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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	EF	
Measure No.	1	Statewide Average Cost Per Care Coordination Client

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

Fall/Annual: N

BL 2006 Definition

This is a measure of the statewide average cost per client provided care coordination, exclusive of the cost of services brokered or procured for the client.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of persons is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The statewide average cost per care coordination client is calculated by dividing area agencies on aging expenditures used to provide care coordination to persons age 60 or older by the unduplicated number of clients year-to-date receiving care coordination services funded by the State Unit on Aging during the fiscal year.

BL 2006 Purpose

This measure identifies the statewide average State Unit on Aging cost per care coordination client.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	EF	
Measure No.	2	Statewide Average Cost Per Person Receiving Legal Assistance

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

Fall/Annual: N

BL 2006 Definition

This measure identifies the statewide average cost per person receiving legal assistance services.

BL 2006 Data Limitations

Only State Unit on Aging clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

One source for the number of persons is individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed. A second data source is the Monthly Case Summary Statistical report from the Legal Hotline for Older Texans that has a contract with the State Unit on Aging to provide legal assistance services. The reported number of persons is the sum of persons reported from the area agencies on aging. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The average cost per legal assistance client is calculated by dividing area agencies on aging expenditures used to provide legal assistance to persons age 60 or older, and when allowed by specific funding, to persons under age 60, by the unduplicated number of clients receiving legal assistance services as reported to the Department by the area agencies on aging as funded by the State Unit on Aging.

BL 2006 Purpose

At the state level, this measure provides a means for decision-makers to project service levels based on a given level of funding. For the state agency, this is a comparative efficiency measure between different programs, and is useful for monitoring and evaluating providers.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	EF	
Measure No.	3	Avg Mthly Cost Per Consumer MR Receiving Assessment & Svc Coordination

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

Fall/Annual: N

BL 2006 Definition

This measure captures information regarding what it costs the state each month, on average, to provide community assessment and service coordination mental retardation services to each consumer regardless of age. It measures the DADs’ appropriation authority cost per consumer as defined by the companion output measure.

BL 2006 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the data warehouse system by the local mental retardation authorities. If the local authority does not provide accurate data for the quarter, this measure will not be accurate. (At the end of the fiscal year, community centers report preliminary expenditure information that is used for reporting in ABEST. Final expenditure information may be entered into the data warehouse up to 4 months following the end of the fiscal year. Therefore, end of year values for efficiency measures will be updated in ABEST when the information is available.)

BL 2006 Data Source

At the end of each quarter, staff of the local authorities input expenditure information into the data warehouse system. The local authority indicates the fund sources used to finance the expenditures. The method of finance includes funds that are part of the DADS appropriation authority as well as other local funds, grant funds, and earned revenues.

BL 2006 Methodology

DADS appropriation authority funds include all general revenue and federal funds allocated through the performance contract. Also included are administrative claiming funds that the local authority receives following the submission of quarterly cost reports and Medicaid Service Coordination that the local authorities receive based on the submission of claims. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9, or 12 for year to date. The numerator is the total DADS appropriation authority funds utilized to fund MR assessment and service coordination services as reported in the data warehouse/ the number of months in the reporting period. The denominator is the average monthly number of mental retardation consumers receiving assessment and service coordination services in the community that are served with DADS appropriation authority funds. The formula is numerator/denominator.

BL 2006 Purpose

This measure captures DADS appropriation authority cost of assessment and service coordination mental retardation services in the community, regardless of age.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	EX	
Measure No.	1	# of Visits to Assisted Living Facilities by a Certified Ombudsman

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

Fall/Annual: N

BL 2006 Definition

This measure identifies the cumulative number of visits by certified ombudsmen to licensed Assisted Living Facilities.

BL 2006 Data Limitations

All visits to licensed Assisted Living Facilities by certified ombudsmen during the fiscal year will be included in this count, as reported by area agencies on aging to the State Unit on Aging.

BL 2006 Data Source

The number of visits to Assisted Living Facilities is reported by area agencies on aging monthly, in the format specified by the Department of Aging and Disability Services (DADS).

BL 2006 Methodology

The calculation is the cumulative number of visits to Assisted Living Facilities by area agencies on aging.

BL 2006 Purpose

This measure is an explanation and identification of the level of effort by area agencies on aging in providing services to residents of licensed Assisted Living Facilities. This level of effort is identified by comparing the number of Assisted Living Facilities to the cumulative number of visits. The number of Assisted Living Facilities is identified in the Department of Aging and Disability Services (DADS) Long-Term Care Regulatory, licensing section. The number of assisted living facilities as of 8-2-04 is 1,384.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	EX	
Measure No.	2	Total Expenditures for the Ombudsman Program

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

Fall/Annual: N

BL 2006 Definition

This measure identifies the reported total of all funds expended for the Ombudsman Program, which includes Federal Older Americans Act Title III and Title VII, other federal, State General Revenue and local cash.

BL 2006 Data Limitations

Only expenditures reported by the area agencies on aging to the State Unit on Aging on the quarterly report are included for this measure.

BL 2006 Data Source

Ombudsman expenditures are reported to the State Unit on Aging quarterly by area agencies on aging.

BL 2006 Methodology

Total expenditures are calculated by compiling the reported expenditures of each area agency on aging.

BL 2006 Purpose

At the state level, this measure provides a means to assess the level of activity and support for the Ombudsman program and is used as a monitoring tool for program oversight.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	OP	
Measure No.	1	Number of Certified Ombudsmen

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

Fall/Annual: N

BL 2006 Definition

The total number of active certified staff/volunteer Ombudsmen is defined as those individuals who have received appropriate instruction/prescribed training, who have received recognition by the State Ombudsman Office as being a qualified Ombudsman and identified as having an active status in the program.

BL 2006 Data Limitations

All certified Ombudsmen who were active during the fiscal year will be included in the unduplicated count of active certified Ombudsmen for this measure.

BL 2006 Data Source

The unduplicated number of active certified Ombudsmen is reported by area agencies on aging quarterly in the format specified by the Department. The area agencies on aging report both the unduplicated number of active Ombudsmen for the quarter and for the fiscal year. To be active in a state quarter, an Ombudsman is certified by the State Ombudsman Office and visits long-term care facilities within the state quarter, or investigates/resolves complaints when identified, or provides other Ombudsman services such as in-services for long-term care facilities/community groups.

BL 2006 Methodology

The calculation is the total of staff and volunteer Ombudsmen listed in the reports as active, certified Ombudsmen. The area agencies on aging report both the unduplicated number of active Ombudsmen for the quarter and for the fiscal year. The number of certified Ombudsmen are reported as unduplicated for the quarter and for year-to-date each quarter.

BL 2006 Purpose

This measure is an explanation and identification of the total number of active certified staff and volunteer Ombudsmen. The output allows decision-makers and state agency staff to identify trends of the program.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	OP	
Measure No.	2	Number of Persons Receiving Care Coordination

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

Fall/Annual: N

BL 2006 Definition

The measure is the unduplicated number of persons age 60 and older receiving care coordination services during the fiscal year. Care coordination is an ongoing process that includes assessment, service plan development, arranging of comprehensive and unified services, follow-up, monitoring of an individual's or family's status and services delivered, and periodic review, with any necessary revision of the service plan. The State Unit on Aging's care coordination services is intended to give preference to short-term intervention. Short-term intervention is considered three months or less; however, this does not preclude clients from receiving longer-term services when deemed appropriate by their care manager.

BL 2006 Data Limitations

Only funded State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of persons is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed.

BL 2006 Methodology

This calculation is based on the total unduplicated persons age 60 and older that receive care coordination services based on individual client data reported to the Department by area agencies on aging.

BL 2006 Purpose

This measure indicates the number of unduplicated persons age 60 or older receiving care coordination services during the fiscal year.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	OP	
Measure No.	3	Number of Information, Referral and Assistance Inquiries

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

Fall/Annual: N

BL 2006 Definition

The measure is the total number of inquiries (i.e., telephone call, visit, letter, or other communication) from or on behalf of a person 60 or older seeking information about services.

BL 2006 Data Limitations

The ability of area agencies on aging to identify individual specific inquiries.

BL 2006 Data Source

The number of inquiries reported to the Department by area agencies on aging.

BL 2006 Methodology

The calculation is the total number of inquiries reported to the State Unit on Aging by area agencies on aging.

BL 2006 Purpose

This measure indicates the number of information and assistance inquiries provided statewide.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	OP	
Measure No.	4	Number of Persons Receiving Legal Assistance

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

Fall/Annual: N

BL 2006 Definition

The measure is the total number of persons age 60 and older and, when allowed by specific funding, to persons under age 60 receiving legal assistance services during the fiscal year. Legal assistance service is advice and representation by an attorney (including assistance by a paralegal or law student under the supervision of an attorney), or counseling or representation by a non-lawyer where permitted by law.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

One source for the number of persons is individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed. A second data source is the Monthly Case Summary Statistical report from the Legal Hotline for Older Texans, which has a contract with the State Unit on Aging to provide legal assistance services. The reported number of persons is the sum of persons reported from the area agencies on aging.

BL 2006 Methodology

The reported number of persons is the sum of persons reported form the area agencies on aging.

BL 2006 Purpose

This measure indicates the amount of legal assistance services provided statewide.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake and Access to Services and Support
Measure Type	OP	
Measure No.	5	Avg Mthly # Consumers w/MR Receiving Assessment & Service Coordination

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

Fall/Annual: N

BL 2006 Definition

This measure captures the unduplicated count of priority population eligible persons whose services are funded with DADs' appropriation authority funds and who receive mental retardation community assessment and/or service coordination services. Assessment services are monthly services. Service coordination services are quarterly services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

BL 2006 Data Limitations

The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service.

BL 2006 Data Source

As persons enter the comm. programs, registration info.is entered into the CARE system by staff of the local mental retardation authority. When an individual is assigned to a specific prog., this information is also entered into the data warehouse system. To be counted as served in assessment or service coordination, the individual must have an open assignment to assessment or service coordination for the month(s) being reported. Production reports of consumers served are issued quarterly based on the information in the data warehouse system. The total unduplicated number of persons with open assignments to mental retardation community assessment and/or service coordination service each month is calculated. For each quarter of the fiscal year, the unduplicated number of persons served in each month of the quarter is averaged. The production report lists total number of persons assigned to a particular service each month regardless of how the services for the individuals were funded.

BL 2006 Methodology

To obtain the number of persons served with DADS appropriation authority funds, the percentage of total expenditures that were funded through the department's appropriation authority is calculated. (See Method of Calculation for the companion efficiency measure for details of calculating DADS authority funding.) This percentage is applied to the average monthly numbers served for the specified quarter and for year to date to yield the average monthly number served for the specified quarter with DADS appropriation authority funds. The numerator is the sum of the number of persons receiving MR assessment and/or service coordination service each month of the reporting period multiplied by the state funded percentage. The state funded percentage is expenditures financed through the DADS appropriation authority for MR assessment and/or service coordination services/total expenditures times 100. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2006 Purpose

Monthly number of persons served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	2	Long Term Care Functional Eligibility
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Case: Community Care

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly cost per community care case. Costs include those associated with the eligibility process.

BL 2006 Data Limitations

NA

BL 2006 Data Source

Two types of data are used to report this measure. The number of clients to receive the above services is obtained from DADS' Service Authorization System (SAS) by means of ad hoc query. These raw client counts by type of service are then multiplied by service specific weights to get a product or caseload equivalent. Data for direct costs related to Community Care eligibility determination are obtained from the department's HHSAS Financials. Primary Home Care nurses as well as Community Care workers are included in the costs. Other sources used in the computation of this measure are identified under output measure 1.

BL 2006 Methodology

The sum of the Community Care and Community-based Alternatives eligibility determination budget expended and cost pool data (PAC 372, 377) for each of the months of the reporting period are divided by the sum of the number of persons determined eligible for Community Care services (as defined in output measure 1) in the months of the reporting period, and this is divided by the number of months in the reporting period to obtain the monthly cost per eligibility determination.

BL 2006 Purpose

This measure is important because it is an indicator of the unit cost associated with implementing the provisions of this strategy as it pertains to providing DADS funded community care services. This unit cost indicates the efficiency of DADS' operations and is a useful 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.	1	Intake, Access, and Eligibility
Strategy No.	2	Long Term Care Functional Eligibility
Measure Type	EF	
Measure No.	2	Average Monthly Cost Per Adult Guardianship Client

Calculation Method: N **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority: H** Cross Reference: Agy 53X 078-R-S70-1 01-03-01 EF 03

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly cost of providing direct delivery guardianship services by DADS staff.

BL 2006 Data Limitations

None.

BL 2006 Data Source

Actual expenditures are from HHSAS-FS for PAC 430 (Guardianship Staff Services). The number of clients receiving APS guardianship services is from IMPACT; located in the guardianship detail table where the guardianship letter was issued on or before the end of the reporting month and the event activity type is coded as 'GUA'. This measure includes both new and on-going guardianship services.

Due to possible modifications in the DADS fiscal system, PACs, service codes, and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

BL 2006 Methodology

Annual expenditure projections for PAC 430 are made using an internal budget document (PACCUM.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per APS guardianship client served is calculated by dividing the average monthly cost by the average monthly number of APS clients served.

BL 2006 Purpose

This measure is useful as a benchmark and to monitor changes in DADS staff costs attributed to serving APS Guardianship clients.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	2	Long Term Care Functional Eligibility
Measure Type	OP	
Measure No.	1	Average Number of Persons Eligible Per Month: Community Care

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated monthly average number of clients authorized by Community Care workers to receive one or more Community Care services. These clients (Income Eligible, SSI) are eligible to receive the following services: Family Care, Primary Home Care, Meals Only, DAHS Only, Foster Care, Special Services to Persons with Disabilities, Residential Care, Emergency Response Services Only, and Community-based Alternatives.

BL 2006 Data Limitations

Since a high percentage of clients who receive meals, Day Activity and Health Services (DAHS) and/or emergency response services (ERS) also receive other services, for Meals, DAHS and ERS, the monthly unduplicated average count of community care clients includes only those Meals, DAHS or ERS clients who are not authorized to receive any other service. For services other than Meals, DAHS, or ERS, clients are counted without regard to duplication.

BL 2006 Data Source

The number of clients receiving the above services is obtained from the department's Service Authorization System (SAS) by means of ad hoc query. These files are used to isolate the Community care caseload by type of service, by region and then summed to a statewide total on a monthly basis. The clients, (Income Eligibles, SSI) receiving community care services only are reported.

BL 2006 Methodology

The data reported for this measure are calculated by dividing the sum of the monthly number of Community Care clients 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 quantifies the agency's workload as it pertains to determining the eligibility of persons receiving DADS funded community care services. This information is useful as a tool for assessing future funding needs.

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

Goal No. 1 Long-term Care Continuum
Objective No. 1 Intake, Access, and Eligibility
Strategy No. 2 Long Term Care Functional Eligibility
Measure Type OP
Measure No. 2 Average Case Equivalents Per Community Care Worker

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average case equivalents per Community Care worker. It is developed by using the unduplicated monthly average number of clients authorized by Community Care workers to receive one or more Community Care services. Clients (IE, SSI) are eligible to receive the following services: Family Care, Primary Home Care, Meals Only, DAHS Only, Foster Care, Special Services to Persons with Disabilities, Residential Care, and Emergency Response Services Only, and Community-based Alternatives. An eligibility worker is defined as a filled position with a budgeted job number that includes an alpha character identifier unique to eligibility workers. Community Care workers determine financial eligibility only for those clients with income above the SSI level. They also determine functional eligibility for all Community Care clients. In addition, they plan and authorize services for all clients, as well as monitor services delivered by providers.

BL 2006 Data Limitations

Since a high percentage of clients who receive Meals, Day Activity and Health Services (DAHS) and/or Emergency Response Services (ERS) also receive other services, for Meals, DAHS and ERS, the monthly unduplicated average count of community care clients includes only those Meals, DAHS or ERS clients who are not authorized to receive any other service. For services other than Meals, DAHS, or ERS, clients are counted without regard to duplication.

BL 2006 Data Source

The number of clients authorized to receive the above services is obtained from the department's Service Authorization System (SAS) by means of ad hoc query. These files are used to isolate the Community Care caseload by type of service, by region and then summed to a statewide total on a monthly basis. The clients, (Income Eligibles, SSI) receiving community care services only are reported.

BL 2006 Methodology

The amount of time needed to perform the functions associated with this measure varies significantly depending upon the type of case. Therefore, the department periodically conducts workload studies in order to develop "relative case weights" by type of case so that "standardized" case equivalents can be used to more effectively manage workloads. A "standardized" case equivalent is defined as a Primary Home Care case, since these cases make up the largest proportion of total cases. Case data are multiplied by relative case weights from the most recent Community Care workload study to obtain the number of Primary Home Care case equivalents. The number of caseload equivalents is divided by the number of (CCAD) eligibility filled workers in PAC 372 and 377 to obtain the reported data.

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 quantifies the level of effort (workload) expended by staff and indicates the efficiency of the agency's operations. It is also a useful tool for assessing future funding needs.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	2	Long Term Care Functional Eligibility
Measure Type	OP	
Measure No.	3	Avg Number of Standardized Community Care Case Equivalents Per Month

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average number of standardized Community Care case equivalents per month. A "standardized" Community Care case equivalent is defined as the amount of monthly work effort associated with a Primary Home Care SSI case. Community Care (CCAD) workers determine initial and on-going financial eligibility for those clients with income above the SSI level. They also determine initial and on-going functional eligibility for all Community Care clients. In addition, they plan and authorize services for all Community Care clients, and update service plans as needed, as well as monitor the services delivered by providers.

BL 2006 Data Limitations

The amount of time needed to perform the above functions varies significantly depending upon the type of case. Therefore, the department periodically conducts workload studies in order to develop "relative case weights" based upon the amount of worker time needed per cases, by type of case, so that "standardized" case equivalents can be used to more effectively manage workloads. The information used to develop the case weights for Community Care services was collected September 2000 – June 2001.

BL 2006 Data Source

The client counts (see method of calculation for list of client populations) are obtained from the department's Service Authorization System (SAS) by means of ad hoc query.

BL 2006 Methodology

The measure is calculated by using the monthly average number of clients authorized by Community Care workers to receive one or more of the following services: Family Care, Primary Home Care, Meals Only, Respite (FY 2003-FY 2005 only), Day Activity and Health Services (DAHS Only), Foster Care, Special Services to Persons with Disabilities, Residential Care, Emergency Response Services (ERS) Only, Meals as a second service, ERS as a second service, DAHS as a second service, and Community-based Alternatives. The above client counts by type of service are then multiplied by the appropriate relative case weights derived from the most recent Community Care workload study to obtain the number of Primary Home Care case equivalents.

BL 2006 Purpose

This measure is important because it is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the workload that must be handled by Community Care workers.

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

Goal No.	1	Long-term Care Continuum
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	2	Long Term Care Functional Eligibility
Measure Type	OP	
Measure No.	4	Average Number of APS Clients Receiving Guardianship Services

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: L** **Priority: H** Cross Reference: Agy 53X 078-R-S70-1 01-03-01 OP 06

Fall/Annual: N

BL 2006 Definition

The measure shows the count of clients for whom guardianship has been established through court order. The count includes both new and on-going guardianships. The latter refers to guardianships initiated in previous months and without closure dates.

BL 2006 Data Limitations

The usefulness of the data as a workload indicator is limited by the fact that the measure does not include the number of cases being assessed for the appropriateness of guardianship or cases for which less restrictive alternatives are found. Documentation can be delayed by the volume of work, which is impacted by vacancies, sick leave, vacation leave, turnover, IMPACT downtime, etc.

BL 2006 Data Source

Using IMPACT, the data are gathered by counting, of APS cases open during the reporting period and cases closed during the reporting period, the number of cases as documented on the guardianship detail table in which clients' guardianship letters were issued on or before the end of the report month and the event activity type was coded as 'GUA' (numerator). The count includes both direct-delivery and contracted guardianships. The denominator is the sum of months in the reporting period.

BL 2006 Methodology

Divide the numerator by the denominator. When calculating the second quarter, third quarter, and fourth quarter, the year-to-date total is recalculated.

BL 2006 Purpose

The purpose of this measure is to show the average number of adults for whom DADS was serving as guardian or purchased guardianship services during the reporting period. It indicates part of the workload volume in DADS guardianship.

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

Goal No.	1	Long-term Care Continuum
Objective No.	2	Community Care - Entitlement
Strategy No.	1	Primary Home Care
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client Served: Primary Home Care

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Medicaid non-waiver Community Care primary home 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 primary home care clients is defined under output measure 1 of this strategy.

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.

BL 2006 Methodology

The sum of monthly expenditures for Medicaid non-waiver primary home care services, by month-of-service, for all months in the reporting period is divided by the monthly average number of Medicaid non-waiver primary home care clients for all months of the reporting period; this result 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 strategy. 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.	2	Community Care - Entitlement
Strategy No.	1	Primary Home Care
Measure Type	OP	
Measure No.	1	Average Number of Clients Served Per Month: Primary Home Care

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of clients who, based upon approved-to-pay claims, received the Medicaid-funded non-waiver community care service, Primary Home Care.

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 count (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 the funding that has been appropriated.

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

Goal No.	1	Long-term Care Continuum
Objective No.	2	Community Care - Entitlement
Strategy No.	2	Community Attendant Services (Formerly Frail Elderly)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client Served: Community Attendant Services

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Medicaid non-waiver Community Care Community Attendant 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 community attendant services clients is defined under output measure 1 of this strategy.

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.

BL 2006 Methodology

The sum of monthly expenditures for Medicaid non-waiver community attendant services, by month-of-service, for all months in the reporting period is divided by the monthly average number of Medicaid non-waiver community attendant services clients for all months of the reporting period; the result 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 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.	2	Community Care - Entitlement
Strategy No.	2	Community Attendant Services (Formerly Frail Elderly)
Measure Type	OP	
Measure No.	1	Average # of Clients Served Per Month: Community Attendant Services

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of clients who, based upon approved-to-pay claims, received the Medicaid-funded non-waiver community care service, Community Attendant Services (CAS) (formerly referred to as Frail Elderly).

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 funding that has been appropriated.

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

Goal No.	1	Long-term Care Continuum
Objective No.	2	Community Care - Entitlement
Strategy No.	3	Day Activity and Health Services (DAHS)
Measure Type	EF	
Measure No.	1	Avg Monthly Cost Per Client Served: Day Activity and Health Services

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Medicaid non-waiver Community Care Day Activity and Health Services (XIX) 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 day activity and health services clients is defined under output measure 1 of this strategy.

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.

BL 2006 Methodology

The sum of monthly expenditures for Medicaid non-waiver day activity and health services, by month-of-service, for all months in the reporting period is divided by the monthly average number of Medicaid non-waiver day activity and health services clients for all months of the reporting period; the result 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 strategy. 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.	2	Community Care - Entitlement
Strategy No.	3	Day Activity and Health Services (DAHS)
Measure Type	OP	
Measure No.	1	Average Number of Clients Per Month: Day Activity/Health Services

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly number of clients who received Day Activity and Health Services funded by Medicaid (Title XIX). Day Activity and Health Services include personal care, nursing services, physical rehabilitation, nutrition, transportation, and support services to persons in adult day care facilities licensed by DADS? Long-term Care Regulatory.

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

Specific data sources for this measure are provided under outcome measure 1 of objective A.2.

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 eligible persons who, because of the receipt of day activity and health services in adult day care centers, are able to remain in their communities, as opposed to being placed in another more restrictive setting.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client: Medicaid CBA Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Medicaid Community-based Alternative 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 Medicaid Community-based Alternatives Waiver clients is defined under output measure 1 of this strategy.

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

Month-of-service to-date data that reports, by type-of-service, the number of clients for whom claims have been 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

The sum of monthly expenditures for Medicaid Community-based Alternative Waiver services, by month-of-service, for all months in the reporting period is divided by the sum of the monthly average number of Medicaid Community-based Alternative Waiver clients for all months of the reporting period; this result 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 funded under this strategy. 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
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	EX	
Measure No.	1	Average Number on Interest List Per Month: CBA Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly unduplicated number of persons who: 1) have requested Community-based Alternative (CBA) Waiver services through completion of a Community Care intake instrument, and, 2) meet the institutional risk criteria used as part of the CBA eligibility process, but are placed on an interest list for CBA due to funding constraints. The count includes persons who are receiving other Community Care services while waiting for CBA services.

BL 2006 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list.

BL 2006 Data Source

Regional staff enters data into a reporting database maintained by State Office program staff.

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 counts of persons on the interest list for CBA services for all months of the reporting.

BL 2006 Purpose

This measure is important because it is an indicator of the unmet need for services provided under the CBA waiver 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.	3	Community Care - Waivers
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	OP	
Measure No.	1	Average Number of Clients Served Per Month: Medicaid CBA Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more services under the Community-based Alternatives (CBA) waiver. This waiver provides an array of home- and community-based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing facilities. Services include adult foster care, assisted living/residential care, nursing, rehabilitative therapies, respite care, emergency response, etc.

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 CBA services 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 clients for whom claims have been 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 the funding that has been appropriated (CBA waiver).

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	EF	
Measure No.	1	Avg Monthly Cost Per Client Served: Home & Community Based Services

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

Fall/Annual: N

BL 2006 Definition

This measure captures the average cost per month for serving Medicaid waiver consumers (HCS and HCS-O).

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. Therefore, for the current quarter, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual enrollments for the current quarter.

BL 2006 Data Source

This measure is derived from enrollment and billing data, which are provided on a monthly basis. The calculation uses the average billing rate per consumer from the HCS billing system for each waiver type. Since there is a 95-day billing window for the waiver programs, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of consumers enrolled from CARE for each waiver type. The enrollment report provides the number of consumers entering and leaving by waiver. The ending enrollment balance at the end of the month represents the beginning balance for the next month. This combination of enrollments and average billing rates is used rather than utilizing the billing system alone because of the 95 day billing window for submitting claims.

BL 2006 Methodology

For each waiver type, the average billing rate for each month is multiplied by the number enrolled for those same months to determine a monthly expenditure amount. The monthly expenditure amount and number of consumers enrolled for each waiver type are aggregated into a total monthly expenditure amount and total number of consumers enrolled for all waivers. The aggregated monthly expenditure amount for each of the three months in the reporting quarter is summed. The aggregated number of consumers for each of the three months in the reporting quarter is also summed. The quarterly aggregated expenditure amount is divided by the quarterly aggregated number of consumers enrolled for an average monthly cost per consumer for all waivers for the reporting quarter. Once the billing data for previously reported quarters is complete, and regularly thereafter, the values reported in ABEST will be updated using only the aggregated average monthly billing rate for all waivers.

BL 2006 Purpose

This measure allows the agency to track the cost of HCS waiver funded services over time and to project the required general revenue matching funds. These projections help to ensure the availability of funds within existing resources and to maintain the fiscal integrity of the program.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	EX	
Measure No.	1	# Clients Receiving Services Per Year: Home & Community Based Services

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

Fall/Annual: N

BL 2006 Definition

This measure provides an unduplicated workload count of priority population eligible persons receiving mental retardation HCS waiver funded services (HCS and HCS-O) during the year.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. If the original claim is rejected for payment for any reason, the provider has up to 180 days from the end of the original service month to correct the claim and re-bill it. Since the documentation of a service being provided to an individual is based on these claims, accurate counts of numbers served during a fiscal year may not be available for several months past the fiscal year. Values reported in ABEST will be updated when the appropriation year closes.

BL 2006 Data Source

The providers of HCS waiver services submit Medicaid claims for the services provided during each month. The numbers of consumers served is taken from a standard production report.

BL 2006 Methodology

This is a simple unduplicated count of persons that received HCS waiver services during the fiscal year. It represents the number of persons enrolled at the end of each given fiscal year.

BL 2006 Purpose

Due to the very high demand for these services, as indicated by the number of persons waiting for waiver services, it is critical that the department monitors how many persons are receiving the service annually.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	EX	
Measure No.	2	Avg # Clients on Interest List Per Month: Home & Comity Based Svcs

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

Fall/Annual: N

BL 2006 Definition

This measure provides a simple count of persons who express an interest in Home and Community Based Waiver services. For purposes of this measure, interest is defined as placing one's name on the interest list with the local mental retardation authority for HCS waiver services.

BL 2006 Data Limitations

The accuracy of the HCS interest list is dependent upon the submission of accurate data by the MRAs. Further, since MRAs are only required to submit data quarterly, average monthly waiting list numbers are based on quarters, not individual months. There may be duplication of names between interest lists for mental retardation services.

BL 2006 Data Source

A person seeking mental retardation services or an individual seeking mental retardation services on behalf of another person with mental retardation begins the review of service options with the local mental retardation authority staff. If the individual, legal representative or family member decides they are interested in HCS waiver services, the name of the consumer is entered onto the interest list for HCS waiver services in the CARE system.

BL 2006 Methodology

This is a simple count on the last day of each fiscal quarter of persons whose names have been entered into the CARE system as interested in HCS waiver services. When calculating the average monthly number of persons on the interest for a given fiscal year, the average of the quarters in the fiscal year is calculated. When necessary, future and past periods are estimated based on the counts of the available quarters.

BL 2006 Purpose

Pursuing HCS waiver services is initiated by consumers, family members, and legally authorized representatives following discussions of service options with staff of the local Mental Retardation Authorities (MRAs).

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	OP	
Measure No.	1	Avg # Clients Served Per Month: Home & Community Based Services (HCS)

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

Fall/Annual: N

BL 2006 Definition

This measure captures the unduplicated count of priority population eligible persons who receive HCS waiver funded services (HCS and HCS-O) on a monthly basis.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of HCS waiver services up to 95 days after the end of the service month. If the original claim is rejected for payment for any reason, the provider has up to 180 days from the end of the original service month to correct the claim and re-bill it. Since the documentation of a service being provided to an individual is based on these claims, accurate counts of numbers served during a quarter may not be available for several months past the quarter. Values reported in ABEST will be updated regularly and when the appropriation year closes.

BL 2006 Data Source

Information used to report the average monthly number of consumers served is contained in the department's CARE system. A standard production report (DADS Waiver Programs – Summary of Slot Types) is generated monthly. DADS Medicaid Administration handles tracking and monitoring of enrollments into a Medicaid waiver funded program.

BL 2006 Methodology

The total unduplicated number of persons that receive HCS mental retardation waiver services each month is summed. For each quarter of the fiscal year, the number of persons served in each month of the quarter is averaged. For the second, third, and fourth quarters, year-to-date calculations are also obtained. The numerator is the total unduplicated number of HCS mental retardation waiver consumers receiving services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate HCS waiver funded services with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	3	Community Living Assistance and Support Services (CLASS)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client: CLASS Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Medicaid Related Conditions Waiver (CLASS) 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 CLASS clients is defined under output measure 1 of this strategy.

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

Month-of-service to-date data that reports by type-of-service the number of clients for whom claims have been 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

The measure is calculated as follows: The sum of the monthly expenditures for Medicaid Related Conditions Waiver (CLASS) services by month-of-service for all months in the reporting period is divided by the average monthly number of CLASS clients for all months of the reporting period; this result 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 strategy. 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
Strategy No.	3	Community Living Assistance and Support Services (CLASS)
Measure Type	EX	
Measure No.	1	Average Number on Interest List: Community Living Assistance & Support

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly unduplicated number of persons who have requested CLASS services, but are placed on an interest list for CLASS due to funding constraints. Persons are placed on an interest list by means of a telephone call to State Office program staff. The count may include persons who are waiting for CLASS while receiving other Community Care services.

BL 2006 Data Limitations

Unlike other Community Care interest lists, individuals on the CLASS list are not contacted (at least) annually to determine whether they are still interested in remaining on the list.

BL 2006 Data Source

Data are captured by means of a reporting database maintained by State Office program staff.

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 counts of persons on the interest list for CLASS (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 important because it is an indicator of the unmet need for services provided under the CLASS waiver as currently funded under this strategy.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	3	Community Living Assistance and Support Services (CLASS)
Measure Type	OP	
Measure No.	1	Average Number of Clients Served Per Month: CLASS Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims by month of service, received services under the CLASS waiver. CLASS offers people of all ages, who have severe disabilities, the opportunity to live in their own home and to work and socialize in their communities. CLASS is a cost effective alternative to institutional care with a service array that includes case management, habilitation, respite care, physical therapy, occupational therapy, speech therapy, nursing services, psychological services, adaptive aids/supplies, minor home modifications, and unlimited prescriptions.

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 report this measure. The number of clients authorized to receive CLASS services 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 clients for whom claims have been 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 funding that has been appropriated.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client: Deaf-Blind Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Deaf-blind with Multiple Disabilities Waiver 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 Deaf-blind with Multiple Disabilities Waiver clients is defined under output measure 1 of this strategy.

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, 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 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

The sum of monthly expenditures for the Deaf-blind with Multiple Disabilities Waiver (by month-of service) for all months in the reporting period is divided by the average monthly number of Deaf-blind with Multiple Disabilities Waiver clients for all 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 funded under this strategy. 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
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	EX	
Measure No.	1	Average Number on Interest List: Deaf-Blind Mult Disabilties Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly unduplicated number of persons who have requested Deaf-blind with Multiple Disabilities Waiver services, but are placed on an interest list for the Deaf-blind with Multiple Disabilities Waiver due to funding constraints. Persons are placed on an interest list by means of a telephone call to State Office program staff. The count may include persons who are waiting for Deaf-blind with Multiple Disabilities Waiver services while receiving other Community Care services.

BL 2006 Data Limitations

Unlike other Community Care interest lists, individuals on this list are not contacted (at least) annually to determine whether they are still interested in remaining on the list.

BL 2006 Data Source

Data are reported by means of a reporting database maintained by State Office program staff.

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 counts of persons on the interest list for Deaf-blind with Multiple Disabilities Waiver (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 important because it is an indicator of the unmet need for services provided under the Deaf blind with Multiple Disabilities Waiver 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.	3	Community Care - Waivers
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	OP	
Measure No.	1	Average Number of Clients Served Per Month: Deaf-Blind Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more services under the Deaf-blind with Multiple Disabilities Waiver. This waiver provides an array of services to people who are deaf-blind with multiple disabilities as an alternative to institutional care. The major focus of the program is to increase the client's opportunity to communicate and to lead active lives. Services include: case management, assisted living, habilitation, respite, nursing, specialized medical equipment, environmental modification, behavior communication specialist, intervener, and therapies.

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. 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 report this measure. The number of clients authorized to receive services are 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 clients for whom claims have been 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 important because it 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 funding that has been appropriated.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client: MDCP Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Medically Dependent Children's (MDCP) Waiver 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 children served is defined under output measure 1 of this strategy.

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

Month-of-service to-date data that reports, by type of service, the number of clients for whom claims have been 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

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

BL 2006 Purpose

This measure is important because it quantifies the unit cost for providing eligible persons with services funded under this strategy. 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
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	EX	
Measure No.	1	Average Number on Interest List Per Month: MDCP Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly unduplicated number of persons who have requested Medically Dependent Children's Program (MDCP) services, but are placed on an interest list for these services due to funding constraints.

BL 2006 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list.

BL 2006 Data Source

Counts are collected on a monthly basis. Data are reported by means of a reporting database maintained by State Office program staff.

BL 2006 Methodology

The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of persons on the interest list for MDCP (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 important because it is an indicator of the unmet need for services provided under the MDCP waiver 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.	3	Community Care - Waivers
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	OP	
Measure No.	1	Average Number of Clients Served Per Month: MDCP Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who received one or more services under the Medically Dependent Children's (MDCP) Waiver.

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 report this measure. The number of clients authorized to receive MDCP services are 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 clients for whom claims have been 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

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 important because it 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 funding that has been appropriated.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	6	Consolidated Waiver Program
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client: Consolidated Waiver (CWP)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of Consolidated Home- and Community-based Services Waiver 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 Consolidated Home- and Community-based Services Waiver clients is defined under output measure 1 of this strategy.

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, 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 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

The sum of monthly expenditures for the Consolidated Home- and Community-based Services Waiver by month-of-service for all months in the reporting period is divided by the average monthly number of Consolidated Home- and Community-based Services Waiver clients for all 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 funded under this strategy. 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
Strategy No.	6	Consolidated Waiver Program
Measure Type	OP	
Measure No.	1	Average Number of Clients Served/Mo: Consolidated Waiver Program (CWP)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more services provided under the Consolidated Home-and Community-based Services Waiver.

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 report this measure. The number of clients authorized to receive Consolidated Home- and Community-based Services Waiver services, 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 clients for whom claims have been 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 funding that has been appropriated.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	7	Texas Home Living Waiver
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Client Served: Texas Home Living Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure captures the average cost per month for serving Texas Homeliving Waiver consumers.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. Therefore, for the current quarter, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual enrollments for the current quarter.

BL 2006 Data Source

This measure is derived from enrollment and billing data, which are provided on a monthly basis. The calculation uses the average billing rate per consumer from the Medicaid waiver billing system for each waiver type. Since there is a 95 day billing window for the waiver programs, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of consumers enrolled from the data warehouse for each waiver type. The enrollment report provides the number of consumers entering and leaving by waiver. The ending enrollment balance at the end of the month represents the beginning balance for the next month. This combination of enrollments and average billing rates is used rather than utilizing the billing system alone because of the 95 day billing window for submitting claims.

BL 2006 Methodology

For each waiver type, the average billing rate for each month is multiplied by the number enrolled for those same months to determine a monthly expenditure amount. The monthly expenditure amount and number of consumers enrolled for each waiver type are aggregated into a total monthly expenditure amount and total number of consumers enrolled for all waivers. The aggregated monthly expenditure amount for each of the three months in the reporting quarter is summed. The aggregated number of consumers for each of the three months in the reporting quarter is also summed. The quarterly aggregated expenditure amount is divided by the quarterly aggregated number of consumers enrolled for an average monthly cost per consumer for all waivers for the reporting quarter. Once the billing data for previously reported quarters is complete, and regularly thereafter, the values reported in ABEST will be updated using only the aggregated average monthly billing rate for all waivers.

BL 2006 Purpose

This measure allows the agency to track the cost of Texas Homeliving Waiver funded services over time and to project the required general revenue matching funds. These projections help to ensure the availability of funds within existing resources and to maintain the fiscal integrity of the program.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	7	Texas Home Living Waiver
Measure Type	EX	
Measure No.	1	# of Consumers Receiving THLW Funded Services (MR) Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure provides an unduplicated workload count of priority population eligible persons receiving mental retardation Texas Homeliving Waiver funded services during the year.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. If the original claim is rejected for payment for any reason, the provider has up to 180 days from the end of the original service month to correct the claim and re-bill it. Since the documentation of a service being provided to an individual is based on these claims, accurate counts of numbers served during a fiscal year may not be available for several months past the fiscal year. Values reported in ABEST will be updated when the appropriation year closes.

BL 2006 Data Source

The providers of waiver services submit Medicaid claims for the services provided during each month. The numbers of consumers served is taken from a standard production report.

BL 2006 Methodology

This is a simple unduplicated count of persons that received Texas Homeliving Waiver services during the fiscal year.

BL 2006 Purpose

Due to the very high demand for these services, as indicated by the number of persons waiting for waiver services, it is critical that the department monitors how many persons are receiving the service annually.

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

Goal No.	1	Long-term Care Continuum
Objective No.	3	Community Care - Waivers
Strategy No.	7	Texas Home Living Waiver
Measure Type	OP	
Measure No.	1	Average Number of Clients Served Per Month: Texas Home Living Waiver

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

Fall/Annual: N

BL 2006 Definition

This measure captures the unduplicated count of priority population eligible persons who receive Texas Homeliving Waiver funded services on a monthly basis.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. If the original claim is rejected for payment for any reason, the provider has up to 180 days from the end of the original service month to correct the claim and re-bill it. Since the documentation of a service being provided to an individual is based on these claims, accurate counts of numbers served during a quarter may not be available for several months past the quarter. Values reported in ABEST will be updated regularly and when the appropriation year closes.

BL 2006 Data Source

Information used to report the average monthly number of consumers served is contained in the department's data warehouse system. A standard production report (DADs Waiver Programs – Summary of Slot Types) is generated monthly. DADs Medicaid Administration handles tracking and monitoring of enrollments into a Medicaid waiver funded program.

BL 2006 Methodology

The total unduplicated number of persons that receive Texas Homeliving Waiver services each month is summed. For each quarter of the fiscal year, the number of persons served in each month of the quarter is averaged. For the second, third, and fourth quarters, year-to-date calculations are also obtained. The numerator is the total unduplicated number of mental retardation Texas Home Living Waiver consumers receiving services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate Texas Home Living Waiver funded services with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	1	Non-Medicaid Services - Title XX
Measure Type	EF	
Measure No.	1	Avg Monthly Cost Per Client Served: Non-Medicaid Community Care (XX)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of non-Medicaid Title XX-funded 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 Title XX-funded Community Care clients is defined under output measure 1 of this strategy.

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 as well as cost per client per month 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-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.

BL 2006 Methodology

The sum of monthly expenditures for non-Medicaid Title XX-funded Community Care services by month-of-service for all months in the reporting period is divided by the average monthly number of non-Medicaid Title XX-funded 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 funded under this strategy. 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
Strategy No.	1	Non-Medicaid Services - Title XX
Measure Type	EF	
Measure No.	2	Average Cost Per Home-delivered Meal

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of a home-delivered meal. 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 meals served is defined under output measure 3 of this strategy.

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 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.

BL 2006 Methodology

The sum of monthly expenditures for meals services by month-of-service for all months in the reporting period is divided by the average monthly number of meals served during 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 average unit cost for one of the services (home-delivered meals) provided under this strategy. 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
Strategy No.	1	Non-Medicaid Services - Title XX
Measure Type	EX	
Measure No.	1	Avg # of Persons on Interest List Per Month: Non-Medicaid CC (XX)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly unduplicated number of persons who have requested one or more Title XX-funded non-Medicaid Community Care services through completion of a Community Care intake instrument, but are placed on an interest list for requested service(s) due to funding constraints. The count includes persons who are waiting for one or more Title XX-funded non-Medicaid Community Care services while receiving other Community Care services.

BL 2006 Data Limitations

Individuals on the interest list are contacted at least annually to determine whether they are still interested in remaining on the list.

BL 2006 Data Source

Regional staff enters the data into a reporting database maintained by State Office program staff.

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 counts of persons on the interest list for (one or more) non-Medicaid Community Care services (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 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.	4	Community Care - State
Strategy No.	1	Non-Medicaid Services - Title XX
Measure Type	OP	
Measure No.	1	Avg # of Clients Served Per Month: Non-Medicaid Community Care (XX)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more non-Medicaid Title XX-funded Community Care services. Services included under this category are: adult foster care, client managed attendant care, day activity and health services (funded through Social Services Block Grant), emergency response services, home delivered meals, family care, special services for persons with disabilities, and residential care.

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. 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 report 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 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

Since a high percentage of clients who receive Meals and/or Emergency Response Services also receive other services, an unduplicated monthly count of clients receiving one or more non-Medicaid Title XX-funded community care services must be estimated. This is accomplished by multiplying counts for these two services by the percentage of clients who are authorized to receive these services only, as opposed to these services in addition to other services, according to information obtained from SAS authorization data. 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 the funding 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
Strategy No.	1	Non-Medicaid Services - Title XX
Measure Type	OP	
Measure No.	2	Average Number of Clients Per Month Receiving Home-delivered Meals

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received a home-delivered meal. Clients are provided with hot, nutritious meals delivered directly to their home.

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 report this measure. The number of clients authorized to receive home delivered meals, as well as the number of meals 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 the number of clients for whom claims have been approved-to-pay, the number of meals 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 eligible persons who are receiving home-delivered meals, which contributes to enabling them to remain in their own home as opposed to being placed in another more restrictive setting.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	1	Non-Medicaid Services - Title XX
Measure Type	OP	
Measure No.	3	Average Number of Home-delivered Meals Provided Per Month

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of home-delivered meals on approved-to-pay claims submitted by Meals providers.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of meals ultimately provided must be estimated for months that have not yet closed out, by using "completion factors" applied to the number of meals approved-to-pay to-date and/or the number of meals authorized. 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 meals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of meals ultimately provided.

BL 2006 Data Source

Two types of data are used to report this measure. The number of clients authorized to receive home delivered meals, as well as the number of meals 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 the number of clients for whom claims have been approved-to-pay, the number of meals 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

Data are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the number of home-delivered meals provided (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 quantifies the volume of services delivered (meals).

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	2	Non-Medicaid Services - General Revenue
Measure Type	EF	
Measure No.	1	Avg Monthly Cost Per Client Served: Non-Medicaid Community Care (GR)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of non-Medicaid GR-funded 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 output measure 1 of this strategy.

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 as well as cost per client per month 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 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. Also note – this measure is only applicable to FY 2003 – FY 2005 data.

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.

BL 2006 Methodology

The sum of monthly expenditures for non-Medicaid GR-funded 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 under this strategy. 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
Strategy No.	2	Non-Medicaid Services - General Revenue
Measure Type	EX	
Measure No.	1	Avg # of Persons on Interest List Per Month: Non-Medicaid CC (GR)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly unduplicated number of persons who have requested one or more non-Medicaid GR-funded Community Care services through completion of a Community Care intake instrument, but are placed on an interest list for requested service(s) due to funding constraints. The count includes persons who are waiting for one or more non-Medicaid GR-funded Community Care services while receiving other Community Care services.

BL 2006 Data Limitations

Individuals on the interest list are contacted at least annually to determine whether they are still interested in remaining on the list. Also note ? this measure is only applicable to FY 2003 ? FY 2005 data.

BL 2006 Data Source

Regional staff enters the data into a reporting database maintained by State Office program staff.

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 counts of persons on the interest list for (one or more) non-Medicaid GR-funded Community Care services (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 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.	4	Community Care - State
Strategy No.	2	Non-Medicaid Services - General Revenue
Measure Type	OP	
Measure No.	1	Avg # of Clients Served Per Month: Non-Medicaid Community Care (GR)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of clients who, based upon approved-to-pay claims, received one or more non-Medicaid GR-funded Community Care services. Services included under this category are residential and respite care.

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. 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. Also note ? this measure is only applicable to FY 2003 ? FY 2005 data.

BL 2006 Data Source

Two types of data are used to report 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 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 the funding 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
Strategy No. 3 Mental Retardation Community Services
Measure Type EF
Measure No. 1 Average Monthly Cost Per Consumer with MR Receiving Community Services

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

Fall/Annual: N

BL 2006 Definition

This measure captures information regarding what it costs the state each month, on average, to provide community mental retardation services to each consumer who is assigned to these services regardless of age. It measures the DADS appropriation authority cost per consumer as defined by the companion output measure.

BL 2006 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the data warehouse system by the local mental retardation authorities. If the local authority does not provide accurate data for the quarter, this measure will not be accurate. (At the end of the fiscal year, community centers report preliminary expenditure information, which is used for reporting in ABEST. Final expenditure information may be entered into CARE up to 4 months following the end of the fiscal year. Therefore, end of year values for efficiency measures will be updated in ABEST when the information is available.)

BL 2006 Data Source

At the end of each quarter, staff of the local authorities input expenditure information into the CARE portion of the data warehouse system. The local authority indicates the fund sources used to finance the expenditures. The method of finance includes funds that are part of the DADS appropriation authority as well as other local funds, grant funds, and earned revenues.

BL 2006 Methodology

DADS appropriation authority funds include all general revenue and federal funds allocated through the performance contract. Also included are administrative claiming funds that the local authority receives following the submission of quarterly cost reports. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9, or 12 for year to date. The numerator is the total DADS appropriation authority funds utilized to fund MR community services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of persons with mental retardation receiving community services that are served with DADS appropriation authority funds. The formula is numerator/denominator.

BL 2006 Purpose

This measure captures DADS appropriation authority cost per person for adult and child community mental retardation services.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	3	Mental Retardation Community Services
Measure Type	EX	
Measure No.	1	Number of Consumers with MR Receiving Community Services Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure provides an unduplicated workload count of priority population eligible adults and children who receive mental retardation community services during one fiscal year. Mental retardation community services include non-residential services including assessment and service coordination, vocational services, training services, respite services, and specialized therapies.

BL 2006 Data Limitations

This measure provides the actual number of persons who receive community services and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years.

BL 2006 Data Source

As persons enter the community programs, registration information is entered into the department's CARE portion of the data warehouse system by staff of the local mental retardation authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse system. Production reports of consumers served are issued quarterly based on the information in the data warehouse system. Individuals who receive more than one community service during the year are counted only once for the year.

BL 2006 Methodology

The total unduplicated number of persons that receive a mental retardation community service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

BL 2006 Purpose

The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities. The Data Verification Criteria Manual provides general guidance regarding timelines for closure of assignments to specific services.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	3	Mental Retardation Community Services
Measure Type	EX	
Measure No.	2	Avg # Consumers MR on Interest List Per Month: MR Community Services

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

Fall/Annual: N

BL 2006 Definition

This measure provides a simple count of persons who express an interest in general revenue (GR) funded mental retardation community services. For purposes of this measure, interest is defined as placing one's name on the interest list with the local mental retardation authority for GR funded mental retardation community services.

BL 2006 Data Limitations

The accuracy of the GR funded mental retardation community services interest list is dependent upon the submission of accurate data by the MRAs. There may be duplication of names between interest lists for mental retardation services.

BL 2006 Data Source

A person seeking mental retardation services or an individual seeking mental retardation services on behalf of another person with mental retardation begins the review of service options with the local mental retardation authority staff. If the individual, legal representative or family member decides they are interested in GR funded mental retardation community services, the name of the consumer is entered onto the interest list for GR funded mental retardation community services in the DADS database system.

BL 2006 Methodology

This is a simple count on the last day of each fiscal quarter of persons whose names have been entered into the DADS database system as interested in GR funded mental retardation community services.

BL 2006 Purpose

Pursuing GR funded mental retardation community services is initiated by consumers, family members, and legally authorized representatives following discussions of service options with staff of the local Mental Retardation Authorities (MRAs).

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	3	Mental Retardation Community Services
Measure Type	OP	
Measure No.	1	Average Monthly # of Consumers with MR Receiving Community Services

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

Fall/Annual: N

BL 2006 Definition

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with DADS appropriation authority funds and who receive mental retardation community services. Mental retardation community services include assessment and service coordination, vocational services, training services, respite services and specialized therapies and excludes residential services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

BL 2006 Data Limitations

The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities. The Data Verification Criteria Manual provides general guidance regarding timelines for closure of assignments to specific services.

BL 2006 Data Source

As persons enter the comm. progs, registration info is entered into the CARE portion of the data warehouse system by staff of the local mental retardation authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse system. Production reports of consumers served are issued quarterly based on the information in the data warehouse system. The total unduplicated number of persons assigned to receive any mental retardation community service each month is calculated. To obtain an unduplicated number of persons, each individual is counted only once each period regardless of the number of different community services to which assigned. For each quarter of the fiscal year, the unduplicated number of persons served in each month of the quarter is averaged. The production report lists total number of adults and children assigned to a particular service each month regardless of how the services for the individuals were funded.

BL 2006 Methodology

To obtain the number of persons served with DADS appropriation authority funds, the percentage of total expenditures that were funded through the department's appropriation authority is calculated. (See Method of Calculation for the companion efficiency measure for details of calculating DADS authority funding.) This percentage is applied to the average monthly numbers served for the specified quarter and for year to date to yield the average monthly number served for the specified quarter with DADS appropriation authority funds. The numerator is the sum of the number of persons receiving MR community service each month of the reporting period * state funded percentage. The state funded percentage is expenditures financed through the DADS appropriation authority for MR community services / total expenditures for MR community services *100. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2006 Purpose

Monthly number of adults and children served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	4	Mental Retardation Community Services Residential
Measure Type	EF	
Measure No.	1	Avg Mthly Cst Non-Medicaid Customer/MR Receiving Community Residential

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

Fall/Annual: N

BL 2006 Definition

This measure captures information regarding what it costs the state each month, on average, to provide mental retardation community residential services to each non-Medicaid consumer who is assigned to these services regardless of age. It measures the DADS appropriation authority cost per consumer as defined by the companion output measure.

BL 2006 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the database by the local mental retardation authorities. If the local authority does not provide accurate data for the quarter, this measure will not be accurate. (At the end of the fiscal year, community centers report preliminary expenditure information that is used for reporting in ABEST. Final expenditure information may be entered into CARE up to 4 months following the end of the fiscal year. Therefore, end of year values for efficiency measures will be updated in ABEST when the information is available.)

BL 2006 Data Source

At the end of each quarter, staff of the local authorities input expenditure information into the CARE system. The local authority indicates the fund sources used to finance the expenditures. The method of finance includes funds that are part of the DADS appropriation authority as well as other local funds, grant funds, and earned revenues.

BL 2006 Methodology

DADS appropriation authority funds include all general revenue and federal funds allocated through the performance contract. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9, or 12 for year to date. The numerator is total DADS appropriation authority funds utilized to fund MR community residential services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of persons with mental retardation receiving community residential services that are served with DADS appropriation authority funds. The formula is numerator/denominator.

BL 2006 Purpose

This measure captures DADS appropriation authority cost per person for mental retardation community residential services that are not funded with Medicaid revenues.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	4	Mental Retardation Community Services Residential
Measure Type	EX	
Measure No.	1	# Non-Medicaid Consumers MR Receiving Commun Residential Svcs Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure provides an unduplicated workload count of priority population non-Medicaid consumers who receive mental retardation community residential services during one fiscal year.

BL 2006 Data Limitations

The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the CARE system by the local mental retardation authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service. The expectation is for assignments to end when the individual is no longer receiving services.

BL 2006 Data Source

As persons enter the community programs, registration information is entered into the department's CARE system by staff of the local mental retardation authority. When an individual is assigned to a specific program, this information is also entered into the CARE system. Production reports of persons served are issued quarterly based on the information in the CARE system.

BL 2006 Methodology

The total unduplicated number of persons without Medicaid benefits that receive a mental retardation community residential service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

BL 2006 Purpose

This measure provides the actual unduplicated number of persons who receive mental retardation community residential services and provides information about the total system activity during one fiscal year.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	4	Mental Retardation Community Services Residential
Measure Type	OP	
Measure No.	1	Avg Mthly # Non-Medicaid Consumers/MR Receiving Community Residential

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

Fall/Annual: N

BL 2006 Definition

This measure captures the unduplicated count of priority population adults and children whose services are funded with DADS appropriation authority funds and who receive mental retardation community residential services on a monthly basis. Persons served in these residential programs are not recipients of Medicaid benefits. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

BL 2006 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the database by the local mental retardation authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service. The expectation is for assignments to end when the individual is no longer receiving services.

BL 2006 Data Source

As persons enter the community programs, registration information is entered into the CARE system by staff of the local mental retardation authority. When an individual is assigned to a specific program, this information is also entered into the database. Production reports of consumers served are issued quarterly based on the information in the database. The total unduplicated number of persons assigned to receive mental retardation non-Medicaid community residential services each month is calculated. For each quarter of the fiscal year, the unduplicated number of persons served in each month of the quarter is averaged. The production report lists total number of persons assigned to a particular service each month regardless of how the services for the individuals were funded.

BL 2006 Methodology

To obtain the number of persons served with DADS appropriation authority funds, the percentage of total expenditures that were funded through the dept's appropriation authority is calculated. (See Method of Calculation for the companion efficiency measure for details of calculating DADS authority funding.)This percentage is applied to the average monthly numbers served for the specified quarter and for year to date to yield the average monthly number served for the specified quarter with DADS appropriation authority funds. The numerator is the sum of the number of persons receiving MR community residential service each month of the reporting period * state funded percentage. The state funded percentage is the expenditures financed through the DADS appropriation authority for non-Medicaid community residential srvs/total expenditures for non-Medicaid community residential services *100.The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2006 Purpose

Monthly number of persons served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	6	Nutrition Services
Measure Type	EF	
Measure No.	1	Statewide Average Cost Per Congregate Meal

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

Fall/Annual: N

BL 2006 Definition

The statewide average State Unit on Aging cost per congregate meal is a measure of the statewide average per meal cost to provide congregate meals to person's age 60 and older and other eligible persons. Congregate meals are hot or other appropriate meals served in a setting, which promotes social interaction as well as improved nutrition. Congregate meals provide one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council and are served in a congregate setting. These meals include standard meals, which are regular meals that are served to the majority of participants. Additionally, therapeutic meals or liquid supplements, which are special meals or liquid supplements that have been prescribed by a physician (i.e., diabetic diets, renal diets, pureed diets, tub feeding) may be served in the congregate setting.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in this measure's calculation.

BL 2006 Data Source

The number of meals is based on individual client data reported to the Department by area agencies on aging. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The statewide average State Unit on Aging cost per meal is calculated by dividing State Unit on Aging appropriated expenditures reported by area agencies on aging used to provide congregate meals to person's age 60 or older and other eligible persons by the number of congregate meals funded by the State Unit on Aging during the fiscal year.

BL 2006 Purpose

This measure identifies the statewide average cost per congregate meal.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	6	Nutrition Services
Measure Type	EF	
Measure No.	2	Statewide Average Cost Per Home-delivered Meal

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

Fall/Annual: N

BL 2006 Definition

The statewide average State Unit on Aging cost per home delivered meal is a measure of the statewide average per meal cost to provide home delivered meals to persons age 60 and older and other eligible persons. Home delivered meals are hot, cold, frozen, dried, canned or supplemental food (with a satisfactory storage life), which provide one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council and are delivered to an eligible person in his/her place of residence.

BL 2006 Data Limitations

Only State Unit on Aging funded units are considered for this measure. While some units funded by other sources may be reported to the State Unit on Aging, they are not included in this measure's calculation.

BL 2006 Data Source

The number of home delivered meals is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed, Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The statewide average State Unit on Aging cost per meal is calculated by dividing State Unit on Aging appropriated expenditures reported by area agencies on aging used to provide home delivered meals to persons age 60 or older and other eligible persons by the number of home delivered meals funded by State Unit on Aging during the fiscal year.

BL 2006 Purpose

This measure identifies the statewide average cost per home delivered meal.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	6	Nutrition Services
Measure Type	OP	
Measure No.	1	Number of Persons Receiving Congregate Meals

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

Fall/Annual: N

BL 2006 Definition

The measure is the unduplicated number of person's age 60 and older and other eligible persons reported to the Department by area agencies on aging as receiving congregate meals funded by the State Unit on Aging. Congregate meals are hot or other appropriate meals served to eligible persons which meets one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council and which is served in a congregate setting. There are two types of congregate meals. These are standard meals which are regular meals from the standard menu that are served to the majority of all of the participants and therapeutic meals or liquid supplements that have been prescribed by a physician and are planned specifically for an individual participant by a dietician (i.e., diabetic diets, renal diets, pureed diets, tub feeding) may be served in the congregate setting.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of persons is based on individual client data reported to the Department by area agencies on aging.

BL 2006 Methodology

The measure is the total unduplicated count by AAA, of persons receiving a congregate meal funded by the State Unit on Aging.

BL 2006 Purpose

This is an Output Measure that identifies an unduplicated count of persons receiving a congregate meal funded by the State Unit on Aging.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	6	Nutrition Services
Measure Type	OP	
Measure No.	2	Number of Congregate Meals Served

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

Fall/Annual: N

BL 2006 Definition

The measure is the # of congregate meals provided to person's age 60 and older and other elig. persons reported to the Department by area agencies on aging as receiving congregate meals funded by the State Unit on Aging. Congregate meals are hot or other appro. meals served to elig. persons that meet one-third (1/3) or the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council and which is served in a congregate setting. There are two types of congregate meals. These are standard meals which are regular meals from the standard menu that are served to the majority or all of the participants and therapeutic meals or liquid supplements which are special meals or liquid supplements that have been prescribed by a physician and are planned specifically for an individual participant by a dietician (i.e., diabetic diets, renal diets, pureed diets, tub feeding) may be served in the congregate setting.

BL 2006 Data Limitations

Only State Unit on Aging funded units are considered for this measure. While some units funded by other sources may be reported to the State Unit on Aging, they are not included in this measure's calculation.

BL 2006 Data Source

The number of congregate meals is based solely on data reported to the Department by area agencies on aging.

BL 2006 Methodology

The measure is the total congregate meals served to person's age 60 and older and other eligible persons.

BL 2006 Purpose

This is an output measure that identifies the total congregate meals served to persons age 60 an older and other eligible persons.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	6	Nutrition Services
Measure Type	OP	
Measure No.	3	Number of Persons Receiving Home-delivered Meals

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

Fall/Annual: N

BL 2006 Definition

The measure is the unduplicated number of person's age 60 and older and other eligible persons reported to the Department by area agencies on aging as receiving home delivered meals funded by the State Unit on Aging. Home delivered meals are hot, cold, frozen, dried, canned or supplemental food (with a satisfactory storage life) which provide a minimum of one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council, and are delivered to an eligible person in his/her place of residence.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of persons receiving home delivered meals is based on data reported to the Department by area agencies on aging.

BL 2006 Methodology

The measure is the total unduplicated number, by AAA, of persons age 60 and older and other eligible persons receiving a home delivered meal.

BL 2006 Purpose

This measure identifies the unduplicated number of persons receiving home delivered meals.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	6	Nutrition Services
Measure Type	OP	
Measure No.	4	Number of Home-delivered Meals Served

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

Fall/Annual: N

BL 2006 Definition

The measure is the number of home delivered meals served to persons age 60 and older and other eligible persons reported to the Department by area agencies on aging as receiving home delivered meals funded by the State Unit on Aging. Home delivered meals are hot, cold, frozen, dried, canned or supplemental food (with a satisfactory storage life) which provide a minimum of one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council, and are delivered to an eligible person in his/her place of residence.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging they are not included in the measure calculation.

BL 2006 Data Source

The number of home delivered meals served to persons age 60 and older is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed.

BL 2006 Methodology

The measure is the total number of meals served to persons age 60 and older and other eligible persons.

BL 2006 Purpose

This measure identifies the number of home delivered meals served.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	EF	
Measure No.	1	Statewide Average Cost Per Person Receiving Homemaker Services

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

Fall/Annual: N

BL 2006 Definition

This is a measure of the statewide average program cost per person to provide homemaker services to people age 60 and older funded by the State Unit on Aging. Homemakers provide services that involve the performance of housekeeping/home management, meal preparation and/or escort tasks and shopping assistance for individuals who need assistance with these activities in their place of residence.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of persons receiving homemaker services is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The statewide average cost per person receiving homemaker services is calculated by dividing expenditures reported by the area agencies on aging used to provide homemaker services to persons age 60 or older by the unduplicated number of clients receiving homemaker services funded by the State Unit on Aging.

BL 2006 Purpose

This measure identifies the State Unit on Aging average cost per person receiving homemaker services.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	EF	
Measure No.	2	Statewide Avg Cost Per Person Rcving Personal Assistance Services

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

Fall/Annual: N

BL 2006 Definition

The statewide average cost per person receiving personal assistance services is a measure of the statewide average program cost per person used to provide personal assistance services to people age 60 and older. Personal assistance is the act of assisting another person with tasks that the individual would typically do if he were able. This covers hands-on assistance in all activities of daily living. Personal assistance staff are trained and supervised.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of persons receiving personal assistance services is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The statewide average cost per person receiving personal assistance services is calculated by dividing State Unit on Aging expenditures reported by the area agencies on aging used to provide personal assistance services to persons age 60 or older by the unduplicated number of clients receiving personal assistance services funded by the State Unit on Aging.

BL 2006 Purpose

This measure identifies the statewide average cost per person receiving personal assistance services.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	EF	
Measure No.	3	Statewide Average Cost Per Modified Home

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

Fall/Annual: N

BL 2006 Definition

This is a measure of the statewide average program cost per home to provide home repair or modification for the dwellings of people age 60 and older. Residential repair services consist of repairs or modifications of client-occupied dwellings essential for the health and safety of the occupants. This service can also include limited housing, counseling, and moving expenses where repairs of modifications will not attain reasonable standards of health and safety.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of homes is based on individual client data reported to the Department by area agencies on aging. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2006 Methodology

The statewide average cost per modified home is calculated by dividing State Unit on Aging expenditures reported by the area agencies on aging used to provide these services to persons age 60 or older by the unduplicated number of homes receiving home repair/modification funded by the State Unit on Aging.

BL 2006 Purpose

This measure identifies the statewide average State Unit on Aging cost per modified home.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	EF	
Measure No.	4	Cost Per Retired and Senior Volunteer Program (RSVP) Volunteer

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

Fall/Annual: N

BL 2006 Definition

The State Unit on Aging provides some of the matching funds for the federal Retired and Senior Volunteer Program during the fiscal year. This program provides volunteer support to local non-profit and governmental entities and provides a way for older persons to remain productive with a sense of purpose.

BL 2006 Data Limitations

None.

BL 2006 Data Source

The data source is a report titled State Unit on Aging-RSVP Program Performance Report, completed by the Corporation for National Service. The data is verified by monitoring activities conducted by the Corporation for National Services which contracts with the Department to administer the state RSVP program as part of the federal RSVP program.

BL 2006 Methodology

The average cost per RSVP volunteer is calculated by dividing State Unit on Aging appropriated cash expenditures used to support RSVP activities by the unduplicated number of volunteers in the program during the fiscal year.

BL 2006 Purpose

This measure indicates the State Unit on Aging cost per RSVP volunteer.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	OP	
Measure No.	1	Number of Persons Receiving Homemaker Services

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

Fall/Annual: N

BL 2006 Definition

The measure is the unduplicated number of persons age 60 and older, who are receiving homemaker services funded by the State Unit on Aging, as reported to the Department by area agencies on aging. Trained and supervised homemakers provide services that involve the performance of housekeeping/home management, meal preparation and/or escort tasks and shopping assistance for individuals who need assistance with these activities in their place of residence.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of unduplicated persons receiving homemaker services is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed.

BL 2006 Methodology

The number of persons 60 and older receiving homemaker services is the unduplicated total reported to the Department by area agencies on aging.

BL 2006 Purpose

This measure identifies the total unduplicated number of persons 60 and over who have received homemaker services funded by the State Unit on Aging.

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

Goal No. 1 Long-term Care Continuum
Objective No. 4 Community Care - State
Strategy No. 7 Services to Assist Independent Living
Measure Type OP
Measure No. 2 Number of Persons Receiving Personal Assistance

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

Fall/Annual: N

BL 2006 Definition

The measure is the unduplicated number of persons age 60 and older who have received personal assistance services funded by the State Unit on Aging, as reported to the Department by area agencies on aging. Personal assistance is the act of assisting another person with tasks that that individual would typically do if he were able. This covers hands-on assistance in all activities of daily living. Trained and supervised home health staffs provide the services for individuals who need assistance with these activities in their place of residence.

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of unduplicated persons receiving personal assistance services is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed.

BL 2006 Methodology

The number of persons 60 and older receiving personal assistance services is the unduplicated total reported to the Department by area agencies on aging.

BL 2006 Purpose

This measure identifies the total unduplicated number of persons 60 and over who have received personal assistance services funded by the State Unit on Aging.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	OP	
Measure No.	3	Number of Homes Repaired/Modified

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

Fall/Annual: N

BL 2006 Definition

The measure is the unduplicated number of homes reported to the Department by area agencies on aging as receiving repair or modification services funded by the State Unit on Aging. Residential repair services consist of repairs or modifications of a client-occupied dwelling that are essential for the health and safety of the occupants.

BL 2006 Data Limitations

None.

BL 2006 Data Source

The unduplicated number of homes receiving repair/modification is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed.

BL 2006 Methodology

The number of homes receiving repair/modification is the unduplicated total reported to the Department by area agencies on aging.

BL 2006 Purpose

This measure identifies the number of homes receiving repair/modification services funded by the State Unit on Aging.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	OP	
Measure No.	4	Number of One-way Trips

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

Fall/Annual: N

BL 2006 Definition

The measure is the number of one-way trips provided to person's age 60 and older and other eligible persons reported to the Department by area agencies on aging as receiving demand-response transportation services. Transportation services consist of taking an elderly person from one location to another. Demand-response transportation carries elderly persons from a specific origin to a specific destination upon advance request (usually 24 hours).

BL 2006 Data Limitations

Only State Unit on Aging funded clients are considered for this measure. While some clients funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

BL 2006 Data Source

The number of one-way demand-response trips is based on individual client data reported to the Department by area agencies on aging. Individual client data is reported only for those persons for whom a client intake form is completed.

BL 2006 Methodology

The number of one-way demand-response trips is the total reported to the State Unit on Aging by area agencies on aging.

BL 2006 Purpose

This measure identifies the total number of one-way trips that are funded by the State Unit on Aging.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	7	Services to Assist Independent Living
Measure Type	OP	
Measure No.	5	Number of Retired and Senior Volunteer Program (RSVP) Volunteers

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

Fall/Annual: N

BL 2006 Definition

This measure is the total number of senior volunteers (age 55 or older) who have provided at least one hour of community volunteer service through the federally funded Retired and Senior Volunteer Programs during the year.

BL 2006 Data Limitations

None.

BL 2006 Data Source

The data source is a report titled, State Unit on Aging RSVP Program Performance Report, completed by the Corporation for National Service. The data is verified by monitoring activities conducted by the Corporation for National Service which contracts with the Department to administer the state RSVP program as part of the federal RSVP program.

BL 2006 Methodology

The total number of senior volunteers (age 55 or older) who have provided at least one hour of community volunteer services through the RSVP program is reported quarterly on a report entitled the State Unit on Aging RSVP Program Performance Report, completed by the Corporation for National Service.

BL 2006 Purpose

This measure accounts for the number of senior volunteers (age 55 or older) who have provided at least one hour of community service through the federally funded RSVP program during the year.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	8	In-Home and Family Support
Measure Type	EF	
Measure No.	1	Average Monthly Cost of In-home Family Support Per Client

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average in-home/family support cash assistance per client per month. Clients are provided assistance for the purchase of supportive services that will enable them to remain independent. Clients are eligible for assistance up to $3,600 a year.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the department's HHSAS Financials.

BL 2006 Methodology

Data are computed by taking the projected in-home funding expended monthly, and dividing by the total number of clients per month. The computation is based on a rolling 12-month average client count and rolling 12-months of expenditure data, with a one-month lag.

BL 2006 Purpose

This measure is important because it quantifies the average cost per unit of service. 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
Strategy No.	8	In-Home and Family Support
Measure Type	EX	
Measure No.	1	Average Number on Interest List Per Month: IHFS Clients

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

Fall/Annual: N

BL 2006 Definition

This measure reports the count of in-home clients who have requested services but, due to funding limitations, have not been able to obtain services. They have been placed on a list along with other persons who have indicated an interest in receiving the service. Eligibility for services is not determined until the client has been taken off of the interest list.

BL 2006 Data Limitations

Potential clients on the interest list are contacted once a year to determine whether they wish to remain on the list.

BL 2006 Data Source

Data are obtained from monthly manual counts of in-home clients on interest lists submitted by regional staff. The interest list is prepared from daily client applications.

BL 2006 Methodology

The interest list data are compiled by DHS regional staff and reported monthly to state office program staff. The number of persons on the regional interest lists is summed to obtain a statewide interest list count.

BL 2006 Purpose

This measure is an indicator of the unmet need for services currently funded under this strategy.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	8	In-Home and Family Support
Measure Type	OP	
Measure No.	1	Average Number of Clients Per Month Receiving IHFS

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of persons who have received in-home/family support assistance during a twelve-month period. Clients are provided assistance for the purchase of supportive services that will enable them to remain independent. Clients are eligible for assistance up to $3,600 a year.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the department's HHSAS Financials.

BL 2006 Methodology

Data for this measure are calculated by using a prior twelve-month average (sum of twelve months of data divided by twelve) from a point in time (i.e. Sept.) to report the number of in-home clients who receive assistance. Reported data reflect a rolling 12-month unduplicated client count, with a one-month lag.

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 receiving services for which funding 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
Strategy No.	9	Mental Retardation In-Home Services
Measure Type	EF	
Measure No.	1	Avg Annual Grant Per Consumer with MR Receiving In-home FS Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure reports the actual average amount per consumer of the grants provided through the In-Home and Family Support program.

BL 2006 Data Limitations

The accuracy of the department's data is dependent upon accurate and timely information being entered into the data warehouse system by the local mental retardation authorities. If information is not entered into the data warehouse system accurately and within the quarter, this measure will be understated each quarter.

BL 2006 Data Source

As persons are approved for and receive In-Home and Family Support grants, the amount of funds distributed is entered into the department's data warehouse system for the individual receiving the funds. Staff of the local mental health authority makes the data entries. The source of funds for these grants is all general revenue. No other funding sources are included in this measure.

BL 2006 Methodology

The amounts of all mental retardation In-Home and Family Support grants awarded are added together and divided by the number of persons awarded the grants.

BL 2006 Purpose

The maximum amount that can be awarded to one individual and/or family is $3,600 per year. Actual needs as expressed by the consumers vary downward from the maximum amount available. Lower averages of grants awarded result in more consumers being served. This measure allows the agency to determine and evaluate how much of the upper limit for the total grants will be needed. Actual needs as expressed by the consumers vary downward from the maximum amount available. Lower averages of grants awarded result in more consumers being served.

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

Goal No.	1	Long-term Care Continuum
Objective No.	4	Community Care - State
Strategy No.	9	Mental Retardation In-Home Services
Measure Type	EX	
Measure No.	1	Avg # Consumers MR on Interest List Per Mth: In-home & Family Support

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

Fall/Annual: N

BL 2006 Definition

This measure provides a simple count of persons who express an interest in In-Home Family Support services (IHFS). For purposes of this measure, interest is defined as placing one's name on the interest list with the local mental retardation authority for IHFS services.

BL 2006 Data Limitations

The accuracy of the IHFS services interest list is dependent upon the submission of accurate data by the MRAs. Further, MRAs are only required to submit this data quarterly. Therefore, averages are based on quarters, rather than individual months. There may be duplication of names between interest lists for mental retardation services.

BL 2006 Data Source

A person seeking mental retardation services or an individual seeking mental retardation services on behalf of another person with mental retardation begins the review of service options with the local mental retardation authority staff. If the individual, legal representative or family member decides they are interested in IHFS services, the name of the consumer is entered onto the interest list for IHFS services in the CARE system.

BL 2006 Methodology

This is a simple count on the last day of each fiscal quarter of persons whose names have been entered into the CARE system as interested in IHFS services. In capturing the average monthly number of persons on the interest list for a given fiscal year, the average of the quarters in the fiscal year is calculated. Where necessary, future and past periods are estimated based on the current quarterly counts available.

BL 2006 Purpose

Pursuing IHFS services is initiated by consumers, family members, and legally authorized representatives following discussions of service options with staff of the local Mental Retardation Authorities (MRAs).

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

Goal No. 1 Long-term Care Continuum
Objective No. 4 Community Care - State
Strategy No. 9 Mental Retardation In-Home Services
Measure Type OP
Measure No. 1 # of Consumers with MR Receiving In-Home and Family Support Per Year

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

Fall/Annual: N

BL 2006 Definition

This is a simple count of persons that receive an In-Home and Family Support grant through community mental retardation services during a fiscal year. The program provides small financial grants to individuals with mental disabilities so that they may live independently or at home with their families. Uses of these funds include purchase of disability related services such as respite care, specialized therapies and support counseling, adaptive equipment and home modifications, as well as training and non-traditional supports such as in-home parent training to address challenging behaviors. Individuals make co-payments, based on income, and the ongoing annual grant amount cannot exceed $3,600. In addition, one-time grants for architectural modifications or specialized equipment are available.

BL 2006 Data Limitations

The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the CARE system by the local mental retardation authorities. If information is not entered into the CARE system accurately and within the quarter, this measure will be understated each quarter.

BL 2006 Data Source

As persons are evaluated for In-Home and Family Support services, registration information is entered into the department's CARE system by staff of the local mental retardation authority. All entries into the In-Home and Family Support services CARE system are given a start date of September 1 of the current fiscal year. Production reports of consumers served are issued quarterly based on the information in the CARE system.

BL 2006 Methodology

The total unduplicated number of persons that receive mental retardation In-Home and Family Support grants during the fiscal year is tallied for each local authority and for the system. The production report lists total number of persons served year to date.

BL 2006 Purpose

Research shows that among the most important factors in predicting success of services are the involvement of the consumer in selection of the service provider and the scope and duration of the services and supports needed. In-Home and Family Support is a strategy that for over 10 years has offered Texans with mental retardation and their families this opportunity. It is a model consistent with the trend in health and social services toward voucher-type alternatives. Data suggest that services and supports made available through this sub-strategy have prevented the need for more expensive interventions.

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

Goal No.	1	Long-term Care Continuum
Objective No.	5	Program of All-inclusive Care for the Elderly (PACE)
Strategy No.	1	Program of All-inclusive Care for the Elderly (PACE)
Measure Type	EF	
Measure No.	1	Avg Monthly Cost Per Recipient: Program for All Inclusive Care (PACE)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost for providing a month of care for a PACE client. PACE provides community-based services for frail elderly people who would qualify for nursing facility placement. A comprehensive care approach is used to provide an array of medical, functional, and day activity services for a capitated monthly fee that is below the cost of comparable institutional care.

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 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

The source for expenditure and recipient data is approved-to pay data from the Claims Management System (CMS) by means of ad hoc query.

BL 2006 Methodology

The sum of expenditures for premiums paid to PACE providers during the months of the reporting period divided by the sum of the number of PACE recipients (output measure 1) during the reporting period, divided by the number of months of the reporting period, yields the reported performance. PACE differs from STAR+PLUS in that all PACE recipients are long-term care utilizers. In addition, the PACE premium includes the cost of Medicare co-insurance and deductibles, as well as the cost of prescription drugs.

BL 2006 Purpose

This measure is important because it provides the unit cost associated with providing long-term care and acute care services to PACE recipients. This data is a useful 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.	5	Program of All-inclusive Care for the Elderly (PACE)
Strategy No.	1	Program of All-inclusive Care for the Elderly (PACE)
Measure Type	OP	
Measure No.	1	Avg # of Recipients Per Month: Program for All Inclusive Care (PACE)

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

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of clients who are enrolled in a Program for All Inclusive Care (PACE) managed care model. PACE is a national demonstration project that provides community-based services to frail elderly people who qualify for nursing facility placement. It uses a comprehensive care approach, furnishing an array of services for a monthly fee that is below the cost of comparable institutional care. All PACE clients are dually eligible (Medicare and Medicaid) long-term-care utilizers.

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 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

The source for expenditure and recipient data is approved-to pay data from the Claims Management System (CMS) by means of ad hoc query.

BL 2006 Methodology

The sum of the monthly number of PACE recipients for all months of the reporting period is divided by the number of months in the reporting period.

BL 2006 Purpose

This measure provides a count of persons served through the agency's PACE project. This data is a useful 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.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	1	Average Daily Nursing Home Rate

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 324 078-R-S70-1 01-01-06 EF 01

Fall/Annual: N

BL 2006 Definition

This measure reports the average daily Medicaid rate (payment) for providing nursing facility care.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the days of service billed for a month of service, the Medicaid payments as well as the amount of client income contribution ultimately incurred for months that have not yet closed out must be estimated using "completion factors". The concept of completion factors is that data, as of a given number of claims processing months after the 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 claims, approved-to-pay to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved-to-pay are obtained from the department's MG 7000 report.

BL 2006 Methodology

The measure is computed by adding the sum of the estimated monthly incurred amount of client income applied to the cost of care for all months in the reporting period, plus the sum of the estimated monthly amount of Medicaid nursing facility payments incurred for all months of the reporting period. This total is then divided by the sum of the total number of Medicaid days of nursing facility service incurred for all months in the reporting period.

BL 2006 Purpose

This measure is important because it quantifies the unit cost of the average rate of reimbursement to nursing facilities for the care provided to eligible Medicaid residents. Texas' reimbursement system has established different rates dependent on the level of care provided. This data is a useful 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.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	2	Average Amount of Client Income Applied to the Cost of Care Per Day

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 324 078-R-S70-1 01-01-06 EF 02

Fall/Annual: N

BL 2006 Definition

This measure reports the average amount of personal income that clients apply to the cost of their care per day. After deductions are made for out-of-pocket medical expenses not covered by Medicaid, for living expenses of a spouse living in the community and the $60 per month that is allowed for personal needs, clients are required to apply their remaining income toward the cost of their own care.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the days of service billed for a month of service, the amount of client income contribution ultimately incurred for months that have not yet closed out must be estimated using "completion factors". The concept of completion factors is that data, as of a given number of claims processing months after the 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 claims approved-to-pay to-date, divided by the appropriate completion factor equals the estimated number of persons ultimately served.

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, the amount of patient's "applied income" associated with approved -to-pay claims, and the amounts approved-to-pay are obtained from the department's MG 7000 report.

BL 2006 Methodology

Data are derived by dividing the estimated total amount of client applied income for a month of service by the Medicaid days of service incurred for the same month of service. The average applied income per (patient) day for a given month of service is then standardized by multiplying by the ratio of calendar days for the month of service to a "standard" month of 30.416 days (365 days per year divided by 12 months). The reported data is calculated by taking the sum of the product of the standardized applied income per day (as calculated above), times the number of Medicaid days incurred for each month of the reporting period, and dividing that sum by the sum of the number of Medicaid days of nursing facility service incurred over the entire reporting period.

BL 2006 Purpose

This measure quantifies the unit cost for one of the components (clients' contribution) in the formula that computes the cost for a day of nursing facility care. This data is a useful 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. 6 Nursing Facility and Hospice Payments
Strategy No. 1 Nursing Facility Payments
Measure Type EF
Measure No. 3 Net Nursing Facility Cost Per Medicaid Resident Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 324 078-R-S70-1 01-01-06 EF 03

Fall/Annual: N

BL 2006 Definition

This measure reports the average net nursing facility cost per Medicaid nursing facility resident (client) per month.

BL 2006 Data Limitations

Does not apply.

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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved-to-pay are obtained from the department's MG 7000 report.

BL 2006 Methodology

The average daily nursing home rate for the reporting period less the (standardized) applied income per day for the reporting period equals the standardized net cost per Medicaid resident per day for the reporting period. The standardized net cost per Medicaid resident per day is then multiplied by 30.416 days to obtain the value for the reporting period. See efficiency measures 1 and 2 under this strategy for discussions of each of these components.

BL 2006 Purpose

This measure is important because it is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the total unit cost to DHS for providing Medicaid reimbursed services in a nursing facility. This data is a useful 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.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	4	Average Monthly Cost Per Client: Personal Needs Allowance

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 324 078-R-S70-1 01-01-06 EF 04

Fall/Annual: N

BL 2006 Definition

This measure reports the average amount of the "State Supplementation for Personal Needs Allowance (PNA)" per client per month. PNA is the amount of money a client is allowed to retain in order to pay for incidentals that are not provided by the institution. The standard SSI payment for a person in an institution is only $30 per month. All eligible clients receive a supplemental payment of $15 per month.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

The payment amount is established by agency rule and does not vary by client.

BL 2006 Methodology

By agency rule, all eligible clients receive a supplemental personal needs allowance (PNA) payment of $15 per month in order to enhance their PNA above the SSI standard payment amount. Since the payment amount is established by agency rule and does not vary by client, the reported value equals the value stated by rule.

BL 2006 Purpose

This measure is important because it quantifies the benefit amount for persons who receive this service, which was mandated by the Texas Legislature.

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
Strategy No. 1 Nursing Facility Payments
Measure Type OP
Measure No. 1 Average Number Receiving Medicaid-funded Nursing Facility Services/Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 324 078-R-S70-1 01-01-06 OP 01

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of persons receiving Medicaid-funded nursing facility services during the reporting period.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of days of service ultimately incurred must be estimated for months that have not yet closed out, by using "completion factors" applied to the number of days of service on claims 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 number of days of service on approved-to-pay claims to-date divided by the appropriate completion factor, divided by the number of calendar days in the month equals the estimated number of persons ultimately served.

BL 2006 Data Source

Two types of data are used to compute this measure. The number of clients authorized to receive the above services is obtained from the department's SAVERR and SAS systems. 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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from the department's MG 7000 report.

BL 2006 Methodology

Data are computed by taking the number of Medicaid days of nursing facility services ultimately incurred for a month of service and dividing by the number of calendar days in the month to derive an average daily census. This result is the average number of persons receiving services during the month. The reported data are calculated by dividing the sum of the monthly number of persons receiving Medicaid-funded nursing facility services 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 receiving the service that expends the majority of funding appropriated to this strategy. This count is an indication of service demand and is a useful 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. 6 Nursing Facility and Hospice Payments
Strategy No. 1 Nursing Facility Payments
Measure Type OP
Measure No. 2 Average Number Receiving Personal Needs Allowance Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 324 078-R-S70-1 01-01-06 OP 04

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average unduplicated number of Medicaid eligible, Supplemental Security Income (SSI) institutional clients who received a 100% state-funded payment to enhance their "Personal Needs Allowance" (PNA) above the SSI standard payment amount. The PNA is the amount of funds a client is allowed to retain in order to pay for incidentals that are not provided by the institution. The standard SSI payment for a person in an institution is only $30 per month. All eligible clients receive a supplemental payment of $15 per month.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Client counts are obtained from the departments HHSAS Financials. The payment amount is established by rule and does not vary by client.

BL 2006 Methodology

Monthly client counts for this measure are derived each month by dividing the monthly amount expended for this service by $15. The monthly average for the reporting period is calculated by dividing the sum of the monthly client counts for all months in the reporting period, by the number of months in the reporting period.

BL 2006 Purpose

This measure is important because it quantifies the number of persons who receive this service, which was mandated by the Texas Legislature.

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
Strategy No. 2 Medicare Skilled Nursing Facility
Measure Type EF
Measure No. 1 Net Medicaid/Medicare Copay Per Client for Nursing Facility Svcs/Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 324 078-R-S70-1 01-01-06 EF 05

Fall/Annual: N

BL 2006 Definition

This measure reports the net monthly payment per client receiving co-paid Medicaid/Medicare nursing facility services.

BL 2006 Data Limitations

Since it takes several months to close out 100% of the days of service billed, the Medicaid payments as well as the amount of client income contribution ultimately incurred, data for months that have not yet closed out must be estimated using "completion factors". 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 claims approved-to-pay to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

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, number of units of service approved-to-pay, amount of patients applied income associated with approved-to-pay claims, and amounts approved-to-pay are from DADS' MG 7000 report.

BL 2006 Methodology

Monthly cost/client depends on 2 factors: 1)avg days of svc/client/month, and 2)avg net $/day of svc. Avg net $/day of svc is broken down: 1)avg daily co-pmt rate less 2)standardized avg amt of client inc applied to $ of care/day. Avg daily co-pmt rate for each mo is calculated by dividing tot pmts incurred for a mo of service + tot amt of clientinc applied to $ of care by the days of scv incurred to-date. Standardized avg amt of client inc applied to $ of care/day for each mo is derived: divide tot amt of applied income incurred for mo of svc by days of svc incurred for same mo of scv. This avg is standardized by multiplying ratio of calendar days for mo of svc to a "standard" mo of 30.416 days (365 days/yr divided by 12 mos). Avg daily co-pmt rate for each mo less the standardized avg amt of client inc applied to $ of care/day for each mo = avg net $/day of svc for each mo.
Continued Below.

BL 2006 Purpose

Continuation of Methodology:
For each mo of svc, net pmt/client for copaid Medicaid/Medicare NF svcs is calculated by: multiply avg days of svc/ client X avg net $/day. Reported data are computed by taking the sum of the product of the net pmt/client (as calculated above),X the # of clients (receiving co-paid Medicaid/Medicare NF svcs) for each mo of the reporting period, and dividing that amt by the sum of the clients for all mos of reporting period.

Purpose:

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the unit cost for the Medicare co-payment for eligible nursing facility residents. This data is a useful 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.	6	Nursing Facility and Hospice Payments
Strategy No.	2	Medicare Skilled Nursing Facility
Measure Type	OP	
Measure No.	1	Average Number Receiving Nursing Facility Copayments/Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 324 078-R-S70-1 01-01-06 OP 02

Fall/Annual: N

BL 2006 Definition

This measure reports the monthly average number of persons receiving co-paid Medicaid/Medicare nursing facility services during the reporting period. The department pays the daily Medicare skilled nursing facility co-insurance payments for persons who are eligible for both Medicare and Medicaid.

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 compute this measure. The number of clients authorized to receive the above services is obtained from the department's SAVERR and SAS systems. 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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from the department's MG 7000 report.

BL 2006 Methodology

The reported data are calculated by dividing the sum of the monthly number of persons receiving co-paid Medicaid/ Medicare nursing facility services 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 receiving one of the services funded under this strategy. This count is an indication of service demand and is a useful 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.	6	Nursing Facility and Hospice Payments
Strategy No.	3	Hospice
Measure Type	EF	
Measure No.	1	Average Net Payment Per Client Per Month for Hospice

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 324 078-R-S70-1 01-01-06 EF 06

Fall/Annual: N

BL 2006 Definition

This measure reports the average net cost per client per month for Hospice Services. 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 Medicaid Hospice clients is defined under output measure 1.

BL 2006 Data Limitations

Because it takes several months to close out 100% of the billings for a month of service, the expenditures ultimately incurred must be estimated using "completion factors" applied to the amount billed 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 number of persons on claims, approved-to-pay to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

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, the amount of patient's "applied income" associated with approved-to-pay claims, 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

The sum of the monthly expenditures for Medicaid hospice services (by month-of-service) for all months in the reporting period, divided by the average monthly number of Medicaid hospice clients for the reporting period, divided by the number of months in the reporting period yields the reported performance.

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 quantifies the total unit cost to the agency for providing Medicaid reimbursed hospice services. This data is a useful 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.	6	Nursing Facility and Hospice Payments
Strategy No.	3	Hospice
Measure Type	OP	
Measure No.	1	Average Number of Clients Receiving Hospice Services Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 324 078-R-S70-1 01-01-06 OP 03

Fall/Annual: N

BL 2006 Definition

This measure reports the average of the unduplicated monthly number of persons receiving Hospice services during the reporting period.

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

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

The reported data are calculated by dividing the sum of the monthly number of persons receiving Hospice services 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 receiving one of the services funded under this strategy. This count is an indication of service demand and is a useful 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. 6 Nursing Facility and Hospice Payments
Strategy No. 4 Promote Independence by Providing Community-based Client Services
Measure Type EF
Measure No. 1 Average Monthly Cost Per Client Served: Promoting Independence

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average monthly cost of Long Term Care waiver services provided to Rider 28 clients. 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 Rider 28, Promoting Independence clients (78th Texas Legislature) is defined under output measure 1 of this strategy.

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 as well as cost per client per month 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 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.

BL 2006 Methodology

The sum of monthly Long Term Care waiver expenditures for Rider 28 clients by month-of-service for all months in the reporting period is divided by the average monthly number of Rider 28 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 partially quantifies DADS’ success in its “Promoting Independence” efforts. As clients relocate from nursing facilities to community care services, Rider 28, Seventy- seventh Legislature, allows DADS 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.	6	Nursing Facility and Hospice Payments
Strategy No.	4	Promote Independence by Providing Community-based Client Services
Measure Type	OP	
Measure No.	1	Average Number of Promoting Independence Clients Served Per Month

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

Fall/Annual: N

BL 2006 Definition

The number of individuals who are successfully moved from a nursing facility into long-term care waiver services provided in the community, and paid for by the State of Texas. Individuals 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 (78th Texas Legislature, Rider 28: Promoting Independence).

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Clients meeting the above criteria are identified and tracked through DADS' Service Authorization System (SAS). Counts are reported through SAS on a monthly basis.

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 Rider 28 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, Rider 28, Seventy-eighth Legislature, allows the Department 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.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EF	
Measure No.	1	Monthly Cost Per ICF/MR Medicaid Eligible Consumer

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

Fall/Annual: N

BL 2006 Definition

This efficiency measure is the average monthly cost per consumer in Community ICF/MR facilities.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of ICF-MR services up to 365 days after the end of the service month. Therefore, for the current fiscal year, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual service authorizations for the current quarter.

BL 2006 Data Source

The measure is derived from service authorizations and billing data provided on a monthly basis. The calculation uses the average billing rate per consumer from the CMS system. The actual billing rates are already net of applied income. Since there is a full twelve-month billing window, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of service authorizations from CARE. This combination of service authorizations and average billing rates is used rather than utilizing the billing system alone because of the twelve month billing window for submitting claims.

BL 2006 Methodology

The average billing rate for each month is multiplied by the number of service authorizations to determine a monthly expenditure amount. The monthly expenditure amount for each of the three months in the reporting quarter is summed. The number of service authorization for each of the three months in the reporting quarter is also summed. The quarterly expenditure amount is divided by the quarterly number of service authorizations for an average monthly cost per consumer for the reporting quarter. Due to the large billing window in this program, the values reported in ABEST will not be updated to reflect actual average monthly billing rates from the billing system alone until a year later. In ABEST, the reported values for each quarter of the previous fiscal year will be updated upon submission of either the Operating Budget or the LAR document.

BL 2006 Purpose

This measure allows the agency to track the cost, over time, of ICF/MR services provided to consumers served by state operated and non-state operated providers

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

Goal No. 1 Long-term Care Continuum
Objective No. 7 Intermediate Care Facilities - Mental Retardation
Strategy No. 1 Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type EX
Measure No. 1 Number of Consumers in ICF/MR Medicaid Beds Per Year

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

Fall/Annual: N

BL 2006 Definition

This output measure is the average number of people who reside in all Community ICF/MR facilities.

BL 2006 Data Limitations

ICF/MR providers are allowed to submit claims no longer than 365 days from the end of the month the service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated. Values reported in ABEST will be updated regularly and when the appropriation year closes.

BL 2006 Data Source

The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/MR placement/reimbursement. Service authorization information is entered into the departmentâ€™s CARE system. A monthly production report (DADS ICF-MR Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

BL 2006 Methodology

Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for all ICFs/MR is counted. The measure is the average number of persons in ICFs/MR each month as calculated for the reporting quarter and year to date. The numerator is the sum of the monthly number of service authorizations for ICFs/MR for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	2	Number ICF/MR Consumers with Residential Length of Stay 0-12 Months

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

Fall/Annual: N

BL 2006 Definition

This measure relates to the length of stay for an individual in an ICF/MR facility and reports the numbers of persons whose length of stay is one year or less. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30 days.

BL 2006 Data Limitations

None

BL 2006 Data Source

Information about client movement is entered into the department's CARE system. Movement includes admission, absence and discharge. From this CARE system, the number of days from admission (date of authorization) to present can be calculated.

BL 2006 Methodology

This measure is calculated for consumers residing in ICFs/MR on the last day of the fiscal year. For all persons residing in the facilities who have not been absent from their facility for more than 30 days during the year, the total days from the date of authorization to the end of the reporting period are counted. From this total count of persons, the number of persons in an ICF/MR facility for one through 365 days is counted.

BL 2006 Purpose

These facilities are intended to provide long-term care for persons with mental retardation that need or desire 24-hour supervised living environments. The number of persons with shorter lengths of stay is relatively insignificant. These facilities have a stable number of residents and new admissions to facilities are dependent upon a bed becoming available.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	3	Number ICF/MR Consumers with Residential Length of Stay 13-23 Months

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

Fall/Annual: N

BL 2006 Definition

This measure relates to the length of stay for an individual in an ICF/MR facility and reports the numbers of persons whose length of stay is 366 days through 730 days. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30 days.

BL 2006 Data Limitations

None

BL 2006 Data Source

Information about client movement is entered into the department's CARE system. Movement includes admission, absence and discharge. From this CARE system, the number of days from admission (date of authorization) to present can be calculated.

BL 2006 Methodology

This measure is calculated for consumers residing in ICFs/MR on the last day of the fiscal year. For all persons residing in the facilities who have not been absent from their facility for more than 30 days during the year, the total days from the date of authorization to the end of the reporting period are counted. From this total count of persons, the number of persons in an ICF/MR facility for 366 through 730 days is counted.

BL 2006 Purpose

These facilities are intended to provide long-term care for persons with mental retardation that need or desire 24-hour supervised living environments. The number of persons with shorter lengths of stay is relatively insignificant. These facilities have a stable number of residents and new admissions to facilities are dependent upon a bed becoming available.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	4	Number ICF/MR Consumers with Residential Length of Stay 24+ Months

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

Fall/Annual: N

BL 2006 Definition

This measure relates to the length of stay for an individual in an ICF/MR facility and reports the numbers of persons whose length of stay is 731 days or more. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30 days.

BL 2006 Data Limitations

None

BL 2006 Data Source

Information about client movement is entered into the department's CARE system. Movement includes admission, absence and discharge. From this CARE system, the number of days from admission (date of authorization) to present can be calculated.

BL 2006 Methodology

This measure is calculated for consumers residing in ICFs/MR on the last day of the fiscal year. For all persons residing in the facilities who have not been absent from their facility for more than 30 days during the year, the total days from the date of authorization to the end of the reporting period are counted. From this total count of persons, the number of persons in an ICF/MR facility for 731 days or more is counted.

BL 2006 Purpose

These facilities are intended to provide long-term care for persons with mental retardation that need or desire 24-hour supervised living environments. The number of persons with shorter lengths of stay is relatively insignificant. These facilities have a stable number of residents and new admissions to facilities are dependent upon a bed becoming available.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	5	Average Monthly Number of Consumers in ICF/MR, 1-8 Beds

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average monthly number of persons who reside in Community ICF/MR facilities that have eight beds or less.

BL 2006 Data Limitations

ICF/MR providers are allowed to submit claims no longer than 365 days from the month service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated.

BL 2006 Data Source

The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/MR placement/reimbursement. Service authorization information is entered into the department's CARE system. A monthly production report (DADS ICF-MR Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

BL 2006 Methodology

Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/MR with eight beds or less is counted. The numerator is the sum of the monthly number of service authorizations for ICFs/MR for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	6	Monthly Cost Per ICF/MR Medicaid Eligible Consumer, 1 to 8 Beds

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average cost per consumer in Community ICF/MR facilities that have eight beds or less.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of ICF-MR services up to 365 days after the end of the service month. Therefore, for the current fiscal year, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual service authorizations for the current quarter.

BL 2006 Data Source

The measure is derived from service authorizations and billing data provided on a monthly basis. The calculation uses the average billing rate per consumer from the CMS system. The actual billing rates are already net of applied income. Since there is a full twelve-month billing window, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of service authorizations from CARE. This combination of service authorizations and average billing rates is used rather than utilizing the billing system alone because of the twelve month billing window for submitting claims.

BL 2006 Methodology

The average billing rate for each month is multiplied by the number of service authorizations to determine a monthly expenditure amount. The monthly expenditure amount for each of the three months in the reporting quarter is summed. The number of service authorization for each of the three months in the reporting quarter is also summed. The quarterly expenditure amount is divided by the quarterly number of service authorizations for an average monthly cost per consumer for the reporting quarter. Due to the large billing window in this program, the values reported in ABEST will not be updated to reflect actual average monthly billing rates from the billing system alone until a year later. In ABEST, the reported values for each quarter of the previous fiscal year will be updated upon submission of either the Operating Budget or the LAR document.

BL 2006 Purpose

This measure allows the agency to track the cost, over time, of ICF/MR services provided to consumers served by state operated and non-state operated providers.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	7	Average Monthly Number of Consumers in ICF/MR, 9-13 Beds

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average monthly number of persons who reside in Community ICF/MR facilities that have more than eight beds but less than 14 beds.

BL 2006 Data Limitations

ICF/MR providers are allowed to submit claims for services for up to two state fiscal years beyond the current fiscal year in order to be reimbursed for the services. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated. The department is proposing a rule revision (effective date 2002) to restrict submission of claims to no longer than 365 days from the end of the month service was provided in order for the claims to be paid.

BL 2006 Data Source

The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/MR placement/reimbursement. Service authorization information is entered into the department's CARE system. A monthly production report (DADS ICF-MR Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

BL 2006 Methodology

Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/MR with more than eight beds but less than fourteen beds is counted. The numerator is the sum of the monthly number of service authorizations for ICFs/MR for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	8	Monthly Cost Per ICF/MR Medicaid Eligible Consumer, 9-13 Beds

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average cost per consumer in Community ICF/MR facilities that have more than eight beds but less than 14 beds.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of ICF-MR services up to 365 days after the end of the service month. Therefore, for the current fiscal year, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual service authorizations for the current quarter.

BL 2006 Data Source

The measure is derived from service authorizations and billing data provided on a monthly basis. The calculation uses the average billing rate per consumer from the CMS system. The actual billing rates are already net of applied income. Since there is a full twelve-month billing window, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of service authorizations from CARE. This combination of service authorizations and average billing rates is used rather than utilizing the billing system alone because of the twelve month billing window for submitting claims.

BL 2006 Methodology

The average billing rate for each month is multiplied by the number of service authorizations to determine a monthly expenditure amount. The monthly expenditure amount for each of the three months in the reporting quarter is summed. The number of service authorization for each of the three months in the reporting quarter is also summed. The quarterly expenditure amount is divided by the quarterly number of service authorizations for an average monthly cost per consumer for the reporting quarter. Due to the large billing window in this program, the values reported in ABEST will not be updated to reflect actual average monthly billing rates from the billing system alone until a year later. In ABEST, the reported values for each quarter of the previous fiscal year will be updated upon submission of either the Operating Budget or the LAR document.

BL 2006 Purpose

This measure allows the agency to track the cost, over time, of ICF/MR services provided to consumers served by state operated and non-state operated providers.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	9	Average Monthly Number of Consumers in ICF/MR, 14+ Beds

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average monthly number of persons who reside in Community ICF/MR facilities which have 14 beds or greater.

BL 2006 Data Limitations

ICF/MR providers are allowed to submit claims for services for up to two state fiscal years beyond the current fiscal year in order to be reimbursed for the services. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated. The department is proposing a rule revision (effective date October 2002) to restrict submission of claims to no longer than 365 days from the end of the month service was provided in order for the claims to be paid.

BL 2006 Data Source

The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/MR placement/reimbursement. Service authorization information is entered into the department's CARE system. A monthly production report (TDMHMR ICF-MR Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

BL 2006 Methodology

Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/MR with fourteen or more beds is counted. The numerator is the sum of the monthly number of service authorizations for ICFs/MR for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	10	Monthly Cost Per ICF/MR Medicaid Eligible Consumer, 14+ Beds

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average cost per consumer in Community ICF/MR facilities that have 14 or more beds.

BL 2006 Data Limitations

Original claims for services provided may be submitted by providers of ICF-MR services up to 365 days after the end of the service month. Therefore, for the current fiscal year, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual service authorizations for the current quarter.

BL 2006 Data Source

The measure is derived from service authorizations and billing data provided on a monthly basis. The calculation uses the average billing rate per consumer from the CMS system. The actual billing rates are already net of applied income. Since there is a full twelve-month billing window, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of service authorizations from CARE. This combination of service authorizations and average billing rates is used rather than utilizing the billing system alone because of the twelve month billing window for submitting claims.

BL 2006 Methodology

The average billing rate for each month is multiplied by the number of service authorizations to determine a monthly expenditure amount. The monthly expenditure amount for each of the three months in the reporting quarter is summed. The number of service authorization for each of the three months in the reporting quarter is also summed. The quarterly expenditure amount is divided by the quarterly number of service authorizations for an average monthly cost per consumer for the reporting quarter. Due to the large billing window in this program, the values reported in ABEST will not be updated to reflect actual average monthly billing rates from the billing system alone until a year later. In ABEST, the reported values for each quarter of the previous fiscal year will be updated upon submission of either the Operating Budget or the LAR document.

BL 2006 Purpose

This measure allows the agency to track the cost, over time, of ICF/MR services provided to consumers served by state operated and non-state operated providers.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	11	Average Monthly Number of ICF/MR Medicaid Beds, 8 or Less

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average number of certified beds in Community ICF/MR facilities that have eight beds or less.

BL 2006 Data Limitations

None.

BL 2006 Data Source

DADS maintains a database within the CARE system of all ICF/MR providers that contains information about location and size of each facility. The agency certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2006 Methodology

The number of Medicaid certified beds in ICF/MR facilities with eight beds or less each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year to date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	12	Average Monthly Number of ICF/MR Beds, 9-13

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average number of certified beds in Community ICF/MR facilities which have greater than eight beds but less than 14.

BL 2006 Data Limitations

None

BL 2006 Data Source

DADS maintains a database within the CARE system of all ICF/MR providers that contains information about location and size of each facility. The agency certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2006 Methodology

The number of Medicaid certified beds in ICF/MR facilities with nine to thirteen beds each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year to date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	13	Average Monthly Number of ICF/MR Medicaid Beds, 14+

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

Fall/Annual: N

BL 2006 Definition

This explanatory measure is the average number of certified beds in Community ICF/MR facilities which have 14 beds or greater.

BL 2006 Data Limitations

None

BL 2006 Data Source

DADS maintains a database within the CARE system of all ICF/MR providers that contains information about location and size of each facility. The Department certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2006 Methodology

The number of Medicaid certified beds in ICF/MR facilities with fourteen beds or more is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year to date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	OP	
Measure No.	1	Average Number of Persons in ICF/MR Medicaid Beds Per Month

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

Fall/Annual: N

BL 2006 Definition

This output measure is the average number of people who reside in all Community ICF/MR facilities.

BL 2006 Data Limitations

ICF/MR providers are allowed to submit claims no longer than 365 days from the end of the month the service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated. Values reported in ABEST will be updated regularly and when the appropriation year closes.

BL 2006 Data Source

The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/MR placement/reimbursement. Service authorization information is entered into the departmentâ€™s CARE system. A monthly production report (DADS ICF-MR Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

BL 2006 Methodology

Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for all ICFs/MR is counted. The measure is the average number of persons in ICFs/MR each month as calculated for the reporting quarter and year to date. The numerator is the sum of the monthly number of service authorizations for ICFs/MR for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermediate Care Facilities - Mental Retardation (ICF/MR)
Measure Type	OP	
Measure No.	2	Average Number of ICF/MR Medicaid Beds Per Month

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

Fall/Annual: N

BL 2006 Definition

This output measure is the average number of certified beds in all Community ICF/MR facilities.

BL 2006 Data Limitations

None

BL 2006 Data Source

DADS utilizes the CARE system database of all ICF/MR providers that contains information about location and size of each facility. DADS staff certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2006 Methodology

The total number of Medicaid certified beds in all ICF/MR facilities each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year to date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/MR Medicaid beds with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per MR Campus Resident

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

Fall/Annual: N

BL 2006 Definition

This measure captures information regarding what it costs DADS each month, on average to provide Mental Retardation campus (state school and state center) services.

BL 2006 Data Limitations

Data must be current and accurate in the department's CARE system as of the date the reports are produced.

BL 2006 Data Source

Funding for mental retardation campus residential services includes the federal portion of Medicaid, Medicare, other federal interagency grants and reimbursements, third party/patient fees, state general revenue match for Medicaid, and other funds. The department's accounting system contains all expenditure data for the state facilities. Costs include both facility administrative and residential operations. Excluded costs include depreciation, employee benefits paid by the Employee Retirement System, Central Office administrative costs and statewide administrative costs.

BL 2006 Methodology

The numerator is the total expenditures paid for by DADS for Mental Retardation campus residential services for each month in the reporting period divided by the number of months in the reporting period. The denominator is the average monthly number of state mental retardation campus residents. The formula is numerator/denominator.

BL 2006 Purpose

This measure allows the agency to track the cost of an occupied bed at a mental retardation campus over time. This is of particular importance in light of increased health care costs due to the complex medical and behavioral needs of the current mental retardation residents.

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

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	EF	
Measure No.	2	Avg # Days Consumers w/MR Wait for Admission Any State School Campus

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

Fall/Annual: N

BL 2006 Definition

This measure provides the number of days that persons with mental retardation wait for admission to a state mental retardation facility, when the individual would accept admission to any facility in the state.

BL 2006 Data Limitations

If an individual submits an application packet for a specific state school and subsequently decides to accept admission to any facility with an appropriate vacancy, the individual is moved from the database for a specific state school to the database for any state school effective on the first day of the month of the change. When the individual is subsequently admitted to a state school, the number of days the individual waited for admission will be calculated from the date of initial referral for a specific state school. The effect of this methodology will be an increase in the average days persons wait for admission to any state school. However, there does not seem to be a more precise method of calculating days that an individual waits for admission.

BL 2006 Data Source

The source of the data is the completed application packet. Once the packet is received at the local state mental retardation facility, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the State mental retardation facilities (SMRF) division at DADS by the local facility. (Maintaining this information in the CARE system is being studied and may be implemented at some future time.)

BL 2006 Methodology

This is an average of days that all persons wait for admission to a state mental retardation facility when any facility would be acceptable. The numerator is the total of all days that persons waited for admission to any state mental retardation facility for those persons admitted to a state mental retardation facility during the quarter. The denominator is the number of persons admitted to a facility during the reporting period from the waiting list for any state mental retardation facility. The formula is numerator/denominator. For year to date each quarter: The numerator is the sum of days all persons admitted during the months from the beginning of the fiscal year to the end of the current quarter waited for admission to any facility. The denominator is the number of persons admitted from the waiting list for any state mental retardation facility since the beginning of the fiscal year. The formula is numerator /denominator.

BL 2006 Purpose

Admissions to state mental retardation facilities are based on specific criteria as defined in Texas Administrative Code, Chapter 412, Subchapter F, Continuity of Services - State Mental Retardation Facilities. Persons are considered to be waiting for admission to a state mental retardation facility upon receipt of a completed application packet by the state mental retardation facility. Responsibility for completion of the application packet to a state mental retardation facility rests with the local Mental Retardation Authority as provided in 25 TAC Â§412.265. Number of days that an individual waits for admission reflects the availability of services and efficiency of the system in accommodating individual choice.

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

Goal No. 1 Long-term Care Continuum
Objective No. 8 MR State Schools Services
Strategy No. 1 MR State Schools Services
Measure Type EF
Measure No. 3 Avg # Days Consumers w/MR Wait Admission Specific State School Campus

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

Fall/Annual: N

BL 2006 Definition

This measure provides the number of days that persons with mental retardation wait for admission to a state mental retardation facility, when the individual would only accept admission to a specific facility.

BL 2006 Data Limitations

If an individual submits an application packet for a specific state school and subsequently decides to accept admission to any facility with an appropriate vacancy, the individual is moved from the database for a specific state school to the database for any state school effective on the first day of the month of the change. When the individual is subsequently admitted to a state school, the number of days the individual waited for admission will be calculated from the date of initial referral for a specific state school. This methodology should not affect the average days persons wait for admission to a specific state school.

BL 2006 Data Source

The source of the data is the completed application packet. Once the packet is received at the local state mental retardation facility, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the State mental retardation facilities (SMRF) division at DADS by the local facility. (Maintaining this information in the CARE system is being studied and may be implemented at some future time.)

BL 2006 Methodology

This is an average of days that all persons wait for admission to a specified state mental retardation facility. The numerator is the total of all days that persons waited for admission to a specific state mental retardation facility for those persons admitted to a state mental retardation facility during the quarter. The denominator is the number of persons admitted to a facility during the reporting period from the waiting list for a specific state mental retardation facility. The formula is numerator/denominator. For year to date each quarter: The numerator is the sum of days all persons admitted during the months from the beginning of the fiscal year to the end of the current quarter waited for admission to a specific facility. The denominator is the number of persons admitted from the waiting list for a specific state mental retardation facility since the beginning of the fiscal year. The formula is numerator/denominator.

BL 2006 Purpose

Admissions to state mental retardation facilities are based on specific criteria as defined in Texas Administrative Code, Chapter 412, Subchapter F, Continuity of Services - State Mental Retardation Facilities. Persons are considered to be waiting for admission to a state mental retardation facility upon receipt of a completed application for packet by the designated mental retardation facility. Responsibility for completion of the application packet to a state mental retardation facility rests with the local Mental Retardation Authority as provided in 25 TAC Â§412.265. Number of days that an individual waits for admission reflects the availability of services and efficiency of the system in accommodating individual choice.

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

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	EX	
Measure No.	1	Number of MR Campus Residents Who Are under 18 Years of Age Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure provides a snapshot look at the age of residents in mental retardation campus based services. Of concern in this measure are those residents who are children and adolescents and require compliance with federal and state regulations pertaining to education.

BL 2006 Data Limitations

None

BL 2006 Data Source

Persons employed by the state mental retardation campus-based facilities enter the date of birth at time of admission into the department's system. A standard production report provides the number of customers served less than 18 years of age.

BL 2006 Methodology

This measure is a simple unduplicated count of mental retardation campus based residents between the ages of 0 and 17 (inclusive). It is a point in time measure obtained on the last day of the state fiscal year (8/31).

BL 2006 Purpose

This measure allows the agency to track the proportion of children and adolescents residing in state mental retardation campuses for planning purposes. Persons with mental retardation who are in residence at mental retardation campus facilities include school aged youth whose educational needs are largely met by the school system.

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

Goal No. 1 Long-term Care Continuum
Objective No. 8 MR State Schools Services
Strategy No. 1 MR State Schools Services
Measure Type EX
Measure No. 2 Avg # Day Consumers w/MR Interested St School Placement Wait Admission

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

Fall/Annual: N

BL 2006 Definition

This measure captures the length of time an individual waits for admission to a state mental retardation facility (SMRF). The wait time begins with the submission of written information to the SMRF and ends with actual admission to a facility.

BL 2006 Data Limitations

The calculation methodology for this measure includes length of time an individual actually waits for admission and the length of time it takes an individual to complete the application process. Efficiency Measures 04.01.01.02 and 04.01.01.03 are subsets of this measure. The accuracy of the SMRF interest list is dependent upon submission of written information to the SMRF by the MRA.

BL 2006 Data Source

When a person seekng state MR facilty admision on behalf of an indivdual w MR begins the applicaton process, the consumers name is put into DADS CARE database (DB) as an inquiry for state MR facilty scvs by facilty staff. When a completed app packet is recvd by the SMRF, DB is updated to indicate the person is waiting for admision. Once the individual is admited to a state MR facilty, the DB system inputs the admision status date into the DB. If an individual is found to not meet the criteria for state MR facilities, MRA staff notify the individual of the right to appeal (as defined by 25TAC Chapter 412, Subchapter F, Continuity of Services-State Mental Retardation Facilities). MRA staff notify the facilty, which will remove the individal from the list if the appeal is not pursued or upheld. If the individual completng the applicaton decides to not pursue the app process, MRA staff will notify the facilty which will input that status date to remove the individal from the list.

BL 2006 Methodology

At the end of the fiscal year, the total number of persons on the list from inception of the list who continue to be on the list or who have been admitted in a state mental retardation facility is calculated. This calculation will exclude those persons who are no longer on the list due to withdrawal of interest or inactivation. The number of days that the identified individuals either waited for admission or have been on the list since their start date is also calculated.

BL 2006 Purpose

The numerator is the number of days persons were on the list from the begin date to the admission date plus the number of days persons were on the list from the begin date to the current date. The denominator is the total number of persons on the list as either active or admitted. The formula is numerator / denominator. Purpose: The length of time an individual waits for admission to a state mental retardation facility reflects the accessibility of 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
Strategy No.	1	MR State Schools Services
Measure Type	EX	
Measure No.	3	Number Interested In State School Placement

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

Fall/Annual: N

BL 2006 Definition

This measure provides a simple count of persons who express an interest in pursuing state mental retardation facility (SMRF) admission by initiating an application for such admission. For purposes of this measure, interest is defined as beginning the application process for state mental retardation facilities.

BL 2006 Data Limitations

The accuracy of the SMRF interest list is dependent upon the submission of written information to the facility by the MRA. This measure captures an unduplicated count of persons throughout the year regardless of on-going or continued interest and does not provide data regarding number of persons interested in state mental retardation facility admission on any given day. Output measures 04.01.01.02 and 04.01.01.03 are subsets of this measure.

BL 2006 Data Source

When a person seeking state mental retardation facility admission on behalf of an individual with mental retardation begins the application process, the name of the consumer is entered into the DADS CARE database as an "inquiry" for state mental retardation facility services. Staff of the SMRF input this data into the database.

BL 2006 Methodology

This is a continuous simple count of persons from point of interest to admission. The count includes the number of persons on the interest list on the first day of the fiscal year and all additions and subtractions to the list during the fiscal year.

BL 2006 Purpose

State mental retardation facility admissions (other than placements pursuant to the Family Code) are initiated by family members and legally authorized representatives following discussions of residential options with staff of the local Mental Retardation Authorities (MRAs).

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

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	EX	
Measure No.	4	Number of MR Campus Residents Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure provides an unduplicated workload count of persons receiving Mental Retardation campus residential services during one fiscal year.

BL 2006 Data Limitations

Data must be current and accurate in the department's CARE system as of the date the reports are produced.

BL 2006 Data Source

Enrollment data are obtained from the department's CARE system. Standard production reports from the CARE system provide the unduplicated number of persons served during the year by the state mental retardation facilities.

BL 2006 Methodology

This measure is a simple count of individuals with one day or longer in residence at a Mental Retardation campus residential program at any time during the state fiscal year.

BL 2006 Purpose

This measure provides the actual number of persons who reside at a mental retardation campus at any time during the year.

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

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	OP	
Measure No.	1	Average Monthly Number of MR Campus Residents

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

Fall/Annual: N

BL 2006 Definition

This measure provides the number of persons enrolled in Mental Retardation campus residential services each month on average. Enrollment is defined as the total number of persons residing at the facility or absent for such purposes as home visits, hospitalizations, etc. with the intention of returning to the facility. Mental retardation campus services are provided at state schools and state centers.

BL 2006 Data Limitations

None

BL 2006 Data Source

This is average monthly enrollment. Enrollment is the census plus all absences (persons are expected to return to the facility). Enrollment data is obtained from the department's CARE system. All persons enrolled in state mental retardation facilities have an assignment code in the CARE system that indicates whether the person is on campus or absent from the campus with reason for absence. A standard production report (HC021950) from the CARE system provides the information.

BL 2006 Methodology

The numerator is the total number of persons absent or present in all state mental retardation facilities for each month in the reporting period (as shown in report HC021950). The denominator is the number of months in the reporting period, quarter or year to date. The formula is numerator/denominator.

BL 2006 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate the utilization of mental retardation campus services with related costs and outcomes.

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

Goal No.	1	Long-term Care Continuum
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	OP	
Measure No.	2	Avg Mthly # Consumers w/MR Waiting Admission Any State School Campus

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

Fall/Annual: N

BL 2006 Definition

This measure provides the number of persons with mental retardation requesting residential services in a state mental retardation facility anywhere in the state, on average any given month.

BL 2006 Data Limitations

The count includes only those persons for whom a completed application has been received and admission to any facility in the state is acceptable to the individual or legally authorized representative.

BL 2006 Data Source

When an individual with mental retardation, or the individual's legally authorized representative requests residential services in a state mental retardation facility, and the MRA determines that the individual meets the criteria for admission or commitment the MRA will compile all information required to complete an application packet. The complete application packet is forwarded to the SMRF serving the area in which the applicant lives. The source of the data is the completed application packet. Once the packet is received at the designated state mental retardation facility, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the SMRF division at DADS by the local facility.

BL 2006 Methodology

This information includes name of individual, CARE ID number, date of referral, designated facility, and the MRA. (Maintaining this information in the CARE system is being studied and may be implemented at some future time.) The State Office for SMRF retains responsibility for management of the waiting list. The average monthly number of persons waiting for admission to any state mental retardation facility is calculated as follows: The numerator is the total number of persons waiting in month one of the quarter, plus the total number of persons waiting in month two of the quarter, plus the total number of persons waiting in month three of the quarter. The denominator is the number of months in the reporting period. For year-to-date the number waiting in 3, 6, 9 or 12 months is summed and divided by the number of months year-to-date. The formula is numerator/denominator.

BL 2006 Purpose

Admissions to state mental retardation facilities are based on specific criteria as defined in Texas Administrative Code, Chapter 412, Subchapter F, Continuity of Services - State Mental Retardation Facilities. Persons are considered to be waiting for admission to a state mental retardation facility upon receipt of a completed application packet by the designated state mental retardation facility. Responsibility for completion of the application packet to a state mental retardation facility rests with the local Mental Retardation Authority as provided in 25 TAC Â§412.265. At times, a completed application packet is received on the same day as admission. These individuals are not counted as waiting for purposes of this measure although the MRA may have been working on getting the application completed for several months.

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

Goal No. 1 Long-term Care Continuum
Objective No. 8 MR State Schools Services
Strategy No. 1 MR State Schools Services
Measure Type OP
Measure No. 3 Avg Mthly # Consumers w/MR Waiting Admission Specific St School Campus

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

Fall/Annual: N

BL 2006 Definition

This measure provides the number of persons with mental retardation requesting residential services in a specified state mental retardation facility, on average for any given month.

BL 2006 Data Limitations

The count includes only those persons for whom a completed application has been received and admission is restricted to one facility.

BL 2006 Data Source

When an individual with MR, or the individual's legally authorized representative requests residential services in a state MR facility, and the MRA determines that the individual meets the criteria for admission or commitment, the MRA compiles all info required to complete an application. The complete application is forwarded to the SMRF serving the area in which the applicant lives. This local state MR facility ensures the application packet is forwarded to the specified state MR facility. The source of the data is the completed application packet. Once the packet is received at the local state MR facility, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the SMRF division at DADS by the local facility.

BL 2006 Methodology

This information includes name of individual, CARE ID number, date of referral, designated facility, the desired facility, and the MRA. (Maintaining this information in the CARE system is being studied and may be implemented at some future time.)The average monthly number of persons waiting for admission to a specific state mental retardation facility is calculated as follows: The numerator is the total number of persons waiting in month one of the quarter, plus the total number of persons waiting in month two of the quarter, plus the total number of persons waiting in month three of the quarter. The denominator is the number of months in the reporting period. For year-to-date the number waiting in 3, 6, 9 and 12 months is summed and divided by the number of months year-to-date. The formula is numerator/denominator.

BL 2006 Purpose

Admissions to state mental retardation facilities are based on specific criteria as defined in Texas Administrative Code, Chapter 412, Subchapter F, Continuity of Services - State Mental Retardation Facilities. Persons are considered to be waiting for admission to a state mental retardation facility upon receipt of a complete application packet by the designated state mental retardation facility. Responsibility for completion of the application packet to a state mental retardation facility rests with the local Mental Retardation Authority as provided in 25 TAC Â§412.265. At times, a completed application packet is received on the same day as admission. These individuals are not counted as waiting for purposes of this measure although the MRA may have been working on getting the application completed for several months.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	EF	
Measure No.	1	Average Cost Per Facility Visit

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of a facility visit. A facility visit is defined as an on-site visit by one or more surveyors for the purpose of conducting a licensing inspection, a standard or a re-certification survey, a complaint investigation, monitoring visit, or a follow-up visit.

BL 2006 Data Limitations

A visit that has multiple purposes is counted only once. (i.e. A standard survey during which a complaint investigation and follow-up are conducted is counted as one visit.)

BL 2006 Data Source

The average cost is based on direct costs attributed to DADS' program activity codes 430, 433, 434, and 436 as recorded in the department's Health and Human Services Administrative System. Included are salary, travel, and overhead (operating costs) expenses. Data for the number of on-site visits is obtained from the CARES system using the ad hoc query system. There is no specific report name or number with this query function.

BL 2006 Methodology

Data are computed by totaling the cost amounts for the appropriate reporting periods (numerator) and then dividing by the number of on-site visits for the same time period (denominator) to yield the average cost.

BL 2006 Purpose

This measure provides the unit cost for a facility visit. It is an indicator of the efficiency of agency operations and is a tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	EF	
Measure No.	2	Average Cost Per Medicaid Facility and Hospice Service Contract Issued

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of issuing a Medicaid contract to a nursing facility or hospice service provider. Issuance of a Medicaid provider contract results after the nursing facility or hospice provider has met all of the criteria discussed under output measure 10 of this strategy.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

The average cost is based on a percentage of the salary costs for the employees (FTEs) in the Facility Enrollment Section, LTCR, who perform the nursing facility and hospice service Medicaid provider enrollment work. These FTE (full-time equivalent) salary costs are accounted for in the department's automated Health and Human Services Administrative System. The affected FTEs expend from 5% to 90% of their time on this effort. The percentage of time each FTE spends on this activity is determined by the Unit manager's administrative experience. Data are obtained from the CARES Central Data Repository (CDR), which pulls data from the CARES system. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report does not have a name or number.

BL 2006 Methodology

Cost data are computed by totaling the associated percentage of salary costs for all FTEs for the appropriate reporting period (numerator). This result is then divided by the number of nursing facility and hospice service Medicaid contracts issued for the same reporting period (denominator) to yield the average cost.

BL 2006 Purpose

This measure provides the unit cost for issuing a Medicaid contract to eligible participating nursing facilities and hospice service providers. It is an indicator of the efficiency of agency operations and is a tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	EX	
Measure No.	1	Number of Facilities Terminated from Licensure and/or Certification

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of facilities that are terminated from the Medicare (Title XVIII) and/or the Medicaid (Title XIX) program, the number of facilities that have had their license revoked, and the number of facilities that were denied license renewal during the reporting period. Reasons for denial of a license are described in the rules for nursing facilities (Section 19.214), for ICF-MR facilities (Section 90.17), for assisted living facilities (Section 92.17), and for adult day care facilities (Section 98.19).

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

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

BL 2006 Methodology

The number of facilities terminated from licensure and/or certification programs during the months of the reporting period is totaled.

BL 2006 Purpose

This measure is a reflection of the agency's performance as it pertains to initiating corrective actions/enforcement (of facilities out of compliance).

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	EX	
Measure No.	2	Number of Medicaid Facility Contracts Terminated

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of nursing facilities that have had their Medicaid provider contract terminated for failure to meet the Medicaid contracting requirements, for revocation or denial of their license, or for termination of their Medicaid certification.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

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

BL 2006 Methodology

The number of Medicaid facility contracts terminated during the months of the reporting period is summed.

BL 2006 Purpose

This measure is a reflection of the agency's performance as it pertains to initiating corrective actions/enforcement (of facilities out of compliance).

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	1	Number of Long-term Care Facility Certifications Issued

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

Fall/Annual: N

BL 2006 Definition

This is the total # of facility certifications issued for nursing facilities (NF) and ICF-MR facilities. It contains 3 components: 1)The Medicare component reports the # of certification forms signed for facilities requesting participation in the Medicare program. The signed Certification and Transmittal (C&T) form (HCFA Form 1539) is evidence of certification and is forwarded to HCFA for contract with the facility (for NF only) 2)The Medicare/Medicaid component reports the number of certification forms signed for facilities participating in both the Medicare and Medicaid programs (dually certified facilities). The signed C&T form is forwarded to HCFA and to LTCRs Facility Enrollment Section (FES) for contract with the facility. (for NF only.) 3)The Medicaid component reports the # of certification forms signed for facilities participating in the Medicaid program. The signed C&T form is forwarded to LTCRs FES or to the TxMHMR for contract with the facility (includes NF & ICFs-MR).

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

The number of LTC facility certifications issued for each of the components during the months of the reporting period is totaled. The components are then summed.

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 quantifies the workload expended by the agency in response to its charge of certifying residential care facilities for participation in the Medicare/Medicaid programs. This data is useful in projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	2	Number of Long-term Care Facility Licenses Issued

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total number of facility licenses issued for all types of facilities (nursing facilities, ICF-MR facilities, assisted living facilities, and adult day care facilities). Data includes new and renewed licenses. A license is considered as issued once it has been printed. Each license has a new expiration date printed on it. (This date may differ from the date on which the license is actually printed.) Nursing facilities and ICF-MR facilities are licensed for a two-year period and assisted living facilities and adult day care facilities are licensed for one year.

BL 2006 Data Limitations

This measure excludes change of ownership during a licensure period, change of facility name during a licensure period, bed decrease and increase changes, change of facility administrator for nursing facilities and ICFs-MR, and change in ownership of facility stock.

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

The number of LTC facility licenses issued during the months of the reporting period is summed.

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 quantifies the workload expended by the agency in response to its charge to license the various types of residential care facilities. This data is a useful tool for projecting future funding needs.

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
Strategy No. 1 Long-Term Care Facility Regulation
Measure Type OP
Measure No. 3 # of On-site Nursing Facility/ICF-MR Monitoring Visits Completed

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of monitoring visits to nursing facilities and ICF-MRs during the reporting period. A monitoring visit is an on-site visit in addition to the annual inspection/survey to determine financially unstable facilities' compliance with state and federal standards. However, if during a monitoring visit, more than one type of activity is performed (a survey, follow-up to investigation and a new investigation) each type of activity is counted separately for reporting purposes.

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

The total number of completed monitoring visits is calculated by summing the number of monitoring visits to nursing facilities with visits to ICF-MRs during the months of 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 and indicates how many regulatory visits nursing facilities average per month to determine compliance with state and federal regulations.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	4	Number of Inspections Completed Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of inspections conducted by the DADS, Long-term Care Regulatory (DADS' LTC-R). An inspection is defined as one of the following: a re-certification survey (ICF-MR facilities), a standard survey (certified nursing facilities), an initial survey (ICF-MR facilities or certified nursing facilities), an initial or annual licensing inspection (licensed only nursing facilities, assisted living facilities or adult day care facilities), or change of ownership. A licensing inspection done in conjunction with a survey of a certified facility is not counted as a separate inspection.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained 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 numbers of inspections completed in long-term care facilities (nursing facilities, ICF-MRs, assisted living facilities and adult day care facilities) during the months of the reporting period are totaled.

BL 2006 Purpose

This measure is important because it is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency?s workload of inspecting facilities to ensure their compliance with state and federal standards. This data is a useful tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	5	Number of First Follow-up Visits Completed Per Year

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of first follow-up visits completed during the fiscal year for all types of facilities (nursing facilities, ICF-MR facilities, assisted living facilities, and adult day care facilities). The number of visits resulting in adverse actions and the number of visits not resulting in adverse actions are both included in the count.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the regional workload report (Excel spreadsheet) 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 calculations. The report does not have a name or report number.

BL 2006 Methodology

The number of first follow-up visits completed during the months covered by the reporting period is summed.

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 quantifies the agency's workload of conducting first follow-up visits to those LTC facilities not in compliance with state and federal standards at the time of the initial survey, most recent re-certification survey, most recent licensing inspection or complaint/incident investigation, bed change visits, or facility status verification visit to determine if the facility (usually unlicensed) is in compliance with licensure standards. This data is useful in determining future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	6	Number of Investigations Completed

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of complaint investigations and the number of incident investigations completed in nursing facilities, ICF-MR facilities, assisted living facilities, adult day care facilities and unlicensed facilities For purposes of this measure, a complaint investigation is defined as the on-site investigation of all allegations associated with an individual complaint intake (assigned an identification number upon intake). An incident investigation is defined as the on-site investigation of all areas of facility compliance associated with an incident as reported by the facility. Facility staff is required to self-report incidents that have resulted in or has the potential of resulting in injury or harm to a resident.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

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

BL 2006 Methodology

The number of complaint and incident investigations completed during the months of the reporting period are summed.

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 quantifies the agency's workload in pursuing the validity of inappropriate treatment of residents and/or the existence of other sub-standard conditions. This data is useful in determining future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	7	Total Dollar Amount Imposed from Fines

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total dollar amount of administrative penalties imposed for all types of facilities during the state fiscal year. It also includes the total amount of civil monetary penalties (CMP) imposed by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs imposed by the federal Centers for Medicare and Medicaid Services (CMS) on facilities participating in the Medicare/Medicaid (dually certified) or Medicare programs. An administrative penalty is imposed after the state-licensing agency (DADS LTC-R Licensing) has reviewed the staff recommendation of penalty based upon the findings of the facility's deficient practice(s) and decided on a final penalty. For CMPs, a penalty is imposed after the State Medicaid agency (DHS' LTC-R Enrollment) and/or CMS have reviewed the state survey/investigative team's recommendation of a penalty based on the facility's deficient practice(s) and decided on a final penalty.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

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

BL 2006 Methodology

The total dollar amounts imposed for fines during the months of the reporting period are summed.

BL 2006 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	8	Total Dollar Amount Assessed from Fines

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total dollar amount of administrative penalties assessed for all types of facilities during the reporting period. It also includes the total amount of civil monetary penalties (CMP) assessed by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs assessed by CMS for facilities participating in Medicare/Medicaid (dually certified) or Medicare programs. A penalty is assessed after the appeal/review process is completed and waiver, negotiated settlement, or hearing proceedings are finalized, and an assessment amount is agreed upon or set.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

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

BL 2006 Methodology

The total dollar amounts assessed from fines during each month of the reporting period are totaled. Monthly totals are summed to obtain the year-to-date amount.

BL 2006 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	9	Total Dollar Amount Collected from Fines

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total dollar amount of administrative penalties collected for all types of facilities during the reporting period. It also includes the total amount of civil monetary penalties (CMP) collected by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs collected by CMS for facilities participating in Medicare/Medicaid (dually certified. "A penalty amount collected is the amount that facilities have actually paid to the State Medicaid agency and/or the Centers for Medicare and Medicaid Services for penalties assessed.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained monthly from the Fiscal Division reports of accounts received for the payment of administrative penalties and civil monetary penalties. They are derived from a combination of the class (appropriation budget) and the cash account (0004500). The reports are named Administrative Penalties, and the Civil Monetary Penalties.

BL 2006 Methodology

The total dollar amounts collected from fines during the months of the reporting period are summed. Monthly data are totaled over the reporting period.

BL 2006 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	10	Number of Medicaid Facility and Hospice Service Contracts Issued

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of Medicaid provider contracts issued to nursing facilities and hospice service providers. Contracts issued include new facilities or services contracted, ownership changes resulting in a contract issuance, and re-applications after a facility or service's contract is terminated. Enrollment of a nursing facility or hospice service into the Medicaid program involves the facility/service meeting all Medicaid contracting criteria including acceptable completion of the enrollment/application process, compliance with the pertinent state licensing regulations and compliance with the applicable federal and state Medicaid certification regulations. A nursing facility or hospice service Medicaid contract is issued after the facility/service is licensed and/or certified. Based on this contract the facility or service is eligible for vendor payments for the Medicaid clients residing in the facility or Medicaid clients receiving hospice services.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

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

BL 2006 Methodology

The number of Medicaid facility contracts issued during the months of the reporting period is summed. The number of hospice service contracts issued during the months of the reporting period is also summed. These two sums are totaled to obtain the reported data.

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 quantifies the workload expended by the agency in response to its charge of issuing contracts to Medicaid certified nursing facility providers and hospice service providers. This data is a tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	11	Number of Home and Community Support Services Agency Licenses Issued

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total number of licenses issued by DADS' Long-term Care-Regulatory/Home and Community Support Services Agency staff. (LTC-R/HCSSA.) For reporting purposes, a license is considered as issued once it has been printed. Each license has a new expiration date printed on it. (This date may differ from the date on which the license is actually printed.) HCSSAs are licensed for one year.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from a Central Data Repository (CDR) compiled from the HCSSA stand-alone regulatory database (Integrated System). 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.

BL 2006 Methodology

Data for the appropriate number of months in the reporting period are summed.

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 quantifies the agency's workload of inspecting agencies to ensure their compliance with state and Federal requirements. This data is a useful tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	12	Number Home & Community Support Services Agency Inspections Conducted

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total number of inspections conducted during the reporting period by the DADS, Long Term Care-Regulatory/HCSSA. For reporting purposes, an inspection is defined as one of the following: an initial licensing survey; an initial certification survey (Medicare certified agencies), a re-survey (licensed only). A licensing inspection done in conjunction with a survey of a Medicare certified agency is not counted as a separate inspection.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the regional HCSSA workload report (Excel worksheet) submitted monthly and compiled by Data Management and Analysis Section. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number. Later, data may be obtained from the central data repository (CDR) using federal and state databases.

BL 2006 Methodology

Monthly data, covering the appropriate months of the reporting period, are totaled.

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 quantifies the agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	13	Number of Complaint Investigations Conducted: HCSSA

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of complaint investigations conducted in Home and Community Support Services Agencies (HCSSA). A complaint investigation is defined as an on-site visit conducted for the purpose of determining compliance with federal and state requirements when a complaint has been filed with the department.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the regional HCSSA workload report (Excel worksheet) submitted monthly and compiled by Data Management and Analysis Section. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number. Later, data may be obtained from the central data repository (CDR) using federal and state databases.

BL 2006 Methodology

For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

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 quantifies the agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	14	# Substantiated Complaint Allegation Abuse/Neglect: Nursing Facilities

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of substantiated complaint allegations of resident abuse and/or neglect in nursing facilities 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 staffs 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 summing the number of substantiated complaint allegations of abuse/neglect in nursing facilities during the months of the reporting period.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	15	# Substantiated Complaint Allegations of Abuse/Neglect: ALF

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated number of substantiated complaint allegations of abuse and/or neglect in assisted living facilities during the state fiscal year. Abuse and neglect are defined by state and federal regulations. {See outcome measure 4 for the definitions 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

The numbers of substantiated complaint allegations of abuse/neglect in assisted living facilities during the months of the reporting period are totaled.

BL 2006 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in assisted living 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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	16	# Substantiated Complaint Allegations of Abuse/Neglect: Adult Day Care

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated number of substantiated complaint allegations of abuse and/or neglect in adult day care facilities during the state fiscal year. Abuse and neglect are defined by state and federal regulations. {See outcome measure 4 for the definitions 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

The numbers of substantiated complaint allegations of abuse/neglect in adult day health care centers during the months of the reporting period are totaled.

BL 2006 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in adult day health care centers. 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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	17	Number of Substantiated Complaint Allegations of Abuse/Neglect: ICF/MR

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of substantiated complaint allegations of abuse and/or neglect in ICF-MR facilities 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 summing the number of substantiated complaint allegations of abuse/neglect in ICFs/MR during the months of the reporting period.

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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	18	# Substantiated Complaint Allegations Physical Plant: NF

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

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

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2006 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in the various types of residential care 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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	19	# Substantiated Complaint Allegations Unsafe Physical Plant: ALF

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

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

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2006 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in the various types of residential care 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
Strategy No. 1 Long-Term Care Facility Regulation
Measure Type OP
Measure No. 20 # Substantiated Complaint Allegations Unsafe Physical Plant: ADC

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

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

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2006 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in the various types of residential care 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
Strategy No.	1	Long-Term Care Facility Regulation
Measure Type	OP	
Measure No.	21	# Substantiated Complaint Allegations of Unsafe Physical: ICF/MR

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

Fall/Annual: N

BL 2006 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

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

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2006 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in the various types of residential care 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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	EF	
Measure No.	1	Average Cost Per License Issued: Nursing Facility Administrators

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost per license issued to nursing facility administrators. The issuance of licenses establishes the minimal competency of practitioners.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

The number of nursing facility administrator licenses is currently entered in a FoxPro system maintained by the Texas Department of Human Services. The cost of nursing facility administrator licensing staff will be obtained from the Health and Human Services Administrative System.

BL 2006 Methodology

The average cost is calculated by dividing the total cost of the direct charge for nursing facility administrator licensing staff by the total number of licenses issued. The total cost of nursing facility administrator licensing staff includes salary, travel, and overhead of direct staff identified by BJN plus a portion of the cost of salary, travel, and overhead of the Licensing Unit supervisor and the Credentialing general administration staff allocated to this function based on FTE. The PAC overhead costs will be allocated to this function based on FTE. The Credentialing staff will report the total number of licenses issued each reporting period.

BL 2006 Purpose

This measure quantifies the unit cost associated with issuing licenses to nursing facility administrators. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting future funding needs.

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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	EF	
Measure No.	2	Average Cost Per Credential Issued: Nurse/Medication Aides

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost per issuance of nurse aide certifications and medication aide permits. The issuance of certifications and permits establishes the minimal competency of practitioners.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Nurse Aide Competency Evaluation Service (NACES) reports the number of nurse aide tests given each month. The number of nurse aide certifications is entered in the Nurse Aide Registry. The number of medication aide permits is entered in the REAL System maintained by Assessment Systems, Inc. (ASI), which DHS Credentialing staff has access to. The cost of nurse aide registry staff and medication aide staff are obtained from the Health and Human Services Administrative System.

BL 2006 Methodology

Divide tot cost of reimbursable nurse aide(NA)tests+tot $ of direct charge NA registry staff who process certs in the Credentialing Sec. & 95% of medication aide(MA)staff by tot # of certs & permits issued. Tot $ of reimbursable NA tests is obtained by multiplying the set fee/test X the tot # of tests given. Fee/test is set by contract w ASI. The $ of NA registry staff who process certs (ID by BJN) includes $ of salary, travel & overhead + portion of $ of salary, travel & overhead of NA Unit supervisor & Credentialing general admin staff allocated to this functon based on FTE. $ of MA staff issuing permits (ID by BJN) includes $ of salary, travel & overhead X 95% + portion of salary, travel & overhead $ of Licensing Unit supervisor & Credentialing general admini staff allocated to this function based on FTE. PAC overhead $ will be allocated to this function based on FTE. Credentialing staff will report the tot # certifications, permits & licenses issued each reporting period.

BL 2006 Purpose

This measure quantifies the unit cost associated with issuing credentials to nurse aides and medication aides. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting future funding needs.

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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	EF	
Measure No.	3	Average Cost Per Complaint Resolved: Nursing Facility Administrators

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost per referral or complaint on nursing facility administrators. The resolution of the referrals and complaints maintains the function of establishing the minimal competency of practitioners.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Referrals are received from the Long-term Care Regulatory staff and complaints are received from the public. The number of referrals and complaints received are manually tabulated from a log maintained by the Complaints and Investigations unit in the Credentialing Section of DHS. The cost of the Complaints and Investigations unit will be obtained from the Health and Human Services Administrative System.

BL 2006 Methodology

The average is calculated by dividing the total cost of direct charge staff in the Complaints and Investigations unit plus the reimbursements made to the Nursing Facilities Administrators Advisory Committee members for travel expenses by the total number of referrals and complaints received. The calculation of this average will be exclusive of the costs for legal support. The cost of staff in the Complaints and Investigations unit (excluding one BJN) includes the cost of salary, travel, and overhead plus a portion of the cost of salary, travel, and overhead of the Credentialing general administration staff allocated to this function based on FTE. The PAC overhead costs will be allocated to this function based on FTE. The staff in the Complaints and Investigations unit will report the number of referrals and complaints received for the reporting period.

BL 2006 Purpose

This measure quantifies the unit cost associated with pursuing the validity of complaints and referrals of nursing home administrators. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting funding needs.

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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	EF	
Measure No.	4	Average Cost Per Complaint Resolved: Nurse/Medication Aides

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost per referral or complaint on nurse aides, medication aides, and uncredentialed direct care personnel. The resolution of the referrals and complaints maintains the function of establishing the minimal competency of practitioners.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Referrals are received from Long-term Care Regulatory staff and complaints are received from the public. The number of referrals and complaints received are manually tabulated from a log maintained by DHS' Credentialing staff. The cost of the staff handling complaints and referrals on nurse aides, medication aides, and uncredentialed staff is obtained from the Health and Human Services Administrative System.

BL 2006 Methodology

Divide tot cost($) of a staff in the Nurse Aide Registry (NAR)unit, 5% of a medication aide (MA), 100% of Employee Misconduct Registry (EMR) staff & 5% of a progr spec ingen admin supvising EMR staff by tot # of referrals & complaints received. Calculation excludes $ for legal support & intake of complaints/ investigations for NAs. Staff $ of NAR unit handling NA complaints (ID by BJN) include salary, travel & overhead (STO) + part $ of STO of NAR unit supervsor & Credentalng gen admin staff alloc to this function based on FTE. MA staff $ (ID by BJN) include STO X 5% + part of STO $ of Licensng supervsor & Credentalng gen admin staff alloc to this function based on FTE. EMR staff $ (ID by BJN) include STO + 5% of STO of a prog spec in gen admin directly supervsing EMR staff & part STO of Credentalng gen admin staff alloc to this functionbased on FTE. PAC OH $ are alloc based on FTE. Complaints/Investigations Unit reports # of referrals/complaints received in the reporting period.

BL 2006 Purpose

This measure quantifies the unit cost associated with pursuing the validity of complaints and referrals of nurse aides, medication aides, and uncredentialed direct care personnel. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting funding needs.

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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	OP	
Measure No.	1	Number of Licenses Issued Per Year: Nursing Facility Administrators

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total number of licenses issued or renewed for nursing facility administrators during all months of the reporting period.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the automated nursing facility administrator database.

BL 2006 Methodology

Data are calculated by totaling the number of licenses issued and renewed during the months of the reporting period.

BL 2006 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

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
Strategy No. 2 Long-Term Care Credentialing
Measure Type OP
Measure No. 2 Number of Credentials Issued Per Year: Nurse/Medication Aides

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total number of credentials issued or renewed for nurse aides and medication aides during all months of the reporting period.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Data are obtained from the automated "REAL" system.

BL 2006 Methodology

Data are computed by totaling the number of permits and certifications issued or renewed during the months of the reporting period.

BL 2006 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	OP	
Measure No.	3	Number of Complaints Resolved/Year: Nursing Facility Administrators

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

Fall/Annual: N

BL 2006 Definition

This measure reports the total number of complaints and referrals against nursing home administrators that were resolved during all months of the reporting period. Complaints and referrals are resolved by DADS, either administratively by the Credentialing Section or through Fair Hearings conducted by the department's Legal Division.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

This information is manually collected. 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 computed by totaling the number of complaints and referrals dismissed by the Nursing Facility Administrators Advisory Committee and number of cases resolved through formal hearing or settlement during the months of the reporting period.

BL 2006 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

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
Strategy No.	2	Long-Term Care Credentialing
Measure Type	OP	
Measure No.	4	Number of Complaints Resolved/Year: Nurse/Medication Aides/Direct Care

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of complaints and referrals against medication aides, nurse aides, and uncredentialed staff that have been resolved. The uncredentialed staff is all direct care personnel not licensed by another state agency in long-term care facilities licensed by DADS. Complaints and Referrals are resolved by DADS either administratively by the Credentialing Section or through Fair Hearings conducted by the department's Legal Division.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

This information 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.

BL 2006 Methodology

Data are computed by tabulating the number of complaints and referrals with final action of dismissal or imposition of sanctions for each month of the reporting period. These monthly numbers for each of the months in the reporting period are summed.

BL 2006 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This data is useful in projecting future funding needs.

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
Strategy No.	3	Long-Term Care Quality Outreach
Measure Type	EF	
Measure No.	1	Average Cost Per Quality Monitoring Program Visit

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

Fall/Annual: N

BL 2006 Definition

This measure reports the average cost of a unit of work of the Quality Monitoring Program during the reporting period. In the case of Quality Monitoring Visits, each visit represents a number of units of work equal to the number of days required to conduct the visit. Rapid Response Team visits, requiring two or more monitors will represent 2 or more units of work. Work units for Provider Technical Assistance Meetings that require the participation of quality monitor program staff is equal to the number of facilities that attend the educational meeting.

BL 2006 Data Limitations

Does not apply.

BL 2006 Data Source

Units of work are obtained from a visit database that records actual units of work and checked against monthly activity reports collected by the Quality Monitoring Program managers. The average cost per unit of work is calculated from the program budget and the units of work. There is no specific report name or number.

BL 2006 Methodology

The total number of completed work units is determined from the quality monitoring visits, rapid response team visits and facility participation in provider technical assistance meetings occurring during the reporting period. The quarterly program budget is one-fourth of the annual total distributed to the regions for this activity.

BL 2006 Purpose

This measure is a mechanism for assessing the unit cost of implementing the provisions of this strategy.

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
Strategy No. 3 Long-Term Care Quality Outreach
Measure Type OP
Measure No. 1 Number of Quality Monitoring Visits

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

Fall/Annual: N

BL 2006 Definition

This measure reports the number of Quality Monitoring Program Work Units that are comprised of Quality Monitoring Visits, Rapid Response Team visits, and Provider Technical Assistance Meetings for Long Term Care facilities during the reporting period. Quality Monitoring visits are usually performed by a single quality monitor; Rapid Response Team visits require two or more quality monitors. Both visit types involve individual facilities. Provider Technical Assistance Meetings, like Rapid Response Team visits, are multidisciplinary; in addition, they provide technical assistance to multiple providers at once. Visit priority is assigned through the use of an Early Warning System algorithm. In this measure, a "visit" is defined as the deployment of an individual monitor to a facility; more precisely this is the program's Unit of Work, and Rapid Response Team visits may represent 2 or more units of work (because they may require 2 or more monitors).
CONTINUED BELOW IN DATA LIMITATIONS

BL 2006 Data Limitations

Does Not apply.

CONTINUATION OF DEFINITION
Provider Technical Assistance Meeting work units are determined from number of facilities that actually attend each such meeting. Technical assistance meetings involve a small number of facilities (usually fewer than ten) brought together for an intensive technical assistance session.

BL 2006 Data Source

Units of work are obtained from a visit database that records actual units of work and checked against monthly activity reports collected by the Quality Monitoring Program managers. There is no specific report name or number.

BL 2006 Methodology

The total number of completed monitoring visits is determined by counting the number of visits identified as Quality Monitoring visits (including Rapid Response visits) occurring during the reporting period. Similarly, Provider Education Meetings are counted from records of the events.

BL 2006 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy and indicates how many Quality Monitoring visits and technical assistance events are occurring in accordance with the requirements of Senate Bill 1839 77th Legislature.