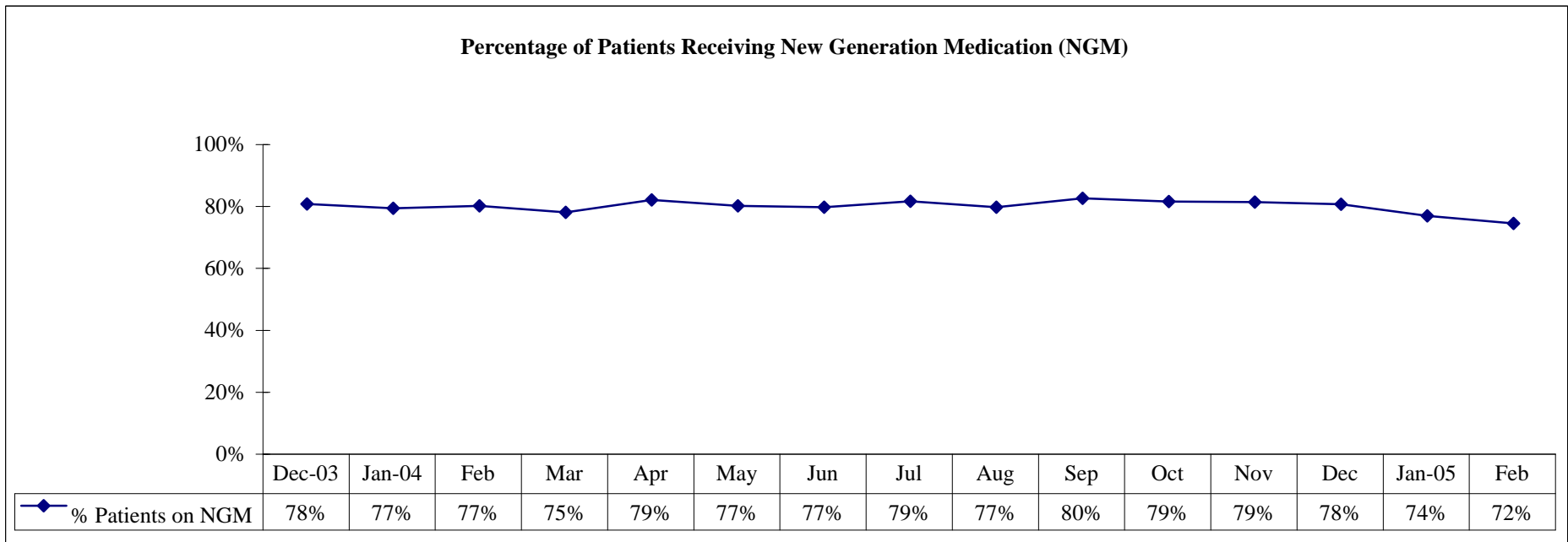
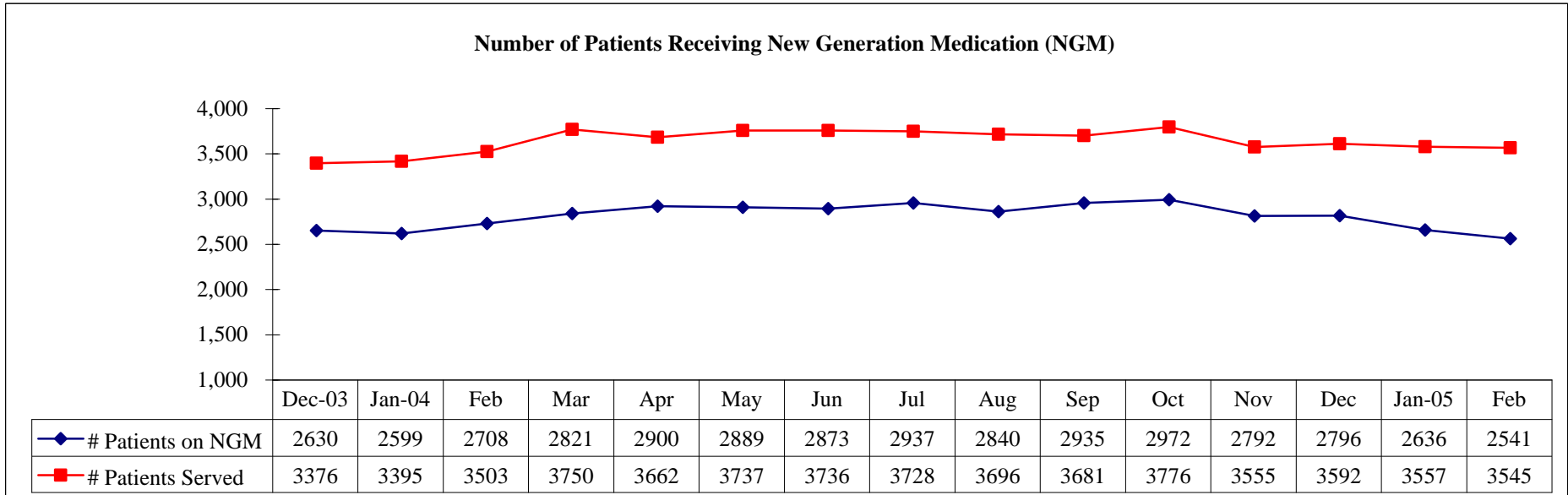
Monitoring Method	Review of physician's orders for a new generation medication that has been ordered by the physician during the review period.
Monitoring Instrument/Tool	Physician orders and DIR Tally Sheet
Description of Review Process	Verification by reviewing physician orders for "new generation" 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
Performance Improvement Trigger	When there are any new generation medications ordered but not found on the crystal report during the quarter reviewed.
DIR/HMDS Report	Summary of review including data accuracy, findings and data analysis.

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



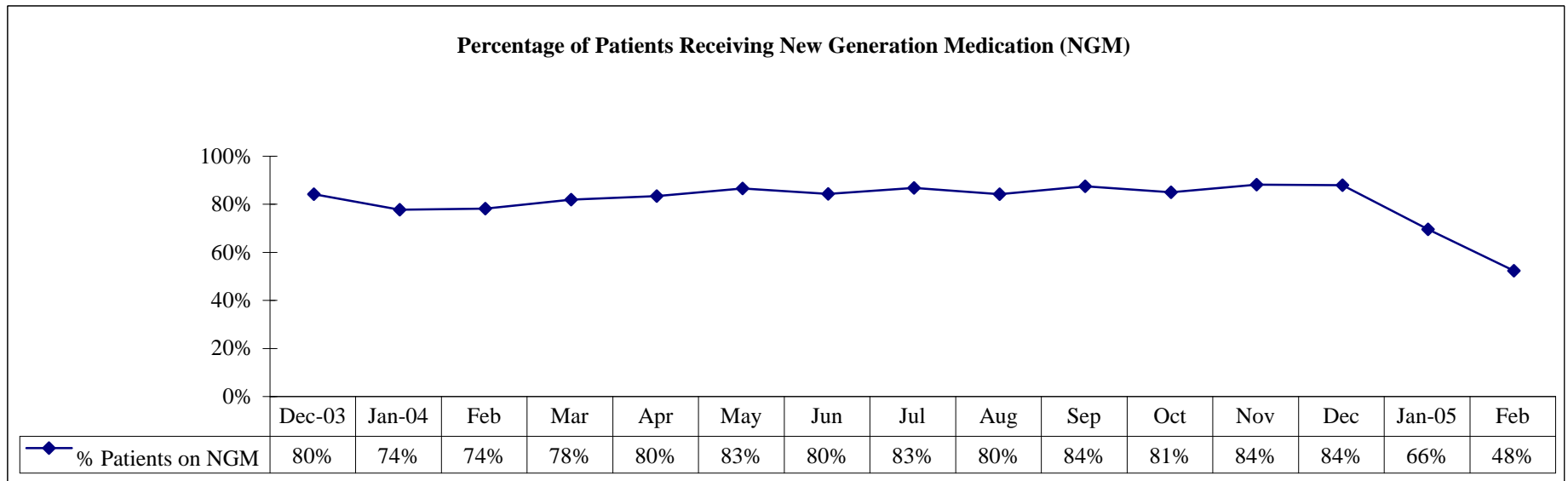
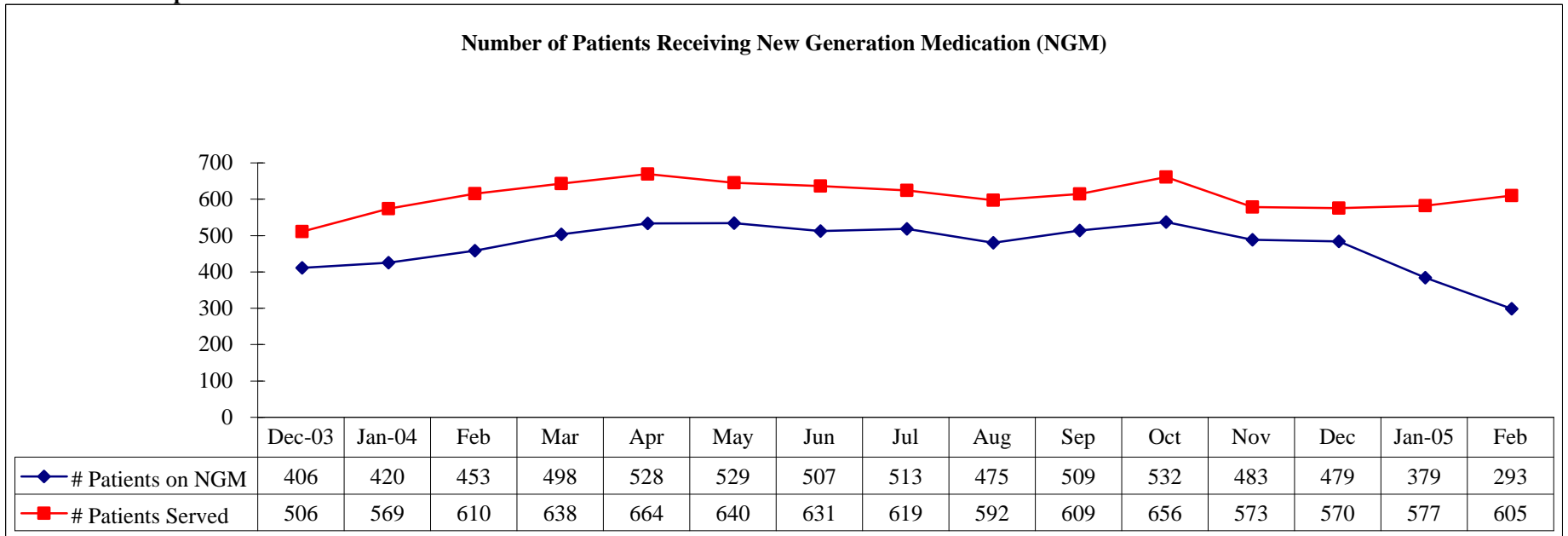
Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

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



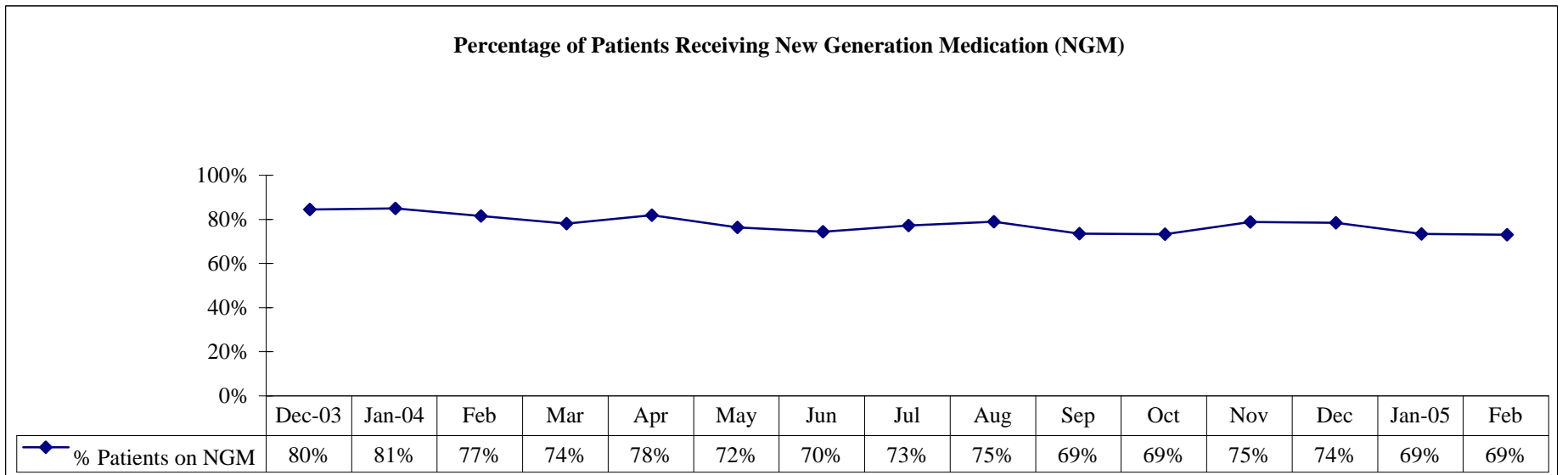
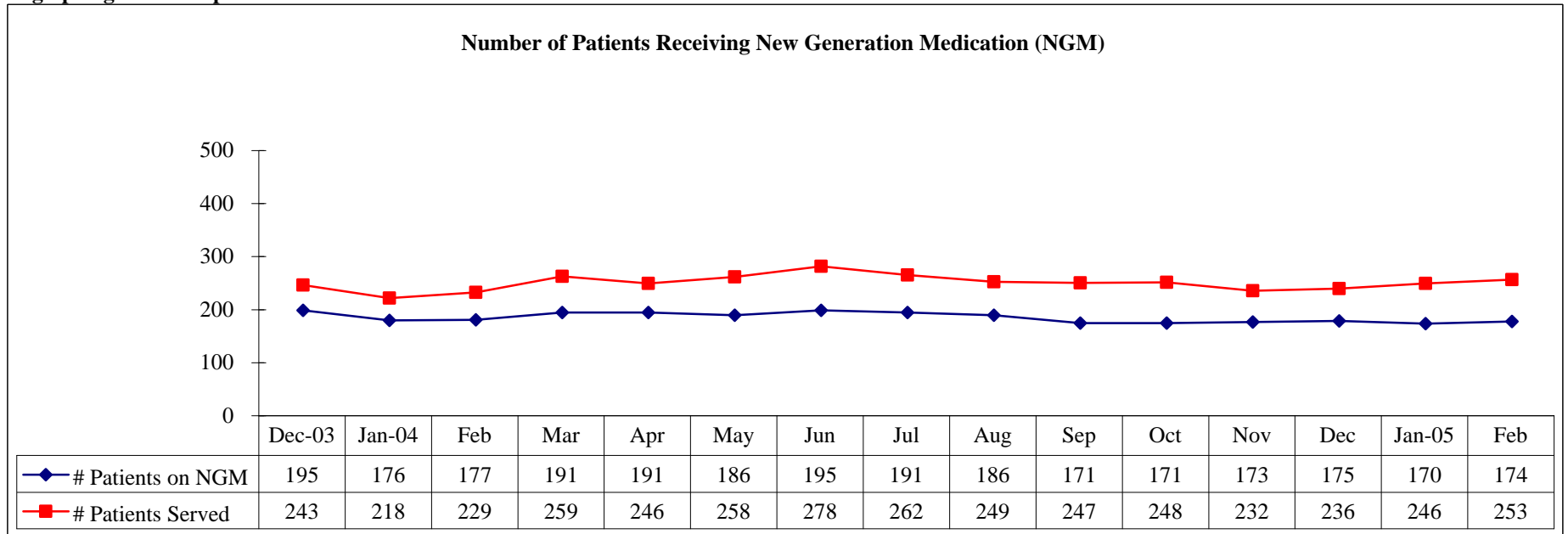
Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

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



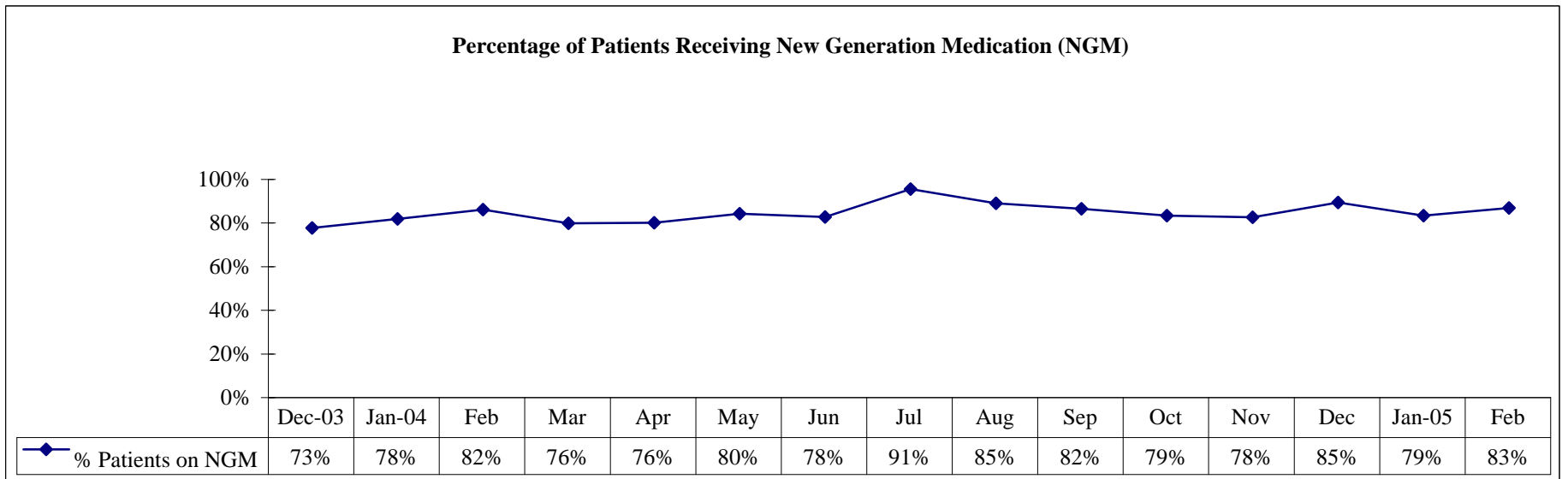
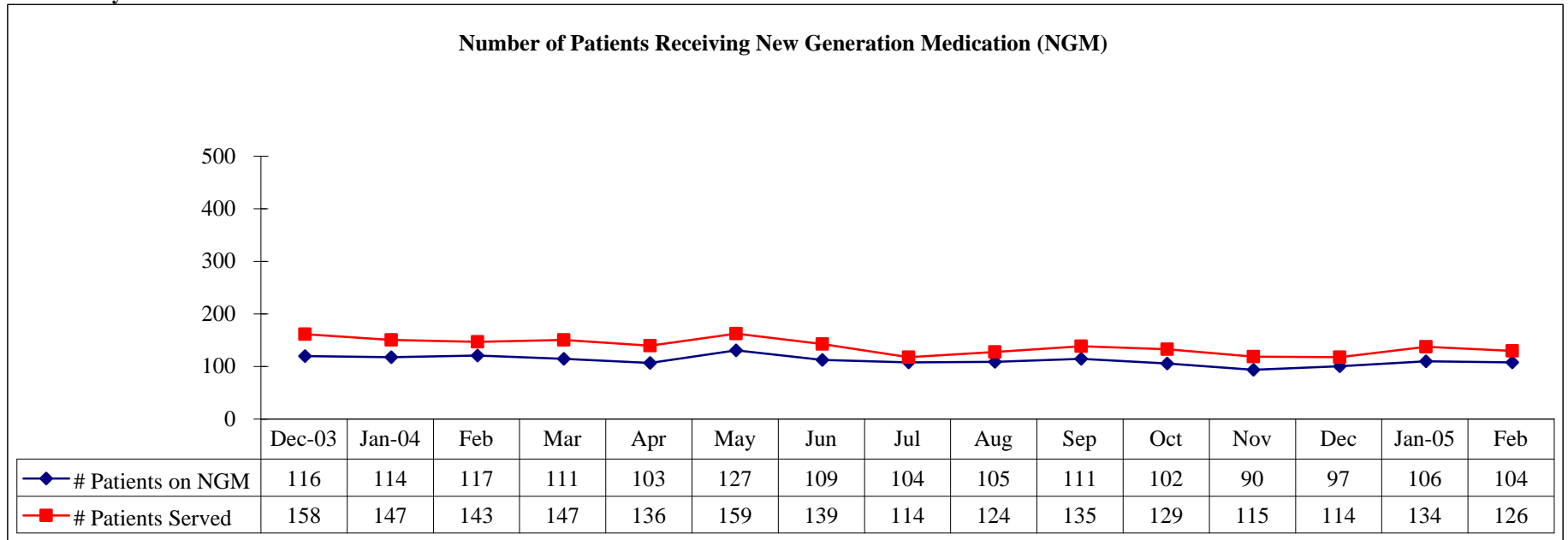
Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

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



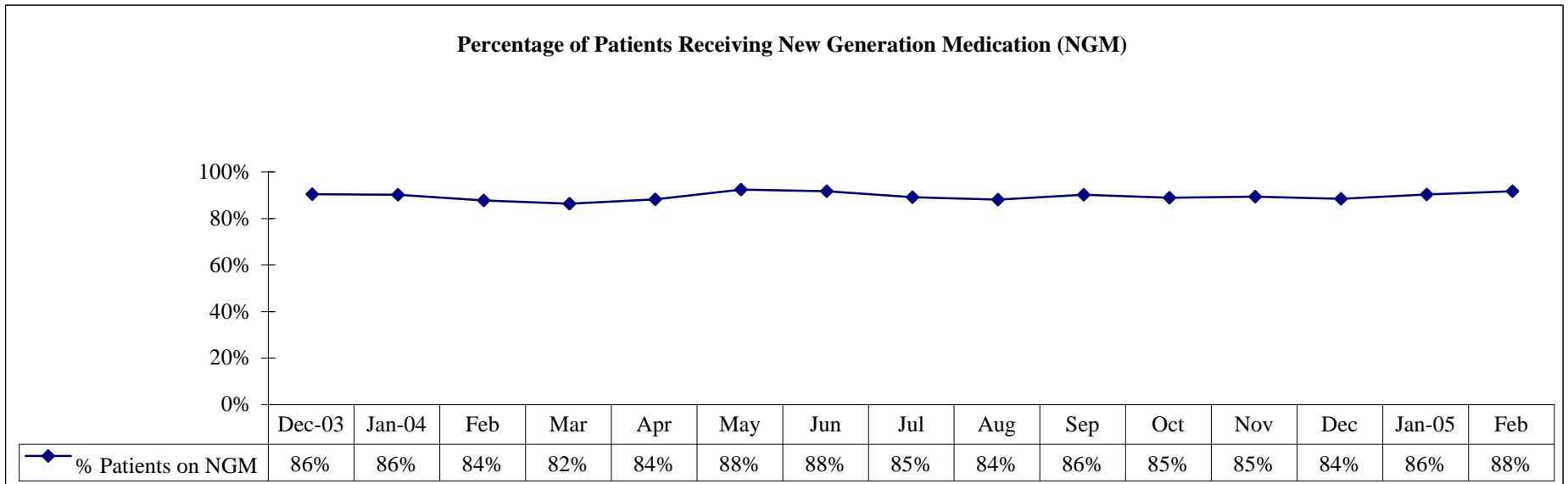
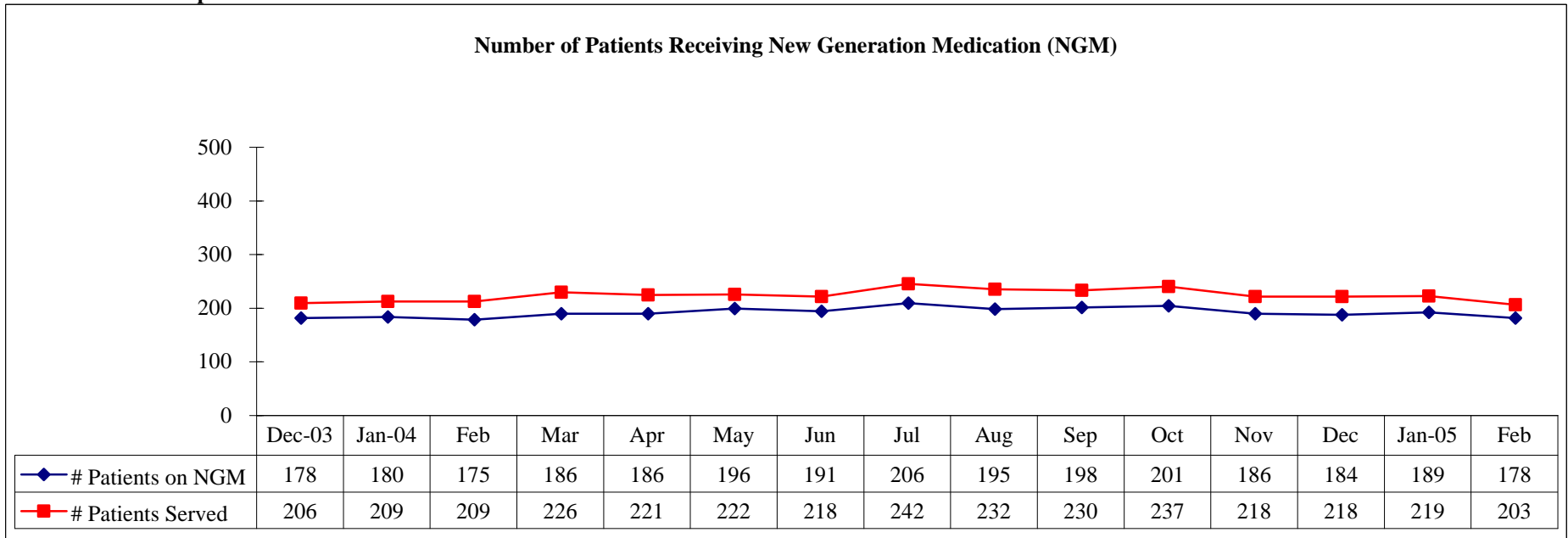
Source: New Generation Drug Counts (BHIS Report);
Counts of Persons Receiving MH Services (HC027245)

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



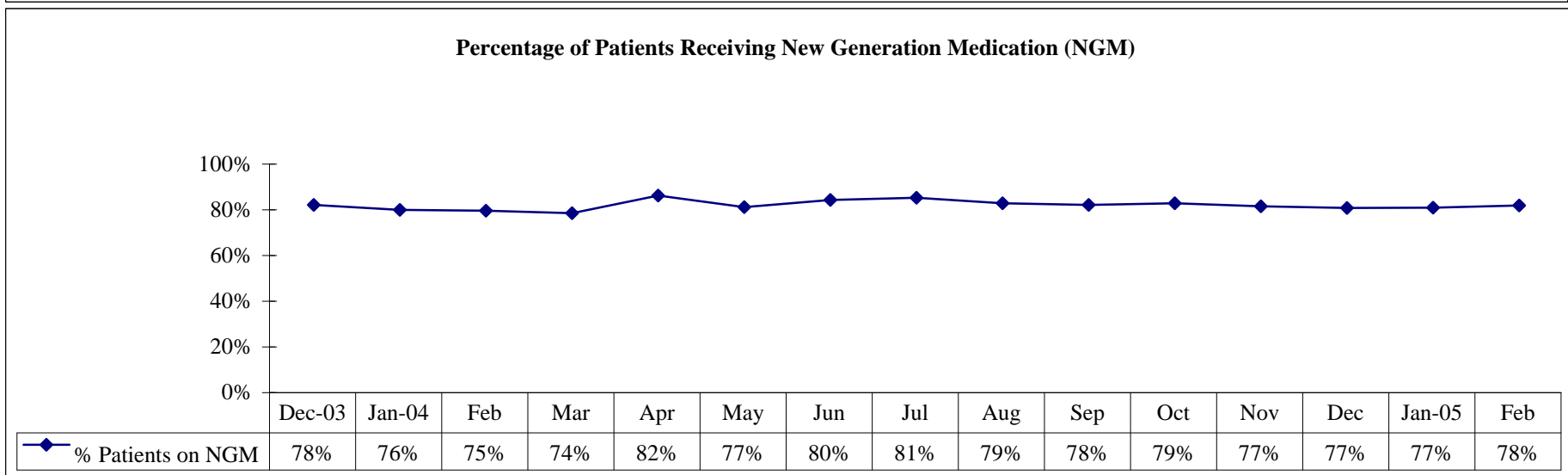
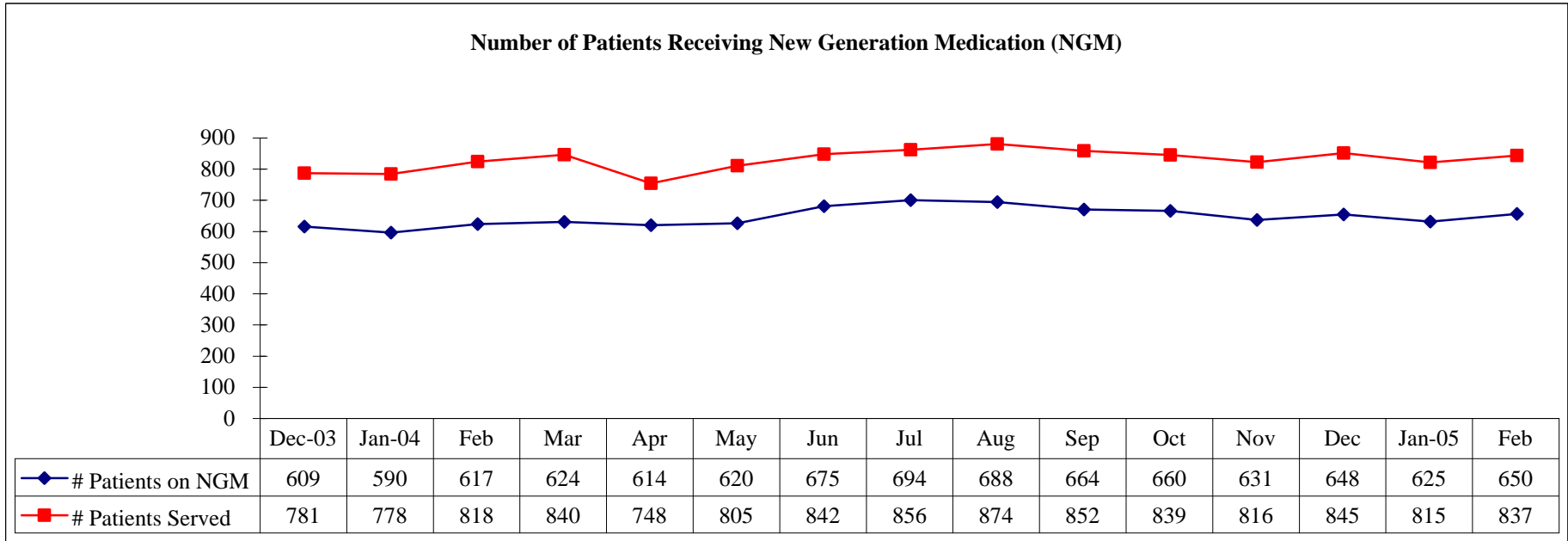
Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

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



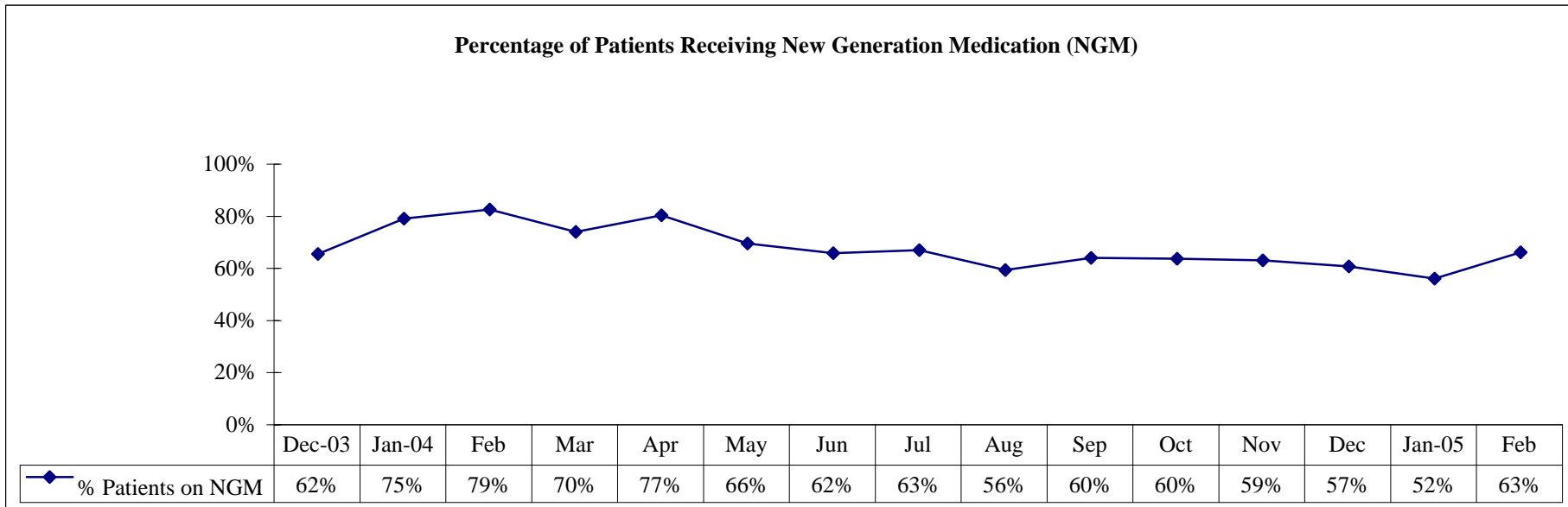
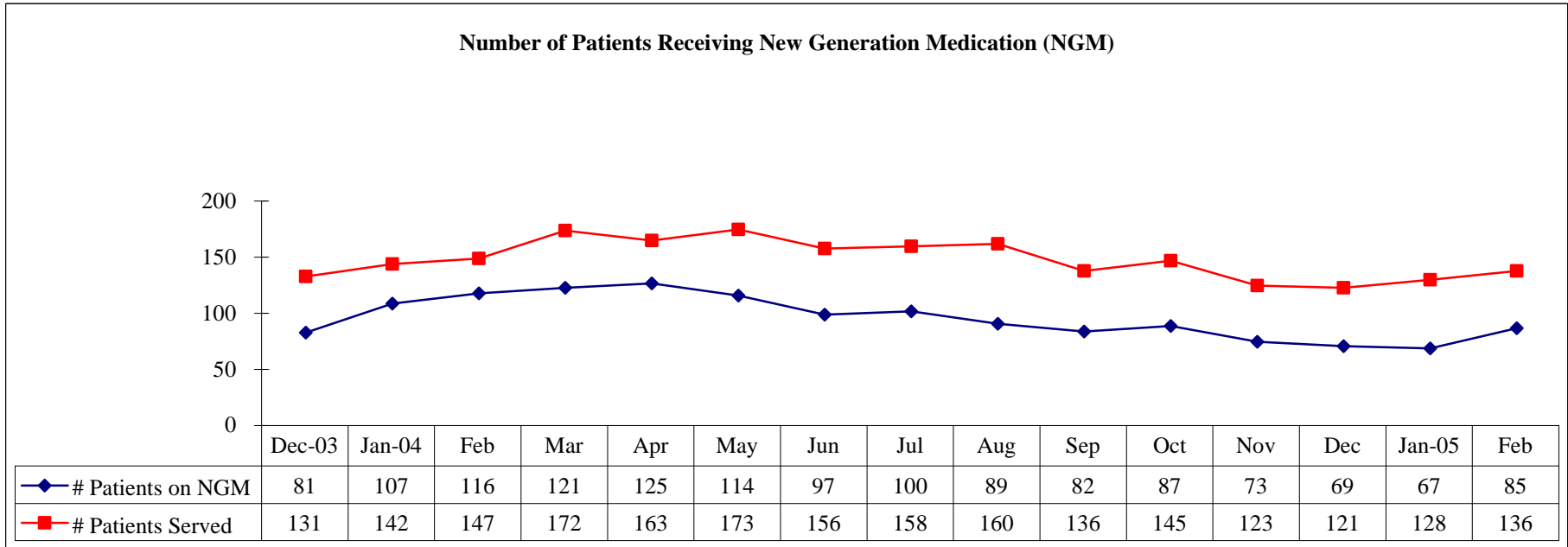
Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

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



Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

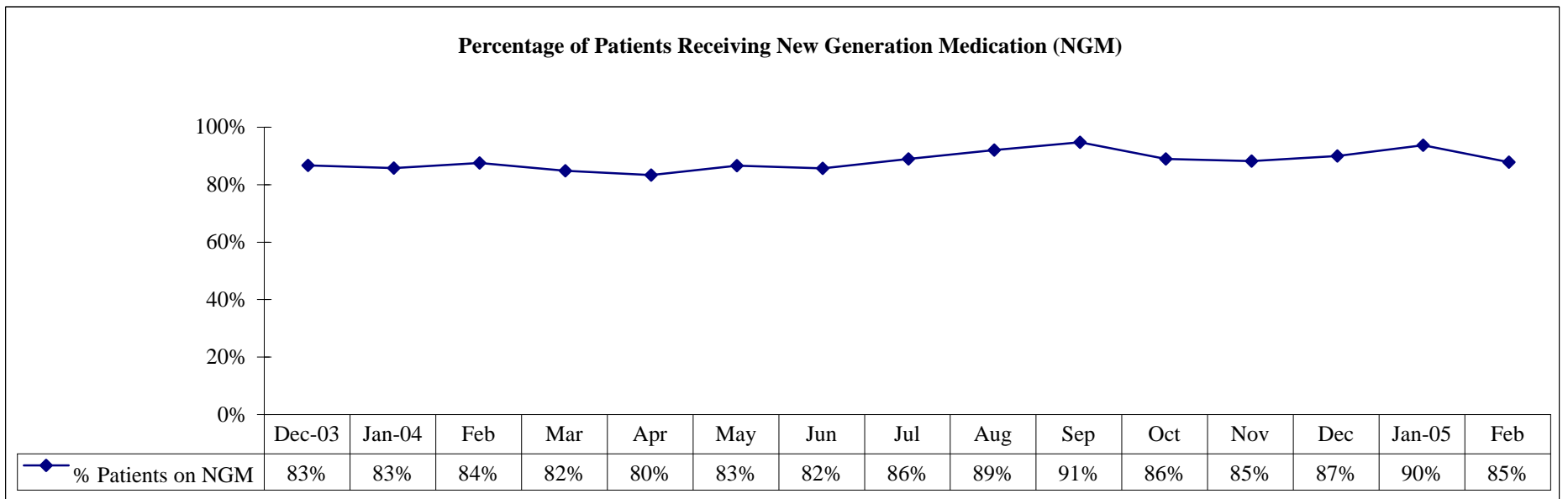
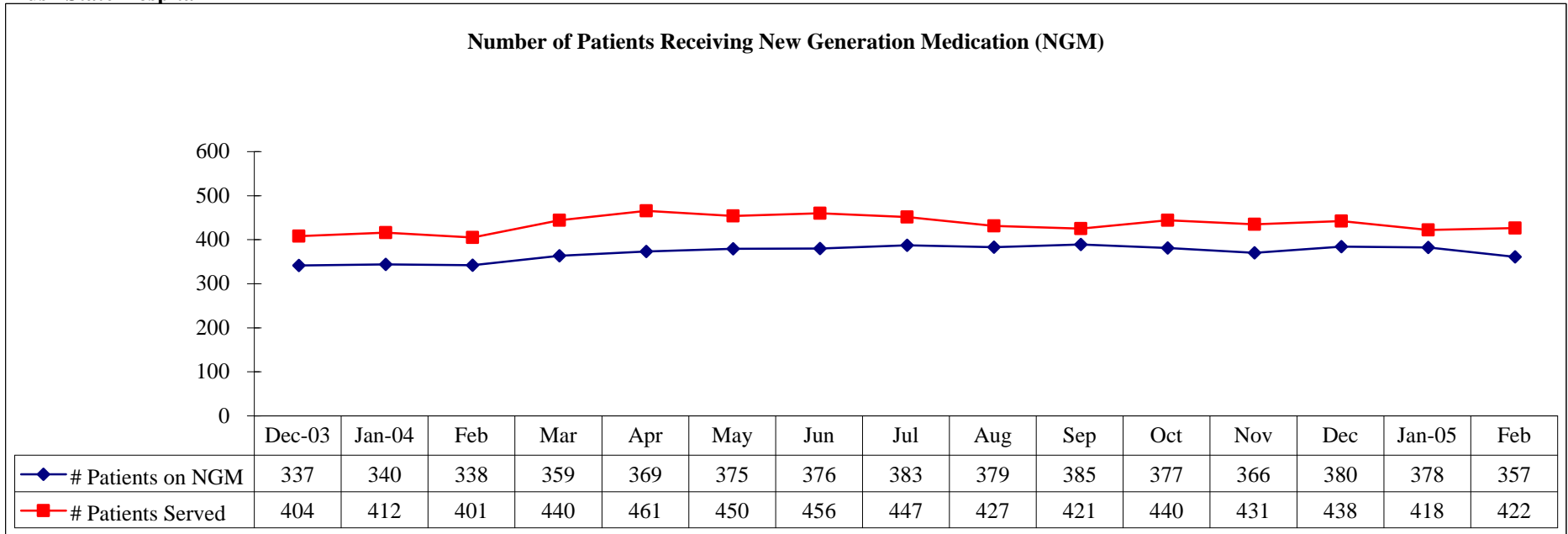
Measure 4A - Patients Receiving New Generation Medication (NGM)
Rio Grande State Center



Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

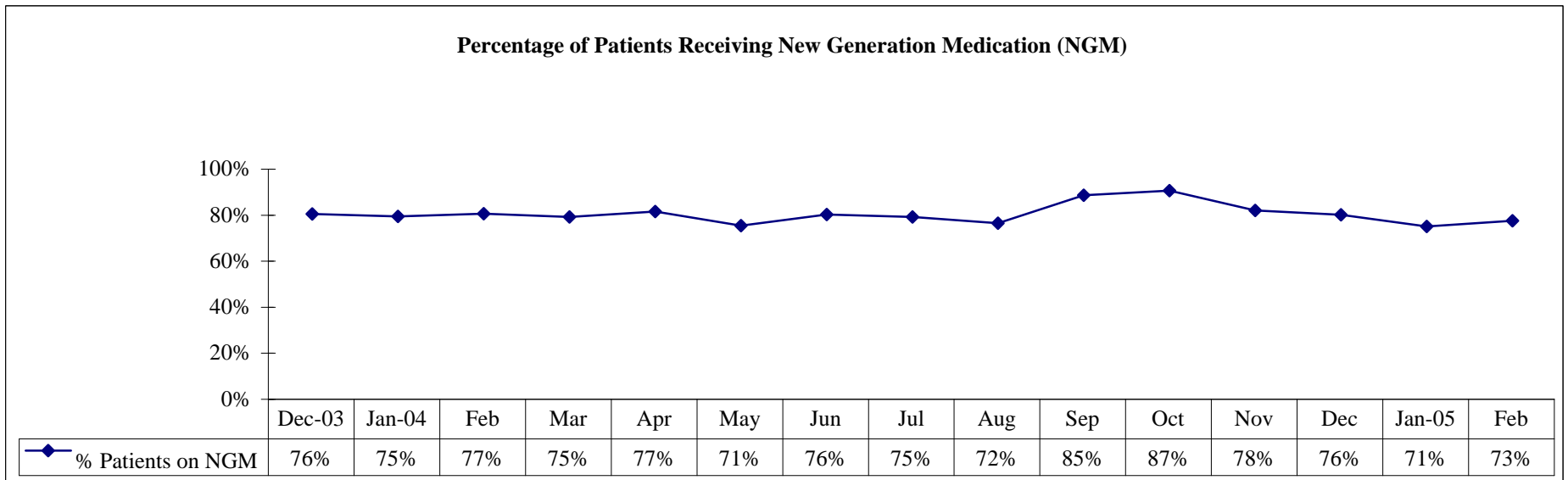
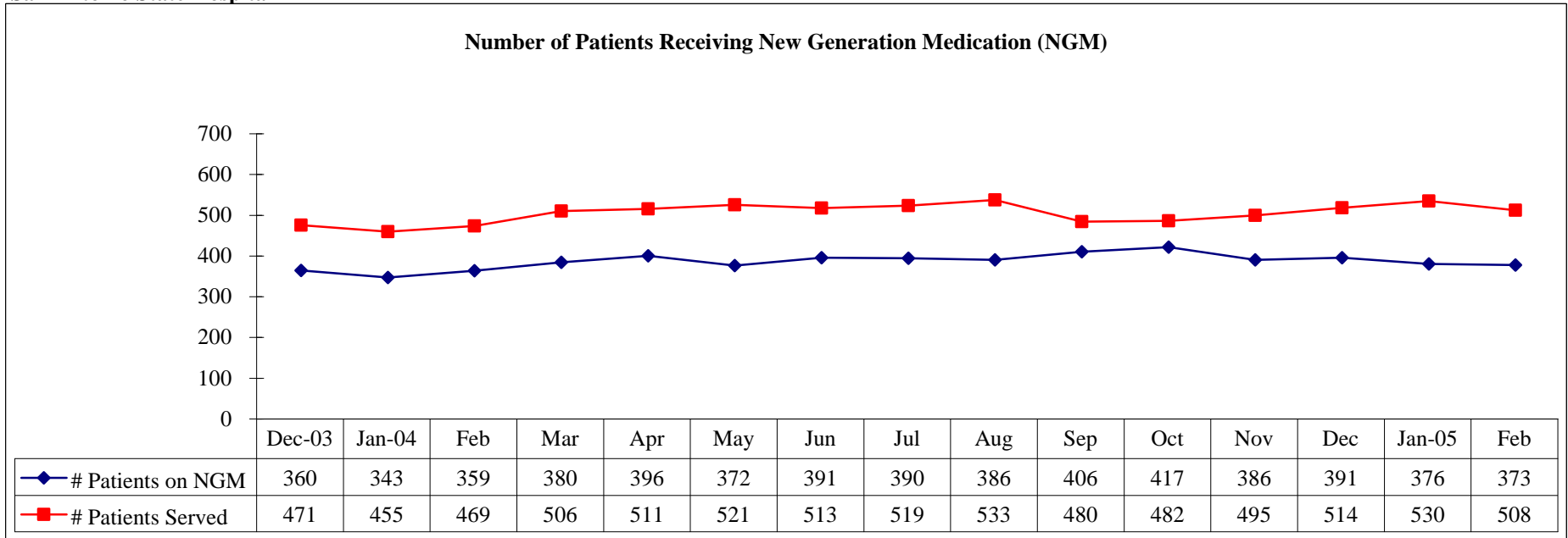
Measure 4A - Patients Receiving New Generation Medication (NGM)

Rusk State Hospital



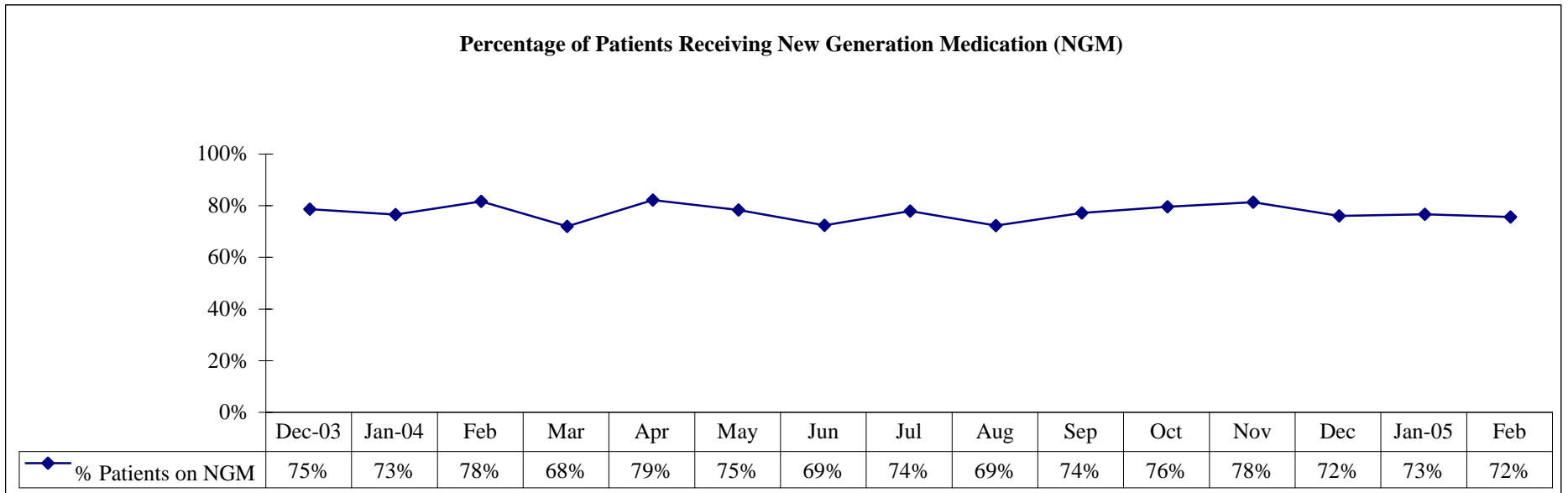
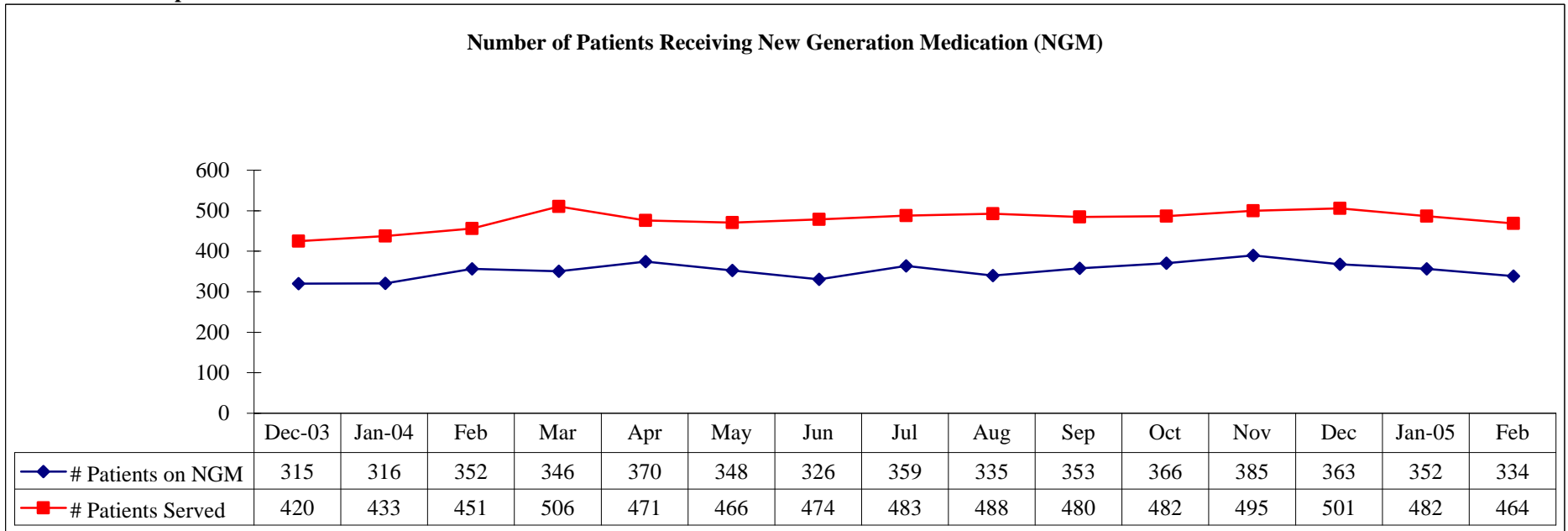
Source: New Generation Drug Counts (BHIS Report);
Counts of Persons Receiving MH Services (HC027245)

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



Source: New Generation Drug Counts (BHIS Report);
 Counts of Persons Receiving MH Services (HC027245)

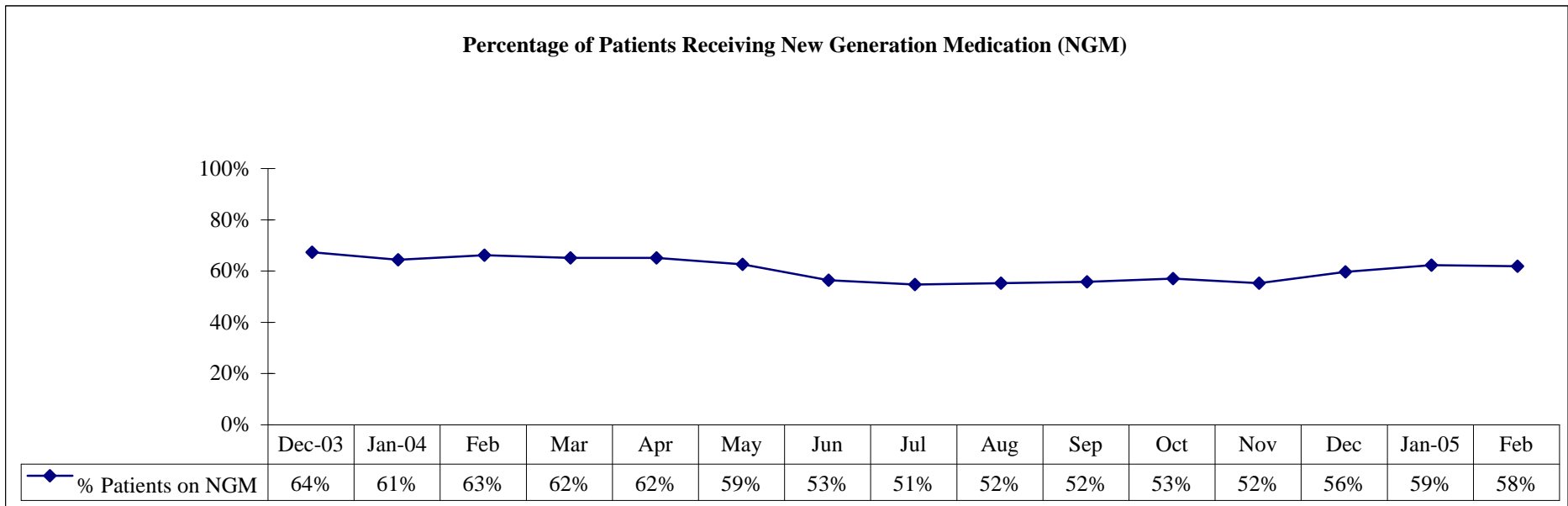
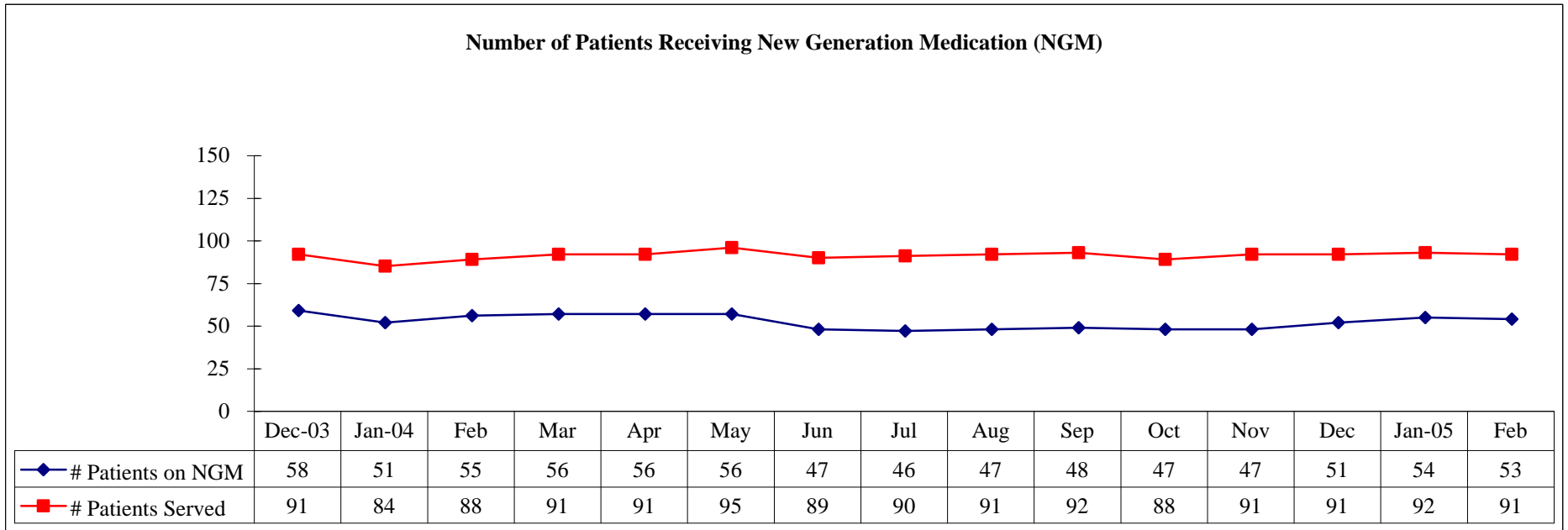
Measure 4A - Patients Receiving New Generation Medication (NGM)
Terrell State Hospital



Source: New Generation Drug Counts (BHIS Report);
 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);
Counts of Persons Receiving MH Services (HC027245)

Performance Measure 4B:

The cost of new generation antipsychotic medication will be tracked and analyzed quarterly.

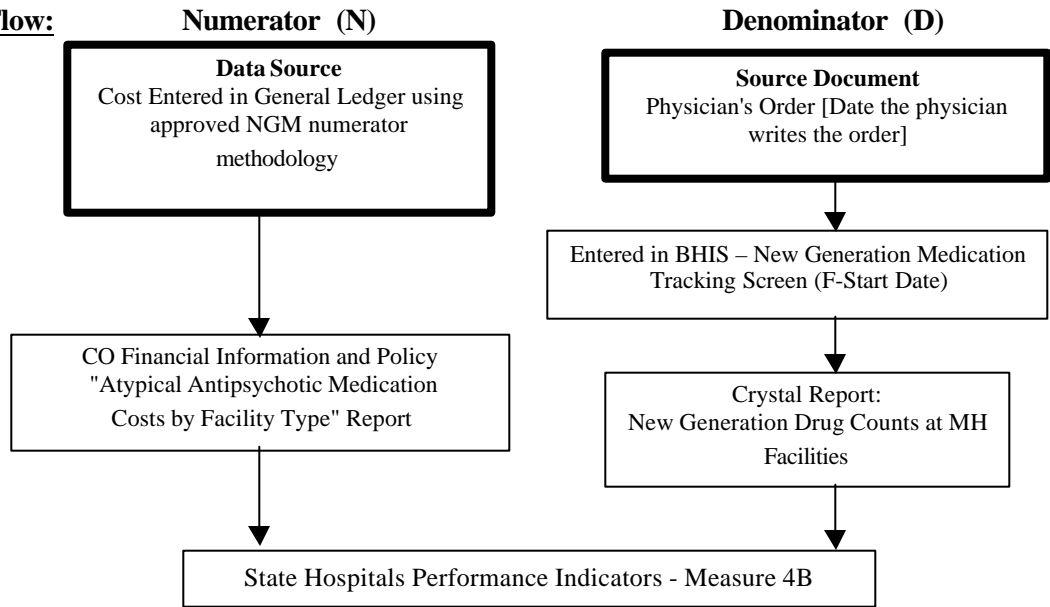
Performance Measure Operational Definition: The state hospitals average monthly cost for new generation medications (risperidone, clozapine, olanzapine, quetiapine, ziprasidone and aripiprazole) per patient.

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.

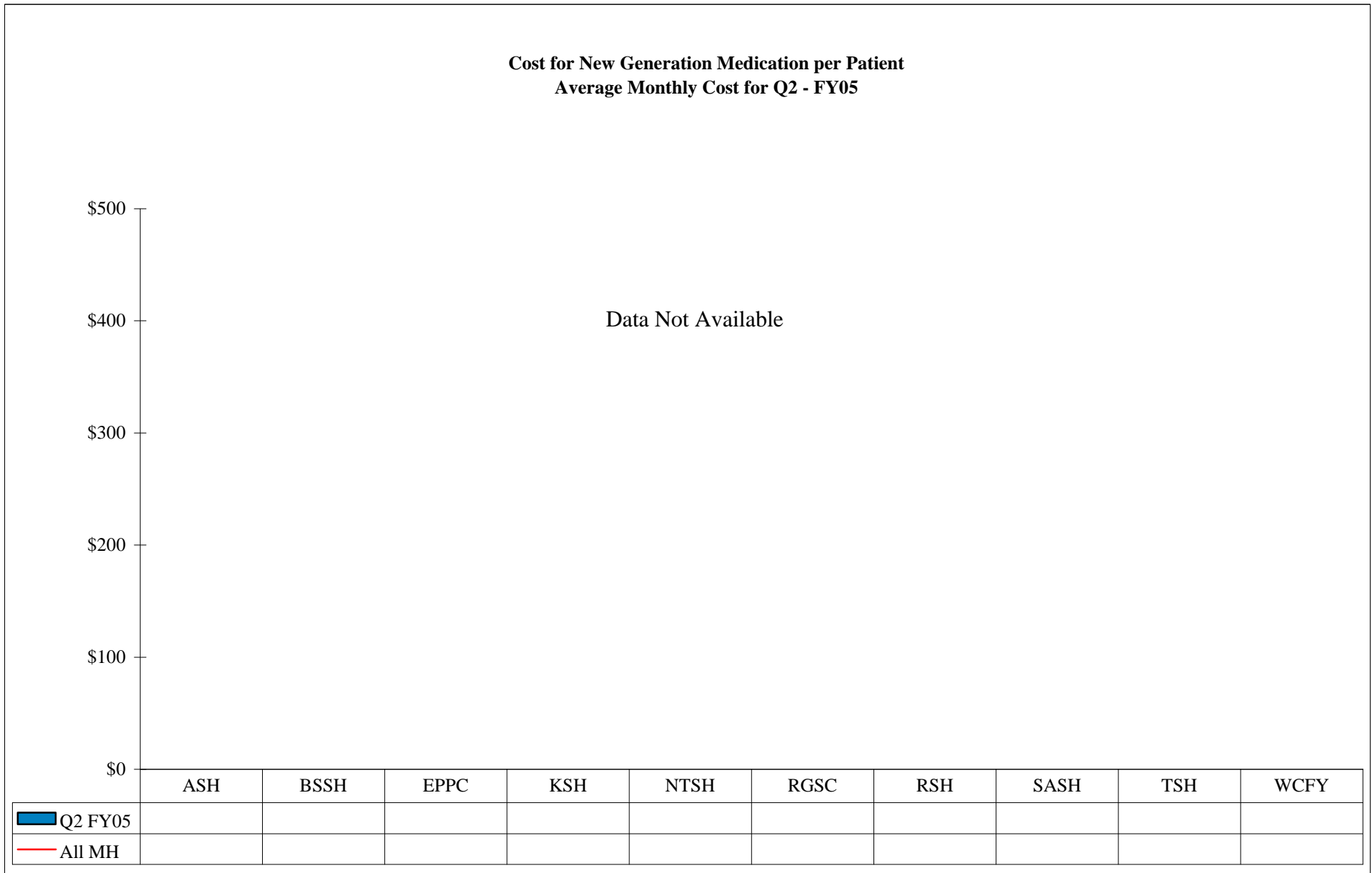
Data Flow:



Data Integrity Review Process:

N/A

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



Performance Measure 4C:

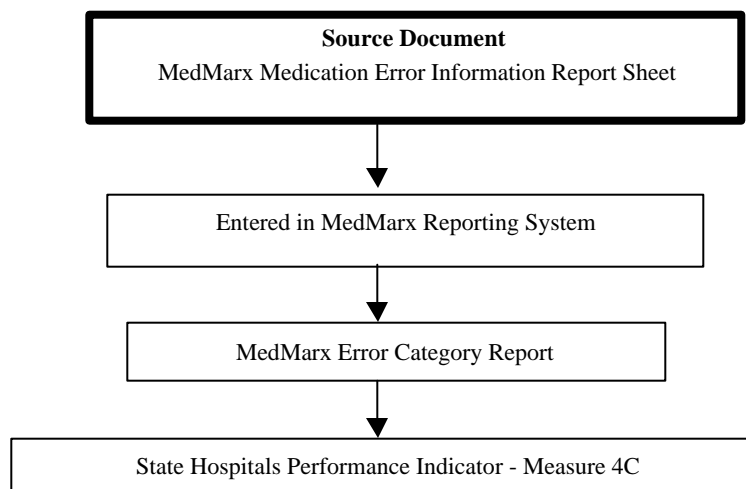
Medication errors will be tracked and analyzed quarterly.

Performance Objective Operational Definition: The number of facility medication errors as documented on the MedMarx Medication Error Information Report form per month. The MedMarx Software will be utilized until the state hospitals decide on a new system for reporting medication errors.

Performance Objective Data Display and Chart Description:

- ◆ Chart with the number of medication errors causing no patient harm; causing patient harm; and causing patient death for individual state hospitals and system-wide
- ◆ Chart with the number of medication errors YTD, in each category for individual state hospitals and system-wide.
- ◆ Chart with monthly data points, for the total number of variances for individual state hospitals and system-wide.

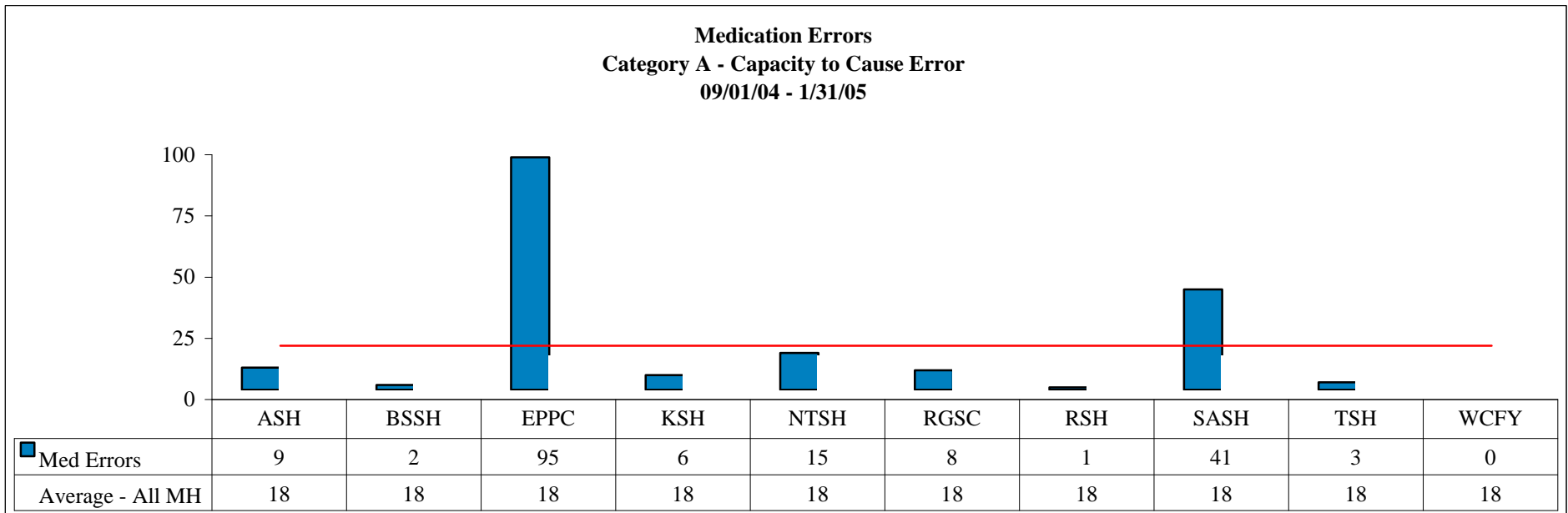
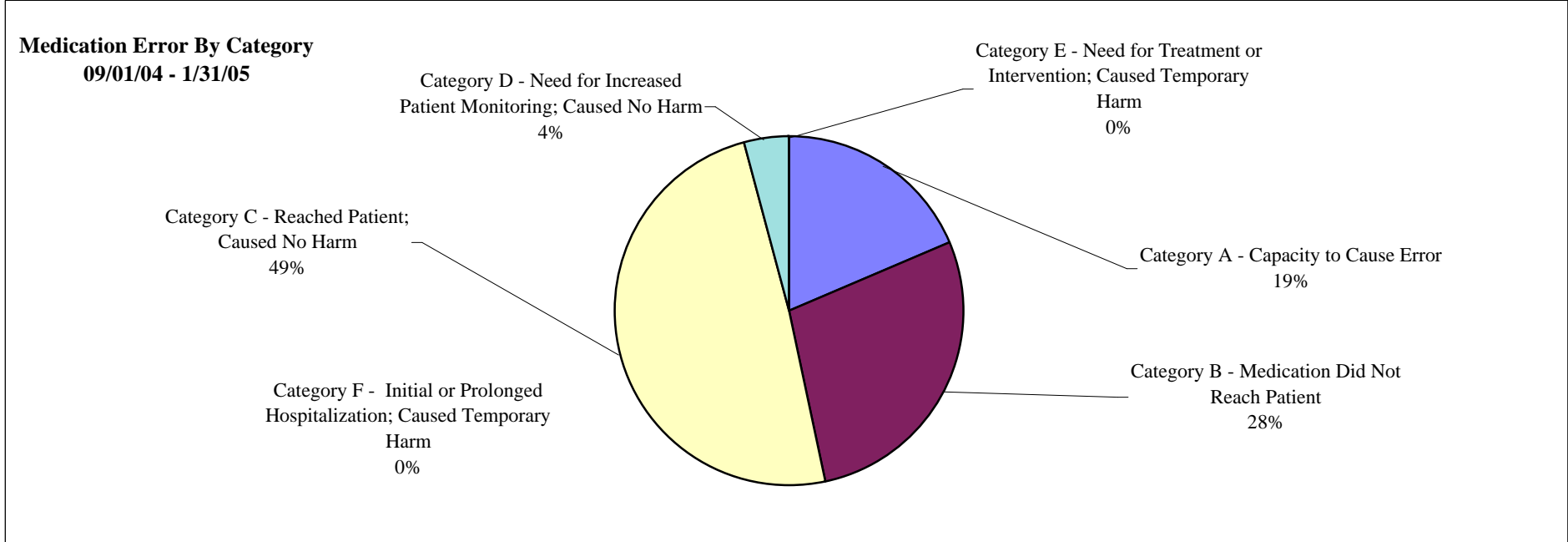
Data Flow:



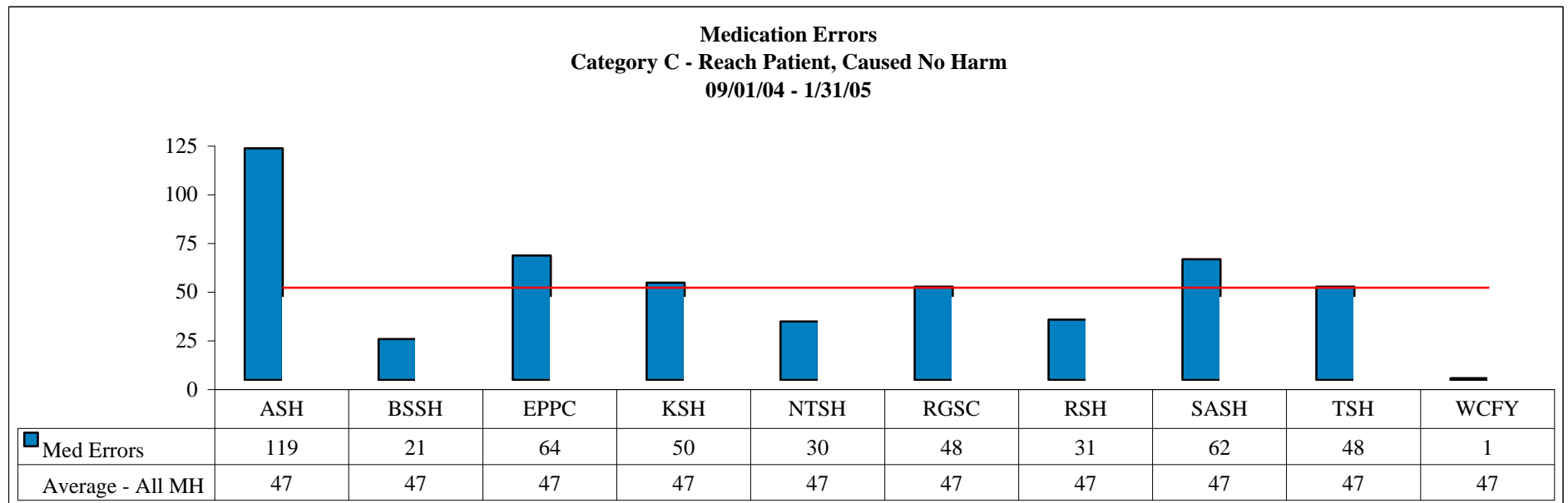
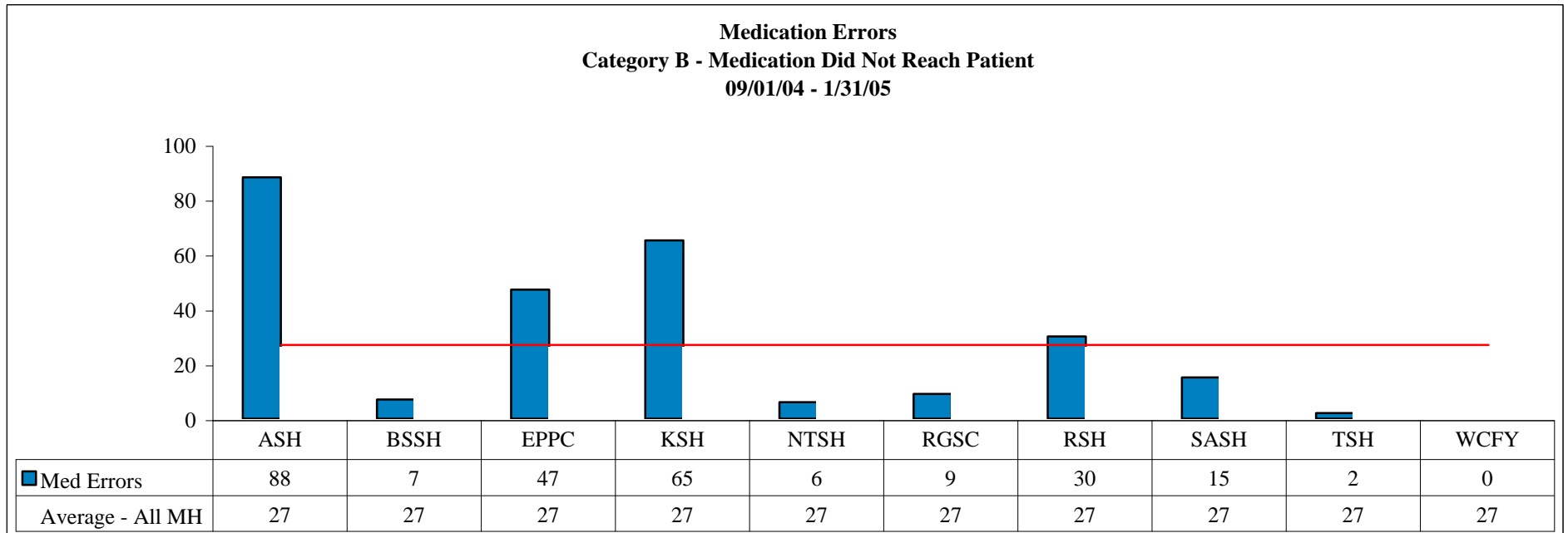
Data Integrity Review Process:

Monitoring Method	Desk Review
Monitoring Instrument	MedMarx Error Category Report, Facility Medication Error Information Report Sheets.
Description of Review Process	Verification by comparing the Facility Medication Error Information Report Sheet to the MedMarx Error Category Report for 100% of the med errors that occurred in the most recent reporting period. To ensure total errors and errors by category match.
Facility/EVT Sample Size	100% Medication errors reported at the facility in the most recent month per report.
Monitoring Frequency	Facility: Semiannually; HMDS: Annually
Performance Improvement Trigger	When there is less than 1.00 correlation or match between the number of med errors recorded on the Facility Medication Error Information Report Sheets as compared to the MedMarx Error Category Report for the specified review period for both total errors and errors by category.
DRI/EVT Report	Summary of percent accuracy findings.

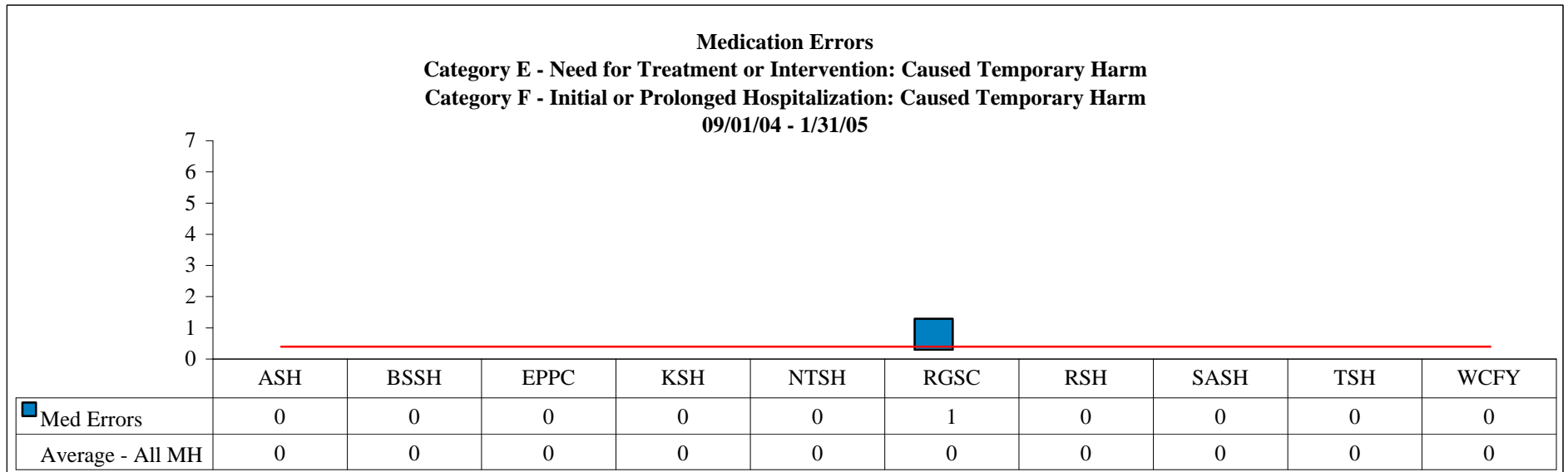
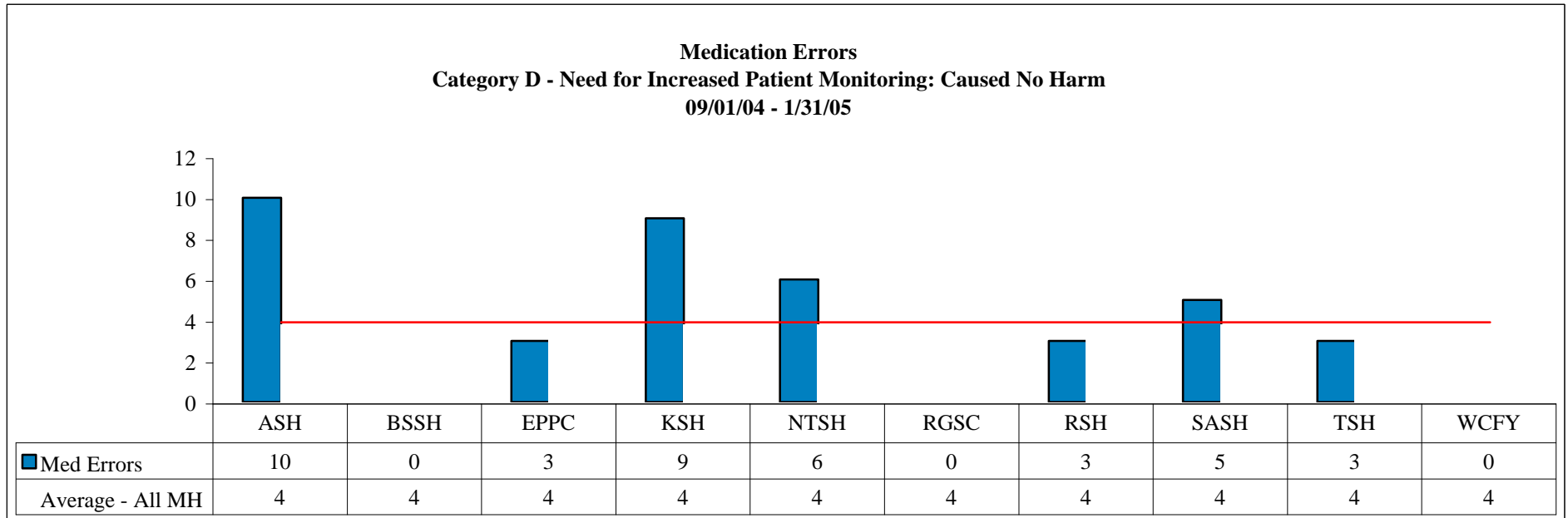
Measure 4C - Medication Variance Data
All MH Facilities



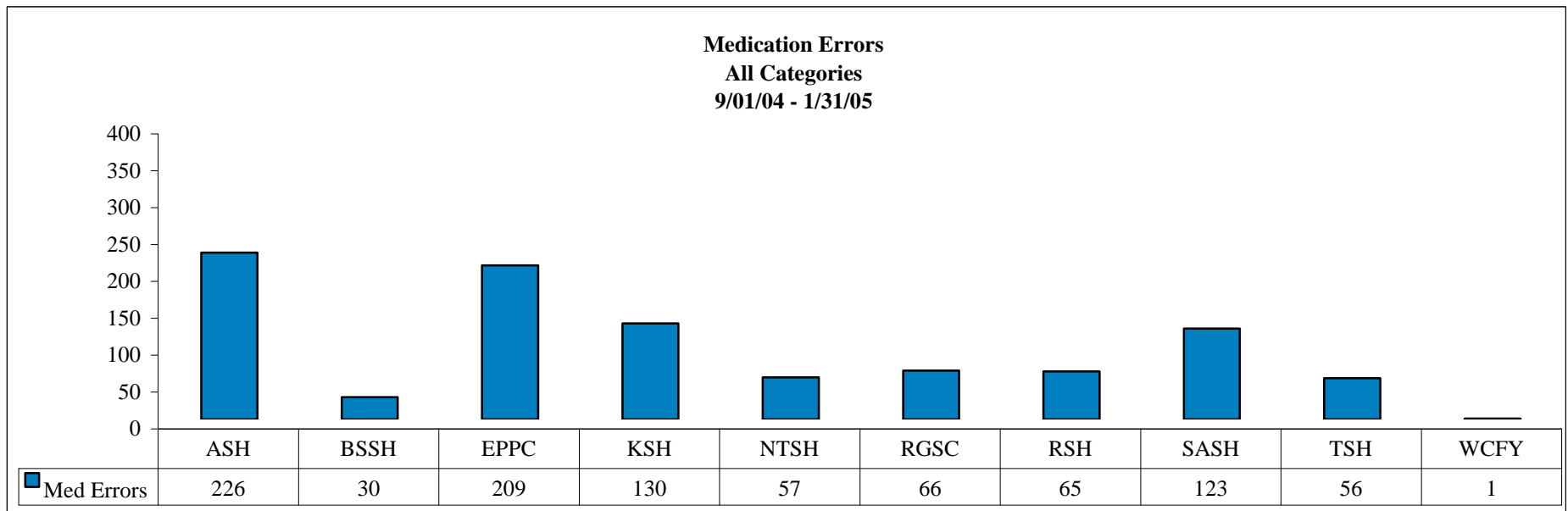
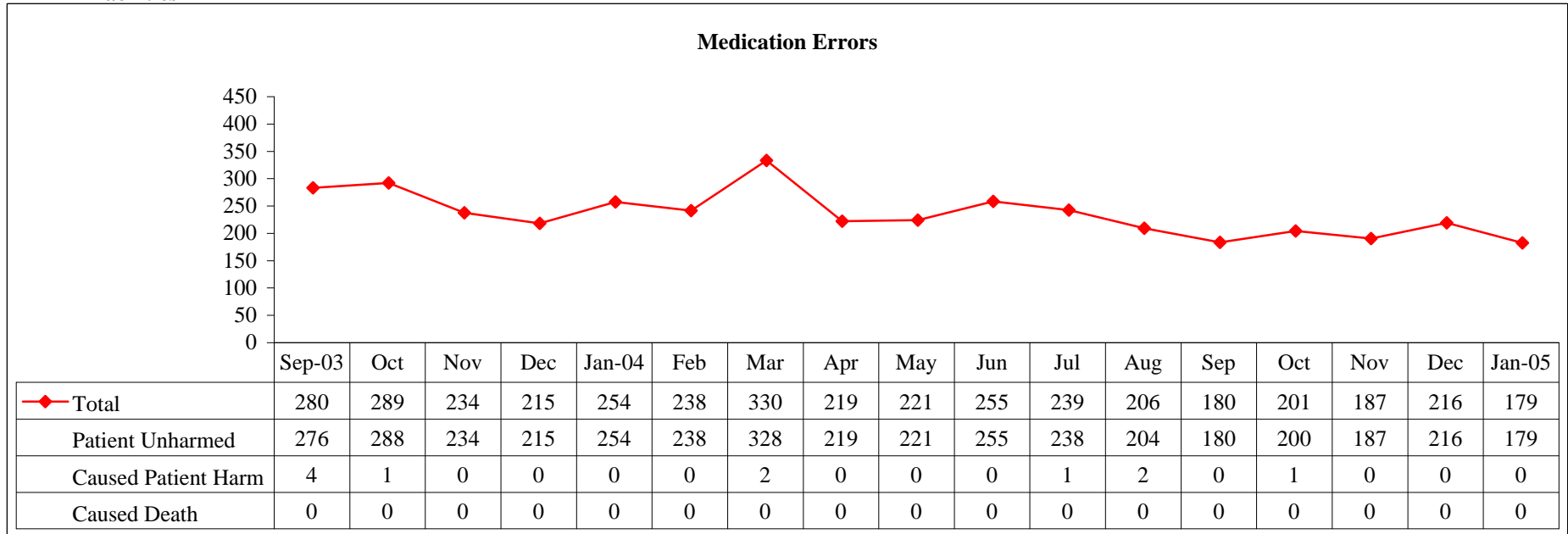
Measure 4C - Medication Variance Data
All MH Facilities



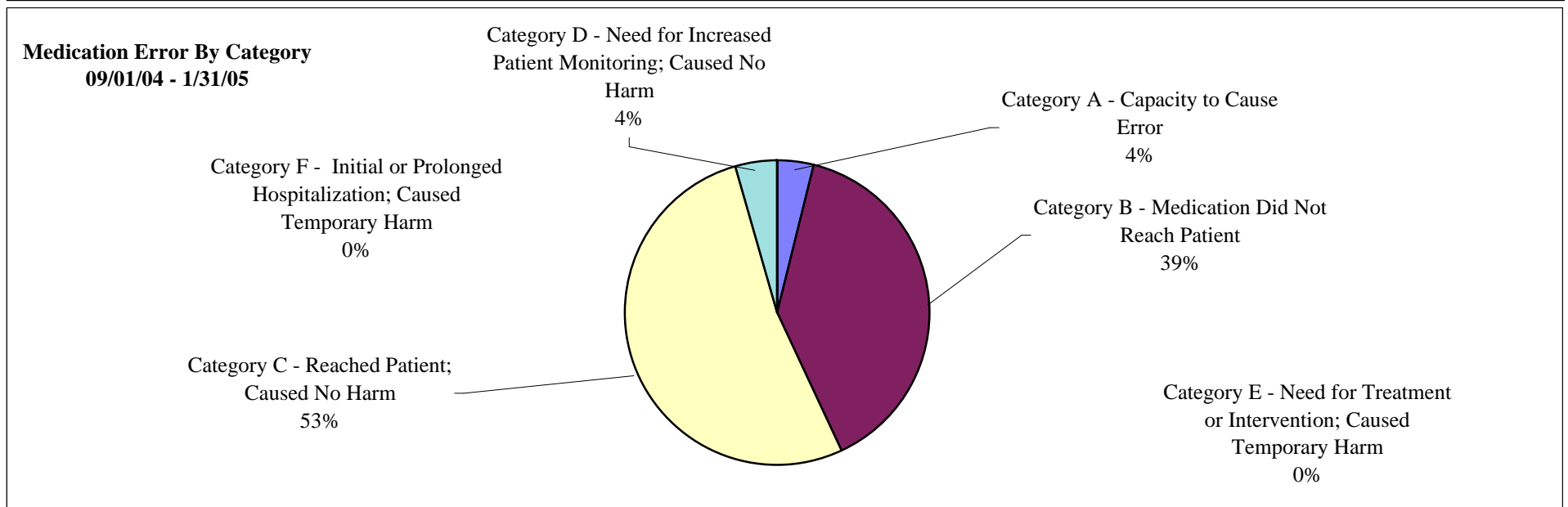
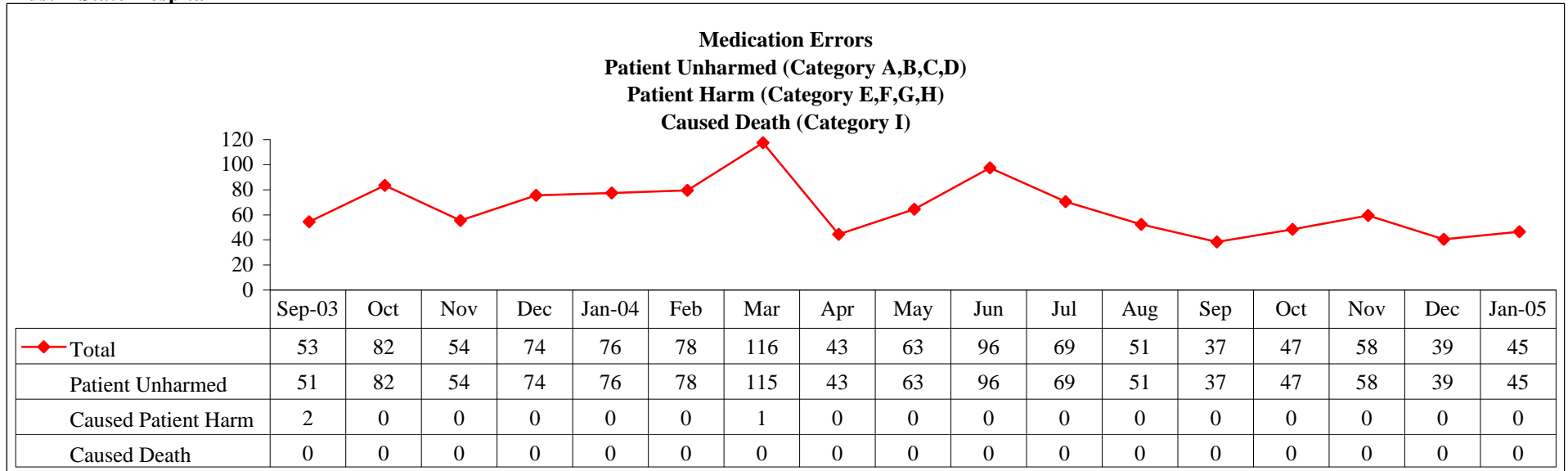
Measure 4C - Medication Variance Data
All MH Facilities



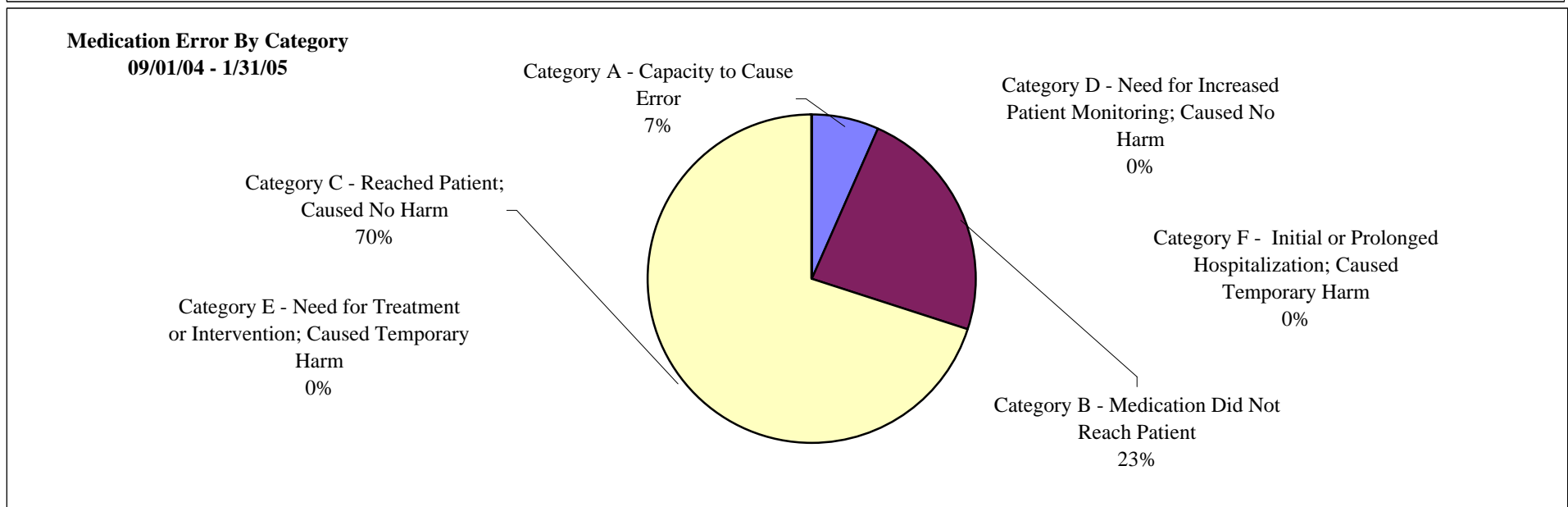
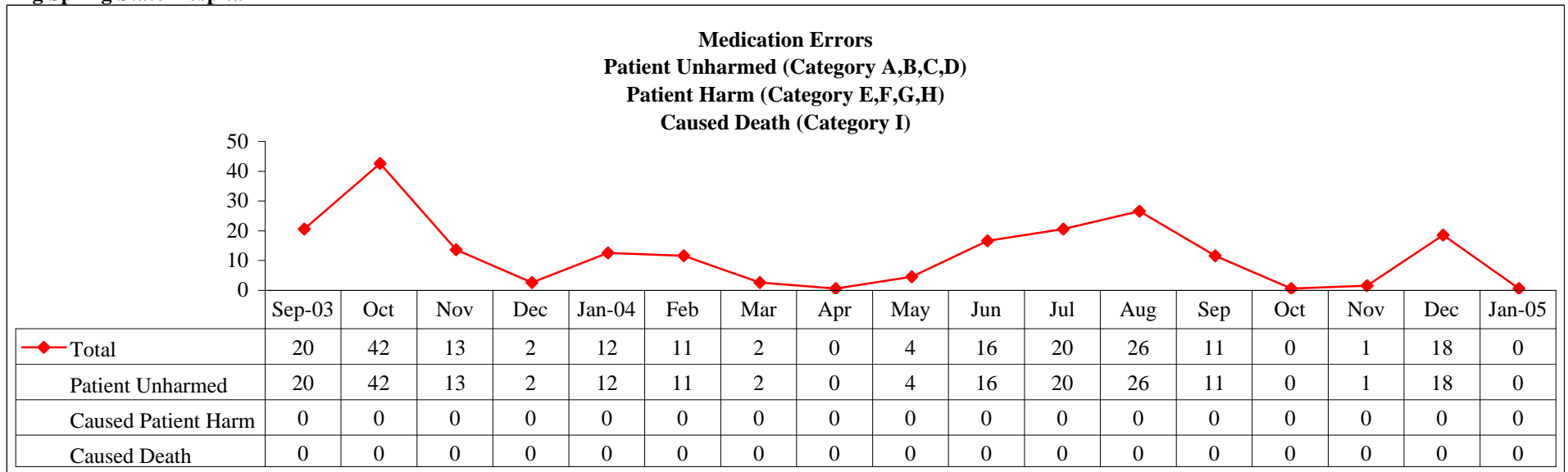
Measure 4C - Medication Variance Data
All MH Facilities



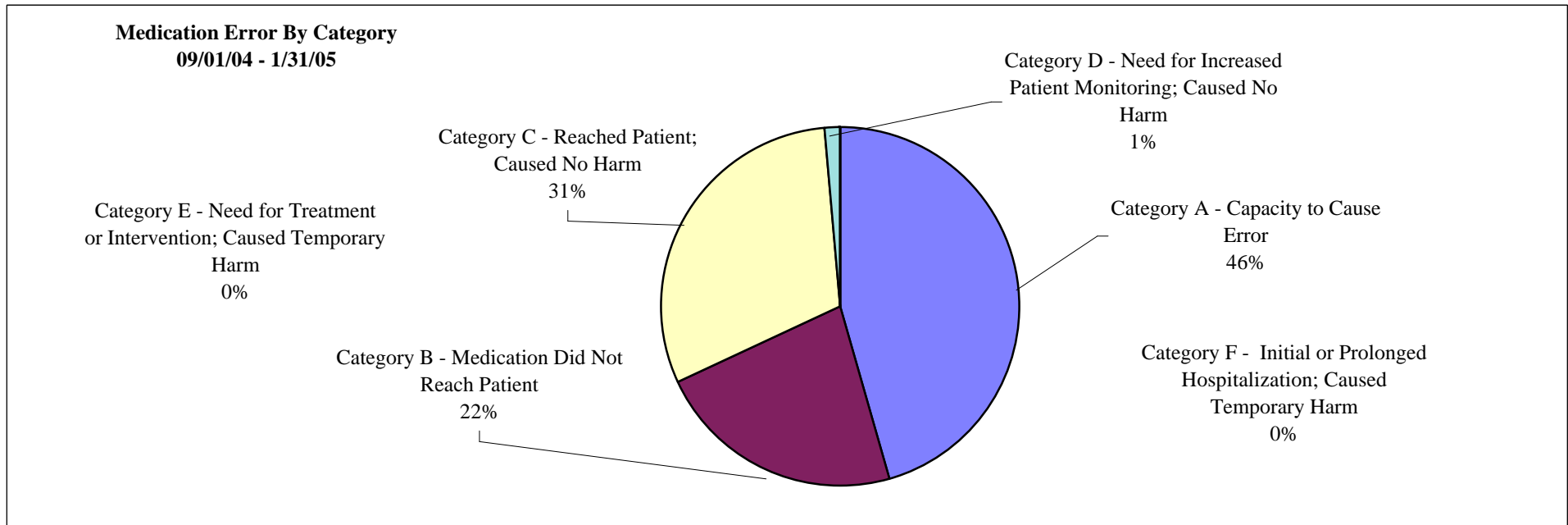
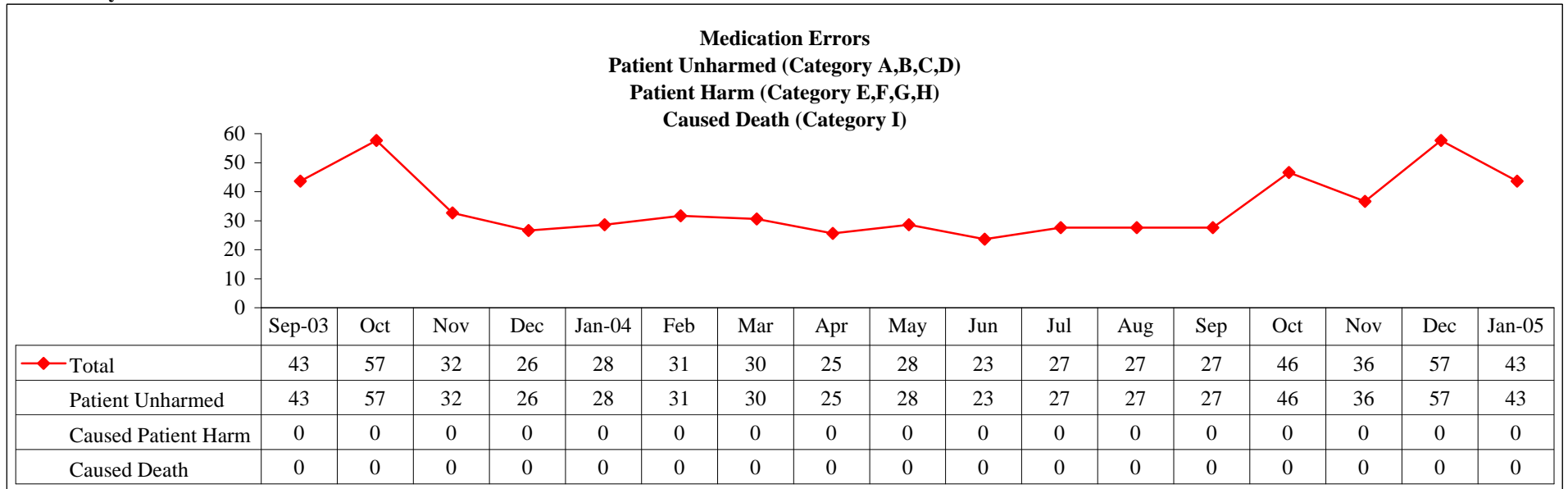
Measure 4C - Medication Variance Data
Austin State Hospital



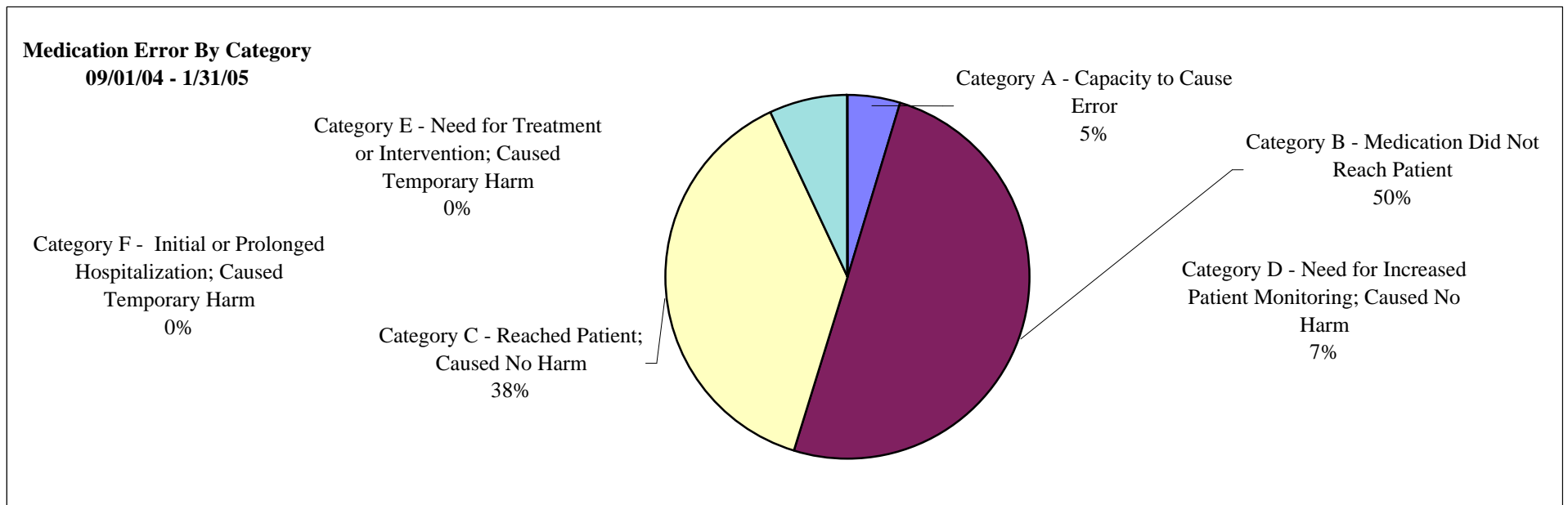
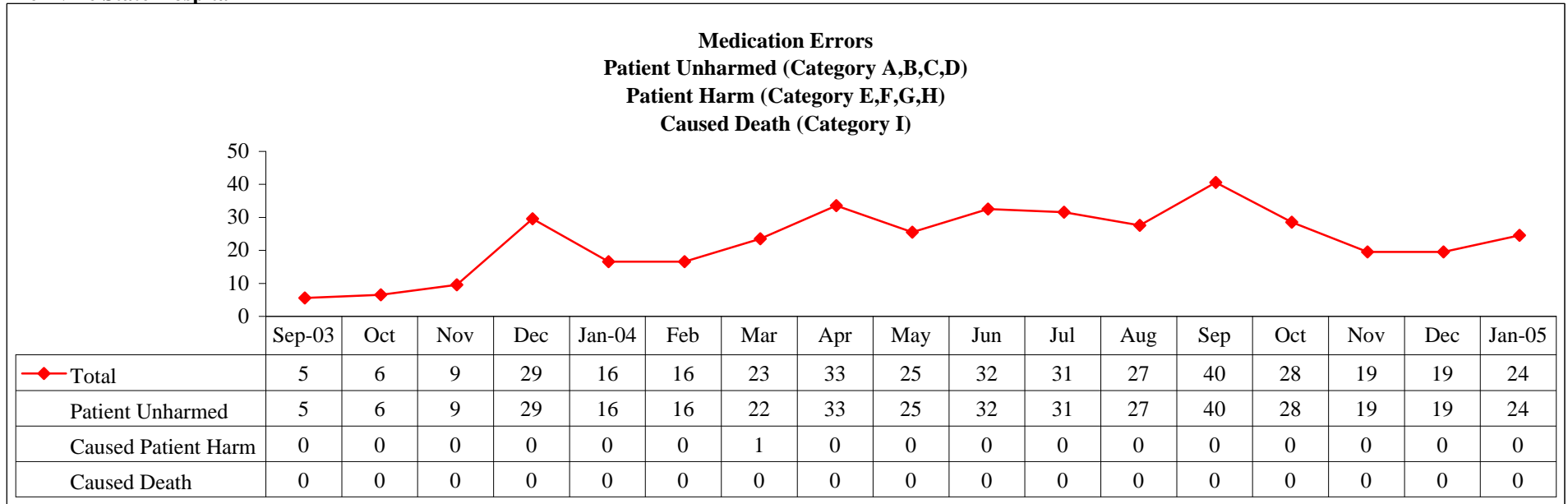
Measure 4C - Medication Variance Data
Big Spring State Hospital



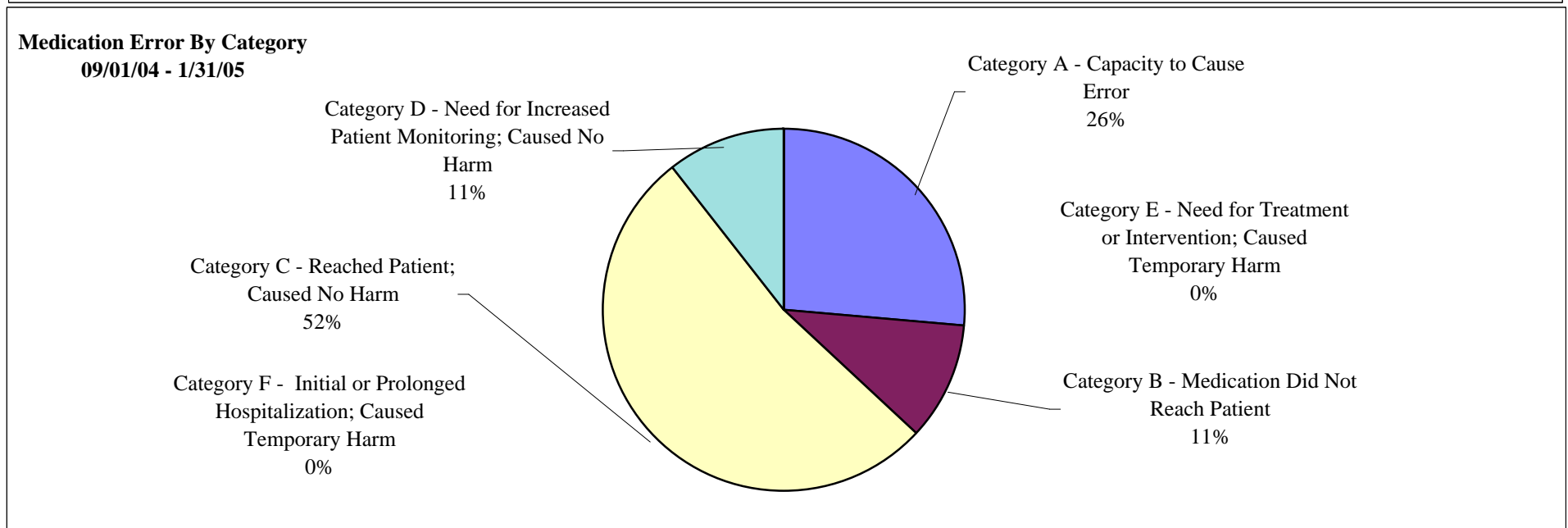
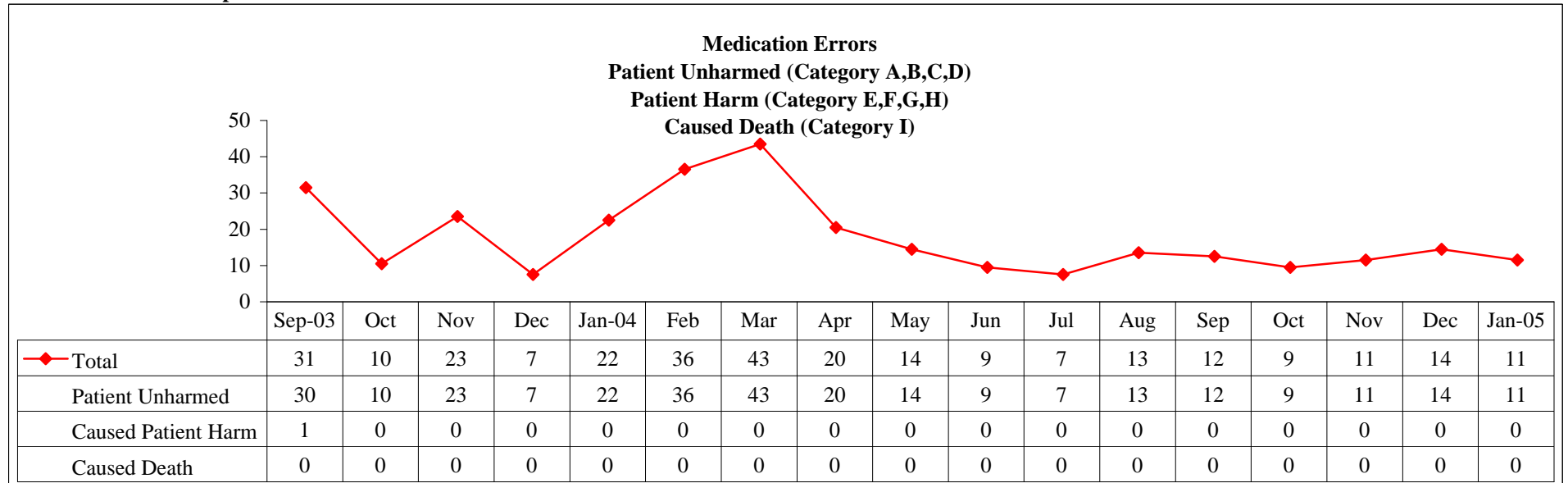
Measure 4C - Medication Variance Data
El Paso Psychiatric Center



**Measure 4C - Medication Variance Data
Kerrville State Hospital**

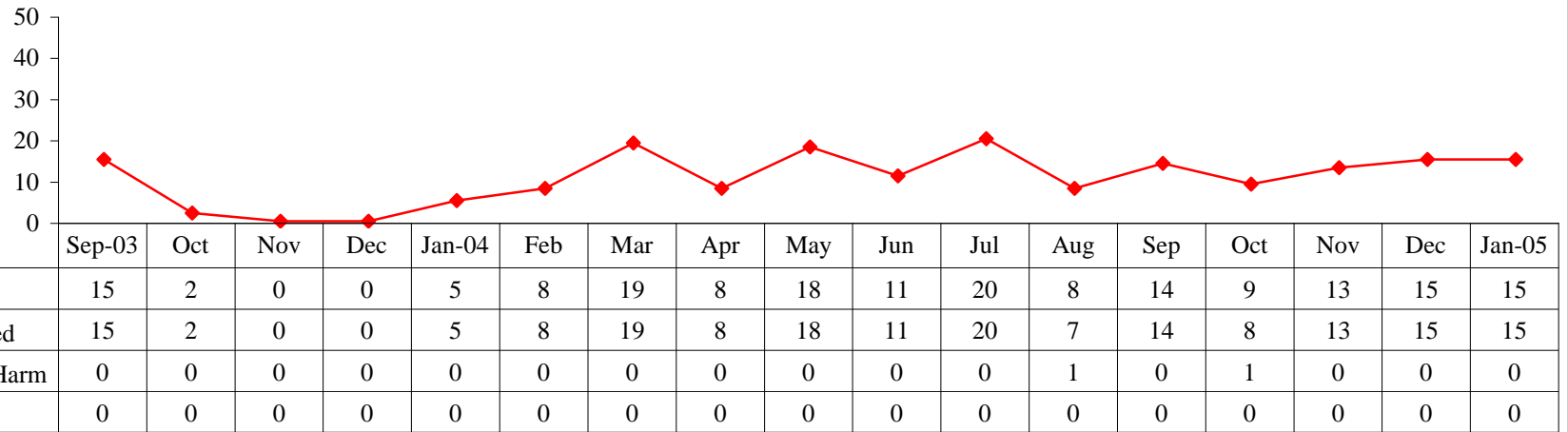


Measure 4C - Medication Variance Data
North Texas State Hospital

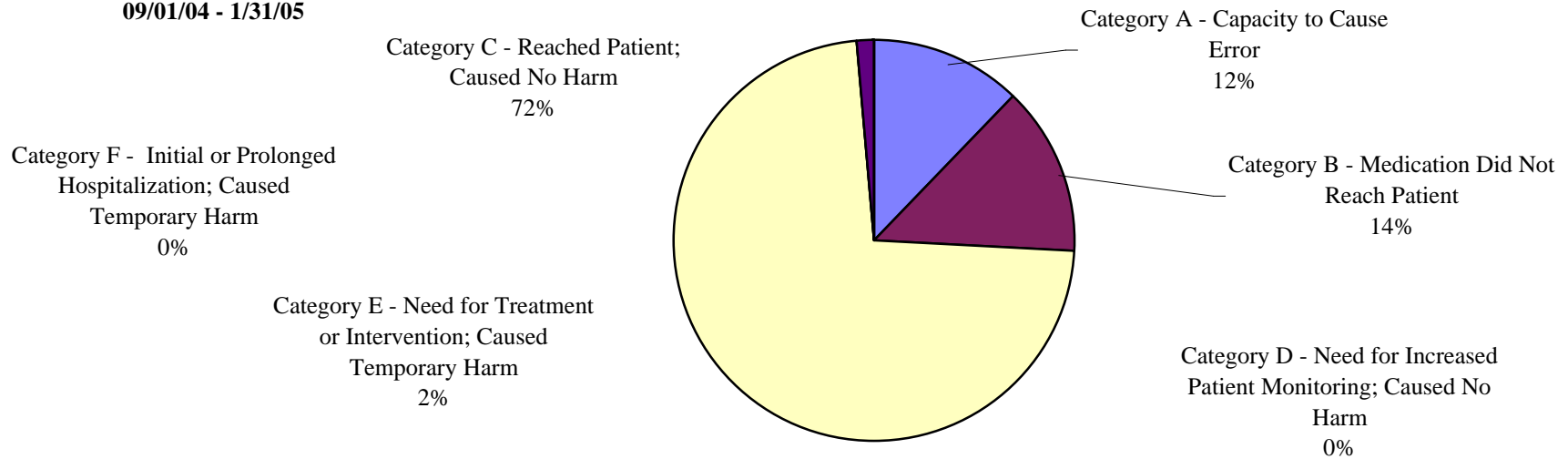


Measure 4C - Medication Variance Data
Rio Grande State Center

Medication Errors
Patient Unharmed (Category A,B,C,D)
Patient Harm (Category E,F,G,H)
Caused Death (Category I)

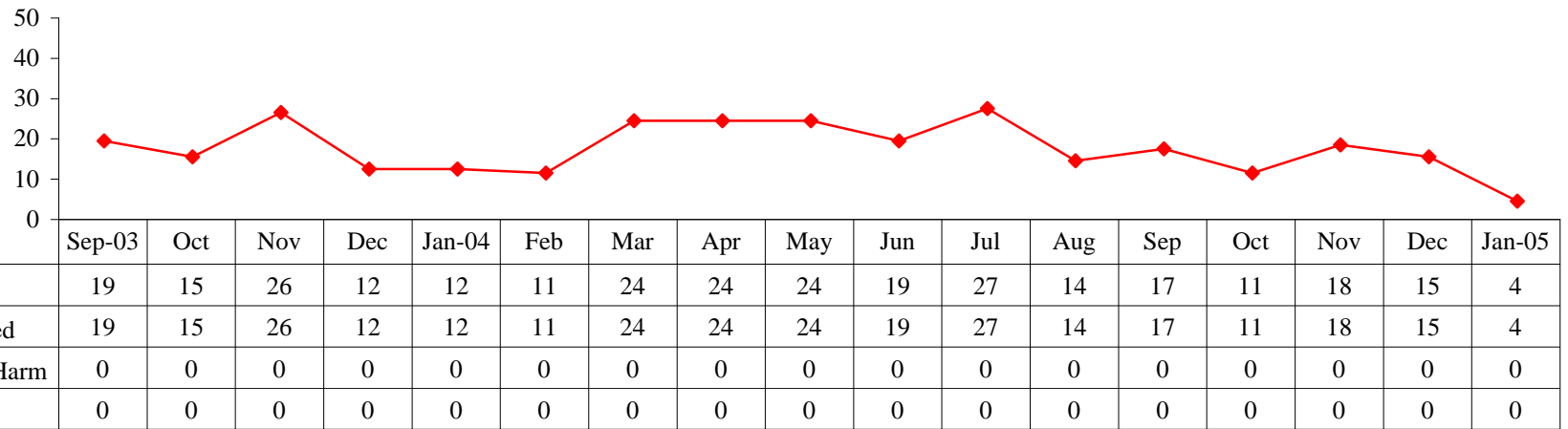


Medication Error By Category
09/01/04 - 1/31/05

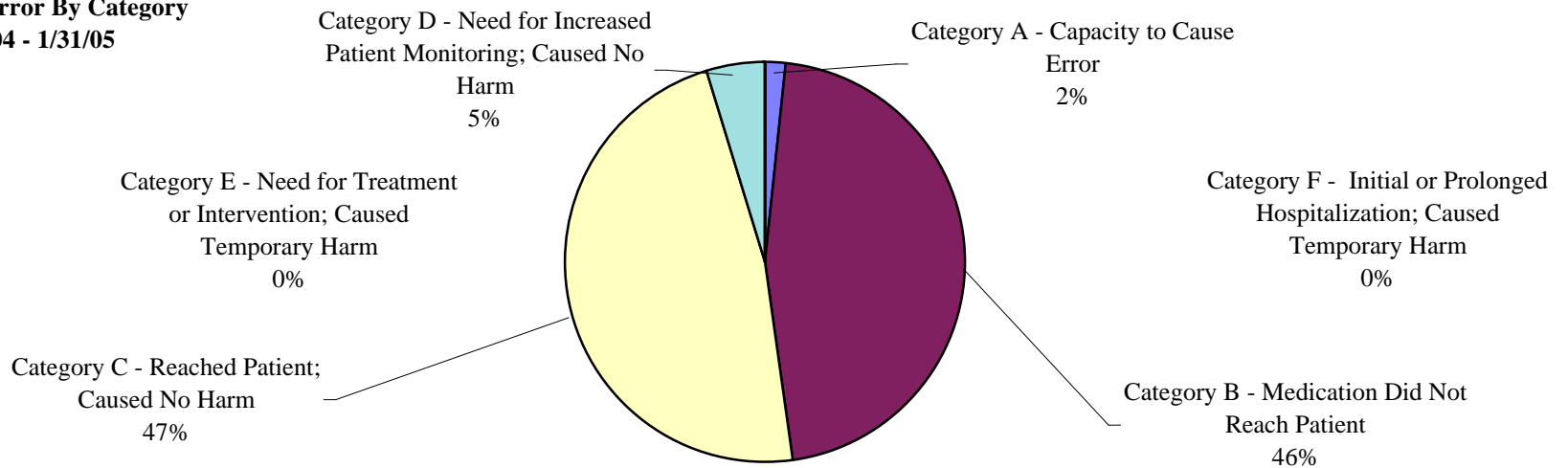


Measure 4C - Medication Variance Data
Rusk State Hospital

Medication Errors
Patient Unharmed (Category A,B,C,D)
Patient Harm (Category E,F,G,H)
Caused Death (Category I)

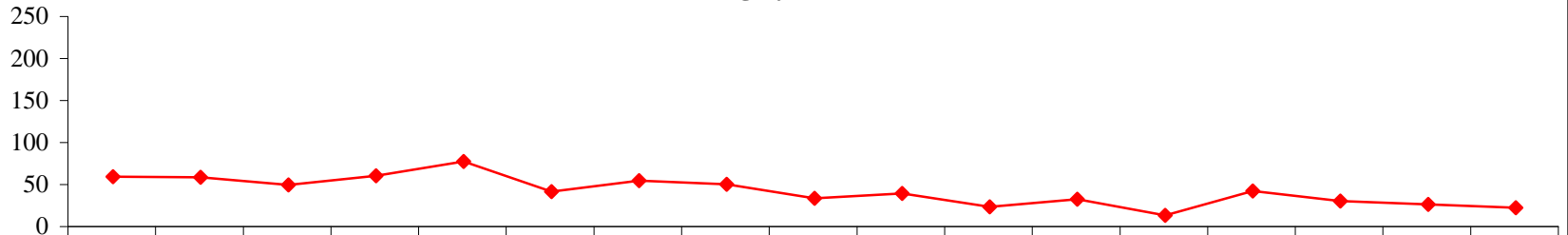


Medication Error By Category
09/01/04 - 1/31/05



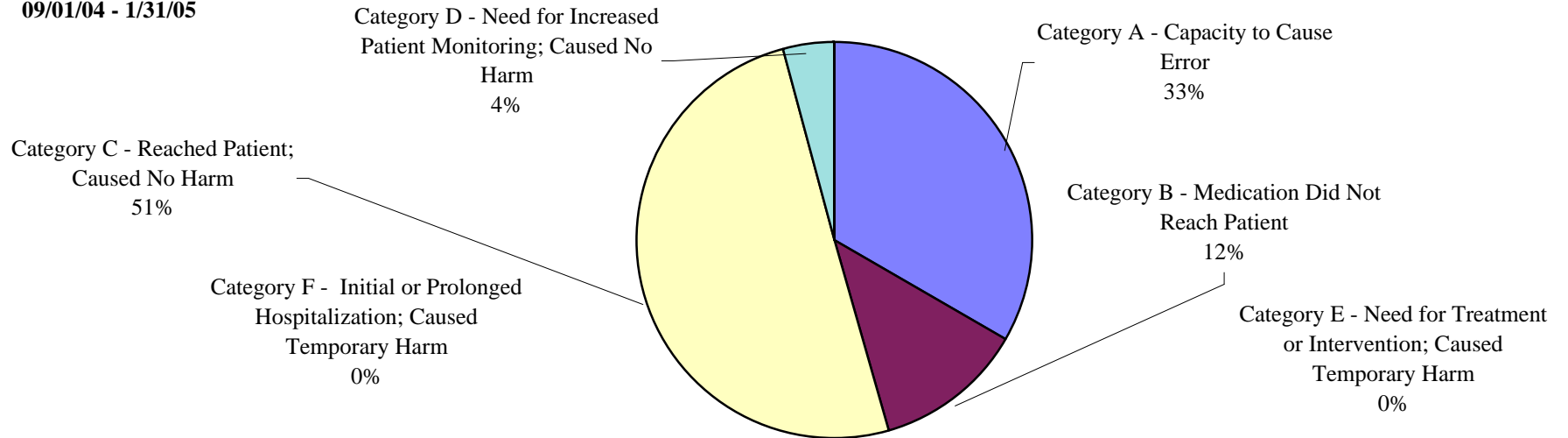
Measure 4C - Medication Variance Data
San Antonio State Hospital

Medication Errors
Patient Unharmed (Category A,B,C,D)
Patient Harm (Category E,F,G,H)
Caused Death (Category I)

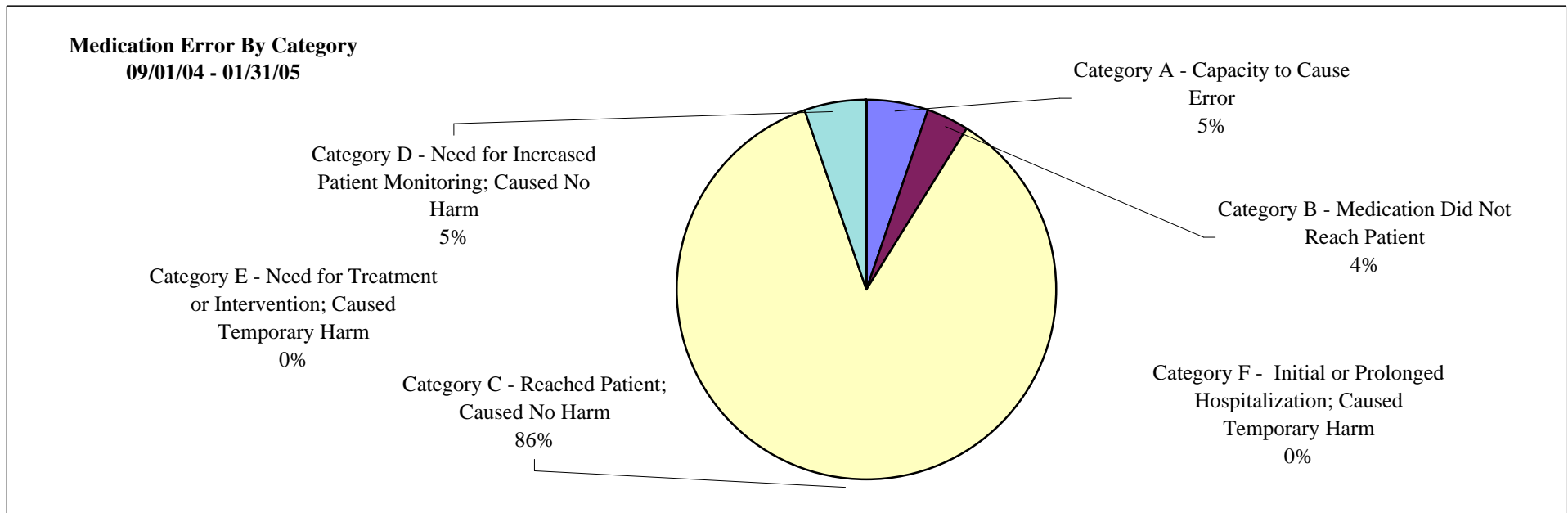
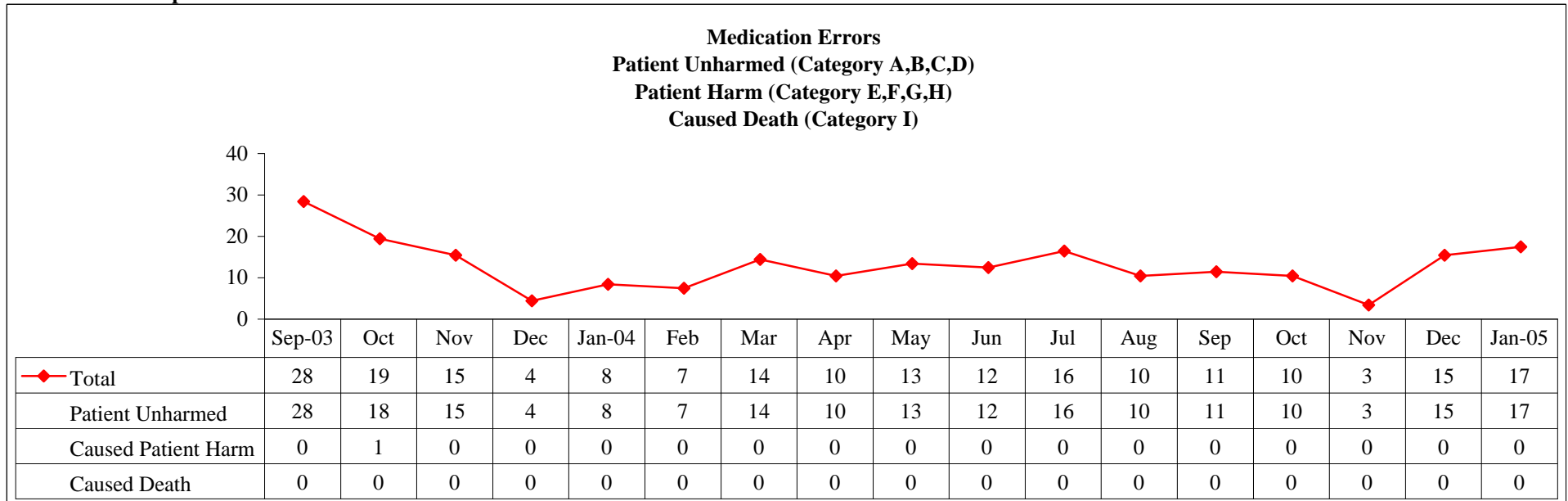


	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05
◆ Total	57	56	47	58	75	39	52	48	31	37	21	30	11	40	28	24	20
Patient Unharmed	56	56	47	58	75	39	52	48	31	37	20	29	11	40	28	24	20
Caused Patient Harm	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0
Caused Death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Medication Error By Category
09/01/04 - 1/31/05

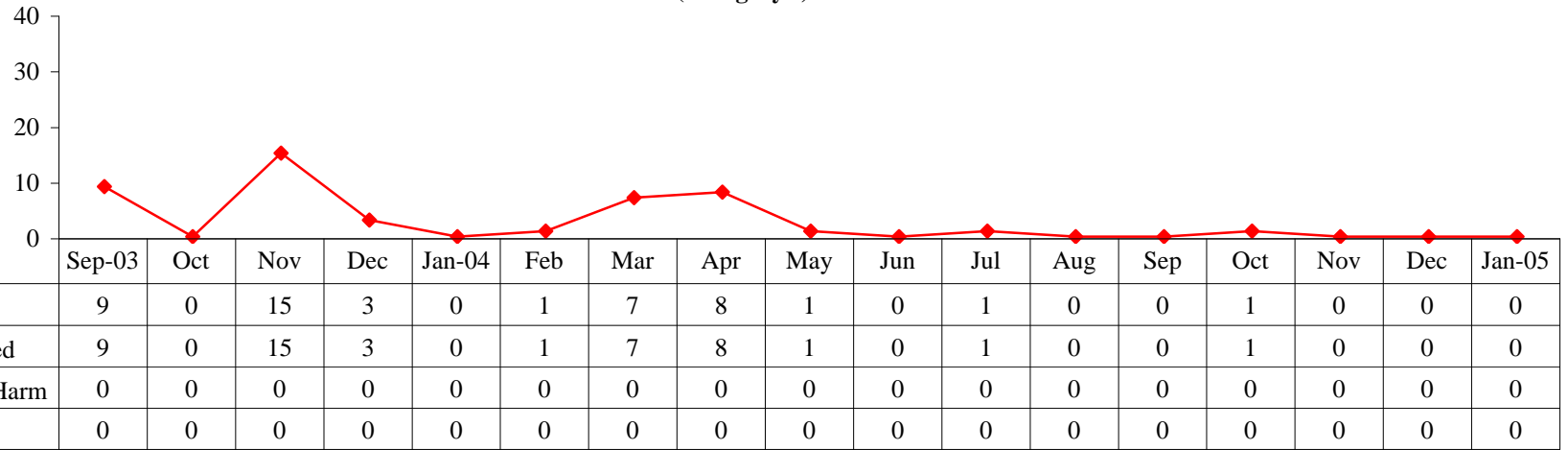


Measure 4C - Medication Variance Data
Terrell State Hospital

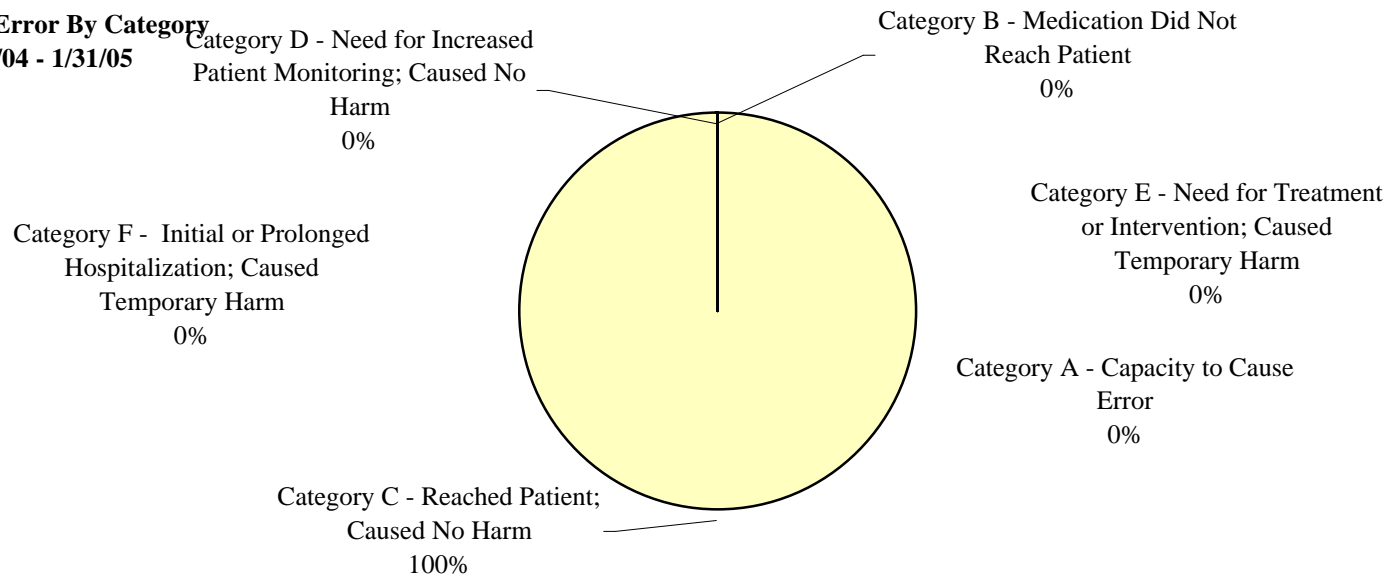


Measure 4C - Medication Variance Data
Waco Center for Youth

Medication Errors
Patient Unharmed (Category A,B,C,D)
Patient Harm (Category E,F,G,H)
Caused Death (Category I)



Medication Error By Category
09/01/04 - 1/31/05



GOAL 5: Assure Continuum of Care

Performance Measure 5A:

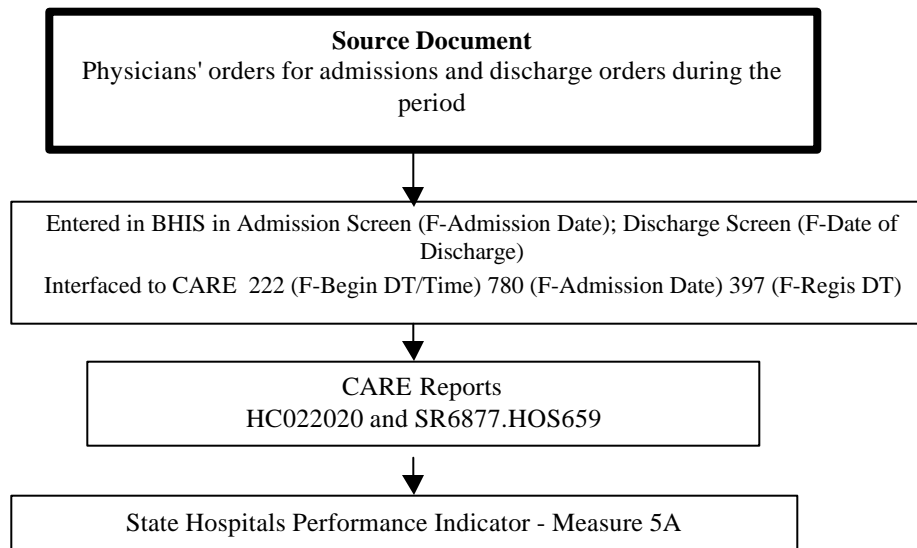
Number and type of admissions, discharges, and readmissions will be calculated and reported for each state hospital on a quarterly basis.

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:

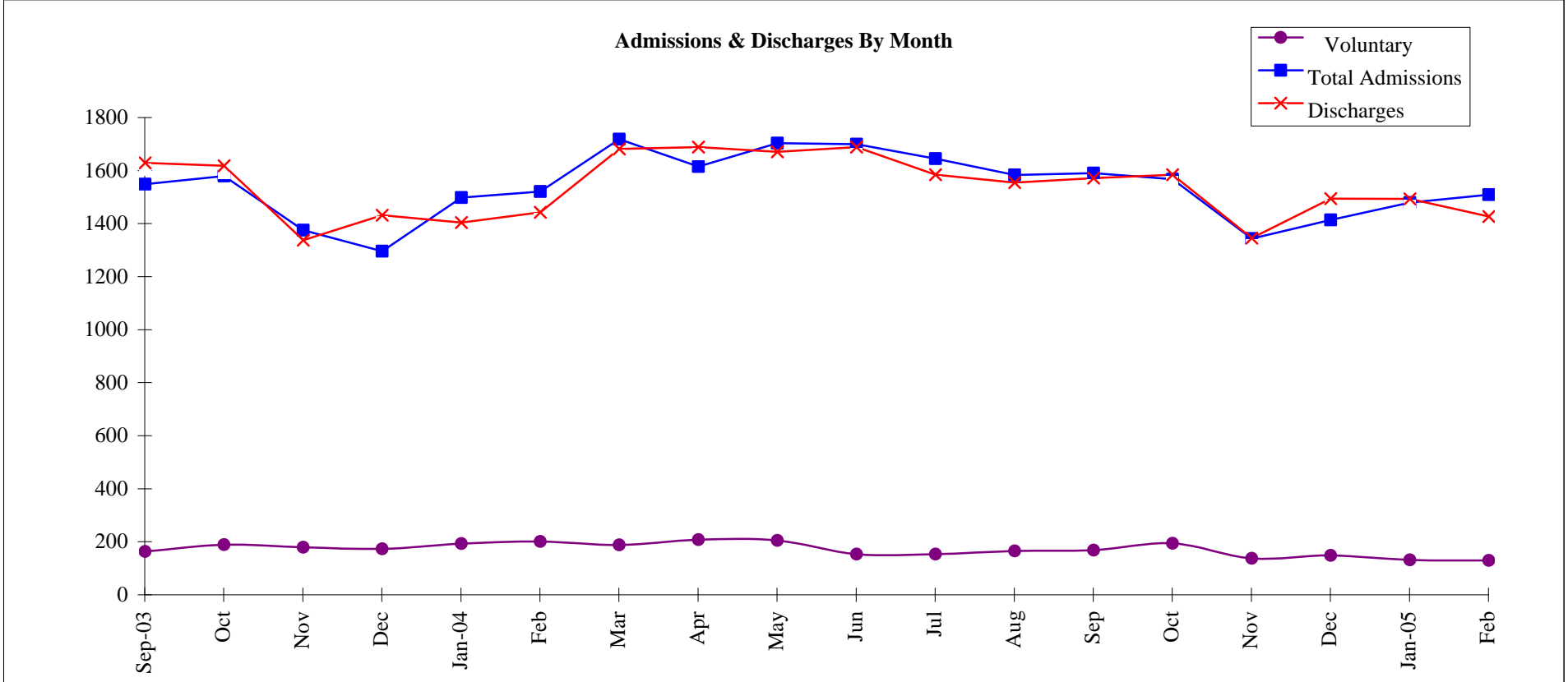
Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date 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

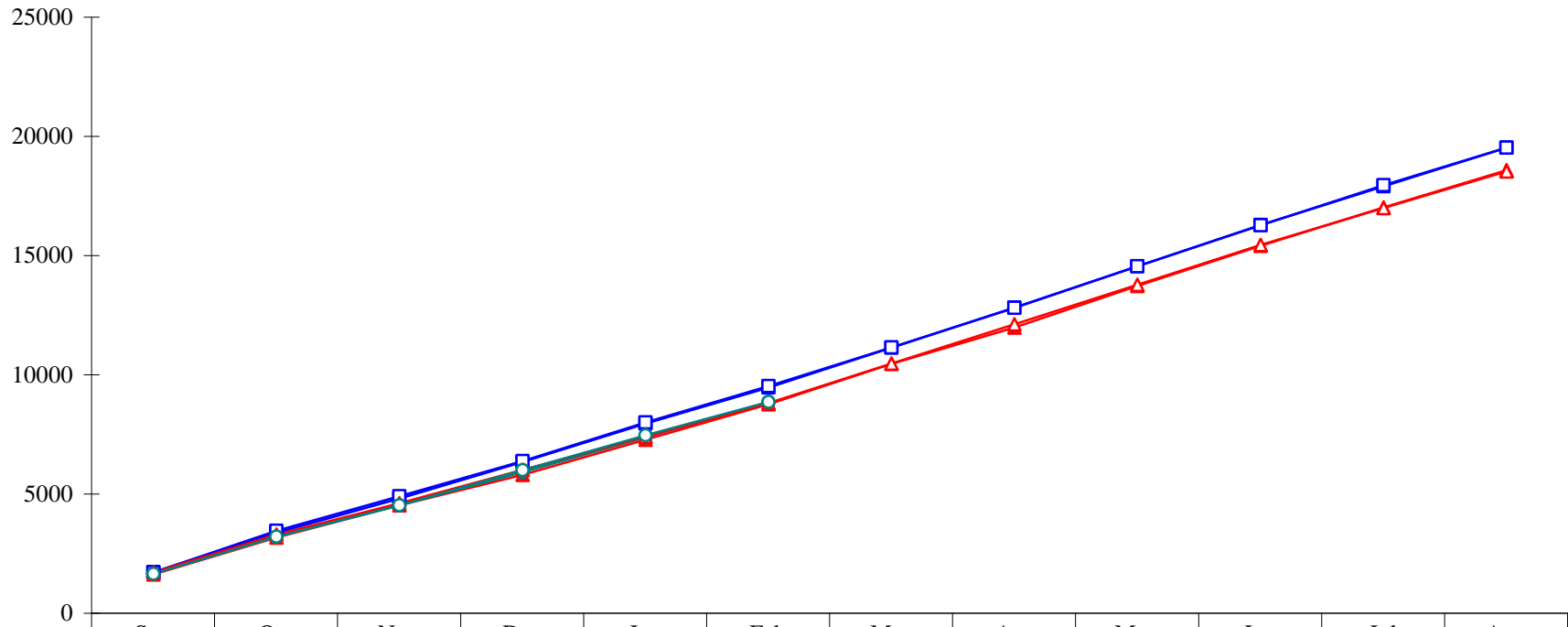
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	1523	1554	1350	1270	1473	1496	1693	1590	1678	1674	1620	1558	1565	1542	1318	1388	1454	1484
Voluntary	138	164	154	148	168	176	163	182	180	128	128	140	143	169	112	123	106	104
Involuntary	1385	1390	1196	1122	1305	1320	1530	1408	1498	1546	1492	1417	1422	1373	1206	1265	1348	1380
OPC	285	301	246	239	303	308	346	356	360	351	372	359	363	305	318	313	325	297
Emergency	756	730	665	636	752	732	814	726	837	807	791	713	712	759	573	613	690	704
Temporary	187	203	155	140	161	147	218	194	185	215	172	185	182	153	170	178	171	186
Extended	8	16	8	9	4	7	2	8	2	4	7	5	7	12	3	11	5	19
46.02/46.03	129	122	105	88	71	103	125	107	96	153	124	135	131	130	124	142	143	151
Order for MR Svc	20	18	17	10	14	23	25	17	18	16	26	20	27	14	18	8	14	23
Discharges	1604	1593	1312	1406	1379	1417	1656	1663	1645	1663	1559	1529	1546	1559	1320	1469	1468	1401
% of Readmissions	58%	56%	57%	56%	58%	57%	57%	56%	54%	57%	56%	57%	56%	54%	56%	55%	56%	58%



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

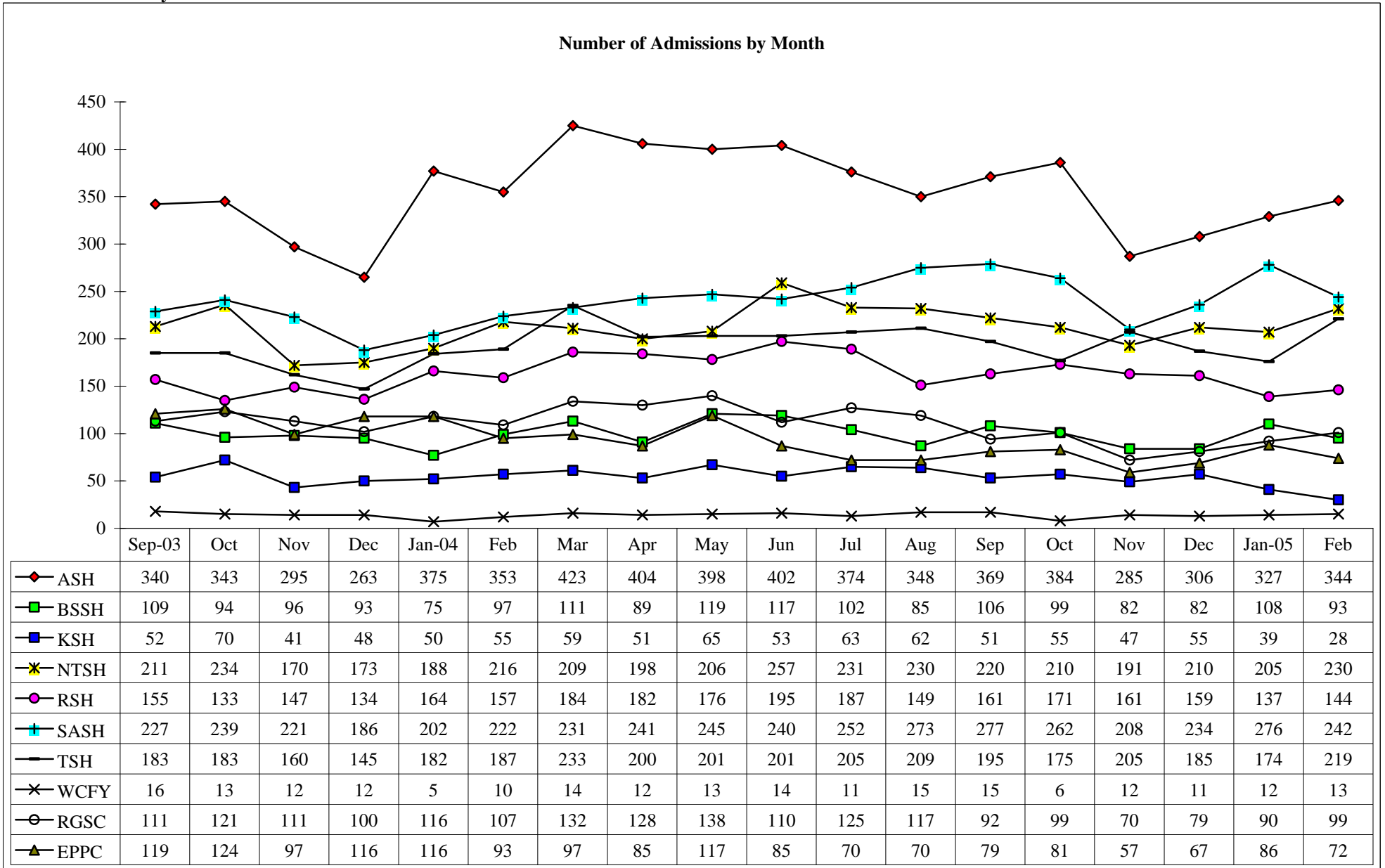
Total Admissions & Discharges Year-To-Date



—■— FY03 Admissions	1625	3273	4708	6240	7844	9363	11036	12714	14445	16176	17804	19427
—▲— FY04 Admissions	1523	3077	4427	5697	7170	8667	10359	11881	13627	15301	16921	18479
—●— FY05 Admissions	1565	3107	4425	5813	7267	8751						
—□— FY03 Discharges	1607	3354	4808	6282	7900	9417	11047	12705	14451	16162	17854	19421
—△— FY04 Discharges	1604	3197	4509	5915	7294	8711	10367	12014	13675	15338	16897	18426
—○— FY05 Discharges	1546	3105	4425	5894	7362	8763						

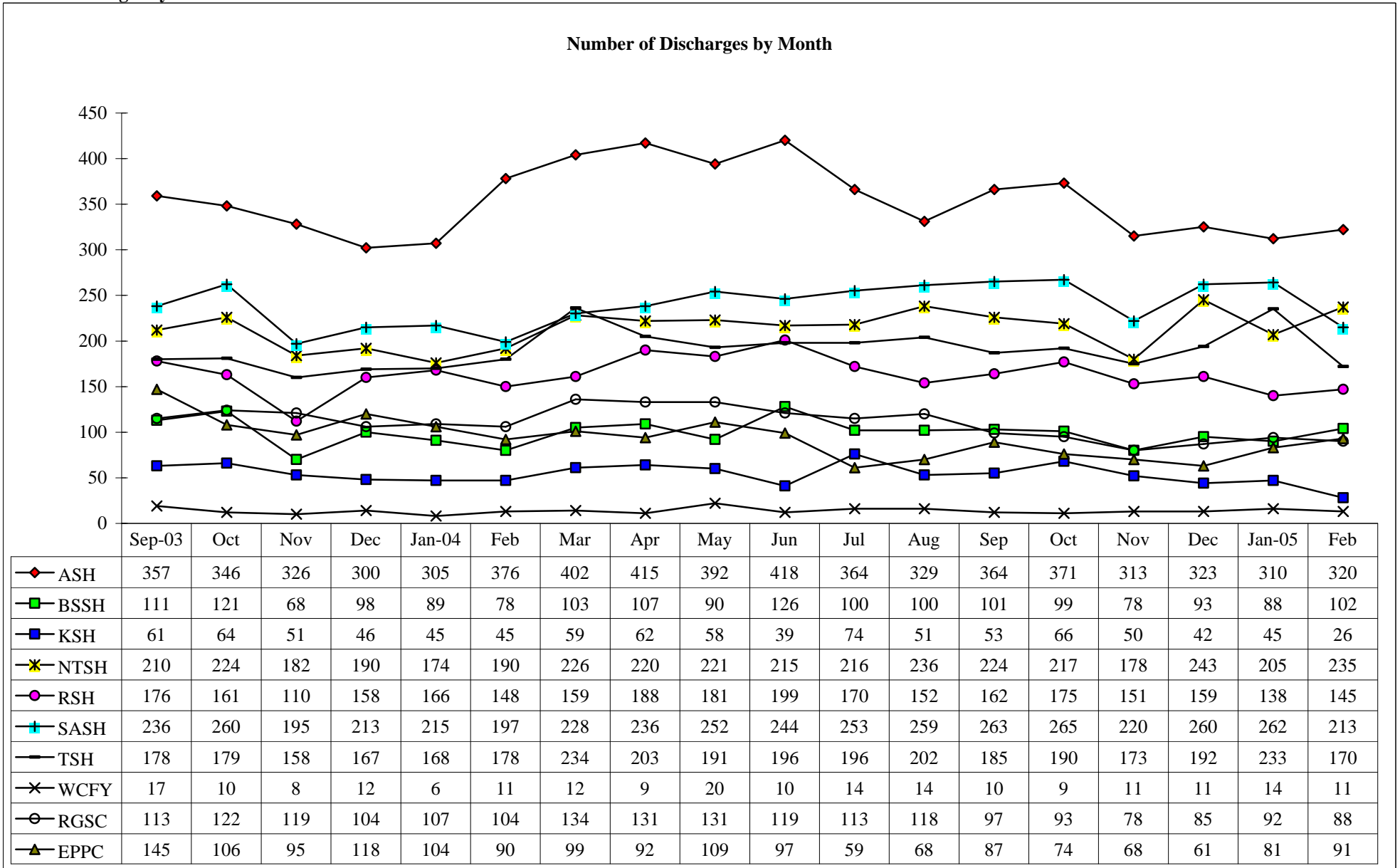
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

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

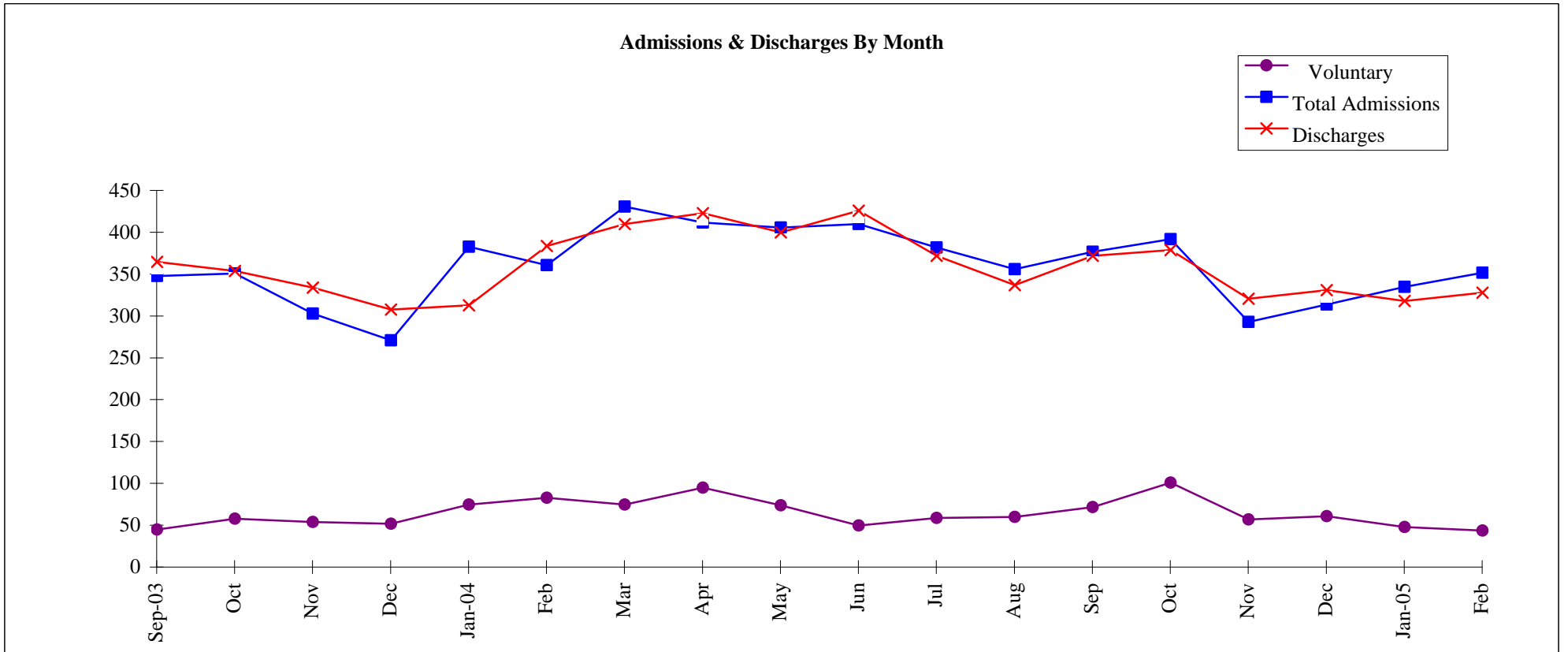


Measure 5A - Number/Type of Admissions and Readmissions

Austin State Hospital

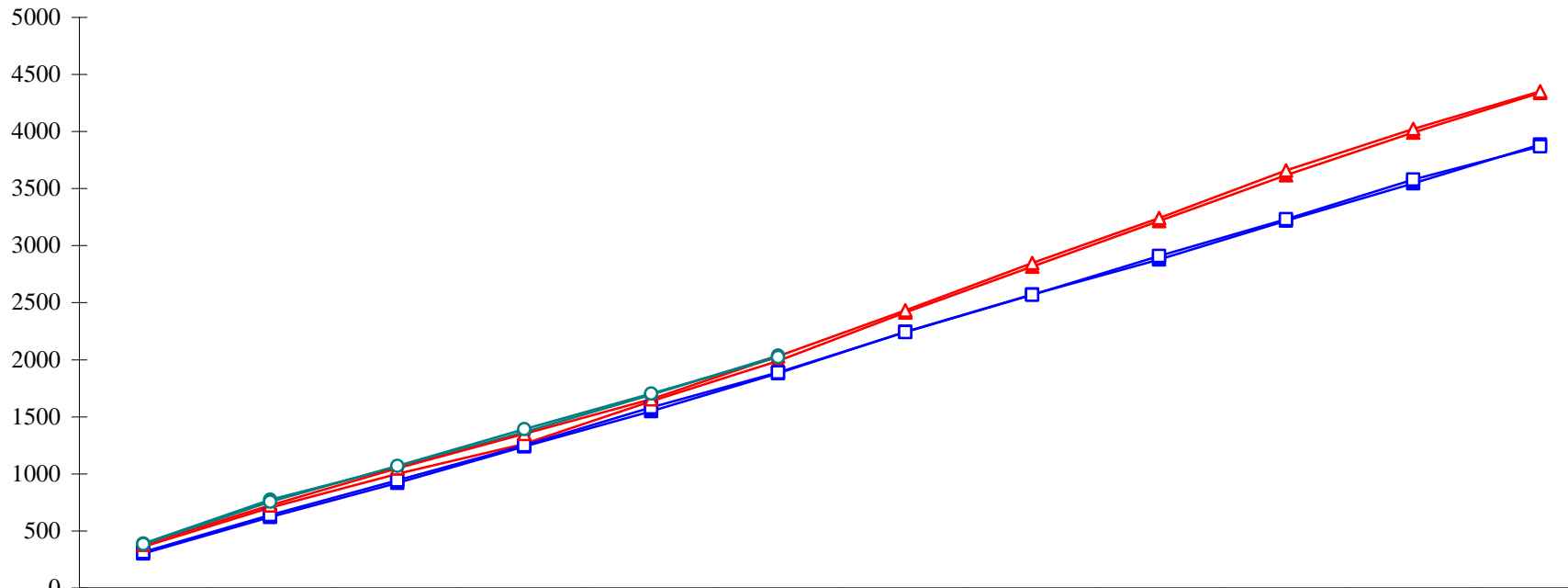
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	340	343	295	263	375	353	423	404	398	402	374	348	369	384	285	306	327	344
Voluntary	37	50	46	44	67	75	67	87	66	42	51	52	64	93	49	53	40	36
Involuntary	303	293	249	219	308	278	356	317	332	360	323	296	305	291	236	253	287	308
OPC	40	33	23	23	42	31	19	34	28	29	27	31	29	25	18	23	27	30
Emergency	221	218	197	161	232	219	272	224	269	277	244	224	225	231	177	178	223	238
Temporary	31	34	26	27	28	22	51	47	28	33	32	33	29	23	27	40	31	26
Extended	1	0	0	1	0	0	1	0	0	1	1	0	0	0	0	0	0	1
46.02/46.03	10	8	3	7	6	6	12	12	7	20	17	7	21	12	14	12	6	13
Order for MR Svc	0	0	0	0	0	0	1	0	0	0	2	1	1	0	0	0	0	0
Discharges	357	346	326	300	305	376	402	415	392	418	364	329	364	371	313	323	310	320
% of Readmissions	56%	50%	49%	52%	55%	50%	60%	53%	58%	62%	58%	57%	55%	55%	58%	54%	54%	56%



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

Total Admissions & Discharges Year-To-Date



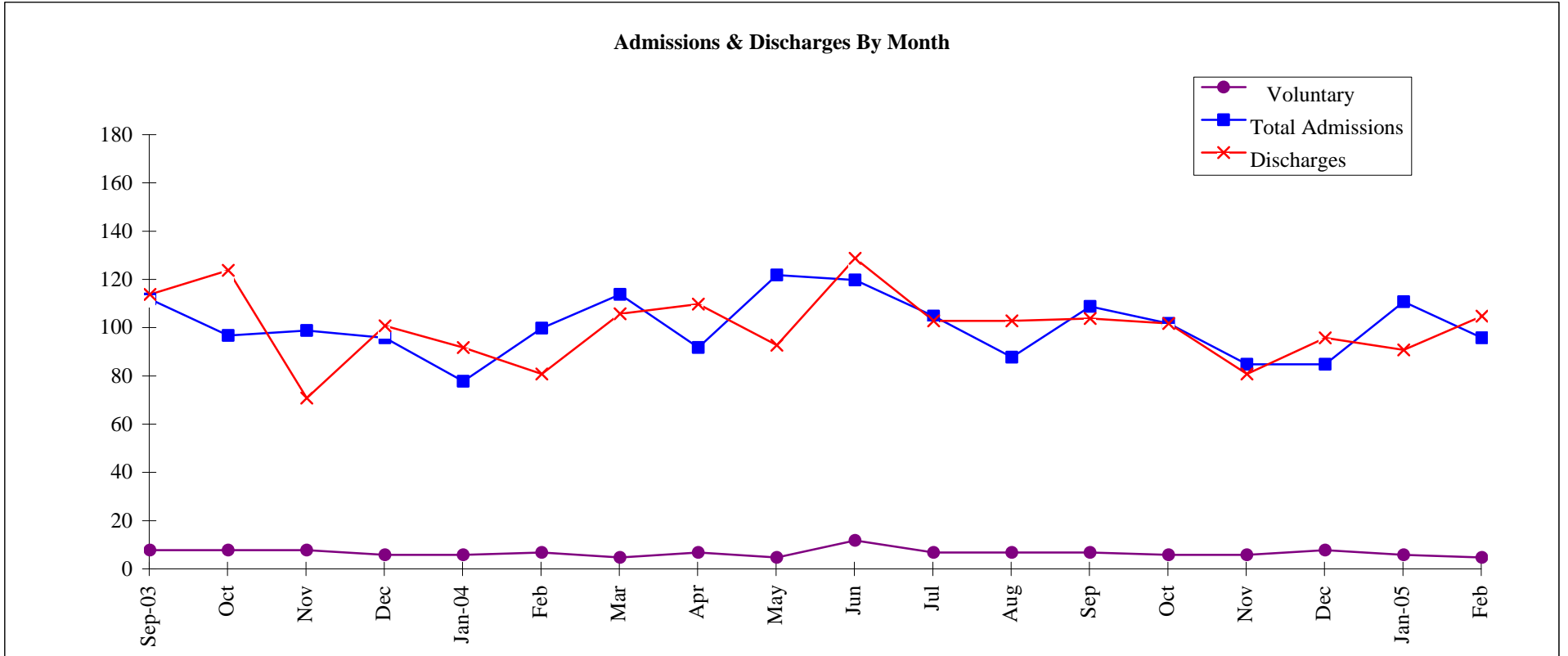
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY03 Admissions	282	601	900	1218	1527	1859	2223	2550	2857	3196	3524	3864
▲ FY04 Admissions	340	683	978	1241	1616	1969	2392	2796	3194	3596	3970	4318
● FY05 Admissions	369	753	1038	1344	1671	2015						
■ FY03 Discharges	293	619	923	1230	1560	1867	2221	2548	2887	3210	3557	3849
▲ FY04 Discharges	357	703	1029	1329	1634	2010	2412	2827	3219	3637	4001	4330
● FY05 Discharges	364	735	1048	1371	1681	2001						

Measure 5A - Number/Type of Admissions and Readmissions

Big Spring State Hospital

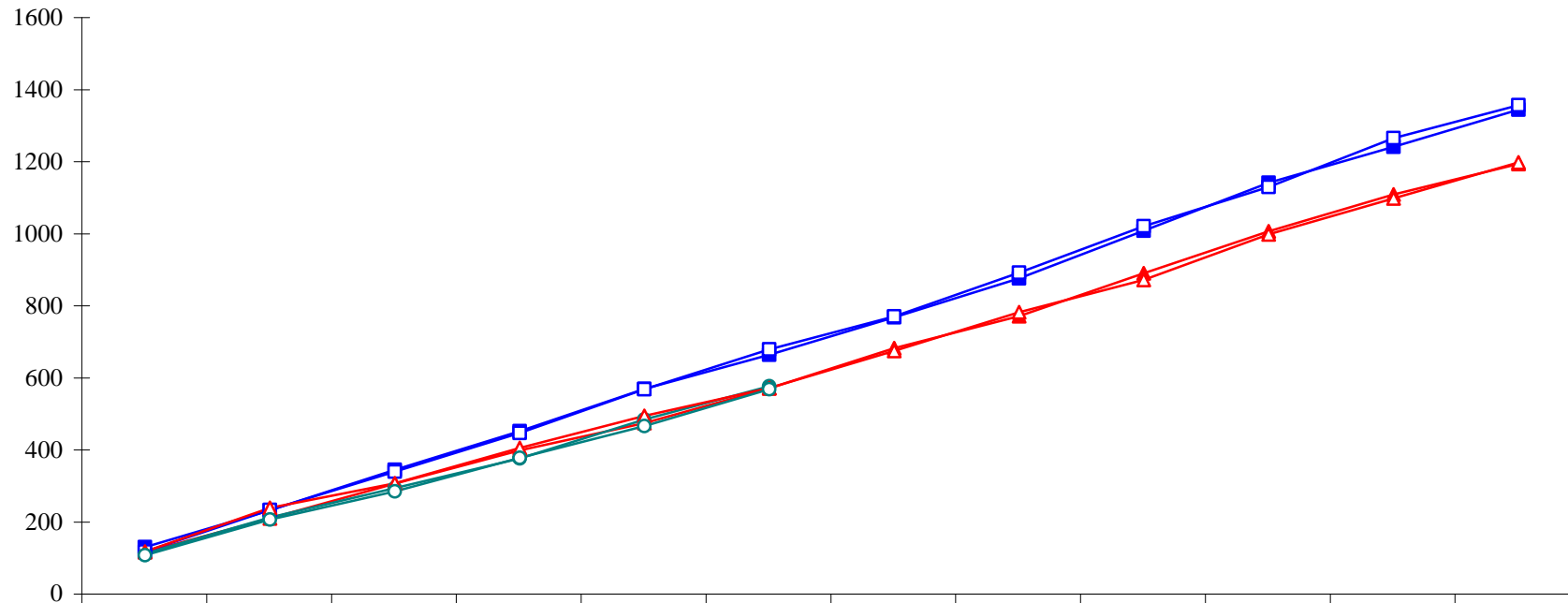
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	109	94	96	93	75	97	111	89	119	117	102	85	106	99	82	82	108	93
Voluntary	5	5	5	3	3	4	2	4	2	9	4	4	4	3	3	5	3	2
Involuntary	104	89	91	90	72	93	109	85	117	108	98	81	102	96	79	77	105	91
OPC	10	10	7	8	10	9	15	15	15	18	23	13	20	18	19	10	15	14
Emergency	76	68	61	71	56	56	69	63	88	75	65	60	57	63	48	61	68	74
Temporary	8	3	15	3	2	20	21	2	11	11	2	3	8	11	4	0	0	0
Extended	1	2	2	2	2	4	0	1	1	1	2	0	2	0	0	1	1	0
46.02/46.03	8	6	6	6	2	4	3	4	1	2	4	4	12	3	5	4	21	2
Order for MR Sv	1	0	0	0	0	0	1	0	1	1	2	1	3	1	3	1	0	1
Discharges	111	121	68	98	89	78	103	107	90	126	100	100	101	99	78	93	88	102
% of Readmissions	70%	62%	73%	66%	67%	66%	68%	56%	60%	62%	62%	69%	69%	63%	55%	61%	69%	61%



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
—■— FY03 Admissions	123	225	338	445	562	657	761	869	1001	1134	1234	1337
—▲— FY04 Admissions	109	203	299	392	467	564	675	764	883	1000	1102	1187
—●— FY05 Admissions	106	205	287	369	477	570						
—□— FY03 Discharges	111	226	333	440	561	672	763	885	1014	1123	1258	1350
—▲— FY04 Discharges	111	232	300	398	487	565	668	775	865	991	1091	1191
—○— FY05 Discharges	101	200	278	371	459	561						

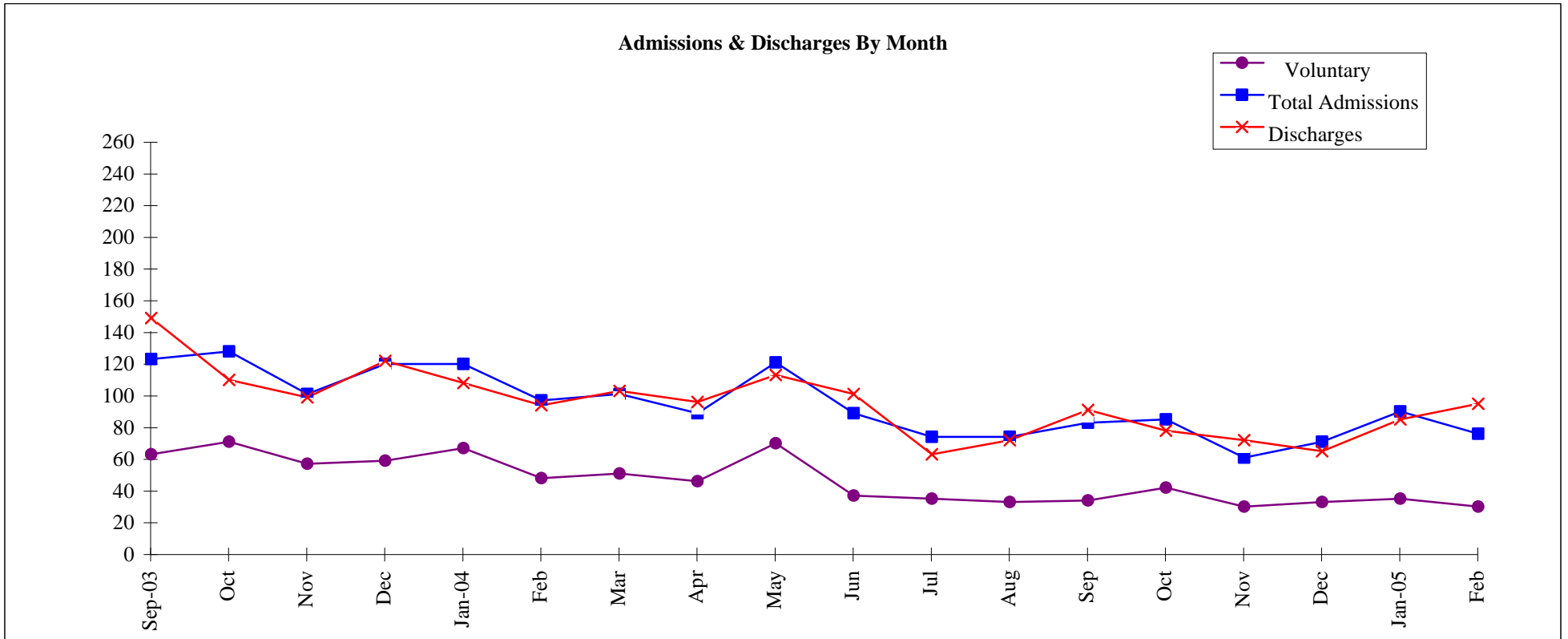
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

El Paso Psychiatric Center

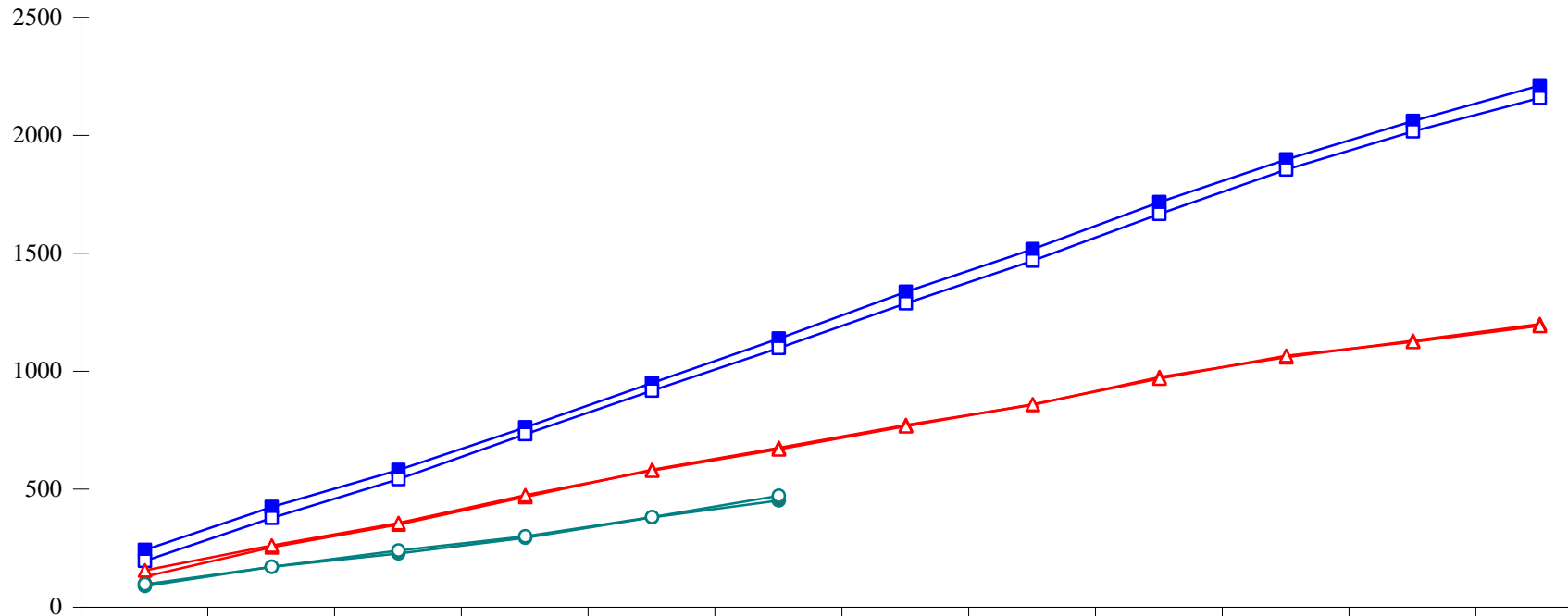
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	119	124	97	116	116	93	97	85	117	85	70	70	79	81	57	67	86	72
Voluntary	59	67	53	55	63	44	47	42	66	33	31	29	30	38	26	29	31	26
Involuntary	60	57	44	61	53	49	50	43	51	52	39	41	49	43	31	38	55	46
OPC	0	0	0	0	0	0	0	0	2	9	3	2	3	2	3	4	4	1
Emergency	58	51	43	61	53	48	50	42	48	42	36	34	45	40	26	29	48	44
Temporary	0	2	0	0	0	1	0	1	1	1	0	2	1	1	2	3	3	1
Extended	2	4	1	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0
46.02/46.03	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0
Order for MR Svc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	145	106	95	118	104	90	99	92	109	97	59	68	87	74	68	61	81	91
% of Readmissions	51%	57%	64%	47%	59%	59%	58%	56%	57%	59%	61%	53%	51%	47%	44%	37%	48%	56%



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

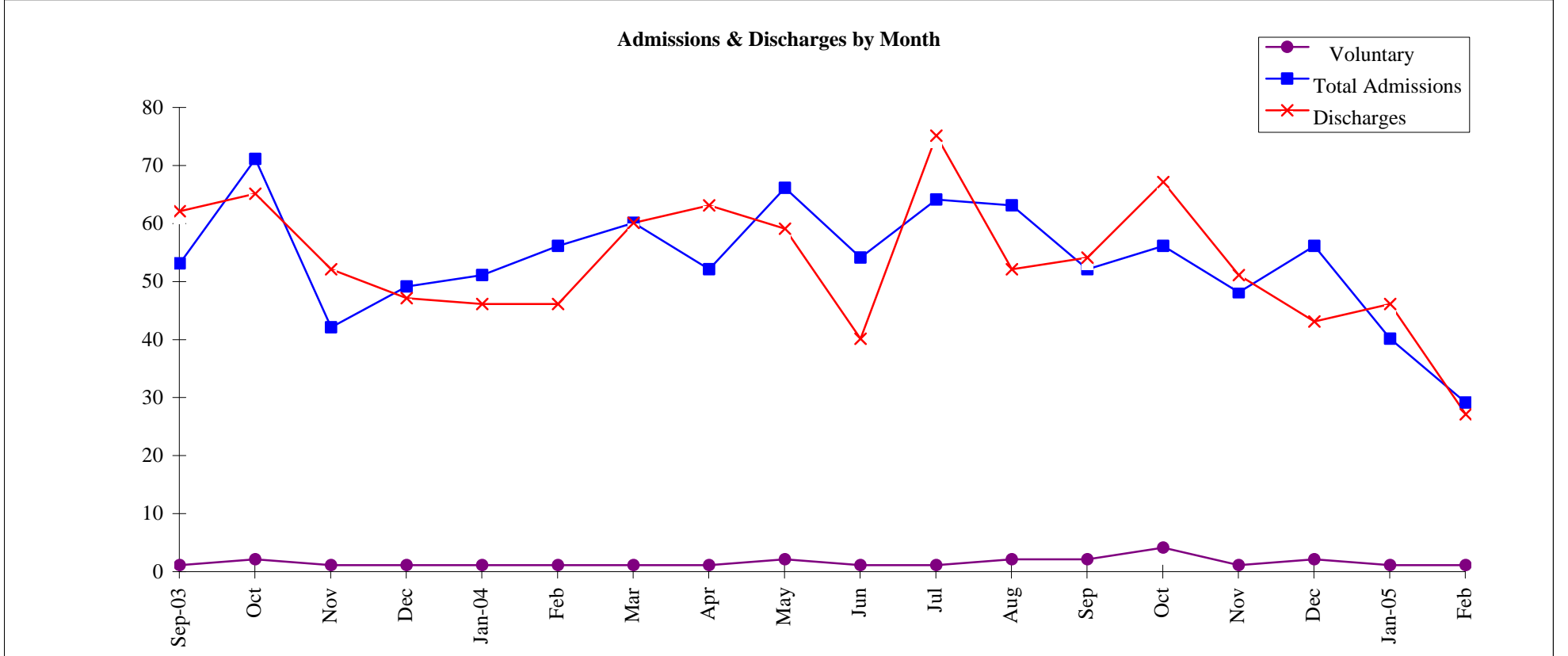
Total Admissions & Discharges Year-To-Date



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY03 Admissions	232	414	571	752	940	1128	1326	1506	1706	1887	2050	2200
▲ FY04 Admissions	119	243	340	456	572	665	762	847	964	1049	1119	1189
● FY05 Admissions	79	160	217	284	370	442						
□ FY03 Discharges	186	367	532	722	907	1087	1277	1458	1656	1844	2006	2148
△ FY04 Discharges	145	251	346	464	568	658	757	849	958	1055	1114	1182
○ FY05 Discharges	87	161	229	290	371	462						

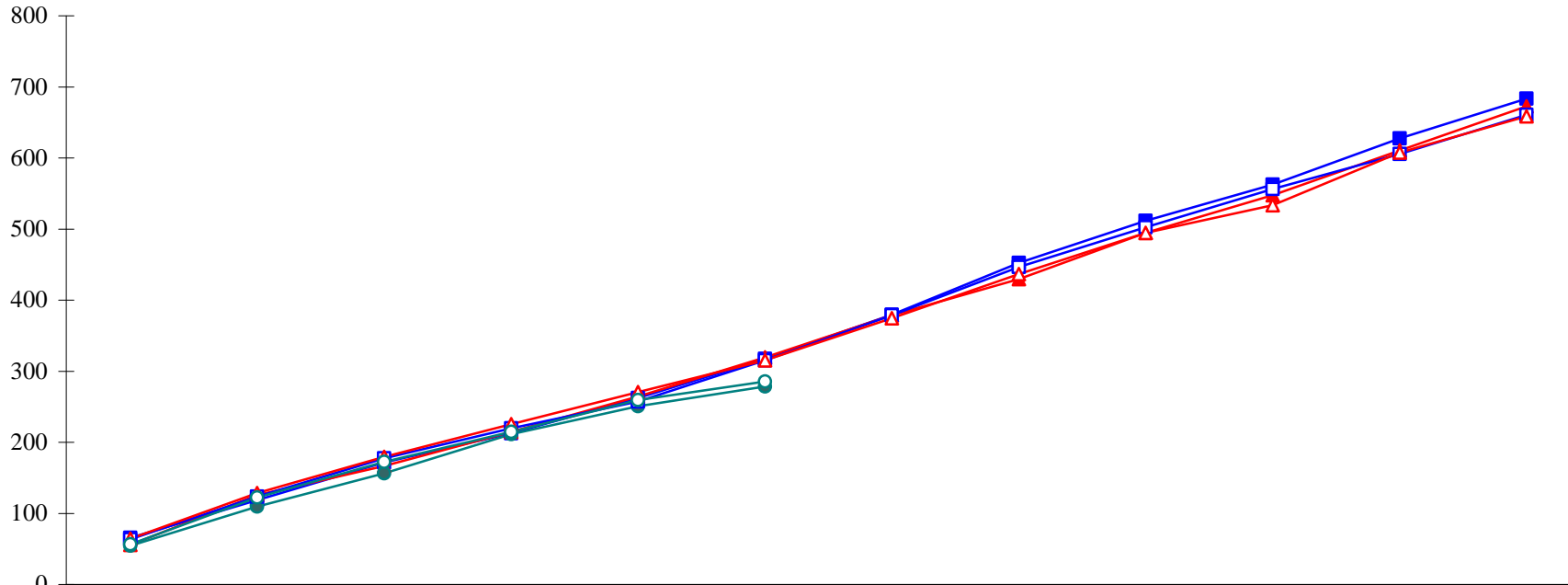
Measure 5A - Number/Type of Admissions and Readmissions
Kerrville State Hospital
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	52	70	41	48	50	55	59	51	65	53	63	62	51	55	47	55	39	28
Voluntary	0	1	0	0	0	0	0	0	1	0	0	1	1	3	0	1	0	0
Involuntary	52	69	41	48	50	55	59	51	64	53	63	61	50	52	47	54	39	28
OPC	1	6	6	4	3	7	11	6	10	7	8	5	5	3	3	2	1	0
Emergency	43	53	27	36	45	44	40	35	42	34	42	38	41	39	34	31	12	1
Temporary	0	1	0	1	0	0	0	2	2	2	0	1	0	0	4	8	0	0
Extended	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
46.02/46.03	8	9	8	7	2	3	7	7	8	10	11	17	2	9	6	13	26	27
Order for MR Svc	0	0	0	0	0	1	1	0	2	0	2	0	2	1	0	0	0	0
Discharges	61	64	51	46	45	45	59	62	58	39	74	51	53	66	50	42	45	26
% of Readmissions	65%	66%	71%	69%	56%	65%	53%	73%	57%	74%	65%	68%	51%	58%	70%	71%	85%	100%



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

Total Admissions & Discharges Year-To-Date



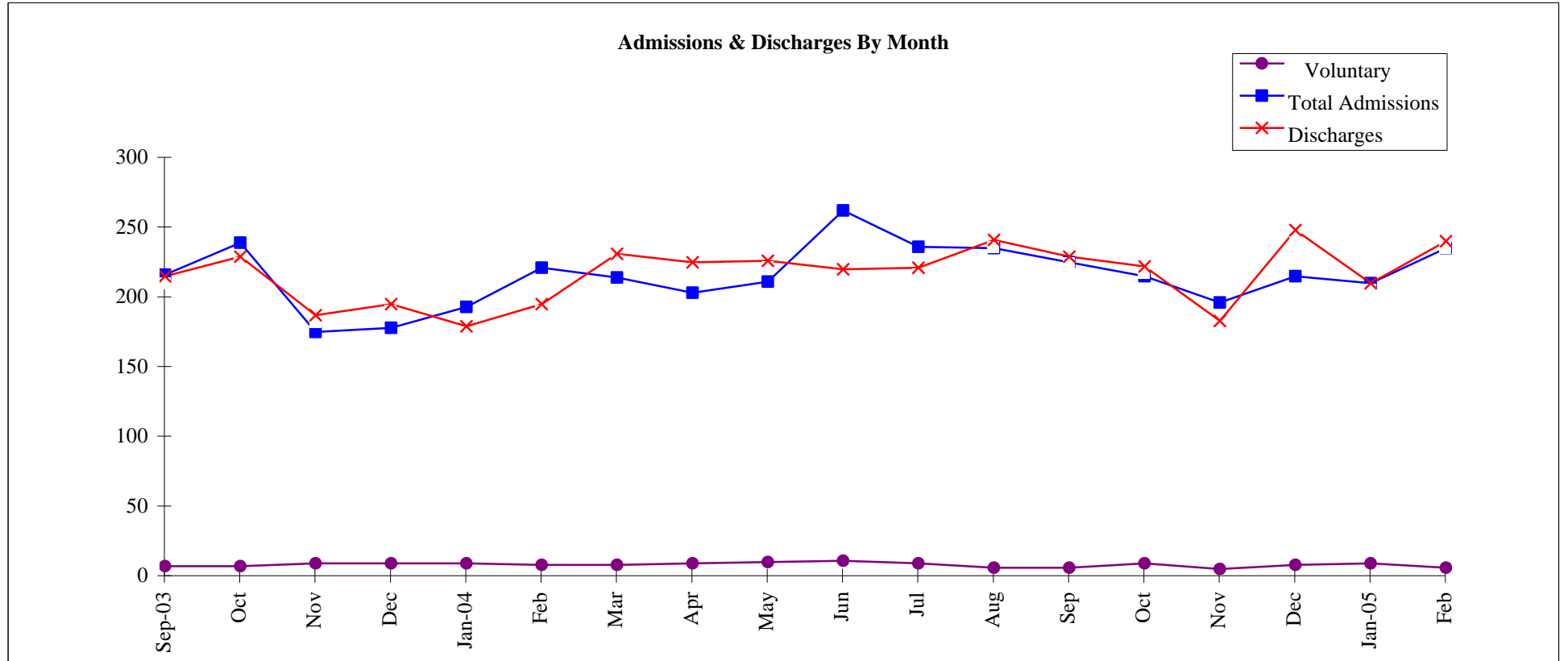
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY03 Admissions	62	115	168	209	259	314	376	449	508	559	624	680
▲ FY04 Admissions	52	122	163	211	261	316	375	426	491	544	607	669
● FY05 Admissions	51	106	153	208	247	275						
□ FY03 Discharges	60	120	174	216	254	312	375	443	499	553	602	657
△ FY04 Discharges	61	125	176	222	267	312	371	433	491	530	604	655
○ FY05 Discharges	53	119	169	211	256	282						

Measure 5A - Number/Type of Admissions and Readmissions

North Texas State Hospital

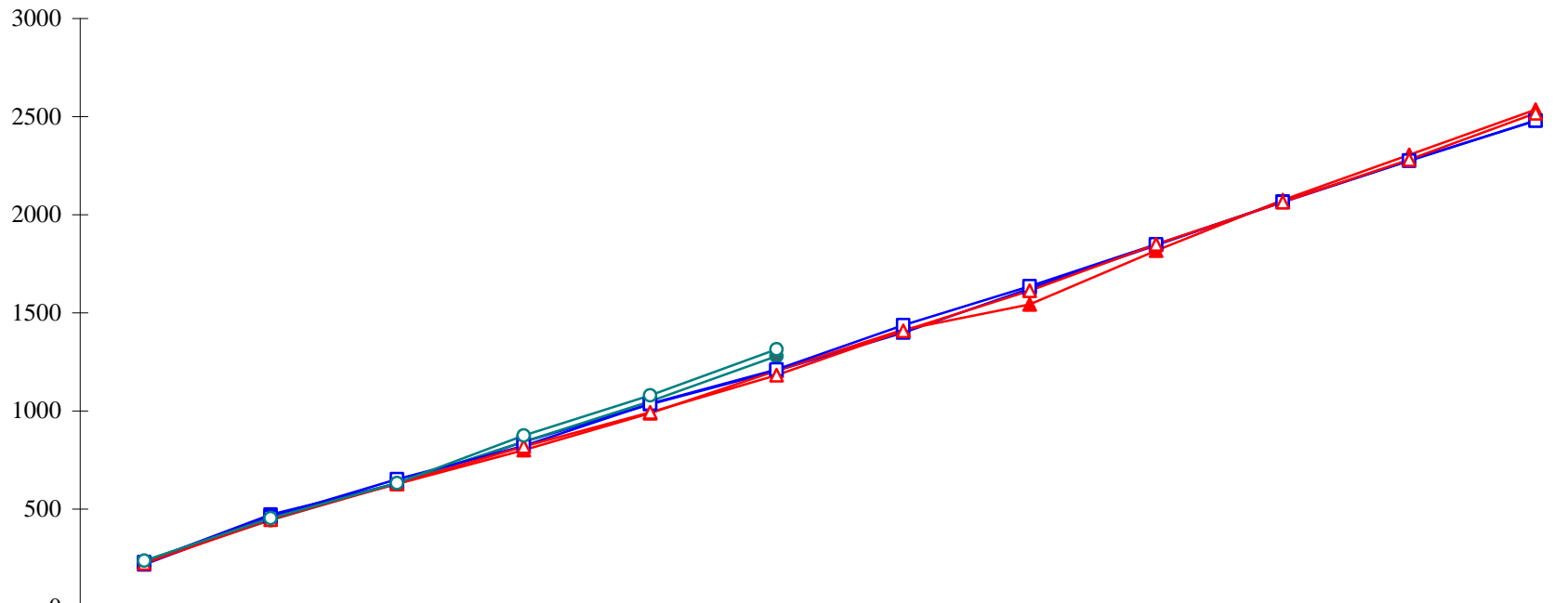
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	211	234	170	173	188	216	209	198	206	257	231	230	220	210	191	210	205	230
Voluntary	2	2	4	4	4	3	3	4	5	6	4	1	1	4	0	3	4	1
Involuntary	209	232	166	169	184	213	206	194	201	251	227	229	219	206	191	207	201	229
OPC	12	30	14	22	24	33	39	36	35	27	41	43	32	27	27	31	41	28
Emergency	48	46	38	40	29	49	35	25	33	46	41	44	44	36	34	38	44	37
Temporary	63	74	43	53	75	44	46	64	71	77	71	57	62	64	59	61	55	64
Extended	1	0	1	2	1	0	0	0	1	1	4	1	1	6	3	2	1	7
46.02/46.03	67	65	53	42	48	73	68	53	47	86	53	69	64	63	58	68	47	71
Order for MR Svc	18	17	17	10	7	14	18	16	14	14	17	15	16	10	10	7	13	22
Discharges	210	224	182	190	174	190	226	220	221	215	216	236	224	217	178	243	205	235
% of Readmissions	55%	57%	54%	53%	56%	55%	50%	56%	49%	54%	53%	53%	54%	51%	59%	53%	50%	54%



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

Total Admissions & Discharges Year-To-Date



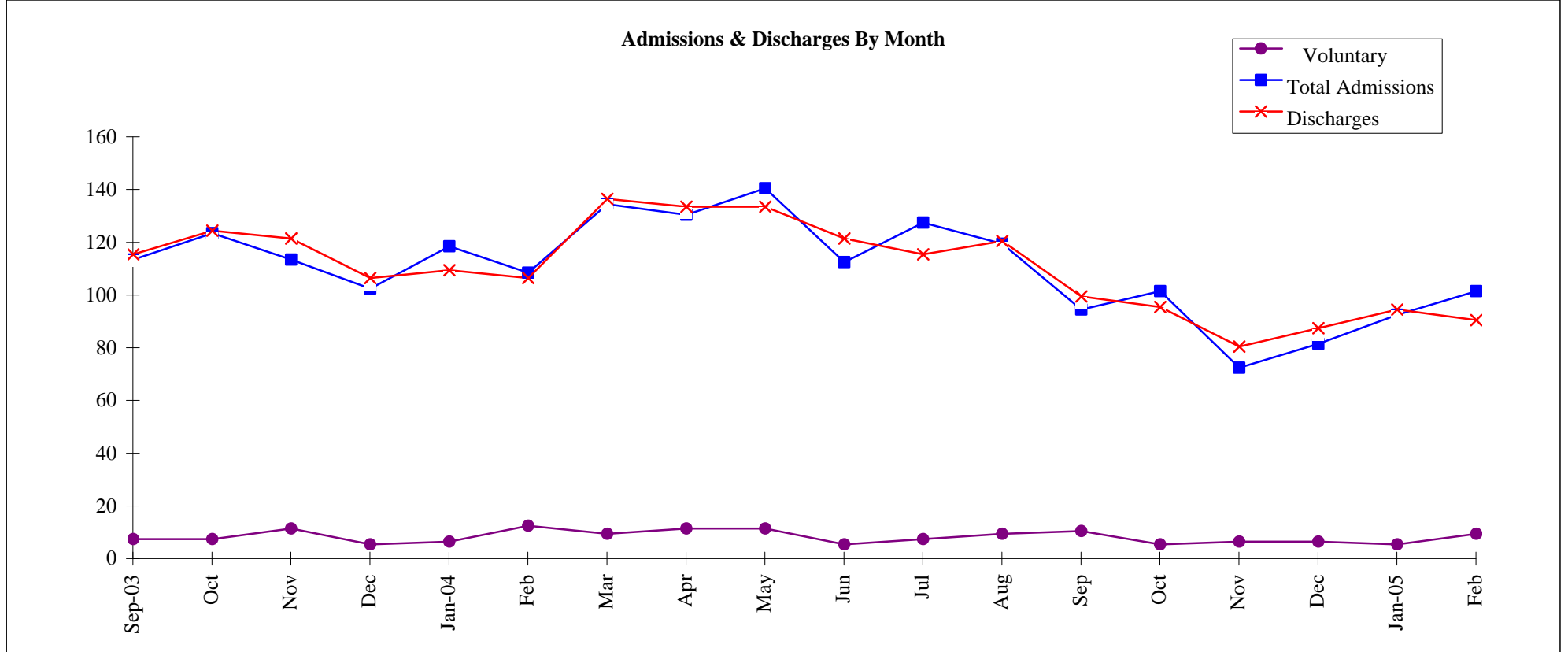
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY03 Admissions	217	459	618	830	1021	1193	1386	1611	1832	2054	2263	2467
▲ FY04 Admissions	211	445	615	788	976	1192	1401	1531	1805	2062	2293	2523
● FY05 Admissions	220	430	621	831	1036	1266						
□ FY03 Discharges	205	447	640	809	1025	1198	1424	1623	1837	2052	2262	2467
△ FY04 Discharges	210	434	616	806	980	1170	1396	1600	1837	2052	2268	2504
○ FY05 Discharges	224	441	619	862	1067	1302						

Measure 5A - Number/Type of Admissions and Readmissions

Rio Grande State Center

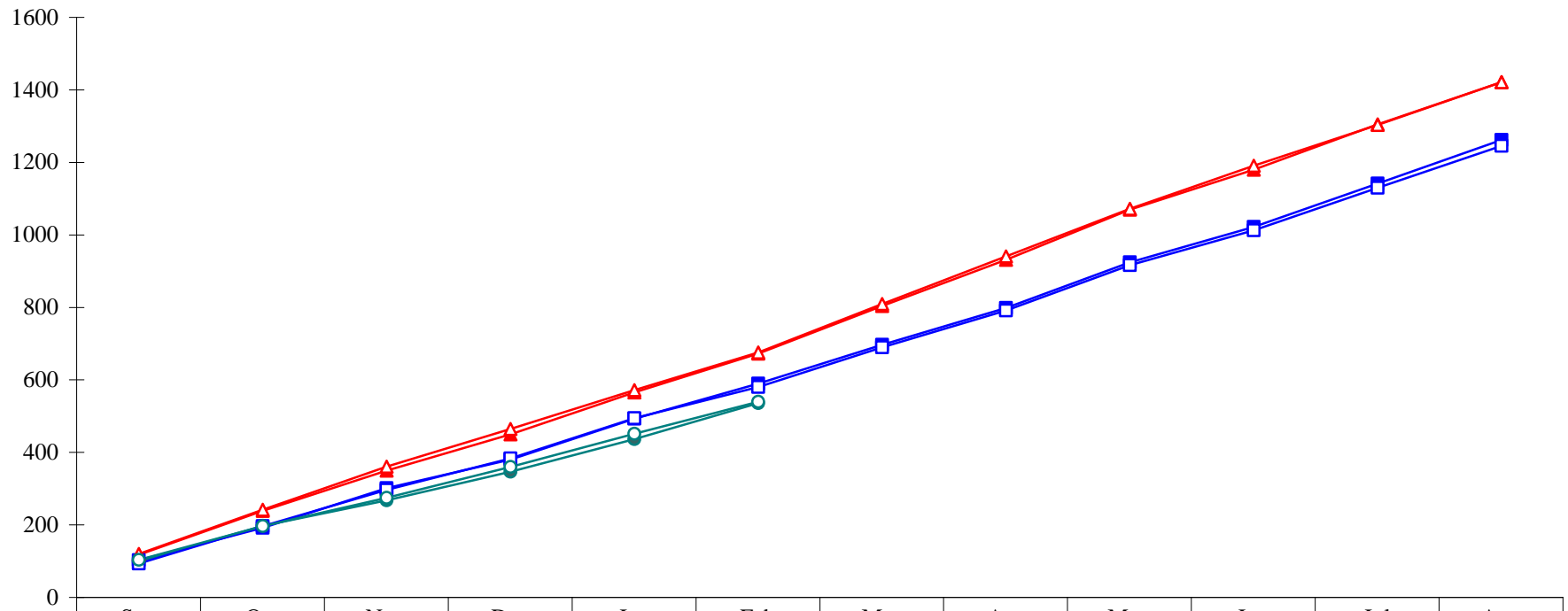
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	111	121	111	100	116	106	132	128	138	110	125	117	92	99	70	79	90	99
Voluntary	5	5	9	3	4	10	7	9	9	3	5	7	8	3	4	4	3	7
Involuntary	106	116	102	97	112	96	125	119	129	107	120	109	84	96	66	75	87	92
OPC	1	2	0	1	3	2	2	5	1	1	2	1	0	1	0	3	1	1
Emergency	105	114	102	96	109	94	123	114	128	105	118	108	83	95	66	71	86	91
Temporary	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	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 Svc	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Discharges	113	122	119	104	107	104	134	131	131	119	113	118	97	93	78	85	92	88
% of Readmissions	63%	52%	62%	57%	67%	64%	56%	61%	58%	44%	63%	52%	55%	53%	61%	62%	53%	63%



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
■ FY03 Admissions	96	185	295	374	486	583	690	792	918	1015	1135	1255
▲ FY04 Admissions	111	232	343	443	559	666	797	925	1063	1173	1298	1415
● FY05 Admissions	92	191	261	340	430	529						
■ FY03 Discharges	87	190	290	377	488	574	683	785	910	1006	1123	1239
▲ FY04 Discharges	113	235	354	458	565	669	803	934	1065	1184	1297	1415
● FY05 Discharges	97	190	268	353	445	533						

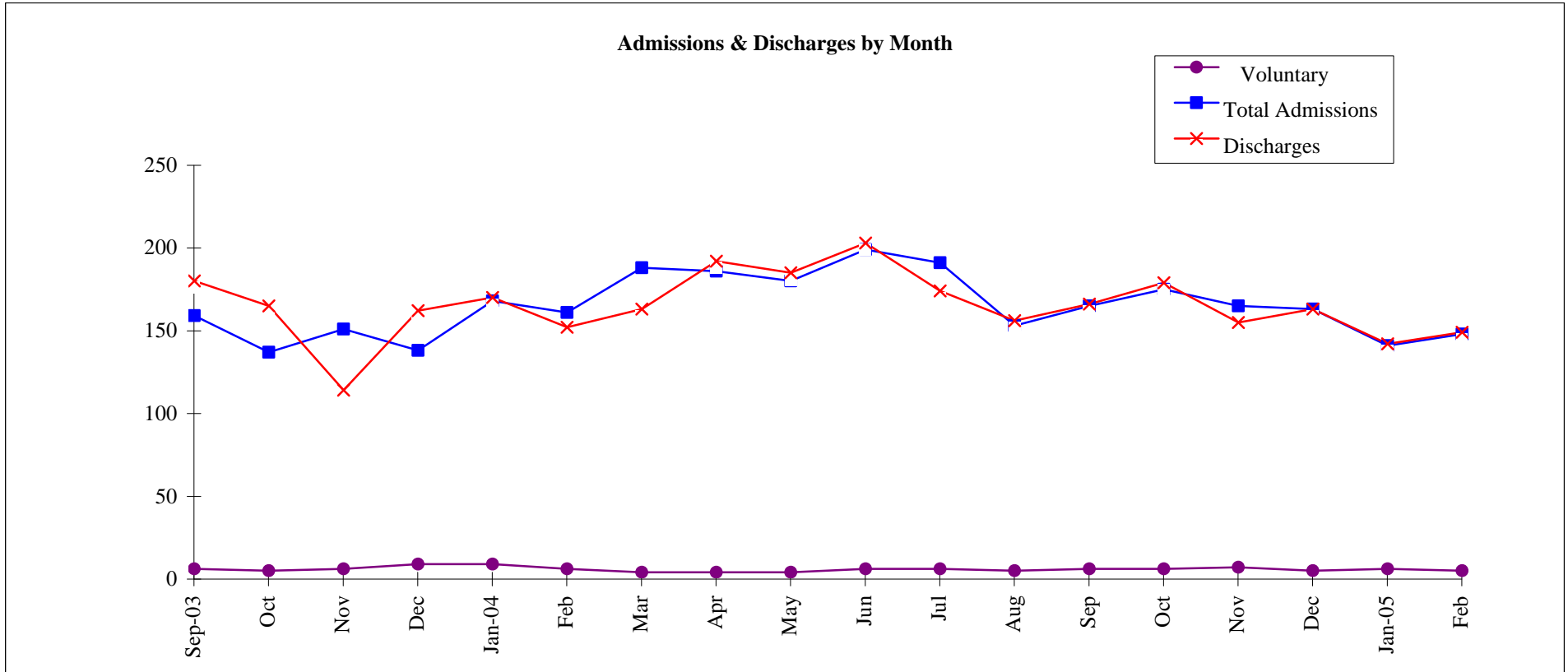
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Rusk State Hospital

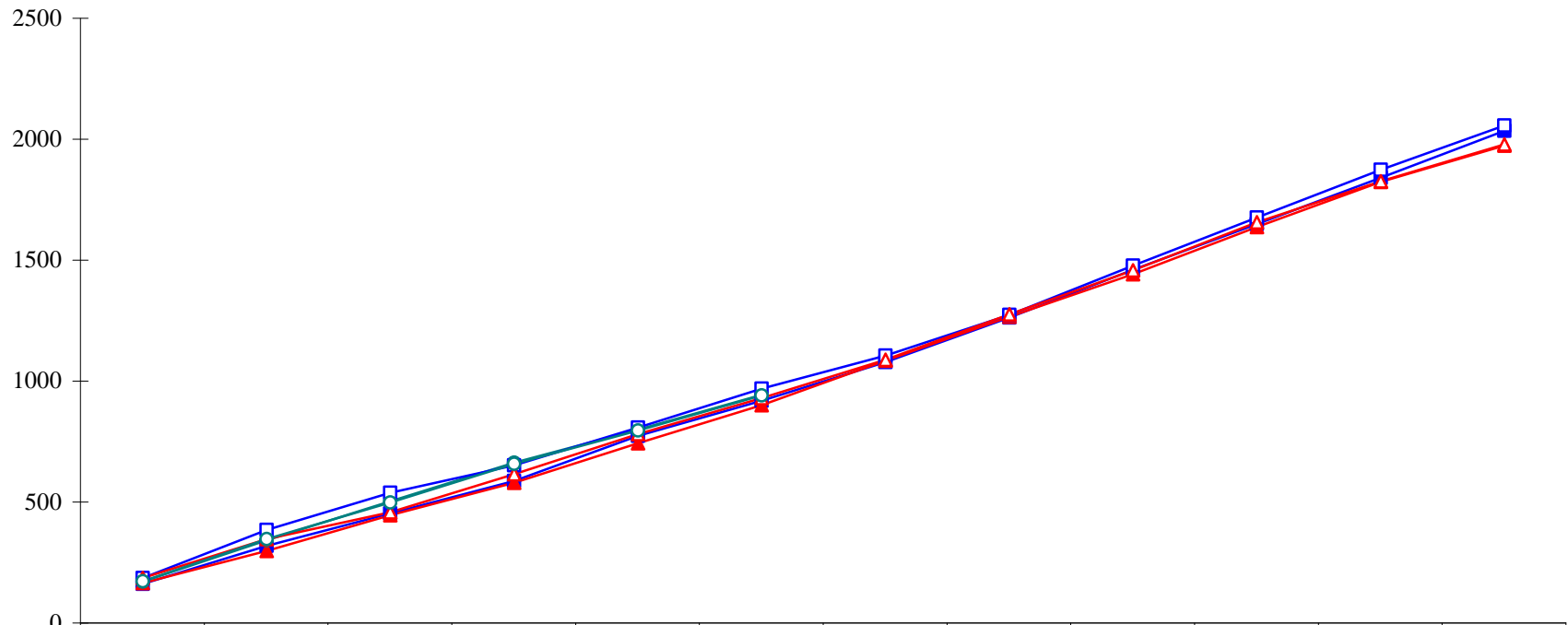
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	155	133	147	134	164	157	184	182	176	195	187	149	161	171	161	159	137	144
Voluntary	2	1	2	5	5	2	0	0	0	2	2	1	2	2	3	1	2	1
Involuntary	153	132	145	129	159	155	184	182	176	193	185	148	159	169	158	158	135	143
OPC	26	42	24	10	33	33	27	46	40	36	38	42	34	39	41	36	39	42
Emergency	76	52	68	81	95	88	110	99	93	106	107	65	82	95	72	83	57	60
Temporary	24	21	30	21	20	24	38	18	33	37	30	29	26	19	28	18	27	30
Extended	2	1	1	2	0	1	1	2	0	1	0	0	0	0	0	2	1	0
46.02/46.03	25	16	22	15	4	2	5	17	10	13	10	11	17	16	17	19	11	11
Order for MR Svc	0	0	0	0	7	7	3	0	0	0	0	1	0	0	0	0	0	0
Discharges	176	161	110	158	166	148	159	188	181	199	170	152	162	175	151	159	138	145
% of Readmissions	63%	59%	60%	58%	55%	64%	53%	51%	47%	51%	51%	59%	57%	53%	57%	62%	65%	58%



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

Total Admissions & Discharges Year-To-Date



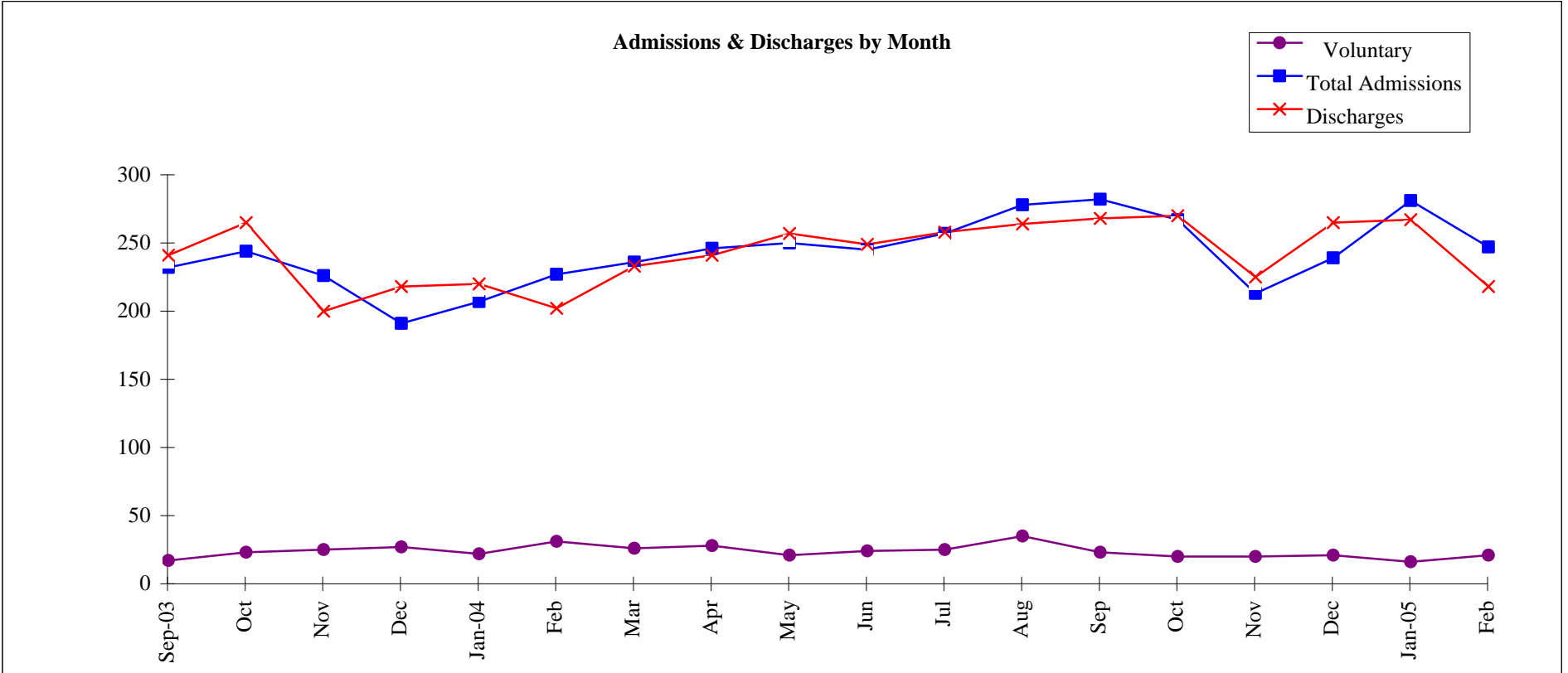
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY03 Admissions	151	308	443	577	763	908	1068	1252	1450	1639	1830	2025
▲ FY04 Admissions	155	288	435	569	733	890	1074	1256	1432	1627	1814	1963
● FY05 Admissions	161	332	493	652	789	933						
□ FY03 Discharges	176	374	528	642	798	958	1095	1263	1467	1666	1863	2046
▲ FY04 Discharges	176	337	447	605	771	919	1078	1266	1447	1646	1816	1968
○ FY05 Discharges	162	337	488	647	785	930						

Measure 5A - Number/Type of Admissions and Readmissions

San Antonio State Hospital

Admissions by Month

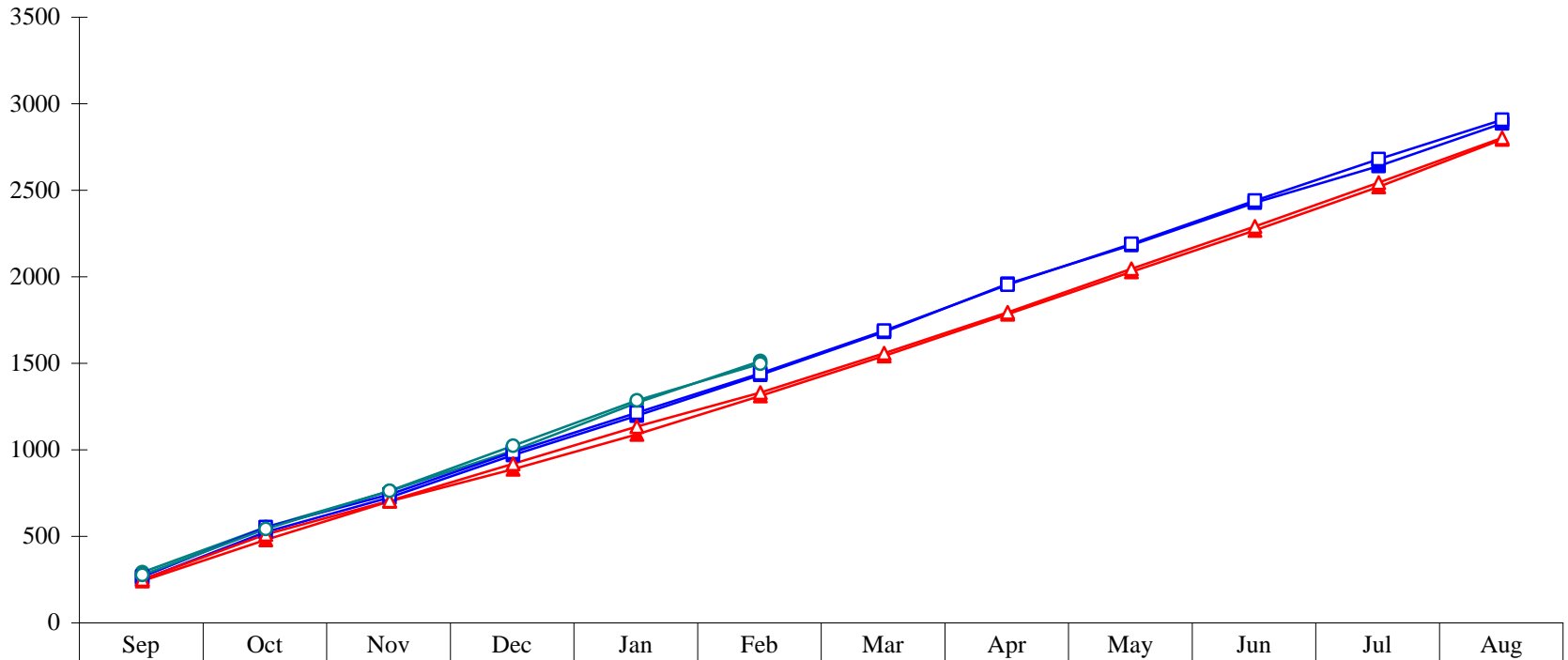
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	227	239	221	186	202	222	231	241	245	240	252	273	277	262	208	234	276	242
Voluntary	12	18	20	22	17	26	21	23	16	19	20	30	18	15	15	16	11	16
Involuntary	215	221	201	164	185	196	210	218	229	221	232	243	259	247	193	218	265	226
OPC	83	75	65	69	50	50	70	68	78	71	81	81	90	64	53	71	76	61
Emergency	101	97	110	69	110	117	97	109	124	111	117	123	116	149	102	109	146	127
Temporary	26	40	23	20	21	21	32	38	17	32	23	28	37	19	29	33	32	25
Extended	1	1	0	2	1	1	0	0	0	0	0	0	3	2	0	1	1	3
46.02/46.03	4	7	3	4	3	6	10	3	9	7	9	10	8	12	5	4	9	10
Order for MR Svc	0	1	0	0	0	1	1	0	1	0	2	1	5	1	4	0	1	0
Discharges	236	260	195	213	215	197	228	236	252	244	253	259	263	265	220	260	262	213
% of Readmissions	53%	53%	57%	62%	58%	56%	55%	56%	52%	50%	52%	59%	54%	50%	52%	47%	49%	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
San Antonio State Hospital
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



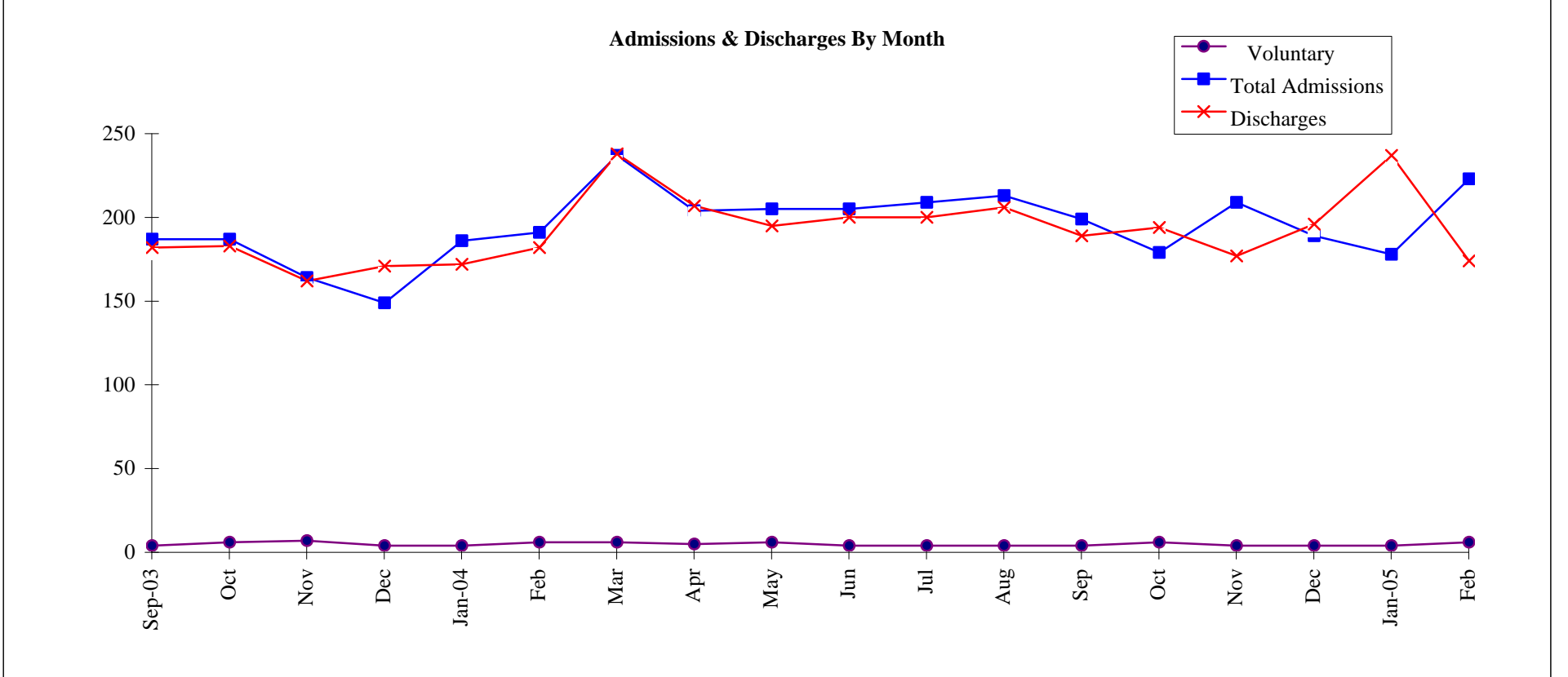
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
■ FY03 Admissions	234	511	710	954	1182	1418	1666	1945	2168	2414	2625	2871
▲ FY04 Admissions	227	466	687	873	1075	1297	1528	1769	2014	2254	2506	2779
● FY05 Admissions	277	539	747	981	1257	1499						
□ FY03 Discharges	251	538	728	973	1199	1427	1673	1939	2176	2425	2665	2893
△ FY04 Discharges	236	496	691	904	1119	1316	1544	1780	2032	2276	2529	2788
○ FY05 Discharges	263	528	748	1008	1270	1483						

Measure 5A - Number/Type of Admissions and Readmissions

Terrell State Hospital

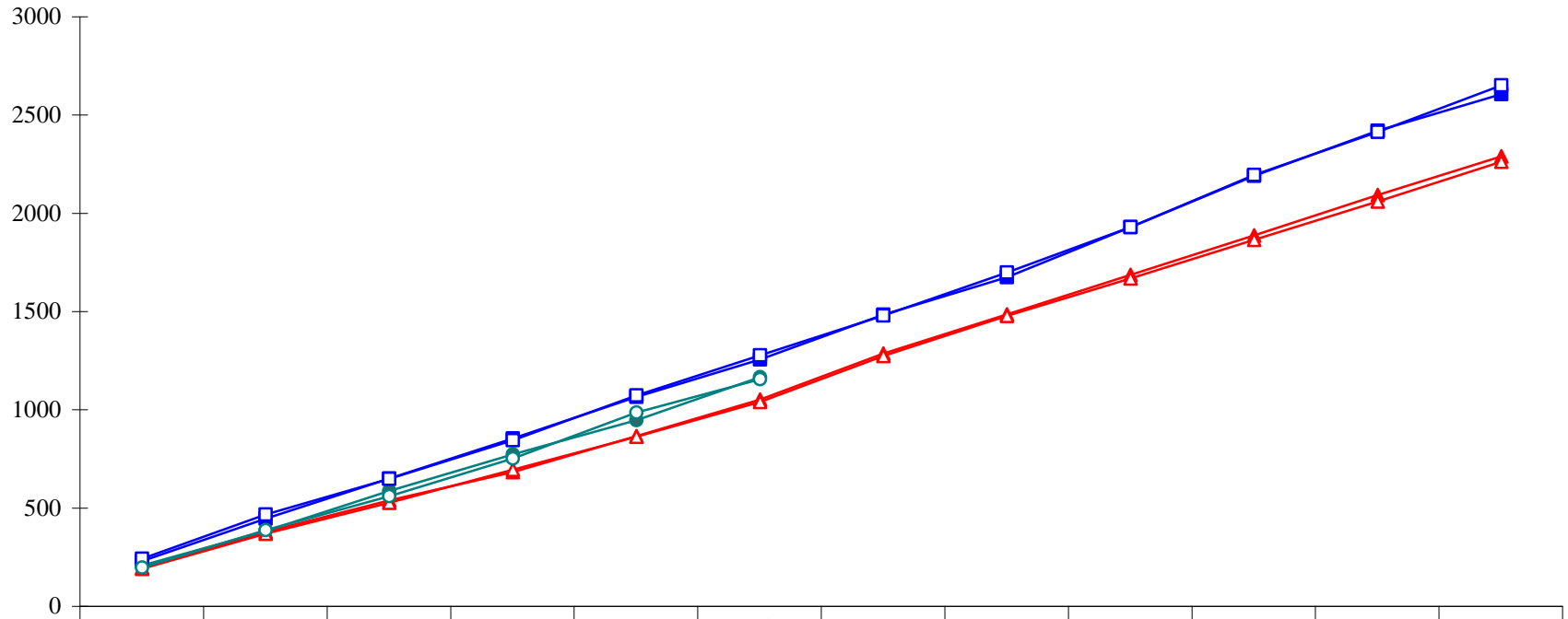
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	183	183	160	145	182	187	233	200	201	201	205	209	195	175	205	185	174	219
Voluntary	0	2	3	0	0	2	2	1	2	0	0	0	0	2	0	0	0	2
Involuntary	183	181	157	145	182	185	231	199	199	201	205	209	195	173	205	185	174	217
OPC	112	103	107	102	138	143	163	146	151	153	149	141	150	126	154	133	121	120
Emergency	28	31	19	21	23	17	18	15	12	11	21	17	19	11	14	13	6	32
Temporary	35	28	18	15	15	15	30	22	22	22	14	32	18	16	17	14	23	40
Extended	0	8	3	0	0	1	0	4	0	0	0	3	1	4	0	3	1	8
46.02/46.03	7	11	10	7	6	9	20	11	14	15	20	15	7	15	19	22	23	17
Order for MR Svc	1	0	0	0	0	0	0	1	0	0	1	1	0	1	1	0	0	0
Discharges	178	179	158	167	168	178	234	203	191	196	196	202	185	190	173	192	233	170
% of Readmissions	62%	68%	56%	54%	60%	54%	61%	60%	54%	64%	57%	59%	58%	58%	55%	57%	61%	70%



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
FY03 Admissions	218	434	637	842	1053	1244	1471	1662	1917	2178	2407	2594
FY04 Admissions	183	366	526	671	853	1040	1273	1473	1674	1875	2080	2277
FY05 Admissions	195	370	575	760	934	1153						
FY03 Discharges	229	455	636	833	1061	1265	1467	1686	1917	2182	2401	2638
FY04 Discharges	178	357	515	682	850	1028	1262	1465	1656	1852	2048	2250
FY05 Discharges	185	375	548	740	973	1143						

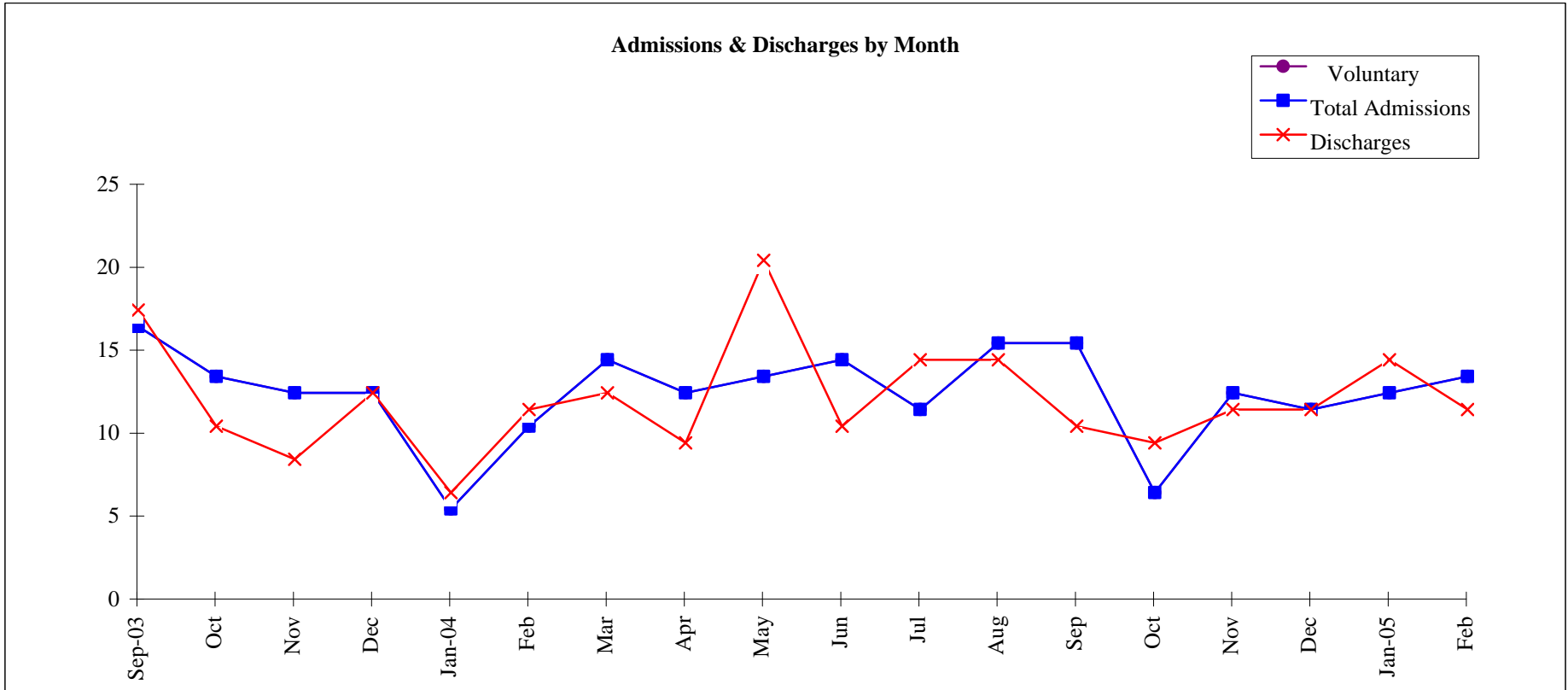
Source: Admis./Disch./Pop. by Month (HC022020/22),
 Admissions To State Hospitals and 659 MH Units (SR6877.Hos)

Measure 5A - Number/Type of Admissions and Readmissions

Waco Center for Youth

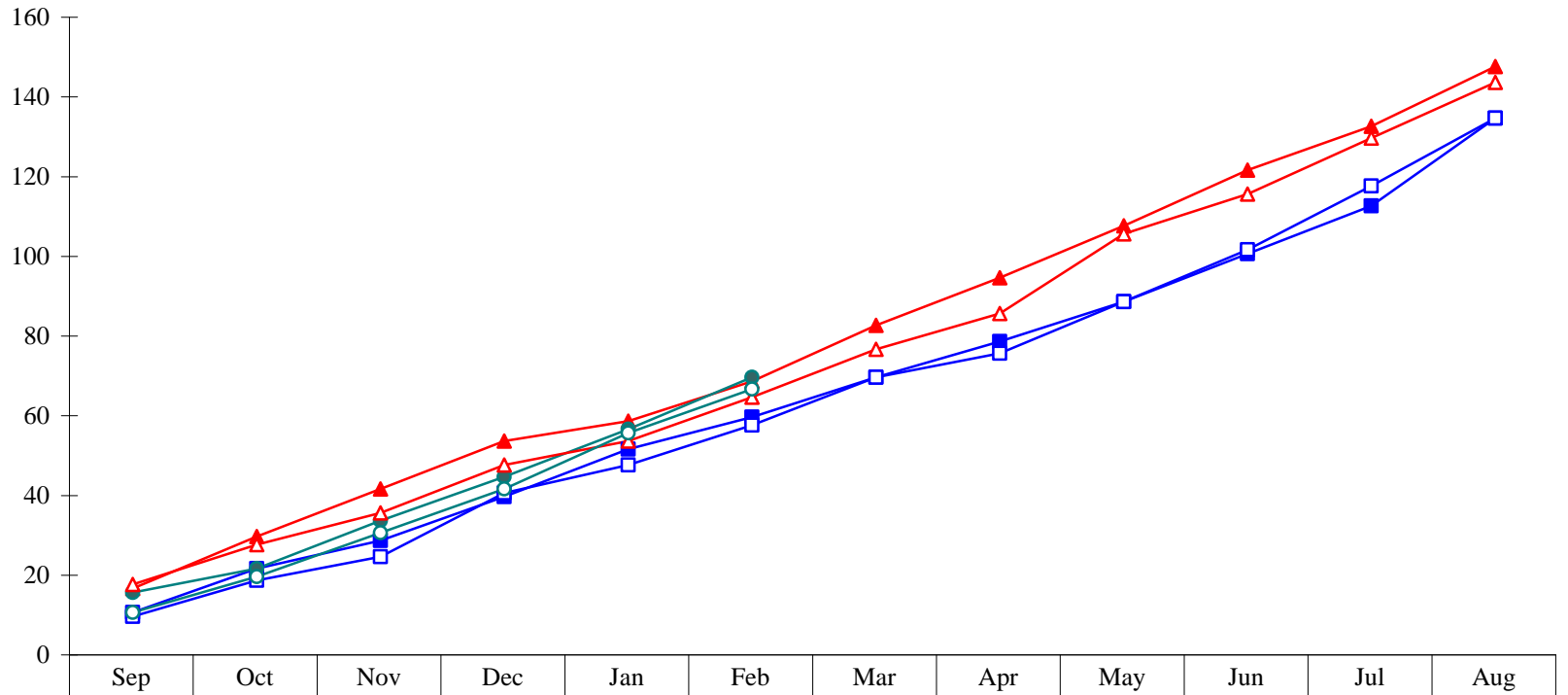
Admissions by Month

	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Admissions	16	13	12	12	5	10	14	12	13	14	11	15	15	6	12	11	12	13
Voluntary	16	13	12	12	5	10	14	12	13	14	11	15	15	6	12	11	12	13
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 Svc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	17	10	8	12	6	11	12	9	20	10	14	14	10	9	11	11	14	11
% of Readmissions	31%	31%	33%	25%	60%	40%	43%	42%	46%	50%	45%	40%	53%	50%	42%	73%	58%	62%

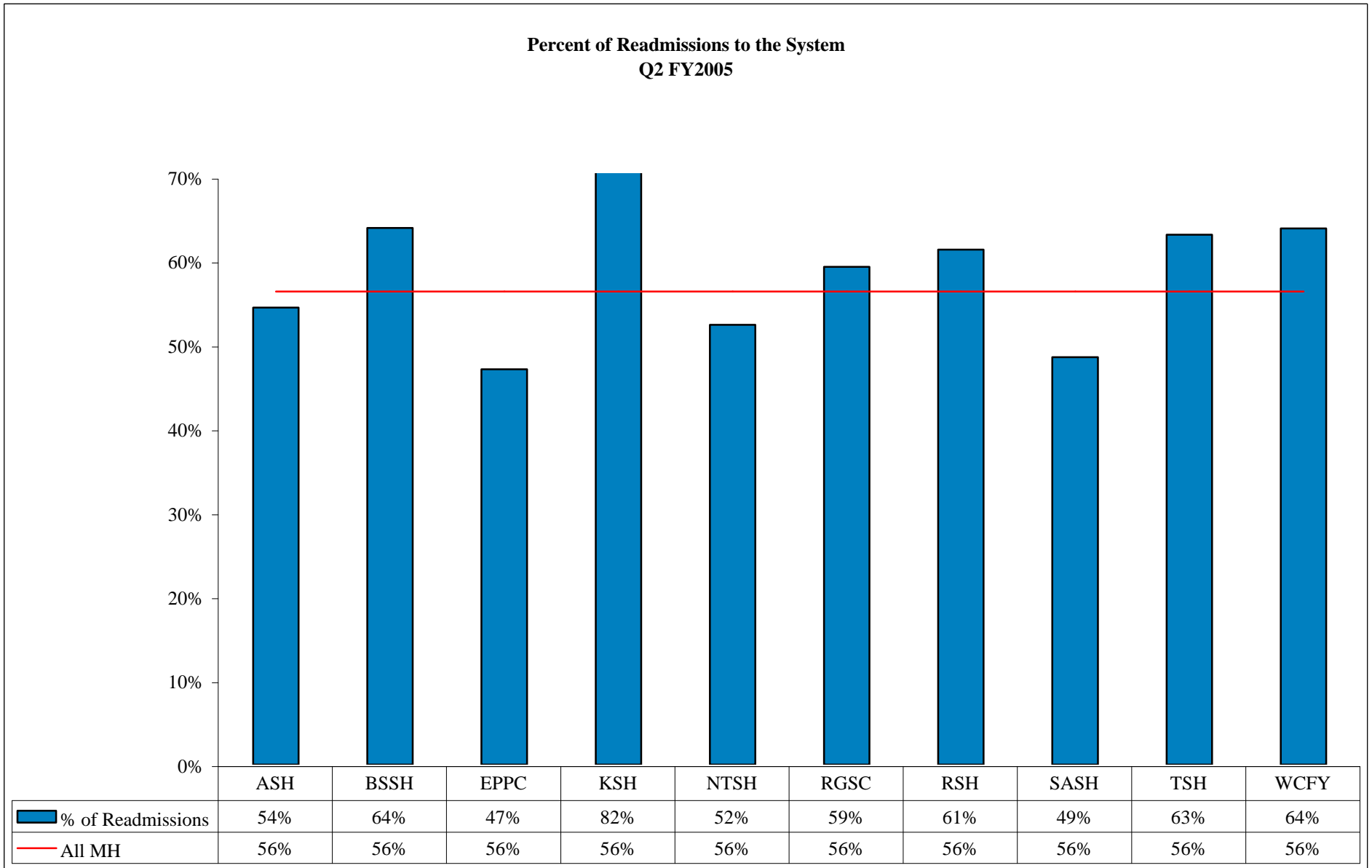


Measure 5A - Number/Type of Admissions and Readmissions
Waco Center for Youth
FYTD Admissions & Discharges

Total Admissions & Discharges Year-To-Date



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



Performance Measure 5B:

Percent of discharges returned to the community will be calculated on a quarterly basis for: 7 days or less; 8 to 15 days; 16 to 30 days; 30 to 45 days; 45 to 90 days, 91 to 180 days, 181 to 365 days and greater than 365 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 15 days; 16 to 30 days; 30 to 45 days; 45 to 90 days, 91 to 180 days, 181 to 365 days and greater than 365 days.

Performance Measure Formula:

Rate = (N/D) x 100

N = # persons discharged during time frame

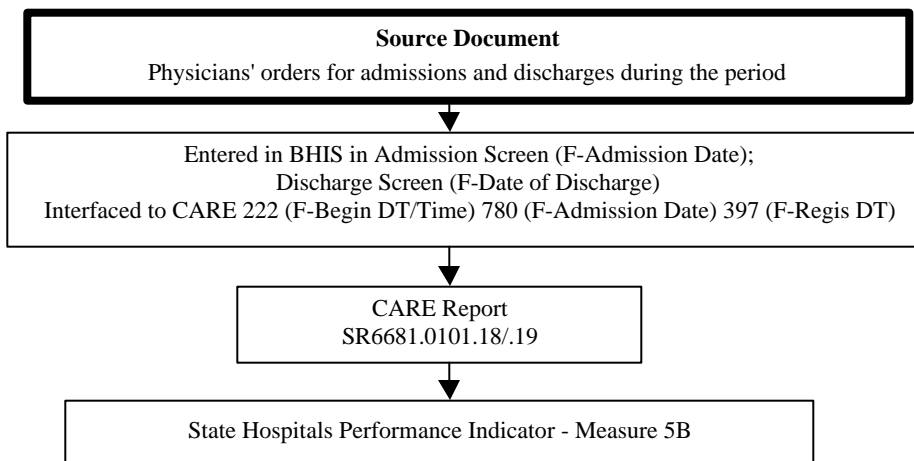
D = total persons discharged during the quarter

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.

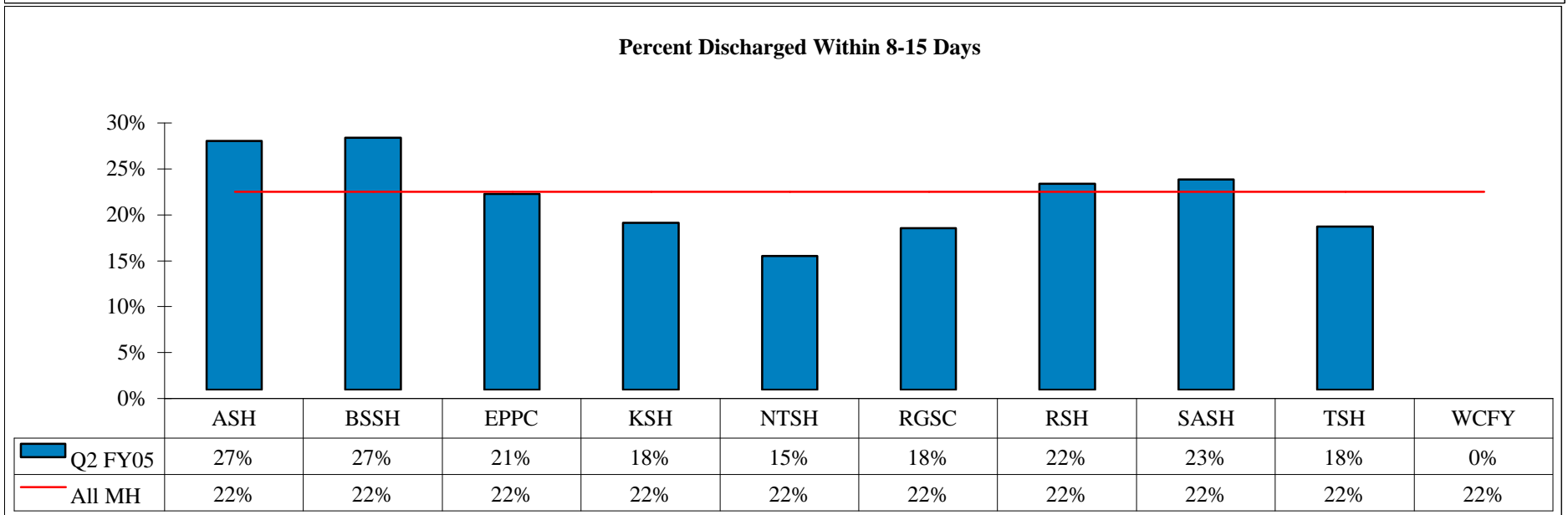
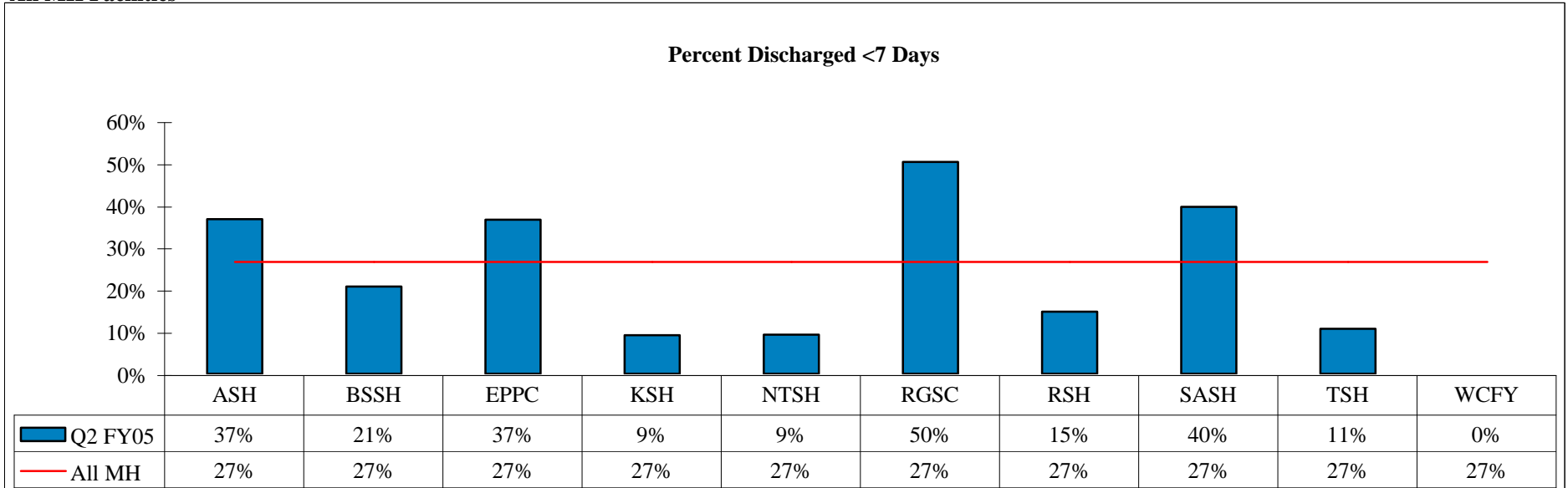
Data Flow:



Data Integrity Review Process:

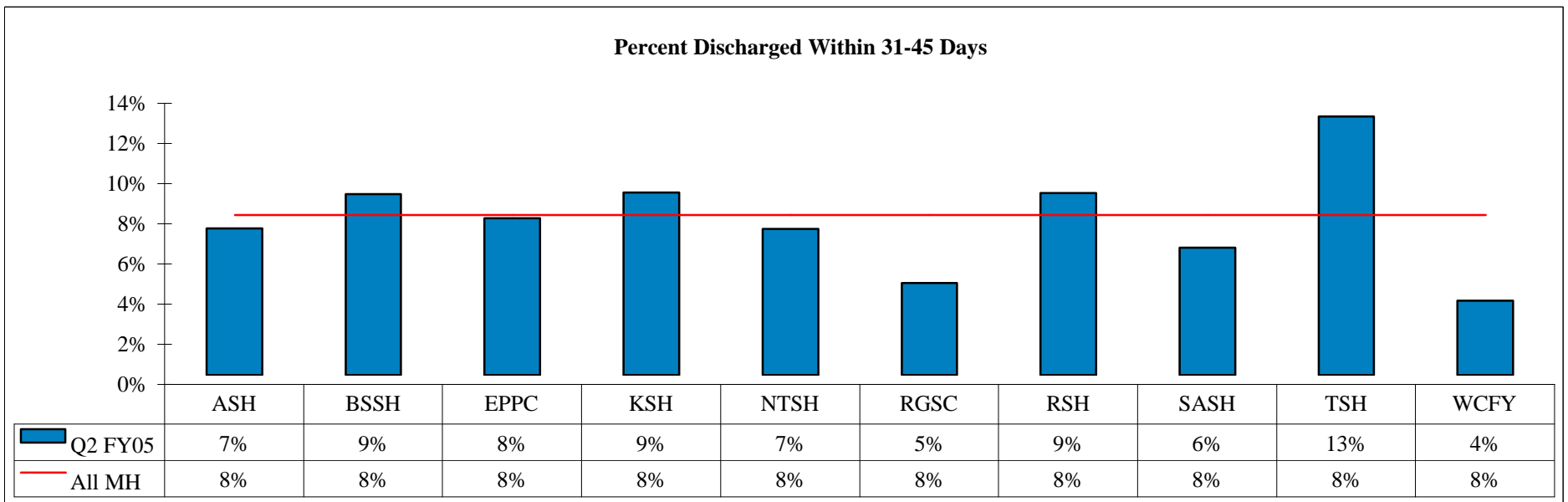
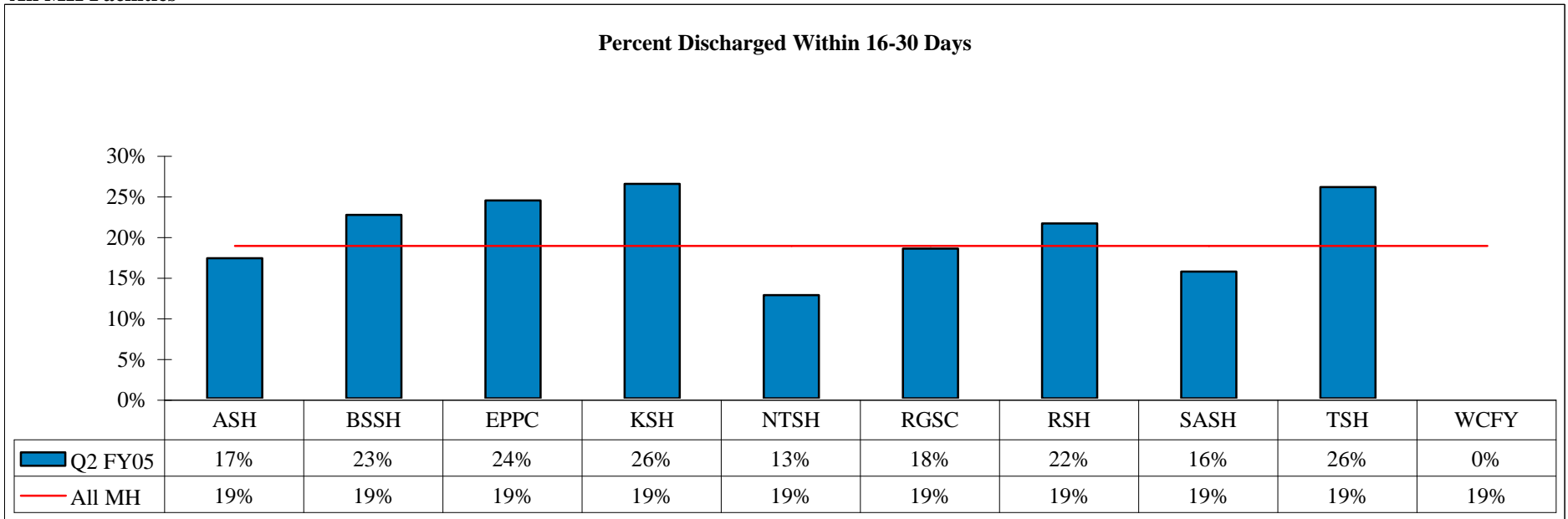
Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date 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



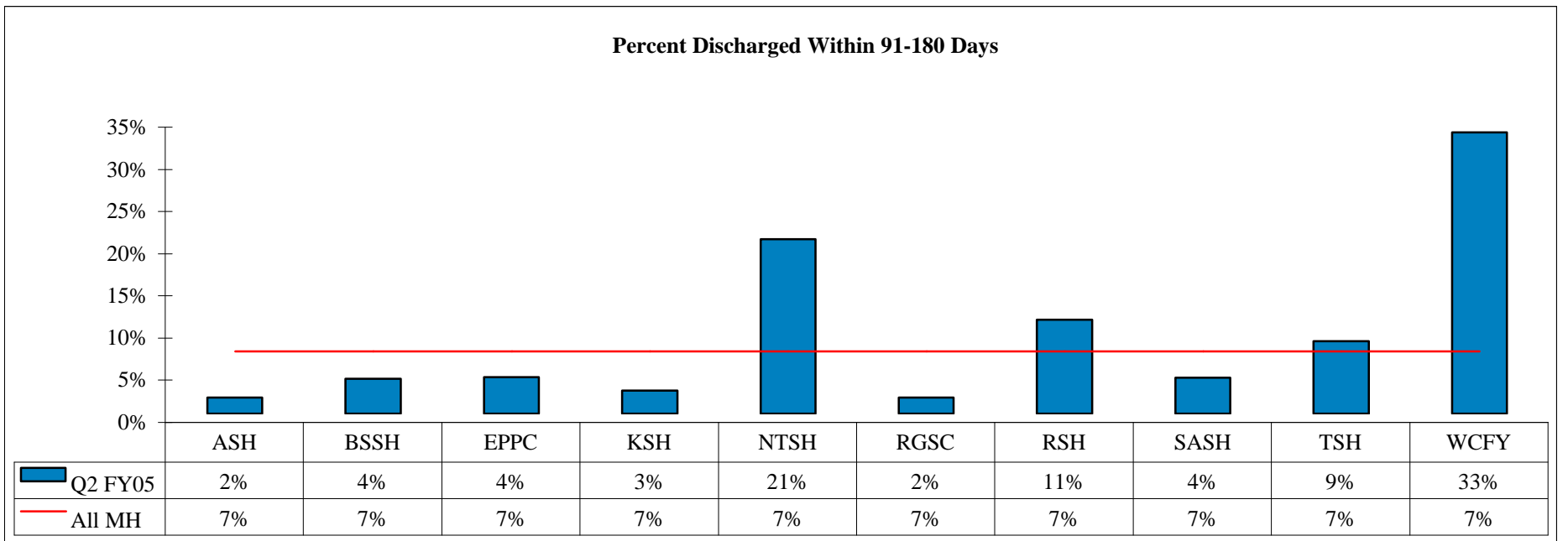
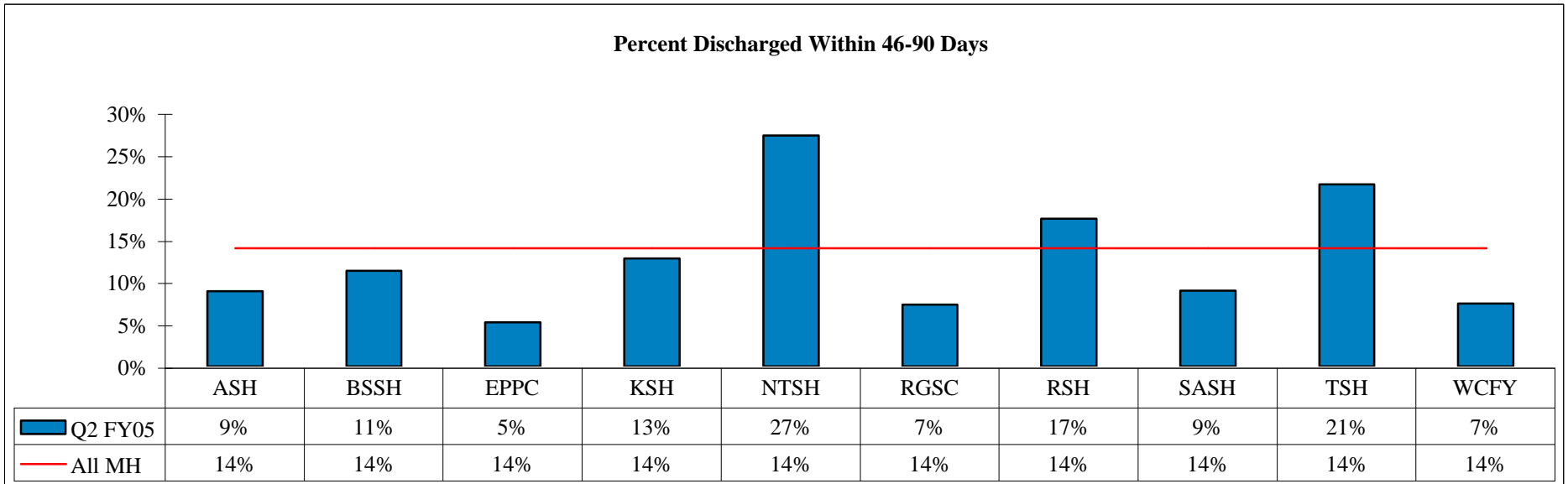
Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
All MH Facilities



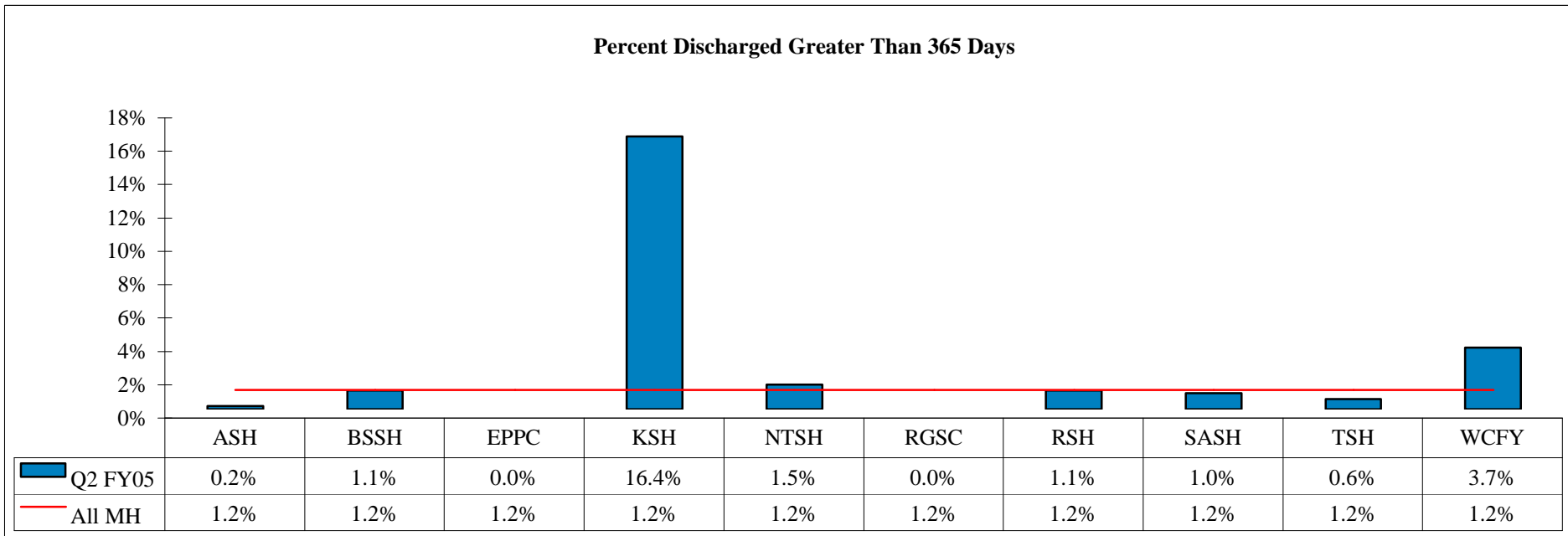
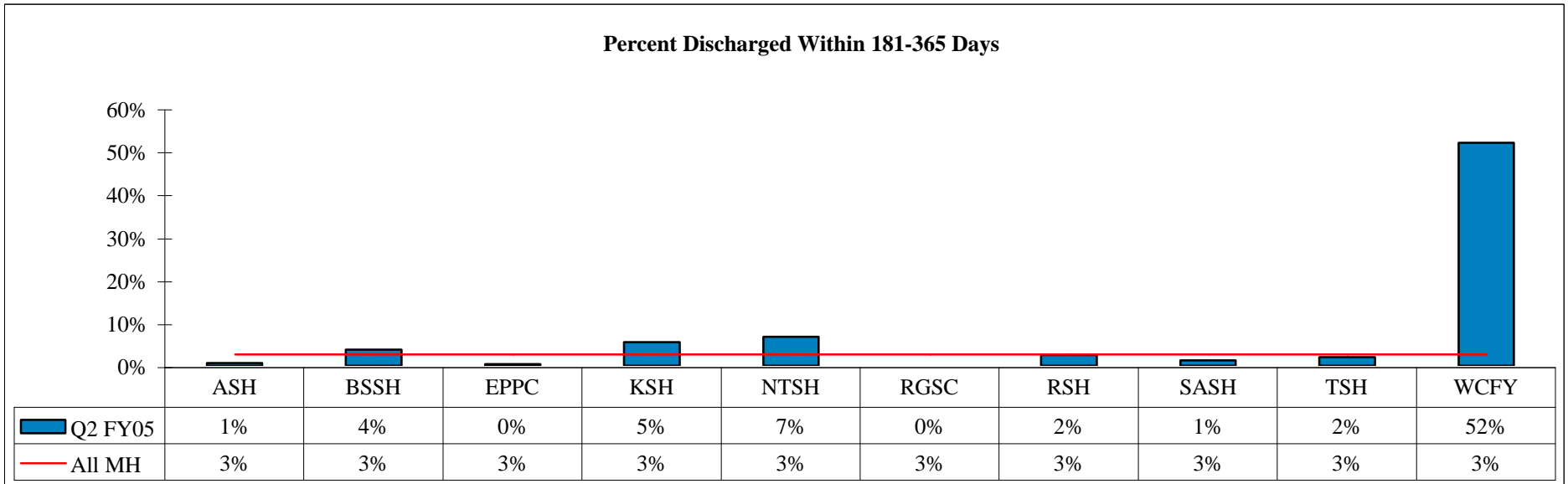
Source: Percent of Admissions Stabilized and Returned to Community (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
All MH Facilities



Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

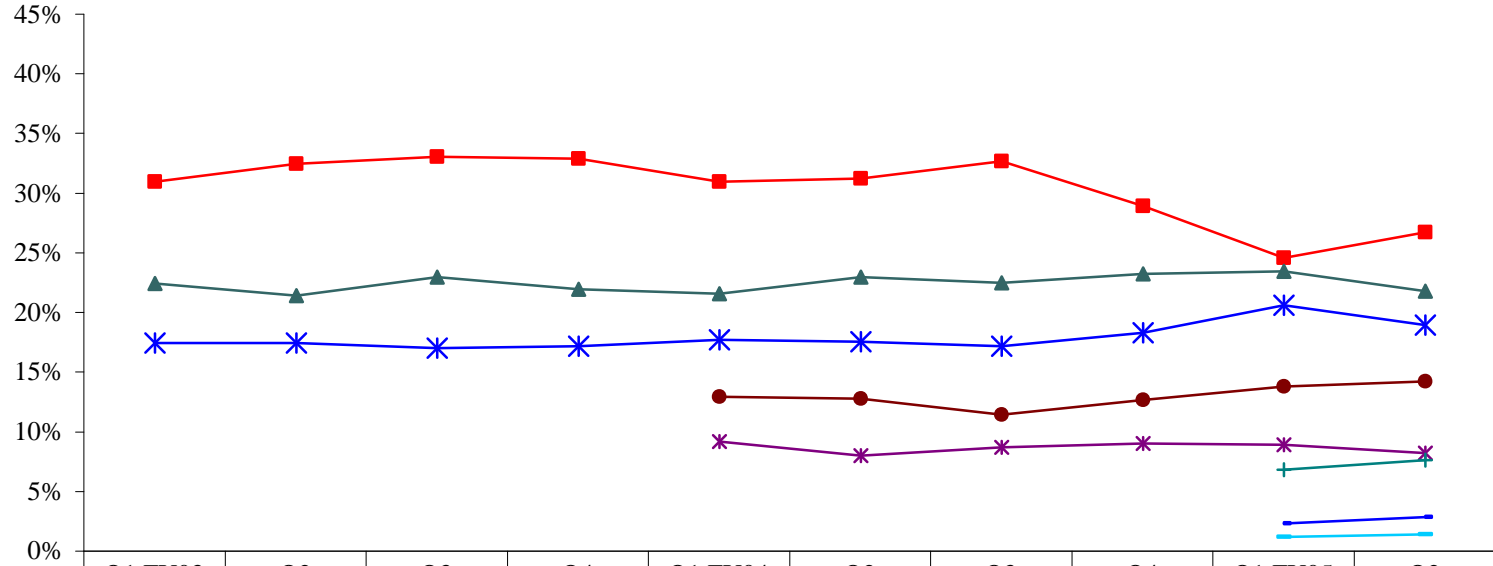
Measure 5B - Percent of Discharges Returned to the Community
All MH Facilities



Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
All MH Facilities

Percent of Discharges

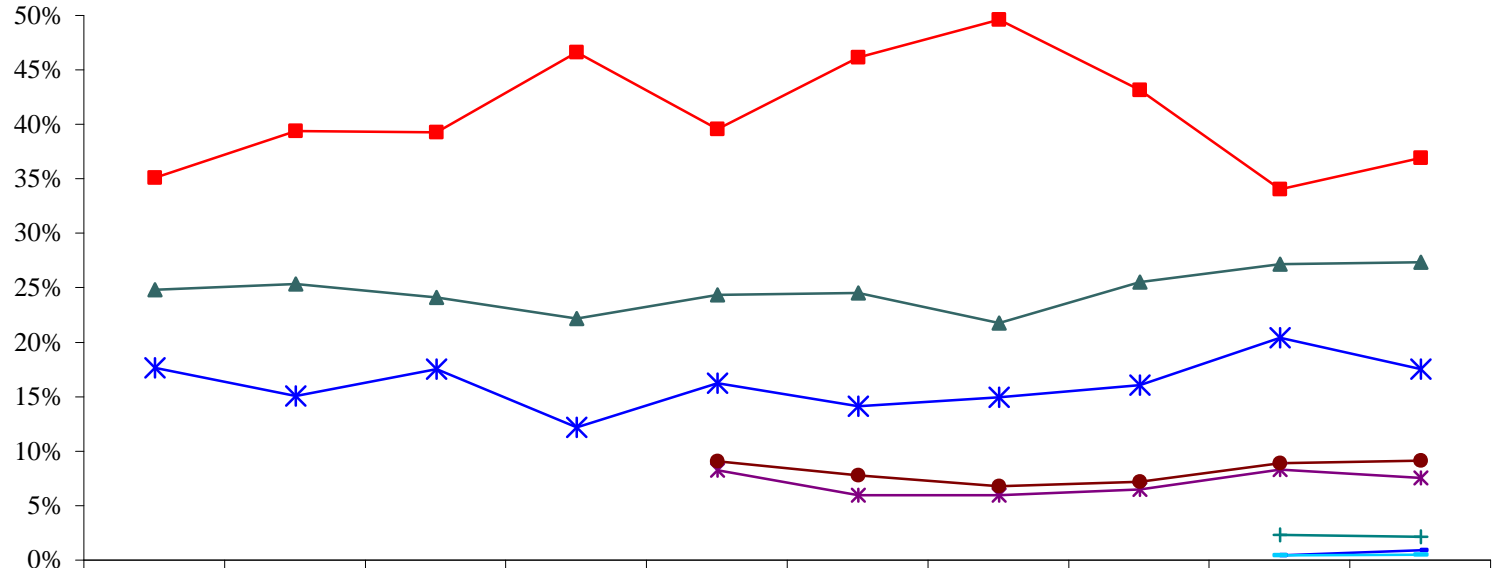


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	4808	4609	5034	4970	4509	4202	4964	4751	4425	4338
■ % Discharged < 7 Days	31%	32%	33%	33%	31%	31%	32%	29%	24%	27%
▲ % Discharged Within 8-15 Days	22%	21%	23%	22%	21%	23%	22%	23%	23%	22%
* % Discharged Within 16-30 Days	17%	17%	17%	17%	17%	17%	17%	18%	20%	19%
* % Discharged Within 31-45 Days					9%	8%	8%	9%	9%	8%
● % Discharged Within 46-90 Days					13%	13%	11%	12%	14%	14%
+ % Discharged Within 91-180 Days									7%	7%
— % Discharged Within 181-365 Days									2%	3%
— % Discharged > Than 365 Days									1%	1%

Source: Percent of Admissions Stabilized and Returned to Community (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
Austin State Hospital

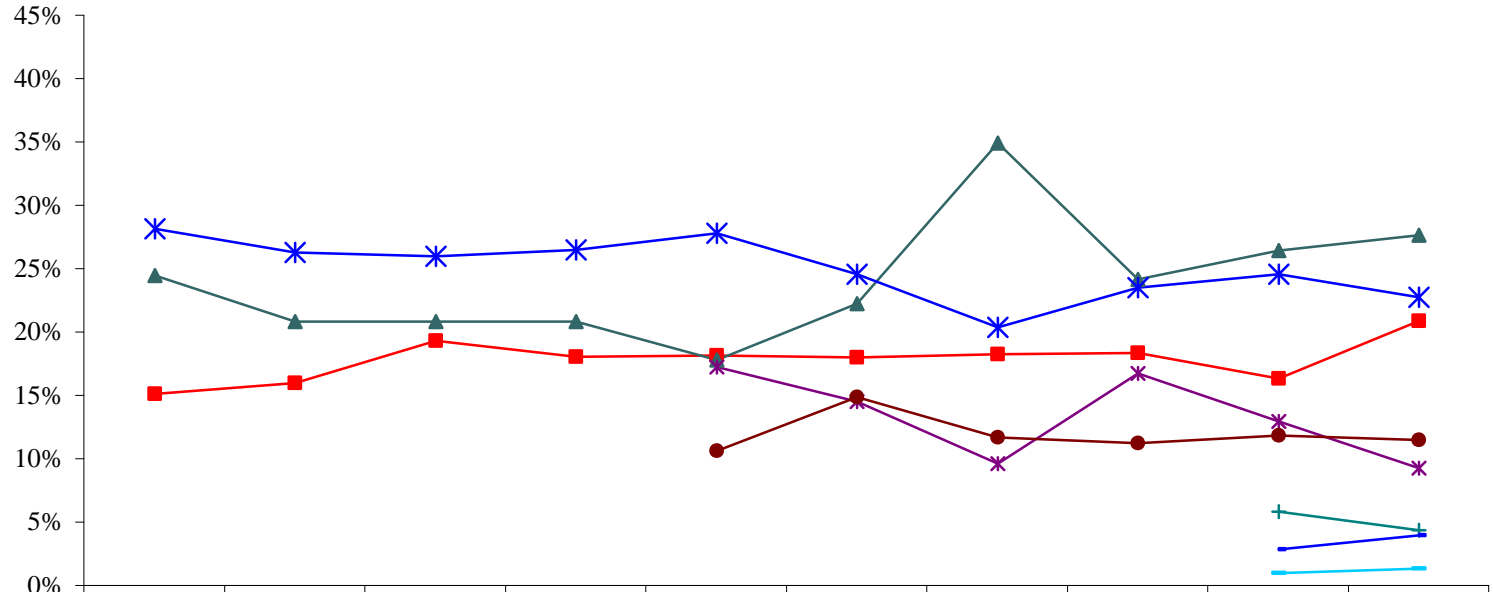
Percent of Discharges Returned to the Community



	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	923	944	1020	962	1029	981	1209	1111	1048	953
■ % Discharged < 7 Days	35%	39%	39%	46%	39%	46%	49%	43%	34%	37%
▲ % Discharged Within 8-15 Days	25%	25%	24%	22%	24%	24%	22%	25%	27%	27%
* % Discharged Within 16-30 Days	17%	15%	17%	12%	16%	14%	15%	16%	20%	17%
* % Discharged Within 31-45 Days					8%	6%	6%	6%	8%	7%
● % Discharged Within 46-90 Days					9%	8%	7%	7%	9%	9%
+ % Discharged Within 91-180 Days									2%	2%
+ % Discharged Within 181-365 Days									0.2%	1%
+ % Discharged > Than 365 Days									0.2%	0.2%

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

Percent of Discharges Returned to the Community

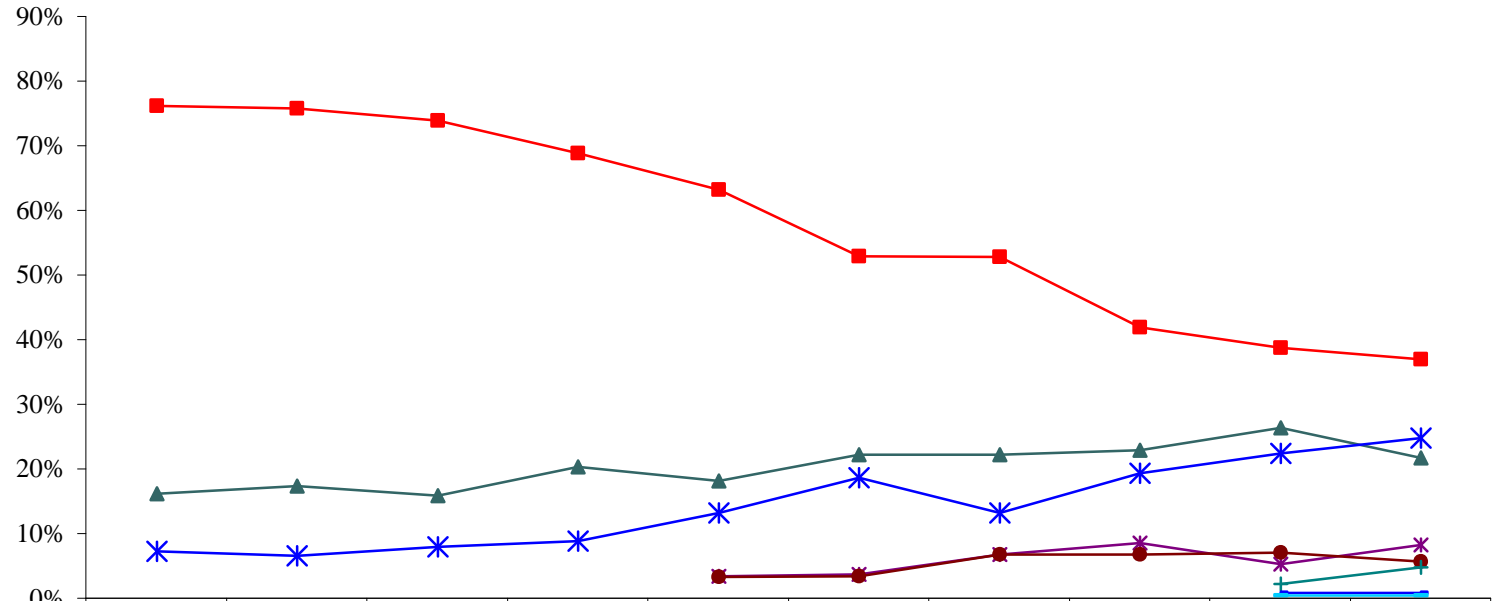


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	333	339	342	336	300	265	300	326	278	283
■ % Discharged < 7 Days	15%	16%	19%	18%	18%	18%	18%	18%	16%	21%
▲ % Discharged Within 8-15 Days	24%	21%	21%	21%	18%	22%	35%	24%	26%	27%
✱ % Discharged Within 16-30 Days	28%	26%	26%	26%	28%	24%	20%	23%	24%	23%
✱ % Discharged Within 31-45 Days					17%	14%	9%	17%	13%	9%
● % Discharged Within 46-90 Days					10%	15%	11%	11%	12%	11%
+ % Discharged Within 91-180 Days									6%	4%
— % Discharged Within 181-365 Days									3%	4%
— % Discharged > Than 365 Days									0.7%	1%

Source: Percent of Admissions Stabilized and Returned to Community (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
El Paso Psychiatric Center

Percent of Discharges Returned to the Community

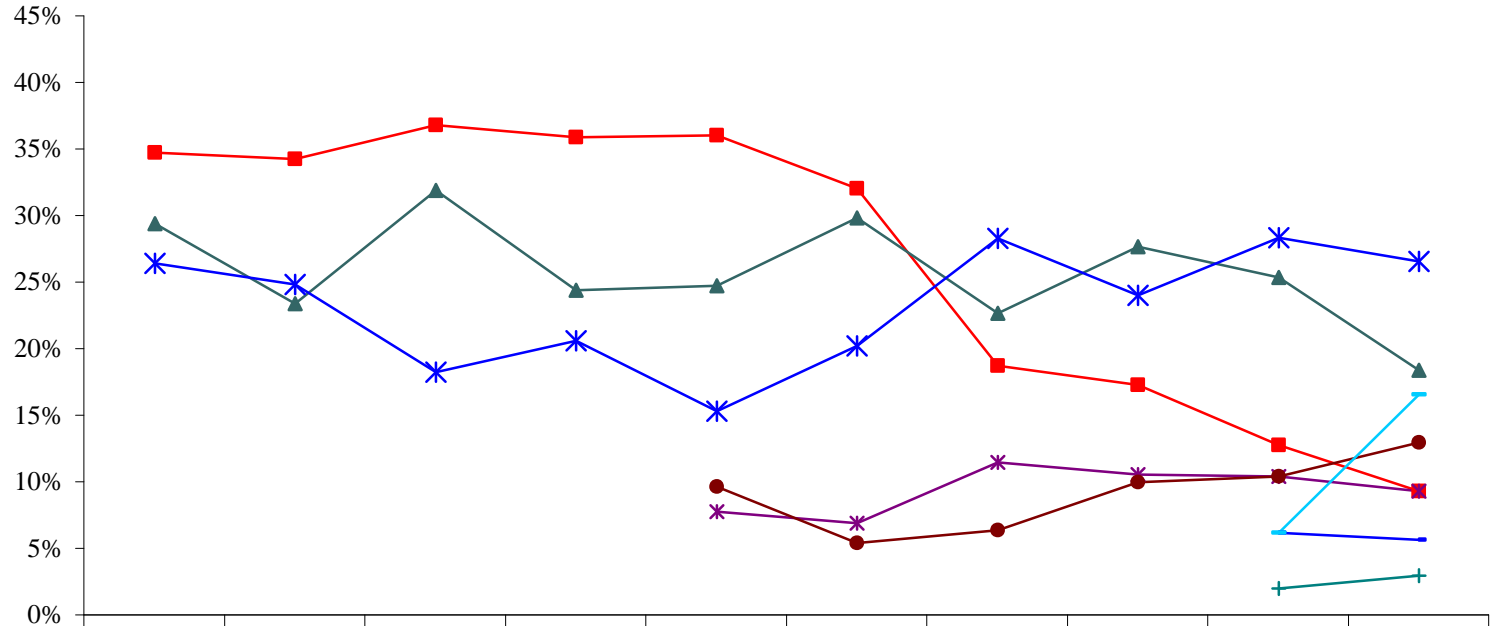


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	532	555	569	492	346	312	300	224	229	233
■ % Discharged < 7 Days	76%	75%	73%	68%	63%	52%	52%	41%	38%	37%
▲ % Discharged Within 8-15 Days	16%	17%	15%	20%	18%	22%	22%	23%	26%	21%
* % Discharged Within 16-30 Days	7%	6%	8%	8%	13%	18%	13%	19%	22%	24%
* % Discharged Within 31-45 Days					3%	3%	6%	8%	5%	8%
● % Discharged Within 46-90 Days					3%	3%	6%	6%	7%	5%
+ % Discharged Within 91-180 Days									2%	4%
+ % Discharged Within 181-365 Days									0.4%	0.4%
+ % Discharged > Than 365 Days									0%	0%

Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
Kerrville State Hospital

Percent of Discharges Returned to the Community

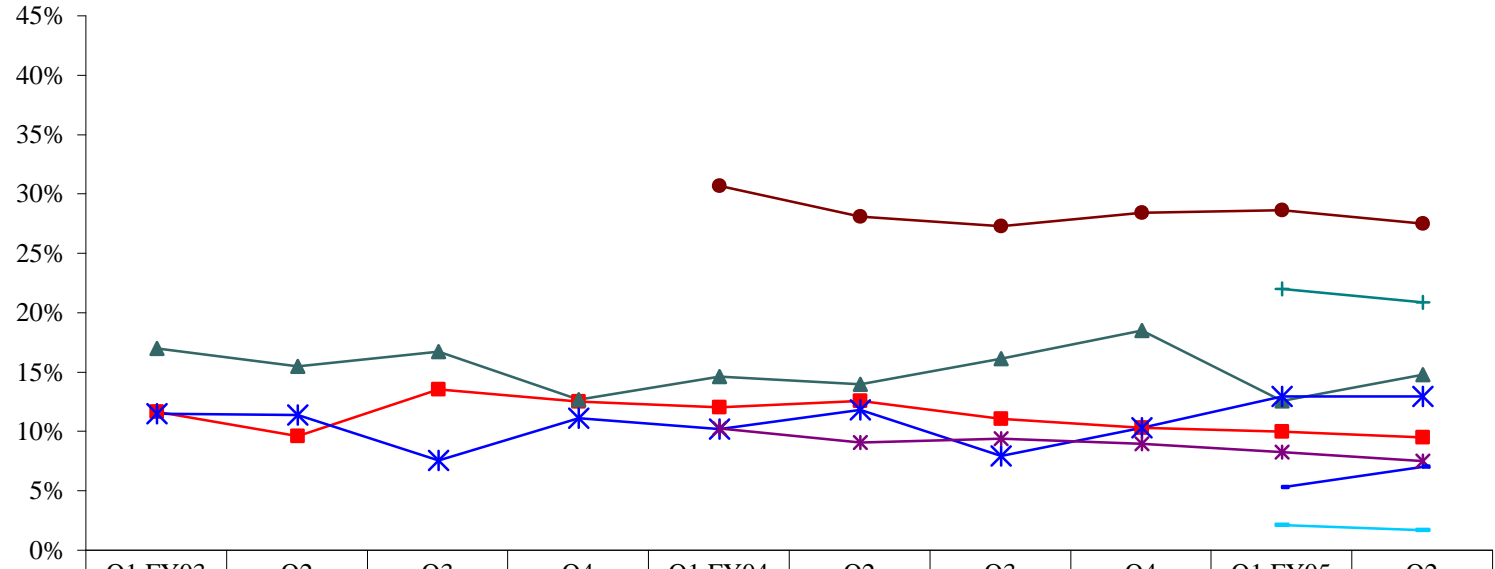


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	174	138	187	158	176	136	179	164	169	113
■ % Discharged < 7 Days	35%	34%	37%	36%	36%	32%	19%	17%	13%	9%
▲ % Discharged Within 8-15 Days	29%	23%	32%	24%	25%	30%	22%	27%	25%	18%
✱ % Discharged Within 16-30 Days	26%	25%	18%	20%	15%	20%	28%	24%	28%	26%
✱ % Discharged Within 31-45 Days					8%	7%	11%	10%	10%	9%
● % Discharged Within 46-90 Days					9%	5%	6%	10%	10%	13%
+ % Discharged Within 91-180 Days									2%	3%
— % Discharged Within 181-365 Days									6%	5%
— % Discharged > Than 365 Days									6%	16%

Source: Percent of Admissions Stabilized and Returned to Community (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
North Texas State Hospital

Percent of Discharges Returned to the Community

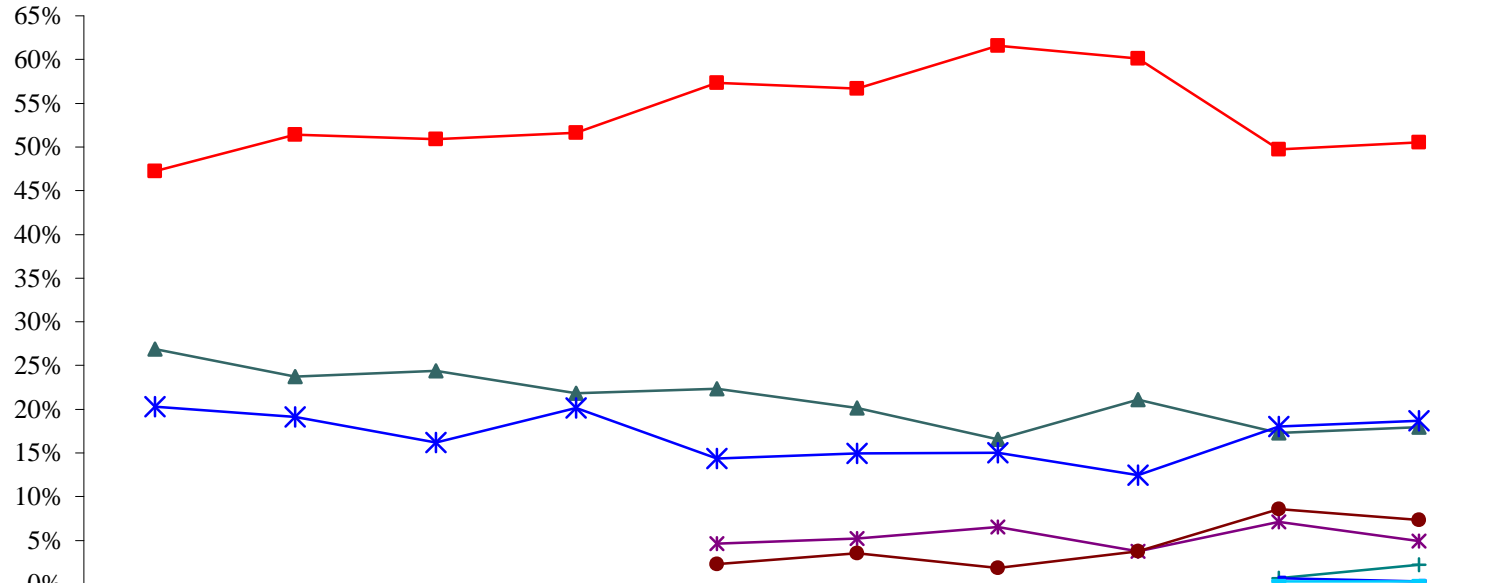


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	640	558	639	630	616	554	667	667	619	683
■ % Discharged < 7 Days	11%	9%	13%	12%	12%	12%	11%	10%	10%	9%
▲ % Discharged Within 8-15 Days	17%	15%	17%	12%	14%	14%	16%	18%	12%	15%
✱ % Discharged Within 16-30 Days	11%	11%	7%	11%	10%	12%	8%	10%	13%	13%
✳ % Discharged Within 31-45 Days					10%	9%	9%	9%	8%	7%
● % Discharged Within 46-90 Days					30%	28%	27%	28%	28%	27%
+ % Discharged Within 91-180 Days									22%	21%
— % Discharged Within 181-365 Days									5%	7%
— % Discharged > Than 365 Days									2%	1.5%

Source: Percent of Admissions Stabilized and Returned to Community (SR6681.0101.18)

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

Percent of Discharges Returned to the Community

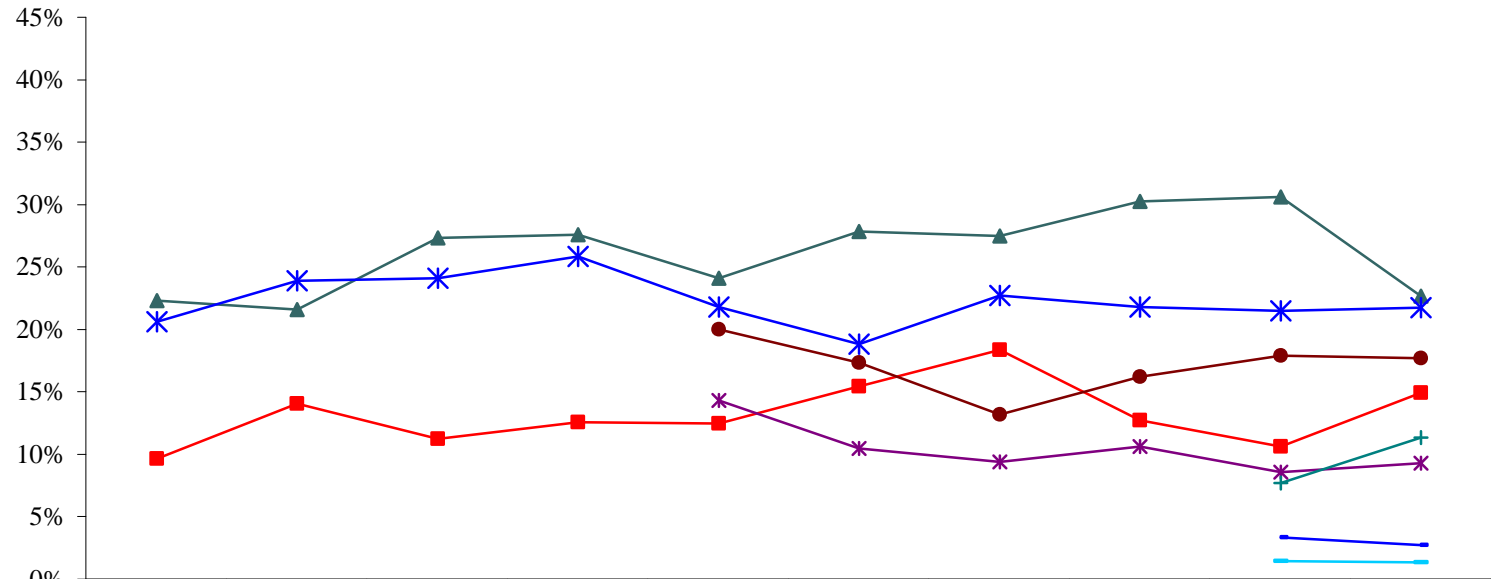


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	290	284	336	329	354	315	396	350	268	265
■ % Discharged < 7 Days	47%	51%	51%	51%	57%	56%	61%	60%	49%	50%
▲ % Discharged Within 8-15 Days	27%	23%	24%	22%	22%	20%	16%	21%	17%	18%
✱ % Discharged Within 16-30 Days	20%	19%	16%	20%	14%	15%	15%	12%	18%	18%
✱ % Discharged Within 31-45 Days					4%	5%	6%	3%	7%	5%
● % Discharged Within 46-90 Days					2%	3%	2%	3%	8%	7%
+ % Discharged Within 91-180 Days									0.4%	2%
+ % Discharged Within 181-365 Days									0.4%	0%
+ % Discharged > Than 365 Days									0%	0%

Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
Rusk State Hospital

Percent of Discharges Returned to the Community

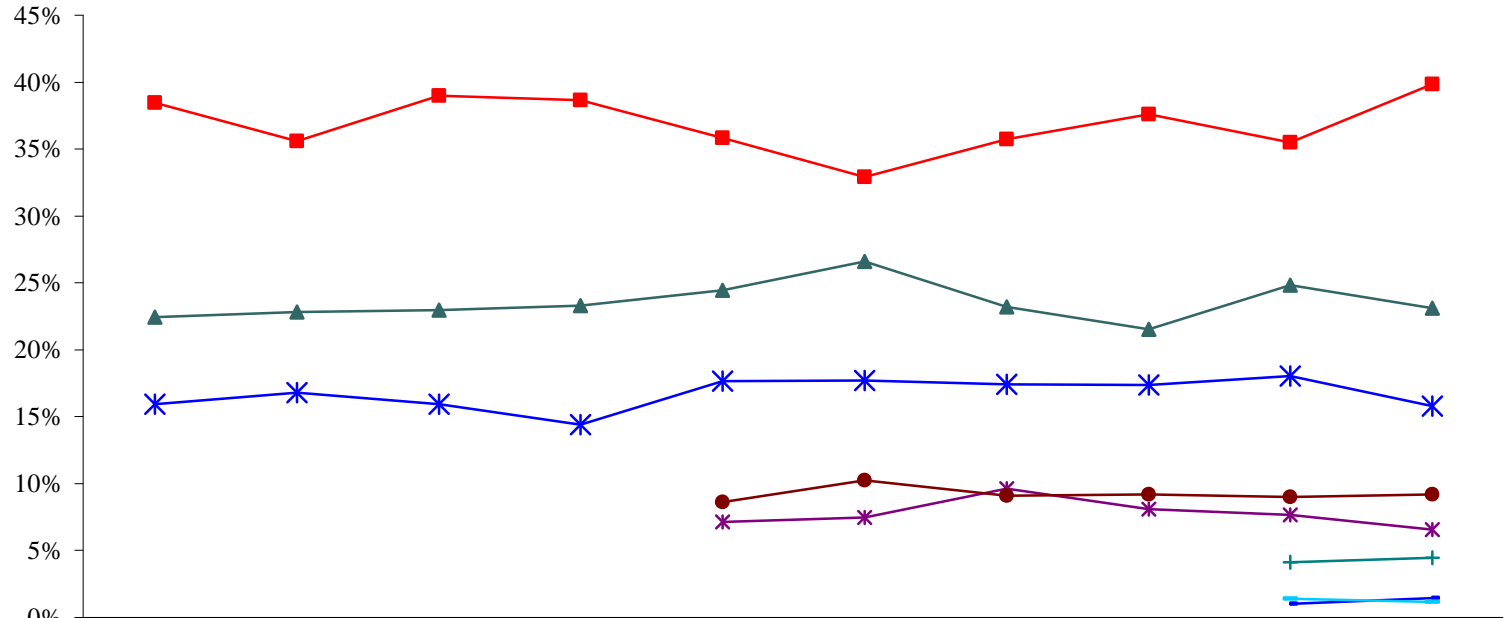


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	528	430	509	579	447	472	528	521	488	442
■ % Discharged < 7 Days	9%	14%	11%	12%	12%	15%	18%	13%	10%	15%
▲ % Discharged Within 8-15 Days	22%	21%	27%	27%	24%	28%	27%	30%	30%	22%
✱ % Discharged Within 16-30 Days	20%	24%	24%	26%	22%	19%	23%	22%	21%	22%
✱ % Discharged Within 31-45 Days					14%	10%	9%	10%	8%	9%
● % Discharged Within 46-90 Days					20%	17%	13%	16%	18%	17%
+ % Discharged Within 91-180 Days									8%	11%
— % Discharged Within 181-365 Days									3%	2%
— % Discharged > Than 365 Days									1%	1%

Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

Measure 5B - Percent of Discharges Returned to the Community
San Antonio State Hospital

Percent of Discharges Returned to the Community

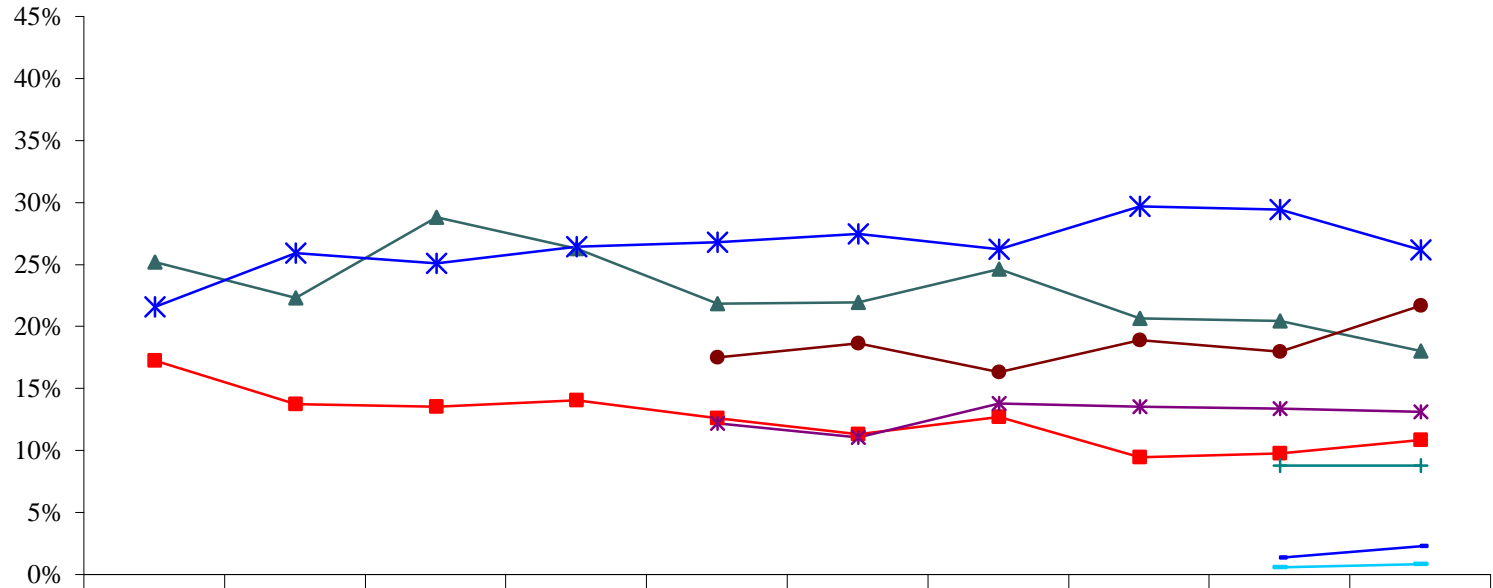


	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	728	699	749	717	691	625	716	756	748	735
■ % Discharged < 7 Days	38%	35%	39%	38%	36%	33%	36%	37%	35%	40%
▲ % Discharged Within 8-15 Days	22%	23%	23%	23%	24%	26%	23%	21%	25%	23%
✱ % Discharged Within 16-30 Days	16%	17%	16%	14%	17%	18%	17%	17%	18%	16%
✱ % Discharged Within 31-45 Days					7%	7%	9%	8%	7%	6%
● % Discharged Within 46-90 Days					8%	10%	9%	9%	9%	9%
+ % Discharged Within 91-180 Days									4%	4%
+ % Discharged Within 181-365 Days									1%	1%
+ % Discharged > Than 365 Days									1%	1%

Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

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

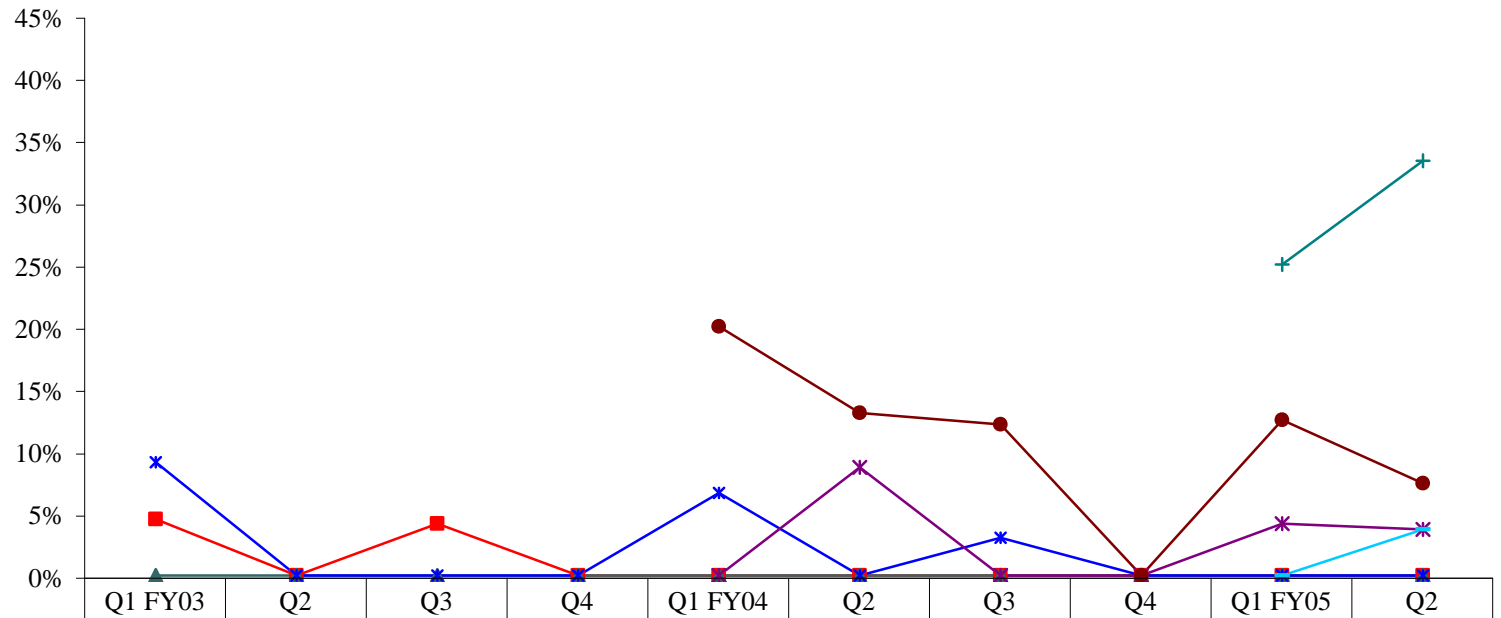
Percent of Discharges Returned to the Community



	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	636	629	652	721	515	513	628	594	548	595
■ % Discharged < 7 Days	17%	14%	13%	14%	12%	11%	12%	9%	10%	11%
▲ % Discharged Within 8-15 Days	25%	22%	29%	26%	22%	22%	24%	20%	20%	18%
* % Discharged Within 16-30 Days	21%	26%	25%	26%	27%	27%	26%	29%	29%	26%
* % Discharged Within 31-45 Days					12%	11%	14%	13%	13%	13%
● % Discharged Within 46-90 Days					17%	18%	16%	19%	18%	21%
+ % Discharged Within 91-180 Days									9%	9%
— % Discharged Within 181-365 Days									1%	2%
— % Discharged > Than 365 Days									0.4%	1%

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

Percent of Discharges Returned to the Community



	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Total Discharged	24	33	31	46	35	29	41	38	30	36
■ % Discharged < 7 Days	5%	0%	4%	0%	0%	0%	0%	0%	0%	0%
▲ % Discharged Within 8-15 Days	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
* % Discharged Within 16-30 Days	9%	0%	0%	0%	7%	0%	3%	0%	0%	0%
* % Discharged Within 31-45 Days					0%	9%	0%	0%	4%	4%
● % Discharged Within 46-90 Days					20%	13%	12%	0%	13%	7%
+ % Discharged Within 91-180 Days									25%	33%
— % Discharged Within 181-365 Days									58%	52%
— % Discharged > Than 365 Days									0%	4%

Source: Percent of Admissions Stabilized and Returned to Community
 (SR6681.0101.18)

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.

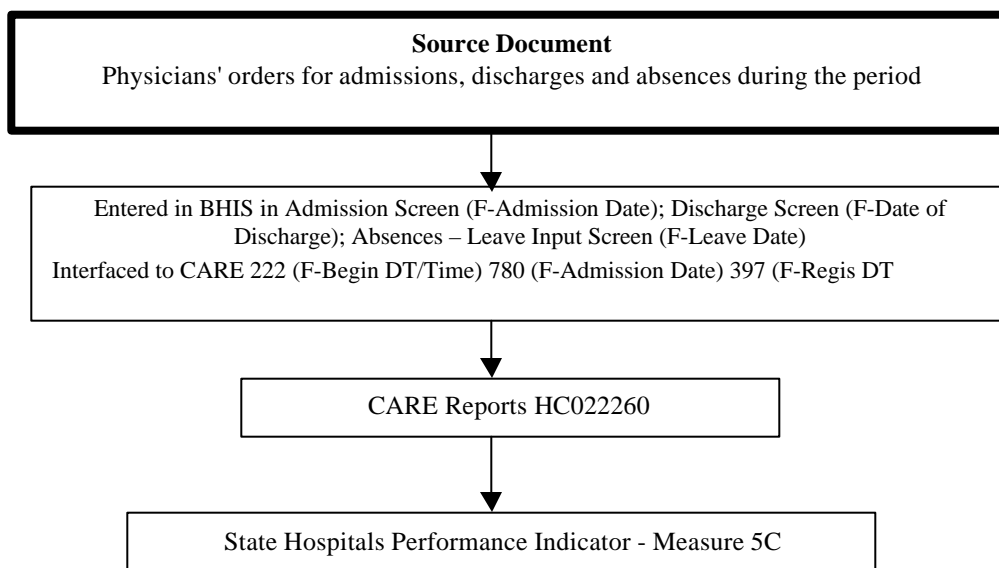
Performance Measure Operational Definition: The state hospital average length of stay at discharged using admissions, absence and discharge data.

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.

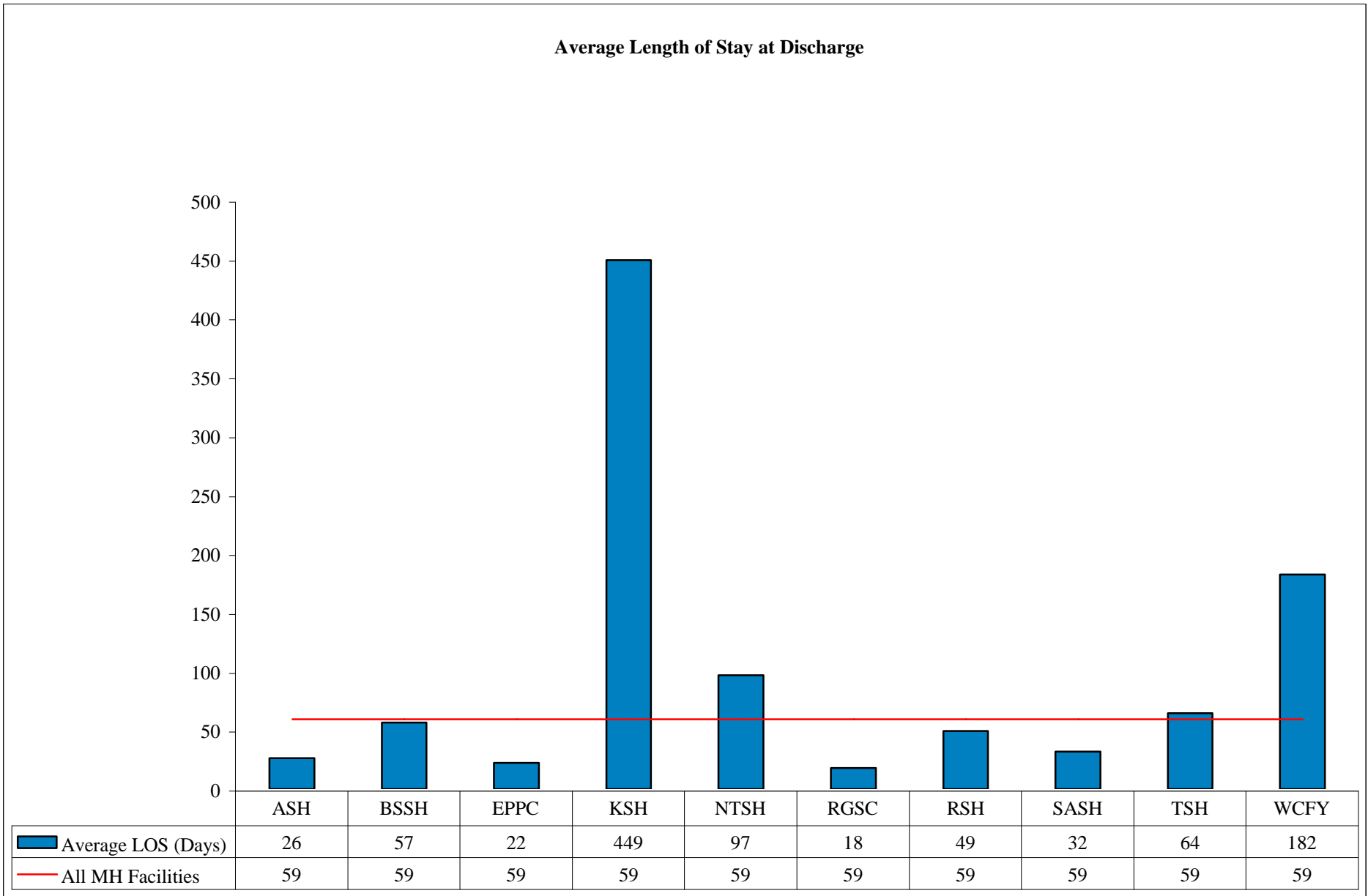
Data Flow:



Data Integrity Review Process:

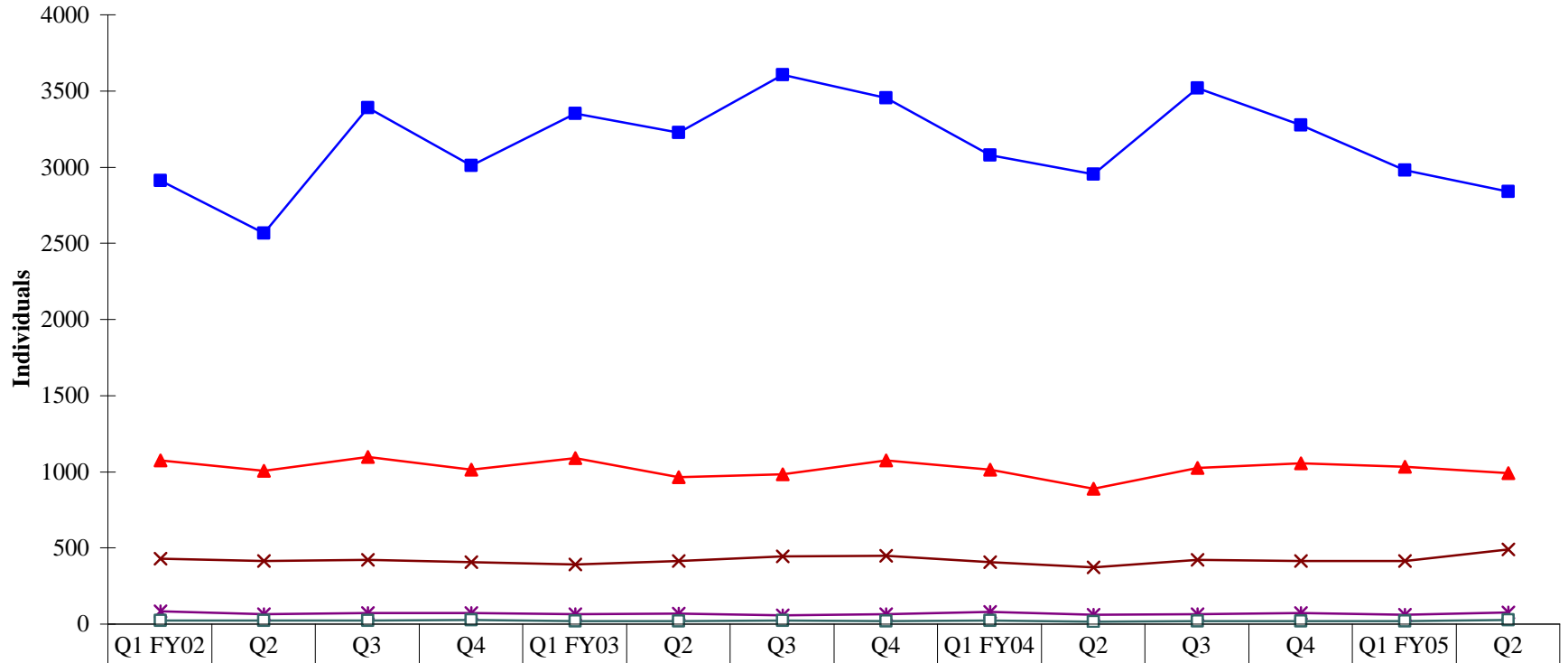
Monitoring Method	Medical record review using the most recent NRI PMS quarterly episode and/or event file data to ensure medical record data corresponds to data reported to NRI PMS. Episode files include admission/discharge dates, patient demographic and diagnostic information. Event files include date 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 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

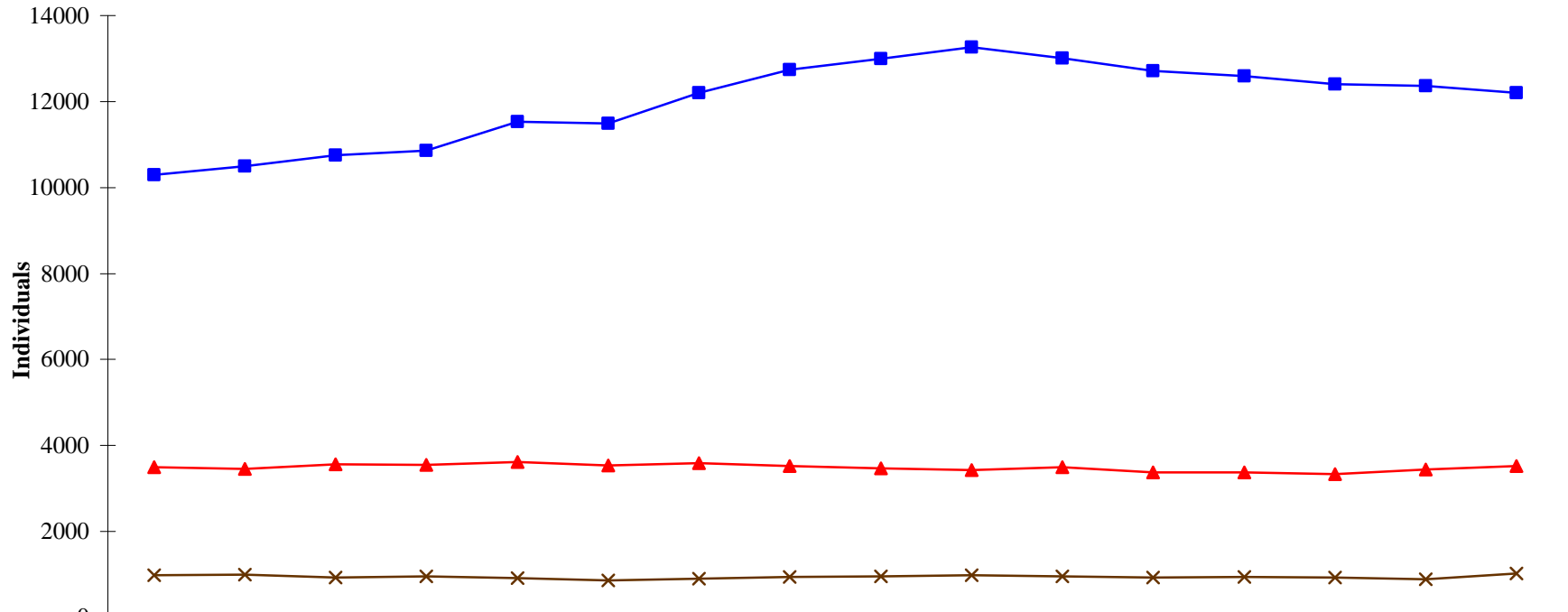


	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	51	55	52	48	40	44	41	43	49	39	45	45	47	59
30 Days or Less	2895	2549	3373	2994	3336	3209	3592	3439	3064	2936	3502	3261	2963	2824
31 - 90 Days	1060	992	1083	998	1074	950	969	1057	998	874	1011	1038	1017	975
91 - 365 Days	412	397	406	391	374	399	430	433	392	357	407	397	400	474
1 - 5 Years	68	50	57	56	51	52	43	50	64	45	49	58	47	61
Over 5 Years	8	8	8	10	3	5	6	3	7	0	5	5	4	12

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

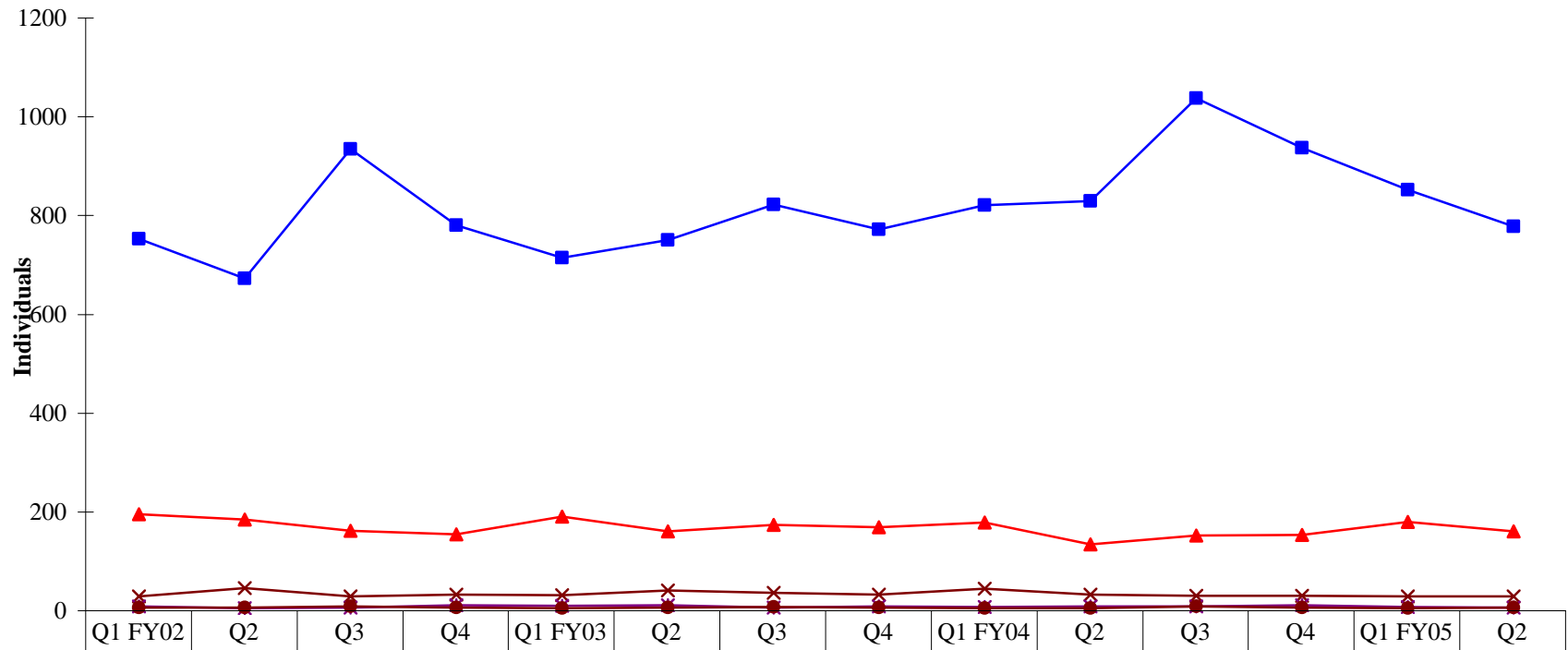


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	30	30	28	28	28	27	26	26	25	25	25	25	26	26	26	27
■ 30 Days or Less	10238	10435	10692	10801	11479	11431	12148	12685	12933	13204	12948	12661	12529	12348	12301	12141
▲ 31-90 Days	3433	3400	3511	3492	3567	3483	3535	3468	3419	3378	3442	3324	3325	3285	3381	3462
✕ 91-365 Days	926	938	879	895	854	806	842	884	897	926	906	867	885	871	833	974

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**

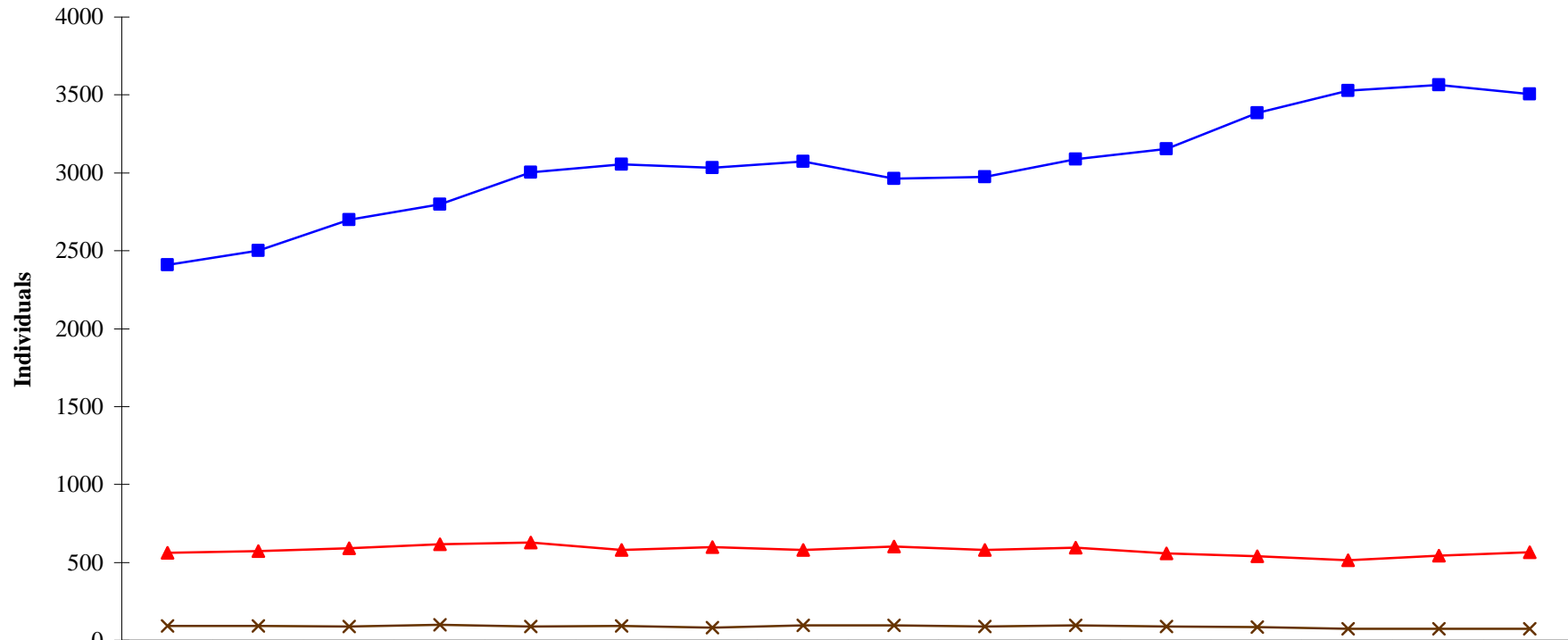
Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	27	34	37	27	26	31	29	34	23	21	34	23	22	26
■ 30 Days or Less	748	667	930	775	709	745	817	767	816	824	1033	932	847	773
▲ 31 - 90 Days	190	180	157	150	186	156	169	164	174	129	147	148	175	155
✕ 91 - 365 Days	24	41	24	28	26	36	31	28	40	27	25	25	24	24
✱ 1 - 5 Years	3	0	1	6	5	6	1	4	2	3	3	6	2	1
● Over 5 Years	1	1	3	1	0	1	2	1	0	0	3	1	0	1

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

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

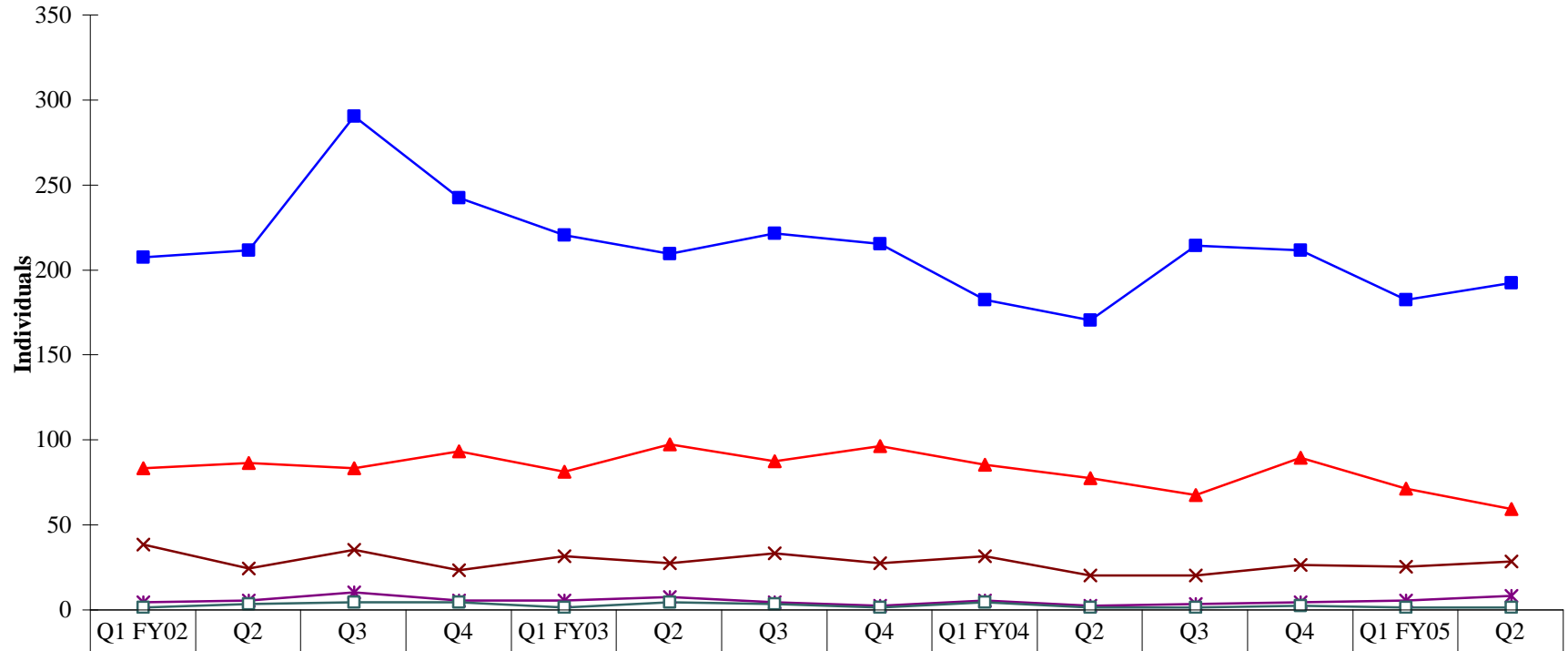


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	21	20	20	20	19	18	18	19	19	18	18	18	17	16	16	17
■ 30 Days or Less	2393	2487	2685	2783	2987	3040	3019	3056	2947	2958	3073	3139	3369	3511	3548	3490
▲ 31-90 Days	547	556	575	602	612	564	582	564	587	566	578	543	526	499	529	550
✕ 91-365 Days	77	77	74	83	72	76	66	79	79	75	79	73	71	58	60	59

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

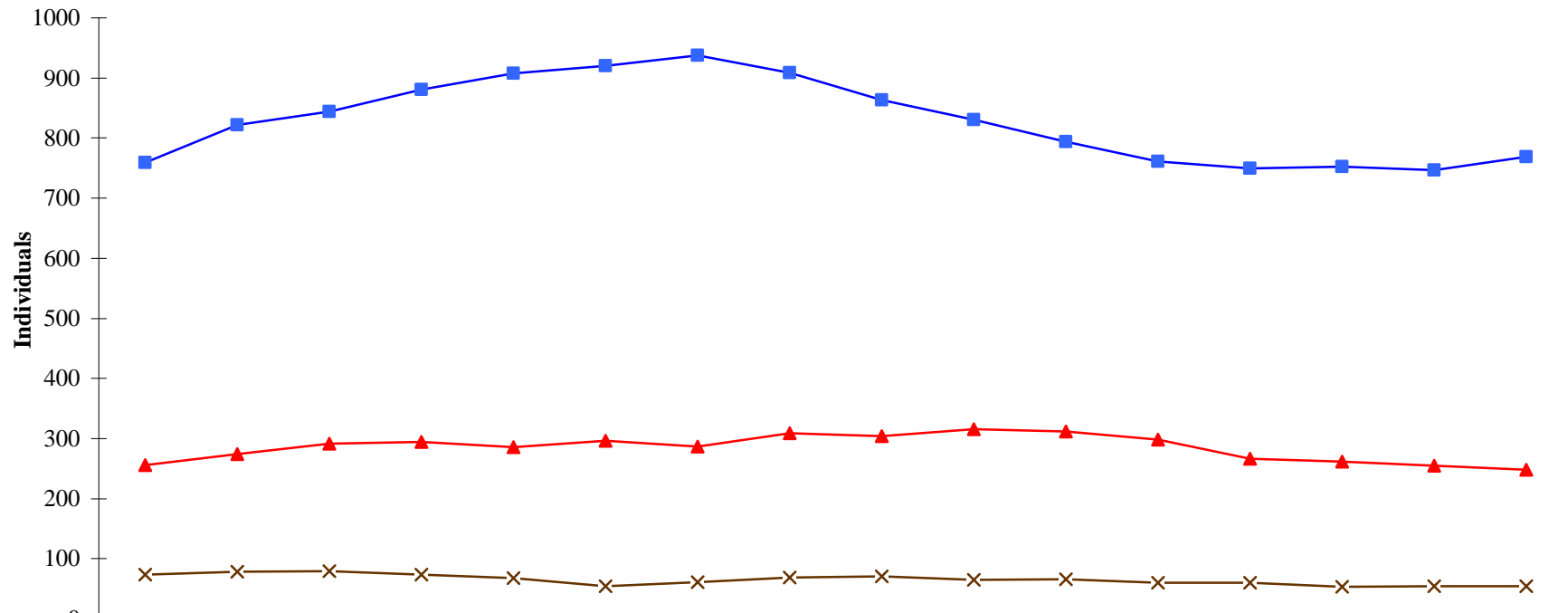


	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	45	64	76	84	43	86	64	42	93	35	35	61	48	57
30 Days or Less	206	210	289	241	219	208	220	214	181	169	213	210	181	191
31 - 90 Days	82	85	82	92	80	96	86	95	84	76	66	88	70	58
91 - 365 Days	37	23	34	22	30	26	32	26	30	19	19	25	24	27
1 - 5 Years	3	4	9	4	4	6	3	1	4	1	2	3	4	7
Over 5 Years	0	2	3	3	0	3	2	0	3	0	0	1	0	0

Source: Average Length of Stay in Hospitals at Time of Discharge (SR6681.5)
Demographic Trends for MH Clients Average Lengths of Stay (HC02260)

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

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

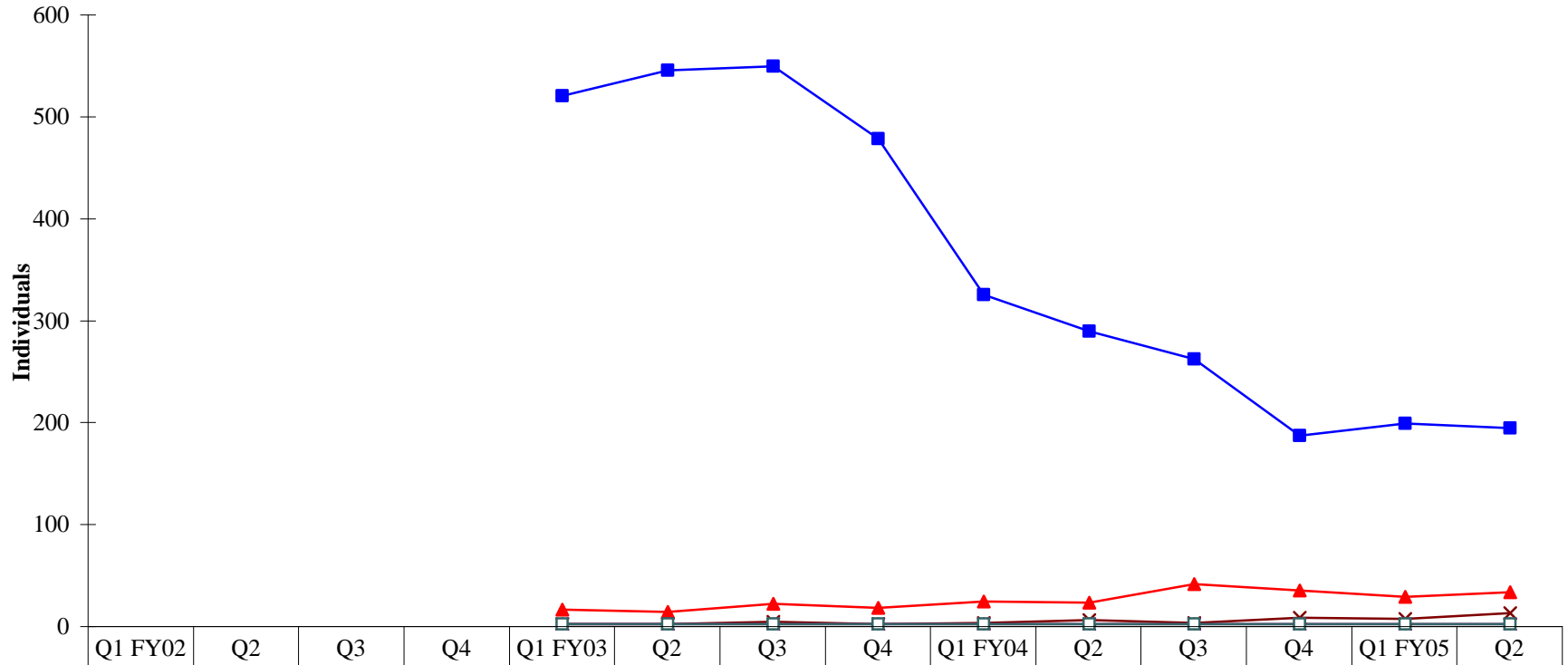


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	31	31	30	29	29	27	27	29	29	30	30	29	29	28	28	28
■ 30 Days or Less	755	818	840	877	904	916	933	905	859	826	790	757	745	748	743	765
▲ 31-90 Days	252	270	287	290	282	292	283	305	300	311	308	294	262	257	251	244
× 91-365 Days	69	74	75	69	64	50	57	65	67	61	62	56	56	49	50	50

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**

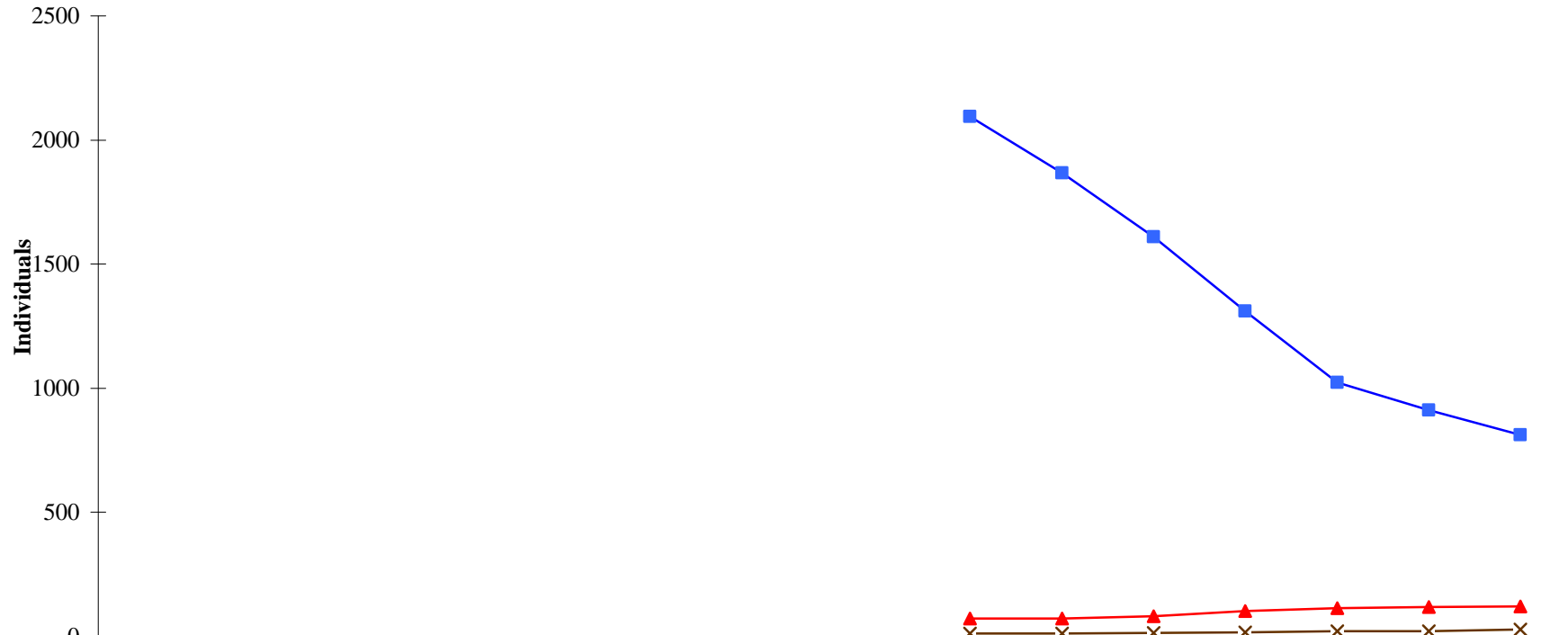
Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS					7	7	8	8	10	13	14	19	18	22
■ 30 Days or Less					518	543	547	476	323	287	260	185	197	192
▲ 31 - 90 Days					14	12	20	16	22	21	39	33	27	31
✕ 91 - 365 Days					0	0	2	0	1	4	1	6	5	11
* 1 - 5 Years					0	0	0	0	0	0	0	0	0	0
□ Over 5 Years					0	0	0	0	0	0	0	0	0	0

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

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

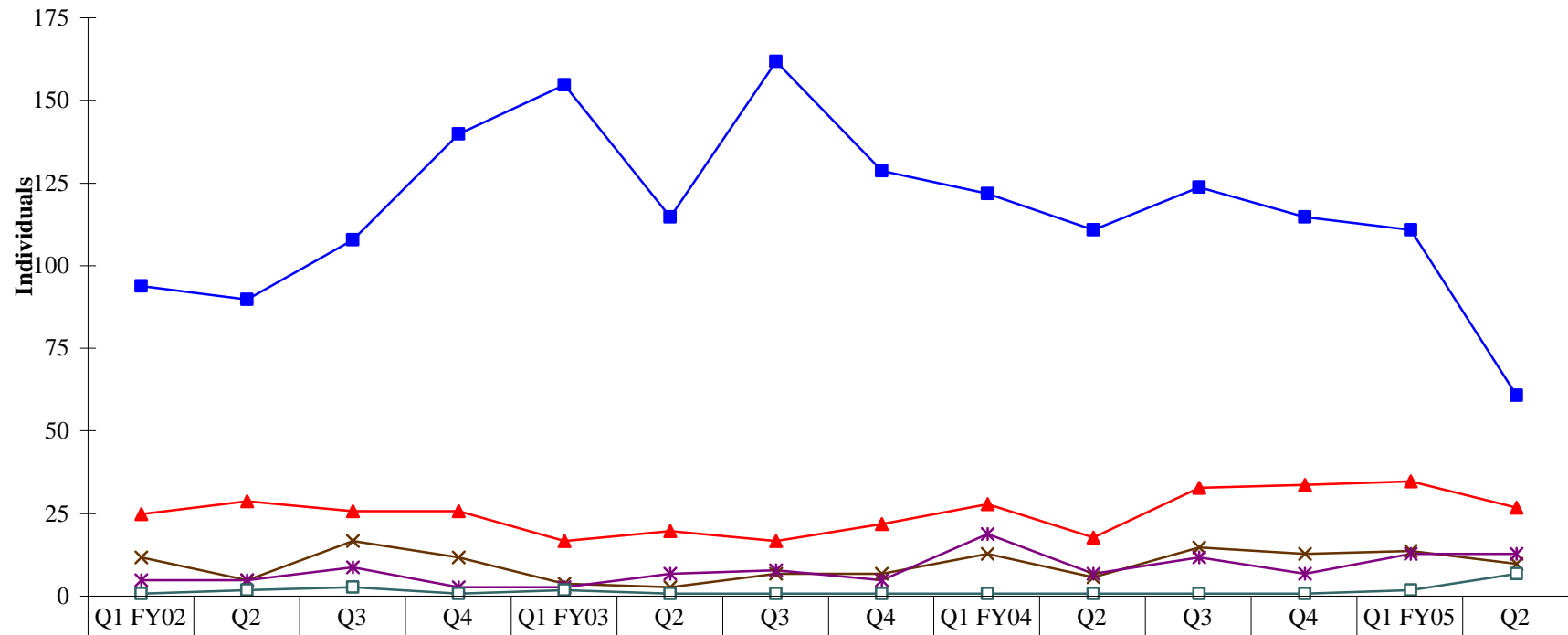


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS										7	8	9	11	13	14	17
30 Days or Less										2084	1858	1601	1300	1013	903	802
31-90 Days										62	62	71	93	105	109	111
91-365 Days										2	2	5	6	11	11	19

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**

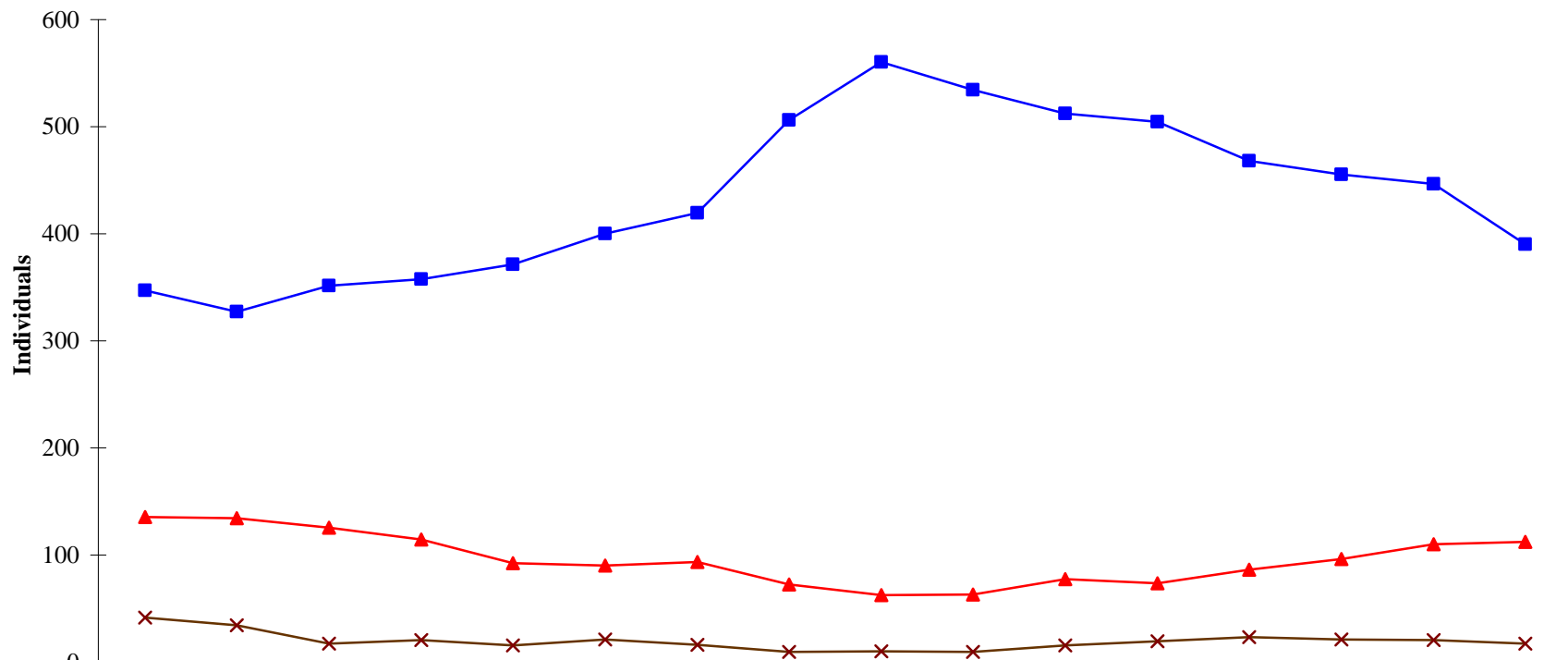
Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	51	77	205	38	55	50	51	45	112	72	97	64	131	449
■ 30 Days or Less	93	89	107	139	154	114	161	128	121	110	123	114	110	60
▲ 31 - 90 Days	24	28	25	25	16	19	16	21	27	17	32	33	34	26
✕ 91 - 365 Days	11	4	16	11	3	2	6	6	12	5	14	12	13	9
✱ 1 - 5 Years	4	4	8	2	2	6	7	4	18	6	11	6	12	12
□ Over 5 Years	0	1	2	0	1	0	0	0	0	0	0	0	1	6

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

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

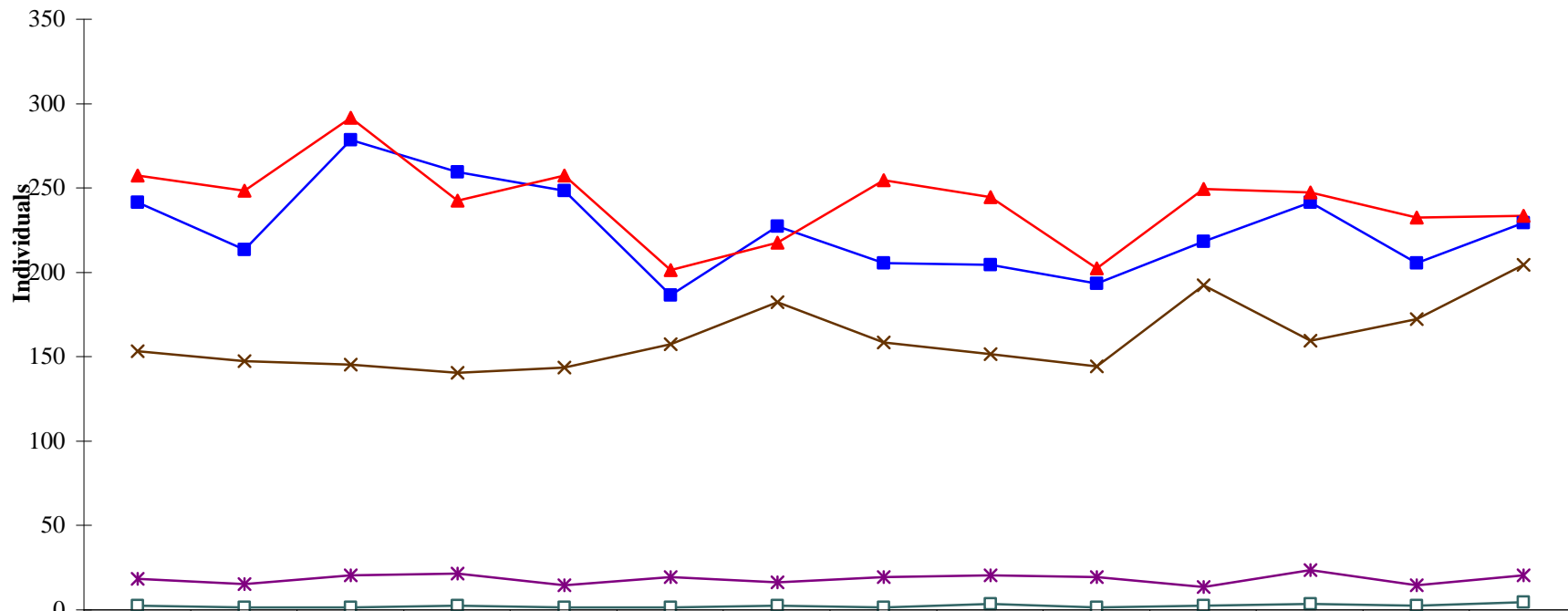


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	33	33	27	28	23	25	22	17	16	16	18	19	23	24	26	27
■ 30 Days or Less	345	325	349	355	369	398	417	504	558	532	510	502	466	453	444	388
▲ 31-90 Days	133	132	123	112	90	88	91	70	60	61	75	71	84	94	108	110
× 91-365 Days	39	32	15	18	13	19	14	7	8	7	13	17	21	19	18	15

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**

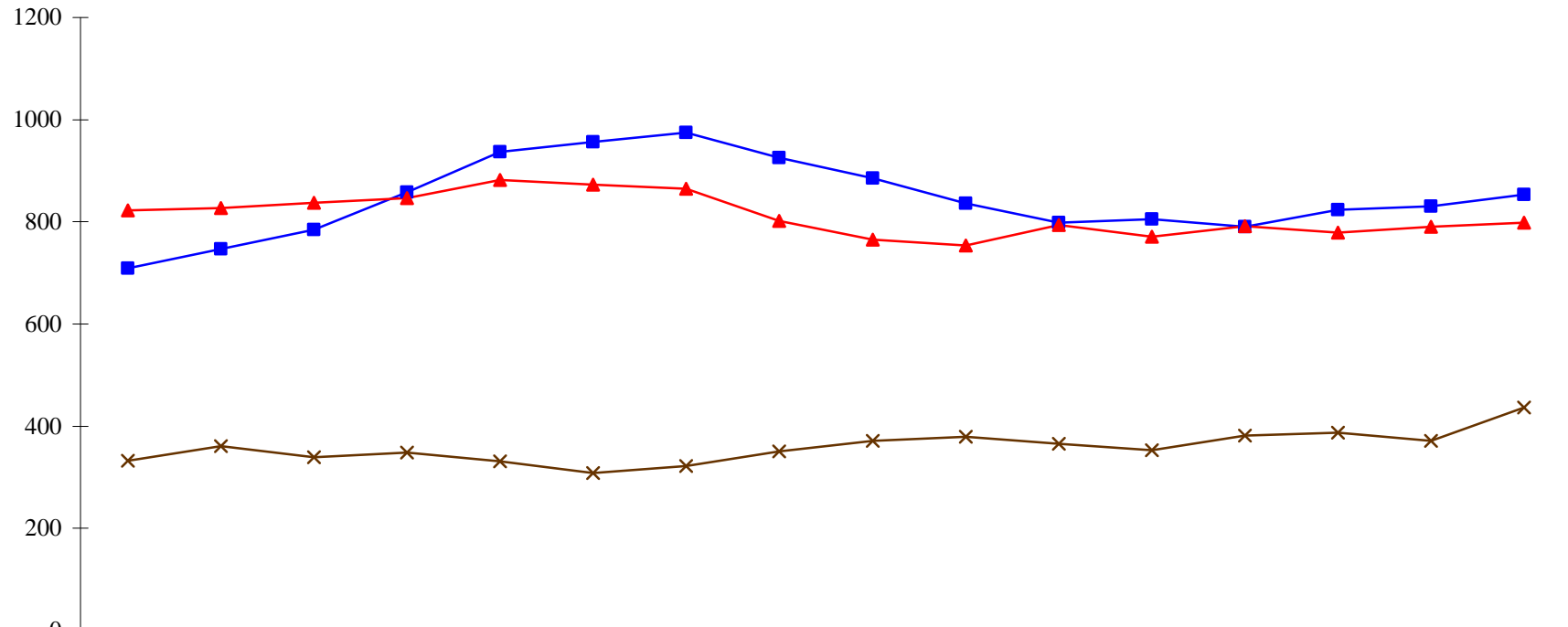
Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	84	85	82	84	72	93	89	80	101	83	89	98	86	97
■ 30 Days or Less	240	212	277	258	247	185	226	204	203	192	217	240	204	228
▲ 31 - 90 Days	256	247	290	241	256	200	216	253	243	201	248	246	231	232
✕ 91 - 365 Days	152	146	144	139	142	156	181	157	150	143	191	158	171	203
✱ 1 - 5 Years	17	14	19	20	13	18	15	18	19	18	12	22	13	19
□ Over 5 Years	1	0	0	1	0	0	1	0	2	0	1	2	1	3

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

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

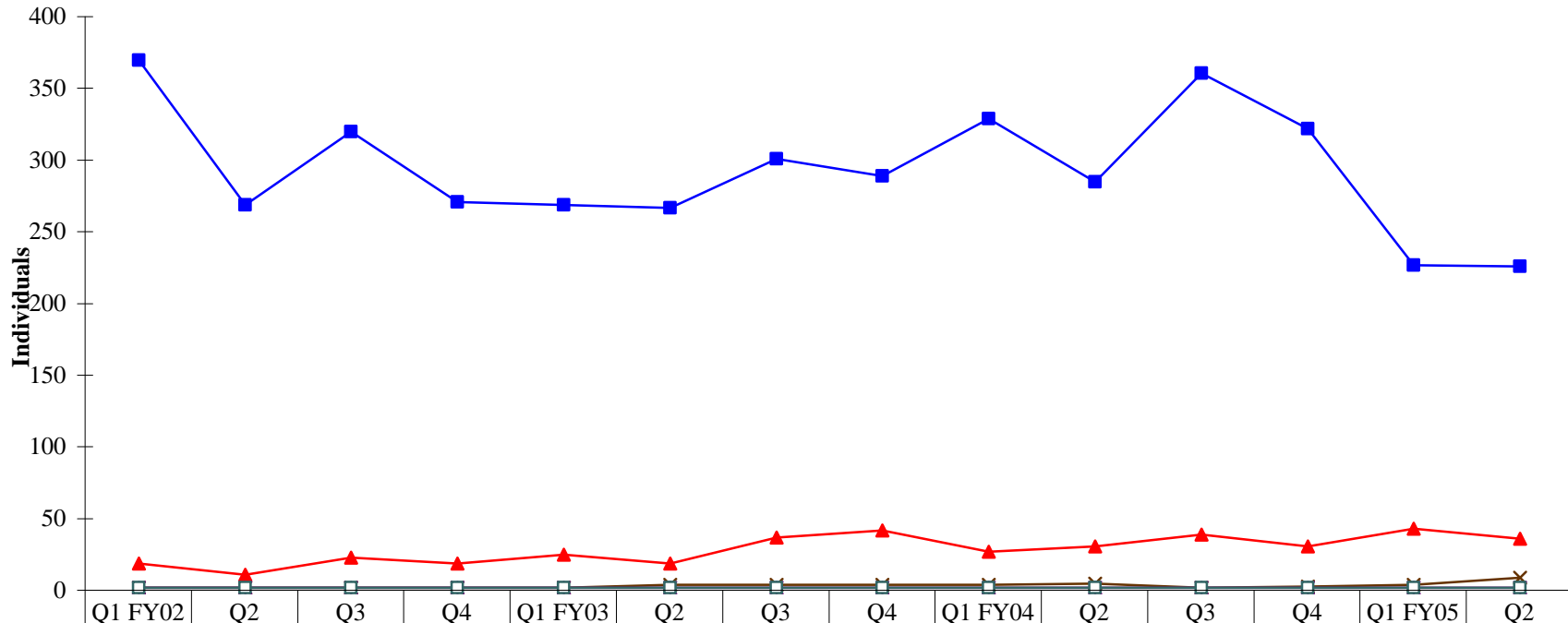


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	58	59	55	53	51	49	49	50	52	53	54	53	56	54	53	56
■ 30 Days or Less	704	742	780	853	932	951	970	921	881	831	793	800	786	819	826	849
▲ 31-90 Days	817	822	832	842	877	868	860	797	760	749	789	766	787	774	786	794
✕ 91-365 Days	327	356	334	344	326	304	317	346	366	374	361	348	377	383	366	432

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**

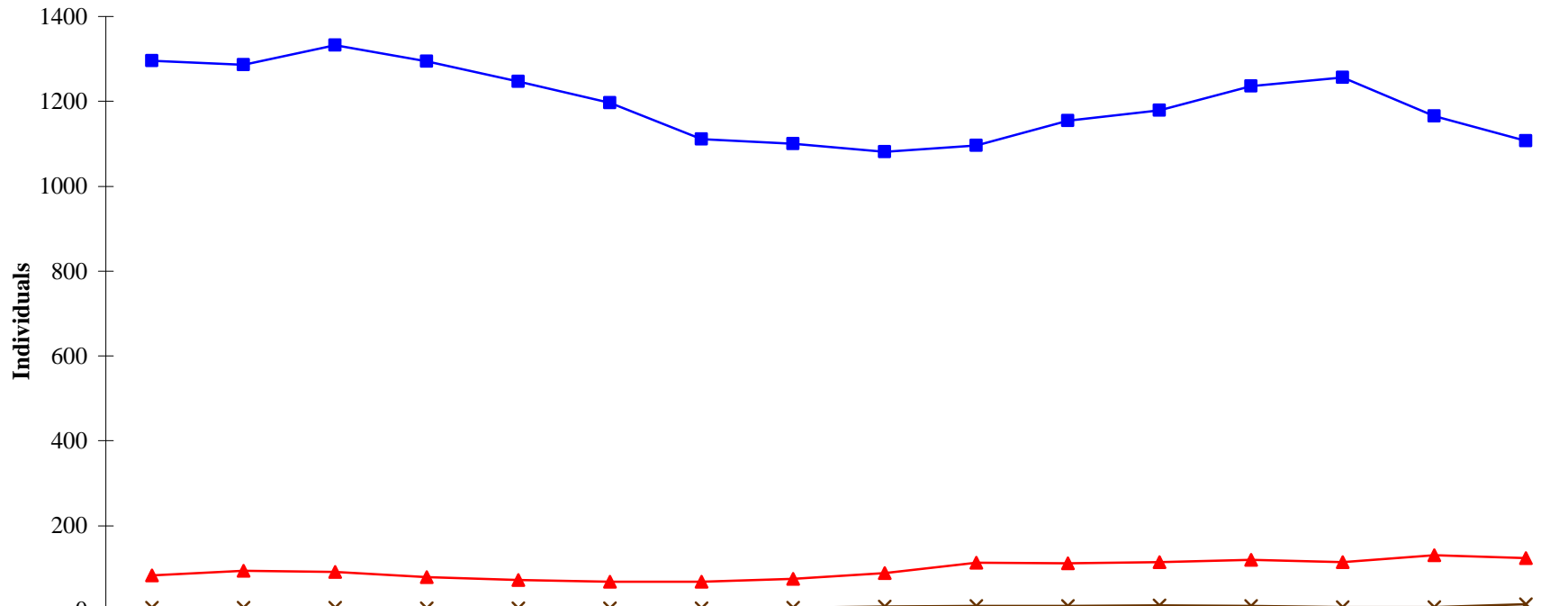
Average Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	9	8	10	10	13	12	13	15	11	13	11	11	16	18
30 Days or Less	368	267	318	269	267	265	299	287	327	283	359	320	225	224
31 - 90 Days	17	9	21	17	23	17	35	40	25	29	37	29	41	34
91 - 365 Days	0	0	0	0	0	2	2	2	2	3	0	1	2	7
1 - 5 Years	0	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	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

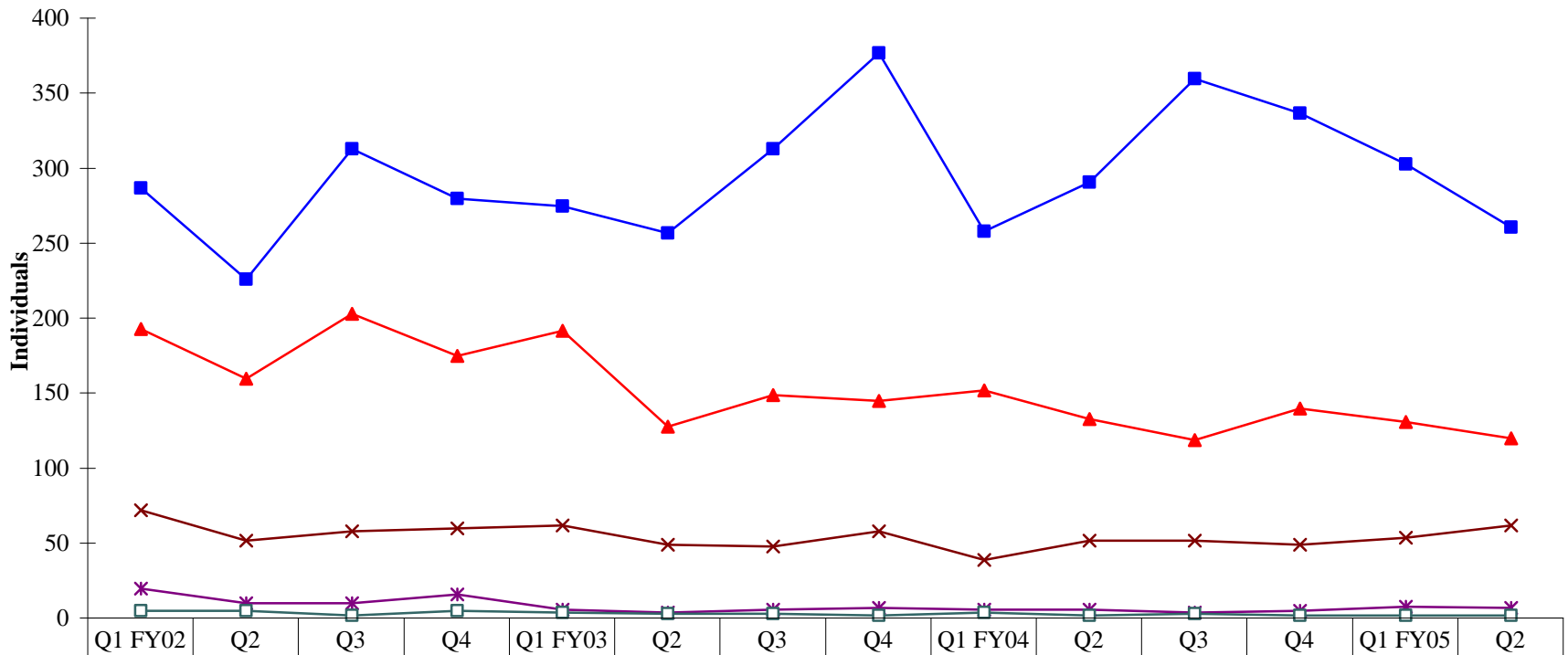


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	10	10	10	9	9	9	10	11	12	12	12	12	11	11	12	13
■ 30 Days or Less	1290	1280	1326	1289	1241	1191	1105	1094	1076	1090	1149	1173	1230	1251	1159	1101
▲ 31-90 Days	78	88	86	74	67	62	63	69	83	107	106	108	114	108	125	118
✕ 91-365 Days	1	1	1	0	0	0	0	2	4	5	6	7	5	3	3	10

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

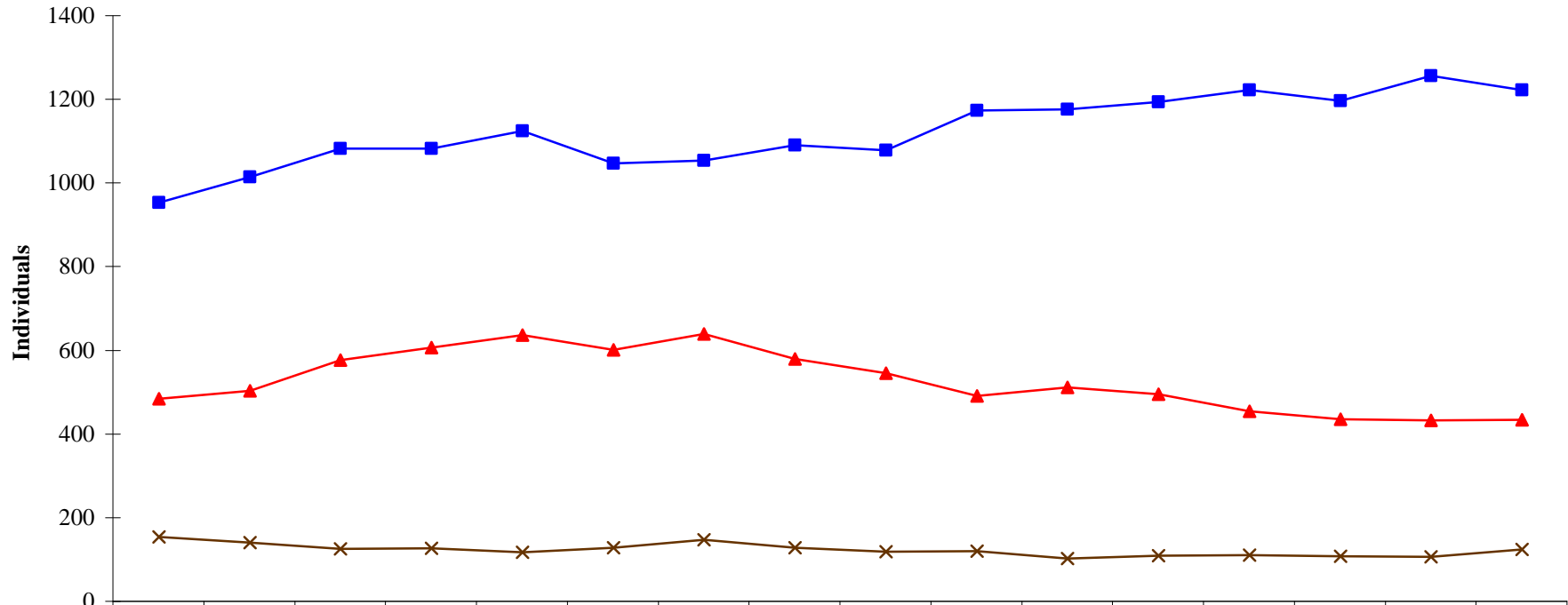


	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	82	93	49	74	60	52	51	45	64	44	46	41	52	49
30 Days or Less	285	224	311	278	273	255	311	375	256	289	358	335	301	259
31 - 90 Days	191	158	201	173	190	126	147	143	150	131	117	138	129	118
91 - 365 Days	70	50	56	58	60	47	46	56	37	50	50	47	52	60
1 - 5 Years	18	8	8	14	4	2	4	5	4	4	2	3	6	5
Over 5 Years	3	3	0	3	2	1	1	0	2	0	1	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

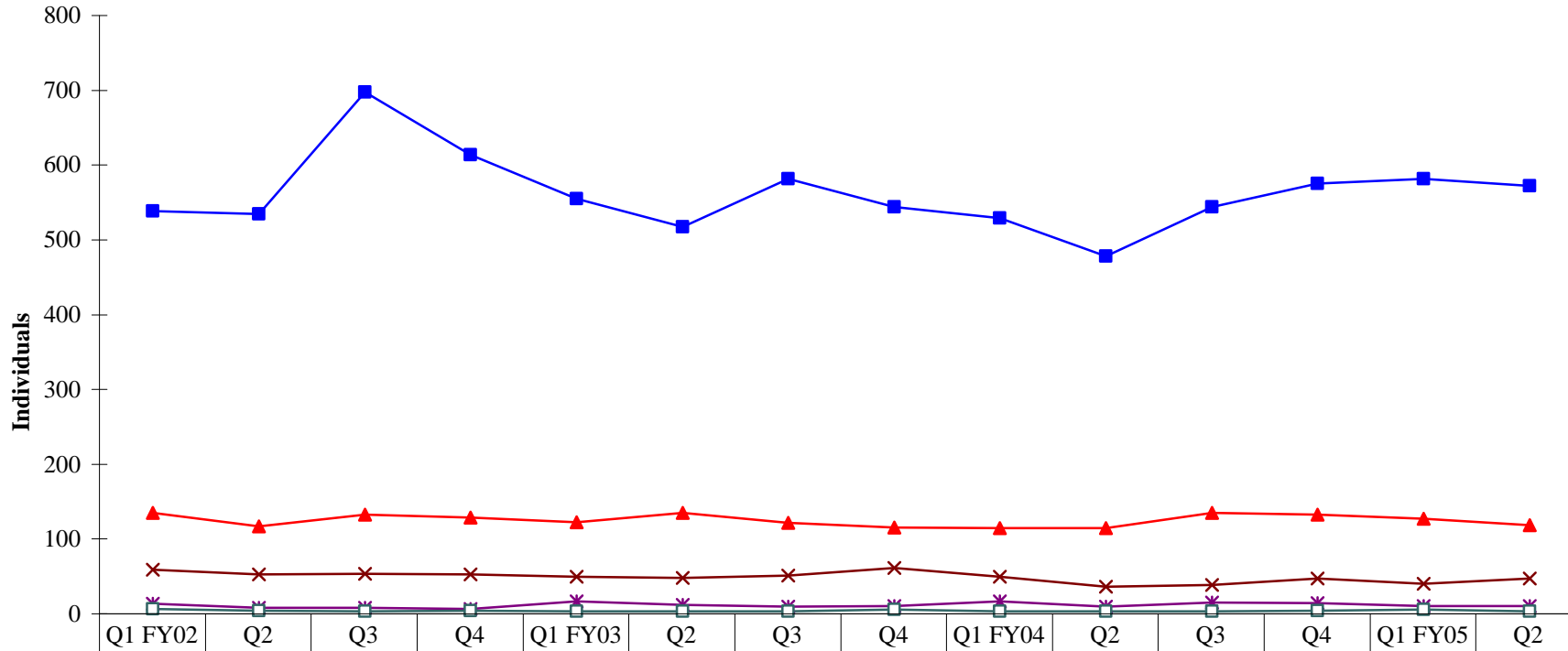
Average Length of Stay for Admitted and Discharged During Prior 12 Months



	6/00-5/01	9/00-8/01	12/00-11/01	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
Average LOS	38	37	36	37	35	36	37	34	34	32	31	32	31	30	30	31
■ 30 Days or Less	948	1008	1076	1076	1118	1041	1048	1084	1072	1167	1170	1188	1216	1190	1250	1216
▲ 31-90 Days	479	497	571	601	630	596	633	573	539	485	505	489	449	430	427	428
✕ 91-365 Days	148	134	119	121	112	122	142	123	113	114	96	103	105	102	100	118

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

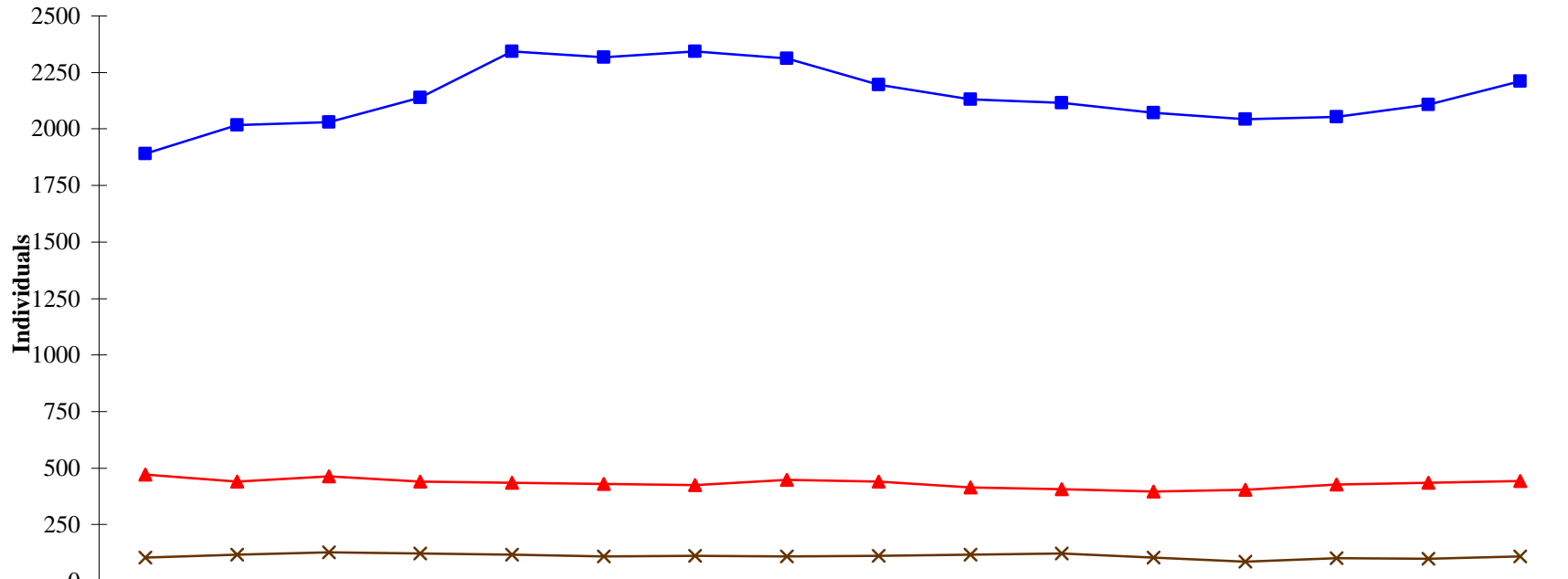
Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	55	36	28	32	35	35	30	48	38	32	38	41	46	32
■ 30 Days or Less	535	531	694	610	552	514	578	541	526	475	541	572	578	569
▲ 31 - 90 Days	132	114	129	125	119	132	118	112	111	111	132	129	124	115
× 91 - 365 Days	56	49	50	49	46	45	48	58	46	33	35	44	37	44
* 1 - 5 Years	10	5	5	3	13	9	6	7	13	6	12	11	7	7
□ Over 5 Years	3	1	0	1	0	0	0	2	0	0	0	1	2	0

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

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

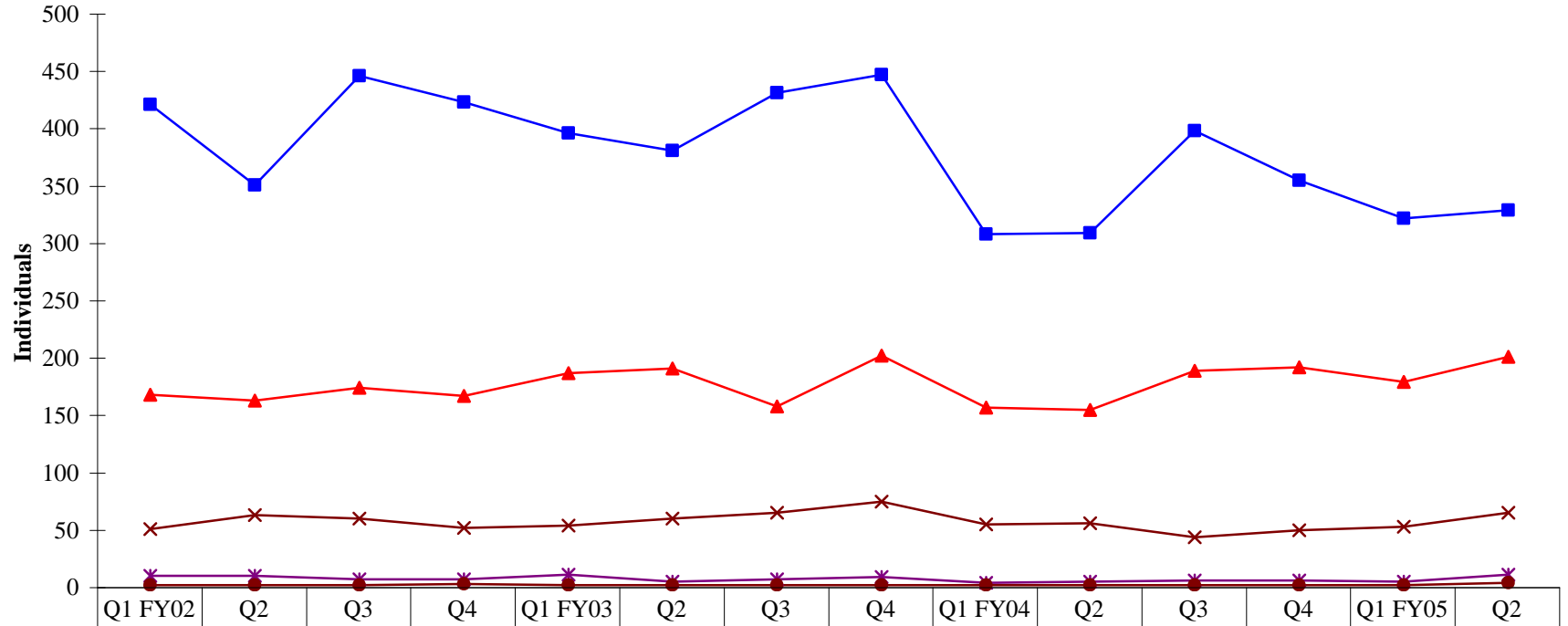


	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	23	22	23	21	21	21	20	20	21	21	21	20	20	21	20	20
■ 30 Days or Less	1879	2007	2020	2129	2333	2305	2333	2301	2184	2120	2104	2061	2032	2043	2096	2199
▲ 31-90 Days	459	430	453	429	424	420	413	436	430	404	396	384	394	417	423	432
✕ 91-365 Days	93	106	117	111	106	99	100	99	100	106	111	93	76	90	87	98

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**

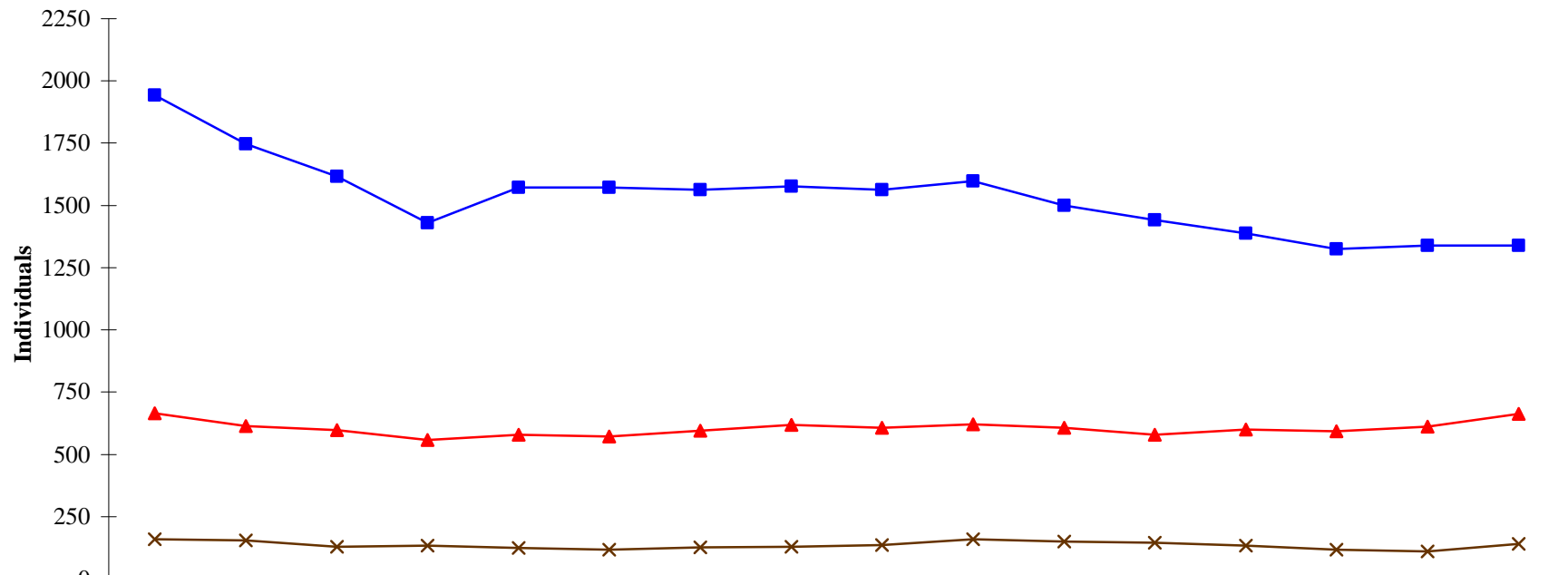
Average Length of Stay at Discharge by Category



	Q1 FY02	Q2	Q3	Q4	Q1 FY03	Q2	Q3	Q4	Q1 FY04	Q2	Q3	Q4	Q1 FY05	Q2
Average LOS	44	52	39	44	47	41	41	46	40	44	40	44	43	64
30 Days or Less	419	349	444	421	394	379	429	445	306	307	396	353	320	327
31 - 90 Days	166	161	172	165	185	189	156	200	155	153	187	190	177	199
91 - 365 Days	49	61	58	50	52	58	63	73	53	54	42	48	51	63
1 - 5 Years	8	8	5	5	9	3	5	7	2	3	4	4	3	9
Over 5 Years	0	0	0	1	0	0	0	0	0	0	0	0	0	2

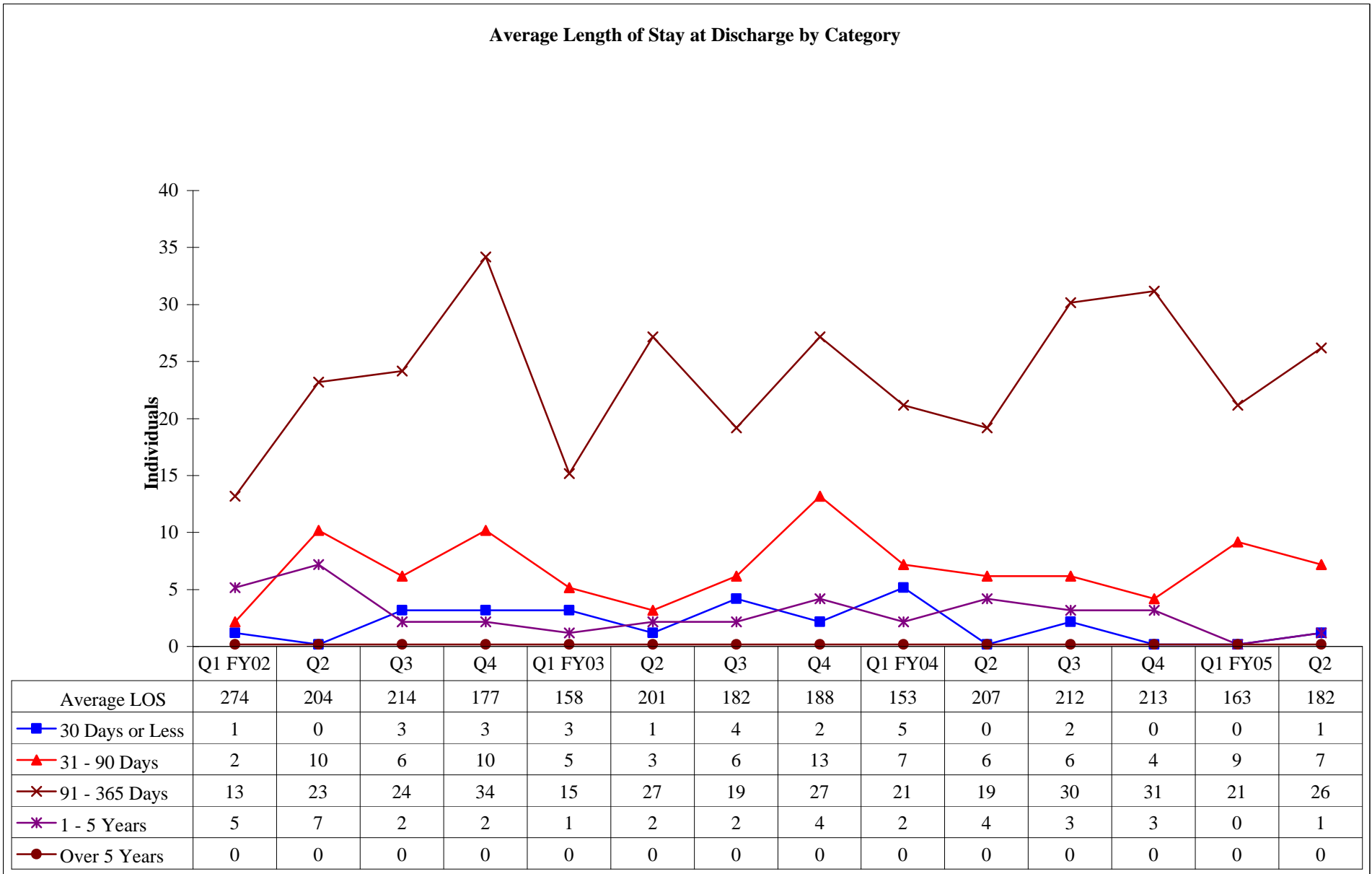
**Measure 5C - Average Length of Stay at Discharge
Terrell State Hospital**

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



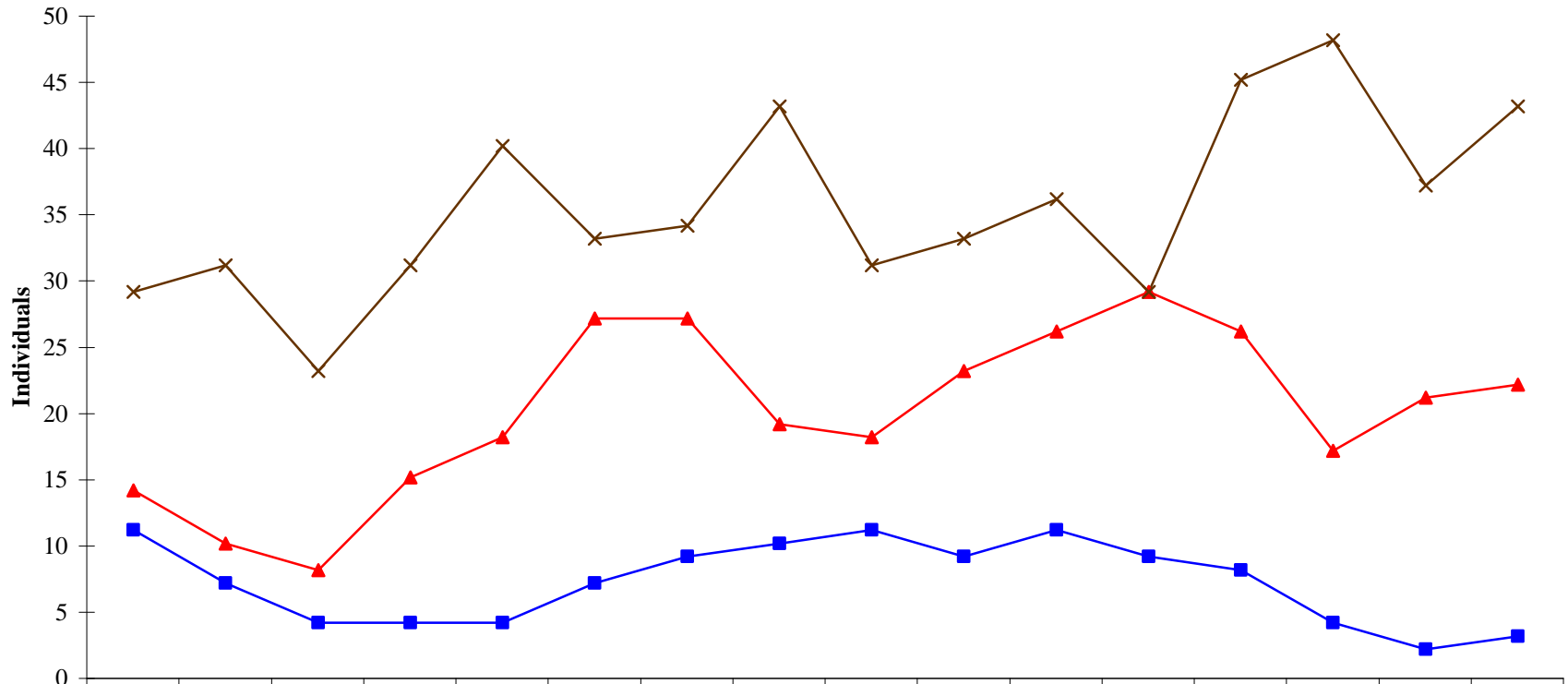
	6/00-5/01	9/00-8/01	12/00-11/01	3/01-2/02	6/01-5/02	9/01-8/02	12/01-11/02	3/02-2/03	6/02-5/03	9/02-8/03	12/02-11/03	3/03-2/04	6/03-5/04	9/03-8/04	12/03-11/04	3/04-2/05
Average LOS	29	30	29	31	29	29	30	30	30	31	31	32	32	32	31	33
■ 30 Days or Less	1933	1737	1606	1421	1562	1563	1553	1566	1554	1587	1490	1431	1377	1316	1330	1328
▲ 31-90 Days	655	604	587	549	569	563	586	609	596	610	597	569	590	584	602	653
✕ 91-365 Days	150	144	118	123	115	108	117	120	127	149	140	136	123	108	101	130

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



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

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



	6/00-5/01	9/00-8/01	12/00-11/01	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
Average LOS	109	141	127	123	147	105	100	116	109	113	109	98	124	151	131	131
■ 30 Days or Less	11	7	4	4	4	7	9	10	11	9	11	9	8	4	2	3
▲ 31-90 Days	14	10	8	15	18	27	27	19	18	23	26	29	26	17	21	22
✕ 91-365 Days	29	31	23	31	40	33	34	43	31	33	36	29	45	48	37	43

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:

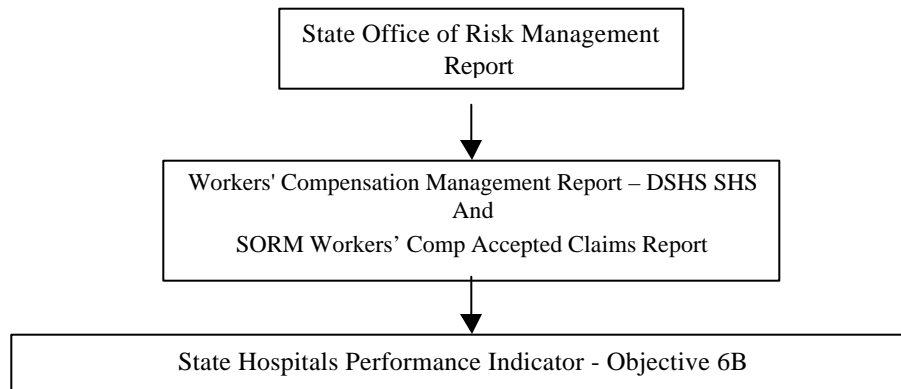
State hospitals will manage workers' compensation claim expenses so that an individual hospital total FY 2005 claims expense will be at or below the dollar target amount established for that hospital.

Performance Objective Operational Definition: Total workers compensation claim expenses filed for FY 2005 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.

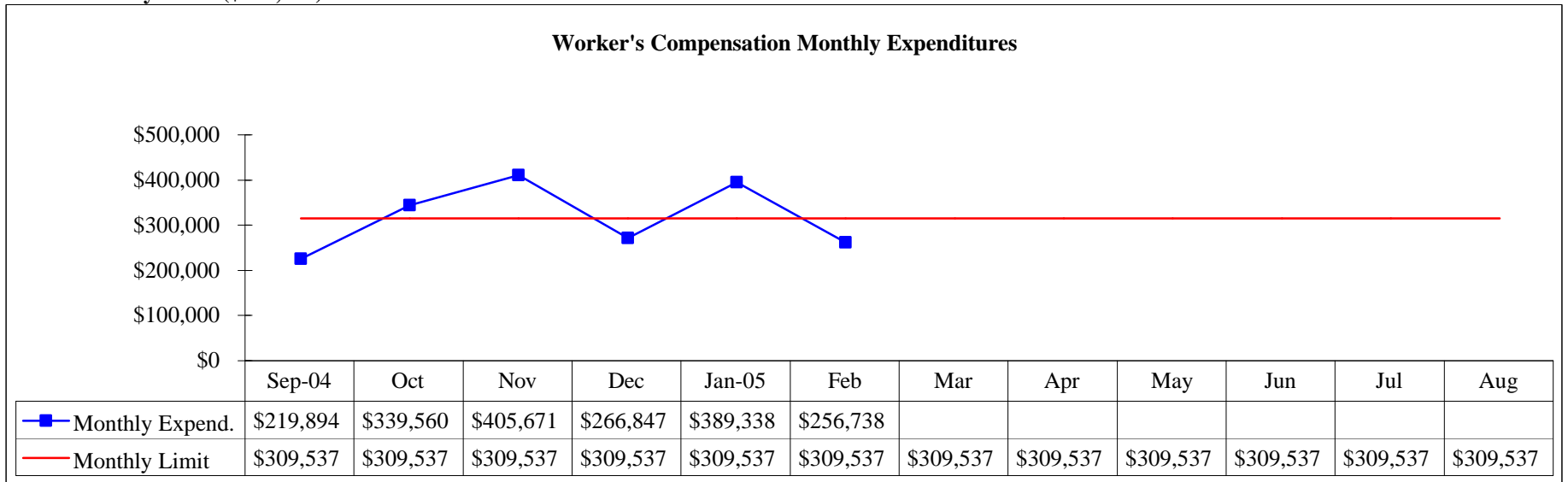
Data Flow:



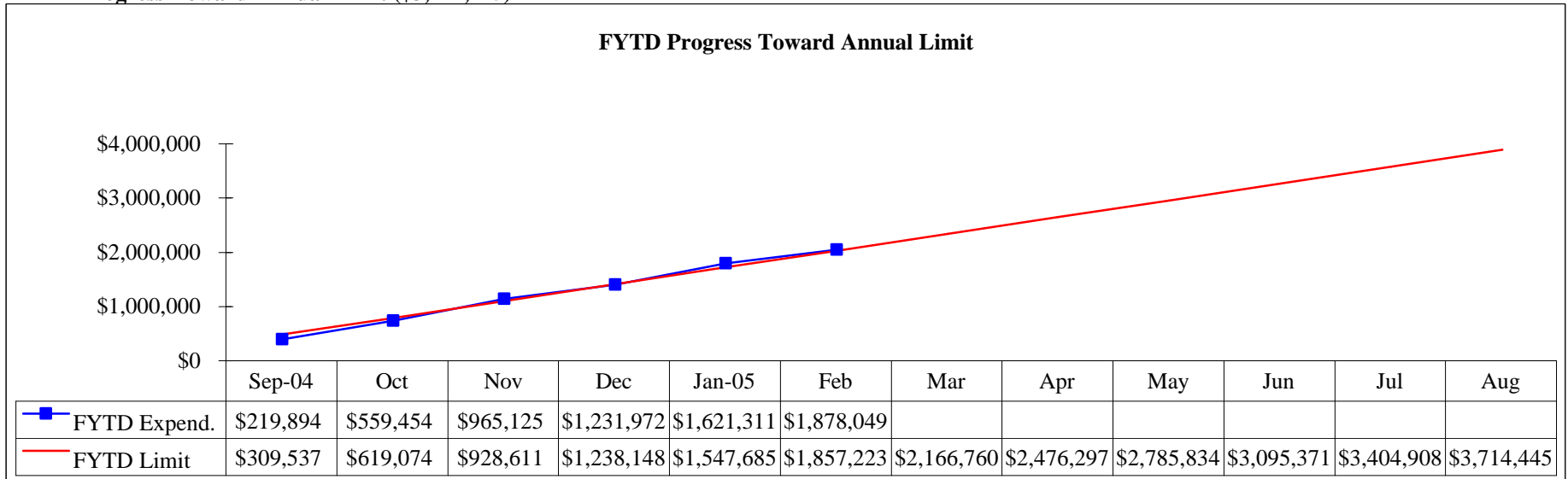
Data Integrity Review Process:

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

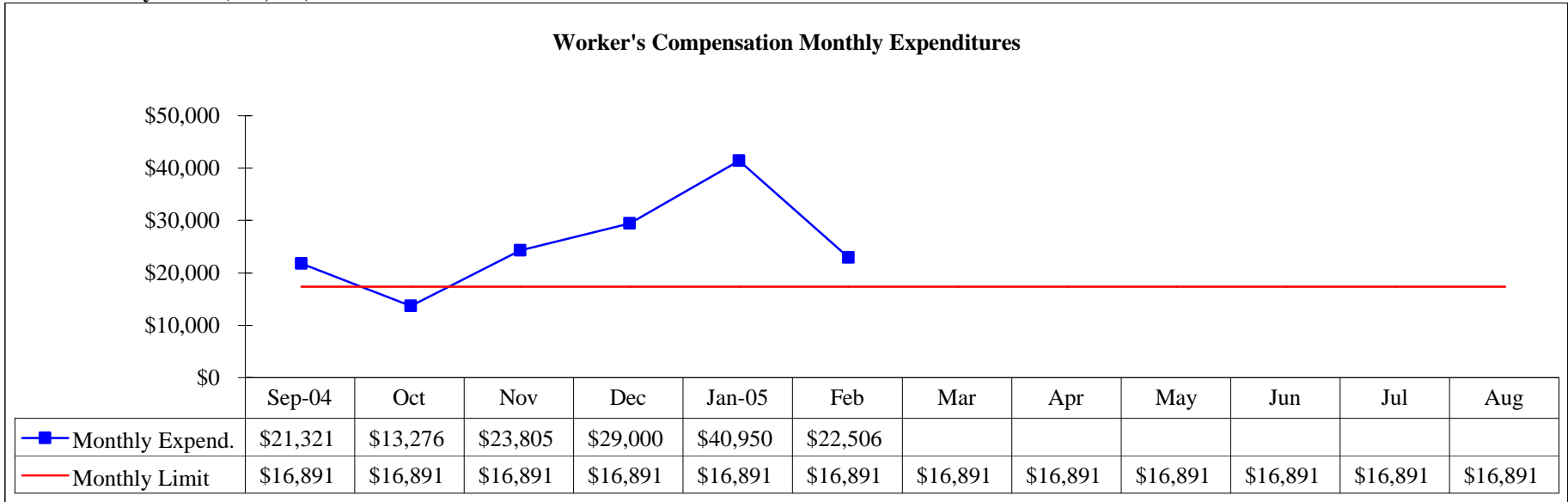
Objective 6B - Workers Compensation
All MH Facilities
FY05 Monthly Limit (\$309,537)



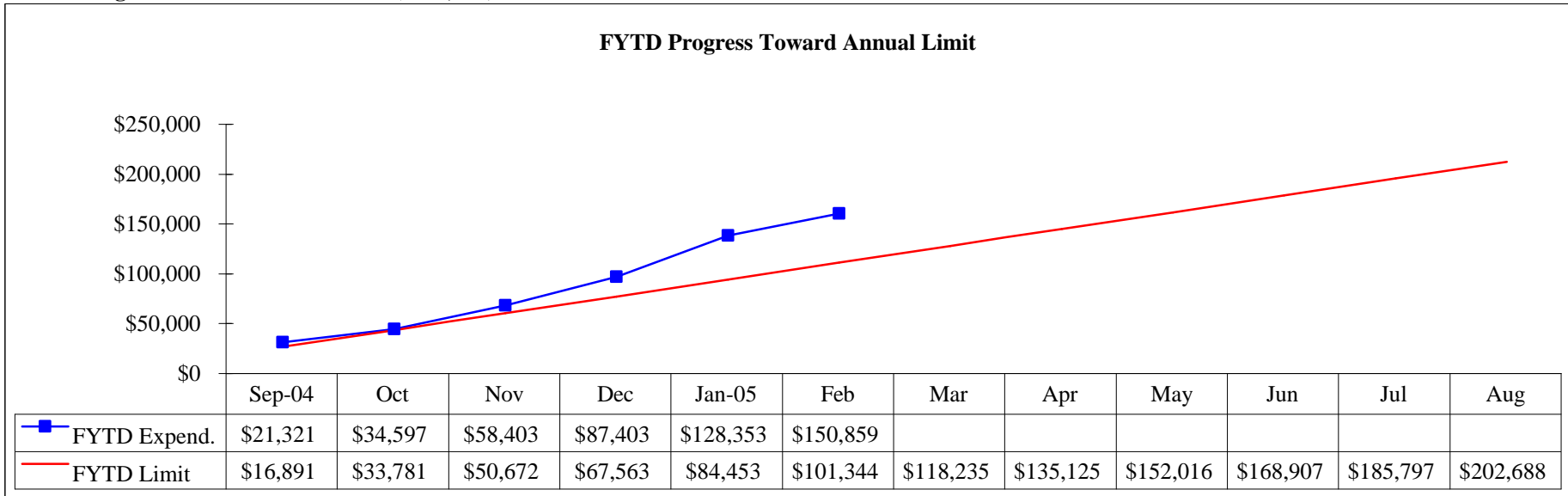
FYTD Progress Toward Annual Limit (\$3,714,445)



Objective 6B - Workers Compensation
Austin State Hospital
FY05 Monthly Limit (\$16,891)



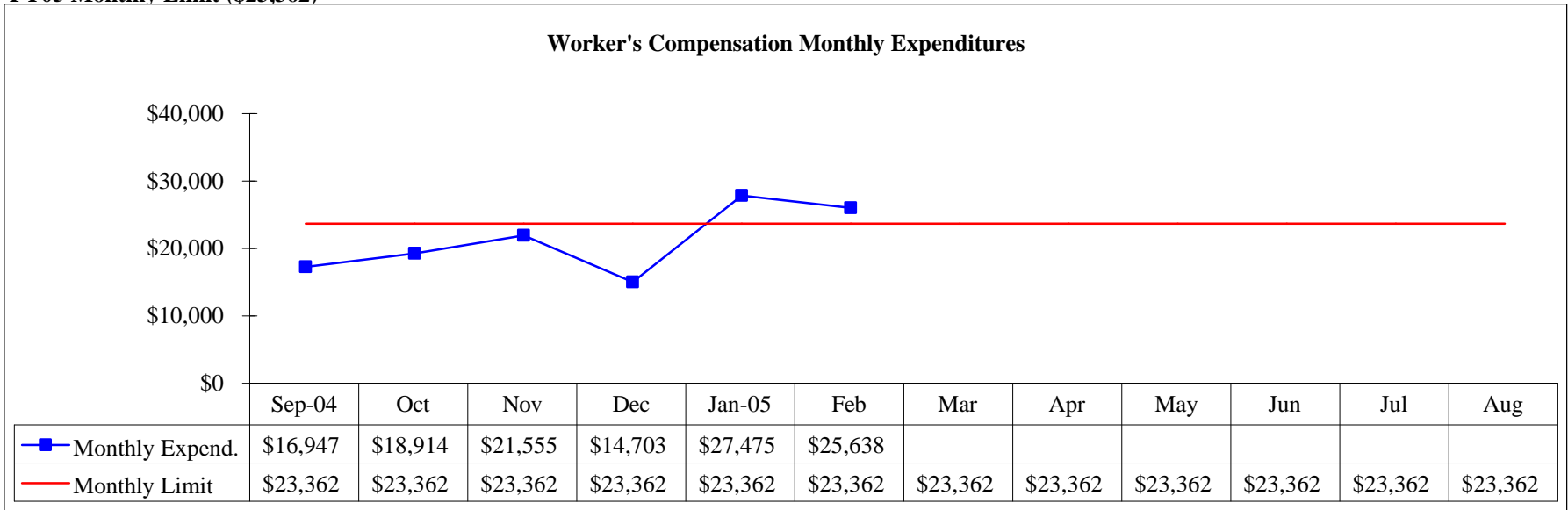
FYTD Progress Toward Annual Limit (\$202,688)



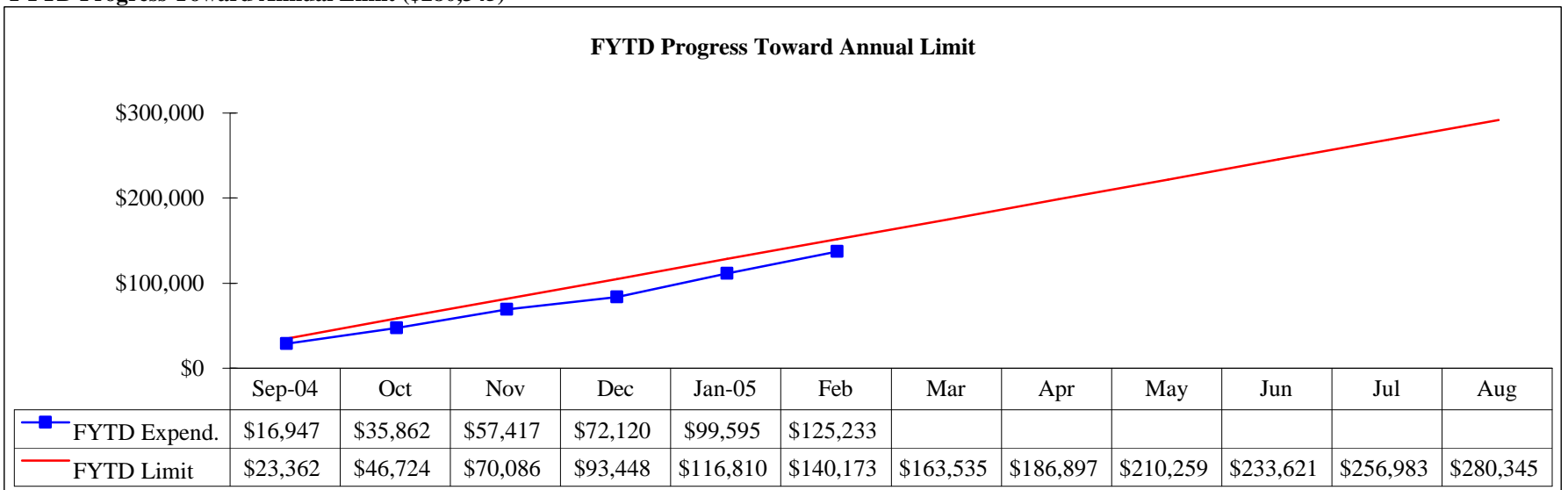
Objective 6B - Workers Compensation

Big Spring State Hospital

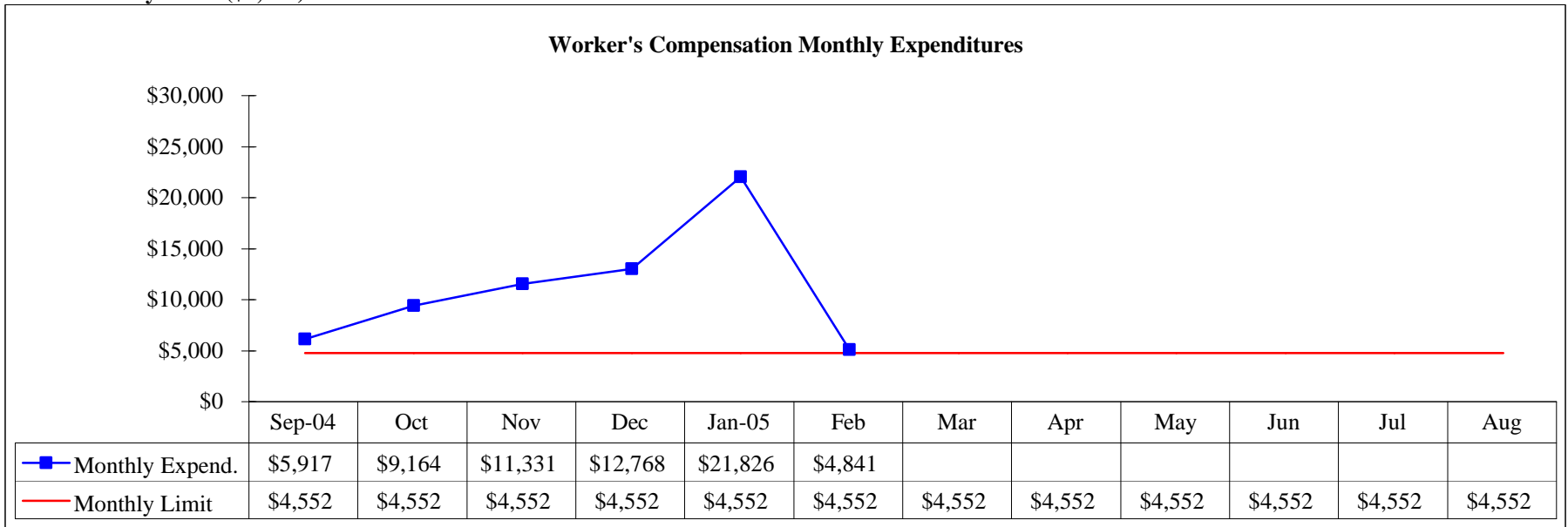
FY05 Monthly Limit (\$23,362)



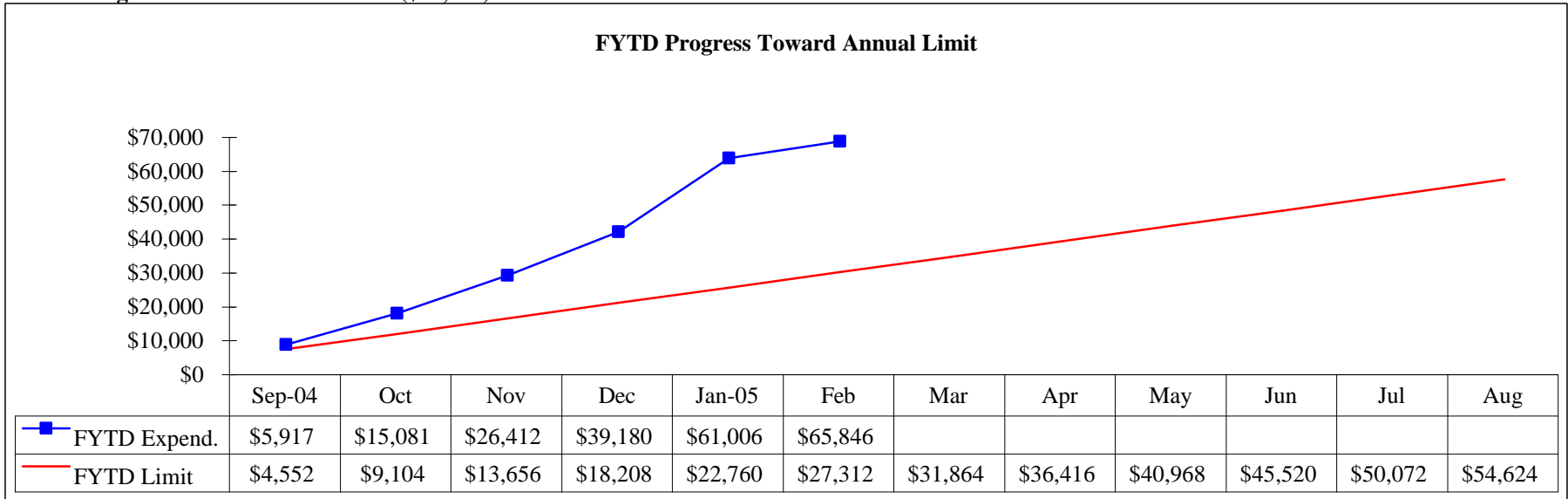
FYTD Progress Toward Annual Limit (\$280,345)



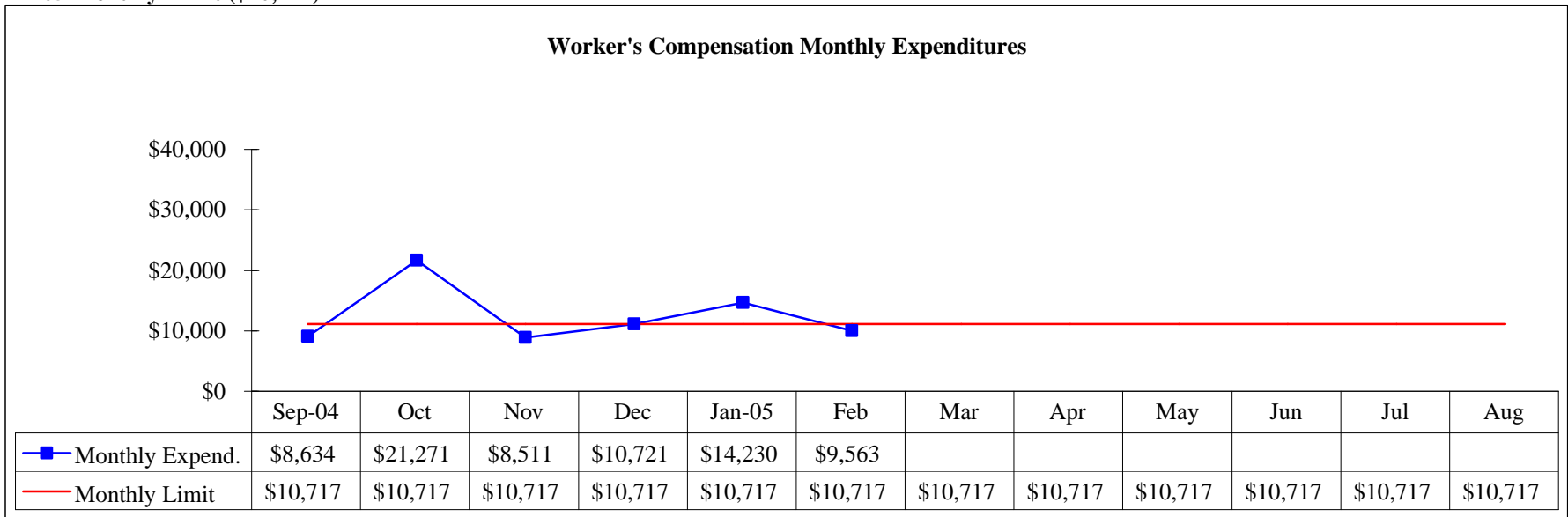
Objective 6B - Workers Compensation
El Paso Psychiatric Center
FY05 Monthly Limit (\$4,552)



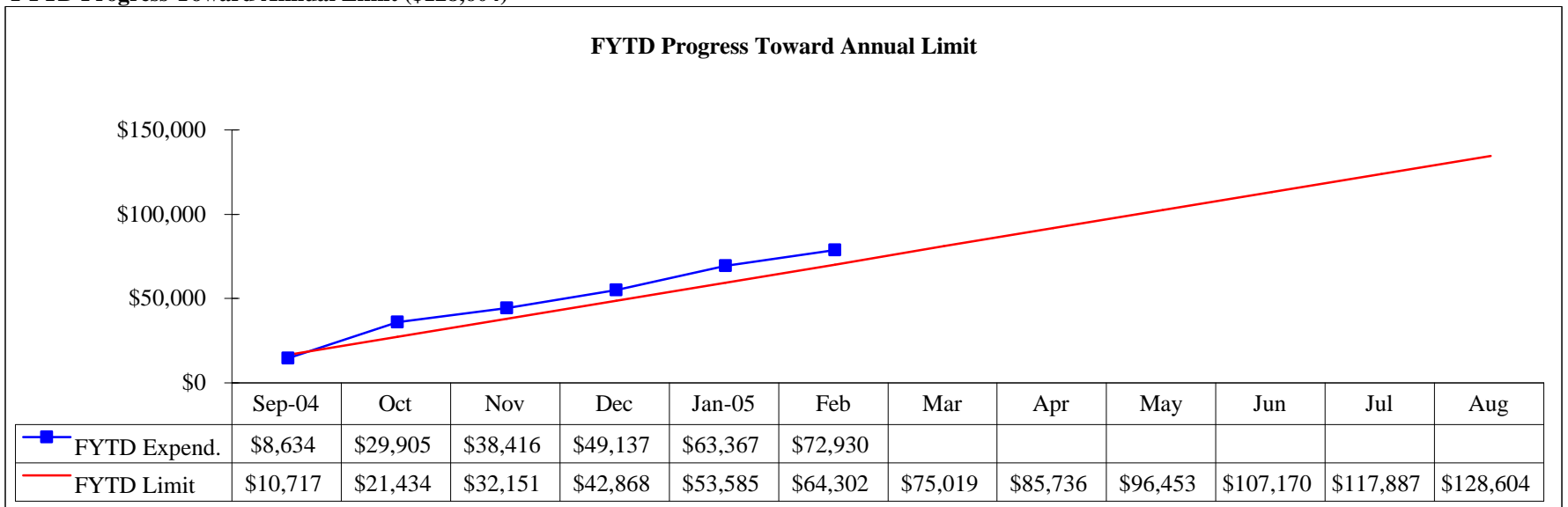
FYTD Progress Toward Annual Limit (\$54,624)



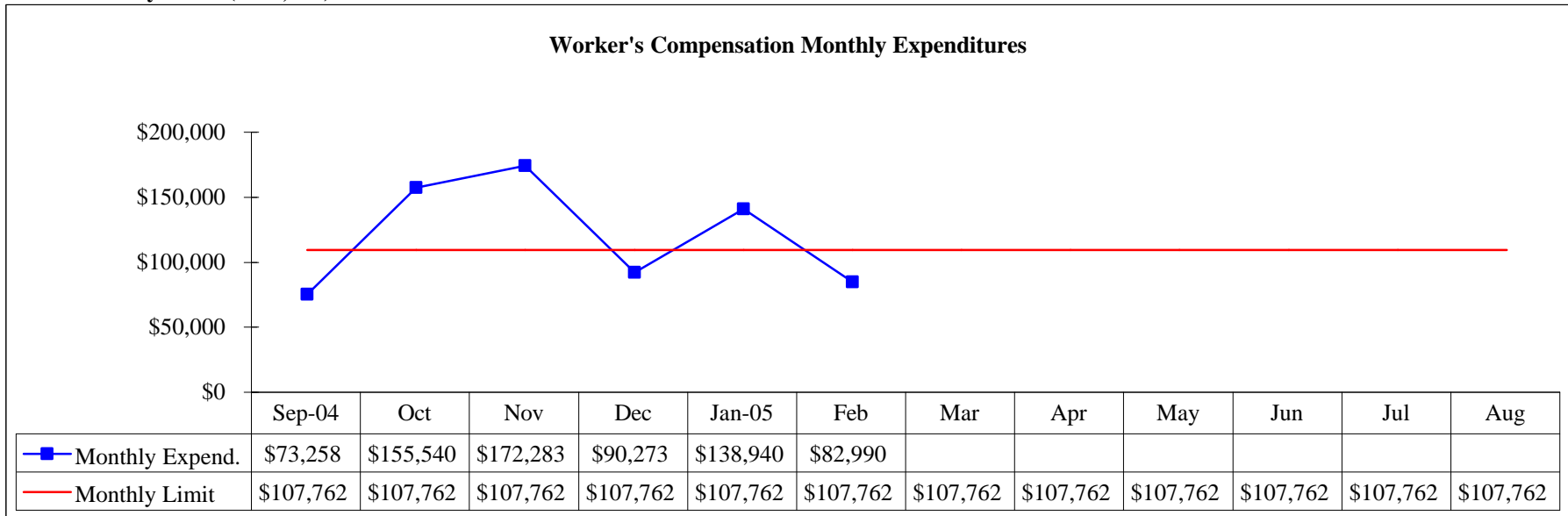
**Objective 6B - Workers Compensation
Kerrville State Hospital
FY05 Monthly Limit (\$10,717)**



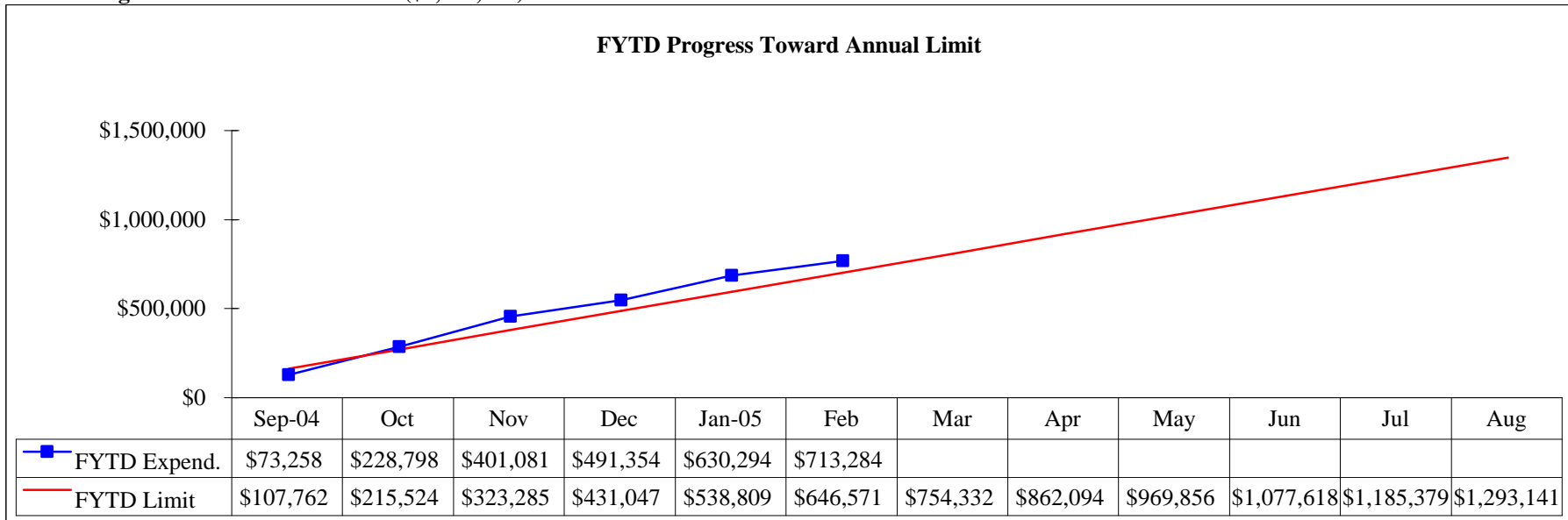
FYTD Progress Toward Annual Limit (\$128,604)



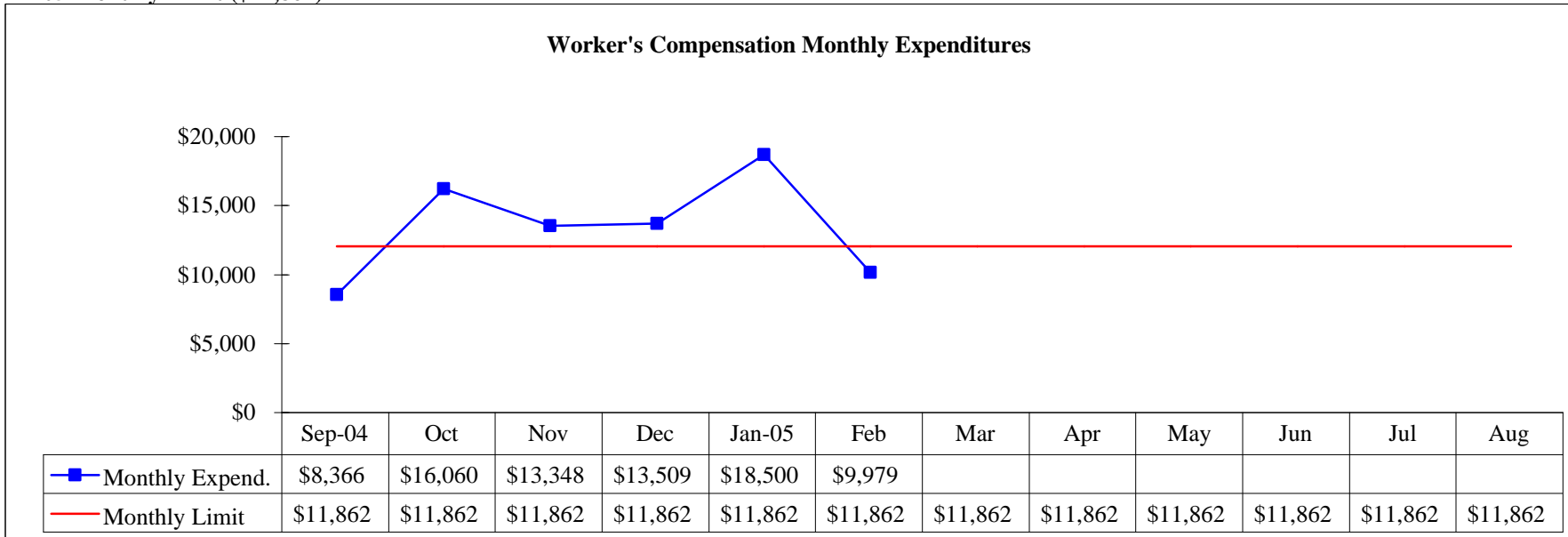
Objective 6B - Workers Compensation
North Texas State Hospital
FY05 Monthly Limit (\$107,762)



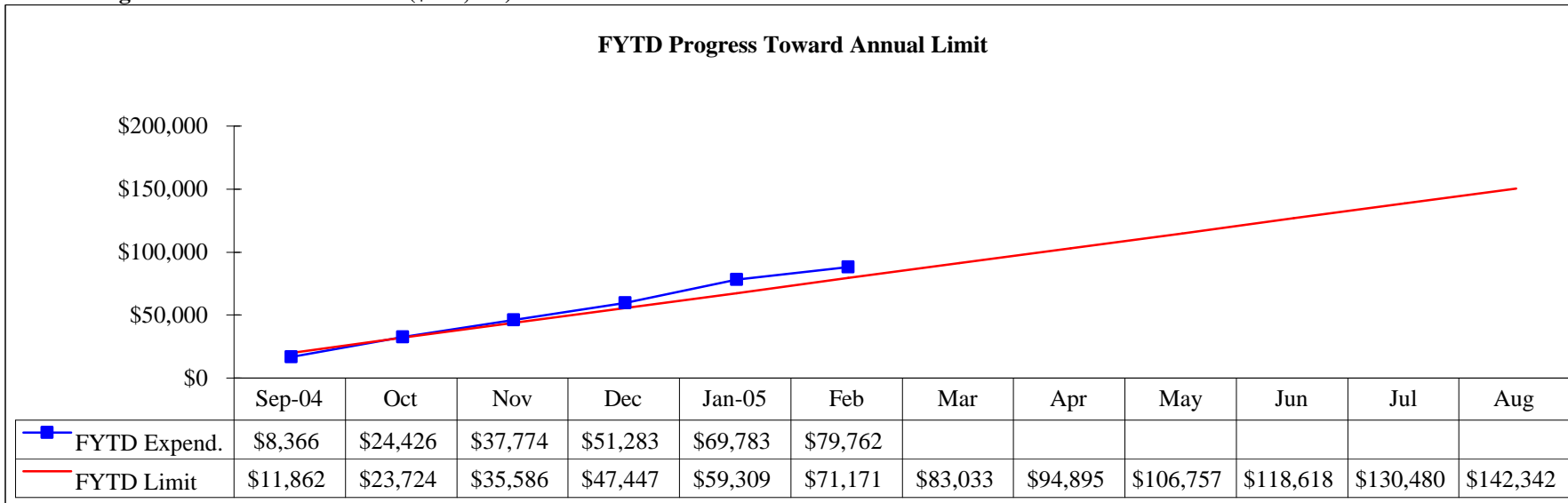
FYTD Progress Toward Annual Limit (\$1,293,141)



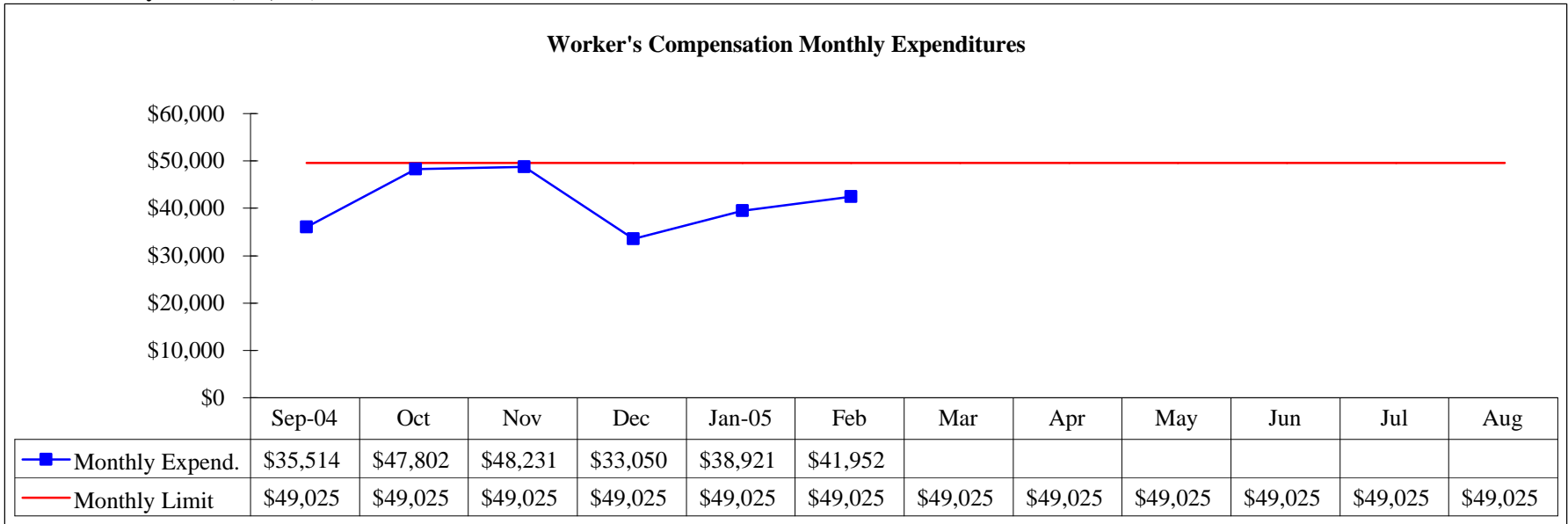
Objective 6B - Workers Compensation
Rio Grande State Center
FY05 Monthly Limit (\$11,862)



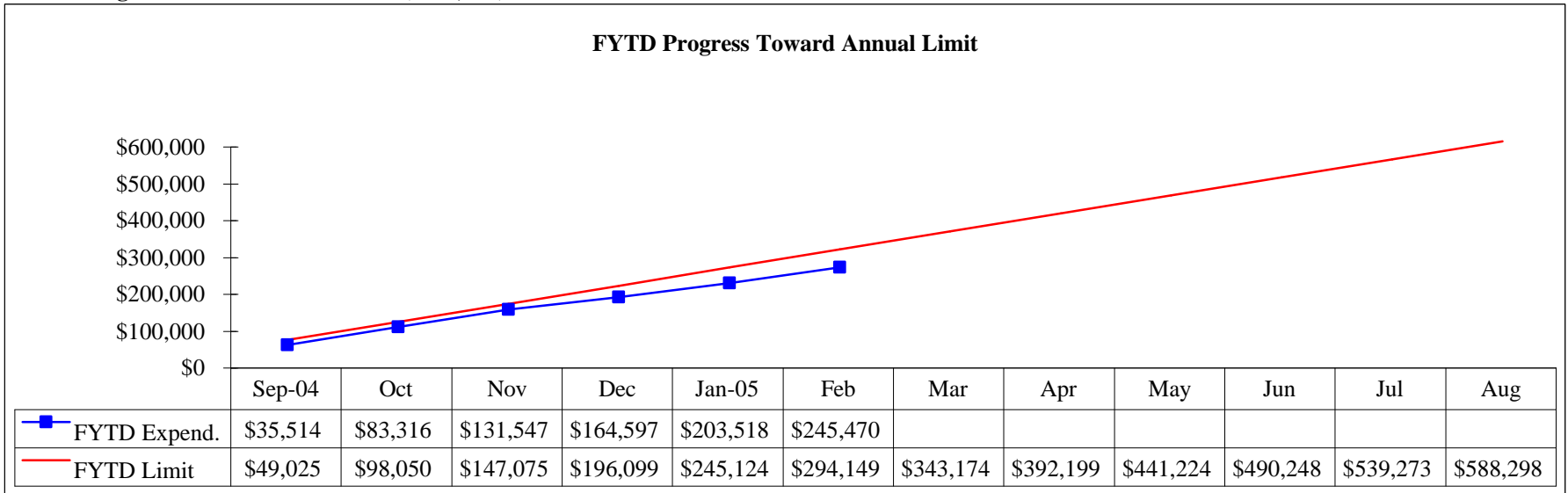
FYTD Progress Toward Annual Limit (\$142,342)



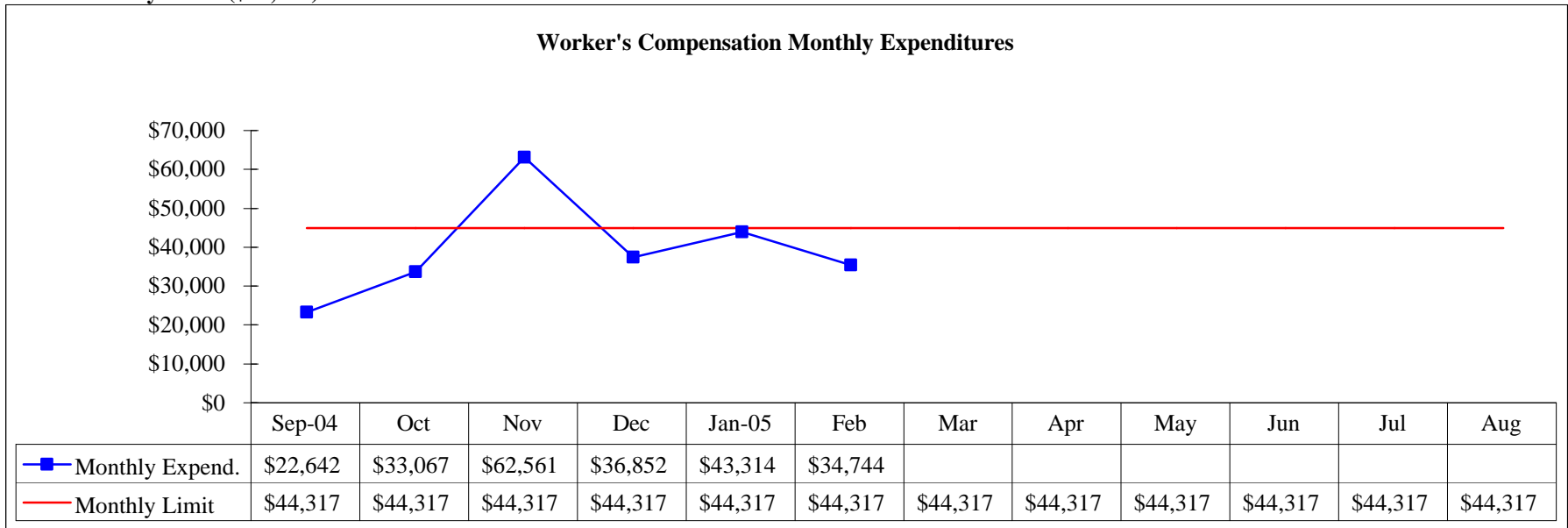
Objective 6B - Workers Compensation
Rusk State Hospital
FY05 Monthly Limit (\$49,025)



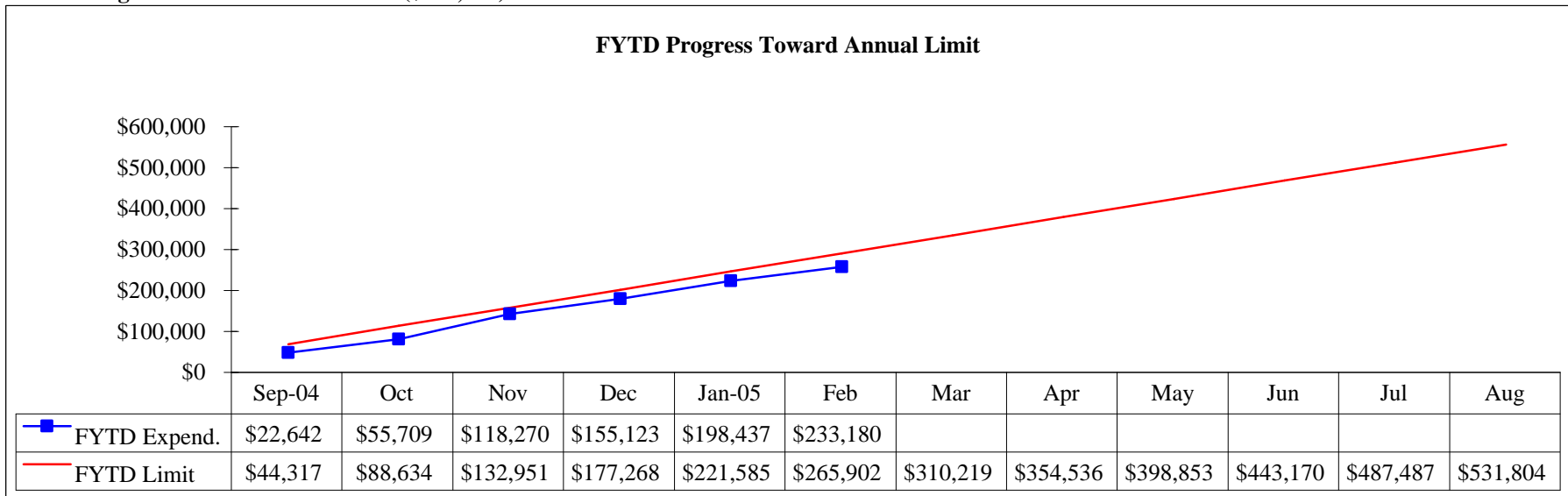
FYTD Progress Toward Annual Limit (\$588,298)



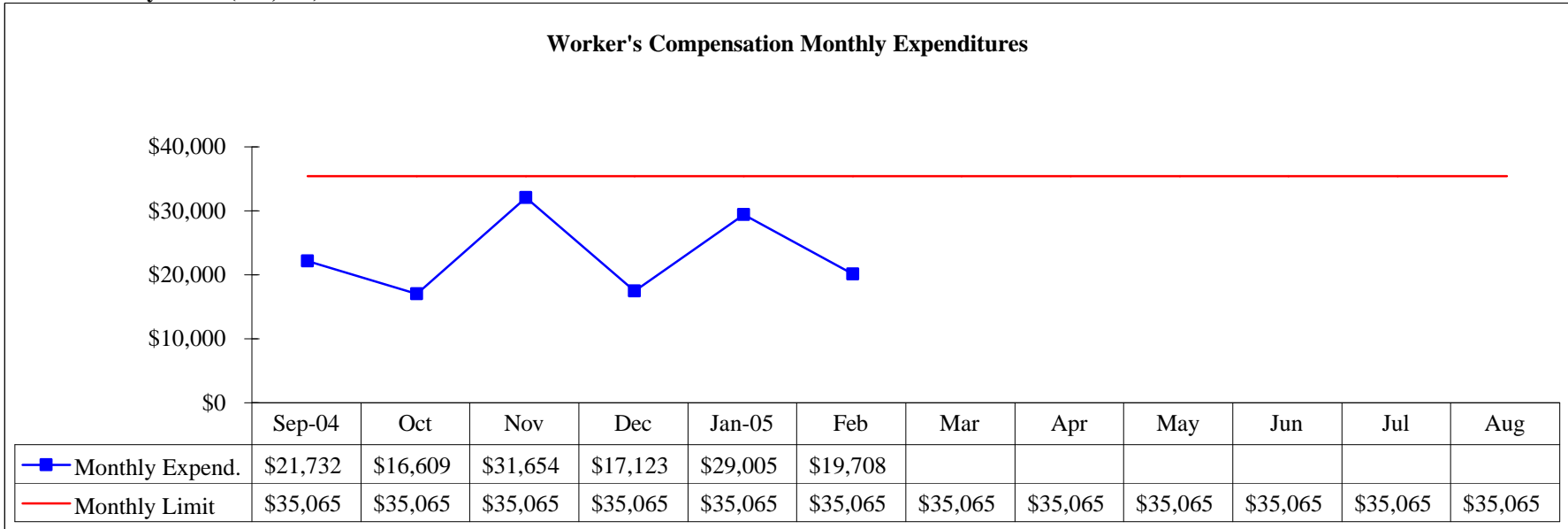
Objective 6B - Workers Compensation
San Antonio State Hospital
FY05 Monthly Limit (\$44,317)



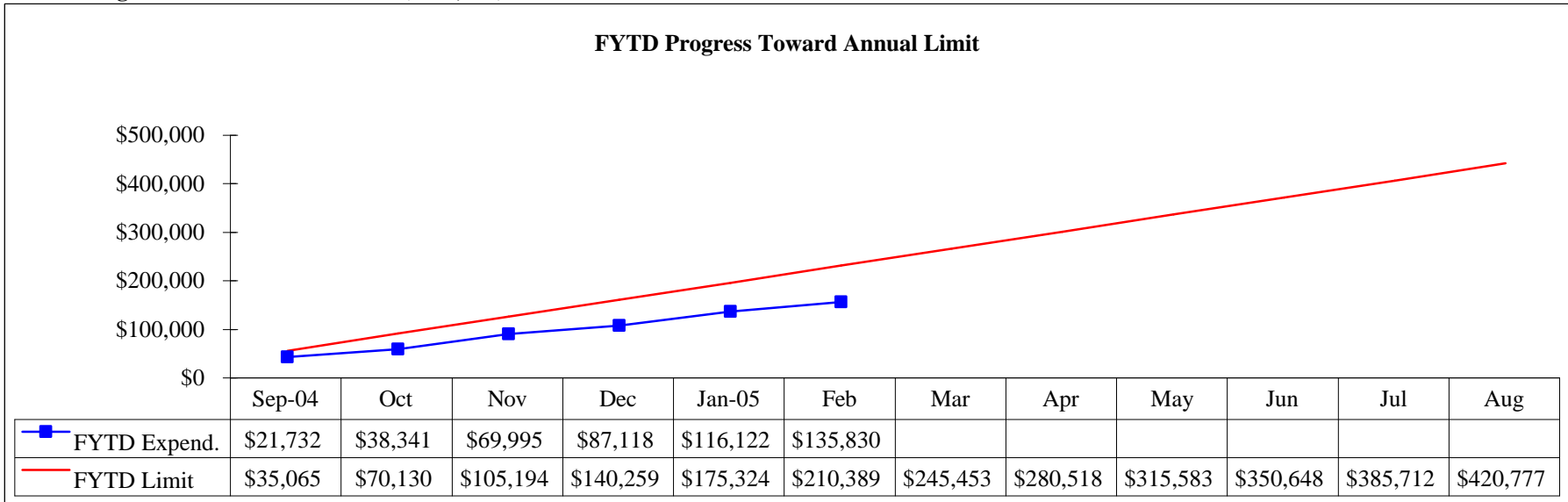
FYTD Progress Toward Annual Limit (\$531,804)



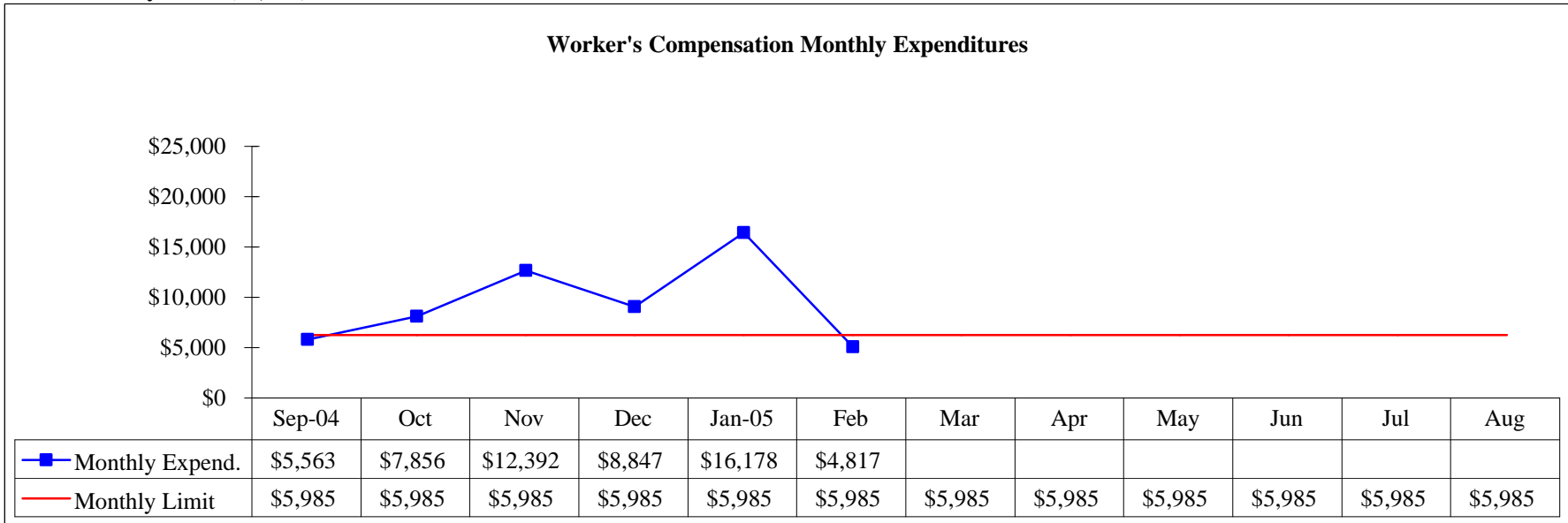
**Objective 6B - Workers Compensation
 Terrell State Hospital
 FY05 Monthly Limit (\$35,065)**



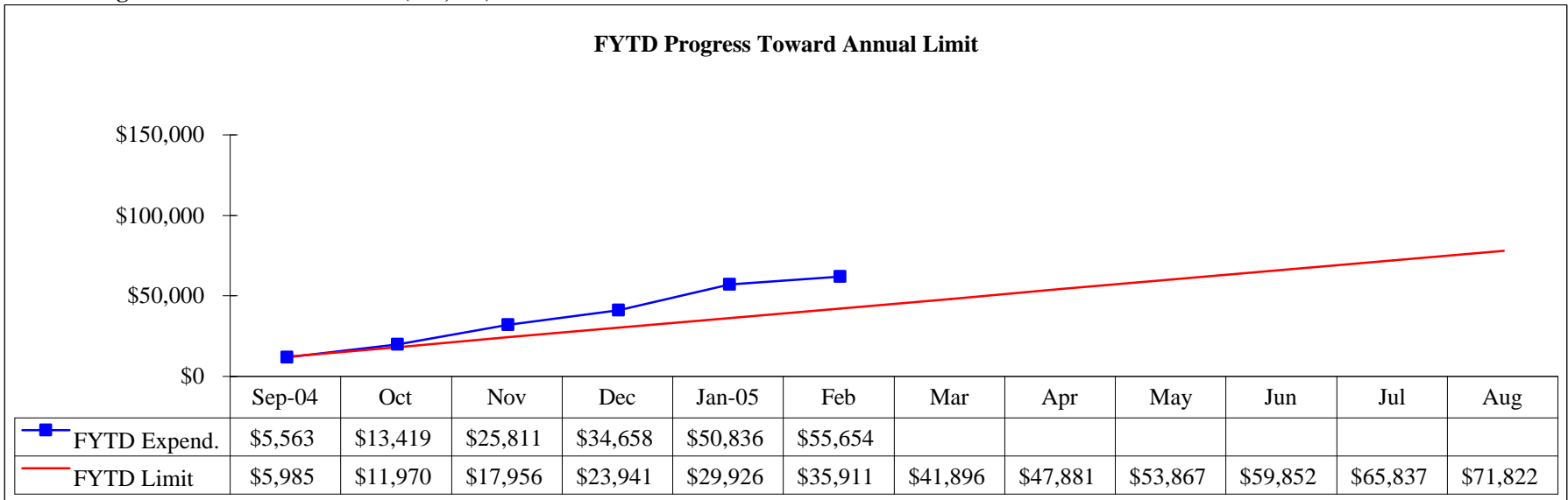
FYTD Progress Toward Annual Limit (\$420,777)



Objective 6B - Workers Compensation
Waco Center for Youth
FY05 Monthly Limit (\$5,985)



FYTD Progress Toward Annual Limit (\$71,822)



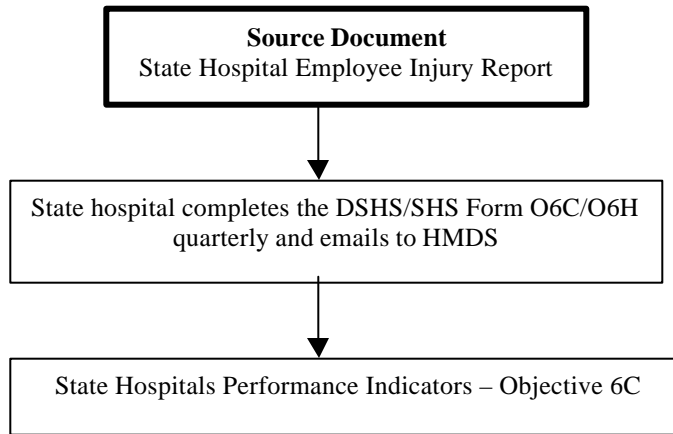
Performance Objective 6C:

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 per1000 bed days.

Data Flow:

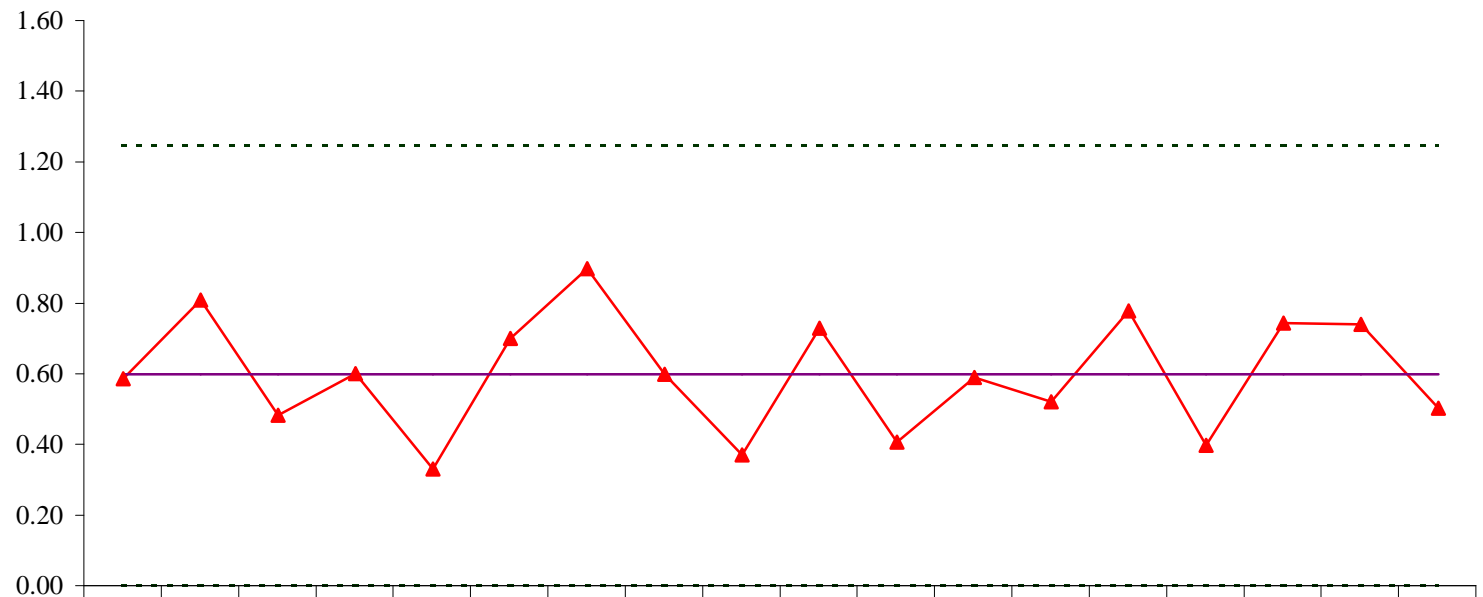


Data Integrity Review Process:

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

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

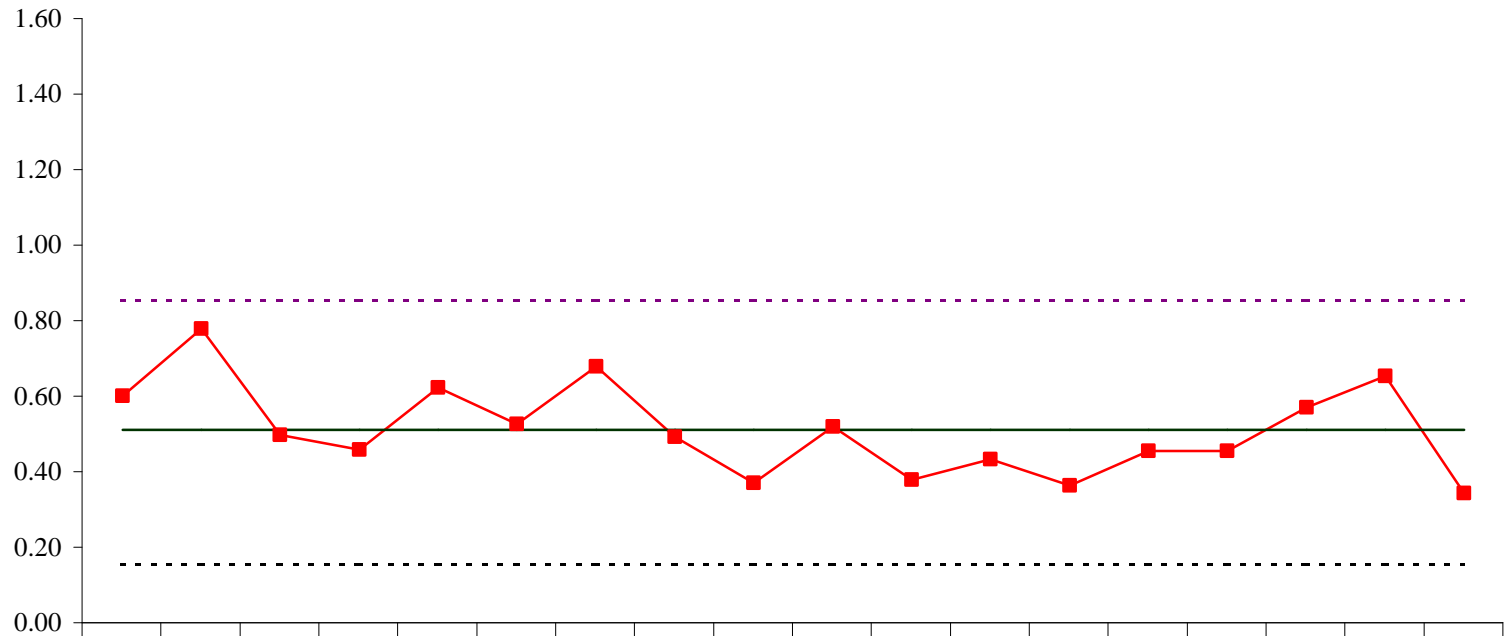
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	155	168	135	138	152	145	191	165	157	162	165	168	170	160	132	150	156	92
Injuries Resulting in a WCC	38	54	31	38	21	44	61	39	25	48	28	41	36	55	27	51	51	31
▲ Emp. Inj.(WCC)/1000 Bed Days	0.58	0.80	0.47	0.59	0.32	0.69	0.89	0.59	0.36	0.72	0.40	0.58	0.51	0.77	0.39	0.74	0.73	0.49
-----UCL	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25
— 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 & 6H - Employee Injuries
All MH Facilities

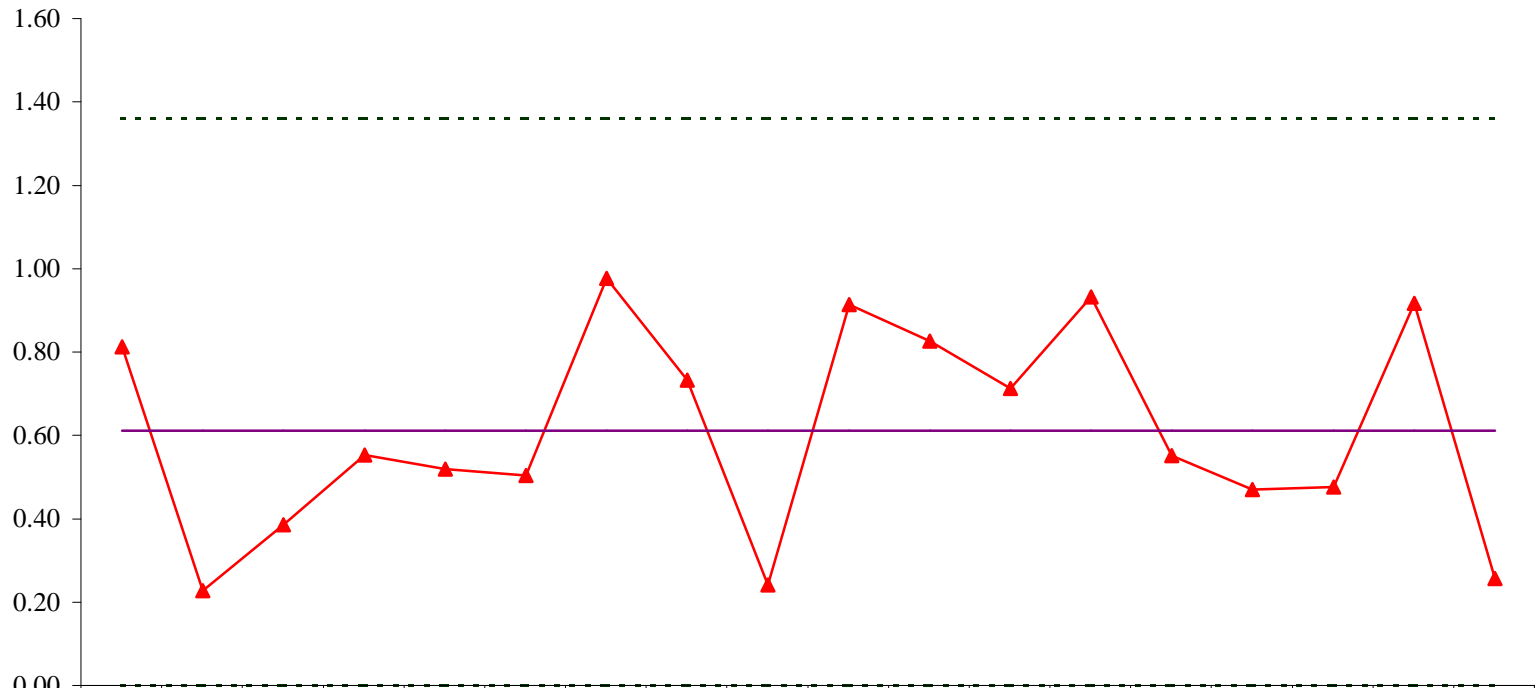
Employee Injuries During Restraint or Seclusion
 (Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	155	168	135	138	152	145	191	165	157	162	165	168	170	160	132	150	156	92
Injuries Associated with R/S	39	52	32	29	40	33	46	32	25	34	26	30	25	32	31	39	45	21
■ Emp. Inj.(RS)/1000 Bed Days	0.59	0.77	0.49	0.45	0.61	0.52	0.67	0.48	0.36	0.51	0.37	0.43	0.36	0.45	0.45	0.56	0.65	0.33
- - - - - 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	0.50	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	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15

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

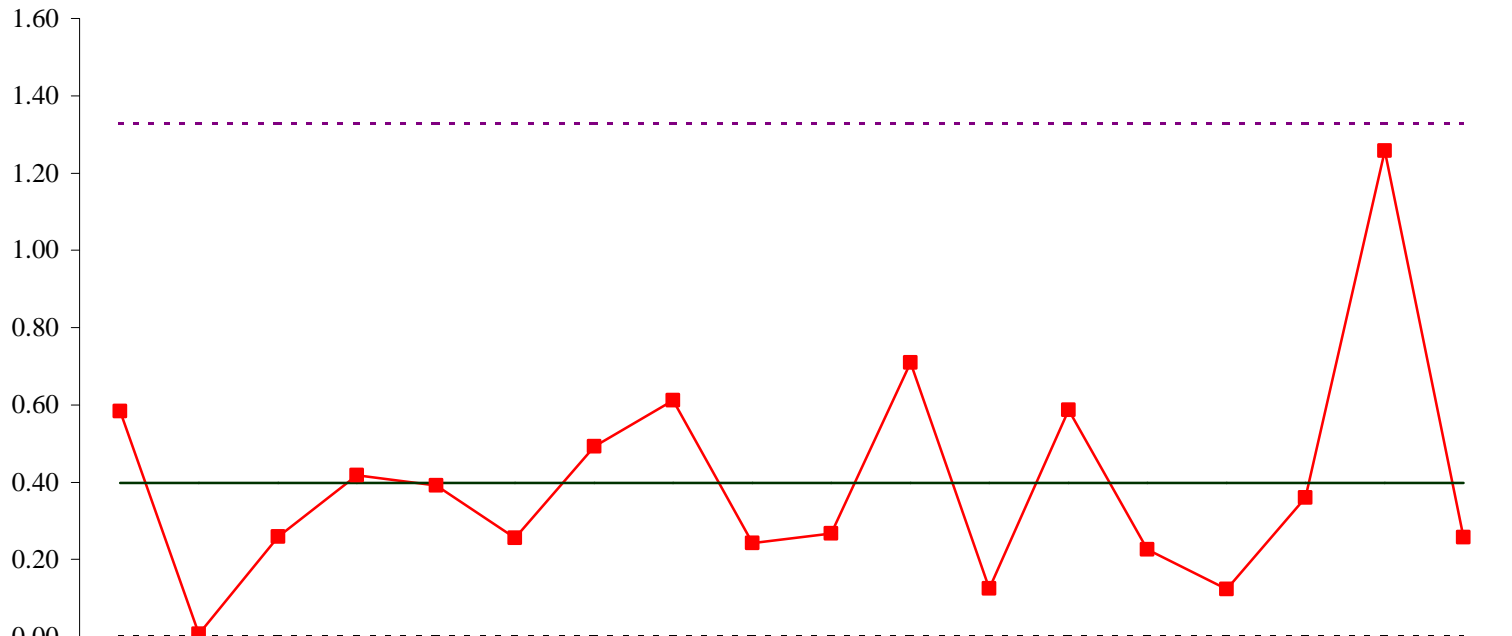
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	13	4	5	8	9	8	11	6	8	7	14	4	9	7	4	6	17	6
Injuries Resulting in a WCC	7	2	3	4	4	4	8	6	2	7	7	6	8	5	4	4	8	2
▲ Emp. Inj.(WCC)/1000 Bed Days	0.81	0.22	0.38	0.55	0.51	0.50	0.97	0.73	0.23	0.91	0.82	0.71	0.93	0.54	0.46	0.47	0.91	0.25
-----UCL	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36	1.36
— Avg	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.61
-----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 & 6H - Employee Injuries
Austin State Hospital

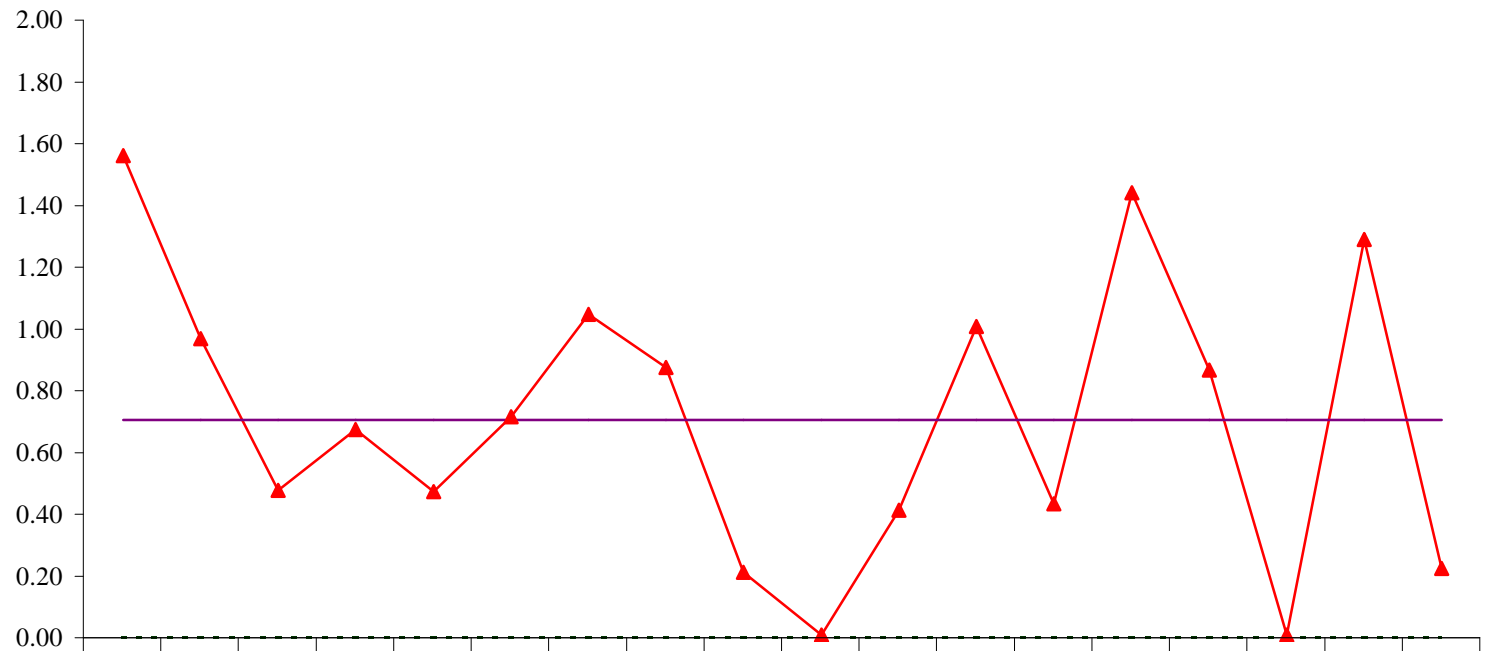
Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	13	4	5	8	9	8	11	6	8	7	14	4	9	7	4	6	17	6
Injuries Associated with R/S	5	0	2	3	3	2	4	5	2	2	6	1	5	2	1	3	11	2
Emp. Inj.(RS)/1000 Bed Days	0.58	0.00	0.25	0.41	0.38	0.25	0.48	0.60	0.23	0.26	0.70	0.12	0.58	0.22	0.12	0.35	1.25	0.25
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	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39	0.39
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 & 6H - Employee Injuries
Big Spring State Hospital

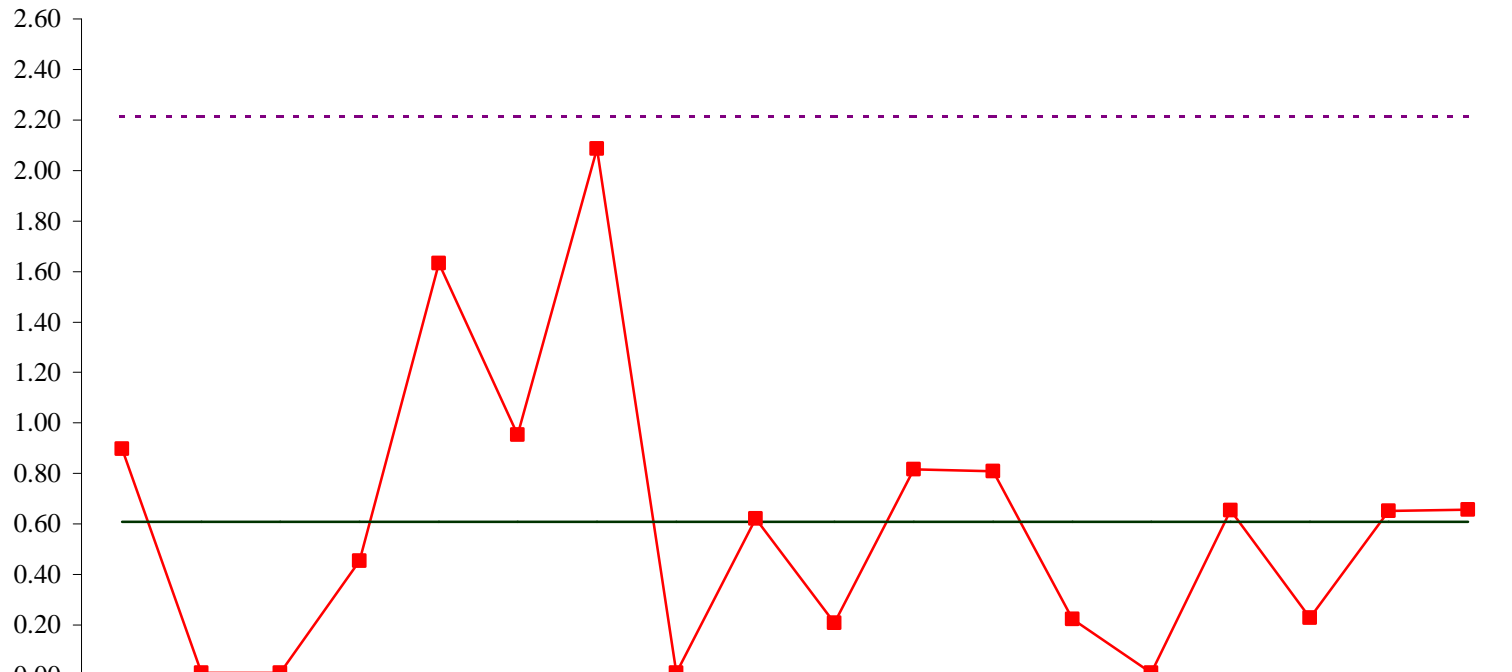
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	29	15	19	13	15	11	26	18	8	12	11	17	9	12	15	9	16	7
Injuries Resulting in a WCC	7	4	2	3	2	3	5	4	1	0	2	5	2	7	4	0	6	1
▲ Emp. Inj.(WCC)/1000 Bed Days	1.55	0.96	0.47	0.66	0.46	0.71	1.04	0.87	0.20	0.00	0.40	1.00	0.42	1.43	0.86	0.00	1.28	0.22
----- UCL	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18	2.18
— Avg	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70
----- 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 & 6H - Employee Injuries
Big Spring State Hospital

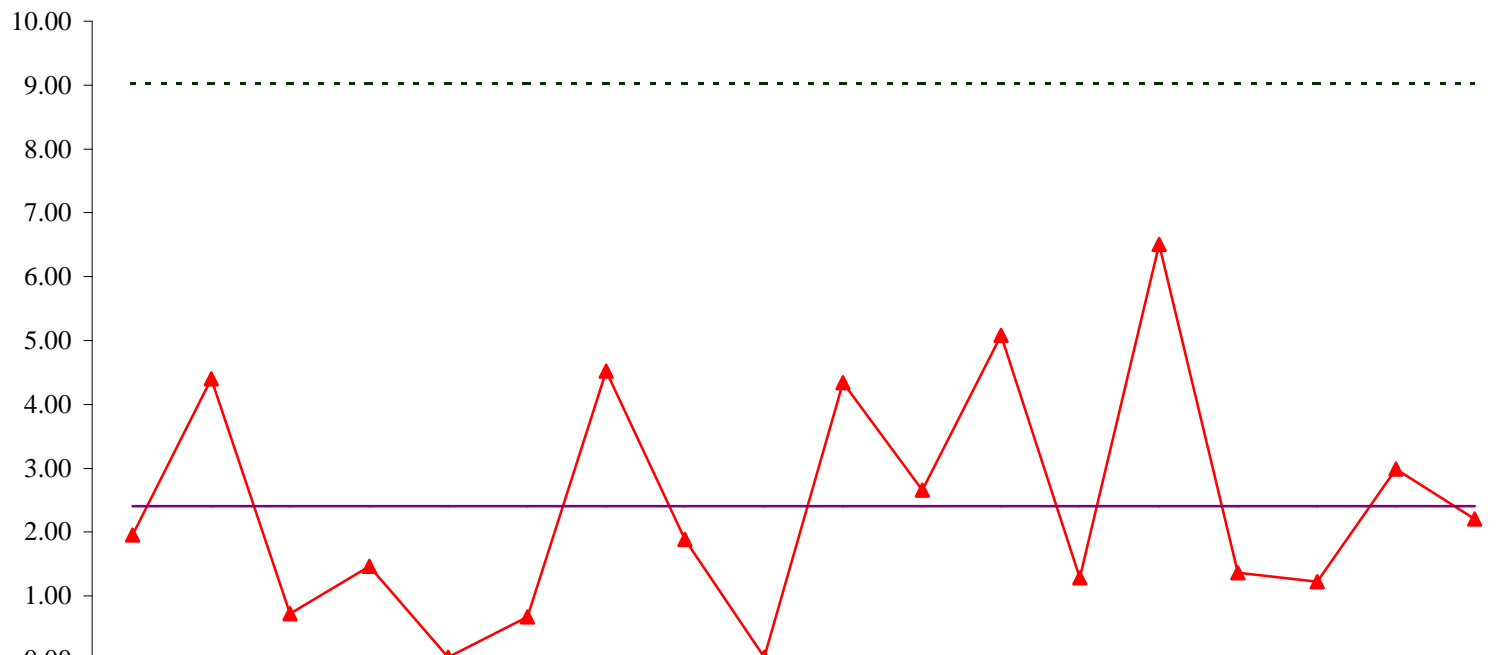
Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	29	15	19	13	15	11	26	18	8	12	11	17	9	12	15	9	16	7
Injuries Associated with R/S	4	0	0	2	7	4	10	0	3	1	4	4	1	0	3	1	3	3
Emp. Inj.(RS)/1000 Bed Days	0.89	0.00	0.00	0.44	1.62	0.94	2.08	0.00	0.61	0.20	0.81	0.80	0.21	0.00	0.64	0.22	0.64	0.65
UCL	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21	2.21
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 & 6H - Employee Injuries
El Paso Psychiatric Center

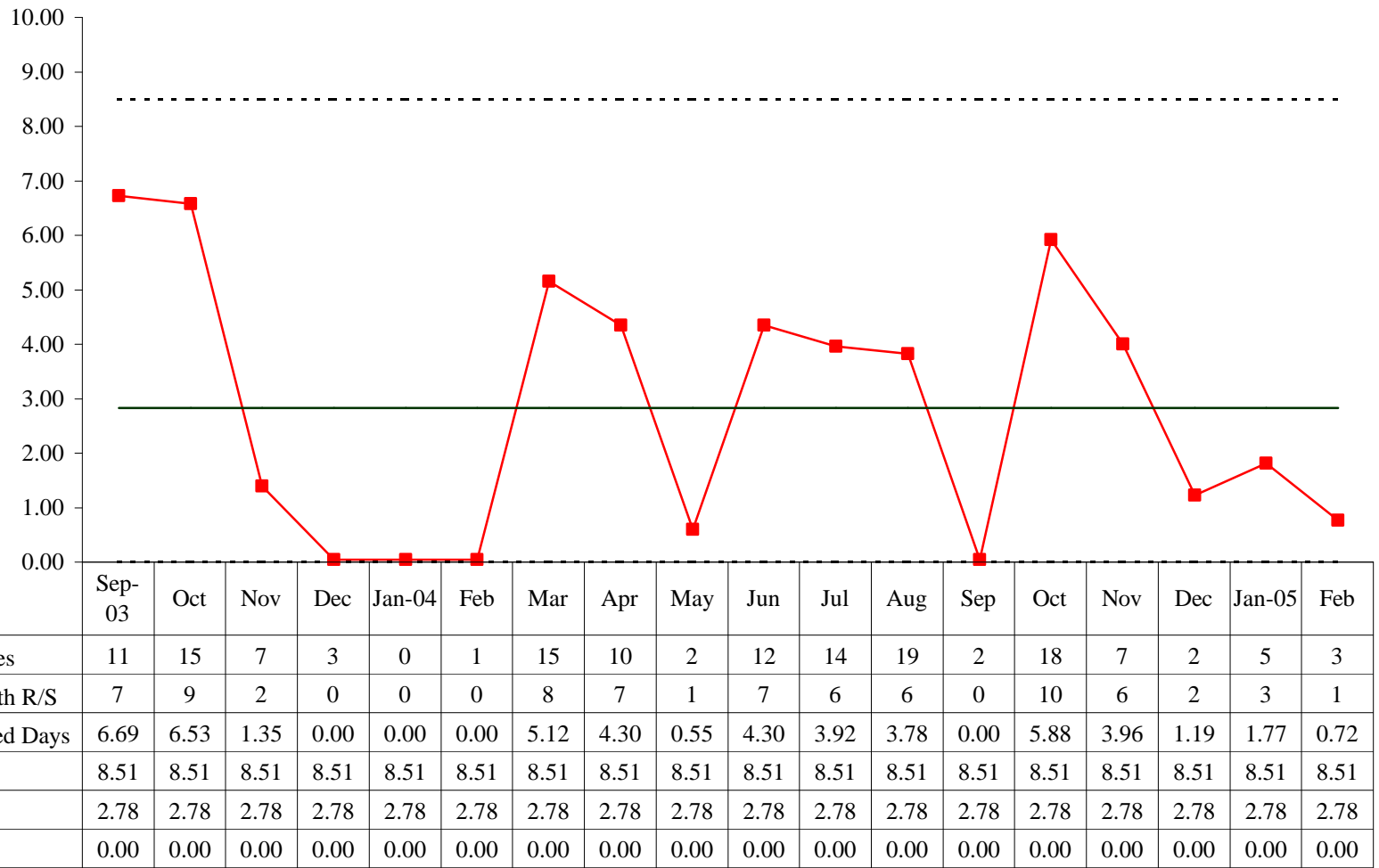
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	11	15	7	3	0	1	15	10	2	12	14	19	2	18	7	2	5	3
Injuries Resulting in a WCC	2	6	1	2	0	1	7	3	0	7	4	8	2	11	2	2	5	3
▲ Emp. Inj.(WCC)/1000 Bed Days	1.91	4.35	0.68	1.42	0.00	0.63	4.48	1.84	0.00	4.30	2.61	5.04	1.24	6.46	1.32	1.19	2.94	2.16
-----UCL	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01	9.01
— Avg	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37	2.37
.....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

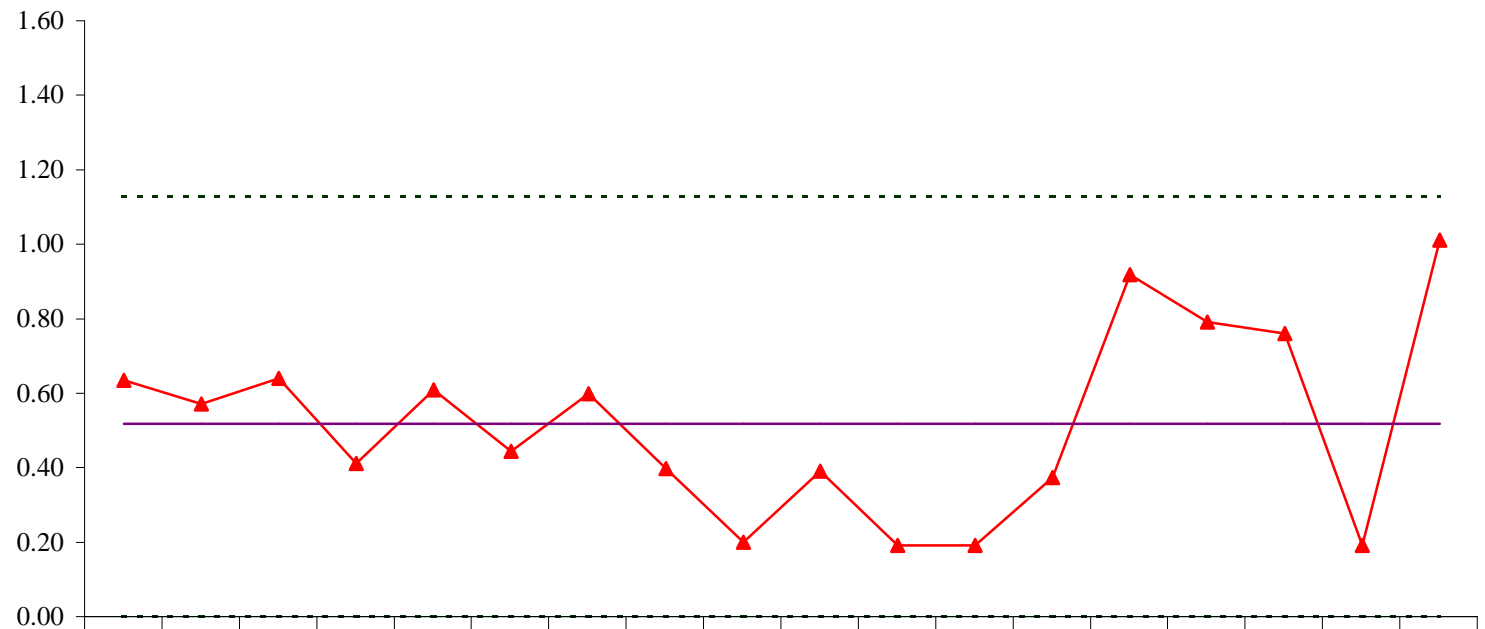
Objective 6C & 6H - Employee Injuries
El Paso Psychiatric Center

Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



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

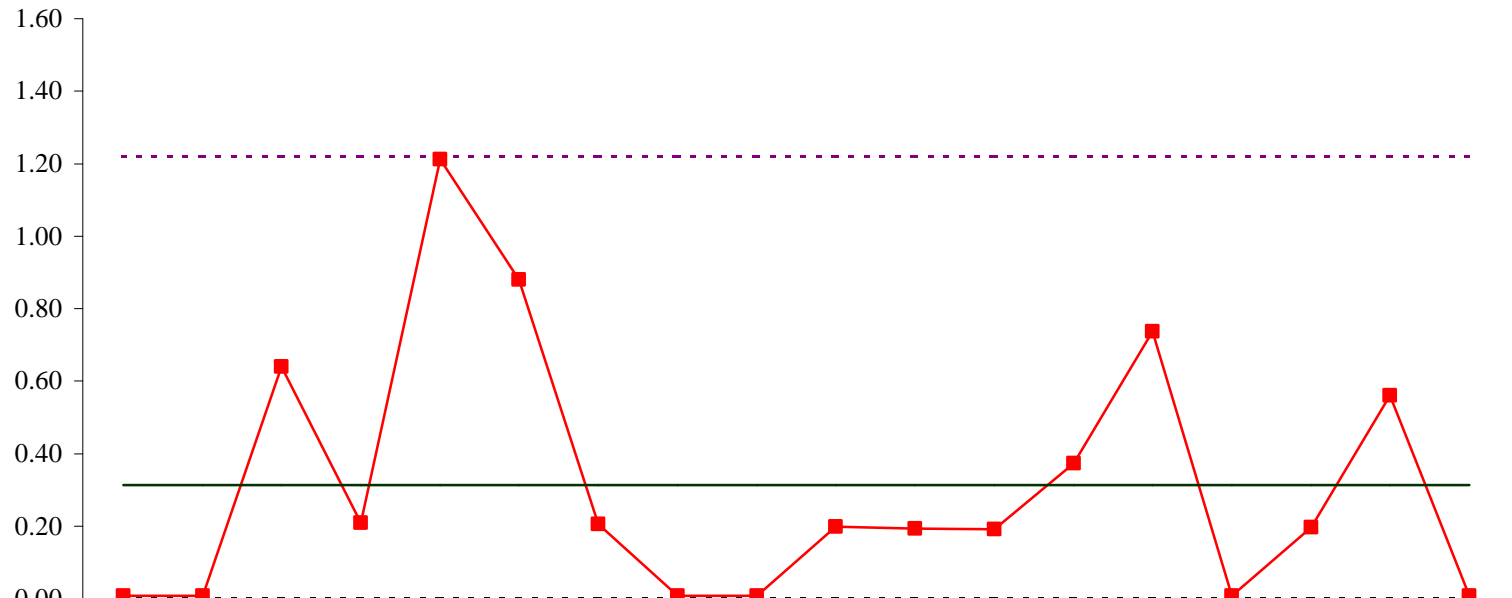
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	7	11	8	10	13	8	8	8	9	6	10	11	7	8	8	8	17	5
Injuries Resulting in a WCC	3	3	3	2	3	2	3	2	1	2	1	1	2	5	4	4	1	5
▲ Emp. Inj.(WCC)/1000 Bed Days	0.63	0.56	0.63	0.40	0.60	0.44	0.59	0.39	0.19	0.38	0.18	0.18	0.37	0.91	0.78	0.75	0.18	1.00
----- UCL	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13
— 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 & 6H - Employee Injuries
Kerrville State Hospital

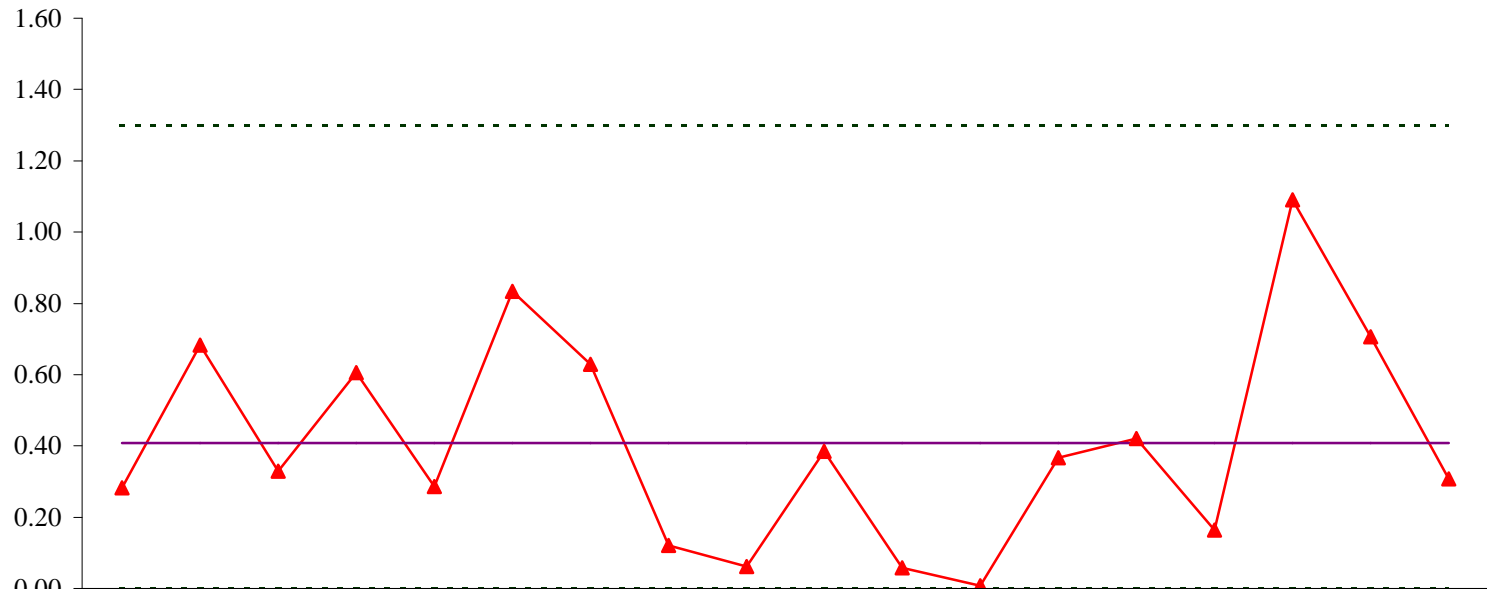
Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	7	11	8	10	13	8	8	8	9	6	10	11	7	8	8	8	17	5
Injuries Associated with R/S	0	0	3	1	6	4	1	0	0	1	1	1	2	4	0	1	3	0
Emp. Inj.(RS)/1000 Bed Days	0.00	0.00	0.63	0.20	1.20	0.87	0.20	0.00	0.00	0.19	0.18	0.18	0.37	0.73	0.00	0.19	0.55	0.00
UCL	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22
Avg	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31
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 & 6H - Employee Injuries
North Texas State Hospital

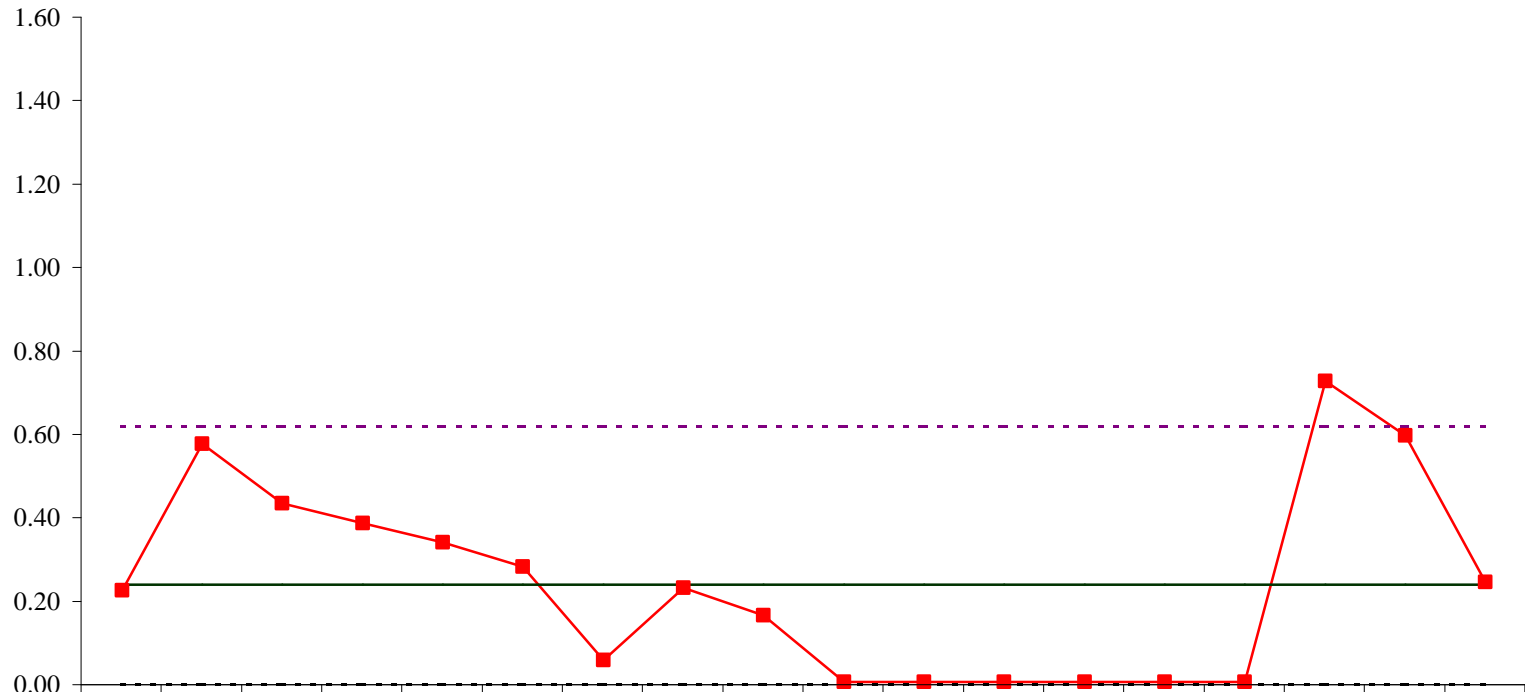
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	35	24	33	32	33	38	40	35	31	39	44	37	52	34	33	36	32	16
Injuries Resulting in a WCC	5	13	6	11	5	15	12	2	1	7	1	0	7	8	3	21	13	5
▲ Emp. Inj.(WCC)/1000 Bed Days	0.27	0.67	0.32	0.60	0.28	0.83	0.62	0.11	0.05	0.38	0.05	0.00	0.36	0.41	0.16	1.08	0.70	0.30
-----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	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40
-----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 & 6H - Employee Injuries
North Texas State Hospital

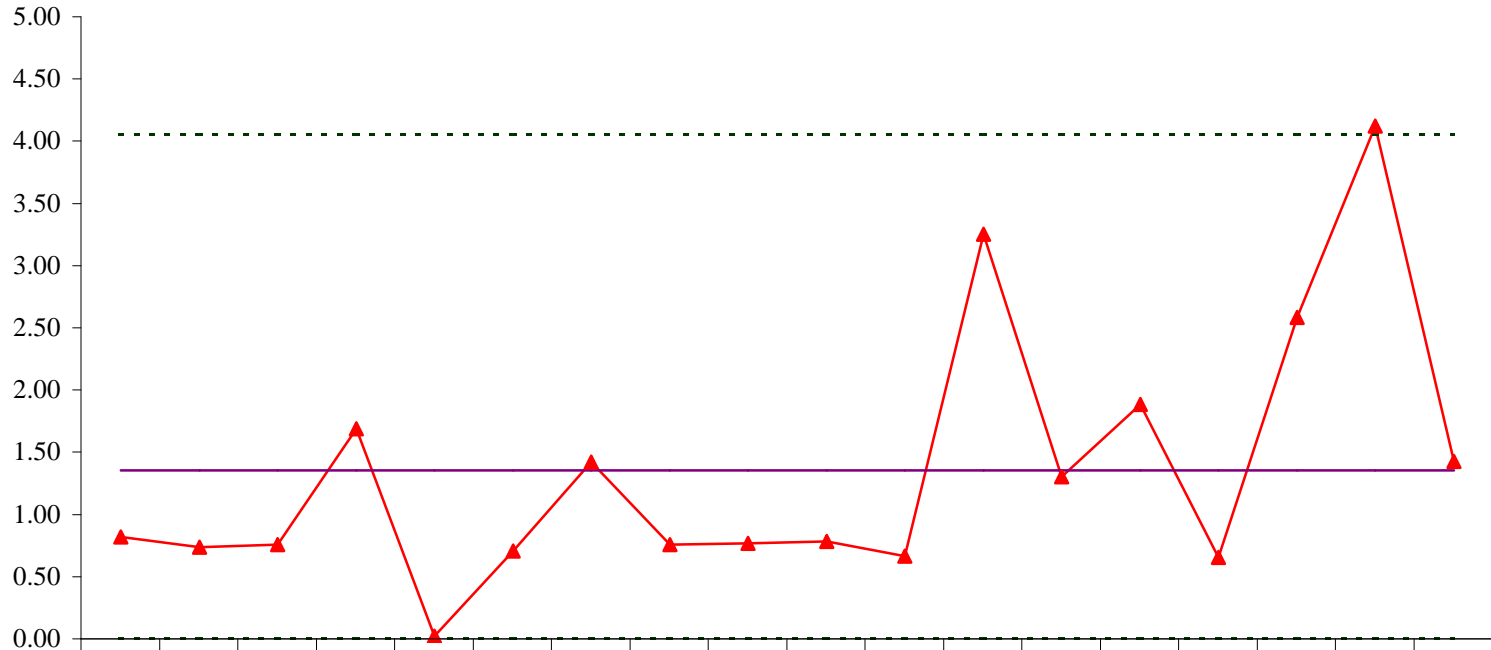
Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	35	24	33	32	33	38	40	35	31	39	44	37	52	34	33	36	32	16
Injuries Associated with R/S	4	11	8	7	6	5	1	4	3	0	0	0	0	0	0	14	11	4
■ Emp. Inj.(RS)/1000 Bed Days	0.22	0.57	0.43	0.38	0.33	0.28	0.05	0.23	0.16	0.00	0.00	0.00	0.00	0.00	0.00	0.72	0.59	0.24
- - - - - UCL	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
— 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 & 6H - Employee Injuries
Rio Grande State Center

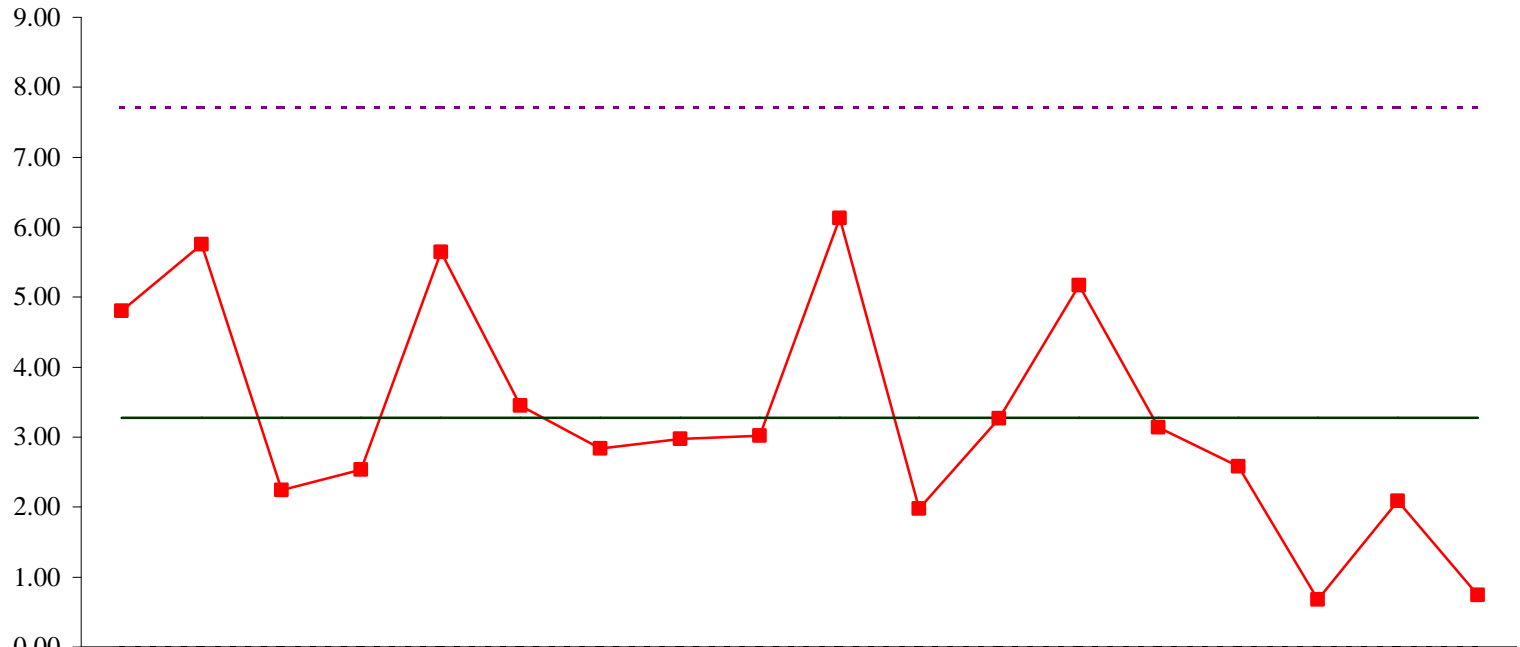
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	8	9	4	8	11	7	6	6	6	11	3	8	10	12	5	19	10	3
Injuries Resulting in a WCC	1	1	1	2	0	1	2	1	1	1	1	5	2	3	1	4	6	2
▲ Emp. Inj.(WCC)/1000 Bed Days	0.79	0.71	0.74	1.67	0.00	0.68	1.40	0.73	0.74	0.76	0.65	3.23	1.28	1.86	0.63	2.56	4.10	1.41
-----UCL	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05
— Avg	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
-----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 & 6H - Employee Injuries
Rio Grande State Center

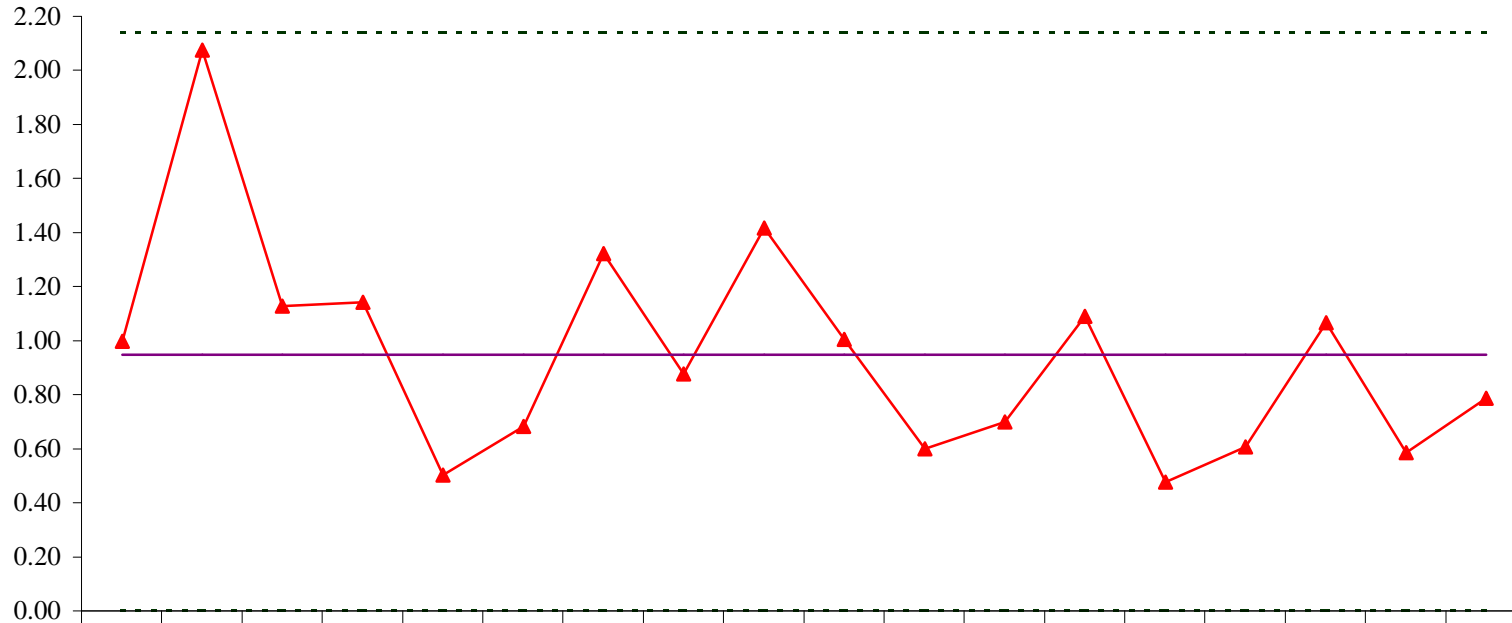
Employee Injuries During Restraint or Seclusion
(Expectation is 1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	8	9	4	8	11	7	6	6	6	11	3	8	10	12	5	19	10	3
Injuries Associated with R/S	6	8	3	3	8	5	4	4	4	8	3	5	8	5	4	1	3	1
Emp. Inj.(RS)/1000 Bed Days	4.77	5.71	2.21	2.50	5.61	3.42	2.80	2.93	2.98	6.09	1.94	3.23	5.13	3.10	2.54	0.64	2.05	0.70
UCL	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71	7.71
Avg	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24	3.24
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 & 6H - Employee Injuries
Rusk State Hospital

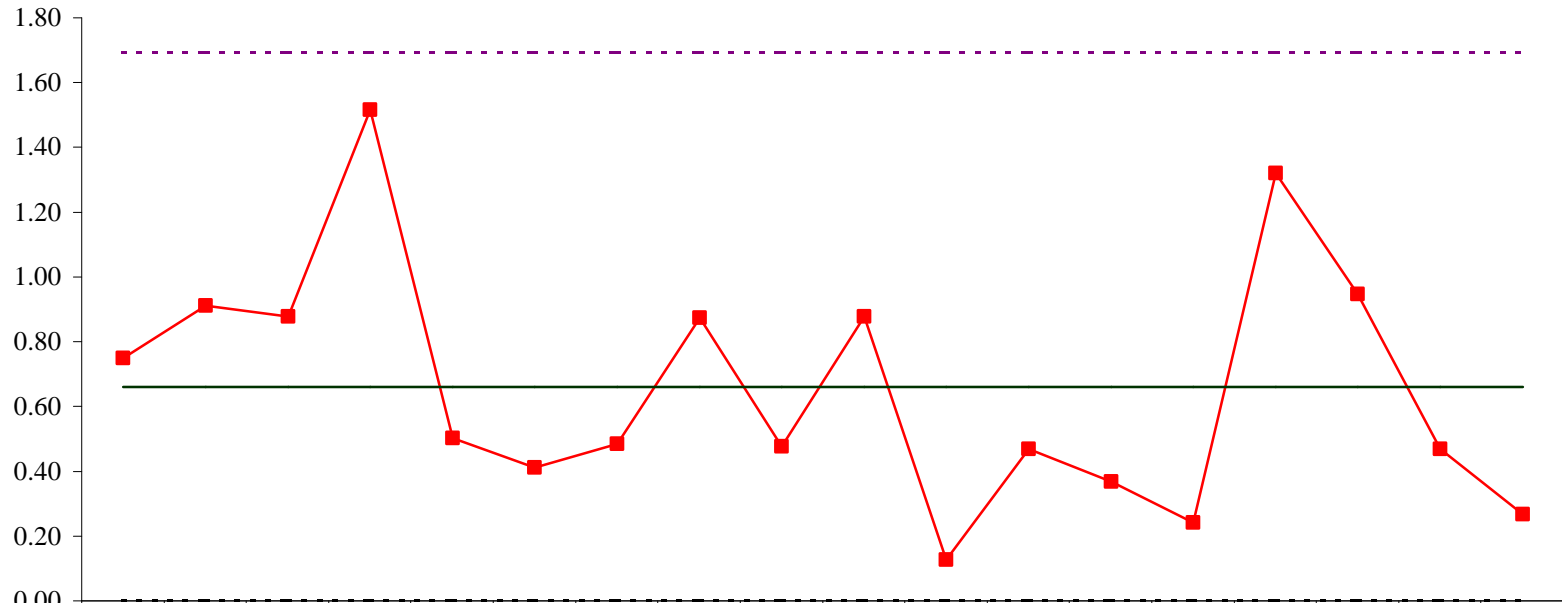
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	20	42	22	23	14	15	26	24	27	20	15	12	28	11	17	21	18	15
Injuries Resulting in a WCC	8	16	9	9	4	5	11	7	12	8	5	6	9	4	5	9	5	6
▲ Emp. Inj.(WCC)/1000 Bed Days	0.99	2.07	1.12	1.13	0.49	0.67	1.31	0.87	1.41	0.99	0.59	0.69	1.08	0.47	0.60	1.06	0.57	0.78
----- UCL	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14
— Avg	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94
..... 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 & 6H - Employee Injuries
Rusk State Hospital

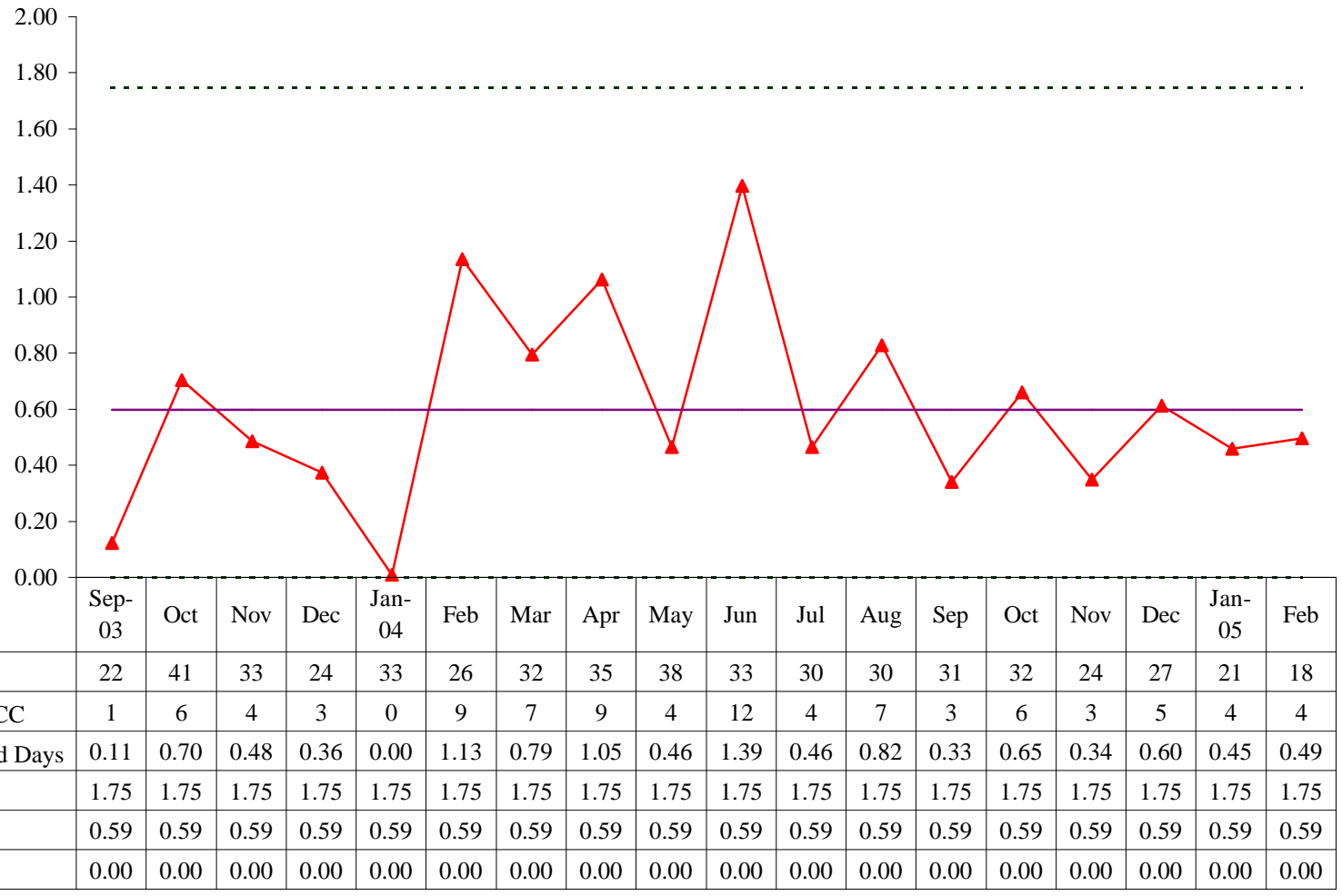
Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	20	42	22	23	14	15	26	24	27	20	15	12	28	11	17	21	18	15
Injuries Associated with R/S	6	7	7	12	4	3	4	7	4	7	1	4	3	2	11	8	4	2
■ Emp. Inj.(RS)/1000 Bed Days	0.74	0.90	0.87	1.51	0.49	0.40	0.48	0.87	0.47	0.87	0.12	0.46	0.36	0.23	1.31	0.94	0.46	0.26
⋯ UCL	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69
— Avg	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65
- - - - - 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

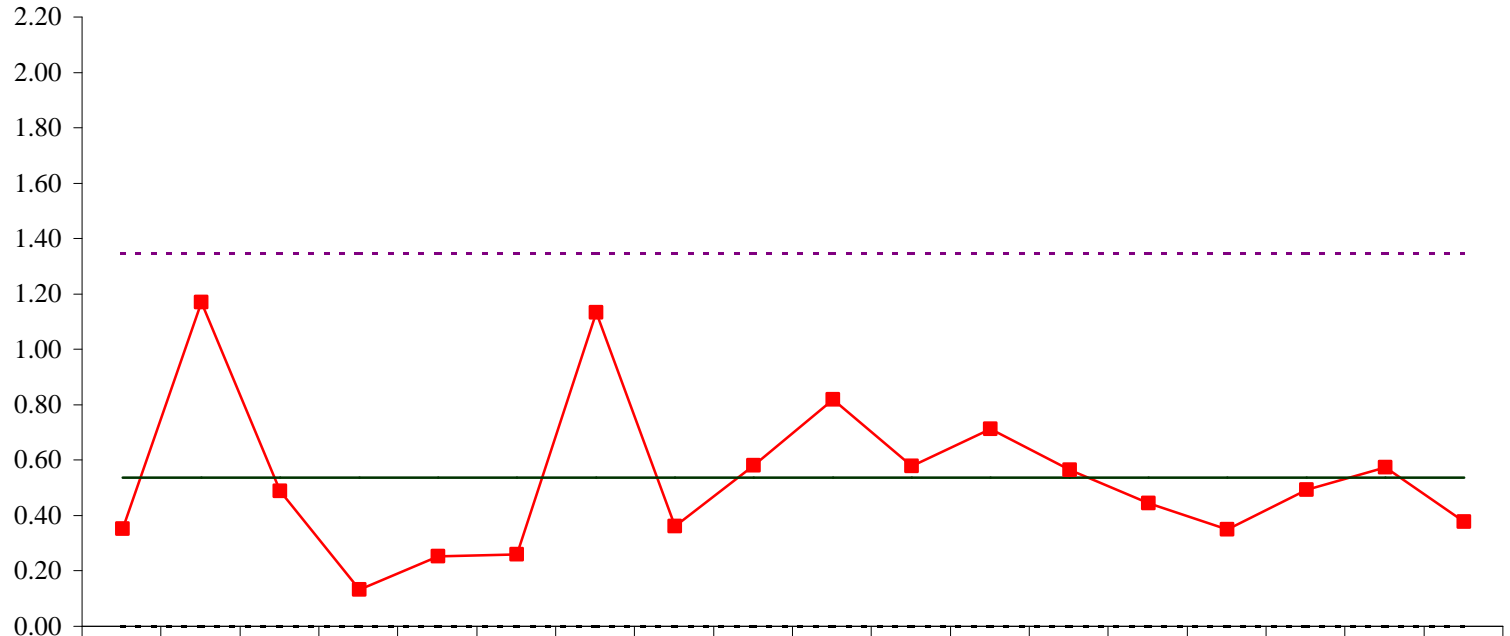
Objective 6C & 6H - Employee Injuries
San Antonio State Hospital

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



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

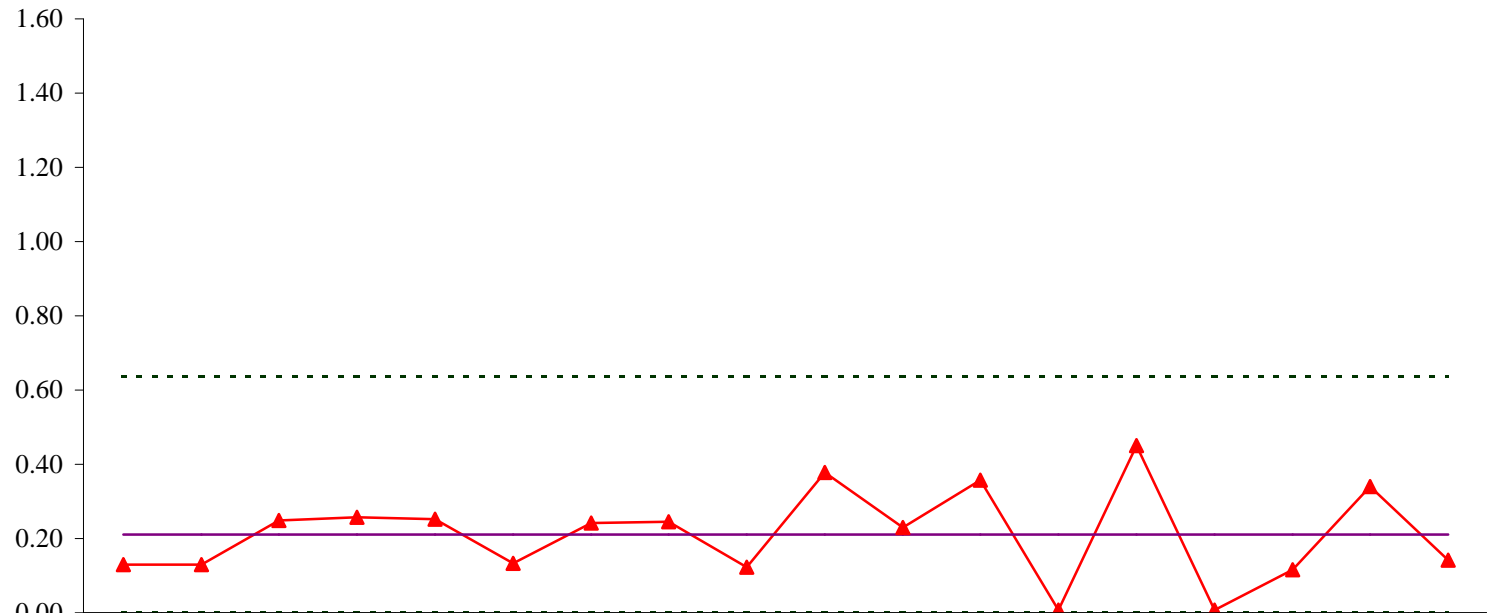
Employee Injuries During Restraint or Seclusion
(Expectation is 1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	22	41	33	24	33	26	32	35	38	33	30	30	31	32	24	27	21	18
Injuries Associated with R/S	3	10	4	1	2	2	10	3	5	7	5	6	5	4	3	4	5	3
Emp. Inj.(RS)/1000 Bed Days	0.34	1.16	0.48	0.12	0.24	0.25	1.12	0.35	0.57	0.81	0.57	0.70	0.55	0.43	0.34	0.48	0.56	0.37
UCL	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35
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 & 6H - Employee Injuries
Terrell State Hospital

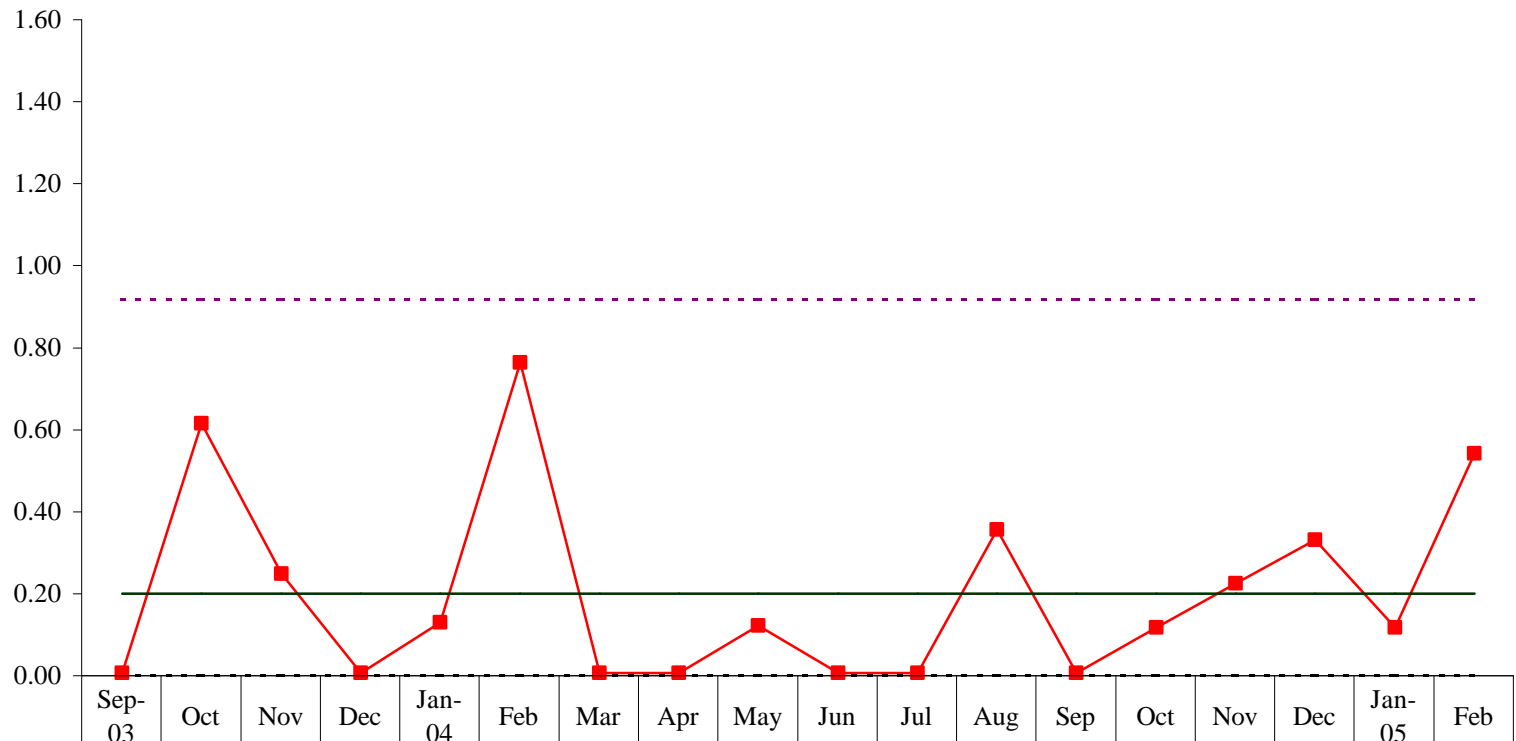
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	1	3	2	16	21	27	20	20	25	21	21	29	20	18	16	17	18	14
Injuries Resulting in a WCC	1	1	2	2	2	1	2	2	1	3	2	3	0	4	0	1	3	1
▲ Emp. Inj.(WCC)/1000 Bed Days	0.12	0.12	0.24	0.25	0.25	0.13	0.23	0.24	0.12	0.37	0.22	0.35	0.00	0.44	0.00	0.11	0.33	0.13
----- UCL	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64
— Avg	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
----- 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 & 6H - Employee Injuries
Terrell State Hospital

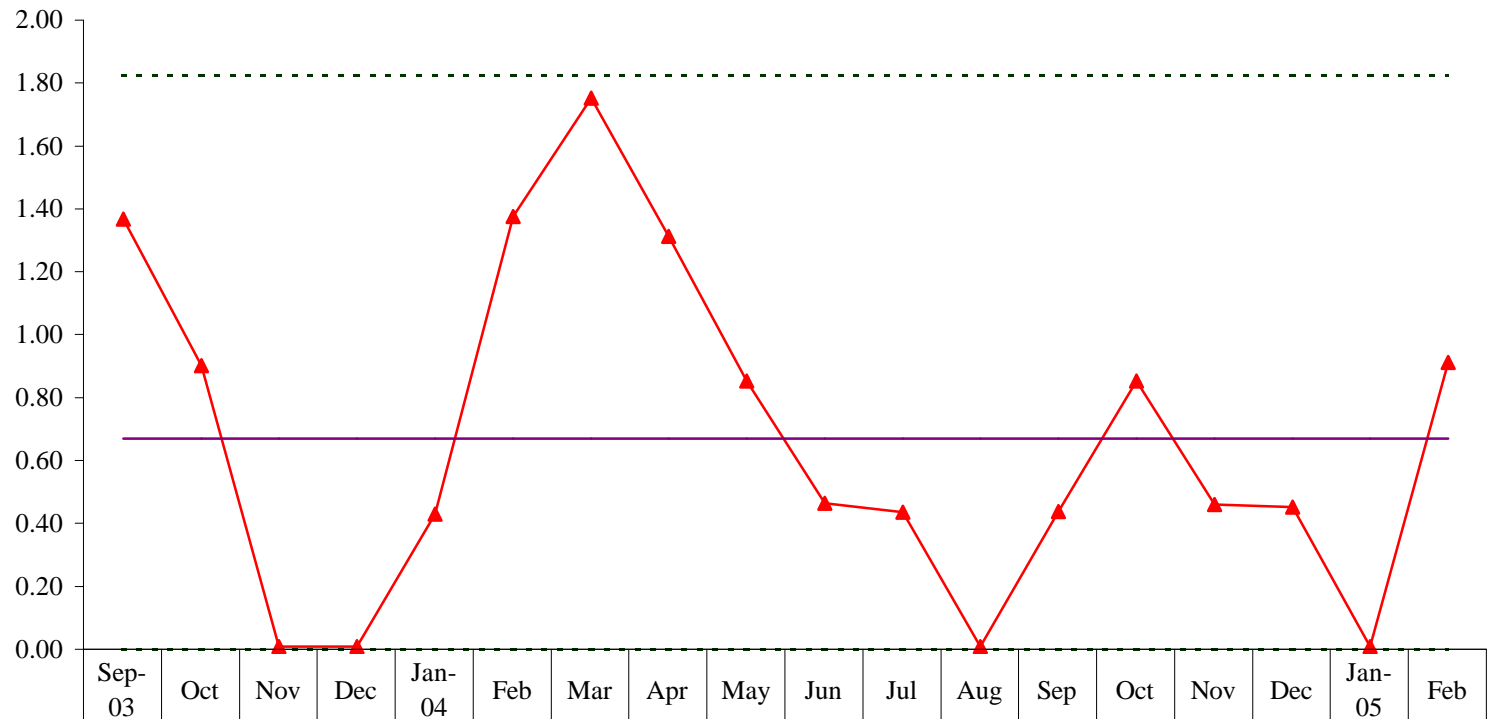
Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	1	3	2	16	21	27	20	20	25	21	21	29	20	18	16	17	18	14
Injuries Associated with R/S	0	5	2	0	1	6	0	0	1	0	0	3	0	1	2	3	1	4
■ Emp. Inj.(RS)/1000 Bed Days	0.00	0.61	0.24	0.00	0.12	0.76	0.00	0.00	0.12	0.00	0.00	0.35	0.00	0.11	0.22	0.32	0.11	0.54
- - - - - UCL	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92
— Avg	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
- - - - - 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 & 6H - Employee Injuries
Waco Center for Youth

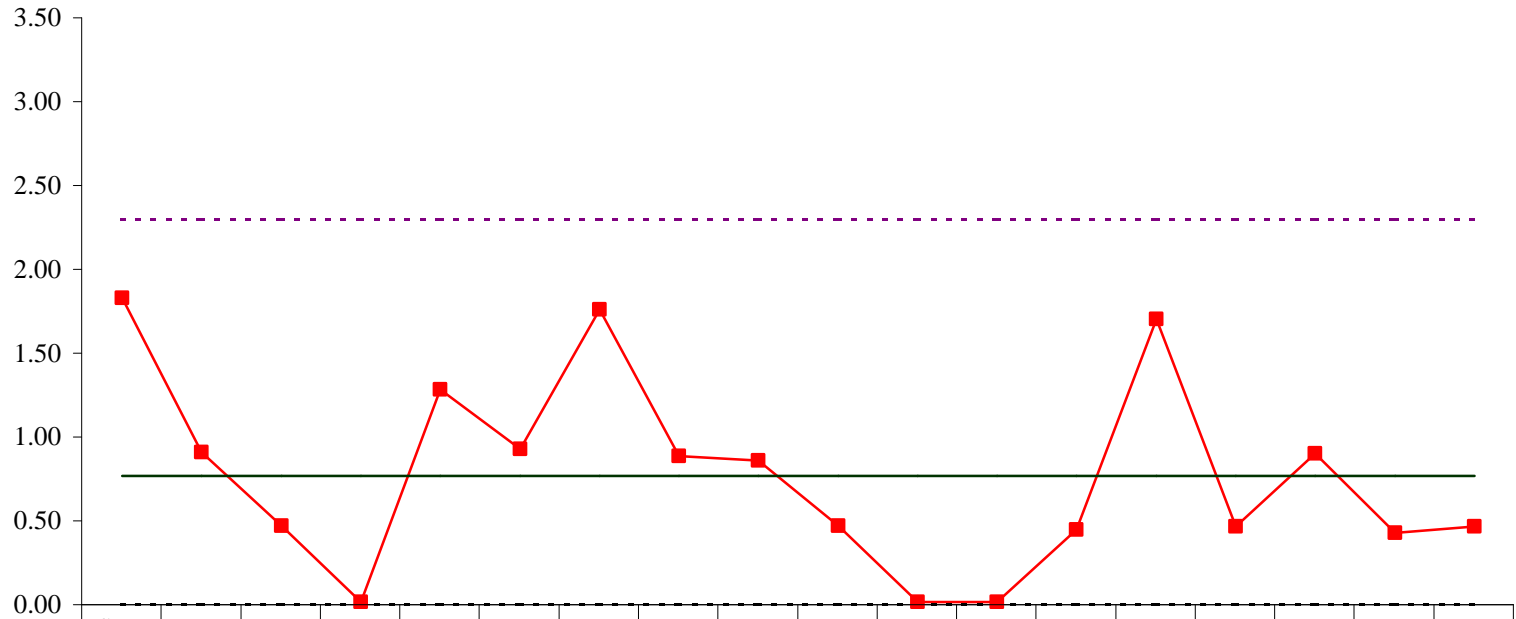
Employee Injuries Resulting in a Workers' Compensation Claim
(Expectation is £1.11 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	9	4	2	1	3	4	7	3	3	1	3	1	2	8	3	5	2	5
Injuries Resulting in a WCC	3	2	0	0	1	3	4	3	2	1	1	0	1	2	1	1	0	2
▲ Emp. Inj.(WCC)/1000 Bed Days	1.36	0.89	0.00	0.00	0.42	1.37	1.74	1.30	0.84	0.45	0.43	0.00	0.43	0.84	0.45	0.44	0.00	0.90
-----UCL	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
— Avg	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66	0.66
-----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 & 6H - Employee Injuries
Waco Center for Youth

Employee Injuries During Restraint or Seclusion
(Expectation is £1.34 per 1,000 Bed Days)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Total Employee Injuries	9	4	2	1	3	4	7	3	3	1	3	1	2	8	3	5	2	5
Injuries Associated with R/S	4	2	1	0	3	2	4	2	2	1	0	0	1	4	1	2	1	1
■ Emp. Inj.(RS)/1000 Bed Days	1.81	0.89	0.45	0.00	1.27	0.91	1.74	0.87	0.84	0.45	0.00	0.00	0.43	1.69	0.45	0.89	0.41	0.45
- - - - - UCL	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30	2.30
— Avg	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75
- - - - - 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).

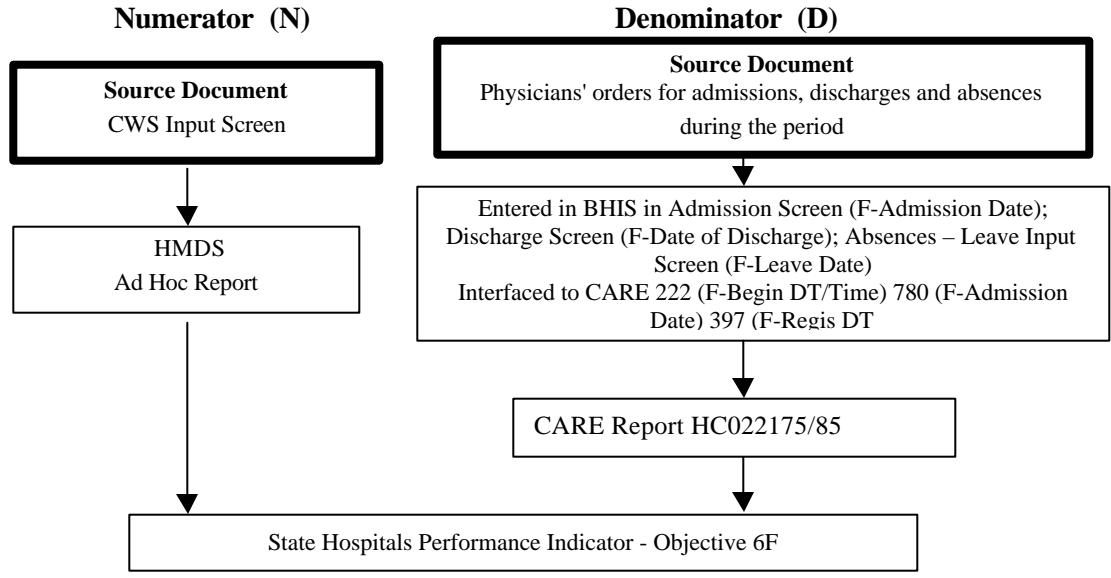
Performance Objective Formula: $R = (N/D) \times 1000$

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.

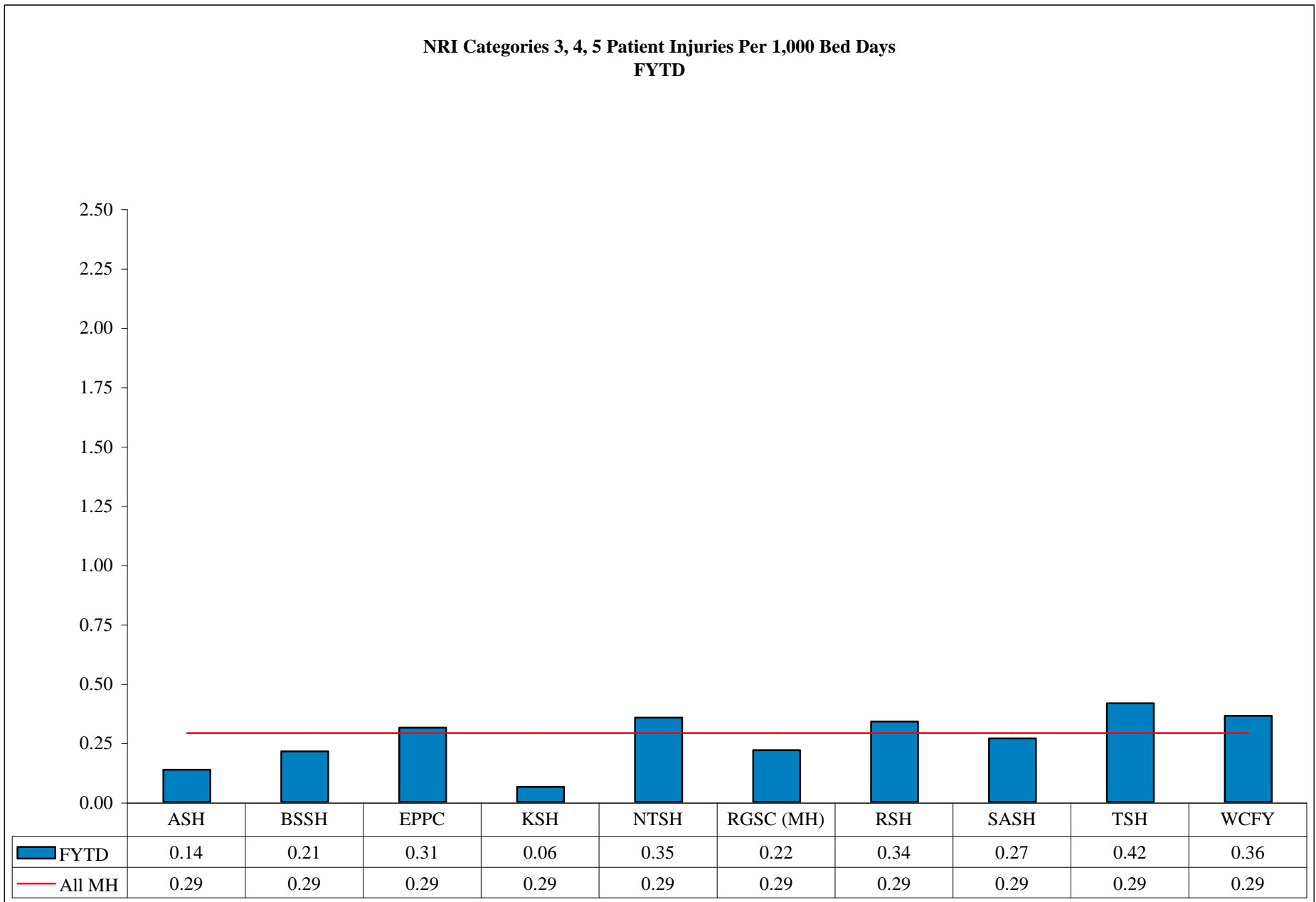
Data Flow:



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 - Patient Injuries
All MH Facilities - As of February 28, 2005



Objective 6F - Patient Injuries

All MH Facilities

Facility	Q1 FY05							Q2							Q3							FY05 - FYTD							
	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	*	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	*	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	*	N/A	No Tx	First Aid	Med Tx	Hospital-ization	Fatal	*	
ALL MH																													
Accident	10	206	257	20	1	0	494	14	181	235	17	6	0	453								24	387	492	37	7	0	947	
Another Client	7	171	179	14	1	0	372	11	149	173	13	1	0	347								18	320	352	27	2	0	719	
Employee/Accident	1	8	11	1	0	0	21	2	4	13	0	1	0	20								3	12	24	1	1	0	41	
Medical Condition	1	7	10	2	0	0	20	3	7	7	1	0	0	18								4	14	17	3	0	0	38	
Self Inflicted	9	74	156	11	1	0	251	10	73	157	15	0	0	255								19	147	313	26	1	0	506	
Undetermined	21	101	60	7	0	0	189	25	121	64	6	0	0	216								46	222	124	13	0	0	405	
Visitor	0	0	0	0	0	0	0	0	0	0	0	0	0	0								0	0	0	0	0	0	0	
Total	49	567	673	55	3	0	1347	65	535	649	52	8	0	1309								114	1102	1322	107	11	0	2656	
Rate/1000 Bed Day	0.23	2.69	3.19	0.26	0.01	0	0.27	0.32	2.65	3.22	0.26	0.04	0	0.30								0.28	2.67	3.2	0.26	0.03	0	0.29	

N/A = Not Available

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

Performance Objective 6G:

When the use of restraint or seclusion in a behavioral emergency is necessary as a last result, the procedures will be performed, appropriately to reduce the risk of patient injury. The rate of patient injury for FY05 will not exceed 0.66 per 1000 bed days for FY04.

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

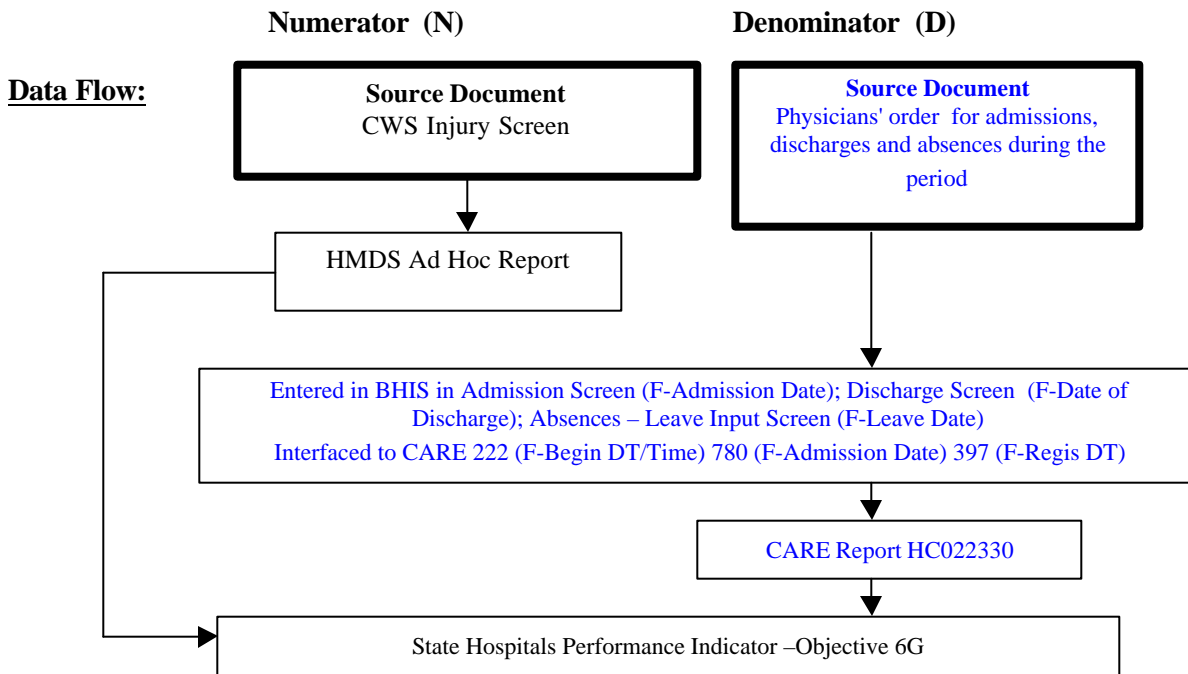
R = rate of patients injured during restraint or seclusion per 1000 bed days per quarter

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:

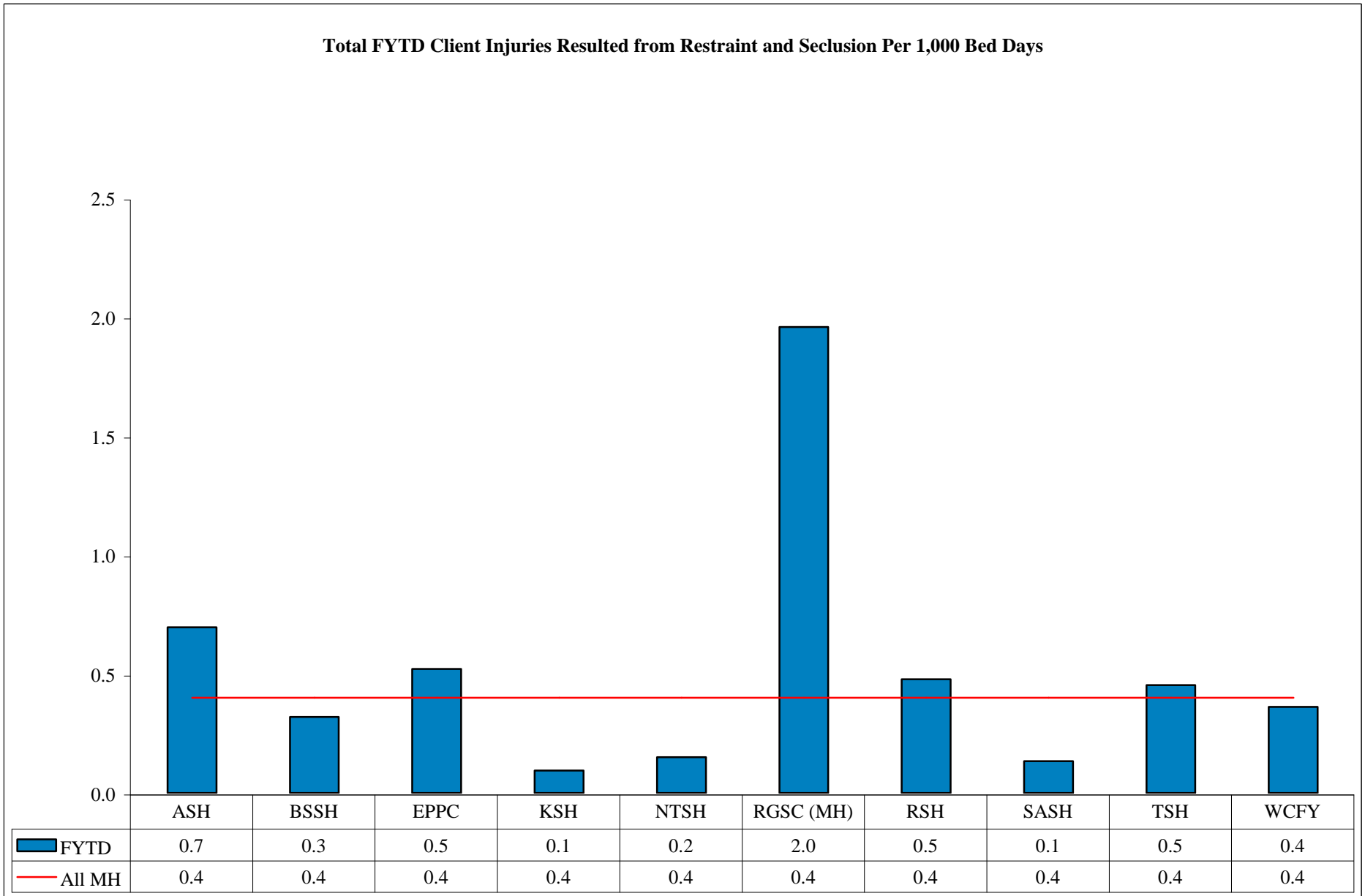
- ◆ Table shows quarterly number of injuries by restraint or seclusion by treatment for individual state hospitals and system-wide.
- ◆ Bar chart with total FYTD client injuries resulted from restraint and seclusion per 1000 bed days.



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 6G - Client Injuries Resulted From Restraint and Seclusion
All MH Facilities - As of February 28, 2005



Objective 6G - Client Injuries Resulted From Restraint and Seclusion

All MH Facilities - FY2005

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	0	24	31	4	0	0	59	5	23	36	4	0	0	68														
Seclusion	0	5	5	0	0	0	10	1	1	8	1	0	0	11														
Total	0	29	36	4	0	0	69	6	24	44	5	0	0	79														
Per 1000 Beddays							0.3							0.4														

Performance Objective 6H:

Employees injured during restraint or seclusion will not exceed 1.34 per 1000 bed days across all state hospitals in FY 2005.

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

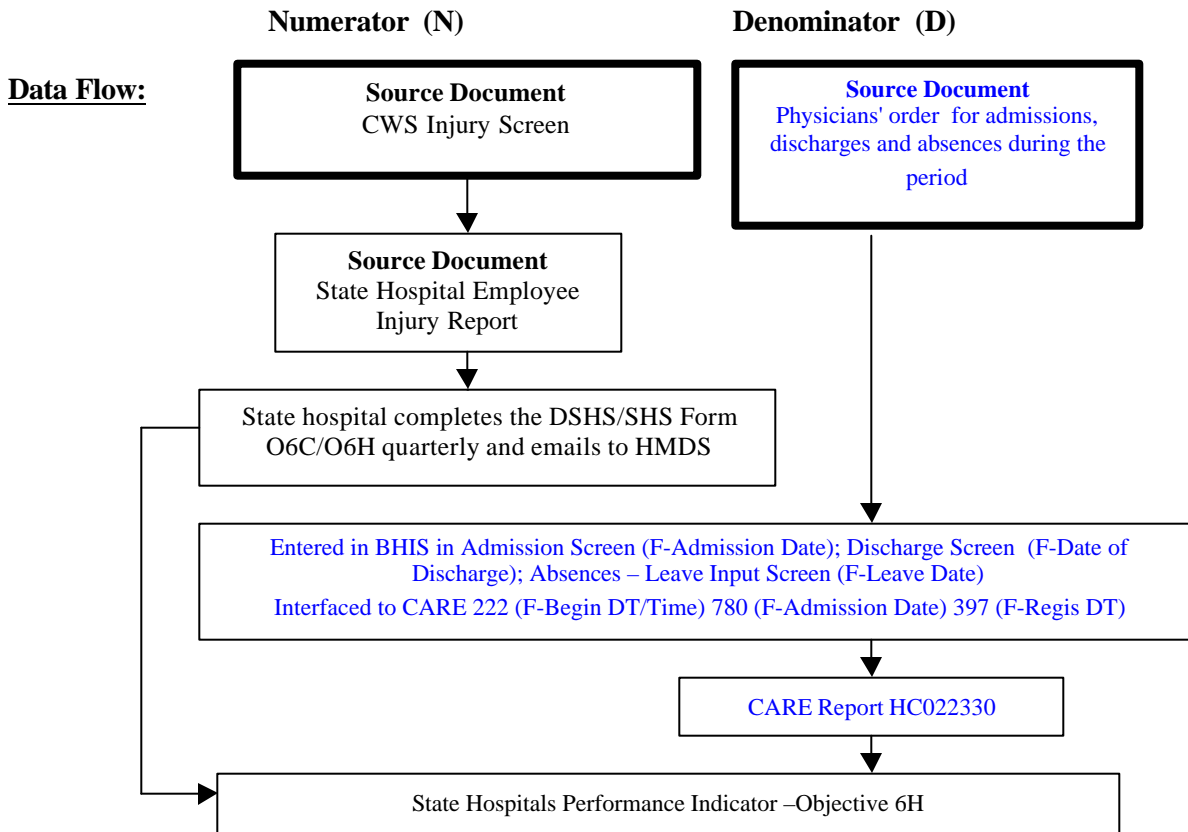
N = number of employees injured during restraint or seclusion per month

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 6I:

The rate of Unauthorized Departures will not exceed 0.42 per 1000 bed days across all state hospitals during FY2005.

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

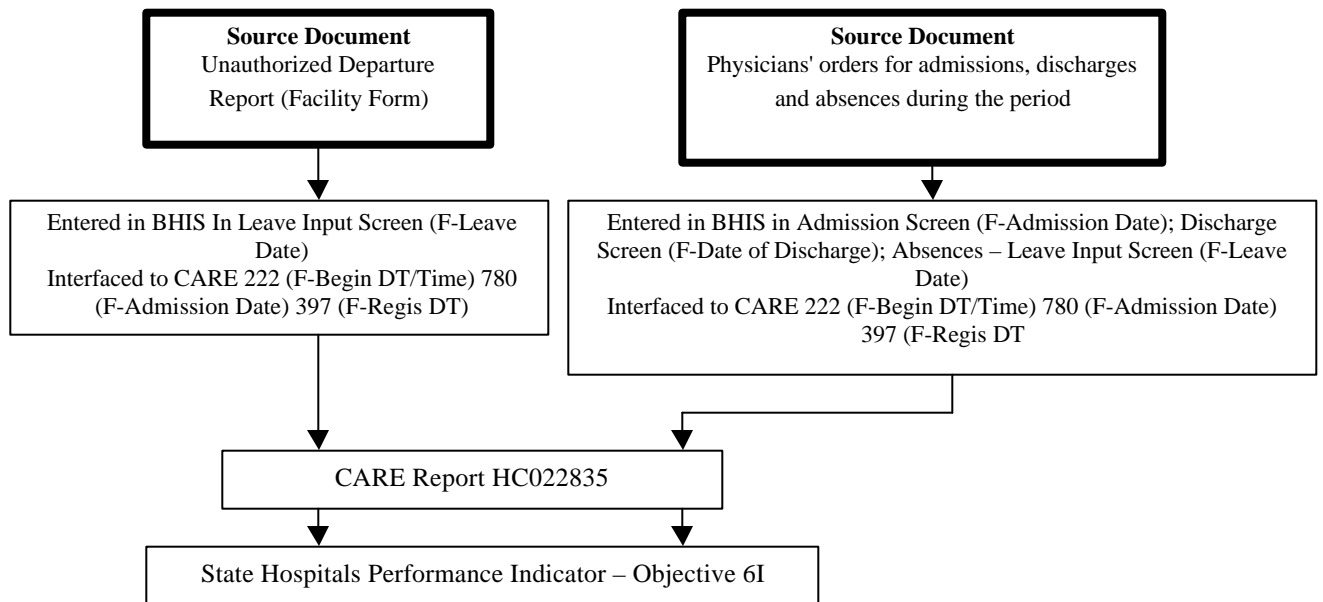
Performance Objective Data Display and Chart Description:

- ◆ 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)



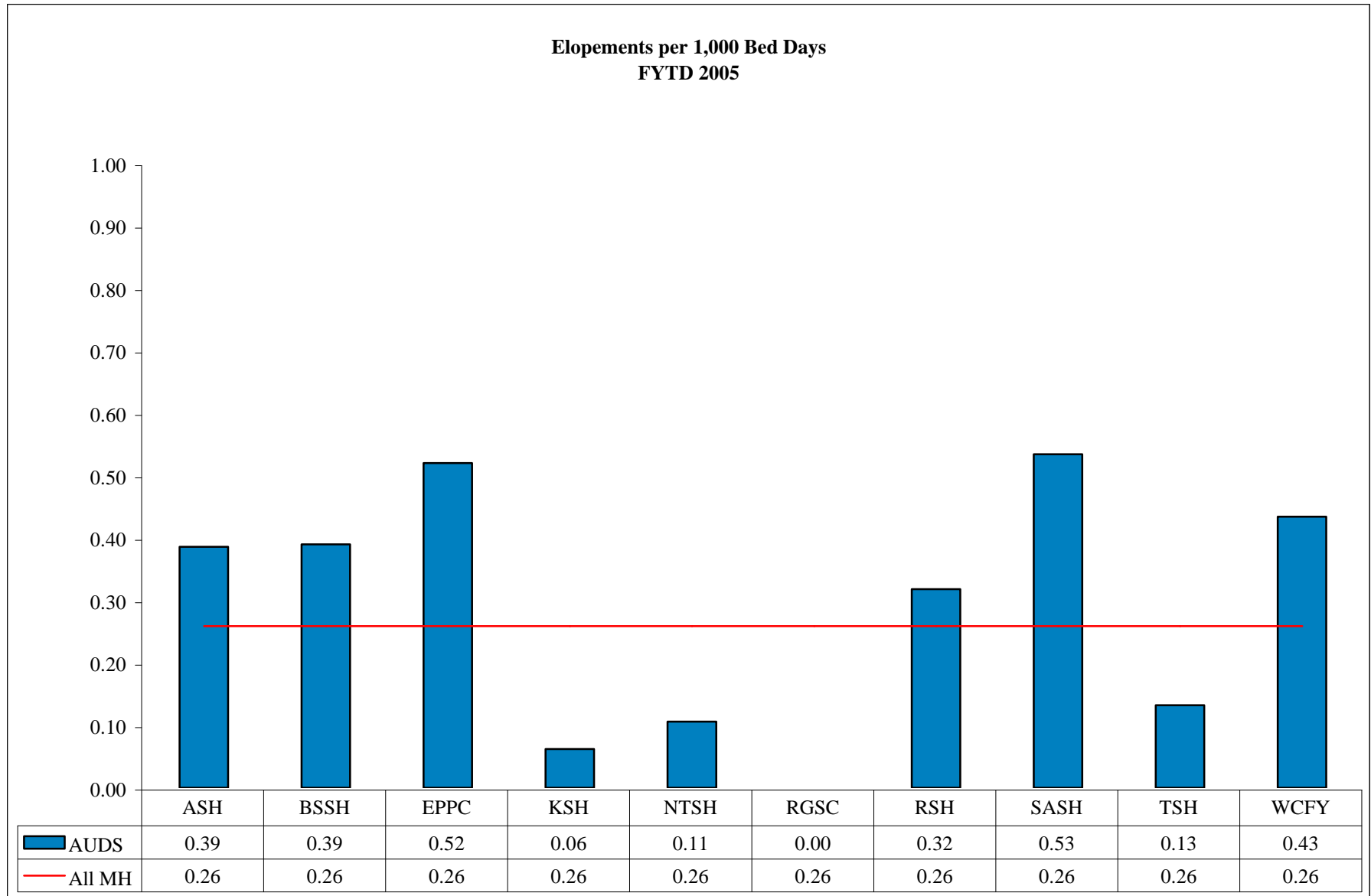
Data Integrity Review Process:

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.

Objective 6I - Rate for Elopements
All MH Facilities - Previous 12 Months

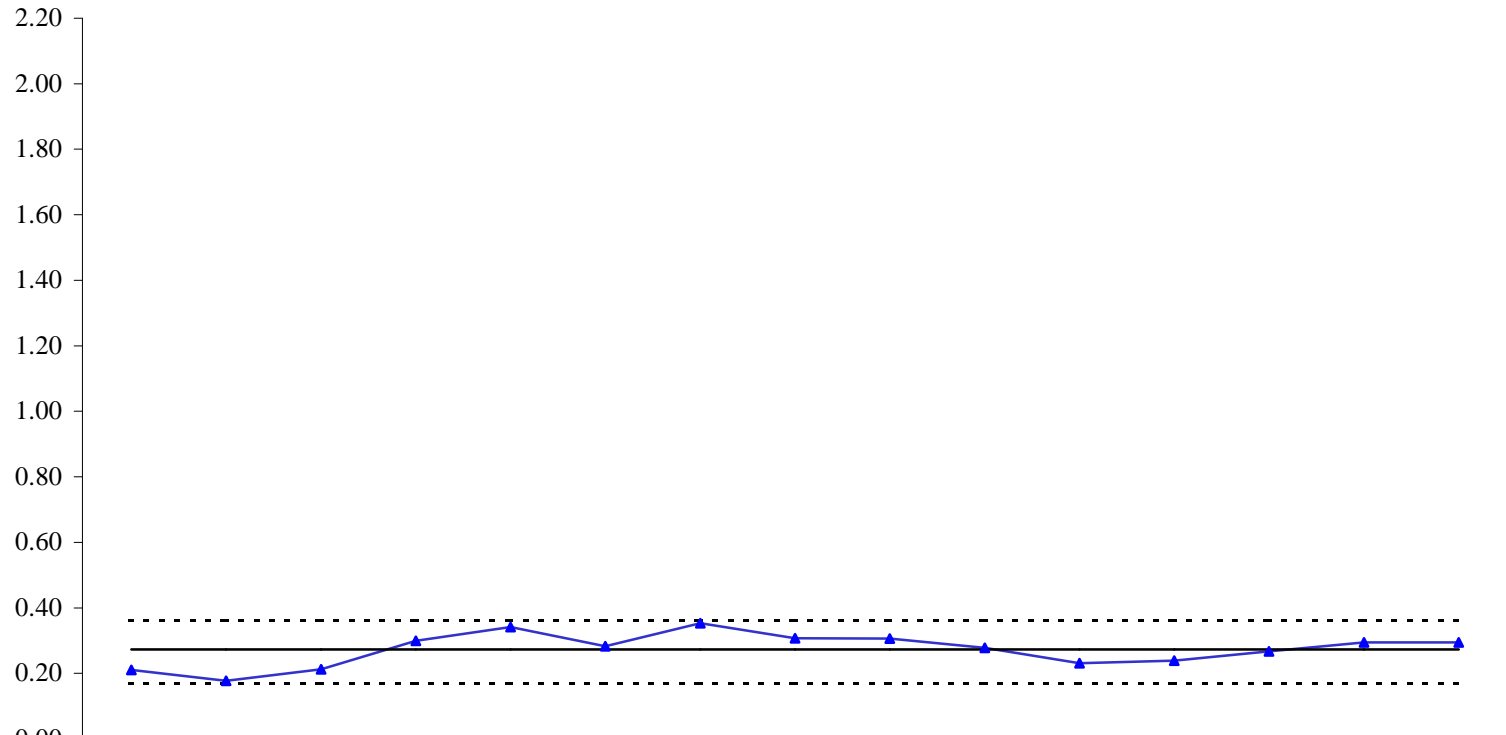
	Mar-04	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
ALL MH FACILITIES												
Unauthorized Departures Incidents	20	22	19	23	21	21	19	16	16	18	20	18
Unauthorized Departures Persons	17	22	19	23	20	19	18	14	16	18	19	16
Bed Days in Month	68644	66879	68860	66541	70214	70468	70306	71490	69234	69346	69708	62776
Incidents/1000 Bed Days	0.29	0.33	0.28	0.35	0.30	0.30	0.27	0.22	0.23	0.26	0.29	0.29

Objective 6I - Rate for Elopements
All MH Facilities - As of February 28, 2005



Objective 6I - Rate for Elopements
All MH Facilities

Elopements per 1,000 Bed Days
 (Expectation is Average Score 0.26 per 1,000 Bed Days)



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—▲— Incidents/1000 Bed Days	0.20	0.17	0.20	0.29	0.33	0.28	0.35	0.30	0.30	0.27	0.22	0.23	0.26	0.29	0.29
- - - - - UCL	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36	0.36
———— Avg	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26
- LCL	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17

GOAL 8: Assure A Competent Workforce

Performance Objective 8A:

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

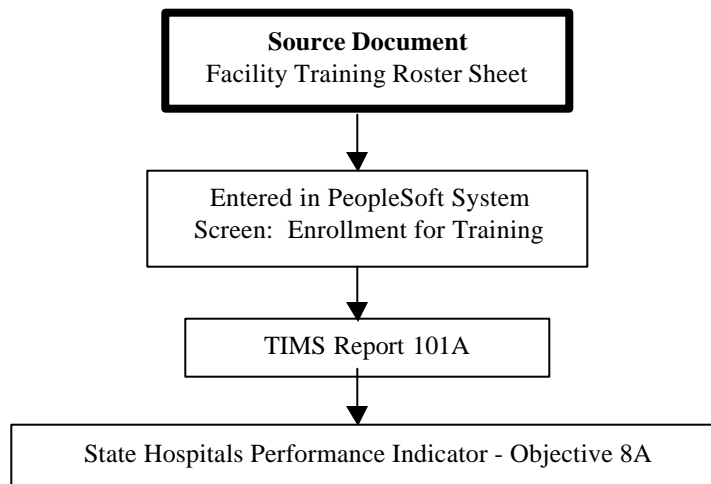
Performance Objective Operational Definition: The state hospital percentage of employees with active training statuses who have completed all courses related to their position type training program within specified time frame. Monthly data (based on data entered up until 5 p.m. on the day the report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

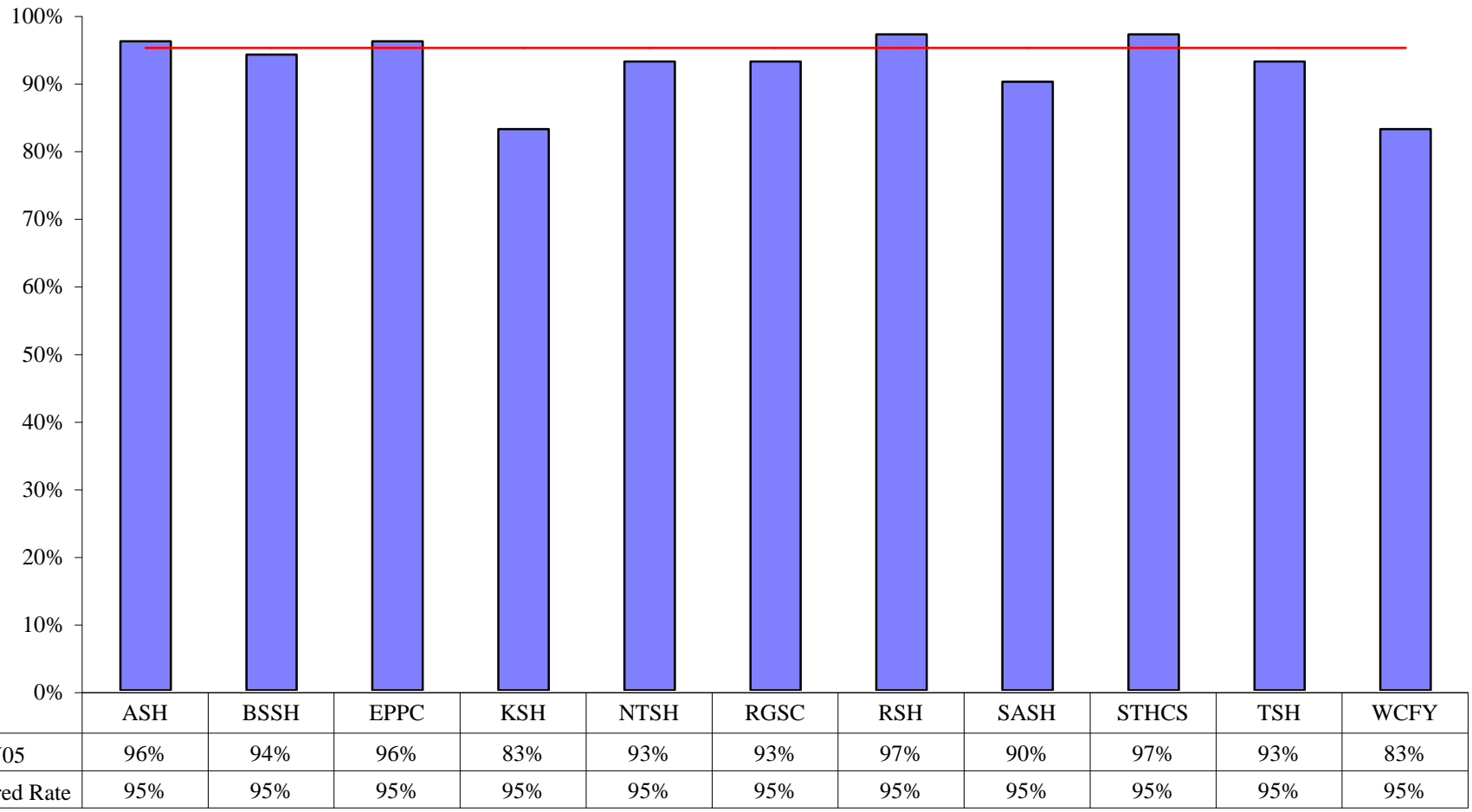


Data Integrity Review Process:

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

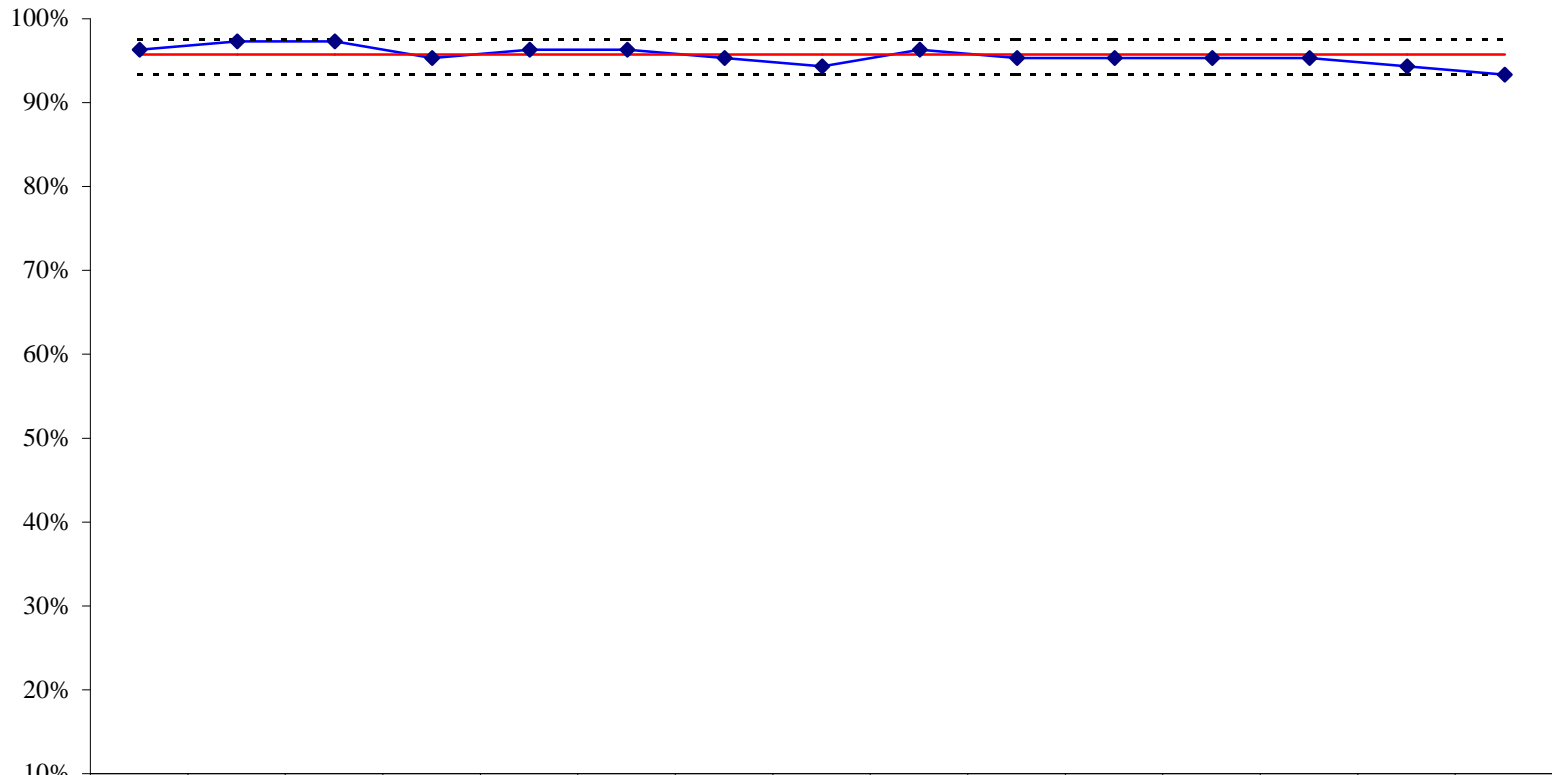
Objective 8A - Staff Current With Required Training
All MH Facilities

Required Training
(As of February 28, 2005)



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

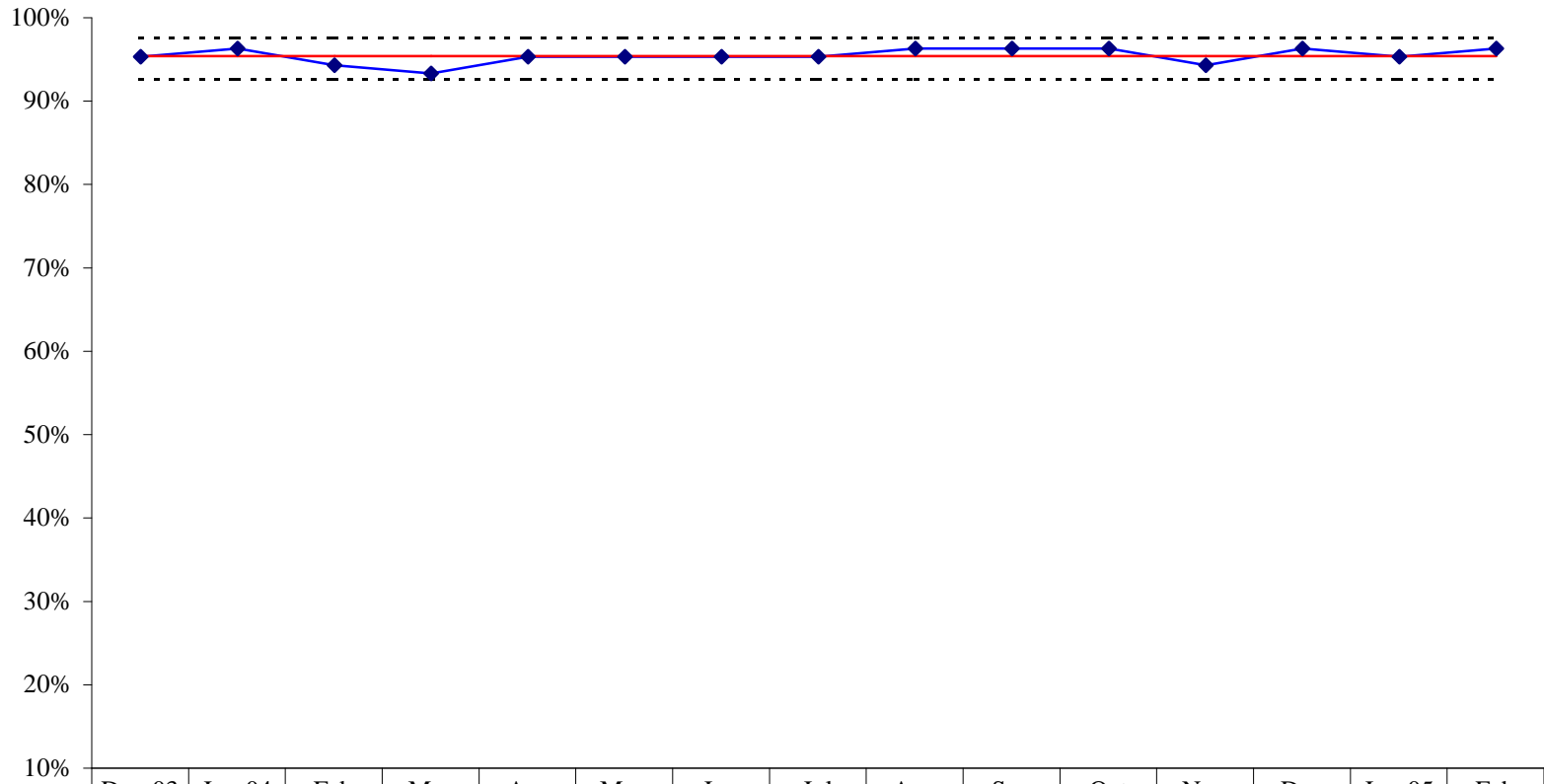
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	96%	97%	97%	95%	96%	96%	95%	94%	96%	95%	95%	95%	95%	94%	93%
- - - - - UCL	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
— Avg	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
- - - - - LCL	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

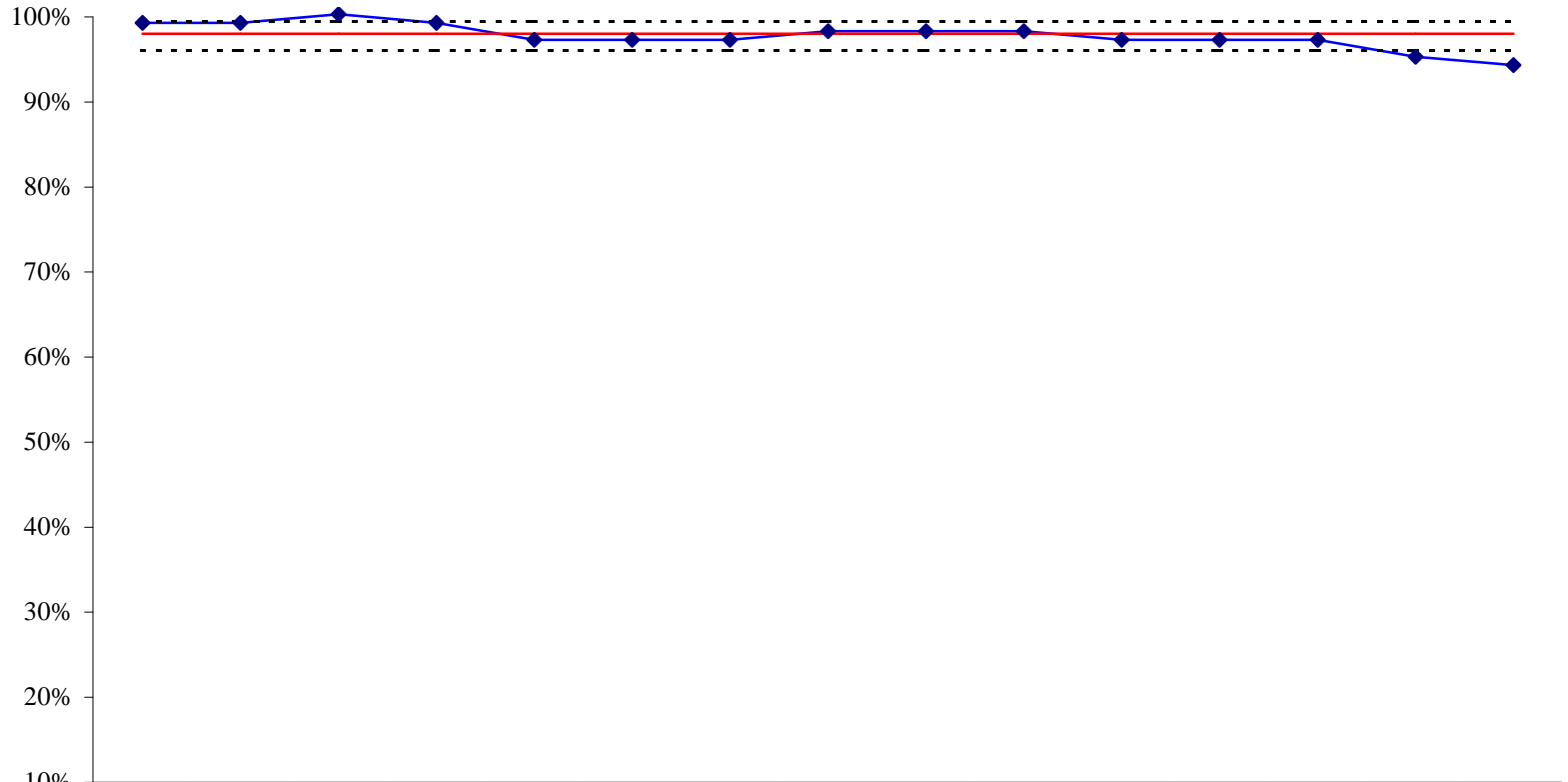
Objective 8A - Staff Current With Required Training
Austin State Hospital

Percentage of Required Training Completed



Objective 8A - Staff Current With Required Training
Big Spring State Hospital

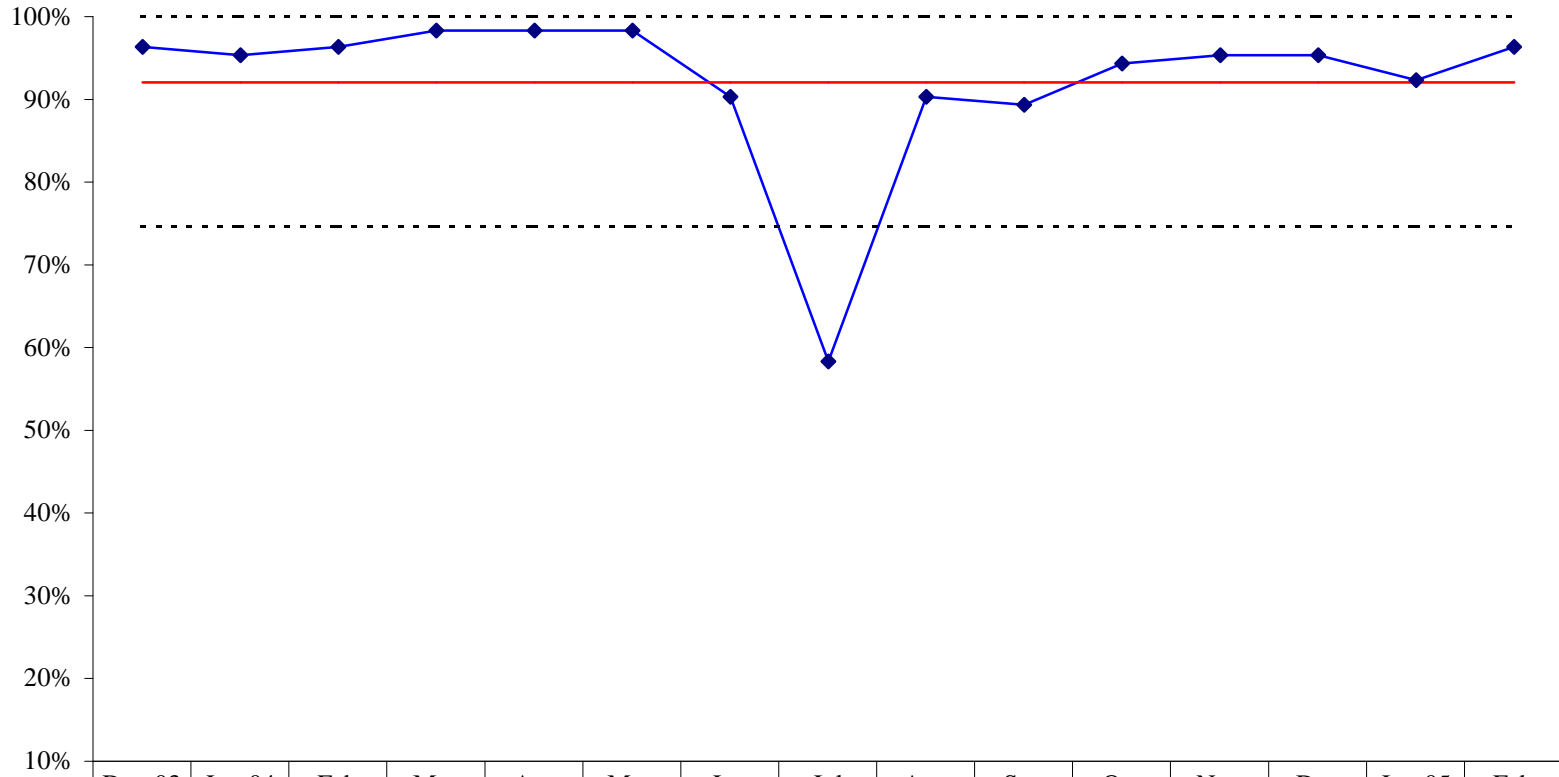
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	99%	99%	100%	99%	97%	97%	97%	98%	98%	98%	97%	97%	97%	95%	94%
- - - - - UCL	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
— Avg	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
- - - - - LCL	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Objective 8A - Staff Current With Required Training
El Paso Psychiatric Center

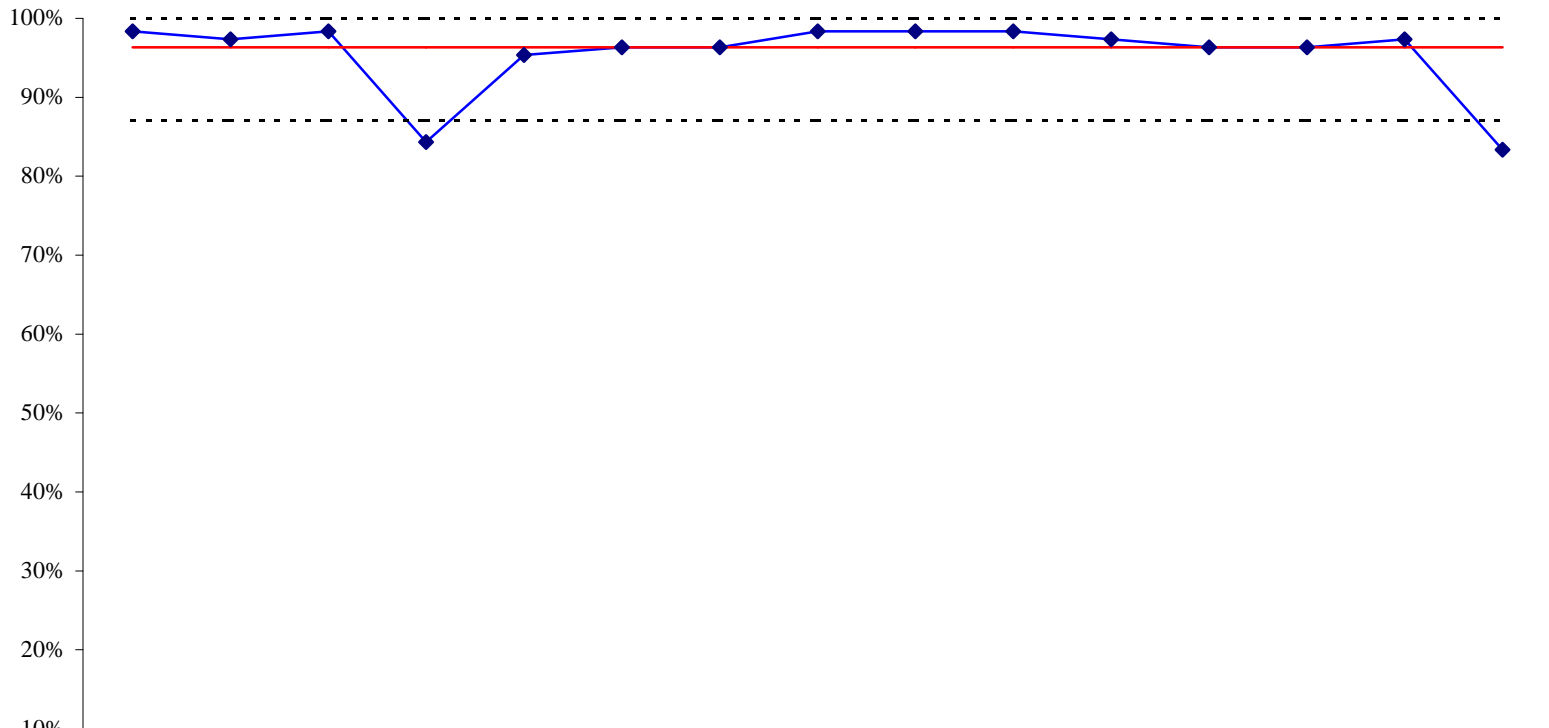
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	96%	95%	96%	98%	98%	98%	90%	58%	90%	89%	94%	95%	95%	92%	96%
----- 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	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

Objective 8A - Staff Current With Required Training
Kerrville State Hospital

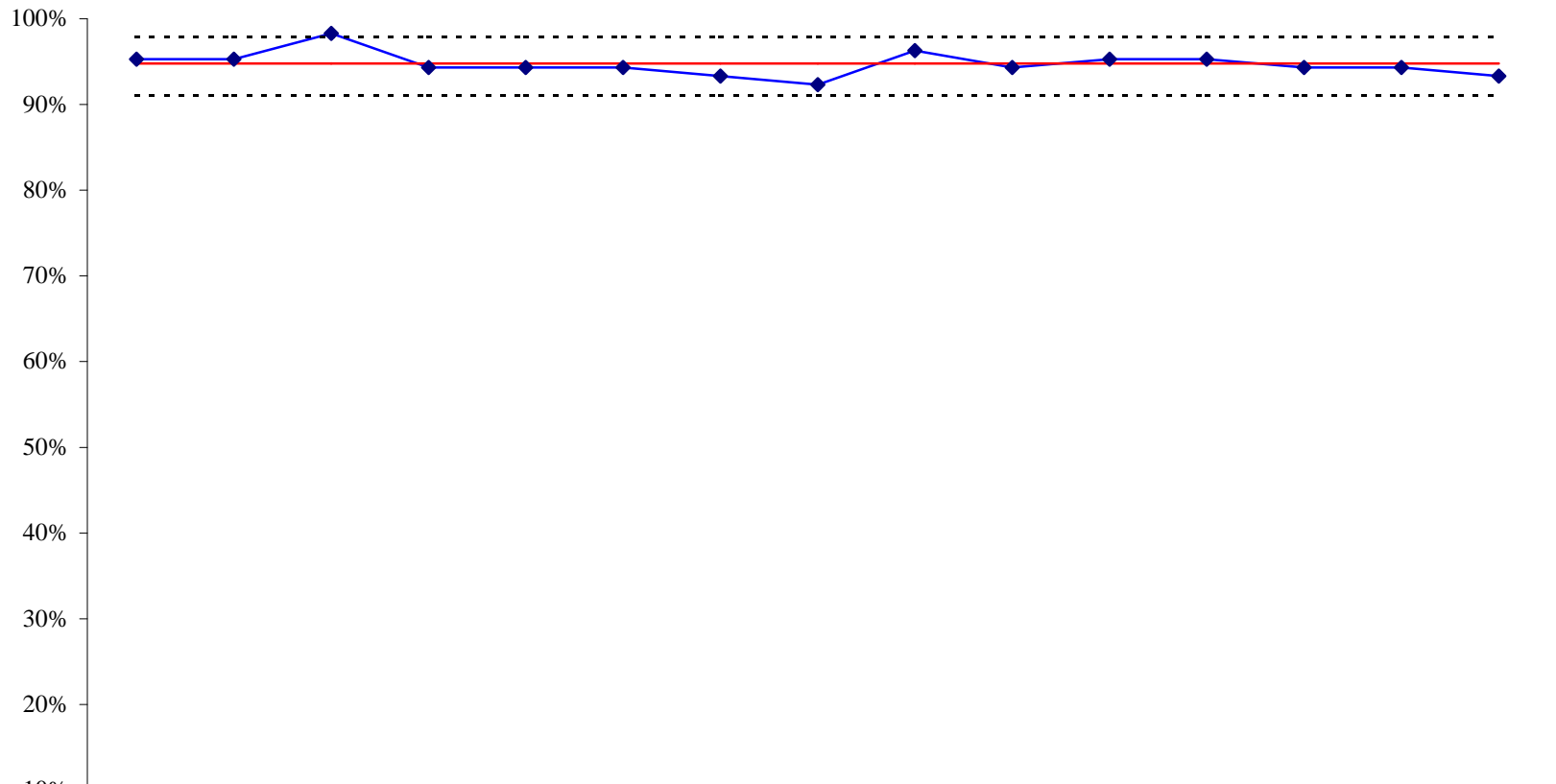
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	98%	97%	98%	84%	95%	96%	96%	98%	98%	98%	97%	96%	96%	97%	83%
----- 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	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%

Objective 8A - Staff Current With Required Training
North Texas State Hospital

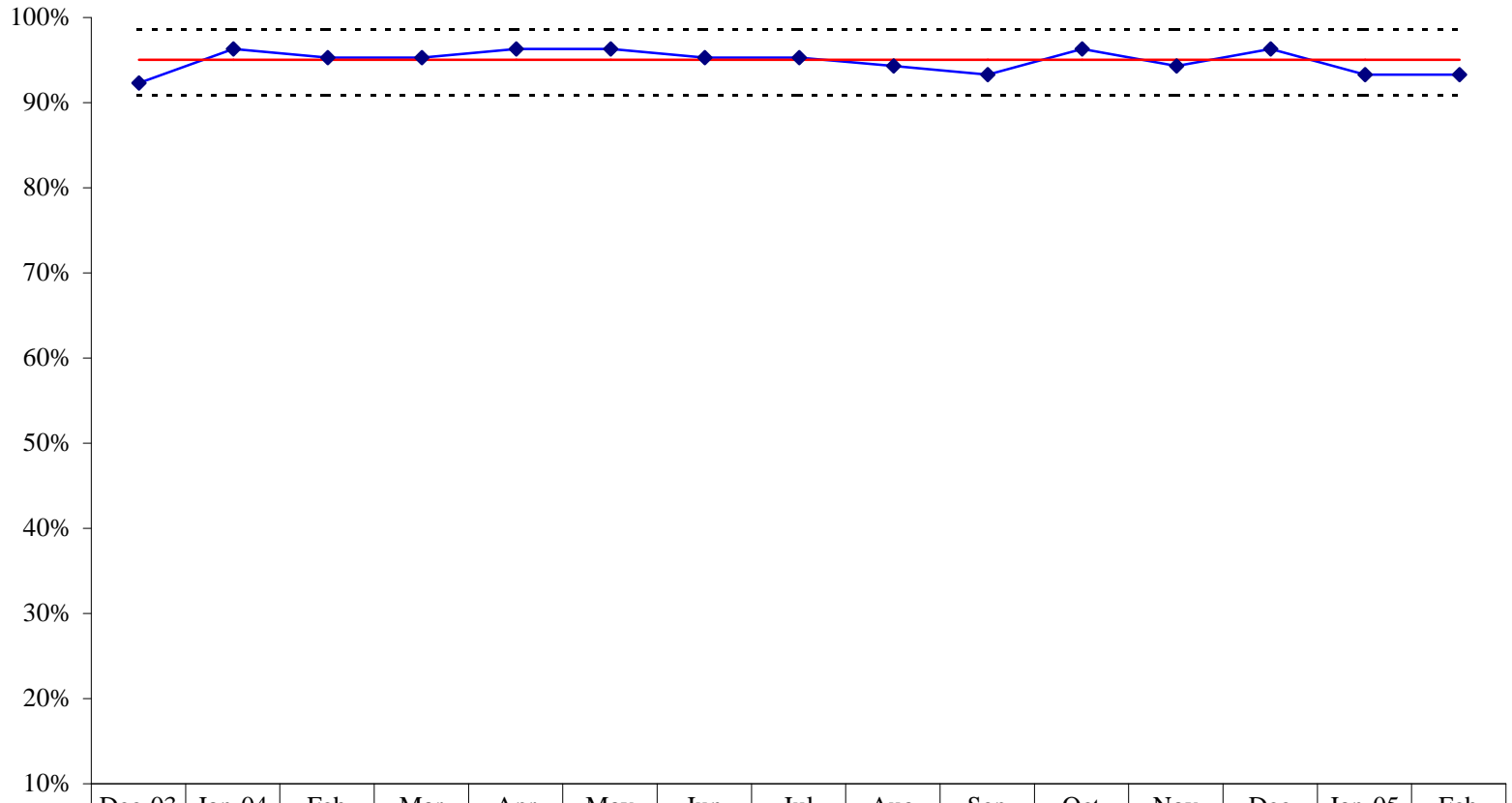
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	95%	95%	98%	94%	94%	94%	93%	92%	96%	94%	95%	95%	94%	94%	93%
-----UCL	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
— Avg	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
-----LCL	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%

Objective 8A - Staff Current With Required Training
Rio Grande State Center

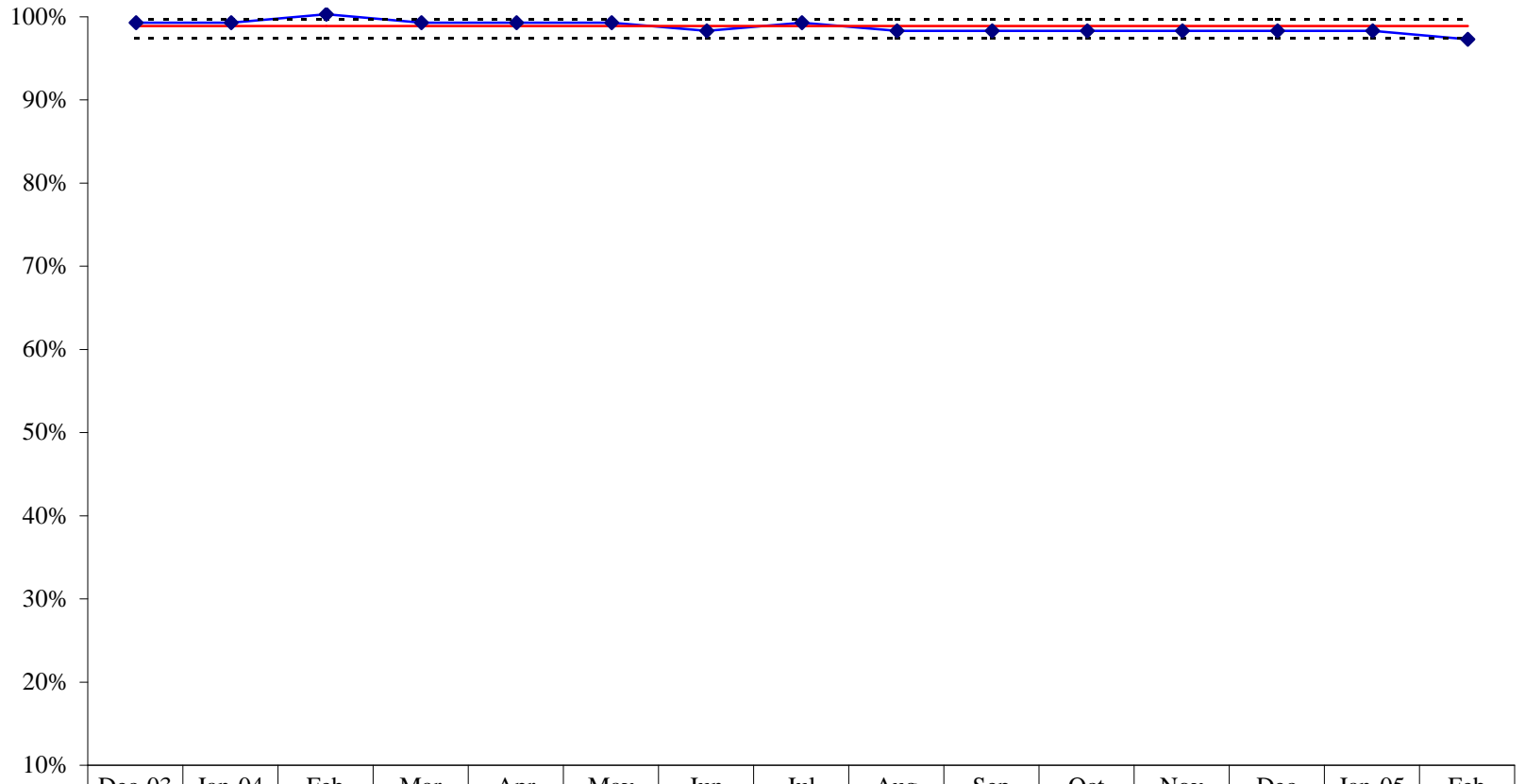
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	92%	96%	95%	95%	96%	96%	95%	95%	94%	93%	96%	94%	96%	93%	93%
-----UCL	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
— Avg	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
-----LCL	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%

Objective 8A - Staff Current With Required Training
Rusk State Hospital

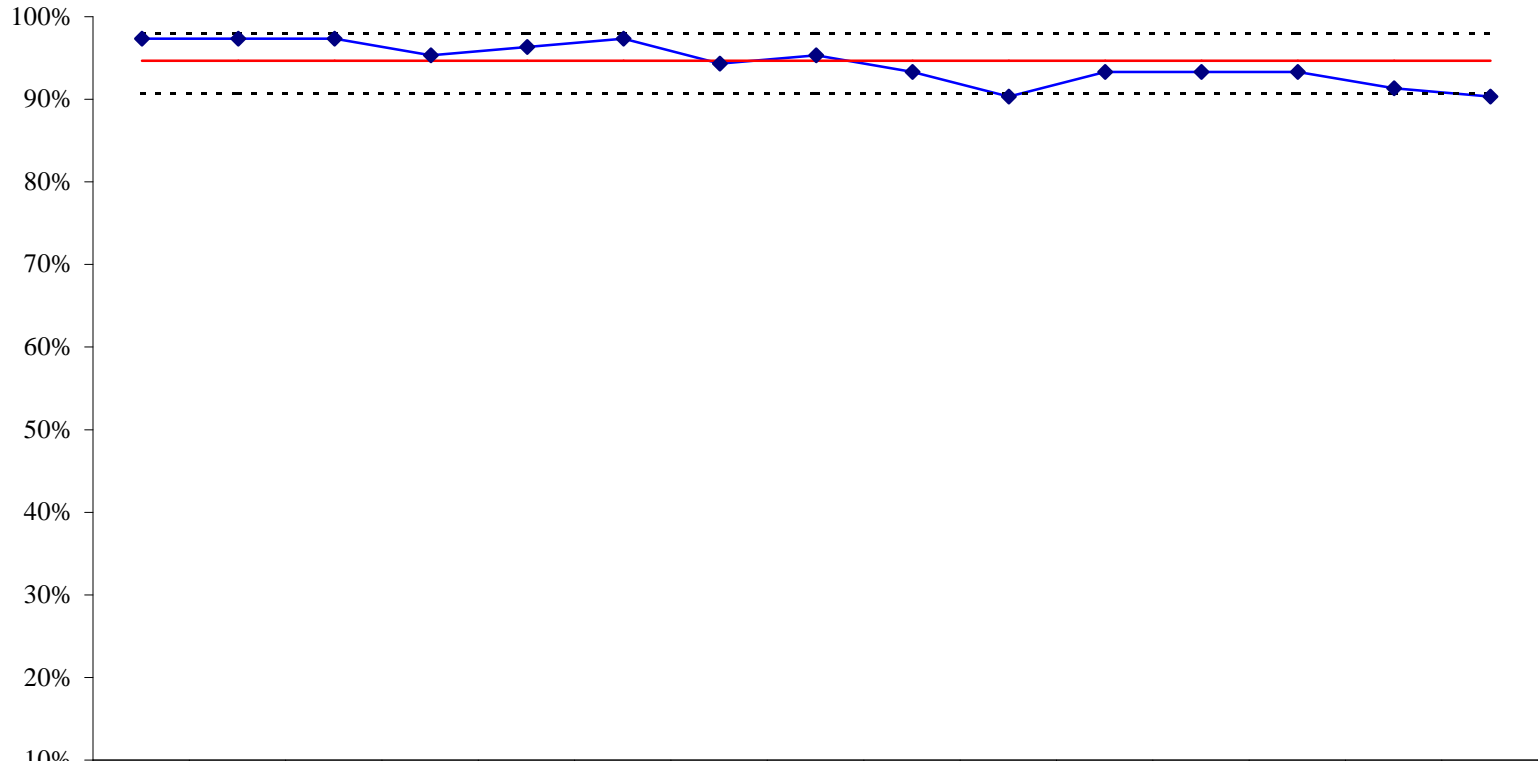
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	99%	99%	100%	99%	99%	99%	98%	99%	98%	98%	98%	98%	98%	98%	97%
-----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%

Objective 8A - Staff Current With Required Training
San Antonio State Hospital

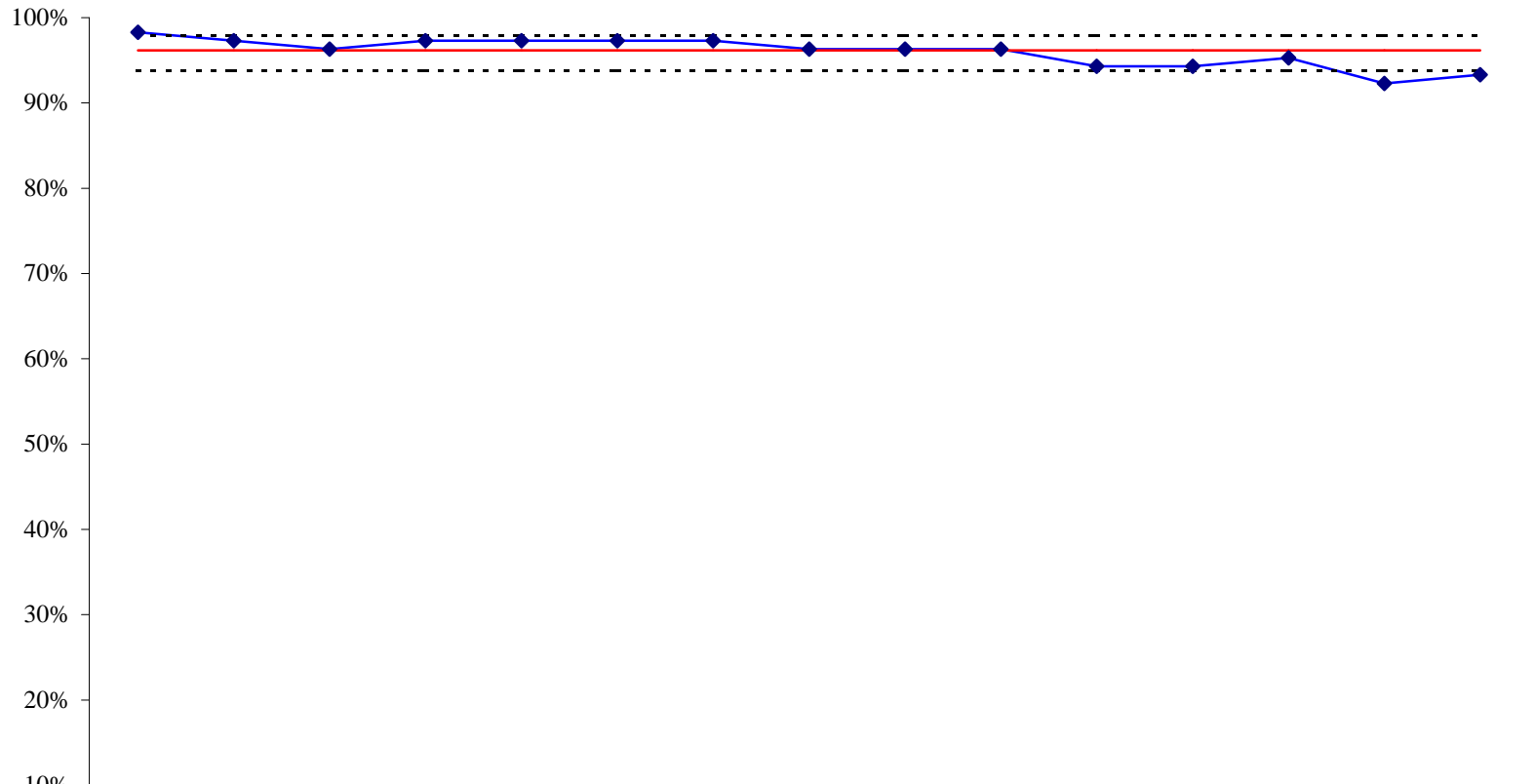
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	97%	97%	97%	95%	96%	97%	94%	95%	93%	90%	93%	93%	93%	91%	90%
-----UCL	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
— Avg	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
-----LCL	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%

Objective 8A - Staff Current With Required Training
Terrell State Hospital

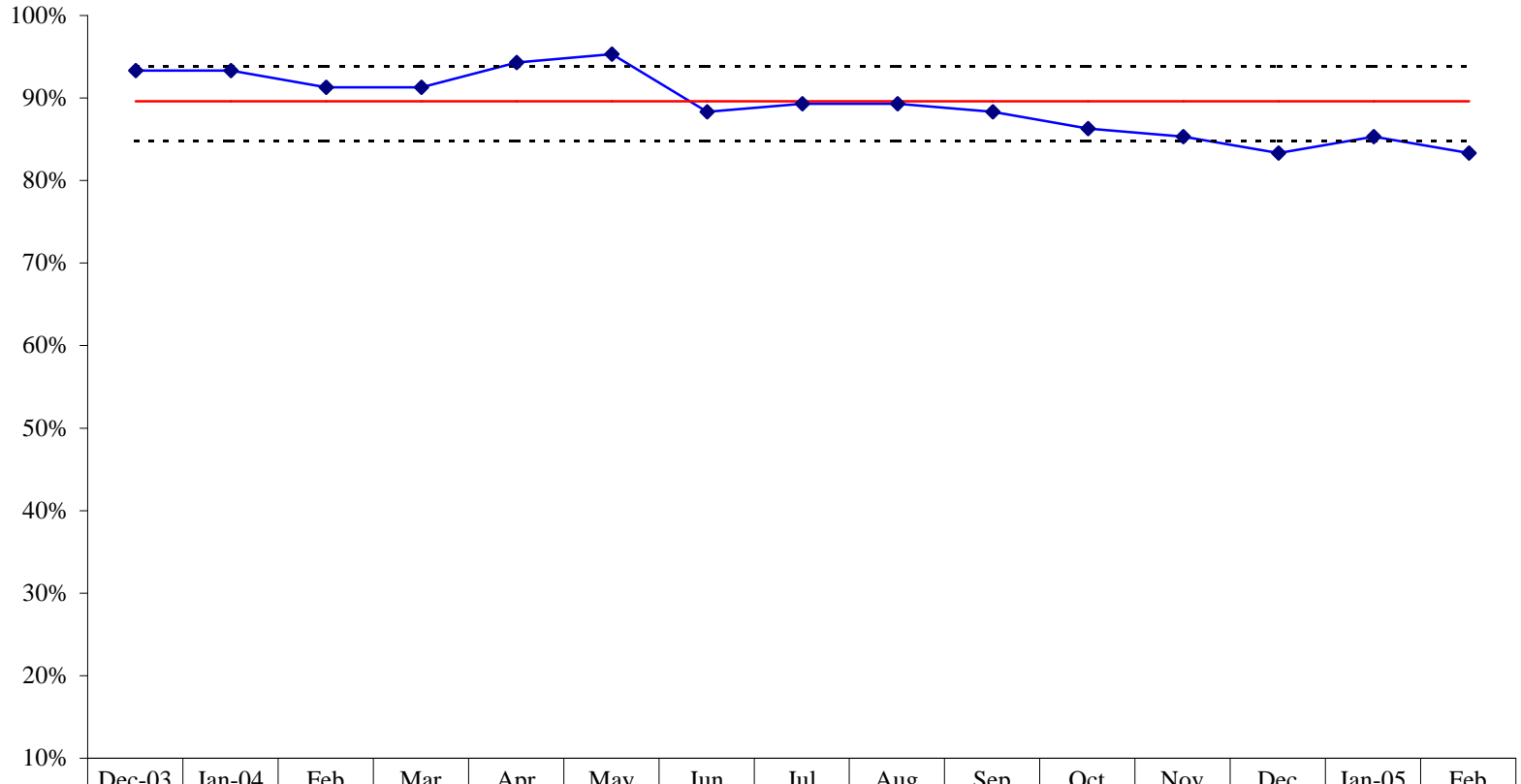
Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	98%	97%	96%	97%	97%	97%	97%	96%	96%	96%	94%	94%	95%	92%	93%
----- UCL	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
— Avg	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
----- LCL	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%

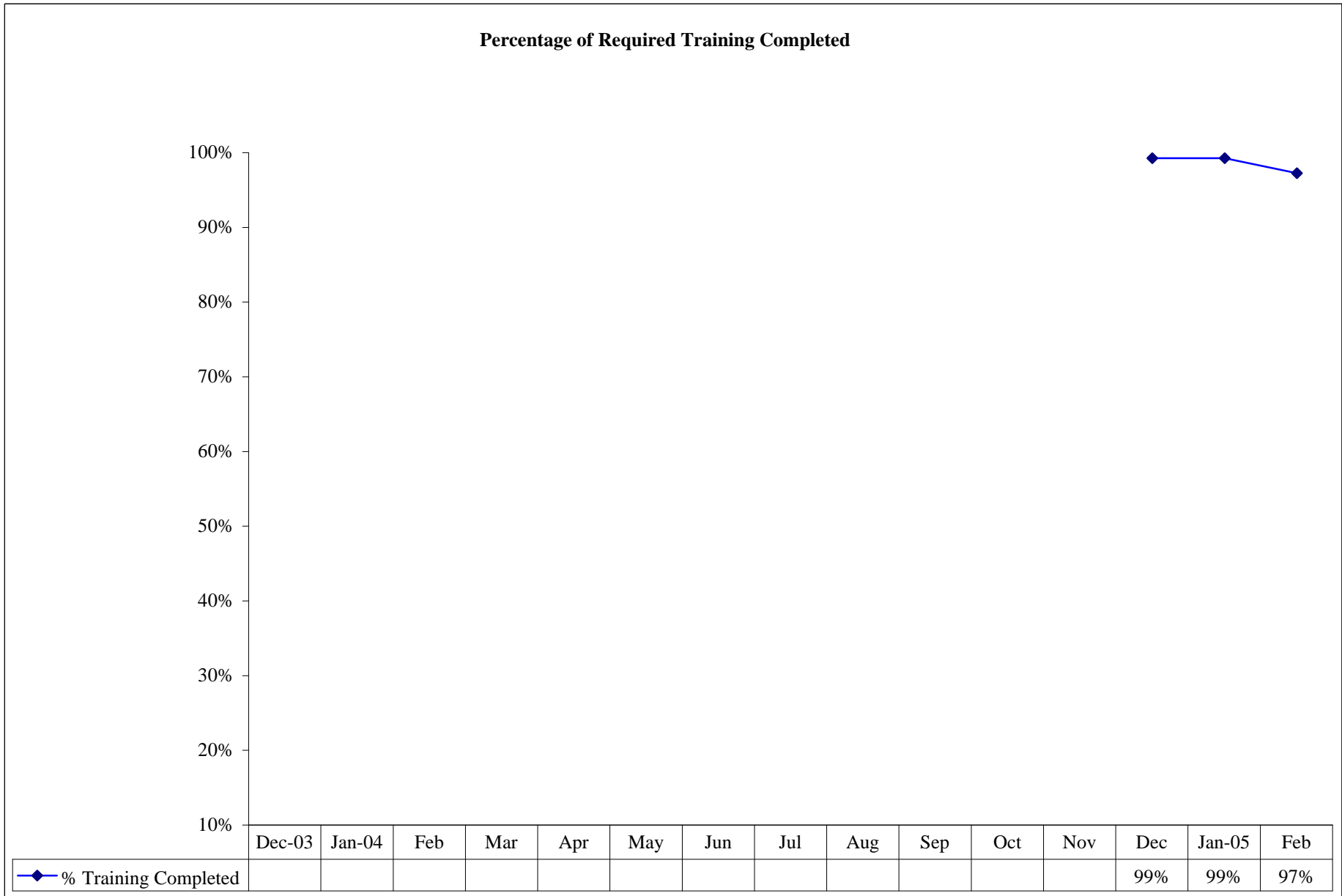
Objective 8A - Staff Current With Required Training
Waco Center for Youth

Percentage of Required Training Completed



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
◆ % Training Completed	93%	93%	91%	91%	94%	95%	88%	89%	89%	88%	86%	85%	83%	85%	83%
----- UCL	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
— Avg	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%
----- LCL	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Objective 8A - Staff Current With Required Training
South Texas Health Care Services



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

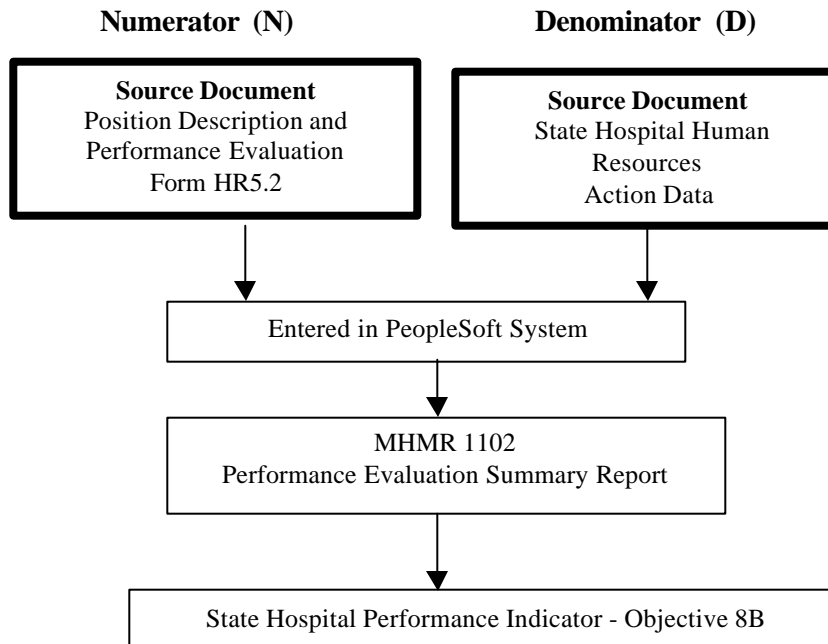
N = number of employees with current evaluations on the last day of the month

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:

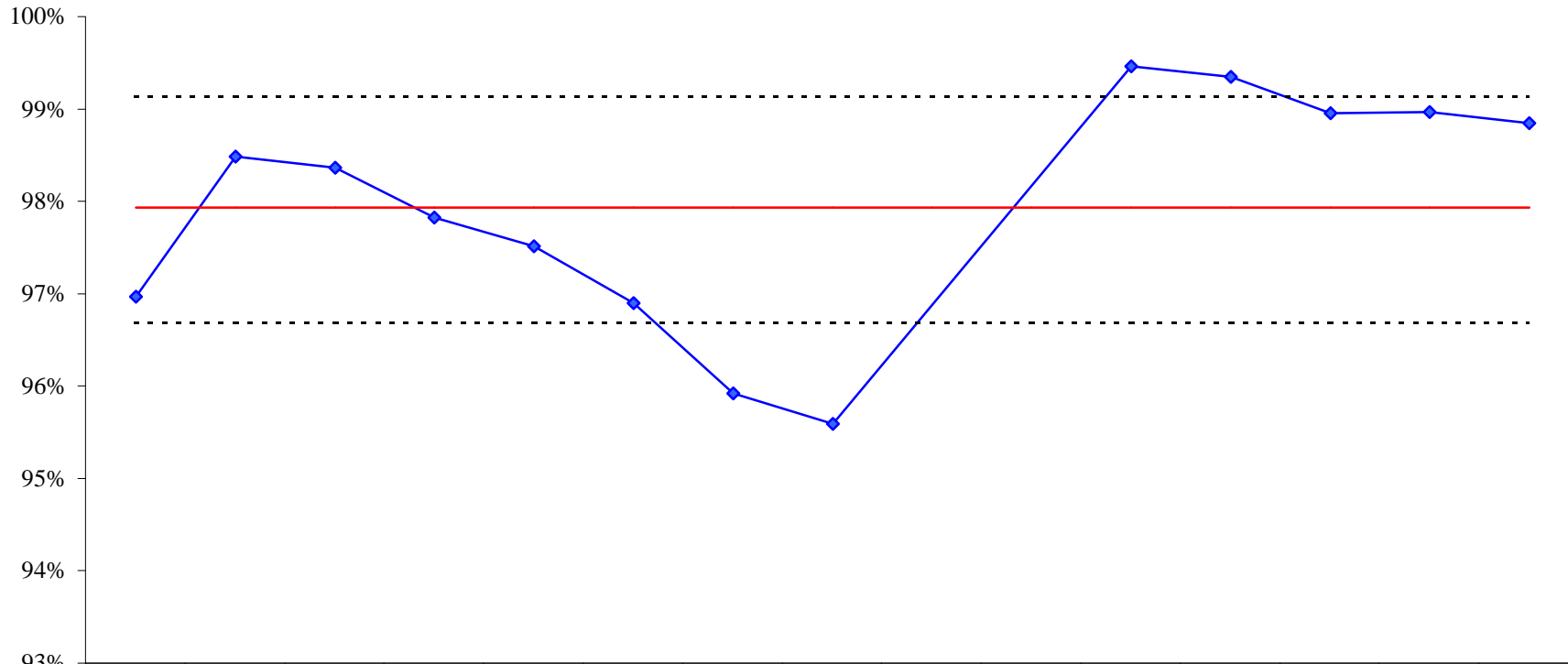


Data Integrity Review Process:

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

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

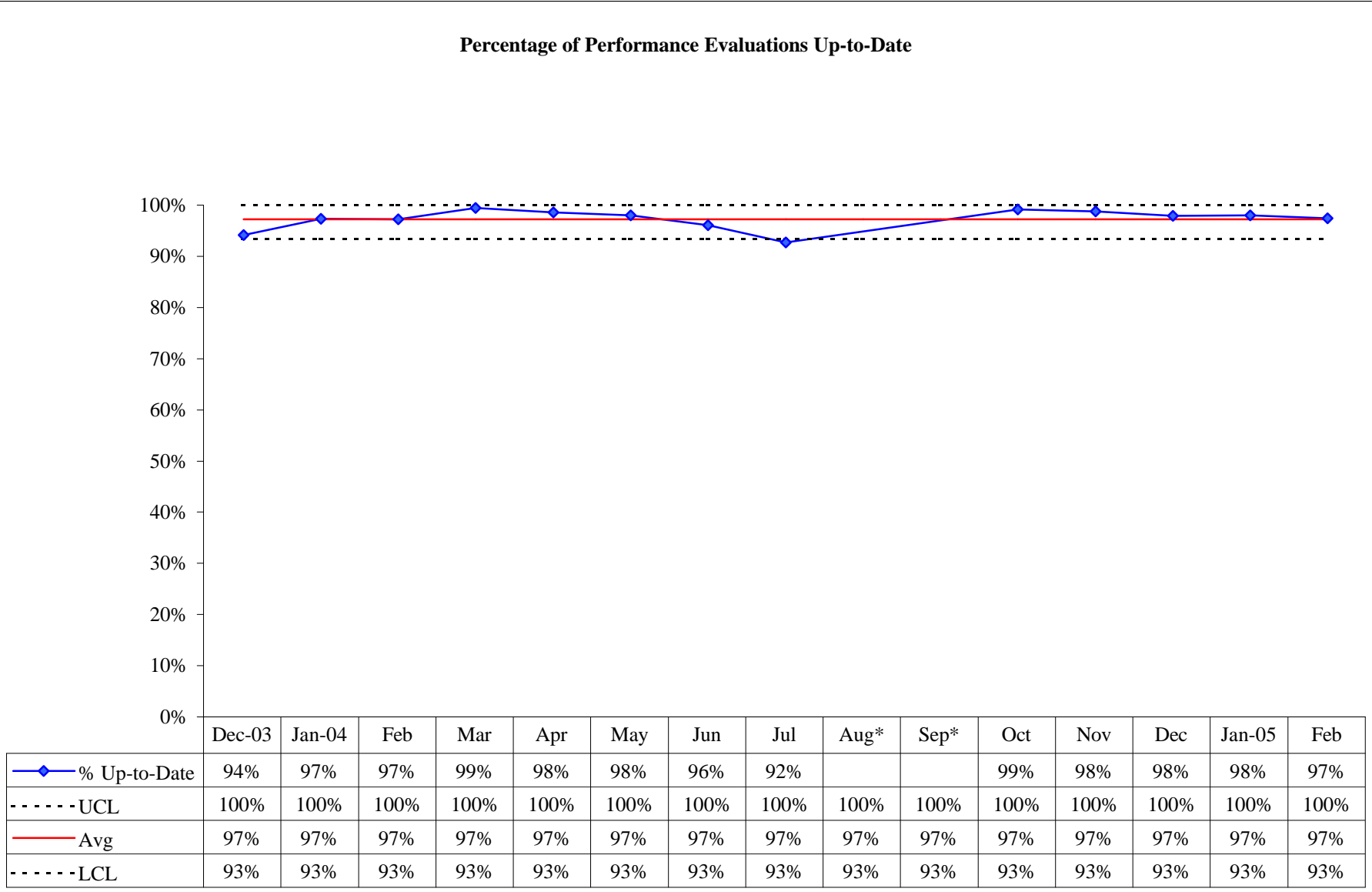
Percentage of Performance Evaluations Up-to-Date



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug*	Sep*	Oct	Nov	Dec	Jan-05	Feb
% Up-to-Date	97%	98%	98%	98%	97%	97%	96%	96%			99%	99%	99%	99%	99%
UCL	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Avg	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
LCL	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

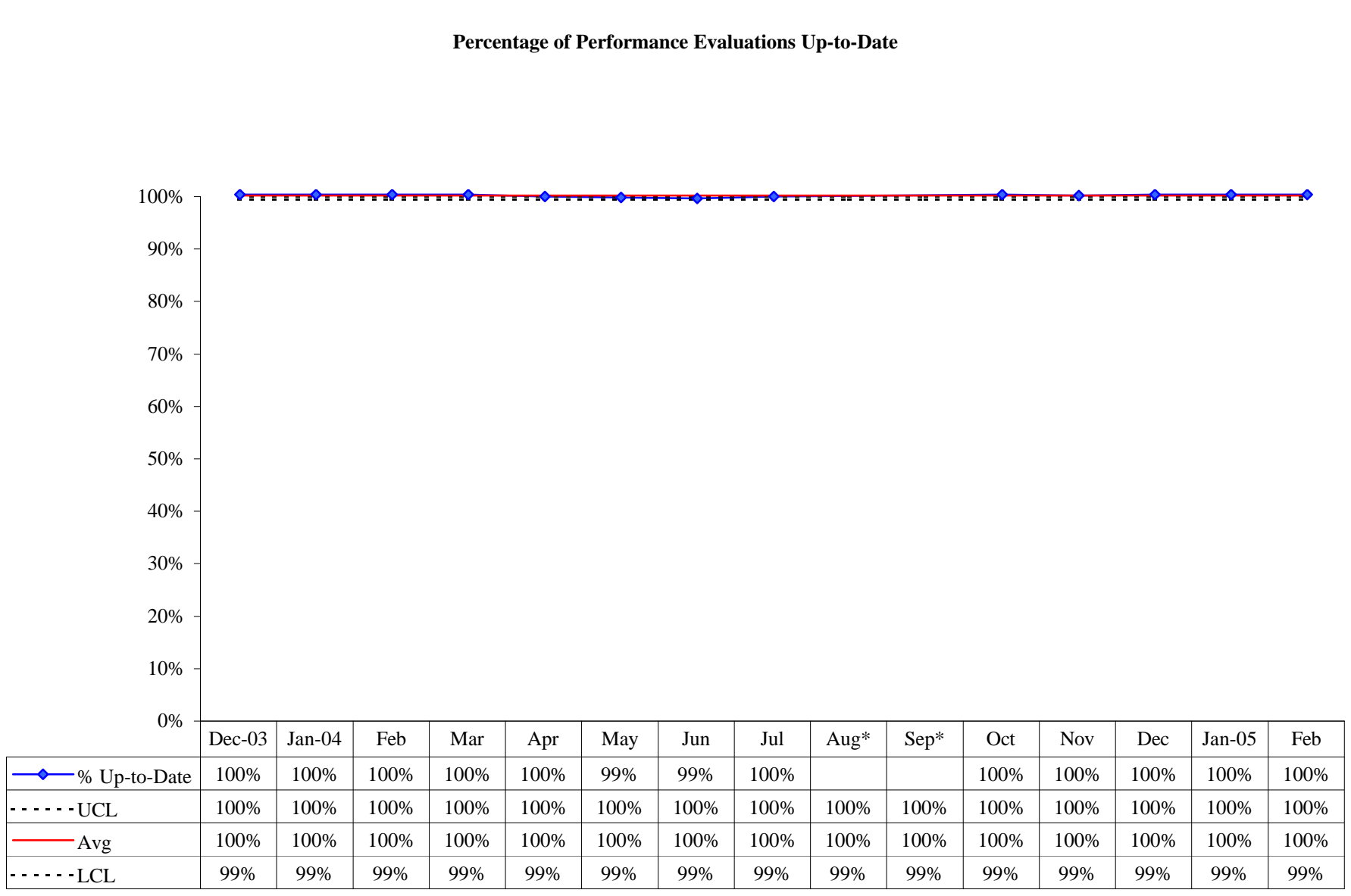
*Data not available

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



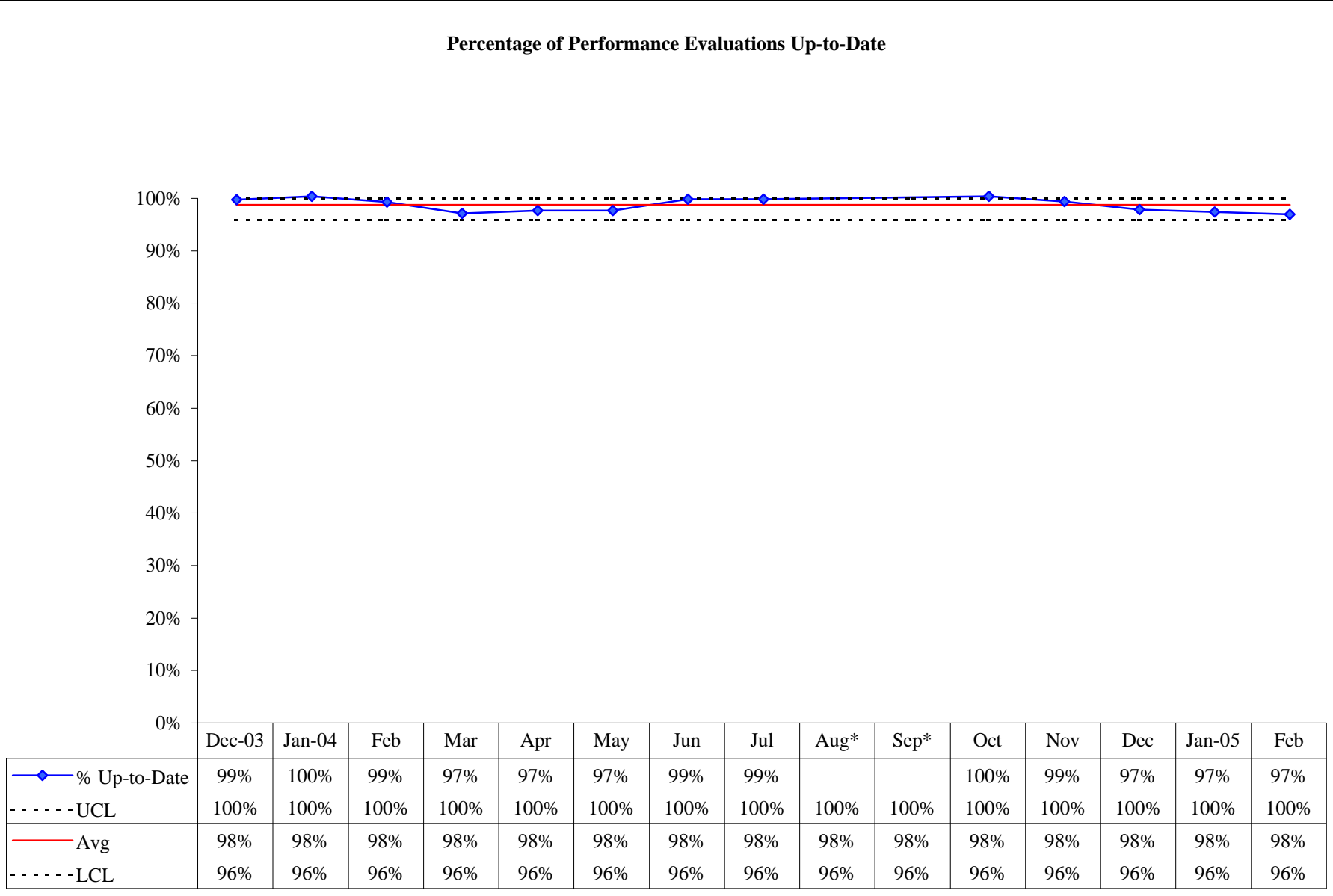
*Data not available

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



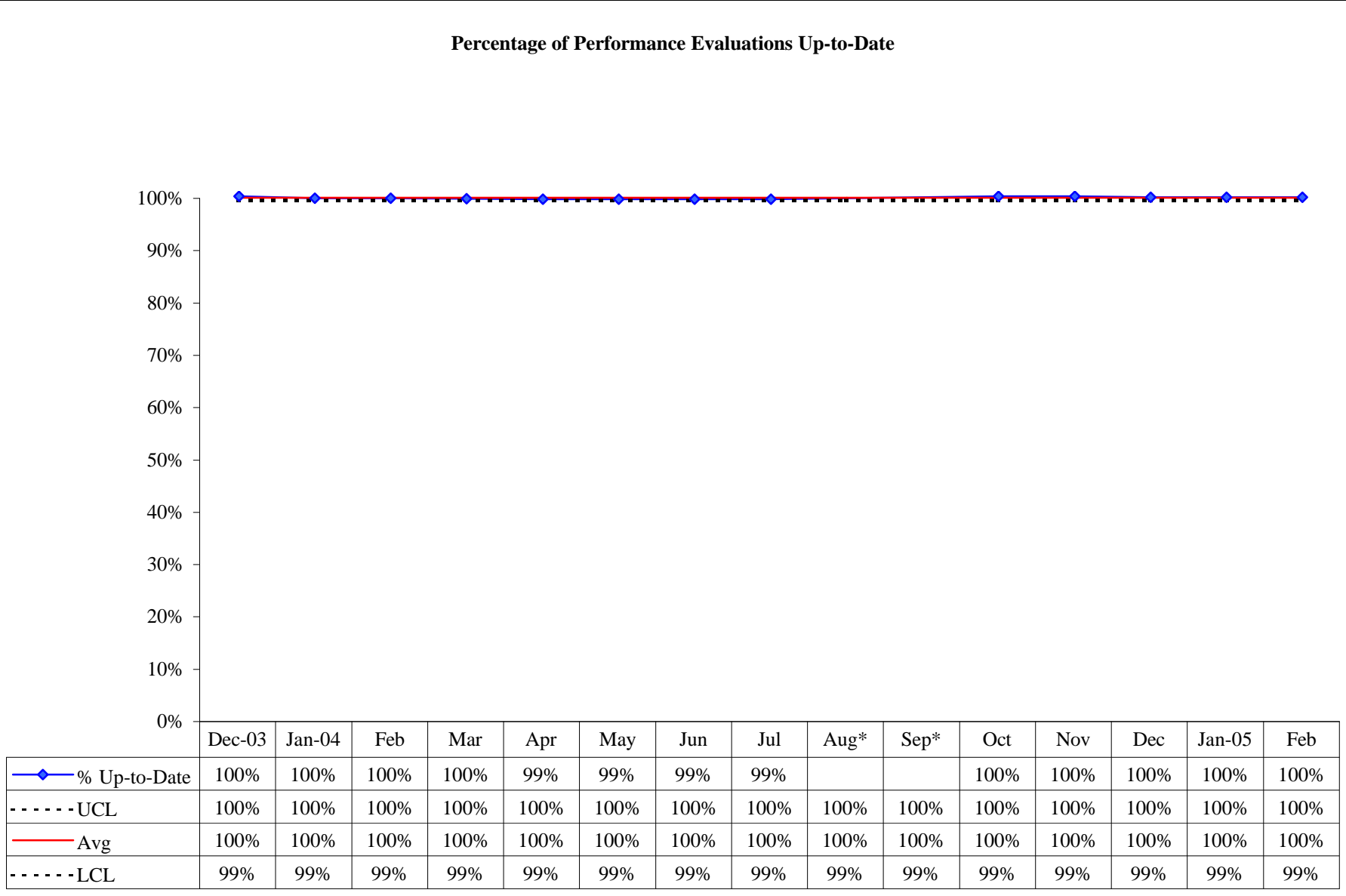
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Objective 8B - Staff Have Current Performance Evaluations
El Paso Psychiatric Center



*Data not available

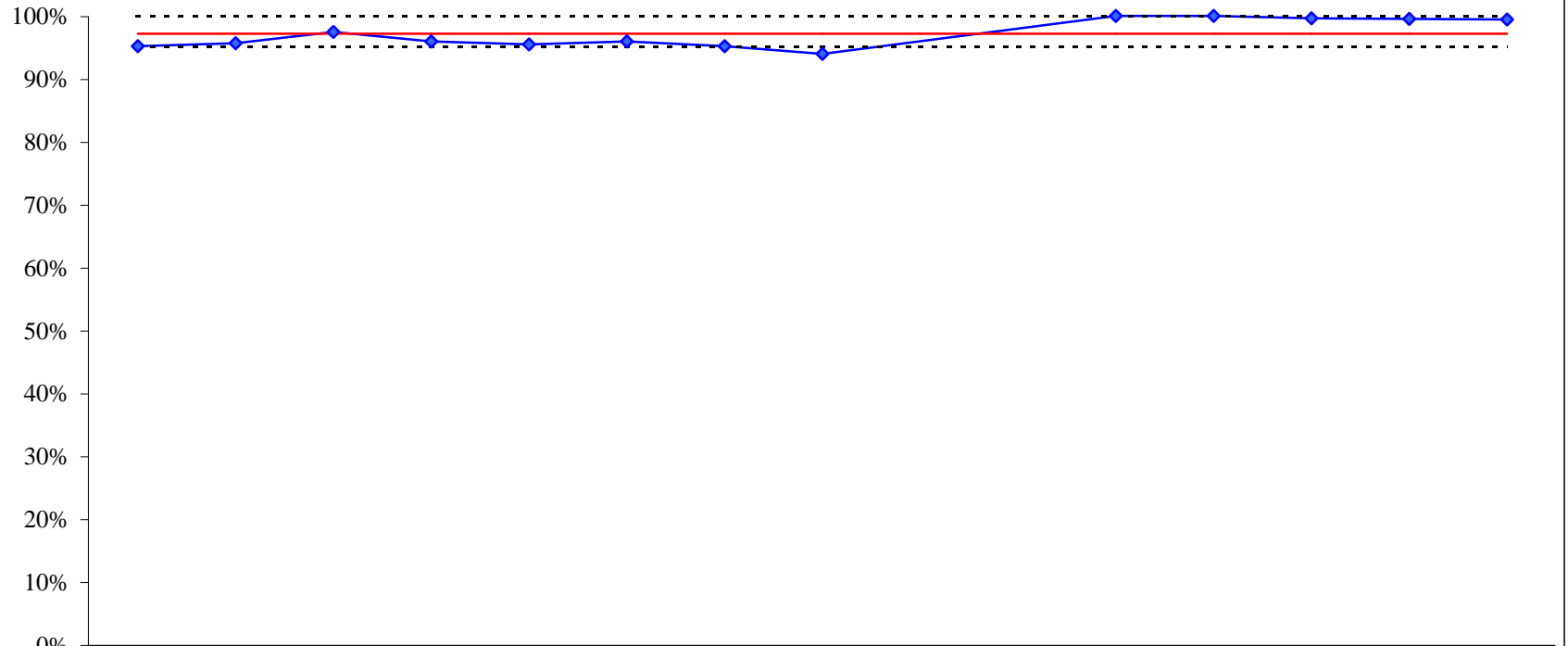
**Objective 8B - Staff Have Current Performance Evaluations
Kerrville State Hospital**



*Data not available

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

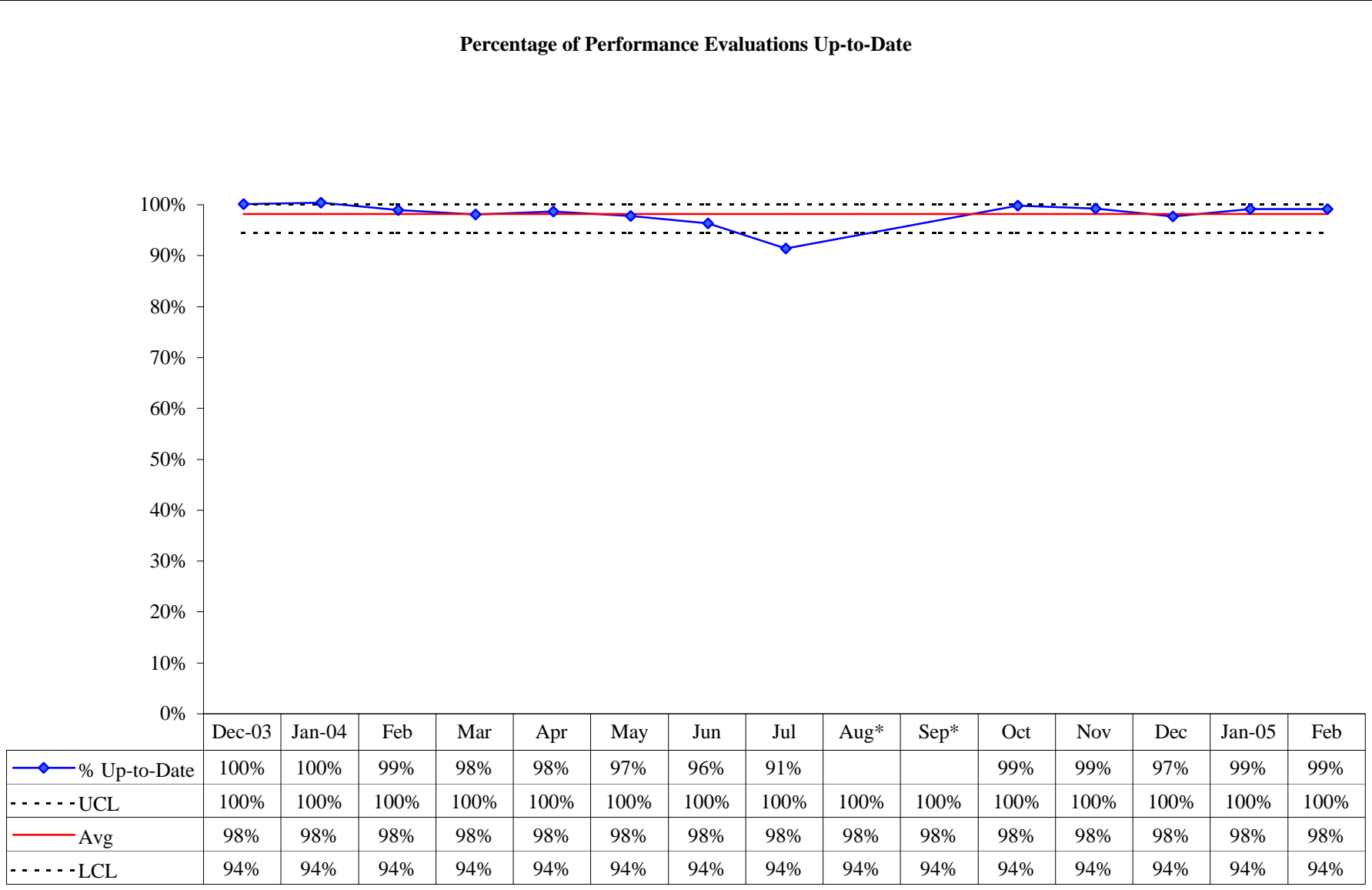
Percentage of Performance Evaluations Up-to-Date



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug*	Sep*	Oct	Nov	Dec	Jan-05	Feb
◆ % Up-to-Date	95%	95%	97%	96%	95%	96%	95%	94%			100%	100%	99%	99%	99%
- - - - - 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	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

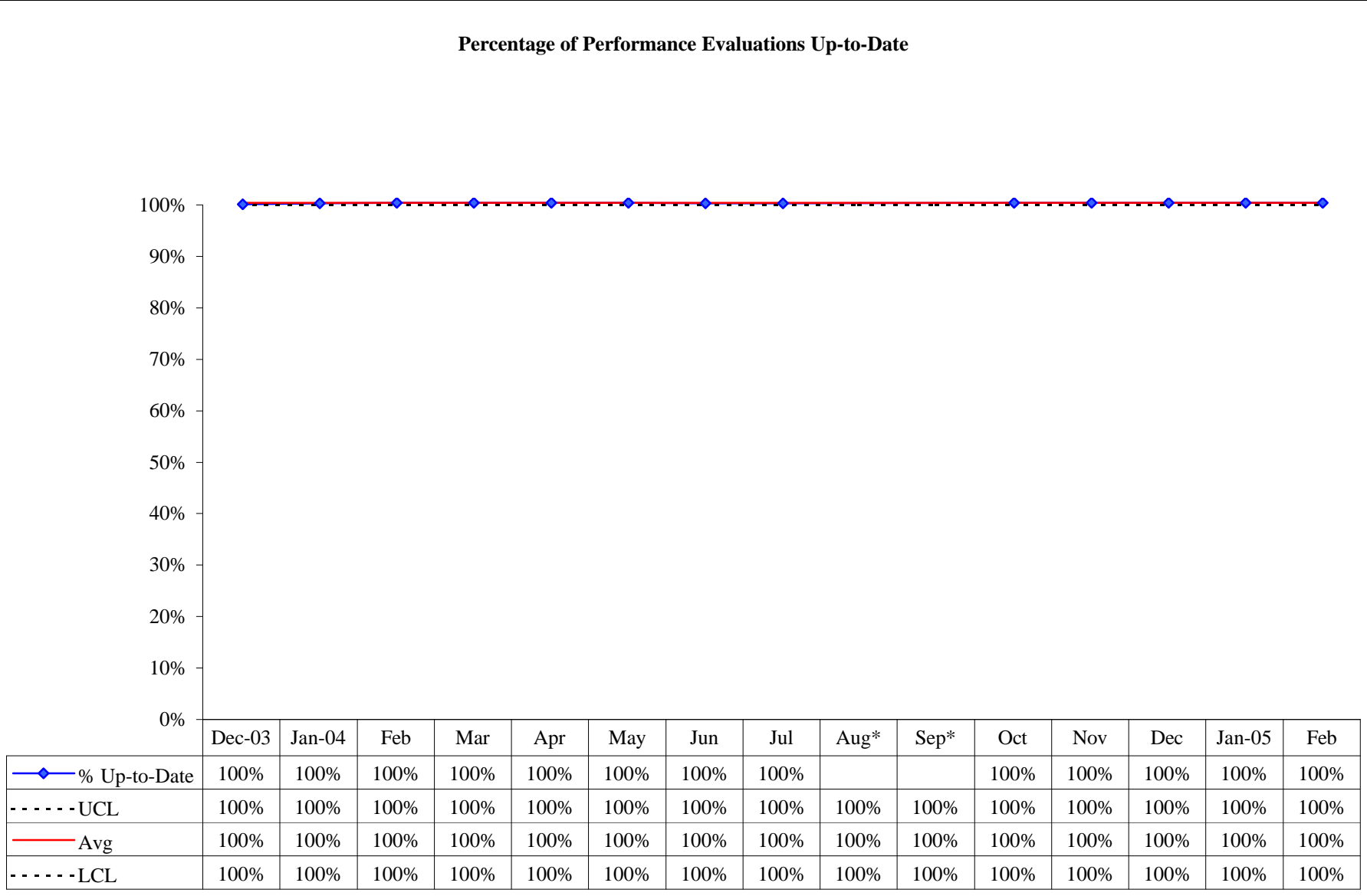
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Objective 8B - Staff Have Current Performance Evaluations
Rio Grande State Center



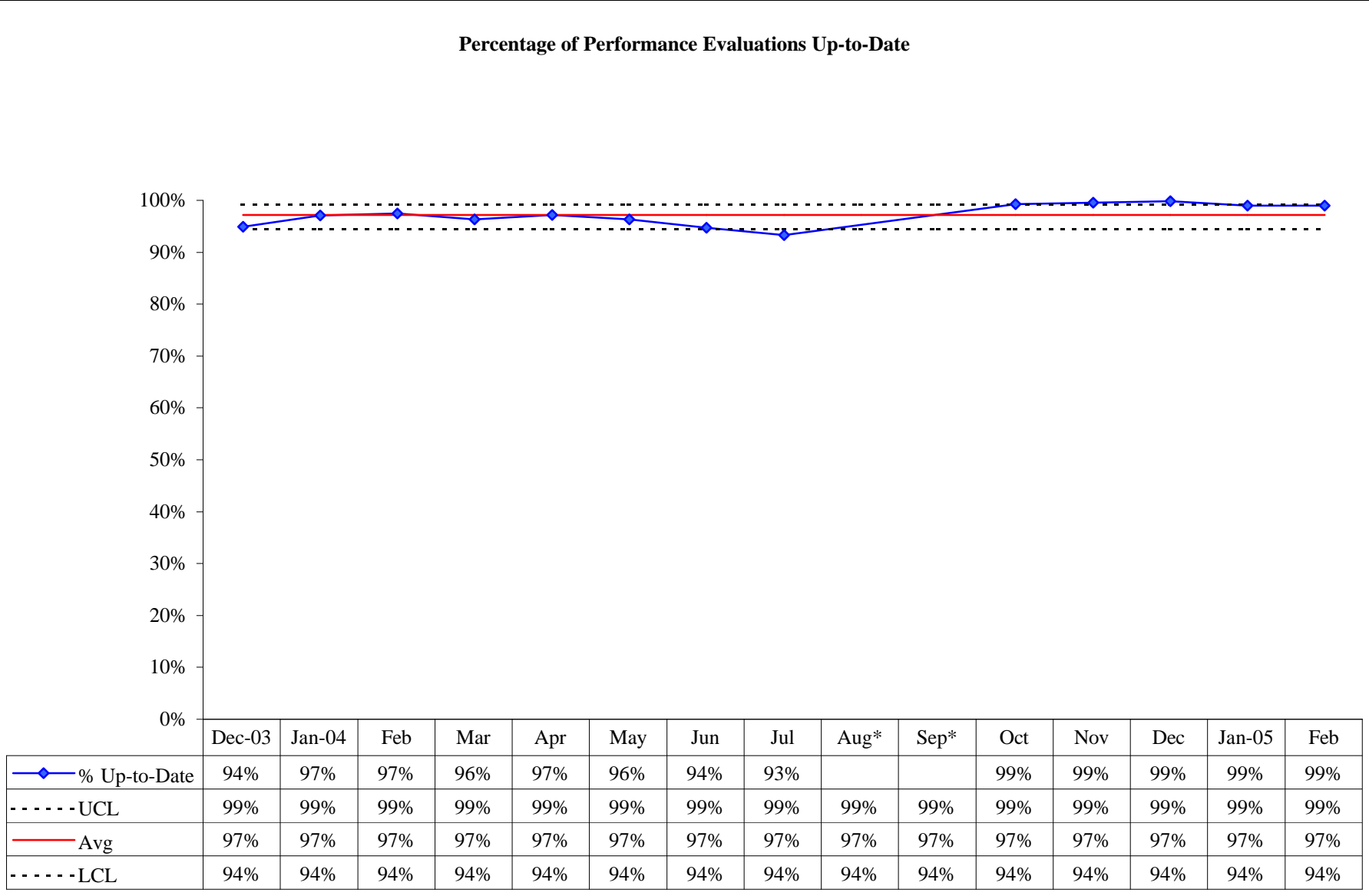
*Data not available

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



*Data not available

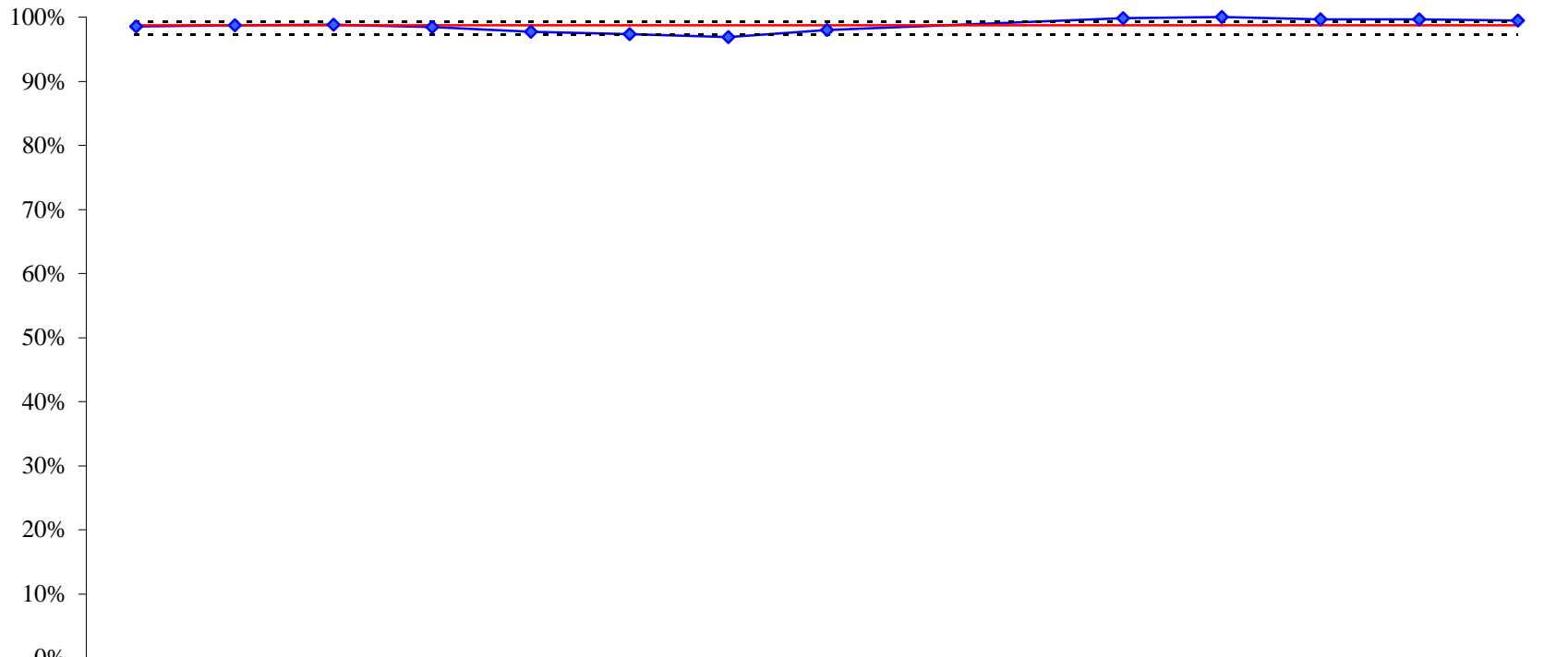
Objective 8B - Staff Have Current Performance Evaluations
San Antonio State Hospital



*Data not available

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

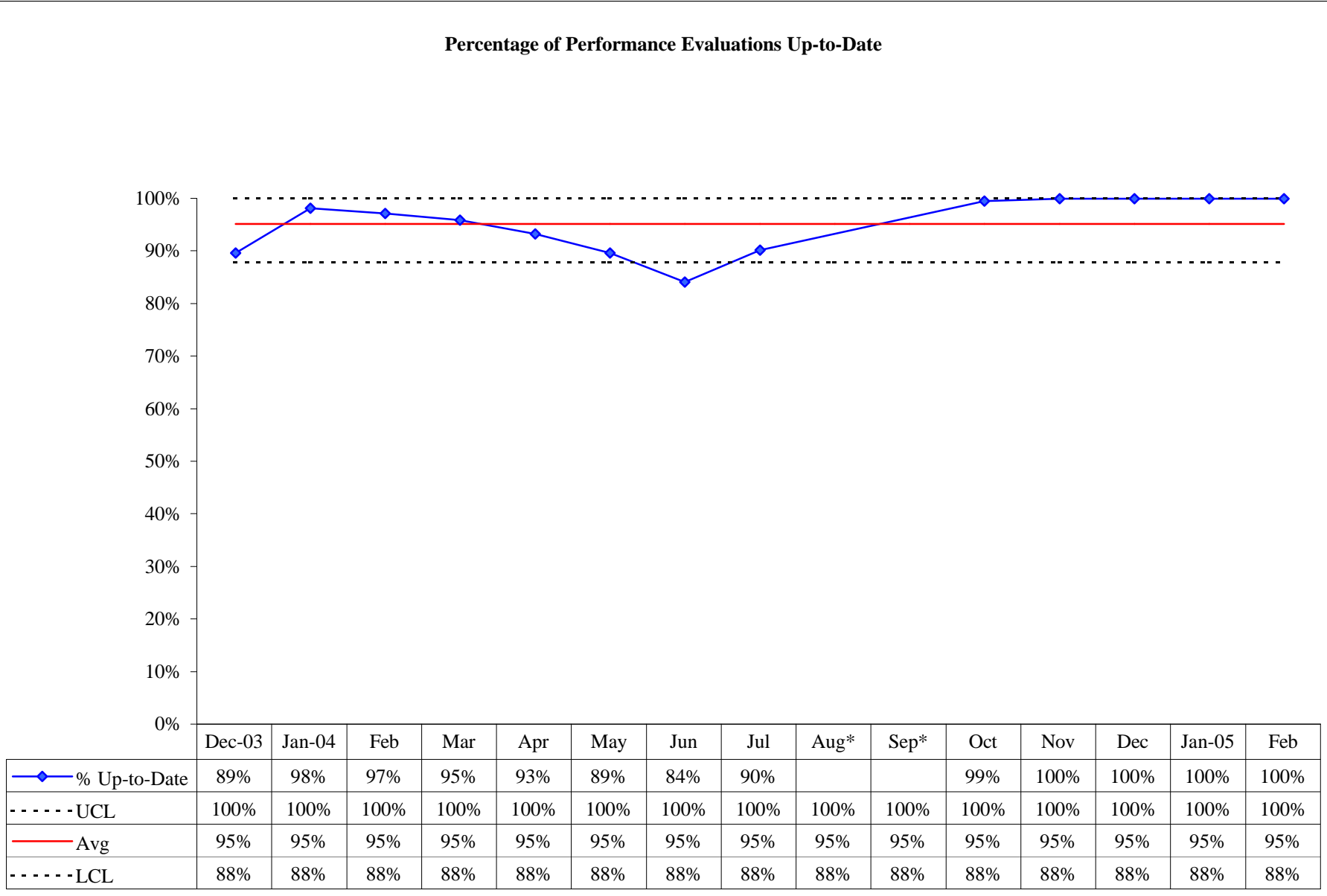
Percentage of Performance Evaluations Up-to-Date



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug*	Sep*	Oct	Nov	Dec	Jan-05	Feb
◆ % Up-to-Date	98%	98%	98%	98%	97%	97%	96%	98%			99%	100%	99%	99%	99%
----- UCL	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
— Avg	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
----- LCL	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

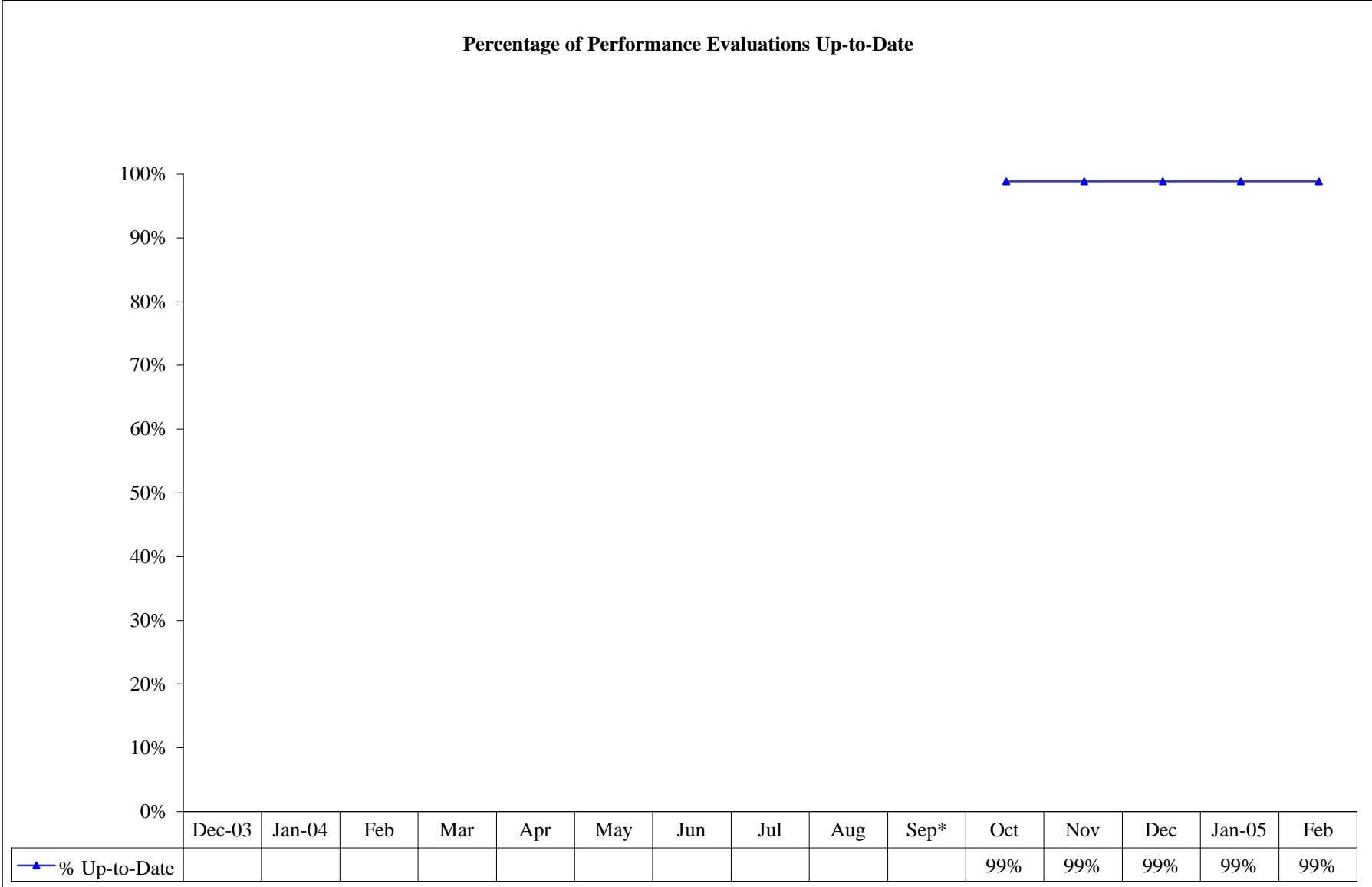
*Data not available

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



*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.

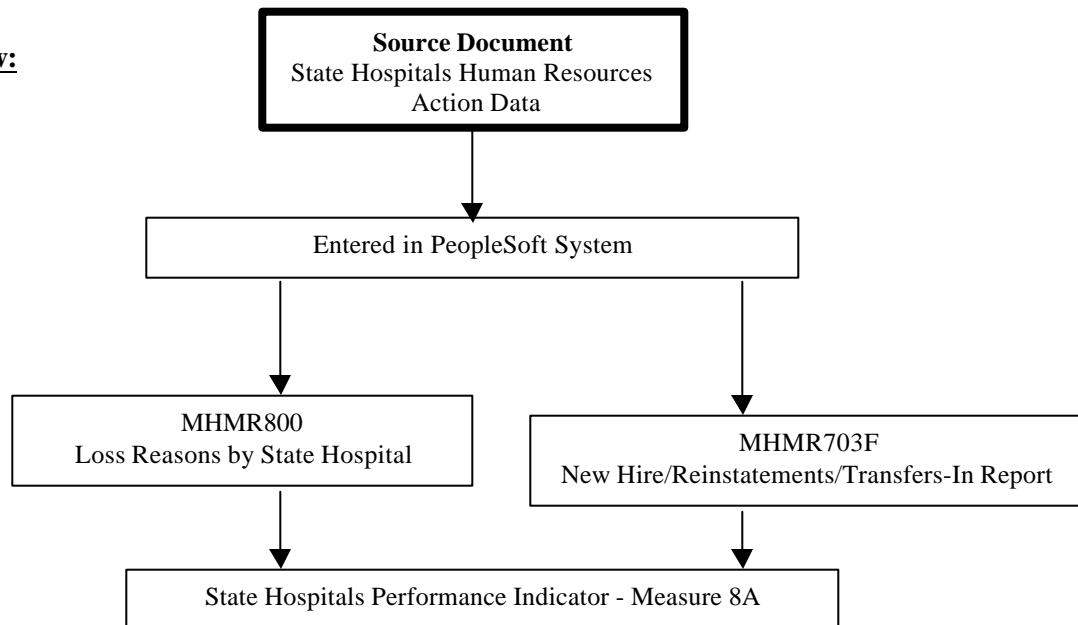
Performance Measure Operational Definition: The state hospital rate of staff turnover relating to “new hires” and “losses” will be available to the board.

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.

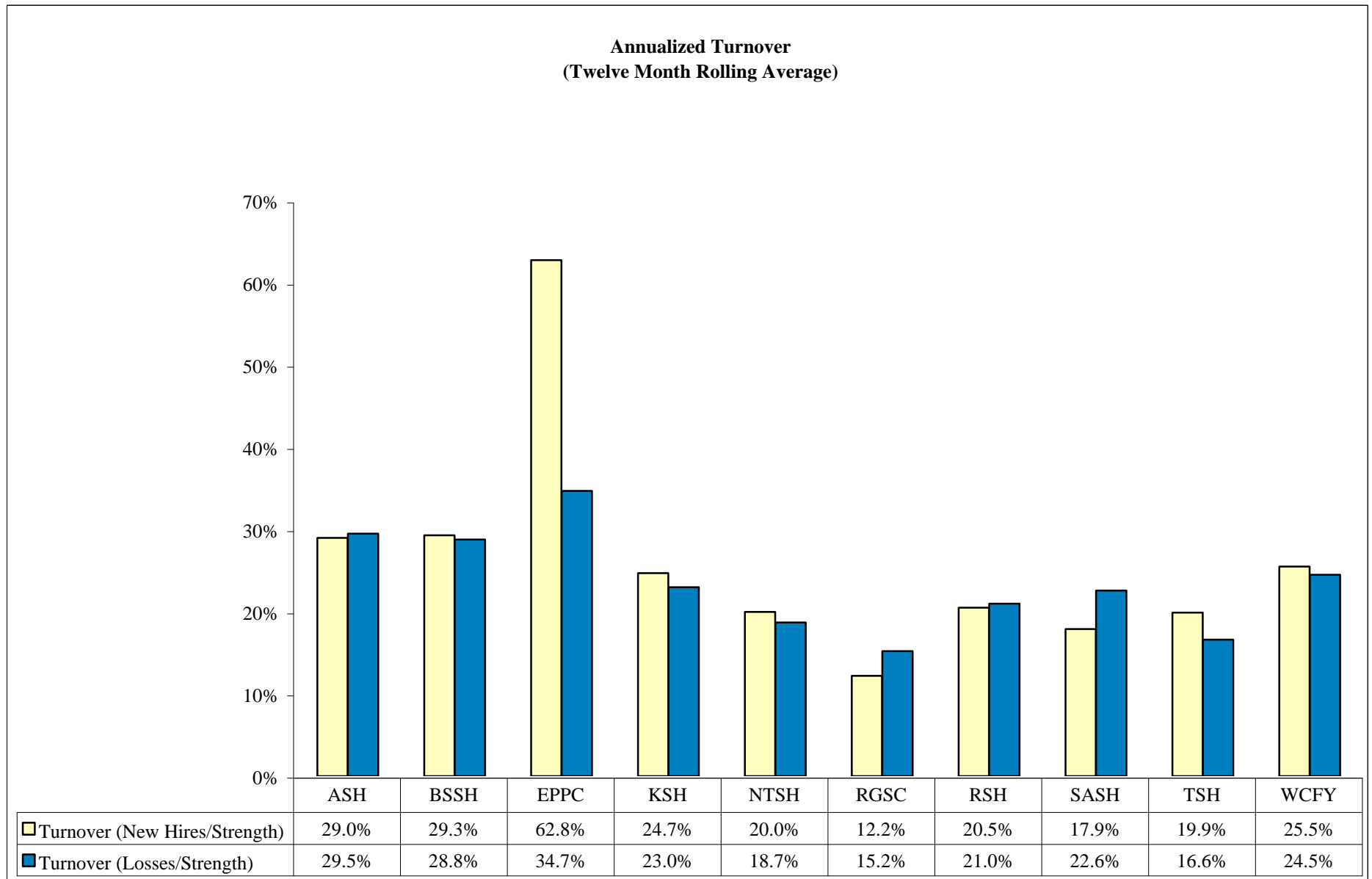
Data Flow:



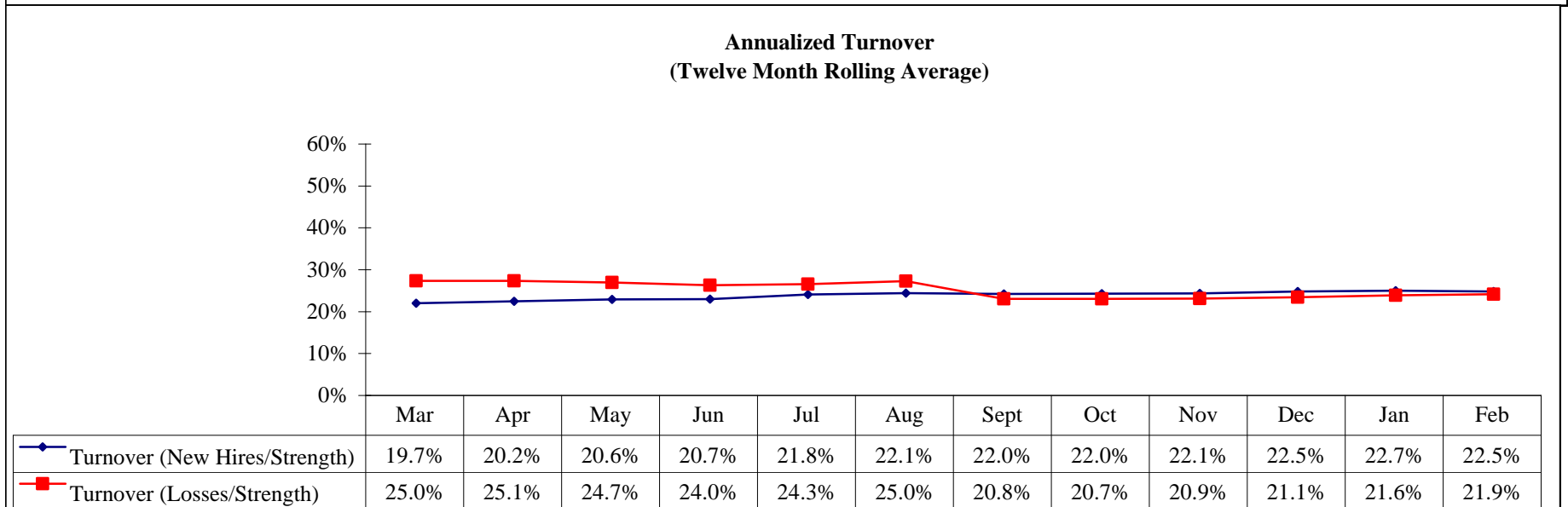
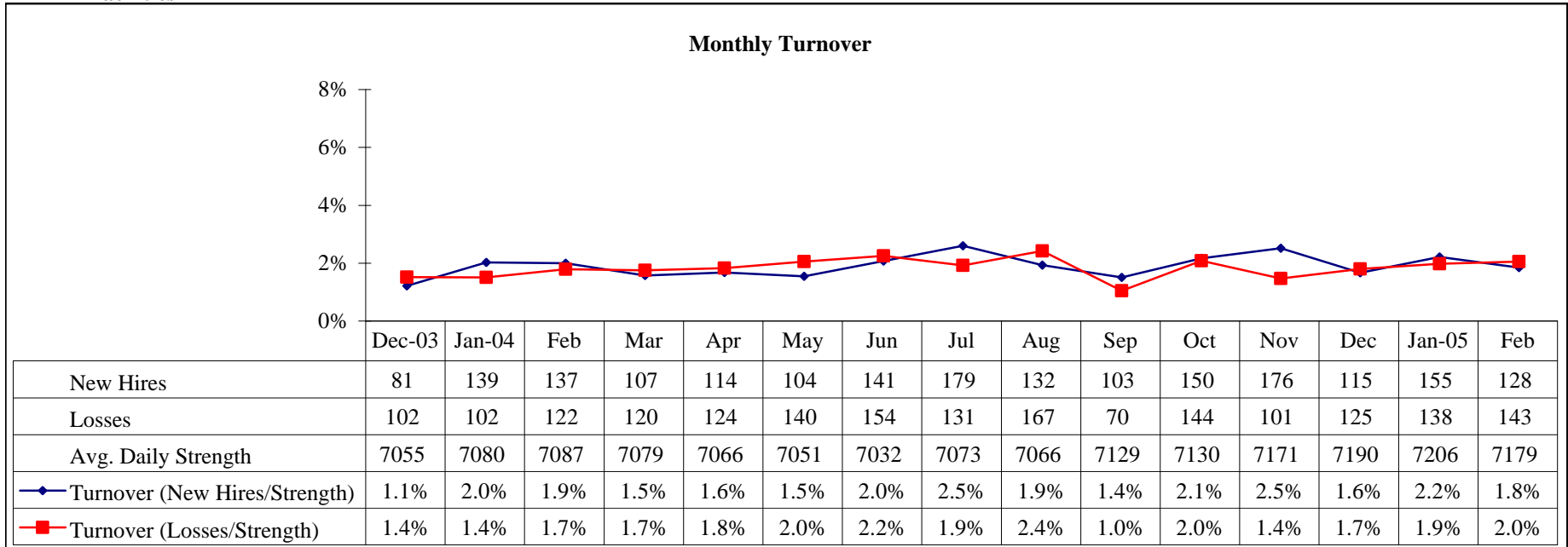
Data Integrity Review Process:

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

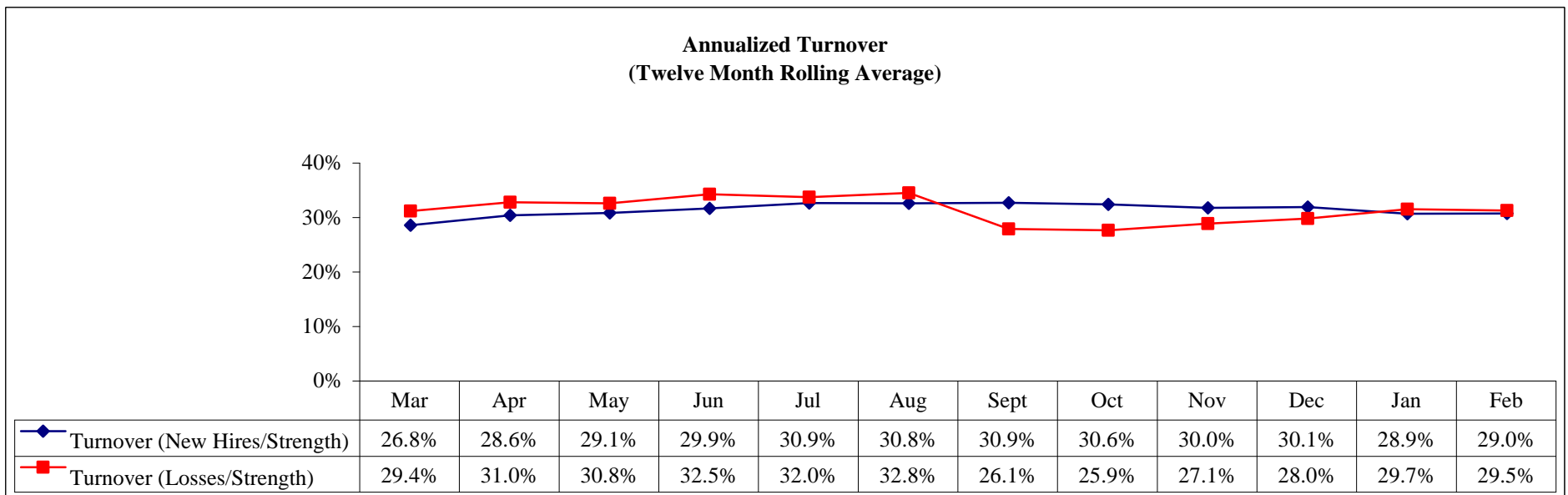
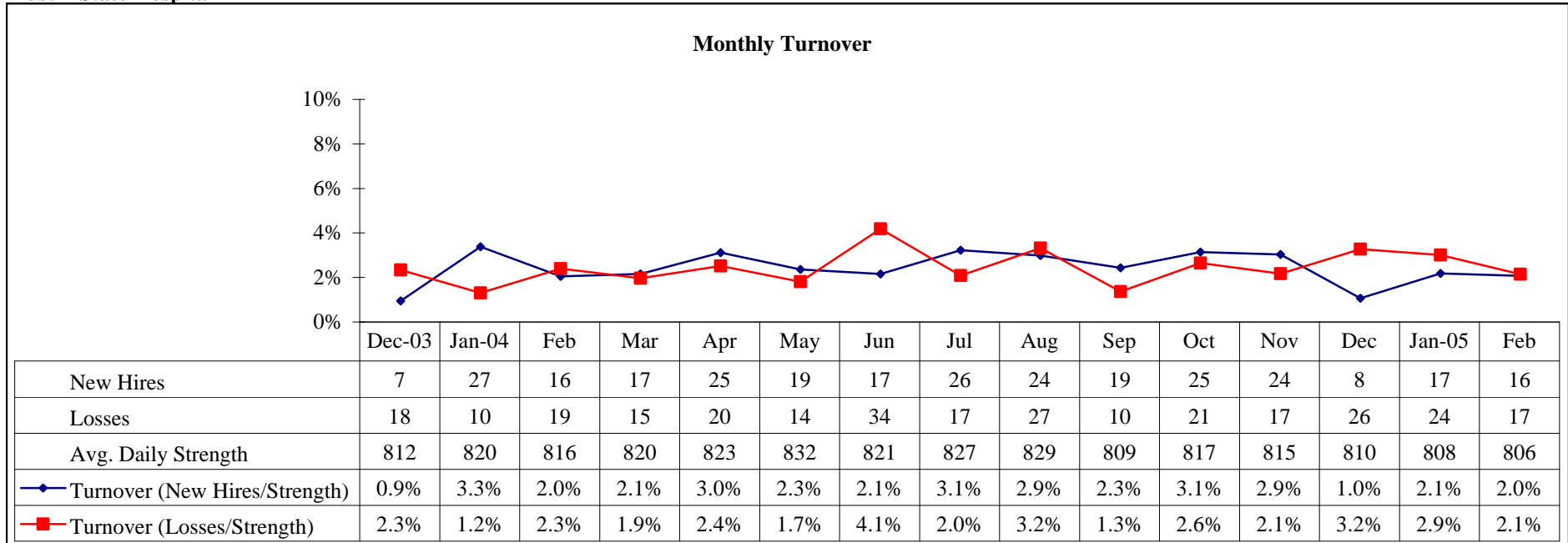
Measure 8A - Staff Turnover Rates
All MH Facilities



Measure 8A - Staff Turnover Rates
All MH Facilities



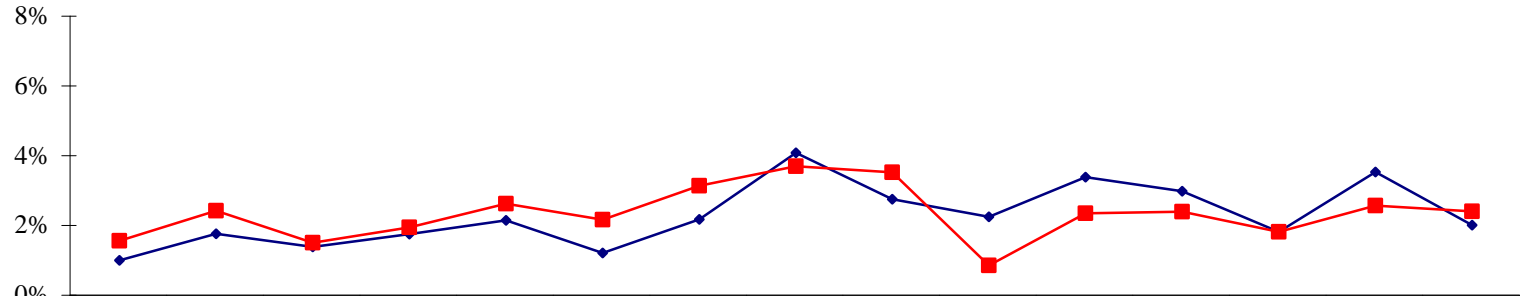
Measure 8A - Staff Turnover Rates
Austin State Hospital



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

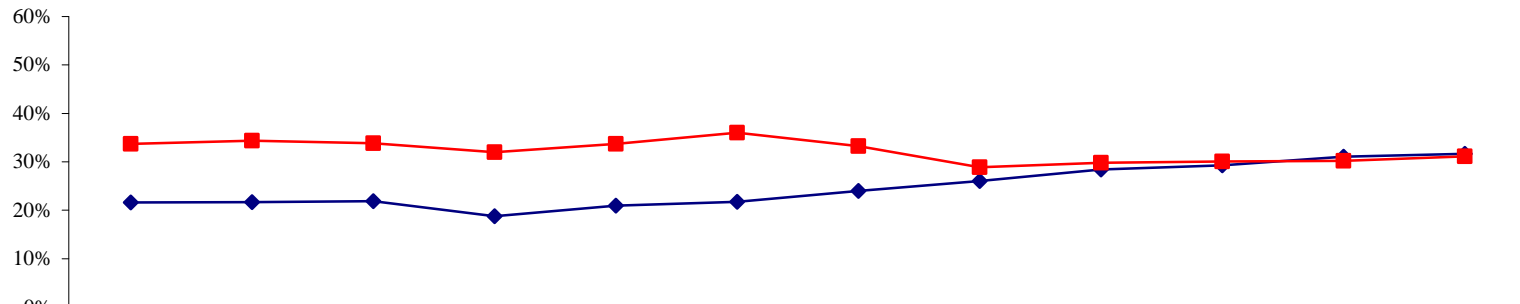
Measure 8A - Staff Turnover Rates
Big Spring State Hospital

Monthly Turnover



	Dec-03	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
New Hires	5	9	7	9	11	6	11	21	14	11	17	15	9	18	10
Losses	8	13	8	10	14	11	16	19	18	4	12	12	9	13	12
Avg. Daily Strength	535	529	529	532	527	524	520	523	521	505	511	515	515	520	514
◆ Turnover (New Hires/Strength)	0.9%	1.7%	1.3%	1.7%	2.1%	1.1%	2.1%	4.0%	2.7%	2.2%	3.3%	2.9%	1.7%	3.5%	1.9%
■ Turnover (Losses/Strength)	1.5%	2.4%	1.4%	1.9%	2.6%	2.1%	3.1%	3.6%	3.5%	0.8%	2.3%	2.3%	1.7%	2.5%	2.3%

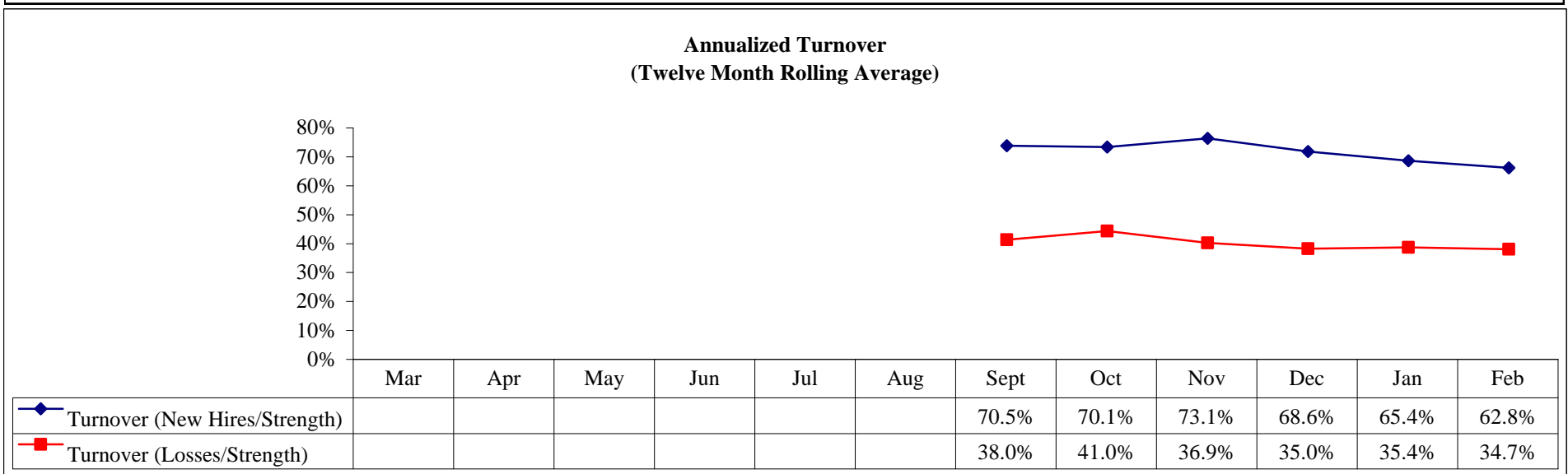
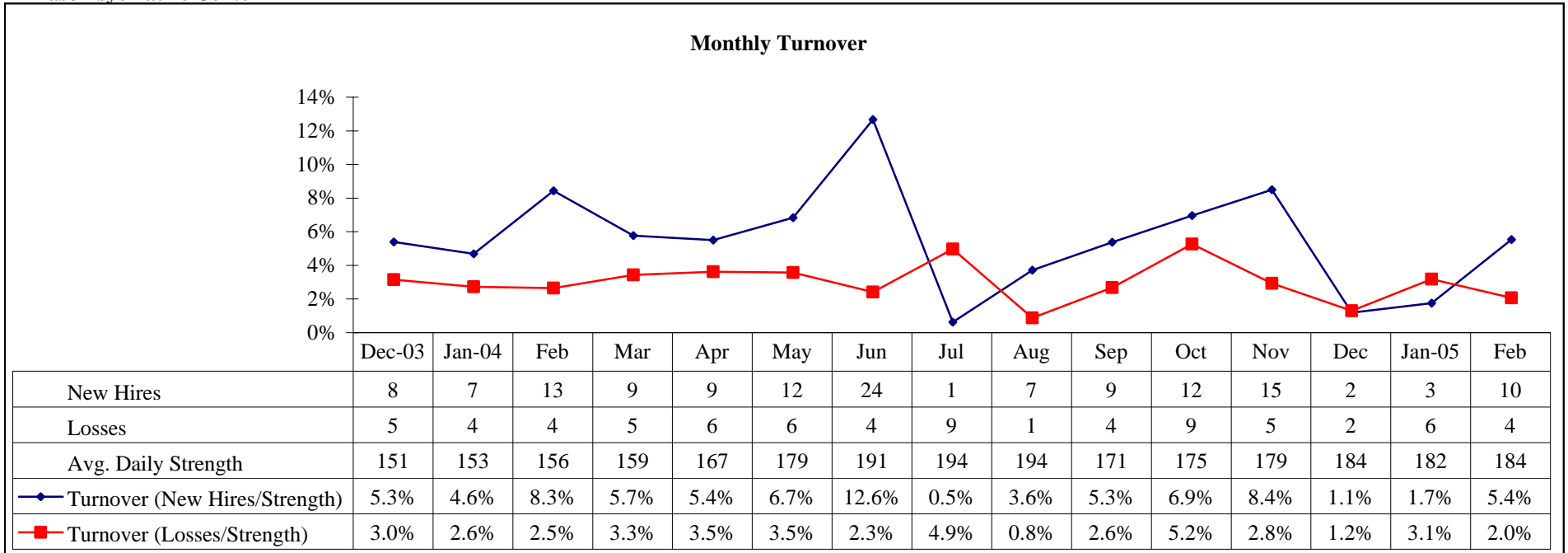
Annualized Turnover
(Twelve Month Rolling Average)



	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
◆ Turnover (New Hires/Strength)	19.2%	19.3%	19.5%	16.4%	18.6%	19.3%	21.6%	23.6%	26.0%	26.9%	28.7%	29.3%
■ Turnover (Losses/Strength)	31.3%	32.0%	31.5%	29.6%	31.3%	33.6%	30.9%	26.5%	27.4%	27.7%	27.8%	28.8%

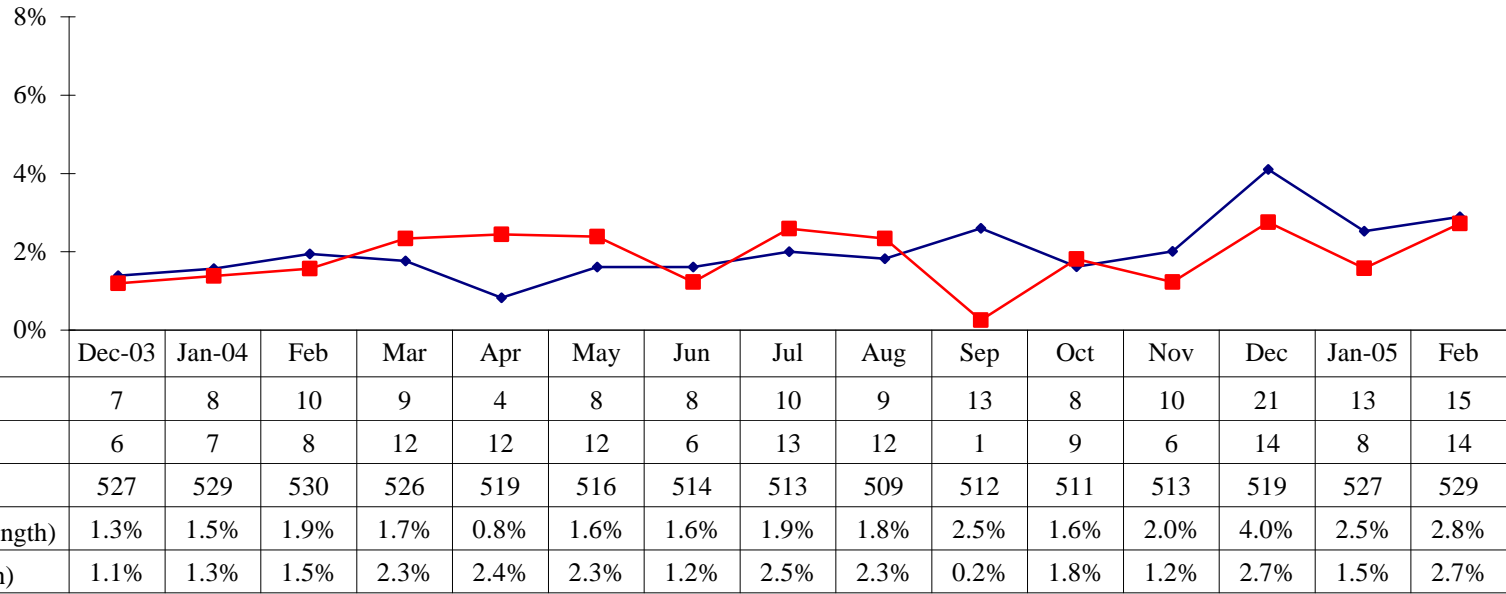
Source: Loss Reasons by Business Unit (MHMR800-PeopleSoft)
 New Hires/Reinstatements/Transfers In (MHMR703F-PeopleSoft)

Measure 8A - Staff Turnover Rates
El Paso Psychiatric Center

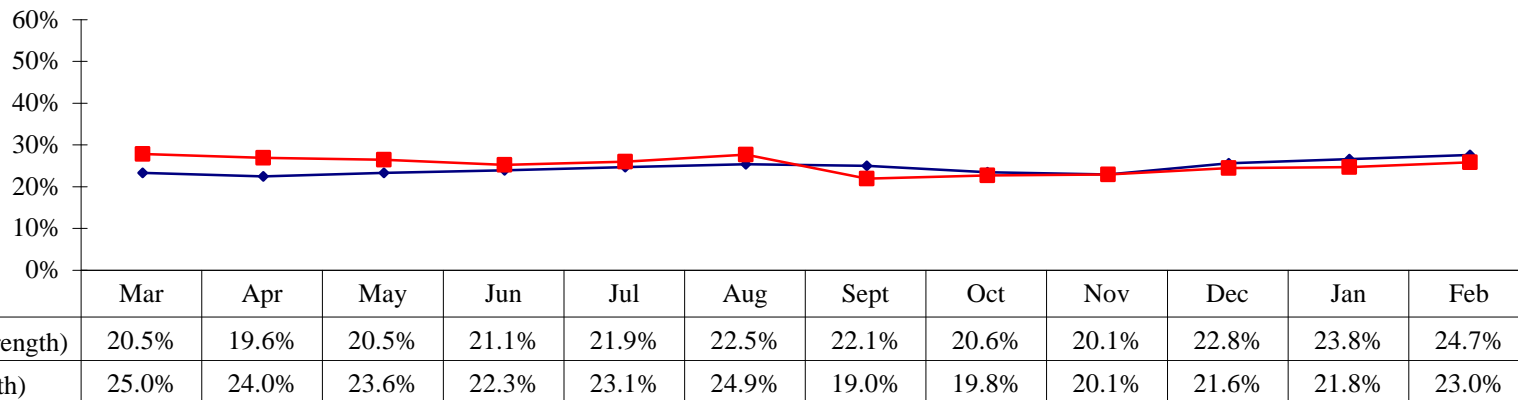


Measure 8A - Staff Turnover Rates
Kerrville State Hospital

Monthly Turnover

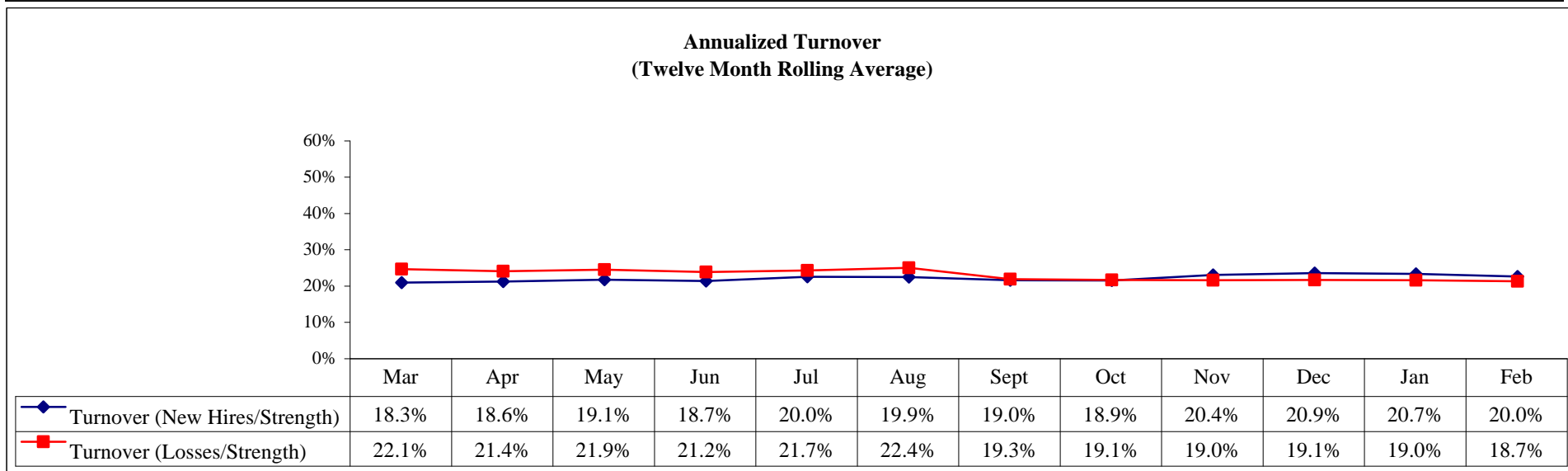
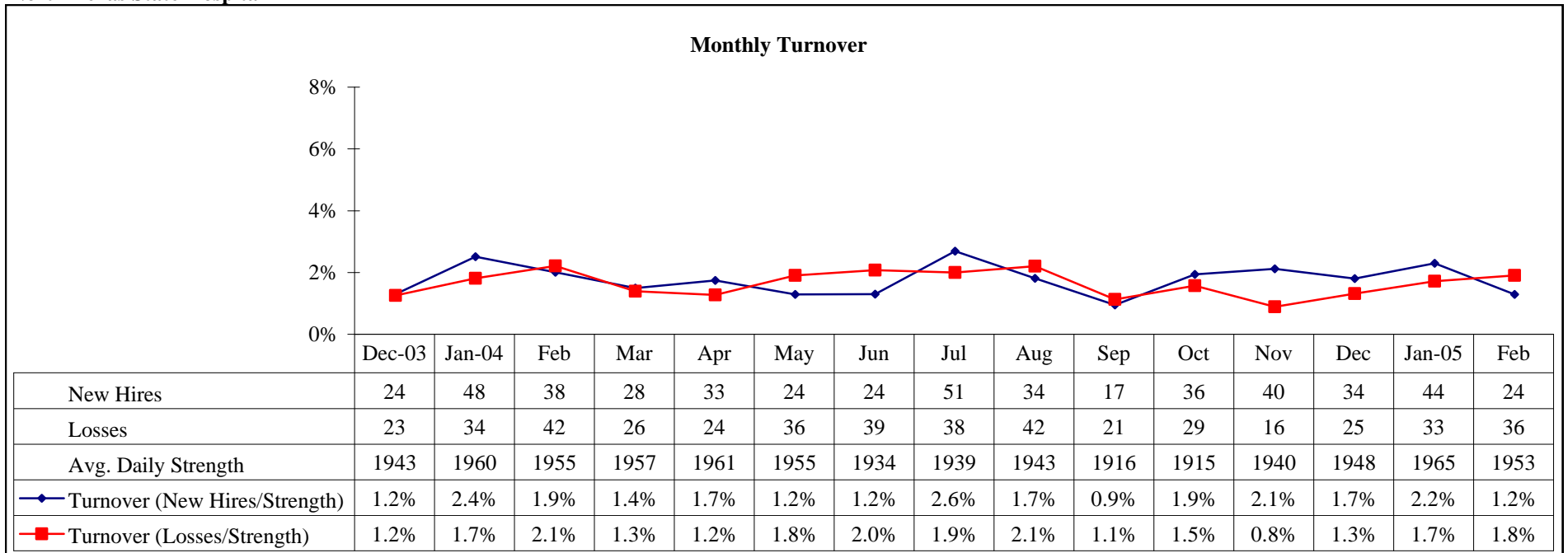


Annualized Turnover
(Twelve Month Rolling Average)

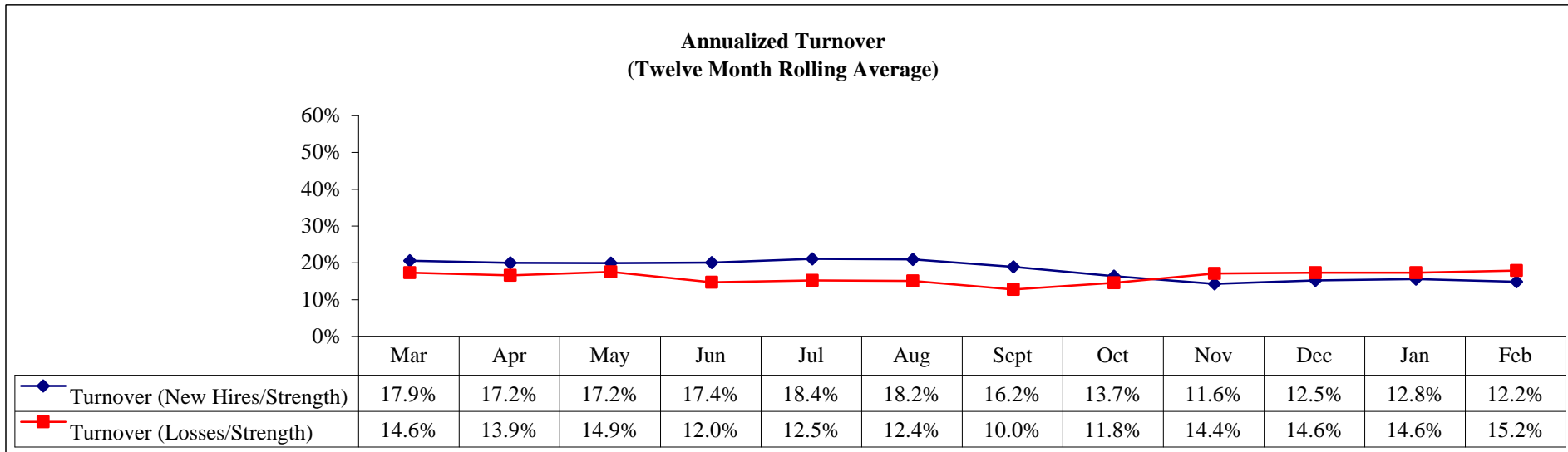
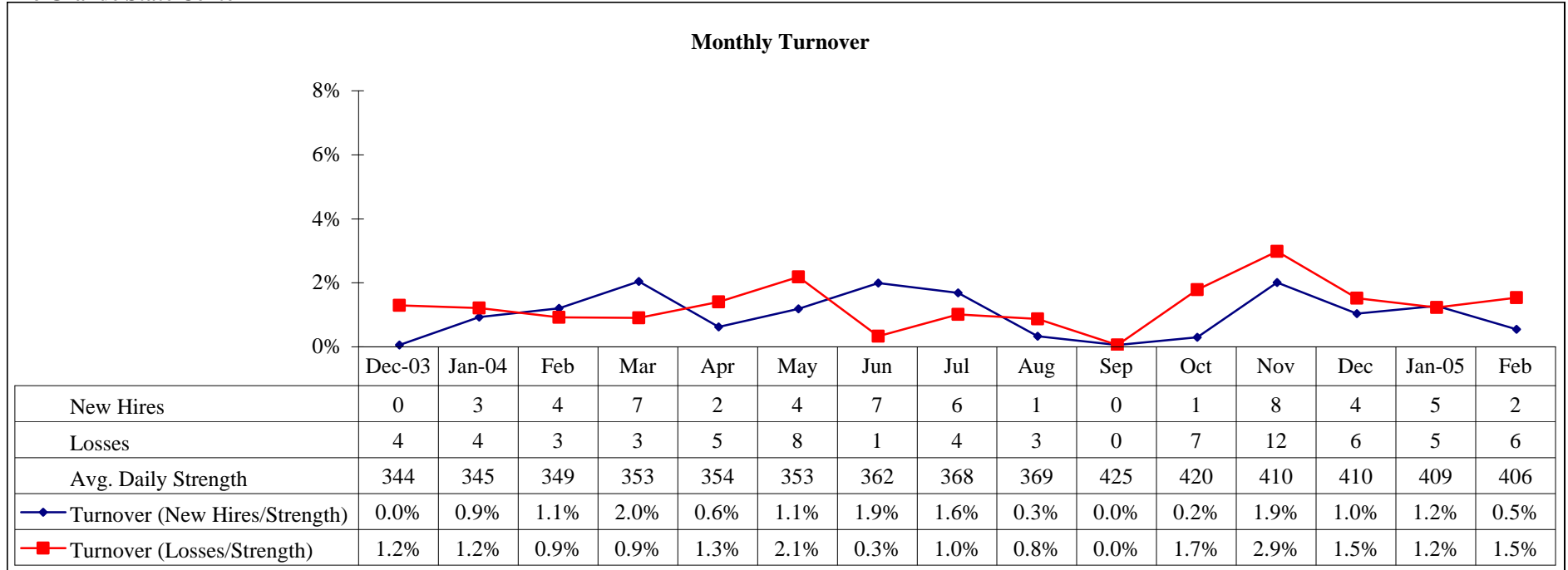


Source: Loss Reasons by Business Unit (MHMR800-PeopleSoft)
 New Hires/Reinstatements/Transfers In (MHMR703F-PeopleSoft)

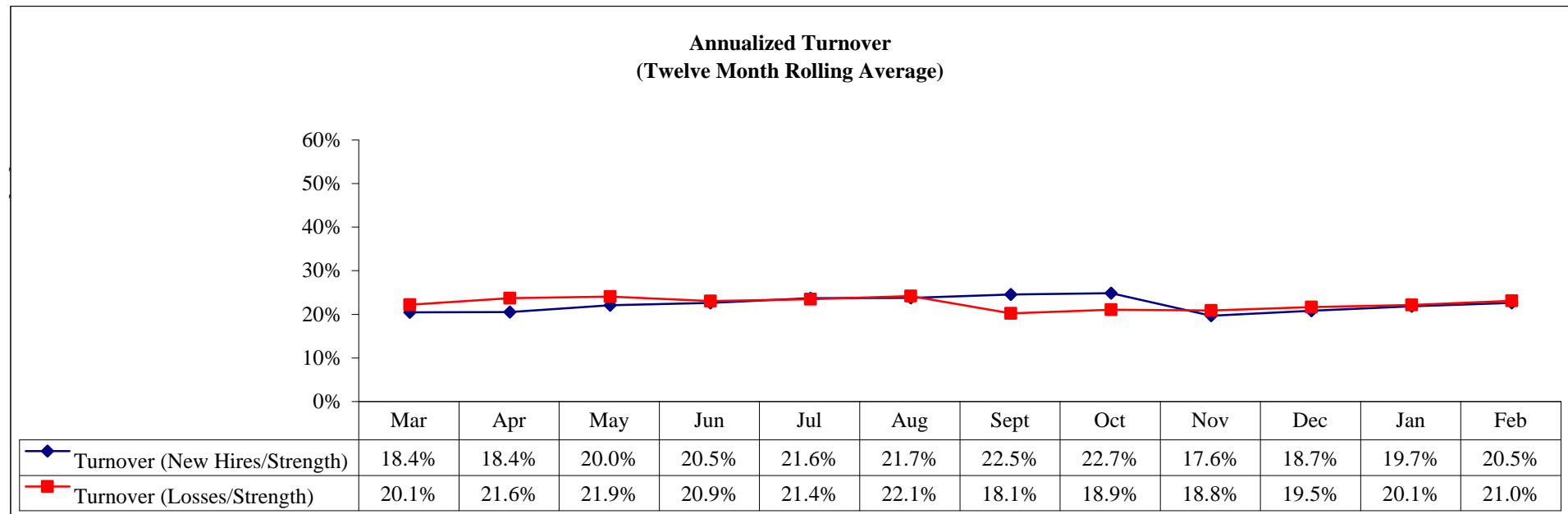
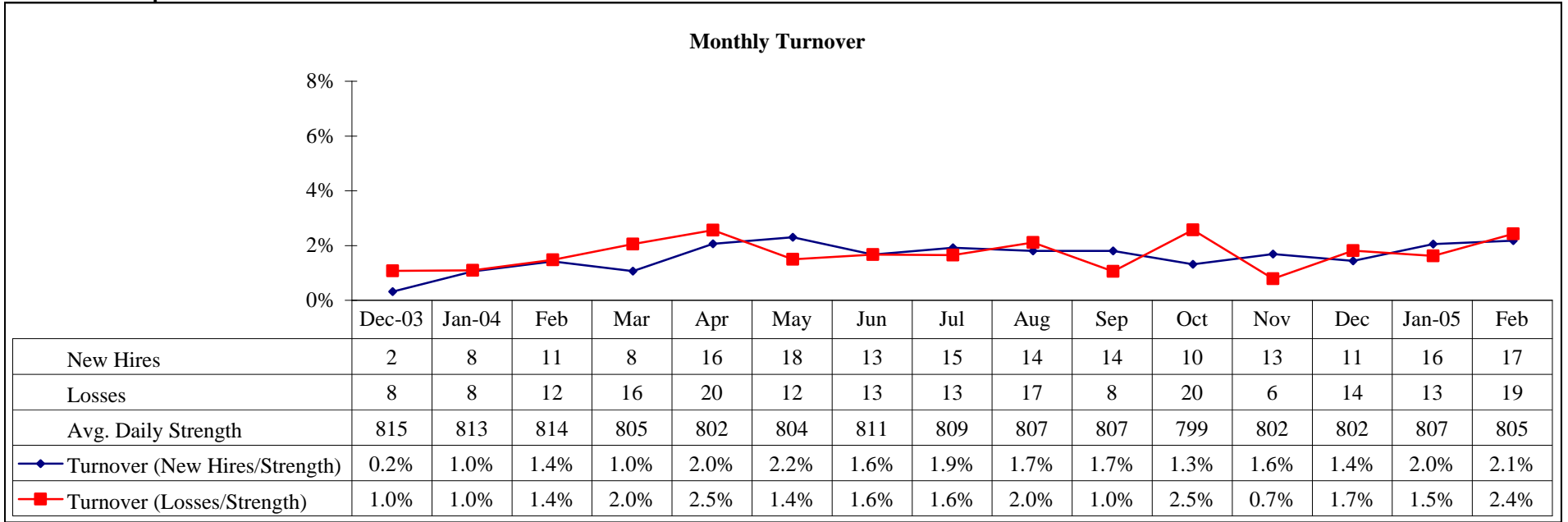
Measure 8A - Staff Turnover Rates
North Texas State Hospital



Measure 8A - Staff Turnover Rates
Rio Grande State Center

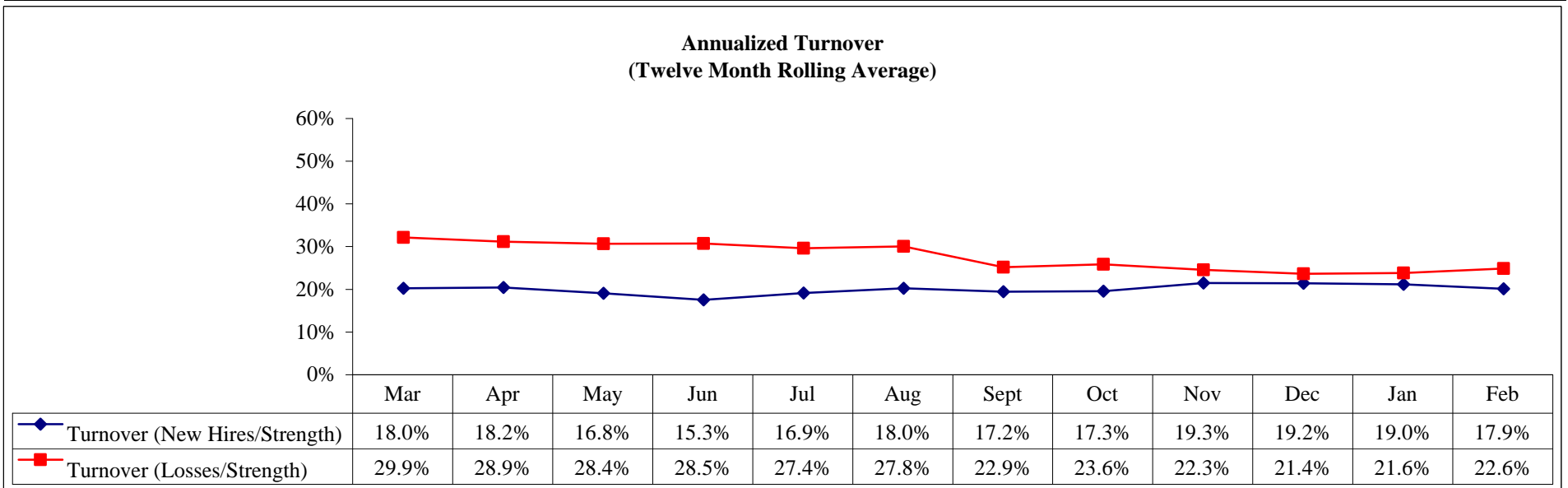
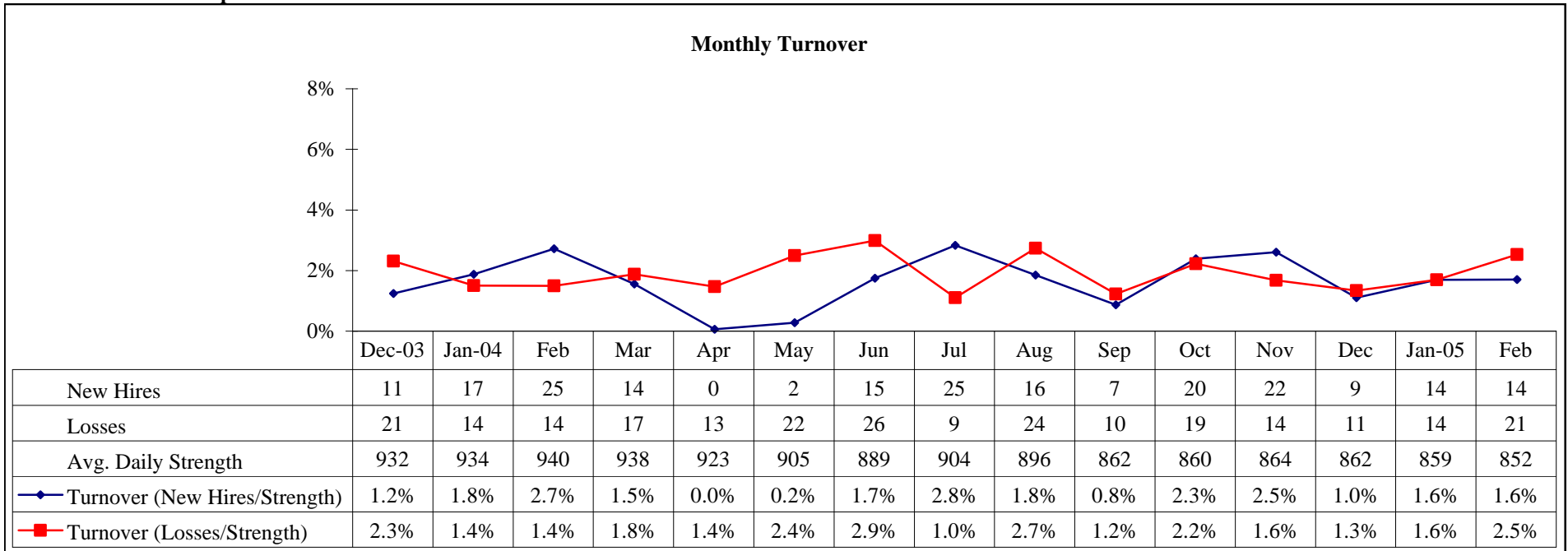


Measure 8A - Staff Turnover Rates
Rusk State Hospital

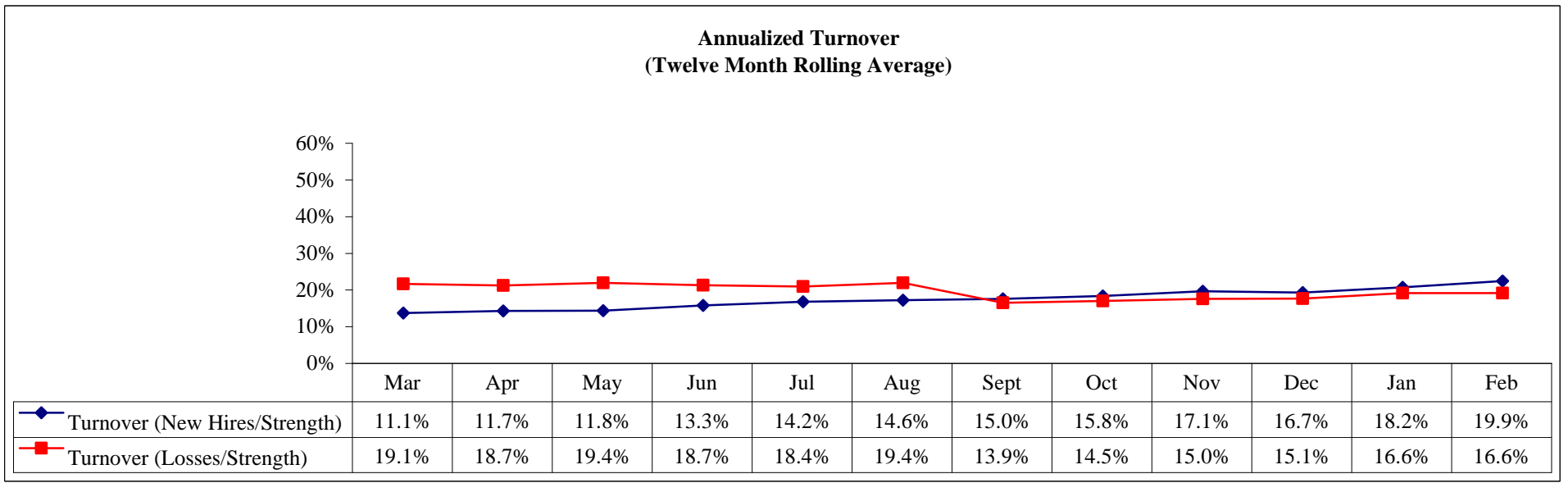
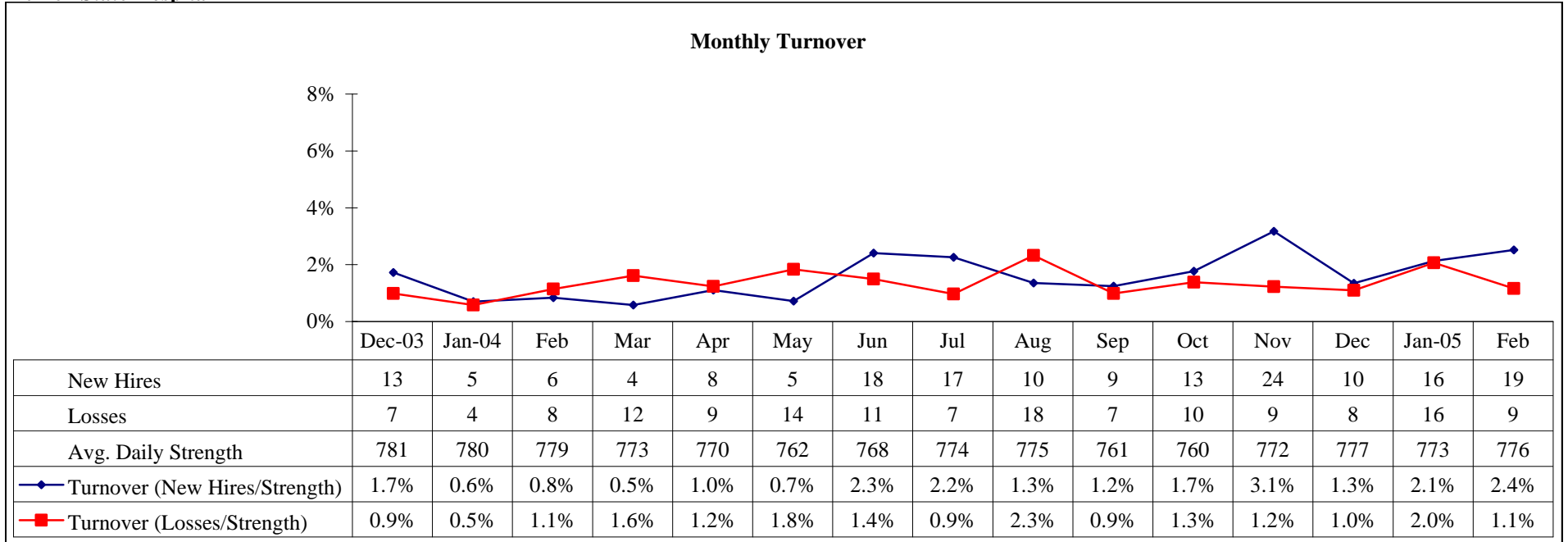


Source: Loss Reasons by Business Unit (MHMR800-PeopleSoft)
 New Hires/Reinstatements/Transfers In (MHMR703F-PeopleSoft)

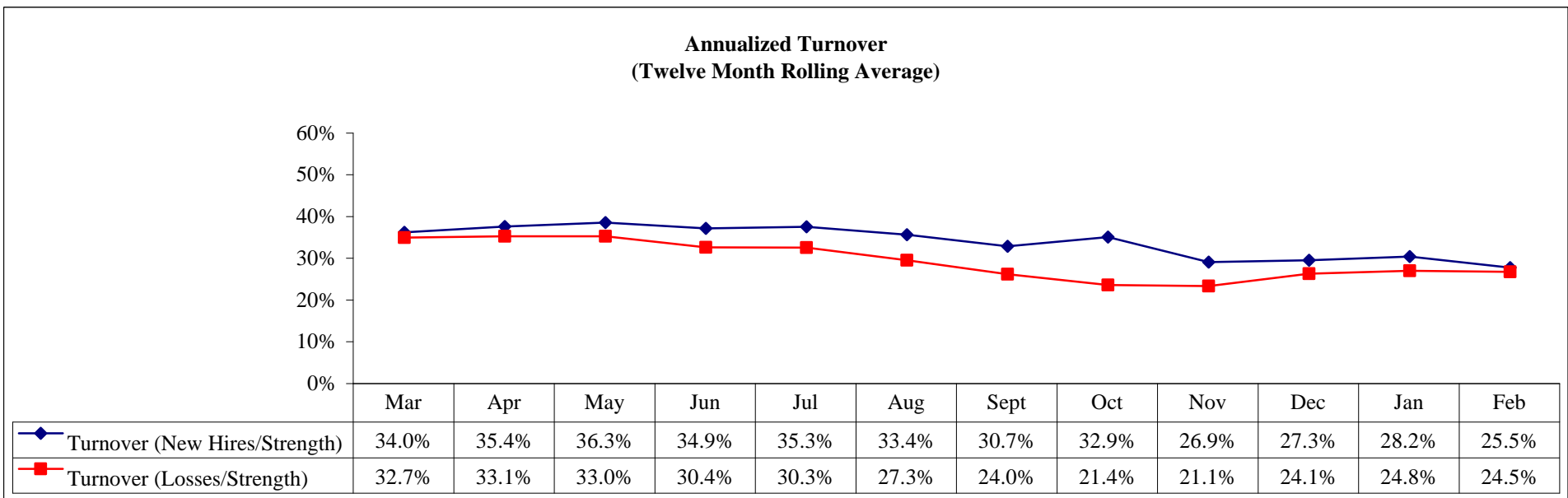
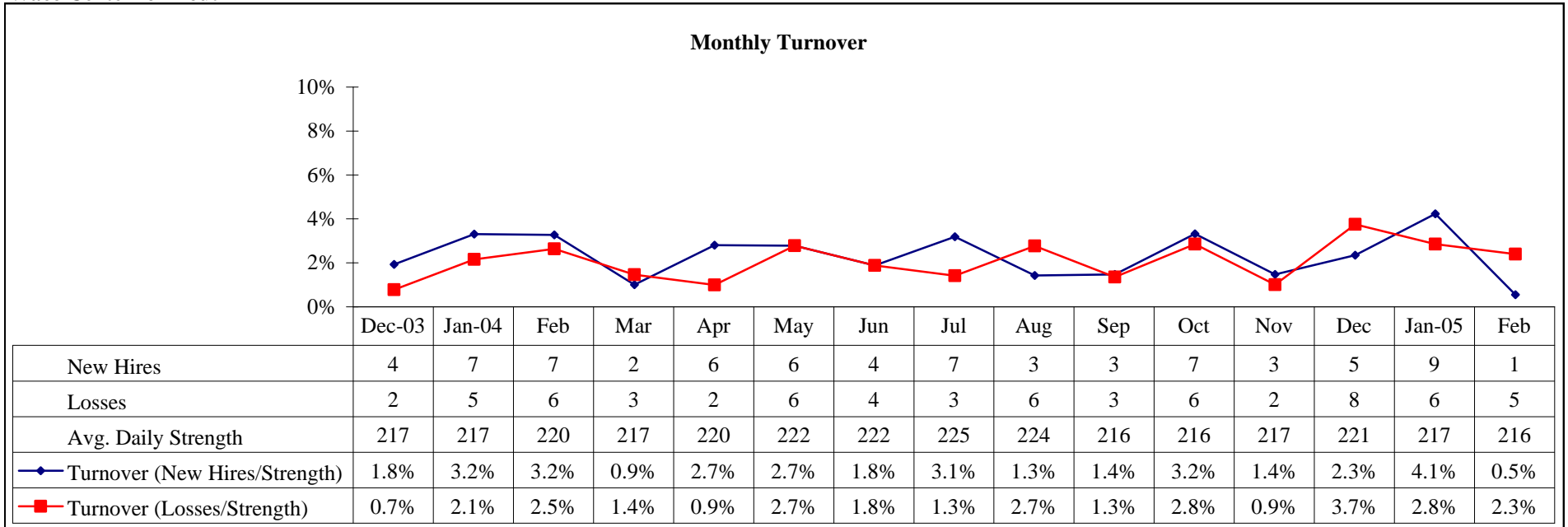
Measure 8A - Staff Turnover Rates
San Antonio State Hospital



Measure 8A - Staff Turnover Rates
Terrell State Hospital

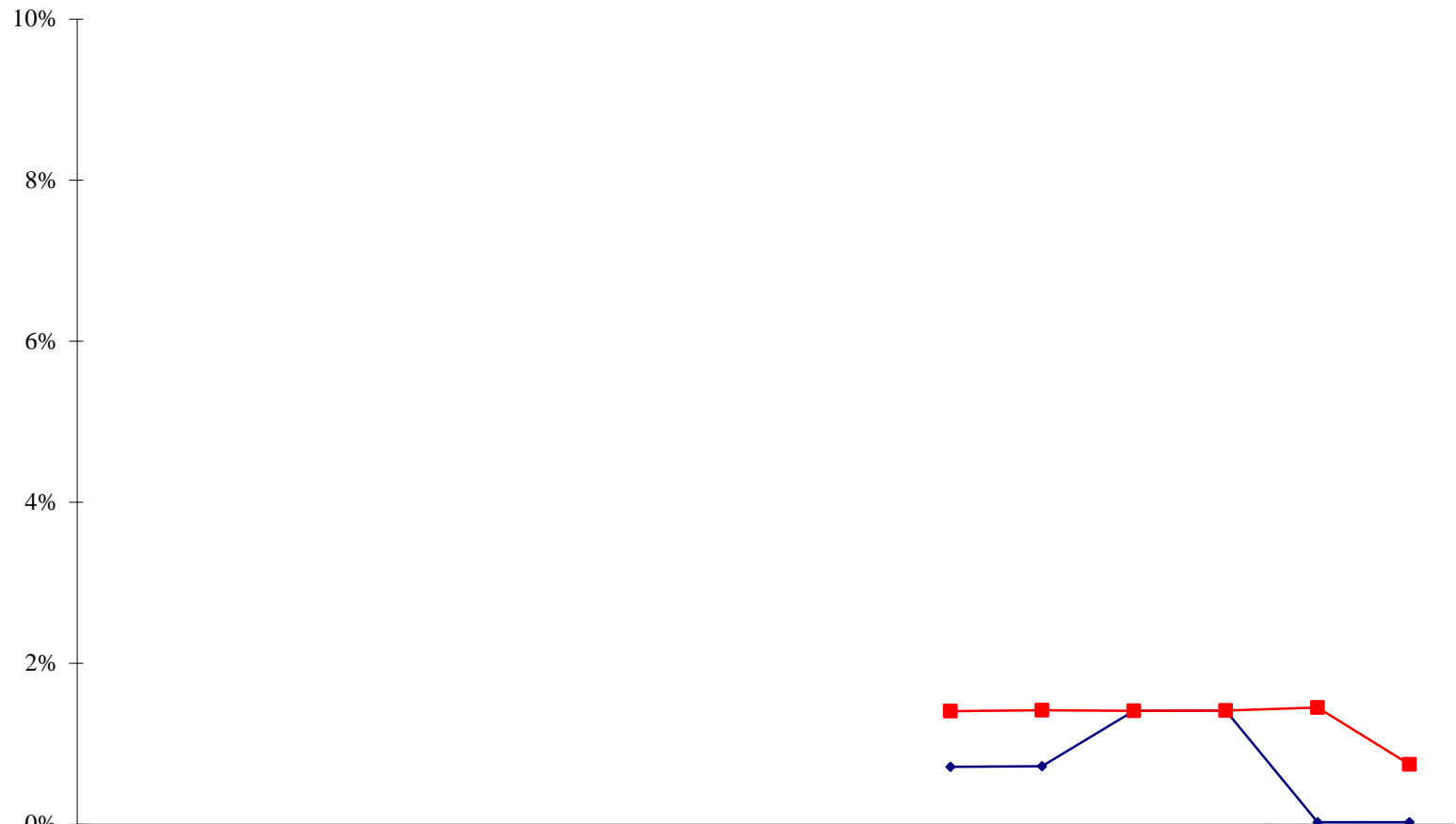


Measure 8A - Staff Turnover Rates
Waco Center for Youth



Measure 8A - Staff Turnover Rates
Texas Center for Infectious Disease

Monthly Turnover



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**

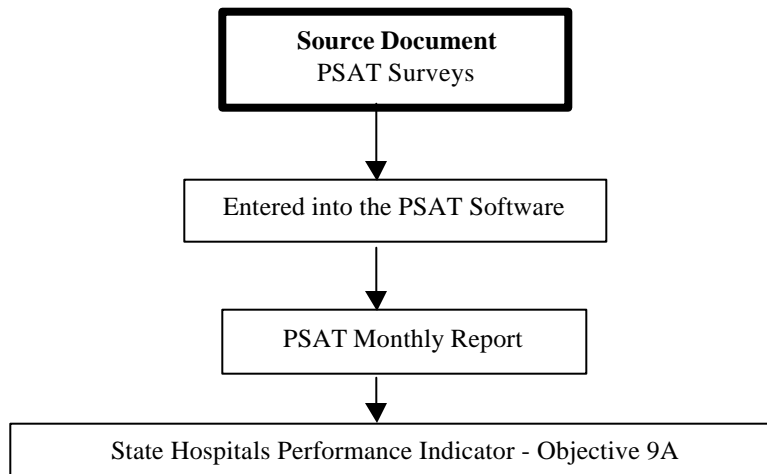
Performance Objective Operational Definition: At least 20% of discharges should be sampled each month for children (age 5-12) and for parents.

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.

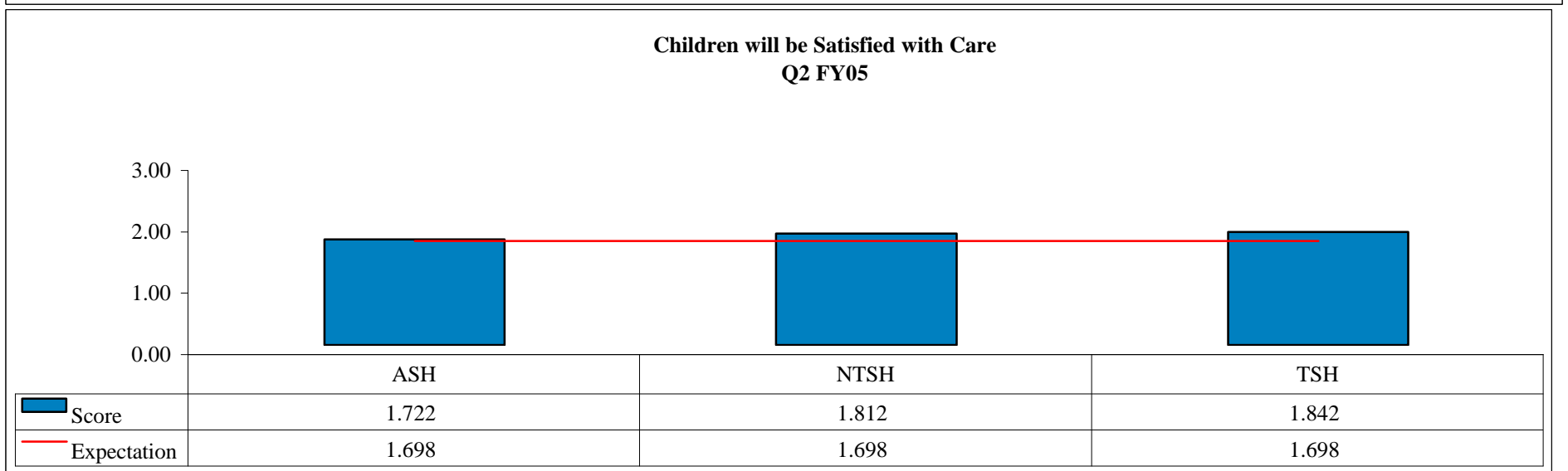
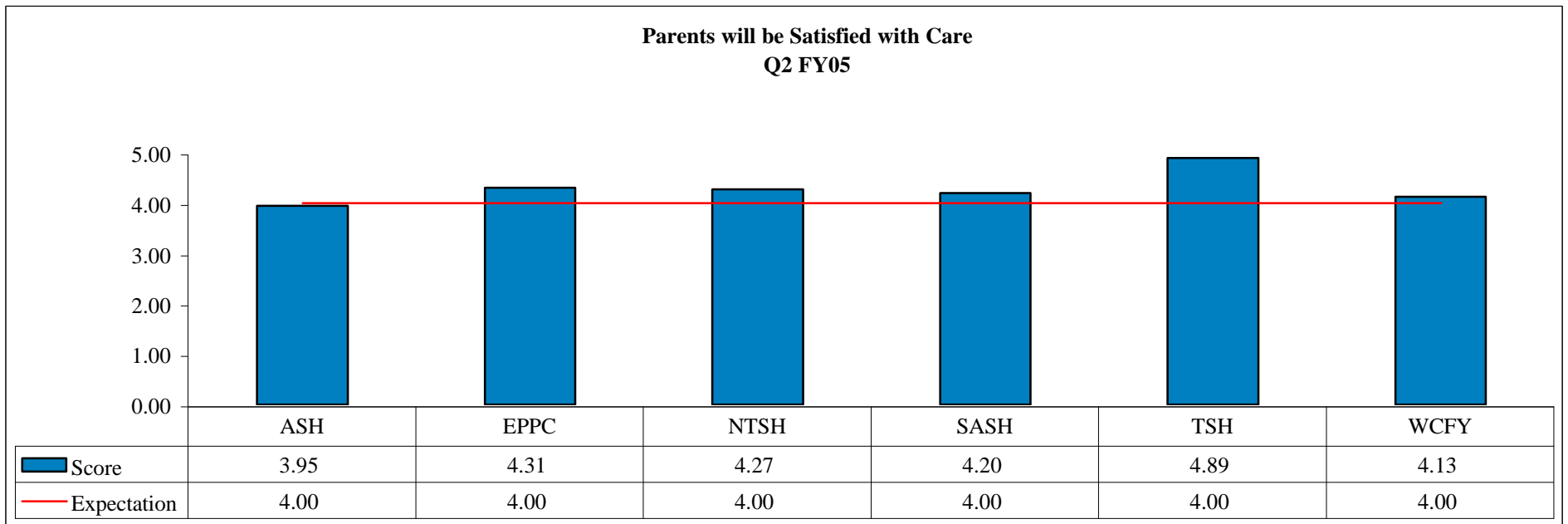
Data Flow:



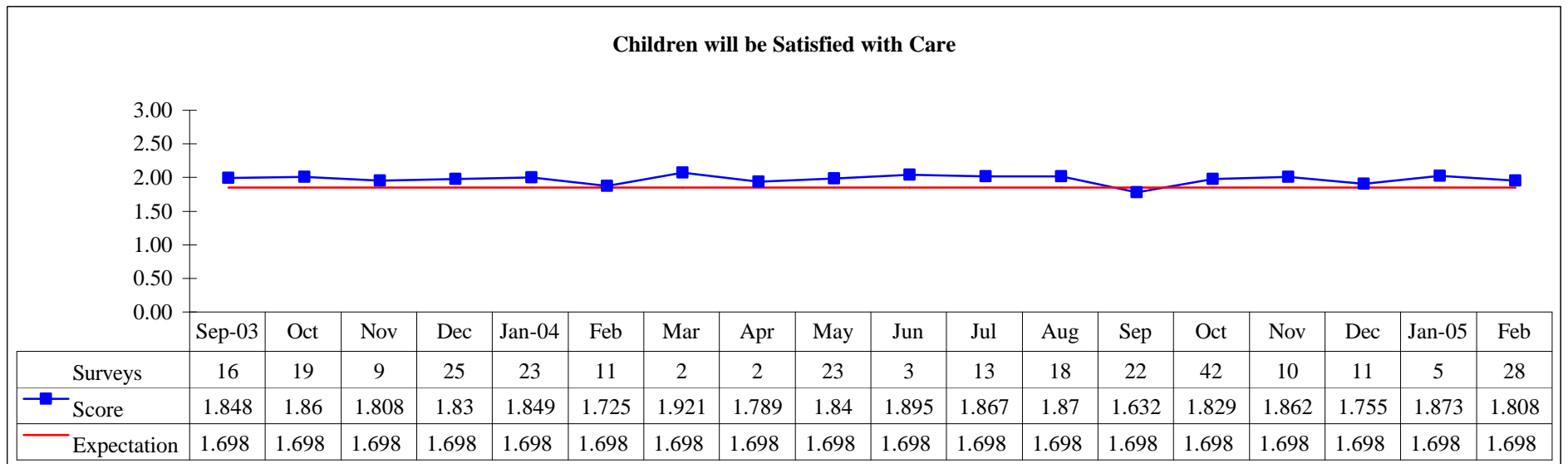
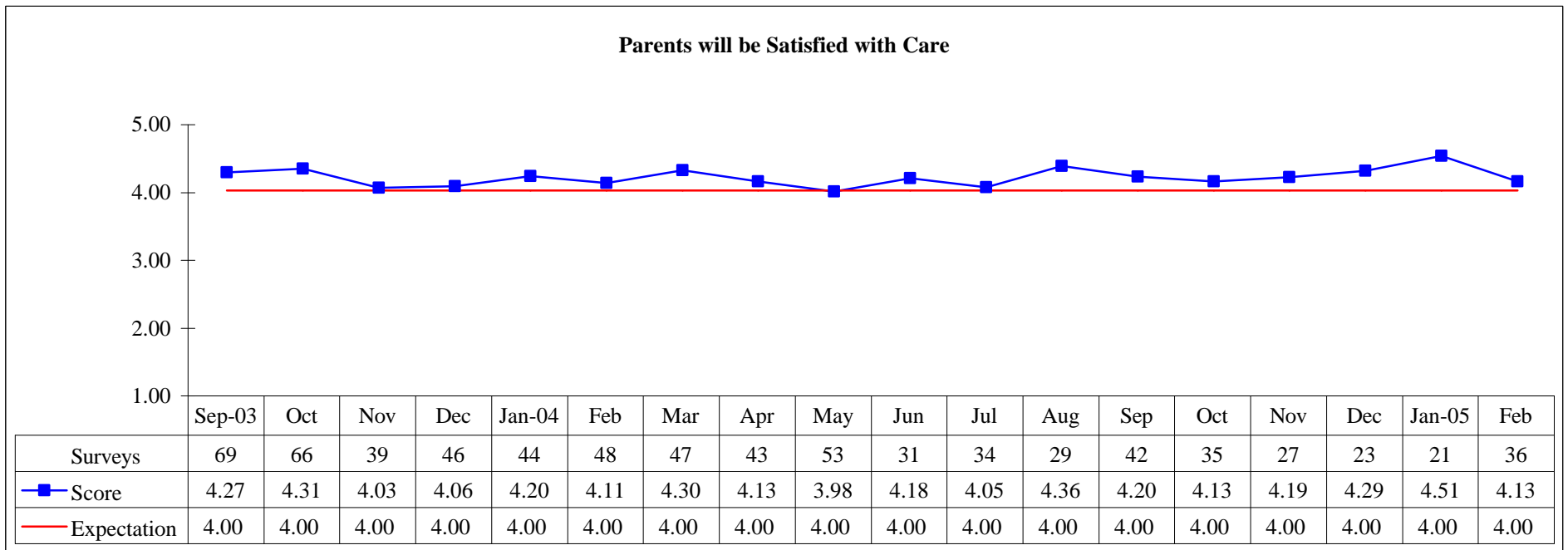
Data Integrity Review Process:

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

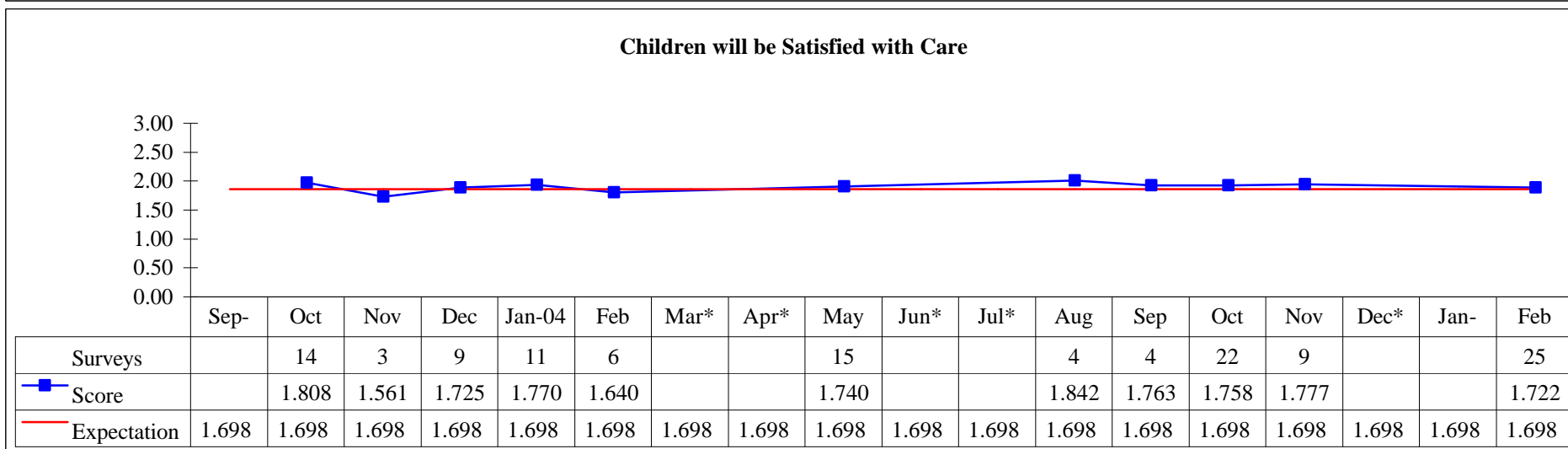
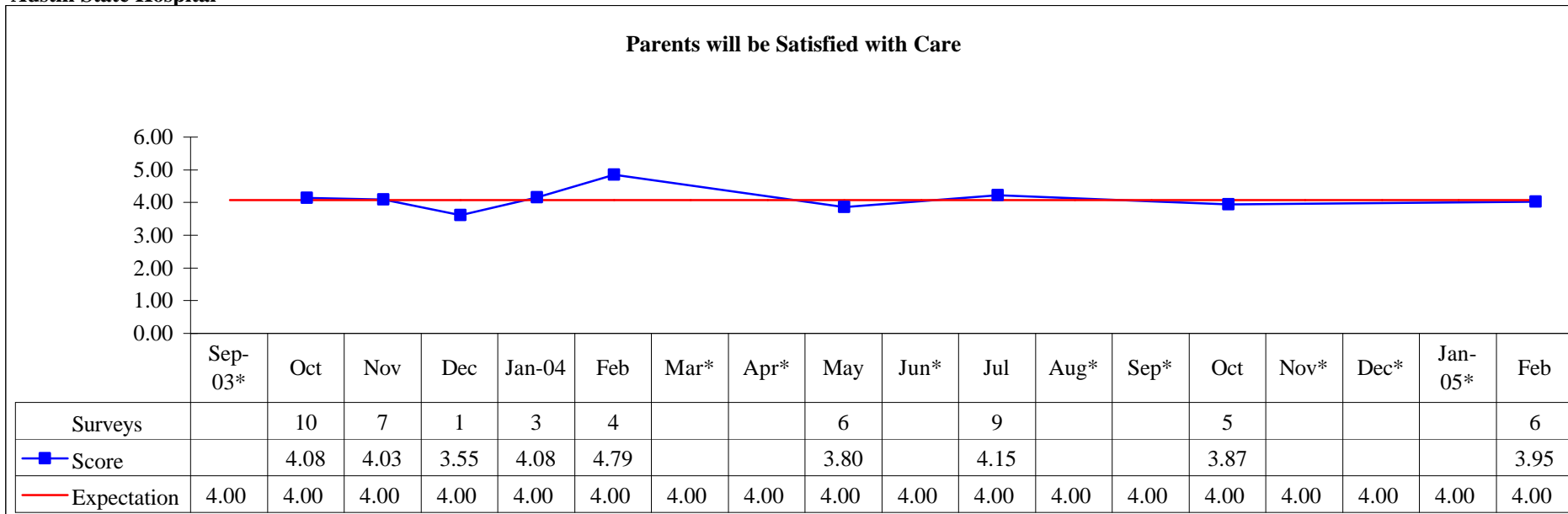
Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
All MH Facilities



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

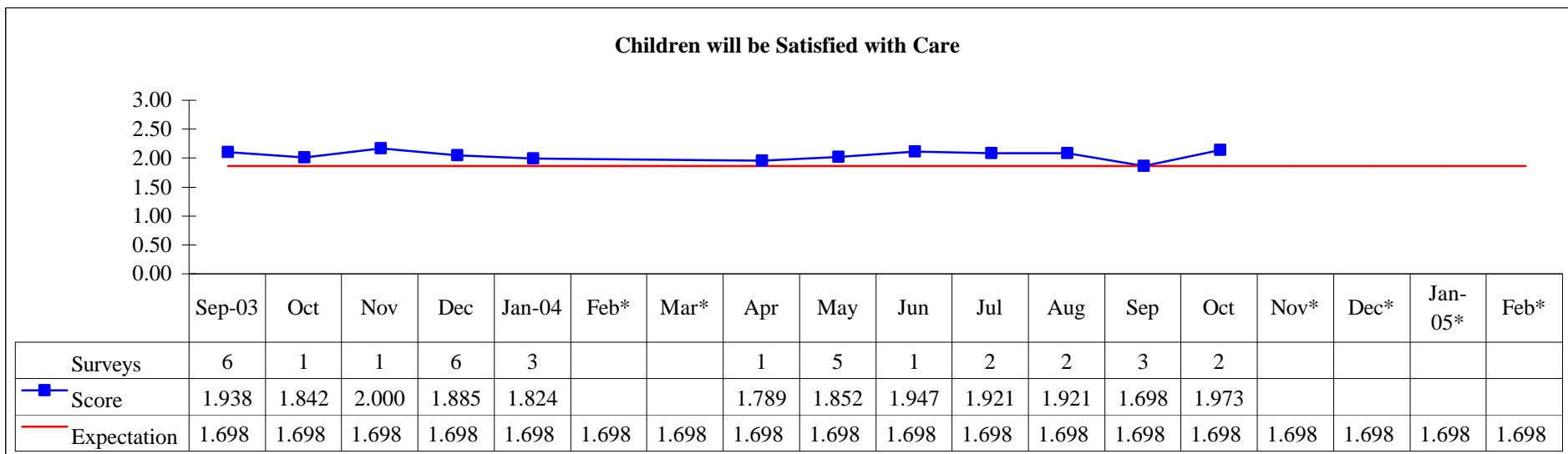
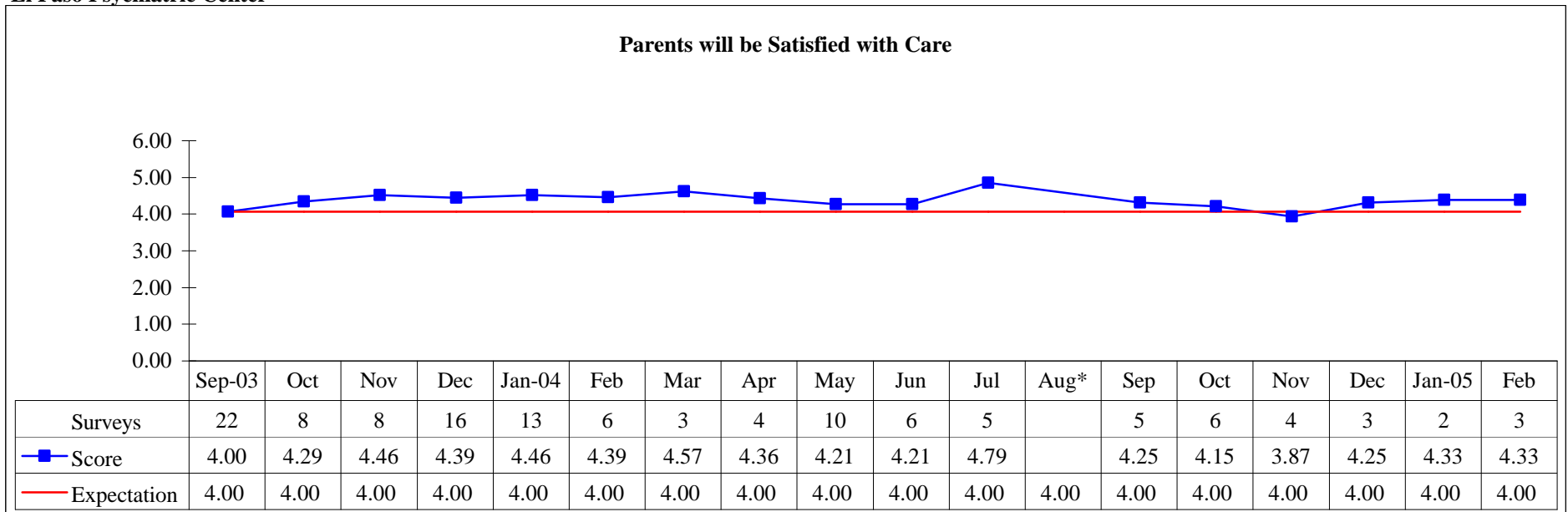


Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
Austin State Hospital



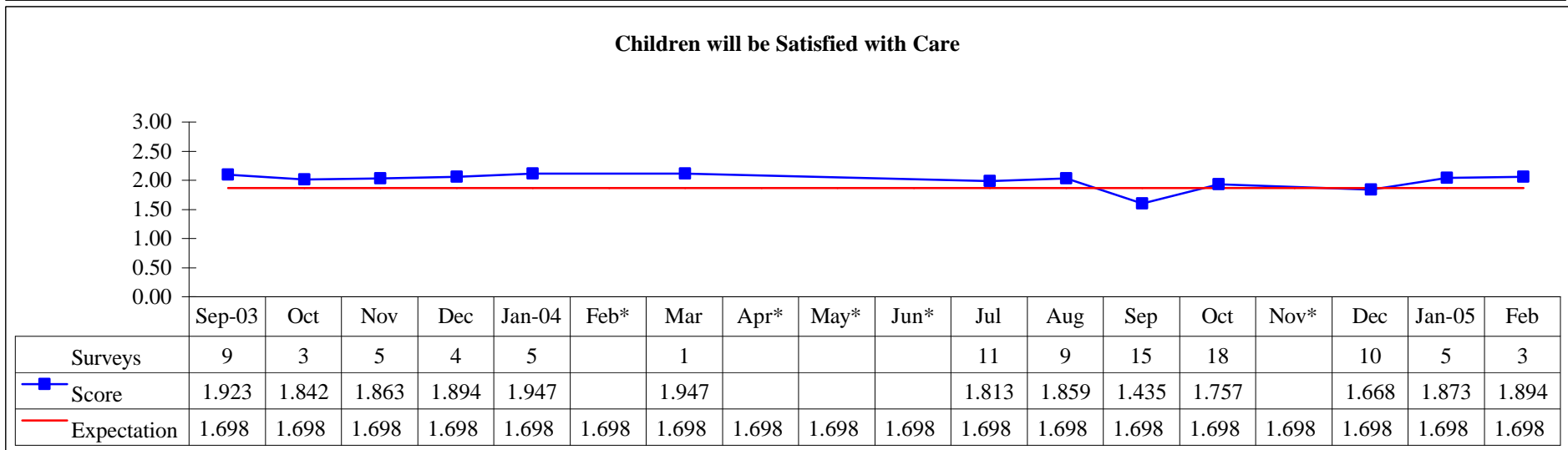
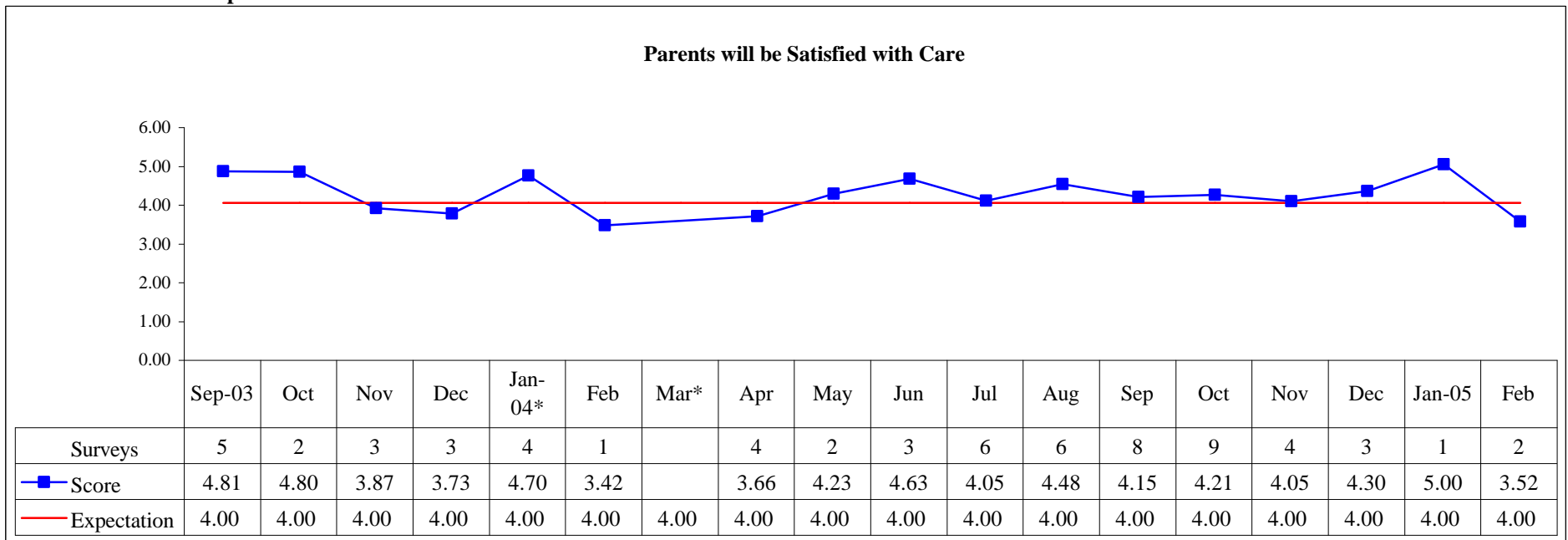
*No surveys submitted

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



*No surveys submitted

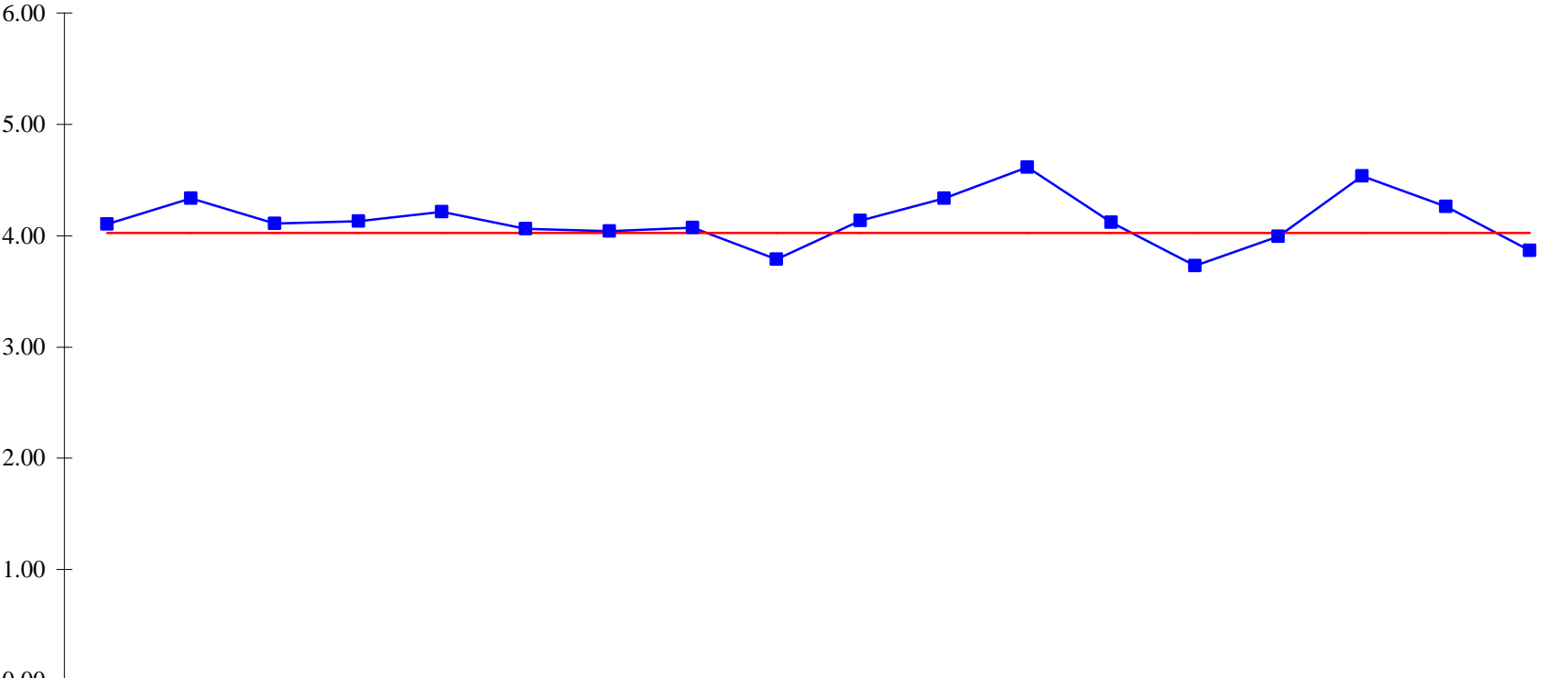
Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
North Texas State Hospital



*No surveys submitted

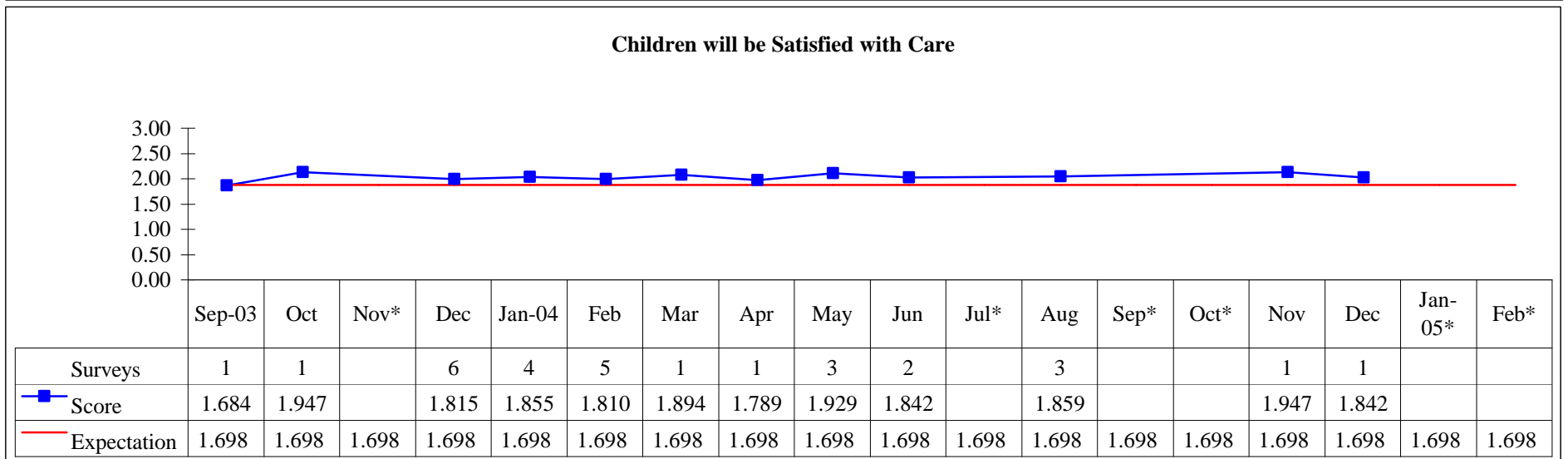
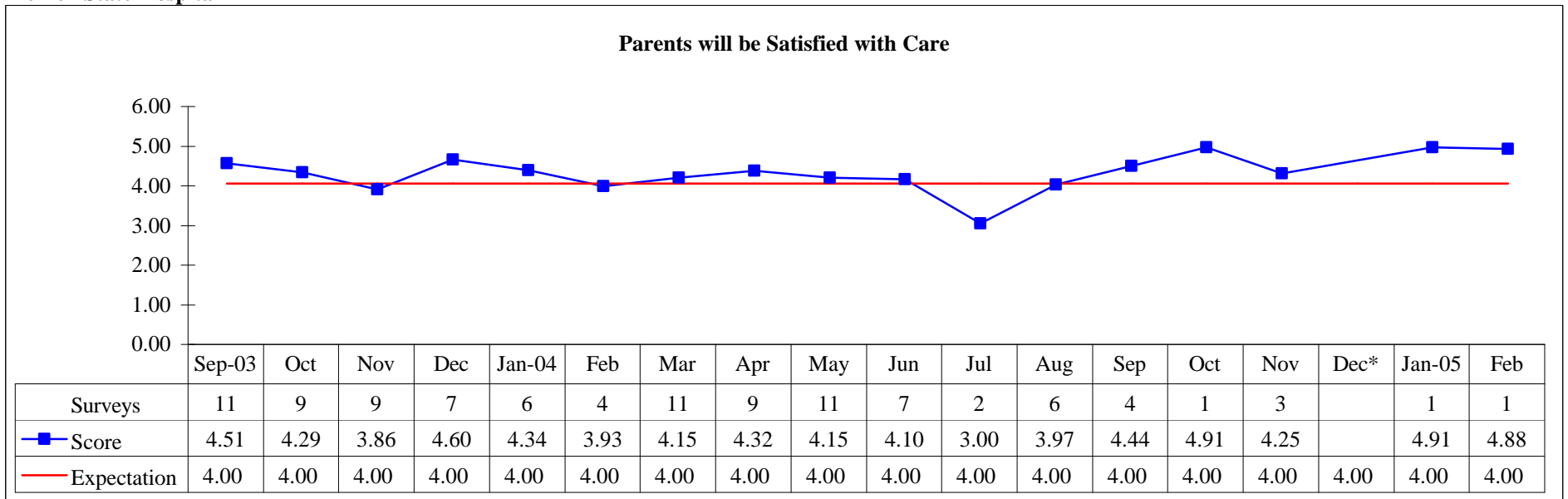
Objective 9A - Patient Satisfaction
Children and Parents will be Satisfied with Treatment and Safe Milieu
San Antonio State Hospital

Parents will be Satisfied with Care



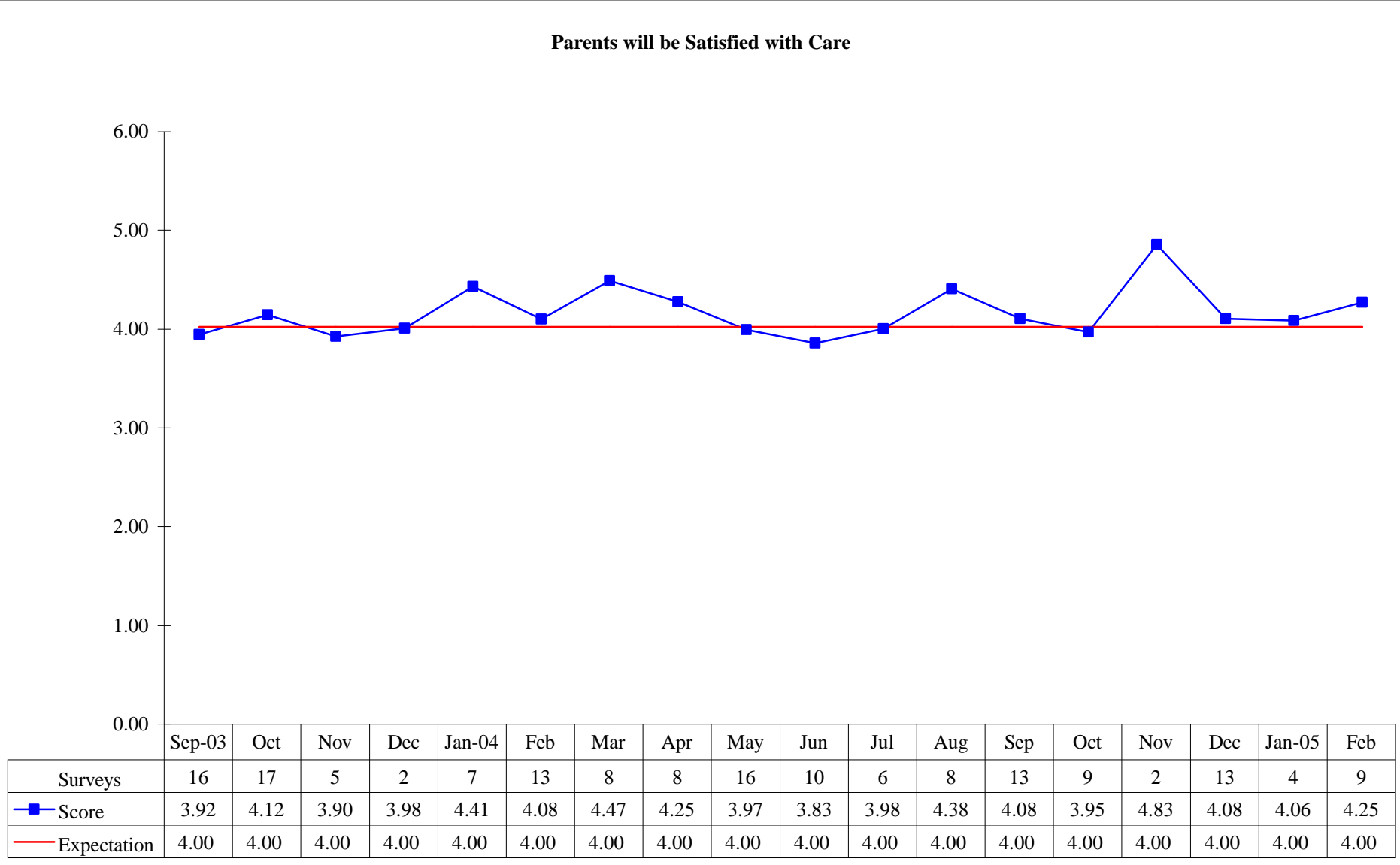
	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Surveys	15	20	7	17	11	20	25	18	10	5	6	9	12	5	14	4	13	15
■ Score	4.08	4.31	4.08	4.10	4.19	4.03	4.01	4.05	3.76	4.11	4.31	4.59	4.10	3.70	3.97	4.51	4.24	3.84
— Expectation	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

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).

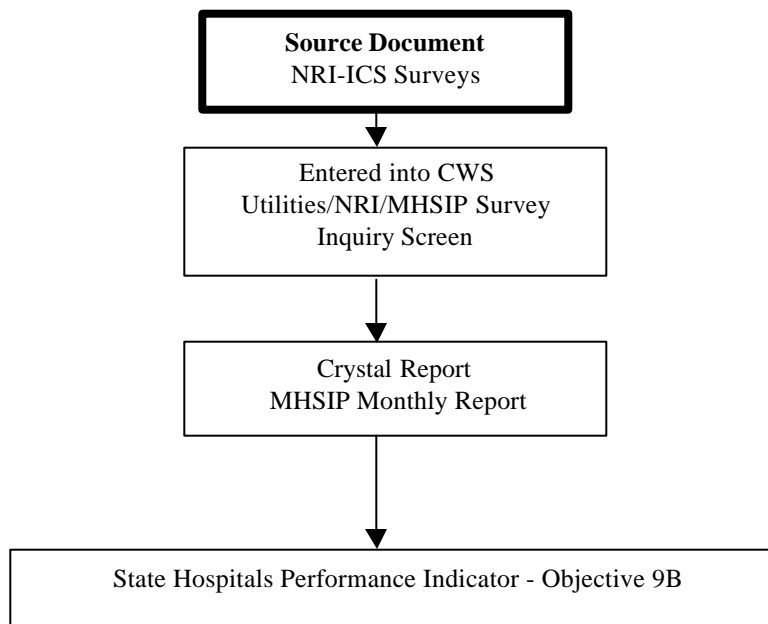
Performance Objective Operational Definition: At least 25% of discharges should be sampled each month for adult and adolescent patients.

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.

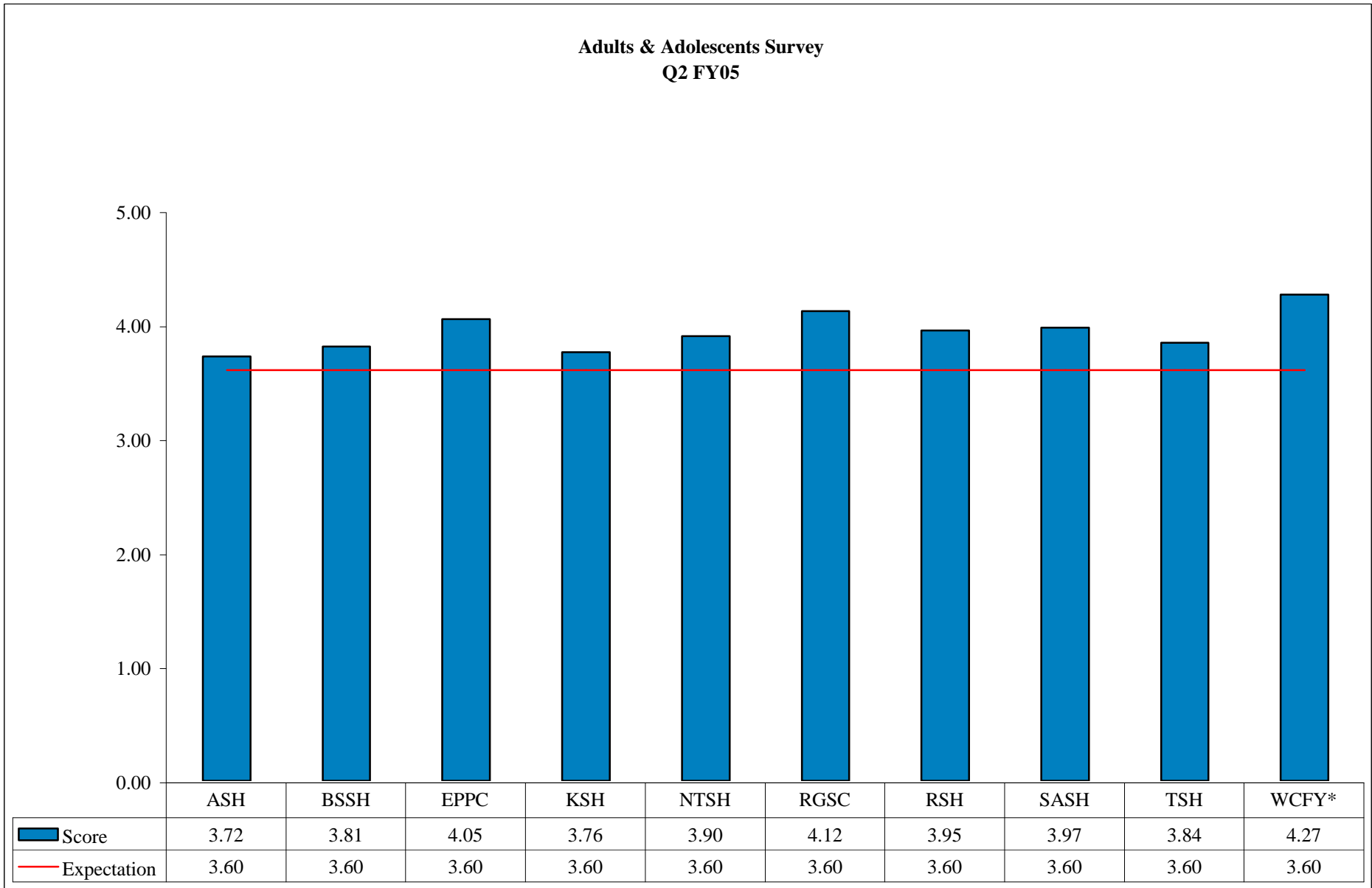
Data Flow:



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.

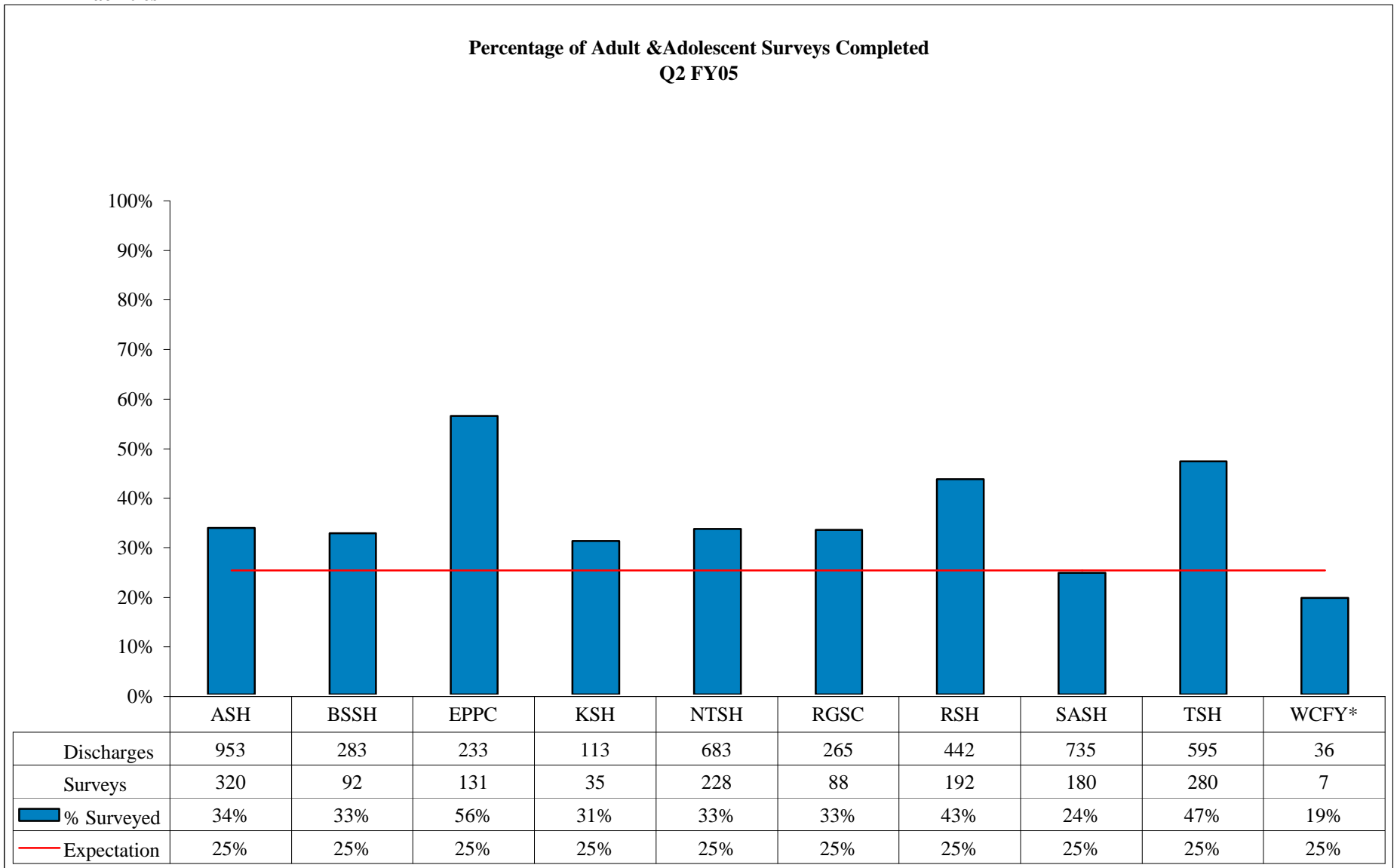
Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
All MH Facilities



*WCFY - Adolescent Surveys Only

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

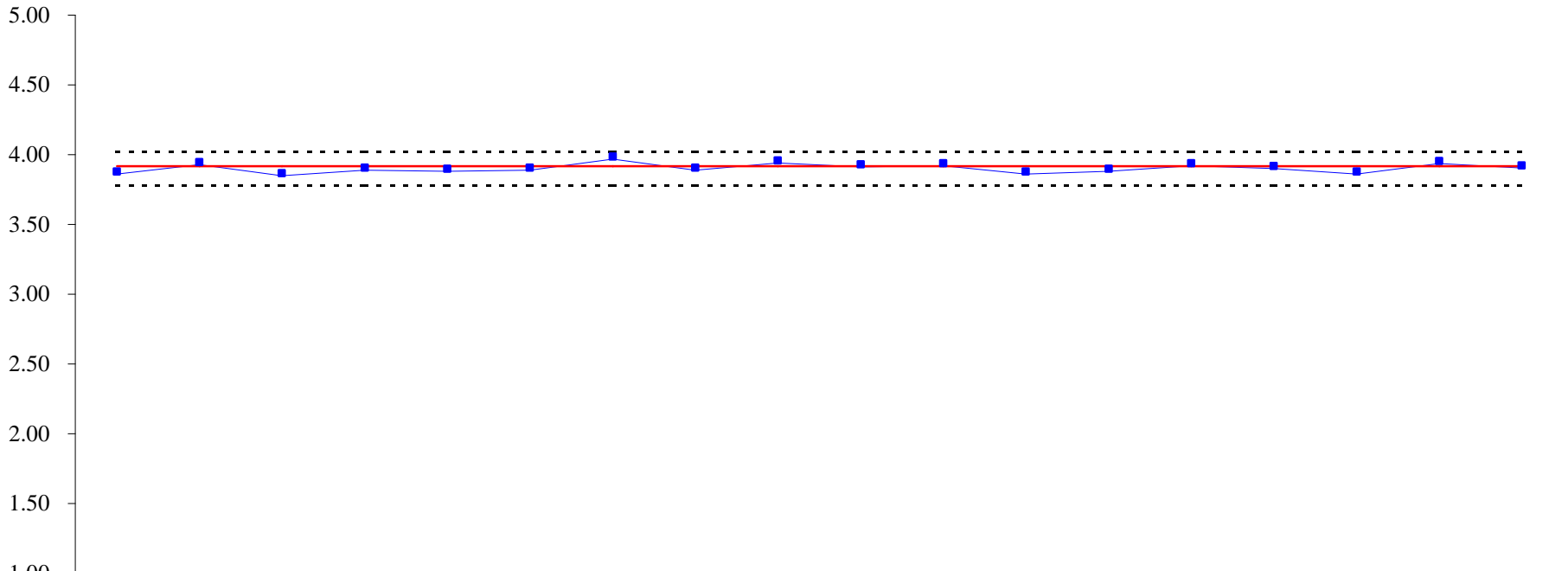
Objective 9B - Patient Satisfaction
Adults and Adolescents will be Satisfied with Care
All MH Facilities



*WCFY - Adolescent Surveys Only

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

Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score ³3.60)

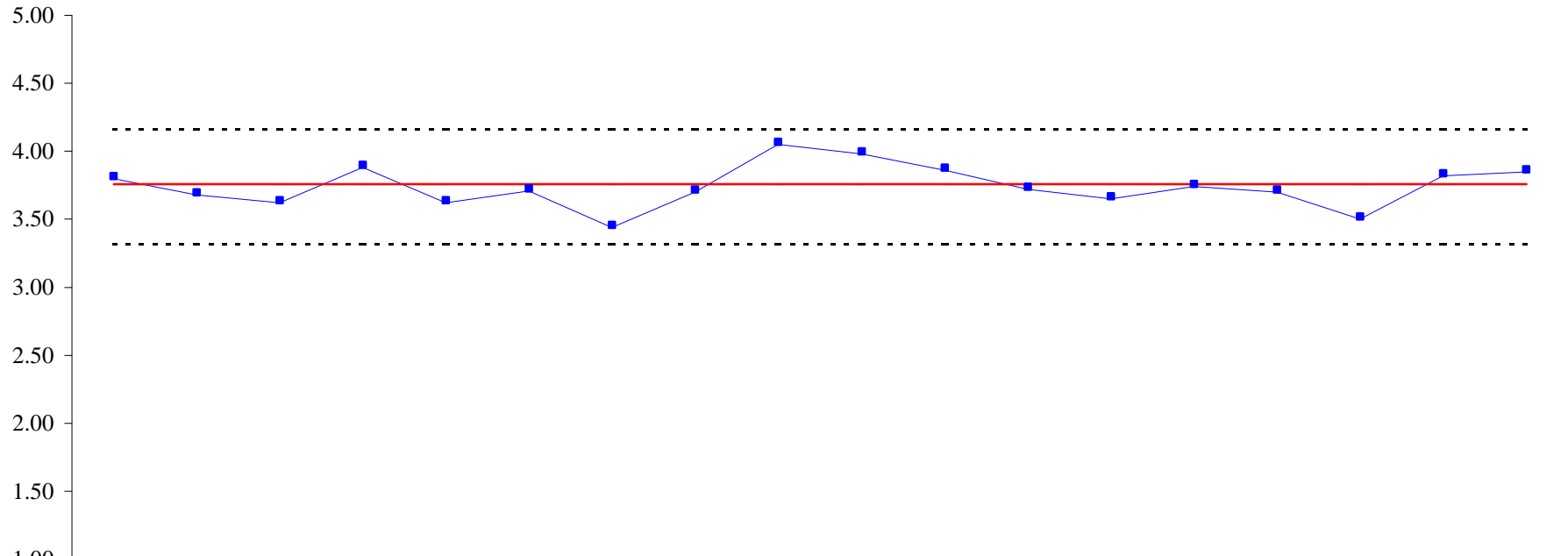


	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
■ Score	3.86	3.93	3.85	3.89	3.88	3.89	3.97	3.89	3.94	3.91	3.92	3.86	3.88	3.92	3.90	3.86	3.94	3.90
Surveys	740	769	621	563	639	635	673	606	586	641	618	742	633	633	538	574	527	452
Discharges	1604	1593	1312	1406	1379	1417	1656	1663	1645	1663	1559	1529	1546	1559	1320	1469	1468	1401
% Sampled	46%	48%	47%	40%	46%	45%	41%	36%	36%	39%	40%	49%	41%	41%	41%	39%	36%	32%
----- 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	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90
----- LCL	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78

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

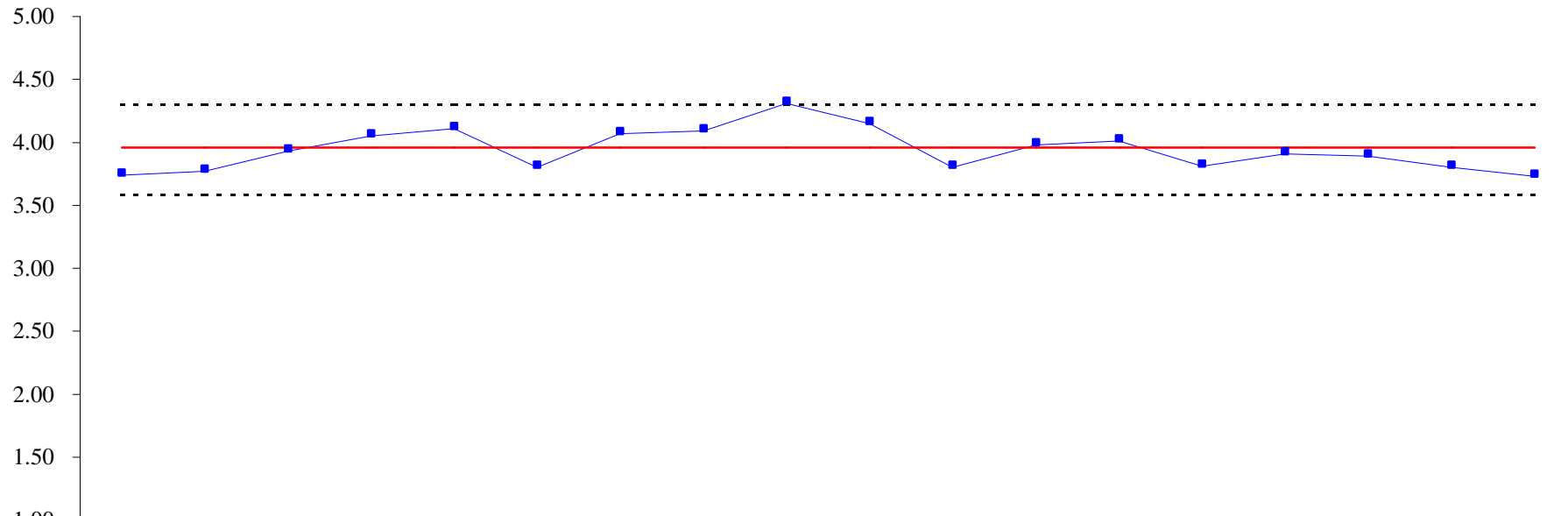
Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score ³3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
Score	3.80	3.68	3.62	3.88	3.62	3.71	3.44	3.70	4.05	3.98	3.86	3.72	3.65	3.74	3.70	3.50	3.82	3.85
Surveys	132	170	121	61	110	74	48	106	50	67	70	200	161	137	113	132	87	101
Discharges	357	346	326	300	305	376	402	415	392	418	364	329	364	371	313	323	310	320
% Sampled	37%	49%	37%	20%	36%	20%	12%	26%	13%	16%	19%	61%	44%	37%	36%	41%	28%	32%
UCL	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16
Avg	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74
LCL	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32

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

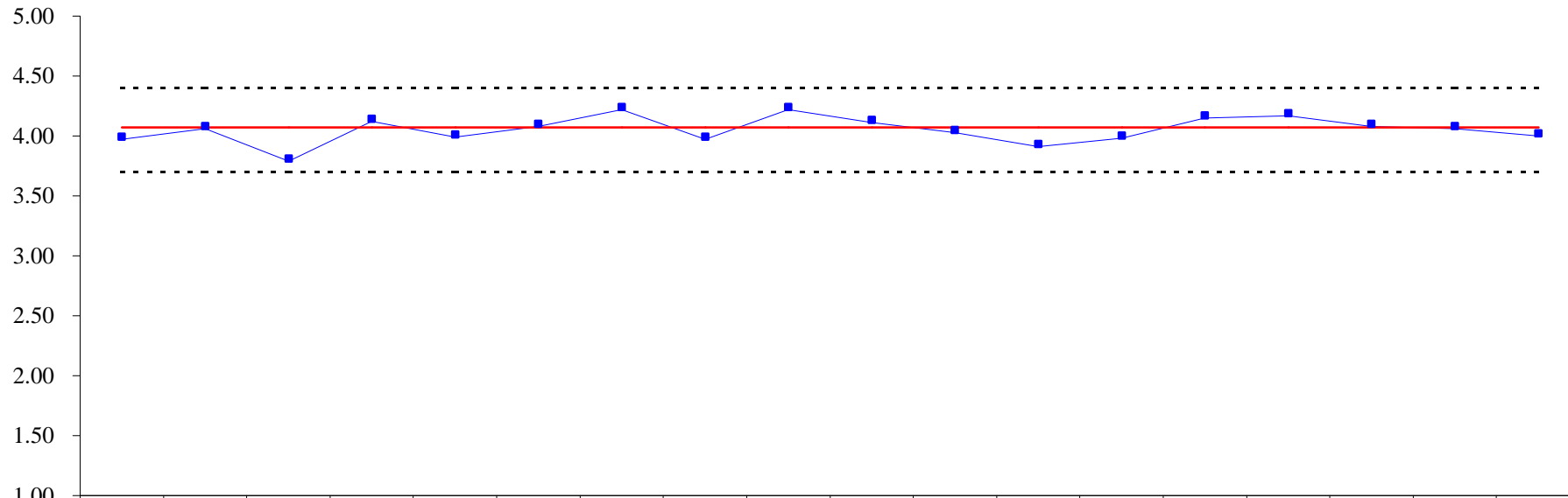
Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score ≈3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—■— Score	3.74	3.77	3.93	4.05	4.11	3.80	4.07	4.09	4.31	4.15	3.80	3.98	4.01	3.81	3.91	3.89	3.80	3.73
Surveys	33	38	26	48	50	34	31	47	32	28	31	45	48	44	28	36	28	28
Discharges	111	121	68	98	89	78	103	107	90	126	100	100	101	99	78	93	88	102
% Sampled	30%	31%	38%	49%	56%	44%	30%	44%	36%	22%	31%	45%	48%	44%	36%	39%	32%	27%
----- UCL	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30
— Avg	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94	3.94
----- LCL	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58	3.58

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

Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score ≈3.60)

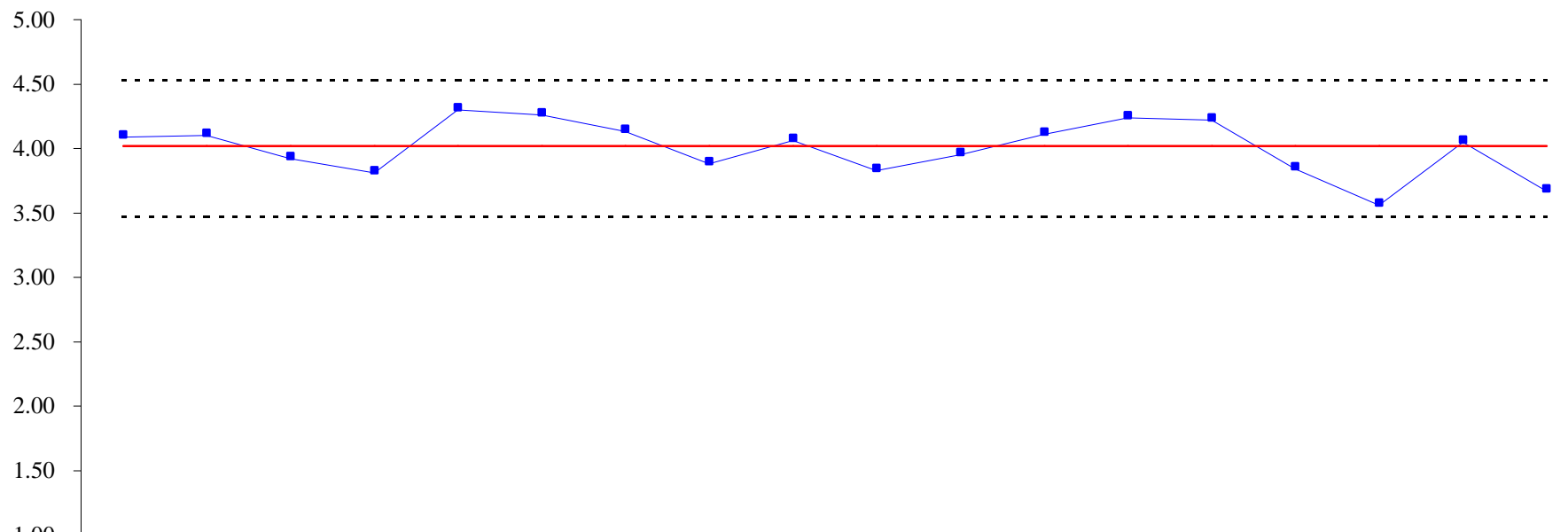


	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—■— Score	3.97	4.06	3.79	4.12	3.99	4.08	4.22	3.97	4.22	4.11	4.03	3.91	3.98	4.15	4.17	4.08	4.06	4.00
Surveys	103	63	41	65	66	56	55	35	59	58	29	27	49	40	44	36	55	40
Discharges	145	106	95	118	104	90	99	92	109	97	59	68	87	74	68	61	81	91
% Sampled	71%	59%	43%	55%	63%	62%	56%	38%	54%	60%	49%	40%	56%	54%	65%	59%	68%	44%
----- UCL	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40	4.40
———— Avg	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05	4.05
----- LCL	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70	3.70

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
(FY2005 Expectation is Average Score ≈3.60)

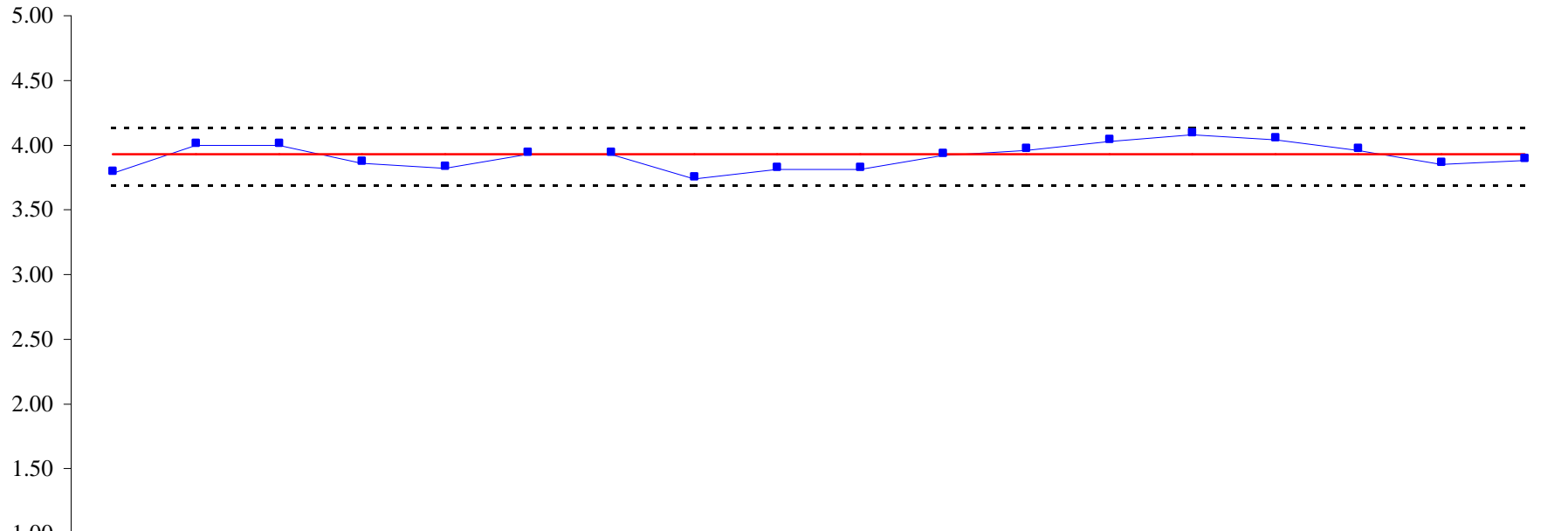


	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—■— Score	4.09	4.10	3.92	3.81	4.30	4.26	4.13	3.88	4.06	3.83	3.95	4.11	4.24	4.22	3.84	3.56	4.05	3.67
Surveys	38	20	24	26	29	29	30	31	23	18	47	27	14	31	21	20	13	2
Discharges	61	64	51	46	45	45	59	62	58	39	74	51	53	66	50	42	45	26
% Sampled	62%	31%	47%	57%	64%	64%	51%	50%	40%	46%	64%	53%	26%	47%	42%	48%	29%	8%
----- UCL	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53	4.53
— 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	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47	3.47

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

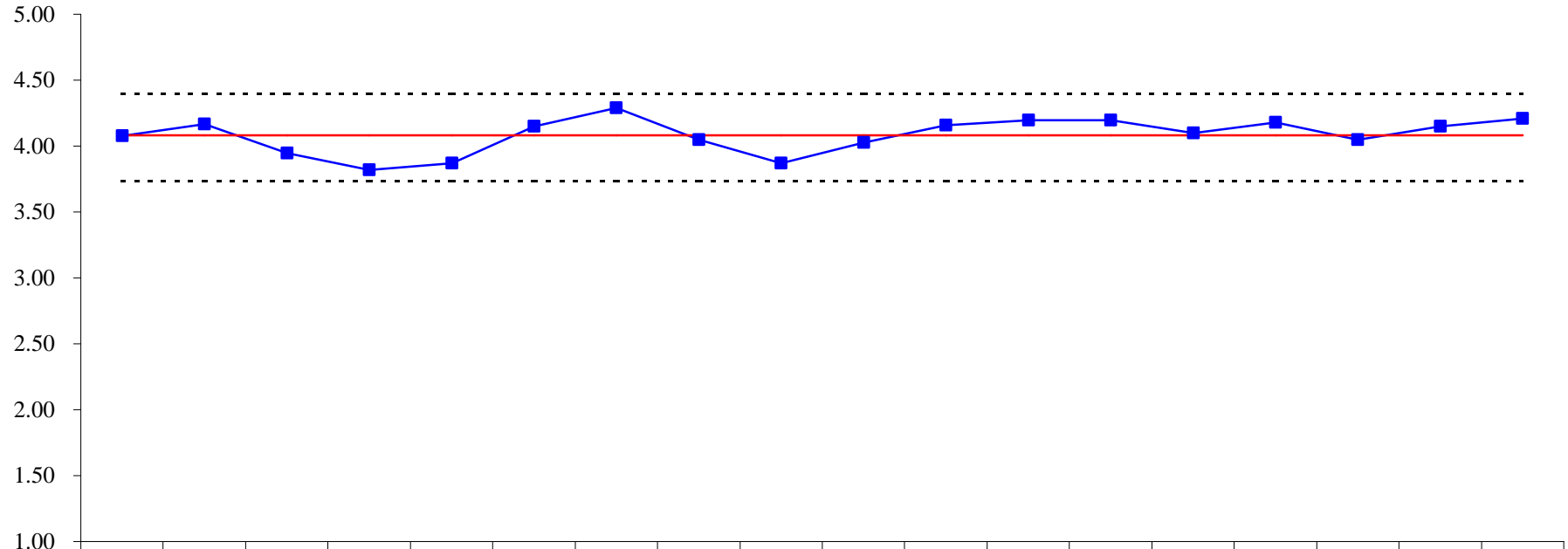
Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score ≈3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—■— Score	3.78	4.00	4.00	3.86	3.82	3.93	3.93	3.74	3.81	3.81	3.92	3.96	4.03	4.08	4.04	3.96	3.85	3.88
Surveys	88	102	90	69	70	85	116	66	81	67	80	62	77	81	56	82	87	59
Discharges	210	224	182	190	174	190	226	220	221	215	216	236	224	217	178	243	205	235
% Sampled	42%	46%	49%	36%	40%	45%	51%	30%	37%	31%	37%	26%	34%	37%	31%	34%	42%	25%
----- UCL	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14	4.14
— Avg	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91	3.91
----- LCL	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69

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

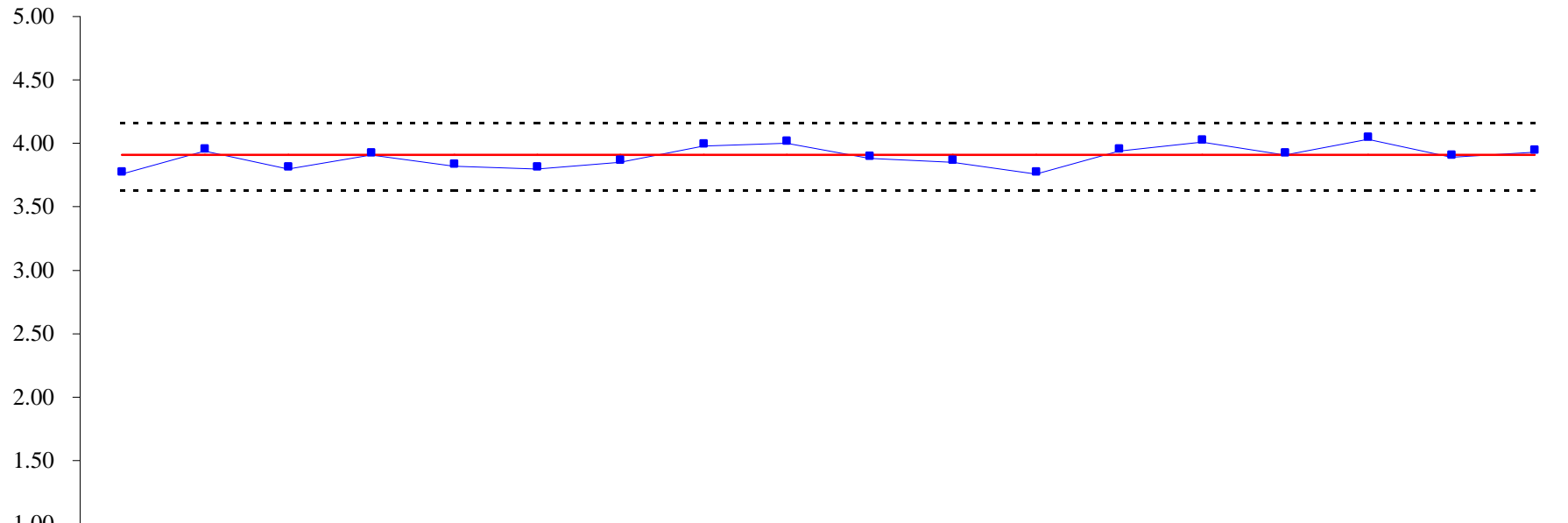
Adults & Adolescents will be Satisfied With Care
(FY2005 Expectation is Average Score ³3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
■ Score	4.06	4.15	3.93	3.80	3.85	4.13	4.27	4.03	3.85	4.01	4.14	4.18	4.18	4.08	4.16	4.03	4.13	4.19
Surveys	57	64	62	47	35	53	58	46	55	59	46	46	36	28	22	28	29	31
Discharges	113	122	119	104	107	104	134	131	131	119	113	118	97	93	78	85	92	88
% Sampled	50%	52%	52%	45%	33%	51%	43%	35%	42%	50%	41%	39%	37%	30%	28%	33%	32%	35%
-----UCL	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39	4.39
— Avg	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07	4.07
-----LCL	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74

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

Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score \approx 3.60)

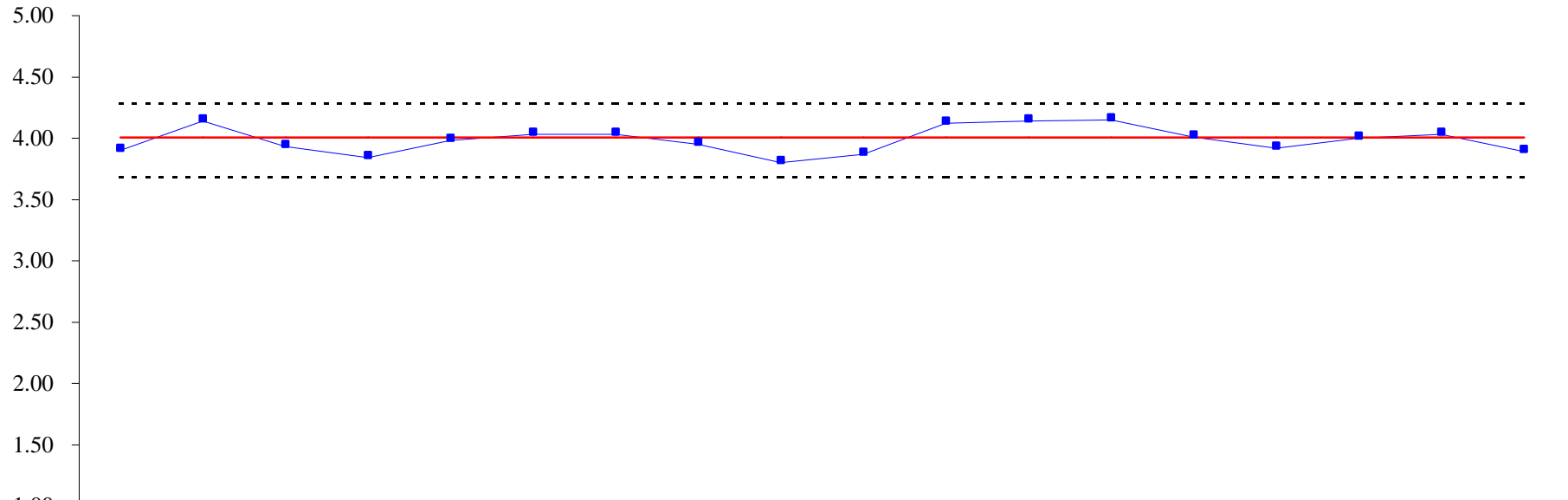


	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—■— Score	3.76	3.94	3.80	3.91	3.82	3.80	3.85	3.98	4.00	3.88	3.85	3.76	3.94	4.01	3.91	4.03	3.89	3.93
Surveys	67	86	46	44	79	91	103	77	80	137	107	177	81	87	90	70	57	65
Discharges	176	161	110	158	166	148	159	188	181	199	170	152	162	175	151	159	138	145
% Sampled	38%	53%	42%	28%	48%	61%	65%	41%	44%	69%	63%	116%	50%	50%	60%	44%	41%	45%
----- UCL	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16
— Avg	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89	3.89
----- 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
San Antonio State Hospital

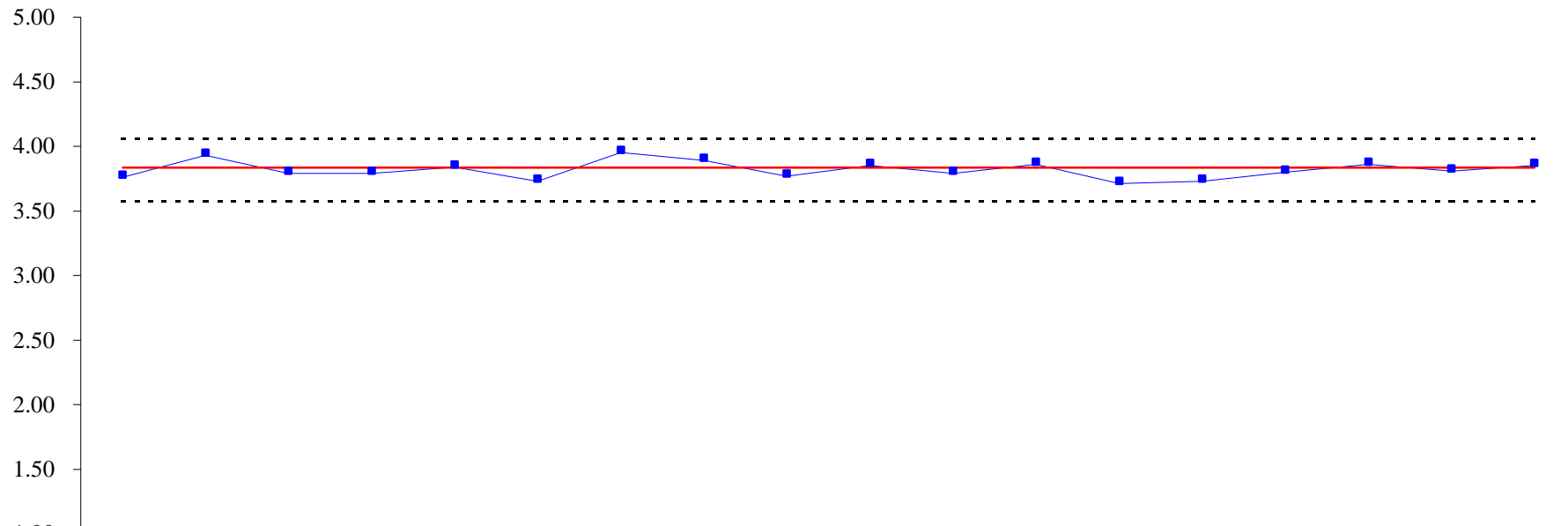
Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score ³3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
■ Score	3.90	4.14	3.93	3.84	3.98	4.03	4.03	3.95	3.80	3.87	4.12	4.14	4.15	4.01	3.92	4.00	4.03	3.89
Surveys	85	88	95	68	68	74	75	51	48	46	74	27	46	46	57	70	61	49
Discharges	236	260	195	213	215	197	228	236	252	244	253	259	263	265	220	260	262	213
% Sampled	36%	34%	49%	32%	32%	38%	33%	22%	19%	19%	29%	10%	17%	17%	26%	27%	23%	23%
----- UCL	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28	4.28
----- 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	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69

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

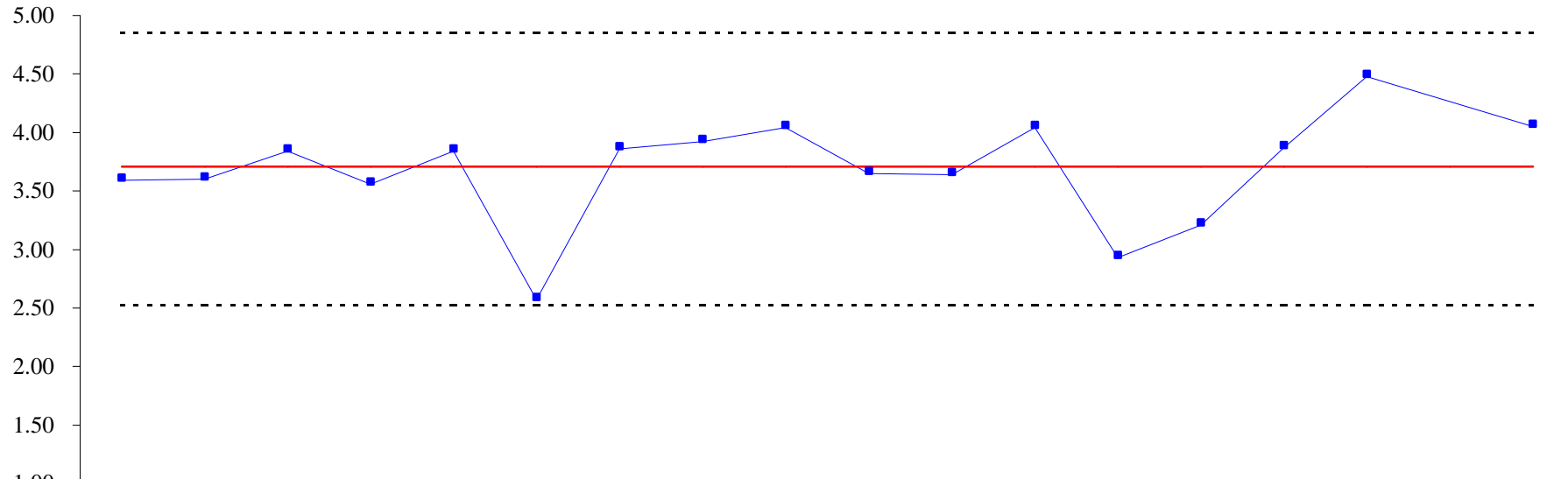
Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score \approx 3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05	Feb
—■— Score	3.76	3.93	3.79	3.79	3.84	3.73	3.95	3.89	3.77	3.85	3.79	3.86	3.71	3.73	3.80	3.86	3.81	3.85
Surveys	127	134	113	129	129	135	154	147	150	157	127	124	120	136	103	97	110	73
Discharges	178	179	158	167	168	178	234	203	191	196	196	202	185	190	173	192	233	170
% Sampled	71%	75%	72%	77%	77%	76%	66%	72%	79%	80%	65%	61%	65%	72%	60%	51%	47%	43%
----- UCL	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06	4.06
— Avg	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82	3.82
----- LCL	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57	3.57

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

Adults & Adolescents will be Satisfied with Care
(FY2005 Expectation is Average Score [≈]3.60)



	Sep-03	Oct	Nov	Dec	Jan-04	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-05*	Feb
—■— Score	3.59	3.60	3.84	3.56	3.84	2.57	3.86	3.92	4.04	3.65	3.64	4.04	2.93	3.21	3.87	4.48		4.05
Surveys	10	4	3	6	3	4	3	5	8	4	7	7	1	3	4	3	0	4
Discharges	17	10	8	12	6	11	12	9	20	10	14	14	10	9	11	11	14	11
% Sampled	59%	40%	38%	50%	50%	36%	25%	56%	40%	40%	50%	50%	10%	33%	36%	27%	0%	36%
----- UCL	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85	4.85
— Avg	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69
----- LCL	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52	2.52

Performance Objective 9E:

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):

- | | |
|------------------------|---------------------------------|
| 1. Fleet Management | 11. Pharmacy Inventory Controls |
| 2. Fixed Assets | 12. Medication Room Controls |
| 3. Maintenance | 13. HRD |
| 4. Consumer Monies | 14. Facility CMM |
| 5. Vocational Services | 15. Procurement Card Controls |
| 6. Community Relations | 16. Warehousing |
| 7. Food Service | 17. Accounting |
| 8. Risk Management | 18. Facility Personnel Actions |
| 9. Cash Receipts | 19. CAFM |
| 10. Petty Cash | 20. Information/LAN Security |

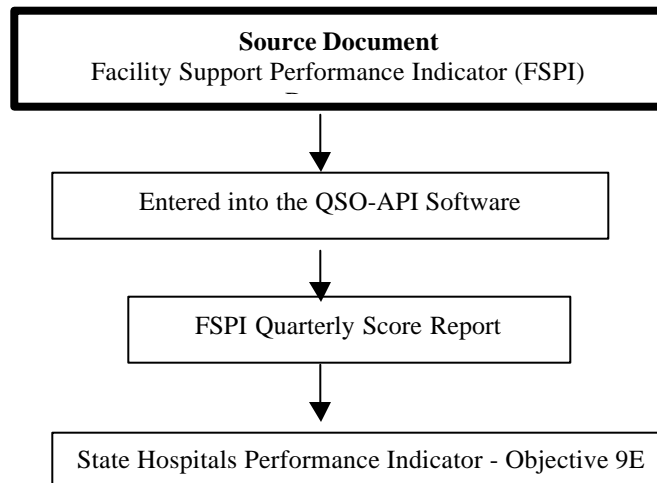
Performance Objective Operational Definition: The state hospital performs the self-assessment once per fiscal year according to the schedule.

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.

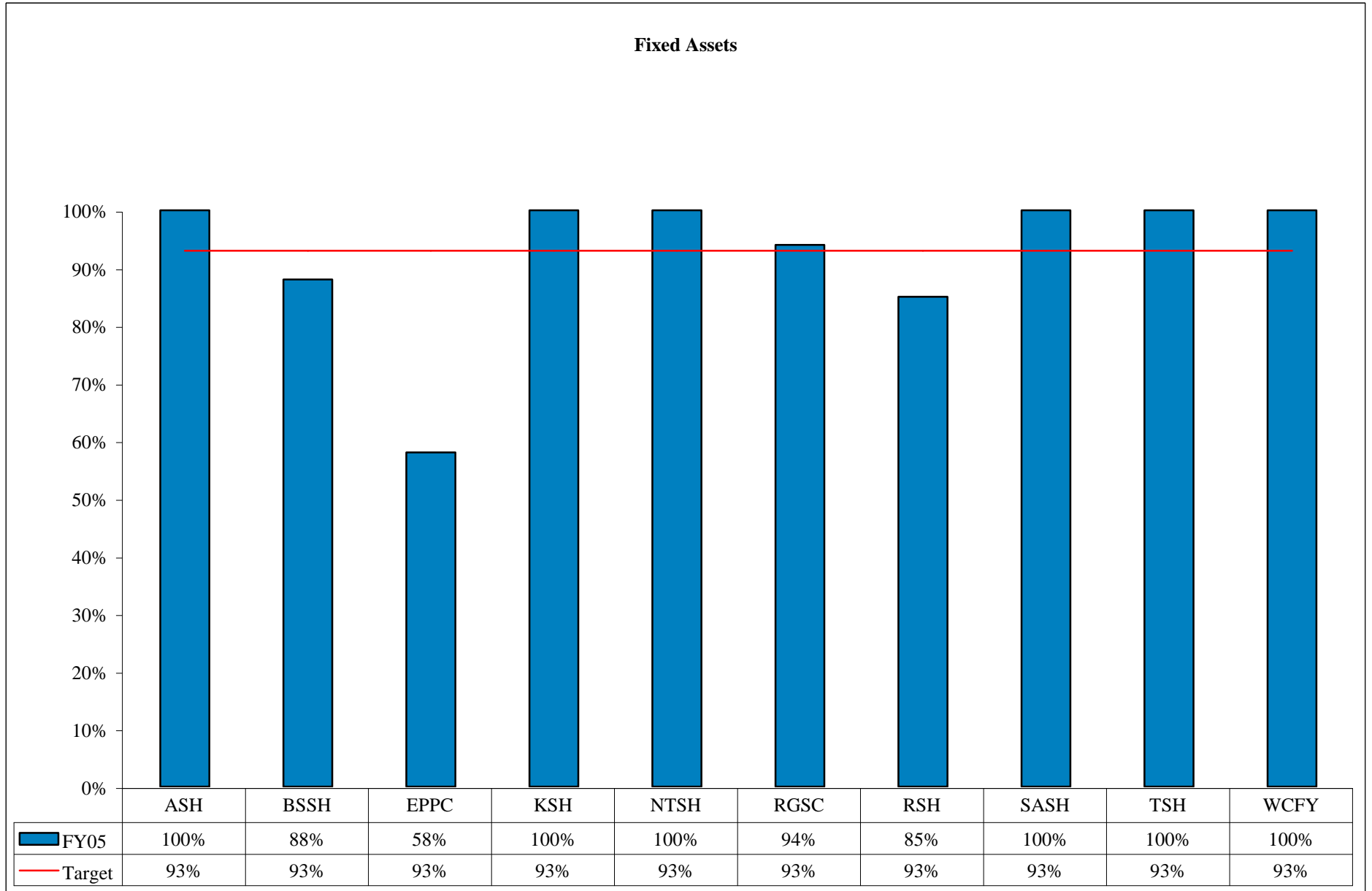
Objective 9E - Facility Support Performance Indicators
All MH Facilities - FY2005

	Q1			Q2		Q3		Q4		
	Fleet Management	Fixed Assets	Maintenance	Consumer Monies & Personal Effects	Vocational Programs	Community Relations	Food Service	Risk Management	Cash Receipts	Petty Cash
Compliance Target	85%	90%	92%	90%	90%					
MH Totals	98%	93%	96%	95%	98%					
Austin State Hospital	100%	100%	100%	90%	NA					
Big Spring State Hospital	100%	88%	100%	95%	96%					
El Paso Psychiatric Center	91%	58%	88%	95%	NA					
Kerrville State Hospital	92%	100%	100%	100%	100%					
North Texas State Hospital	100%	100%	86%	100%	93%					
Rio Grande State Center	100%	94%	100%	100%	NA					
Rusk State Hospital	100%	85%	100%	100%	100%					
San Antonio State Hospital	100%	100%	100%	100%	100%					
Terrell State Hospital	100%	100%	100%	95%	100%					
Waco Center For Youth	100%	100%	82%	70%	NA					

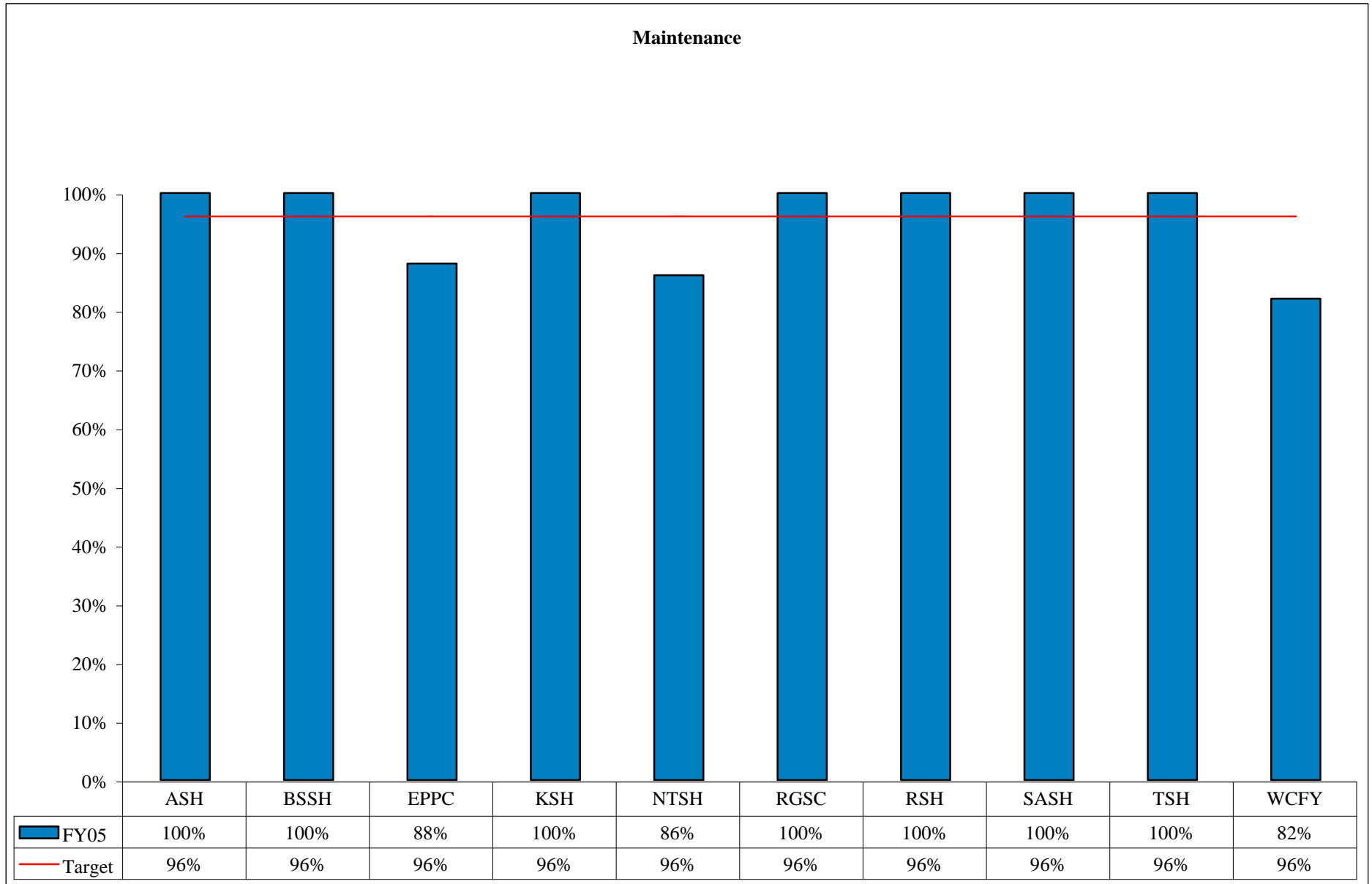
Objective 9E - Facility Support Performance Indicators
All MH Facilities
Fleet Management



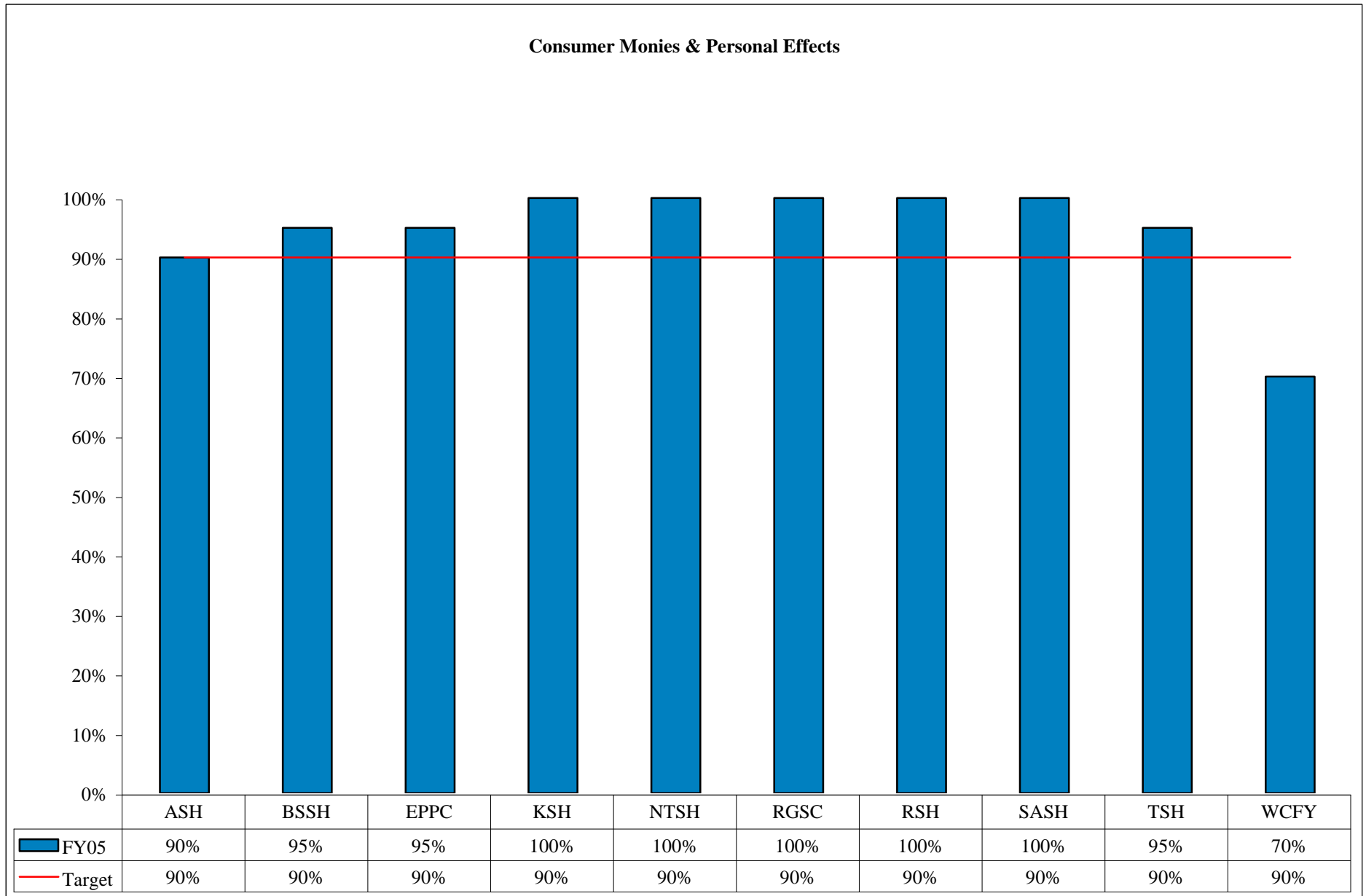
Objective 9E - Facility Support Performance Indicators
All MH Facilities
Fixed Assets



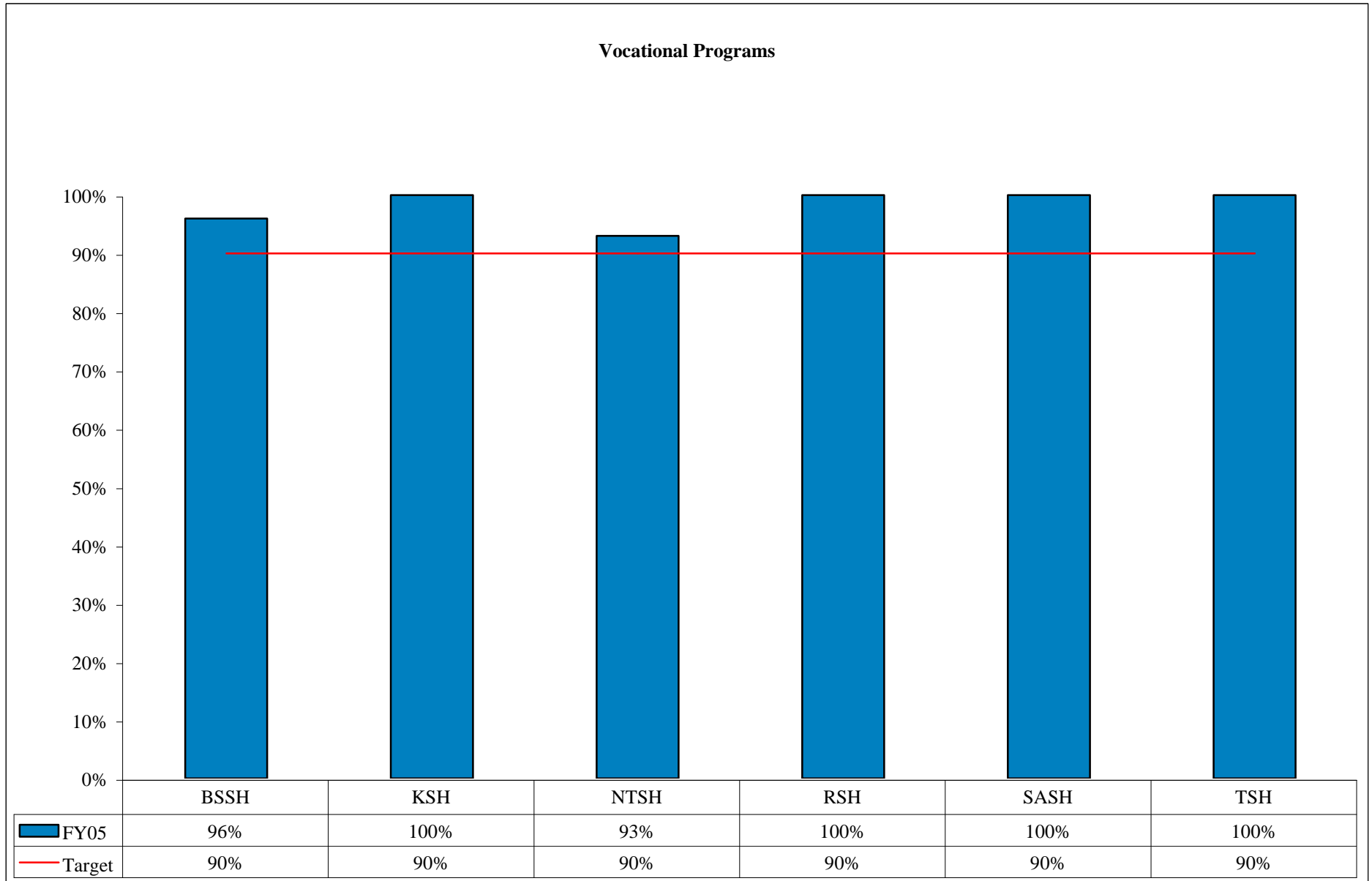
Objective 9E - Facility Support Performance Indicators
All MH Facilities
Maintenance



Objective 9E - Facility Support Performance Indicators
All MH Facilities
Consumer Monies & Personal Effects



Objective 9E - Facility Support Performance Indicators
All MH Facilities
Vocational Programs



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?

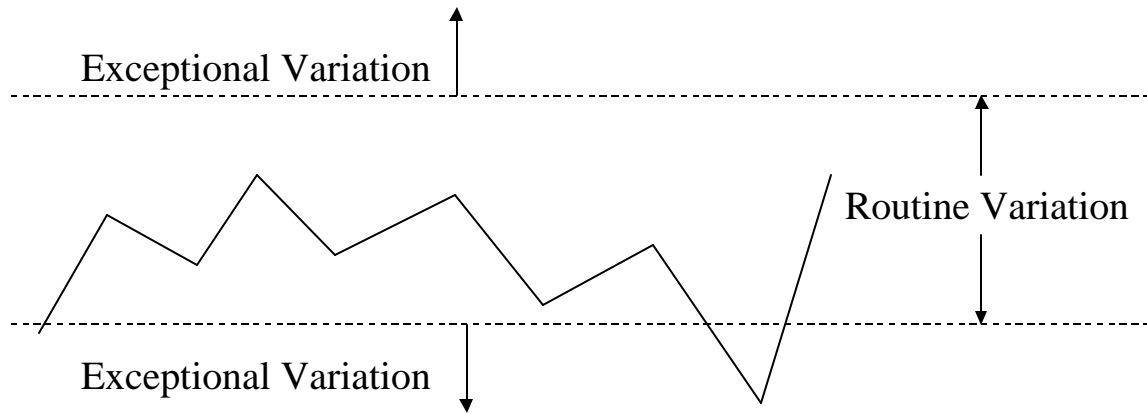
The key to understanding what information control charts provide is to make a distinction between two types of variation. The first type of variation is routine variation. It is always present. It is unavoidable. It is inherent in the process. Because this type of variation is routine, it is also predictable. 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.

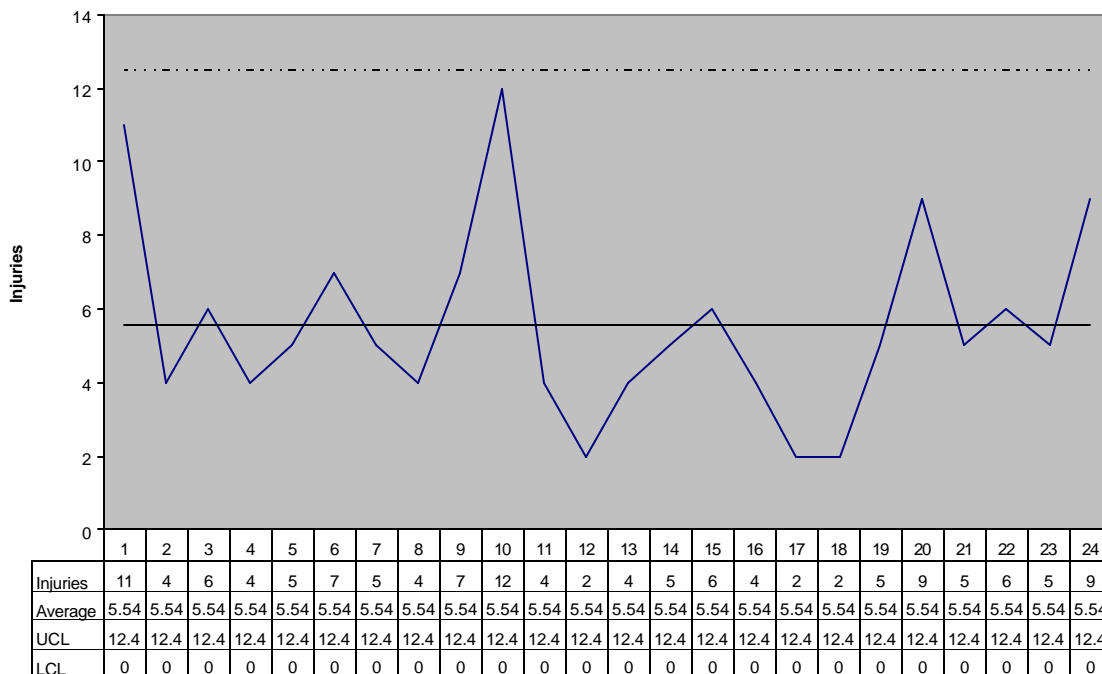
- If a process displays predictable variation, then the variation is the result of many common causes and it will be a waste of time to look for assignable causes. Improvement will only come by changing a major portion of the process.
- If a process displays unpredictable variation, then in addition 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	LCI	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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