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

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

Calculation Method: N Key Measure: N New Measure: N Target Attainment: H Priority: H Cross Reference: Agy 539 079-R-S70-1 01-01 OC 01

BL 2008 Definition

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

BL 2008 Data Limitations

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

BL 2008 Data Source

The total number of nursing facilities served by an ombudsman is reported monthly on the Ombudsman Program Performance Report. The total number of nursing facilities is based upon the most recently published data from the Department of Aging and Disability Services, Regulatory Services Data Management, as of the end of each fiscal year.

BL 2008 Methodology

This measure is calculated by dividing the total number of nursing facilities served by an ombudsman by the total number of licensed nursing facilities in the

BL 2008 Purpose

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

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

Goal No. 1 Long-term Services and Supports
Objective No. 1 Intake, Access, and Eligibility
Outcome No. 2 Avg # of Clients Served Per Month: Total Community Services & Supports

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-01 OC 02

BL 2008 Definition

This measure reports the total monthly average number of clients served through many of the agency's community services and supports programs. The different types of clients that comprise this measure are identified under output measure 1 of strategies 1.2.1., 1.2.2., 1.2.3., 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.3.6., 1.3.7., 1.4.1., 1.4.2., 1.4.4., 1.4.5, 1.5.1., and 1.6.4. Output measure # 2 is also included from strategy 1.4.2.

BL 2008 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Data for these services are based on annual unduplicated client counts that cannot be combined with the monthly averages reported for each of the other non-Medicaid Community services and supports measures. Specific data limitations for each of these other measures are identified under output measure 1 of strategies 1.2.1., 1.2.2., 1.2.3., 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.3.6., 1.3.7., 1.4.1., 1.4.2., 1.4.4., 1.4.5., 1.5.1., and 1.6.4. Output measure 2 of strategy 1.4.2. is also included.

BL 2008 Data Source

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

BL 2008 Methodology

This measure reports the sum of the average number of consumers served per month through Medicaid entitlement programs (Primary Home Care, Community Attendant Services and Day Activity and Health Services (XIX)); Medicaid waiver programs (Community-based Alternatives, Home and Community-based Services, Community Living Assistance and Support Services, Deaf-blind with Multiple Disabilities, Medically Dependent Children Program, Texas Home Living and Consolidated Wavier Program); non-Medicaid Title XX programs; In-Home and Family Support Services; PACE; promoting independence services; and the average number of consumers with mental retardation (MR) receiving community, residential, and MR In-Home services.

BL 2008 Purpose

This measure is a mechanism for assessing the agency’s performance as it pertains to services provided through community services and supports programs.

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

Goal No. 1 Long-term Services and Supports
Objective No. 1 Intake, Access, and Eligibility
Outcome No. 3 Avg # Persons on Interest Lists/Mth: Total Community Serv & Supports

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-01 OC 03

BL 2008 Definition

This measure reports the sum of the average monthly number of persons on an interest list for: Medicaid Community-Based Alternatives (CBA) Waiver services, Medicaid Home and Community-based (HCS) Waiver services, Medicaid Related Conditions (CLASS) Waiver services, Deaf-blind with Multiple Disabilities Waiver services, Medically Dependent Children Program services, non-Medicaid XX Community Services and Supports, Mental Retardation (MR) Community Services, In-Home and Family Support Services and MR In-Home Services. See explanatory measures under strategies 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.4.1., 1.4.2., 1.4.4. and 1.4.5.

BL 2008 Data Limitations

See specific data limitations for each of the services that comprise this measure.

BL 2008 Data Source

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

BL 2008 Methodology

This measure is derived by summing the component measures that comprise this measure. See explanatory measures under strategies 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.4.1., 1.4.2., 1.4.4., and 1.4.5.

BL 2008 Purpose

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

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

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

Calculation Method: N Key Measure: Y New Measure: N Target Attainment: H Priority: H Cross Reference: Agy 539 079-R-S70-1 01-01 OC 04

BL 2008 Definition

This measure reports the # of persons served in community settings expressed as a % of all persons receiving DADS Long-term Services and Supports. The # of clients served in community settings is defined as the # of persons served/month in the community (defined in outcome 2 of obj 1.1). The total avg # of clients served in long-term services and supports/month is defined as the total avg # of persons served in the community/month (defined in outcome 2 of obj 1.1) plus the avg # of clients receiving Medicaid-funded nursing facility services/month (strategy 1.6.1 output 1), the avg # of clients receiving co-paid Medicaid/Medicare nursing facility services/month (strategy 1.6.2. output 1), the avg # of clients receiving Hospice services/month (strategy 1.6.3. output 1), the avg # of persons in intermediate care facility for the mentally retarded (ICF/MR) beds/month (strategy 1.7.1. output 1), and the avg monthly # of MR campus residents (strategy 1.8.1 output 1).

BL 2008 Data Limitations

See data limitations listed under outcome measure 2 of objective 1.1. and output measure 1 of strategies 1.6.1., 1.6.2., 1.6.3., 1.7.1. and 1.81.

BL 2008 Data Source

Specific sources used in the computation of this measure are identified under outcome measure 2 of objective 1.1. and output measures 1 of strategies 1.6.1.,1.6.2., 1.6.3., 1.7.1., and 1.8.1.

BL 2008 Methodology

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

BL 2008 Purpose

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

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

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

Calculation Method: N Key Measure: N New Measure: N Target Attainment: H Priority: L Cross Reference: Agy 539 079-R-S70-1 01-01 OC 05

BL 2008 Definition

This measures reports the number of individuals who are diverted from institutional care services into community services as well as those who are successfully moved from a nursing facility into Medicaid-funded waiver services provided in the community, and paid for by the State of Texas. Individuals in this latter group must be residing in a Texas nursing facility immediately prior to transitioning, and their nursing home stay must have been eligible for reimbursement by Medicaid. The number of deinstitutionalized or diverted clients is the total average number of Medicaid waiver clients served per month (outcome measure 1 under objective 1.3.), the number of Program of All-inclusive Care for the Elderly (PACE) recipients per month (output measure 1 of strategy 1.5.1), and the number of Promoting Independence clients served per month (output measure 1 of strategy 1.6.4.).

BL 2008 Data Limitations

See data limitations discussed under outcome measure 1 of objective 1.3. and output measure 1 of strategies 1.5.1. and 1.6.4.

BL 2008 Data Source

Clients meeting the above criteria are identified and tracked through the Department of Aging and Disability Services' (DADS') Service Authorization System (SAS). Two types of data are used to report this measure. The number of clients identified as meeting the above criteria is obtained from SAS by means of ad hoc query. Month-of-service to-date data that reports the number of these clients for whom claims have been approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query. Other data sources are identified under output measure 1 of strategies 1.3.2., 1.3.7., 1.5.1. and

BL 2008 Methodology

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

BL 2008 Purpose

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

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

Goal No. 1 Long-term Services and Supports
Objective No. 2 Community Services and Supports - Entitlement
Outcome No. 1 Avg # Clients Serve/Mth: Medicaid Non-waiver Community Serv & Supports

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 01-02 OC 01

BL 2008 Definition

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

BL 2008 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 2008 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 2008 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 2008 Purpose

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

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

Goal No. 1 Long-term Services and Supports
Objective No. 2 Community Services and Supports - Entitlement
Outcome No. 2 Avg Mthly Cost/Client: Medicaid Non-waiver Community Serv & Supports

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-02 OC 02

BL 2008 Definition

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

BL 2008 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 2008 Data Source

Month-of-service to-date data that reports, by type-of-service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query. Data for this measure is based on strategy 1, efficiency measure 1; strategy 2, efficiency measure 1; and strategy 3, efficiency measure 1 of objective1.2.

BL 2008 Methodology

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

BL 2008 Purpose

This measure quantifies the unit cost for providing eligible persons with services and supports 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 Services and Supports
Objective No. 3 Community Services and Supports - Waivers
Outcome No. 1 Avg # of Clients Served Per Mth: Community Serv/Supp Waivers (Total)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 01-03 OC 01

BL 2008 Definition

This measure reports the total monthly average number of Community Services and Supports Medicaid waiver clients served. See output measures 1 under the following strategies for more detail: Community-Based Alternatives (CBA) Waiver –1.3.1; Home and Community-Based Services (HCS) Waiver –1.3.2; Community Living Assistance and Support Services (CLASS) Waiver –1.3.3; Deaf-blind Waiver – 1.3.4; Medically Dependent Children Program (MDCP) –1.3.5; Consolidated Waiver –1.3.6; and Texas Home Living Waiver –1.3.7.

BL 2008 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 2008 Data Source

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

BL 2008 Methodology

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

BL 2008 Purpose

This measure reflects the combined level of activity occurring in the agency’s Medicaid waiver programs over time. It is an indicator of the impact on the state’s elderly and disabled population who qualify for nursing facility services and supports but who can be served at home or in the community, helping these individuals to maintain their independence and prevent institutionalization.

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

Goal No. 1 Long-term Services and Supports
Objective No. 3 Community Services and Supports - Waivers
Outcome No. 2 Avg Cost/Client Served: Community Services & Supports Waivers (Total)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-03 OC 02

BL 2008 Definition

This measure reports the total monthly average cost of serving Community Care Medicaid waiver clients. See efficiency measure 1 under the following strategies for more detail: Community-Based Alternatives (CBA) Waiver –1.3.1; Home and Community-Based Services (HCS) Waiver –1.3.2; Community Living Assistance and Support Services (CLASS) Waiver –1.3.3; Deaf-blind Waiver –1.3.4; Medically Dependent Children Program MDCP –1.3.5; Consolidated Waiver –1.3.6; Texas Home Living Waiver –1.3.7.

BL 2008 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 2008 Data Source

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

BL 2008 Methodology

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

BL 2008 Purpose

This measure reflects the combined level of activity occurring in the agency’s Medicaid waiver programs over time. It is an indicator of the impact on the state’s elderly and disabled population who qualify for nursing facility services and supports but who can be served at home or in the community, helping these individuals to maintain their independence and prevent institutionalization.

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

Goal No. 1 Long-term Services and Supports
Objective No. 4 Community Services and Supports - State
Outcome No. 1 Avg # Clients Served Per Mth: Total Non-Medicaid Community Serv/Supp

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-04 OC 01

BL 2008 Definition

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

BL 2008 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Data for these services are reported as annual unduplicated counts that cannot be combined with the monthly averages reported for each of the other services. For other data limitations, refer to output measure 1 under strategies 1.4.1., 1.4.4. and 1.4.5., and output measures 1 and 2 under strategy 1.4.2.

BL 2008 Data Source

Specific data sources are detailed under each of the measures that comprise this “roll-up” measure. See output measure 1 under strategies, 1, 4, 5, and output measures 1 and 2 under strategy 1.4.2.

BL 2008 Methodology

This measure is the sum of output measure 1 under strategies 1, 2, 4, 5, and output measure 2 of strategy 2 of this objective.

BL 2008 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 Services and Supports
Objective No. 4 Community Services and Supports - State
Outcome No. 2 Avg Mthly Cost/Client Served: Total Non-Medicaid Community Serv/Supp

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-04 OC 02

BL 2008 Definition

This measure reports the average cost of non-Medicaid Community Services and Supports 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 Services and Supports clients is defined under outcome measure 1.

BL 2008 Data Limitations

This measure does not include services provided by the Area Agencies on Aging (AAA). Average cost data for these services are based on annual unduplicated client counts that cannot be combined with the monthly averages reported for each of the other non-Medicaid Community Services and Supports. Specific data limitations for each of these other services are identified under efficiency measure 1 of strategy 1, 4, 5, and efficiency measures 1 and 2 of strategy 2, of this objective.

BL 2008 Data Source

Specific data sources are detailed under each of the measures that comprise this measure. See efficiency measure 1 under strategies 1, 4, and 5 and efficiency measures 1 and 2 of strategy 2.

BL 2008 Methodology

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

BL 2008 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 01-04 OC 03

BL 2008 Definition

This measure reports the sum of the average monthly number of persons who have requested one or more non-Medicaid Community Services and Supports but are placed on an interest list for requested service(s) due to funding constraints. Interest lists are maintained for Title XX funded services, for GR funded services, for all In-home and Family Support services, and for mental retardation (MR) Community and Residential Services. The count only includes those persons on the list who are in "open" status (i.e., it excludes those persons who are being processed for eligibility to begin receiving the service.) The count includes persons who are waiting for one or more non-Medicaid Community Services and Supports while receiving other Community Services and Supports. See explanatory measure 1 under strategies 1.4.1, 1.4.4., and 1.4.5., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this "total"

BL 2008 Data Limitations

See explanatory measure 1 under strategies 1.4.1, 1.4.4., and 1.4.5., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this "total" measure.

BL 2008 Data Source

Specific data sources are identified under each of the measures that are included in this count. See explanatory measure 1 under strategies 1.4.1, 1.4.4., and 1.4.5., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this "total" measure.

BL 2008 Methodology

This measure is the sum of explanatory measure 1 under strategies 1.4.1, 1.4.4., and 1.4.5., and explanatory measure 3 under strategy 1.4.2.

BL 2008 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 01-06 OC 01

BL 2008 Definition

This measure reports the number of persons served in nursing facilities expressed as a percent of the state's population at risk of needing nursing facility services. Persons served in nursing facilities is defined as the sum of: the average number of persons receiving Medicaid-funded nursing facility services per month (strategy 1.6.1, output measure 1), and the average number of persons receiving co-paid Medicaid/Medicare nursing facility services per month (strategy 1.6.2., output measure 1). The population at-risk is defined as aged and disabled persons with income at or below 220% of the poverty level that need assistance with

BL 2008 Data Limitations

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

BL 2008 Data Source

Specific data sources for the number of persons served in nursing facilities are identified under strategy 1.6.1 and strategy 1.6.2., output measure 1. The at-risk population is estimated using baseline information obtained from the last two March Current Population Surveys and the on-going Survey of Income and Program Participation administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center at Texas A&M University, College Station, Texas.

BL 2008 Methodology

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

BL 2008 Purpose

program (i.e. indicates percent of need met).

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 539 079-R-S70-1 01-06 OC 02

BL 2008 Definition

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

BL 2008 Data Limitations

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

BL 2008 Data Source

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

BL 2008 Methodology

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

BL 2008 Purpose

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

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 01-08 OC 01

BL 2008 Definition

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

BL 2008 Data Limitations

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

BL 2008 Data Source

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

BL 2008 Methodology

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

BL 2008 Purpose

Ideally, campus residents recommended for community placement would be placed within 180 days. (Movement within 180 days of an individuals

community placements for campus residents who can benefit from community placement.

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 01-08 OC 02

BL 2008 Definition

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

BL 2008 Data Limitations
None

BL 2008 Data Source

Movement of persons served by the DADS campus based system is recorded in the department's data warehouse system by staff at the facilities. The source of data is the “CAM3 Campus-Based Discharge/Community Placement” Client Assignment and Registration (CARE) system form which indicates actual date of community placement. These forms are located in records available from the state mental retardation facilities. The Community Placement Living Plan is available in the clinical record and projects a date for community placement that may be changed based on a variety of factors. Assignment/Absence codes are used for these movements in the CARE system. The Community Placement (CP) code is used to indicate a community placement from a state mental retardation

BL 2008 Methodology
This is a simple count of persons with an Assignment/Absence code of CP over the fiscal year.

BL 2008 Purpose
The implementation of the Governor's Executive Order, RP 13 and the Health and Human Services Commission's Promoting Independence Plan should have

community placement should have the opportunity for community placement

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 01

BL 2008 Definition

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

BL 2008 Data Limitations

Does not apply.

BL 2008 Data Source

Data are obtained from the Regulatory Services Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing all of the data elements needed to perform the necessary calculations. The report will be titled “% Facilities Complying with Standards at Inspection Licen-Medicare/Medicaid” in the future.

BL 2008 Methodology

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

BL 2008 Purpose

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

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

Goal No. 2 Regulation, Certification, and Outreach
Objective No. 1 Regulation, Certification, and Outreach
Outcome No. 2 % Facilities Correcting Adverse Findings by 1st Follow-up Visit

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 02

BL 2008 Definition

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

BL 2008 Data Limitations

Does not apply.

BL 2008 Data Source

Data are obtained from the Central Data Repository (CDR) that pulls nursing facility only data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. 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 will be titled “Facilities Correcting Adverse Findings by 1st Follow-up Visit” in the future.

BL 2008 Methodology

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

BL 2008 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 03

BL 2008 Definition

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

BL 2008 Data Limitations

Does not apply.

BL 2008 Data Source

Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. 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 will be titled “% NF with More Than Six on-site Monitoring Visits Per Year” in the future.

BL 2008 Methodology

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

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 04

BL 2008 Definition

This measure reports the rate of substantiated complaint allegations of resident abuse and/or neglect in nursing facilities (NF) per 1,000 residents during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional Regulatory Services survey/investigation staff determine whether allegations are substantiated after a thorough investigation. Abuse and neglect are defined by state and federal regulations. Abuse is defined as the willful infliction 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

BL 2008 Data Limitations

Does not apply.

BL 2008 Data Source

Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “Rate (1000) Substantiated Complaint Allegations of Abuse/Neglect: NF” in the future. The data for the number of residents in nursing facilities is reflective of facility census data collected at the last Regulatory Services staffs visit and entered into CARES. The census data may range from several weeks to several months old.

BL 2008 Methodology

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

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programs effectiveness and accessing the accountability of facilities.

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 05

BL 2008 Definition

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

BL 2008 Data Limitations
Does not apply.

BL 2008 Data Source

Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “Rate (1000) Substantiated Complaint Allegations Abuse/Neglect: ICF/MR” in the future. The data for the number of residents in ICF/MR facilities for persons with related conditions is reflective of facility census data collected at the last Regulatory Services staff visit and entered in the CARES system. The census data may range from several weeks to several months old.

BL 2008 Methodology
This measure is computed by dividing the number of substantiated complaint allegations of abuse/neglect in ICF/MR facilities during the months of the reporting period by the total number of residents in ICF/MR facilities during this period, and then multiplying this result by 1,000.

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program's effectiveness and accessing the accountability of facilities.

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 06

BL 2008 Definition

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

BL 2008 Data Limitations

Does not apply.

BL 2008 Data Source

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

BL 2008 Methodology

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

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assessing the programs effectiveness and the accountability of nursing facility personnel.

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

Goal No. 2 Regulation, Certification, and Outreach
Objective No. 1 Regulation, Certification, and Outreach
Outcome No. 7 Percent of Nurse Aides and Medication Aides with No Recent Violations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 07

BL 2008 Definition

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

BL 2008 Data Limitations
Does not apply.

BL 2008 Data Source

Data are obtained from the automated Nurse Aide and Medication Aide Tracking Systems.

BL 2008 Methodology
Data are calculated by dividing the number of medication aides and nurse aides without an imposed sanction (numerator) by the number of all credentialed medication aides and nurse aides (denominator), multiplied by 100. The numerator is derived by subtracting the number of medication aides and nurse aides with sanctions imposed within the last 24 months from the total number of medication aides permitted and nurse aides in active status on the nurse aide registry at the time of reporting. The denominator is derived by tabulating the total number of medication aides permitted and nurse aides in active status on the nurse aide registry at the time of reporting.

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evaluating the programs effectiveness and assessing the accountability of nursing facility personnel.

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

Goal No. 2 Regulation, Certification, and Outreach
Objective No. 1 Regulation, Certification, and Outreach
Outcome No. 8 % Complaints and Referrals Resulting in Disciplinary Action: NFA

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 08

BL 2008 Definition

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

BL 2008 Data Limitations

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

BL 2008 Data Source

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

BL 2008 Methodology

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

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evaluating the Program's effectiveness and assessing the accountability of nursing facility personnel.

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 09

BL 2008 Definition

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

BL 2008 Data Limitations
Does not apply.

BL 2008 Data Source

This information is manually collected and tabulated. Manual collections of data are pen and paper tabulations of information manually pulled from the Nurse Aide and Medication Aide tracking systems. There are no report titles or identifying numbers associated with this process.

BL 2008 Methodology
Data are calculated by dividing the number of sanctions imposed against medication aides and nurse aides (numerator) by the number of complaints and referrals received on medication aides and nurse aides (denominator), multiplied by 100. The numerator is derived by tabulating the number of sanctions imposed during the reporting period up to the time of reporting. The denominator is derived by tabulating the number of complaints and referrals received during the reporting period up to the time of reporting.

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evaluating the programs effectiveness and accessing the accountability of nursing facility personnel.

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

Goal No. 2 Regulation, Certification, and Outreach
Objective No. 1 Regulation, Certification, and Outreach
Outcome No. 10 % HCSSA Complying with Standards at Time of Inspection

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 10

BL 2008 Definition

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

BL 2008 Data Limitations
Does not apply.

BL 2008 Data Source

Data are obtained from regional HCSSA staff workload input reports. Data will be contained in an ad hoc report at the end of the reporting period. This report will be titled “% HCSSAs Complying with Standards at Time of Inspection” in the future.

BL 2008 Methodology
The percentage of agencies complying with standards during the state fiscal year is calculated by dividing the number of facilities determined to be in compliance at the time of inspection (numerator) by the total number of agencies inspected (denominator) during the reporting period, and multiplying this result by 100

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 079-R-S70-1 02-01 OC 11

BL 2008 Definition

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

BL 2008 Data Limitations

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

BL 2008 Data Source

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

BL 2008 Methodology

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

BL 2008 Purpose

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