OBJECTIVE OUTCOME DEFINITIONS REPORT

79th Regular Session, Performance Reporting
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Outcome No.	1	% Nursing Homes with a Certified Ombudsman

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:**

BL 2006 Definition

The purpose of this measure is to determine the extent to which nursing facilities have the services of either a certified volunteer ombudsman or a staff ombudsman. As this measure is a statewide average, the actual percentage in each area agency on aging region varies. The total number of nursing facilities with an assigned ombudsman is reported on a monthly basis to the Department by Area Agencies on Aging on their Ombudsman Program Performance Report. The total number of nursing facilities is based upon the most recently published data from the Department of Aging and Disability Services (DADS) Long-Term Care, licensing section, as of the end of each fiscal year.

BL 2006 Data Limitations

All nursing facilities in which an ombudsman is assigned will be included in the unduplicated account of this measure.

BL 2006 Data Source

The total number of nursing facilities with an assigned ombudsman is reported monthly on the Ombudsman Program Performance Report. The total number of nursing facilities is based upon the most recently published data from the Department of Aging and Disability Services Long-Term Care Regulatory, licensing section, as of the end of each fiscal year.

BL 2006 Methodology

This measure is calculated by dividing the total number of nursing facilities with an assigned ombudsman by the total number of licensed nursing facilities in the state.

BL 2006 Purpose

The purpose of this measure is to determine the extent of which nursing facilities have the services of an ombudsman and have a visible presence and advocate on behalf of nursing home residents and/or their families.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Outcome No.	2	Average Number of Clients Served Per Month: Total Community Care

Calculation Method: N Key Measure: N New Measure: Y Target Attainment: H Priority: M Cross Reference:

BL 2006 Definition

This measure reports the total monthly average number of clients served through many of the agency's community care programs. The different types of clients that comprise this measure are identified under output measure 1 of strategies A.2.1., A.2.2., A.2.3., A.3.1., A.3.2., A.3.3., A.3.4., A.3.5., A.3.6., A.3.7., A.4.1., A.4.2., A.4.3., A.4.4., and A.4.8. The monthly average number of clients receiving IHFS/MR services is also included.

BL 2006 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Data for these services are based on annual unduplicated client counts that cannot be combined with the monthly averages reported for each of the other non-Medicaid Community Care services. Specific data limitations for each of these other services are identified under output measure 1 of strategies A.2.1., A.2.2., A.2.3., A.3.1., A.3.2., A.3.3., A.3.4., A.3.5., A.3.6., A.3.7., A.4.1., A.4.2., A.4.3., A.4.4., and A.4.8.

BL 2006 Data Source

Specific sources from which the data are obtained are listed under each of the output measures identified under the short definition.

BL 2006 Methodology

This measure reports the sum of the average number of Primary Home Care clients served per month, the average number of Community Attendant Services clients served per month, the average number of Day Activity and Health Services (XIX) clients served per month, the average number of Medicaid Community-based Alternatives (CBA) Waiver clients served per month, the average number of Home and Community-based Services clients served per month, the average number of Medicaid Related Conditions Waiver (CLASS) clients served per month, the average number of Deaf-Blind with Multiple Disabilities Waiver clients served per month, the average number of Consolidated Waiver Program clients served per month, the average number of Medically Dependent Children served per month, the average number of Texas Home Living Waiver clients served per month, the average number of non-Medicaid Community Care XX clients served per month, the average number of non-Medicaid

Continued Below In Purpose

BL 2006 Purpose

Continued Methodology:
Community Care GR clients served per month, the average number of consumers with MR receiving community services per month, the average number of consumers with MR receiving community residential services per month, the average number of clients receiving In-home Family Support Services per month, and the average number of persons receiving IHFS/MR services per month.

Purpose: This measure is a mechanism for assessing the agency?s performance as it pertains to implementing the provisions of this strategy. It provides a count of the number of persons assisted through the various service components funded under this strategy.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 1 Intake, Access, and Eligibility
Outcome No. 3 Average # of Persons on Interest Lists Per Month: Total Community Care

Calculation Method: N Key Measure: N New Measure: Y Target Attainment: L Priority: M Cross Reference:

BL 2006 Definition

This measure reports the sum of the average monthly number of persons on an interest list for: Medicaid Community-Based Alternatives (CBA) Waiver services, Medicaid Home and Community-based Waiver services, Medicaid Related Conditions Waiver (CLASS) services, Deaf-blind with Multiple Disabilities Waiver services, Medically Dependent Children?s Program services, non-Medicaid Community Care XX services, non-Medicaid Community Care GR services, MR Community Services, MR Community Residential Services, In-home Family Support Services and MR In-home and Family Support Services. See explanatory measures under strategies A.3.1., A.3.2., A.3.3., A.3.4., A.3.5., A.3.6., A.3.7., A.4.1., A.4.2., A.4.3., A.4.4., A.4.8 and A.4.9 for more detail on each of these measures.

BL 2006 Data Limitations

Not all interest lists are updated on a regular basis. See specific data limitations for each of the services that comprise this measure.

BL 2006 Data Source

Specific sources from which the data are obtained are listed under each of the component measures that comprise this measure. These measures are identified under the short definition above.

BL 2006 Methodology

This measure is derived by summing the component measures that comprise it. See explanatory measures under strategies A.3.1., A.3.2., A.3.3., A.3.4., A.3.5., A.3.6., A.3.7., A.4.1., A.4.2., A.4.3., A.4.4., A.4.8 and A.4.9.

BL 2006 Purpose

This measure is important because it is an indicator of the total unmet need for services provided.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 1 Intake, Access, and Eligibility
Outcome No. 4 Percent of Long-term Care Clients Served in Community Settings

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: H** **Priority: H** **Cross Reference:**

BL 2006 Definition

This measure reports the number of persons served in community settings expressed as a percent of all persons receiving (DADS) Long-term Care Services. The number of clients served in community settings is defined as the number of persons served per month in the community (defined in outcome measure 2 of objective A.1.). The total average number of clients served in long-term care per month is defined as the total average number of persons served in the community per month (defined in outcome measure 2 of objective A.1.), plus the average number of persons served in nursing facilities per month (defined in output measures 1 and 2 of strategy A.6.1).

BL 2006 Data Limitations

See data limitations listed under outcome measure 2 of objective A.1. and output measures 1 and 2 of strategy A.6.1.

BL 2006 Data Source

Specific sources used in the computation of this measure are identified under outcome measure 2 of objective A.1. and output measures 1 and 2 of strategy A.6.1.

BL 2006 Methodology

This measure is derived by dividing the total average number of clients served in community settings per month by the total monthly average number of clients served in long-term care, multiplied by 100.

BL 2006 Purpose

This measure quantifies the extent to which the agency's Long-term Care (LTC) clients are being served through the agency's community care programs. Community care services are less costly and less restrictive, allowing individuals more independence than if they were institutionalized.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Outcome No.	5	Avg # Clients Deinstitutional/Diverted from Instituti Settings per Mth

Calculation Method: N Key Measure: N New Measure: Y Target Attainment: H Priority: L Cross Reference:

BL 2006 Definition

This measures reports the number of individuals who are diverted from institutional care services into community services as well as those who are successfully moved from a nursing facility into Medicaid-funded waiver services provided in the community, and paid for by the State of Texas. Individuals in this latter group must be residing in a Texas nursing facility immediately prior to transitioning, and their nursing home stay must have been eligible for reimbursement by Medicaid. The number of deinstitutionalized or diverted clients is the total average number of Medicaid waiver clients served per month (outcome measure 1 under objective A.3.) and the number of Rider 28, Promoting Independence clients served per month (output measure 5 of strategy A.6.1).

BL 2006 Data Limitations

See data limitations discussed under outcome measure 1 of objective A.3 and output measure 5 of strategy A.6.1.

BL 2006 Data Source

Clients meeting the above criteria are identified and tracked through DADS' Service Authorization System (SAS). Two types of data are used to report this measure. The number of clients identified as meeting the above criteria is obtained from the department's Service Authorization System (SAS) by means of ad hoc query. Month-of-service to-date data that reports the number of these clients for whom claims have been approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query. Other data sources are identified under strategies A.3.2, A.3.7 and output measure 5 of strategy A.6.1.

BL 2006 Methodology

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly number of de-institutionalized and diverted clients (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2006 Purpose

This measure partially quantifies DADS' success in its "Promoting Independence" efforts. As clients relocate from nursing facilities to community care services, the department is allowed to transfer funds from nursing facilities to community care services to cover the cost of shift in services.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	2	Community Care - Entitlement
Outcome No.	1	Avg # of Clients Served Per Month: Medicaid Non-waiver Community Care

Calculation Method: N Key Measure: Y New Measure: N Target Attainment: H Priority: H Cross Reference:

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more of the following Medicaid-funded non-waiver community care services: Primary Home Care, Community Attendant Services (CAS) (formerly called Frail Elderly), or Day Activity and Health Services (DAHS) Title XIX. See the following measures for more information: strategy 1, output measure 1; strategy 2, output measure 1; and strategy 3, output measure 1.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of clients ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of clients approved-to-pay to-date and/or the number of clients authorized to receive services. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the number of persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2006 Data Source

Two types of data are used to calculate this measure. The number of clients authorized to receive the above services, as well as the number of units of service authorized, are obtained from the department's Service Authorization System (SAS) by means of ad hoc query. Month-of-service to-date data that reports, by type-of-service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2006 Methodology

Client counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly client counts (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2006 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons served with appropriated funding.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	2	Community Care - Entitlement
Outcome No.	2	Average Monthly Cost Per Client: Medicaid Non-waiver Community Care

Calculation Method: N Key Measure: N New Measure: N Target Attainment: L Priority: M Cross Reference:

BL 2006 Definition

This measure reports the average cost of Medicaid non-waiver Community Care services per client per month. Expenditures are defined as payments made to providers for services delivered to clients as well as amounts incurred for services delivered but not yet paid. The average monthly number of Medicaid non-waiver clients is defined under outcome measure 1 of this objective.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of clients ultimately served as well as cost per client per month must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of clients "approved- to-pay" to-date and/or the number of clients authorized to receive services, the units of service approved-to-pay to-date, and the payment amounts approved-to-pay to-date. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the payment amounts approved-to-pay to-date divided by the appropriate completion factor equals the estimated expenditures ultimately incurred.

BL 2006 Data Source

Month-of-service to-date data that reports, by type-of-service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query. Data for this measures are based on strategy 1, efficiency measure 1; strategy 2, efficiency measure 1; and strategy 3, efficiency measure 1 of objective A.2.

BL 2006 Methodology

The sum of monthly expenditures for Medicaid non-waiver services, by month-of-service, for all months in the reporting period is divided by the monthly average number of Medicaid non-waiver clients for all months of the reporting period; the result is then divided by the number of months.

BL 2006 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. This unit cost is a tool for projecting future funding needs.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Outcome No.	1	Avg # of Clients Served Per Month: Community Care Waivers (Total)

Calculation Method: N Key Measure: N New Measure: Y Target Attainment: H Priority: H Cross Reference:

BL 2006 Definition

This measure reports the total monthly average number of Community Care Medicaid waiver clients served. See output measures 1 under the following strategies for more detail: CBA Waiver – A.3.1; HCS Waiver – A.3.2; CLASS Waiver – A.3.3; Deaf-blind Waiver – A.3.4; MDCP – A.3.5; Consolidated Waiver – A.3.6; Homeliving Waiver – A.3.7; and other Waivers – A.3.8.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of clients ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of clients approved-to-pay to-date and/or the number of clients authorized to receive services. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the number of persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2006 Data Source

Specific sources are identified under each of the output measures for the waiver programs identified above under short definition.

BL 2006 Methodology

The measure is the sum of each of the individual waiver output measures identified above under short definition.

BL 2006 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this objective. It provides a total count of persons receiving services through the agency’s Medicaid waiver programs.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 3 Community Care - Waivers
Outcome No. 2 Average Cost Per Client Served: Community Care Waivers (Total)

Calculation Method: N Key Measure: N New Measure: Y Target Attainment: L Priority: M Cross Reference:

BL 2006 Definition

This measure reports the total monthly average cost of serving Community Care Medicaid waiver clients. See efficiency measures 1 under the following strategies for more detail: CBA Waiver – A.3.1; HCS Waiver – A.3.2; CLASS Waiver – A.3.3; Deaf-blind Waiver – A.3.4; MDCP – A.3.5; Consolidated Waiver – A.3.6; Homeliving Waiver – A.3.7; and other Waivers – A.3.8.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of clients ultimately served as well as cost per client per month must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of clients approved-to-pay to-date and/or the number of clients authorized to receive services and the payment amounts approved-to-pay to-date. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the payment amounts approved-to-pay to-date divided by the appropriate completion factor equals the estimated expenditures ultimately incurred.

BL 2006 Data Source

Specific sources are identified under each of the efficiency measures for the waiver programs identified above under short definition.

BL 2006 Methodology

Data reported for this measure are the weighted average cost per client, based on the client populations identified under the short definition above.

BL 2006 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this objective. It provides a total count of persons receiving services through the agency’s Medicaid waiver programs. This unit cost is a tool for projecting future funding needs.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 4 Community Care - State
Outcome No. 1 Avg # of Clients Served Per Month: Total Non-Medicaid Community Care

Calculation Method: N Key Measure: Y New Measure: Y Target Attainment: H Priority: M Cross Reference:

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more of the following non-Medicaid Community Care services: adult foster care, client managed attendant care, day activity and health services (funded through Social Services Block Grant), emergency response services, home delivered meals (XX funded), family care, special services for persons with disabilities, residential care, respite care and In-home Family Support. Also included are MR community services consisting of assessment and service coordination, vocational and training services, respite, residential services, specialize therapies and n-home and Family Support.

BL 2006 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Data for these services are reported as annual unduplicated counts that cannot be combined with the monthly averages reported for each of the other services. For other data limitations, refer to output measures 1 under strategies A.4.1., A.4.2., A.4.3., A.4.4. A.4.8 and A.4.9.

BL 2006 Data Source

Specific data sources are detailed under each of the measures that comprise this “roll-up” measure. See output measure 1 under strategies, 1, 2, 3, 4, 8, and 9.

BL 2006 Methodology

This measure is the sum of output measure 1 under strategies 1, 2, 3, 4, 8, and 9 of this objective.

BL 2006 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons served with ffunding that has been appropriated.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Outcome No.	2	Avg Monthly Cost Per Client Served: Total Non-Medicaid Community Care

Calculation Method: N **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority: M** **Cross Reference:**

BL 2006 Definition

This measure reports the average cost of non-Medicaid Community Care services per client per month. Expenditures are defined as payments made to providers for services delivered to clients as well as incurred amounts for services delivered but not yet paid. The average monthly number of non-Medicaid Community Care clients is defined under outcome measure 1.

BL 2006 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Average cost data for these services are based on annual unduplicated client counts that cannot be combined with the monthly averages reported for each of the other non-Medicaid Community Care services. Specific data limitations for each of these other services are identified under efficiency measure 1 of strategies 1, 2, 3. 4, 8, and 9 of this objective.

BL 2006 Data Source

Specific data sources are detailed under each of the measures that comprise this measure. See efficiency measure 1 under strategies, 1, 2, 3, 4, 8, and 9.

BL 2006 Methodology

The sum of monthly expenditures for non-Medicaid Community Care services by month-of-service for all months in the reporting period is divided by the average monthly number of non-Medicaid Community Care clients for the months of the reporting period; this is then divided by the number of months in the reporting period.

BL 2006 Purpose

This measure quantifies the unit cost for providing eligible persons with services available under this objective. This unit cost is a tool for projecting future funding needs.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 4 Community Care - State
Outcome No. 3 Avg # of Persons on Interest List Per Month: Total Non-Medicaid CC

Calculation Method: N Key Measure: N New Measure: Y Target Attainment: L Priority: M Cross Reference:

BL 2006 Definition

This measure reports the average monthly number of persons who have requested one or more non-Medicaid Community Care services but are placed on an interest list for requested service(s) due to funding constraints. Interest lists are maintained for XX funded services, for GR funded services, for MR Community Services and for MR Community Residential Services. The count includes persons who are waiting for one or more non-Medicaid Community Care services while receiving other Community Care services. See explanatory measures under strategies A.4.1, A.4.2, A.4.3., A.4.4., A.4.8. and A.4.9 for the detail of the component measures that comprise this “total” measure.

BL 2006 Data Limitations

See explanatory measures under strategies A.4.1, A.4.2., A.4.3., A.4.4., A.4.8. and A.4.9 for the detail of the component measures that comprise this “total” measure.

BL 2006 Data Source

Specific data sources are identified under each of the measures that are included in this count. See explanatory measures under strategies A.4.1., A.4.2., A.4.3., A.4.4., A.4.8. and A.4.9 for the detail of the component measures that comprise this “total” measure.

BL 2006 Methodology

This measure is the sum of explanatory measure 1 under strategies 1, 2, 3, 4, 8, and 9 of this objective.

BL 2006 Purpose

This measure is important because it is an indicator of the unmet need for services provided under non- Medicaid community care services as currently funded by this strategy.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 6 Nursing Facility and Hospice Payments
Outcome No. 1 Percent of At-risk Population Served in Nursing Facilities

Calculation Method: N Key Measure: N New Measure: N Target Attainment: L Priority: H Cross Reference:

BL 2006 Definition

This measure reports the number of persons served in nursing facilities expressed as a percent of the state's population at risk of needing nursing facility services. Persons served in nursing facilities is defined as the sum of: the average number of persons receiving Medicaid-funded nursing facility services per month (strategy A.6.1, output measure 1), and the average number of persons receiving co-paid Medicaid/Medicare nursing facility services per month (strategy A.6.1, output measure 2). The population at-risk is defined as aged and disabled persons with income at or below 220% of the poverty level that need assistance with daily living.

BL 2006 Data Limitations

The estimated number of persons at-risk is subject to change as a result of updates/ revisions to the population estimates and projections.

BL 2006 Data Source

Specific data sources for the number of persons served in nursing facilities are identified under strategy A.6.1, output measures 1 and 2. The at-risk population is estimated using baseline information obtained from the last two March Current Population Surveys and the on-going Survey of Income and Program Participation administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center at Texas A&M University, College Station, Texas.

BL 2006 Methodology

This measure is derived by dividing the monthly average number of persons served in nursing facilities by the number of persons at-risk of nursing facility institutionalization, multiplied by 100.

BL 2006 Purpose

This measure quantifies the extent to which the population at-risk of nursing facility institutionalization is being served through the agency's nursing facility program (i.e. indicates percent of need met).

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	6	Nursing Facility and Hospice Payments
Outcome No.	2	Medicaid Nursing Facility Bed Utilization Per 10,000 Aged and Disabled

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:**

BL 2006 Definition

This measure reports the rate at which Medicaid beds in nursing facilities are being utilized expressed in terms of per 10,000 aged and disabled persons in Texas. The number of persons utilizing Medicaid nursing facility beds is defined as the average number of persons per month served in nursing facilities (defined in outcome measure 1).

BL 2006 Data Limitations

The estimated number of aged and disabled persons is subject to change as a result of updates/revisions to the population estimates and projections.

BL 2006 Data Source

Specific data sources for the number of persons utilizing Medicaid nursing facility beds are identified under strategy 1, output measures 1 and 2. The aged and disabled population is estimated using baseline information obtained from the on-going Survey of Income and Program Participation administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center at Texas A&M University, College Station, Texas.

BL 2006 Methodology

The number of persons utilizing Medicaid nursing facility beds is divided by the number of aged and disabled persons in Texas. This result is then multiplied by 10,000 to obtain the utilization rate per 10,000 aged and disabled persons in Texas.

BL 2006 Purpose

This measure compares the occupancy of Medicaid certified beds in nursing facilities to the potential demand for Medicaid nursing facility services.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 1 Long-term Care Continuum
Objective No. 8 MR State Schools Services
Outcome No. 1 Avg # Days MR Residents Recom for Comunty Placement Wait for Placement

Calculation Method: N Key Measure: Y New Measure: N Target Attainment: L Priority: H Cross Reference:

BL 2006 Definition

As campus residents are recommended for community placement, DADS begins a process of locating and/or developing community locations. Placement is a dynamic process with the consumer, family or guardian and community providers involved in the placement process. There is high variability in the amount of time needed for actual community placement due to the uniqueness of the consumer's needs and the location preferences of the consumer and family or guardian.

BL 2006 Data Limitations

With the implementation of the standardized instrument for recommending that persons currently residing in state mental retardation campus-based facilities be placed in the community, the data collected for this measure should have inter-rater reliability.

BL 2006 Data Source

The recommendation for placement in the community is from each consumer's annual review. Recommendations for community placements are entered into the department's CARE system with the recommended movement code 5 (move from campus to community). Actual placement in the community is entered into the CARE system with the Assignment/Absence code of CP (Community Placement). Persons employed by the state mental retardation campus-based facilities enter the annual review recommendations into the department's CARE system.

BL 2006 Methodology

For the numerator, the sums of days between community placement recommendation and actual placement for each state mental retardation campus resident recommended for community placement and placed in the community during the fiscal year are added together. The denominator is the number of consumers placed in community during the fiscal year. The formula is numerator/denominator.

BL 2006 Purpose

Ideally, campus residents recommended for community placement would be placed immediately. A shorter average wait indicates success in developing community placements for campus residents who can benefit from community placement.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Outcome No.	2	Number of Consumers with MR Who Moved from Campus to Community

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:**

BL 2006 Definition

This outcome is based on persons with mental retardation who desire community placement obtaining such placement. It is actually a measure of the availability of Medicaid Waiver funded services (HCS, HCS-O, MRLA, & any others directly administered by DADS in the future) and Intermediate Care Facilities for persons with mental retardation funding for new capacity. Movement from campus (i.e. state mental retardation facilities which are large self-contained areas where persons live and receive 24-hour supervised care) to community tends to be from one type of residential setting to another residential setting.

BL 2006 Data Limitations

None

BL 2006 Data Source

Movement of persons served by the DADS campus based system is recorded in the department's data warehouse system by staff at the facilities. The source of data is the â€œCAM3 Campus-Based Discharge/Community Placementâ€O CARE form which indicates actual date of community placement. These forms are located in records available from the state mental retardation facilities. The Community Placement Living Plan is available in the clinical record and projects a date for community placement that may be changed based on a variety of factors. Assignment/Absence codes are used for these movements in the CARE system. The CP code is used to indicate a community placement from a state mental retardation facility.

BL 2006 Methodology

This is a simple count of persons with an Assignment/Absence code of CP over the fiscal year.

BL 2006 Purpose

The implementation of the Governor's Executive Order, RP 13 and the Health and Human Services Commission's Promoting Independence Plan should have significant impact on this measure. Persons residing in state mental retardation facilities that want community placement and for whom staff recommends community placement should have the opportunity for community placement.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	1	% Facilities Complying with Stds at Inspection Licen-Medicare/Medicaid

Calculation Method: N Key Measure: Y New Measure: N Target Attainment: H Priority: M Cross Reference:

BL 2006 Definition

This measure reports the number of facilities (nursing facilities, ICF-MR facilities, assisted living facilities, and adult day care facilities) complying with standards at time of inspection expressed as a percent of all of these facilities(nursing facilities, ICF-MR facilities, assisted living facilities, and adult day care facilities). Complying with standards is defined as a recommendation to continue/renew licensure and/or certification. An inspection is defined as a standard survey of a nursing facility, a re-certification survey of an ICF-MR facility, or a licensing inspection. Licensing inspections conducted in conjunction with a standard or an annual survey are counted as one activity.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the LTCR Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES system. At the end of the reporting period, an ad hoc report will be done containing all of the data elements needed to perform the necessary calculations. The report does not have a name or report number.

BL 2006 Methodology

The percentage of facilities complying with standards during the state fiscal year is calculated by dividing the number of facilities determined to be in compliance at the time of inspection (numerator) by the total number of facilities inspected (denominator) during the reporting period, and multiplying this result by 100.

BL 2006 Purpose

This measure quantifies the achievement of the program's objective while also indicating public accountability of facilities.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	2	% Facilities Correcting Adverse Findings by 1st Follow-up Visit

Calculation Method: N Key Measure: N New Measure: N Target Attainment: H Priority: M Cross Reference:

BL 2006 Definition

This measure reports the percentage of facilities (nursing facilities, ICF-MR facilities, assisted living facilities, and adult day care facilities) that have corrected adverse findings/actions by the time of the first follow-up visit. The first follow-up visit is defined as the visit conducted for the purpose of determining correction of deficiencies cited at the time of inspection or investigation. This visit is the first visit conducted for this purpose. A second, third, or subsequent visit would not be counted under this measure. Adverse findings are defined as recommendations other than to continue/renew licensure and/or certification.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the CARES Central Data Repository (CDR) that pulls data from the CARES system. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report does not have a name or report number.

BL 2006 Methodology

The percentage of facilities correcting adverse findings by time of the first follow-up visit after inspection or investigation is calculated by dividing the number of facilities determined to be in compliance with standards at the time of the first follow-up visit (numerator) by the total number of such visits conducted during the reporting period (denominator), and multiplying this result by 100. Data are reported for the state fiscal year.

BL 2006 Purpose

This measure quantifies the achievement of the program's objective while also indicating public accountability of facilities.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	3	% NF-ICF/MR with More Than Six On-site Monitoring Visits Per Year

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:**

BL 2006 Definition

This measure reports the percentage of nursing facilities that have more than the average number of regulatory visits per year. A regulatory visit is defined as any on-site licensure inspection, certification survey, complaint and incident investigation, or follow-up to inspections, surveys and investigations. Licensure inspections conducted in conjunction with a certification survey are counted as one regulatory visit for purposes of this measure. However, if during a regulatory visit, more than one type of activity is performed (a licensure inspection, a follow-up and an investigation) each type of activity is counted separately for reporting this measure.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the CARES Central Data Repository (CDR) that pulls data from the CARES system. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report does not have a name or report number.

BL 2006 Methodology

The percentage of nursing facilities with more than six regulatory visits is calculated by determining the number of nursing facilities with more than 6 visits per year (numerator) and dividing by the average number of nursing facilities licensed and/or certified (denominator) during the reporting period, and multiplying the result by 100.

BL 2006 Purpose

This measure quantifies the achievement of the program's objective while indicating the public accountability of nursing facilities.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	4	Rate (1000) Substantiated Complaint Allegations of Abuse/Neglect: NF

Calculation Method: N Key Measure: N New Measure: N Target Attainment: L Priority: H Cross Reference:

BL 2006 Definition

This measure reports the rate of substantiated complaint allegations of resident abuse and/or neglect in nursing facilities per 1,000 residents during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional LTC-R survey/investigation staff determine whether allegations are substantiated after a thorough investigation. Abuse and neglect are defined by state and federal regulations. Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse and neglect of children residing in nursing facilities is defined by Texas Family Code, Section 261.001.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the regional workload report submitted monthly and compiled by Data Management and Analysis Section. The LTCR monthly report is called the LTCR Performance Measures. Later, data may be obtained from CARES Central Data Repository (CDR) that pulls data from the CARES system. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report does not have a name or report number. The data for the number of residents in nursing facilities is reflective of facility census data collected at the last LTCR staffs visit and entered into the CARES system. The census data may range from several weeks to several months old.

BL 2006 Methodology

This measure is computed by dividing the number of substantiated complaint allegations of abuse/neglect in nursing facilities during the months of the reporting period by the total number of residents in nursing facilities, and then multiplying this result by 1,000.

BL 2006 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in nursing facilities. It is a tool for evaluating the programs effectiveness and accessing the accountability of facilities.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	5	Rate (1000) Substantiated Complaint Allegations Abuse/Neglect: ICF/MR

Calculation Method: N Key Measure: N New Measure: N Target Attainment: L Priority: H Cross Reference:

BL 2006 Definition

This measure reports the rate of substantiated complaint allegations of abuse and/or neglect in ICF-MR facilities per 1,000 residents during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Abuse and neglect are defined by state and federal regulations. See outcome measure 4 for definition of abuse and neglect.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the regional workload report submitted monthly and compiled by Data Management and Analysis Section. The LTCR monthly report is called the LTCR Performance Measures. Later, data may be obtained from CARES Central Data Repository (CDR) that pulls data from the CARES system. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report does not have a name or report number.

BL 2006 Methodology

This measure is computed by dividing the number of substantiated complaint allegations of abuse/neglect in ICFs/MR during the months of the reporting period by the total number of residents in ICFs/MR during this period, and then multiplying this result by 1,000.

BL 2006 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in ICF/MR facilities. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	6	Percent of Nursing Facility Administrators with No Recent Violations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:**

BL 2006 Definition

This measure reports the number of nursing facility administrators who have had no recent violations expressed as a percent of all nursing facility administrators licensed by the agency.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from both automated and manual sources. The information regarding licensees with an imposed sanction within the last 24 months is collected manually. Manual collections of data are pen and paper tabulations of information manually pulled from case folders. There are no report titles or identifying numbers associated with this process. Information regarding the number of licensees at the time of reporting is collected from the automated administrators licensing database.

BL 2006 Methodology

Data are computed by dividing the number of administrators without an imposed sanction (numerator) by the number of all licensees (denominator), multiplied by 100. The numerator is derived by subtracting the number of licensees with a sanction imposed within the past 24 months from the total number of licensees at the time of reporting. The denominator is derived by tabulating the total number of licensees at the time of reporting.

BL 2006 Purpose

This measure shows the effect of the agency's program to ensure that nursing home administrators are in compliance with legal requirements. It is a tool for assessing the programs effectiveness and the accountability of nursing facility personnel.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 2 Licensing, Certification, and Outreach
Objective No. 1 Long Term Care Facility Regulation and Support
Outcome No. 7 Percent of Nurse Aides and Medication Aides with No Recent Violations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:**

BL 2006 Definition

This measure reports the number of nurse aides and medication aides who have had no recent violations expressed as a percent of all nurse aides and medication aides credentialed by the department.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from automated sources (Nurse Aide Registry).

BL 2006 Methodology

Data are calculated by dividing the number of medication aides and nurse aides without an imposed sanction (numerator) by the number of all credentialed medication aides and nurse aides (denominator), multiplied by 100. The numerator is derived by subtracting the number of medication aides and nurse aides with sanctions imposed within the last 24 months from the total number of medication aides permitted and nurse aides in active status on the nurse aide registry at the time of reporting. The denominator is derived by tabulating the total number of medication aides permitted and nurse aides in active status on the nurse aide registry at the time of reporting.

BL 2006 Purpose

This measure shows the effect of the agency's program to ensure Medication Aides and Nurse Aides are in compliance with legal requirements. It is a tool for evaluating the programs effectiveness and assessing the accountability of nursing facility personnel.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	8	% Complaints and Referrals Resulting in Disciplinary Action: NFA

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:**

BL 2006 Definition

This measure reports the number of complaints and referrals against nursing facility administrators that resulted in disciplinary action expressed as a percent of all complaints and referrals against nursing facility administrators.

BL 2006 Data Limitations

The Nursing Facility Administrators Advisory Committee (NFAAC) is advisory only. The department has the ultimate authority to decide on an administrator's culpability and what sanctions, if any, are to be imposed. Therefore, the department can and routinely does amend, and in some cases dismiss, the NFAAC's recommendations. The department must take action on a complaint/referral when the NFAAC fails to meet/review cases, such as last year, when the NFAAC was temporarily abolished.

BL 2006 Data Source

This information is electronically tabulated from data entered into the Complaints and Information Tracking System (CARTS). CARTS is an ACCESS database maintained by DHS' Credentialing staff. There are no report titles or identifying numbers associated with this ad hoc report.

BL 2006 Methodology

Data are calculated by dividing the number of sanctions imposed (numerator) by the number of referrals and complaints reviewed by the NFAAC and/or the department (denominator), multiplied by 100. The numerator is derived by tabulating the number of sanctions imposed during the reporting period up to the time the report is prepared. The denominator is derived by tabulating the number of complaints and referrals reviewed by the NFAAC and/or department during the reporting period up to the time of reporting.

BL 2006 Purpose

This measure shows the effect of the agency's program to ensure nursing facility administrators are in compliance with legal requirements. It is a tool for evaluating the Program's effectiveness and assessing the accountability of nursing facility personnel.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No.	2	Licensing, Certification, and Outreach
Objective No.	1	Long Term Care Facility Regulation and Support
Outcome No.	9	% Complaints and Referrals Resulting in Disciplinary Action: NA & MA

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:**

BL 2006 Definition

This measure reports the number of complaints and referrals against medication aides and nurse aides that resulted in disciplinary action expressed as a percent of all complaints and referrals against nurse aides and medication aides.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

This information is manually collected and tabulated. Manual collections of data are pen and paper tabulations of information manually pulled from case folders. There are no report titles or identifying numbers associated with this process.

BL 2006 Methodology

Data are calculated by dividing the number of sanctions imposed against medication aides and nurse aides (numerator) by the number of complaints and referrals received on medication aides and nurse aides (denominator), multiplied by 100. The numerator is derived by tabulating the number of sanctions imposed during the reporting period up to the time of reporting. The denominator is derived by tabulating the number of complaints and referrals received during the reporting period up to the time of reporting.

BL 2006 Purpose

This measure shows the effect of the agency's program to ensure medication aides and nurse aides are in compliance with legal requirements. It is a tool for evaluating the programs effectiveness and accessing the accountability of nursing facility personnel.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 2 Licensing, Certification, and Outreach
Objective No. 1 Long Term Care Facility Regulation and Support
Outcome No. 10 % HCSSA Complying with Standards at Time of Inspection

Calculation Method: N Key Measure: N New Measure: N Target Attainment: H Priority: H Cross Reference:

BL 2006 Definition

This measure reports the number of Home and Community Support Services agencies (HCSSAs) complying with standards at the time of inspection expressed as a percent of all HCSSA's inspected. Complying with standards is defined as a recommendation to continue/renew licensure and/or certification. An inspection is defined as a standard survey, a re-certification survey, or licensing inspection. Licensing inspections conducted with a standard or annual survey are counted as one activity.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from a central data Repository (CDR) compiled of HCSSA staff workload report data and HCSSA stand-alone regulatory database. Data will be contained in an ad hoc report from the CDR done at the end of the reporting period. This report has no official name or report number. Later the data may be obtained from the CARES system, as the HCSSA program data becomes operational.

BL 2006 Methodology

The percentage of agencies complying with standards during the state fiscal year is calculated by dividing the number of facilities determined to be in compliance at the time of inspection (numerator) by the total number of agencies inspected (denominator) during the reporting period, and multiplying this result by 100.

BL 2006 Purpose

This measure is important because it quantifies the achievement of the program's objective, while also indicating public accountability of agencies.

Agency Code: **539** Agency: **Aging and Disability Services, Department of**

Goal No. 2 Licensing, Certification, and Outreach
Objective No. 1 Long Term Care Facility Regulation and Support
Outcome No. 11 % Residents Care Has Been Improved through Evidence-based Practices

Calculation Method: N Key Measure: N New Measure: N Target Attainment: H Priority: H Cross Reference:

BL 2006 Definition

This measure reports the number of nursing facility residents whose appropriateness of care has been improved through the consistent use of evidence-based resident care planning and practice expressed as a percent of all residents in the sample.

BL 2006 Data Limitations

Appropriate care is defined based on clinical evidence that identifies care planning and care practices that have been shown to yield improved resident outcomes. Appropriateness of care is determined from data obtained from bedside resident assessments performed by contracted nurse assessors. A random sample of nursing facility residents serves as the basis for this performance measure; therefore, the measure is statistical in nature and must be viewed in the context of its confidence interval.

BL 2006 Data Source

Resident assessments performed on a sample of 2000 randomly selected residents in Texas nursing facilities as part of the agency's annual statewide assessment of quality of care and quality of life in Texas nursing facilities.

BL 2006 Methodology

Appropriateness of care is determined in up to three clinical domains (ex: Toileting, Restraint Use, Indwelling Bladder Catheter use). The percentage of residents receiving appropriate care in each the confidence interval for the sum is determined.

BL 2006 Purpose

To promote the improvement in quality of care in one or more care domains that the Department and HHSC have identified as statewide priorities.